The established state and patient X's rebellion

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Abstract

Purpose – *The purpose of this paper (anonymised case study) is to explore political perspectives on the detention of patients under the Mental Health Act.*

Design/methodology/approach – *The approach is ethnographic and narrative.*

Findings – *The essay offers an exploratory explanation using political theory, of a violent and rebellious act by a person detained as a formal mental health patient. The protest relates to the treatment offered to the patient.*

Research limitations/implications – *This essay offers a new explanation for a protest for a person detained as a compulsory mental health patient. The essay explores issues relating to political philosophy that the patient applies to their detention.*

Practical implications – *An understanding of how a patient with a background in academic politics is related in this essay. There is consideration of how an education in politics can be as valid in wellbeing, as a medical degree. It may be that more patients will be spared multiple hospital admissions by the use of effective therapies.*

Social implications – *There is consideration of the debate about the fitness of current mental health legislation to enable wellbeing, and the debate about the review of mental health law begun in 2017.*

Originality/value – *This is a perspective of how political theory can inform individual acts. The political inquiry is not of dogma or ideology, either critical or affirming. The discourse is of rebellion with a purpose, not of revolution, class war or national dispute. However, aspects of works that are critical of psychiatry are included in the considerations.*

Keywords *Mental Health Act, Political theory, Psychiatric medication*

Paper type *Viewpoint*

This paper addresses Patient X who has been sectioned under the Mental Health Act. Her first experience of the psychiatric system was 15 years previously. Her multiple admissions have been characterised by non-compliance with medication after being discharged whilst prescribed injections of antipsychotic medication.

Patient X has never refused medication by tablet, but she avoids the injections on discharge because of the side effects: akathisia or extreme restlessness. This has led to contact with the criminal justice system and homelessness, as well as previous sectioning. At stake is a trend best described as a revolving door, a ping-pong ball, a merry go round. After being sectioned this time, the doctors again prescribe injections after a period on oral medication in the secure unit.

Patient X declares that the British State is being used to abuse her in her weakness, so when she has recovered after a week of akathisia she expects from an injection, she will abscond and hit the British establishment where it is vulnerable. She declares that she will smash a Church of England window. This, which is under the monarch's realm as is the National Health Service as part of the State, is where the establishment is weak. An injection is administered, and Patient X duly smashes a Church window a week later. She is called before the psychiatrists who tell her that the therapeutic effect of the injections is different from the therapeutic effect of the tablets, so she will be put back on tablets.

Patient X goes on to pass out with an Honours BA and an MA, starts her own mental health social enterprise, gives talks on mental health for over 10 years, becomes a published author,

ceases to claim benefits, and is not again arrested or put into a psychiatric hospital. As far as she can tell, she has not been paranoid or deluded for this time, and continues to take atypical antipsychotic medication by tablet.

So what is this relationship built on? What are the actors in this scenario? Can the State act with legitimacy when it detains and treats those such as Patient X in the way that she was treated? What is right for an individual to do when confronted by State power?

There has been an increased resort to the use of the UK Mental Health Act in recent years, so to be detained and to have freedom and access to property denied, is an imposition for more individuals, and is an impediment for minority ethnic communities in some geographical areas. Patient X initially accepted the unbound power of the medical establishment and the medical model of psychiatry, as if there was no alternative.

This feeble acceptance has put her onto the revolving door of repeated admissions, as she has no chance of meaningful dialogue around the unacceptable side effect leading to akathisia. She experiences this from psychiatric injections. Patient X is disempowered and she self-stigmatises in her compliance. This is summed up in a famous phrase from the Geneva-born philosopher Jean-Jacques Rousseau: Man (*and woman—author's italics*) is born free; and everywhere he (*and she*) is in chains (Rousseau, 1973, p. 165).

