Narratives of reform: The Mental Health Act (MHA) in England and Wales from the 1983 MHA to the Wessley Review (2018)

Purpose This paper examines reform of mental health legislation in England and Wales. It covers the period from the introduction of the 1983 MHA to the proposed reforms outlined in the Wessley Review that was published in December, 2018.

Design/methodology/approach This is a literature based project

Findings Reform of mental health legislation reflects two potentially conflicting strands. One is the state's power to incarcerate the "mad", the other is the move to protect the civil rights of those who are subject to such legislation. The failures to development adequately funded community based mental health services and a series of Inquiries in the 1990s led to the introduction of Community Treatment Orders in the 2007 reform of the MHA. *Research limitations/implications* The development of mental health policy has seen a shift towards more coercive approaches in mental health.

Practical implications The successful reform of the MHA can only be accomplished alongside investment in community mental health services

Originality/value The paper highlights the tensions between the factors that contribute to mental health legislation reform

Keywords deinstitutionalisation Mental Health Act, community care

Introduction

This paper outlines reforms mental health legislation in England and Wales from the introduction of the 1983 MHA to the Wessley Review of December, 2018. It argues that reform of mental health legislation can be understood as being driven two potentially conflicting and contradictory concerns. The first is the role of the state and state agencies in wider public protection. In this is discourse, the "*mad*" both individually and collectively pose a threat. The state requires a range of professionals to manage this potential threat and mental health legislation encodes the powers of these groups - psychiatrists, mental health social workers, psychiatric nurse and the police. The second is a concern with and a recognition of the need to protect the civil rights of those who are subject to such legislation. In the period since the introduction of community care, mental health legislation has swung between these two poles. The failures to development adequately funded community based mental health services and a series of Inquiries in the 1990s led to the 2007 reform of the MHA, which saw the introduction of Community Treatment Orders. The development of legislation, in the period from 1983 onwards, reflects the broader pattern of community care as a policy. This paper explores the recent development of mental health legislation in England and Wales. It argues that the initial optimism and progressive reforms of the early 1980s were overtaken by a more managerialist, pragmatic approach focused on risk and risk management. The recent Wessley Review has outlined reforms that offer a rights based approach. This is a welcome shift. However, these reforms need to be part of wider cultural and organisation shift in mental health services.

Mental Health Law and policy: a brief overview

This section is a brief outline of the development of mental health legislation prior to the 1983 MHA which will then be discussed in more detail. Scull (1986) notes that the development of mental health and other areas of policy such as those in the criminal field have involved a greater role for the modern state. Within this field, one sees the emergence of new fields and new professionals who claim expertise in the identification, assessment and treatment/management of conditions and individuals. Prior to the modern view of

madness as a form of illness, there was little specific specialist provision for those regarded as mad (Foucault, 2003). The Poor Law Act 1601 placed a duty to the old and the sick, including idiots and lunatics. Outdoor relief was provided. If the however the poor, who were unable to work due to infirmity, they could be placed in workhouses.

In *Madness and Civilisation* , Foucault described the development of asylums as the '*Great Confinement* ' . The *Great Confinement* reflected shifts in social and cultural attitudes. Foucault argued that prior to this period, the *"mad"* had been treated in a very different fashion. The geography and the architecture of the new asylums reflected these notions of exclusion. They were physically separated from the wider society and they allowed for the surveillance and daily management of the patients. Foucault uses the phrase ' dividing practices ' to capture the way that new forms of knowledge – in this case, psychiatry – are used by new groups of professionals to identify, classify and ultimately separate groups. A progressive interpretation of the rise of the asylums sees them as being driven by humanitarian concerns, physical restraint involving chains and manacles
giving way to a new approach – moral treatment. Foucault argued that the abandonment of the use of physical restraint was not driven by humanitarian concerns but was done as it provided a different, possibly better, means of control. For example, Foucault describes the regime at the York Retreat as a ' *moralising sadism* '. This view is in stark contrast to most other commentators who regard it as a progressive regime. For Foucault, the development of psychiatry becomes a a monologue of reason about madness. Psychiatrists debate madness within the confi nes of the profession. The *"mad "* become subject to the disciplinary gaze of the emerging psychiatric profession. From this standpoint, changes in legislation and policy are seen as changes in technologies of power.

