



**An Examination of the Mental Health Act in the UK: How
to Avoid Human Rights Abuses by Re-conceptualising the
Mental Health Services**

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TABLE OF CONTENTS

I.	Introduction	3
II.	Conceptual Framework	5
	a. Consent-Intervention	5
	b. Foucault, Szasz, and Moncrieff	8
III.	Empirical Analysis	12
	a. Mental Health Act 1983	12
	i. Non-absolute rights	12
	ii. Right to tribunals	15
	b. Mental Health Act 2007- Amended Version	17
	i. CTOs and Human Rights Act	17
	c. The report of the Independent Review of the Mental Health Act (2018)	21
IV.	Need for Re-conceptualising the Mental Health Service	24
	a. The validity problem: Rosenhan experiment	24
	b. Searching for a humanistic model	25
	i. Open Dialogue	26
	ii. Soteria Project	28
V.	Conclusion	31
VI.	Bibliography	34

I. Introduction

Based on research and surveys involving over eight thousand people who use mental health services in the UK, the results show that the Mental Health Act (MHA) does not prevent human rights abuses where many people still feel like they have not been treated with dignity and respect throughout their detention (Mind, 2017). Moreover, the absence of efficient treatment and services causes more people to be exposed to psychiatric treatments in psychiatric institutions which are associated with massive human rights violations such as degrading treatment and terrible living conditions in hospitals. Although the problems in the MHA 1983, which made a provision for compulsory involuntary detention and treatment in hospital, created a need to revise and modernise the document, the amended version in 2007 did not solve the problems at all. In fact, the use of the MHA to detain people has increased every year since 2007, especially the detention of people from black and minority ethnic background (Full Fact, 2017). Between 2005/06 and 2015/16, the number of detentions increased by 40 %, from 45,484 to 63,622 (Care Quality Commission, 2018). As a result, in 2017, Prime Minister Theresa May requested an independent review of the MHA to address the problems of rising detentions, racial inequality and concerns about dignity and human rights (Department of Health and Social Care, 2018). However, if any review is done by psychiatrists, unless by a critical one such as Joanna Moncrieff, it is more likely that it remains in biomedical model and causes more human rights abuses. As the United Nations Special Rapporteur on the right to health, Dainius Pūras said: “There is of unequivocal of the failures of a system that relies too heavily on the biomedical model of mental health services, including the front-line and excessive use of psychotropic medicines, and yet these models persist” (OHCHR, 2017).

The purpose of this research is to address the human rights violations on mental health issues and investigate what kind of rights individuals have against psychiatric interventions,

such as involuntary hospitalisation or detention conditions and bad treatments in the hospitals. I will specifically focus on the human right abuses in the UK; examining the MHA (1983), the amended version of the Act (2007), the report of the Independent Review of the MHA (2018) in the light of several documents such as the Human Rights Act (1998), and the European Convention of Human Rights (2005).

This is going to be a library-based research and the first part of it is going to be a critical analysis of the current concepts and framework encompassing “mental health area”, most particularly focusing on the human right violations due to labelling various consequences of unpleasant life experiences as “mental disorders” or “illnesses”, inevitably causing these suffering individuals to be exposed to “biomedical model”. Elaborating on the arguments and theories from different scholars and philosophers like Michel Foucault, Thomas Szasz, and Joanna Moncrieff, this research underscores the need to re-conceptualise the psychological helping practices and to create radical changes to stop human rights abuses.

The second part of the research is going to be an empirical analysis; examining what kind of power the institutions have in terms of detaining and medicating people, what rights existing law documents do offer and how sufficient these documents are. Finally, the last section of this research will provide solid examples of sound and effective helping practices, such as Soteria Project and Open Dialogue, which in effect show the direction of a transition from a “biomedical model” to a “psycho-social” and “rights-based” model. This dissertation aims to argue that as “mental illness label” and “biomedical model” are being used, any revisions of the Mental Health Law within this framework will be less likely to eradicate the human rights abuses.

II. Conceptual Framework

a. Consent-Intervention

The practices in mental health are formed by the dominant psychiatric approach which frames psychological problems as symptoms of serious mental illnesses, caused by biochemical imbalance in the individuals' brain that can only be "cured" by psychiatric treatments, including hospitalisation and medicating people with various mind-altering drugs, mostly by "antipsychotics". Vasak's (1977) first and second generations of rights can show how this psychiatric framework in mental health field causes severe human rights violations. "First generation" rights are often referred as "negative" rights which restrict coercive state intervention, inhumane treatment and arbitrary arrest, and promote right to life, freedom of speech, equality before law etc. Therefore, psychiatric treatment, intervention and coercion without consent (medicating or hospitalisation without consent) violate the Universal Declaration of Human Rights (UDHR) (1948) as the Art. 3 of UDHR states; "no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment." The consequences of medical treatment without the patient's consent would be considered as inhuman or degrading in many cases (Campbell, 2017). Similarly, Art. 5 of the European Convention of Human Rights (ECHR) (1950) emphasises the importance of right to liberty and security.

On the other hand, the first part of the Art. 5.1 of the ECHR (1950) indicates all the exceptional situations where people can be deprived of their physical liberty, and Art. 5.1 (e) reads that a person's liberty can be lawfully curtailed such as detaining an individual in an open ward of a mental hospital: "the lawful detention of persons for the prevention of the spreading infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants." Besides, as far as the detention of individuals of "unsound mind", there is no need for any proof of an established mental disorder at the first phase of the detention since the

concern that the person could hurt himself or others would be seen sufficient (Campbell, 2017). Therefore, these exceptions on the law documents give permission to authorities to use the MHA to lock someone to hospital and treat them against their wishes.

