

Philosophy of Psychiatry and Mental Illness

Brendan's Big Book of Bioethics | Brendan Shea, Ph.D. (Brendan.Shea@rctc.edu)

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2 INTRODUCTION

In this chapter, we'll consider some ethical and philosophical issues surrounding **mental illness**: what it is, how we treat it, and what we might do differently. Even more so than other chapters, this is an “overview” of a rich field of study (though it's often one left out of “standard” bioethics textbooks and courses). If you are interested in learning more, I'd encourage you to check out the following (which I consulted when putting this chapter together).

- “Mental Illness, Philosophy Of.” 2022. In *Internet Encyclopedia of Philosophy*.
<https://iep.utm.edu/mental-i/>.
- Murphy, Dominic. 2020. “Philosophy of Psychiatry.” In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Fall 2020. Metaphysics Research Lab, Stanford University.
<https://plato.stanford.edu/archives/fall2020/entries/psychiatry/>.
- Radden, Jennifer. 2019. “Mental Disorder (Illness).” In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Winter 2019. Metaphysics Research Lab, Stanford University.
<https://plato.stanford.edu/archives/win2019/entries/mental-disorder/>.

2.1 THE STANDARD MODEL OF MENTAL ILLNESS

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or

culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (American Psychiatric Association 2013, 20).

Psychiatry (the branch of medicine concerned with diagnosis and treatment of mental illness) is still a relatively “young” science, and psychiatrists (unlike their peers in the “hard” sciences such as chemistry, physics, or biology) still disagree on fundamental questions about the underlying nature of the conditions that they study and treat. Some emphasize the biological/neurological underpinnings, others the thought patterns, and others their behavioral/social manifestations. This pluralism is reflected in **The Diagnostic and Statistical Manual of Mental Disorders (DSM)**, which provides the official definitions of “mental illness” for medicine, the law, and related areas (such as insurance coverage). The first edition of the DSM was published in 1952; it is currently in version 5.

Since DSM III (1980), the DSM has used variants of “bio-psycho-social” model of illness, according to which an **illness** is defined in terms of “dysfunctions” of an individual biological, social, or psychological function. The quote at the beginning of this section gives an example of this definition.

According to this definition, a **mental illness** must meet

1. Be a clinically significant disturbance in cognition, emotion regulation, or behavior
2. Reflect a dysfunction in biological, psychological, or developmental processes
3. Usually cause “significant” distress or disability (some conditions, such as antisocial personality disorder, are primarily characterized by the distress caused to others)
4. Not reflect a culturally approved response to a situation or event
5. Not result purely from a problem between an individual and her society

All aspects of this definition have been the subject of intense debate and discussion.

2.2 QUESTIONS ABOUT THE “STANDARD” MODEL AND ITS APPLICATION

There are many interesting ethical and philosophical questions about mental illness (many more than we have time to cover here). However, here are a few to get you started:

1. **Is a “science” of the mental realm possible? If it is, what form should it take?** The concept of mental illness was developed initially as an analogy with physical illness (such as heart disease or cancer). Some critics, such as the (in)famous Thomas Szasz have argued this in an inappropriate and unhelpful way of thinking about human thoughts and emotions, since the methods we rely on to investigate and treat physical illness (detailed anatomical studies, application of biological/chemical “laws”, etc.) can’t be applied to the mental realm. Other (notably less radical) critics have contended that mental illness should be defined more narrowly than it currently is, and that definitions need to be tied more tightly to other, better understood areas of science (such as neuroscience—the study of the brain). The DSM has moved toward including more neuroscience; however, there is still a lot we don’t know about how the brain operates, even in very well studied conditions (for example, the brain mechanisms behind autism, depression, etc.).
2. **Is “mental illness” a natural kind? A social kind? Something else?** Many scientists and philosophers believe that core concepts of sciences like physics, chemistry, and biology are *natural kinds* that reflect deep facts about “the way our world is.” So, for example, it entities such as electrons, genes, neurons, DNA, and atoms would exist in more or less their same form even if humans were never around to label them. However, it’s not clear that mental illnesses such as anxiety/depression disorders are natural kinds in this same sense. Instead, some have argued that they are **social kinds (or “looping kinds”)**, in that

labeling a person as having a particular illness changes how people think about themselves and how others treat them. This makes diagnosis and treatment tricky, as it can sometimes be hard to separate the “objective” components of the illness with the “social” effects of the label. The fact that mental illness might be (partly) socially constructed in this way does NOT mean it isn’t “real.” There are plenty of things that are socially constructed (computers, cars, the English language) that are real.

3. **Are “lists of symptoms” an effective way to diagnose mental illness, even if we don’t understand the underlying mechanism?** According to the DSM-5, most mental illnesses are diagnosed using a “cluster” of cognitive, social, or (in some cases) physiological symptoms, and patients are said to have the condition if they have a certain number of those symptoms. For example, conditions such as Autism Spectrum Disorder (ASD), Schizophrenia, Generalized Anxiety Disorder (GAD), and Major Depressive Disorder are all diagnosed by (1) considering a list of symptoms and (2) determining whether a patient has at least a certain number. This approach to diagnosis has led to several worries. First, there has been considerable debate about whether defining “illness” in this way makes sense. For example, there have long been arguments about the “scope” of diagnoses like ASD, GAD, since patients diagnosed with these conditions have such different symptoms from one another (and thus, need very different treatment). On the one side, there are those who argue that these diagnoses should be defined relatively narrowly, and only in cases where we can reasonably hope to find some sort of underlying “brain” mechanism. Among other things, they contend this would prevent “overtreatment” or “overdiagnosis.”

On the other hand, some would like to define them more broadly. This would allow a broad spectrum of severity, and might help remedy the problem of “undertreatment” or “underdiagnosis.” Over the years, the DSM has attempted to take these criticisms into account (for example, by changing the definitions of these conditions).

4. **How consistent/reliable are mental health professionals at applying definitions of mental illness?** The DSM approach to defining mental illness has been criticized for being not “reliable”, in that two trained psychiatrists can disagree on (1) whether a particular patient has a mental illness and (2) what mental illness they have. This results partly from the “grab bag of symptoms” approach to diagnosis and partly from the fact that determining the presence of symptoms often requires “subjective” judgement by clinicians. This is the case in other areas of medicine, as well, but the issue seems more pronounced when it comes to mental illness. Again, this is an issue that new editions of the DSM have tried to address. However, it is probably unrealistic to think that psychiatric diagnosis will ever have the same “reliability” as disciplines like cardiology (studying heart disease) or oncology (studying cancer).

The “**neurodiversity**” movement holds that medicine has historically been too willing to diagnose anyone who is different from the norm with mental illness. So, for example, it wasn’t until 1973 that the DSM removed “homosexuality” as a mental illness. More recently, there have been debates about conditions ranging from ADHD to gender dysphoria to ASD.