There is not the space here to provide a more detailed history of mental health legislation. However, it is possible to identify some common themes. Until the period of deinstitutionalisation, from the 1960s onwards in England and Wales there was a focus on segregation and institutionalisation. Alongside this, the response to institutional scandals played a key role in the development policy. The York Retreat was established following the death of a

local Quaker woman, Hannah Mills. The 1774 Act for *Regulating Private Madhouses* which saw the introduction of a requirement of the medical certification for insanity followed a Parliamentary Inquiry into private madhouses. The *Poor Law Amendment Act* 1834, was not specifically concerned with the treatment of the mentally ill. The indoor relief in the workhouses was designed specifically to act as a deterrent to those who might make a claim. As pauper lunatics were seen as an increasing burden in this system, more of them were sent to the asylums. The *Lunatics Asylums Act* 1845, made it mandatory for each borough and county to provide a publicly funded asylum. The 1913 *Moral Deficiency Act* classified mental subnormality into three categories - *idiot, imbecile and feeble minded*. It also saw the creation of the category of *moral imbecile*.

Prior to World War I, psychiatry and the asylum system was heavily influenced by the notions of social hygiene. The experiences of the Great War had a profound impact on these notions. Shell shock was experienced by soldiers of all classes thus it could be the result of inferior breeding or character. Freudian and psychoanalytic theories became more influential.The Tavistock clinic opened in 1920. A Royal Commission on Lunacy and Mental Disorder was established in 1924. The Mental Treatment Act 1930 saw the term asylum replaced by *"mental hospital"* and *"lunatic"* by *"patient"*. Asylum and lunatic clearly remained powerful terms in popular culture. The act established three categories of patient - *certified, voluntary and temporary.* Temporary was a certified category but lasted up to six months. This was the first time that patients could admit themselves on a voluntary basis.

The 1959 Mental Health Act

The Macmillan Commission, which established the framework for the *Mental Treatment Act* 1930, had made a clear statement that mental disorder was a medical illness like any other. The creation of the NHS in 1948 included saw the incorporation of the mental hospitals into the broader system. Significant changes in the provision of mental health treatments occurred in the post War period. In 1954 neuroleptics (major tranquillisers for the treatment of psychotic symptoms) were introduced in the UK. These drugs marked a shift in treatment but were also immensely problematic because of their potential side effects.

The criticisms of the mental hospital system - both in terms of the physical conditions and the denial of civic rights became more vocal during the 1940s and 1950s. The Percy Commission was established and this led to the Mental Health Act 1959, Despite the broader currents of optimism about the potential for new forms of service provision, the 1959 MHA was very much focused on hospital admission. The 1959 MHA defined mental disorder as "*mental illness; arrest or incomplete development of mind; psychopathic disorder; and any other disorder or disability of mind*". The 1959 MHA abolished the distinction between psychiatric and general hospitals. Sections 25, 26 and 29 of the 1959 MHA outlined the criteria for formal admission. Social workers also took on the role of mental welfare officers working in the community but were also involved in the formal admissions process. A tribunal system was also established for patient appeals. The Royal Commission of 1926 had examined the possibility of abolishing the magistrate's role in the commitment process. However, it was not until the introduction of the 1959 MHA that this occurred. It was at this point that the responsibility for the assessment and detention of the mentally ill became solely the responsibility of professionals in the field.