“Second generation” rights are often referred to as “positive” rights which require governments to provide economic, social and health support to its citizens (Vasak, 1977). The lack of efficient treatment in mental health area and inadequate welfare support in times of crisis result in violating the individuals’ rights. As stated in Art. 25 of the UDHR (1948): “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

In the discussion of liberty and safety as first generation rights, one of the main arguments to support and justify the psychiatric practices is the question of whether we can get consent from people who are not able to make decisions themselves. This question does not only justify the degrading treatments of individuals in hospitals but also give power to governments to put people into hospitals easily. Different from the basic definition of self-determination which is mostly related to the collective rights, some scholars define individual self-determination as the right to decision-making, the right to information, the right of consent, the right to reject treatment, and the right to be heard (Välimäki, Leino-Kilpi and Helenius, 1996). The Mental Capacity Act 2005 (MCA) in the UK concerns the treatment of individuals when they seem to lack the mental capacity to make decisions themselves. Although, individuals are often thought to have the mental capacity to decide for themselves and cannot be treated without their consent, Section 3 (1) of the MCA (2005) suggests that if a person with “mental impairment” cannot understand, retain, use and weigh, or communicate a decision, then that person does not have the mental capacity and therefore

loses their legal capacity (Buchanan, 2004). The treatment of that person would be decided by a third party in his/her “best interest” (Section 4, MCA 2005). However, when we examine the Convention on the Rights of Persons with Disabilities (CRPD) (2007) which the UK signed up to it in 2009, the article 14 (1) (b) of the CRPD says: “The existence of a disability shall in no case justify a deprivation of liberty.” This article refers directly to the legal systems which allow for the forced treatment and assessment in the mental health field. Although the UK ratified the CRPD, unlike the ECHR, the rights that are in the CRPD have not been converted into enforceable rights in the UK (Office for Disability Issues, 2011). One of the reasons is that some people prefer to justify their actions by claiming that the risk “mental health patients” pose is high and therefore depriving them of liberty is totally acceptable (Glover-Thomas, 2018). This statement begs the question: Why don’t we apply this to all the other individuals who can also be seen as “risky” in society and why is this only applied to individuals with “mental health problems”?

Since the concept of legal capacity is a tool for people to exercise their moral agency, the loss of legal capacity can be very harmful for any individual. Therefore, some argue (e.g., Buchanan, 2004) that mental capacity should not be a factor when determine a type of treatment because any approach to define people as legally incompetent has severe detrimental consequences on individuals and the care they get. However, in the UK, mental capacity seems to have a primacy which affects the cases that reach the courts and therefore influences the decisions in many cases (Buchanan, 2004). This results in a dilemma: If a person lacks the mental capacity and can't decide for themselves, what kind of practices are available other than forced psychiatric treatments so that even when individuals lack the mental capacity, the helping practices that they seek do not violate human rights? Thus, thinking beyond the psychiatric framework to solve this problem and come up with efficient

solutions, it is worth focusing on Foucault, Szasz and Moncrieff's anti-psychiatry discussions.

b. Foucault, Szasz, and Moncrieff

Although Foucault's and Szasz's work both embrace a critical approach to mental health practices and some of the concepts that are embedded in the mental health area, their approaches differ from each other. While Foucault (2001) focuses more on the historical context and investigates how power produces "regimes of truth"; practices and discourses that determine what we accept as true or false, Szasz (1974) questions the concept of "madness" and invites us to think about the limits to what it is legitimate to label as "illness."

Despite the fact that both scholars handle the topic in different ways, some of their ideas converge. For Szasz (1974), physical problems with our body functions can be defined as pathology or illnesses, but individuals' difficulties with their thoughts, feelings, behaviours and relationships cannot be categorised as mental disorders or pathologies; they should be simply defined as "moral" issues or "problems in living." He frames the physicochemical derangement of the body as the literal meaning of disease or illness, and the disability and psychological suffering of the person as the metaphorical meaning of disease or illness. This discourse of physical vs. mental health can be also seen in Foucault's "Madness and Civilization" (2001) where he argues that for a long time in Middle Age Europe, so called "madness" was understood differently; people with psychological problems were just thought to be different. However, following the decline of a physical illness "leprosy" which is an infectious disease that causes serious skin sores, those with psychological problems started to be detained with the label of "mentally ill." Therefore, individuals with psychological problems started to be seen as carriers of disease and similar to how the individuals with leprosy were marginalized and stigmatized, people started to associate the term "madness" with being a social outcast.

In his book “The Myth of Mental Illness”, Szasz (1974) further elaborates how the category of physical illnesses was extended to include all the psychological problems people were dealing with. He argues that until the middle of nineteenth century, illness was defined as a bodily disorder and identified by a physical change in the structure of a person’s body such as visible deformity, lesion, wound, cancer, heart failure, tuberculosis or a dysfunction of an organ. However, with the rise of modern psychiatry after the nineteenth century, there was a new creation of what constituted disease: to the category of change in body structure was now added the category of change in bodily function. The former was detected by observing the individual’s body and the latter by observing the individual’s behaviour. Thus, unlike how new diseases are discovered in modern medicine, Szasz claims that in modern psychiatry, they are invented. This becomes clearer when people tolerate uncertainty poorly and claim that any misbehaviour that seem socially deviant should be classified as sickness; anything from addiction, delinquency, depression to homosexuality, homicide and suicide become psychiatric illnesses that have to be “cured” in psychiatric institutions (Szasz, 1974). This fact can be especially seen in Foucault’s “History of Sexuality” (1990) which points out the problem of medicalisation of sexuality and turning homosexuality into an illness or an abnormality as a result of the discourse of power and increase of surveillance. Turning “deviances” from social norms and/or psychological problems into diseases does not only disregard the social, political, and cultural context in which these bearings and/or problems occur, but also marginalises and ostracises the individuals. Both scholars emphasise the importance of discourse and claim that any behaviour that seems not “normal” in a society may be classified in numerous ways as an alternative to call them sicknesses, or they may be even left unclassified.

