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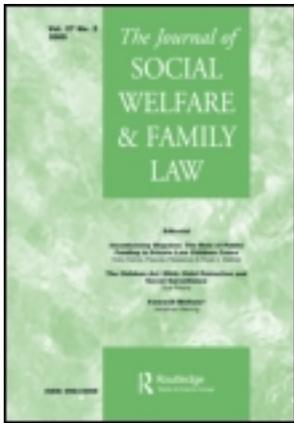
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MAIN SECTION

Using Simon's *Governing through crime* to explore the development of mental health policy in England and Wales since 1983

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The reform of the Mental Health Act in 2007 saw the introduction of Supervised Community Treatment Orders (CTOs) in England and Wales. It is argued that this marks a fundamental shift in the rights of those subject to mental health legislation. This paper will explore the developments in mental health policy in the 1980s and 1990s that form the backdrop to the introduction of CTOs. It uses Simon's *Governing through crime* (2007) as a basis to explore the developments in mental health policy that resulted in the final introduction of CTOs. The paper explores the paradox at the heart of mental health policy. This paradox being that while the protections and the rights of the mentally ill have increased in a formal legal sense, this has not resulted in the achievement of full citizenship that the idealism of the original proponent of the closure of the asylums envisaged.

The policy of deinstitutionalisation was based on a series of progressive notions and explicit rights based approach to the treatment of citizens with mental health problems. However, the implication of this policy has not resulted in the end of stigma, marginalisation and discrimination. Many commentators would suggest that the asylums have now come to the community rather than the reverse. The mental health policy response to the failings of community care was one characterised by an increased managerialist culture with a focus on audit and risk. These events are discussed in terms of Cohen's (1972) notion of a 'moral panic'. In addition, they are analysed as part of Hall and others' view of the crisis of legitimacy faced by Welfare States from the early 1970s onwards. The eventual result was the introduction of CTOs. This marks a fundamental shift in the balance between individuals with mental health problems and the therapeutic state. It is argued that the fact that such a significant change has been introduced in the face of opposition from virtually all the key stakeholders in the area indicates that the 'mentally ill' and the 'mad' continue to be marginalised.

Keywords: community treatment orders; deinstitutionalisation, governing through crime

Introduction

Simon's Governing through crime

Simon (2007) argues that the period of mass incarceration is a new form of statecraft. The main thrust of his argument is that new civil and political structures have developed. He terms this process '*Governing through crime*'. This is fundamentally different to the process of managing criminal behaviour that all states have to undertake. In his work he outlines the ways in which the perceived danger of being a victim of crime has had an impact on a range of behaviour and choices that citizens make. For example, the increase in sales of Sports Utility Vehicles (SUVs) in the US and the rise of the gated community

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are both directly linked to the fear of crime. Throughout areas of daily life, including schools and schooling, a fear of violent crime lies at the root of a number of policy developments.

For Simon, the roots of '*Governing through crime*' lie in the economic and political crisis of the 1970s and 1980s. The failure to manage the economic crisis led to a crisis in government legitimacy. The politicalisation of the law and order question was a feature of the elections that returned neo-liberal governments in the US and UK throughout the 1980s. Simon argues that the victim of crime, particularly violent crime came to act as the dominant model of citizenship. He provides several examples where violent crime has had a direct impact on the election process. The most famous of these is the case of Willie Horton, a convicted murderer, who raped a woman whilst he was on a period of weekend leave. This case was used by George Bush (Snr) in an attack advert on Dukakis in the 1988 Presidential campaign. In 1993 a 12-year-old school girl, Polly Klaas, was kidnapped and murdered by Richard Allen Davis. Following the public and political response to this appalling crime – Governor Wilson spoke at the funeral – Mike Reynolds, whose own daughter had been shot, used the case to support his campaign to introduce Proposition 184. This led directly to the introduction of the '*three strikes*' law in California, which has been such a driver of mass incarceration. As Simon argues the logic of such policies is to replace the perceived weakness of liberal Courts and judges with a clear populist response. In this process, the individual and ultimate social costs of mass incarceration are ignored.