The 1983 Mental Health Act (MHA)

The MHA 1983 was introduced following campaigning by MIND. At this point, MIND was led by an American civil rights lawyer - Larry Gostin. Under Gostin's leadership, MIND took a campaigning rights based approached to mental health issues - seeing the law as one of the key tools in ensuring that people with mental health problems were not subject to abuse. By the 1970s, one of the periodic pressures to reform legislation that is such a feature of the history of mental health policy was beginning to develop. This was triggered by a range of factors. As always in this field, scandals and inquiries had a role to play. The poor care and treatment of people with mental health problems and learning difficulties had been highlighted by scandals at Ely Hospital (1969), Farleigh Hospital (1971) and Whitingham Hospital (1972) (Fennell, 2002). Barbara Robb published Sans Everything (1967). This collection provided a devastating account of the appalling conditions in long stay wards at seven hospitals. As well as describing dirty overcrowded wards, Sans Every-

thing (Robb, 1967) contained examples of the staff treatment of patients, for example, verbal and physical abuse. The collection also highlighted the lack of dignity in standard practices such as a *"production line"* for the bathing of patients.

These concerns led to a shift away from the processes of detention to the conditions on wards. Both are, of course, fundamental issues of human rights. A state cannot detain an individual in accordance with a rights based approach and do so in physical conditions that amount to a breach of those rights.The wider developments in the mental health field such as concerns about controversial treatments such as psychosurgery, a focus on the civil rights of patients in the USA (Fennell, 2002) meant mental health came to be viewed much more as a civil rights issue.). Gostin arrival at MIND was thus timely as the human rights law had yet to play the hugely significant role that it would do in the mental health field.

The 1983 MHA clarified the consent to treatment provisions. Providing additional safeguards for patients detained under the MHA , in cases where they are treated against their will. The Mental Health Act Commission (MHAC) was established oversee the use of the MHA. The MHAC produced an annual report on such issues on trends in the use of the MHA and other related matters. This role has subsequently been taken on by Care Quality Commission (CQC). The final change was the creation of the Approved Social Worker (ASW) role. The role of the ASW was to provide a social perspective in the MHA assessment. This included not only ensuring that the views of the person being assessed were taken into account but also exploring all alternative and community based options to a formal MHA admission. Section 117 MHA created a duty on Health and Social Services Authorities to provide aftercare for patients who have been subject to section 3 and section 37 MHA admissions.The 1983 MHA was not a key driver in shaping the development of community care. It created the legal framework, in which, the policy of community care was played out in the late 1980s and early 1990s.

The challenge to psychiatry

The use of language is vitally important. In recognising the complexity of the usage of terms such as patient, mad and mental illness, I acknowledge that this a fluid and changing picture. Binaries such as professional/service user mask a series of much more complex relationships. The policy changes outlined above even those that were instigated by people with progressive views were imposed from above. One of the most significant changes in modern mental health policy has been the moves to include service users fully in these processes. There is clearly still much to be done and tokenism is a constant danger.

.The use of language is very important as it reflects not only changing social attitudes but also the political shifts that underpin these moves. Porter (1987) notes that as long as people have been defined as "mad" by the medical profession and the wider society, individuals have resisted or challenged the diagnosis and label. The refusal to accept the label is, of course, often seen as further evidence of the correctness of the diagnosis. Porter (1987) quotes the English playwright, Nathaniel Lee (1653-1692) who was admitted to Bedlam and afterwards remarked

Crossley (1999, 2004) identifies the features of a social movement that are present in the user/survivor challenge to the power of psychiatry. A social movement consists of a network of agents and groups which can develop, sustain and transmit a culture or set of views. In this case, the culture is one of resistance and challenge. However, it is important to recognise that within any social movement, there will be different and often opposing viewpoints. Crossley (1999, 2004) identifies the anti-psychiatry movement of the late 1950s and 1960s as a "revolution from above". The "leaders" of the revolution were academics and psychiatrists. Crossley (2004) notes that the anti-psychiatry "revolt from above" preceded and gave some impetus or ideological support to the "revolt from below" that created the modern user/ survivor movement. TheScottish Mental Patients Union was established in 1971 followed by the Mental Patients'Union in 1973. In Italy,

the work of Basaglia led to the establishment of the campaigning movement Psichiatra Democratia(Foot, 2015). These movements were all influenced by the radicalism of Laing andhis challenge to the basis of diagnosis and the practice of institutionalised psychiatry. These groups and campaigns all share a commitment to challenging the medical model and thus the authority of psychiatrists and other mental health professionals.

