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**Who Cares about the Mad These Days? Some Reflections on the**

**Post-Asylum Landscape[[1]](#footnote-2)\***

Peter Barham

I first embarked upon *Closing The Asylums* almost thirty years ago, though the second edition appeared in the late 1990s. I am pleased that a decision has been made to reissue it, mainly because I feel that while much has changed, both in British society and in mental health, in the intervening period, many of the paradoxes, dilemmas, uncertainties, and ironies of the post-asylum landscape that I identify in the book are still very much alive and relevant to current debates. It may be helpful if, in this introduction, I try briefly to set the book in the context of its emergence and also draw attention to some features of the current scene, notably the dramatic increase in the recourse to coercion and constraint in the delivery of mental health care in the community, that are less prominent in the book.

 On page 123, referring to the proposals for Community Treatment Orders that were already being debated in the 1990s, I say that it ‘appears unlikely that they will be implemented’. Well, I obviously made the wrong call there for they were indeed introduced in England and Wales in 2008. And yet, ten years later, the controversy around them, far from abating, has if anything increased, and research has now questioned their effectiveness and value. So, as I shall discuss, having taken off with determination in one direction, the debate has now circled back to re-engage with some of the same questions and concerns, practical and ethical, that I try to identify here.

**‘Community Care has Failed’**

Starting in the early 1990s already community care was being widely derided as an idealistic, foolhardy, ill-judged, irresponsible, and even cynical, endeavour, a deceitful foil for cost-cutting measures that involved the ‘release’ (as though the penitentiary and the psychiatric hospital were indistinguishable) of mental patients into the community whose propensity for violence was, apparently, perfectly obvious to everyone apart from the misguided elite (politicians and doctors mostly) who had the power to make the critical decisions concerning them. An association between mental illness and violence was widely assumed and if a person with a psychiatric diagnosis committed any kind of act that could be characterised as violent it added fuel to a combustible stereotype, even more so if a person from the BME communities was involved. Amidst headlines such as ‘Freed mental patients kill two a month’ (*Daily Mail*, 13 October 1997) and ‘Abandoned to wreak havoc” (*Daily Mirror*, 24 February 1994), a succession of cases involving former mental patients were flagged by the media, notably the killing by Christopher Clunis of Jonathan Zito, a complete stranger, on the platform of a tube station. The ‘tube murder case’ was widely deployed as a symbol of the failings of community care policies.

 In a climate increasingly governed by the politics of fear, the incoming Labour government announced sterner and more restrictive, not to say draconian, measures. ‘Community care has failed’, declared Health Minister Frank Dobson. Throughout much of 1998 newspapers were blasted by headlines such as: ‘Care in the Community is Dead’; ‘£1 Billion to End Care in the Community’; and ‘Dobson Acts to Sweep the Mentally Ill off the Streets’. 'A sad and sorry episode in the history of British social theory is drawing to a close’, declared an editorial in the *Daily Telegraph* in January 1998. ‘The policy known as care in the community which plucked the mentally ill out of huge Victorian asylums and sent them to live, often alone, in towns and villages is to be reversed'. 'Care in the community’, opined *The* *Independent*, ‘was based on lofty and widely held ideas . . . Whatever the theoretical benefits of care in the community, in practice it was a disaster . . . hundreds of thousands of vulnerable and disturbed patients were simply turfed out to fend for themselves . . . public anxiety and the needs of the mentally ill have meant that a rethink is necessary' (editorial*,* 30 July 1998).1

 Action was now promised: Health Secretary Frank Dobson ‘will announce shortly that the controversial care in the community policy is to be reversed and the Mental Health Act rewritten. Money will be allocated to build new institutions around the country to house schizophrenics and other patients’ (*Independent on Sunday,* 15 November 1998). From much of the press coverage the public could reasonably conclude that all tragedies could be averted if only people with a diagnosis of schizophrenia were to take their medication and comply with treatment. Much of this coverage was, however, highly selective and slanted, for no less tragic cases of the death of a patient as a result of neuroleptic drugs, for instance, were mostly hailed with a resounding silence. When the unfortunate Munir Majotti died in hospital in York after being injected five times within 40 minutes with the maximum recommended dose for a powerful neuroleptic, there was, alas, no lament in the press over his untimely end or an outcry over the deficiencies in the care he received. As an influential review of media influences on mental health policy in this period concluded, ‘policy measures introduced in response to public concerns about risk and dangerousness have further stigmatized people with serious mental health problems’. Under such circumstances, ‘the vulnerable mental health service user is unlikely to receive appropriate care’. 2

***Closing the Asylum***

*Closing the Asylum* was commissioned by Penguin as long ago as 1988 after I was  approached by an editor on the strength of my  previous work. The stimulus to commission the book obviously took from  the topicality of the asylum closure programme. It was very much all happening just then. Indeed, originally it was intended to publish the book as a 'Penguin Special'. And it was at this point that the plan for the book got rather diverted, for a lot was happening in my life at that  time as well, both on a professional and a personal front, so the  completion of the work was considerably delayed.  I must have started  serious work on it in about 1990, though I had given a number of  presentations around the theme before then. And by the time I did finish it, Penguin had pretty much decided to  get rid of the  ‘Penguin Special’ category: they were now seen as being  'instant analysis' books on topical subjects which were issued with  considerable publicity but mostly enjoyed only a limited shelf life.

 The last few Penguin Specials had not been very successful, so it was decided to publish *Closing the Asylum* as an 'ordinary' Penguin in the hope that it would  prove a little more durable.  With hindsight, I think this was a wise decision. Publication was again a bit delayed, however, this time on  account of James Joyce and Virginia Woolf.  Their works had just come out of copyright and Penguin were intending to issue new editions in the Spring of 1992, so *Closing the Asylum* and other contenders were placed on the  back burner for a little while. It was eventually published in August 1992.  Penguin had initially come up with 'The Mentally Ill in Society' as a subtitle, but on my objection it was changed to 'The Mental Patient in Modern Society'. Historian Roy Porter, from the Wellcome Institute for the History of Medicine at that time, was  approached for an assessment that might be used for the cover and he picked  up on the theme of the 'mental patient': 'With a powerful logic, Peter Barham demonstrates why the closure of psychiatric hospitals cannot meet the real needs of the mentally ill  without a profound rethinking of the role, rights and position of the  mental patient in society'.

 The book did not exactly attract a fanfare of publicity, but I did quite a number of interviews for radio, local and national, one of  them for Radio 4 which was set up by Marjorie Wallace, the campaigning journalist and founder of the charity SANE (Schizophrenia: A National Emergency), who was incensed  by the comments I had made about SANE, and my enthusiasm for  'community care', as she saw it,  and was eager for an opportunity to vent  her opinions on my creation.  I arrived at Broadcasting House to find Marjorie already installed in the studio and the exchange on air was, shall we say, quite lively. Marjorie notwithstanding, the reviews were mostly favourable and Penguin were quite pleased with the sales of the book for they approached me in 1997 to produce a second edition with an additional chapter, in which I updated on the programme of hospital closures as  the millennium was approaching.

 Ironically, on the recommendation of the editorial director at Penguin, the new edition sported a rather brighter cover than the first one, more accurately to reflect the upbeat mood of the text, for though the book is consistently critical and questioning of the way in which policies of community care have been implemented, it nonetheless holds steadfast to a positive view of the capabilities of the diverse range of people who are assembled under the banner of ‘the mentally ill’, and to the promise of community-, above asylum-, led lives for enhancing their life prospects.

 I envisage the process of closing the asylum as an emancipatory project that is inevitably unfinished, a matter of closing not only buildings but also out-dated attitudes, opening windows and new paths, and challenging disadvantage. With hindsight, the timing of the second edition was not entirely well chosen, however, for it saw the light very much on the eve of the major political volte-face over the policy of care in the community. Against the background of pronouncements about the terminal failure of community care, the tone and argument of the book were not well-calculated to secure a sympathetic reception, and in this febrile atmosphere it could be taken for a busted flush, the vestige of a frustrated promise, out of step with the new political and public climate of opinion. Though reviews were still quite positive, the sales figures for the second edition were rather disappointing and the book finally went out of print in 2000.

