

# Mental Health Law

*Policy and Practice*

*Fourth Edition*

PETER BARTLETT  
AND  
RALPH SANDLAND

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# 1

## Conceptualising Mental Health Law

In the serene world of mental illness, modern man no longer communicates with the madman: on one hand, the man of reason delegates the physician to madness, thereby authorizing a relation only through the abstract universality of disease; on the other, the man of madness communicates with society only by the intermediary of an equally abstract reason which is order, physical and moral constraint, the anonymous pressure of the group, the requirements of conformity. As for a common language, there is no such thing; or rather, there is no such thing any longer; the constitution of madness as a mental illness, at the end of the eighteenth century, affords the evidence of a broken dialogue, posits the separation as already effected, and thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason *about* madness, has been established only on the basis of such a silence.

Foucault, 1965: x–xi

### 1.1 Introduction

In his usual rather dense style, Foucault encapsulates many of the paradoxes at the root of the study of mental health and illness, and sets the stage for many of the themes which will be of significance in this volume. The centrality of a medical model of insanity is asserted, imposing a scientific order onto the profoundly unordered world of the mad. While madness is displayed in the form of a disease, sanity is a constraint, both physical and moral, into which the insane person is confined through pressure of the group, the sane. All this is a construction of the reasoned, and reflects the world of the reasoned; to the insane person, it is an alien landscape.

The situation is yet more complex than Foucault posits here, however, for mental health law, like psychiatry, is also a language 'of reason about madness'. The two languages, law and psychiatry, speak sometimes symbiotically and sometimes in uneasy juxtaposition in the pages which follow. Each are paradigms of rationality in their way, and thus each is faced with the same problem: how to impose order onto madness, a realm which would seem *ex hypothesi* to be lacking order, to be irrational.

This may sound hopelessly abstract, but a few examples will clarify. How exactly, if at all, can mental health (or perhaps more importantly, mental illness) be defined; and are

the existing legal and medical definitions clear, consistent with each other, and appropriate? How can we impose reason, rationality, onto the irrational? Does the process of definition not imply a logical structure which cannot be assumed to exist in madness by its very nature? At what point do mad people acquire rights and corresponding responsibilities and authority over what happens to them? Are we content that these languages of mental health and illness remain exclusive of the voices of the people identified as mad, and if not, how are those voices to be included in an understanding of law and policy in the mental health area? And if mental health law and psychiatry are both discourses of reason about madness, what do those discourses tell us about the reasoned people who create them? If, as Foucault claims, the languages of mental health law and psychiatry develop in the silence of those they affect, what do our views of how the insane are understood and when we should intervene in their care tell us, about us, the people who construct the languages about the insane?

These are some of the big issues at the heart of this book. There is no pretence that they will be solved; indeed, it is a fundamental belief of the author that the purpose of a textbook such as this is not to present solutions, but instead to articulate problems for discussion and investigation.

The questions will be addressed through consideration of the Mental Health Act 1983 as amended (hereinafter, the MHA) and the Mental Capacity Act 2005 as amended (hereinafter, the MCA). By way of introduction, and in very basic terms, the MHA regulates compulsory admission to hospital, treatment for mental disorders in hospital, and, to a limited degree, the control of people with mental disorders in the community. Its key triggering mechanism is a mental disorder (as defined by the MHA, but including mental illnesses, personality disorders, and in some cases, learning disabilities) of sufficient severity (again defined in the MHA) to warrant the compulsion being instituted. The MCA also requires a mental disorder or disability, but its primary triggering factor is instead an individual's incapacity to make a decision at issue. That might well be the result of a mental disorder within the scope of the MHA, but it does not need to be. The MCA is thus about making decisions on behalf of a person lacking capacity, and on its face requires consideration to be given to the wishes and values of that person in deciding what decision should be made. The MHA does not include such a requirement: its agenda, at least on the face of the Act, is providing interventions that are objectively necessary because of an individual's mental disorder. The implementation of the Acts is of course not nearly so stark. No good psychiatrists implementing the MHA will ignore the views of patients, and the judicial decisions under the MCA often show a striking lack of regard for the subjective views of the person for whom a decision is to be taken, but nonetheless, it may be helpful to keep the overall legal bases of the two Acts clear in the discussions that follow.

The first three chapters are essentially introductory, considering how mental disability (here taken to mean both mental health problems, now increasingly referred to as 'psychosocial disabilities', and learning disabilities) is to be understood, and an introduction to how the law is structured overall in this area. Chapters 4 and 5 consider mental capacity both in the realm of general decision-making and when the lack of capacity

is used as a justification for depriving an individual of his or her liberty, most frequently in a hospital or care home. Chapter 6 looks at detention under the MHA of people who have not become involved with the criminal system, where Chapters 7 and 8 look at the use of criminal law and related powers to coerce admissions. Chapter 9 considers treatment for mental disorder, and in particular treatment without consent. Chapter 10 follows treatment in the community, and looks at how formal and informal community controls function to govern the lives of people with mental disabilities. Chapters 11 and 12 concern legal safeguards of rights, the former in the form of review tribunals and similar quasi-judicial mechanisms, and the latter in the context of advocacy, both by lawyers and the growing array of lay advocates.

## 1.2 Who are the insane?

The newspapers would leave us in little doubt. In their eyes, the insane are a threat, a lurking menace in society, a hidden and violent element, which may erupt without notice. The Glasgow Media Group analysed news items about the mentally ill for the month of April 1993, mainly in the tabloid press and on television. It found 323 stories relating to dangerous or violent behaviour by people with mental illness—roughly twice as many as concerned their other categories (stories about harm to self, prescriptive or advice columns related to treatment or care, and stories critical of accepted definitions) combined (Glasgow Media Group, 1993: 47–81). In the subsequent 20 years, little would appear to have changed (see Thornicroft, 2006: ch. 6; Pirkis and Francis, 2012). The portrayals may no doubt be in part a function of the economics of publishing—scaremongering sells newspapers—but the Glasgow Media Group further makes a persuasive case that these representations have their effects on public perceptions. The image is profoundly misleading. The vast bulk of those with psychiatric difficulties are simply not dangerous (Bowden, 1996: 17–22; Thornicroft, 2006: ch. 7). Not only that, but the numbers of persons killed by people with psychiatric problems has been falling since 1970 (Taylor and Gunn, 1999; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2012). The media tends to focus on cases where the assailant was psychotic, or was refusing medical treatment, but these numbers are miniscule. Of homicides committed between 1999 and 2009, only 6 per cent were committed by people with psychosis at the time, or an average of 33 per year. Refusal of medication was even less common—an average of seven assailants per year had refused treatment in the month prior to the homicide: (National Confidential Inquiry, 2012: tables 21, 25).

The images do not stop with violence, however. The mentally ill are perceived as homeless and poor, the deserted of society. There may well be some truth in these allegations in many cases, although much depends on how mental illness is defined, and in particular regarding homelessness, whether substance addiction is considered a mental illness. Certainly, many of those who have been involved with the psychiatric system are poor, although it is a fair question to ask the degree to which this is due to a prejudice

of employers against hiring people who have been institutionalised (see Thornicroft, 2006: ch. 3). The image is nonetheless of people who have fallen through the net, tragic figures, lonely, to be pitied rather than valued.

These images cannot tell the whole story. There are countervailing images. When we think of the mentally ill, we might alternatively think of Virginia Woolf, Robert Schumann, Sylvia Plath, or Vincent Van Gogh. The image of the mad artistic genius is in its own way a part of western cultural imagination. The connection between madness and genius excited considerable academic debate in the nineteenth century, and more recently, the American psychologist Kay Redfield Jamison has argued for a correlation between manic depression and artistic genius (Jamison, 1993). The image of the insane person as genius, warranting respect rather than pity or fear, is a refreshing counterweight to the images of the insane person as dangerous lunatic or homeless vagrant. It becomes possible to ask whether madness is something to be valued rather than disparaged. Rather than silencing the mad, should we encourage them to speak?

In the end, all these images must be approached with considerable caution, since the mad artistic genius like the mad killer focuses on the statistically rare exception. The reality in the overwhelming number of cases is likely to be characterised by banality rather than extremes. Current estimates are that mental illness will affect roughly one in six adults in Britain per year, although psychotic illnesses are much less common, closer to one per cent of the population. Depression alone will affect roughly half of women and a quarter of men before the age of 70 (Department of Health, 1998a: 10). This would suggest that it is not appropriate to think condescendingly in terms of 'them', but rather, somewhat more humbly, of 'us'. The frequency suggested by the statistics would suggest that any generalisation may well mislead as much as it informs.

That is perhaps particularly important in so far as it challenges the popular sense that everyone with mental difficulties must somehow be the same. Different difficulties affect people differently. It is simply wrong, for example, to expect that people with mental illness will also have intellectual limitations. The fact that an individual is profoundly depressed or hearing voices, for example, does not mean they are unable to understand complicated information and process it at a reasonably sophisticated level. Certainly some people with mental illness are not intellectually high achievers, but others are very bright indeed, and most are somewhere in the middle. The experience of people affected would suggest that the stereotype associating mental illness with lack of mental ability remains widespread, a depressing comment on how far society has yet to come in understanding both mental illness and developmental disabilities.

A similar warning ought to be made regarding developmental or learning disabilities. Frequently, one hears the phrase 'mental age' used regarding people in this group. It is at best a caricature. People develop in different ways, and at different rates, and the person 'with a mental age of 6' may well have little in common with a 6-year-old child. To refer to a 25-year-old woman in this way is unhelpful: in a very real sense, she is still a 25-year-old woman. Rather than to identify her with the child she manifestly is not, it is far more sensible to consider her actual situation, understanding, and abilities, and proceed accordingly.

Romanticisation of mental illness, whatever image is adopted, is unlikely to be helpful. That said, it is surely appropriate to provide some sort of starting point to understanding what it feels like to be mentally ill. The writings of those who have experienced mental illness first hand provide invaluable reading to the student beginner in the area. A selection is provided in the bibliography (Mays, 1995; Hart, 1995; Dunn *et al.*, 1996; Jamison, 1996; Lewis, 2002; Pegler, 2002; Read and Reynolds, 1996; Styron, 1990, Cockburn and Cockburn, 2011). These readings drive home the point that mental illness, particularly in its more extreme forms, can be a profoundly unsettling and unpleasant experience. Consider U. A. Fanthorpe's description (1996: 52–4) of the experience of depression:

Again I find myself waking miserably early, even before the summer birds; again I find music unspeakably painful; again my speech becomes slow, and my arms seem grotesquely long; again I'm afraid to go out, because people will see at a glance that there's something wrong, and shun me; I can't face the garden because, although in one part of my brain I know the blackbirds are just making their usual evening calls, I'm convinced that the cats are after them and that it's my fault; above all, my vocabulary shrinks to such an extent that the only word I'm really at home with is 'sorry'.

When I'm badly depressed I long above all things to be a prisoner. I imagine this as a life where you don't make choices, where the pattern of life is plain and involuntary. Life in depression is like this anyway, but it retains the illusion of choice. If you had to do the sad things you are doing because someone had ordered that you should, indeed because you'd deserved it, the despair might (you think) go.