Crossley's (2006) recognised that the user/survivor movement represents a diversity of views that are often inconflict. For example, this approach allows for the inclusion of groups such as National Schizophrenia Fellowship (NSF) and Schizophrenia A National Emergency (SANE) in his discussion. Both these groups essentially set out to represent the views of families, not necessarily those of patients.Jayne Zito established the Zito Trust following the murder of her husband Jonathan Zito in 1992. The trust campaigned for reform of the MHA - it closed when community treatment orders were introduced - and supported families where there had been a homicide committed by a person in contact with mental health services. SANE and the Zito Trust received wide media coverage for their campaigns (Author, 2012). These organisations were very influential in the construction of a narrative of community care that saw its failings being the result of a liberal mental health legislation.

The consumer movement in health helped to create a space for the "survivor" in mental health. Crossley (2004, p167) argues that

"survivors have been able to convert their experiences of mental distress and (mis)treatment into a form of cultural and symbolic capital. The disvalued status of the patient is reversed within the movement context"

Reform of the 1983 MHA

In the area of mental health, there were a series of inquiries into institutional abuse played a key role in highlighting the abusive nature of the asylum regime. This is not just a recent phenomenon. One of the most famous psychiatric institutions in the UK - The York Retreat, established in 1796, was a response to a scandal.A series of inquiries alongside a rise

in homelessness and pressures on mental health services alongside concerns about the legal powers of the MHA all played a role in undermining confidence in the broader policy aims of community care. As outlined above, the general thrust of policy responses was to focus on audit of services and professionals alongside changes to mental health legislation. In the background of these reforms, there were ongoing debates about the ethical implications of the community treatment orders (CTOs). These issues were not limited to England and Wales. A form of CTO was introduced in a number of jurisdictions. The period of de-institutionalisation saw the introduction of some form of compulsory community treatment in a number of jurisdictions (Lawton-Smith et al 2008). Vergunst et al (2017) found that CTOs of one form or another exist in over seventy mental health systems across North America, Europe and Australasia. The key element of this legislation is that it allows for the imposition of conditions on discharged patients, for example residence and compliance with medication and treatment alongside the power of recall to hospital where patients failure to meet them.

Inquires

Inquiries quickly became embedded within the mental health landscape. RCP (1996) noted that there were 39 homicides over two periods totalling 26 months by patients who had had contact with mental health services in the previous 12 months. There were only 9 inquiries between 1988 and 1994 Sheppard (1996). There were 27 published in 1997 and 1998 (Sheppard, 1998). The Royal College of Psychiatrists (RCP,1996) produced a summary of the key themes that emerged from a series of inquiries. These included: failures in communication, poor and unclear care plans, lack of direct contact with patients, gaps in staff training and poor compliance with medication. The RCP (1996)

also highlighted that a series of Inquiries had focused on professionals' understanding and use of legal powers under the MHA. The Ritchie Inquiry (1994) recommended the establishment of specialist outreach teams for the homeless as well as consideration of new legal powers. In later Inquiries, there were recommendations for reform of the MHA including the introduction of a form of community treatment order.