5. **How effective are current treatment mental health methods?** Both psychology and psychiatry have regularly been subject to methodological critiques regarding their methods. In recent years, the so-called “**Replication Crisis**” has called many textbook results of social and clinical psychology into doubt, as well as the results of some psychiatric drug trials. In essence, the crisis is that contemporary researchers have discovered that the scientific studies on which our current methods are based “can’t be replicated.” That is, when other researchers try to do “the same experiment,” they find that they can’t get “the same results.” It seems plausible that many factors have contributed to this, including biased selection of test subjects, journals’ bias in publishing only “positive” results, the widespread use of sloppy statistical methods, and industry funding of studies (especially drug trials). There is currently a significant effort (by statisticians, scientists, philosophers, and others) to correct these issues in the future, though it remains to be seen how successful this will be.

6. **Why aren't we happier?** A wide variety of research has found that people report being “less happy” than they used to be, even as psychology has made considerable advances as a science, and access to mental health care has increased. What is behind this?
7. **How do the “Four Principles” apply to treating patients with mental illness?** Finally, given all of these issues, how can mental health professionals and others best help those with mental illness? A few ideas:
- a. **The Principle of Autonomy** requires that we respect and support the ability of others to make their own decisions about their life. Historically, society has NOT done a good job of this when it comes to mental health, and being diagnosed with a mental illness (from depression to Alzheimer's to developmental disability) has often led to a person losing much of their ability to “choose” for themselves. On other other, leaving people WITHOUT treatment can also compromise their autonomy (since this allows their illness to “dominate” them).
 - b. **The Principle of Nonmaleficence** requires that we don't HARM people. Again, this is an issue psychiatry has struggled with, and there is a long history of using inappropriate medical interventions (lobotomies, electro-shock therapy, certain medications) in ways that harm people with mental illness. In many cases, the issue here has been one of confusing *society's* view of the “good life” (“We'd like these people to behave more like us!”) with the individual's view of the good life (“Here's how I would like to live.”). On the flip side, there is the issue of **negligence**, and many people who could benefit from mental health care are denied it.
 - c. **The Principle of Beneficence** requires that we use our resources effectively to promote mental health. Because “happiness” isn't “objectively” measurable, this is something that governments have often failed to do. People, in general, are happier if they can make social connections, get out in nature, pursue meaningful activities, etc. How can we promote these things as society, especially for the most vulnerable members?
 - d. **The Principle of Justice** requires that we distribute benefits and burdens fairly. This requires both equitable access to mental health care and the “just” treatment of people with mental illness (for example, ensuring that they aren't discriminated against in the workforce). Again, these are big issues.

2.3 QUESTIONS

1. How has mental illness touched your own life, or the lives of those around you?
2. In what ways has society gotten better (or worse) in its treatment of mental illness over the years? What do you hope will better 25 years from now?
3. Do you think that neuroscience (the study of the brain) will eventually replace psychiatry? Should it?
4. If you make ONE law or policy related to mental health, what would it be? Why?

3 READING: THE TROUBLED HISTORY OF PSYCHIATRY (JEROME GROSSMAN)¹

Modern medicine can be seen as a quest to understand pathogenesis, the biological cause of an illness. Once pathogenesis—the word comes from the Greek *pathos* (suffering) and *genesis* (origin)—has been established by

¹ Jerome Groopman, “The Troubled History of Psychiatry,” *The New Yorker*, 2019, <https://www.newyorker.com/magazine/2019/05/27/the-troubled-history-of-psychiatry>.

scientific experiment, accurate diagnoses can be made, and targeted therapies developed. In the early years of the AIDS epidemic, there were all kinds of theories about what was causing it: toxicity from drug use during sex, allergic reactions to semen, and so on. Only after the discovery of the human immunodeficiency virus helped lay such conjectures to rest did it become possible to use specific blood tests for diagnosis and, eventually, to provide antiviral drugs to improve immune defenses.

Sometimes a disease's pathogenesis is surprising. As a medical student, I was taught that peptic ulcers were often caused by stress; treatments included bed rest and a soothing diet rich in milk. Anyone who had suggested that ulcers were the result of bacterial infection would have been thought crazy. The prevailing view was that no bacterium could thrive in the acidic environment of the stomach. But in 1982 two Australian researchers (who later won a Nobel Prize for their work) proposed that a bacterium called *Helicobacter pylori* was crucial to the onset of many peptic ulcers. Although the hypothesis was met with widespread scorn, experimental evidence gradually became conclusive. Now ulcers are routinely healed with antibiotics.

But what can medicine do when pathogenesis remains elusive? That's a question that has bedeviled the field of psychiatry for nearly a century and a half. In "Mind Fixers" (Norton), Anne Harrington, a history-of-science professor at Harvard, follows "psychiatry's troubled search for the biology of mental illness," deftly tracing a progression of paradigms adopted by neurologists, psychiatrists, and psychologists, as well as patients and their advocates.

Her narrative begins in the late nineteenth century, when researchers explored the brain's anatomy in an attempt to identify the origins of mental disorders. The studies ultimately proved fruitless, and their failure produced a split in the field. Some psychiatrists sought nonbiological causes, including psychoanalytic ones, for mental disorders. Others doubled down on the biological approach and, as she writes, "increasingly pursued a hodgepodge of theories and projects, many of which, in hindsight, look both ill-considered and incautious." The split is still evident today.

[Brendan: What do you think is the "best" way to conceptualize mental illness? Is it "biological" condition of the brain? A social/cognitive condition? Some combination of these?]

The history that Harrington relays is a series of pendulum swings. For much of the book, touted breakthroughs disappoint, discredited dogmas give rise to counter-dogmas, treatments are influenced by the financial interests of the pharmaceutical industry, and real harm is done to patients and their loved ones. One thing that becomes apparent is that, when pathogenesis is absent, historical events and cultural shifts have an outsized influence on prevailing views on causes and treatments. By charting our fluctuating beliefs about our own minds, Harrington effectively tells a story about the twentieth century itself.

In 1885, the *Boston Medical and Surgical Journal* noted, "The increase in the number of the insane has been exceptionally rapid in the last decade." Mental asylums built earlier in the century were overflowing with patients. Harrington points out that the asylum may have "created its own expanding clientele," but it's possible that insanity really *was* on the rise, in part because of the rapid spread of syphilis. What we now know to be a late stage of the disease was at the time termed "general paralysis of the insane." Patients were afflicted by dementia and grandiose delusions and developed a wobbly gait. Toward the end of the century, as many as one in five people entering asylums had general paralysis of the insane.