Linda Hart (1995: 19) described the sensations accompanying her schizophrenia as follows:

The top half of my head feels quite light but the thread that runs down from my head to my stomach is soaked in a deep despair. Maggots in my belly multiply. Rotting flesh. Want to drink bleach to cleanse them or a sharp knife to cut them out. They told me I needed a psychiatrist and not a medical surgeon back in September. They said Graham [the psychiatrist] would get rid of the maggots but he hasn't.

These are not pretty images, and one would be inhuman not to feel considerable sympathy for the individuals affected by these experiences. Yet sympathy is a double-edged sword, for it can easily lead to a paternalist impulse to intervene whether the individual likes it or not, 'for their own good'. The result is a risk of marginalising the person we intend to help, and the reinforcement of the gulf of silence of which Foucault speaks.

This is not merely a civil rights point, nor an abstract issue of discourse construction. It is also a practical point: if intervention is to be successful in the long term, its subject must in the end be supportive of the intervention. In the environment of intrusive surveillance in a psychiatric facility it is possible to force a patient to take drugs they do not wish to take. It is much more difficult outside that environment, and if the patient is not convinced at that time of the continuing benefits of medication, it seems unlikely that he or she will continue taking it.

This marginalisation further pre-supposes a gap between the individual and his or her disorder, or a 'real' person who has been subverted by the disorder into someone

else of an unknown character. Such an articulation is contained in the following passage, in which an author describes his first interview with Leslie, the mother of a mentally ill man [Karp, 2001: 3–4]:

Near the beginning of our first conversation she said that ‘so much has happened in three years that I don’t even know where to begin... It’s overwhelming.’ There was, though, one thing that she absolutely wanted to bring up right away and have me understand. [...] She went on to explain that ‘Mike has the potential for violence. And... because I know this is being recorded, it’s really important to me for you to know that he is innately a very, very sweet and kind person. But [because of] the disease he gets very paranoid. His disease has made him a danger to others... I mean, he wouldn’t even step on a bug, you know? But this illness is so [awful] and he has attacked his brother and attacked his sister.’ Throughout our nearly ten hours of talk, Leslie repeatedly sought assurance that I would not confuse Mike with his disease.

Such a clear division is presupposed in much of the popular and professional understanding of mental disorder, and articulates the experiences of many people affected by mental disorders. It is further implied in a medical model of mental illness, where imagery in pharmaceutical advertisements, for example, will frequently refer to the drug as allowing for the return of a person, previously ‘lost’. At the same time, other accounts call into question whether the disorder is readily distinguishable from the person with the disorder. This ambiguity is apparent in Marie Cardinal’s description (1996: 108):

But for my children, I might let myself go completely, stop fighting, perhaps, for the struggle against the Thing was exhausting. More and more, I was tempted by the medication that delivered me to a nothingness which was dull and sweet.

In this articulation, it is the medication, the alternative to the disorder, which is a void, a nullity. The disorder itself is in Cardinal’s reality. This image of mental illness as constructive of self is similarly evident in Sheila MacLeod’s description (1996: 81) of her anorexia:

Two facts emerge immediately from this résumé. The first is that I felt my battle to be with authority, whether in the form of teachers, matrons, parents, or even nature itself. The second is that, up until this point, I was winning. It seems to me that anorexia nervosa acts as a metaphor for all the problems of adolescence. But instead of meeting each problem separately and assessing it for what it is, the anorexic thinks she has a master plan, designed to solve them all at one stroke. She is convinced that it works; it can’t fail. It is like a dream come true. It is euphoria.

When I first came across Szasz’s dictum, ‘Mental illness is a self-enhancing deception, self-promoting strategy’, I considered it to be a harsh judgement on a fellow creature. But when I substituted ‘anorexia nervosa’ for ‘mental illness’ I could see the truth in what Szasz was saying, and realize at the same time that his judgement was not so harsh. After all, if the self is felt to be nothing, any strategy adopted to enhance or promote it, desperate though it may be, is a step towards what most of us would consider to be health, and an action necessary for survival. The anorexic’s skinny body proclaims, ‘I have won; I am someone now.’

In this view, the disorder is intrinsic to the self and constitutive of who the individual is. As such, it need not necessarily be viewed in simplistically negative or undesirable terms. Lewis notes (2000: xv):

If you can cope with the internal nuclear winter of depression and come through it without committing suicide—the disease’s most serious side effect—then, in my experience, depression can be a great friend. It says: the way you’ve been living is unbearable, it’s not for you. And it teaches you slowly how to live in a way that suits you infinitely better. If you don’t listen, of course, it comes back and knocks you out even harder the next time, until you get the point.

Over twenty years I’ve discovered that my depression isn’t a random chemical event but has an emotional logic which makes it a very accurate guide for me.

A similarly complex vision regarding schizophrenia is discussed by Chadwick (1997). This is not to suggest that either Chadwick or Lewis rejoiced in their disorders. It is instead to suggest that a simplistically dismissive view of the values associated with the disorder may deny an important aspect of the experience of the individual patient.

This view of mental illness as intrinsic to self receives judicial acknowledgement in the case of *B v Croydon District Health Authority* (1994) 22 BMLR 13 (HC). That case involved a patient suffering from a personality disorder, not anorexia, which nonetheless manifested itself in the refusal of food to the point of near self-starvation. The primary issue before the trial court was whether the patient had the capacity to consent to treatment, in this case feeding. Thorpe J (as he then was) cites (at p. 19) an expert witness, a forensic psychiatrist, as identifying the relation between the individual and the personality disorder as a factor for the court’s consideration:

The third feature is the patient’s necessity to control her own internal world and her relationship with others. In a pathological way, she uses maladapted methods to control distress in herself and to control others around her. Her need to use abnormal coping mechanisms stems from her abnormal development. In relation to this feature, Dr Eastman poses the question: Have we the right to remove the only mechanism that remains to her without the prospect of being able to help her to cope in other ways?

The court gives considerable credence to this concern (at p. 22):

Here the patient has developed in adolescence an individual personality which can be medically classified as disordered. But the disorder is the person and we must question the justification of depriving such a person of all that is available without the prospect of being able to help her to cope in other ways.

In this formulation, intervention will affect the core of who the individual is. This raises an obvious ethical problem: should the state apparatus be used to enforce this kind of personal alteration?

Various points may be made about this approach. First, the comments occur in an appraisal of capacity. While a similar logic may ethically apply to other branches of mental health law, capacity is a field with its own idiosyncrasies: see Chapters 4 and 5. Secondly, such nuanced assessments are rare in judicial reasoning, and indeed the decision of Thorpe J on capacity was expressly doubted by the Court of Appeal, albeit in

comments that are summary and obiter: see [1995] 1 All ER 689. As will be seen in the rest of this book, judges much more frequently uncritically adopt medical approaches, and the factual tensions involve assessments of medical testimony. Normally, and with the important exception of tribunals concerning detention under MHA, courts fail even to hear testimony from the person with mental disability.

Finally, while the relation between the individual and the disorder was clearly a matter considered by Thorpe J, and a factor in his decision that B had the capacity to consent to treatment, it did not in the end preclude him from ordering the provision of tube-feeding as treatment, pursuant to s. 63 of MHA: see further Chapter 9.4.1. In that discussion, there is little of the nuanced consideration of the ethics of forced intervention on the patient.

Even in cases such as *B v Croydon*, therefore, the centrality of the disorder to the individual is at best a factor which raises ethical issues regarding intervention; it does not necessarily determine whether intervention is ethically justified. On the question of compulsion, there are a variety of ethical positions. At one extreme, it might be claimed that intervention, and particularly intervention over the patient's objection, is rarely if ever justified on the basis that it constitutes extraordinarily intrusive meddling with an individual's personality and psyche. At the other, it might be argued that intervention is justified on the basis that after the intervention, some people are grateful (this 'thank-you theory' will be examined in more detail in Chapter 6.2.2, in the context of civil confinement), or that the symptoms of the condition are significantly improved by the treatment. Intermediate positions are also possible. Presumably, the wishes of the affected individual may be a significant factor; it would seem positively cruel not to support an individual who wishes to be free of the trait. Thorpe J distinguishes between alterations to an individual's normal personality, and a situation where the disorder is intrinsic to the personality. In *B v Croydon*, there was 'no overlay of illness upon the patient's norm' (p. 22). This might be distinguished from a situation where a medically defined variation appears in an already existing personality, where intervention might be justified to restore the pre-existing personality. The difficulty with this approach, of course, is to determine how long the disorder must exist before it becomes integral to personality. In addition, it does not solve the question of what to do when the cure will remove more than the disorder. Marie Cardinal's reference to a 'nothingness which was dull and sweet' suggests a cure removing not only the disorder, but also other parts of her nature as well.

### 1.3 Mental illness and medicine: A complex relationship

Students of mental health law are often quick to adopt a medicalised model of mental illness, that it is appropriately the realm of a specialised, medical practitioner. Certainly, there is compelling evidence to associate biomedical factors with mental illnesses, but the evidence shows not merely the strengths, but also the limitations of a medical approach. Schizophrenia may be used as an example.

Contrary to popular usage, schizophrenia does not in the overwhelming number of cases have to do with a so-called 'split personality'. It is instead a psychotic disorder: fundamental to its nature is a fractured relationship to reality. This is typically manifested in hallucinations, particularly hearing voices. An interference in the thinking process is common (i.e. 'delusions'), where the individual believes that others are controlling their thoughts, or know what they are thinking. Similarly, a loss of autonomy may be experienced, where strange physical sensations may be felt, or movements occur without the patient's will. A lack of emotional engagement with surroundings, poverty of or minimal speech, lack of drive, lack of pleasure, and poor attention may also appear, generally gradually over a longer period than the earlier symptoms.

Schizophrenia is chosen as an example to explore the medical model in mental illness for a variety of reasons. In the popular imagination, such psychotic disorders are viewed as particularly clear cases of mental illness: people who hear hallucinatory voices are at the centre of the popular understanding of madness and requiring medical treatment in a way that people who are overactive as children or who are depressed, for example, are (rightly or wrongly) not necessarily viewed in the popular imagination as mentally ill, or as medical cases. They are also cases where a medical model seems a relatively good fit: we can conceptualise what a 'cure' for schizophrenia would look like. Schizophrenia is also an example that medicine itself claims: where there are still debates about the role of doctors in the care or control of people with personality disorder, for example, but schizophrenia is taken by psychiatry to be part of its core role. In these ways, therefore, this is an example of the medical model at its strongest.

There is compelling evidence that genetics plays a factor in the occurrence of schizophrenia. The relevant studies are summarised by Thomas (1997: pp. 31–6). If genetics were the sole cause of schizophrenia, one would expect the identical twin of a person with schizophrenia also to have the disorder, since identical twins have the same genetic code. Studies do indicate a much higher probability of this occurring. Thomas cites a study by McGue *et al.*, for example, showing first cousins of people diagnosed as schizophrenic as having a 1.6 per cent chance of developing the disorder, where identical twins of schizophrenics have a 44.3 per cent chance (Thomas, 1997: 33, citing McGue *et al.*, 1985). That is an impressive difference.