Patient X is an agent of her own outcomes. Society is not about doing what you are told. Jean-Jacques Rousseau describes how giving up the freedom of a state of nature, where man and woman are able to obtain their needs, is replaced by the liberty of social life. Political and social legitimacy is summed up by John Locke (1993, p. 217): for wherever the power that is put in any hands for the government of the people, and the preservation of their properties, is applied to other ends, and made use of impoverish, harass, or subdue them to the arbitrary and irregular commands of those who have it: there it presently becomes tyranny. Patient X needs to be her own person, as we all do, to fulfil this purpose of society. She is capable of doing more than doing what she is told.

As Michel Foucault points out, pathology lies in alienation (Kindle, loc 2684), and indeed Patient X has an enduring condition and lives a marginalised life. Somehow, as some have observed, derived from Karl Marx, Patient X has been alienated from the origins of her shelter and sustenance, and is hence exploited by the system. She cannot live a full life like this.

Patient X wants the health service to work for her and not to condemn her to a life of intolerable side effects from compulsory medication by injection, interspersed with periods of meniality, destitution, hopelessness, criminality and vagrancy. And so resorts to an act of civil disobedience when she smashes the Church window.

We live in a fragmented world, where postmodern and poststructural influences mean less certainty from the old monoliths that are dissipating into the margins of our lives. Globalisation and the information society are what we live with. Yet the nation state is still an actor, and as Patient X discovered, the old school can have an overwhelming power. The hegemonic model that could build empires, wage war, threaten invasion, bring about full employment and universal healthcare, and foreshadow global thermonuclear destruction, is no more, but Patient X is subject to a legacy of state authority.

From the days of Thomas Hobbes there was an assumption that a social contract legitimised the obedience of the governed to the sovereign. Why should Patient X obey the state? Are there Hobbesian justifications for the demand that she accept the decisions of the state, here in the form of the National Health Service and the Mental Health Act? This is iniquity to Jean-Jacques Rousseau and he sees the situation of Patient X in this relief: the depositories of the executive power are not the people's masters, but its officers (Rousseau, 1973, p. 245). How can Patient X have consented to what is done to her by the state? No, she has not agreed to interminable akathisia.

Fortunately that is not all there is to the state.

What of God and the Church? Thomas Hobbes wrote in the *era of the Divine Right of Kings*. Karl Marx's collaborator, Frederick Engels, describes "making (the working class) submissive to behests of the masters it had pleased God to place over them" (Marx and Engels, 1968, p. 386).

Locke (1993, Part 2, Ch. 5) had a different view of how God worked. “God has given the Earth to the children of men”. Locke gives hope for Patient X and her fellows in that there is a citizen duty to challenge where necessary. The purpose of government is to allow individuals to thrive, and clearly Patient X is at odds with this, as the government in the form of the NHS psychiatrists, is imposing intolerable conditions on her.

For John Locke, humans have the power of reason that may be a divine gift. Reason gives rise to ideas, which exist in the cosmos of experience. In the analysis of twenty-first century poststructuralism, experience is in the landmarks which occur in a fragmented social and political milieu.

The Church of England had been established by Henry VIII from the 1530s onwards, so the considerations of Hobbes and Locke had a bearing for all under the monarch’s realm, that is to say church and state. Their era was common. Hence Patient X has the perception that her misfortune and years of destitute alienation have an origin in this establishment of church and state.

The state actors detaining her in accordance with the Act and the responsible clinicians have a greater and lesser shared experience with Patient X. Her knowledge of the state leads her to that nocturnal church defenestration.

Since the time of John Locke liberal democracy has prevailed in the UK. Perhaps this is a crucial development that enables Patient X to have the hope that she can escape the misery of medication by injection and its accompanying devastating akathisia side effect. She has found a way to illustrate the doctrine that the state should enable fulfilment, not misery. Patient X may well have demonstrated that the fulfilment of a political right may mean transgressing a legal obligation.