Proof of a causal relationship between the condition and syphilis came in 1897, and marked the first time, Harrington writes, that "psychiatry had discovered a specific biological cause for a common mental illness." The discovery was made by the neurologist Richard von Krafft-Ebing (today best known for "Psychopathia Sexualis," his study of sexual "perversion") and his assistant Josef Adolf Hirschl. They devised an experiment that made use of a fact that was already known: syphilis could be contracted only once. The pair took pus

from the sores of syphilitics and injected it into patients suffering from general paralysis of the insane. Then they watched to see if the test subjects became infected. Any patient who did could be said with certainty not to have had the disease before. As it turned out, though, none of the subjects became infected, leading the researchers to conclude that the condition arose from previous infection with syphilis.

This apparent validation of the biological approach was influential. “If it could be done once,” Harrington writes, “maybe it could be done again.” But the work on syphilis proved to be something of a dead end. Neurologists of the time, knowing nothing of brain chemistry, were heavily focussed on what could be observed at autopsy, but there were many mental illnesses that left no trace in the solid tissue of the brain. Harrington frames this outcome in the Cartesian terms of a mind-body dualism: “Brain anatomists had failed so miserably because they focused on the brain at the expense of the mind.”

[Brendan: Why was syphilis such a big deal for the “biological” approach to mental illness? What shortcomings did it have (at least at time)?]

Meanwhile, two neurologists, Pierre Janet and Sigmund Freud, had been exploring a condition that affected both mind and body and that left no detectable trace in brain tissue: hysteria. The symptoms included wild swings of emotion, tremors, catatonia, and convulsions. Both men had studied under Jean-Martin Charcot, who believed that hysteria could arise from traumatic events as well as from physiological causes. Janet contended that patients “split off” memories of traumatic events and manifested them in an array of physical symptoms. He advocated hypnosis as a means of accessing these memories and discovering the causes of a patient’s malady. Freud believed that traumatic memories were repressed and consigned to the unconscious. He developed an interview method to bring them to consciousness, interpreted dreams, and argued that nearly all neuroses arose from repressed “sexual impressions.”

Freud acknowledged the fact “that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science.” He justified the approach by pointing to the inefficacy of other methods and asserting that there was “an intimate connection between the story of the patient’s sufferings and the symptoms of his illness.” Many neurologists, responding to the demand for confessional healing, gave up on anatomy and adopted psychotherapeutics.

Soon, however, the limits of this approach, too, were exposed. During the First World War, men who returned from the trenches apparently uninjured displayed physical symptoms associated with hysteria. Clearly, they couldn’t *all* be manifesting neuroses caused by repressed sexual fantasies. The English physician Charles Myers coined the term “shell shock,” proposing a physiological cause: damage to the nervous system from the shock waves of artillery explosions. Yet that explanation wasn’t entirely satisfactory, either. Sufferers included soldiers who had not been in the trenches or exposed to bombing.

[Brendan: Have you heard of Freud and his theory? How do his ideas differ from the “biological” approach just mentioned?]

Harrington commends physicians who charted a middle course. Adolf Meyer, a Swiss-born physician who, in 1910, became the first director of the psychiatry clinic at the Johns Hopkins Hospital, advocated an approach he called, variously, “psychobiology” and “common sense” psychiatry—the gathering of data without a guiding dogma. Meanwhile, in Europe, Eugen Bleuler, credited with coining the term “schizophrenia,” took a view somewhat similar to Meyer’s and incurred the wrath of Freud. In 1911, Bleuler left the International Psychoanalytical Association. “Saying ‘he who is not with us is against us’ or ‘all or nothing’ is necessary for religious communities and useful for political parties,” he wrote in his resignation letter. “All the same I find that it is harmful for science.”

As the century progressed, the schism between the biological camp and the psychoanalytic camp widened. With advances in bacteriology, the biological camp embraced the idea that microbes in the intestine, the mouth, or the sinuses could release toxins that impaired brain functions. Harrington writes of schizophrenia treatments that included “removing teeth, appendixes, ovaries, testes, colons, and more.”

The most notorious mid-century surgical intervention was the **lobotomy**. Pioneered in the thirties, by Egas Moniz, whose work later won him the Nobel Prize, the treatment reached a grotesque apogee in America, with Walter Freeman’s popularization of the transorbital lobotomy, which involved severing connections near the prefrontal cortex with an icepick-like instrument inserted through the eye sockets. Freeman crisscrossed the country—a trip he called Operation Icepick—proselytizing for the technique in state mental hospitals.

On the nonbiological, analytic side of the discipline, world events again proved pivotal. The postwar period, dubbed “The Age of Anxiety” by W. H. Auden, was clouded by fears about the power of nuclear weapons, the Cold War arms race, and the possibility that communist spies were infiltrating society. In 1948, President Harry Truman told the annual meeting of the American Psychiatric Association, “The greatest prerequisite for peace, which is uppermost in the minds and hearts of all of us, must be sanity—sanity in its broadest sense, which permits clear thinking on the part of all citizens.”

Accordingly, American neo-Freudians substituted anxiety for sex as the underlying cause of psychological maladies. They replaced Freudian tropes with a focus on family dynamics, especially the need for emotional security in early childhood. Mothers bore the brunt of this new diagnostic scrutiny: overprotective mothers stunted their children’s maturation and were, according to a leading American psychiatrist, “our gravest menace” in the fight against communism; excessively permissive mothers produced children who would become juvenile delinquents; a mother who smothered a son with affection risked making him homosexual, while the undemonstrative “refrigerator mother” was blamed for what is now diagnosed as autism.

In 1963, Betty Friedan’s “Feminine Mystique” denounced neo-Freudian mother blamers. She wrote, “It was suddenly discovered that the mother could be blamed for almost everything. In every case history of a troubled child . . . could be found a mother.” Her indictment was later taken up by the San Francisco Redstockings, a group of female psychotherapists who distributed literature to their A.P.A. colleagues which declared, “Mother is not public enemy number one. Start looking for the real enemy.”

Feminism furnished just one of several sweeping attacks on psychiatry that saw the enterprise as a tool of social control. In 1961, three influential critiques appeared. “Asylums,” by the sociologist Erving Goffman, compared mental hospitals to prisons and concentration camps, places where personal autonomy was stripped from “inmates.” Michel Foucault’s history of psychiatry, “Madness and Civilization,” cast the mentally ill as an oppressed group and the medical establishment as a tool for suppressing resistance. Finally, Thomas Szasz, in “The Myth of Mental Illness,” argued that psychiatric diagnoses were too vague to meet scientific medical standards and that it was a mistake to label people as being ill when they were really, as he termed it, “disabled by living”—dealing with vicissitudes that were a natural part of life.

[Brendan: The 1950s and 1960s are famous for their “aggressive” treatment of mental illness, both on the biological side (lobotomies) and on the behavioral/psychoanalytic side (“treatments” for things like homosexuality.) At the time, there was widespread hope/belief that psychiatry was on its way to becoming just as “effective” as things such as antibiotics. Why do you think this was?]