While there would thus appear to be a genetic susceptibility, it is not the whole story, as even in the identical twins, sometimes the disorder manifests itself and sometimes not. The reasons for this are not clear. There are biomedical theories, reflected in the medical treatments for the disorder. Anti-psychotic medication tends to inhibit chemical receptors in the brain. Originally, the drugs targeted the uptake of a dopamine, but more recent drugs affect a wider variety of chemicals in the brain. Sometimes (but not always) these drugs are effective at reducing symptoms, although the reasons for this are not yet understood. That suggests, at best, a partial explanation of why symptoms develop. Neuro-developmental models of schizophrenia also exist (Thomas, 1997: 39–44). Here, the idea is that for any of a variety of reasons, be it maternal illness, birth injury, disease, or other factor, an abnormality in the brain occurs and schizophrenia is the result. This, like the genetic factors discussed, seems to apply for a subgroup of

the schizophrenic population. In the end, we are left with theories, some more promising than others, but none in the end able to offer a comprehensive explanation.

The search for validation of the concept of schizophrenia can be understood in professional terms: geneticists, neurologists, and medical bio-chemists each attempting to find an explanation for the condition, based on the training they have received and the intellectual structures of their sub-disciplines. Social scientists have made similar enquiries, based on social science methodologies. Reflecting the history of social science research generally, social causes, social reactions, and social constructions of schizophrenia have all been identified. For reviews of the literature, see Thomas (1997: 51–6). Regarding social causes, sociologists have identified class, poverty, and social disintegration as correlatives of schizophrenia. As schizophrenia is geographically centred in inner cities, sociological debate developed around the question of whether it is caused by increased stress in such environments. The alternative explanation, of course, is that the onset of schizophrenia precipitated a fall in socio-economic status, resulting in a disproportionate move by people with the disorder to the inner cities. The social solutions are thus as problematic as the medical ones. In the end, we are left with a variety of partial explanations.

Consistent with this, people affected by mental disorders will often understand their experience in a multi-faceted way. William Styron, for example, writes (1996: 57):

I shall never learn what 'caused' my depression, as no one will ever learn about their own. To be able to do so will likely for ever prove to be an impossibility, so complex are the intermingled factors of abnormal chemistry, behaviour and genetics. Plainly, multiple components are involved—perhaps three or four, most probably more, in fathomless permutations.

Certainly, those with mental health problems often receive medical attention. Usually this is voluntary on their part, but at the same time, there may be an element of ambivalence to it, even when the treatments work relatively according to plan, and thus alleviate the condition. U. A. Fanthorpe describes (1996: 52) this ambivalence as follows:

When depression hits me, the last thing I want to do is see the doctor, because it seems hard to define anything 'wrong'. When I have finally made myself go, and the doctor has slotted me back into a medical definition again, the reactions are odd: relief at knowing where I am again and what I have to do, but at the same time resentment that this has happened again, the same symptoms, prescriptions, general fears, and dreariness.

John Bentley Mays describes (1995: xiv, xv) the medicalisation of his condition, in his own eyes as much as those of the doctors, more expressly in terms of alienation, reflecting the Foucauldian vision with which this chapter commenced:

Yet the forensic language I invoke springs from nothing in my own heart or mind, is no more original than my routine complaining. Rather, it slides down on the page out of clinical case histories and medical records, a portrait of the *nobody*, nameless, extinguished, who is the topic of the technical literature on depression.

I have read the literature now that provides me with terms of order, pretending to study the technical language of depression—but really studying the way of looking, of writing, embodied in such texts. It is a poetry of the scalpel's quick slash, the spurt and stanching of blood, clamping back successive layers of skin, fat, muscle, the probe with a point of

gleaming metal of the nothingness at the centre. Writing myself up as a *case*, I experience myself, pleasurably, obscenely, as object. The former exacerbation of subjectivity is gone, now that the cyst known as *soul* is lanced, and all that remains is flesh, killed by the invasion of medical power, stiffening, cooling.

A similar ambivalence can be seen in attitudes to medication itself. Gwyneth Lewis (2002: 72–3) describes her experience of anti-depressant medication as follows:

After three weeks the anti-depressants began to kick in. These affected the quality of my depression but without changing its nature. What they gave me was some psychic space, a small but crucial distance between me and the horrors. Like a line of crustacean riot police, they pushed back the nightmares clamouring for my attention. This gave me a narrow cordon sanitaire in which to move, some room to breathe. The mental crowds were still there, of course, but they had less power over me, as if the anarchists had turned into paparazzi. The lightning of intrusive cameras was blinding, but at least I was free to move out of their way and into the foyer.

Fanthorpe, Mays, and Lewis describe continuing and successful relations with their respective medical advisors, and acknowledge the benefits they have received from medication: there is no element of sour grapes here. At the same time, they display a real sense of ambivalence to a medical model of their experience, and a resistance to any simplistic association between drugs and cure.

This is significant not merely as an insight into the way those in the affected group perceive their condition; it is also significant because of the way the world, or at least social policy, reacts to this uncertain relationship with the medical model. The silence between the insane and the rational is becoming further enforced, as the failure to follow medical advice is increasingly perceived as an unacceptable act of deviance. The response can take several forms. While mental capacity—the practical ability to make decisions—is not lost simply because an individual has a mental illness or developmental disability, it has long been a matter of concern that disagreement with a doctor may trigger a finding that the psychiatric patient lacks capacity to make treatment decisions. This generally has the effect of removing from the patient the legal right to refuse treatment (see further Chapter 4.4.2). Inpatients detained under the MHA lose the right to consent to most psychiatric treatment whether they have capacity to consent or not (see further Chapter 9.4 and 9.5). This view seems to be a non-negotiable element in government policy. Introducing a process of re-assessment of the MHA in 1998, the then Minister of State for Health, Paul Boateng spoke of the ‘responsibility’ of patients to comply with the care they were offered: ‘Non compliance can no longer be an option when appropriate care in appropriate settings is in place. I have made it clear to the field that this is not negotiable.’ (Press release, 22 Sept 98, contained in Department of Health and Welsh Office 1999a: App. C, para. 11). In the White Paper two years later, the point was only slightly softened: ‘Care and treatment should involve the least degree of compulsion that is consistent with ensuring that the objectives of the [care] plan are met.’ (Department of Health and Home Office, 2000: para. 2.11) Patients were to be as free as is possible, it would seem, as long as they did what they were told. Consistent with this, the legislation finally passed at the end of this process of reform in 2007 did not alter the MHA

rules allowing compulsory treatment in hospital. It did introduce community treatment orders. People under such orders still have the right to refuse treatment provided in the community, but can often be recalled to hospital and forcibly treated there if they exercise that right. Given this power, it is fair to wonder whether the consent to treatment in the community of people on these orders necessarily represents their will or desires.

This approach is problematic. Is it reasonable or appropriate to expect unswerving adherence to treatment in a professional context perceived by the patient as alienating? Will this breakdown not be exacerbated if the doctor/patient relationship is not as successful as it appears to have been in the cases of Mays, Lewis, and Fanthorpe? Can the enforcement of treatment be justifiable, when all the indications are that psychiatry is not an exact science? Should the law really be used to enforce compliance with treatment when such levels of uncertainty exist? Many patients embrace the treatments that medicine has to offer, but others are content to live with their disability, even when a treatment exists. The Hearing Voices Network, for example, assists people who hear voices to live with their voices and to get on with their lives (see James, 2001). Many do so, quite successfully. Whether their refusal to take medication is the result of the adverse effects of the medication, a view that the 'cure' affects their self-perception, or because they view their disorder as an integral part of who they are, is it obvious that their views should be subordinated to a medical vision of their condition?

Students new to mental health law sometimes perceive mental illness as something which can be cured permanently, rather like measles, where with appropriate treatment the patient is free of the malady forever. This is often a misleading view particularly in the case of serious mental illness. The better image is of a chronic condition, sometimes controllable but often recurring even if the individual complies with prescribed medication, which may affect the individual for much of their life. This again has social policy implications: if intervention is to be enforced on the individual, is it to be enforced in perpetuity? This seems extremely intrusive to the life of the individual affected, and must therefore be approached with considerable hesitancy.

Viewed in this light, mental health law and policy might be seen as dispiriting subjects. Those affected by mental illness often face a selection of possible courses of action, none of which on balance is particularly appealing. Continuation with the experience of disorder may not be an attractive option, and medicine may either provide an incomplete answer, or entail adverse effects perceived by the individual to be as unpleasant as the disorder. Alteration of the social, cultural, and environmental factors that may contribute to the malady is extremely difficult to achieve in practice. Forced intervention, be it through confinement in hospital, enforced medication, or control of the individual in the community, seems both intrusive and not obviously effective except perhaps in the very short term. One of the difficult things for new students in this area to understand fully is that here, as with many areas of law, there will often be no good solution possible for a client. Instead, there will be a selection of problematic or downright bad possibilities from which a choice must be made.

At the same time, it would be wrong to assume that all persons with mental health difficulties live miserable lives. Again, generalisations are likely to be unhelpful here,

but like most of the rest of us, it is reasonable to understand this client group as happy with some parts of their lives, unhappy with others, having some good times and some less good times. While it is inappropriate for the student of mental health law to ignore the realities of the life imposed by the mental condition, it would be equally inappropriate to focus on the mental disorder in a way which obliterates the remainder of the life of the individual.

## 1.4 The statutory definition of mental disorder and the scope of the MHA

The MHA purports to govern ‘the reception, care and treatment of mentally disordered patients, the management of their property and other related matters’ (s. 1(1)). The reference to management of property and related matters is a relic from the past, as such matters are now governed by the MCA (see further Chapter 4). Now, the MHA is primarily concerned with hospital admissions (particularly compulsory admissions) and medical treatment of ‘mentally disordered patients’ and, to a lesser degree, community treatment of such individuals. The phrase ‘mental disorder’ is thus of importance, as it defines the scope of the MHA.

‘Mental disorder’ is defined as ‘any disorder or disability of the mind’ (s. 1(2)). It thus includes the array of mental illnesses such as schizophrenia, depression, bipolar disorder (formerly called ‘manic depression’) and the like, personality disorders, and learning disabilities (although these last are subject to special provisions in some cases: see further 1.4.1). Notwithstanding this broad definition, dependence on alcohol or drugs is defined not to be a mental disorder (s. 1(3)).

