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The discreditation of mad people within legal and psychiatric decision making: a systems theory approach

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Abstract

This thesis is about the ways in which mad people are excluded from the decisions reached about their lives. It uses Niklas Luhmann's theory of social systems to explain and describe why this exclusion arises.

Luhmann defined social systems as structured around specific social codes, and comprised of the communications relating to that code. This thesis asks how the phenomenon of madness can be understood within this framework and argues that mad utterances are statements or acts which cannot be parsed according to any existing system of social or interpersonal meaning. The psy-disciplines transform these uncertain acts into stable meaning by defining them within a functionalist or pathological framework. These meanings are fragile because the operations of the psyche are socially invisible and so mad utterances have to be defined in relation to existing social systems of meaning. Mad utterances therefore generate uncertainty, which leads systems such as law and the economy to over-react to madness and discredit to a disproportionate degree what mad people have to say.

The discreditation of mad people is problematic because it limits their personal autonomy. The ways in which systems exclude mad people, even when their stated objective is to promote their inclusion, is illustrated by the research literature on involvement in healthcare decision-making. The law plays a particular role in sustaining discreditable assumptions about mad

people, and this is evidenced by a close examination of the research literature and case law relating to the Mental Health Review Tribunal in England and Wales.

Luhmann's systems theory is not normative, so no clear normative agenda for change can be adduced from this description alone. Instead, this account offers a new theoretical framework within which to understand some of the shortcomings of mental health law, which is of particular relevance now that the involvement of mad people in decision-making them has been firmly placed on the legal and political agendas.

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Appendix One

Chapter One
Introduction

1.1 Introduction

This is a thesis about the exclusion of mad people from the decisions made about their lives. It explores why the mad person remains *"the outsider par excellence"* (Foucault 2006a p.183) despite the best efforts of committed activists, practitioners and researchers to change this status.

My interest in this conundrum arose when I was working as a lay mental health advocate. Many of my clients described feeling that they were not listened to at meetings where their health and welfare were discussed. They felt they were not seen as experts on their own lives. Even those people who felt the practitioners they encountered were 'good listeners' were anxious because they felt these relationships were fragile. If they were not able to rapidly reach agreement on an issue, it would be their view which was overridden, not that of the practitioner. Many of them saw their advocate as someone who could help amplify what they themselves were saying, and yet all of them were people who were physically and mentally capable of speaking up on their own behalf. Sometimes the substance of what they said might be challenging, but it was rare for me to encounter a client who said things which were wholly unreasonable.

At the same time, I saw that many of the practitioners I met were deeply committed and compassionate. Despite scarce resources and heavy workloads I saw many instances of social workers, psychiatric nurses, psychiatrists and others going out of their way to treat their clients with respect and to make time to listen to them. Finally, I noted that our advocacy service was massively ineffective. Despite obtaining high quality legal advice and representation none of my clients ever won any dispute. We lost Mental Health Review Tribunals, Housing and Council Tax Benefit Appeals, Welfare Benefits Tribunals, Housing Appeals, Employment Tribunals and Family Court hearings.

Taken together, these facts suggested to me that there was a need for an underlying structural explanation which could account for both the anxiety my clients felt about being discredited, and the high degree of discreditation they suffered in practice. I recognised that attitudes alone did not provide an explanation because the attitudes of many of the decision-makers involved were impeccable. Instead, I wondered if the imperatives of social systems such as the law and the economy might account for this phenomenon.

So this thesis employs Niklas Luhmann's highly distinctive theoretical account of the interactions of social systems to explain the discreditation of madness and to describe some of the implications of this discreditation. It argues that madness takes the form of utterances that cannot readily be comprehended by others and because these problems of comprehension are so threatening to social systems of meaning, the things mad people say which are not mad are disproportionately discredited. Disciplines such as psychiatry, psychology and psychiatric nursing attempt to engage meaningfully and therapeutically with madness. Problems with discreditation arise when the specific knowledge of these disciplines is translated into legal, political and economic distinctions.

1.1.2 Thesis outline

Law and policy on mental health service provision emphasise the importance of promoting the involvement of the service user in decision-making. At the same time, empirical evidence demonstrates that people with mental health needs typically retain the capacity to make decisions about their lives and survey data into the attitudes of healthcare professionals suggest that most of them also support the involvement of service users in decision-making. Nevertheless service users report high-levels of exclusion from decision-making, and the legal system has been an imperfect ally in promoting the rights of people with mental health needs to have a greater say in their own lives. This thesis attempts to explain this problematic disjuncture between policy and evidence.

I start by exploring how the social phenomenon of madness looks different when viewed from the perspective of social systems theory. So this Introduction will outline how social systems theory describes society as comprised of a variety of functionally differentiated subsystems of meaning, including the legal, economic and political systems. Chapter Two examines how madness can be understood as consisting of utterances or acts which lack a specific meaning referent and therefore cannot be made sense of either within the operations of social systems, or more locally within the operations of interaction systems such as the family. Chapter Three describes the operations of the psy-disciplines as unified around a distinction between madness and sanity and asks what functions this system of knowledge of madness is able to perform for society. Chapter Four then looks beyond madness and the psy-system to the operations of other systems such as the law and economy and asks why these systems may be motivated to exclude mad utterances from their operations to the greatest degree possible. I argue that the function which the distinction disdain/esteem performs within interaction systems such as local communities is mirrored in the function which the distinction discreditation/accreditation performs for social systems. Social systems discredit and accredit utterances in order to maintain their boundaries, and to ensure that they can continue to apply their own internal code effectively.

One of the criticisms which has been levelled at systems theory is that far from being a sociological description of modern societies, it is in fact *"not sociological enough"* (Cotterrell 2003 p.250). This is certainly a fair criticism of Luhmann's own work, which tends to describe social trends in general rather than specific terms and relies primarily on secondary literature as a source for claims about social change. It is also true, to a more limited extent, of much of the literature which has attempted to employ systems theory within socio-legal research. There are some exceptions, Paterson's work on the regulation of the offshore oil and gas industries is based upon extensive empirical study (Paterson 2000) and King and Piper's work on the law relating to welfare of children draws systematically and exhaustively on the large empirical literature on the work of child welfare services and the family courts (King and Piper 1995). This thesis explores how the impact of the meaninglessness of madness can be used to explain the shortcomings of policy and legal interventions intended to afford mad people a greater say in the decisions which affect their lives. Chapter Five looks at the research literature on mental health service user involvement in decision making and argues that the difficulties of promoting involvement can be understood as resulting from the ease with which social systems discredit mad people. The problem of discreditation is compounded by the difficulties of constructing a positive social identity around madness and the weakness of social knowledge of madness. Chapter Six then looks at how the legal system responds to what mad people have to say about their care. Using the Mental Health Review Tribunal as a case study, it argues that the legal system systematically privileges psy-system accounts of the individual over the individual's self-understanding, not as a result of bigotry but simply because of anxiety about the uncertainty madness generates around social meaning.

In conclusion, Chapter Seven summarises some of the strengths and some of the limitations of the systems theoretical approach and argues that the theory provides a provocative lens through which to view developments in mental health law and policy.

1.2 What [some] mad people have to say...[1]

Systems theory does not provide a grounded or bottom-up account of individual experiences. It has been criticised for offering an excessively complex top-down description of society which supplants people's own self-understanding of their situation (Flood 2005). This is a significant criticism and one which will be engaged with in this chapter (pp.46-51). But the observations I made above about the degree of exclusion and discreditation mad people experience are consistent with the personal accounts they provide of their treatment by mental health services. Research has demonstrated that

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[1] A note on term: as the next two chapters will make clear it is a central contention of this thesis that the category of 'mad' is socially constructed and therefore always contingent. Terms for madness which imply a pathological categorisation such as mental illness have been avoided throughout this thesis. Instead I have used the terms 'mad people' and 'mad person' to denote people who are perceived to be distinguishable on the basis of their madness. When talking specifically about the delivery of mental health care I have used the term 'service user' to refer to the subset of mad people who use mental health services.

mad people's views on services are typically heterogeneous (Lammers and Happell 2003) and that as a result attempting to adequately summarise the likely views of service users based on a few personal accounts is essentially futile. The accounts quoted here are not intended to provide an aggregate picture of mad people's views. Instead, they demonstrate that both individual experiences and understanding of madness are diverse, with mad people expressing views which range from the radical to the conservative, the critical to the accepting and the political to the spiritual:

> *"They treated me as though I was ill, so I became more passive. Part of being a patient is to expect a cure...it is not surprising that people take on this state of mind, expecting the next drug to be a cure, that doctors know best. It takes away one's initiative and the search for other, human action-based solutions."* (Lindow 1995)

> *"I thought I'd cracked the system. I laugh now, painfully. The system well and truly cracked me. The freedom I had found for six short weeks was now over. Everything I had felt, loved, over that time, I was told was 'all a delusion'. Time to conform."* (Shaughnessy 2000)

> *"I hated the regimentation, the requirement that I take drugs that slowed my body and my mind...My only aim during my two month stay in hospital was to get out...At the same time I was consumed with the*

> *clear conviction that there was something fundamentally wrong here. Who were these people who had taken such control of our lives? Why were they the experts on what we should do, how we should live? Why was the ugliness, and even the brutality, of what was happening to us overlooked and ignored?"* (Chamberlin 1998, original emphasis)

Vivien Lindow, Peter Shaughnessy and Judi Chamberlin describe how the mere fact of being an inpatient took away their right to claim knowledge of themselves or how best they should be treated. However, the substituted rationality of the medical system did not offer a desirable alternative; the diagnoses and treatment they received replaced action, initiative, love, spontaneity and vigour with control, conformity, regimentation, ugliness and brutality. However, medical labels are not always rejected, and some people find them reassuring. Esther Freud writes about her anxieties on seeing a therapist after an unexplained crisis:

> *"'But what happened on the bus...' I tried to explain the drowning.*
>
> *'A normal panic attack,' he assured me and I almost laughed, normal, normal...*
>
> *'So you don't think I'm beyond hope?' And he smiled with me and said I was going to be alright."* (Freud 1996)

Some mad people both accept the medical account of madness and argue that normalising the experience of mental distress and treating mad people as if they had a physical illness would reduce the disempowerment and stigma they experience.

> *"To clear up stigma we have to recognise that madness is just another illness, one that should inspire compassion and not ridicule. We have to show that it is 90% curable. And it could happen to anyone. It makes a marvellous plot for plays and films, but it is not different to sciatica and lumbago."* (Jameson 2004)

> *"With my rheumatologist and my lung doctor...I am a full partner in my own treatment and recovery. I am consulted, listened to, and given the information I need to make informed choices."* (Chamberlin 1998)

As an alternative to medical accounts of mental distress some service user advocates have argued for a social model to be employed instead. Rather than seeing such symptoms as innate problems they argue that mental distress is made problematic by the attitudes of the wider community and that it is the community which needs to change not the individual if the suffering and social exclusion associated with mental distress is to be eliminated (Sayce 2000 pp.133-139). Sometimes it is not the illness a person has but their use of mental health services which takes away their social standing.

> *"I have a neighbour who used to run inside when she saw me and now ignores me. She will have seen dramatic incidents such as me being taken to hospital by the police when I was very ill."* (Antoniou 2004)

Even professionals who might be expected to know better make assumptions about the likely status of people with mental health needs:

> *"When I first decided to become active in the consumer movement, to speak out and stand up, to be counted, I was very apprehensive and unsure. My first experience of public speaking, following becoming ill, was at a conference attended by psychiatrists, psychologists and lawyers...The organisers of the conference included me in the program as Dr Helen Connor, Psychiatrist. When I attempted to correct this the conference organiser said 'But of course you are a psychiatrist, look at the quality of your paper; well you must be a clinical psychologist then, a consumer wouldn't have written that paper'. That hurt me deeply."* (Connor 1999)

Finally, some service users actively seek out alternative and individual explanations of their distress, which they feel valorise aspects of their experiences which are excluded from medical and sociological accounts of illness. Rosalind Caplin, for example, describes how she valued the approach taken by a homeopath she consulted:

> *"My label was not considered in the remedy – which was given on the basis of my overall personal makeup, my emotional, physical and energy states at the time. I was treated as an individual – a response*

> *far removed from the psychiatric one, which still considered me to be abnormal."* (Caplin 2000)

Other social factors which service users have identified as formative in their experiences of mental distress include racism and gender bias from within the community and within the 'system'. Veronica Dewan, for example, writes about how her suicide attempts as an adolescent were in part triggered by the identity crisis she felt as the child of an Indian father and Irish mother growing up in an Irish family (who had adopted her) in England. This feeling of lacking an identity and its impact upon her were compounded by the insensitivity of her local hospital when she arrived there asking for help:

> *"Back at A&E reception they ask you lots of questions... 'Ethnic background?' Why? I have to tell someone – I don't know how to explain. Well, I was born here. He keeps staring at me. 'I'm British.' He taps his pen on the desk. 'Where are your parents from?' he insists. Which parents, which ones? English and Irish, Irish and Indian. 'Where are your parents from originally?' 'I'm mixed Irish and Indian.' 'Indian – that's what I thought', he snaps and ticks the box for Asians. But I'm – it's just that – oh what's the point?"* (Dewan 2000)

Despite the significance of these self-understandings, many mad people recount how they do not feel that the system empowers them to introduce their own perspectives on their care into decision-making processes:

> *"At the end of the section my consultant...said to me 'Your girlfriend visits too much, it's bad for you.' I had to bite my tongue - I'm still on a section. He said to me, 'When you are in hospital you complain a lot.'*
>
> *'Yeah, that's right,' I said.*
>
> *'Complaining is a symptom of your illness. Next time you come in, we'll ignore them.'"* (Shaughnessy 2000)

Shaughnessy's description of how his attempts to influence the care he received in hospital were in turn pathologised and thus defused are acknowledged in research into user involvement (Barnes 1995, Rose 2001, Hodge 2005) but rarely expressed so clearly. In addition he raises the issue of how his legal status further disempowers him; being on a section means that he is not in a position to disagree with this analysis. Christine McIntosh also argues that rights to information are a prerequisite for patients wishing to challenges decisions reached upon their behalf:

> *"...after much soul searching, I consulted a lawyer and was shocked to discover that nowhere in law does it state that a patient has a categorical right to be informed of their diagnosis...I have little recourse against the very people who were supposed to look after my mental welfare. I would happily trade the empty Patient's Charter for a few basic civil rights."* (McIntosh 2000)

Rachel Perkins makes the further point that she needed information in order to make treatment choices not only as an empowerment strategy but because without it she couldn't be an active participant in her treatment or reduce the risks associated with ECT:

> *"...this was brought home to me when the consultant psychiatrist with whom I work asked me questions like 'What equipment did they use?', 'How many volts?', 'What anaesthetic?', 'What seizure length?'. My rather pathetic answer – 'I don't know' was greeted with the response: 'Why ever not? I bet you know the name of the medication you're taking'...I have worked in mental health for many years and I did not know these things. It transpires that they are important questions especially for women."* (Perkins 2000)

1.3 The voice of the service user in law and policy

1.3.1 Service user involvement policy in England and Wales[2]

One reason why these accounts of feeling excluded from decision-making should be surprising is that involving people in the decisions made about their healthcare and treatment is a central objective of current healthcare policy in England and Wales. Guidance on the delivery of care to people with mental health needs describes patient involvement as playing a primary role in ensuring better treatment outcomes (Department of Health (DH) 1999a, DH 2008a). However, the meanings attached to the term 'involvement' in research findings on the effectiveness of involvement as a strategy are diverse and confusing. Both professionals and service users have been actively involved in researching service user involvement, sometimes to determine the significance

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[2] Another note on terms: the terms 'user participation' and 'user involvement' are used largely interchangeably in the research literature in this area. Whilst some authors would imply that the two terms connote very different things (Arnstein 1969, Chamberlin 1988) the distinction between the two terms is not observed consistently. The term favoured in English and Welsh policy-making is user involvement, and so for ease of reference that will be the term employed here.

of involvement for professional practice (Anthony and Crawford 2000, Summers 2003), sometimes to highlight the lack of 'real' involvement for some service users (Peck et al. 2002, Langan and Lindow 2004, Hodge 2005a) and sometimes to develop a better understanding of related topics, such as the origins of social movements (Crossley 1999) or the impact of consumer models on health service provision (Barnes and Prior 1995). As a result it is not easy to summarise what is known about service user involvement since knowledge in this area is locally situated and contingent. However, the very fact that involvement is seen as a distinct phenomenon and worthy of study is interesting. People who use mental health services are inextricably involved in their delivery: services could not be offered if there were not individuals there to receive them. The phenomenon being described must be something beyond the unremarkable degree of involvement implicit in simply receiving care and treatment. This new 'involvement' must presumably be intended to change the existing possibilities for communication within mental health settings, since otherwise no new policy making would be required.

The bulk of references to service user involvement as a principle are contained within national non-statutory regulations and policy documents. There are also references to involvement as a practice in some guidance documents published by international bodies including the World Health Organisation and the Council of Europe. However, summarising the law on service user involvement in personal care planning is simple. The law requires the consent of patients for decisions relating to medical care and treatment but does not expand on the requirement for consent to specify any particular form of involvement in the decision reached. Mental health legislation in England and Wales has historically been preoccupied with delivering procedural justice to those subject to compulsory powers, and has avoided addressing the more thorny issues of what mental health professionals might be expected to do to ensure that service users feel meaningfully involved in decisions about care. Since the Mental Health Act 1983 (MHA) is primarily concerned with determining when the involuntary detention and treatment of individuals in hospital may be lawful it is perhaps not surprising that it originally omitted any reference to involving the service user in decision making. Its operating assumption is that ordinarily service users will be able to decide when they want care and treatment and that in those circumstances they should be treated as identical in terms of rights to those using somatic health services.

The expert committee convened to review the Mental Health Act agreed with the view that the role of compulsory powers under statute should be essentially residual, with the ordinary assumption being that treatment decisions will be made outside of the law and on the basis of consent (DH 1999b). They recommended that the right to participation in assessment, care planning and treatment should be one of a number of general principles given an elevated status in any new legislation, but they make clear that they do not intend these principles to be interpreted as enforceable rights for service users. The Government White Paper on 'Reform of the Mental Health Act 1983' (DH and Home Office 1999) did not accept the need for these general principles, although it did assert that it was government policy to promote involvement of service users and carers though other policy initiatives (presumably the National Service Framework for Mental Health (DH 1999a) and the revised guidance on the CPA (DH 1999c)). The final outcome of these lengthy debates over mental health legislation for England and Wales has been the introduction of a short act to amend existing legislation. The new Mental Health Act 2007 does not contain a statement of principles, but S.8(2)a of the Mental Health Act 2007 requires that the Secretary of State include a statement of fundamental principles within the Mental Health Act Code of Practice and s.8 (2)b states that:

> *"In preparing the statement of principles the Secretary of State shall, in particular, ensure that each of the following matters is addressed—*
>
> *(a) respect for patients' past and present wishes and feelings,*
>
> [and]
>
> *(d) involvement of patients in planning, developing and delivering care and treatment appropriate to them,"*

The latest version of the Code of Practice accordingly includes involvement under the banner of the 'participation principle' (DH 2008b para.1.5). However, the significance of references to involvement in this and other soft-law sources has not yet been given any attention by the courts. This is perhaps not surprising given the legal status of the Code of Practice. In a recent decision on the legal status of the Code of Practice a majority of the House of Lords held that the Code could not be departed from unless there were cogent reasons for doing so (*R (Munjaz) v. Ashworth Hospital Authority [2005]*). But in the case in question (which concerned the application of a seclusion policy within one hospital which was wildly at odds with that prescribed nationally in the Code of Practice), the fact that medical opinion at that hospital favoured not applying the Code justified the hospital's decision to apply a different policy. In other words, the Code must be adhered to unless the patient's doctor favours not applying the Code. The weak status of such regulatory documents means that a service user who wished to contest her exclusion from decision-making might well be advised that she did not have a case. It might also be the case that given the conceptual uncertainty attached to the term involvement, any right to it as such would not make a radical difference to service users.

Elsewhere, legislation has been used to ensure that health service providers have a duty to promote community participation in decisions relating to service planning and delivery (i.e. beyond merely personal care planning). However, the history of legal reforms in this area has been chequered. S. 11 of the Health and Social Care Act 2001 provides that

> *"It is the duty of every body to which this section applies to make arrangements with a view to securing, as respects health services for which it is responsible, that persons to whom these services are being or may be provided are, directly or through representatives, involved and consulted on:*
>
> *(a) the planning of the provision of these services*
>
> *(b) the development and consideration of proposals for changes in the way those services are provided, and*
>
> *(c) decisions to be made by that body affecting the operation of those services."*

The following year, s.20 of the NHS Reform and Healthcare Professionals Act 2002 required the Secretary of State for Health to establish a Commission for Public and Patient Involvement in Health (CPPIH) (this section was further amended by s.32 by the Health and Social Care Commission Healthcare and Standards Act 2003). The CPPIH was intended to coordinate the creation of patient and public forums in NHS Trusts around the country and to evaluate their performance. But in June 2004, after a review of spending on 'Arms Length Bodies' across government it was decided to amend primary legislation, abolish the CPPIH and create a new Patient and Public Involvement Resource Centre which would be privately run but managed by the NHS Institute for Innovation and Improvement. A new non-statutory 'NHS Centre for Involvement' which operates independently but under the auspices of the NHS was founded to replace the CPPIH in 2007. The CPPIH had been instrumental in ensuring that every health trust in England and Wales had a Patients Forum (PPI). However, these forums have in turn been dissolved and replaced with Local Involvement Networks (LINks) under Part 14 of the Local Government and Public Involvement in Health Act 2007. The continual upheavals in government policy on the promotion of patient involvement has meant that although this strategy was first outlined in the NHS Plan (DH 2000), it is still too early to comment upon what effects it is having on service delivery on the ground.

LINks cover the same geographical areas as local authorities but must be hosted by an organisation independent of both the local authority and the NHS. They are intended to work on both health and social care delivery, unlike the old Patients Forums. Many of them have connections to non-statutory public consultation forums, such as those set up expressly by or for service users. However, the degree of active involvement in service planning they undertake is likely to be dependant both on local membership and the relationship they have with health service providers. Although research into these forums has not yet been conducted, the potential vulnerability to service provider control of existing consultation bodies has been demonstrated in a number of research studies (Pilgrim and Waldron 1998, Peck et al. 2002, Diamond et al. 2003, Rutter et al. 2004, Hodge 2005a).

The provisions of the Health and Social Care Act 2001 provide an example of what seems to be a slightly paradoxical state of affairs. The complexities of securing effective involvement at the service planning level would seem to be far greater than those involved in promoting involvement as a matter of policy (not just practice) at the personal level, and yet in national policy terms it is the latter not the former which has been neglected. Some of the historical and political reasons for this will be discussed in greater detail later on. It is notable that in the most recent NHS Plan, commitments are made to increasing the role service users play in making treatment choices and increasing the say service users have in planning services at all levels of delivery (DH 2000). However, a specific reference to involving people with mental health needs is only made once: the Plan comments that service user involvement forums should draw on the experience of specialist advocacy organisations in working with people with mental health needs. It is not suggested that specialist external advice should be sought before working with any other category of service users. The Department of Health also commissioned 12 research studies to look at the practice of increasing public involvement in health service planning. Not one of these studies looked at involvement in the context of mental health services and the subsequent report contains no references to mental health service provision (DH 2004). This would tend to support the view that policy makers have sometimes failed to exclude mental health service users from the new consumer led agenda in the health service rather than chosen to include them. Mental health service users have not even been an afterthought, which is why no attention appears to have been paid to the question of how such choices could be exercised within a context of potential compulsory treatment, growing public anxiety about violence and the increasing use of extra-legal coercion within specialist mental health services to ensure treatment compliance.

References to involvement in personal care planning and in service planning are also sparse when one looks specifically at mental health policy documents. However, Standard 4 of the National Service Framework for Mental Health, which relates to care planning and delivery, states that:

> *"When service users are involved in agreeing and reviewing the [care] plan, the quality of care improves, and their satisfaction with services increases."* (DH 1999a)

And the latest guidance given by the Department of Health on care planning in mental health also states that:

> *"...service users and their carers are partners in the planning, development and delivery of their care [and] need to be fully involved in the process from the start...Service users will only be engaged if the care planning process is meaningful to them, and their input is genuinely recognised, so that their choices are respected."* (DH 2008aa)

It seems fairly clear then, that involvement is something that the Department of Health thinks mental health professionals and service providers should aspire to. However, as Chapter Five will outline, realising these aspirations has proven difficult in practice, and this may be linked to the fact that whilst involvement is widely endorsed, the reasons for involving service users are rarely explained.

1.3.2 Involvement in international law and policy

Involvement is also mentioned in a variety of documents addressing the rights of mad people that have been produced by international bodies including the United Nations, European Union and the World Health Organisation. Since the European Convention on Human Rights forms a justiciable part of English law, it is the jurisprudence of the European Court of Human Rights (ECHR) that might be expected to have the greatest impact upon the rights of mad people. However, the ECHR case law on the rights of mental health service users has been, if anything, even more preoccupied with procedural justice than the national law. Commentators have noted that in many of the key cases relating to the rights of people with mental health needs including *Winterwerp v Netherlands [1979]* and *Herczegfalvy v. Austria [1993]*, the European Court has skirted round many substantive issues whilst reinforcing the view that procedural measures alone can ensure convention compliance (Fennell 2005, Richardson 2005, Bartlett et al. 2007 p.18). Although the jurisprudence does not deal directly with the issue of involvement, the issue of this focus on procedural justice is important because it demonstrates why a right to involvement, even if it existed, might lack any teeth. Bartlett and Sandland (2007) suggest that the rulings in *R (Wilkinson) v. Broadmoor and MHA SOAD [2002]* and *R (Wooder) v. Feggetter and MHAC [2002]* may reflect a shift in the approach taken by judges in the English courts to cases in which the application is a mental health service user. Both cases, however, involved issues of traditional procedural justice, and they only suggest that the courts may take a marginally more creative approach to determining issues of administrative law in light of the Human Rights Act 1998 (HRA). It has not been suggested anywhere that that HRA requires that the views of the service user be given greater weight.

Fennell (2005) takes a gloomier view. He suggests that the 'new human rights agenda' has been used to emphasise the role of government in promoting the Art 2. right to life and therefore having a duty to protect the public from harm at the hands of mad people and this has been at the expense of service user's rights not to be arbitrarily detained or treated. In this respect, the HRA may have even set back the agenda to promote rights for service users to participation and autonomy. Richardson (2005) suggests a number of directions which the courts could take in extending the reach of convention rights beyond process, although she concludes that in most respects the approach of the English courts to date has been disappointingly narrow.

The Council of Europe has however, made a recommendation on the 'Protection of the Human Rights and Dignity of Persons with Mental

Disorder' (CoE 2004) which includes as a general principle the requirement that where possible individuals should be consulted on their treatment plan (Art.12.1). These guidelines are not intended to have binding effects on member states and the UK is, in any event, not a signatory to the Recommendation. Current English mental health law does not comply with a number of the principles in the Recommendation, including the requirement that a capacity based test be used to determine whether or not treatment without consent is lawful (Art.12.2) and the requirement that decisions on compulsory admission to hospital be made by a court or other competent body (Art 20.2). Despite the fact that the Recommendation pays much greater attention to substantive issues around the practices of mental health professionals than the case law of the ECHR it nevertheless continues to pay considerable attention to issues of process which perhaps reflect the largely legal and judicial capacities of this organisation.

It is clear that the primary objectives of an organisation affect the way in which they conceptualise involvement. The European Union, for example, wants to establish an EU-wide strategy to improve mental health. They perceive the economic impact of mental illness in particular as a growing problem for member states. Their green paper on 'Improving the Mental Health of the Population' (European Commission 2005) strongly advocates public involvement in redesigning mental health services and reforming policy in order to increase the efficiency of such services. The World Health

Organisation in its 2001 World Health Report focussed on mental health and made 10 recommendations to countries around the world on how to improve mental health in their populations (WHO 2001 pg.110-2). Recommendation 5 was that policy makers should 'Involve communities, families and consumers'. The report argues that this should improve services and ensure that they are better suited to the needs of the community. This echoes the statement on involvement made in the National Service Framework for Mental Health (1999a) but no supporting evidence for this claim is cited.

The United Nations in their "Principles for the Protection of Persons with Mental Illness" (High Commission for Human Rights 1991) state that "*The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient,*" (Principle 9.2) and that patients shall be *"involved as far as practicable in the development of the treatment plan."* (Principle 11.9). These principles cannot be enforced by individuals, and, unlike other similar documents, there is no body charged with monitoring their implementation. Their use as a tool for advocates and individual service users is therefore limited (Rosenthal and Rubenstein 1993). Gendreau (1997) points out that the Principles, rather than reinforcing the rights of people with mental health needs to non-discrimination, instead delineate when such discrimination is acceptable; in the process they make such discrimination easier for states to justify. In an analysis which bears some similarity to that of Fennell cited above she asks: *"Is this the unavoidable effect of the explicit recognition of psychiatric patients' rights at the international level?"*.

A new and hopefully less overtly discriminatory approach is adopted under the UN Convention on the Rights of Disabled People. The Convention includes mental disorder within its definition of disability for the first time, and places a number of obligations on state parties to work towards securing positive social inclusion for disabled people. Significantly, it places considerable emphasis upon participation, and creates specific rights to participation in political and public life (Art. 29) and participation in cultural life (Art. 30). It is also the case that during the drafting of the convention considerable attention was paid to the views of disabled people. The Ad Hoc Committee appointed to draft the convention took an unprecedentedly open approach to promoting the involvement of civil society in its work, and placed considerable emphasis on the need to hear evidence from disabled people (including people with mental illnesses) (Light 2005). The Convention was only ratified in March 2007, and the United Kingdom is only a signatory to the Convention itself and not to the Optional Protocol which allows for individual complaints, so it is too early yet to assess what impact, if any, this much more robustly worded document will have on the right to participation enjoyed by mad people in England and Wales.