Simon (2007) outlines the ways in which the optimism of the 1970s, when penologists saw prison as an institution that might well disappear, has been replaced by mass incarceration. In major works, *Prisons of poverty* (2009a) and *Punishing the poor* (2009b), Wacquant has argued that the US welfare state has been dismantled whilst the incarceration rates have grown exponentially. He argues that *welfare* has been replaced by *prisonfare*. The US welfare state that did not offer European levels of protection has been swept away. In its place, mass incarceration has taken on a key role in the management of the urban – largely black and male – population. As the welfare state has contracted in the US, the UK and other liberal democracies, then the penal state in all its forms has expanded. Wacquant (2005, 2008) has highlighted the extraordinary rates of incarceration of young African-American males. Alexander (2012) has termed these developments '*The new Jim Crow*'. There are some parallels in the UK. The *black manifesto* (2010) highlights the fact that African-Caribbean citizens are imprisoned at a rate of 6.8 per 1000 compared to 1.3 per 1000 among white citizens. Twenty-seven per cent of the UK prison population comes from a black minority ethnic background and over two-thirds of that group are serving sentences of over four years.

Schrag (2004) outlines the '*neo-populist*' terms, in which, law and order debate are consistently framed. As Garland (2004) suggests, this includes an element of distrust of experts, policy makers and political elites. The political Right has successfully exploited these populist themes. Simon observes that all violent crime poses difficult political questions for governments of all persuasions. These problems are particularly acute for parties on the Left as they have a belief in the possibility of rehabilitation. One feature of the period of mass incarceration has been a shift by social democratic parties in their position on crime, offending and prison. This is illustrated by the New Labour Governments in the UK, which did not halt the rise in prison numbers but, in fact, continued the policy of mass incarceration.

The expansion of the penal state occurred as the policy of reducing the number of inpatient mental health beds was reaching its height (Cummins 2010c). The combined effect of these policies has been to increase the number of people with mental health

problems coming into contact with the Criminal Justice System (CJS). Seddon (2009) has argued that there have always been people with mental health problems in the prison system. This has been a consistent feature of the modern prison. Following Foucault (1972), Seddon argues that there has never been a clear divide between the psychiatric and criminal justice systems. Singleton *et al*'s 1998 study remains the key study of psychiatric morbidity among prisoners. It found that more than 90% of prisoners had a mental health problem. In addition, 7% of male sentenced prisoners and 10% of men on remand had a psychotic illness. These figures have to be treated with some caution as the prison population is clearly not a cross-section of the general population. However, they do indicate the level of need. The *Corston inquiry* (2008) and the *Bradley review* (2009) have both highlighted the need for agencies in this field to address the mental health needs of offenders. For example, Corston explores the complex range of factors, which lead to such high levels of self-harm and suicide among women prisoners. As Appleby (2010) notes, despite significant improvements in prison mental health care, prison is not the place ethically or clinically where psychosis should be treated. A recent landmark judgment by the US Supreme Court *Brown v Plata* will have far-reaching implications for mass incarceration. The case was brought against the State of California. It was the last in a long line of cases in relation to the provision of medical care in the prison system. The decision in the case recognised that the overcrowding and poor provision of services in jails could and did amount to inhumane and degrading treatment. The financial implications of the case are huge (Simon forthcoming). The irony may well be that it is ultimately fiscal rather than moral concerns that lead to the collapse of the penal state.

Deinstitutionalisation

The policy of the closure of large psychiatric hospitals '*deinstitutionalisation*' has been pursued across developed societies. The policy has its roots in the challenges to the power of psychiatry and psychiatric institutions that were a feature of the 1960s. The treatment of the mentally ill is clearly an issue of human rights not just because it can include the imposition of compulsory treatment. The state has a responsibility to ensure the safety and dignity of those in its care. Institutionalisation thus becomes a fundamental issue of human rights. The old asylum regime was marked by a systematic erosion of the civic status of patients. Not only were these patients geographically and socially isolated from their fellow citizens, they were denied other rights such as the right to vote.

