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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 that 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 of 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, because mental health law, like psychiatry, is also a language ‘of reason about madness’. The two languages, law and psychiatry, sometimes speak symbiotically and sometimes in uneasy juxtaposition in the pages that 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 that would seem *ex hypothesi* to be lacking order, to be irrational.

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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, and appropriate? How can we impose reason, rationality, onto the irrational? Does the process of definition not imply a logical structure in madness, a structure that 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 their client groups, 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 authors that the purpose of a text such as this is not to present solutions, but instead to articulate problems for discussion and investigation. The first three chapters concern broad issues of interest, such as the general structure of mental health services, including (in Chapter 2) the definitions of mental illness and mental disorder. Chapters 4 and 5 concern civil confinement, and Chapter 6, criminal confinement. Chapter 7 concerns treatment for mental disorder, Chapter 8, the law and procedure surrounding mental health review tribunals, and Chapter 9, community care. Chapters 10 and 11 concern the law of civil capacity, and Chapter 12 contains an overall discussion of the efficacy of legal remedies for those with psychiatric difficulties, and an introduction to advocacy for this particular client group.

1.2 Who are the insane?

Issues of psychiatric and legal definition will be reserved for Chapter 2, but it is appropriate at the outset at least to start the discussion of who the insane are. 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, 1996: 47–81; see also Thornicroft, 2006: ch. 6). These may no doubt be in part a function of the economics of publishing – scaremongering sells

newspapers – but the Glasgow Group further makes a persuasive case that these representations have an effect 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 have been steadily falling since the 1970s: Taylor and Gunn, 1999.

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 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 US 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 of 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, at 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 in terms condescendingly of ‘them’, but rather, somewhat more humbly, of ‘us’. The frequency suggested by the statistic 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

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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 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 six' may well have little in common with a six-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). 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, because 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 re-enforcement 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, in part, 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 presupposes 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

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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 (2002: 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 10 and 11. Second, 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.

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 the Mental Health Act (MHA) 1983. The intricacies of this part of the decision will be discussed in Chapter 7. The instant point is instead that the centrality of the disorder to the individual is a factor that raises ethical issues regarding intervention; it does not necessarily determine whether intervention is ethically justified. A number of positions may be potentially adopted here. 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 frequently justified, on the basis that, after the intervention, many people are grateful. This 'thank you theory' will be examined in more detail in Chapter 4, in the context of civil confinement. 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.

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, medicine will often have a role to play, and this is acknowledged by most, but not all, people affected by mental disorder. Those in the subject group, however, will

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often understand their experience in a multifaceted 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 this ambivalence (1996: 52) 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 (1995: xiv, xv) describes the medicalisation of his condition, in his own eyes as much as those of the doctors, more expressly in terms of alienation, reflecting the Foucaultian 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 describes her experience of antidepressant medication (2002: 72–3) 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 advisers, 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 Chapter 11). Further, government discussion surrounding proposals to reform the Mental Health Act 1983 would suggest that non-compliance with medical advice is not to be tolerated. Thus, at the press conference establishing the expert panel to consider reform, 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.’ (Department of Health, 1999a: AC, para. 11). In the White Paper published 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, 2000c: para. 2.11) Patients are to be as free as is possible, it would seem, as long as they do what they are told.

This position 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 and Fanthorpe? Can the enforcement into 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?

A broader view of the nature of mental disorder is consistent with public perceptions of insanity. The British studies uniformly indicate that the public perceives behaviour

typical of mental disorders as caused by a wide range of factors. Social and environmental factors are identified as causes more frequently than physiological or moral factors (see analysis contained in Glasgow Media Group, 1996: 5–8). Nor is this multifaceted view the preserve of the laity. While medical professionals hotly dispute the relative significance of various factors, few would now question the relevance of social and environmental factors to the occurrence of mental disorder. There is a risk that this view may fuel a different stereotype, that the mentally ill individual is really a malingerer, who should simply buck up and get on with their life. It is difficult to see this view accurately describing many of the people affected with mental illness. At the same time, the public perception of mental illness as more than just medical gives additional credence to the broader views of those affected. In short, everyone else agrees: mental disorder is not just a medical matter, suggesting that this view, when held by people directly affected, should not be dismissed lightly.