Psychiatrists were particularly critical of these processes. Muijen (1996) saw inquiries failing either to reassure the public or improve mental health systems. The consultant psychiatrist, George Szmulker (2000) wrote a reflective piece about his involvement in the Inquiry into the care of Luke Warm Luke (Scotland, 1998). Michael Folkes, 32, who had changed his name to Luke Warm Luke murdered his partner Susan Crawford. To emphasise Warner's (2006) point about the intertextuality of media and inquiry reports - the Independent newspaper article on the publication of the report was headlined *Schizophrenic visited clinic before killing*. It went on to say

Despite a history of violence, he had been allowed to live alone and take responsibility for his own medication.The killing happened eight hours after a doctor had put Luke on a list for emergency attention. He turned up in a distressed state at the Maudsley hospital on 3 October, 1994, but was allowed to leave.

(https://www.independent.co.uk/news/schizophrenic-visited-clinic-before-killing-1184675.html).

Szmulker is clearly not an impartial observer. He is open about this. He points out that the Inquiry took four years and cost in the region of £750k. Szmulker (2000) argues that the inquiry culture rather than reassuring the public has actually increased fears that they will be killed by a psychotic stranger. The risks of this are 1 in 10 million. This case was similar to others, in that, those at greatest risk are family and carers. Szmulker (2000) concludes that the inquiries reinforced a spurious relationship between community care and homicides. A form of community care hindsight bias (Hawkins and Hastie, 1990) developed which assumed that these cases could be prevented by good services or by professionals following the procedures and policies as they currently existed. This is far too strong a claim(Szmulker, 2000). The process is also a traumatic one for the family and friends of both the victim and the perpetrator - often these groups can overlap. The publication is potentially the third or fourth time that the case has received media coverage - the initial

homicide, reports that the perpetrator is mentally ill, the court case and finally a press conference. The final area to consider is the impact on staff morale both in the long and the short term

Inquiries were criticised for being too costly and time consuming. In addition, the process was seen as part of the creation of a blame culture. Organisations and industries, for example the airline industry, which have created a more open culture to address safety issues, have recognised the importance of examining all cases where things go wrong. This includes "near misses". It also requires that all staff at any level are encouraged to raise potential issues. Reith (1998) in an analysis of inquiry reports emphasised that this was not a luxury but a necessity. It is, of course, somewhat easier said than done. The hierarchical nature of the medical profession is clearly a factor. Stanley and Manthorpe (2001) highlight the dangers of hindsight bias in the Inquiry process. Inquiries placed huge emphasise on the importance of chronologies - a key feature of risk assessment being a detailed history. This is not that surprising as it is the role of the Inquiry. However, there is an inherent danger in working backwards from the homicide that triggered the Inquiry. If the homicide had not occurred then there would not have been an Inquiry. This does not mean that the structural and other issues highlighted in the final report did not exist.
Warner (2006) argues that inquiries should be seen as *"active texts"* (Prior 2003). They have to examined in the social and political context, in which, they were created and written. She highlights that the inquiries in this period had a vital role in the construction of a narrative that linked the asylum closure programme - which had been underway for thirty years at this point - to alleged increases in violent offences committed by mentally ill perpetrators.

Coppock and Hopton (2000) note that the inquiry culture by focusing on individual cases inevitably produces a narrative of local, perhaps individual failures. The more fundamental issues and fissures in community care that exist at a policy level - the lack of adequate funding, the complex organisational structure, the impact of professional hierarchies and a

legal framework that was based on the asylum system - become marginalised or even totally ignored. Stanley and Manthorpe (2001) argue that inquiries focus on the failure of services to police risky individuals rather than organisational and structural issues. The only inquiry that did this in the period was the Audit Commission's (1994) *Finding a Place.* This document starts from a values based approach rather than an organisational one - it asks the fundamental question what should be the core of mental health services. It has a focus on service user views and needs that is largely missing from the other inquiries. These core values such as respect and support then form the building blocks for the structure of services. The owner of a music shop wrote to the Audit Commission Inquiry into community care, with his memories of Clunis. These were of a talented musician, who was a regular customer at his shop, a quiet rather unassuming character. He had no recollection of Clunis being violent and was shocked by the newspaper reports of the murder of Jonathan Zito.