The physical conditions in asylums, as Goffman (1968) identifies, involved the loss of individuality and exercise of choice that form the basis of citizenship in a liberal democratic society. Barton (1959) identifies the effects of these regimes as creating 'institutional neurosis'. He suggests similarities between the behaviour of psychiatric patients and survivors of concentration camps – a more damning indictment of an allegedly therapeutic regime it is impossible to imagine. These findings were later supported by Scott (1973) who highlighted the levels of passivity and apathy among patients. The 1970s saw a series of scandals at long-stay hospitals. Martin (1985) highlights the way that closed institutions have the potential to become abusive environments. These include the lack of privacy and autonomy for patients. Large staff: patient ratios make it impossible to develop a functioning therapeutic environment. Staff received very little training and were largely isolated from mainstream services and the development of practice. In addition, in a number of institutions, staff were largely recruited from a small geographical area or local community. These factors combine to produce an environment where abuses can occur and if they do there are not systems to challenge them.

The development of community care can be seen as part of a wider development in liberal democracies where marginalised and discriminated against groups challenged these established norms. In 1955, there were 151,000 patients in psychiatric hospitals in England and Wales. Enoch Powell, as Secretary of State for Health, in the 1962 Hospital Plan announced that the long-term aim was to close these institutions. By 1984, there were 71,000 in-patients. Leff and Triemann (2000) argue that the first wave of community care was largely seen as a positive move. This period saw the resettlement of long-stay patients with improved quality of life and social functioning for the individuals. However, as early as 1976, John Pilger was reporting in the *Daily Mirror* of problems with the policy. He talks of 'Dumped on the streets and in the slums – 5000 people who need help' and describes Birmingham as 'The city of lost souls'.

The policy of deinstitutionalisation, a progressive policy aimed at reducing the civic and social isolation of the mentally ill, did not achieve its utopian aims. Wolff (2005) and Moon (2000) argue that the asylum has been replaced by a fragmented, dislocated world of bedsits, housing projects, day centres or, increasingly, prisons and the criminal justice system. This shift has been termed '*transinstitutionalisation*'. This incorporates the ideas that individuals live in a community but have little interaction with other citizens and major social interactions are with professionals paid to visit them. Other social outcomes such as physical health, which can be used as measures of citizenship or social inclusion, are also very poor. Kelly (2005) uses the term 'structural violence' – originally from liberation theology to highlight the impact of a range of factors including health, mental health status and poverty that impact on this group.

Knowles (2000) highlights the ways, in which, the responsibility for the care of the 'mad' has moved from public to private institutions. She goes on to suggest that the restructuring of mental health services acted as a model for other 'problematic populations'. The fiscal retrenchment was accompanied by an idealised rhetoric of community and family support. This ignored the collapse of community that neo-liberalism entails but also the fact that the 'mad' had not been fully supported in the first place – hence asylums. In his discussion of asylum seekers, Bauman (2007) argues that in a world of 'imagined communities' they are the 'unimaginable'. The 'mad' in the process of 'transinstitutionalisation' can be said to perform a similar function, in but not 'of' the community.

As Cross (2010) suggests, pre-existing social representations of the 'other' are very powerful in their ability to create a new identity for social categories. In this case, the representation of the mad from the asylum era has followed those people into the community. The representation has changed – the mad are not now dishevelled creatures chained to walls – they are the homeless of the modern city living on the streets with all their belongings in shopping carts. Their presence on the margins is accepted as a feature of modern urban life. Knowles' (2000) ethnographic study of the experience of the mentally ill on the streets of Montreal, illustrated by a series of powerful black and white photographs, captures the ways that the mad exist alongside but are ignored by the wider society. To borrow a phrase from Bauman, the mad have become the 'internally excluded'. Cummins (2010) has outlined the ways, in which, the media debates about community care led not to calls for investment in community mental health services but changes to legislation – i.e. a demand for the return of institutionalised care.

1990s community care as a moral panic'

The term 'community care' came to be used as a shorthand for the reforms to health and social care introduced in the UK by the National Health Service and Community Care Act

(1990). This legislation was clearly driven in part by the Thatcherite agenda of reducing the welfare state and introducing element of the market into service delivery (Gilmour 1992). However, the reforms did place an emphasis on ensuring that institutional care was only used in circumstances when all community based options had been exhausted. This aim was to be applied to the whole range of services for adults and children with health and social care needs. However, the term soon became a shorthand for community based mental health services. It carried with it the negative connotations that are explored below.