Students new to mental health law sometimes perceive mental illness as something that 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, at best controllable, 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 bad times. While it is inappropriate for the student of mental health law to ignore the realities of the life imposed by the reality of the mental condition, it would be equally inappropriate to romanticise the mental disorder in a way that obliterates the remainder of the life of the individual.

1.3 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 above 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. 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 professional issues will be noted further in Chapters 5 and 7.

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; the result is nonetheless the privileging of a set of assumptions, or of a specific way of looking at things. It is this process that 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 above 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.

These day-to-day pragmatic issues have become increasingly important in recent years. The policy drive in the last twenty years has been towards economic efficiency in services provided by the state. The result has been a service stretched beyond reasonable limits. Deahl and Turner describe general psychiatric wards, particularly in London, where bed occupancy rates are routinely in excess of 120 per cent capacity, where virtually all admissions are emergencies (1997: 6). Government moves to introduce supervised discharge and supervision registers in the mid-1990s for those released from psychiatric facilities (see Chapters 3 and 9) are a further pressure to hold hospital and other medical personnel responsible when things go wrong following discharge, with no extra resources. The results were perhaps predictable: there was a crisis of morale in much of the mental health services. Deahl and Turner claimed that the burnout period for a psychiatric nurse on an adult general psychiatric ward is seven months, and cite a study that 88 per cent of consultant psychiatrists wished to leave the profession (1997: 6). The picture is of a set of professionals, overworked and disillusioned, unable to provide the sort of service that they think it appropriate to give, and which would match their professional ideals and ideology.

How are we to approach this in a social policy or a legal context? Should we abandon our vision of a health service able to provide the continuing framework of care required by those suffering from chronic conditions, such as many mental illnesses? Should we design policy on the basis that service will be minimalist, able to intervene only in crisis situations, targeting care at those in most need while leaving those with less pressing problems to their own devices? How should law approach these situations? In the law of negligence, for example, should doctors be given an increased margin of appreciation for their errors, on the basis of working conditions that are far from ideal? Or should the courts continue to insist on standards of professional practice that the public may feel it has a right to expect, but which professionals themselves feel they are no longer able to provide?

Not all of 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 US evidence to suggest that the role of families is pivotal to relapse (Dixon *et al.*, 1995; 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, whether 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, because such carers provide important services, in conditions that may be very difficult. Some public support is available for these activities (see Carers (Recognition and Services) Act 1995) and there have been some recent moves to increase public funding 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 that, 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 service provider and those of the mentally ill person are difficult to disentangle, suggesting difficulties with formal control of these individuals 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,

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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 that creates the appeal of their greater involvement; 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 one quarter of the prescriptions dispensed by the NHS are to affect the central nervous system, to alter moods, states of mind or behaviour (Lacey, 1996: xiii). 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 antipsychotic 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 7; 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 psychogeriatric 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 about 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 £175m of £3,000m in charitable revenues in 1976, or roughly six per cent; by 1984, this had grown to £1bn of charitable revenue of £10bn, 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, their 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 increasingly on government, 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, of course, 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 cooperation. 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 rests at the local authority level, where policymaking rests primarily with central government. The same is true of healthcare 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.

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 Court of Protection, which handles the property and affairs of those found incapable of so doing themselves under Part VII of the MHA 1983, is a part of the Lord Chancellor's Department. Psychiatric treatment in hospital is, of course, a matter for the Department of Health. 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 re-enforces that mental health policy may be as much a function of competitive negotiation between government departments as it is of cooperation.

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 of the parties noted above. 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 entirely the relevance of a medical model to insanity. 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 above 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 that influence policy formation.

1.4 Sources of law

1.4.1 The roots of the Mental Health Act

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 1983, 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. Four nineteenth-century streams, and one additional one from the early twentieth century, warrant particular note, because they combine in somewhat amended form to comprise the MHA 1983.