New Labour provided its own analysis of the failures of community care. *Modernising Mental Health Services* (DH, 1998) argued that community failed because of

- *inadequate care, poor management of resources and underfunding;*
- *the proper range of services not always being available to provide the care and support people need;*
- *patients and service users not remaining in contact with services;*
- *families who have willingly played a part in providing care have been overburdened;• problems in recruiting and retaining staff*
- *an outdated legal framework which failed to support effective treatment outside hospital.*

There is not the space here to outline the tortuous path that led to the reform of the MHA. The introduction of the CTO was the most significant of the 2007 MHA reforms. It can be imposed when a patient who has been detained under Section 3 is discharged from hospital. Conditions that can be placed on the discharge might include:

- *having to live in a certain place;*
- *being tested for alcohol or illegal drugs;*

- *attending appointments for treatment.*

The CTO introduced the power of recall to hospital if the responsible clinician has concerns that:

- *the patient needs medical treatment in hospital for a mental disorder; and*
- *there would be risk of harm to the health or safety of the patient or of others*

The power of recall means that be admitted to hospital for to 72 hours. Decisions can be then made about future treatment plans and support. Those in favour of the CTOs argue that their use puts pressure on services to ensure that they provide adequate community mental health services to support individuals. It should be noted that an individual has to be subject to section 3 of the Mental Health Act for a CTO to be considered, so mental health services have an ongoing duty under section 117 MHA to provide aftercare.

Maden (2007) has estimated that compliance rates are often under fifty per cent in circumstances where people experience chronic conditions. Despite a whole series of moves and policies that seek to place physical and mental health on similar footing, the area of consent remains a key difference. In the case of treatment for physical health care, doctors can only act with the informed consent of the patient. If an individual has capacity, then they can make a decision as to whether to accept or refuse the treatment. Szmulker (2018) argues that this key difference in the area of mental health law means that is it fundamentally discriminatory and stigmatising. Non -compliance with medication is presented as a key, if not the key feature of relapse . Relapse in this model is thus a purely medical phenomenon and social factors and pressures are simply taken as a given or ignored. Non-compliance - an interesting term in itself as it is not one that is generally used in other areas of medicine - is seen as an indicator that the patient lacks insight. Insight is something of a vague term but it includes an awareness of illness but also the benefits of prescribed treatment. The point here is that not taking medication is never a presented as a positive choice or a decision that may be based on rational factors, for example, deciding not to take medication because of potential side

effects. Lack of insight is seen as a potential feature of serious psychotic illness and of non-compliance (Farnham & James 2000). Amador (2006) goes further and suggests that this lack of insight is a permanent feature of conditions such as schizophrenia. Thus CTOs are presented as a necessary, paternalistic feature that is required to manage risk. Warden (1998) argued that CTOs mark the end of community care. The use of the term community care in any positive sense was increasingly limited from the late 1980s onwards. It is now virtually non-existent. It is clear that the document marks the end of an official commitment to the idealism that underpinned community care. The pendulum had swung back towards concerns with public safety. In the process, the rights of individuals were significantly harmed. The fact is that recall to hospital without any requirement for a further formal mental health assessment represents a significant shift in the balance between individuals and the state. The fact that these reforms were passed with little or no opposition from libertarian politicians committed to the rights of individuals tells one a great deal about the status of those detained under the MHA.

The Wessley Review

When she arrived in Downing Street, Theresa May made a speech, in which, she outlined what she described as the *"burning injustices"* in modern Britain. Mental health services and the overuse of the MHA was one of the areas she highlighted. This was a shock as many pointed out that she had been a senior figure in Governments committed to austerity policies that had had a devastating impact on mental health services and the mental health of individuals (Author, 2018). The review was chaired by an eminent psychiatrist Professor Sir Simon Wessely and completed in December 2018 (DHSC, 2018).