**‘Brotherhood’**

Such a drastic turnabout in the revaluation of a disadvantaged population is strongly reminiscent of racialized discourses about other marginal and subjugated populations that have held sway over the past two centuries. Some fifty years after abolition, the slave trade was showing signs of a revival, helped along by a complacent public. A new generation found anti-slavery ‘old and tiresome’, with some propagandists even claiming that ‘negro servitude to the white man is not human slavery, but the normal condition of the inferior race’.3 This was the ideology, legitimated by the new racial science, and eclipsing the Old Testament belief that Africans and whites were members of one family, that gave succour to Governor Edward Eyre in quelling a rebellion in Jamaica in 1865 and justifying his actions before the scruples of what his ally Thomas Carlyle termed ‘rabid Nigger-Philanthropists’.

 As scholars have recently shown, Charles Darwin derived from the British anti-slavery movement an abhorrence of racial servitude and brutality that was never to leave him, jotting in his notebook as early as February 1838 when his musings on evolution were still taking shape: ‘Animals –whom we have made our slaves, we do not like to consider our equals.--Do not slaveholders wish to make the black man other kind?’.4 In this, his ‘most generous, relativistic phase, at the height of Britain's radical political period in the late 1830s. he extended the kinship to all groaning, degraded, disparaged races of animals’, seeing them as sharing our common deep ancestry.5 From the outset Darwin displayed a concern with the unity of humankind grounded in a notion of ‘brotherhood’.

 ‘If we choose to let conjecture run wild’, he noted, ‘then animals our fellow brethren in pain, disease death & suffering & famine . . . they may partake from our origin in one common ancestor we may be all netted together’6 By the 1860s, however, attitudes towards the black races were hardening and the opinion was gaining ground that black people ‘could never be made into gentlemen, at least not for a very long time’.7 By the time he came to write *The Descent of Man,* Darwin adopted the prevailing cultural ladder, with the ‘lowest’ races on the first rung. Amidst fears that the process of natural selection was being diverted in a modern society like Britain in which institutions such as insane asylums were permitting ‘inferior’ classes to survive and reproduce, Darwin’s cousin Francis Galton, among others, invoked the spectre of racial degeneracy. Darwin did not dissent, but still he declared that we must bear the consequences of the weak surviving ‘without complaining’ for to curtail ‘the aid which we feel impelled to give to the helpless’ would no less cause a ‘deterioration in the noblest part of our nature’8 Though such moral and intellectual commitments of this sort were sorely tested in a mutating and less hospitable political climate, Darwin 'never lost faith in the brotherhood of races'.9

 This may also be viewed as a ‘brotherhood’ book, to use that rather old-fashioned term. As an undergraduate at Cambridge in the 1960s, I had the immense good fortune to be able to spend a long vacation at Kingsley Hall, the settlement in Bromley-by-Bow, East London, founded by Doris and Muriel Lester, where Mahatma Gandhi had lived for several months in 1931, during the period that it was a therapeutic community run by the Philadelphia Association under the inspiration of Dr. R. D. Laing. Most of all, what I took away from this experience was a compelling sense of the humanity of the people living there.

 For all their difficulties and peculiarities, sometimes, to me they were fellow human beings. This is a message that has always stayed with me. As I later discovered, out of the First World War there emerged a current of psychiatric thinking that was starting to deliver an alternative cast on psychosis and human life. Instead of portraying the psychotic as someone apart, or radically divergent, from the norm, these new theories retained a view of the patient as a fellow human being. In the idiom of Millais Culpin, a surgeon who had been turned on to the new psychology by his experience of the war, and subsequently became a psychoanalyst, psychosis was the action of life. 10

 ‘According to our present day concept’, wrote the Swiss psychiatrist Manfred Bleuler, ‘schizophrenics founder under the same difficulties under which all of us struggle all our lives’. In his writing and his practice Bleuler gives substance to a conception of the schizophrenic person ‘not as someone who has become unintelligible in his thinking and feeling and in principle a creature different from ourselves’, but ‘as a brother whom we can judge according to our own nature’.11 ‘It is the burden of those who care for the suffering’, asserts moral philosopher Stanley Hauerwas, ‘to know how to teach the suffering that they are not thereby excluded from the human community. In this sense, medicine’s primary role is to bind the suffering and non-suffering into the same community’.12 This is a provocative statement, and it is not without ambiguity, but it enjoins reflection on the kinds of messages, in the present as much as in the past, that psychiatrists communicate to their patients about their place in the human community and in society.

**Emancipating the Mental Patient**

There are constant fraternal and communal resonances in Mark Gallagher’s recent historical study of the mental health service user movement in Scotland in which he describes how by the early 1980s, in an edgy act of self-definition that both played to, and mocked, the Thatcherite ideology of self-help and independent living, user groups were no longer identifying as ‘mental patients’ but instead were referring to themselves as ‘consumers’ of mental health services, and challenging the passive ‘sick role’ of ‘being the good obedient patient’ to which state-sanctioned medicine still expected psychiatric patients to adhere.

 In sociologist Talcott Parsons’ classic formulation of the ‘sick role’, the sick were ‘deprived of the possibility of forming a solidary collectivity’ or a subculture of the sick. In actuality, from the mid-twentieth century onwards, diverse groups among the disabled and sick were starting to organize and form collective identities, and former mental patients were just the latest recruits to an increasingly non-deferential medical culture. ‘What we mean by self-help’, asserted one such Glaswegian ex-mental patient action group, ‘is organizing ourselves to get what we need, and doing so on our terms, and not allowing ourselves to be patronized or led by the nose under any circumstances’.

 In 1975 the moral philosopher Alasdair MacIntyre had proposed ‘to invite patients to become moral agents in an area where they have been passive: patients have to become agents.’ As Mark Gallagher comments:

Within a few years, psychiatric patients in Glasgow, the city where Alasdair MacIntyre was born, were realizing in practice what he had advanced in thought. These psychiatric patients and ex-patients were no longer prepared to passively submit, as powerless and isolated individuals, to the authority of the state-licensed psychiatrist. Instead they began to form associations and to see themselves not only as patients, but as citizens with the capacity to act and with the potential to contribute and participate in civic, social political and economic life . . . They had learned to see their own pursuit of self-determination and individual flourishing as bound up with their shared fate with other people.13

 Here we can see enacted the radical sense of ‘recovery’ that, as mental health activist Alastair Kemp has described, was born of the struggles of psychiatric service users or survivors in the era of decarceration, recovery as an emancipatory process through which users and survivors recover their own powers of self-determination, and the control over their personal and collective histories.14 Starting with the eighteenth century Enlightenment there has been a predisposition in the West to equate humanity with reason and to strip madness of significance. Through to the present day, psychiatric modernity has viewed madness essentially in defect or deficit terms as a transgression, or an offence, against civilization. The ‘twentieth century collars madness’, stated Michel Foucault the French philosopher and anatomist of psychiatric modernity, in an early interview, ‘reducing it to a natural phenomenon bound up with the truth of the world’.15

**Waste Products of Civilisation**

The revolution of laissez-faire capitalism brought about the eclipse of customary forms of social protection, or of moral economy, hastening the establishment, and soon enough the expansion, of a system of public lunatic asylums in Britain for a surplus population who would otherwise have been without protection. The product of a Victorian culture of domination and subordination, psychiatry (as the profession later came to be known) treated the great majority of its subjects (those, at least, who languished in public asylums) as if they were a colonised people. Perceived as a failed cadre in the cultural politics of the imperial race, psychological medicine obligingly spawned a condemnatory rhetoric about the mad, masquerading as science.