It is worth noting that the WHO and EU recommendations conflate the roles of service users, their carers and the wider community into public involvement even though their agendas may often conflict. Barnes and Bowl (2001 pp.42-3) discuss the prevalence of this conceptual confusion, and suggest one reason for it is that, historically, carer led campaigning groups often presented their agendas as being identical to those of the people they care for in order to increase their political leverage. Similarly, the rhetoric of some groups campaigning on public safety issues such as the Zito Trust and SANE might lead people to believe that their primary concern is the promotion of rights for mad people. This confusion is not helpful for mad people who are trying to argue that they have a distinct contribution to debates about the services they and others receive. As a result the extent to which the recommendations of the WHO and EU really indicate a commitment to meaningful involvement for mad people is debatable.

The extent to which individuals with mental health needs are excluded from the decisions made about their lives is both unsurprising and surprising. It is unsurprising because mad people are often assumed to be incapable of exercising decision making powers in their own best interests. Indeed the earliest legal interventions designed to protect the interests of people with presumed mental health needs were occasioned in part by the need to protect them from making poor decisions about the allocation of their property (Bartlett and Sandland 2007 p.17). But empirical research conducted into the operation of care planning processes tends to assume that people are ordinarily excluded from the settings within which decisions about care are reached and therefore can have little control over their outcomes (Pilgrim and Waldron 1998, Anthony and Crawford 2000, Peck et al. 2002). It is abnormal insofar as mental health law typically begins with a presumption that individuals enjoy physical and mental autonomy, and are not merely capable but are also the best people to make decisions about their lives. And for many people with mental health needs, who have never been subject to legal compulsion of any sort and who have little contact with specialist mental health services, such a model makes sense. From this perspective, it is the legal assumption that people with mental health needs should not have their liberty infringed unnecessarily which appears innovative.

The law, however, is an imperfect ally because the available evidence on involvement suggests that it is as yet imperfectly defined (see Chapter Five pp.183-92) and cannot readily be reduced to the narrow set of procedural and substantive distinctions which the legal system is typically capable of observing. For example, it is notable that whilst the emergence of evidence based psychiatry has led to increasingly nuanced accounts of mental disorder (the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM IV-TR) contains considerably more diagnostic possibilities than those available to nineteenth century physicians), legal constructions of the individual with mental health needs continue to revolve around a handful of key attributes such as capacity and dangerousness, which are held to contain as much information as it is necessary for law to grasp about an individual before pronouncing upon the legality of an intervention. Most of all the need for legal decisions to be binding over time and across cases with similar facts does not reflect the contingent nature of mental disorder itself. The contingency of mental disorders can be observed from the fact that their symptoms, and consequently diagnoses and treatment plans, are dynamic rather than static, and can change within timescales far shorter than those within which the law operates. But the contingency may also arise from other elements of the social context. Peay (2005) provides an example of this when describing a study of how doctors and social workers reach decisions on whether or not to compulsorily admit patients. They presented a group of 40 psychiatrists with a scenario concerning a man whose mental health appeared to be deteriorating and found that 30 of the 40 would choose to compulsorily admit him. When they presented the same scenario to a group of 20 forensic psychiatrists they found that none of them would choose to compulsorily admit since they viewed the patient as a comparatively 'soft case'. So decisions about the application of the law made by non-legal actors may be affected by (amongst other things) the specific expertise and experience of the person in question.

1.4 Defining systems theory

One theory of why the law deals with contingency in the way that it does is advanced by Niklas Luhmann. Luhmann was a German sociologist working in the latter half of the twentieth century who set himself the ambitious task of outlining a complete theory of society which could explain the emergence and maintenance of social order in the face of continued disruption and disorder (Luhmann 1997a p.11). He was strongly influenced by the emergence of systems theory as a cross-disciplinary approach to understanding interaction. Systems theories are diverse but they all aim to provide an account of the interactions of components of a system. These components could be the parts of an aircraft, sections of code operating within a computer program, the DNA of living organisms or the members of a family. Systems theoretical approaches are further unified by a desire to explain the dynamics that operate within a system, rather than simply describe the attributes of these components in an atomistic fashion. Von Bertalanffy, in a wide ranging discussion of systems theory, makes the claim that *"Social science is the science of social systems"* and that the claim of sociology to scientific distinction is founded upon its focus on interactions which can best be understood at the level of the system (von Bertalanffy 1969 pp.194-7).

Luhmann was particularly impressed by the systems theory of Talcott Parsons (Parsons 1991/1951), with whom he worked for a year whilst conducting his doctoral thesis. But he swiftly moved on from Parson's action based theory of society to advance an alternate model based on the observation that communications rather than actions provide the fundamental building blocks of systems of social meaning. Communications rather than actions are the indissoluble basic elements of society, they provide the means by which information is coded and transmitted so as to produce social order (Luhmann 1995/1984 pp.38-9. Whilst Luhmann accepts that there exists an ontologically real world comprised of organisms and objects, meaning exists only at the level of the social and can be transmitted and understood only through communication. Communications are comprised of three components: utterance → selection → understanding. Thus communication must always involve at least two psychic systems, 'psychic systems' being the term Luhmann employs to describe individual systems of consciousness. Communication has no ontological reality for Luhmann. It cannot be reduced to physical acts because it is the unique preserve of the social. He asserts that even though we can retrospectively break social systems down into their constitutive actions, we cannot form social systems out of an accumulation of acts - for that one needs communication (ibid. pp.137-41). Communication for Luhmann is therefore mysterious, because it is so very improbable that it should ever happen at all. Meaning can arise only at the level of the social system and utterances can contain no inherent meaning. Luhmann terms individual systems of consciousness (or human minds) *'psychic systems'*. Psychic systems and systems of communications are structurally complementary, although the relationship is asymmetrical since psychic systems can exist without communication but communication systems cannot exist without psychic systems (Luhmann 2002a). Luhmann further distinguishes between the emergence of small locally defined interaction systems such as families and local communities and functionally differentiated subsystems of meaning such as systems of legal meaning, economic meaning or scientific meaning. The emergence of the latter is, for Luhmann, a hallmark of modernity.

We can identify the social system to which a communication belongs by reference to the binary code it addresses. All those communications which address the code legal/illegal comprise the legal system and can be distinguished from the code of the economic system (efficiency/inefficiency), business (profit/loss), politics (power/not power, which in democratic societies is often marked as the distinction between government/opposition), religion (immanence/transcendence) and so on (Hornung 2006). Closure arises from the systems attempts to functionally differentiate itself from other systems. In this respect each communication about the legal code, helps to define the law's boundaries to those of other systems in the process closings its operations to them. However it is the self-referentiality of systems which leads to their ultimate closure from other systems. Law defines laws 'truth' solely by reference to its own operations, its previous decisions and the statutes it chooses to interpret and apply in a particular way. In this way, just as other theories of law have attempted, systems theory provides an account of law's separation from morality (Luhmann 1993).

Luhmann sees functional differentiation as a product of social evolution. Prior to the Enlightenment, codes were not differentiated. Society was instead stratified, with religiously justified moral communication providing the schema within which communications relating to law, politics and the economy were understood. Functional differentiation is an emergent quality, which Luhmann describes as happening in Europe as a product of the Enlightenment during the eighteenth and early nineteenth centuries. However, Luhmann is at pains to point out that this evolutionary model is not goal-oriented (Luhmann 1995/1984 pp.397-8). Evolution only describes the mechanism, in this case the selection of operations, by which social systems have attained the characteristics we can now observe them to have. He argues that the view that law operates as an external regulatory lever upon society is flawed. Instead, law is just one part of the web of social systems that collectively create the framework we call society (Luhmann 1989a). As a result, law has no privileged insight into the operations of other systems, its insight is always constrained by its need to reconceptualise the operations of other systems in order to see them from within its own frame.

Luhmann defines this closure as a product of social *'autopoiesis'* a concept he developed from research in the field of biology where the term had been coined to define the key characteristics of living systems (Maturana and Varela 1980). Autopoietic systems are those which are capable of maintaining themselves internally and of reproducing themselves, provided they can take some resources such as sunlight from the natural environment. Autopoiesis is thus characteristic of living systems, but not of systems arising in the physical environment, such as waterways, nor of engineered systems, such as machines or computer programs. The creative impulse Luhmann derived from the work of Maturana and Varela (who have also applied the term to social systems, see Maturana and Varela 1992) was to identify that social systems of meaning share these attributes of living systems: they are capable of maintaining their own boundaries, employ self reference in their reproduction and nonetheless remain operationally open to their environment in a manner analogous to the relationship between living organisms and their environment.

But it has been argued that law appears to connect with other systems far more than autopoiesis allows, indeed, it is forced to, since it does not function purely to prescribe the conditions of its own continuing operations but to prescribe the correct, i.e. legal, operations of other systems (Teubner 1989). Luhmann argues that law never has direct effects on the operations of other systems (Luhmann 1992a). Instead, events take place within the environment of the legal system, which come to have meanings applied to them within more than one system, so a woman who develops the belief that she must kill her own child, may be reconstructed within the psy-system as suffering post-puerperal psychosis, within the legal system as having a mental disorder which is sufficiently serious as to warrant a compulsory admission to hospital, within the child welfare system as an instance of child endangerment which warrants intervention and so on. All of these constructions will unleash a chain of operations within each system, and will also act as irritants for the operations of other systems.

This example gives some idea of how powerful social systems theory could be in helping us understand how communications about mad people are made, or fail to be made. Rather than locating the incoherence of the mental health 'system' (which is really not a system at all, but a conglomeration of communications made within a wide range of different closed discourses) in shortcomings of individual actors, or in the lack of a shared language, Luhmann's systems theory suggests that we should anticipate communication failures.

1.4.1 Radical consequences

Luhmann himself (1995/1984 p.lii) suggested that his writings about systems theory resembled a labyrinth, such that pinpointing precisely what Luhmann means is not always possible. He has bequeathed a body of texts which are not always internally consistent (nor should we expect the products of a forty year career to be so) and not, perhaps ironically, self referential. Luhmann rarely distinguishes between his earlier or later work, or steps back from the central thesis he is expounding to explain how his ideas fit together. As a result, any account of his account of autopoietic systems will necessarily be partial and oriented towards the theoretical concerns of its author. This may help to explain why the reception of his ideas within the English-speaking world has been inconsistent, and has resulted in considerable dissent over how his work should be interpreted (see the dispute between Mingers 2002 and King and Thornhill 2003 for example).

Within socio-legal theory, the idea of law as a social system comprised of communications has also been explored by Gunther Teubner. However, Luhmann's ambition of providing a complete account of modernity led him to employ an incredibly far-reaching approach to theory building. Teubner's body of writing does not approach it in terms of depth or breadth. Consequently, in considering how law interacts with other social systems, Luhmann's theories provide the more obvious starting point. Both Luhmann (1992b) and Teubner (1993 pp.27-30) agreed that much of their work was complementary, and it has been argued that with the exception of some key differences, including differences in their views on closure and evolution (that is whether autopoietic closure results from evolutive or evolutionary forces), it is possible to employ the extensive work of Luhmann in making supporting claims for the work of Teubner (Paterson 1996).

Teubner's work has tended to focus on the interactions of law and the economy, and in particular upon the phenomenon of regulatory failure (Teubner 1998). Regulatory failure arises when the implementation of a regulatory regime in another social system results in unintended and adverse consequences for the regulating system (or law). It occurs because other systems will always seek to minimise the difference between what their own binary code demands and the legal code. The economic system will be concerned with maximising the efficiency of implementing regulations, communications within political system will be concerned with adopting regulatory interventions in such a way as to maximise the chances of achieving or maintaining the power to govern. In mental health law, we could see the widespread use of extra-legal coercion in preference to legal coercion as a consequence of regulatory failure. Extra-legal coercion involves the use of threats or moral suasion to ensure that a patient complies with treatment in the community (Monahan et al. 2005) or agrees with admission to hospital (Poulsen 2002). Patients who agree to the demands placed upon them are treated as acting voluntarily and decisions made about their care and treatment are not subject to the same degree of scrutiny as decisions to compulsorily admit or treat a patient would be. Nor do such patients have a right to appeal to a tribunal or court to demand an end to the compulsion. However, from the difference minimising perspective of the psy-system such voluntary-involuntary compliance is to be preferred to legal coercion, because the latter requires that paperwork be completed, hearings attended and legal oversight of diagnostic and treatment decisions be permitted.

As an explanation for regulatory failure systems theory offers a number of benefits over competing explanations located in social theory. Firstly, as noted above, it removes the idea of the incompetent or corrupt subject from the explanation. Secondly, it makes us realise the radical limitations placed on the law, since it can only observe, and never directly affect the operations of other systems. Thirdly, for Teubner at least it suggests a way forward through the use of reflexive law (Teubner 1983, Teubner 1993 pp.82-99). Reflexive law creates the possibility of other systems developing their own internal regulatory structures which can define norms for the system which are agreed within the system. Teubner envisages that those who act within a system may be in the strongest position to define the norms they uphold in such a way as to minimise the difference between their own operations and those required under the regulatory code. Luhmann (1992b) however, points out that this may simply create an additional problematic for the law, and still result in perturbations within the operations of the system being regulated. Since, the creation of a reflexive structure implies the possibility of the operations of the other system becoming a legal event, law will continue to need to make observations about the operations of other reflexively regulated systems.

There are not many instances of legal scholars applying systems theory to mental health law, although certain characteristics of mental health law would seem to make it a particularly attractive candidate for an autopoietic makeover. In England and Wales the bulk of decision making about the application of mental health law is conducted by non-legal actors. The majority of decisions about whether to compulsorily admit or detain someone in hospital rely on these actors conducting three simultaneous appraisals of the person's situation, one of whether her state of health warrants admission, one of whether her needs could otherwise be met in the community and one of whether it would be lawful given these circumstances to decide to admit. Moreover, the process of decision making is intended to be carried out jointly by two doctors and an approved social worker. The opportunities here for communication failures seem legion. Indeed, it would seem that the only reason why the vast majority of patients subject to compulsory powers are not in hospital unlawfully is that the law is not that fussy about substance provided that its procedures are followed correctly.

Keywood (2003), in an article about the law's construction of the anorexic body as it applies to decisions about force-feeding, argues that law has enslaved psychiatric concepts and robbed them of their inherent indeterminacy, in the process artificially simplifying the concepts involved. The law only recognises a narrow band of clinical knowledge, which she suggests overstates the view that there is consensus on forced feeding as a practice. If the same analysis is applied to compulsory admissions it might suggest that by requiring a decision about admission or detention to follow a prescribed format, the law is effectively fettering the medical system, which might otherwise reach conclusions on the basis of a wider array of evidence, justify them using wholly different language, and consider a wider range of options than the narrow binary between admit/not admit.

Peay (2005) also offers a brief analysis of how mental health law looks when seen autopoietically. She draws on the findings of an empirical study into decision making in the mental health service and considers what this tells us about the nature of communications made by non-legal actors about the law. Amongst other findings, this study demonstrated that in pairings of doctors and approved social workers (ASWs), the legal role of the professionals involved appeared to influence which member of a discussion's views would dominate the decision reached (Peay 2003). So ASWs were far more influential in discussions concerning compulsory admissions, i.e. when their approval of the decision is essential, than they were in discussions about discharge, when it is the doctor's statutory responsibility to reach the final decision. She suggests that 'creative misunderstandings' about the term 'best interests' may offer a way forward, since this was a term which although not especially relevant to statute, was nonetheless employed in descriptions of their deliberations by many of the professionals involved in her study. And whilst the law, medicine and social welfare may apply different meanings to 'best interests', they can nonetheless paper over the cracks of their disagreements with an appearance of unity.

Both these analyses are interesting in their application, but whilst Keywood is certainly concerned about the meanings applied by law and psychiatry to anorexic bodies, neither analysis affords a space to service users themselves. The law as it relates to the use of compulsion affords no space to the account the service user gives of herself. Instead, the mad person's appearances before the law must always be mediated through another discourse.

To take a recent case as an example, in R (B) v. Ashworth Hospital Authority (2005), B challenged the decision of the hospital authorities to move him, without his consent, into a specialist unit which treated patients with personality disorders. B had been admitted to hospital with a diagnosis of a mental illness and had later been given a further diagnosis of personality disorder. The classification of his mental status under s.37 (the section of the MHA 1983 under which B had been admitted) had not been changed and B's lawyers argued that as a result s.63 which allows for the administration of compulsory treatment in hospital could not be applied.

Baroness Hale gave the leading judgement in which she argued that given the uncertainties attendant upon psychiatric diagnoses, hospitals had to be granted the power to exercise a degree of flexibility when it came to making decisions about referrals. Interestingly however, she also observes that the treatment being offered to B could not, in any event, be unlawful since it did not require any physical interference with his person, he was simply experiencing a different behaviour management regime. This is true, but it also raises the question of why B took the case? B may have taken the case because he felt strongly that the incoherent application of the statutory rules relating to classification and compulsory treatment needed clearing up, but this seems unlikely.

In the earlier judgement of the Court of Appeal some of B's reasons for complaining are outlined more fully (R (B) v. Ashworth Hospital Authority [2003] para.13). Amongst other things he was unhappy that higher levels of surveillance were employed in the specialist unit, that he would be required to attend workshops during the day, and that he would see his RMO less frequently. He was also concerned that the stricter regime on the ward would prevent him from demonstrating that he was able to control his own behaviour effectively and thus secure his discharge.[3] Given that in the special hospital environment B's liberty was already severely constrained, the impact of these new restrictions might be felt especially acutely. However, they are also concerns which are in themselves legally invisible. B does not state that he objects to the physical environment of the ward, nor in this statement does he state that he disagrees with the diagnosis of personality disorder (although he had argued this point at an earlier tribunal). It is, however, only the argument that his reclassification is unlawful that the law can recognise, irrelevant to B though this may be. Both Gledhill (2005) and Bartlett (2006) make the point

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[3] This is based on a statement made by B's solicitor and may therefore also represent a selective account of B's own version of events.

that the safeguards which exist to protect patients from battery or negligence do not meet the mischief, which is that the decision in this case extends the reach of compulsion to any manifestation of a person's mental illness, without affording the patient any power to dispute the appropriateness of such treatment. However, for legal safeguards to truly make a difference to B, both the medical and legal system would need to be able to recognise that being denied access to television, or to one's room during the day, constitutes a valid complaint.

The history of mental health law is often written as a history of a pendulum swinging between law and medicine for control of the process of making decisions about the lives of people with mental health needs (Glover-Thomas 2002 is a good example of this). With such an account in hand it is possible to point to the cruelties meted out by the medical profession when their work is subject to inadequate legal scrutiny and argue in favour of according service users evermore procedural rights to ensure that such abuses are prevented. It is equally possible to point to the impact of cumbersome legal procedures upon the complex and subtle judgements psychiatrists are required to make, and argue that their imposition is antithetical to humane medical practice (Obomanu and Kennedy 2001, Sarkar and Adshead 2005). In recent years the political and policing systems have influenced debates about reform of mental health law in England and Wales. It is argued that the law is insufficiently oriented towards ensuring public safety and reform is needed to encourage doctors to use the powers they have to compulsorily treat patients when a failure to do so might put others at risk (Sheppard 1996, Tidmarsh 1997). The same theme has been heavily promoted in the popular press. It has also been suggested that rather than furthering the 'jurigenic harm' which results from heavy handed debates about rights versus best interests, law could instead play a role in promoting healing by incorporating therapeutic objectives into its reasoning (Winick 2003). The former critique could be seen as an argument in favour of red light or prohibitive regulation whilst the latter mirrors arguments for green light or facilitative law in other areas which require regulation. In both cases however, law is conceptualised as capable of having direct and predictable influence over the behaviour of actors in other domains.

Luhmann suggests that law is incapable of steering social change in this fashion (Luhmann 1997b and Luhmann 2004/1993). Neither prohibitory nor facilitative regulation can alter the normative closure of both law and the social systems whose operations it is attempting to influence. That is not to say such regulation will not have an effect, but its effects will be felt in the form of irritations to the operations of each social system, which will then respond by reconstructing the law in such a way as to minimise the differences between its own operations and those expected of it. As a result, simply giving mad people a 'right to involvement' or to be consulted, might well alter practice, but possibly only to allow for the service user to attend meetings, or whatever else becomes the minimum necessary to avoid excessive interference from the law.

1.4.2 Where have all the people gone?

"Partisans of the subject attack behaviourism, systems theory, information technology, survey research, and ask for the recognition of the subject. But they have forgotten what the word means." (Luhmann 1986)

Bankowski (1996) observes that autopoiesis leaves the individual stranded on the outside of numerous impenetrable social systems. Individuals have closed psychic systems but these are not capable of communicating directly with social systems. Nor are they able to directly observe the functioning of social systems. Instead their selves are reconstructed anew within each system. This total fragmentation has two consequences. One is that it causes acute pessimism about the possibility of humanism within social systems. There is no space for empathy or holistic approaches within systems theory. Systems cannot offer such responses, and closed psychic systems may make noise within the social world but can never communicate directly with the social. However, Bankowski is even more worried about the second consequence which is what Teubner's account of the operations of the law, honour and morality systems implies for individual responsibility. He argues that operations rely on individuals, and that it is incoherent to define the legal system without reference to those individuals acting within it. However, Luhmann's theory does not suggest that social systems could function without the operations of individual psychic systems. Such an outcome would be impossible because psychic and social systems have evolved simultaneously and are mutually dependent upon each other for their operation. Selves are therefore important to systems, but also problematic.

Cotterrell (1993) suggests that autopoiesis constructs a world where individuals have *"not only lost control but in relation to which they might also absolve themselves of autonomous action"*. Bankowski argues that in legal terms this could create amoral disconnections between fragmented selves and their actions. Individuals are no longer required to take responsibility for their actions since it is not they, but the system operations which dictate outcomes. In addition, the closure of systems implies that we can never achieve consensus on whether responsibility was correctly exercised by the individual.

To some extent these criticisms can be answered by the observation that they could be extended equally both to all forms of constructivist social theory, and all theories (including systems theories) which argue that social systems or institutions function to constrain the behaviour (or operations) of individuals/psychic systems. Paterson (1996) argues in opposition to Bankowski that the problem of individual responsibility has been exaggerated. Psychic systems may be constrained by the operations of social systems, but because the theory defines communications and not individuals as constitutive of such systems, individuals are capable of performing operations in multiple systems. The choice of which system to operate within remains that of the individual. So health practitioners may *choose* to act illegally to secure an outcome which they think is optimum for a service user's health. Luhmann (1992b) suggests that because systems theory does not conceive of psychic systems being components of social systems, far from diminishing the status of the individual, it elevates it. Human beings should not be conceived of as cogs in machines, capable of acting in only one way because of the constraints of the system. From the perspective of the legal system, they remain responsible for their decision to act illegally, but from the perspective of the psy or social welfare system they may nonetheless have acted correctly. Choosing which system to operate under also requires the implicit acceptance of what kind of irritations from other systems one is willing to suffer. Paterson uses the example of honour killing: if one chooses to observe the honour system then one is faced with the necessity of acting when ones honour has been impugned, but this means also choosing the possibility of interference from the legal system (assuming the legal system in question treats honour killings as illegal). Of course, the individual acting within a community which widely respects a code of honour may feel highly constrained to observe it. But she nonetheless remains free to act in a different way, as is demonstrated by the fact that people can and do opt to observe minority religious and moral distinctions despite considerable pressure from the legal and political systems to conform to generic moral codes.

However, the question of what the consequences of the autopoietic closure of social systems are for individuals remains. And in particular what are the consequences for individuals experiencing mental distress. Some of these consequences are implicit in the accounts service users have given of being excluded from communications and of being talked over, and their resultant feelings that they are either not being listened to or are being consistently misunderstood. Neither empowering service users nor encouraging staff to be more empathic will automatically correct the blindness of the social welfare and psy-systems. In both cases these remedies appeal to some kind of underlying safety net of understanding which can rescue us from the consequences of closed discourses. But Luhmann explicitly states that systems theory precludes humanism (Luhmann 1986 p.138), and also precludes a concept of power which could be redistributed in favour of mad people (Luhmann 1979/1975).

As the quote from Luhmann at the top of this section suggests, he is critical of a belief in the existence of subjects that goes beyond the use of the term as analogous to individual or psychic system (both of which he prefers). The idea of a conscious subject capable of observing its own operations and therefore of having a transcendent 'self' is, he argues, outmoded. Instead he argues, the entities we call individual human beings are made up of an autopoietically closed living system, and an autopoietically closed consciousness or psychic system. Our psychic systems bear the autopoietic characteristics of paradox, closure, self-referentiality, complexity, and temporal location. As a result, our consciousnesses are not available to others, we live with the illusion that we can communicate: *"Even clever analysts have been fooled by this convention"* (Luhmann 2002a). Communication however, could not exist without the social. Understanding cannot occur at the level of interaction between two minds, but only at the level of society, which has evolved contemporaneously with the evolution of language, text and concepts capable of being communicated. Teubner (2001) argues that the separation between mind and society which Luhmann posits is one of the greatest strengths of systems theory, since it avoids (evades?) the problems facing phenomenologists trying to understand the role consciousness plays in meaning making (such as Husserl) and the role language plays in meaning making (such as Wittgenstein). There are two sites of meaning making, the individual and the social, and their closure to each other can be understood in precisely the same way as we understand the closure of the legal system to the political.

Luhmann points out that it is possible for communications to be made about failures of communication, although the fact of their having been made does not imply that the misunderstandings will consequently be resolved (2002b). Continuing to make utterances indicates that the continuation of communication albeit under other terms and with a new understanding may be possible. However, as observed above, systems can place considerable constraints upon the freedom of individuals to choose which system their operations take place within and consequently what understanding can be applied to the utterances they hear.

1.5 Conclusion

"...this is not a nice theory..."(Luhmann 1986)

When the implications of this theory for people with mental health needs are considered we seem to return to the same problematic which motivated Foucault to excavate the history of psychiatry: the silence of the mad in the face of psychiatric discourse. But his problematic now seems to carry an additional burden. What kinds of communications were made using those *"stammered imperfect words without fixed syntax"*? Can 'mad' utterances form communications, or if there is no social system within which they can be understood, are they inevitably just noise?

Chapter Two
Madness: the absence of meaning

2.1 The social location of madness

Systems theory looks like an unpromising starting place from which to theorise about the social location of madness. Luhmann refuses to accept that it is feasible to theorise human behaviour on a grand scale (Luhmann 1995/1984 pp.210-3). Namely, we cannot build up a theoretical account of society that corresponds to or is grounded in the psychology of the individual. Instead, our model of society must be grounded in communications, and communication systems observe different rules to those constraining individual action. How can we start to define what madness is if the theory does not allow us to speculate about what is going on in peoples' minds?

This chapter will argue that madness is located outside the social, because mad utterances by definition cannot form part of a communication. Madness can be understood, although not explained, by reference to what we understand as social meaning. Many efforts to explain the social implications of madness focus on describing the institutional apparatus which exists around madness but ignore the question of what madness actually is. Others take as read the pathological account of madness provided by psychiatry and ignore the question of whether madness has different social implications to physical illness. This confusion is problematic for systems theorists. For Luhmann, medicine is simply a functionally differentiated system comprised of communications. One system amongst many, operating under the constraints imposed by its environment and by the operations of other systems. He does not discuss the distinction between psychiatric and somatic medicine in his work. Those who have used Luhmanns work to explore the problems encountered by the legal regulation of mental illness have tended to assume that psychiatric medicine is a branch of medicine as a whole and observes the code of sickness/health (Richardson and Machin 2000, Keywood 2003, Peay 2005). But the very small amount Luhmann wrote on the function and code of the medical system indicates that this elision of psychiatric and somatic medicine is not sustainable. In a short paper discussing the absence of a social theory of medicine, Luhmann argues that the mind and body are both functionally differentiated and operationally interdependent (Luhmann 1983). Pain and physical discomfort occur when the body needs to ensure that its malfunctions become known to the mind. Ordinarily, the mind is unconscious of the operations of the body. And the function of medicine is to restore this mutual indifference of mind and body through identifying and treating the causes of the pain which might otherwise cloud one's consciousness. Luhmann does not address the phenomenon of madness. But madness cannot be solely explained by reference to a malfunction in the mind, or brain. The strongest proponents of a biomedical model of mental disorder would accept that even where a physical cause can be identified the degree of distress experienced by the individual will be determined in part by the social response to her symptoms (see Shorter 1997 pp.326-7 for example). It is also the case that much mental distress is actuated by events entirely outside the body, such as the loss of a loved one. As a result, Luhmann's account of the function of physical pain cannot create a corresponding account of the function of mental pain. Something else must be going on.

Madness does not necessarily manifest itself as physical pain (although pain is often used as a metaphor to describe the experience of mental distress) but as a breakdown in the relationship between the self and the social. Whether this takes the form of having excessively negative or fearful thoughts, or false beliefs about the nature of reality, the effect is to at least temporarily prevent the psychic system (or self or mind) from engaging in society. Madness also becomes a problem in the social world when psychic systems contribute utterances which are incomprehensible to the social system being addressed. Using Luhmann, we can redefine madness as incomprehensible utterances. Madness is then relocated outside the systems of meaning which make up our society. This in itself is uncontroversial. Madness, however defined, has always been located outside society or at least upon its margins. However, to follow Luhmann to his logical conclusion there are no mad people, there are only mad utterances, and if we make enough of them we may acquire the label mad. Although Luhmann never discussed the phenomenon of madness, this point is made explicit in his description of the social function of the moral code:

> *"...moral coding is always coding of communication. There are, in other words, no good or bad people, but only the possibility of indicating people as good or bad."* (Luhmann 1993)

We can indicate madness and sanity in others, but in doing so we are applying a social distinction to their utterances. The threshold for acquiring the label 'mad' clearly varies across time and between individuals, depending on their social situation. As with all social systems, knowledge about madness is socially constructed, in this case within a system of social knowledge of the self, which I will call the psy-system, because it is similar to what Foucault terms the psy-function (Foucault 2006b pp.85-7), and is made up of communications within and between the psy disciplines: psychiatry, psychology, psychoanalysis etc.