This brings us to the critical discussion by Foucault (2011) where he describes how some certain ideas, practices and a certain understanding of the world came to be accepted as

true and common sense. Through his observations of the prisons and mental health hospitals, he came up with the concept of “disciplinary power”, that is, the use of power is exercised not necessarily through using physical force, but through using practices to discipline and control the bodies and behaviours. He further argues that individuals’ struggles with their relationships, problems with their beliefs, behaviours or sexualities are perceived as not religious, moral or psychological issues, but as technical problems that are open to analysis, intervention, examination and classification by the power authorities. Thus, a Foucauldian analysis connects social exclusion of the “mad”, psychiatric practices and mental health hospitals to the operation of power/knowledge and the development of modern culture and economy in shaping how we live as governed and ordered. Foucault (2011) especially focuses on how the birth of asylums and using hospitals to deal with the people who have psychological problems made psychiatry develop as a “science”. It was the concept of hospitalisation which gave rise to treatments being tested in a controlled environment and some empirical evidence being collected.

Both scholars (Szasz, 2007; Foucault, 2001), criticise the role of the states which control the body and mind. Szasz describes the state as evil which limits the individual’s liberty and independence. He claims that, “undeniably, the state is primarily an apparatus of coercion with a monopoly of the legitimate use of violence” (Szasz 2007, p.151). In his conceptual framework, his binary distinctions become critical: By separating biology from social science, autonomous psychotherapy from psychiatry, freedom from coercion, individual from state, and bodily illness from psychological problems, he tries to draw a clear line between these terminologies and practices, and shows that it is very unlikely that these two opposite terms can exist together.

The emphasis on the role of state intervention can also be seen in Moncrieff’s (2009) work who is a psychiatrist criticising the modern psychopharmacological model of mental

disorder and drug treatment. She argues that Mental Health legislation cannot be used just to lock someone whose behaviour seems different, violent or dangerous so that the states can justify their coercive action of hospitalisation on the basis of giving people good “treatments” that will be beneficial to them by mitigating their so called “illnesses.” Thus, involuntary hospitalisation is presented as something as serving the best interest of the individuals. Also, Moncrieff (2009) argues that the use of the concept of diagnosis, which is a medical term to cover both the process of defining and identifying the disease, implies that these psychological problems are caused by a bodily dysfunction, like chemical imbalances in the brain or biological abnormality. Therefore, a psychiatric diagnosis paves the way for approaching psychological problems within the medical framework which can be seen as one of the various ways of how psychiatry enhanced its medical use from the 1970s onwards.

Moncrieff (2009) claims that in contrast to medical conditions like tuberculosis, heart disease or diabetes, there is still no concrete proof that these psychiatric conditions are the result of dysfunction in the body, physical abnormalities or neurological impairment. She underlines how the real evidence of these psychiatric drugs’ serious damages like brain shrinkage and diabetes, and increase in suicidal risk has been ignored and suppressed while the evidence of their benefits has been exaggerated and over-stated.

Harrow et al. (2017) give support to Moncrieff’s arguments about the effectiveness of psychiatric drugs. In this longitudinal research study, they assess the long-term effectiveness of antipsychotic medications on the individuals diagnosed with schizophrenia. Following individuals over 20 years, the results yield that the ones who were never on antipsychotics do much better than the ones who continuously took antipsychotics. At the 20 year assessments, 73% of the patients not on psychotics were working half-time or more, while only 25% of the patients taking antipsychotics were (Harrow et al., 2017). This outcome raises critical

questions about the long-term effects of antipsychotic medication on individuals diagnosed as schizophrenic.

Above all, Moncrieff (2009) argues that the despair that is caused mostly by poverty, unemployment, social problems, discrimination, social isolation or difficult relationships cannot be solved by the forced psychiatric treatments, and national governments and local communities should be the ones who address the underlying causes of these problems and inform people that these are not illnesses but the outcomes of the social, cultural and economic struggles.

III. Empirical Evidence

a. The Mental Health Act 1983

i. Non-Absolute Rights

“If you have somebody who needs to be detained because they are a risk to others, but they are found to have capacity to refuse treatment, what are you going to do? You can’t release them because of the risk, but we don’t have the beds to keep them in hospital forever”, says Nicole who is a social worker and Approved Mental Health Professional (Mental Health Today, 2017).

This quotation points to several problems about the mental health situation in the UK. On the issue of consent and coercion, the UK mental health system faces a dilemma between a rights-based orientation and a public/risk-based agenda. However, more importantly, being sectioned and detained in hospital seems to be the only option available since there are fewer alternatives to detention. Many people who end up being detained under the MHA (1983), which is the law in England and Wales that determines the rules when people can be treated in hospital against their will, face challenges to get sufficient help they need. For example, under the MCA (2005), individuals’ decisions about their treatment are legally binding whereas for individuals who are sectioned under the MHA (1983), these decisions do not

have any legal weight. The recent statistics display that only half are admitted voluntarily while nearly 50,000 individuals are detained against their will (Triggle, 2018). One issue that causes more people to be detained is the increased reliance on the Section 2 of the MHA 1983 which legally permits the imperative admission of an individual for the aim of assessing their mental condition and determining whether a section 3 application, mostly known as “treatment order”, would be appropriate for the next level treatment. Although Section 2 should only be used for a short duration according to the Article 2 (4); “A patient admitted to hospital in pursuance of an application for admission for assessment may be detained for a period not exceeding 28 days beginning with the day on which he is admitted”, the data indicates that Section 2 has been used beyond these restrictions (Glover-Thomas, 2018).

Another particular issue about the detention under Section 2 of the MHA 1983 is the use of the “nearest relative” mechanism under which the MHA determines who should be consulted on a person’s treatment. In situations where a person has a pretty damaging relationship with their parents or abusive spouse who is perceived as the nearest relative by the MHA, serious problems occur. Therefore, some critics argue that nearest relative system should be changed with a system where individuals are allowed to specify the person close to them regarding the decisions about their care (Spencer-Lane, 2014).