In his foreword to the final report, Simon Wessely outlines the case for change. These concerns have echoes of earlier reviews that led to changes in legislation. Alongside the increase in the number of detentions, the review sought to address long-standing concerns about the processes of admission under the MHA and patients' experiences on inpatient

units.The review reports that there were 49,551 detentions under the MHA in 2017/18, excluding short-term orders such as Section 5(2)(DHSC, 2018: 44). There was a 40% increase in detentions in the period 2005/06 to 2015/16. The risks of black patients, particularly young men, to be subject to community treatment orders (CTOs) were also noted. Black people were eight times more likely to be subject to a CTO than their white fellow citizens. These are trends that have been in existence for some time. The review proposes a number of significant changes to the MHA. It starts from the position that we need to move to an approach that is fundamentally rights based. The key principles of the new MHA will be: choice and autonomy, least restriction, therapeutic benefit, and the person as an as an individual – ensuring patients are viewed and treated as rounded individuals. The challenge now then lies in making sure that policies and legislation are implemented based on these principles and that they produce significant change in services.

Conclusion

Simon and Rosenbaum(2015) note that mental health policy is cyclical, characterised by periods of boom and bust. There are periods where the fundamental questions of how society should respond to citizens who experience mental distress make their way to the top of the social policy agenda. This usually follows an institutional scandal of some sort. There then follows a period where these questions are debated, an Inquiry or Commission may be established, reforms to legislation are recommended, new policies or ways of working are introduced. There may even be a period of increased investment in services and attempts to change social attitudes. These issues then retreat from the public view. The policy of deinstitutionalisation was the result of a period when the institution of the mental health hospital came under huge criticism. The asylum was presented as a Gothic abusive institution which was essentially beyond reform. These attacks were based on the abusive practices that existed in the asylums, which denied the incarcerated fundamental human rights. Shen and Snowden (2014) in their analysis of the impact of deinstitutionalisation highlight how widespread the policy has become. They examine its impact in 190 countries. It is a policy that has the support of the WHO. They note that it has become something of a marker of "progress". Moves away from institutionalised forms of care are

apparent in other areas such as learning disability services. They argue that these changes are often introduced in a wave of optimism with a consideration of the local conditions.

Deinstitutionalisation is a mark of modernity and transition, possibly linked to wider political changes such as the establishment of liberal democracy and strengthening the institutions of civil society. Gostin (2007) sees the 1959 MHA and the 1983 MHA as moves towards a rights based approach. The focus was, thus, inevitably concerned with the key areas of admission and treatment. The reforms that New Labour introduced have to be linked to its wider view of citizenship.The 2007 reform is a significant move to a 'responsibility agenda'. The opposition to the initial reforms suggested by the Richardson Committee and other political factors meant that it took nearly ten years for the legislation to be enacted. However, the New Labour case for reform was made in Modernising Mental Health Services (DoH, 1998). This document outlined the structural and organisational factors that had led to the failings of community care. These included issues organisational and funding issues as well as lack of support for families and carers. The document argued that the law was focused on an institutionalised model of care - ie admission and treatment. The argument was that this legislation could not cope with the new environment and the demands of community care. There is an implicit assumption here that community care requires powers for community treatment. This article has examined the tensions in the development of mental health law and policy. These can be summarised very broadly as a clash between the rights of the individual and the rights of the wider community to protection. I accept that this characterisation is based on an implicit assumption that the wider community needs protection. The development of legislation and policy over the past 35 years has shown that the rights of the individual can become marginalised. The solution to structural and financial issues in mental health services has consistently been presented as changes in legislation. These changes have focused on surveillance, audit and coercion.The report of the Wessley Review is subtitled Increasing choice, reducing compulsion. It is to be hoped that its implementation will achieve these goals, the concern is that the history of mental health reform will repeat itself.

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