The definition in s. 1(2) was introduced in its present form by the MHA 2007, and there is as yet no jurisprudence on its breadth, but the case law from the earlier legislation suggests it will be accorded a broad meaning by the courts. The Mental Health Act Code of Practice (the Code) (an extensive collection of guidance for practitioners under the MHA) encourages professionals to determine mental disorder ‘in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability’ (Department of Health, 2008: para. 3.2). This suggests a medical frame of reference, and that is consistent with the requirements of the European Convention on Human Rights (ECHR) when the category is used as a justification for detention. For deprivation of liberty of ‘persons of unsound mind’ under Article 5(1)(e) of the ECHR, *Winterwerp v the Netherlands* required that a ‘true mental disorder’ be shown by ‘objective medical expertise’ (Application no. 6301/73, judgment of 24 October 1979, (A/33) (1979–80) 2 EHRR 387, para 39). This can be juxtaposed to earlier English jurisprudence which held the phrase ‘mental illness’, then a sub-category of mental disorder in the MHA, to be not medical, but rather ‘ordinary words of the English language [which] should be construed in the way that ordinary sensible people would construe them’: *W v L* [1974] QB 711 at 719. After *Winterwerp* and subsequent ECHR jurisprudence, the

approach in *W v L* must be considered doubtful. Where a broader range of perspectives may be relevant to determining whether a mental disorder is sufficiently severe to warrant compulsory intervention such as detention (see, e.g., *R (Ryan) v Trent Mental Health Review Tribunal* [1992] COD 157), and while the evidence of doctors should of course be held up to appropriate scrutiny, s. 1(2) does appear to create a diagnostic threshold, to be determined according to medical criteria.

The use of a medical approach to the definitions of mental disorder is problematic for a variety of reasons. The first question is *which* medical approach? There are two primary medical nosologies of mental illness. The one in use primarily in North America is the Diagnostic and Statistical Manual of Disorders, currently in its fourth edition (DSM-IV-TR), published by the American Psychiatric Association. Most of the rest of the world relies primarily on the World Health Organization standard, the International Classification of Diseases and Related Health Problems, currently in its tenth edition (ICD-10), which contains a classification of mental disorders in Chapter 5. Both are currently under revision, with a new ICD expected in 2015 and DSM in 2013. Previous versions of these nosologies had been converging, but initial indications suggest that the new versions may have significant differences, particularly in the areas of autistic spectrum disorders and personality disorders. The development of these diagnostic structures is governed to a considerable degree by medical evidence, but they are also both the products of negotiation, mainly within the medical professions, and will to some degree, at least, reflect the diverse interests and political factors that come to bear in any comparably complex process of negotiation. Occasionally, these become publicly visible, as in the removal of homosexuality from the DSM in 1974 (see discussion, e.g., in Lewes, 1988: ch. 10) (homosexuality was not removed from the ICD until 1993), or the inclusion of self-defeating personality disorder and premenstrual dysphoric disorder into DSM-IV, diagnoses that were perceived to stigmatise women (Caplan, 1995). More frequently, they are internal debates that do not attract public attention; but they still exist.

These debates serve as reminders that even within the medical realm, definitions are contested. The nosologies are used in diverse contexts, ranging from identifying and defining topics of research to identifying disorders on forms required for reimbursement from health insurance companies. It is not obvious that their legal function as one of the borderlines between compulsion and non-compulsion is a significant factor in the development of the medical classificatory structures. That raises a question: if this is not specifically what they are designed for, should they be used this way? But if not, how should mental disorder be defined?

#### 1.4.1 Learning disability

For some provisions of the MHA, a learning disability will be considered a mental disorder only if it is 'associated with abnormally aggressive or seriously irresponsible conduct on his part' (s. 1(2A)). These provisions include:

- compulsory admission for treatment under s. 3 of the MHA (but not for assessment under s. 2, so compulsory detention for up to 28 days may be possible even

if a learning disability is not associated with the abnormally aggressive or seriously irresponsible conduct: see further Chapter 6.3.1);

- MHA guardianship under s. 7;
- community treatment orders under Part 2 of the MHA;
- most psychiatric admissions under Part 3 of the MHA of people either accused or convicted of criminal offences.

Learning disability is defined as ‘a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning’ (s. 1(4)). The Code advises that this involves ‘a significant impairment of the normal process of maturation of intellectual and social development that occurs during childhood and adolescence’ (para. 34.4). People who experience similar limitations that originate after maturity—people whose impairment results from injury as an adult, or who have some forms of dementia, for example—are not within the scope of s. 1(4), and so do not have a learning disability. Such people do still have a mental disorder, but are thus not within the protections of s. 1(2A). Doctrinally, it is not obvious why such categories of people, who may present in notably similar ways to people with learning disabilities, are treated differently by the statute.

The Code notes that there is no defined limit in the statute as to how these terms are to be interpreted, and in particular there is no specific IQ score that determines the matter. Instead, it promotes ‘reliable and careful assessment’ of the impairment of intelligence, and ‘reliable and recent observation’ to determine the extent of social competence (para. 34.4). Little further guidance is provided as to how this determination is to be conducted, leaving a considerable degree of professional discretion.

The leading case on the phrase ‘abnormally aggressive or seriously irresponsible conduct’ is *Re F (Mental Health Act: Guardianship)* [2000] 1 FLR 192. That case involved a young woman nearing her 18th birthday. She had lived all her life, along with seven younger siblings, with her parents in a home where she had allegedly been exposed to chronic neglect, including uncleanliness in the home, sexual abuse by visitors to the home, and the failure of her parents to provide appropriate standards of parenting. All the children including F were removed from the home under a family law emergency protection order.

The remainder of the children were dealt with through family court wardship proceedings, but because of her age, the local social services decided to apply for a guardianship order for F, under s. 7 of the MHA, an application which fell within the scope of what is now s. 1(2A). There was no doubt that F had arrested or incomplete development of mind; the question was whether this resulted in aggressive or seriously irresponsible conduct. Social services took the view that F’s desire to return home was sufficient to meet this standard.

It is not difficult to see why they took this view. To them, a desire to return to what they clearly perceived as an inadequate home, a home indeed in which abuse was alleged to have taken place, must indeed have appeared grossly irresponsible. The Court of Appeal

did not see it that way. The legislative history of the section suggested that guardianship was perceived by the drafters as a restriction on civil liberties, and this suggested a restrictive reading of the conduct criterion. On this point the court was not guided by the professionals' view. Instead, it was swayed by F's account of her actions, as reported by the trial judge (196):

What she said to me was that she wanted to go home. Her father is getting old, he is ill and he is dying soon. She has lived with him for 17 years and wants to be with him. She was happy at home, had plenty to do, went to the park. Her mother took her. She had always been with her mother and father and brothers and sisters and wanted to get back.

In the view both of the trial court and the Court of Appeal, this was not irresponsible. There was no question that the social services authorities had acted in good faith and with the best of motives, but their reading of the facts was markedly different from that of F—a reminder of the division between professional and client to which Foucault refers.

It should be noted that these restrictions apply only to learning disability under the MHA. A learning disability that renders an individual unable to make a competent decision may still be within the scope of the MCA, and mechanisms put in place to make the decision on his or her behalf (see further Chapters 4 and 5).

#### 1.4.2 Dependence on alcohol or drugs

Section 1(3) of the MHA provides that 'dependence on alcohol or drugs is not considered a disorder or disability of the mind.' It should be noted that dependence on alcohol or drugs does not preclude an individual from being dealt with under the MHA for other subsisting mental disorders, merely because they are accompanied by a dependence on alcohol or drugs. It states instead that the dependence itself is not a mental disorder. That said, the existence of a mental disorder cannot be used to detain someone to control their use of alcohol or drugs, even if there is some concern that such drug use may eventually result in the individual ceasing to take medication for their mental disorder (*CM v Derbyshire Healthcare NHS Foundation Trust* [2011] UKUT 129 (AAC)).

The exclusions created raise the question of when conduct is considered to be mad, and when bad. The fact that dependence on drugs is not to be considered a mental illness does not make that behaviour acceptable. If it constitutes a crime, as much of the behaviour closely related to drug dependency will, it will instead be categorised as criminal.

Prior to 2007, the exclusions also included 'promiscuity or other immoral conduct' and 'sexual deviancy'. These can be understood as flowing from the historical experience of detention as a way of enforcing moral standards, in particular onto the poor. An ambiguity between socially inappropriate behaviour and institutional control may be seen in the Mental Deficiency Act 1913, one of the precursors to the MHA, where 'feeble-mindedness' was not clearly distinguished from immoral behaviour. Feeble-minded unmarried woman giving birth while on poor relief for example were to be subjected to confinement in an asylum, (Mental Deficiency Act 1913, s. 2(b) (vi)) and there are indications that some local authorities required little further proof

of mental status, once the fact of the birth on poor relief was discovered (Zedner, 1991: 275). This was consistent with Victorian and Edwardian social policy (see Bartlett, 1999). The rise of the welfare state and the creation of the NHS was intended to constitute a break from this tradition of moral judgment, and the exclusions, originally introduced in the MHA 1959 and expanded in 1983, were to draw a clear line between moral governance, which was outside the MHA, and treatment of illness, which was within.

Promiscuity, immoral conduct, and sexual deviancy disappeared as exclusions in 2007. The government took the view that the mischief they were to remedy was no longer an issue, and were concerned that people were being refused treatment because their underlying disorder manifests itself as sexual deviance (Department of Health, 2006a: A1, 3). While this may be true, it does re-open the ambiguities between mental disorder and bad conduct, particularly in cases of some personality disorders, where the diagnostic criteria are intimately bound up with immoral conduct. Is a serial paedophile a criminal or a person with mental disorder? The removal of sexual deviancy from the list of exclusions makes it easier to define such individuals as persons with mental disorder. Lest that be viewed as a 'light option' relative to criminal sanction, it might be noted that with a criminal sanction, the accused is likely to get a release date set by the court, reflecting the offence committed. That will not occur if he or she is admitted under the MHA. Indeed, it is quite possible that they will be held to have criminal responsibility and therefore first be sent to prison, and then admitted under the MHA as their release date approaches. The changes to s. 1(3) may thus represent an extension of state power over these individuals, rather than a reduction.

#### 1.4.3 Mental disorder, compulsion, and race

The MHA does not affect all groups equally. Black people are just under 3 per cent of the population of England, but they represent almost 10 per cent of psychiatric inpatients, and more than 15 per cent of people on community treatment orders (Care Quality Commission, 2013). Notwithstanding a government policy from 2005 to reduce the prevalence of black people in psychiatric hospitals (Department of Health, 2005b), admission rates actually increased overall, and for almost all sub-categories of black people from 2005 through 2008 (Commission for Healthcare Audit and Inspection, 2008: table 2). Black patients were, further, more likely to be found unable to consent to treatment, held in more secure settings, and kept in hospital for longer periods of time than white people.

The reasons for this are hotly disputed. Singh *et al.* have published a systematic review of the literature (that is, a publication synthesising and analysing the reliability of the range of empirical studies) relating to race and detention under the MHA (Singh *et al.*, 2007). They identify five categories of explanation in the literature:

- 'Patient-related' explanations: these argue that black and minority ethnic (BME) patients have 'higher rates of psychoses, are perceived as being at greater risk of

violence and disturbed behaviour, have higher rates of co-morbid drug use and have greater delays in help-seeking’.