Considering the ongoing injustices, there have been significant discussions about what rights these individuals have while they are being detained in a mental hospital. Although Section 2 (assessment) and Section 3 (treatment) of the MHA 1983 seem to offer more rights to the individuals than the other parts of the document, they still lack the most important rights such as liberty and dignity. Under Section 2 Article 63, the staff can give a treatment to a person even if they refuse it; “The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering (not being a form of treatment to which section 57, 58 or 58A above applies) if the treatment is

given by or under the direction of the (approved clinician in charge of the treatment).” The situation is similar under Section 3 where individuals can be treated against their will for 3 months. After 3 months, staff can only treat people without their consent if there is an approval of a “second opinion approved doctor”. Section 58A specifically says that, except in an emergency, electroconvulsive therapy (ECT) cannot be given without either the capable consent of the patient, or, in the absence of such consent, the authorisation of a Second Opinion Appointed Doctor (SOAD). Nevertheless, this article still causes many problems although consent is needed to give ECT. First of all, the rights are not absolute for everyone since in emergency cases, no consent is required. Secondly, even if the individuals give their consent to ETC, many research studies prove that ETC poses severe documented risks such as permanent cognitive impairment, permanent memory loss, head trauma or injury, impaired judgement and emotional instability (Mind, 2019). Therefore, in any case, Article 63 and 58A violate person’s dignity, liberty and cause severe human rights violations.

As seen in the treatment section, under both Section 2 (assessment) and Section 3 (treatment), individuals hold certain rights with limits, but these rights become invalid under the different sections of the MHA. Individuals lose their rights if they are under an emergency section (Section 4), under holding powers of the MHA (Section 5) or in a place of safety under police powers (Section 135 and 136). These exceptions beg the question of how much power these authorities possess to make the final decision about the individuals’ conditions. As we look at the Section 5 (2) and 5 (4) of the MHA which allow a doctor or a nurse to prevent individuals from leaving hospital, even if they stay in the hospital voluntarily, it becomes clear that the rights offered in the MHA 1983 are not absolute and can be used against individuals any time doctors find appropriate. Moreover, the police in England and Wales hold powers under Section 136 of the MHA 1983 to take a person to a safe place when the person is found to be risky to either himself/herself or to others so that

they can be examined by a doctor. Although there is an assumption that the MHA is used as a last resort, the rise in the use of Section 136 by the police indicates that MHA is used more arbitrarily (O'Brien et al., 2017).

Rose (1998) argues that one of the reasons why the rights are not absolute in the MHA 1983 is the language of “pervasive risk” which determines the nature, the length and the extent of a person’s engagement with the mental health services. However, several scholars argue that what constitutes as a risk is left to the decision-makers only which make it hard to trust the reliability, validity and professionalism of these risk assessments (Glover-Thomas, 2018). This becomes clearer as the data shows that ethnic minorities and people of colour are more likely to be seen as dangerous, especially by the excessive police response, and they are perceived to possess more risk to society (Grey et al., 2013). For instance, although people of African Caribbean origin in the UK have lower rates of “mental illnesses” than other ethnic groups, they are diagnosed with severe mental illnesses more (Grey et al., 2013). Fernando (2003) claims that the MHA 1983 operates within a Eurocentric model which influences the way the ethnic minorities and people of colour are diagnosed. Fernando (2003) also emphasises the importance of how our perception of illness and their causes vary by culture and how culture impacts the way people seek health care. Therefore, during risk assessments, he reveals the danger of health professionals’ imposing their own worldviews and values on the individuals within the Eurocentric paradigm and biomedical model which cause more discrimination, prejudice, and “race-based” explanations of some of the socio-economic problems that individuals deal with.

ii. Right to Tribunals

Under Section 2, 3 and 37 of the MHA 1983, individuals can be discharged by several people, including their responsible clinician, the hospital managers, their nearest relative and the tribunal. However, their responsible clinicians can stop individuals’ nearest relatives if

they think that a person is still a danger to themselves or others (Rethink Mental Illness, 2016). The second option is to ask the hospital managers for discharge which includes a long process of managers' reading through the clinicians' report, hearing the individual's experiences and giving a final decision about whether a person should stay under the MHA. Although these options seem the most convenient and easiest way to discharge someone from detention, the responsible clinicians and hospital staff who give the first decision to detain an individual hold powers to stop someone from discharge.

If none of those solutions work, individuals' human rights still seem to be protected by the Mental Health Review Tribunal appeal system which involves a review of the detention by a panel consisting of a judge, an independent doctor and a lay member. Nevertheless, the success of these tribunals is open to discussion where the data from 2017 shows that out of 96 people's appealing, only four patients were discharged by the tribunal (Gosney, 2017). Regarding race and ethnicity issue during the detention process of individuals, the most critical problem about these tribunals is that they are not concerned with assessing whether the clinicians' initial decision to detain a person under the MHA 1983 is right or wrong. Instead, the tribunals focus more on the assessment of the individual's condition on the day of the hearing to determine whether continued detention is necessary and justified (Gosney, 2017). Although the tribunals still offer a sufficient system of hearing process, ignoring the initial evaluation, risk assessment and context of the initial entry makes the process not just enough.

In addition, the rise in tribunal, the hearings create important practical challenges; for Section 2 review applications of the MHA 1983, hearings must be formed within 7 days of application, and undertaken within 14 days of the date of admission. However, the individuals were found to experience delays which cause more stress and anxiety (Glover-Thomas, 2018) and which breaches the Article 5 (4) of the ECHR (1950): "Everyone who is

deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.” In order to end this human rights violation, the tribunals have made an effort to hear the cases quickly which presents another problem: The short timeframe to review the cases and enormous workload influence the decision-making process which degrades the quality and the depth of the reports that the courts investigate. Additionally, the court still relies on the clinical team to assess the person’s current mental state, but for many cases, writing a report about an individual for whom the team knows little causes more problems (Glover-Thomas, 2018).

b. The Mental Health Act 2007-Amended Version

Considering the rise in the human right violations, contrary to expectations after the introduction of the MHA 1983, there was a need to discuss what could have been done to prevent the human rights abuses. However, the 2007 Act amended the MHA 1983, rather than replacing it or changing it. Amending something that is already loaded with flaws did not only create more complications, but also did very little to prevent human rights abuses repeating themselves. The most significant consequence of the failure of the 2007 Act is the rise in the number of detention of individuals since 2007 (Care Quality Commission, 2018).

i. CTOs and Human Rights Act

Although there were not so many changes in the 2007 MHA amended version, there were some new elements added aiming to reduce the detention rate such as Supervised Treatment (SCT), and Community Treatment Orders (CTOs). Inurement of CTOs is one of the most controversial reforms in the MHA since CTOs give a legal permit to mental health professionals to enforce compulsory supervision on individuals after they are discharged from an involuntary hospitalisation. Considering Human Rights Act (HRA) (1998), the requirements in CTOs such as compulsory medication in the community or living in a

specified place, or being faced with the possibility of readmission to hospital, the use of CTOs violate certain human rights and restrict individuals' personal liberty as they extend psychiatric coercion into the community. Although supporters of CTOs claim that these services are necessary to prevent repeated admissions or relapse, and maintain stability, the studies by University of Oxford and other research centres in the UK, and Norway show that CTOs neither shorten the length of time individuals' stay in hospitals nor do they reduce the severity of the problems people deal with (NHS, 2013).