 'Sanity is self-control and insanity is the want of it', asserted Sir Thomas Clouston, the hugely influential medical superintendent of the Royal Edinburgh Asylum, in 1896, who regarded his patients as unruly children in need of discipline, summing up his approach as ‘discipline, order, a life under medical rule’.16 Alienists, as psychiatrists were formerly known, made it their corporate mission to deliver the message to the suffering inmates that their membership of the ordinary human community had been permanently suspended. With the ascendancy of Social Darwinist ideologies, the type of person classified as a lunatic, at 'home’ or on the colonial periphery, became emblematic of an inferior type of being, as a throw-back, or regression, to a more primitive stage of human development, or as a waste product of civilization. Towards the end of the nineteenth century especially, the mad poor were confined not only physically but also bonded to a perverse outlook in which mental suffering was frequently conflated with moral turpitude. ‘Lunatic*s*’*,* opined the distinguished psychiatrist Daniel Hack Tuke in 1878, are ‘an infirm type of humanity’and on admission to the asylum, ‘No good is plainly inscribed on their foreheads’.17

**An End to Segregation?**

As Alastair Kemp remarks, in a variation on Michel Foucault’s history of madness, the forces of ‘recovery’ and the forces of containment have always been in tension in the history of mental health, in a dialectical movement in which now one, now the other, succeeds, temporarily or provisionally at least, in gaining ascendancy. The emancipatory struggles of former mental patients have continued apace over the past twenty years or so, and the psychiatric survivors movement has become a more definitive presence in the mental health landscape and in the wider society, but by no means have they succeeded in quashing or side-lining the forces of containment. As Kemp describes, ‘recovery’ is now ‘returning back as a form of containment after its thirty or forty years ‘emancipatory push’, playing a pivotal strategic role in a neoliberal health agenda geared towards short-term interventions that aim to return the temporarily sick or disabled to productive roles in the marketplace as quickly as convenient.18

 Here the irony may be that in running with the baton of ‘self-help’, some survivor groups have become victims of their own success, intentionally or inadvertently giving off the message that longer-term support or care structures are now no longer needed. As I discuss later in this book, enthusiasm for deinstitutionalization has generated a number of paradoxical, and not infrequently ironic, alliances between unlikely partners in which the lines of demarcation between ‘liberation’ and ‘neglect’ may sometimes be blurred or equivocal. In our own neoliberal, post-colonial, and post-asylum present, the realities of the mental health scene are at one and the same time conflicting and contradictory, dispiriting and encouraging. Vigorous challenges from the grass roots or the psychiatrised, to the post-Enlightenment legacy of the mad person as a totally discredited person are coincident with the reassertion, and reinvention, of that same legacy in familiar, and sometimes in novel, forms.

 As historians have shown, from the seventeenth century onwards there was an accelerating movement, much intensified in the nineteenth century, to segregate those deemed to suffer from mental disturbance from society, both physically and categorically. It is exactly this segregated universe that policies of deinstitutionalization were intended to dismantle, demolishing not just buildings but also oppressive and isolating categories, in the name of a more inclusive and welcoming ethos of mental health understanding and care. But have they just? On a more sceptical reading the segregational universe epitomised by the mental hospital has not been eradicated at all, for the forces of containment have merely regrouped, and reorganised, around psychiatric patients in the community, as tightly as every they did in the hospital.

**The Landscape of Psychiatric Coercion**

Psychiatrist George Szmukler, Emeritus Professor of Psychiatry and Society at King’s College London, titles his remarkable new book *Men In White Coats: Treatment Under Coercion* in order to evoke a disquieting metaphoric truth about the contemporary landscape of psychiatric coercion.19 Today, we inhabit a radically split, or bifurcated, mental health culture in which opposing tendencies, some of them contemporary, others the relics or hang-overs from eras that one might have supposed long surpassed, nonetheless co-exist, sometimes going their own way, apparently oblivious of each other, but sometimes colliding.

 The Mental Health Act 2007 introduced for the first time the right to Independent Mental Health Advocacy for service users in order to support them in understanding and exercising their legal rights. An Independent Mental Health Advocate, who worked for a year at the Maudsley Hospital supporting inmates to understand and exercise their rights, recounted how the legitimate objections of the clients he was working with to the drugs they were put on were routinely ignored:

‘As soon as the patient disagrees with the medication they are coerced into taking it. If you question the diagnosis, that is seen as part of their illness and is used to justify forced treatment. As soon as you disagree with the professionals, you’re in trouble basically’. And then the white coats move in: ‘The patient is forcibly taken by six people, held down, and injected . . . I’ve seen people crying and shaking, in absolute distress, following being restrained . . . But from what I’ve seen, professionals don’t seem to appreciate the impact of what they’re doing. They just see it as, “this is the medication that is best for the person, the person doesn’t agree because they don’t understand their illness, so we’re going to use force”. There is no attempt at negotiation’2

**Psychiatry and Colonial Relations**

In an accomplished and finely-honed analysis, critical psychologist China Mills interrogates the ‘uncomfortable question of whether psychiatry (and the disciplines of the psy) can be both a tool of more traditional colonialism and a form of colonialism itself’. Though we should not collapse colonialism and psychiatrisation together, it is at the same time very relevant to trace the interlacing histories of colonialism and psychiatry and especially their co-constitutive metaphors of savagery and madness. Thus, for instance, ‘the dog-eared textbooks of psychology and psychiatry are full of parallels drawn between colonised peoples (“savages”, “primitive peoples”) and people with “mental illness”.’

 ‘What if psychiatry itself mobilises a colonial relation’, Mills asks, ‘alienating people from their own understandings of distress & violently interpellating them into a ‘fixed’ identity as ‘mentally ill’? Even when applied within the countries it originates from, ‘psychiatry has been criticised as being a form of colonisation . . . labeling people as ‘irrational’ and thus in need of care in their ‘best interests’, and subjecting people to forced ‘treatment’ and involuntary detention’. Psychiatric and colonial discourse both ‘construct subjects who are understood as degenerate in order to justify intervention’; and ‘produce forms of governmentality that appropriate and dominate the subject peoples they constitute and “fix” as others’. In order ‘to better understand the continued coloniality of psychiatry’, Mills invites us to ‘read psychiatry as enacting a colonial relation’ and as a mechanism to enable a ‘perpetuated coloniality’. 21

**Coercion and Community Care**

It is, of course, in the much-intensified recourse to involuntary detention that the forces of containment have most obviously been manifest. The number of people detained involuntarily in mental hospitals in England and Wales rose from 21,897 in 1988 to 58,399 in 2015. Nearly 50% of in-patients are now detained on an order under the Mental Health Act. Psychiatrist George Szmukler, Emeritus Professor of Psychiatry and Society at King’s College London, recalls that when he was a trainee psychiatrist in the late 1970s it was less than 10%. Tania Gergel and George Szmukler invite us to ponder the irony that ‘while community care may have been envisioned as a step towards greater liberty within psychiatry, use of coercion in many countries is currently increasing’.22 In addition, when Community Treatment Orders (CTOs) were introduced in England and Wales in 2008 the government had predicted a take-up of not more than a few hundred year, but in actuality by the spring of 2015 there were as many as 5461 people on a CTO, and there are no signs that their use is likely to abate.

 A ‘coercive shadow’ has always hung over psychiatry, especially public psychiatry, since until 1930 all patients in public mental asylums were detained against their will, but in recent years it has expanded and intensified, spurred very largely by the huge reduction in the availability of in-patient beds—down from 150,000 in the mid-1950s to 67,000 in 1987 and to just over 19,000 in 2016—coupled with the rise of a strongly risk-averse society, with the consequence that the void left by the erasure of the old mental hospital regimes has been filled, or compensated for, by a new coercive and fear-driven zealotry.

 The ‘shadow of coercion’ refers especially to the knowledge that patients possess of the coercive taint that permeates the psychiatric treatment context. As Peter Campbell observes: ‘That an individual can be compelled to receive psychiatric treatment affects each in-patient regardless of whether his stay is formal or informal. It is hardly possible to be unaware that you are being cared for within a legal framework that allows for treatment against your will’. Similarly, Jasna Russo and Jan Wallcraft underline the ‘coercive potential of psychiatric treatment itself’ for in a system based on the option of using force ‘the question of whether a person is legally coerced or not may become a side issue on an experiential level’23

**‘People Who do not Count for Very Much’**

The winds of change that have blown across Britain, and others parts of the western world, over the past thirty years or so have brought to an end an era of welfare capitalism that hinged on expectations of full employment, with an encompassing sense of social citizenship, and tested to the limit any lingering idea of the welfare state as a set of social protections to modify and moralize the market economy. The asylums may long since have emptied, but in essential respects the policies of contemporary politicians and health managers mark an abandonment of the post-war welfare settlement in Britain and a return to the market-driven values of the nineteenth century. Following an onslaught on ‘dependency culture’, Britain has shifted from a universalistic welfare state to a more restrictive and residualist regime in which the satraps of contemporary welfare reform disseminate the virtues of 'going lean', and the uses of 'lean', in mental health and other welfare services. The emotional suffering, and long-term support needs, of psychiatric patients are side-lined, or even disavowed, by a managerial 'virtual reality' with a premium on targets, protocols and outcomes, that coerces patients into a market model where their progress is continuously measured and rated in *Health of the Nation* outcome scales. 24 People with long-term mental health disabilities now mostly lead lean existences amidst the continuing ruination of the buildings, services and other connective tissues that formed the old welfare state, frequently demoralized and reduced to poverty.