By the early seventies, such critiques had entered the mainstream. Activists created the Insane Liberation Front, the Mental Patients’ Liberation Project, and the Network Against Psychiatric Assault. Psychiatry, they argued, labelled people disturbed in order to deprive them of freedom.

Challenges to the legitimacy of psychiatry forced the profession to examine the fundamental question of what did and did not constitute mental illness. Homosexuality, for instance, had been considered a psychiatric disorder since the time of Krafft-Ebing. But, in 1972, the annual A.P.A. meeting featured a panel discussion titled “Psychiatry: Friend or Foe to Homosexuals?” One panelist, disguised with a mask and a wig, and using a voice-distorting microphone, said, “I am a homosexual. I am a psychiatrist. I, like most of you in this room, am a member of the A.P.A. and am proud to be a member.” He addressed the emotional suffering caused by social attitudes, and called for the embrace of “that little piece of humanity called homosexuality.” He received a standing ovation.

Homosexuality was still listed as a disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, even as many psychiatrists clearly held a different view. Robert Spitzer, an eminent psychiatrist and a key architect of the *DSM*, was put in charge of considering the issue, and devised what has become a working criterion for mental illness: “For a behavior to be termed a psychiatric disorder it had to be regularly accompanied by subjective distress and/or ‘some generalized impairment in social effectiveness of functioning.’” Spitzer noted that plenty of homosexuals didn’t suffer distress (except as a result of stigma and discrimination) and had no difficulty functioning socially. In December, 1973, the A.P.A. removed homosexuality from the *DSM*.

Today, around one in six Americans takes a psychotropic drug of some kind. The medication era stretches back more than sixty years and is the most significant legacy of the biological approach to psychiatry. It has its roots in the thirties, when experiments on rodents suggested that paranoid behavior was caused by high dopamine levels in the brain. The idea that brain chemistry could offer a pathogenesis for mental illness led researchers to hunt for chemical imbalances, and for medications to treat them.

In 1954, the F.D.A., for the first time, approved a drug as a treatment for a mental disorder: the antipsychotic chlorpromazine (marketed with the brand name Thorazine). The pharmaceutical industry vigorously promoted it as a biological solution to a chemical problem. One ad claimed that Thorazine “reduces or eliminates the need for restraint and seclusion; improves ward morale; speeds release of hospitalized patients; reduces destruction of personal and hospital property.” By 1964, some fifty million prescriptions had been filled. The income of its maker—Smith, Kline & French—increased eightfold in a period of fifteen years.

Next came sedatives. Approved in 1955, meprobamate (marketed as Miltown and Equanil) was hailed as a “peace pill” and an “emotional aspirin.” Within a year, it was the best-selling drug in America, and by the close of the fifties one in every three prescriptions written in the United States was for meprobamate. An alternative, Valium, introduced in 1963, became the most commonly prescribed drug in the country the next year and remained so until 1982.

One of the first drugs to target depression was Elavil, introduced in 1961, which boosted available levels of norepinephrine, a neurotransmitter related to adrenaline. Again there was a marketing blitz. Harrington mentions “Symposium in Blues,” a promotional record featuring Duke Ellington, Louis Armstrong, and Artie Shaw. Released by RCA Victor, it was paid for by Merck and distributed to doctors. The liner notes included claims about the benefits that patients would experience if the drug was prescribed for them.

Focus shifted from norepinephrine to the neurotransmitter serotonin, and, in 1988, Prozac appeared, soon followed by other selective serotonin reuptake inhibitors (SSRIs). Promotional material from GlaxoSmithKline couched the benefits of its SSRI Paxil in cozy terms: “Just as a cake recipe requires you to use flour, sugar, and baking powder in the right amounts, your brain needs a fine chemical balance.”

Yet, despite the phenomenal success of Prozac, and of other SSRIs, no one has been able to produce definitive experimental proof establishing neurochemical imbalances as the pathogenesis of mental illness. Indeed, quite a lot of evidence calls the assumption into question. Clinical trials have stirred up intense controversy about whether antidepressants greatly outperform the placebo effect. And, while SSRIs do boost

serotonin, it doesn't appear that people with depression have unusually low serotonin levels. What's more, advances in psychopharmacology have been incremental at best; Harrington quotes the eminent psychiatrist Steven Hyman's assessment that "no new drug targets or therapeutic mechanisms of real significance have been developed for more than four decades." This doesn't mean that the available psychiatric medication isn't beneficial. But some drugs seem to work well for some people and not others, and a patient who gets no benefit from one may do well on another. For a psychiatrist, writing a prescription remains as much an art as a science.

[Brendan: In recent years, there's been a fair amount of debate over the way psychiatric drug trials have been conducted over the last 50 years. Among other things, critics have pointed to problems with industry-funded trials, publication bias (journals only want "positive" results), and underreporting of side effects (either by "excluding" subjects from the study or by failing to monitor them over the "long term." However, we can't just "throw out" all this science (the drugs really do help some people!). How can we improve science in this area going forward?]

Harrington's book closes on a sombre note. In America, the final decade of the twentieth century was declared the Decade of the Brain. But, in 2010, the director of the National Institute of Mental Health reflected that the initiative hadn't produced any marked increase in rates of recovery from mental illness. Harrington calls for an end to triumphalist claims and urges a willingness to acknowledge what we don't know.

Although psychiatry has yet to find the pathogenesis of most mental illness, it's important to remember that medical treatment is often beneficial even when pathogenesis remains unknown. After all, what I was taught about peptic ulcers and stress wasn't entirely useless; though we now know that stress doesn't cause ulcers, it can exacerbate their symptoms. Even in instances where the discovery of pathogenesis has produced medical successes, it has often worked in tandem with other factors. Without the discovery of H.I.V. we would not have antiretroviral drugs, and yet the halt in the spread of the disease owes much to simple innovations, such as safe-sex education and the distribution of free needles and condoms.

Still, the search for pathogenesis in psychiatry continues. Genetic analysis may one day shed light on the causes of schizophrenia, although, even if current hypotheses are borne out, it would likely take years for therapies to be developed. Recent interest in the body's microbiome has renewed scrutiny of gut bacteria; it's possible that bacterial imbalance alters the body's metabolism of dopamine and other molecules that may contribute to depression. Meanwhile, Edward Bullmore, the chief of psychiatry at Cambridge University, argues that the pathogenesis of mental disorders will be deciphered by linking the workings of the mind to that of the immune system. Bullmore's evidence, presented in his recent book, "The Inflamed Mind" (Picador), is largely epidemiological: inflammatory illness in childhood is associated with adult depression, and people with inflammatory autoimmune disorders like rheumatoid arthritis are often depressed.

