LETTERS on LIBERTY

ESCAPING THE STRAITJACKET OF MENTAL HEALTH

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ESCAPING THE STRAITJACKET OF MENTAL HEALTH

The 2002 film *Minority Report* concerns a fictional 'precrime' police unit tasked with apprehending future murderers before they commit the crime. The information they act on comes from three clairvoyant humans, known as 'precogs', who can foresee the impending homicide. The arrested would-be killers are not incarcerated in the normal prison system - after all, they have not committed a crime - but are instead detained in a benign and compassionate virtual-reality state.

Such pre-emptive action by the state is not confined to the fictional world of Hollywood. In fact, it forms a key feature of many countries' mental-health legislation. In this *Letter,* I will concentrate on developments within the UK to highlight the complexities of mental-health policy and practice, and show how the law interacts with and compromises the rights and freedoms of those subject to them. Somewhat paradoxically, such involuntary state intervention is both necessary and justifiable in terms that uphold the sovereignty of the political subject.

Legislating madness

In England and Wales, the 1983 Mental Health Act (MHA), amended in 2007, is the key piece of legislation concerned with the hospitalisation and treatment of those diagnosed with a mental disorder - including treatment that can be imposed post-discharge. While the criteria differ depending on what section of the MHA is being implemented, that of Section 3 is most instructive. A decision to take a patient into care can last for up to six months in the first instance, be renewed for a further six months and then renewed annually if professionals agree it is necessary. In other words, you could find yourself detained for years, or even indefinitely, under such an order. The medical recommendation that an approved doctor completes has the following criteria:

> *'In my opinion, (a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital, and (b) it is necessary (i) for the patient's own health (ii) for the patient's own safety (iii) for the protection of other persons.'* [i]

There are two key things to notice. First, the recommendation is based on the doctor's opinion; under mental-health legislation, it is not necessary for a jury of your peers to weigh up the evidence before

you lose your liberty. Second, you do not have to be deemed a risk to yourself or others to be so detained (the professionals act as mental-health 'pre-cogs' foreseeing the future). Instead, removing your freedom can be justified merely on the basis that professionals believe it to be beneficial to your health. Nevertheless - and perhaps surprisingly to many of you freedom lovers reading this as part of the *Letters on Liberty* series - such measures are necessary at times.

I will return to the legal situation later. But first, let us look at some of the criticisms of psychiatry and the implications for liberty in the wider field of mental health.

Psychiatry and society

From its inception to the present day, psychiatry's theories, practices and societal role have been subject to much critique. One of the early objections to psychiatry was from the Church. By viewing insanity as a disease and not as punishment from God for sin or immoral ways, the emerging discipline found itself in conflict with the religious authorities. More importantly, it also posed a threat to the very fabric of Christian theological beliefs.

As Norman Dain pointed out:

> *'Traditional Christian thought saw the mind as closely associated with the soul and assumed to be, like the soul, immortal and impervious to disease. However, if madness was a physical disorder of the brain, and the mind simply the brain functioning, then the brain, mind and the soul were subject to disease and death. From such a perspective, the Christian concept of the immortal soul was invalid.'* [ii]

The role of psychiatry in legitimising oppressive social relations has been extensively documented. In 1851, Samuel Cartwright detailed a 'mental disorder' he named drapetomania, which was said to afflict black slaves who fled captivity.[iii] With slavery justified on the basis that it was part of the natural order, those slaves not content with their 'natural' position were therefore deemed to be disordered.

While Cartwright's theory was widely mocked at the time, it does highlight the interaction of societal prejudices with psychiatric diagnosis. In the early to mid-twentieth century, many women were labelled as 'mentally defective' and incarcerated for long periods following pregnancy or during adolescence or early adulthood, reflecting societal fears of female sexuality.[iv]

Even in the later decades of the twentieth century, unmarried mothers were seen as a socially deviant group. The fear of female sexuality was particularly acute in Ireland, where a commission of inquiry estimates about 56,000 unmarried mothers lived in the mother-and-baby homes it investigated. While most entered mother-and-baby homes voluntarily due to being ostracised by their families and communities, many of these women were admitted as recently as the 1960s and early 1970s.[v]

In the former Soviet Union, political dissidents were often labelled mentally ill - with one dissident being told 'your disease is dissent'.[vi] It was not until 1973 that the American Psychiatric Association voted to declassify homosexuality as a mental disorder.[vii]

Examples of both explicit and implicit racist assumptions have also been highlighted in the history of psychiatry,[viii] as has its role in the construction of madness as a female malady.[ix] In addition, numerous psychological, psychoanalytical, sociological and philosophical perspectives have criticised much psychiatric theory and practice.