 ‘Part of the very problem of contemporary political life’, remarks the political philosopher, Judith Butler, ‘is that not everyone counts as a subject. What is at stake are subjects who are living, but not yet regarded as “lives’. Some groups or populations ‘are considered from the start very much alive and others more questionably alive, perhaps even socially dead’. These valuations are vectors of power relationships for **‘**the frames through which we apprehend or, indeed, fail to apprehend, the lives of others as lost or injured . . . are politically saturated. They are themselves operations of power’.25

 Prominent among those population groups who do not count for very much are mad people for contemporary mortality statistics strongly suggest that mad lives may count for even less today than they did in the past. Studies have shown that after one year of treatment patients with a diagnosis of schizophrenia are ten times more likely to be dead, and after five years eleven times more likely, than they were a hundred years ago. More generally, the life-expectancy gap between people with mental illness and the general population has widened over the last thirty years, and the average reduction in life expectancy for people with a diagnosis of schizophrenia, for instance, is now ten to twenty years.26

*‘****Treatment Room’***

In 1983-84, British artist Richard Hamilton created an installation that he named ‘*Treatment Room’* in which he created an interior inspired, as he put it, ‘by the bleak, disinterested, seedily clinical style of the establishment institution' that reflected 'the present consciousness of depression' in the 1980s, the crumpled hopes and expectations that were all that was left from the utopianism of the 1950s and 1960s and the spirit of the artist's earlier work. In one corner there stands a sink and a bucket and in the centre a white wooden gurney with a rumpled orange blanket with the outline shape of an 'absent' body, and a pillow at the head, and suspended over it a monitor showing a film of former prime minister Margaret Thatcher speaking that is continuously playing, soundlessly in actuality, but with Thatcher's lips in constantly movement, so that the effect is earnest, loud and relentless. This is a bleakly functional and indeterminate environment, with echoes of DHSS labour exchanges, NHS waiting rooms and hospital bedrooms, where the roles of subject, consumer and patient are blurred. *'Treatment Room'* is, obviously, a rather grim and unadorned emblem of the situation of the individual in relation to the state in modern society, but at the same time, in a more specific way, it also reflects the diminished prospects available to clients of welfare and mental health services, the depletion and wilting of the psychiatric imaginary, in the era of welfare cutbacks and reforms. 27

 What kind of 'treatment' is on offer here? What has happened to the person under the blanket? Is this just a temporary absence or has he/she been flattened by the 'message', so all that is left is a trace in the rumpled blanket of an obliterated individuality? Or perhaps the 'person' is absent because he/she has answered the call from She Who Must Be Obeyed and responded to treatment? Assuredly, it *can* be interpreted as a paean to the ideologies of 'recovery' extolled by contemporary welfare reformers, for when ‘*Treatment Room’* was exhibited in a major retrospective of his work at Tate Modern in 2014, one journalist who was viewing it overheard 'a Barbour jacket type' behind him, saying to another: 'this is a very optimistic work . . . you see, the patient must have got better and got out of bed and walked off'.

**‘Recovery’**

In recent years, claims psychiatrist David Bell, ‘we have taken an extraordinary step backwards in our attitude towards people with mental illnesses’ who are ‘once again being represented as closer to being delinquents than being ill’. Wards are now grossly overcrowded with newly admitted patients sleeping on mattresses on the floor and a majority of patients held compulsorily. The atmosphere on these wards creates a toxic environment that inevitably impacts upon the mental states of the patients but, argues Bell, ‘this deterioration is most unlikely to be thought of as brought about by these environmental and systemic causes. Instead, it will be recorded in terms only of the individual factors in the patient, and is then seen as indicating a need for increased medication.’ Where until recently day hospitals provided supportive environments for clients with enduring mental health problems, many of them have either been closed or (subject to a name-change, like almost every other institution these days) re-designated as ‘recovery centres’ on the assumption that clients can quite quickly be returned to ordinary living. As David Bell sardonically remarks: ‘This conception not only bears no relation to the nature of most of these patients’ difficulties, but also creates a kind of tyranny for the staff. Patients are now supposed to recover, and there are performance targets against which this will be judged: if they don’t recover the conclusion drawn is that the staff have failed.' 28

 Nowadays, the performative norm in the treatment room is that of the 'active' or 'self-governing' subject, with an emphasis on taking personal responsibility through self-management and self-care. This is all part of the heavily promoted ideology of 'recovery' which expects clients to adopt a 'recovered identity', and quite quickly shake free of services. In this climate, people with severe and enduring mental health problems who seek continued support are something of an embarrassment, at risk of being stigmatised as dependents or shirkers, for they have not learnt their new lines or script, which requires them to actively update their skills and attitudes, rather than tag along as chronic veterans.

 The 'recovered' identity is extolled as being in line with government norms, but the 'unrecovered' identity is viewed in a negative light, insinuating a disturbing ambiguity between chronic problems or chronic illness and non-conformist or deviant behaviour. Believing that mental health services are using ‘recovery’ ideology to mask greater coercion, a group of mental health survivors and supporters have formed a user led group, ‘Recovery in the Bin’, for those who are ‘fed up with the way colonised “recovery” is bring used to discipline and control those who are trying to find a place in the world, to live as they wish, trying to deal with the very real mental distress they encounter on a daily basis’.

 They have introduced ‘UnRecovered’ as a new word or signifier, considering it to be as valid and legitimate as ‘Recovered’, though they do not want to imply that they want to stay ‘unwell’ or ‘ill’ (whatever that means), rather to ‘reject this new neoliberal intrusion on the word “recovery” that has been redefined, and taken over by marketization, language, techniques and outcomes’.29

 This is, perhaps, a new variation on an old plot for in the history of mental health care there has been a continuing tension, and not infrequently a polarity, between the claims of acute versus chronic cases: the promising versus the unpromising; the hopeful versus the hopeless; the efficient versus the inefficient and so forth. The recovery, or cure, agenda has for long tended to disparage chronic cases and even the historiography has tended to favour the history of curing over that of caring. At the AGM of the Mental After Care Association (MACA) in 1888 the psychiatrist George Savage asked: ‘How often one ought to help a patient who had broken down more than once?’ The question was merely rhetorical since Savage had his answer at the ready. Those who suffered from ‘recurrent insanity’, he exhorted, should be bypassed ‘in favour of sufferers who were of a more hopeful character.’ MACA later disclosed that some applicants for their services had been turned away as ‘they would never be fit for the struggle of life again’, and a spokesman gave his assurance that the Association ‘took no cases where recovery was not certain’30

 At present, however, it is undoubtedly through the Work Capability Assessment (WCA) process conducted by the Department for Work and Pensions, in which claimants are assessed for their fitness for work, that the neoliberal intrusion on ‘recovery’ is most egregiously displayed. Out-sourced to companies such as Atos and Maximus, the WCA has attracted enormous opprobrium for, as David Bell attests, the ‘brutal way in which it has been managed, the lack of skill of those carrying out the task and the profoundly traumatic effects it has’. Bell has ‘known a number of patients suffering from enduring mental illness, who feel so persecuted by the WCA process that terror of it comes to dominate their mental state . . . many people who are mentally ill are already, internally, persecuted by a terrible kind of inner self-judgment that relentlessly tells them they are worthless, filling them with humiliation and shame’.