The reporting and response to the policy of community care has many of the features of a *moral panic*. Cohen (1972) is concerned with the ways in which the media, particularly the press and later TV, produced a series of stereotypical representations of events. Furedi (1994) has identified the ways, in which, newspapers continue to highlight new threats or potential threats to readers' health and well-being. Crime is a constant and very significant feature of the news agenda. Cohen suggests that by their very nature *moral panics* are volatile and unpredictable. Butler and Drakeford (2005) highlight the very important impact that scandals have had on the development of social welfare policies in the UK. In the current 24-hour rolling news environment there is an even greater likelihood that an event or series of events will take on the form of a *moral panic*.

In Cohen's analysis, the *moral panic* begins with a period of concern about a social issue. These issues are very often related to youth culture and or deviant subcultures. This process produces a *folk devil*. In the reporting of mental health inquiries, the *folk devil* was clearly the '*schizophrenic*' usually, male, usually black and usually violent. As noted above, Cross (2010) emphasises the continuing influence of representations of madness. These notions are transmitted through a range of popular cultural forms – song, film, TV drama and so. Cross is not arguing that modern cultural representations are continuations of older forms. However, he suggests it is important to recognise the similarities as well as the disjunctions. The physical representations of the 'mad' emphasise wild hair and physical size as signs of their irrationality and uncontrollability. It is interesting to note, in this context, the overlaps between these representations of the mad as almost bestial and deeply engrained racist stereotypes of black men – see Cummins (2010) for a discussion of the case of Christopher Clunis to illustrate this point.

Cohen goes on to suggest that in the *drama* of a *moral panic* a '*disaster mentality*' is created akin to that which occurs at the time of a natural disaster. The features of this new societal mindset include rumour, false alarms, '*institutionalization of threat*' and even mass delusion.

Stuart Hall (1997) used Gramsci's concept of *hegemony* to analyse the alleged 'discovery' of the new crime of 'mugging' in mid-1970s UK. Hall draws heavily on the work of Gramsci (1971) and Foucault (1972) in arguing a social constructionist (Burr 2003) position on the debate about the relationship between the mass media and 'reality'. The representation of different groups or issues has become a key focus of study for scholars of media and cultural studies (Hall 1997, Gripsrud 2002) and the question of whether the media reflects or constructs reality is central to the debate on representations. Branston and Stafford (1996, 78), for example, claim that the 'reality' represented in the media is 'always a construction, never a transparent window', while Kellner (1995, 117) argues that within media culture 'existing social struggles' are reproduced and that this has a key impact on the production of identities and the ways in which people make sense of the world.

One of the key questions for Hall is how dominant economic classes exercise their power within the political processes in advanced liberal democracies. He argues that this is a process of creating an impression of consensus rather than one of coercion. Hall argues

that consent is the most important mode of state functioning. The state is seen to represent the interests of all and to be the embodiment of series of national values. A ‘crisis of hegemony’ occurs when the state is threatened or challenged. This crisis might be triggered by economic conditions or the emergence of new cultural forms. The crisis creates a *moral panic*. Hall notes that the nature of a panic is that there is a ‘discrepancy’ between the perceived threat and the reaction to it. Hall seeks to explore how and why particular themes including crime and other deviant acts produce such a reaction. He argues that social and moral issues are much more likely to be the source of these panics. There are certain areas, for example youth culture, drugs or lone parents, where there are recurring panics.

Hall suggests that the panic is triggered by a particular event. He describes the ways, in which, these events cause ‘public disquiet’. The response to this panic includes not only societal control mechanisms such as the courts but also the media becomes an important mediating agency between the state and the formation of public opinion. In the case of mental health in the 1990s, key figures included Marjorie Wallace – journalist and founder of Schizophrenia A National Emergency (SANE) and Jayne Zito – widow of Jonathan Zito and founder of the Zito Trust (Cummins 2010). As Hall argues such figures are seen as having expert knowledge and therefore play key roles in the development of public opinion.