One set of legislation governed private madhouses. The Madhouses Act of 1774 required private madhouses to be licensed by the College of Physicians if in London, or otherwise by the local magistracy. In 1828, this legislation was replaced by a new Madhouses Act. While amended repeatedly over the course of the century, this Act set the structure for these establishments for much of the nineteenth century. The College of Physicians lost its formal role. Up to 1845, madhouses outside London were inspected and licensed by the Justices of the Peace. In London, these inspection and licensing functions were conducted by a new body, the Metropolitan Commissioners in Lunacy. With an amending statute of 1845, the Metropolitan Commissioners were renamed the Commissioners in Lunacy, with jurisdiction to inspect madhouses throughout the country, although their licensing authority remained restricted to 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.

The Madhouse Acts covered only private madhouses and charitable hospitals. While these may occasionally have been quite extensive in size, they were not the vast public

asylums of popular memory, which were instead governed by a series of County Asylum Acts. The first of these was passed in 1808. This Act allowed asylums for the relief of the insane poor to be built on the county rates. The facilities were overseen by a committee of Justices of the Peace until 1888, when they were passed to local authority control: Local Government Act 1888, ss. 3(vi), 86, 111. 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. The frequent rewritings of, and amendments to, the County Asylum Acts in the nineteenth century did little to change this structure, although legislation in 1845 made county asylum provision mandatory for the first time.

The nineteenth century also saw a string of statutes relating to clarifying, modernising, and rationalising the procedures relating to the Royal Prerogative powers. These powers allowed control over the person or property and affairs of an individual to be taken over, once incapacity to make relevant decisions had been shown (see Chapters 10 and 11). This power thus related to decision-making authority, not institutional confinement. Technically, the Royal Prerogative vested authority over lunatics and idiots in the monarch, who by tradition granted the power to make determinations of lunacy and idiocy to the Lord Chancellor at the beginning of each reign. By the beginning of the century, the Lord Chancellor in turn delegated the inquisition into the lunacy of an individual to three Commissioners. This panel of three was reduced to a panel of one in 1833. Where originally the Commissioners had been judges, they became, in 1842, barristers of at least ten years' standing. In 1862, the Commissioners lost the authority to try lunacy and idiocy matters where a jury was requested. That was removed to the common law courts, where the Commissioners continued to try lunacy or idiocy when no jury was requested. This gives a flavour of the nineteenth-century statutes relating to Chancery jurisdiction.

Finally, the nineteenth century saw a stream of statutes devoted to the detention of criminal lunatics. The initial statute was forced by *Hadfield's Case* (1800) 27 Howell's St Tr 1281, where it was held (at p. 1354) that notwithstanding a successful plea of insanity in defence of an attempted murder, the prisoner 'for his own sake, and for the sake of society at large, must not be discharged'. Legislative authority was provided for such detentions later that year. For the next half-century, criminal lunatics were included in county asylum legislation, but the construction of Broadmoor Asylum, opened in 1863, was reflected legislatively by a new stream of statutes devoted to criminal lunacy specifically, commencing 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, which 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, nearly 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 National Health Service 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 or 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 *et al.*, 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 régime.

The MHA 1959 once again placed mental disorder and developmental disorder in the same statute, an approach continued under the MHA 1983, currently in force. The result has been a mixed blessing. On the one hand, legislation combining the responses to be available in appropriate circumstances, irrespective of whether an individual suffers from mental illness or developmental disability, increases the flexibility of responses in a way that must be to the benefit of both groups. At the same time, 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 developmental disabilities, which, in discussions related to the current Act, are overshadowed by issues of mental health and illness. This is reflected in the title of the Act: why should people with developmental 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 1983 as a whole, much of the discussion does show an inappropriate assumption that the prime users of the legislation are mentally ill, not developmentally disabled.