- **Illness-related explanations:** these argue that psychiatric illness manifests itself differently in BME populations, ‘with more challenging behaviour or violence, association with offending behaviour, poorer adherence [to medication] and greater denial of illness’.
- **Service-related explanations:** these involve poor early recognition procedures for BME populations, lower likelihood of early referral for treatment, greater contact with the police as a route of admission, and systemic racial stereotyping and discrimination in the mental health and social services.
- **Cultural explanations:** these included ‘a mixed set of explanations ranging from cultural differences in explanatory models of illness, stigma of mental illness in BME communities, alienation from and mistrust of services due to negative perceptions and experiences, and unwillingness to seek help’.
- **Overall racial stereotyping, labelling and discrimination as explanations:** These factors in turn led to a breakdown of trust of BME service users in professionals, and increased perceptions by professionals of BME people as violent and as a result of stereotyping failing to provide services of suitable standard.

Singh’s analysis finds that none of these have sufficient systematic study, or the studies do not have adequate evidential power, to be probative at this stage. It is also fair to note that the descriptions are not neatly delineated. For example, ‘delay in help-seeking’ as an explanation begs the question of why the delay occurs. Is it really because the individual does not understand their situation (a patient-related or illness-related explanation), or is it that he or she feels that engagement with the system will create more problems than it solves, as a result of racial stereotyping and discrimination? The explanations are further not mutually exclusive: they may all, or some, be contributors to the differential representation.

It would seem that there is little evidence to suggest that BME populations are at higher risk of serious mental illness in their countries of origin (Fearon and Morgan, 2006), suggesting that the increased incidence is not simply a biological matter. Social factors may however be relevant. There is evidence that mental disorders may for example be affected by social deprivation (see, e.g., Stilo *et al.*, 2012), and if this is the case it would affect representation of BME groups disproportionately (Morgan and Hutchinson, 2010). It is not obvious that they can be a complete explanation, however. Singh’s study notes that rates of compulsory detention increase disproportionately for BME populations over time, suggesting that the relationship between BME populations and mental health service providers deteriorates over time. That would suggest that satisfaction with services in this population is a relevant issue.

## 1.5 Other interests: Mental health care

People with mental disabilities or disorders are of course the client group who are the objects of the psychiatric system, and thus of mental health law, but they are not the

only people with interests in the delivery of mental health care. Mental health care is delivered in a system, in part based in the National Health Service, in part elsewhere in the state social services network, and in part in the private sector. A detailed survey of the range of interests operating in this system, and the sociology of how those interests interact, is beyond the scope of this chapter; but a brief survey of some of the players will provide an indication of the complexity of the influences on mental health policymaking.

The prime medical personnel involved in the care of the mentally ill are, of course, nurses and doctors, primarily general practitioners and psychiatrists. These people work in conjunction with social workers, psychologists, community mental health nurses, health visitors, social service agencies and, particularly in recent years, health administrators in the administration of the mental health system.

It is abundantly clear that the vast bulk of these people have a real and honest concern about the people in their care. The power-hungry doctor who has no interest in his patients but merely a desire to control may make good television drama, but it has little to do with the reality of the individuals involved in the mental health system. That said, the individuals listed are all professionals, operating in an administrative system. Vast sociological literatures exist on the way people operate in such bureaucracies, and strive to enhance professional status. The tensions may be within individual professions: psychiatrists, for example, have tended historically to feel undervalued among medical specialisms. The tensions may run between groups: nurses have long been working to see their own profession recognised in the broader medical hierarchy, and social workers have similarly struggled for professional recognition.

Such projects of status enhancement are clearly a part of the sociological and historical fabric of the administration of mental health. They are not generally crass attempts at power-grabbing, but manifest themselves instead primarily in articulation and formation of the values and expertise of the group in question. The group will no doubt sincerely believe, often entirely appropriately, in the value of the expertise it has to bring to a specific set of issues, but the result is nonetheless the privileging of a set of assumptions, or of a specific way of looking at things. It is this process which may result in the person with the mental health difficulty being unable to recognise himself or herself in clinical descriptions. Other ways of looking at things, whether those of the individual with the difficulty or of the other professions, are implicitly challenged or marginalised in the process. Perhaps unintentionally, the knowledge or expertise of the profession becomes the exercise of power, in potential conflict with other professions or ways of looking at things.

On a more mundane note, the professionals noted in this section are also all human, with understandable concerns about job satisfaction and job conditions. The image of the doctor willing to abandon all family or personal life and devote himself or herself entirely to the care of patients has a romantic appeal, but does not represent reality in most cases. The professionals, entirely reasonably and like the rest of us, must balance priorities.

Not all those with an interest in the care and treatment of the mentally ill are contained within the public sector. Overflows of patients from NHS psychiatric wards may

be moved to private facilities, simply to alleviate space pressures. Further, many of the facilities such as group homes through which community care is offered are provided by the private sector. Sometimes these private sector providers are non-profit organisations, established through charities such as MIND; in other cases, they are standard businesses, run with a profit motive. Either way, the shift to the private sector means that maintenance of standards and control of staffing are out of direct government control. Regulation is theoretically possible, but complicated by the fact that if unattractive standards are set, the private operator can fold up shop, a possibility the government can little afford given the inability of the NHS to service the demand. This is not a desirable option from the private operator's viewpoint either, since considerable investment will have been made. In this balance policy must be made.

Care is not, of course, the exclusive preserve of the professionals. Families and friends also provide care, and there is considerable American evidence to suggest that the role of families is pivotal to relapse (Dixon and Lehman, 1995; Dixon *et al.*, 2000). The specific role of these informal carers will depend on the circumstances. Sometimes, they provide housing, with or without a day centre providing a formalised programme during the day. Sometimes, the person with mental illness will reside elsewhere, be it in hospital, at a group home, or alone in the community. Here, the role of family and friends may be to provide a sense of community and support, or it may also be to provide some sort of overview, to ensure that the appropriate services are being provided.

These services and the people who provide them have traditionally been largely taken for granted in the administrative structure of mental health. This is difficult to justify, for such carers provide important services, in conditions which may be very difficult. Some public support is available for these activities (see Carers (Recognition and Services) Act 1995) and there are some schemes in place to assist or relieve carers, for example, by allowing them to take the occasional weekend break from their caring duties. Such programmes seem appropriate acknowledgements of services performed which, at their best, provide the person with the mental disorder an optimal home environment at minimal cost to the state.

The family role can also be perceived as much more problematic. Particularly at the onset of an illness, the family may have little understanding of mental disability, and may react with stereotyped views (Thornicroft, 2006: ch. 1). Further, perhaps even more than with the professional actors, the interests of the family member providing care and those of the mentally ill person are difficult to disentangle, suggesting difficulties with formal control of these carers over the decisions that are made about mentally ill family members. Like other service providers, but perhaps more than other service providers, the family and friends of the individual will have an emotional and practical interest in the fate of the individual. The effect of the condition on relations within the family and, if the affected person is a breadwinner forced to cease employment, on the economic life of the family, can be profound. More poignantly, it can be profoundly painful to witness the onset of mental illness in a loved one. Karp comments regarding his attendance at a support group for friends and family of persons with mental disorder (2001: 22):

On any given evening I might hear about the unimaginable pain surrounding the decision to have a child removed from one's home by the police, the powerlessness of visiting a spouse or child in a hospital who is so muddled by powerful medications that he or she can barely speak, the shame that accompanies hating someone you love because of what their illness has done to you and your family, the guilt that lingers from the belief that you might somehow be responsible for another person's descent into mental illness, the confusion associated with navigating the Byzantine complexities of the mental health system, the fear associated with waiting for the next phone call announcing yet another suicide attempt by someone close to you, the disappointment that a talented son or daughter may never realize even a fraction of their potential, the exhaustion that accompanies full-time caregiving, or the frustration of being unable to take even a brief vacation. Pain, powerlessness, shame, guilt, confusion, fear, disappointment, exhaustion, frustration: these emotions are the currency of conversion among the Family and Friends group members.

It is difficult to see how family members can be expected to divorce these feelings from their views of the person with the disorder, and what ought to happen to that person. Unsurprisingly, Karp's study finds family carers building practical and emotional walls, setting up 'boundaries of obligation', to use his term, in their care relationships. The result is a paradox: it is the family's intimate knowledge and relationship with the affected person which creates the appeal of their greater involvement; but at the same time, this same factor creates the risk that decisions will be made on criteria other than the best interest of the affected person.

The private interests in the mental health field extend well beyond carers. Pharmaceutical manufacturers are a particularly clear example of these other interests. Pharmaceuticals are big business. Roughly 10 per cent of the NHS prescription budget is spent on drugs for mental disorders—or more than £881 million in 2010 (Ilyas and Moncrieff, 2012: table 1). Clearly, medication for mental illness has brought considerable benefits in many cases. At the same time, the adverse effects of medication can be profoundly unpleasant. The precise nature of these adverse effects will, of course, depend on the patient and medication in question, but they can be significant enough to dissuade patients from continuing the treatment. Ron Lacey (1996: 118) makes the point this way, regarding depot anti-psychotic medications, long-lasting medications injected into patients at intervals of weeks or months.

Whilst they can relieve the torment of the symptoms of serious mental illness for many people, they can also reduce an individual to an unprotesting zombie-like state. For some patients the use of depot antipsychotics is little more than an exchange of one form of human misery for another. Drowsiness, lethargy, loss of motivation, impotence, stiffened muscles, shaking hands, physical restlessness, severe anxiety and persistent constipation may be more distressing to some people than a fixed belief that their thoughts are being controlled by the international brotherhood of Freemasons. For others these side effects are a small price to pay for the relief that the drugs give them from a much more distressing and terrifying psychotic inner reality.

The varieties of psychiatric medication and their adverse effects will be discussed in greater detail in chapter 9.3; suffice it here to say that while their benefits should not be ignored or underestimated, they are not problem-free, miracle drugs.

Pharmaceutical manufacturers spend a considerable amount of money advertising their products, particularly in specialist medical, nursing, and health care journals related to mental illness and disability. Unsurprisingly, the advertisements emphasise the potential benefits of the medications, and place the adverse effects in very small print, either at the bottom of the page or off to the side. More interesting are the images used to sell the drugs, often reflecting themes discussed elsewhere in this chapter, although usually with a particularly sugary gloss. Thus images of a patient's return to true self-hood as a result of the drug, or scenes of restored domestic bliss, are common. Perhaps more worrying are advertisements that, often very subtly, suggest the use of medications as an efficient control of patients. These are presumably directed to the harassed doctor, presenting a fast and efficient way to restore order onto their ward or into the local psycho-geriatric nursing home. Are the advertisements effective? The continued use of large advertising budgets by these firms would suggest that they think so. A field trip to the medical library for a critical viewing of these advertisements is instructive to the student who is new to mental health law.