 The WCA process itself, ‘and in particular the assumptions which it has come to embody–that those on benefits are trying to get away with something, the whole atmosphere of distrust of claimants–creates an external reality that far from providing reassurance, reinforces these menacing internal processes’. Bell has known patients with enduring serious mental illness who, from a wish to prove themselves worthy, ‘inform the panel that they are “feeling much better and are ready to work”’, even though this may quite fallacious. ‘There are cases of people dying not long after ATOS has considered them fit for work, including cases of suicide’.31

**‘Social Defeat’**

Originating in ethology, the concept of social defeat has recently been applied by anthropologists Tanya Luhrmann and Jocelyn Marrow to draw attention to how vulnerable people, especially in societies of the West, may be driven mad by repeated experiences of social failure. Though other social constraints and stresses may also be implicated, it is above all the dominant psychiatric model, with its cavalier disregard for the person, they conjecture, that is driving the experience of social defeat. Acquiring a psychiatric label that ‘simultaneously defines and defiles them’, people with a diagnosis like schizophrenia are ‘vulnerable in many different ways to the sense that that they have been defeated at the hands of others’. The type of madness that is generally called schizophrenia is, they write, ‘the story of the way that poverty, violence and being on the wrong side of power drives us mad’.

 The assault of stigma is revealed in ‘corrosive perceptions by others that eat at the soul’, such as the public image of the homeless as waste product and as disease. In an arresting statement that summons echoes of the classic account of slavery as a form of social death by Owen Patterson, or of the decomposition of the colonized subject, unable to answer the question ‘Who am I?, by the revolutionary theorist and psychiatrist Frantz Fanon, they conclude that in defeat: ‘you have lost the status war. You have accepted your subordinate role. You lie there beaten in a ditch’.

 In a social world where market values dominate, the emotional pain of derailed selfhood characteristic of psychosis may often be compounded by an experience of social defeat–one might almost say a climate of social defeat–in which individuals in their significant social encounters are made to fail, and to fail again, and be brought to envisage themselves as inferior and 'no good', responsible for their own illness and misfortune. Only through a psychiatric approach that is not all encompassing, and permits respect for the person, can such degrading subordination be avoided, Luhrmann and Marrow avow.32

 Mental health campaigner and survivor Peter Campbell, founder of the activist group ‘*Survivors Speak Out’*, is strongly resistant, and far from defeated, yet he locates people like himself on a social and historical terrain in which they are engaged in an analogous struggle to challenge the negative context of mad people’s lives. He makes a poignant and angry statement from within an experience of life that has continually been devalued and discredited:

The feeling that the diagnosed mentally ill don’t know what they are talking about limits the scope of our lives . . . If I am to be confined to a category of persons whose experience is devalued, status diminished, and rational evidence dismissed, simply because at a certain time, or times, I lost contact with the consensus view of reality agreed on by my peers, then it is scarcely possible to expect that my control over my life will ever be more than severely circumscribed . . . My experience is shared and is relevant. It is not an interesting cul-de-sac. Tut-tutting and sympathetic frowns from those who are paid to intervene in my affairs merely confirms my powerlessness. They accept me as an individual pathology; they deny me as a cogent element of a social reality **33**

Some twenty three-years later, in a conversation with me, he reaffirms this outlook, now identifying the assault of stigma with the obliteration of credibility:

A mental illness diagnosis leads to a complete loss of credibility. That is the stigma of so-called “mental illness”: not having credibility. Even today one is still at ground zero, or below ground zero, in a transaction with a mental health worker.(Peter N. Campbell, 2012)

It is as though Campbell is responding directly—there is a congruence in sentiment and vocabulary—even though, most likely, he has never come across it, to a pronouncement by Lord Macmillan in 1926 in the course of conducting the ‘Royal Commission on Lunacy and Mental Disorder’:

One would like to analyse what the stigma really is. The stigma means this, that the person has, owing to his misfortune, or his fault sometimes, ceased for a time to be a normal, rational human being. No amount of beating around the bush, or calling things by different names, no amount even of humane treatment, will obliterate the fact that in a person's life there has been an episode, a pathological episode, if you please, which to some extent will place him apart from others. Is not that almost inevitable?’ *34*

Lord Macmillan does not dispute the stigma that is inflicted upon the mad but sees it as an almost inevitable by-product of civilized life. That Macmillan’s outlook on mental disorder could still be an implicit reference point, and possess salience, more than sixty years later is hugely indicative, which no amount of ‘beating around the bush, or callings things by different names’, can obscure, of the enduring power of a certain kind of cultural reflex, and of the brute stubbornness of the legacy of suspicion and disregard that Peter Campbell, and others like him, still labour under. Here we are brought up against the norms of a culture, originating in the eighteenth century Enlightenment, for which a loss of reason constitutes a transgression that in the ‘official’ mind it is difficult, if not impossible, to row back from. Hence why, traditionally, the phrase ‘has a history of mental illness’ is laden with grave implications. 35

**Suicide and Austerity**

A study published in the *British Medical Journal* in November 2017 accused the Conservatives of ‘economic murder’ for austerity policies which may have caused 120,000 deaths. Though mortality rates in the UK had declined in the first decade of the new century, they quickly picked up again after the onset of austerity. In 2013 suicides reached a 13 year high in the UK, with population level data linking these suicides to austerity policies. China Mills has undertaken a psycho-political autopsy to trace suicide as one of the symptoms of austerity and welfare reform in an approach that embeds ‘psychic distress in a context of social disease’ in order to counter what has been termed the ‘alchemy of austerity’, the ideological work of reconfiguring economic inequalities into individualised problems of ‘welfare dependence’ and the like, and to ‘structure into our analysis of a person’s death the context of social injustice in which they lived’.

 There is compelling evidence, Mills claims, of a relationship between austerity and suicide, though within the welfare system it has become normalized as a by-product of the pathological clients who are to be found there. Indeed, there are guidelines from the WHO cautioning against ‘reporting suicidal behaviour as an understandable response to social or cultural changes or degradation’36 In operation here is what Ian Marsh has termed the ‘compulsory ontology’ of the pathology of suicide, the idea that suicide is by definition the product of an unstable or irrational state of mind.37

 Many of the clients in the WCA system feel themselves to be a burden by dint of their internalization of a eugenic and market logic that reduces the measure of personal worth and value to market value. ‘He feared being “a burden”, said Mrs. Rust about the suicide of her son. Central to this logic is the stigmatization of dependency on the state. Lives that refuse to improve or to self-govern may be cast as a form of ‘surplus humanity that is superfluous to a regime of capital value’.

 Dependency is a naughty word. In the hierarchy of worthiness, the mad already occupy a very lowly position and with the internalization of market values stigmatization is made flesh and accordingly people may ‘come to think of, and act, on themselves as though their lives have no value’. ‘It is not a coincidence that some people deemed a “burden” by neoliberal market logic would end their lives’, Mills observes. ‘People are killing themselves because they feel exactly the way that the Government is telling them that they should feel –a burden’38

**Psychiatry and Mental Health Law: Not Fit for Purpose**

As George Szmukler shows, mental health law has not altered in its fundamentals over the past two hundred years or so, the criteria for compulsion have remained essentially the same. Though in the rest of medicine there has been a marked evolution in the concept of consent, over the past forty years or so, especially, with paternalism losing significant ground to patient autonomy, in mental health an underlying paternalism has continued largely unchallenged. Until relatively recently, the “mentally ill” were powerless, without a “voice” in society, permitting the perpetuation of stereotypes of people with mental disorders as incompetent and lacking in agency or the capacity for self-determination.

 Ironically, the dawning of the community care era has not really been accompanied by any significant challenges to these stereotypes. Negative stereotypes of people with mental illness are deeply rooted in our culture, argues Szmukler, not merely among the media but equally in assumptions implicit in mainstream psychiatry and in mental health law. They ‘paint such people as having qualitatively different, “diseased” minds that make them incapable of rationality and whose values, beliefs and wishes are thus not to be taken seriously and, furthermore, that dangerousness is intrinsic to, part and parcel of, mental illness’39

 Yet it is not just mental health law that has not altered much in its fundamentals over the past century or so, the same is true of the basic language of description–what is formally known as descriptive psychopathology—of psychiatry itself, most of which was constructed before 1990 and has changed little since. In a stimulating discussion, Ivana Marková and German Berrios two very distinguished psychiatrists and historians of psychiatry, argue that the so-called science of mental illness that we have inherited from the nineteenth century may no longer be fit for purpose. We need a new language for talking about the contemporary realities of madness.