The HRA 1998 becomes significant in the discussion of CTOs since they enact most of the ECHR into the UK law which means that courts and mental health tribunals have to deal with the HRA consistently. When we look at the compatibility between the HRA and MHA, some problems occur regarding Article 3, 5, and 8. As Article 3 of the HRA (1998) addresses the degrading and humiliating treatment, could the enforcement of CTOs be considered degrading treatment? The main problem with the amended Act 2007 is that the definition of medical treatment is very vague and wide, so any form of treatment can be acceptable to a certain extent. Considering dignity as a significant component of the definition of degrading, the law says that any physical force diminishes human dignity. Besides physical force, if the treatment humiliates an individual and creates feelings of fear, anguish or inferiority, it may also be categorised as degrading (*Pretty v. UK*, 2002). Although serious physical force is unlikely to happen under the conditions of CTOs, CTOs might still affect the individuals' sense of dignity and autonomy negatively in several ways, such as forcing them to take medications which usually have very serious adverse effects, imposing conditions about where they can live, what they can and can't do, and where they can go. These usually cause the public to stigmatise the individuals on CTOs, causing them to feel more anxious and anguish and therefore, often leading to degrading treatment and violating the Article 3 of the HRA (*Khurmi and Curtice*, 2010). However, not having a clear definition

of what count as degrading treatment becomes problematic since these violations are usually justified by the authorities.

Similar to the vagueness of the Article 3 where there are a lot of disagreements about the definition of degrading treatment and which help authorities to escape from criticisms about the CTOs, the Article 5 of the HRA also causes some complexities when it comes to individuals' security and liberty. Some argue that it is not easy to determine whether restriction of movement would mean deprivation of liberty. The scale of severity of restriction is what matters and therefore, some case laws such as *HL v. UK* (2004), *JE v. DE & Ors* (2006), *Guzzardi v. Italy* (1980), *Storck v. Germany* (2005) suggest that deprivation of liberty should be decided on a case-by-case basis. The imprecise definition of deprivation of liberty results in accepting that CTOs do not necessarily lead to a person's deprivation of liberty and in some occasions, they might be considered acceptable.

Finally, the Article 8 of the HRA prohibits authorities from interfering with individuals' right to private life, their family and home. Interferences with Article 8 can only be justified if they are in accordance with the law and if they are necessary in a democratic society. Given that the power to put individuals on CTOs is found in the MHA amended version 2007, it is usually considered that CTOs are in accordance with the law. To be "necessary in a democratic society", CTOs must only be used when the national security or public safety are under threat or when it is essential to prevent crimes or to protect the health and rights of individuals (Kinderman and Tai, 2008). However, the question of whether the CTOs achieve their aim leads scholars to discuss the findings of important research studies about the CTOs which show that there is no evidence of individuals benefiting from current CTOs. The Oxford Community Treatment Order Evaluation Trial by Burns and Molodynski (2014) published their research study results where they found that individuals released from hospital under the CTOs were just as likely to be readmitted to hospital as those released

under “Section 17 leave” of the MHA. That is the permission to leave the hospital approved by the doctors in charge of the specific individual, all with the provision of an approved accommodation and length of stay. Another follow up study by Burns et al. (2015) focused on the long term effect of CTOs on readmission rates over 12 months in a randomised trial and proved that the group with the CTOs experience had significantly more readmissions than the group without. These findings create doubt over the usefulness of CTOs; if they are not effective tools for protecting the rights, health and safety of the individuals or if they do not reduce the amount of time individuals stay in the hospital, then can the interference with individuals’ private lives be justified?

Another important question arises when it comes to consent and treatment: Although the individuals with capacity under CTOs cannot be given treatment without their consent, can these individuals fully consent if they only take the medication because of the fear of being forced to return to the hospital? For example, Conroys Solicitors LLP (2017) based in Cornwall claimed that their clients clearly object to their treatment but “consent” to it because they do not want to be faced with the risk of going back to the hospital. In fact, the Mental Health Act Code of Practice (2015) guides professionals how to carry out their responsibilities to make sure that all individuals receive good care. It states (14.17) that the “threat of detention must not be used to coerce a patient to consent to... treatment.”

Considering all the arguments above, CTOs can’t be justified by using the risk and public safety arguments. Moreover, one improvement in the 2007 MHA Act is that it gives individuals the right to be supported by an advocate called Independent Mental Health Advocate (IMHA), but with limitations. Individuals only can get help from IMHAs if they are detained in hospital under the MHA, if they are under a CTO, or if want to seek information about the electroconvulsive treatment. However, if they are taken to a place of safety under the MHA or if they are kept in hospital under emergency “holding powers”, they

can't get any help. In fact, if a person is an informal "patient" (not detained), there is no support for him/her to learn what rights are available and during the sectioning process, there is no advocacy that individuals benefit from. All these limitations and problems about the MHA 2007 amended version led the UK government to set up a Review Committee in 2018 to investigate how the MHA practices can be improved, understand the reasons for rising rates of detention under the Act and the discrimination against the black and minority ethnic groups, and make recommendations about how to move forward.

c. The report of the Independent Review of the Mental Health Act (2018)