It's too early to say whether any of these hypotheses could hold the key to mental illness. More important, we'd do better not to set so much store by the idea of a single key. It's more useful to think in terms of cumulative advances in the field. Many people have been helped, and the stigma both of severe mental illness and of fleeting depressive episodes has been vastly reduced. Practitioners and potential patients are more knowledgeable than ever about the range of treatments available. In addition to medication and talk therapy, there have been other approaches, such as cognitive-behavioral therapy, which was propounded in the seventies by the psychiatrist Aaron Beck. He posited that depressed individuals habitually felt unworthy and helpless, and that their beliefs could be "unlearned" with training. An experiment in 1977 showed that cognitive-behavioral therapy outperformed one of the leading antidepressants of the time. Thanks to neuroscience, we can demonstrate that cognitive-behavioral therapy causes neuronal changes in the brain.

(This is also true of learning a new language or a musical instrument.) **It may be that the more we discover about the brain the easier it will be to disregard the apparent divide between mind and body.**

[Brendan: What does this quote mean? Do you agree with it?]

In the late nineties, as an oncologist, I treated a teacher in her fifties suffering from metastatic melanoma. It had spread from her upper arm to lymph nodes in one of her armpits and her neck. The surgeon had removed as much of the disease as he could, and referred her to me because I had previously conducted early clinical trials of an agent called interferon. Interferon is a naturally occurring protein that our bodies produce as part of the immune response to infection. Initially hailed as a possible panacea for all cancers, interferon eventually proved beneficial for some twenty per cent of patients with metastatic melanoma. But the treatment required high doses, which sometimes caused considerable side effects, including depression.

My patient had been widowed and she had no children. “My pupils are my kids,” she said. Unable to teach, she missed the uplift of the classroom. She told me that she was anxious and had been unable to sleep well; she knew that the treatment might not help, and would make her feel sick. In the past, she had experienced depression, and, before I administered interferon, I wanted her to consult a psychiatrist at the hospital who served as a liaison between his department and the oncology unit. He was in his early sixties, with a graying beard and a wry sense of humor: the staff often remarked that he reminded them of Freud. But, unlike Freud, he was not dogmatic. He treated his patients, variously, with medications, talk therapy, hypnosis, and relaxation techniques, often combining several of these.

It was a pragmatic, empirical approach, trying to find what worked for each patient. I admired his humility and reflected that his field was not so unlike my own, where, despite a growing knowledge of the pathogenesis of cancer, one could not precisely predict whether a patient would benefit from a treatment or suffer pointlessly from its side effects. In some sense, everything my colleague and I did for the patient was in the end biological. Words can alter, for better or worse, the chemical transmitters and circuits of our brain, just as drugs or electroconvulsive therapy can. We still don’t fully understand how this occurs. But we do know that all these treatments are given with a common purpose based on hope, a feeling that surely has its own therapeutic biology. ♦

[Brendan: Overall, how would you describe this author’s attitude toward modern psychology/psychiatry? What are your thoughts on the article?]

4 READING: THE HUMANE ASYLUM (BY MADELEINE RITTS AND DANIEL ROSENBAUM)²

As a society we are failing people with severe, persistent mental illness. It’s time to reimagine institutional care.

Myra hears violent and upsetting voices that nobody else can hear; she struggles with hygiene and remembering to change her clothing. Unable to achieve employment, she receives a paltry monthly welfare payment that she spends almost entirely on rent. For that, Myra has access to a lice-ridden shared room in a private-market boarding home where fights break out regularly. Owing to certain symptoms of her illness, including profound disorganisation of her speech and thoughts, Myra has been deemed ‘incapable’ of managing her money, so a public trustee oversees her spending. Similarly, her psychiatrist believes she lacks the capacity to appreciate the benefits and risks of receiving or refusing treatment. Being estranged from her

² Madeleine Ritts and Daniel Rosenbaum, “The Humane Asylum,” Aeon, November 3, 2021, <https://aeon.co/essays/we-are-failing-people-with-severe-mental-illness-what-can-we-do>.

family, Myra's treatment decisions are therefore made on her behalf by an appointed 'substitute decision-maker'.

'Myra' is a fictionalised account (based on real cases) of contemporary life for a person with a **severe and persistent mental illness** (SPMI) – our preferred term given the important critiques of specific diagnostic mental illness categories on validity grounds. She is in receipt of the most comprehensive community mental health service for people with SPMI – known as assertive community treatment (ACT). Primarily available in North America, western Europe, Scandinavia, Australia and New Zealand, this type of treatment (which can go by different names in different regions) offers intensive outreach-based care to support living independently and safely in the community, with some clients seen as often as twice a day. To coordinate access to essential items (eg, food, shelter and clothing), services (eg, medical and dental care), and personal support workers for their clients, ACT teams rely on a mixture of private, public and not-for-profit services.

Severe and persistent mental illness impacts people differently. For some, robust social support and outreach-based mental health programmes can make a powerful difference to their functioning and quality of life. But an unfortunate few like Myra continue to suffer significantly, even with intensive support. Compounding her problems, imagine now that Myra starts collecting items she finds on the street and that soon her unit is declared a fire hazard. Myra now faces eviction and, because housing is so hard to find, she will likely end up homeless. In the past, she has had difficulty remembering to take her medication while staying in shelters, leading to instances of self-harm and significant injury, and so her life has been punctuated with periods of involuntary acute care hospitalisation.

[Brendan: What experience, if any, do you have with “severe and persistent mental illness”? For example, has this affected your family? Friends? Patients?]

Psychiatry today is tasked with the daunting responsibility of attending to the mental suffering of Myra, and countless others like her, with imperfect tools and a painful awareness of its own violent history. Despite more than half a century of pharmaceutical and psychotherapeutic treatment development, it's not clear whether there are any medications or social interventions available to genuinely relieve the pain and harms experienced by some people living with severe and persistent mental illness. As Myra's story reflects, the patchwork array of public, private and not-for-profit services that compose our community mental health 'systems' are so under-resourced and poorly designed, one can't help but wonder how they could be fixed, or how they even came to be. Yet the reality today is that there is nowhere else for Myra to go.

How did we get to this wretched state of affairs? The historical roots of the current situation go back hundreds of years. For much of western European and North American history, there was no singular or overarching system of care for those deemed 'mad', comparable with the asylums or custodial institutions of the 19th and 20th centuries. Individuals in the medieval and early modern periods who had 'bizarre' ways of thinking or behaving tended to receive whatever level of care a family was willing or able to provide (which often meant none at all).