The MHA 1983, still currently in force, albeit as amended, kept the basic provisions of the 1959 Act. The new Act was passed in a climate where patient rights were treated more seriously than ever before. There were some changes in nomenclature: ‘mental welfare officers’ became ‘approved social workers’, and ‘mental subnormality’ and ‘severe mental subnormality’ became ‘mental impairment’ and ‘severe mental impairment’ respectively, for example. Some more substantive changes were also made at this time, however. 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 might reside (but not require him or her to be returned there, if, for example, he or she were wandering), and where they might attend 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 Mental Capacity Act 2005 (MCA 2005): see Chapter 11. In the interim, the courts expanded common law on an ad hoc basis to fill the apparent gap.

Most of the changes since 1983 have occurred in the realm of a forest of policies, guidance, and directives from the Department of Health. These have been legion, 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 care plans for patients – 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 extralegal 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 1983 Act already made the provision of aftercare in the community mandatory for people who were released from civil confinement in psychiatric facilities (s. 117). The 1995 amendments allowed service providers in the community to be appointed, who would ensure that the patient live in a specific place, attend a specific place for treatment (although there is no power to require that the person consent to the treatment), and could require access to the individual by other service providers (s. 25A–25J; see further, Chapter 9). The particular relevance of these provisions in an historical context is the blurring of control between the institution and the community and, perhaps more significantly, the debate surrounding the introduction of these provisions turned from a language of rights, the predominant discourse in the 1983 debates, to a language of risks. That latter language has proven central to the government's thinking regarding mental health reform in the last few years.

What are we to make of this long and somewhat tortuous history? 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 Act, the structure is otherwise reminiscent of the strands of nineteenth-century law identified above: Parts II and VI on admission to facilities, including removal of patients to the various parts of the UK; Part III on criminal confinement; Part VII on management of property and affairs. On a more minute level, the continuities are similarly notable. The current role of the approved social worker (ASW) looks remarkably similar to that of the poor law relieving officer, 150 years ago.

At the same time, the context of the Act 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. Take, for example, the provisions defining the right of the nearest relative to insist on the release of a patient, contained in s. 23(2). This originates 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 own 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 the inclusion of the role, but they are *ex post facto*.

These 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 Act; 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'; is this 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. A Code of Practice, most recently revised in 1999, has been issued to assist those charged with the Act's administration (Department of Health and Welsh Office, 1999). In a sense, this only complicates matters further, because the Code contains material supplementary to the legal standards of the Act. While the Code is not legally binding on practitioners, it is identified as something the Secretary of State is obliged to produce by s. 118 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.

1.4.2 Potential reform

Reform of mental health law and mental capacity law has long been in the air. The project to reform the mental capacity legislation started with a project of the Law Commission in the late 1980s (see Law Commission, 1995). The eventual result was the

MCA 2005, currently expected to take effect in April 2007, almost two decades after the reform process commenced (re revised timetable, see preface to this volume). This statutory reform affects people lacking capacity, that is, people who are unable by reason of mental disability to make decisions (see Chapters 10 and 11). As such, it affects some, but not all, people with psychiatric problems: there is nothing legally inconsistent between having a mental illness or developmental disability and being able to make decisions. Indeed, people with mental illness, like other adults, are presumed able to make decisions unless the contrary is shown: *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819. The 2005 Act is not intended to affect the compulsion powers under mental health legislation, although it will be relevant for people without decision-making capacity in the psychiatric system but outside the formal powers of compulsion (see Chapter 11).

From 1998, reform of the MHA 1983 has also been on the legislative agenda. This has not yet borne fruit, although the latest bill has been expected imminently for some time. The purpose of the current discussion is not to chronicle the detail of the proposed reforms; their detailed content will be discussed as it arises elsewhere in this book. Instead, the purpose here is to provide a general guide to their development, range and general content: an overview so that the references to the various reform packages will be comprehensible as they arise in the rest of the book.