All these groups—patients, the varieties of medical personnel, social workers, hospitals and NHS health trusts, private caregivers, families, and pharmaceutical companies—make use of lobbyists and pressure groups to press their views. Sometimes these roles are performed by professional organisations, such as the Royal College of Psychiatrists, the College of Physicians, or the British Medical Association. Sometimes, they are performed by charities, such as MIND, Mencap, or the National Carers' Association. Sometimes large organisations such as pharmaceutical companies will hire lobbyists directly. Once again, there is a considerable sociological literature on how these bodies work. If the group represents a variety of different persons or providers, decisions as to what position is to be lobbied for may become complex. This may be particularly complex in some of the groups in the charitable sector, for example, which do not 'represent groups' per se, but exist instead primarily to focus attention on sets of issues. While MIND, for example, endeavours to give particular consideration to the views of users, its mandate and membership is considerably broader than this.

Lobby or pressure groups may further have independent interests involving their reputations or financial integrity that may influence them in addition to, or, occasionally, at odds with the interests of the groups they represent. If a private firm of lobbyists is hired, for example, the firm will have a profit motivation. Even in the charitable sector, the financial integrity of the organisation must remain a factor in its priorities. Amendments to the way in which services are provided has complicated this since, in the last two decades, government has increasingly provided funding in the charitable sector. Nationally, the government provided £175 million of £3,000 million in charitable revenues in 1976, or roughly 6 per cent; by 1984 this had grown to £1 billion of charitable revenue of £10 billion, or 10 per cent (Prochaska, 1988: 4). By 1999,

somewhere between 35 and 40 per cent of charitable income was thought to come from government sources (Whelan, 1999: 3). While these figures reflect the entire charitable sector, mental health charities have garnered at least their share of this new money. Indeed, as the charities have found an increasing role for themselves in the provision of community mental health services, the financial relations with government have intensified. The effect on these organisations is ambiguous. On the one hand, government relies on these organisations more than ever before to fulfil government objectives; at the same time, the organisations rely on government increasingly, to provide the funding for their activities. It is difficult to see that this uneasy relationship would not have its effect on the role of these charitable organisations to comment upon and to influence government policy.

Lying across all these interests is the government. It would be an error to think of the government as a monolith; like the remainder of the system, it is composed of parts, which may be characterised as much by competition as co-operation. The clearest of these possibly divergent interests arises between central and local government. The tradition in this country has long been for local government to have a particularly central role in service provision. Thus the actual purchase, and some of the provision, of community care rested at the local authority level, where policy-making rests primarily with central government. The same is true of health care provision, which will be administered at the local level, in the context of central regulation. In each case, much of the core funding will originate with the central government. This suggests that local and central interests may well disagree on a wide variety of issues, from priorities in service provision, to, most pivotally, the appropriate level of funding for service provision. The introduction of commissioning groups in 2013 will remove much of the purchase of services from local government control, to consortia of clinicians. How significant this change will be remains to be seen. It is hard to imagine central government bowing out of regulation, and it will certainly not be ceasing to provide funding. It may well be that the fights will have merely moved to new, quasi-private entities from local government ones.

Even central government must be understood as a complex entity. Mental health care will span a variety of offices and departments. Disability benefits for those living in the community are a social security issue. The Office of the Public Guardian, which has a variety of duties relating to persons lacking capacity, is under the Ministry of Justice. Psychiatric treatment in hospital is of course a matter for the Department of Health, although when such treatment involves people within the criminal justice system, the Department of Justice is also involved (albeit a different part of the Ministry of Justice than that containing the Public Guardian). Within government, status is measured largely in terms of staff allocations and budget. The way in which programmes are divided between departments is thus profoundly relevant to the status of the departments concerned, with corresponding impact on government policy. The interests of a variety of departments in mental health services reinforces that mental health policy may be as much a function of competitive negotiation between government departments as it is of co-operation.

Throughout the system, lawyers can be expected to be active. They will be hired, either to lobby for specific interests or to represent clients in specific situations, by all the parties noted at the beginning of this section. Here again, while the lawyer should of course defend the interests of those clients with all ferocity, limited only by professional standards such as the duty to uphold the dignity of the court, other factors can creep into the picture. Practising lawyers quickly learn that their individual reputations are profoundly significant to the attainment of their career aspirations and, sometimes, to the success of their causes. In practice, this may affect how the lawyer presents a case, and occasionally, what arguments will be made. Similarly, the realities of private legal practice require a cash flow. The lawyer representing clients in mental health, as much as any other, cannot in the end ignore that reality. This is seen with clarity in some of the debates surrounding legal aid. Certainly, availability of legal aid is likely to be vital to many poor psychiatric patients if their rights are to be protected. At the same time, the reason it is vital is because without an appropriate legal aid structure, lawyers simply cannot afford to accept many cases: the issue here is about the economics of running a law office as much as it is about abstract notions of rights.

The resulting picture is of a complex system of actors and interests in the provision of mental health care. It would be unduly cynical to take the view that the people with the mental health problems, the people whom the system ought most to support and assist, are ignored. It would be fair to say that the users of mental health services have not traditionally been as successful as the professional groups in having their voices heard directly. This problem is complicated by the fact that the users of mental health services do not speak with one voice. They range from enthusiastic proponents of medication to people denying the relevance of a medical model to insanity entirely. User views instead tend to be filtered through a professionalised view of best interests. While it would be inappropriate to deny the good faith of much of this professional concern, the other factors noted in this section may distort or influence the message. If it is inappropriate to say that the person with mental health difficulties is absent from policy formation, it is certainly inappropriate to deny the other factors which influence policy formation.

## 1.6 Sources of law

### 1.6.1 The roots of the mental health law

Mental health law is as old as law itself. The earliest codified reference in the English statute book is contained in a 1324 statute defining the Royal Prerogative, giving the king jurisdiction over the persons and property of 'idiots' and those who 'happen to fail of [their] Wit' (*De Prerogativa Regis* c. ix, x). Nonetheless, much of the care of the insane in medieval and early modern England occurred outside the realm of statute, and it was not until the eighteenth and particularly nineteenth centuries that the insane became, increasingly, subject to statutory jurisdiction. These statutes may have been the precursors of the MHA and MCA, but they were markedly different in form. Specifically,

for much of the nineteenth century, mental health law was not contained in a single Act, but instead in a variety of streams of statutes, each quite distinct from the others (see Bartlett, 2001a). Four nineteenth-century streams, and one additional one from the early twentieth century, warrant particular note, as they combine, in somewhat amended form, to comprise the MHA 1983. The nineteenth century strands were as follows:

- Private madhouse acts. Commencing in 1774, these required privately owned madhouses to be licensed and inspected. These reached maturity in 1845, when a national government body, the Commissioners in Lunacy, were formed to inspect all madhouses in England and Wales. Licensing was done by justices of the peace outside London, and the Commissioners in Lunacy in London. Admission to private madhouses was upon the application of a family member, supported by two certificates of insanity signed by medical practitioners not directly associated with the madhouse.
- County Asylum Acts. These commenced in 1808. They allowed (and after 1845, required) county asylums to be built for the insane poor, financed by the county rates. Throughout the nineteenth century, these facilities were generally restricted to paupers, although in practice a somewhat wide definition of that term might sometimes be employed. Admission was by order of a justice of the peace, upon the application of a poor law relieving officer supported by one medical certificate, almost invariably signed by the poor law medical officer.
- Statutes concerning the Royal Prerogative, and determination of mental incapacity: originally, the control of 'idiots' and 'lunatics' had rested with the Crown, but this was generally delegated to the Lord Chancellor. Nineteenth-century statutes further arranged that incapacity would be determined initially by chancery judges, then by senior barristers specially appointed to the role (when no jury was requested).
- Criminal lunatics: the first of these statutes was required following *Hadfield's Case* (1800) 27 Howell's St Tr 1281, where it was held that although the insane accused was not to be convicted, he was not to be set free either. A legislative framework to accomplish this came into effect later that year. In the first half of the century, legislation in this area was contained in the County Asylum Acts, but specific statutory regulation occurs in the second half of the century, beginning with the Criminal Lunatics Act 1860.

The Lunacy Act 1890 is sometimes perceived as a watershed statute. In a sense it is, in that for the first time it combines the four legislative streams relating to the laws of insanity into one statute. Further, it was in effect for much of the twentieth century, not being formally repealed until 1959, and the MHA 1983 still resembles it in general structure. In its historical context, however, the 1890 Act is something of an anticlimax, although it did make some changes. For the first time, for example, privately paying patients could not be admitted to psychiatric facilities without the order of a justice of

the peace. If the 1890 Act consolidated the various strands into one statute, however, it did not consolidate the strands themselves; for example the paupers who had been under the jurisdiction of the County Asylum Acts continued to be subject to a set of rules quite different from private patients.

The first half of the twentieth century offered two significant developments. The first was to add yet another strand of legislation, the Mental Deficiency Acts, commencing in 1913. These seem to have been given short shrift by legislative historians of insanity. That is unfortunate. Not only did they provide the basis of the current guardianship provisions of the MHA; they also provided the legislative framework for some early care in the community, before the Second World War (Thomson, 1998; Walmsley *et al.*, 1999). This provision was not negligible: by 1939, almost 90,000 people were controlled by these Acts in England and Wales, almost half of which were living in the community (Walmsley *et al.*, 1999: 186). Further, they provided a legislative framework for an increasingly ornate social discourse relating to developmental disabilities. While 'idiocy' was expressly covered under the nineteenth-century legislation, for much of that period little distinction was made between this and 'lunacy'. The Idiots Act of 1886 began to acknowledge the distinctness of problems relating to developmental disability; the differential nature of the issues, and a different set of social responses, was given clearer articulation by the Mental Deficiency Act 1913.

The second development was that the Mental Treatment Act 1930 introduced informal admissions for the first time. In law, this is extremely significant. Up to this time, there was no distinction between admission to and confinement in a psychiatric facility. From 1930, it became possible for an individual to be admitted to a psychiatric facility without a formal and binding order of admission. For the first time, the patient might also be free to leave. While this admission route took some time to gain widespread popularity, it now accounts for around 90 per cent of psychiatric admissions.

It is in this legislative context that we must understand the Mental Health Act 1959. The creation of the NHS in 1948 had largely removed the distinction between public and private facilities, with the incorporation of charitable hospitals into the public sector. The old legislative distinctions appeared to make less and less sense. Where the 1890 Act had left the distinctions largely untouched, but included all legislative strands in one statute, the 1959 Act actually tried to consolidate the divergent strands into one. The solution of the 1959 Act was largely to ram the different processes together. For example, where compulsory admission before that time had been in the hands of poor law/social service officials if the patient was poor and the family if the patient was able to afford private care, under the new system both admission mechanisms were combined for all patients, so that all compulsory admissions required both family and social services involvement.

The 1959 Act did make a few significant changes. First, admissions were now removed from justices of the peace. The process allowed admission instead upon the agreement of a mental welfare officer and the nearest relative of the patient, accompanied by certification of mental disorder by two doctors. This may have reflected

existing practice in any event, for there is evidence that in some areas at least, justices of the peace were signing multiple copies of blank orders of admission, in anticipation of applications from poor law relieving officers and medical officers (Forsythe, Melling, and Adair, 1999: 83). Nonetheless, albeit perhaps unintentionally, the 1959 Act is said to have had the effect of moving power from hospital administration and judicial officers directly to treating physicians (Fennell, 1996: 168–9). Secondly, the Act introduced mental health review tribunals. For the first time, a dedicated mechanism was created by which patients could challenge their confinement. Finally, the 1959 Act moved the *parens patriae* power to an entirely statutory footing. Where the previous legislation of this power had functioned as amendments of the common law, the 1959 Act subjected guardianship and conservatorship to a purely statutory regime.