Due to the severity of the problems in the MHA, the report by Simon Wessely et al. (2018), Wessely being the former president of the Royal College of Psychiatrists, seems a significant step towards investigating the concerning issues in the current law. However, although there are some useful recommendations, the report is written from within the profession of psychiatry which impedes professionals to go beyond the biomedical framework and to see the injustices created as a result of psychiatric practices. For example, the report (2018) approaches the doctrines of "diagnosis", "pathology" and "symptoms" as objective facts rather than socially and culturally constructed labels that are formed in Western institutions. At the foreword section, the report clearly shows where it stands by accepting the MHA as a must for societies. The report gives place to a quote by the British sociologist Nikolas Rose (2019) to make it clear that the MHA is not something to change or abolish but something to amend and make it better: "Sometimes compulsory admission to a place of safety for a short period of respite care, even where conditions are far from ideal, together with the short term, even involuntary, administration of some sedative medication, can be a way of returning an individual in such a state of extreme distress to a condition where they can make thoughtful decisions about their own lives." (p.175). Therefore, while the report accepts that the MHA takes away individuals' liberty and gives them treatment that

they don't want, it claims that the Act helps restore health. There are several problems regarding this statement: First, retaining the MHA with compulsive powers is only the justification for the powers the state authorises and uses in the mental health field (Fernando, 2018). Second, by making those psychiatric interventions less invasive and restrictive is not enough when the interventions themselves cause the main problem.

Furthermore, regarding the most controversial issue of the MHA which is the institutional racism and the increase in the detention of ethnic minorities/people of colour, the recommendations in the report do very little to address those problems and even fail to dig into institutional racism. For example, the foreword of the report (2018) goes on to say: "So we have to accept the painful reality of the impact of that combination of unconscious bias, structural and institutional racism... I recognise that no one is completely free from biases, and all of us can have feet of clay." (p.10). Although the report's (2018) main recommendation aims to mitigate the problem of racism and discrimination, it does not offer any solution for the problems before detention where the most injustices occur. The recommendation goes for a new systematic approach to improving the mental health services such as Organisational Competence Framework (OCF), and Patient and Carer Experience Tool to support cultural change to be embedded into mental health delivery system, responding to essential needs of the ethnic minorities and people of colour. Other recommendations include cultural changes in advocacy, letting individuals to follow religious and spiritual practices while in hospital, representation of people of Caribbean and African heritage in mental health professions. Given the tribunals' role on hearing appeals and evaluating the treatment, the report (2018) does not address the diversity and cultural issues occurring during the tribunal process. It also does not mention anything about how to reduce the detention rate at the first place for the vulnerable population. All the recommendations attempt to make changes during the detention when so many people are already detained

wrongly, as these recommendations are not really helpful in addressing the main problems in the system.

In terms of the Review Committee's (2018) approach to human rights, they claim to meet human rights obligations, but they also indicate that meeting those obligations is not their priority. "We believe the Review's recommendations meet those demands. However, we would have made the recommendations that we have, even if they were not necessary to meet those obligations." (p.60). In fact, they even say that they do not share all the goals of the CRPD because of what the Committee on the Rights of Persons with Disabilities (CRPD/C/GBR/CO/1) recommended in October 2017: "(...) repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment" (para. 35). The Review Committee clearly states that they don't agree with doing fundamental changes to the MHA which would mean that it is no longer possible to treat someone against their will, or to detain someone who is "risky" to themselves or others. This statement shows that even though the Modernising Act 2018 claims to be the most progressive one and to improve the current system, the Committee can't think beyond the state coercion, detention or compulsory treatment, and whatever changes are made, these are made within their biomedical perspective where state coercion is seen inevitable.

The failure of the revised document becomes even clearer in the discussion of ECT and the CTOs. Although the coercive nature of ECT is well known and accepted (Citizens Commission on Human Rights International, 2018), the Review Committee does nothing to abolish the use of ECT. Instead, they suggest: "Expressions of wishes around ECT could be overruled only by the authorisation of a judge of the Court of Protection on strict criteria." (p.22). Then again, given people's experience of CTOs and their opinions, the racial discrimination that occurs during the use of CTOs, and the research evidence that they are not

effective (Mind, 2019), the Review Committee rejects to repeal them, and rather, recommends further research about the effectiveness of CTOs and an evaluation after five years (p.28).

IV. Need for Re-conceptualising the Mental Health Service

After analysing three important documents; the MHA 1983, the amended version 2007 and lastly the Modernising Act 2018, it seems quite clear that modifying a legal document which is already problematic in nature does not help for any betterment. This dissertation argues for the need to re-conceptualise the current mental health service by embracing the psycho-social models when making changes in the system, instead of being stuck in the biomedical model, psychiatric practices and state coercion.

a. The validity problem: Rosenhan experiment

To understand the problems existing in the current system, it is worth reviewing the Rosenhan experiment briefly which is designed by a psychologist, David Rosenhan of Stanford University, and discuss how the experiment showed that the professionals in the psychiatric hospitals cannot really distinguish the “sane” from “insane”. Rosenhan and seven other individuals check in to various psychiatric hospitals from 1969-1972 to test whether the psychiatrists could distinguish the fake from the real “mentally ill.” The participants created false names and professions and they made up the story that they had been hearing strange voices and murmuring words like “empty” and “hollow” (Rosenhan, 1973). After the appointments, every single participant who was faking to be insane was admitted to the hospital although none of these participants really believed that they would be admitted so easily, and all except one were diagnosed as “schizophrenic.” Even though the participants exhibited no new symptoms and claimed that they were not hearing the strange voices anymore, the doctors kept believing that their diagnoses were extant and correct (Rosenhan, 1973). Sadly enough, hospital staff treated the participants coldly, mostly being disinterested

or being abusive occasionally. Even when the participants tried to express that they were feeling good and when they tried to talk to staff in a friendly manner, the staff was not really responsive. In brief, Rosenhan experiment illustrated that there was a great willingness to diagnose a “healthy” person as “sick” since the doctors made their diagnosis without any clear existing and manifesting symptoms other than their expressions of hearing voices and admitted those individuals to the hospitals very easily (Thirunavukarasu, 2011).