Mental health has for a long time been a contradictory field. So whereas there is a body of practice that seeks the best, most therapeutic experience, to include the minimum effective dose of medication, the least restrictive conditions, early intervention and even inclusion of innovative models of care; in spite of these aspirations, many mental health service users are subject to no choice in medication as well as denial of their freedom and access to assets and opportunity. These considerations may be included in the 2018 Review of the Mental Health Act.

Michel Foucault echoes Thomas Szasz in describing the dispossession of the mentally ill, but also places pathology in the form of mental illness, in the context of alienation. So not only are some subject to exploitation through an alienated production system, but they are also located where pathology prevails, where dispossession and incarceration occur.

In recent times in the UK, the debate around the 2007 Mental Health Act that changed the law, epitomised the two countervailing aims in the mental health world. On the one hand were supporters of a liberal context for mental healthcare with rights to effective treatment, on the other were those who went with the phrase “how many more people must die (at the hands of the mentally ill) before the government will act?”. What emerged was the addition to powers, under the law, of supervised community treatment, which is an extension of clinical regulation and compulsory treatment into the community.

Patient X has had this experience: I may have lived like a dog, but at least I will die as a human being.

The opportunity in 2007 was to provide rights to income, housing, physical wellbeing, family and personal life, and an end to discriminatory practice. However, it was not to be that hope, choice and control and opportunity would be enshrined in UK law for mental health.

Day to day occupation of the democratic space belongs to the power elite. Whether there by reason of charismatic leadership, economic dominance, nepotistic bloodlines, school or university attended or practice with the media, the elite has a day to day say in decisions. Bottomore (1993, p. 21) describes “[…] an idea which recurs continually in popular thought and in social theory, namely that one of the principal structural features of human societies is their division into a ruling and exploiting group on one side, and subject, exploited groups on the other”.

We still need to address why it should be that Patient X may consent to her detention and administration of akathisia-inducing injections. This in the face of a seemingly non-negotiable diktat.

For John Locke and Jean-Jacques Rousseau the state of nature is benign, and modern society imperfect. Jean-Jacques desires to create a social medium where the freedom to furnish needs is as equitably availed in modern society as in his perception of a state of nature. Rousseau maintains that what we need to have in mind is that we should strip away that which prevents us from providing for ourselves in modern society, a theme echoed by Marxist alienation and anarchist utopianism. "Man (*and woman—author's italics*) is separated from his (*and her*) own products (he (*and she*) has no control over what he (*and she*) makes or what becomes of it afterwards)" (Ollman, 1971, p. 133). Clearly this is the crux of Patient X's statement. She is separated from how she can provide for her needs as a result of 15 years on the revolving door between the mental institution and street homelessness.

Patient X has clearly not consented to the administration of antipsychotic medication by injection. She has been capacitous enough to object to this method and concoction because of the side effect of akathisia, which causes her to be uncomfortable for a week. A week of restlessness when she cannot remain still. Her considerations reflect a profound political discourse.

Patient X sees the application of the law as transgressing her rights. As discussed above, she has moved from abject submission to a coercive state that must be complied with, does her no good, and has resulted in disabling side effects from medication and wasted years as a ping-pong ball between mental ward and the street. She has moved to a realisation that she must do something to stop this.

John Locke (1993, p. 218), it can be said, has a place for Patient X's church window smashing: "[…] force is to be opposed to nothing, but to unjust and unlawful force". Patient X sees the coercive proposition she is faced with, as something to be met with force.

Patient X has thoroughly roadtested the system of asylum care with its waste of years, medication side effects and vagrancy. She contrasts this with the outcome from a new life with Recovery focussed practice.

Patient X's violent protest is an act in a political context, and she has declared to the clinicians that she will act in the context of the political union between state and Church. At last she thinks of Martin Luther King when he declared that you cannot justify obeying an unjust law. For Patient X the implementation of coercive treatment is unjust. She sees the justification for her violent act of civil disobedience in the context of the British Ploughshare women of 1996. (Independent newspaper 30 July 1996 from a search 26 January 2018, www.independent.co.uk/news/pounds-15m-hawk-attack-women-freed-1331285.html).