Reform of the Mental Health Act grew from two unrelated directions. On one side, the 1997 Labour Party election manifesto had contained a pledge to include Community Treatment Orders. Some legislative reform was therefore going to be necessary, and in part because of the impending implementation of the Human Rights Act 1998, which allowed the provisions of the European Convention on Human Rights to be raised in domestic courts, the government decided a full review of mental health law was appropriate. An expert committee was established, chaired by Professor Geneva Richardson, in October 1998. Over the course of the following year, that committee consulted broadly, before submitting its report to the Department of Health in the summer of 1999 (Department of Health, 1999a).

The Richardson Committee proposed fundamental amendments to the administration of mental health law, based on a set of general principles that would be incorporated into the Act. These were generally the broadly accepted principles of mental health law of the last decades: the desirability of patient autonomy; a preference of informal care over compulsory measures; a preference for the least restrictive manner and environment for treatment; a preference for care reflecting the preferences of the user; the participation of users in all aspects of their treatment and care, in so far as their capacity allows; reciprocity (i.e., that mandatory orders create a corresponding duty to provide a high standard of service); no discrimination, but context-sensitive services based on background, age, gender, sexual orientation, ethnic group, and social, cultural or religious background; respect for carers; the importance of communication and the provision of information to users.

The Committee proposed increased flexibility in the mandatory orders that could be made, including increased powers of coercion in the community. While these powers

stopped short of enforced treatment in the community, they would, if the order so specified, allow the confinement of the individual in hospital in the event of non-compliance with treatment. Due process safeguards were included, however: the process would begin with a mandatory assessment period of up to seven days; in that period, with narrow exceptions, only emergency treatment could be administered involuntarily. An application to a tribunal would be necessary within the seven days, for a mandatory order to issue that would allow involuntary treatment. This initial mandatory order would last for up to 28 days; further orders, for which tribunal sanction would be mandatory, would last up to six months.

The Richardson Committee also proposed changing the substantive criteria for the imposition of mandatory powers, according a considerably increased role for the capacity of the patient. The Committee stopped short of saying that people with capacity could never have their decisions overridden, as is the case in other branches of health law, but the views of the competent patient were accorded considerably more emphasis.

The Committee's report, along with a Ministry of Health Green Paper on mental health reform (Department of Health, 1999c), was published in November 1999.

The second influence on the Mental Health Act reforms flowed from the Fallon Committee, appointed in 1998 following concerns about mismanagement and abuse at Ashworth Special Hospital. Its report to the Department of Health and the Home Office, published in 1999 (Department of Health, 1999b), was not restricted to that institution, but included a broader discussion of the law relating to criminals with personality disorder. As will be discussed further in Chapter 2, persons with personality disorders are controversial in legal regulation of mental health, because they are often untreatable. Such untreatable 'psychopaths' (to use the language of the existing legislation) cannot be confined under the 1983 Act. The Committee was concerned that appropriate services ought to be available to members of this group who were treatable, but it was also concerned to ensure that criminals with personality disorders who might still pose considerable danger to the community would not be released at the end of a fixed sentence. The committee proposed that a reviewable sentence be introduced for individuals who remained dangerous.

The Department of Health and the Home Office largely accepted the Fallon Committee's recommendations, and, in the summer of 1999, published a Green Paper exploring the possibility of either strengthening the existing criminal law to make greater use of discretionary life sentences, or creating a new legal framework to allow the confinement of dangerous persons with personality disorders indefinitely, whether or not they were treatable, and whether or not they had come into contact previously with the criminal justice system. Effectively, this would create a parallel system to the Mental Health Act for those with dangerous and serious personality disorder. Unsurprisingly, these proposals were highly controversial. Civil libertarians objected to the unlimited detention of those who had not committed any offence; mental health professionals objected to the detention of those whom they could not treat.

It is at this point that the two streams of mental health law reform were combined: the Department of Health issued one White Paper on mental health reform in December 2000, flowing from its two Green Papers the previous year, and a draft bill in June 2002 (Department of Health, 2000c; 2002d). Perhaps unsurprisingly, given the concern of the Fallon Committee regarding criminals with personality disorder, much of the due-process protections and concerns about general principles, non-discrimination, respect and capacity had disappeared. Instead, much of the language of dangerousness contained in the post-Fallon discussion had entered the picture, along with requirements that persons thought to pose a threat to the public should be treatable, which would be met if their symptoms could be managed.