What is also significant about Luhmann's theory of social systems is that he attributes many system operations to attempts at boundary maintenance. It is this boundary maintenance which drives madness to the margins and then makes every effort to keep it there. Mad utterances threaten the boundaries of social systems, and this provides all systems with a strong motive to collude in their exclusion. Theorising the social location of madness from a Luhmannian perspective allows us to bring together two separate phenomena which are not adequately explained by existing social theories of madness. The first is the vast governmental apparatus aiming to achieve social control over madness, the history of which Foucault describes so brilliantly, and which can also be observed in the legislation and policy governing the treatment of mentally ill people today. The second is the very high levels of compliance with treatment and other interventions observed among people with mental illness. The great silence of the mad which Foucault attributed to the dominance of psychiatry is deafening. People with mental illness, when contrasted with other socially controlled groups, are rarely seen or heard except when demands are made that harsher controls be placed on them. Often their staunchest, and indeed only, audible advocates are those people whom some social control theorists would posit as their worst enemy: the psychiatrists, nurses, social workers and family members who stand in judgement upon their behaviour, seek to constrain it, and to restore them to the status of the functioning citizen. This paradox can be understood, if we see social control as resulting from two entirely separate goals. The first is the desire of social systems to silence what they cannot understand, and thus reduce the threat which madness represents to their operations. The second being the desire of individuals labelled mad to participate in future communications even when earlier utterances have not been understood. The first goal is often realised in a spectacularly clumsy and excessive fashion, whilst the second, which is well understood by 'mad' individuals and those close to them, is rarely acknowledged in the communications governing law and policy.

2.1.2 Locating madness

Madness has many locations. In the findings of biomedical research madness is located at its source: in a malfunction in the body such as the gaps between folds of brain tissue, in our genes, in our water supply, even in viruses (see Bentall 1990, Read 2004a). For practicing psy-system diagnosticians madness is behaviour that conforms to the lists of symptoms cited for disorders in the American Psychiatric Associations Diagnostic and Statistical Manual (APA 2000) or the World Health Organisations International Classification of Diseases (WHO 2004). For some social theorists madness is located in the social roles individuals are expected to play: the person labelled mad may begin to perform the role of 'mad' under the weight of social expectation (Scheff 1999). For others madness is what happens in mad places such as the asylum, it is not only located in the mad individual, but in the totalising effects of the institution (Goffman 1961, Goffman 1971, Rosenhan 1973). For some linguistics scholars madness is made up of meaningless statements (Rochester and Martin 1979). Madness has been seen as arising out of the gap between the power wielded by the psychiatrists with the authority to diagnose and the supposedly mad patient (Palmer 2000). And many people, including many service users, assert that a focus upon madness misses the point. They argue that the meaning of madness is irrelevant whilst mental distress, misunderstood as madness, remains a real and problematic phenomenon that rarely receives a compassionate response (Scull 1989 p.9, Beresford, Gifford et al. 2000).

The fact that views diverge on what can be pointed to and described as madness 'properly so called' demonstrates little, but it contrasts strongly with the huge swathe of utterances made every day about the problems facing mad people, the legal regulation of their lives, and the therapeutic interventions they need. It is clearly the case that the concept of madness has a kind of discursive integrity: we can all talk about it. This cohesion falls apart, however, when we try to establish what causes, promotes, heals or sustains madness. Making the claim that madness is evidenced by the absence of meaning does not resolve or invalidate any of these debates. But it does provide a starting point for talking more constructively about what exactly it is that social systems are trying to achieve control over.

2.2 Madness and language

Equating madness with an absence of meaning is not a new idea. It is implicit in the works of a number of theorists from a range of backgrounds including philosophy, psychiatry and psychology. It is, however, an idea with implications which have not been fully understood. To understand madness as a failure of communication does not undermine the logic of those disciplines which try to restore meaning to mad utterances. The means by which the psy-system attempts this task are sometimes questionable, but the debate is worthwhile, if not always productive. Psychiatry is not rendered meaningless by the meaninglessness of madness. The fact that what we call madness is really a small number of utterances which cannot readily be understood raises significant questions about the role of society in responding to and attempting to silence and sustain mad utterances. This theory does not call into question the work of clinical researchers trying to identify the biomedical conditions which lead to the making of mad utterances. Or the work of psychiatrists trying to promote meaningful communication. Instead it explains why the degree of social exclusion people who have made mad utterances face is wholly disproportionate to the social impact of what they are saying.

Foucault's accounts of the social location of madness vary. In his most celebrated work on the subject, a 'History of Madness' (Foucault 2006a),[4] he suggests that his initial project aimed to account for the silencing of the madman, which began with the emergence of a psychiatric discourse about

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[4] Foucault's work was published in France as 'Folie et déraison. Histoire de la folie à l'âge classique' in 1961. Three years later a heavily abridged version was published and it was this abridged version which was subsequently translated into English and published under the title 'Madness and Civilisation' in 1965. In 2006 a complete translation of the original unabridged text was published in English for the first time under the title 'History of Madness'. I have used the unabridged translation in this thesis.

madness in the 18th century (Foucault 2006a p.xxviii). This discourse, he argued, supplanted an earlier discourse between reason and madness, which did not lead to the excessive cruelties of incarceration, exclusion and enforced silence, which were the hallmarks of the Age of Reason. The 'History of Madness' is concerned with the subsequent development of psychiatric discourse, and not with this earlier period so Foucault provides little evidence to support the assertion that such a golden age ever occurred. Scull robustly criticises Foucault for naively assuming that the development of confinement represented a dramatic rupture between the past acceptance of folly and unreason, and the moralising discourse about madness with its exclusionary consequences that subsequently occurred (Scull 1989 pp.18-20). Indeed, the quality of Foucault's historical scholarship has been more widely called into question for tending to ignore contradictory evidence, overstate his case and over-simplify the historical record (Midelfort 1980). Regardless of its validity as historical fact, the notion of an era in which madness spoke to reason is intriguing, largely because according to modern conceptions of madness and reason it is so difficult to imagine.

Foucault does not return to this point in his later work, although he repeatedly returned to the topic of psychiatric discourse. He relates in the 'Archaeology of Knowledge' (Foucault 1973) that this was partly because he became disillusioned with the project he described in 'History of Madness', and the possibility of reducing the complexity of discourse down to what was essentially true prior to its emergence. Instead, he saw his task as capturing this complexity of discourse, and exploring its contingency. As a result:

> *"We are not trying to reconstitute what madness itself might be, in the form in which it first presented itself... [although] ...such a history of the referent is no doubt possible"* (ibid. p.47).

This is frustrating, as he did expand very slightly, on what he thought madness might be in a short article, published as an appendix to the 1972 edition of 'History of Madness'. In 'Madness: the absence of work', Foucault argues that madness can be understood as a non-language which does not say anything beyond itself, or code to any fixed meaning (Foucault 1995/1972). Instead, Foucault suggests that madness acts as a reserve of meaning, which exposes *"that chasm where linguistic code and utterance become entangled', shaping each other and speaking of nothing but their still silent rapport".* Foucault goes on to explore the intriguing idea that madness is unable to create, or give birth to a work (the meaning of the title), but is nonetheless an empty space from within which the creation of literature may emerge. This linking of madness and the creative imagination has been made elsewhere (Becker 1978, Jamison 1996), and would suggest that the relationship arises because both madness and creativity represent a form of challenge to reason, and to what is already known and understood. However, what is most interesting about Foucault's piece is his description of madness as utterances which are not understood.

At one level it is obvious that madness can only be known in the form of utterances. Despite our casual references to disordered minds and mentally ill people, the psy-system has no 'way of seeing' analogous to the clinical gaze which would allow it privileged insight into the operations of the self. We cannot predict madness, or know what form it will take until the person has spoken. We know madness where mad utterances occur. The point is made succinctly, by Rochester and Martin in their book 'Crazy Talk', in which they describe a study of the disordered speech of people diagnosed with schizophrenia. They point out that although disordered thoughts are seen as definitive of schizophrenia, we can only know that thought is disordered through incoherent talk:

> *"To say that a speaker is incoherent is only to say that one cannot understand the speaker. So to make a statement about incoherent discourse is really to make a statement about one's own confusion as a listener. It is therefore just as appropriate to study what it is about the listener which makes him or her 'confusable' as it is to study what it is about the speaker which makes him or her 'confusing'."* (Rochester and Martin 1979 p.3)

Despite this observation, Rochester and Martin's study focuses on statements made by people diagnosed with schizophrenia, and they acknowledge this as a potential weakness (ibid. p.51). Subsequent researchers have explored the idea that thought disorder could be better understood as a disorder of communication, and a number of studies in linguistics have explored the grammatical features of the language used by people diagnosed with thought disorders in the hope of identifying what makes it incomprehensible (Bentall 2004 pp 388-95). But this research has not explored the 'confusability' of the listener, or asked whether social circumstances, as well as the content of the speech, contribute to this confusion.

Szasz made a related point about the confusion created by mad speech when he observed that hysteria can be understood as a language comprised of non-discursive units such as crying, self harm, shouting etc. This language lacks a generalisable meaning content and can only refer to specific events. The function of psychotherapy is to transform the local and specific meaning the individual expresses through hysterical symptoms into a discursive account of her distress (Szasz 1973/1963 pp.128-36). But again, Szasz fails to go on to explore the radical implications of non-discursivity outside the clinical setting. Lacan similarly recognises the primacy of meaningful speech in promoting psychological wellbeing, and perhaps contrary to Szasz, charges psychoanalysts with the responsibility to focus upon what the client says and resist the temptation to draw elaborate and false inferences about the meaning of the clients actions (or inactions) (Lacan 1989/1953 pp.44-50). But again, his massively intriguing work on the role of speech and language in psychoanalysis does not ask what implications an absence of meaningful speech has for both the individual and her community in everyday life.

The underlying notion that madness is inherently incomprehensible has been criticised in different ways. Porter points out in relation to autobiographical accounts made by mad people that these accounts put:

> *"...a different complexion on the claim so often made down the ages that madness is radically incoherent, unintelligible, meaningless. As often as not if the speech and behaviour of the mad person seem peculiar...it is because the mad person is deprived of the expected and approved environment for normal living."* (Porter 1987 p.232)

A similar point is made by Laing, although he founds his account on observations of his own patients. He argues that psychiatry has tended to accept too readily that the mad person is incomprehensible and then supplant her account of herself with a psychiatric account (Laing 1967). Both of these arguments tend to reinforce rather than rebut the central claim I am making here. Madness, properly so called, is a property of utterances and not people. What Laing and Porter are both observing in different ways is that the perception that an individual has made mad utterances has a dramatic impact on her audience. It is for this reason that madness has to be understood as resulting from interaction, rather than in glorious isolation. The opposite of a mad utterance is not a sane utterance but a chain of acts demonstrating effective communication.

2.3 Madness and communication

Luhmann's definition of communication requires three stages: utterance, selection, and a subsequent act which demonstrates to the first party that she has been understood (Luhmann 1995/1984 p.140). This definition highlights the self referential nature of communication. Efforts at communication fail more often than they succeed, and the reason for this is that communications rely on a tri-partite set of selections, all of which must coincide for the communication to occur. Communication occurs when the communicator (*alter*) believes that the communicatee (*ego*)[5] has understood the information conveyed, and she can then continue the chain of communication by making further utterances. For communication to succeed first *alter* must make a selection from all the possible utterances she could make as to what information she wishes to convey. An utterance in this context is simply an act which can be interpreted as indicating a selection to communicate on the part of *alter*. Gestures, noises, facial expressions and modes of dress are all capable of being utterances for the purposes of communication. Sometimes

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[5] Because the third selection, between information and utterance, is decisive, and because this third selection is performed by the second party, Luhmann unconventionally refers to the second party as *ego*, and the first as *alter*. Luhmann's terminology has been followed here. However since mad utterances convey no information, when they are made the third selection cannot be performed and communication does not occur. Perhaps appropriately, this leaves the person making the mad utterance irrevocably cast as an *alter*, for whom no *ego* exists.

communication may be initiated by someone misinterpreting the communicative intent of another, for example by inferring that an act such as brushing a fly away indicates a welcoming wave instead. But Luhmann stresses that even in these circumstances the communicative intentions of both parties must be engaged: *"There is no communication when observed behaviour is interpreted only as a sign of something else"* (Luhmann 1995/1984 p.151). The ambiguity of certain acts and the difficulty of determining communicative intent arises frequently as a problem in the context of madness, for example, it can be hard to determine whether a suicidal act represents a 'cry for help' and is therefore an extreme attempt to indicate mental distress, or is in fact the product of a 'genuine' desire to die.

Having identified an act as an utterance denoting communicative intent, *ego* must next select to attend to the utterance. Information itself implies a selection from what is known about the environment and *ego* must also select the right system within which to extract the information from *alter's* utterance. Communication failures can be readily identified when *ego's* response does not meet *alter's* expectation. If communication fails *alter* can modify her utterance and try again. This is the self-referential dimension of communication; we can only know it when the actions of the other conform to our own expectations. To an outsider, the actual transfer of information and meaning cannot be observed, only inferred from the conduct of the actors. (Luhmann 1995/1984 pp.137-41).

If both parties share the understanding that they are, for example, communicating around the code lawful/unlawful then communication will succeed. But if *alter* makes an utterance intended to relate to the legal code and *ego* attempts to process it according to the code of the economic system (profit/loss) then it will fail. This selection of the wrong system, from *alter's* perspective, will occur frequently because all actors enjoy the freedom to apply meanings to utterances as they see fit and in accordance with their ability to comprehend their information content. But as long as *ego* wishes *alter* to comprehend her operations, she will try to select the same system as *alter*. Simple communication failure is so common that it cannot amount to a useful definition of madness. Otherwise the operations of all other social systems would appear mad from the internal perspective of each system. Systems appear to be able to distinguish between utterances which can be understood within a different system and utterances which cannot be understood at all.

One way to explain this is to look at the form and content of utterances to see if distinctions can be drawn between mad utterances and those utterances made according to a code other than the system's own. Using King's example of a car accident as an instance of a perturbation which affects the operations of multiple systems we can see that the utterances 'The car was worth £1000', and 'The other driver was at fault' can readily enter into chains of economic and legal communication respectively (King 1993). If a party asserts that 'The car did not exist' however, the statement is meaningless from the perspective of all systems. The content of the statement does not need to be false for this perception to arise. If an injured driver made a point of asserting that her car *did* exist, then those around her might wonder if she was concussed. Individual psychic systems are capable of comprehending that an utterance may be interpreted in multiple ways (although they can only respond to one meaning at any one time). It follows that psychic systems are also capable of comprehending when a statement is patently incomprehensible across different system operations. Consequently, such a statement is unable to penetrate the boundaries of any system, or form part of any chain of communications.

Mad utterances do not necessarily involve absurd or incredible assessments of reality. They may simply take an incomprehensible form. In their Communication Disturbance Index, Docherty et al. list six categories of speech disturbance observed in patients diagnosed with psychotic illnesses (Docherty et al. 1996). These are: vague references which are insufficiently specific, confused references which could equally refer to more than one referent, missing information references, ambiguous use of words where the meaning cannot be deduced from the context, use of what appears to be entirely the wrong word, and structural 'unclarities' resulting from inadequate or absent grammar. Only some of these suggest the absence of a meaningful referent, and yet, by definition, statements with these attributes cannot readily be understood.

However, to understand its social function, madness cannot be reduced to the form and content of specific utterances. The statement 'I want to die' is grammatically coherent, and refers to a person's subjective experience of the world in a form which makes it difficult to rebut. It is analogous in form to the statement 'I want a glass of water', which no one would normally challenge, and yet, it is typically treated as unreasonable and rarely heard on its own terms. There are exceptions of course; where the honour system recognises suicide as a response to dishonour, then 'I want to die' may have a socially acceptable meaning attached to it. And when an individual is in unmanageable physical pain, such that only death could end it, then the desire to die is seen as comprehensible. But outside these exceptional states, the assertion by an individual that she wants to die, which is made fairly frequently, is treated as a statement which means something other than what it says; that for example the person is irrationally depressed, or living in difficult circumstances, or lacks a clear perspective on the difficulties she has encountered. All of these interpretations load additional meanings onto the utterance which are not inherent to it and are not necessarily intended by *alter*, although they may be accurate when weighed against the information *ego* determines from the environment within which they are made. For the second order observer however, it is important to note that this absence of social meaning cannot be deduced from the form the utterance takes; it can only be inferred from the responses of the surrounding social systems.

2.4 Madness and mental distress

It could be argued that 'I want to die' is typically seen as an indication of mental distress and not madness, and that whilst madness is conceptually unstable, mental distress remains real and problematic. This is the line taken by Scull when he argues, in a critique of 'Madness and Civilisation', that Foucault failed to acknowledge the reality of the mental distress which afflicted the mad and which caused genuine social problems both for them and their families (Scull 1989 p.9). In a more recent paper he makes the same criticism of Szasz and suggests that a common misreading of Goffman's 'Asylums' is to conclude that it is the institution which creates the problem of madness, thus failing to examine what aspects of the patients prior history lead them there (Scull 2007). From within the psy-system, critics of the biomedical model of mental illness tend to argue that whilst mental *illness* is a questionable concept, mental *distress* is nonetheless a 'real' phenomenon deserving of a better explanation (Read 2004b). Service users have also argued that they do not recognise their subjective experience of distress in the medical interpretations placed upon their behaviour (see Chapter One pp.6-7). Within literature intended to promote public awareness, mental distress has recently been adopted as an acceptable substitute for terms which imply a medical model of madness when discussing symptoms such as sadness or anxiety (see for example Mind 2007 and Scottish Association for Mental Health 2006). It is an implicit assumption in these texts that mental distress is the thing that is real and knowable, whilst psychosis or mental illness are categories imposed upon this experience by others. Scull argues that whilst we critique these latter categories we should not lose sight of the reality of the former.

Mental distress however, only adds to our confusion about what it is we are dealing with. It is a mistake to assume that any challenge to an accepted ontology of madness represents an attempt to diminish the significance of the distress caused to the individual and those around her by unreasonable utterances. But asserting the reality of mental distress does not help us understand why this phenomenon should attract coercive interventions, social isolation and exclusion. If we ask 'How do we know when mental distress is occurring?' it becomes clear that mental distress functions as an interpretation of some types of verbal and non-verbal actions which are widely understood as indicating unpleasant emotions. Such indications may be very diverse: from tears to laughter. Mental distress may also be indicated through changes to the individual's physical state such as extreme weight loss, or through explicit statements pertaining to her state of mind. These indications can be questioned, challenged and discussed. They can stimulate communication and in some cases be resolved trivially. At the social level we readily distinguish between mad and sane distress. The person who cries because she has suffered a recent bereavement is seen as comprehensible, fitting within the range of expected responses whereas the person who exhibits the same response over a bereavement that took place long ago, may not be understood so readily. Indications of mental distress do not inevitably give rise to social problems, such as causing further distress in those around the sufferer, or isolating the sufferer from others. Indeed, distress in the form of indications of negative emotions is so common it cannot usefully help us to understand why some manifestations of distress warrant such a dramatic social response. Conversely, the concept of madness does not inevitably imply mental distress. The person who adopts an entirely false and idiosyncratic set of beliefs about the world may exhibit no signs whatsoever of distress and yet could still be understood as mad.

One obvious response to the question of why mental distress can in some cases give rise to the social problem of madness is tautologous: distress is distressing. This tautology is unhelpful, it does not help to explain why the ubiquitous experience of distress can in some cases be interpreted as the unusual phenomenon of madness. If we instead understand the problem of mental distress as one of incomprehension, we retain the possibility of discussing this lack of comprehension. Indications of distress are, like apparently meaningless statements, resistant to easy interpretation. If *ego* can clarify the intentions of *alter*, then non-verbal indications of distress can enter the chain of communications. If *alter's* intentions cannot be clarified, then these indications, like incomprehensible statements, drive the process of communication into the sand. Madness is therefore conceptually distinct from, though not exclusive of, mental distress.

In observing the social response to mental distress, it is also notable, that some people who have been diagnosed as mentally ill describe feeling that only their madness is seen as a significant problem whilst their mental distress goes unheard. Or as Shaughnessy puts it:

> *"It's almost like walking up to the nurse wearing wet clothes, and the nurse treats you for a cold. The nurse then lets you walk out without changing your clothes. When you return the next day, the nurse wonders why you still have a cold. Similarly, I'm walking around a product of emotional and physical abuse, broken relationships, no meaningful employment, stressful housing - and I'm taking a tablet for the symptoms."* (Shaughnessy 2000)

2.5 Madness as an anti-medium

Madness is frequently identified with utterances which lack an information content. In everyday language it is mad to assert a state of affairs which is evidently false, mad to hear invisible voices, or to believe oneself to be God. However, the fact that it is possible for others to perceive these statements as false indicates that a prior order exists against which their meaning content can be evaluated. As discussed in the Introduction, the sheer improbability of this order arising at all, given the complexity of communication, was what stimulated Luhmann to engage with systems theory. Talcott Parsons had already observed that the condition of contingency (that nothing is either impossible or inevitable), which he assumed to exist prior to human social interaction, makes successful interaction wildly improbable (Parsons 1968). Luhmann argues that the double contingency of communication is what leads to the emergence of social systems (Luhmann 1995/1984 pp.104-14). Over time, psychic systems encounter each other, select to perform contingent acts, observe the response of the other system and modify their actions, until what appears to be coherence emerges. The evolution of social systems is made possible by the desire of psychic systems to reduce the contingency of their own operations. Contingency however, can never be eliminated, and communication, even in an era of functionally differentiated systems of communication, retains an improbable character, and can all too readily be undermined.

Fortunately not all utterances are created equal, because some of them benefit from being conveyed through what Luhmann describes as a generalised symbolic medium of communication:

> *"Generalised symbolic media of communication are primarily semantic devices which enable essentially improbable communications nevertheless to be made successfully."* (Luhmann 1998 p.18)

Luhmann identified love, power, trust and money as examples of such media (Luhmann 1979/1975, Luhmann 1995/1984 p.161). Such media are able to bridge the double contingency of communication (Luhmann 1979/1975 p.112). A generalised symbolic medium of communication is a mechanism additional to language which guides the selections made by *ego* when attempting to comprehend the utterance made by *alter*. Love achieves this by reducing the need for explicit communication between the parties. Lovers can anticipate the desires of their beloved and so avoid the need to say aloud that which might threaten the unity created by their love (Luhmann 1998 p.25). And holding power allows *alter* to influence the selections made by *ego*, but only within limits. For Luhmann, power is sustained by the possibility of employing coercion, but power diminishes as the likelihood of using coercion increases. Conversely, power increases as the freedom of *ego* to act other than as *alter* would wish increases, because the effects of power are most evident when *ego* has many viable and attractive alternative options available but nonetheless makes the selection *alter* would wish for (Luhmann 1979/1975 pp.122-3).

Madness, in addition to being non-discursive and thus incommunicable appears to function as an anti-medium. It attenuates communicative processes and reduces the probability of subsequent attempts at communication succeeding. For communication to succeed it is necessary for both parties to believe that they will meet with a reasonable degree of success (Luhmann 1995/1984 pp.142-3). Consequently communication is undermined, and contingency increased, by the failure of an utterance to make any sense. When a meaningless utterance is made, the availability of social systems will not avail the parties. *Ego* cannot parse the statement according to any established parameters, and so infers that the statement is incomprehensible. If *ego* indicates that lack of understanding, *alter* can try again. But if *alter's* utterances repeatedly make no sense then *ego* may give up. The same thing, Luhmann argues, happens when we lie, or repeatedly present untrustworthy information (whether or not we intend to mislead) (Luhmann 1979/1975 p.93).

Time is important here, since in the short term time is able to resolve misunderstandings and confusion. Given time we can clarify misunderstandings, identify disagreements and expose falsehoods. Indeed madness is sometimes explicitly defined in relation to time. For example, the DSM IV-R states that symptoms of schizophrenia must persist for at least a month before an individual can be designated schizophrenic (American Psychiatric Association 2000). A single instance of saying something meaningless is unlikely to have much impact on the operations of other psychic systems. A sustained employment of meaningless utterances may, however, lead to the individual being designated mad. This designation reduces the credibility of the individual in question, and reduces the likelihood that others will believe their efforts to communicate with them will meet with success.

Madness increases the contingency, and reduces the probability of communication. The function of discrediting madness is to reduce the complexity which other social systems are exposed to, and to protect the internally coherent system of meaning they have created from ambiguity and confusion. It is therefore not surprising that efforts to discredit what mad people say are so widespread and destructive.

2.5.1 Who or what can be mad?

From a systems theory perspective, madness is evidenced by an absence of meaning which cannot be resolved quickly, and which consequently forces other systems to exclude it in order to reduce their contingency. Typically we understand madness as a designation pertaining to psychic systems. However, as discussed in Chapter One (pp.49-51), meaning processing for Luhmann occurs both at the level of the individual and at the level of the social. Social systems such as law exhibit characteristics which enable them to stabilise meaning over time, such as the closure of their operations from those of other social systems, their capacity for reproducing their operations, and their ability to construct meaning self-referentially. If social systems can functionally differentiate themselves effectively, it may also be true that social systems can operate in a manner which is dysfunctional as opposed to merely un-understandable from the perspective of other systems. The un-understandability of the operations of other systems is a constant state of affairs for all functionally differentiated systems. Economic operations are meaningless from a legal perspective and so forth. However, social systems can also operate destructively or repressively in a way which curtails possibilities for other systems. This kind of excessive perturbation in the environment of another social system is often colloquially described as madness. The law, the economy and the political system frequently garner the description 'mad' when their operations look set to threaten the functioning of society in some fundamental way. Rather than seeing this as an improper use of a term which can only be applied to psychic systems, I would suggest that this is in fact a further instance of meaningless behaviour constituting madness, taking place within a different set of systems of meaning. Another instance of meaninglessness occurs when computer programmes crash, and are thus unable to interact with other programmes. To say the computer has 'gone mad' when attempts to interact with it fail, is not to use a metaphor, but to quite literally describe an incomprehensible state of affairs.

Madness then, is a discursive continuum without fixed boundaries, which semantically and analytically allows us to group together instances of incomprehension. Although the madness of psychic systems and their control by the legal and medical systems is the focus of this thesis, the same mechanisms of discreditation and control which characterise the social response to meaningless utterances can also be observed (albeit with very different ethical and social implications) in the interactions between systems at all levels.

2.6 Conclusion

Attempts to build up accounts that can explain the incoherence of our social response to madness have been confounded by a desire to understand madness sociologically in 'all or nothing' terms. It is either a social construction or a real illness, but not both. Similarly, attempts to control madness are either wholly justifiable expressions of concern for the welfare of incapable people, or excessive abuses of state power. In practice, things are rarely so simple. The phenomenon of madness is, along with everything else we know, at some level a social construction. It is also profoundly and distressingly real. Social efforts to constrain or manage mad people are therefore an inevitable response to madness because left unchecked it threatens the fundamental building block of society: communication.

This systems account of madness is not a theory with any major explanatory power. It does not help us to understand why some people make mad utterances whilst others do not. Nor does it help us to know what the 'right' response to madness might be. The possible advantages of this approach are twofold. First, it makes it possible to theorise about the socially constructed dimensions of madness, without simultaneously having to challenge existing biomedical and psychological accounts of madness. Biomedical accounts have their place, and so do social accounts, and since they emerge within separate systems of meaning it is futile to attempt to unify them into one explanation for madness. Secondly, this theory generates grounds for speculation about the social limitations imposed upon the individual designated mad. In recognising that madness exists outside the social, we can develop a clearer understanding of why people who make mad utterances experience such devastating social exclusion. We can also begin to understand why the law is so inadequate to the task of hearing what people who have made mad utterances have to say about their experiences. And we can develop a more useful description of the limitations that may be placed upon person-centred practices as a global policy within health services, i.e. outside the local confines of the therapeutic relationship.

Chapter Three
Knowing the self: the fragility of the psy-system

3.1 Introduction

How is it possible for knowledge to exist about madness if madness denotes an absence of meaning? Since the emergence of the psy-disciplines in the eighteenth and nineteenth centuries a lot appears to have become 'known' about madness. Mental illnesses have been categorised and diagnostic tools and treatment options standardised. A highly specialised language which describes madness, and its containment and cure, has developed. Even outside the confines of the mental health 'system', in wider society, a large number of distinctions delineating madness are readily drawn, such as those between neurotic/psychotic, treatable/untreatable and psychosomatic/'genuine'. The operation of these distinctions within the domain of popular knowledge is rarely exact (Kennedy 1996, Sullivan 2005). Terms like 'psychotic', 'psychopathic' and 'schizophrenic' are used interchangeably to indicate that someone is extremely mentally ill, with a subtext that he or she is likely to behave unpredictably and even dangerously (ibid. and Philo 1996) And whilst the term 'neurotic' has entered the popular imagination, it is used to designate a raft of negative or anxious beliefs about the world, in this case with the subtext that the belief is held unreasonably and in some contexts wilfully. But the existence of this vocabulary implies that those using it are confident that meaningful distinctions can be drawn between different madnesses, even if their own use of it is not especially consistent or precise.

This chapter will argue that there exists a system of knowledge – the psy-system - structured around the distinction between madness and sanity which makes it possible to talk about madness. It will consider how this system's operations are differentiated from those of other systems, especially the medical system, and explore its coding, closure, and reflexive accounts of its operations. It will then examine existing accounts of the psy-disciplines and the historical conditions that contributed to their emergence and ask how they can be re-evaluated in the light of this generalised description of the psy-system.

3.2 Knowledge of the self within interaction systems

Before one can examine what kind of knowledge of madness might be possible within a Luhmannian frame, one first has to ask what kind of role the individual or the self plays in the social world. One criticism made of autopoietic systems theory has been that when the theory is applied at the level of the social, it seems to give an account of society in which the individual is inevitably alienated, excluded and atomised (Bankowski 1996, Mingers 2002). This is precisely Luhmann's intention. Society is not made up of individuals, but of communications. He argues that the idea of a conscious subject capable of observing its own operations and therefore of having a transcendent 'self' is outmoded (Luhmann 1986). Instead the entities we call individual human beings are made up of an autopoietically closed living system, and an autopoietically closed consciousness or psychic system. Our psychic systems bear the autopoietic characteristics of paradox, closure, self-referentiality, complexity, and temporal location. As a result, our consciousnesses are not available to others; we live with the illusion that we can communicate when we are in fact always determining our participation in communication through self-reference.

This creates, for systems theory, a 'mind-communication problem' which Moeller suggests encompasses three distinct issues: the problem of how relations between the mind and communication are structured, the problem of how social conditions determine this structure and the question of what kind of agency the individual retains in a functionally differentiated society (Moeller 2005 p.81). The first of these questions is crucial here, because although the operations of both psychic and social systems are dependent on the availability of meaning, they employ different forms of operation: consciousness for the psychic system and communication for the social system (Luhmann 1995/1984 pp.98-9). The mind or self or psyche is inherently unable to participate in the social because its operations have adopted a different form (Luhmann 2002a).