The reporting of the community care in the 1990s had all the features of a moral panic (Butler and Drakeford 2005). The crux of the media reporting was that there was a new threat from the ‘mad’ who had been released from asylums where they posed an immediate violent threat to the local citizenry. The dynamic of the panic produces a call for ‘something to be done’. In this case, the calls were not for the asylums to be rebuilt – this would have required a level of public investment that would not have been politically acceptable – but for new forms of surveillance and control. These developments are part of the response to the financial crisis and crisis of legitimacy that Welfare States faced from the mid-1970s onwards (Habermas 1976). Hallsworth and Lea (2011) outline the process of ‘securitisation’. It is argued that, in this process, the state uses processes and technologies of risk management that were developed in responses to external threats such as terrorism to manage a range of different groups. As Wacquant (2007) argues the neoliberal attack on the fundamental basis of the welfare state served to ‘criminalise poverty’ and confine the poor to a marginalised status. The ‘mad’ are part of this new landscape of urban poverty.

Policy and legislative responses to the failings of ‘community care’

The response of successive UK governments since 1983 to the developing crisis in the provision of mental health services has been to focus on the legislative and policy framework. The main themes of these developments are moves to more systematic surveillance of patients and the audit of mental health professionals.

The changes in mental health policy reflect wider developments in society. Young (1999) discussed what he termed the ‘narrative of modernity’. He saw the Fordist regime of production as leading to a stable pattern of employment supported by a universalist welfare regime. Young suggests that this was an inclusive society – in comparison to the later neo-liberalism regimes it was. However, this society, as Foucault (1977) argues, was also built on exclusion and marginalisation. As Nye (2003) argues women, the poor and the mentally ill were seen as ‘other’. As Yar and Penna (2004) note, in reality the mentally ill were among those groups excluded from the allegedly inclusive Fordist society.

The historical narrative of modernity includes an emphasis on the development of individualism and the progressive implementation of Enlightenment ideals. This view was challenged from the 1960s by a number of social movements which included mental health service user groups. As O' Brien and Penna (1998) suggest, the development of wider democratic forms had actually hidden the exclusion from civil society of marginalised groups.

The responses to the failings of community based mental health services are a reflection of and contribute to the development of the 'risk society' (Beck 1992). Giddens (1991) argues that the socio-economic and political changes, including: globalisation, technological developments, and new patterns in employment and changes in gender relations, have led to what Beck terms 'ontological insecurity'. The risk society or late modernity is thus characterised by an emphasis on individualism and challenges to traditional structures. Young (2004) calls this process of rapid social change the 'loosening of the moorings'. Beck (1992) argues that a 'risk consciousness' develops. Society is preoccupied with a whole new range of risks.

As the difficulties in mental health services increased, a series of measures were introduced. HC (90)23/LASSL (90)11 established the Care Programme Approach (CPA). The initial aim of the CPA was to develop a system of case management to ensure that services were provided to those in most need because of their mental health problems. It was a response to the failings of services highlighted by, for example, the *Spokes Inquiry* (DHSS 1988) into the murder of social worker Isabel Schwartz, as well as wider concerns about the rise in homelessness. As Simpson *et al.* (2003) argue, the aim of the CPA was initially to improve services. However, in its implementation, it shared a number of the wider characteristics of New Public Management (NPM) (Pollitt 2003). The establishment of the CPA brought with it added layers of bureaucracy and audit which did not seem to enhance the effective provision of mental health services. Each service-user who was registered on the CPA was meant to have a care plan, key worker and regular reviews. The system became more focused on audit than the provision of care. As Simpson *et al.* argue

There were few agreed procedures for risk assessments, care plans were often found to be ineffective and some areas had difficulty keeping up regular reviews. Service users and carers were more likely to be invited to reviews but often found them formal and intimidating and arranged at the convenience of medical staff. (2003, p. 493)

The introduction of the CPA was followed in 1993 by *Guidance on the introduction of supervision registers*. People considered to be 'at risk of harming themselves or other people' could be placed on a supervision register, with the aim of ensuring that they remain in contact with mental health services. The argument here is not that these particular individuals did not need support from community based mental health services. It is rather questioning not only the effectiveness of such measures as a means of enhancing the delivery of that support but also noting the role that such developments play in the construction of the 'mad' as dangerous and physically violent. It should be emphasised here that these are not individuals who have committed any offences. In such cases, it is possible to mount an argument that would lead to the curtailment of civil liberties.

