Lunacy, Liberty and Law: A tale of two shackles?

Pinel freeing the insane from their chains (at la Salpêtrière). Oil painting by T. Robert-Fleury, ca. 1876. Credit: Wellcome Collection. CC BY

Sabina Dosani questions whether the mad have been liberated from mass confinement

Tony Robert-Fleury's 1876 painting, 'Pinel Freeing the Insane,' is one of my favourite works of art. I first came across it during my training to become a psychiatrist, in the early 2000s. A few years earlier in the 1990s, while still a medical student, I had been a psychiatric in-patient. I was never detained under the Mental Health Act; my liberty was never limited. It was that sort of ward, for 'informal' patients. Some of the friends I made on that ward had been 'sectioned' on other admissions. My mind goes back to their stories, their accounts of fear and sometimes relief, whenever I look at Fleury's painting.

Community Treatment Orders

CTOs are a legal tool, compelling patients to accept treatment. Tim Lambert, a psychiatrist investigating treatments administered to a group of patients on CTOs, published his findings that 'proportionally more patients with a CTO are prescribed long acting antipsychotics rather than oral second generation antipsychotics.' The CTO emerged in the context of a neoliberal state, initiated by Thatcher in the late 1970s and continued by Labour during the Blair years. It is my opinion that CTOs are a legacy of UK neoliberalism.

To what extent are patients in the community – who are subject to the legal conditions of CTOs – at greater liberty than those depicted in Fleury's painting? I use

Michel Foucault's analysis to question whether allowing residence and movement away from hospital through Community Treatment Orders (CTOs) actually delivers greater liberty.

Madness and Civilisation

Michel Foucault's 1961 book *Madness and Civilisation* presents a 'prehistory' of psychiatry, criticising what he termed 'The Great Confinement', claiming that in the 18th and 19th Centuries, prisons, workhouses and madhouses were established to deal with the 'social inconvenience' of the mad. This occurred, he suggested, due to breakdown of dialogue between 'reason and unreason'. In his view, reason dictated that 'madness' be negated as 'unreason.' This climate, he claimed, helped the psychiatric profession to claim great power in the late 18th and early 19th Centuries. He argued the 'great confinement' arose as a way of managing the fluctuating condition of the poor and marginalised during the emergence of capitalism; and that Philippe Pinel did not change that dynamic. So he did not accept Fleury's view of Pinel as a saviour-liberator. He argued that unchaining doesn't deliver liberty. On the contrary, he noted a steep rise in those incarcerated in the Bicêtre under Pinel's medical directorship and asserts many were detained while awaiting Revolutionary Tribunal hearings.

Enlightened Progress?

In England in 1790, Hannah Mills, a young Quaker suffering from melancholy, was sent to York Asylum. Members of the Religious Society of Friends were denied access. Mills died in suspicious circumstances. Samuel Tuke founded the York Retreat after Mills' death. In the name of 'enlightened progress', he proposed, 'moral treatment: kindness, reason and humanity.' Patients enjoyed daily walks, gardening and sewing. Historian Roy Porter described Tuke's methods as re-humanising: 'moral treatment aimed to revive the dormant humanity of the mad, by treating them as endowed with normal emotions'. Influenced by Tuke's work at the York Retreat, John Connolly also advocated moral treatment. When he became head of Hanwell Asylum in 1893, he was renowned for prohibiting restraint.

Foucault believed there was untold political motivation: 'Tuke's work was carried along by the readjustment of English social welfare legislation.' Foucault stressed sinister dimensions of moral therapy, in its potential for political abuses of psychiatry. He considered it uncivilised to remove physical chains, for them to be replaced by forced work, when a person might not feel well enough. Historian Andrew Scull takes issue with Foucault's romanticisation: 'Notions of the mad roaming free in the countryside must be considered alongside facts that they were beaten, chained-up or left to die.'