One way in which the self is made sense of in the social is through the coding of behaviours as signs of mental distress. Signs of mental distress are read as emotional indicators, windows into the internal world of the person exhibiting them. These signs may be best understood within local informal systems of interaction. An interaction system is comprised of interactions between individuals within which localised and highly specific systems of meaning may arise, such as families and workplaces (Luhmann 1995/1984 pp.412-6). These interaction systems do not achieve closure in the way that social systems do, nor is closure necessary for their operations. Because meaning within these systems can be determined locally and only affects a small number of communications it can also be adjusted with comparative ease. The boundary of the system will either be self-evident to those who participate within it or readily redefined when new participants enter the system. For example, a visitor to a workplace will either recognise immediately that she does not belong to the local interaction system, or she will be invited to join in.

Within interaction systems emotional responses to events may play a particular role in ensuring that vital aspects of interior experience are communicated to others. Behaviours indicating emotional responses may be readily interpreted as meaningful. Between lovers, friends and family members systems of meaning can rapidly emerge which make sense of certain acts or utterances and enable communication about people's mental state to take place. It goes without saying that when an individual experiences mental distress it is generally assumed that those who are closest to her will exhibit the greatest understanding of her experience. This is possible because so many more communication possibilities exist between people who love and trust one another than between those who do not (Luhmann 1998 p.24-5). This highly specific knowledge of an individual which is given expression only within interaction systems also has to be able to distinguish between ordinary happiness and mania, or ordinary unhappiness and melancholy. Where a person makes mad utterances or exhibits acute distress, her loved ones are typically best placed to identify this as madness.

Historically, a distinction about the difference between madness and sanity could be generated anew in each interaction system and as with all interaction systems the meanings applied to this distinction could be fluid and variable. When Foucault talks of madness communicating with reason in the Middle Ages (Foucault 2006a p.145), he is perhaps observing that within tight knit communities which have little contact with other communities, madness has to be engaged with and understood within the limited frames for generating meaning that are available. Nevertheless, where a person made frequent mad utterances or acts, then it was necessary to explain this madness outside the community, to those who might be able to help or at least provide refuge for the mad person. Failing this, the mad person could be simply cut adrift from her community because it lacked the resources to support her. At first then, only one crude distinction between madness and sanity was required. Where madness was manifest it was treated as a self-evident state of affairs, a decision either to intervene or to neglect the person involved rested only upon the distinction between madness and sanity and not on complex categories of classification (Gauchet and Swain 1999 pp.174-5).

But at some point this distinction ceased to be effective. There is widespread agreement that during the eighteenth and nineteenth centuries families not only ceased to be the primary locus for care-giving but their capacity to deliver care effectively began to be called into question. Large state funded institutions were instead created to accommodate and to cure the mad (Scull 1993 p.33, Shorter 1997 pp.49-53). In the same period a new form of knowledge about madness began to emerge which attempted to distinguish madness on a systematic basis, and to differentiate different madnesses consistently.

3.2.1 Social knowledge of the self

Attempts to make sense of the histories of the psy-disciplines have demonstrated conclusively that this knowledge emerged within a highly complex and still obscure set of interactions between social events. These shifts in society included economic change and the growth of market capitalism (Scull 1993), religious pluralism (Porter 1983), new forms of political life (Gauchet and Swain 1999) and the changing role of the state (Foucault 2000).

For Luhmann, all of these changes could be grouped under one heading: the shift from a hierarchically ordered to a heterarchically ordered form of society. Prior to the eighteenth century the social system in Europe was organised hierarchically and the functions an individual performed were determined by her place within this hierarchy. This hierarchical model held good across cultures, although in every culture and place it was expressed slightly differently. This model of system differentiation was extremely robust, as can be seen from the fact that the roles ordained for those participating within it were widely accepted as self-evident (Luhmann 1995/1984 p.338). But nonetheless by the end of the eighteenth century Luhmann suggests we can see that Europe has already shifted towards functional differentiation. Social subsystems such as law and politics now distinguish themselves anew against their environment by reference not to their relation to the hierarchy but to their internal binary coding. Luhmann argues that this shift arises in specific relation to the Enlightenment. Rather than suggest that it was Enlightenment values which caused the system to call the hierarchy into question and generate new structures within which to differentiate social functions however, Luhmann argues that the Enlightenment was quite specifically the product of the explosion in criticism made possible by the printing press (ibid. p.343). The printing press made texts available for comparison and these texts in turn exposed their surplus meanings, overlapping content, unclarities and confusion:

> *"The world itself could be compared to a book, written by God in partly illegible letters; and immediately Protestants, philosophers, and scientists began to read it in different ways. The unfamiliar no longer screens off possible dissensus, tension, and conflict. The social world is reconstructed in terms of 'interests'."* (Luhmann 1988 p.101)

Baecker argues that the response of Descartes to this new knowledge of uncertainty was to call everything, including himself, into doubt, generating a new theory form: "*self-referential restlessness*" (Baecker 2006). This self-referential restlessness is exhibited in an attitude which cannot settle for an answer purely on the basis of extrinsic evidence. Instead, the individual infected with this new perspective recognises that her own inner convictions must be engaged before an answer can be considered sufficient. This drives individuals to begin to observe society at second order and generate reflexive accounts of the functions which each social system performs. Theories of law, economics, politics and morality all flourished in the period of the Enlightenment. This capacity to engage reflexively with the task of defining what constituted meaning within the system was an essential pre-requisite for their functional differentiation and autopoietic closure.

In addition to generating new functionally differentiated social subsystems the eighteenth century also saw the invention of the individual. The individual is rendered homeless by the destruction of the comforting old hierarchy. Her social identity is now fragmented amongst systems, she can be reconstructed anew as a legal actor, as an economic participant, as a member of the electorate, as a patient.[6] In response, society reconstructs the individual as someone whose self-understanding determines her identity. The individual understands herself as distinct from her social environment, as carrying her own meanings within her (Luhmann 1986). In turn, functionally differentiated subsystems organise their interactions with individuals in ways which indicate that they acknowledge the autonomy of the individual. The political system endorses democracy as a means of securing political coordination, the economic system embraces the free-market within which consumer choices dictate priorities, even some legal systems (those of France and the US) acknowledge the possibility of fundamental rights which protect individual autonomy in the face of political coercion.

Finally, this new account of the individual meant that new types of knowledge about human behaviour became socially necessary. Demographic data, statistics and survey reports all began to take on a new significance as the means by which each system could 'know' its participants (see Hacking 1990 pp.9-11). Foucault characterises this explosion in data collection and interpretation as a practice of 'biopolitics', a type of power practiced by the

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[6] To avoid anachronisms I have used the term patient instead of service user throughout this chapter.

state which serves to exert control over events affecting large populations (Foucault 1998/1976 pp.139-42). From a systems perspective it is possible to reverse this argument and suggest that, far from achieving influence from the centre, the significance of this data lies in how it was employed by each system in a subtly different way. Since specific knowledge of the individual about whom a decision must be made is impossible, and since specific understandings of the form of selfhood of another can only be built up through interpersonal interaction, the insurance company, the judge, the doctor all make their decisions on the basis of what is 'known' about individuals who share relevant characteristics. It is true that governments also make their policy decisions on the basis of population data, but this is only one of the many uses to which it is put.

So between the early eighteenth century and the early nineteenth century we can observe a radical restructuring of society, a new social construction of the individual, and a new way of making the individual 'knowable' to social systems which does not rely upon interpersonal communication with the individual. It is against this backdrop that a specific form of knowledge of madness emerges.

3.3 The emergence of the psy-system

The history of the psy-system is a divisive subject, with much antagonism shown between those advancing competing accounts of the interactions which made the psy-system possible. In this context it is not especially necessary either to synthesise the findings of these accounts or to resolve their differences. There seems to be strong agreement that in the period between 1690 (at the earliest) and 1890 (at the latest) a new set of distinctions with which to apply meaning to madness began to emerge across Europe. This new type of knowledge focussed on the symptoms of madness in a systematic fashion, and was interested in reformulating the old distinction between madness and sanity in a way that could be consistently applied to similar cases (see Berrios 1994 pp.15-26). This new system of knowledge was concerned with classification and constructed elaborate taxonomies of diagnoses (Bentall 2004 pp.12-29). It was also concerned with identifying and communicating the causes of mental illness and sought to ameliorate madness, not merely by rendering madness manageable but by identifying the root cause of the madness and eliminating it. Eventually, this system of knowledge became concerned with identifying its own internal rules for managing redundancy; for identifying information irrelevant to the system. It devised schedules for clinical interviews, diagnostic tests and checklists of symptoms to ensure that only those symptoms consistent with the condition were included in the diagnosis (see Lunbeck 1994 pp.133-51).

For Luhmann, the cultural shift in this period from hierarchy to heterarchy provides an adequate, if not especially nuanced, account of why new types of knowledge became necessary at this juncture. The power to critique meant that the distinction between madness and sanity was no longer self-evident and had to be reinforced through the identification of information about madness. The power to critique also meant that therapeutic interventions were subjected to far greater scrutiny than had previously been the case. Those which did not work were observed and discussed, and books and journal articles debating their merits were published. However, those authors who have attempted to explain the emergence of the psy-system have emphasised a number of other significant events within this period which help to explain not just why this knowledge became necessary, but why it adopted the idiosyncratic form that it did.

Foucault's account of this period is amongst the most famous. During the seventeenth and eighteenth centuries, he argues, a sequence of inter-related responses to madness arose. The first was the 'Great Confinement', a mass institutionalisation of the impoverished within hospitals and workhouses, which began in the seventeenth century as a response to the desperate situation of many of the rural poor (Foucault 2006a pp.62-9). Madness was one of many conditions which could lead to destitution. The mass institutionalisation of the insane arose in the context of a wider anxiety about the dangers posed by those who had been left destitute and desperate as a result of economic crises which occurred across Europe, which were in turn precipitated by numerous ongoing wars. The Great Confinement was only the beginning however because by the mid-eighteenth century a new trend was evident in Germany, France and the UK: the creation of special hospitals for the insane (ibid. pp.383-7). These settings aimed to treat the mad, rather than to merely contain their symptoms. At the same time medical knowledge itself was being reformulated in favour of achieving the cure rather than the panacea. The identification of panaceas had been the goal of early medical science. By the eighteenth century a new type of knowledge of treatment was beginning to emerge which identified specific cures for specific illnesses; knowledge of illness and of cure were therefore inter-related (ibid. pp.306-7):

> *"This was a domain where the constant and reciprocal relation between theory and practice was supplemented by an immediate confrontation between doctors and patients...this would require a common language, a communication at the very least imagined between doctor and patient."* (ibid. p.307)

Psychiatric knowledge emerged at the confluence of these two events. The creation of the asylums meant that those seeking knowledge of madness had patients available to observe and communicate with. At the same time, the wider shift in medical objectives towards promoting a cure meant that there was, for the first time, a motivation for producing a more precise typology of mental symptoms and descriptions of how these symptoms responded to specific interventions. Madness then, ceased to be understood as undifferentiated unreason, but began to be distinguished as a *"specific object of perception"*:

> *"Forms now multiplied and doubles appeared; imbeciles were now to be distinguished from the weak-minded and the senile; disturbance, disorder and extraordinary sentiments were now no longer the same thing, and there was even a difference between the alienated and the insane, a division that seems enigmatic in the extreme to our eyes."* (ibid. p.388)

Most famously of all, Foucault posits a specific relationship between the power of psychiatric discourse and the consequent ability of this discourse to determine what constituted truth in relation to madness and thus supplant the mad person as the self-evident expert upon herself. This knowledge of mental symptoms and their management achieved enormous influence, such that the operation of power over the bodies and minds of the mad came to define the psychiatric profession:

> *"The great asylum physician...is the one who can tell the truth of the disease through the knowledge he has of it and the one who can produce the disease in its truth and subdue it in its reality, through the power that his will exerts upon the patient himself."* (Foucault 2000 p.43)

Foucault's account of this period in the history of psychiatry is richly textured and this summary ignores most of this detail, but even a summary helps to identify some of the themes that other historians have pointed to. Two types of fear were significant, a fear of unreason and a fear of civil unrest among the impoverished and disenfranchised. Economic upheaval mattered, partly because it contributed to poverty and unrest, but also because the emergence of the modern state generated the conditions necessary for the central planning of welfare provisions, a phenomenon that occurred in England, France and Germany during this period. More specifically for the creation of a distinctive psy-system of meaning, it was necessary for the medical system to first embrace the idea that the body and its dysfunctions could be understood in atomised instead of holistic terms. Finally, Foucault identifies an aspect of psy-system knowledge that is still evident today: the specific types of madness the system identifies have a tendency to multiply, mutate and then become obsolete over time.

A further theme is illustrated neatly by Porter who suggests that a distinctive Whig psychiatry can be observed emerging as early as the late seventeenth century, generated in response to the threat posed by religious faith rather than by poverty (Porter 1983). This psychiatric account of madness was needed to neutralise the threat to the social order made by those who claimed, as a result of their madness, to have spiritual authority and thus set themselves up in opposition to the established religious hierarchy. By neutralising the subversive effects of religious enthusiasm, this Whig psychiatry:

> *"... sought to normalize and condition the disturbed into the managed, conformist, accommodating, pluralist Georgian world of polite repressive desublimation."* (ibid. p.48)

The pre-conditions necessary for this distinctive psy-knowledge to emerge therefore included a challenge to existing forms of social hierarchy and an embrace of Lockeian Enlightenment values including the belief that madness could be cured with kindness. This theme of domesticating or taming madness is also picked up by Scull, although he argues that a discourse and set of practices associated with 'taming' madness did not emerge as a sudden response to political change as Porter asserts, but instead developed gradually across the course of the eighteenth century (Scull 1983 pp.55-79). However, most interesting of all, Porter argues that this psy-knowledge took a specific direction in favour of explaining and even flattering the neuroses of the elite, as opposed to merely containing the threat posed by the impoverished masses. Porter's thesis adds further force to the idea that a psy-system of knowledge, like other functionally differentiated systems, is necessitated by the restructuring of society away from simple hierarchies.

Changing economic structures also affected the mad in a number of ways. Scull emphasises the significance of market economics in the late eighteenth century. Once set free from its hierarchical moorings, economic exchange within a free market was able to foster the generation of enormous wealth, but at the same time it destroyed the social obligations which had formerly existed between employers and the employed. Whilst the poor were more mobile, those who employed them no longer shared their community and felt no specific sense of duty to secure their well-being. Consequently, a much larger class of profoundly impoverished people emerged in England and Wales who could no longer afford to provide for those family members who were unable to work. These families gratefully sought relief for their mad relatives in new state asylums (Scull 1993 pp.29-34). Wright points out that evidence about asylum admissions in England and Wales in the nineteenth century indicates that periods of confinement were often quite short and suggests that families might have been making strategic use of the asylum as an economic 'coping strategy' with which to handle unproductive members temporarily when other forms of relief or support gave out (Wright 1997). Both suggest that poverty played a significant role in making mad people available as objects of study for the psy-system, where previously they would have remained invisible within the family. Bartlett emphasises that in identifying patients for admission the Poor Law officers appeared to play a reactive role rather than a pro-active one, in most cases only intervening after requests had been made by family members (Bartlett 1999 pp.153-4). But the asylum only plays a role in providing care as a consequence of the economic system failing. A specific form of psy-knowledge is not required if family members with their highly specialised knowledge of the mad persons needs are primarily responsible for requesting confinement.

Scull does suggest that in some cases asylum admissions also functioned to achieve a specific economic end. The presence of impoverished mad people within the workhouses was seen to have a demoralising and disruptive effect within these institutions. The primary goals of the workhouses were economic; they sought both to make the indigent economically productive by requiring them to work, and also to communicate the moral importance of work to the wider population. Mad people who refused to work and who could not humanely be forced to work, undermined the principles along which the workhouses operated. Distinguishing them and arranging for them to be confined elsewhere thus appeared to serve a specific economic function, that of maintaining the efficiency of poor law relief (whether or not efficiency was actually secured by these means is another question) (Scull 1993 pp.38-40). However, whilst the economic and psy-systems may have sustained each others operations during the nineteenth century it was other contingent events, including the birth of bio-medical science, which provided the conditions necessary for an elaborate system of psy-knowledge to emerge.

Hacking argues, persuasively, that mental illnesses acquire both their form and their classification from the specific 'ecological niche' they inhabit (Hacking 1998). He explores this through the figure of the fugeur, a person whose mental illness exhibited itself through going on long journeys without an obvious rationale, and without being able to provide an account of herself on her return. He demonstrates that this diagnosis was first made in France in the 1880s, when a cluster of cases sharing these characteristics first came to light. The fugeurs in question tended to be men who lived in urban areas, had skilled work and sufficient disposable income to be able to disappear in this way without resorting to vagrancy. They belonged to a social category that had not previously existed in France. At the same time the railways enabled them to disappear effectively and anonymously in a way which had not previously been possible. Hacking argues that the presentation of mental illness as 'fugue' (a diagnostic category which still exists but is now only rarely applied) came about in this precise ecological niche and no other.

We can apply this metaphor to the psy-disciplines themselves. Efforts to construct a stable system of social meaning around the distinction between madness and sanity could have taken many forms. The form of the psy-system, its fragmentation, its relationship to medical knowledge, and the fact that it flourishes within therapeutic institutions, are all products of historically contingent events.

3.3.1 Medicine and the psy-system

Most of the historians cited above focus their attentions specifically upon the history of psychiatry, for it was psy-medicine which exhibited the earliest evidence of an internal infrastructure, and of external institutional support. But the coincidence of psy and medical knowledge emerging at the same point and adopting overlapping forms could be just that. The invisibility of conscious has meant that psy-knowledge was and remains inherently fragile. As a result it survived through finding niches within which its accounts could be rendered plausible and looked at from this perspective, the medical 'form' functioned as a carapace within which psy-knowledge could quietly evolve without fear of its weak epistemic underbelly being exposed.

In a paper on the implications of decarceration for the social lives of mad people, Goffman makes the point that the medicalisation of madness is a new phenomenon, dating back only to the late eighteenth century. Since this period the medical model of madness has gained considerable authority, despite the fact that most of the treatments offered in its name do not appear to work very well (Goffman 1971). Whilst there are still some cultural communities which employ religious, moral and symbolic codes to make sense of madness rather than a medical code, it is the medical coding of madness which enjoys the greatest degree of transnational and intra-community acceptance. Goffman suggests that this indicates that the medicalisation of madness serves social functions: *"Were there no such notion, we would probably have to invent it"*. Goffman is pointing up a paradox: for all its shortcomings, psy-medicine has managed to generate a perception of its own self-evidence, such that it does not need to be troubled by reflexive accounts of what it is doing. Other systems, such as the law, defer quite specifically to the authority of psychiatrists with their medical training and not other psy-professionals in the determination of madness. But looked at from a systems perspective it is unclear whether psy-system communication can truly be said to occur under the auspices of the medical system. As I outlined in Chapter Two, it is not inevitable, or even convincing, that madness should be understood as belonging to the same order of dysfunction as physical illnesses.

That is not to say that mental and physical illnesses are of a wholly different order, but that the social phenomenon of madness is far-more complex and wide-ranging than the concept of mental *illness* allows for (Simon 1999). Simon, for example, distinguishes accounts of madness which adopt a medical form from accounts generated by other psy-disciplines because of the focus of the medical system upon the symptom as a discursive unity around which communication can be held (Simon 1996 pp.6-11). The designation of madness as illness is therefore problematic because madness can only be known through behaviour (or as I argued in Chapter Two, through acts or utterances which cannot enter into chains of communication). Cconsequently, it differs from physical illness in that persons are not typically held responsible for their bodily dysfunctions, whilst they are held responsible for their actions. He suggests that this guillotine of responsibility, that one should be held accountable for rationally chosen acts but discharged from responsibility for those over which one has no control, imposes a moral flavour upon determinations of mental illness which is absent from diagnoses of physical illness. Of course the determination of the cause of a physical defect may also have moral implications. Now that we are aware of the way in which lifestyle factors influence physical dysfunction, those suffering from physical illnesses are increasingly accorded sympathy to a degree corresponding to the extent to which they 'brought it upon themselves'.

Another important distinction between madness and physical illness is that, since madness can only be known by acts, there is no possibility of asymptomatic madness arising. An individual can be diagnosed with a wide range of bodily defects, even in the absence of symptoms which can be linked to the defects arising. These defects might in time give rise to problems, and one of the key methods medicine employs to improve life expectancy is to screen whole populations to identify and treat these defects, even before the patient herself is aware of them. Of course, a psychiatrist may suggest that a person is at a high risk of becoming mentally ill in the future due to observable genetic or environmental factors, but one cannot be schizophrenic in advance of the symptoms, in the way in which one can have cancerous tissue in one's breast without being able to discern it (Bentall 2004 pp.95-116).

Luhmann himself defined the function of the medical system as being to restore the mind and body to their usual state of mutual indifference, so that mental operations are not overwhelmed by awareness of bodily dysfunction as they are when pain, or fatigue, or unconsciousness are present (Luhmann 1983). Psychiatry does not perform an equivalent function for the body. If and when a patient's mad symptoms are determined to have arisen from a bodily defect she will usually be referred on to a different specialist. It could be argued that, depending on what model of the mind one employs, the psy-system is seeking to restore indifference between the conscious and unconscious minds (Snyder 1999), or between the rational and emotional causes of behaviour (Bentall 2004 pp.205-227). But debates about how best to restore calm to the troubled mind of the mad person do not take place exclusively within psychiatry, but across all of the psy-disciplines.

In a further paper on the code of the medical system, Luhmann argued that it was often assumed that medicine prioritises health over sickness, but that in fact medicine actually has a distinctive knowledge only of pathology and not of health (Luhmann 1990). As a result, he suggests that the code of the medical system exhibits a 'perverse switch', prioritising the negative value: sickness over the positive value: health. It is this perversity that explains the medical system's failure to engage in building up a reflexive account of its operations. In other systems, it is the negative value of the code which has driven the development of reflexive accounts of the system's operations. Luhmann defines reflexivity as *"communicating about communication"* (Luhmann 1995/1984 p.452), and it becomes necessary at any point at which system operations cease to be self-evident. Theories about the law are driven by the knowledge that legal operations demand their own legitimacy. Theories about the mysterious operations of capital arise for the economic system at the point where systems of exchange have become so complex that their underlying logic is no longer immediately obvious. In both cases these systems had to justify their distinction and explain the negative value. The positive value of health, however, is apparent to anyone who has ever been ill, and the value of restoring patients to what is assumed to be the healthy status quo is therefore generally treated as self-evident. It is not surprising that reflexive accounts of the medical system only become necessary when medicine is in some way implicated in sickness as, for example, in the case of iatrogenic harm (Illich 1977). The dramatic increase in public and academic scrutiny of medical ethics means that it is no longer self-evident that the medical system does not engage with reflexive accounts of its operations.

The psy-system can be distinguished in this respect from the medical system, because communications about psy-system communications are abundant. Two types of description of the psy-sytem are available. Partly as a result of the desire of the psy-disciplines to distinguish their practices from each other a great deal has been said about their social function/s, underlying logics and the conditions necessary for their emergence. Some of this communication is communicating about the operations of systems other than the psy-system. These works contribute to reflexive accounts of the operations of power (Foucault 2006b), the economy (Scull 1977), law (Foucault 1978) and risk (Castel 1991), but not necessarily to the operations of the psy-disciplines. Whilst these accounts might observe that the distinction between madness and sanity is distorted by the imperatives of other systems, they fail to either collapse the distinction entirely or justify its continued observation. However, reflexive self-descriptions of their operations are also provided within the psy-disciplines. The philosophy of psychiatry, for example, attempts to explore the concept of madness using philosophical analytic tools, rather than treating the phenomenon as self-evident (Radden 2004). Psychologists and psychiatrists have promoted accounts of madness which highlight the shortcomings of the 'biomedical model' but which, in turn, provide a further description of what psy-knowledge should really be aiming to achieve (Bentall 2004, Read 2004a). Psychoanalysis was founded upon a presumption that some madnesses are not self-evident, but instead wholly opaque, and definable only through close communication with the patient. Psychology similarly, in the early part of its history expended much of its energies upon distinguishing psychological 'science' from the earlier accounts of human behaviour offered by the mesmerists, phrenologists and other newly supposed charlatans with whom the discipline had to compete (Rose 1997). However, these individual reflexive accounts do not generate coherent system boundaries, but instead multiple metrics according to which madness might be determined. The high degree of willingness to engage in reflection upon psy-operations exhibited by those communicating around this distinction is, therefore, a further characteristic which can be seen to distinguish psy-knowledge as a whole from the medical system.

The adoption of medicine as a convenient niche by the psy-system, does not rest purely on the perceived authority of medicine. The medical form and the use of medical concepts such as the symptom, aetiology, diagnosis, prognosis and cure to structure an account of madness does, as Goffman suggests, perform many useful functions. It allows for determinations of madness to be made ostensibly independently of culturally or religiously ordained moral codes, although as Simon points out, individual conduct is too inextricably entwined with perceptions of moral status for the two to always be successfully distinguished (Simon 1996 p.9). It also allows for accounts of madness to mirror existing accounts of physical dysfunction which are readily understood. This is important because, as Chapter Two outlined, incomprehensibility is definitive of madness. Finally, placing madness in the same bracket as physical illness acts as a way of managing expectations about the future. All illness creates uncertainty. One important function the medical system performs is transforming the experience of something unexpected and therefore distressing into something which from the patient's perspective will (hopefully) follow a predicted path (Simon 1996 p.10). However, the business of making prognoses about illness performs wider social functions than alleviating the patient's own anxiety. It makes the path of the illness comprehensible to others and enables the economic system in the form of employers, insurers, and the state, to make predications about their own ensuing liabilities. Drawing a parallel between physical and mental illness, reduces complexity for the economic system by enabling it to employ the same schema for assessing financial liabilities in both cases. In some cases, the parallel proves less helpful. The courts in England and Wales have historically had difficulty determining liability in cases of psychiatric injury because of the problems these cases pose, both in terms of establishing whether the injury was foreseeable and in placing reasonable limits upon the extent of the defendant's liability (Napier and Wheat 2002, pp.32-40). In this scenario the limitations of our social knowledge about madness (or perhaps in this case simply mental distress) are exposed. The historical preference of the courts to establish arbitrary 'lines in the sand' around the limits of liability and foreseeability has been attributed to the uncertainty of psychiatric diagnoses and prognoses, and the huge debates that exist around causal explanations for madness (ibid., Mendelson 1998 pp.287-90).

Despite these factors, psy-medicine is far from immune to challenges to its authority. Psy-medicine has simply developed some very effective strategies to address the threat of fragmentation posed by the emergence of competing models of madness. Whilst hard to pinpoint precisely, the end of the nineteenth and beginning of the twentieth centuries saw a dramatic flourishing in the accounts of madness available within society. By the 1880s advances in neurology had led to an awareness of the role of brain chemistry in epileptic behaviour and efforts to distinguish hysterical from epileptic seizures or absences (Hacking 1998 pp.31-50). Paresis or general paralysis of the insane was alleged to be caused by syphilitic infection as early as 1857, and by 1904 doctors were confidently asserting, on the basis of statistical correlations, that the two were linked (Braslow 1996). These events both led to growing confidence amongst physicians and psychiatrists in particular that other somatic explanations for mental illnesses could be found. At the same time, psychology was emerging as a distinct discipline with a concern for explaining the bases of human behaviour. Rose cites the emergence of laboratories, degree programs, the establishment of journals and learned societies, all taking place in the US and UK in the period between 1875 and 1925. He suggests that:

> *"In this way it* [psychology] *would gradually (and incompletely) distinguish itself from philosophy and ethics on the one hand and medicine and biology on the other, to form itself into a single, though inherently divided and fractured, discipline."* (Rose 1997)

Psy-medicine could have disappeared completely at this juncture. By identifying those whose mad symptoms resulted from physical dysfunction, somatic medicine was able to reduce the size of the population properly understood as mad effectively. Whilst on the other hand, at a time when most medical interventions in madness were proving ineffective, the new science of human behaviour demonstrated by psychology could easily have taken over from psychiatry in managing the mad. And yet psy-medicine survived, and even the strongest advocates for psychiatry can offer only a weak explanation for this:

> *"...psychiatrists do essentially two things that their competitors on either side – the psychologists on the one side, the neurologists on the other – do not. Psychiatrists offer psychotherapy, which the neurologists generally speaking do not...And psychiatrists prescribe medications, which the nonmedical competition is not permitted to do."* (Shorter 1997 pp.326-7)

This neatly illustrates the way in which psy-medicine adopts the form available to it, and exploits attributes which make it distinctive. In the context of the nineteenth century, one reason why psy-medicine was able to retain its dominance over psychology was that the medical model of madness chimed with popular views on moral authority. Psy-doctors assumed the role of moral advisors to their patients who, by dint of their illness, were incapable of making their own moral judgments (Clark 1981). Psychologists lacked equivalent authority. At the same time psy-doctors lost patients to the neurologists, and in the US this led to angry stand-offs between the disciplines. And yet in response to this stand-off, Blustein observes the mental hospital superintendents (who represent the ancestors of modern psychiatrists) dealt with this 'crisis of legitimacy' by actively seeking new models of madness which could adequately explain those madnesses which did not respond to physical interventions (Blustein 1981).

This constant re-engagement with its own differentiation is further apparent in the approach taken by the psychiatric profession in the late nineteenth century to the newly emerging psychoanalytic approach to madness. Blustein's account suggests that psychoanalysis became popular in the US at a point when psychiatry had already been weakened by its stand-off with neurology. The birth of psychoanalysis would appear to have further challenged psy-medicine because unlike biological accounts it locates the origins of madness entirely within the socially invisible internal operations of the psyche, although, like biomedical accounts, it attempts to explain this phenomenon independent of moral or religious distinctions. Instead psychiatry subsumed Freud's methods, in order to bring him within their fold and neutralise his subversive and demoralising impact on their newly emerged discourse (Ingleby 1983). Foucault argues that a popular misreading of Freud as delivering a 'meaningful' account of madness was promoted by the 'human sciences' as part of their drive to psychologise the individual and understand him as a subject in glorious isolation (Foucault 1995/1972).