The overwhelming majority of patients who met the criteria for inclusion on the supervision register would have been entitled to section 117 MHA aftercare provided to patients detained under section 3 MHA 1983. It should be noted that section 117 of the 1983 MHA established a clear duty on social services departments and local health authorities to provide aftercare to patients who had been detained under section 3 MHA. This section allows for the detention of a patient for up to six months in the first instance.

Section 117 MHA is unusual for a number of reasons. It provides that any services should be free of charge. The fact that such section with its commitment to free services was introduced by the first Thatcher government is noteworthy in itself. In addition, the obligation to provide such services is not time limited. The duty exists so long as the individual appears to be in need of the services provided. In this context, services have a very wide meaning. As the response to mental health crises becomes more holistic so the range of service provision widens.

One of the problems with the implementation of section 117 MHA was that it was not applied on a consistent basis. Some local authorities were charging for services; others were not. The House of Lords decision in 2002 in *Regina v Manchester City Council, Ex P Stennett* confirmed that services had to be provided free of charge. This had particular implication for the financial assessment of individuals, entitled to s 117 aftercare, who were living in or moving to residential care. The fact that it took 20 years for the law on this point to be clarified and the unlawful action of local authorities to be overturned and a judgment in favour of patients to be made indicates the marginalised status of individuals with severe mental health problems. The judgment received little, if any, wider publicity outside of the specialist mental health and social work journals. This placed a duty on *mental health service providers* to provide services to meet their needs. This implies that services had a duty to remain in contact with service-users and not the other way around.

HSG (94)/27 established Inquiries must take place following a homicide by a person with previous contact with Mental Health services. The Ritchie Inquiry (1994) into the care and treatment of Christopher Clunis made a series of recommendations including the setting up of specialist teams to work with the homeless mentally ill. The Inquiry also recommended that consideration be given to the introduction of CTOs. If such legislation had existed then, no doubt, Mr Clunis would have been made subject to its provisions. However, its possible efficacy in the turmoil of the inner-city mental health services of the time is highly questionable. The therapeutic state did not appear to have the resources to supervise Mr Clunis so it is not clear how this legislation would have changed that.

In 1995 the Mental Health (Patients in the Community) Bill introduced 'supervised discharge' a short-lived piece of legislation which can be seen as a forerunner of the Community Treatment Order legislation we have today. This was a rather confused piece of legislation. It attempted to impose conditions including their contact with mental health professionals on the discharge of patients detained under section 3. These policy developments share some common themes. The focus is on the surveillance – in its widest sense – of discharged patients. There is an implicit assumption that these tragedies have occurred because of patients have failed to take medication. The service context of high levels of need, poorly organised and underfunded services is ignored. Ironically, such a description is finally provided in *Modernising Mental Health Services* (DH: 1998). This policy document was introduced by the then Secretary of State, Frank Dobson with his famous observation that 'community care has failed'. Such policies not only add to the stigma that people with mental health problems face, they also inevitably deter individuals from seeking help.

The above forms the backdrop to the changes in policy and legislation. As argued below, these moves culminate in the introduction of the Community Treatment Orders. Yar and Penna (2004) see a paradox of modernity in that whilst this is an era of mass penal incarceration, the segregation of other groups including the mentally ill has decreased. Unfortunately, they have, in many cases, joined another or been moved to another socially excluded group: offenders. One of the effects of deinstitutionalisation has been to increase the contact between those with mental health problems and the police and prison systems

(Robertson 1988, Singleton *et al.* 1998, Shaw *et al.* 2004). Barr (2001) argues that the widespread policy of 'zero tolerance' disproportionately impacts on the homeless mentally ill. In 1987, the Mental Health Act Commission (MHAC) published a discussion document on community treatment. From this point on the debate about the introduction of CTOs was a feature of the mental health policy landscape. This debate was overwhelmingly framed in terms of the alleged efficacy of such orders – how they would enable patients to remain in the community and services to provide support. The evidence to support these contentions is debatable. However, the wider philosophical issues concerning the nature of citizenship, the use of compulsion in the provision of mental healthcare were pushed to the extreme margins of the public discourse.