The White Paper and draft bill 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, particularly the initial tribunal review at the seven-day period proposed by Richardson. The overall direction of change can be illustrated by reference to the guiding principles contained in the bill. As noted above, 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; 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, a subsequent subclause 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.

That said, some of the objections are not entirely convincing. Certainly, the language of risk in the debate was prominent; it was, indeed, contained in the guiding principles quoted. At the same time, it was already justifiable to confine an individual whose mental disorder makes this necessary 'for the protection of others' (MHA 1983, ss. 2, 3). Certainly, the requirement that persons with personality disorders and mental impairment be treatable if they are to be confined was to disappear, but there was no meaningful requirement under the existing legislation that persons with other forms of mental illness should have an effective cure. Why should personality disorder be treated differently from schizophrenia? Certainly, the move to a dangerousness standard risks the over-representation of black people in our psychiatric facilities, but the current system stands equally accused of this problem: see Chapter 4.

A subsequent draft bill introduced in 2004 (Department of Health, 2004a) was not well received for similar reasons. This bill was subjected to a highly critical report by a Joint Scrutiny Committee of the House of Commons and House of Lords (House of

Commons and House of Lords, 2005). The government initially defended its focus on safety to the public and to users themselves, stating that it was only users, and medical and social care professionals who seemed concerned by this focus (Department of Health, 2005a: 4). Nonetheless, faced with the opposition of the key players, it decided the following year not to proceed with the bill, and instead to introduce amendments to the MHA 1983.

As a bill has not yet been forthcoming, although a variety of policy statements have articulated the government's general direction, the changes will be modest. Some amendments will be made to the definition of 'mental disorder'. The different standards of 'treatability' required for compulsory admission will be made consistent. Supervised community treatment will be given statutory form. Additional flexibility will be introduced regarding appointment and replacement of 'nearest relatives'. Application for compulsory admission will no longer be managed exclusively by social workers, but by a broader category of 'approved mental health professionals', and in appropriate circumstances, the person in charge of a patient's care will be able to be someone other than a doctor. Some changes are to be made to processes before Mental Health Review Tribunals, to make them proceed more expeditiously. As required by the European Court of Human Rights, some additional protections will be offered for people who are admitted to hospital informally, but who lack the capacity to consent to that admission ('*Bournemouth*' patients).

This is a disappointing outcome to a process of reform lasting eight years so far. It is difficult to see that such limited reform will provide long-term legislative stability. Mental health issues have been arising with increasing frequency before the European Court of Human Rights (see Bartlett *et al.*, 2006). As will be seen in the pages that follow, mental health issues are showing up routinely in Human Rights Act litigation. Success in this litigation has been mixed, but it is difficult to see that these challenges will go away, particularly when the 1983 Act is not designed with these human rights issues in mind. Human rights is also a moving target: as human rights develop in domestic and international discourse, evidenced, for example, by new international conventions, the standard of scrutiny under the ECHR is likely to rise. The 1983 Act was passed prior to the significant movements in disability rights of recent years, and already looks antiquated. It is likely to appear increasingly out of step with human rights standards as time passes. It seems inevitable, therefore, that the proposed government amendments will not be the last word.

1.4.3 Other law and mental disorder

The MHA 1983 may provide the core of the law for this text, but it will be clear from the preceding discussion that it cannot stand on its own. The MCA 2005 will also be relevant, and in the silence of the statutes, common law will continue to apply. In addition, 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, because it allows a reassessment of those disciplines from a new and different angle to 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 1983 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 1983 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. When people lack capacity, the MCA 2005 will apply in these situations, creating mechanisms governing decision-making on behalf of people lacking capacity. In this sense, it is really a guardianship statute.

Capacity is, of course, not merely about guardianship; it is a threshold whenever people enter into legal relations. The MCA 2005 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 below, requiring some consideration of the broader laws in these areas.