These internal inconsistencies and threats to the supremacy of a bio-medical account have by no means gone away, but unlike other medical specialisms, psychiatry seems abnormally willing to countenance a kind of methodological pluralism. Shorter (1997 pp.239-87) argues that during the twentieth century psychiatry has had to adapt first to the challenges to early biomedical accounts of insanity posed by psychoanalysis and later to the challenges to psychoanalysis posed by the re-emergence of the biomedical model in the 1970s. Shorter perceives psychiatry's ongoing flirtation with a diverse range of psychodynamic interventions as a product of the 'psychologisation' of everyday life and sees this as a challenge to psychiatric 'science' properly so called. But we could equally see psychiatry's willingness to employ a wide range of methods as a product of the uncertainty of psy-knowledge. Lakoff gives a nice example of this in a description of the work of a women's psychiatric unit in Buenos Aires which offered Lacanian psychoanalysis as an intervention. He quotes one of the clinicians who worked there as saying: *"What I can't explain is how you could have a theoretical construct like* ***lacanismo*** *and medicate heavily without having your head explode."* (Lakoff 2005 p.83, original emphasis). Regardless of the threat posed by psychoanalysis to a biomedical model of madness, Lakoff observed that in practice that the two approaches were more than capable of co-existing despite their fundamental contradictions.

3.3.2 Morality and the psy-system

Besides sickness/health, psy-knowledge also had to emerge in the shadow of another distinction, that between good and bad conduct. Luhmann argues that the moral code in Europe has historically been concerned with applying a distinction which is socially invisible. The moral person is the one who has wholly internalised the application of the good/bad code to her actions, but it is of course impossible for her to communicate this fully to others. Ethical theories emerged to provide reflexive accounts of the moral code which enable the individual to provide a theoretical description of the basis for her behaviour (Luhmann 1993).

So morality, like psy-knowledge, is concerned with a person's state of mind. And where an individual's conduct is consistently bad, the moral system is concerned with how this can be addressed. It is not surprising then that the moral code played a formative role in the development of some early approaches to madness. Moral treatment as it was practiced at the York Retreat, a hospice for mad people established in 1796, aimed to offer rehabilitation independent of medicine. At the same time, the term moral treatment was employed within the French psy-medical system to describe a pioneering approach to engagement with mad patients. Charland distinguishes moral treatment as it was understood at York from the term as employed by Pinel and Esquirol in France. Samuel Tuke, the founder of the York Retreat, built up an account of madness which argued that the humanity of the mad person was retained by dint of their *'inner light'* a moral sensibility which even the most extreme evidence of unreason could not extinguish. Consequently, treatment was offered on the basis of unlimited compassion and respect in the hope that this retained sensibility could still be reached and healed (Charland 2007). By contrast, Esquirol's description of the rationale underlying his mentor Pinel's practice of '*traitement morale*' placed an emphasis on the view that the mad person always retained a *'rational kernel'*, and that if sufficient efforts were made to communicate with the individual this kernel could ultimately be liberated and the patient restored to reason (ibid. and Gauchet and Swain 1999 pp.230-3). However, despite these differences both models indicate a recognition that the self has to be understood not merely in relation to a model of a functional mind, but also within the context of a functioning system of interactions. By emphasising the significance of engaging with the patient Pinel and Tuke both implicitly acknowledged the possibility that madness results from a two way failure in communication, and not merely from within the defective individual. Interestingly these therapeutic institutions sometimes invoked the form of the family in their organisation, and likened their patients to children, even encouraging them to conceptualise their medical attendants as parents (see Foucault 2006b pp.84-7, Charland 2007). Perhaps this respect for the form of the family was based on the observation that interpersonal communication founded upon trust is generated far more readily within families than in the anonymous impersonal context of the asylum.

It is possible to imagine the emergence of a system of psy-knowledge in which the medical form was not adopted, and instead the imperatives of the moral code provided the niche within which meaning making activity could flourish. Certainly, religious views on morality, the operations of popular morality, and the newly emerging therapeutic practices of the psy-disciplines continuously intersected throughout the nineteenth century. And these intersections can sometimes still be observed today. Fuchs, for example, sees the pastoral care provided by ministers of religion, often in therapeutic settings such as hospitals, as overlapping with the operations of psychotherapy and yet retaining a distinctive character because it retains the notion of a transcendent soul which secular psy-practices typically avoid (Fuchs 2005a). And yet despite the significance of knowledge of social mores, the psy-system as it attempts to distinguish mad/sane has tended, like the medical system, to prioritise the negative value of its code and emphasise the description of madness over the description of sanity.

3.4 Plumbing for the soul – the pragmatism of the psy-system

The psy-disciplines recognise the profound limitations imposed upon their practice by the shortcomings of psy-knowledge. They have engaged with these shortcomings pragmatically, constantly redefining their operations in relation to the shifting sands of what can be considered to be their territory, or their functional differentiation. But the body of psy-knowledge they have generated as a consequence remains highly fragile. Whilst psy-professionals have considerable authority to ordain distinctions between the mad and the sane, their diagnostic categories are in a constant of flux (Horwitz 2002 pp. 67-79, Charland 2004), the medication they prescribe is criticised for being at best ineffective (Kirsch et al. 2008) and at worst dangerous (see for example the recent scandal over the safety of Seroxat: Boseley 2008), and their ability to predict the outcome, particularly adverse outcomes, of psychiatric illnesses is demonstrably weak (Peay 2003 pp.129-30, Szmukler 2003). The community psychiatric nurses and social workers who attempt to ensure that the welfare of mad people is secured, are nonetheless dealing with the social demographic most likely to be unemployed and living below the poverty line. This tension between fragile and elusive knowledge and the demand for practical intervention is neatly pointed up in the German slang-term for psychiatrists: '*seelen-klempner*' (soul-plumbers) (see Fuchs 2005a).

The fragility of psy-knowledge is not surprising when one considers that the object of this knowledge is consciousness. Psy-knowledge can only communicate about consciousness and not with consciousness (Luhmann 2002a). Fuchs makes the point that a parallel can be drawn between the systems theoretical account of consciousness as socially invisible and the psychoanalytic conception of the unconscious which defines the self as largely invisible, even to the self (Fuchs 1999). This invisibility means that for both theories individual consciousness is neither the subject nor object of the theory but an *'un-jekt'*, something conceived of but unseen and inherently unknowable. Systems theory addresses this paradox by shifting the focus of its analysis away from efforts to make sense of social acts, to the level of communication, where notions of individual motivation become theoretically redundant. However, psychoanalysis, because it aims to heal the self has to make attempts to transform this '*un-jekt*' back into an object of knowledge, perhaps assembled from the gaps in meaning in what the individual says. What is available to the psy-system in the absence of a direct mapping of consciousness on to communication are a number of sources of information about the environment of the mind, all of which are of distinctly limited usefulness. One source is the utterances made by the possessor of the mind supposed to be mad. These will always be delivered through the imperfect media of language, text or image, and information will inevitably be lost in this translation, thus conscious attempts to comprehend the operations of the psyche always suffer from a shortage of information (Ort 1999). Another source of data for psy-operations is observations of the body and, most recently, of the brain. Again, representations of the physical operations of the body inevitably involve considerable information loss, and even once data is gained, its ambiguities make theorising about its implications extremely difficult (Read 2004a). The psy-system may also seek evidence from the people who care for the supposedly mad person. But all of the problems which apply to information extracted from the body and utterances of the mad person, apply simultaneously to information extracted from his or her loved ones: it may not be credible, it certainly doesn't reflect a priori access to the operations of the psyche, and it demands considerable post hoc theory building to become intelligible. It is the shortcomings of the empirically available data about the psyche which have lead to the emergence of a plethora of different theoretical models of madness. Finally, psy-systems have to evaluate what they have learnt about the mad person in light of what is known about what is considered to be meaningful or rational behaviour within society as a whole. This information may also be ambiguous, as the work of transcultural psychiatrists has demonstrated (Littlewood and Lipsedge 1989, Bentall 2004 pp.122-7). It may also be hard to articulate what makes a specific behaviour abnormal. Bergmann (1992), in a study of psychiatric admission interviews, describes how psychiatrists deliberately avoided specifying what was abnormal about the patient's behaviour, instead leaving the patient to fill in the gaps and explain what she had been doing which precipitated the admission. He suggests that psychiatrists do this to evade the difficult task of explaining why the patient's behaviour was transgressive and required intervention.

At the same time as dealing with the consequences this shortage of information presents for the system, the psy-system is placed under pressure from the legal system to provide meaningful distinctions between mad people. Foucault provides the example of the 'dangerous individual', one who could not provide a satisfactory, i.e. comprehensible, account for her criminal acts although she might not appear to be 'mad' in any other way (Foucault 1978). The French legal system in the nineteenth century had begun to determine lawful punishment upon the basis of 'fitness': a crime must correspond morally to the punishment imposed. But the dangerous individual, whose motivations could not be determined, challenged all efforts to determine precisely which punishment fitted the crime in her case. The psy-system was then called upon to furnish an account of the differences within and between mad and bad people in order to enable this distinction to be retained. Such a distinction is highly problematic to operate in practice, so much so that in writing about a trial held in 1975 Foucault was still able to observe the character of the dangerous individual bringing the legal system to a halt. This is just one example of a way in which the legal system demanded certainty from the psy-system. Chapter Six will argue that one way in which the legal system has addressed the fragility of psy-knowledge has been to allow the psy-system to largely determine the legitimacy of its own operations. But it is perhaps because of this tension between the need for certainty on the one hand and fragility on the other that the psy-system survived as a set of interconnected disciplines.

The psy-system distinction between madness and sanity is communicated about by practitioners within a large network of disciplines – psychiatry, psychology, psychiatric nursing, neurology, psychiatric social work, psychoanalysis etc. These disciplines have in turn spawned their own offspring - forensic psychiatry, neuro-psychiatry, forensic psychology, neuro-psychology, forensic neuro-psychology and so on. The psy-system in this respect is quite different from the legal system, where disciplinary and system boundaries overlap considerably. Legal professionals are readily identifiable, and whilst no one is precluded from communicating about the legal code, lawyers can be distinguished by the degree to which they participate in such communication and the comparative degree of success they enjoy when they communicate with each other. Lawyers may specialise, but they typically treat the topic of their specialism as self-evident. A family lawyer will not need to expend much energy on explaining how family law can be distinguished from criminal law for example, even though the two areas often overlap in practice. By contrast, sub-branches of the psy-system expend enormous energy on defining how their precise knowledge of psy is distinct, because their underlying subject – the operations of the self – is the same. This plethora of disciplinary constructs is less surprising if we consider madness according to the broad definition I provided in Chapter Two (p.78): a discursive continuum without fixed boundaries, which semantically and analytically allows us to group together instances of incomprehension.

We have seen how psychiatry survives the destruction of its paradigms, not by endorsing a single method (he who lives by the sword dies by the sword), but by defining itself anew as a different discipline to that which has been debunked (Ingleby 1983, Shorter 1997 pp.288-9). In this way the fragmentation of the psy-disciplines actually helps to sustain the system, because whilst new definitions are created, no possible information is actually lost to the system. Although Freud has been debunked, the most hopeless cases can still be offered psychoanalytic treatment for want of anything better.

This hydra of a system remains fragile but it has an underlying resilience resulting from the fact that no matter how weak a psy-theory is it is still better than no theory at all. And if one psy-theory is helpful, ten may be even more helpful.

3.5 Conclusion

Many accounts of the emergence of psy-knowledge have emphasised discontinuities between the disciplines concerned. Even those applying a systems theory analysis have asked how different branches of psy-knowledge can communicate with each other (Simon 1996, Fuchs 1999). To suggest that in fact a functionally differentiated system of meaning has built up around the madness/sanity distinction seems counterintuitive. The breakdowns in understanding between these disciplines and the discrepancies between their different types of knowledge are far more evident than their continuities.

Luhmann is often interpreted as suggesting that in order for functional differentiation to arise it must be possible to observe a decisive break; a point at which the system's self reference is operationalised. It is clearly not possible to do this in the case of the psy-system, to select one event as definitive of the system's own freedom from reference to another distinction - reference to a medical or moral distinction for example – is impossible. But, in any event, Teubner suggests an alternative view to Luhmann's: that it is possible to think of self-referential systems in terms of degrees of autonomy (Teubner 1993 pp.31-46). In order for autopoiesis to arise, the system must be able to reproduce its own elements, so legal acts are constitutive of further legal acts, the reporting of medical diagnoses informs future diagnoses and participation in monetary exchanges makes future monetary exchanges possible. But Teubner also argues that all of the components of the system - the acts, boundaries, structures and processes it employs - must be cyclically interlinked for total autopoietic closure to occur. Thus autonomy increases as the system recognises its components, engages in reflexive communication about them (self-observation), is able to act to alter its operations on the basis of these communications (self-constitution) and links these processes together in a hypercycle (autopoiesis).

Despite the absence of any agreement as to which event constituted the birth of psy-knowledge, we can observe a psy-system that conforms to this description. It can recognise its own institutional components, a psychiatric setting can be distinguished from a spiritual retreat for example. The psy-system has developed a highly sophisticated reflexive account of its own operations, characterised by a very low degree of agreement, but nonetheless generating considerable communication. Finally, psy-settings and practices have demonstrated that they are able to adjust on the basis of information available to the system about how best to apply the distinction between madness and sanity. This description may only be recognisable within Europe and North America, within other parts of the world the psy-system may have only achieved relative autonomy.

Acknowledging the possibility of psy-knowledge being organised around a meaningful distinction does not mean accrediting the psy-system with operating that distinction especially effectively, any more than acknowledging the existence of the legal system means that one endorses the content of the law. But observing the fragility of psy-knowledge suggests a further reason why discreditation processes are so entrenched in our society: not only is madness discredited, but knowledge about madness is discredited too.

Chapter Four

Discreditation: Silencing the voices of mad people

4.1 Introduction

The exclusion of people who make mad utterances from society far exceeds the extent to which their presentation of unreason makes exclusion inevitable. This exclusion continues long after symptoms have become manageable and into areas of social life where the individuals ability to function has not necessarily been affected by her mental disorder. Madness, from a systems perspective, is definitively excluded from social systems. However, madness is a definition that in and of itself can only be attributed to utterances. It is through the work of the psy-system that mental illness becomes a label attached to an entire individual which can then be used to define the role she plays in society.

This chapter will examine what happens to madness once it has been launched into the social world and how the social processes of discreditation and accreditation may account for the scale of this exclusion. These processes collectively enable social systems to reduce the complexity of the information they perceive about their environment and help to reinforce their boundaries. Discreditation processes are a response to the profound problems caused for social and psychic systems by the unpredictable nature of mad utterances. Understanding what function these processes perform is a necessary first step on the path to ensuring that those who have made mad utterances are appropriately accredited and included within systems of communication.

4.2 Differentiating social exclusion

Although social exclusion was placed on the political agenda in Britain by the newly elected Labour Government in 1997, the definition of this term has been widely contested. Social exclusion is typically defined as the outcome of interactions between different types of social disadvantage; as for example in this definition given in a think tank report on the social inclusion of people with mental health needs:

> *"Social exclusion can be defined as a series of interconnected problems around poverty, discrimination, unemployment, low skills, bad housing and poor health."* (Rankin 2005)

However, identifying which disadvantageous factors contribute to social exclusion, and what the causal relationship is between occurrence and outcome has proven extremely difficult (Burchardt et al. 1999, Curran et al. 2007). These problems with the term have been so great that they have tended to obscure the other important question it raises – why do these factors contribute to social exclusion? In the context of this thesis then, social exclusion will have to mean two things. One is the comprehensible but nonetheless complicated use of the term to describe the social problems which coalesce when people suffer from multiple social disadvantages. The other is an attempt to look at social exclusion through the other end of the telescope by examining what aspects of what people say lead to their experiencing exclusion, and why this problem may be exacerbated by their exclusion from the operations of multiple social systems.

4.2.1 Defining social exclusion

The term social exclusion is not new. It has been widely used in European social policy since the 1970s (Lenoir, 1974), although its meaning has shifted over time. It was originally coined to refer to those who were excluded from the benefits of social insurance in France, but came to mean those who were excluded from a wide range of different social spheres by dint of unemployment. It has been suggested that the development of the term in the European poverty research literature mirrors the problematisation of ghettoes and the underclass in the US (Burchardt et al. 1999). Research into the dimensions of social exclusion has tended to emphasise that unlike poverty, which is typically measured against income as either a relative or absolute outcome, social exclusion takes place across a wide range of social domains and that not everyone who experiences social exclusion will experience this exclusion consistently across all domains, or consistently over time.

Those concerned with social exclusion are typically aware that social structures may exclude, and that the problem cannot be conceptualised wholly in terms of the moral inadequacies of those excluded (as theories of an underclass suggest). They accept that it is not within the agency of individuals to alter the fact of their exclusion but they nonetheless conceptualise exclusion in terms of thwarted agency. For example, Burchardt et al. (1999) adopt a working definition which is oriented around the individual:

> *"An individual is socially excluded if (a) he or she is geographically resident in a society but (b) for reasons beyond his or her control he or she cannot participate in the normal activities of citizens in that society and (c) he or she would like to so participate."*

This definition implies that what is wrong with social exclusion is that it prevents participation in society and thus diminishes quality of life. However, they do not frame their concerns in terms of social justice: the phenomenon of exclusion is unfortunate rather than inevitably unfair. An alternative is to adopt the approach employed by Walzer in his book 'Spheres of Justice' (1983), in which he argues that social equity is based on the individuals right to inclusion within the group and is evidenced by their inclusion in a range of social spheres such as the economy, politics, the family and workplace. Societies which effectively exclude people from the benefits of any of these spheres are unjust, even where they have made a commitment to formal equality. As a result, large disparities in the distribution of social goods can be seen as evidence of injustice. A definition of social exclusion grounded in social justice arguments clearly problematises relative poverty or unemployment without having to evidence the denial of agency to affected individuals. The exclusion is the problem in and of itself. But this ethically grounded approach does not appear (based on the absence of research evidence employing it) to yield a more useful definition from which to theorise the causes or effects of social exclusion. It is those employing participation based approaches who have done most to develop robust tools for defining and measuring the impact of social exclusion.

The definition provided by Burchardt et al. is based on an analysis of the British Household Survey for 1991-1995. The five key areas of activity the authors see implicated in social exclusion are: low consumption activity; low savings activity; low production activity (e.g. unemployment); low political activity and low social activity (Burchardt et al. 1999). Although their statistical analysis exposes significant relationships between each of these factors, the relationships are not so strong that their coincidence is in anyway inevitable, or even especially probable when only one factor is evident. Importantly the relationship between these factors is not consistent; low consumption activity correlates strongly with all other factors, whilst low production, political and social activity correlate more strongly with each other than they do with low consumption or savings activity. They argue that attempts to define the 'socially excluded' as a population with distinctive shared attributes are therefore misguided, and that research activity should focus upon understanding these dimensions separately.

However, understanding the strands of exclusion in isolation obviates the need for the study of social exclusion as a unified phenomenon. As some of Burchardt et al.'s related work shows it is the unexpected dynamics of exclusion, especially over time, which make it interesting. In a later study, employing a larger dataset, they demonstrate that the likelihood of an individual being excluded within one dimension over time, i.e. year on year, is much greater than the likelihood of the same individual being excluded over a range of different dimensions (Burchardt et al. 2002). So in addition to being weakly multidimensional, the problem of social exclusion is strongly persistent, and perhaps difficult to reverse.

These seminal studies on defining social exclusion do not address the specific relationship between madness and social exclusion. But it has been argued in a number of policy documents and reports from the voluntary sector that mad people, defined as the population of people diagnosed with 'severe mental illness', are also extremely likely to experience social deprivation across the dimensions associated with social exclusion (Mind 1999, Social Exclusion Unit 2004, Rankin 2005). However, the definitions employed in these reports vary widely. The definition in the report by Rankin quoted at the beginning of this section, is similar, though not identical to that suggested by Burchardt et al. and focuses on the multi-dimensional aspects of the problem. Whilst the government's Social Exclusion Unit report 'Mental Health and Social Exclusion' defines the problem in three ways: firstly as one of unemployment; only 24% of people with long-term mental health problems are in full time employment; and secondly in terms of economic cost: mental health problems are estimated to cost the British economy £77 billion per year. The alleged association between madness and poor living conditions comes a poor third. They argue that experiencing mental illness creates a cycle of exclusion, because it can lead to unemployment, debt and homelessness. But this is a purely theoretical construct; no quantitative evidence is advanced to describe how common this phenomenon is. The Mind report does not provide a definition of social exclusion but emphasises a quote from one of the participants in its inquiry: *"Social inclusion must come down to somewhere to live, something to do, someone to love"*. The political conception of the link between social exclusion and madness tends to pick up on the fact that exclusion is multi-dimensional and persistent, but also identifies an aspect of the concept which Burchardt et al.'s definition does not: that it is intransigent. All three of these reports concur when it comes to emphasising the fact that simplistic interventions, which tackle social exclusion along just one dimension, are not especially effective.

In an attempt at a systematic review of the literature on mental health and social exclusion, Curran et al. (2007) observe that in their trawl of the research literature they found that definitions of social exclusion and of mental disorder are not employed consistently. In addition, a wealth of information, particularly about the views of service users, is contained in the 'grey literature' of which these three reports are good examples, and this is difficult to compare systematically with the findings of empirical research. There is therefore a danger that good quality qualitative data will be excluded from systematic reviews. Related concerns are raised by Fryers and Melzer (2003). Both reviews raise the interesting point that there is a great need for more robust hypothesis driven research into social exclusion. The field is beset by studies which adopt highly simplistic definitions of the term, and proceed to test very basic hypotheses, and this typically results in negative, and arguably, futile findings. For example, one study found that a government policy of requiring GPs to maintain registers of severely mentally ill patients did not appear to reduce the degree of social exclusion these patients experienced (Bonner et al. 2002). But this was hardly surprising since their report defines social inclusion as somewhere to live, something to do and someone to love and fails to assess whether these correlate with measurable outcomes. Many studies also rely on the measurement of social exclusion by service providers, but the indicators service providers employ are not necessarily validated or consistent across different health authorities, or even between teams in one health authority region (see for example Todd et al. 2004).

If the intransigence of the problem is definitive of social exclusion then it would not be surprising if social interventions aimed at tackling it had a low success rate. But as the research cited above makes clear, it is impossible to say what works in reducing social exclusion for mad people, because the lack of coherent definitions makes analysing research findings extremely difficult. The UK Government issued a 27 point action plan to tackle the social exclusion of mentally ill people in 2004 (Social Exclusion Unit 2004, pp. 95-113). This is to be monitored by an Independent Advisory Group, and progress towards their targets is to be measured using mainly existing data sources, such as the Labour Force Survey, and the annual figures collected by the Benefits Agency on the take-up of incapacity benefits. The report notes the problems with the validity and comparability of this data, but at this stage the Social Exclusion Unit have only committed to improving the evidence base in the future. Although most of the points on the Action Plan have now been implemented (National Social Inclusion Programme 2006), it is still too early for their impact to be evaluated.

Taken together, these problems suggest that the difficulties with defining social exclusion arise from the fact that it is theoretically underdetermined. Attempts at robust definitions have been made, but these typically emphasise outcomes, and do not enlighten us when it comes to causes. In many cases efforts to define the causes of social exclusion lead to circular reasoning: poverty is believed to lead to social exclusion, but social exclusion in turn is defined as living on a relatively low income, or as having no fungible assets, which are both definitive of poverty. But however defined, the work of most theorists of social exclusion in the UK has tended to focus upon developing a definition which can lead to better measurement of the scale of the problem, and hence a useful yardstick for measuring the outcome of targeted interventions.

4.3 A systems theory of social exclusion

The consensus that social exclusion occurs across a range of different social spheres and persists over time means that the concept lends itself well to a systems theory analysis. From a Luhmannian perspective, it makes sense that an utterance is likely to be excluded from the economic system if the person making the utterance does not have money or the means of obtaining it, thus depriving the individual of the chance of entering into whole swathes of economic communications (Luhmann 1995/1984 p.461-2). Money is a medium which is crucial to the viability of economic communications. The ability to participate in the economic system is often a prerequisite for participating in other systems, which is why living on a low income correlates with the four other dimensions of social exclusion which Burchardt et al. explored. In contrast participation in politics (defined broadly as involvement in any shared cause, from the local to the global) is not necessarily a prerequisite for economic participation, so this indicator does not correlate as strongly with social exclusion as it does with other indicators such as employment or social activity.

However, whilst the relationship between indicators can be understood from a systems theory perspective, the fact that exclusion persists over time, requires an understanding of the way in which discredited utterances impact upon future utterances. This is easily seen when we look at the economic system, where the logic of discreditation and accreditation is made explicit in the use of credit checks and ratings. An existing history of participation renders a person creditable, whilst a history of non-participation; perhaps the failure to have previously bought financial products or hold a bank account, will discredit an individual (Luhmann points out that this failure to participate can in turn generate negative feedback and make future participation even harder: see Hagen ed. 2005 p.40). Whilst the rationale of the calculations made about whether an individual should be accredited or discredited is made explicit in the practices of financial service providers, it is not inherently different from the rationale doctors apply when deciding whether a patient is likely to be genuinely ill, or that a jury employs when deciding whether a witness is telling the truth. Processes of accreditation and discreditation intervene all the time in attempts at communication, rendering some feasible and others not. Their impact is clearly not restricted to those who have previously made mad utterances. People's utterances may be discredited as a consequence of their own conduct: if they have previously lied for example. Or they may be discredited if their lifestyle associates them with discreditable attributes: if they live in an impoverished area, or work in a discredited profession.

The credit and debit model is helpful here, because it is clear that discreditation across one dimension at one time often has very little impact on the individual's ability to engage in other areas of social life in the future. If other aspects of their lifestyle or behaviour are creditable, then these may counteract the effects of an isolated discreditable feature. One reason why mad utterances lead to a wholly disproportionate discreditation response, is that madness threatens the operations of all systems, rather than just one, and as I will discuss later on, it is possible for systems to unconsciously collude in the exclusion of mad people.

This emphasis on discreditation indicates that a systems theory analysis of social exclusion might have more to say about the processes which cause exclusion, than it does about the effects on people of being excluded, or the interventions which might help reduce its impact. As such, it is not necessarily a useful basis for developing a theory of social exclusion in isolation. But it does provide a useful starting point for theorising about why those who have made certain classes of utterance, including mad utterances, may suffer the effects of exclusion across a range of social systems.

4.4 Processes which discredit mad people

If we return to Luhmann's definition of communication as discussed in Chapter Two (pp.65-7) it is apparent that in selecting which utterances to take account of *ego* has to consider what makes an utterance worthy of attention. A number of factors may influence this selection: relevance, correspondence to reality, the esteem *ego* holds for *alter*, and whether or not *alter* has been discredited. The act of selecting an utterance does not demand that *ego* agree with the content of the utterance, only that she gives it her attention and indicates a response to it (Luhmann 2002b). Luhmann himself did not explore the significance of coding utterances according to the schema accredit/discredit. He did, however, emphasise the significance of the schema esteem/disdain and the role it played in sustaining the interpenetration of psychic and social systems. He argues that holding someone in esteem is a generalised symbol of the fact that *"others accord with the expectations one believes must be assumed for social relations to continue"* (Luhmann 1995/1984 p.235). Esteem then, is an evaluation that relates to the whole individual, and is accepted reciprocally by human beings, most of whom acknowledge that the esteem of others matters to them. By acting as if esteem matters to them, human beings reinforce the coherence of the social order, despite their differences. However, esteem is only relevant to inter-human interpenetration and not to social interpenetration. Esteem matters within interaction systems because one may require the esteem of one's neighbours in order to be able to call upon them in a time of need. Within functionally differentiated social systems esteem is not effectively communicated throughout the wide range of systems with which each psychic system must engage. For example, it ceases to be relevant once money enters the equation and labour is typically exchanged for a wage:

> *"Here the inclusion of a human being's full complexity in that of another is not only unnecessary but is even avoided as a disturbance factor"* (ibid. p.239).

Discreditation also performs useful functions for interaction systems. Discreditation and accreditation processes operate within these systems, but for different reasons. The utterances of a family member may be discredited if this serves to shore up other relationships within the system. The distinction between interaction systems and social systems allows for these two types of discreditation process to be understood as distinct phenomena.

Unlike esteem/disdain, the distinction between accredit/discredit is not an evaluation of the whole individual. Instead accreditation is a process which directly assesses utterances and whether or not they should be accorded a value within the system. It is a distinction which is useful within a society comprised of functionally differentiated systems because it allows multiple systems to make use of shared information in order to determine how to evaluate an utterance. Accreditation processes are so widely employed that they frequently cease to be visible to those whom they concern. Systems employ internal schema to identify discreditable attributes, which may render a person's utterances unworthy of attention, but these schema are rarely explicitly identified as operating a distinction around accreditation/discreditation.

Social processes of discreditation affect those who have made mad utterances disproportionately. Systems employ a wide range of processes to discredit future utterances, and signal to others that the utteror should not be treated as credible. Some of these have already been theorised extensively in the literature on the sociology of mental illness, such as the effects of labels and stigma. In addition it is arguably the case that many of the benign interventions operated by the psy-system to protect the interests of mentally ill people, such as paternalism and normalisation, function to discredit their efforts to operate within other social systems. Processes of accreditation and discreditation are clearly generalised symbols, but they are effective at the level of social interpenetration as well as at the level of interpersonal interpenetration. Rather than existing prior to communication, they arise in response to utterances and are intended to have effects over time which are generalisable across different systems of communication, rather than simply between humans. A generalised symbolic medium such as love may increase the viability of communication between actors in love with each other, for as long as the love lasts (Luhmann 1998 pp.20-3), whilst having a creditable attribute, such as an educational qualification, is intended to have effects across a wide range of communication systems, and to last into the future.