The MHA 1959 once again placed mental disorder and learning disabilities in the same statute, an approach continued under the current MHA. This has not been entirely a success. The combined statute means that the legislative space to consider problems specific to each of these groups has disappeared. This would seem to have worked to the disadvantage of those with learning disabilities, who in discussions related to the current MHA are overshadowed by issues of mental health and illness. This is reflected in the title of the Act: why should people with learning disabilities be subject to a ‘mental health’ Act, when they are not, *per se*, mentally ill? Indeed, this book can be justly criticised for this bias. While purporting to discuss the ambit of the MHA as a whole, much of the discussion does show an inappropriate assumption that the prime users of the legislation are mentally ill, not learning disabled.

The MHA 1983, still currently in force, albeit as amended, kept the basic provisions of the 1959 Act. There were some changes in nomenclature: ‘mental welfare officers’ became ‘approved social workers’. Some more substantive changes were also made at this time, however. The new Act was passed in a climate where patient rights had entered the political landscape. Treatment while in a psychiatric facility was for the first time brought into the legislative realm, albeit only for those confined in the facility. That inclusion nonetheless made it equally clear for the first time that those not covered by the provisions, that is, those informally admitted, had the same rights regarding treatment as the common law provides to people outside the facility. In addition, the powers of personal guardians were significantly reduced. The guardian could now only determine where the person could reside (but not require him or her to be returned there, if for example he or she were wandering), and to attend somewhere for treatment (but not to consent on the person’s behalf). While they can also ensure access to the individual by social services or medical personnel, they have authority to make no other decisions for the individual. This triggered a process of law reform, eventually resulting in the passage of the MCA. In the interim, the courts expanded common law on an *ad hoc* basis to fill the apparent gap.

The last decades of the twentieth century saw a forest of policies, guidance, and directives from the Department of Health, introducing best practice policies for a wide variety of matters relating to psychiatric care. While these have been enforced through

administrative audit and similar mechanics of government—woe betide a provider who fails to develop the administratively appropriate systems of management—they have no formal legal effect. The courts may look to them, of course, but will not be bound by them when they do not reflect statute or common law: see, for example, *R v Department of Health, ex p Source Informatics Ltd* [1999] 4 All ER 185. The trend towards this form of extra-legal regulation is typical across government, and is certainly prevalent in health matters generally. The move raises questions of accountability: while some of the guidances have considerable effect, they will not have been scrutinised by Parliament.

In the 1995, in response to two *causes célèbres*, significant amendments were made to the Act regarding control of patients released into the community. The MHA 1983 already made the provision of after-care in the community mandatory for people who were released from civil confinement in psychiatric facilities (s. 117). The 1995 amendments began to focus on requiring the person released to accept the care offered. The details are unimportant for present purposes: they are no longer in effect. The relevance of these provisions in an historical context is the blurring of control between the institution and the community and, perhaps more significant, turning the debate surrounding the introduction of these provisions from a language of rights, the predominant discourse in the 1983 debates, to a language of risk. That latter language has become increasingly central to government thinking regarding mental health law since that time.

In the 1990s, various reform projects were undertaken. The Law Commission took up the question of a statutory framework for mental capacity (see Law Commission, 1995). Most of their proposals were eventually passed into law in 2005.

Meanwhile, in the late 1990s, the government introduced a programme of reform to the MHA. This was occasioned in part by concerns that the existing Act would not comply with the Human Rights Act 1998, an ongoing concern raised in numerous contexts later in this book. The reform process cannot be considered to have been a success. An expert committee, well-respected among legal and medical practitioners, reported in 1999 (the Richardson Committee). Its recommendations were rather modest, and reflected the emerging orthodoxies among mental health practitioners, service users, and policy analysts. Thus, for example, service users were to be involved as far as reasonably possible in their own care, and higher requirements for detention would apply if a competent patient was objecting to admission (Department of Health and Welsh Office, 1999a).

At the same time, a second committee was concerned with mismanagement and abuse at Ashworth Special Hospital (the Fallon Committee). Also reporting in 1999, this committee called for stronger controls over people with personality disorders who were perceived as dangerous (Department of Health, 1999b).

The government combined the Richardson and Fallon proposals into one White Paper and draft bill, in 2002. They were not well-received. Service users and their advocates complained about the disappearance of many of the rights-based protections, and the notion that users were to be treated with dignity. Doctors objected that they would be required to warehouse people for whom there was no treatment. Civil rights

advocates complained at the demise of due process safeguards proposed by Richardson. The overall direction of change can be illustrated by reference to the guiding principles contained in the bill. The Richardson Committee proposed an array of progressive principles, supportive of patient dignity, liberty, and rights. The draft bill contained three general principles, securing that patients be involved in the making of decisions; that decisions be made openly and fairly; and that 'the interference to patients in providing medical treatment to them and the restrictions imposed in respect of them during that treatment are kept to the minimum necessary to protect their health or safety of other persons' (cl. 1(3)). Unlike the Richardson principles, these simply did not reflect the direction and complexity of discussion and debate in the mental health arena in recent decades. As if this were not enough, the following sub-clause went on to say that the Code of Practice could specify circumstances or decisions or people to which even these minimal principles would not apply (cl. 1(4)). It is unsurprising that the proposals did not receive broad support among users, service providers, and carers, and the government eventually withdrew the bill.

A subsequent draft bill in 2004 was also withdrawn, again attracting little support from stakeholders, and following a highly critical report from a Joint Scrutiny Committee of the House of Commons and House of Lords (House of Commons and House of Lords, 2005).

Eventually, the government abandoned the prospect of a new statute. Instead, it introduced amendments to the existing MHA in 2007. These, like the previous proposals, met with considerable resistance, but the government did manage to get them passed. Most significantly, the 2007 Act created community treatment orders (a manifesto commitment) (see further Chapter 10.4) and introduced procedures by which people without capacity could be detained (the deprivation of liberty safeguards, or 'DOLS') (see further Chapter 5). A variety of other more minor changes were made, and will be discussed as they arise later in this book. The result is an extraordinary disappointment for almost 10 years of effort, and, perhaps most disappointingly, the factors that were the impetus for the reform process in the late 1990s are still there: the MHA is badly drafted, out of date both with modern professional practice and modern views of patient rights, and of doubtful consistency with the ECHR on a variety of points.

In considering the legal developments over the last 200 years, perhaps what is striking is less how much things have changed, as how much they have remained the same. While the distinctions between public and private admissions have disappeared under the current MHA, the structure is otherwise reminiscent of the strands of nineteenth-century law identified in this section: Parts 2 and 6 on admission to facilities, including removal of patients to the various parts of the United Kingdom; Part 3 on criminal confinement. On a more minute level, the continuities are similarly notable. The current role of the approved mental health professional (AMHP) looks remarkably similar to that of the poor law relieving officer, 150 years ago.

At the same time, the context of the MHA has changed markedly, making interpretation complex. When the Act contains the old nineteenth-century clauses, as it often

does, their relevance or applicability is no longer clear. Thus s. 1 of the MHA still refers to the Act governing 'the management of [the patients'] property and affairs', although it has not done so since the introduction of the MCA in 2005. Similarly, the provisions defining the right of the nearest relative to insist on the release of a patient contained in s. 23(2) originate in the nineteenth-century statutes. If the confinement was in the private sector, the relative was responsible for paying the patient's upkeep, and therefore was perceived to have the right to demand the release of the patient, to limit their financial exposure. If instead the patient was confined in a county asylum, the right to order release was conditional on an undertaking by the person ordering the release that the individual would no longer be chargeable on the poor law. The right to release was thus a way to enforce public economy in care provision, and to limit the shame of the family at receiving poor relief. Neither of these justifications continues to exist; yet the section remains in relatively unamended form. Justifications may continue to exist for its inclusion, but they are *ex post facto*.

The nineteenth-century rights to order the release of the patient were circumscribed if the patient were 'dangerous to other persons or to himself', a restriction remaining in s. 25 of the MHA; yet how are we to read that section given the standard of confinement introduced in 1959 and still in force, that the civil confinement is 'necessary for the health or safety of the patient or for the protection of other persons'? If it is the same standard, the right of the nearest relative is removed in all cases where the patient is rightly confined, rendering the power a nullity. If the standards are different, how are they different? The answer would have to be to introduce a relatively low standard for 'health' in the 1983 provision, since it is difficult to see how 'safety' of the patient or 'protection of other persons' provides the necessary flexibility to provide a standard different from 'dangerous'; but is that really consistent with the meaning of the 1959 standard as a whole? Does the phrase 'the health or safety of the patient or for the protection of other persons', when read as a whole, not instead imply a relatively high standard of risk to health? And should the determination of modern standards of confinement be based on arcane arguments about nineteenth-century legal history?

The MHA 1983 is full of this sort of difficulty. Its construction and interpretation can be fiendishly difficult. The Code of Practice, most recently revised in 2008, has been issued to assist those charged with the Act's administration (Department of Health, 2008). In a sense, this only complicates matters further, since the Code contains material supplementary to the legal standards of the Act. While the Code is not legally binding on practitioners, they are required to 'have regard' to it (s. 118(2D), introduced 2007) and it is identified as something the Secretary of State is obliged to produce by s. 118 (1) of the Act. As such, while service providers may depart from it, they are required to give the Code 'great weight' and to depart from it only when they have 'cogent reasons' for doing so (*R (Munjaz) v Ashworth* [2005] UKHL 58, para. 21). The result can appear to establish ambiguities in the standards to be applied: one is reminded of the Japanese proverb that a person with a clock knows the time; a person with two clocks is never sure. Even without reference to issues of social policy in interpretation,

the MHA therefore provides a veritable panoply of difficulties, testing the lawyer's skills in statutory interpretation to their limit.

### 1.6.2 Other law and mental disorder

The MHA and MCA may provide the core of the law for this textbook, but it will be clear from the preceding discussion that they do not stand on their own. Other legal subject areas may come into play in understanding the rights of those with mental health problems. The modern law curriculum, frequently modular, is appropriately criticised for treating legal subjects as self-contained packages, with little to do with each other. The study of mental health law allows the law student an ideal opportunity to think across legal subjects, analysing which approach will yield a desirable result. Mental health law spans almost all legal disciplines. The student of mental health law should see this as an opportunity, not a threat, for it allows a reassessment of those disciplines from a new and different angle from that usually forming the base of law school curricula. A brief survey will show how some of these related areas intersect with mental health law.

The MHA itself involves subjects such as confinement and enforced treatment, performed on statutory justification. These matters tend to be controlled by judicial review, and students should be aware of the relevance of their study of public law to mental health law.