 Significantly, Marková and Berrios use the term 'madness' in preference to that of mental illness. What kind of legitimacy does psychiatric knowledge possess, the authors ask, and how stable and enduring it? Psychiatric objects (that is to say, mental disorders and mental symptoms), are hybrid objects that are deeply embedded in contexts spanning the wider societal, cultural, and political spheres. By definition, these contexts are not static. Take ‘homosexuality’, for example, which was once regarded as a mental illness. This, and other examples, illustrate very clearly the constructive powers of social and historical forces in determining what counts as pathological and the need for a new epistemology of psychiatry that is attuned to a recognition and understanding of the contexts of mad lives and the power relations that they are embedded in.40

**A Culture of Risk Aversion**

Since the 1990s there has come about a drastic change of attitude as to what constitutes an acceptable risk in mental health care. As Tania Gergel and George Szmukler observe, ‘community coercion’ appears to cover a new ‘grey area’ that has grown up around the arrival in the community of a group of people who are not necessarily considered to be full persons.41 Though they may be deemed well enough to live within the community they are apparently not considered fit to make their own decisions about matters such as treatment.

 As has been remarked, ‘mental patients may be more of a mystery today, living among us, than they were when hidden away in the asylum. We do not know them, because they are neither outside society in the world of exclusion, nor are they full citizens –individuals who are like the rest of us’42 Risk aversion has now become the dominant leitmotif of mental health services. Every patient who comes into contact with mental health services must now be subjected to a risk assessment of the risk he or she poses both to him or herself and, crucially, to others. If they are to reside in the community, service users must be prevented from ‘falling through the net’ of services or defaulting from them. They are in all but name community mental patients, not really so different from their counterparts who used to reside in the former mental hospitals. Escapes are as much a cause for concern in community mental health services as ever they were in the mental hospital environment for ‘discontinuance of treatment or escaping from surveillance by the clinical team is believed to indicate a serious risk of violence to others’43

**Community Treatment Orders**

Traditionally, formal coercion, or coercive measures regulated by law, had invariably taken place in mental hospitals, but nowadays in many countries, depending on the nature of the local legislation, coercive practices may equally occur in community settings outside hospital where they may be identified under different names, such as Community Treatment Orders (CTOs), ‘mandated outpatient commitment’, ‘involuntary outpatient commitment’, and even, in a duplicitous euphemism, ‘assisted outpatient treatment’.

 Coercive measures are frequently risk-based, despite the evidence that procedures for assessing the risks of serious harm or violence are notoriously unreliable with ‘false positives’ (those failing to live up to their classification as ‘high risk’) vastly outnumbering the ‘true positives’. As a number of commentators have remarked, such measures constitute unfair discrimination against people with mental illness. Psychiatric patients are the only group in society who can be detained on the basis of a perceived risk of committing a harmful action, rather than by actually committing such an act: ‘It is difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest’.

 From an ethical standpoint it is hard to justify the use of inducements within psychiatry, argue Gergel and Szmukler. ‘Mental health patients commonly experience a lack of respect from many sources for their preferences and values and are marginalized as participants in society’ and ‘there is a clear risk that inducements will serve as a structural reinforcement of this marginalization and disempowerment’.44

 Of course, psychiatrists frequently equivocate over whether they consider people with enduring mental health issues to be capable of legitimate debate. So, for instance, Tom Burns, until quite recently a staunch advocate of CTOs, states that many of the patients cared for by community mental health services ‘remain doubtful of the reality of their illness or the value of the treatment offered’ and that the rationale behind ‘assertive community treatment’ is ‘to engage patients in treatment that they fundamentally do not want’.**45** Burns is reluctant to expand on the status of such doubts and preferences among service users. Are we to construe these as by definition symptoms of psychotic irrationality, or may they be legitimate questions from a capable agent, regardless of how distressed he or she may also be? Left unaddressed here is the legitimacy of patient doubt or uncertainty, and hence by implication also the legitimacy of a coercive psychiatric intervention bent on overriding such doubts and uncertainties.

 Led along by the guiding star of the medicated patient in the community, most conventional researchers regard ‘adherence’ or compliance as the goal of treatment, and as justifying coercion if it is challenged. Adherence diehards are unsympathetic to calls for what many service users would consider to be legitimate debate about alternative treatment options. Yet, as Diana Rose has forcibly argued, an uncritical allegiance to compliance as the ultimate goal of treatment obscures essential questions about the side effects of, in particular, depot injections as the medication of choice for most patients under CTOs, heavily disliked as these injections are by many users as tending to produce more noxious side effects than oral medication.46 Indeed, it is the insistence on adherence, and the occlusion of debate of any kind, that powerfully heightens the culture of fear around CTOs.

 ‘We must be especially wary in psychiatry,’ warns George Szmukler, ‘because of a particular combination: the power we have to force treatment, and a disempowered, socially marginalized patient group whose experience of their treatments can so easily be ignored as the ranting of disturbed minds’.47 Szmukler argues strongly that the grounds for involuntary treatment should not be based on the ‘status’ of having a diagnosis of mental disorder. Instead the grounds for compulsion should in part be based on what the ‘person does with that diagnosis –how he or she understands it, how relevant it appears to be in the circumstances in which the person finds himself or herself, and how it is used in making a decision to accept or reject the proposed treatment’. Here, then, Szmukler opens a space for the conversation with the patient that Tom Burns seems strangely reluctant to have.

 Without question, Community Treatment Orders (CTOSs) have become the mainstay of regimes of community coercion and their introduction has generated intense controversy all along the line, both between, and also within, various professional carer and user groups. In her study of patient experiences and perceptions of coercion, Krysia Canvin found that as a result of the stigma that being made subject to a CTO produces, some people feel that normality has been suspended and that they are ‘locked’ into a mental patient identity which, in the words of one patient’, prevents her from ‘getting on with my life like a normal person would’.

 Other people claim that they have lost a ‘credible’ identity and have been turned into second-class citizens, brought down by a stigma still more damaging than the ones that cluster around mental illness in itself.48 Canvin is critical of a self-serving literature where the meeting of patients’ basic needs are cited as a benefit of community coercion and patients who are able to identify gains from their experience of coercion may be deemed not to have experienced coercion at all, drawing on Amartya Sen’s (1992) strictures on those who overlook or wash away deprivations just because ‘a deprived person may not seem particularly disadvantaged’. For as Sen argues, a deprived person or group may have become ‘habituated to inequality, may be unaware of possibilities of social change, may be resigned to fate, and may be willing to accept the legitimacy of the established order’.49

 For Gergen and Szmukler: “An increase in the use of compulsion in the context of a social change that aimed to enhance the standing of people with a mental illness in the community was perturbing. It paints a troubling picture of people with a mental illness; to live in the community, it would appear they need special control and discipline’.50 For Tom Burns, on the other hand, until quite recently a leading advocate of CTOs, there was little about them to unsettle his professional placidity: ‘They mark a phase in the development of psychiatry, a practice that is always changing as the society it serves continues to change. CTOs are an innovation that requires a detailed, thorough, and rational examination before final decisions about their place in mental health care can be made’.51 In an exchange over the merits of community treatment orders in 2008, Simon Lawton-Smith from the Mental Health Foundation rebuked mental health professionals and others for brushing aside the concerns of service users, citing the words of Mary O’Hagen, the first chair of the World Network of Users and Survivors in Psychiatry: 'community treatment orders are oppressive and corrupting’. In reply John Dawson and Tom Burns ignore the concerns of service users and instead invite consideration of the matter at the personal level:

 ‘Assume your brother has resistant schizophrenia and lives alone in a room near you. He is poorly adherent with medication and regularly needs compulsory treatment for serious self-neglect and acute relapse (the ‘typical’ community treatment order candidate). Here are two scenarios: he spends 6 months in hospital involuntarily, receiving a depot antipsychotic to restore his health and then 6 months at home ‘free’, refusing medication and slowly deteriorating before another admission occurs; or he spends the whole 12 months at home, effectively treated on depot and required to keep weekly contact with services, subject throughout to a community treatment order. Which is preferable, and which the more humane and dignified response? Which puts more restrictions on his liberty? This is the choice with community treatment orders. We think they should be available. Few professionals seem to disagree once they have experience of their use. This is not an empirical debate, but one about whether it is a ‘good thing’ to have the option of using a properly regulated community treatment order regime. We believe it is a good thing’.52

 Five years later, in 2013, reporting on a major national study, the Oxford Community Treatment Order Evaluation Trial (OCTET), a randomised controlled trial of community treatment orders for patients with psychosis, Tom Burns and his team concluded that CTOs did not after all confer benefits on patients with a diagnosis of psychosis and that their current high usage, involving as they did substantial curtailment of individual freedoms, should be urgently reviewed.53 The following year Burns and Andrew Molodynski concluded an appraisal of OCTET with the remarkable suggestion that: ‘it may be time to cease pursuing risk-based coercive interventions (which lack evidence) and refocus our efforts into restoring enduring and trusting relationships with patients’. By this point, Burns is evidently rather less phlegmatic about CTOs than he was just a few years earlier for it is now declared that CTOs ‘were introduced in the UK by a government which knew that there was no convincing evidence of their effectiveness.’ There is a strong hint here that CTOs no longer mark an acceptable or promising phase in the development of psychiatry, instead they are a retrograde turn for the profession, foisted on them by an over-anxious and fearful government, that, as they now admit, it is awkward to justify clinically, ethically, legally, economically, and professionally (‘it is unedifying for psychiatrists to be observed continuing with an ineffective intervention’).