Labels, for example, have some of the most far-reaching discreditation effects, because they are readily transferrable and generalisable. Applying a label to a persons disordered conduct or speech serves to make the phenomenon more comprehensible to others. But this increase in comprehensibility relies on knowledge about the label being shared between actors. Although mechanisms, such as confidentiality, are used to control this transfer of knowledge, this is always balanced against the drive to maximise the functionality of the label, by increasing awareness of it. But in addition to being transferrable, labels also serve to generalise discreditation. If a diagnosis of schizophrenia in one case indicates that the person is prone to violent actions, then it may mean it in other cases too. This may mean that, even where someone who has made a mad utterance has never acted violently, they can nonetheless be discredited by association. The association of some labels indicating madness with horrifying events or disgusting acts represents one of the most extreme forms of discreditation. Of course, labels also serve to accredit, even labels indicating mental illness. Porter point out that in the seventeenth century a label of mental illness was not inevitably stigmatising and instead could be used to accredit women who would otherwise be condemned as witches (Porter 2003). It is still possible for a diagnosis of mental illness to accredit an act which might otherwise be understood as wicked. For example, the mother who harms her baby may be understood as wicked unless and until she acquires a diagnosis of post-natal depression at which point she becomes a potentially good mother suffering a dreadful disease.

One way in which discreditation pervades discussions of madness, for entirely benign reasons, is in the context of substituted decision making. Well-intended paternalistic interventions, whether legally authorised or not, function to continuously discredit mad people. Whilst the use of such interventions can be minimised, they nonetheless have the effect of reinforcing the view that having made mad utterances, such people may be less capable than others of reaching sound decisions about their lives.

Another way in which a wholly well-intentioned project can nonetheless serve to discredit is in the efforts made to normalise madness by conceptualising it as the mental counterpart to physical illness. As discussed in Chapter Two (pp.53-4), this attempt to elide the mental and the physical falls apart when we consider the social responses to madness and to physical illness. Mental and physical symptoms frequently coincide, but their effects on the ability of the patient to subsequently engage in social systems are wholly different. Normalisation presumes that since physical illnesses are real and worthy of sympathy, and mental illnesses have similar causes to physical illnesses, mental illnesses are equally real and worthy of our concern. But employing physical illness as the yardstick for 'real' symptoms, only serves to reinforce scepticism that madness by contrast is 'all in the mind', and ignores the reality that much of the distress caused by madness arises at the level of the social.

This brief list of discreditation processes is not exhaustive, and in any given case analysing the sources of discreditation is complicated further by the fact that these processes interact with each other and are not static over time. And in addition, whilst individuals are being discredited in some ways, they may also be benefitting from other social processes of accreditation which can serve to control or reverse discreditation effects. One way in which people diagnosed as mad may choose to challenge the social exclusion they experience is by building their own inclusive communities. The ways in which people engage with their identity as 'mad' are diverse, as evidenced in the discussion of the labels mental health service users apply to themselves in the Introduction. They may seek to challenge the structures of the psy-system entirely and build communities within which inclusion is based on a shared non-medical conception of madness (Curtis 2000). Or they may actively seek to enjoy the benefits of having a medical label, which has been described as pursuing a 'madness for identity' (Charland 2004), and see themselves as belonging to a special patient community, within which they are understood. Charland suggests that this active engagement with identity may be harmful, and cites the effects of pro-anorexia websites on susceptible young women as evidence. But actively engaging with a mad identity, whether medically ordained or adopted separately, could in an era of identity politics, also have beneficial political consequences. For example, given the current focus on involving service users in policy making, an individual researching mental health law might find that identifying herself as a service user served to accredit rather than discredit her work in the eyes of others.

Another and perhaps more challenging source of accreditation lies in the exploitation of victim status. To the extent that modern political discourse often emphasises the 'rights' of the victim it may be politically worthwhile to be able to assert that one has experienced victimisation. However, Brown (1995 pp.3-28) argues that the modern re-conceptualisation of the law as a guarantor of rights promotes a paradoxical relationship between injury and identity. Individual claims are founded on the assertion that the victim's rights have been violated through her association with an oppressed group. The injuries that minority groups suffer are, therefore, politicised which in turn helps to cement the social identity of the oppressed as victims. Brown's own analysis focuses primarily on the experiences of women. As I argued in Chapter One it might appear that mad people have not enjoyed the same degree of social emancipation as a consequence of the articulation of rights, as other groups of victims, and as Chapter Five (pp.217-24) will argue the progressive movements established in the name of madness have failed to define a coherent identity for themselves. But it is nonetheless the case that in the context of rights discourse within the legal system, belonging to a victimised minority group may serve to accredit rather than discredit.

Accreditation and discreditation processes do not communicate equally well. The benefit of being accredited through ones status as a victim is less transferrable across systems besides law, than the discreditation effect of receiving a diagnosis of mental illness within the psy-system. Why are discreditation effects so pernicious? One reason is that they are often not articulated explicitly and are therefore difficult to challenge. Even if one assumes that schizophrenia is a robust diagnostic label, of no more or less medical significance than a diagnosis of chicken pox or a broken leg, it is clearly the case that the label schizophrenia carries a host of other connotations which are difficult to isolate and rebut. Another reason is that although recovery from mental illness is very common, the very small number of people who have enduring problems have a very high public profile. Consequently, madness and the discreditable consequences of madness are often presumed to endure for far longer than is necessarily the case. The time-binding function of discreditation - that it serves to protect systems of meaning from future meaningless utterances - is therefore rationalised to justify further discreditation. Finally, discreditation often results from emotional responses with a high transmission value such as disgust and horror. Our disgust at madness is not only a powerful motivator for discreditation; it is also readily communicated to others. Disgust and horror in particular are also strongly normative; they tend to encourage those around us to demonstrate the same emotion.

4.4.1 The functions of discreditation

If we accept that discreditation processes are widespread, we then need to consider what functions these processes perform for systems. The answer is implicit in Luhmanns' theoretical starting point: that communication is inherently improbable because every successful communication has to overcome the problem of double contingency (see Chapter Two pp.74). The prevalence of discreditation processes would suggest that they perform a necessary function for systems in increasing the probability of communications, but how?

Luhmann has been criticised for the emphasis he places on the existence of binary codes which determine what can be understood within the system (Wolfe 1992, Grant 2004). Wolfe argues that this emphasis on codes leads Luhmann to make unnecessarily simplistic assumptions about the ways in which systems 'reason' and determine the meaning to be applied to an utterance, whilst Grant suggests that Luhmanns account of communication does not engage adequately with the ways in which communication systems handle uncertainty. The implication is that Luhmann theorises codes as effectively and consistently distinguishing the meaning to be applied to an utterance, when in reality their application is frequently not effective or consistent. Luhmann's use of codes is not exactly false, but it creates the false impression that systems are doing something straightforward which they are not. However, as Baecker (2001) puts it:

> *"A system is not a mechanical device to ensure closure and to control everything inside it. Rather, a system is a highly precarious 'dance' of ensuring a distinction between the system and its environment, which is the only way of ensuring the system reproduces itself."*

This nicely emphasises the vulnerability of systems and the uncertainty they face. And this vulnerability is crucial to understanding the functions which discreditation processes perform.

The identification of an utterance as mad is in itself a highly complex process. As the last chapter outlined, the psy-system, which operates upon a distinction between mad and sane people, is itself inherently fragile. It bases the distinctions it observes on something unobservable, the invisible operations of the psyche, and as a result has struggled to establish a coherent and consistent account of why mad utterances are made. But whilst the attempt to explain and respond to madness is the preserve of the psy-system, the identification and exclusion of mad utterances is the concern of all systems. Utterances may be deemed mad according to multiple distinctions: their information content, their grammatical form, the audience *alter* selects and the medium *alter* employs to deliver the utterances. These may all contribute to the assessment that such and such a statement is meaningless. Often initial mad utterances will be identified as meaningful, and *ego* will expend considerable time and effort in trying to apply meaning to a string of utterances, before determining that communication is not actually occurring. In some cases, the failures may be mutual, with both parties failing to make sense of what the other is saying. Whilst in others, the individual making mad utterances, may simultaneously respond in ways which indicate that she has understood the other party, and thus cause confusion in their mind about why they have not understood her. These processes may be resource intensive for social systems. They may also be threatening and distressing to individual psychic systems. So one function discreditation performs is ensuring that in the future time and resources are not wasted by systems, both psychic and social, on the determination of madness.

Another function which discreditation performs for systems is the reduction of complexity. Systems have to select from the sea of utterances around them the utterances to which they are prepared to attribute meaning and thus transform into information. This transformation is both necessary and problematic for system operations since information is necessary for communication, but also increases the complexity within the system. So the system will try to exclude as many utterances as possible, whilst nonetheless having to make some selections in order to continue its operations. Luhmann describes two distinct forms of complexity, environmental complexity and system complexity (Luhmann 1995/1984 pp.26-9). The environment is inherently complex. System complexity arises because the survival of the system depends upon its continuing to mark a distinction between itself and the environment. But each distinction marked by the system in turn gives rise to greater complexity within the system. Thus complexity emerges both at the level of the environment and of the system, giving rise to a paradox: "*Only complexity can reduce complexity*" (ibid. p.26). Complexity reduction is the goal of the meaning-making operations of social systems, but they must create complex systems of meaning in order to reduce the complexity of their environment.

Even after an utterance is transformed into information for the purposes of the system, internal system operations may seek to determine its redundancy. All information contains redundancy. The legal system, in order to maintain its own internal coherence, has evolved a complex system of rules of interpretation which govern exactly which pieces of information can be retained by the system and which must be discarded (Luhmann 2004/1993 pp.316-30). Reducing complexity is therefore in itself a complex process. Mad utterances form a part of the environment of all systems, and by definition cannot be readily included within chains of communication. But they mislead systems by taking the form of spoken or written acts which typically do communicate. Thus they perturb system operations, forcing them to make selections around the utterance, even if it lacks a meaning content to be referred to directly. For the psy-system, these communications around mad utterances are the core of its operations. But other systems must also communicate around madness, generating complexity in the process. And because madness is unobservable, and thus typically unknowable, this generation of complexity does not necessarily reduce the complexity of the environment for the system. Subsequent meaningless utterances may not necessarily be manageable in the same way. To take the example of 'I want to die' again, this statement will properly generate psy-system communications, and potentially medical and legal communications. It may also perturb the political system if made within a political context. And yet for the legal, medical and political systems, any communications they make about a single instance of this statement being made, may not be transferable to subsequent instances. The circumstances which give rise to the making of this statement are too diverse and 'un-understandable' for robust responses to develop. This is why systems often employ an undifferentiated response to death-wishes and treat them all as undesirable events. Simply discrediting the source of a mad utterance reduces the perturbation effects of whole swathes of utterances before they have the capacity to disrupt. If 'I want to die' is always understood as the product of a disordered mind, then it never needs to be engaged with upon its merits, regardless of the context within which it is said. Complexity reduction therefore extends beyond the need to rationalise the operations of the system.

Complexity reduction is also best achieved when social systems adopt a united front. An utterance, such as stating that one wishes to buy five cars because one cannot decide which colour one wants, takes a meaningful grammatical form, and expresses a wish which it would be within the power of most car dealers to grant. Thus it may readily enter a chain of communication. It might also be seen as mad, because it is so out of kilter with normal car-purchasing behaviour. If the economic system treats the utterance as meaningful then this may create problems for the legal system further down the line, if the purchaser cannot afford the cars, or wishes to have the contract declared void. When one event has effects on two systems simultaneously Luhmann terms this phenomenon structural coupling (Luhmann 1992b). Since a 'precarious dance', to use Baecker's phrase, cannot readily coordinate its operations with those of another such dance, the complexity reduction effects of two systems adopting the same response simultaneously will only arise inadvertently. However, systems can reinforce each others operations. If the legal system declares that the contract made by the over-enthusiastic purchaser is void because of her state of mind, then this will perturb the operations of the economic system, and in turn provide a motivation to exclude more potentially mad purchasers as early as possible.

Discreditation processes perform one further function, which is that of demarcating and cordoning off unreason to reinforce the boundaries of the system. Social systems achieve autopoietic closure against the odds, and their ability to continue to produce their own internal order, relies on their ability to continue to exclusively operate their binary code, and perform the social function demanded of them. So for example, the legal system enjoys autopoietic closure only because it continues to function to maintain expectations about the conduct of other systems, despite counter-factual evidence that these expectations may be disappointed (Luhmann 1992b). If operating the code lawful/unlawful proved insufficient to perform this function (if political coercion were needed instead for example) then law's closure would be undermined. The contingency of closure, like the uncertainty inherent in communicative processes, contributes to the vulnerability of systems.

Mad utterances don't simply threaten the internal operations of the system then, but also its closure, because they threaten the operation of binary codes. As discussed above, binary codes may not be adequate to account for the subtlety of communicative processes within systems, but they are logically fundamental to Luhmann's account of autopoietic closure. Luhmann defines codes as *"totalizing constructions"* which lead to *"the contingency of all phenomena without exception"* (Luhmann 1989b pp.38-43). Within the legal system nothing is ever inevitably lawful or unlawful, since the existence of the counter-value always calls each distinction into question. However, codes are totalising only insofar as they extend to data which falls within their domain. Everything which demands a legal response must be either lawful or unlawful, but, of course, not everything demands a legal response. The operation of these codes may be determined by guiding values such as truth (for the natural sciences), justice (for law) and property (for economics), but the codes the systems actually apply must be evenly weighted: the determination of unlawful conduct is as relevant to achieving the objective of justice as the determination of lawful conduct. Third values such as truth and justice, Luhmann suggests, can only emerge at the level of programming the system, to guide it towards correct behaviour (ibid. p.43).

Communication chooses whether or not specific events enter within the domain of a system. An event may never perturb the legal system at all if those involved in it can settle their differences outside the law. But once one of them goes to court, the operation of the code becomes necessary and inevitable. However, distinguishing between lawful and unlawful conduct is inherently hard, and controversial decisions can lead to political and economic repercussions for the legal system. Utterances which cannot enter into a chain of legal communications, because no meaning content can be determined from them, threaten to complicate legal matters and undermine the operation of the code. Excluding them entirely and at as early a stage as possible reduces the threat they pose. But because psychic and social systems are so wedded to holistic accounts of human behaviour they treat mad utterances as mad people and thus exclude considerably more than is necessary.

However, taken together, the goals of rationalising system operations, reducing complexity, managing redundancy and preserving the integrity of the system, can all help to explain why systems are especially quick to discredit those who contribute meaningless utterances.

4.5 The functions of the emotions in discreditation

Discreditation effects may well appear to have rational justifications, but discreditation is also sustained by reference to visceral and irrational responses to madness. For example, madness generates a disproportionate degree of fear in others, much to the frustration of those who point out that mad people are themselves rarely dangerous, and that if they are, they typically harm themselves (Wahl 1995, Busfield 2002). The suffering of mad people, unlike those suffering from physical illness, also inspires curiously ambivalent responses in others, in which disgust and disdain sometimes feature more heavily than empathy and compassion. Disgust plays a role both in placing an emotional distance between the mad person and the observer, and in communicating to others that this person should be discredited. Both responses will be discussed here.

It has been observed that Luhmann pays insufficient attention to the social functions of the emotions, and consequently, that his theory fails to take account of the role emotions play in causing or driving particular social outcomes. Ciompi has argued that this failure to address the significance of the emotions is not just an oversight in Luhmanns's theory, but fundamentally undermines it because it means that the theory fails to account for the underlying motor which drives individual psychic systems to collaborate in the production of social meaning and generate social systems (Ciompi 2004). Several attempts have been made to explore how differing models of the emotions might be understood within a Luhmannian frame (ibid. and see also Staubmann 2004, Stenner 2004 and Fuchs 2005b pp.80-4), and the question of which model is most adequate will not be resolved here. However, emotional responses to madness clearly play a significant role in generating discreditation effects. The nature of these emotions and the impact they have upon communications can help to explain why discreditation effects are so difficult to reverse once they have been established.

Luhmann understands the emotions as operating within the domain of consciousness i.e. within psychic systems, but not within social systems of communication (Luhmann 1995/1984 p.269-75). Consequently emotions form part of the environment of the social, but are not in any way constitutive of the social. The role of the emotions in the social then is not readily observable and attempts to synthesise emotion and action to provide accounts of social behaviour are likely to prove inadequate. Within psychic systems, expectations are necessarily formulated in order to enable the system to negotiate its environment. We formulate expectations, act upon them, and understand our expectations as having been disappointed or fulfilled and can then use this experience to enable us to formulate future actions. Over time we may condense our expectations into claims: concrete demands placed upon the social system which we are now so confident will be met that we may feel thwarted when they are not. Psychic systems hold both normative and cognitive expectations about the world. Cognitive expectations are those which we are capable of re-evaluating in the case of evidence to the contrary, for example I may expect my neighbour who has schizophrenia to act bizarrely and re-evaluate my cognitive expectations about schizophrenia when I discover that she is actually a very ordinary individual. Normative expectations are those which we sustain even in the face of disappointment, for example I expect that my neighbour will not maliciously damage my property. Regardless of how my neighbour actually behaves I retain the normative expectation that people *should* not behave in this way. Of course normative and cognitive expectations can overlap: I may re-evaluate my normative expectations when I learn that the people of Rome observe different norms to those I am used to. But normative expectations expose us to disappointment in a way that cognitive expectations do not (Luhmann 1985/1974 pp.31-40). A normative claim in turn places the psychic system at an even greater risk of an adverse emotional response than a mere normative expectation. Luhmann suggests that emotions perform a function within psychic systems analogous to the function of the immune system for the body (Luhmann 1995/1984 p.274). They sustain the operations of consciousness when it is threatened by external forces, either physical risks, or risks to one's social self, by enabling the system to act swiftly to shore up its operations without making reference to reason.

He also argues that to understand the phenomenon of emotion at the level of the psychic system does not require that distinctions be made between specific emotions. The task of specifying emotions only becomes necessary when we wish to discuss them, and to make sense of their social implications.

By juxtaposing the functions of emotion and of reason Luhmann suggests that the two responses are separate. Contemporary theorists of the emotions have, however, argued that in fact reason and emotion are deeply intertwined and their operations cannot be readily distinguished in this way (see Damasio 1994). Luhmann's account of the function of emotions for the psychic system may therefore be inadequate. But an even greater problem, given that Luhmann's focus is upon the social, is that he ignores any possibility that emotions play a role in determining the operations of social systems. Stenner argues that whilst this is undoubtedly a blind spot, and this can be demonstrated by reference to the work done in the sociology of the emotions, it can be overcome by conceptualising the emotions as instrumental in transforming the operations of consciousness into communication (Stenner 2004). Emotions should be understood as operating within a transitional space between psyche and society and not simply as belonging within the realm of consciousness. We can demonstrate this by pointing to how readily newborn infants communicate their emotions by crying, and in the process transform them into something external to themselves. It does not make sense to understand the infant's response to the shock of being born as resulting from a conscious selection of available utterances, as if she could choose to simply say she is frightened instead. But her cries nonetheless communicate the information that she is distressed very readily. Rcognising the ability of the emotions to generate efforts at communication even in the absence of conscious selection can be understood as complementing rather than contrasting with Luhmann's own account of the usefulness of the emotions for the internal operations of the psychic system.

4.5.1 Disgust and discreditation

Emotions influence the viability of communication. And their effects can work in two directions: they can contribute to regulating the behaviour of the individual in relation to the social system and the functioning of the social system can, in turn, influence the emotions of the individual. Emotions can also interact with discreditation processes, reinforcing and also undermining them. Emotional responses can generate social consequences in a number of ways. But the most significant driver for discreditation effects is their normativity. Individual psychic systems rapidly become aware that the social system determines certain emotional responses as correct. Consequently we are strongly inclined to indicate specific emotional responses when we can observe them in others. Certain responses such as disgust can therefore spread rapidly across social groups. The presence of an emotional response to a specific stimulus may also reflect underlying social distinctions. So theorists have variously argued that disgust reflects a distinction between moral/immoral, clean/unclean, taboo/not taboo, repress/express and solid/slimy (see Wilson 2002 pp.49-82). However one defines the function that disgust performs, the communication of disgust always marks an extreme distinction between society and its margins. To be disgusting is to be associated with behaviours which place one on the margins of social acceptability, it marks a more significant distinction than that observed within interaction systems between esteem and disdain.

To take the moral distinction as an example, William I. Miller argues that disgust is of particular significance to the development of moral and legal regulation of human society (Miller 1997 pp.11-8). According to this argument certain things are invariably, and almost universally, found to be disgusting and this disgust guides humans away from behaviours or physical objects which might prove to be dangerous sources of contamination. But disgust does not simply protect individual psychic systems from exposure to harm, but also communicates itself to others, motivating them to adopt the same attitude to the object of disgust and thus to protect whole communities. As Miller puts it disgust *"communicates rather better than most emotions"*. Whilst such a response may have been evolutionarily advantageous it also causes problems when disgust responses become confused or are associated with objects or behaviours which do not actually pose any risk. The evolutionary basis for Miller's account of disgust and the implication that disgust at some contaminants is inevitable has been criticised for being unnecessarily essentialist (Wilson 2002 pp.51-4). But leaving this aspect to one side, Miller's account of the social function of disgust as being to communicate the need for communal rejection is also identified by a number of others theorists of disgust. For example, Susan B. Miller (no relation) has argued that disgust works "in concert to reject and devalue outsiders" and is thus of particular significance when attempting to understand group psychology (Miller 2004 pp.153-62). She gives examples of disgust being consciously manipulated by racists wishing to justify their prejudices, but also argues that individuals can find their own outsider status disgusting. Thus disgust intersects with both shame and fear, legitimating (at a personal level) fearful responses and generating shameful ones. Disgust responses are often experienced as visceral and inevitable, they can obtrude upon others even without a selection to communicate them having been performed. And disgust responses can also be deliberately generated in order to increase the plausibility of a claim: the Nazis deliberately portrayed the Jews as unclean in order to convince the German people of the necessity of violence towards the Jews. Kolnai argues strongly that disgust is ethically relevant, it is not a sufficient condition for identifying that which should be shunned, but it is a useful starting point from which to identify conduct which we find morally abhorrent (Kolnai 2004/1929 pp.81-6). Interestingly, he even uses mental illness as an instance of 'moral putrefaction', a state of affairs in which the person's core being is damaged by depravity, lust, or greed to the point where it *"glows with a moldy phosphorescent sheen"* (ibid. p.84). Kolnai was writing in 1929, and this association is of primarily historical significance, but it is nonetheless significant because it so strongly links disgust to moral contempt and goes further to suggest that such disgust can usefully inform our determination of another's moral worth.

Nussbaum argues, in contradiction to this, that because disgust is so powerful in its effects, and also so difficult to control, it is in practice a very poor guide to how societies should regulate themselves (Nussbaum 2004 pp.115-23). She has a point. Disgust may or may not have been a self-evidently useful response to danger in the past, but in complex modern societies it is frequently and evidently counter-productive. Far from simplifying our responses to the world it complicates them, it intertwines itself with other negative feelings, and with our more sober responses to that which disgusts us and generates confusion rather than certainty. However, to disambiguate disgust from our 'rational' responses to the world requires an ability to distinguish emotions and reason which, as mentioned earlier, may not always be possible.

What does disgust have to do with madness? Disgust tends to be directed towards bodies and acts rather than towards words. This is why disgust at the bodies of mad people, the physical conditions in which they live and the physical symptoms they experience has been historically significant and remains widespread. Madness is frequently associated with other phenomena which generate disgust such as defecation, vomiting and self-harm. Foucault picks up on an example of the association between madness and 'vileness' being used for effect in a nineteenth century textbook on psychiatry:

> *"Less than eight hours had passed* [since the marriage] *when the new wife as beautiful, fresh, and spiritual as she was young, discovered that the Count* [her husband] *spent his mornings and gave all his attention to making little balls with his excrement, lining them up in order of size in front of his clock on the mantelpiece. The poor child saw all her dreams evaporating."* (from Trélat's *La Folie Lucide* quoted in Foucault 2003 p.151)

Foucault selects the example to illustrate how madness was conceptualised by nineteenth century psychiatrists in terms of 'bad family feelings' which contrast with the wholesomeness of 'normal' family behaviour. But this breathless description also indicates that a particular disgust is warranted by the husband's behaviour, over and above that warranted simply by the unpleasantness of being exposed to excrement. This use of disgust by association has not gone away. In a House of Lords debate over new mental health legislation in England and Wales, Lord Soley argued that compulsion against people with personality disorders could readily be justified and selected this example to make his point:

> *'Another case which came to me was that of a woman who had plenty of money and was not unintelligent, but her house was getting into ever-worse repair. I would have classed her without any hesitation as having a personality disorder...Her house went downhill. She set fire to parts of it and began to use the garden as a toilet. You can do things about a garden being used as a toilet if you can show that it is a danger to others in terms of environmental health, but you cannot always do that, particularly if they bury it. Eventually, after five years of the neighbours putting up with this, I got a compulsory purchase order on the house... When we talk about patients' rights, we need to understand that for some people whose behaviour is disturbed and shows signs sometimes, but not all the time, of mental illness, we might need to exercise some control and restraint. If you do not, you are behaving like the bad parent. If you say, "Well, it's all right for her to go to the toilet in the garden and it is not harming anyone else", you are being a bad parent."* (Lords Hansard 10/01/2007 Col.297)

Disgust is a common response to faecal matter but the disgust in both these instances is not directed at the faeces but at the unusual behaviour displayed towards it by the mad person, by implication the mad person herself is disgusting. And in both instances, the disgust response is being played upon to justify interventions.

The bodies of mad people also become objects of disgust when their symptoms result in changes to their appearance. Torsos scarred by cutting, and the emaciated frames of anorexic people both invoke disgust as a response. This disgust is often linked to a moralising discourse about the undesirability of the conditions which led to these symptoms. For example, in the autumn of 2007 there was a furore in Italy over the decision made by a clothing chain to advertise their brand with a photograph of an exceptionally thin woman, naked and gazing backwards over her shoulder at the camera, with an anxious expression and the accompanying slogan "No Anorexia". Their stated goal was to deter young women from developing eating disorders which they asserted were commonly caused by the images employed by the fashion industry (The Times 26/09/2007). But the underlying logic of the advert was that the woman's body it depicted was disgusting and that consequently her condition was disgusting and should be shunned. Indeed the images were deemed so offensive that the adverts were banned by the Italian Publicity Control Institute (BBC 20/10/2007).

The social system can more effectively marginalise madness by making madness an indirect object of disgust. This disgust serves to attenuate efforts made at communication by mad people, and to further delegitimise their claims upon the social. Individual actors may seek to engage certain emotions for specific strategic reasons: for example to improve the likelihood of their utterances being treated as plausible. But it is important to note that disgust is in no way a straightforward response. Miller distinguishes disgust and contempt as two distinct emotional responses which lead to a social demarcation, and suggests that contempt has been democratised and brought within the mainstream. As an instance of this he cites the fact that it is possible for marginalised social groups to feel contempt for dominant social groups, such as the contempt black people feel for white people (Miller 1997 pp.220-34). Disgust meanwhile remains marginalised, its political significance is uncertain, whilst its influence remains immense. Rather than clarifying how one should behave, disgust reminds the person feeling the emotion of her own complicity in the maintenance of a state of impurity. It is an ambiguous and distressing emotion to feel. So, while it can be employed deliberately to increase the effectiveness of other efforts to discredit mad people, it also complicates our responses, engendering sympathy, guilt and even shame on the part of those feeling it.

4.5.2 Fear and discreditation

Strong emotions can also simply motivate us not to engage in communication. If emotions help us to regulate our expectations about the world, if we begin to associate strongly negative emotions such as fear or disgust with certain communications, we will be motivated to simply shy away from communications about these areas. Fear of the unknown, for example, can give rise to efforts to compartmentalise and isolate that which we cannot understand. Fear is strongly linked to disgust as an emotion which can be manipulated in order to maintain social distinctions between insider and outsider groups (Miller 2004 pp.153-62). It has been argued that fear is more than ever a feature of our social life, implicated in changes in our social behaviour and a reduction in levels of social trust (Furedi 1997, Tudor 2003). Tudor's account argues that fear needs to be understood as operating within and being facilitated by a wider fearful culture which reinforces and legitimates fearful responses. As with disgust, it is necessary to move away from the notion that fear is a wholly intuitive and inevitable emotional response to certain stimuli. However, fear always implies the perception of a threat, and the fears which have the most profound impacts tend to be those which relate to threats upon the body.

Fear of madness is not a new response. Foucault identifies a fear of madness and a corresponding fear of unreason flourishing in the late eighteenth century. A fear of unreason grew in the wake of an all-conquering enlightenment commitment to the promotion of reason, and fear of mad people as a visible manifestation of unreason was a related consequence of this (Foucault 2006a pp.362-3). Fear continues to present itself in discussions of madness, but this modern fear appears to be quite specifically focussed upon the threat of violence posed by mad people (Link and Cullen 1986). Fears of contagion have been all but eradicated by the explosion in knowledge of how illness is transmitted, whilst fears of harm to the psyche caused by exposure to madness tend to be limited to close family members of mad people (Thompson et al. 2002). This fear of violence is sustained by the ways in which madness is discussed in popular media especially film and television (Wahl 1995 pp.56-83). Reports of mental illness issues in the news are also dominated by accounts of harm done to others by people with mental disorders, with comparatively little attention paid either to positive stories concerning mental illness, or to stories concerning suicide or self-harm (Philo 1996). Crimes committed by mad people are also not reported consistently, with media attention focussed on attacks which exhibit particular characteristics. In particular, attacks on strangers and attacks with a component of sexual deviance get especial attention (ibid. and Sullivan et al. 2005). Crimes are likely to get especial attention when they correspond to facts which have been presented in fictional accounts as well, and in some instances fictional accounts of madness even appear to stand in for psy-system accounts in convincing people that a given case of madness is really genuine. For example, Kennedy (1996) argues that this is what happened during the trial of John Hinckley for the attempted assassination of President Reagan. The similarity between Hinckley's offence and that perpetrated by the central character in the film Taxi-Driver (a film Hinckley was obsessed with) was used to demonstrate to the jury that Hinckley himself must not be guilty by reason of his insanity, but this evidence was achieved simply by repeated association, and was not endorsed by those experts who gave evidence.

Fear of madness may have begun as a result of anxiety about unreason, but it has developed an internal momentum which cannot easily be challenged either by reference to external authority, or to its own inherent redundancy. Both fictitious and true accounts of madness have become enmeshed, making a simple recourse to the 'true' facts impossible. This leaves fear of violence dominating people's immediate responses to madness which significantly reduces the degree of esteem in which mad people are held by those around them. In both cases, the effects of disgust and fear can be seen to be played out in system operations, and may be particularly exposed during political deliberations on policy relating to mad people.