What Rosenhan experiment tells about the current mental health system is significant since Rosenhan (1973) noted that the experience of hospitalisation made the participants feel depersonalised and powerless where they were deprived of human rights such as freedom of movement and privacy. Furthermore, the experiment showed that psychiatric labels cause the professionals to interpret every action of individuals in the hospital in accordance with the diagnostic label shackling themselves against helping the individuals truly.

b. Searching for a humanistic model

The mental health system has been trying to incorporate human right values for a long time which gained its main importance with the publication of the World Health Organisation’s (WHO) guidelines in 1996. In fact, in the decades before 1990, the WHO created two research studies to compare the results for people who are diagnosed with schizophrenia in three developing countries (Nigeria, Columbia, and India) with the results in the US and five other developed countries (Jablensky et al., 2009). In each study, the findings were striking; outcomes for people in the developing countries were much better, and the reason of the difference was that the individuals in the developing countries used antipsychotic medications only for short periods, whereas those in developed countries used them longer term (Jablensky et al., 2009). Also, the statistics yield that a century ago, fewer than two people per 1000 were considered to be “mentally ill” and in need of being put into a hospital. By 1955, that number has risen to 3.38 people per 1000 and with the increase in the

use of psychiatric drugs during the 50 past years, the diagnosis of “mentally ill” reached around 20 people per 1.000 (Whitaker, 2005). The research studies illustrate that although psychiatric drugs may suppress the symptoms over a short period of time, in the long run, they increase the possibility that an individual become chronically “ill”, and “ill” with new and more serious symptoms as a result of side effects of drugs (Whitaker, 2005).

In the latest report, the UN Special Rapporteur for the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health introduced the principle of “human rights first” (p.1) which specifically emphasises that any intervention must align with and strengthen human rights (OHCHR, 2017). This does not only include serious human rights violations such as discrimination, lack of individual autonomy, lack of freedom of arbitrary detainment, restraint, medication without consent, but also more subtle violations that may cause exclusion, stigmatisation, depersonalisation, and disempowering of individuals (Peter et al., 2019). This dissertation searches for alternative programs within the psycho-social framework in place of hospitalisation and medical treatment which would certainly lessen and possibly abolish the human rights violations in the mental health field.

i. Open Dialogue

Open Dialogue which was originated in Finland by Jakko Seikkula (2011) involves a consistent family/social network approach to care and emphasises the importance of carrying out the “treatment” through meetings with the individual, his/her family members and extended social network. Although the Open Dialogue approach, which is mainly a social work practice, largely differs from the mental health care in the UK, the idea has been discussed for several years by some NHS Trusts since it is believed that this approach has a lot of potential to reduce the human rights abuses (NHS Trust Foundation, 2019). In both the UDHR (1948) and the CRPD (2007), three important principles become prominent: self-determination, autonomy, and giving the affected individuals a voice. These are all at the

centre of the Open Dialogue approach. The self-determination and autonomy aspect is accomplished by the dialogic practices which largely turn to meaning-making of individuals and an understanding of life-related problems (Seikkula, 2011). Unlike the current mental health system where creating diagnoses or clinical classifications surpass the individuals' own opinions and experiences, in Open Dialogue approach, the individuals' own language and accounts of their experiences are prioritized through the network meetings (Peter et al., 2019). Given the nature of Open Dialogue which is non-institutional and non-medicalising, it becomes easier to give individuals a chance to explore and explain themselves, and determine for their own lives. Such an approach resonates well with human rights for several reasons:

Firstly, the Article 3 of the CRPD (2007) focuses on the importance of individual autonomy and independence, freedom to make choices and individuals' involvement in the decision-making process, especially those directly affecting them. Moreover, the Article 1 of the UDHR (1948) emphasises human dignity and value of individuals by saying: "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience..." Unlike the current mental health approach which objectifies people by attributing a diagnostic label and removing their autonomy, in Open Dialogue approach, individuals are appreciated as full human beings, capable of meaning-making and understanding with the support of their social network and the professionals (Razzaque and Stockmann, 2016).

Secondly, Preamble (e) of the CRPD (2007) puts importance on the environmental factors when explaining the cause of disabilities: "Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others" Thus, both the Open Dialogue approach and the CRPD focus more on the life conditions and individuals' experiences, and claim that anyone can be

affected at any time depending on their life experiences and conditions, in opposition to the biomedical perspective that categorises every problem as a disease and identifies disease as an inherent trait of an individual. This biomedical approach does not only create social distance, exclusion and alienation but also forms power dynamics between professionals and the individuals since professionals claim agency over those individuals and stigmatise them with labelling (Stockmann, 2015).

Lastly, both CRPD (2007) and UDHR (1948) recognize the significance of inclusionary approach and freedom of expression. The Open Dialogue's social network perspective attempts to bring inclusive elements to the problem solving process which goes parallel with the CRPD and UDHR objectives: "Everyone has the right to full and effective participation and inclusion in society" (CRPD, Art 3), "services must be accessible to all" (CRPD, Art 9), "everybody has the right to receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice" (CRPD, Art 21), and "everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference..." (UDHR, Article 19). Thus, open and non-coercive ways of communication in network meetings of Open Dialogue allow individuals express themselves freely and fully, and prevents any coercive or compulsory action that are seen in the MHA 1983. Above all, the evidence manifests that after five years of Open Dialogue experience in Lapland between 1992 and 1997, 81% of participants had no remaining "psychotic symptoms" and also 81% went back to full employment (Stockmann, 2015).

ii. The Soteria Project

In search for a rights-based approach to mental health practices, the Soteria Project exemplifies a community service for individuals experiencing distress or crisis, and offers a drug-free environment and preserves the individual's personal power. Originally, the Soteria

Project was designed by a critical psychiatrist Loren Mosher to compare the Soteria methods with the psychiatric hospital treatment for people who are “diagnosed” as “schizophrenic”, and the results of the study illustrated that 85-90% of individuals can be returned to the community without the general psychiatric hospital intervention and antipsychotic drug use (Mosher, 1999). The project started when Loren Mosher’s experiences as a hospital intern made him feel helpless after seeing dying patients on the psychiatric ward and witness the limitations of medical treatments: “Because I hadn’t found a large role for drugs in the helping process, I was led to believe more in interpersonal than neuroleptic cures. I did worry about what went on in the 164 hours a week when my patients were not with me- was the rest of their world trying to understand and relate meaningfully to them?” (Mosher, 1999).