For radical critics such as Thomas Szasz, the mind - like the economy - could only be sick in a metaphorical sense. For Szasz, sufferers were experiencing 'problems in living', not a medical illness.

Others, such as RD Laing, who was influenced by the existentialism of Jean-Paul Sartre, rejected psychiatric classifications altogether. Laing believed that it was necessary to try to understand the patient's reality, using existential phenomenology in order to gain an understanding of what their 'world' is and their ways of being in it.[x] Such views influenced the counter-cultural movements of the 1960s and 1970s, with the psychiatric regime seen as dehumanising patients.

This wider cultural resonance can be seen in the 1975 film *One Flew Over the Cuckoo's Nest*, in which the psychiatric institution and staff within it are viewed as oppressive and damaging to the wellbeing of the inmates. The film's main character - McMurphy, played by Jack Nicholson - feigns madness and is portrayed as liberating and enlightening, a free spirit who is confined and gradually destroyed by a brutal regime. The film was widely interpreted as a metaphor for the enforced conformity and moral vacuity of postwar consumer society.

In criticising psychiatry, many made the point that the reasons people suffered mental distress were rarely due to individual malfunction. Instead, they were the result of societal disadvantage, past or current traumatic experiences and the lack of adequate support services - whether psychological, social or material - to enable them to overcome their

difficulties. Consequently, psychological and social explanations for mental distress grew, with an array of professionals - psychologists, counsellors and social workers - staking their claim to expertise within the field of mental health.

From hospital to community

The process of de-institutionalisation, and the move to care in the community, was the result of various factors. Indeed, it was criticised by many on the Left as being a Conservative government's response to the fiscal crisis - although such criticism was muted by their hostility to psychiatry and pharmacological interventions.[xi] Nevertheless, it was, overall, a progressive and more humane approach to the mentally distressed, with the aim of re-integrating people back into society.

Unfortunately, the planning was often lax. Poor co-ordination regarding what few services were available led to many ex-patients being neglected rather than cared for. It also led to some high-profile cases where ex-patients committed homicides, leading to calls for the modernisation of services and new legal powers to cement the provision of mental-health care in the community, rather than the hospital.

This culminated in the Mental Health Act 2007, which revised the 1983 Act in several ways - most notably was the introduction of Supervised Community Treatment, more commonly known as a Community Treatment Order (CTO), which allows professionals to impose certain conditions on patients once they leave hospital. This mainly involves ensuring that they continue to take their prescribed medication post-discharge. A failure to comply can mean a recall to hospital.

As the number of conditions has grown, the number of people said to suffer from such problems also continues to rise.

Once professionals had the power to put people on CTOs, they made full use of them. The government envisaged that between 350 and 450 CTOs would be issued in England and Wales in the first year that the powers came into force. The actual figures turned out to be somewhat higher. In the first five months in which professionals were able to issue CTOs, 2,134 were issued in England alone. The numbers have continued to rise. The number of people subjected to a CTO increased from 6.4 per 100,000 of the population in 2009-2010 to 10 per 100,000 in 2013 - 2014,[xii] with the most recent statistics showing the figure is now at 21.5 per 100,000 in the year 2020-

2021.[xiii] Those identified as 'black or black British' were almost 10 times more likely to be placed on a CTO than their white counterparts. Such high numbers have led to the suspicion that CTOs are being used to cover the backs of professionals in case something goes wrong, rather than for the benefit of the patient.

From clinic to culture

In the twentieth century, there was an increase in classification and objectification in the psychological realm - with more and more categories, diagnoses and quasi-diagnoses used to explain human experience and interaction. As the number of conditions has grown, the number of people said to suffer from such problems also continues to rise. No area of life is immune.

According to the psychologist Oliver James, one third of the adult population shows signs of 'psychiatric morbidity'.[xiv] Student life - once seen as a time of excitement, experimentation, learning and moving towards independence - is now seen as a toxic environment harmful to students' mental health. The Student Minds 2019 annual report claimed that 'roughly one in three students experience clinical

levels of psychological distress'.[xv] This is actually an improvement: according to a previous report by the National Union of Students, 80 per cent of students experienced mental-health problems.[xvi]

Children are now said to be suffering from mental-health problems of epidemic proportions, with the government called to act to avert a crisis.[xvii] There is a strong social and political consensus that educational settings should be key sites for such interventions,[xviii] with a focus on 'happiness' and 'wellbeing' becoming powerful rhetorical themes in policy and culture.[xix]

The broadening of 'mental health' encourages us to view ourselves as patients rather than active political subjects.

Such developments are portrayed as caring and benign initiatives to relieve the mental distress of the population. However, behind this lies some worrying assumptions and practices - specifically, the way in which the psychological disciplines can be used, both explicitly and implicitly, as a form of control. In this sense, they carry more of a political threat than the more extreme measures in mental-health provision.