Reform of the Mental Health Act and the introduction of Supervised Community Treatment Orders (SCTOs) in England and Wales

There is not the space here to discuss in detail the tortuous path of the legislation that eventually became the new Mental Health Act in 2007. The failings of community based mental health services in the 1980s and 1990s, which form part of the backdrop to this reform, are discussed in more depth below. Some of the key themes of the New Labour project and its view of the nature of citizenship are prominent features of this fundamental overhaul of mental health legislation. As Gostin (2007) argues, the reform of the 1959 MHA by the 1983 MHA can be seen in terms of a shift from an essentially paternalist view of mental health patients to a rights based module. For example, the Mental Health Act Commission was established to oversee the treatment and care of all those detained under the legislation. The 2007 reform is very much about a shift to the New Labour mantra that 'with rights come responsibilities'.

Soon after it came to power, New Labour established an Expert Committee to review mental health legislation. This was partly to ensure that it was compatible with the Human Rights Act (1998) but also to examine the position of those who needed treatment but not in inpatient settings. The fundamental argument here was that the legislation was not 'fit for purpose' as a range of treatments now existed that meant that patients did not need to spend long periods in psychiatric hospitals. The Richardson Committee report (1999) proposed legislation based on notions of reciprocity. These proposals were not accepted. A draft Mental Health Bill was introduced in 2002. This was a remarkable document as it had the effect of uniting a series of professional and service-user groups in opposition to it. The root and branch reform never materialised. A series of amendments to the 1983 MHA were introduced in 2007. These included the introduction of the CTO.

Some form of CTO exists in a number of jurisdictions across North America, Australia and New Zealand. The 2007 legislation in England and Wales was heavily influenced by the Australasian models. Section 3 1983 MHA allows for a patient to be initially detained in a psychiatric hospital for up to six months. If a patient is detained under section 3, then, on discharge from hospital, s/he can be made subject to supervised community treatment. Conditions, for example, to take medication, live at an approved address and allow staff access can be imposed. Under previous legislation, similar powers existed. However, the fundamental difference is that under a CTO an individual can be recalled to hospital if they do not comply with the conditions imposed. This recall can be enacted without any assessment of the individual's current mental state. Under previous guidance, a formal Mental Health Act assessment would have to be carried out by a psychiatrist, general practitioner and an approved social worker. The patient can be recalled for a period of up to 72 hours. This period would be used to start the patient on medication

The main arguments put forward to support CTOs are that they are essentially the least restrictive way to treat the most seriously mentally ill members of the community. It is argued that the CTO will only be used in cases where patients have experienced repeated compulsory admissions to hospital with all the mental distress and wider disruption to their lives that these admissions entail. It is thus argued that the initial restrictions on the freedom of the individual will eventually allow him or her to avoid the repeated restrictions on their liberty of numerous compulsory admissions to hospital.

Discussion

As Eastman and Starling (2006) observe, the treatment of the mentally ill was always a fundamental exploration of the balance between the rights and autonomy of the individual and a wider societal paternalism as represented by professional decision makers. This debate arises because of the nature of mental illness and its impact on individuals. Only the extreme wings of libertarian thought (Szasz 1963, 1971) do not accept the need for the therapeutic state to have powers to intervene when individuals are putting themselves or others at risk. The main themes of this discussion chime with those outlined in Simon's analysis of the development of penal policy. Both the main political parties subscribed to the view that the response needed to be based on an increasingly coercive legislative framework.