Bethlem Hospital in Moorfields, London. *Photo courtesy the Wellcome Collection*

The rise of proto-asylums in the mid-18th century catered exclusively to the wealthy and their comforts. These ‘madhouses’ owed more to a flourishing consumer society than to any centralised action of the state or tangible medical breakthroughs. Charitable asylums to ‘treat’ the poor emerged more slowly, and their so-called patients were treated with far more cruelty: held, often chained, in large galleries where abuse and physical violence were meted out daily. By the early 19th century, public outcry against the barbaric treatment of ‘the mad’ emerged independently and almost simultaneously across Europe and North America. Calls to radically reform institutionalised care were coupled with a rejection of treatments that had proven to be ineffective and medically unfounded. Reformers urged for a more humane approach where those deemed mad could find refuge from life’s cruelties.

The most famous of these approaches, known as **‘moral treatment’**, has a rich and eclectic history. Generally speaking, proponents of this model advocated for the avoidance of force and restraint, the salutary benefits of soft and hard skill development, and the modelling of kindness, reason and humanity within a familial atmosphere. The earliest models of moral treatment were pioneered by Quakers and were rooted in their religious commitments to equality, respect and community. Others were inspired by Enlightenment ideals and a strong conviction in the power of reason and behavioural conditioning.

Moral treatment spread rapidly across western Europe and North America owing to extraordinary claims of its success, as well as the growing role of state regulation, administration and funding. The new asylums were seen as triumphs of science and beacons of possibility for achieving utopian ideals. It’s important not to romanticise moral treatment, however, even in its ideal form. ‘Reconditioning’ the minds of people with

mental illness through the ethos of self-control and discipline, some argue, merely exchanged one set of chains for another. Without any overarching system or regulation there was great diversity in size, quality and philosophy. Correspondingly, historical records show vastly different experiences among patients: some suffered disrespect and domination, while others found pride and purpose in running farms and gardens. Some asylums ran programming to cultivate residents' passions and develop their skills in crafts, art and ideas. The oft-overcrowded asylums for the poor, on the other hand, offered few opportunities for leisure, let alone self-actualisation. And yet, testimony from former patients suggests that a meaningful sense of 'community' and belonging could still be found.

The incredible optimism of the early to mid-19th century soon fizzled: patient numbers quickly outpaced capacity, and the once-central notions of intimacy and community were abandoned in favour of large, sterile and impersonal environments. Therapeutically oriented labour degenerated into rigidly enforced work, and recreational programming was mostly eliminated. Rates of cure failed to materialise in anything like the proportions that had been promised, leading to disillusionment and backlash. Greater recourse was given to radical treatments that sedated and stupefied asylum residents – for instance, the lobotomy, which won its developer, Egas Moniz, the Nobel Prize in 1949, but has (rightly) become one of the most powerful symbols of psychiatric abuse. Decades of financial stringency and poor oversight, overdiagnosing, understaffing and overcrowding transformed these places into what the British-born sociologist Andrew Scull in 1990 called 'warehouses of the unwanted'.

[Brendan: What was the general idea behind “moral treatment”? Why do you think it “failed”? What, if anything, could have been done differently?]

Many prominent historians agree that the impetus for deinstitutionalisation (the process of moving the care of people such as Myra out of institutions and into the community) was primarily financial in nature. Despite the hype around novel antipsychotic medications such as chlorpromazine (developed in 1951), the influence of treatment 'breakthroughs' over social policy was arguably minimal, and their benefits rarely lived up to their promise. As institutions became end-point destinations for a growing number of people, even the most derelict asylums were incredibly costly to run (grassroots and legal advocacy against the grave abuses found in these institutions also hastened their closure). In North America, expenses fell to local state and provincial governments who had little power or desire to generate more revenue through taxation or welfare state reform. New federal programmes in the United States, such as the Community Mental Health Act (1963) and Medicare and Medicaid (1965), incentivised states to discharge patients and defer costs to new federally funded community clinics, which ultimately failed to materialise in the quantity or quality that was promised.

In Canada and the United Kingdom, deinstitutionalisation policy unfolded with more explicit aims to reduce healthcare expenditures at all levels of government. Behind a rhetoric of human rights and freedom, politicians – already eager to rid themselves of the political baggage and financial burdens of asylums – emptied institutions before adequate resources and robust community services were secured. Intended as cheap alternatives, the ramshackle networks of private, charitable and government services that developed were both ill-equipped and unable to provide humane and continuous care to many people struggling with severe and persistent mental illness.

From this nadir in the 1970s, a series of community care models have emerged, the most enduring and well known being assertive community treatment. ACT teams intend to offer a 'hospital without walls' and provide around-the-clock, seven-days-a-week, multidisciplinary support to people with the highest needs. ACT operates from a chronic disease model of SPMI as characterised by alternating periods of acute illness exacerbation and (potentially lengthy) periods of stability. Correspondingly, the ACT care model is explicitly geared towards preventing re-hospitalisation.

ACT psychiatrists, nurses and social workers visit clients in their residences, in shelters, and on street corners if they can't make it to the office. Case managers help clients cope with distress, attend appointments, develop life skills, access welfare benefits, reconnect with family and loved ones, and find recreational and social programmes. They also deliver and encourage clients to take medications but, if a client is mandated by law to do so, the looming prospect of hospital admission should they decline highlights the coercion that remains in community-based care. Indeed, the often-coercive mechanisms by which ACT clinicians try to achieve their core mission – to lengthen periods of stability between acute hospitalisations – highlight the double-edged sword of the 'hospital without walls' mantra.

Needless to say, the lofty ideals of the ACT model have been brought down to earth by the complexities of real life. ACT teams work within fragmented community support and social service systems that place an impossible burden on clinicians. The ravages of poverty and inadequate resources to meet basic shelter and safety needs impose huge restrictions on how clinicians can meaningfully support their clients, whom they cannot protect from day-to-day violence and criminalisation. The comprehensive suite of health and social services once packaged together within the bricks-and-mortar of the asylum are incredibly difficult to access in the community given inordinately long waiting lists and the often mystifying bureaucracy behind the public, private and not-for-profit services intended to replace them.

[Brendan: The author has some worries about ACT, as you'll soon see. What do you think about the "ACT model" versus the "institutions" it was designed to replace?]

Following convention in mental health research, one way to assess the quality of life afforded by current community care approaches is by considering the extent to which people with SPMI are free from constraint (ie, they have liberty) and free to self-govern (ie, they are able to exert autonomy). In these debates, liberty is often considered in the context of whether people are subject to involuntary hospitalisation, but there are broader issues to consider, such as whether people's liberty is constrained by a lack of sufficient societal support (ie, constraint via omission – for a physical parallel, think of how the liberty of a wheelchair user is unduly restricted in the absence of ramps or other needed accommodations). Autonomy, on the other hand, is usually measured by people's ability to exercise reason according to their own value system, regardless of the *substance* of their values, reasons or motives (for instance, choosing to ride a bike without a helmet would be to exercise autonomy while rejecting common sense). In healthcare, autonomy often, but not exclusively, is considered in the context of a person's capacity to make important decisions about how they live their life.