Despite its faults, psychiatry provides relief and help for many people, and most mental-health

professionals are caring individuals working within an often chaotic and under-resourced system. We cannot blame them for the wider failings of society any more than we can point the finger at any individual practitioner or service within the mental-health system.

The medicalisation of more and more problems of the human condition, whereby we are encouraged to view our difficulties through the prism of mental illness, can erode the distinction between those who require expert intervention and those who are simply experiencing normal but unpleasant emotions as a result of adverse life-events. An unintended consequence of this is that we risk reducing the time and resources available to those who do require external help - and we should never forget that there are very many children and adults who do - as the system gets clogged up with inappropriate referrals.

Perhaps more importantly, the broadening of 'mental health' encourages us to view ourselves as patients rather than active political subjects who are able and willing to direct our lives and challenge any political barriers that prevent us from doing so. It can encourage us to lower our horizons, with coping or 'surviving' seen as the best we can achieve.[xx]

Defending compulsion and liberty

For some radical libertarians, such as Szasz (a psychiatrist himself), any form of psychiatric coercion is akin to the Spanish Inquisition. Nevertheless, it is possible to be a defender of liberty and to acknowledge the need for some people to have their liberty restricted by the state and its proxies - in this case, psychiatrists and social workers.

That paragon of liberalism, JS Mill, recognised the need for psychiatric intervention in particular cases. After all, in addition to the harm principle, Mill states that his doctrine of individual freedom should apply only to human beings in the maturity of their faculties - which precludes children and others unable to take care of themselves. In cases where someone is severely psychotic or suffering from dementia, psychiatric coercion, constraint and intervention is not a violation of individual autonomy because the subject, at that point in time, is not autonomous in any moral sense.[xxi]

This is where my objection to CTOs comes in. While the case for psychiatric compulsion can be justified at the point of hospital admission, it is not necessarily justified at the time of discharge. On admission, the patient may be in an acutely psychotic state, having

lost touch with reality. However, at the time of discharge this is rarely the case. At discharge, the patient can be well, have full mental capacity with greatly reduced psychotic symptoms or even none at all. Prior to the 2007 Act, on leaving hospital an ex-patient regained the rights of citizenship that we take for granted - such as being able to refuse medical treatment even if doctors say such treatment is in their best interests. The subject of a CTO returns to the community as neither patient nor citizen but a diminished hybrid of the two - the 'community patient'.

We cannot deny the potential for psychiatric power to be abused; there are far too many historical and contemporary instances of this to be so naïve. Indeed, it is precisely because of this that we must always err on the side of individual liberty and only intervene against someone's wishes as a last resort. When we move away from such extreme cases, we need to emphasise our political subjectivity and ability to take control over our lives. We should encourage each other to come to our own conclusions as to what is the cause of our emotional or material problems, and then decide the best course of action for us to deal with them.

Embracing the human condition

Despite the criticisms of psychiatry noted above, and the rise of alternative explanations and interventions by other professional groups, psychiatrists have maintained their position at the top of the mental-health hierarchy. In many respects, the psychiatric profession poses less of a threat to individual liberty than those who seek to replace it. It is often psychiatrists who see their role as keeping some sort of divide between mental disorder and eccentricity, between distress at such a level that professional intervention is necessary and that which is a normal but unpleasant aspect of the human condition.

And while such a threshold can be used to deny services to people who do require them - eligibility criteria are all too often dependent on available resources - a bigger problem is the way many of psychiatry's critics seek to promote their services. These critics often present themselves as a new expert class, using ever-expanding categories of mental ill-health to create a veritable industry of counsellors, therapists and psychological practitioners, all claiming equal status to psychiatrists.

There is a lot to criticise about the medicalised view of mental distress. However, the approach of these critics

- self-styled therapeutic experts, or more accurately, therapeutic entrepreneurs - is more corrosive to liberty. It inadvertently pathologises more aspects of life than the medical approach by blurring the lines between such terms as mental illness, mental distress, mental disorder and mental-health problems in such a way that any problematic human interaction or emotion can be categorised as a psychological problem.

In failing to distinguish between mental distress, which requires serious help, and the more mundane, albeit painful, times when we might feel low or anxious, many within the mental-health industry inadvertently lead more people to view themselves through the prism of mental illness. Not only does this increase pressure on an already overloaded and under-resourced system, such an environment also leads to more subtle means of manipulating our internal life.[xxii] The old way of viewing mental health is being replaced by a process that sets parameters on how we view ourselves and our relationship with the external world.

If we care about helping those in mental distress, and want to protect our freedoms, we need to ensure that we do not swap the literal straitjacket for its metaphorical equivalent.

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