 ‘There is strong evidence’, the authors aver, ‘that liberty is being substantially curtailed without any obvious clinical benefit to justify it . . . If we believe that psychiatry should be an evidence-based profession and clinical trials are a worthwhile exercise, then we should not ignore the finding . . . Our findings are strong and should be taken seriously.’4 In 2017 Jorun Rugkasa and Tom Burns concluded a review of the utility of CTOs with the opinion that there was no evidence of any benefit to them. Where improvements are observed, it seems to be a result of good clinical follow-up, not coercion. ‘We believe’, they conclude, ‘that the time is ripe to think alternatively about how we seek to help those whose lives are made exceptionally difficult by severe mental illness’.55

**Containment and Control**

Currently, a standoff frequently exists between a new generation of mental health survivors and official agencies of psychiatric containment and control. The mental health survivor today is not the mental patient, or even the ex-mental patient, of yesteryear. Even so, frequently the reflexes of psychiatric officialdom, and the regular mental health system, emit the message that nothing has really changed at all, and they are still dealing with the same ‘inferior’, substandard natives who have long resided at the racialized heart of the psychiatric imaginary.

 Psychiatric research, comment survivor advocates and researchers Jasna Russo and Jan Wallcraft, ‘has so far failed to acknowledge the political organizing of people with psychiatric diagnoses and the fact that a large portion of participants in this movement define themselves as ‘survivors of psychiatry’.56 Confides an Independent Mental Health Advocate at the Maudsley Hospital in a clandestine interview: 'There are all these debates publicly about the meaning and reality of mental illness, but once a patient on the ward starts debating, they tell you that you lack insight . . . I think once the person is labeled mentally ill, and has got into the system, that person in a way is kind of pensioned off. The labeling just destroys the communication between the client and the professional . . . everything the client has to say can potentially be silenced on the basis that they don't know what they are saying.’57

 Here we have a system of containment in which patients or clients are still routinely made to feel inferior, and to convince themselves that they really *are* inferior, in a self-reinforcing process distilled by mental health survivor and activist Peter Campbell in 2001: ‘What we are experiencing is a hierarchy of disempowerments that stretches from the psychiatrist’s consulting room to the queue for bread and jam at bed time. It is interlinked and greater than the sum of its parts. In the end, it is sustained by our own suspicions that we are truly inferior. We come out of these isolating places and we are much too afraid to tell ordinary people what it was like.’58

 This is a troubling portrait of a very demoralised and dysfunctional psychiatric culture in which psychiatry is in danger of losing its legitimacy. It resembles what the anthropologists Jocelyn Marrow and Tanya Luhrmann call a zone of social abandonment, in which subjects are divested of normal relational reciprocity, their communications stripped of intention and meaning by those with whom they interact, with the added twist that in this instance the zone of social abandonment is situated at the heart of the hospital.59 Is this the new social psychiatry in action, we may wonder, producing a form of containment that is in equal measure a cruel form of neglect? In spite of recent evidence questioning their effectiveness, there is no sign that psychiatrists as a body are giving up on CTOs. Their use continues to increase and it seems likely that clinicians across the UK will continue to use them in large numbers as long as they remain available. 60

**Alternatives to Coercive Psychiatric Treatment**

Yet, as we have seen, this is not the whole story. There *is* scope for alternatives and a few of those who had been most closely allied with coercive interventions have been brought to reassess their positions. Tom Burns, for several years a leading advocate of CTOs, now avers that it is time ‘to think alternatively’ about how to help those with severe mental illness, and in place of risk-based coercive interventions to refocus on ‘restoring enduring and trusting relationships with patients’. Here we have, perhaps, an example of how a coercive or violent form of treatment in psychiatry that is justified on the grounds of treating the ‘dangerous’ or ‘incompetent’ patient before too long comes to grate against psychiatry’s own language of ‘therapeutics’. It illustrates the disjunction in colonial discourses more generally, highlighted by post-colonial critics, that they are prone to bring about their own undoing by alienating their own language of liberty and civilization.61

 As it turns out, learning ‘to think alternatively’ is exactly what Jasna Russo and Jan Wallcraft were doing two years previously in their exploration of the structural obstacles to the inclusion of survivor perspectives in psychiatric research on coercion, recommending that: ‘systematic investigations of the values, principles, practices and achievements of alternatives to coercive psychiatric treatment should be called for as a necessary component in informed public debates about this issue’. Though Tom Burns does not acknowledge their work, there is a definite shift in the terrain here, with the potential of more scope for dialogue and cross-cutting connections.

 As I mentioned earlier, in outlining the shape of a new epistemology for psychiatry, Ivana Markova and German Berrios proceed from a recognition that what they term psychiatric objects, mental disorders and symptoms—are inextricably embedded in social, cultural and political contexts. The complaint of the advocate from the Maudsley was precisely that for most of his clients context had been stripped away, thus disabling them from being able to make sense of their experiences, and the power relations they were embedded in. The reflections of the advocate, and those of Marková and Berrios, throw light on each other. There is a potential dialogue between them, for they are moving in the same path.

 The iconic critiques from anti-psychiatry and their affiliates, Markova and Berrios aver, were partially right. All mainstream psychiatry has been able to do to justify its activities and existence is to bring out tired arguments from the epistemology of general medicine.‘Neglecting the obvious fact that it is a hybrid discipline’—of mixed character, that is to say, composed of different elements spanning the arts, the human sciences and the natural sciences—‘has cost psychiatry dearly for it has deprived it of a language with which to build an adequate defence of its existence’.62

**Challenges to Mental Health Law**

Just recently, an independent review of the Mental Health Act, led by Sir Simon Wessely, has been published recommending, *inter alia*, new rights for patients to legally challenge their treatment, and more frequent opportunities to challenge detention.63 ‘I was abused and ignored’, stated one former mental health patient who contributed to the review, which strives to deliver the overall message that: ‘when someone is detained they don’t suddenly stop being a person worthy of dignity and respect. But too often that is how it feels . . .particularly . . . if you come from an ethnic minority and especially if you are of black African or Caribbean heritage’. This is somewhat ironic since this is the same Simon Wessely whom I take to task in this book (pp.171—3) for his attack in the *British Medical Journal* some years ago on ‘the obsession with severe mental illness’ and ‘the increasing emphasis on the care of the long-term-psychotic patient’ at the expense of other areas of clinical concern.

 Though this is now a step in the right direction, for some it does not go far enough. Many survivors had wanted the government to make legislation rights-based and consistent with the United Nations’ Convention on the Rights of Persons with Disabilities [CRPD] which adopts a human rights model of disability (as opposed to the medical model which prevails in the UK) and calls for the abrogation of detention, substitute decision-making and compulsory treatment. Following decades of work by the UN to change attitudes and approaches to persons with disabilities, the CRPD was adopted in 2006 and claims to ‘take to a new height the movement from viewing persons with disabilities as “objects”  of charity, medical treatment and social protection towards viewing persons with disabilities as “subjects” with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.’ 64

 The Committee charged with implementing the CRPD stipulates that the existence of an impairment (to include a physical, mental, sensory or psychosocial impairment) must never be grounds for denying legal capacity and the imposition of a ‘substitute decision-making’. Though for some people with disabilities, the exercise of that capacity will require support—sometimes a great deal of support—the Committee takes the view that all persons retain legal capacity, rejecting impaired ‘mental capacity’ as a basis for denial of legal capacity, and believing that with the right level of support people with disabilities will be able to express their ‘will and preferences’. To ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others, the Committee also insists that the ‘will and preference’ paradigm must replace the ‘best interests’ paradigm.