4.6 Discreditation and identity formation

Psychic systems are able to perform selections about social identity: they can choose which acts they perform and which utterances to make about themselves and in the process manage the impression they create. However, a psychic system can never 'know' itself in totality, like all systems it has its own blindspots (Luhmann 1995/1984 p.266), in order to understand her own social identity each psychic system must project expectations on to her identity which can then be tested against the responses she elicits (ibid. pp.313-4). For the psychic system which has been socially identified as mad these expectations may be frequently disappointed. Madness does not provide an accepted social or political identity for many people (Barnes and Shardlow

1996, Hodge 2005b) and as outlined above identifying oneself as mad may generate considerable discreditation effects. There are people for whom being identified as mad is inevitable; those in hospital or those whose behaviour is distinctive and has lead to their being widely identified as mad within their community. But there are many people who are able to manage the mad component of their identity, by only revealing their label at points where it is either unavoidable (when applying for health insurance for example) or to those whom they already feel able to trust. Their willingness to embrace madness as a political identity is compromised by the fact that a label of madness may be something it is possible to conceal, unlike attributes such as being black or female or physically disabled.

Those who advocate a politics of identity/difference argue that the assertion of both the relevance of difference and the reification of certain forms of social identity is essential within democratic systems (Young 2000). However, this can prove highly problematic for vulnerable groups. Connolly (2002) argues that all of us have fragile identities which we wish to protect and we do this offensively, by labelling those with attributes different to our own as intrinsically deviant in some way, thus shoring up our own self identity as good, normal and certain. As a result, those labelled deviant by the majority within a society are highly vulnerable because their exclusion results not merely from a passive indifference to the interests of minority groups but from an active attack on them which stems from the majorities own fear of difference. Shared social institutions are both necessary to human wellbeing and formative of identity, but they also exclude and marginalise, and Connolly argues that this paradox of difference cannot be resolved, only endlessly addressed and engaged with through the political process. The ambivalence people feel about engaging with madness as an identity provides a partial explanation for the comparative instability of the mad civil rights movement despite its ability to be structured around a shared identity of victimhood (see Chapter Five pp.217-24).

4.7 How does discreditation intersect with stigma and labelling theory?

Observing that mad people suffer discreditation is hardly new. Perhaps the most influential description of the causes of and effects of this discreditation has been provided by Erving Goffman in his book on stigma. Goffman defines stigma as a social response to *"an attribute which is deeply discrediting"* (Goffman 1990/1968 p.3). Stigma, in Goffman's definition, generated a discrepancy between an individual's virtual social identity, which is composed of all the characteristics others assume her to have, and her actual identity, which is composed of the actual characteristics or attributes she possesses. This process is not inevitably negative. But mental illness is one example of a *"trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us"* (ibid. p.15). Stigma pervades the social meanings applied to a specific attribute, so that even where misconceptions about specific labels are rebutted, the effects of stigma can still be observed. The impact of a stigmatised trait can be influenced by attributes, such as how easy it is to conceal and how much it disrupts normal interaction between the stigmatised person and those around her. The stigma that attaches to mental illness is thought to have considerable impact on the lifestyles, health outcomes and even the degree of physical safety which mentally ill people enjoy. As a result stigma reduction has become a government priority, and anti-stigma campaigns are one of the strategies for mental health promotion outlined in the National Service Framework for Mental Health (DH 1999a). Stigma is also closely identified with the social exclusion of mad people (Social Exclusion Unit 2004 pp.24-33), and with discrimination against mad people within the economic system (Sayce 1998).

Stigma is theorised as a generalised social process which attaches to a specific attribute and has unspecified but immense implications for that person's future acceptance within the group. The rationale for this is not systematic, but is borne out of conceiving of a generic distinction between 'normals' and 'abnormals'. Goffman does not explore the origins of stigma, but Reidpath et al.(2005) suggest a structural account of the emergence of stigma effects. They argue that historically social groups needed to restrict membership according to a criterion of social value. People with low social value are those whom it is feared will not reciprocate in an exchange of social goods; who will, in other words, 'cheat' the system. However, employing a generalised concept of stigma, as Goffman does, does not necessarily generate useful accounts of what functions stigma performs. Goffman suggests that it is possible to generalise about stigma as it affects mad people, black people, gay people and disabled people, because all of these stigma effects are grounded in the disapproval of the majority for social deviance (Goffman 1990/1968 pp.151-3). In practice, the reasons why people are discredited on the basis of these very disparate attributes are distinctly different, and the functions their discreditation will perform also vary.

Labelling theory goes further than Goffman's account of social stigma by suggesting that the label of mental illness not only leads to ill informed assumptions being made about the individual, but argues that these assumptions in turn perpetuate the supposedly deviant behaviour which is being stigmatised (Scheff 1999). According to Scheff's theory, applying a label to an individual alters the expectations of those around her, which in turn forces the individual to adopt the social role of 'being mentally ill'. A person's social identity is then constructed upon the basis that she is mentally ill, and in time this becomes a stable component of her identity which she is not empowered to challenge or shake off. The aetiological dimension of Scheff's theory has been highly controversial, since it challenges the view that psychopathological symptoms are biologically based, and instead suggests that mental illness is predominantly a social construction.

Some of the critics of labelling theory have argued that the empirical evidence that societal responses such as stigma have such a major impact on individual behaviour is weak. Instead, it is argued that it is the mad individual's behaviour which causes the social rejection she suffers (Gove 1982). However, Link et al. (1987) refute this. They suggest that although aggregate data taken from surveys about social attitudes to mental illness in the US demonstrated that, on the whole, attitudes were not as negative as either Scheff or Goffman might have supposed, there is nonetheless a significant section of the community which holds negative beliefs about people with mental illness, and in particular assumes that mental illness is closely correlated with dangerousness. Most importantly, people with mental health needs have no way of knowing who these individuals are in advance, so many conceal their diagnosis of mental illness as a defensive strategy. In a later study Link et al. (1989) found that when they surveyed current service users, former service users, and individuals who had never used services, about the effects of labelling the majority tended to agree that people with mental health needs will be rejected socially. Moreover, the strength of this belief amongst services users tended to have a significant impact on their help seeking behaviour: the stronger their belief that they would be rejected, the less likely they were to seek help outside the home. This held true even when the severity of the person's psychopathological symptoms had been controlled for: that is the effect on their help seeking behaviour could not be explained as being the result of their holding false or excessively negative beliefs resulting from mental illness. They suggest a 'modified labelling theory approach', and although they do not share Scheff's view that socially deviant behaviour can be explained as the result of having a label of deviance applied, they nonetheless agree that the widespread belief in the existence of negative social attitudes reinforces the mentally ill persons role as 'deviant' and contributes to their social exclusion.

Hacking proposes a further refinement to the way in which we understand the intersection between labels and identity. He argues that classifications of dysfunctional conditions such as mental illness generate 'looping effects' which other types of labels do not precisely because the person to whom the label is applied is also interacting with those applying the label (Hacking 1986). Some formerly clinical labels such as homosexual take on a general social meaning. The homosexual may meaningfully apply the term to herself without any form of clinical diagnosis. Thus to argue, as some labelling theorists have, that the label homosexual creates the entirety of the social category of homosexual and the behaviours associated with the label is untenable. At some point after the creation of the category it took on a social and political significance of its own which cannot be reduced to the original clinical distinction. The same does not apply for many diagnoses of mental illness. The labels that are applied to mad people have remained within the gift of the psy-system. These psy-system classifications then are a type of 'interactive kind': their application influences the behaviour of the person being labelled and in turn the person being labelled influences the subsequent application of the label (Hacking 1999 p.103). To take this argument full circle, Hacking in turn acknowledges the significance of Goffman's own work on the sociology of face-to-face interactions in explaining how interaction influences subsequent behaviour (Hacking 2004). He also argues that Goffman's work provides an example of an interactive kind in action. Goffman's work on the totalising effects of life within asylums (Goffman 1961) provided a classification for the disquiet the wider public already felt about the practices that occurred within these places. In turn, the availability of this classification of the asylum as a totalising institution contributed to the movement to close down such hospitals, thus rendering the specific description obsolete (although totalising institutions can still be observed).

Discreditation is clearly implicated in stigma, but are discreditation processes as I have described them above analogous to stigma? I would argue not. Stigma is itself a poorly defined phenomenon, and the case for its generic effects is not made out. In the 40 years since Goffman's book on stigma was first published many of the stigma effects he has identified have been transformed. Attitudes to ethnicity, sexual orientation and even disability have shifted immeasurably. These changes could not have been predicted by

Goffman, because his focus on interpersonal sociology is unable to generate an account of how wholesale social change arises. The stigma associated with mental illness, however, has remained curiously resistant to change. I would argue that stigma may be a further example of an interactive kind of classification, and that the shortcomings of stigma as a functional account of exclusion have helped to perpetuate many of the effects Goffman described. For example, the focus of many attempts to de-stigmatise mental illness has been on normalisation. This reflects the underlying distinction between normal and abnormal applied by the stigma model of discreditation. Mental illness can be normalised by arguing that it is an 'illness like any other'. The approach implies that physical illness represents the yardstick whereby the genuineness or otherwise of a socially dysfunctional behaviour can be assessed, which is problematic because as Chapter Two argued, madness will always fall short of the physical illness yardstick and will therefore always be comparatively discreditable. The ineffectiveness of this approach has been emphasised by a review of the empirical literature on anti-stigma campaigns which found that, internationally, the public were more sympathetic to psychosocial accounts of mental disorder than biomedical accounts (Read et al. 2006). Rather than accrediting mental illness, many anti-stigma campaigns served to further discredit people and to reinforce existing fears about the dangers of mental illness. It has been argued that campaigns to reduce stigma through public education are:

> *"underpinned by a view that those who stigmatise have the agentive capacity to behave differently, and that knowledge is all that stands in the way of the behaviour change"* (Reidpath et al. 2005).

In practice this has not been shown to be the case at a whole population level. Mental health surveys indicate that on some measures public attitudes to mental illness in the UK have worsened in recent years, despite a number of stigma reduction campaigns such as the Royal College of Psychiatrists 'Changing Minds' campaign. In the UK in particular, more of the population now believes that not enough is being done to protect the public from mentally ill people than was the case in the 1990s (DH 2003, Shift 2007, Shift 2008).

4.8 Conclusion

Although the case for stigma is not made out, the existence of stigma as a category indicates a widespread awareness that mad people experience degrees of disdain and discreditation which are out of proportion to the symptoms they display. Accreditation and esteem processes do, however, perform demonstrably useful functions for social and interaction systems, which may explain why crude attempts at re-accrediting mad people fail to have much social impact.

Esteem functions exclusively within interaction systems, and can be best observed through the kind of micro-sociology Goffman specialised in.

However, the effects of esteem cannot simply account for the much wider exclusion from social systems which mad people encounter. To explain how this exclusion can arise, without the need for any face-to-face interaction, it is necessary to explain how a generalised code of accredit/discredit is employed by social systems, in order to filter out irrelevant information and maintain their boundaries effectively. This generalised code has a particular relation to utterances; those who are able to communicate meaning most effectively within the interaction systems to which they belong will be the people who enjoy the most widespread accreditation across other social systems. Mad people acquire their label through a failure to contribute meaningfully within communication and as a result suffer a high degree of discreditation. This is not to say this discreditation is justified, these processes are necessarily crude and function to exclude both meaningful and meaningless utterances from social systems. However, being excluded from social systems, especially the economic system, places mad people in a weak position to challenge their exclusion. Discreditation affects are not unique to madness: being associated with untrustworthy or criminal behaviour will have similar consequences for example. But discreditation effects will have less significant consequences for groups whose ability to communicate meaningfully is not assumed to be compromised by the attribute which discredits them. The specific relationship madness bears to meaning can help to explain why mad people suffer such a high degree of social exclusion.

The last three chapters have sought to outline how Luhmann might have understood the silence of mad people as a social phenomenon. Inspired by the idea of social systems, it has been possible to identify some key features of the social phenomenon of madness. In particular, I identify madness as evident when someone says something which cannot be understood. If efforts at clarification fail, 'mad' is the residual diagnosis. Consequently, madness is inherently uncommunicative. However, it is rare for anyone to exclusively make mad utterances, and if they do go through a period of making only mad utterances this proves, in most cases, to be temporary. In Luhmannian terms it is not possible for a person to *be* 'mad', only their utterances can garner this description, but socially the term 'mad' and any of a number of related labels are readily applied to someone once their madness is deemed manifest through their acts or utterances.

This designation as mad has massive social consequences. Some of these consequences are inevitable, but many of them are wholly disproportionate to the degree of unreason displayed by the mad person. In addition the task, which is reserved for the psy-system, of determining when someone is 'mad' (properly so called) is itself inherently difficult, because so little information is available to the system to aid it in making its distinctions. The next two chapters will examine the role of law and policy in redressing the enforced silence of mad people. The legal and political systems have been called upon to secure a number of outcomes for mad people: freedom from arbitrary or excessive interventions, freedom from discrimination, and increasingly positive rights including rights to participate in decisions reached about their lives. But these systems have no internal account of madness to draw upon when reaching conclusions about applicants, and are as likely to discredit mad people as any other system. Can systems theory provide a more useful account of the limitations of mental health law than is provided by existing theories?

Chapter Five
The promotion of involvement as a strategy for accrediting mad people

5.1 Introduction

Our society struggles to make sense of madness, and one of the consequences of this has been to allow processes of discreditation to flourish. Madness is incomprehensible and social systems excessively exclude the contributions to society made by mad people because they wish to avoid wasting resources on unsuccessful efforts at communication. Whilst the knowledge of the psy-system represents the most widely accepted schema within which to make sense of madness, the psy-system is in a weak position to challenge the discreditation of mad people because its own knowledge base is inherently unstable and consequently implausible, and because the system's autopoietic closure limits its ability to steer the operations of other systems.

One strategy which may serve to reduce the degree of discreditation mad people experience is the active promotion of their right to involvement in the decisions which affect their lives. As outlined in Chapter One (pp.14-30), the importance of involving health service users in decision-making is heavily emphasised in current healthcare policy, and the importance of participation is increasingly being given attention within human rights discourse too. This chapter will ask whether involvement policies as they are envisaged currently can overcome the effects of discreditation and increase the possibilities for meaningful communication between mad people and decision-makers. It will start by describing Luhmann's critique of the usefulness of social law and policy intended to steer specific social outcomes. It will then consider what kind of outcomes involvement policies are trying to steer services towards, and ask how effective involvement practices have been at achieving these outcomes. Finally, it will examine what reasons the existing research literature advances for some of the shortcomings of involvement policy and asks whether these can be understood differently from a systems theory perspective.

5.2 Reforming mental health law and policy: the limits of steering

Luhmann's model of society indicates that absolute control through communication is always impossible, since communication always leaves open the possibility of *ego* making a different selection to that intended by *alter*. The imposition of coercive force renders temporary control possible but always offers limited returns over time. Indeed the use of coercion is diametrically opposed to communication since as Luhmann points out:

> *"the person exercising coercion must himself take over the burden of selection and decision to the same degree as coercion is being exercised*

> *– for many cases we can even say that coercion has to be exercised where these is lack of power"* (Luhmann 1979/1974 p.112)

Not only is absolute control through communication not possible, but communication itself is frequently impossible. As Chapter Six will outline (pp.236-7), the legal system performs a stabilising rather than a controlling function upon society which it achieves through effective internal communication dependent upon its operational closure. Luhmann speculates that efforts to achieve social change through the law are limited by a number of factors. The first is that many modern legal systems are characterised by the complexity of the regulatory frameworks they prescribe. Legal systems have responded to the growing factual complexity of society by reaching decisions in a multitude of new ways, without a corresponding growth in the interdependence of the decisions reached (Luhmann 1985/1974 pp.249-55). As the next chapter will demonstrate, the mental health legal system exhibits this low interdependence perfectly. Legal decisions reached by non-legal actors are reached with a low degree of uniformity (Peay 2003 pp.14-5). There is also evidence which suggests that the underlying rationales for Mental Health Review Tribunal (MHRT) decisions may vary considerably (Perkins 2003 pp.126-9). Like cases are not treated alike, and MHRT decisions do not necessarily reflect a conception of the law which is shared with first order decision-makers (Peay 1989 pp.70-1). And the analysis of case law on the MHRT which I describe in Chapter Six shows that the High Court in England

and Wales itself employs quite disparate approaches to reasoning about the application of mental health law (although the outcomes in terms of who wins and who loses betray a high level of consistency). It is only at the level of the Court of Appeal and House of Lords that consistency in reasoning seems to occur. At this level there are only a few decisions to be reached, and the decisions that get as far as the higher courts tend to display a high degree of factual consistency; unusual or outlier cases having been filtered out by the system at an earlier stage. So we can achieve consistency in legal decision-making if we restrict our decision-making to a handful of cases largely concerning service users detained in special hospitals. Or we can make decisions which cover a wide range of circumstances. But we cannot expect, given the numbers of decision-makers and decision-making processes involved, to achieve the latter consistently all of the time. Luhmann argues that whilst this compromise position may be adequate it calls into question the usefulness of hard law as an instrument for engineering social change.

Luhmann develops this idea in a paper entitled 'The Limits of Steering' in which he employs the metaphor of steering as opposed to planning (Luhmann 1997a). Having observed that central planning can be counterproductive, Luhmann observes that many modern political systems have opted instead to employ techniques of steering. Steering does not involve prescribing specific outcomes, but framing choices in such a way as to provide incentives towards making the choices the political system wishes one to make anyway. Luhmann's identification of this trend was prescient, since in the decade since this paper was written, steering appears to have become the preferred governmental response to engineering social change in many neo-liberal political systems. Steering always implies an attempt to reduce difference, to guide operations in such a way as to coordinate them successfully with the system's own objectives. For Luhmann, steering is possible in physical interactions, and occasionally within inter-human interaction. But steering of other social systems is always illusory; whilst the political system may be able to steer its own internal operations it is only able to produce effects within the environment of other systems which they will then adjust to, but these effects and counter-effects do not amount to steering. In these cases efforts to employ policy *and* positive law to 'steer' social change are compromised, but Luhmann recognises that this is no longer merely a problem of complexity, but occurs as a result of the difference-minimising objectives of each and every social system. This argument implies that significant limitations apply to efforts to reform mental health law and policy to promote better or fairer outcomes for mad people.

5.3 Mental health policy and the promotion of service user's voices

As Chapter One made clear (pp.14-23), in recent years there has been a strong trend evident in healthcare law and policy on healthcare towards the accreditation of users of health and welfare services as the experts upon their own lives. In England and Wales, policies to promote service user involvement or participation in healthcare have been vigorously advanced and a series of specialist bodies have been created to promote such involvement at every level of health and social care decision making. These policies apply to mental health service provision too. However, the fact that discreditation processes and the possibility of coercion might undermine service user involvement is rarely acknowledged.

A systems theoretical approach challenges the view that there are self-evident benefits for mad people resulting from policy and legal reforms intended to promote their involvement. At the same time it points up some of the limitations of efforts to challenge discreditation or exclusion which have failed to recognise how deep-rooted the social processes underlying these problems actually are. This chapter will review the evidence available on the effectiveness of involvement policies and ask how the strengths and weaknesses identified within the research literature can be comprehended from within a systems theoretical frame.

5.4 The meanings of involvement

The research literature on involvement in mental health services is still small and rarely addresses the issue of what is meant by involvement. However on closer examination a number of different definitions of involvement appear to be being used, and the concepts underpinning these definitions are often very disparate indeed. The models of involvement that are most apparent within the research literature and reviewed here include involvement as engagement, involvement as participation and involvement as control. This diversity of interpretations betrays the fact that the term 'involvement' is capable of being employed in different ways by different systems.

5.4.1 Involvement as engagement

As a major public policy initiative, involvement merits a mention in most new public policy documents relating to healthcare. Involvement, here, is typically described as desirable insofar as it helps improve health outcomes. For example a report on the evidence for patient and public involvement states that:

> *"The outcomes for patients, for staff, for communities and for health are almost universally positive...patient involvement improves patient satisfaction and is rewarding for professionals."* (DH 2004).

The website for the NHS Centre for Involvement states that:

> *"We believe involvement drives a patient-led NHS by:*
>
> - *improving the patient experience;*
> - *generating mutually supportive relationships between patients and professionals;*
> - *engaging with local communities; and*

- *developing responsive and publicly accountable services."*

(www.nhscentreforinvolvement.nhs.uk, accessed on 10/05/2008)

And to reiterate Chapter One, the National Service Framework for Mental Health also states that

> *"When service users are involved in agreeing and reviewing the [care] plan, the quality of care improves, and their satisfaction with services increases."* (DH 1999b)

In all of these cases however, the evidence provided to support the assertion that involvement improves service user satisfaction is either weak or non-existent.

One mechanism for achieving these purported improvements in healthcare for mad people is suggested by Latvala (2002). She argues that it is desirable to ensure that service users feel that they are active participants in their own care because this will make them more likely to cooperate with professionals. She sums up this model of involvement in a later study as:

> *"The patient cooperates with professionals, sharing and modifying his/her individual and shared awareness of care during the processes of planning, implementation and assessment. The patient as a responsible participant in his/her care needs professional support, which helps him/her become aware of his/her own possibilities, be able to analyse these possibilities and find resources to manage with the mental illness* [sic] *and its consequent limitations and changes."* (Latvala et al. 2004)

For Latvala et al. patient-centred practice turns on the involvement of the service user. However, for involvement to work the service user needs to acknowledge her need for professional support, and modify her views on the care she receives through the involvement process. Promoting involvement is, according to this definition of involvement, analogous to promoting a good outcome for the service user since the two things are interdependent.

This seems remarkably like the promotion of engagement with services. Engagement describe the process whereby service users are encouraged to build a relationship with staff (Gillespie et al. 2004). It has garnered considerable research interest in recent years because it is seen as central to the practice of Assertive Outreach (AO). AO teams aim to promote engagement by proactively following up service users who do not attend services, delivering services to the person at home (including holding care plan reviews at home), and actively discussing care plans, the reasons for them and possible alternatives with the service user. When combined these practices may increase the likelihood of individuals using services (Priebe et al. 2005) and the level of satisfaction with services they describe (Manfred-Gillham et al. 2002, Watts and Priebe 2002). However, the National Service Framework for Mental Health clearly states the object of securing engagement for mental health services in England and Wales is to ensure personal and public safety (DH 1999b p.53). Indeed service providers are instructed that if they think there is a danger of a service user disengaging then the care plan must state what measures are being put in place to reduce the risk to the individual, their carers or the public. In other words, in order to comply with the policy, engagement strategies need only be practiced to reduce risk, and are thus a product of a public safety agenda and not an emancipatory agenda to increase the control service users have over their own lives.

Conceptualising involvement as engagement may, therefore, help to secure two distinct outcomes. One is the promotion of the service user's own health, but the second is better risk management. This model of involvement seems to leave little space for the service user's own values to influence decision-making. Promoting engagement can mean that greater opportunities for the service user to communicate her views will arise. But the fact that the desired outcome has already been defined by professionals and policy-makers means that the scope for actually altering the decisions they reach is limited.

5.4.2 Involvement as participation

Understanding involvement as engagement is consistent with current policy on service user involvement, which tends to emphasise the possibility that involvement will improve therapeutic outcomes. But it is not consistent with the meaning applied to involvement in much of the mental health research literature, especially the nursing literature. Instead, the research literature often emphasises a model of involvement which goes beyond simply securing the person's engagement with treatment. In these cases, involvement is understood as implying that either service users have a right to participation in decision-making, or that their active participation should be encouraged. But the object of this participation is to enable the service user to communicate her values and to influence the decisions reached about her, rather than to merely secure her cooperation with care or treatment.

Much of this research literature draws upon a wider literature on public or citizen participation. One of the most influential papers in this field has been Sherry Arnstein's 1969 paper 'A Ladder of Citizen Participation', which defines participation as occurring on a ten-rung ladder with manipulation at the bottom and citizen control at the top. The idea of a ladder or continuum model of participation has been widely endorsed. Pilgrim and Rogers (1999), for example, argue that that service users can belong to three categories: user as patient, user as consumer, and user as survivor. In this last category service users campaign collectively for control of services, thus mirroring Arnstein's view that the apex of involvement is control. However, Pilgrim and Rogers emphasise that achieving involvement is the result of a dynamic played out between providers and service users.

An alternative participation continuum is described by Hickey and Kipping (1998). They argue that participation represents an equilibrium between consultation and control in which the user is an equal partner in the decisions made about her care. They further distinguish between models of participation justified on the basis of consumerism and those justified on the basis of democratisation. This is a valuable distinction, since there is good evidence that policy commitments to increasing service user involvement are generally justified on neo-liberal grounds which transform the citizen into a consumer and see choice as a crucial lever in driving improvements in services (Barnes and Prior 1995, Crossley and Crossley 2001). On the other side of the debate, participants in the service user movement have defined themselves as engaged in a struggle for civil rights, which parallels the disabled peoples movement, and see involvement in one's care as a central component of being accorded the full rights of citizens (Barnes and Shardlow 1996, Beresford et al. 2000). As Hickey and Kipping point out, where one stands on the issue of why involvement is important will determine the limits placed on the degree of involvement possible. For example, it is not the intention of those advocating a consumerist approach to cede total control of services to service users.

Other commentators have also raised concerns about the limits of a ladder model of involvement since it fails to take into account not only the existence and possible validity of competing agendas, but also the *"dynamic and evolutionary nature of user involvement"* (Tritter and MacCallum 2006). According to this view health service users are accorded insufficient agency in a ladder model. In reality service users may choose involvement at some times but not others, they may value relationships with certain service providers over others and as a group they exhibit far more diversity than the ladder model allows for. In trying to encapsulate what service users want from services we need to be clear who the service users are. Arnstein's article assumed that anyone with a stake in the decision being made within the relevant geographical area should be assumed to have a potential contribution to make. However, these contributions may generate conflicts in their own right between service users, carers and the wider public. Tritter and MacCallum suggest that a multi-dimensional model of user involvement needs to be developed, in which different categories of user climb different ladders, leading to greater or lesser degrees of participation, dependent on their concerns which may overlap or conflict. This mosaic approach is not a normative model advocating control as the desired or desirable outcome for all citizens at all times, but they argue that it better reflects the complexity of promoting involvement.

5.4.3 Involvement as control

The summit of the ladder of participation envisaged by Arnstein is citizen control of services (Arnstein 1969). In mental health services this has been envisaged as mental health services staffed, managed and wholly controlled by service users. This understanding of what involvement 'really' means is widely endorsed by service users and advocates (Connor and Wilson 2006). For example, the aspiration expressed in the highly influential 'On our own' (Chamberlin 1988) was that ultimately all services for mental health service users would be run by mental health service users with minimal intervention from external professionals. This aspiration reflects a particular account of mental distress, as a human condition best understood by those who have shared similar experiences. Individuals experiencing mental distress may need sensitivity and space in which to talk with those who empathise with them, but they do not need to be given labels which they do not recognise, or coerced into receiving treatment which they do not want. For Chamberlin, user led services will empower service users, at the expense of mental health professionals whom she believes are ultimately parasitic. It is an approach which treats the dominance of psy-accounts of the self as highly problematic. Involvement is understood as only the first step on the road to empowerment. Arguing that service users should be 'involved' in their care planning when they do not have control over the decisions reached is mistaken. Placing control in the hands of service users obviates the need for person centred practice, rights to procedural involvement or service users forums.

However, while involvement as control might not be an impossible dream, it remains, nearly 30 years after the original publication of Chamberlin's book a comparatively rare model for service provision. There are examples, especially from the US (McLean 1995), Canada (Nelson and Lomotey 2006) and occasionally in the UK (Truman and Raine 2002). But for user control to occur, considerable political will is needed and some commentators in the UK believe that service user activists are currently losing and not gaining ground in their campaign to achieve greater control over services (Barnes and Bowl 2001). One study of user involvement in local service planning, found that projects initiated by service users only succeeded where existing funds could cover them, there was no motivation within the health authority to increase the total amount of expenditure on mental health services, even though it was the health authority which had initiated the service user forum which was being studied (Pilgrim and Waldron 1998). The authors point out that *"the economic realm is the final and ultimate constraint upon user involvement"*. There is currently no top down policy agenda for promoting user control of services in England and Wales at present, so a growth in the development of user controlled services looks doubtful.

5.5 The effectiveness of promoting involvement

Given the plethora of values attached to the term involvement, measuring the effectiveness of involvement policies is a complex task. Involvement defined as engagement might be deemed effective if it promoted speedier or more sustainable recoveries from mental illness, or if it reduced the degree of risk service users or others were exposed to. Unfortunately demonstrating either outcome is complicated by the fact that indicators of engagement are themselves contentious (Gillespie et al. 2004, Priebe et al. 2005).

Measurements of the extent of participation in decision making have also been used to determine whether or not involvement is happening. In some cases this leads to research findings which seem to imply that turning up is the same as taking part. Downing and Hatfield (1999) for example wanted to evaluate whether the Department of Health's policy on the Care Programme Approach (CPA) was actually being implemented. The CPA is a care planning policy intended to ensure that mental health service users receive effective care in the community. The study followed up service users who were about to be discharged from hospital, and should therefore automatically be subject to the CPA, to see the extent to which practice matched policy. The measure selected for whether or not service users were involved in drawing up their care plan (a requirement of the policy they were evaluating) was attendance at the discharge review meeting. Since all of the service users in the study (n=35) attended the authors concluded that *"involvement is clearly on the agenda of key workers"*. However, since the discharge meeting takes place before discharge and 19 of the service users were subject to compulsory powers high attendance rates might not indicate voluntary or active involvement. What this finding shows instead is that service users were not *excluded* from care planning meetings.

Trying to measure the degree of involvement attained by examining the procedures in place does however throw up some interesting findings. In a 1997/8 survey of mental health trusts it was found that three quarters of the trusts surveyed claimed that service users were *always* informed of the contents of their care plan (Schneider et al. 1999). This became a requirement under a subsequent revision of the guidance on the CPA (DH 1999c) so one might expect the number of trusts in which this was the case to increase. However in a later survey Carpenter et al. (2004) found that only between 37% and 60% (depending on district) of service users were aware that they had a written care plan. When participation in the CPA does occur it does seem to correlate with increased satisfaction with services, although most of the research conducted in this field acknowledges that their focus has been on whether or not participation arises, not on the substantive content of such participation (Rose et al. 1998, Carpenter and Sbaraini 1997). As a result, the mechanism which causes this increased satisfaction is not known. And it is also possible for involvement to increase user dissatisfaction. A large scale study of service user involvement in care planning in Norway (n=1080) found that during care planning work healthcare professionals tended to identify service users as having a wider range of needs than service users did themselves. When this was the case multi-disciplinary teams tended to respond to the needs identified by the health worker, in the process offering more services than the user herself had requested (Hansen et al. 2004). Ironically, the researchers noted that many of the service users they interviewed described doing their utmost to avoid contact with what they perceived as intrusive and unwanted service provision.