The MHA is not a complete code, and in the silence of the statutes, the common law will apply. The treatment of people with decision-making capacity who are informally admitted to psychiatric facilities is governed by common law, with the standard rules of consent and medical negligence applicable.

Capacity is a threshold whenever people enter into legal relations. The MCA creates prospective mechanisms to allow individuals to make decisions on the incapable person's behalf, but it does not alter the pre-existing legal rules applicable when the incapable person has nonetheless entered into relations with others. Here, capacity law, generally based in common law, reaches into virtually the entire law school curriculum. As an illustrative list, there are rules regarding capacity to marry, to engage in sexual relations, to file for divorce, to sign contracts, to commit crimes and to enter a plea when charged with an offence, to serve as trustee or corporate director, to execute a will, and of course to consent to medical treatment. Some of these will be discussed as they arise in this textbook, most notably in Chapters 4 and 9, requiring some consideration of the broader laws in these areas.

Even regarding mental disorder distinct from incapacity, the MHA does not of course affect all of the individual's life. A variety of other statutory regimes may also be significant. People with mental disorders face, with embarrassing frequency, problems of maintaining jobs and finding places to live (Thorncroft, 2006: ch. 3 and *passim*). The former of these will be subject to employment laws, which articulate the degree to which mental illness can be used to justify dismissal. Similarly, both employment and housing are covered by the Equality Act 2010, which prohibits discrimination on the basis of disability. This may be particularly helpful, as it can require the employer or landlord to make reasonable accommodation to take account of the needs of the

disabled person. Disability rights are also noted in the Treaty of Amsterdam 1997, and the Charter of Fundamental Rights of the European Union signed in Nice in 2000 (2000/C 364/01) and strengthened by the Treaty of Lisbon in 2009, suggesting that a European dimension may become increasingly relevant as that treaty is implemented. Particularly if employment fails, the individual may be in need of social services, where a range of disability benefits may be available under social security legislation.

The ECHR has become increasingly relevant to mental disability law in recent years. This is in part because, following the Human Rights Act 1998 taking effect in 2000, the ECHR may be pleaded in the domestic courts of the United Kingdom, so that decisions of the European Court of Human Rights (ECtHR) have a more immediate relevance. It is also because, in the last decade or so, the ECtHR has taken an increasing interest in issues concerning mental disability. Where the first case involving mental disability (*Winterwerp v the Netherlands*, (1979–80) 2 EHRR 387) was not decided until almost 30 years after the ECHR took effect, now there is a steady flow of decisions coming from Strasbourg. *Winterwerp* laid down core standards which states must apply when detaining ‘persons of unsound mind’ if they are to comply with Article 5.1.e. This case has proven extremely important at establishing fundamental standards in the mental health area. The experience since that time has been mixed (see Bartlett, Lewis, and Thorold, 2006). The ECtHR has been strong on ensuring appropriate due process protections, but weak on substantive issues. As perhaps an extreme example, in *Johnson v United Kingdom* (1999) 27 EHRR 296, the court held that while an individual who had been but was no longer mentally ill had a variety of process rights to challenge their confinement, the fact that they were no longer mentally ill did not mean that they had a right to an immediate and unconditional release from their psychiatric facility. This does seem to be an extraordinarily conservative reading of the phrase ‘person of unsound mind’ in Article 5.1.e.

Where early decisions primarily concerned detention, more recent cases cover an increasing range of issues, for example, the right to vote (*Kiss v Hungary* Application no. 38832/06, judgment of 20 August 2010); issues concerning the control of people under guardianship because of alleged incapacity (e.g., *Shtukaturov v Russia*, Application no. 44009/05, judgment of 27 June 2008; *Stanev v Bulgaria*, Application no. 36760/06, judgment of 17 January 2012, *DD v Lithuania*, Application no. 13469/06, judgment of 14 February 2012); detentions occurring in care homes rather than hospitals (e.g., *X and Y v Croatia* Application no. 5193/09, judgment of 3 February 2012); the failure to protect people with mental disabilities from harassment (*Đorđević v Croatia*, Application no. 41526/10, judgment of 24 July 2012); and the appropriateness of psychiatric treatment (*Gorobet v Moldova*, Application no. 30951/10, judgment of 11 January 2012, *X v Finland* Application no. 34806/04, judgment of 3 July 2012). The growth of this jurisprudence looks set to continue, and students serious about mental health law will need to take account of it.

Also of importance is the work of the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), another body of the Council of Europe. The CPT has taken the view that people who are institutionalised

are particularly vulnerable to abuse, and therefore form a particularly important part of their mandate. It has issued standards applicable to psychiatric facilities (see European Committee for the Prevention of Torture, 2011) and routinely visits not merely prisons, but also psychiatric hospitals, social care homes, and similar institutions, to ensure that appropriate standards are met. Their reports are not as influential in domestic English courts as the decisions of the ECtHR, but they may nonetheless be given some consideration: see, for example *R (Wilkinson) v RMO Broadmoor Hospital and MHA Second Opinion Approved Doctor* [2002] 1 WLR 419 (CA) at para. 28 *per* Simon Brown LJ., regarding the rights of persons with capacity to make treatment decisions.

The most recent innovation in international law is the United Nations Convention on the Rights of Persons with Disabilities (the CRPD) (UN General Assembly, A/61/611). This convention was passed by the United Nations General Assembly in December 2006, and took effect in 2008. The CRPD takes a fundamentally different approach to previous international and domestic law. Previous articulations of mental health law had focused on mental disorder, a condition lying in the individual, analogous to a sickness. The CRPD requires a redefinition of the field, placing mental health law (if that is still the appropriate label) in the context of disability law and adopting a social model of disability: what renders the individual 'disabled' is not something analogous to an illness contained in the individual, but rather the response of society in failing to take adequate account of the person's situation. To pick a somewhat simplistic example, a person in a wheelchair is only disabled if no wheelchair ramp is provided. Similarly for mental disabilities, the disadvantage in the view of the CRPD flows from a failure of society adequately to cater to the needs of people with these disabilities—the failure to provide 'reasonable accommodations' in the language of the Convention.

This has important consequences. Previous international instruments such as the ECHR and the United Nations Mental Illness Principles (General Assembly, 46/119, 1991) had accepted the appropriateness of coercing people with mental disorders in some circumstances; the issue was how to define the circumstances. The CRPD takes no such starting point. It instead starts from the position that coercion in situations where people without disabilities would not be coerced is discriminatory on the basis of disability, and therefore unacceptable. On that basis, much of the mental health and mental capacity law currently existing is in violation, and that appears to be the view of the Committee on the Rights of Persons with Disabilities, the UN body charged with the oversight of the implementation of the Convention: see United Nations Committee on the Rights of Persons with Disabilities, 2011, 2011a, 2012; see also United Nations High Commissioner for Human Rights, 2009 at, e.g., 43–45; United Nations Special Rapporteur on Torture, 2013. At the time of writing the ramifications of the CRPD have not yet been thought through by the government (see discussion in Bartlett, 2012). Certainly, if English and Welsh law are to be made compliant, significant changes will be necessary, and they will be discussed elsewhere in this textbook.

Unlike the ECHR, there is nothing corresponding to the Human Rights Act 1998 for the CRPD. The CRPD is international law, and while the UK is obliged to implement it and comply with it, there is nothing that corresponds to a declaration of incompatibility

such as would force the government's hand, as there is for the ECHR. At the same time, it is international law, a Convention that the UK has signed and ratified, and we are meant to implement it. Not only that, but we are required to report every four years on our progress towards implementation, and the Committee on the Rights of Persons with Disabilities comments publicly on those reports. Not only that, but the UK has also signed the optional protocol to the CRPD, which allows individual complaints to the Committee once domestic remedies have been exhausted. While the CRPD may not be directly enforceable by the UK courts the way the ECHR is, we nonetheless cannot assume that non-compliance will go unnoticed.

## 1.7 Concluding comments

This book views mental health law both as a subject in its own right, and as a case study. In the former context, it provides an opportunity for law students to exercise their skills in statutory interpretation and case analysis, but it requires more. Mental health law and policy is by its very definition an interdisciplinary study. It is not an area where law should be considered independently, divorced from the realities of clinical practice or life for the client in the community. It requires the student to consider how various actors work together, and which interests take precedence over others. Thus empirical research and sociological approaches will often be as enlightening as pure legal analysis.

Mental health law as case study instead requires the student to consider the nature of law. As we have seen, mental health law spans the curriculum. In this, it is typical of other types of law—a secret often kept from students, who seem determined to view law in discrete and unrelated subject packages—and the skills acquired by the student in thinking across these legal areas should be expected to assist him or her in any sort of law they eventually practise. If critical theory and sociology may be required to make sense of what mental health law is about, so mental health law provides a way for the undergraduate student to approach these subjects, and once again, these approaches will prove valuable in other contexts. No law operates divorced from the real needs of clients and the pressures of social policy. Mental health law creates a suitable study of how these interact, and an understanding of this can certainly be applied by students to other areas of law.

In closing, this chapter returns to its beginning: silence. It will be clear that in our view, the silence must be broken. This is, in a sense, a lawyer's conceit, for law glorifies the representation of the individual client: in our professional ideology, based in rights theory and liberalism, the model of the lawyer defending the interests and acting on the instructions of the individual client is pivotal. Yet this is not merely conceit. The more offensive conceit would be to treat mental health law as a set of academic constructs, and ignore the people contained within the system. These are real people with real problems. This is true of everyone in the system, but is perhaps most true of the people with mental health difficulties or developmental disabilities; yet it is their voices that remain largely outside the hearing of judges and policymakers.

If this book argues for the necessity to break down the silence described by Foucault, it should also challenge the reader to question the discourse that has resulted from that silence. If policy has developed through silencing the mad, if it is, as Foucault claims, a discourse of reason about unreason, it then tells us as much or more about the reasonable as the mad. For reason to articulate insanity, it must do it with reference to sanity, for that is the only way the border can be understood. In this way, mental health law and policy can be seen as a mirror, in which we see our own values reflected. For Foucault, this language of reason bears no particularly enhanced status. It is instead 'that other form of madness, by which men, in an act of sovereign reason, confine their neighbors, and communicate and recognize each other through the merciless language of non-madness' (Foucault, 1965: ix). Yet if reason is madness, it is nonetheless our madness, and thus something we should strive to acknowledge and understand.

In the first chapter of *Madness and Civilization*, Foucault uses the imagery of the ship of fools, the *stultifera navis*, as the paradigm of a Renaissance view of madness. Foucault seems to have believed that these ships actually existed, a view which has attracted criticisms from historians (e.g., Midelfort, 1980). He also draws a symbolic meaning from this image: 'It is possible that these ships of fools, which haunted the imagination of the entire early Renaissance, were pilgrimage boats, highly symbolic cargoes of madmen in search of their reason' (Foucault, 1965: 9). This is, in a sense, as appropriately a metaphor for Foucault's view of the result of the enlightenment: the journey of 'that other form of madness' in search of its reason. It is also the project of this book.