Under the competing pressures of public safety and individual freedom as well as budgetary constraints and political will, finite resources and, perhaps most importantly, our incomplete knowledge of SPMI, it would be impossible to expect any system of care to fully enhance an individual's liberty and autonomy. There are always going to be tradeoffs. Given the dearth of effective psychiatric therapies and treatment options for people with SPMI, this is especially true when it comes to mental health care. The key, as others have argued, lies in reaching the appropriate balance between allowing so much liberty that an excess of harm results, and so little liberty that people do not have enough control over their lives to make them feel meaningful or worthwhile. Superficially, the shift from asylum to community appeared to maximise patient liberty. Our view, however, is that a blinkered, and at times insincere, promotion of liberty in the mental health system has led to situations for people with SPMI in which excess harm occurs and opportunities for flourishing and a life well lived are unduly restricted. What's more, serious violations to liberty through omission and neglect persist.

According to some proponents of the 'rights revolution' of the 1960s and '70s, people with SPMI, then freed from the asylum, were able to exercise their autonomy and live in closer alignment with their values in 'the community' – a term as commonly used as it is ill defined in contemporary mental health policy and clinical practice. 'Discharging someone to the community', for example, refers simply to a range of potential

settings *other than* bricks-and-mortar institutions, such as hospitals, rehabilitation or long-term care facilities, jails or prisons. Given high rates of incarceration, homelessness, hospitalisation and compulsory outpatient treatment, the cold reality is that people with SPMI who reside in the community are rarely ‘deinstitutionalised’ in a meaningful sense. Their lives have instead been subsumed by the revolving door of the so-called ‘invisible asylum’. The ‘freedom of choice’ that they ostensibly enjoy in the community generally implies that they have the benefits of *consumer choice*, yet – given that many live in deep poverty – such freedom is arguably meaningless. Meeting basic needs often means choosing between what’s cheap, free or simply going without. **Without access to essential material and social resources, one is not truly free to make decisions, big or small.**

[Brendan: What does this claim mean in the context of a person living with severe and persistent mental illness?]

Many individuals with SPMI experience repeated and at times frequent psychiatric admissions, even when supported by an ACT team. For some, hospitalisation comes with the provision of basic necessities not afforded to them in the community, but at the expense of their liberty: regular meals, safety from violence, a clean environment, and daily structure and routine. Acute care hospitalisations are often undertaken involuntarily, and locked seclusion, chemical and physical restraint can be used in cases of extreme behaviour after attempts at verbal de-escalation have proven ineffective. Even when people stay voluntarily, wards are often locked and freedom of movement is restricted.

Given the limitations of available treatments for some people with SPMI, hospital admissions are often geared toward a return to ‘baseline’ (ie, someone’s expected level of functioning when receiving their usual treatment and support), while care in the community aims to manage symptoms and minimise associated risks that persist at someone’s ‘baseline’. In both settings, the known harms of antipsychotic drug treatment – including significant (and often long-term) side effects, such as sedation, movement disorders, dramatic weight gain or metabolic derangements such as diabetes – can often outweigh the expected benefits for some people at certain points along their care trajectory. Today, people with SPMI can be at risk of aggressive, potentially harmful overtreatment early in their involvement with the mental health system. Later – after suboptimal or negligible responses to available therapies, and in the face of persistent psychological suffering and associated disability – they are at risk of therapeutic neglect, coloured in part by burnout and therapeutic nihilism among caregivers, and in part by a dearth of suitable models and care settings.

Life in the community can entail a great deal of risk and vulnerability. Priced out of safer parts of the city, people with SPMI – more commonly victims of violence than they are perpetrators – are forced to live in highly concentrated areas where violence is commonplace. High levels of stigma compound the social isolation experienced by many with SPMI, and any sort of social connection or community participation can be challenging due to histories of abandonment and broken trust.

The current system clearly isn’t working, so where do we go from here?

Some commentators believe that unresolved mental distress and suffering could be largely mitigated, if only there were adequate investment in healthcare and the social determinants of health. Others contend that community care lacks a coherent vision and has never been properly designed or conceived. At a time when public programmes have been gutted and important social responsibilities have been shunted to the private sector, it is difficult to assess whether a lack of political will is denying community-based programmes their full potential, or if there are intrinsic shortcomings to the community care model itself.

Yet another camp explicitly suggests, as Oliver Sacks once argued in his essay *The Lost Virtues of the Asylum* (2009), that there were truly salutary aspects of life in some of these institutions – and that what they needed was fixing, not dissolution.

[Brendan: In what follows, the author lays out a case for “bring back the asylum.” In what ways is it different from the current ACT model? From the “old” asylum model?]

No one could reasonably contest the importance of access to safe, affordable housing, a liveable income for all, and meaningful social inclusion. Yet we believe that weighing the current realities of material deprivation against an ideal vision of robust social support and fully funded community programmes represents a false dichotomy. These political achievements are unlikely to be adequate for those whose care needs are highest and who suffer most from enduring distress, severely limited organisational capacity, great difficulty regulating their emotions and persistent disability. For that reason, we suggest a ‘both/and’ approach, one that involves addressing social and material drivers of poor mental health and providing quality community care, while *also* considering what further residential supports might still be required for those with the highest needs.

Holding a clear understanding of what it would take to offer safe, dignified and meaningful conditions of life for people with severe and persistent mental illness is a necessary part of developing the political will to do so – even if what we wind up with falls short of our ideals. While vague utopian fantasies about maximising liberty and autonomy can lead us astray, excessive cynicism can also fuel self-fulfilling prophecies that stymie real change. Building from the virtues and advances made in community mental healthcare, we believe that permanent housing for individuals with SPMI must also be tailored to their needs and values.

A residential environment of this sort will require a broad range of social, medical and support services. Recreational programming might add therapeutic structure to the day, but activities could also be available for residents to pursue their interests and curiosities at will. Animal husbandry or horticulture could take the form of therapy or work for those who are interested – one of many opportunities where work could be offered as a meaningful activity, not as an expectation or survival necessity. Personal support workers would be required to assist individuals with everyday tasks, and the 24/7 need for well-trained caregivers capable of crisis de-escalation and supporting people in extreme states cannot be overemphasised. Timely access to medical and psychiatric care, coupled with these improvements to the social determinants of health, could make meaningful inroads in closing the mortality gap that exists between people with severe and persistent mental illness and those without.

Taking stock of the intensity and quality of support that we argue to be necessary, a facility of this kind would certainly fulfil certain definitions of an ‘institution’. While history is rife with examples of institution-based coercion and cruelty, they can and must be run differently. To this effect, adequate funding, well-paid and well-trained staff, incorporating resident input and strong oversight bodies are vital. The Worcester Recovery Center and Hospital in Massachusetts, once lauded as an exemplar of humane and dignified psychiatric care, illustrates the hazards of prioritising ‘cost-efficiency’ over quality. A failure to provide adequate training in violence prevention and crisis de-escalation, along with critical staffing shortages, have undermined the facility’s mission and jeopardised the safety of nurses, staff and residents alike.