 Some activists celebrate the achievements of the CRPD. For instance, Bhargavi Davar, a campaigner and a survivor of psychiatry in India, delivers an eloquent account of the lingering legacy of colonial psychiatry and of the role of CRPD in transforming the prospects for survivors in contemporary India. Yet others have misgivings.65 George Szmukler addresses the challenges of the CRPD by proposing a form of Fusion law, a generic capacity-based law for everyone who may develop a problem with decision-making ,whatever the diagnosis or setting, that does away with the requirement for a specific ‘mental health’ law. At the same time, Szmukler’s proposals do not go the whole way to the CPRD, leaving ‘a “morally defensible” place–as a last resort when all attempts at support have failed—for involuntary treatment’.66

 Anne Plumb, a survivor and a stern critic of orthodox psychiatry, maintains that the premise of CRPD that self-determination is paramount, and that people are able at all times, given the right amount of support, to express their own wishes, is deeply flawed. She writes movingly about her own experience and the dilemmas it poses:

How can we instruct an advocate when we ourselves may be bewildered by what is happening, especially if we have not encountered such an experience before?.... In hindsight, I may know what I do not want (for example, removal to a psychiatric ward, psychiatric medication or some forms of psychotherapy . . . However, at the time I was overwhelmed by confusion and indescribable despair (no imminent heaven on earth!)

Though Plumb agrees wholeheartedly that the really radical development in the survivor movement was its insistence on ‘speaking out’, she is no less adamant in her belief that we should not see this as ‘claiming that we fully understand our experiences’. Attentive though she is to the unacceptable ways in which authorities have frequently responded to the risks posed by people in mental distress, she provides a robust justification for intervention as such.

 In her own case, for instance, she ‘very nearly stepped into a bath of boiling water in the belief that I needed to demonstrate faith in God (aka mystics running over hot coals)’. The danger with those who uncritically embrace the CRPD, Plumb claims, is that they risk running from the frying pan of traditional psychiatry into the fire of libertarian ideology.67

**Freedom or Dependence?**

Rather tongue-in-cheek, Helen Spandler offers a positive cast on the appeal of a libertarian outlook in the erosion of formal mental health services:

Maybe, just maybe, this isn’t such a bad thing . . . Maybe it will force us, as a society, to truly embrace madness and distress. Maybe users and survivors will be free to develop their own support systems –away from psychiatry and the state. Hopefully we will see a proliferation of genuine “alternatives”. Rather than being hived off into mental health service ghettos, maybe madness will be “mainstreamed”–like most things these days. Perhaps this is the ideal culmination of the neo-liberal project. Or maybe it’s the real meaning of “market madness”–each to their own, with no collective responsibility for those in need. 68

The trouble with this, as Spandler herself will most likely agree, is that in a society formed around an ethos of freedom, people with mental health issues–and people with disabilities more generally—cannot help but appear anomalous.69 We need concepts that are both more nuanced, and more attuned to the substantive commitments that actually exist between people, than idealised notions of autonomy and independence. So, for example, Lennard Davis, the distinguished theorist of disability, is interested in the way that normalcy is constructed to create 'the problem’ of the disabled person. In place of the normal, he proposes a new category based on ‘the partial incomplete subject’ whose realisation is not autonomy and independence but dependency and interdependence ‘Dependence is the reality’, he writes, ‘and independence grandiose thinking’.70

 Similarly, in a sensitive exploration of the work and activity of people with mental health problems, Jennifer Laws draws attention to the busyness and competence of even the most apparently ‘workless’ members of the mental health community. In an ironic re-description that demonstrates that work itself is a fractured term that is frequently ‘not working’, she draws out the shortcomings in a conservative ethics of relation (that we should work in *this* way, at *these* time etc), arguing instead for a more plural, and less normatively-centred, framework to account for the multiple meanings of work and the diverse ways in which happiness can be found.71

 The explorations and arguments in this book do not claim to deliver answers but they are framed within the same kinds of concerns about the human complexities -- cultural, social, institutional and political in equal measure-- of the relational fields that people with severe and lasting forms of mental distress must perforce navigate and survive, and I hope that readers may still find something of value in them.

 **Notes**

1. On the media influences on mental health policy in these years see especially Hallam 2002.

2. Ibid.

3. Cited in Desmond & Moore 2010: 301

4. Ibid: 115

5. Ibid: xvii—xviii

6. Ibid: 115

7. Ibid: 365

8. Ibid: 368

9. Ibid: 116

10. Barham 2004: 155—159

11 Barham 1984: 170-74

12 Hauerwas 1986: 26

13 Gallagher 2018; see also Gallagher 2017.

14 Kemp, critique of neo-liberal 'recovery' model, presentation at *Capitalism is Bad for Your Health* event at Housman's Bookshop, London, on 21 January 2015. And see also www.recoveryinthebin.org & www.studymore.org.uk/binrec.htm

15 From an interview in the French newspaper, *Le Monde,* 1961.

1896.

17 Tuke 1878

18 Kemp op.cit.

19 Szmukler 2018

20 YouTube: A Year as a Mental Health Advocate at South London & Maudsley Mental Health Trust (2014)..

21 Mills 2018(a)

22 Gergel & Szmukler 2016

23 Campbell 1996; Russo & Wallcraft 2011

24 Bell 2013; Kearney & Dye 2010

25 Butler 2009

26 Healy et al. 2012

27 Godfrey et al. 2014. On the contemporary culture of psychiatric neglect see also Helen Spandler's (2016) brief but pointed critical commentary.

28 Bell 2013. Against this background, I strongly recommend historian Barbara Taylor's (2014) vivid personal memoir of her journey through the mental health system & her reflections on the death of the asylum.

29 Rose 2014; [www.recoveryinthebin.org](http://www.recoveryinthebin.org/)

30 Long 2014: 124 & 116.

31 Bell 2013. For a consideration of how welfare, and welfare services, might be revitalised, and made to work for all of us, I recommend Peter Beresford (2016), which combines personal & family memoir with solid analysis & policy discussion. For an acerbic reflection on our current discontents see also Tony Judt (2011).

32 Luhrmann & Marrow 2016

33 Campbell 1989

34 *Royal Commission on Lunacy & Mental Disorder* (London, 1926), Minutes of Evidence, Part 2, q.16,935

35 Pilgrim & Tomasini 2012.

36 Mills 2018(b)

37 Marsh 2010

38 Mills 2018(b)

39 Szmukler 2018: xxi

40 Markova & Berrios 2012. For a thoughtful reflection on the current crisis of psychiatric legitimacy see also Alastair Morgan (2015).

41 Gergel & Szmukler 2016

42 Lewis et al. 1989

43 Szmukler 2018: 19

44 Gergel & Szmukler 2016.

45 Burns 2016

46 Rose 2016

47 Szmukler 2018: 28

48 Canvin 2016

49 Sen 1992

50 Gergel & Szmukler 2016

51 Burns 2016=

52 Lawton-Smith et al., 2008

53 Burns et al. 2013.

54 Burns & Molodynski 2014

55 Rugkasa & Burns 2017

56 Russo & Wallcraft 2011

57 YouTube: A Year as a Mental Health Advocate at South London & Maudsley Mental Health Trust (2014)

58 Campbell 2001

59 Marrow & Luhrmann 2012

60 DeRidder et al 2016

61 Mills 2015

62 Berrios & Markova 2017

63 [www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review](http://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review)

 64 [www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html](http://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html)

65 Davar 2015

66 Szmukler 2018

67 Plumb 2015

68 Spandler 2016

69 Hauerwas 1986

70 Davis 1997

71 Laws 2013

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1. \* *Prologue to the New Edition of ‘Closing the Asylum: The Mental Patient in Modern Society* [↑](#footnote-ref-2)