The law, then and now

The 1774 Act for the Regulation of Private Madhouses was the first Act of Parliament preventing wrongful incarceration of people deemed sane. It stipulated that 'madhouse keepers could only accept a paying patient on the signed certificate of a medical man.' Our current Mental Health Act requires two such signatures. A CTO is an option for patients detained under Section 3 of the Act and unrestricted criminal patients. Section 3 is a detention order for assessment and treatment, lasting up to six months, at the end of which it can be renewed.

In 1774, the onus was on proving sanity: 'For the individual named insane, it was sanity that became impossible to prove. The law might want to protect the individual's liberty...lost when he or she was declared insane.' Under the current Act, patients liable to detention can appeal to a tribunal, in an attempt to regain their liberty. However, Gosney and colleagues found tribunals discharged just 4.1% of those who appealed.

Although CTOs are used internationally, they were not introduced into the Mental Health Act in England and Wales until 2007. Perhaps the reason why CTOs were introduced in the 2007 Mental Health Act reforms relates to Connoly and his legacy. To ease pressure on Hanwell, a new asylum was built under Connoly's steer, at Colney Hatch, on Friern Barnet Road. In 1959, Colney Hatch became Friern Barnet Hospital. Then, in 1981, as part of a policy of introducing free-market competition into public sector spending, 'The Care in the Community' green paper recommended closure of long-stay mental hospitals. In 1989, Friern Barnet Hospital was sold to Comer Homes, a luxury property developer.

Roy Porter commented on the effects of asylum closures, 'controversy rages, within and beyond the profession, about the success (or failure) of deinstitutionalisation and community care, leading to calls (from both the profession and the public) to bring back the traditional asylum as a safe haven for the insane.' Andrew Scull describes community care that took place after closure of the asylums in Britain as a 'dismal and depressing experience.' His economic detail is bleak: '£300 million was spent on the mentally ill receiving institutional treatment, a mere £6.5 million was spent on 'care in the community.''

The 1795 repeal of the Settlement Act meant responsibility of the mad moved from parish to private enterprise. Politically driven closure of mental hospitals, and 'care in the community' policy paralleled this. The failure of 'care in the community', especially for those with schizophrenia, who lack insight, and therefore have poor compliance with medication, led to so-called 'revolving door patients.'

CTOs were introduced to address non-compliance by patients with severe mental illness who are now largely treated in the community. If neoliberal administrations

had not closed asylums and sold so many to property developers, we would arguably not need CTOs.

Foucault argued it is better to have someone chained, than pretend they are free, yet under surveillance. He said of the power imbalance, 'the chains that hindered the exercise of his free will were removed, but only so he could be stripped of that will itself, which was transferred to and alienated in the doctors' will.'

Chapman was made subject to a CTO in 2009 after twenty-five admissions to hospital with psychosis. He described being stripped of his will under the conditions of the CTO, 'Instead of them being concerned out of care and compassion for the problem I was having, there was reason for them to be responsible and have authority over me. It was the mental health equivalent of having a tag. If I became unwell again or stopped taking my medication – like re-offending – I would have gone straight back into hospital.'

Solo-navigation Sailors

Foucault's *Madness and Civilisation* referred to 'Stultifera Navis', the Ship of Fools. Using this analogy I suggest that compelling patients to treatment in the community smashes up their ship, replacing it with a flotilla of lone sailors. The collective identity of the asylum is lost and the mentally ill are left isolated. Patient support groups and the solidarity often found on inpatient units is jettisoned.

Patients liable to a CTO have some liberties in common with those of unchained asylum patients, including liberty of thought and liberty of discussion. Patients on CTOs are able to discuss their liberty at an appeal to the Mental Health Tribunal, although they are statistically unlikely to regain it. Given that CTO conditions include an identified address for patients, their liberty is arguably less than those unchained by Pinel and Tuke. Given the numbers of patients on CTOs who are compelled to have injectable antipsychotic treatment, neither are they free from the adverse effects of medication. Therefore, I conclude they have only the surface appearance of liberty. ▪

Sabina Dosani is a consultant child and adolescent psychiatrist with lived experience of mental illness.

Image: 'Abstract brick wall obstructing freedom'. By dtvphoto.