However, fruitful counterexamples of more successful institutional settings can be found in innovations in dementia care in the US and in the Netherlands. Nestled in the small town of Weesp in northern Holland, De Hogeweyk is an elder-care facility for people with advanced dementia that is curated to look and feel like home, down to the finest detail. While basic necessities and meals are provided, residents can shop for clothing and food in on-site stores. These transactions don’t always involve money, but they do allow residents to exercise their tastes and preferences. Visitors are commonplace, and can join their loved ones for art or cooking classes, concerts or a film in one of the on-site theatres. The cost of housing someone at De Hogeweyk is similar to that of more traditional Dutch nursing homes, and it’s run and funded primarily by their government.



The De Hogeweyk elder-care facility for people with advanced dementia, Weesp, Holland. *Courtesy Buro Kade Architects, Holland*



De Hogeweyk. *Courtesy Buro Kade Architects, Holland*

Modest prototypical settings for people with severe and persistent mental illness that are similarly well designed and resourced as this Dutch elder-care facility exist already, for example the Peace Ranch in Ontario,

Canada. Scaling up this model and expanding it to meet a wider range of needs would no doubt be costly, but we can't have it both ways – there is no solution that is both cheap and ethically sound. A truly humane approach to care is antithetical to profit-seeking motives that trade in the misery of others – it recognises all people as equally deserving of safety, pleasure and dignity. Government funding and associated oversight and regulation are thus key, and would protect people with severe and persistent mental illness against the sorts of pitfalls that beset private, financialised long-term-care facilities for the elderly.

In his 2009 essay, Sacks wrote about how the **benevolent paternalism** of the long-stay psychiatric institution could offer asylum in a genuine sense – and perhaps more than that, the **freedom ‘to be as mad as one liked and, for some patients at least, to live through their psychoses and emerge from their depths as saner and stabler people’**. In keeping with this sentiment, reimagined residential facilities for people with severe and persistent mental illness must foster a culture of true social inclusion, and a sense of *home*. For those who struggle most with basic tasks, hygiene and personal safety, such settings would offer marked improvements in quality of life when compared with repeated involuntary stays on psychiatric wards, or the exploitation and violence that can be experienced in ‘the community’. Robust mental health legislation would need to maintain strong checks and balances on a substitute decision-maker’s ability to decide where someone with severe and persistent mental illness ought to live, but such programmes would certainly not represent an endpoint for all such people: many could graduate or leave when they are prepared or choose to do so.

[Brendan: What do you think of Sacks’ ideas here?]

One might call these facilities supportive mental health housing, psychiatric long-term care facilities, asylums or something else. While this model would inhibit certain liberties – residents’ freedom from constraint – doing so would strongly promote a significant set of autonomy-enhancing freedoms. By ensuring that important social and material needs are met, people with severe and persistent mental illness would be able to exercise more choice in their daily lives, develop skills and passions, and build meaningful relationships in service of a life well lived. Don’t we all deserve as much?

[Brendan: How would you describe the author’s primary thesis? Do you agree? Disagree? A bit of each?]

5 CASE STUDY: ALL EYES ON YOU (ETHICS BOWL 2022)³

Agustín, 15, is a tenth-grader attending a public school in Charlotte, North Carolina.⁴ One Saturday evening, he posts a photo on Instagram of himself and a group of his friends (most of whom are also tenth-grade boys) with the caption “Me and The Crew.” The boys in the photo display a variety of hand gestures—peace signs, thumbs-up signs, and other signs whose meanings are unclear. Agustín’s school, which makes use of a third-party social media scanning program, is alerted by the company, whose algorithms have defined the photo as “suspicious.”

³ The Executive Committee and Case Advisory Committee have voted to re-use a small number of Regional Cases for the NHSEB National Championship on an experimental basis. This case originally appeared in the 2021-2022 Regional Case Set. The committees welcome participant input on this practice, and feedback can be directed to ethicsbowl@unc.edu.

⁴ This story is adapted from an illustrative compilation of student experiences by Barbara Fedders, “The Constant and Expanding Classroom: Surveillance in K-12 Public Schools,” *North Carolina Law Review* 1673 (2019).

Monday morning, his school's Principal, Mr. Raines, asks the school resource officer (SRO) to question Agustín about the post. Unsatisfied with the explanation that the photo just shows him and his friends enjoying each other's company, the officer follows Agustín through the halls during class changes. The SRO also reviews footage of Agustín from school security cameras, and Mr. Raines alerts Agustín's teachers that he is suspected of possible gang involvement. Later that day, Agustín's smartphone is confiscated by his Biology teacher because he was caught text messaging during class. On Monday evening, while doing homework on his school-issued Chromebook, Agustín confides in a friend via email that he is feeling depressed and anxious about the SRO, and angry at a mutual friend of theirs, Manuel. Within the hour, a different police officer knocks on the door of his home, telling Agustín's parents that he is there to conduct a "wellness check" based on concerns raised by his email.

The ability of schools to keep tabs on their students is on the rise, particularly in the wake of accelerating technology adoptions brought on by widespread school violence across the U.S., as well as the COVID-19 pandemic. Digital learning platforms like Canvas and Moodle not only streamline students' assignments and grades, but provide extensive data profiles on millions of students to private corporations each year. Web, email and social media "listening" platforms like Varsity Monitor, Gaggle, and Bark allow administrators to track student communications, web usage, and search histories, in school and out. District-level purchasing of these platforms saw a tenfold increase between 2013 and 2018.⁵ Cameras and facial recognition technology are now essential parts of schools' security strategies, with the number of schools conducting video monitoring having risen from 19% in 2000 to 83% in 2018.⁶

Administrators and district officials often argue that these strategies are common sense measures to keep students safe from harassment, bullying, and gun violence. Critics argue that students' privacy rights are being violated with invasive technologies whose effectiveness is thus far unproven. Furthermore, for students of color, who often face disproportionate disciplinary measures in schools, new kinds of surveillance may be especially harmful.⁷

5.1 DISCUSSION QUESTIONS

1. Is the fact that Agustín was outside school when he sent the email morally relevant?
2. How, if at all, do the privacy rights of minor students differ from those of their adult counterparts? What about those rights associated with freedom of speech?
3. How should schools balance the objectives of student safety with student privacy? What is the relative importance of these goals?
4. When, if ever, are schools justified in disciplinary interventions based on students' personal communications?

5 <https://www.brennancenter.org/our-work/research-reports/school-surveillance-zone>

6 <https://nces.ed.gov/fastfacts/display.asp?id=334>

7 <https://www.theatlantic.com/education/archive/2016/09/when-school-feels-like-prison/499556/>