Although there were some attempts to provide a more humane, a community-based and a therapeutic mental health service after the 2007 amendments in MHA where the use of CTOs was introduced, the CTOs did not achieve its purposes for several reasons: Firstly, unlike the CTOs, the core practice of the Soteria House is to develop a non-controlling but empathetic relationship with the individuals. In other words, “being with” the individuals throughout the whole process by living and learning together in a community within the house (Mosher, Hendrix and Fort, 2004). However, right from the beginning, the CTOs have been the replicate of the hospitals as a new version of hospitalisation in the community where forced medication was in the centre of intervention. Secondly, there is a great difference between “being with” and “doing to”; while Soteria House offers a shared experience and building meaningful relationships similar to Open Dialogue to understand the individual’s social background and experiences in a non-coercive way, the CTOs in continuing hospitalisation effect restricted individual’s autonomy and liberty.

One of the most crucial aspects of the Soteria Project is that the whole process prioritizes the human dignity and self-respect (Soteria Network, 2011). Human dignity is

usually defined as “an individual or group’s sense of self-respect and self-worth, physical and psychological integrity and empowerment” (Duhaime, 2000), a feeling that every human being should be allowed to experience. In mental health practices, while treating people with respect and avoiding labelling people are crucial in realising human dignity, person-centred care and putting individual’s needs, preferences and experiences at the centre of care also becomes critical (Faulkner, 2010). The Soteria Project makes it clear that there can be no predefined therapy methods, preset opinions or definitions about what psychosis is, and no universal diagnosis or “universal recipe and cookbook” to cover every individual’s experiences (Mosher, 1999). Thus, the experience in Soteria House is not about “treating” psychosis. Instead, it is about seeing the individual in the middle of a changed experience who is supported and accompanied by other people around, and most importantly, it is about acknowledging each individual’s experiences being different from one another where special care and attention are required. The project elicited additional benefits for individuals who participated in it; since they were less likely to be treated with psychiatric drugs (usually very minimal or none), they were not exposed to any side effects, drug dependence or withdrawal effects. Unfortunately, despite these positive results, the Soteria House did not last for long because of lack of funding and little incentive to continue by the authorities. Indeed, Soteria’s minimal or no use of psychiatric drugs was seen as a threat to the traditional biochemical model running with pharmaceutical companies where there are huge profits (Soteria Network, 2011).

There are several ways how Soteria House can support human rights values. The power balance in the Soteria makes it possible for individuals to make their own choices about staying at the House, taking drugs and withdrawal from any care they receive. In fact, the environment in Soteria House becomes more therapeutic when it is used alongside Advance Decisions which takes place in MCA 2005; documents that individuals draw upon

in advance about how they would like to be treated if, any point in the future, they lack the mental capacity (Soteria Network, 2011). However, Advance Decisions documents are not legally binding in the MHA 1983 which allows forced and coercive treatment in the psychiatric wards. Although the Soteria Network was formed in 2004 in Bradford to promote the Soteria tradition in the UK, there is still no established program that provides services in the UK. Therefore, it is significant for the UK law to make more progress on introducing the Soteria House or similar practical implications gradually as an alternative to current mental health system.

V. Conclusion

This research has presented a critical analysis of the mental health system in the UK, by examining three important documents, and illustrated that modifying the legal documents to clear away the flaws in the system, simply doesn't work if the modifications are done within the biomedical framework. The potential harm to individuals admitted to hospitals, i.e., dependency, institutionalisation and state coercion, restriction of freedom and movement, degrading treatment, separation of individuals from friends and family, loss of employment, stigmatisation and adverse effects of heavy psychiatric drugs, have been discussed and acknowledged by many (e.g. Whitaker, 2005; Double, 2006), including people within the system (e.g. Moncrieff, 2009, 2013). However, psychiatric practices and hospitalisation have been legitimised and justified by the state and professionals in the mental health area by the safety discourse and risk argument (risks of individuals' either harming themselves or others) despite significant evidence refuting these practices' efficiency and individuals' narratives depicting serious harm. The safety argument does not only remove an individual's connection to the outside world through the oppressive practices and compulsory detention in hospitals but also causes surveillance, control and limit on individual's autonomy and self-expression. This research paper has argued that in order to reach the human rights standards fully, there

should be a radical shift from the safety discourse to embracing more empathetic and interactive practices. Given the adverse effects of seclusion such as humiliation, feeling of distress and fear, and given the fact that ethnic minorities and people of colour are considered riskier, approaching individuals as “pervasive and absolute potential dangers” does only cause more dehumanisation.

There are alternatives to hospitalisation and compulsory detention by implementing community programs and social service such as Soteria House and Open Dialogue which are proven to work efficiently, meet the human rights standards and help individuals much more than the current system. It would be wise to find ways to support and fund these programs and place these meaningful programs at the centre of mental health system instead of trying to fix the current mental health system which is already problematic since it heavily relies on strict drug-based treatment and diagnosing people with very controversial and hardly scientific psychiatric labels. The concept of dignity which has been at the heart of human rights values in defining equality and assessing discrimination requires an approach that sees individuals’ life problems as unavoidable consequences of ongoing unpleasant life experiences rather than as something inherent, genetically transmitted or biochemical. The rhetoric to describe individuals who are struggling with serious life issues as “potential dangers”, “inherently insane”, “mentally ill” or “sick” does not only create more exclusion, discrimination, perpetuate racism and stigmatisation, but also pose a challenge to us to see those individuals as fully human beings who deserve to be treated with respect.

As proposed in this research study, a shift from the biomedical model to a psycho-social model would certainly create an atmosphere where being with suffering individuals, understanding their experiences, having genuine dialogues with them would be in the centre of helping practices instead of coercion, restriction, and institutionalisation, and would offer

not only to the UK but to other societies in the world an opportunity to overcome human rights abuses occurring in the current mental health system.



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