These women had sought through the legal means they could employ, to halt the sale of British fighter aircraft to the repressive Indonesian regime which used them to attack their own people in East Timor. When this route was exhausted they vandalised an aircraft about to leave the UK for Indonesia. They fully identified themselves to the authorities and stated their intentions. At Liverpool Crown Court their defence was that they had exhausted non-violent means, and were using violence as a last resort. The verdict on the Ploughshares Four, as they were known, was that their action was reasonable under the Genocide Act to prevent the crime of mass murder. They were found not guilty of the violent attack on the aircraft.

In the same way Patient X has acted to defend her rights: her rights to fair treatment, and to be free of cruel and unusual punishment as defined by the UN Charter on Human Rights.

In making her successful protest, Patient X would have the approval of the likes of John Stuart Mill for the usefulness of her action. "It is a great misunderstanding […] to suppose […] that (human beings) should not concern themselves about the well-doing or well-being of one another" (Mill, 1869, p. 136). Patient X also feels that her plight before recovery may have reflected her protected characteristics of gender and disability, and so can empathise with the disproportionate number of black and minority ethnic people, especially males, who are detained under section.

Finally, if Patient X is to gain anything from what happened to her, she may say several things. Of course, why did she have to endure 15 years before returning on track to academic

achievement. Why was it not possible to arrange her degrees when in her 20's rather than years later when they were not to be life-changing assets?

Patient X assumes of course that it was her action, after enduring a final week of akathisia, in smashing the window that brought about a return to tablet medication after the injections. However, in prescribing this, the clinicians told her that the therapeutic effect of the tablets is different from the effect of the injections, so she was being returned to tablets. There was no mention of the breaking of the church window, and that this was an act taken in a political spirit with the connection between church and state.

Perhaps the clinicians did not even know of this connection between the Church of England and the state. Perhaps it was a change in Patient X's mood or behaviour that got her returned to tablet medication. In our poststructural world there is the possibility of many explanations, and the above has aimed to tackle a number of issues pertinent to the pursuit of legitimacy between a victim and the state.

Implications from Patient X's history

The assumptions for detained persons who have schizophrenia in particular under the medical model are: you are psychotic and I/we will prescribe for you antipsychotic medication. Also I/we have to assume that you are likely to be non-compliant so just to make sure I/we will prescribe depot injections of the antipsychotic.

When returned to an institution as a revolving door patient (yes this still happens) there may have been non-compliance with medication. So regardless of why the patient has avoided supervision to have the medication, medication is only offered by injection. In the case of Patient X, avoidance has been because medication has only been offered by injection. In the January 2018 report, the Law Society is critical of the use of supervised community treatment under section of the Mental Health Act as primarily a way of enforcing compliance with medication. The Law Society is also critical of the use of payments to ensure community patients have depot injections.

Medication can be crucial to Recovery (McManus cites effective therapies as essential to Recovery). Medication that is complied with, with tolerable side effects, can be the foundation for lasting Recovery. Medication that brings on unacceptable side effects such as akathisia (not to sit) will probably result in non-compliance and relapse. Both these propositions were in Patient X's history.

Dare we think that disciplines other than psychiatry can lead MDT's (multi disciplinary teams)? For example, a formulatory approach in an MDT may recognise effective medication as essential. The slavish adherence to the administration of type of medication from a prescriptive handbook will be avoided if that derivative practice is no longer dominant when an MDT' treats a (detained) patient. So, for example, rather than diagnosis and medication being dominant, there may be a different and more relevant version of who the patient is. This may enable a meaningful life for the patient and a regained sense of self where medication is effective and accepted.

NHS England is making great strides in accumulating data on individuals in the mental health systems. Useful questions to ask of this data include how many relapsed revolving door patients have avoided medication that was administered as depot injection and how many suffered from akathisia.

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