Even regarding mental disorder as distinct from incapacity, the Mental Health Act 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 the problems of maintaining jobs and finding places to live (Thorncroft, 2006: ch. 3 and *passim*). The first 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 Disability Discrimination Act 1995 and subsequent amendments to that statute. This may be particularly helpful, because 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), 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 Human Rights Act 1998 came into effect in October 2000. It allows the provisions of the European Convention on Human Rights to be pleaded in the domestic courts of the UK for the first time. The convention provides an array of classically liberal rights:

- right to life (Article 2);
- prohibition of torture and inhuman or degrading treatment or punishment (3);
- prohibition of slavery and forced labour (4);
- right to liberty and security of person (5);
- right to a fair trial regarding civil rights or criminal charges (6);
- no conviction or punishment for a criminal offence without prior law prohibition (7);
- right to respect for private and family life (8);
- freedom of thought, conscience and religion (9);
- freedom of expression (10);
- freedom of assembly and association (11);
- right to marry (12).

Its introduction in 2000 was an oddity in historical terms, because the Convention itself was drafted in the late 1940s, eventually coming into effect in 1953. It therefore contains the presuppositions about rights current at that time, when the rights of persons with disabilities were not on the political agenda. This different attitude is easily illustrated by reference to the wording of Article 5, the Article protecting citizens from wrongful confinement and deprivation of liberty:

5.1 Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

* * *

e. the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants

The teaming of ‘persons of unsound mind’, itself a term from a previous age, with alcoholics, drug addicts, and vagrants bespeaks a very different rights culture than that prevailing at the beginning of the new millennium. There can be little doubt that the rights of people with mental disabilities were not in the minds of those ratifying the original text, more than half a century ago, and the early, formative jurisprudence of the Convention was formulated without reference to the needs of people with mental health problems. One might reasonably ask how far we can really look to the introduction of this antiquated language into English law as a way forward for mental health law.

The view from Europe is mixed (see Bartlett *et al.*, 2006). Over the last quarter-century, consistent with the shift in attention towards a rights-based model for those with mental disabilities, the European Court of Human Rights has become involved in reinterpreting and developing its jurisprudence to take account of cases relating to those with

mental health problems. This began, in 1979, with the case of *Winterwerp v The Netherlands* (1979–80) 2 EHRR 387, which laid down core standards that Member States must apply, if they are to rely on Article 5.1(e). This case has proven extremely important in establishing fundamental standards in the mental health area. The experience since that time has been mixed. The Court has been strong on ensuring appropriate due process protections, but weak on substantive issues. As perhaps an extreme example, in *Johnson v UK* (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). At the same time, the court has been strong on ensuring appropriate procedural safeguards for those in facilities. Thus the court has held that detention will only be justified on the basis of objective medical evidence. It has provided general statements as to the substantive standards of that evidence, but little guidance specific enough to be useful to policymakers in determining what substantive threshold that evidence must meet (see Bartlett *et al.*, 2006: 42–9). Similarly, the court has established requirements regarding access to a judicial-style procedure to challenge detention, and the availability of hearings before such tribunals at reasonable intervals. It is thus clear that the aspiring mental health lawyer will need to have a good grasp of ECtHR jurisprudence in the future.

Movement on the substantive side of mental health issues has been much more the province of the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The Committee has taken the view that people who are institutionalised are particularly vulnerable to abuse, and therefore form a particularly important part of its mandate. It routinely visits not only prisons, but also psychiatric hospitals, social care homes, and similar institutions, to ensure that appropriate standards are met. Its 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 paragraph 28 per Simon Brown LJ, regarding the rights of persons with capacity to make treatment decisions.