There is a paradox at the heart of the development of mental health policy. In a number of ways, the rights of the mentally ill are on a much stronger footing than they have ever been. Those who experience discrimination as a result of their mental health problems have greater legal protections. In cases of compulsory detention, there is a new legal framework introduced to ensure compatibility with the provisions of the HRA (1998). In addition, there is a wider public discussion and acknowledgement of the impact of mental illness. Stigma and fear remain but the physical segregation in asylums has gone. In addition, psychiatry, mental health social work, nursing and other disciplines have a wider range of interventions to alleviate distress to offer. However, the policies and legislation which will impact on those in greatest need do not reflect these progressive themes. The failure to provide a very vulnerable group – those suffering from severe mental illness who had been detained under section 3 MHA (1983) – with their legal entitlement to section 117 MHA aftercare was recast as a law and order issue. In doing so, a shift occurred in the balance between individuals and the state. It is a clear statement of the marginalised status of this group that this shift was hardly noticed by the wider community and there was certainly little effective opposition to it. The physical asylums may have gone but the CTOs may turn out to be the longest-lasting feature of their legacy. The legislation suggests that CTOs will only be used in very limited circumstances and for those patients who have experienced repeated admissions. It can actually be used for *any* patient detained under section 3 MHA. In addition, the early indications are that it is used in many more instances than was originally envisaged (Williams 2010).

Bauman (2007) argues *we* have seen the development of what he terms the 'personal security state'. One of the key ways, in which, the modern state claims legitimacy is by its ability to defend its subjects. In modern society, these threats or perceived threats are increasingly internal or domestic ones. The 'madman' of tabloid legend is one of these. Bauman (2007) suggests that states and political elites lose legitimacy if they are seen to fail to protect citizens. As Cummins (2010) has demonstrated, the UK government's response to the community care crisis of the early 1990s was largely carried out on the terms of reference provided by the tabloid media. There was little if any attempt to

challenge the underlying assumptions about the nature of mental illness or to acknowledge the limits on the role of community services. The response is to seek new forms of legislation or surveillance – as in the penal sphere – rather than to expand social welfare programmes to tackle the underlying causes. New Labour's wider discourse of rights and responsibilities was soon overlaid with a tabloid-influenced discourse of the risk posed by the 'mad'.

All the policy responses discussed share a fundamental belief that the problems in mental health services lie in the legislative framework rather than the organisation, structure and delivery of services. This resulted in CTOs being given an almost mythic status as the solution to the problems of community care. In addition, there was a belief that one of the causes of the collapse in services was the increased rights being afforded to patients (Cummins 2010). It should be emphasised here that this predates the introduction of the Human Rights Act and was in a period of Conservative governments, which up to 1992, had significant Commons majorities. In any event, as the path of the reform of the MHA discussed below demonstrates, there is not an easily recognisable powerful party political grouping which will defend the rights of the mentally ill. This is not meant, in any way to minimise the work of those that do, rather it is a comment on the relative political importance given to the issue. In addition, the terms of the debate are structured in such a way as to place great emphasis on a number of key themes: *violent offences committed by those, particularly young black men, in some form of contact with MH services, the new for some of Compulsory Treatment order and the so-called liberal perspective that dominates social work.*

Conclusion

Simon's '*Governing through crime*' superbly dissects the ways, in which, debates around law and order have not shifted. It also explores the ways those debates have come to have such a profound influence on the wider political culture. Using this framework provides an insight into the development of mental health policies in England and Wales. This issue does not have the same electoral profile as law and order – one of the reasons being that there is essentially a wide political consensus on these issues. The option of building new asylums was not available. This would have required a huge fiscal commitment from the state. There has been the establishment of a private sector in mental health care. This has seen the development of private or voluntary sector run residential and nursing homes. However, there are some important points of overlap. Simon has highlighted that it has so far proved very difficult to challenge the terms on which these debates are conducted. A similar phenomenon is apparent in mental health policy. Both these areas reflect a crisis in the legitimacy of the state in the face of fiscal and other pressures including high-profile cases. The impact of the media coverage of high-profile cases led to the creation of a climate of public opinion where '*something has to be done*'. In the mental health field this was the introduction of increasingly restrictive and bureaucratic approaches focusing on the doxa of the audit culture – registration, review and inspection. In this schema, the actual quality of service provision can be lost. The eventual result was the introduction of CTOs.

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