The experience so far in the British courts is mixed. Thus far there have been a number of procedural successes. The burden of proof before review tribunals is now clearly on the doctor justifying confinement, rather than on the patient applying for release: *R v MHRT North and East London Region, ex p H* [2001] 3 WLR 512, [2002] QB 1. Scheduling of review tribunal hearings must now be done more promptly: *B v MHRT and Secretary of State for the Home Department* [2002, QB Admin]; *R (IH) v Home Secretary, Health Secretary* [2003] UKHL 59. New procedures are available for courts to determine whether rights have been violated: *R (Wilkinson) v Broadmoor Hospital*. Substantive issues have fared less well. Thus the House of Lords has held that the Human Rights Act imposes no requirement that a person’s illness be treatable for that person to be confined: *A (A Mental Patient) v Scottish Ministers* 2002 SC (PC) 63, [2002]

HRLR 6, affirmed *Hutchison Reid v the UK* (2003) 37 EHRR 9. Where specific aftercare is a condition of a tribunal's release order for a patient, the Human Rights Act creates no obligation on a health authority to provide the treatment, beyond making reasonable efforts: *R v Camden and Islington HA, ex p K* [2001] 3 WLR 553, affirmed *Kolanis v UK* (2006) 42 EHRR 12. Challenges to surveillance practices of forensic psychiatric facilities have been generally unsuccessful: *R v Ashworth Special Hospital and Secretary of State for Health, ex p N* [2001] EWHC Admin 339; *R v Ashworth Hospital, ex p Munjaz* [2005] UKHL 58.

The more interesting question is perhaps whether the Human Rights Act is effecting a cultural change on the judiciary: are they now perceiving issues relating to those with mental health difficulties as human rights questions, rather than mere questions of administrative law? This is a difficult question, because judges do not act with one mindset. There are some indications, however, that judges are approaching matters differently. *R (Wilkinson) v Broadmoor and MHA Second Opinion Approved Doctor* [2002] 1 WLR 419 (CA), for example, held that where fundamental rights under the Convention, including legality of psychiatric treatment, were in doubt, the court should not base its decision on the reasonableness of the defendant doctor's view, but should instead decide between expert opinions, making findings of fact as required. Witnesses should be called and cross-examined as necessary. That is a marked departure from standard judicial review procedure, which is generally conducted on the basis of written evidence only.

Also indicative is the re-litigation of the question of whether a patient can be immediately re-sectioned, following release by a review tribunal. Recent litigation under the Human Rights Act has applied increasingly clear rules as to when this can happen: see *R v East London and City MH NHS Trust and Snazell, ex p Count Franz von Brandenburg* [2003] EWHL 58. This case is effectively a rehearing of the issue in *R v South Western Hospital Managers and Another, ex p M* [1994] 1 All ER 161, yet the court in the more recent case markedly restricted the grounds on which re-application should be made. It is not obvious that there is a direct influence of the Human Rights Act – the recent cases could equally have been decided on the grounds of abuse of process, as the earlier one had been. The question is whether the culture of perceiving the issues had changed, from one of deference to medical professionalism to one acknowledging to a greater degree the rights of the patient in question. Similarly, the case of *R v Feggetter and MHAC, ex p John* [2002] EWCA 554 concerned the duty of doctors providing second opinions prior to compulsory treatment of patients to provide reasons. The decision was based on traditional common law principles, but the language of the reasons harkened instead to the human rights discourse contained in *Wilkinson*, above.

How far this cultural shift will move remains to be seen. It is, as yet, early days in the Human Rights Act jurisprudence. There is a final wild card in the equation: under the Human Rights Act, our judges must take into account the ECtHR jurisprudence, but they are not formally bound by it. This may mean a retreat from some of its principles, but it may also mean development in new ways. A variety of other commonwealth jurisdictions have established traditions and jurisprudence of human rights, which may

apply more or less forcefully to the English situation, and which may or may not convince English judges. It remains to be seen whether or how these other influences will influence our jurisprudence.

1.5 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 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, because 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: it is their voices that remain largely outside the hearing of 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, because this 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). 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 *stultifara navis*, as the paradigm of a Renaissance view of madness. Foucault seems to have believed that these ships actually existed, a view that has attracted criticisms from historians (e.g. Midelfort, 1980). Foucault also draws a symbolic meaning from this image (1965: 9): '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.' This is, in a sense, an appropriate 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.