The limitations of measuring involvement through measures of passive participation such as attendance at meetings or receipt of care plans were highlighted by Peck et al. (2002). This study involved surveying professionals and service users within a mental health and social care trust to find out to what extent both groups felt that service user involvement was actually occurring. The trust in question had already made pro-active efforts to increase the levels of user involvement occurring within both personal care planning and service planning. The study differentiated between 'users as recipients of communication' (who have an essentially passive role), 'users as subjects of consultation' and 'users in control'. Although levels of communication with users were very high, with 100% receiving copies of their care plan for example, the levels of consultation were much lower, only 60% of service users at the initial survey felt that they had been consulted on their care plan, and this fell to 49% thirty months later at the second survey. The survey identified only one instance of a user actually describing herself as having control over a decision making process.

Measuring the effectiveness of user controlled services is also complicated. There is the possibility that control is not itself an aspiration shared by all service users: the paradox of choosing not to have a choice. For example, U A Fanthorpe describes how depression makes her long for a lack of control.

> *"When I'm badly depressed I long above all things to be a prisoner. I imagine this as a life where you don't make choices, where the pattern of life is plain and involuntary. Life in depression is like this anyway, but it retains the illusion of choice. If you had to do the sad things you*

> *are doing because someone had ordered that you should, indeed*
> *because you'd deserved it the despair (you think) might go."*
>
> (Fanthorpe 1996)

Similarly, mental health service users find that the power to make choices is only useful if it means a power to make choices that other people disagree with. Both fellow service users and professionals may disagree with individual choices. For example, Perkins found that when she *chose* ECT as a treatment for her depression it was her friends with mental health needs, and not the professionals, who disagreed vehemently with the choice she had made (Perkins 2000).

Some researchers have noted the fragility of user led groups and services. This fragility is associated with a number of factors including poor fidelity with original service objectives, and continual problems in securing funding (Chamberlin 1988, Lindow 1995, McLean 1995, Pilgrim and Waldron 1998). Interestingly Chamberlin (1988) and Lindow (1995) both identify a lack of 'real' user control as a problem within some user run services. In both cases they found that where users had only peripheral control of service planning and delivery, professional accounts of mental distress quickly began to dominate and user-led challenges to these understandings were in turn pathologised. Another potential pitfall for user-led services is described in a study of an American user-run day service (McLean (1995). The author describes how the centre she observed had an empowerment philosophy and a service user as manager, but was nonetheless ridden with continual internal conflicts, and service users expressed strong dissatisfaction with the way things were run. She points out that consumer control in this instance had been taken to mean consumers control things from the top down, i.e. they were employed as staff, but did not mean that bottom up control from those using the service had occurred. All of these studies were on a small scale, but they indicate how difficult it is to promote radical models of user involvement as control, against the prevailing political assumption that mental health services are best led by trained professionals. McLean also observed that the service she studied depended on funding from the state, this meant the service had to demonstrate it was the equal of more traditional facilities and this lead to them compromising their original goals.

One explanation which could be advanced for the vulnerability of service user-led initiatives is that service users simply lack the competence to deliver services. One study of psychiatrist's views on involvement found that around half of those interviewed expressed reservations about service users having control over service delivery because they felt that their choices might not be rational. At the most sceptical end of the spectrum was the opinion that:

> *"Most patients, or the patients I have been dealing with are – I don't think they understand what day it is really, they are willing to be advised by the consultants."* (Summers 2003).

The same caveat is raised (though not endorsed) by Roe and Davidson (2005) in a description of the development of the service user movement in the USA. However, a more positive picture of service user-led services is given in a study of such groups in Ontario, Canada (Nelson and Lomotey 2006). This study followed 79 service user participants over a period of 18 months and found that they participated fairly consistently in the user-led services they attended, and that their perceptions of the service were largely positive. The study did not control for outcomes in more traditional services (and they acknowledge this limitation), however their findings suggest that where service user-led organisations are well supported and provided with stable funding they can be successful and well liked by those who use them. This does not seem compatible with the view that service users who attempt to lead services should be automatically discredited on the grounds that they lack the necessary abilities.

5.6 Explaining barriers to involvement

Despite the range of meanings applied by researchers, policy makers and service users to the term involvement, the concept would appear to be inherently normative. It would appear that everyone believes involvement *should* occur, but they cannot always agree on whether or when involvement *does* occur. Consequently the range of barriers to involvement identified in the research literature is broad, and many of the categories of barrier overlap.

Many theorists have conceptualised barriers to involvement as structural, and reflective of the fabric of social life. However, those researchers who take the view that involvement is in the service user's therapeutic interests have also tended to focus on providing guidance to individual practitioners on how to achieve involvement as an outcome. As a result they tend to conceptualise barriers to involvement as practical and identifiable. For example the fact that service users often do not know they have a care plan acts as a clear practical barrier to involvement which needs to be addressed (Schneider et al. 2002). Survey findings in this area are surprisingly consistent, Rose (2003) and Carpenter et al. (2004) in separate studies both identified that the proportion of service users who knew that they had a care plan varied depending on the area from between 35% to 65%. Even within the health trusts which take the greatest pro-active steps to ensure that people are aware of the care-planning process around a third of service users still seem not to be kept informed. As a result, a number of researchers have argued that service users should ordinarily be copied into all written correspondence about their care (Carpenter and Sbaraini 1997, Downing and Hatfield 1998, Loveland 1999, Schneider et al. 1999, Simpson et al. 2002).

Rose points out that the attitudes of staff may explain why so little attention is given to sharing information with service users. Her survey found that many respondents were aware of their care plan but nobody had explained what it meant for them (Rose 2001). She cites her experience of running a workshop for professionals, many of whom stated that service users weren't interested in care-planning. When she questioned them about how much effort they paid to explaining the function of the care plan she found that the average time spent discussing it with individual service users was around five minutes, whilst the average time spent training staff on care-planning was two days. Another practical problem is that staff may themselves lack necessary knowledge. Alexius et al. (2000) in a Swedish study looking at inpatient satisfaction with the information provided noted that service users were happiest with the information on medication which their doctors provided and least satisfied with the information their doctors offered on their legal rights or access to medical records, indicating perhaps that it was the areas where the doctors were most knowledgeable which determined their willingness to provide information.

As was noted in relation to service user led services above, limited resources can also limit the extent to which a service user can influence the decisions reached about her care (Pilgrim and Waldron 1998). Limited resources mean that certain choices will be impossible to support. In addition complex arrangements will typically be in place to ensure that those resources which are available are allocated both efficiently and equitably. For example, in a typical care plan review meeting none of the professionals present will actually be in a position to make decisions about the allocation of funding, these decisions will generally be reached by other committees at which the service user will not be represented, and at which the needs and demands of large numbers of service users will be considered simultaneously. For significant resources to be allocated to an individual, perhaps to fund specialist treatment, housing or help and support in the home a case has to be made to justify this expenditure for this individual, and service users can only make such a case with the support and agreement of those already providing care to them.

In addition to not being able to directly influence or make the decisions about allocation of resources which affect them, poverty can simply preclude any form of participation. For example some service users describe being unable to attend meetings because they did not have the bus fare, or feeling self-conscious when they arrived because their clothes were not very smart (Pilgrim and Waldron 1998). Poverty can also be a distraction. When focus groups of service users in Canada were asked about empowerment many of them described poverty as a barrier because it caused practical problems, but they also pointed out that poverty meant that service users had bigger things to worry about than the contents of their care plan, such as ensuring that they had food on the table (Nelson et al. 2001).

Finally, it is clear that a failure to communicate effectively between service users and providers prevents services users becoming meaningfully involved in the decisions service providers are making. Communication between healthcare professionals and service users is a large subject in its own right, and many theorists are interested in the ways in which meaning is constituted intersubjectively in interactions between doctor and patient (Heritage and Maynard 2006, Godin 2007). This clearly has considerable significance for service user involvement for which the possibility of meaningful communication between user and professional has to be a prerequisite.

Some of the communication barriers which occur between professionals and service users are perhaps already implicit in the way in which different types of knowledge act as a barrier. Service users have noted that lack of time to respond in meetings (Loveland 1998), not knowing what medical terminology or jargon means and feeling too shy to speak (Diamond et al. 2003) all make communication difficult or impossible. Even more crudely, service users cannot communicate their wishes and feelings if they are unable to attend CPA reviews, are not invited to attend or are not even aware that the review is taking place. As has been noted above both of these circumstances occur frequently.

In addition, some studies have explored how misunderstandings arise between actors in a setting. In the case of involvement, it would appear that both service users and professionals are capable of attributing motives to each other's behaviour which the other would not recognise. For example, one study employed focus groups to examine how mental health service users made use of primary care services (Lester et al. 2004). Amongst other concerns the professionals who attended expressed irritation at the fact that mental health service users failed to make appointments early enough and waited until they were experiencing a crisis before seeking help. They attributed this to malingering, chaotic lifestyles or attempts to play the system. The service users however, described how doctors waiting rooms were often stressful environments, reception staff were unsympathetic, and there was often little privacy when it came to discussing their reasons for wanting an appointment with the receptionist. As a result they avoided making appointments unless absolutely necessary. In a later paper the authors attribute this to a wider lack of sensitivity to the specific needs of mental health service users on the part of primary care providers (Lester et al. 2006). However, even where the setting is oriented around mental health service users such as a forum for service user involvement, it has been noted that utterances made by service users may go unheard, be reformulated in such a way as to deprive them of their intended meaning by the more powerful actors present or be actively rebuffed and excluded (Hodge 2002).

Most authors recognise that these practical barriers are in their turn caused by wider structural biases in society. In theorising why involvement policies do not always translate into involvement practice, or why involvement practices do not always translate into better outcomes for mad people, researchers have tend to focus on three major themes: power, identity and knowledge. These factors can in turn be understood as resulting from system differentiation.

5.6.1 Power and control

Arnstein argued that public participation in decisions about public service provision was often deceptive, and that it was common for supposed participation strategies to be used to either manipulate public opinion or change the popular perception of the decision being taken (Arnstein 1969). For example, practices like setting up 'advisory panels' can be used manipulatively, the role of those citizens who sit on them is often mere window dressing because they lack the knowledge or resources necessary to effectively engage in the decision-making process. As a result she argues that participation can only be rendered meaningful by a redistribution of power:

> *"...citizen participation is a categorical term for citizen power. It is the redistribution of power that enables the have-not citizens, presently excluded from the political and economic processes, to be deliberately included in the future."*

It is clearly the hope of many advocates for user involvement that mechanisms to increase involvement will challenge medical and social care orthodoxies and increase the power of service users (Hannigan and Cutcliffe 2002). But by far the most widely cited barrier to service user involvement is the difference in the degree of power wielded by those who provide services and those who use them. Interestingly, this critique has remained largely static throughout the last 30 years. When 'On Our Own' (Chamberlin 1977) was published the author argued that unless community mental health services adopted a bottom-up approach to service development the delivery of service in the community would only recreate the old hierarchies employed in hospital provision in which psychiatrists wielded the power and could determine which service users were allowed to raise 'legitimate' concerns and which service users lacked the credibility to contribute to this dialogue. A critique of the political framework within which decisions about mental health service provision were made published in 1985 commented on the issue of public participation in mental health service provision that:

> *"...it is extremely hard to get 'the community' involved in 'their' service, a difficulty easily ascribed to passivity when in fact it reflects the lack of control actually given to people in planning these services".*
>
> (Banton et al. 1985 p.179)

A study of how adults with mental health needs participated in a local users forum, carried out twenty years later, described how the professionals present at this forum played a role in policing discourse and in determining what could and could not be placed on the agenda (Hodge 2005a). The author concluded that such policing amounts to an exercise of power which was of particular significance because the forum was not freestanding but had been deliberately convened by a Mental Heath Trust. As a consequence rather than yielding any control over issues of service delivery to mental health services users the forum was only able to endorse decisions already reached elsewhere. Harrison and Mort (1998) argue that this kind of exercise in public involvement serves largely to legitimise managerial control within ostensibly pluralistic policy-making settings. They do this by taking on the semblance of the democratic process and thus appearing legitimate to the outsider, whilst remaining internally dependant on informal social networks which remain in the hands of managers.

Any demands service users make of those who provide services must be mediated through individual health and social care professionals who must determine whether such a demand is reasonable or likely to succeed. Hodge (2005a) found that even when service users are involved in decisions being made only certain types of debate were constructed as 'legitimate'. Finally, where involvement is employed as a *"technology of legitimation"* (Harrison and Mort 1998), a problem which Arnstein clearly anticipated, it becomes easy for those who have power to argue that participation, even where it is passive, is equal to involvement and thus legitimises managerial or professional led approaches over service user led approaches. In these circumstances, when service users climb a few rungs of the ladder they may find it harder and not easier to climb to the top. Indeed, one of the problems with literature on the promotion of participation is that it often fails to distinguish between active and passive strategies. Passive strategies such as inviting service users to meetings, or copying them in to correspondence may be a condition of possibility for communication, but they do not reflect the huge structural imbalance that exists between service users and professionals. As the section on the effectiveness of involvement policies made clear, the promotion of participation sometimes results in service users being invited to meetings at which they are not permitted to speak, or being asked to sign care plans which they have not been consulted upon.

5.6.2 Knowledge

> *"Different forms of knowledge are...encapsulated and kept separate from each other, so that they might co-exist alongside but they don't overflow and intermingle with each other, and there is this awareness of – oh this is professional knowledge and this is service user knowledge so obviously that's going to be an experiential thing...I think that is a real fundamental issue."* (a service user talking about sitting on a service user forum quoted in Hodge 2005b)

As Hodge's interviewee noted, there continues to be mistrust within the psy-system of the type of knowledge which service users are likely to have. Summers' (2003) study of the views psychiatrists hold on user involvement, found that some psychiatrists objected to service user involvement where it conflicted with evidence-based practice. They argued that service user involvement should not be allowed to trump the 'right' decision being made by health service providers. The view that service users lack the knowledge to make meaningful contributions to the decision making process is also identified as a barrier to involvement in a number of the empirical studies discussed above (see for example Forbes and Sashidharan 1997, Pilgrim and Waldron 1998, Peck et al. 2002, Langan and Lindow 2004, Lester et al. 2006). Faulkner and Thomas (2002) suggest that service user involvement and evidence based medicine (EBM) are based on conflicting logics. They argue that where conflicting views on contentious diagnoses arise EBM is *"ill-suited to resolve the resultant conflict because it is unable to reconcile the values and beliefs of different stakeholders"*. This tension has often been seen as a problem for those working in mental health care and the problem of ensuring that service users values are upheld in treatment decisions has been the source of much debate (Hughes and Fulford 2005). Specific solutions, such as the adoption of a values based medicine paradigm to complement EBM have been put forward (Woodbridge and Fulford 2004). These tensions are not, however, restricted to medical practice, the practice of nursing and the logic of service user involvement can also come into conflict (Anthony and Crawford 2000). And whilst it would appear that attitudes to service user involvement are more positive amongst clinical psychologists than they are amongst psychiatrists (Kent and Read 1998), psychologists nonetheless acknowledge that the role of service users in care planning is typically to endorse the goals of a treatment plan determined by an expert (Soffe et al. 2004).

Service users who may also be conscious of a tension in their role between expressing their views and being discredited, or saying nothing and suffering the consequences of inappropriate or insensitive treatment. The values based medicine approach offers guidance to doctors anxious to ensure that service user's values are not compromised whilst they deliver the best treatment they can, but it offers no guidance to service users on how to convey their concerns without fear of discreditation or coercion. One widely promoted solution has been to incorporate the views of those using services into the mainstream evidence base by promoting service user participation in research, and thus ensure that what is known about the experiences of service users forms part of mainstream EBM (Oliver 1995, Faulkner and Thomas 2002, Spiers et al. 2005). In this way the knowledge of service users can influence medical decision making without necessarily placing service users under an obligation to explain or justify their concerns. Faulkner and Thomas suggest that *"Psychiatrists should attach as much importance to user led research in the processes of clinical decision making as they do to randomised controlled trials"*. Glasby and Beresford (2006) argue that the notion of evidence itself should be re-evaluated, and recognition given to the fact that there are other ways of knowing the world than through randomised controlled trials and systematic reviews. They suggest a knowledge based rather than evidence based approach to planning care at both the micro and macro levels. This is a process which requires participants in policy making to ask what is known but also to ask what constitutes knowledge and who gets to determine this. Their suggestion of a method goes further than other commentators in suggesting how service user's knowledge of their own experiences and values should not simply complement EBM but instead radically change the relationship between service user and professional knowledges.

5.6.3 Identity

> *" 'I like 'survivor'. My favourite saying is 'We're still here – we've survived.' A lot of the people who have been through this project have had horrendous pasts. But we're here, we've got here – we wouldn't be here if we hadn't.'*
>
> ...
>
> *' 'Survivor' I hate. You've survived as in you're still here but not as you should be. It implies you've come out the other end. – I haven't.' "*
>
> (two service users quoted in Ferguson 2003)

Ferguson's study looked at which terms people who use mental health services preferred to apply to themselves. No term came out obviously ahead among the 43 people he interviewed and all of the terms he suggested encountered strong opposition from some of those interviewed. A number of other researchers have highlighted the fact that people who use mental health services do not necessarily share a common sense of identification as service users (Wadsworth and Epstein 1998, Speed 2007, Forrester-Jones and Barnes 2008, McLaughlin 2008). Services users when asked often comment on the tension they feel between their diagnosis, their status as service users, and their private sense of self. They also invest great significance in deciding which labels they are happy to have applied to them (Barnes and Shardlow 1996, Hodge 2005b). In this respect mental health service users contrast with users of other health services who appear to concur that 'patient' is a neutral term which they can accept if not positively endorse, and who dislike, but do not strongly oppose, terms which imply a provider/consumer relationship in healthcare interactions (Deber et al. 2005).

As outlined in Chapter Four (pp.165-7), social identity from a systems perspective is fragmented and reconstructed anew within each system. Work on labelling theory and on stigma has demonstrated convincingly that the label 'mad' is widely discredited across social systems, and that where individuals have control over how they engage with this aspect of their identity, they may well choose to avoid being linked to it to avoid the wider repercussions that could arise (Corrigan and Keinlein 2005). One limitation, therefore, on the involvement of mental health service users in service planning in delivery is that they may have cogent reasons for refusing to participate in public forums. Whether such service users actually are deterred in practice is hard to determine. Since the closure of the Commission for Public and Patient Involvement in Health no single body is responsible for auditing the levels of public involvement in strategic healthcare service planning: the new NHS National Centre for Involvement acts as an advisory rather than a regulatory body. The bulk of research on public involvement has been qualitative in nature and therefore cannot tell us whether as a population mad people are happy to participate in mental health service planning, although Hodge identifies that ambivalence about engaging with an identity as mad considerably influences whether or not people choose to participate in local service planning (Hodge 2005a).

Another problem for the promotion of participation in particular, is that permitting participation is often constructed as a duty owed by the state to its citizens. The continued assent of citizens to the decisions reached by those in power is seen as fundamental to political legitimacy. Citizenship, however, is not simply a status which accords all people equal rights, but is instead a practice associated with ones degree of involvement in the community, and the way in which one exercises the rights accorded to citizens (Lister 1998). Historically mental health service users have been excluded from citizenship on the grounds that they lack competence. So before service users can even climb on to the ladder they need to be constructed as legitimate participants by the official discourses which determine who can and cannot be considered a citizen (Barnes 2002). These discourses often operate under normative imperatives which cannot easily bend to accommodate the different needs of service users.

5.7 Systems and the involvement of mad people

The contested nature of participation and involvement has been acknowledged by some researchers in this field (Thompson 2007). However, establishing consensus on what constitutes meaningful involvement is likely to be impossible. From a systems perspective, the fact that different discourses apply different meanings to the same term can be readily understood as resulting from the fact that meaning in each case has been reconstructed anew with reference to the system's code. The tension, or irritation, this generates, can have positive consequences: it can encourage creativity and innovation in healthcare delivery, since it would appear that even where they feel daunted by the task of imagining alternatives both professionals and service users are dissatisfied with inadequate or tokenistic mechanisms for supporting involvement (Campbell 2001, Diamond et al. 2003, Soffe et al. 2004).

It is unfortunate that this tension is not acknowledged by the Department of Health in their policy work in this area, and that government led innovation has tended to focus on the procedural dimensions of involvement. It is also unfortunate that government policy gives mixed messages about involvement as it applies to mental health service users. Overall, policy research, and the growing interest in research in this area strongly indicates that the problem of what service user involvement might mean and what implications it has remains a very current problem for those working within mental health services. This problem remains poorly defined. Re-defining it from a systems perspective means reconfiguring some of the problems which have already been outlined above as problems of communication.

Involvement and participation are sufficiently vague to allow multiple interpretations to be placed upon the term where they appear in legal and policy documents. For Luhmann, such policies will inevitably merely irritate the boundaries of the system to which they are addressed because they cannot themselves form part of a communication with the system. In the case of terms as vague as 'involvement' the irritation is minor because each system has a wide range of approaches available to it which will enable it to assimilate effectively the policy upon the system's own terms. One example of this is the way in which involvement appears to have entered into many new psy-system communications about the management of treatment for mad people. Perhaps this is because involvement practices appear to correlate with the attainment of a psy-system objective: the promotion of better mental health. As Luhmann points out steering is itself a difficult outcome for political systems to achieve. In this case, it is made more difficult by the fact that it is not clear exactly what involvement policies are aiming to achieve and therefore what they are steering towards. Better risk management, better therapeutic outcomes, more efficient service delivery, more respectful service delivery and the greater social inclusion of mad people are all outcomes which have been linked to effective involvement practices, and yet it is rarely made clear in policy documents or guidance which outcome or outcomes are intended.

Having said that, there does seem to be some confidence amongst service users themselves that the promotion of involvement is worthwhile (Forrester-Jones and Barnes 2008). Involvement practices such as inviting service users to meetings and sharing information with them create the pre-requisite conditions for communication between service users and professionals. This possibility of communication can in turn lead to the user being able to exert some control over those decisions which are reached. For Luhmann, unlike his early mentor Talcott Parsons, control within social systems is not responsible for producing social order. Communication systems exist in order to communicate, not in order to control. Control however, is inherent to communication. Or as Baecker has put it:

> *"A system is a way to communicate control if there is no other way to communicate. It is a way of considering how control is possible if control makes the controller and the controllee do away with degrees of freedom they would otherwise enjoy, and if it makes them resort to communication instead. Control...implies consent, if not collusion, on both sides of the control relationship even if that consent, which must be uncertain is at once dissimulated in favour of the establishment of an asymmetrical relationship."* (Baecker 2001)

Individual control over the social world may be achieved in a number of ways: by entering into a legal contract, by seeing one's doctor or by buying something and entering in a relationship of exchange for example. But wherever control occurs, communication must have occurred first. In the context of care planning, the service user has no possibility of exerting control over the decisions made about her life if no effort is made to communicate the content of these decisions to her. If care-planning meetings take place without the service user present, if information about her care is not shared with her, or if everything she says is routinely discredited and not treated as an utterance worthy of a response then no possible control through communication can occur. Equally, service providers are aware that communication is also a pre-requisite for control over the service user. If they cannot communicate with the service user about her care and treatment then their capacity to control her behaviour or to promote specific outcomes such as treatment compliance is hugely limited. When communication breaks down the imposition of coercion may be the only option available to them.

The promotion of patient/user involvement in healthcare decisions can be understood then, as creating the conditions necessary for everyone involved to exercise control and counter-control over the decisions being reached. In practice, the creation of conditions does not amount to the actual achievement of communication, and the fact that service users still continue to feel that they are not able to communicate with service providers in many cases reflects this. In particular, the problems identified above with power, identity and knowledge can all be characterised as different facets of the problem of discreditation.

5.7.1 Service user knowledge and becoming a system

Luhmann defines power as a medium capable of promoting communication on the one hand and attenuating freedom on the other. Significantly, Luhmann links power to the possibility of exercising coercion over others (Luhmann 1979/1975 pp.112-5). Power enables the holder to limit the range of the other parties responses not through the active exercise of coercion, or the breaking of the other's will but through neutralising the other's will. So the psy-system is powerful to the extent that its ability to exercise coercive force over resistant mad people acts as a constraint upon their behaviour. To the extent that this is irrelevant to mad people in selecting how to behave, it lacks power.

In the context of care planning, knowledge of the power of the systems involved may undermine the willingness of service users to participate in care planning forums. The availability of power as a means for promoting the effectiveness of their communications means that the psy-system has limited reasons for altering its practice to better accommodate the values of the service user where these values do not correspond to the normative goals of the system. To take the example which Hodge gave of a service-planning meeting where the agenda was set beforehand by the service providers, this was only possible because those setting the agenda knew of the power they held (Hodge 2005a). In this instance, the power in question was largely financial. In being able to decide the allocation of funds the service providers had ultimate control over the decisions being reached by the meeting. Not only this, but it was clear to those present, that the forum's continued existence was dependent upon the compliance of service users with the agenda of the service providers.

One way in which individuals can counter the capacity for power which social systems have is to promote the creation of an alternative social system. Luhmann recognises social movements as examples of social systems structured around a specific goal which is perceived to be at odds with the actual direction of society (Luhmann 1995/1984 pp.398-401). These systems are then able to generate meanings around the goal, to determine how it is to be defined, how it is to be achieved, even to determine their own history through reference to the goal. It has been argued that such systems provide a necessary corrective to the powerful social systems such as law, politics and the economy which determine the dominant values extant in any given society (Fuchs 2006).

Those who see meaningful involvement in one's care, and possibly total control over its delivery, as the aims of the service user movement, see the origins of the involvement debate located within the service user movement (Chamberlin 1988, Tomes 2006). That is to say, at the point service users started asserting a voice which was constructed independently of medical authority, and which challenged the tenets of medical discourse, they were also demanding to be actively involved in their care and not just passive recipients. However, it has been argued that mental health service users may lack the collective identity necessary to function as social movement and that the service user movement remains inherently fragile as a result (Barnes 1999). This leaves open the question of whether the service user movement at present constitutes a social system?

It has been argued that the mental health service user movement began with the creation of the Alleged Lunatics Friend Society in 1845 (Barnes and Bowl 2001 p.27), or even earlier with a petition sent to parliament on behalf of the inhabitants of Bedlam in 1620 (Coleman 1996). The majority of those writing in this area seem to accept that these earlier movements were different from the user movement which began to emerge in the 1970s and 80s. Barnes and Bowl however, suggest that these early pioneers on behalf of service users were stifled by the emerging biologically based medical discourse which came to dominate accounts of mental distress during the 19th century. They argue that earlier movements did not differ significantly in terms of their objectives from those which succeeded them but the surrounding cultural climate did. It was not until the 1970s, when sympathy to counter-cultural accounts of mental distress began to grow, that a mental heath user movement was able to flourish.

Crossley (1999) takes a different approach and suggests that earlier service user led campaigns never achieved the ability to reproduce their agendas across different fields of activity. Social movements, Crossley argues, drawing on Bourdieu, are networks of interaction which have the capacity to transform practices within a specific social sphere, in this case psychiatry. This transformation however is achieved through changes in the operation of other related and overlapping fields of activity, including the media, parliamentary and legal fields. In addition, the transformation of psychiatry involves the transformation of service users too, who as a result of the movement begin to think and feel differently about themselves too. This is a result of the habitus (shared systems of perception, conception and action) which service users belong to also having changed. These changes have the ability to generate a resistance habitus, a particular habitus shared by core activists within a field who subsequently see their position differently and are able to use their transformed perceptions to influence others. In the case of mental health service users, Crossley argues that such a transformation came about with the creation of the Mental Patients Union (MPU) in 1973. The MPU was founded by a group of staff and service users at the Paddington Day Hospital, a radical therapeutic community in London which had been threatened with closure. The union rapidly extended the remit of its campaigning activities to take in providing legal advice to service users, lobbying parliament and talking to the media about mental patients' rights more generally. It was the scale of the campaign and the levels of public awareness that the campaigners were able to generate which distinguished the MPU from all of its predecessors and also from professional led campaign groups such as the National Association for Mental Health (soon to become Mind). However, by 1976 the MPU had effectively ceased to operate, and in 1979 Paddington Day Hospital itself closed down. Crossley's argument that the 1970's witnessed the birth of a growing social movement is complicated by this fact. Although the late 1970s were marked by considerable campaigning activity on behalf of people with mental health needs, culminating in the Mental Health Act 1983, it would appear the bulk of this activity was neither initiated nor led by service users.

There are conflicting accounts as to why the MPU and the therapeutic community which spawned it failed to survive (Baron 1987, Spandler 2006) and its demise should not necessarily be taken to mean that the fledgling service users movement was dysfunctional. The story of the MPU has some parallels with the story of user led services, and as noted above there are numerous structural reasons which account for their fragility. Rogers and Pilgrim (1991) argue that the service user movement only really began to be effective in the late 1980s and that it is the organisations which came to prominence in this period including Survivors Speak Out, the Hearing Voices Network and MindLink which really represent the birth of a service user movement in the UK. It is noticeable that the last two groups were both facilitated by larger national charities (the National Schizophrenia Fellowship, now Rethink, and Mind respectively) which paid the salaries of those service users who acted as coordinators. These groups were particularly active in campaigning against stigmatising media representations of people with mental health needs and in campaigning for greater rights for service users, and unlike earlier groups they achieved some success, particularly with regard to placing pressure on service providers to increase service user representation within their service planning structures.

But if, as Rogers and Pilgrim argue, sustained action leading to social change is what constitutes a social movement, then it may still be too soon to confirm the existence of a service user movement in the UK. At the time of writing the Mad Pride movement in the UK is not operating, although a campaign conducted under the umbrella of the international Mad Pride movement – KissIt: The Campaign Against Psychiatric Assault – is still organising protests. Survivors Poetry survives, and Rethink still facilitates the Hearing Voices Network, but many other smaller campaigning bodies have either disappeared or been subsumed within larger non service user led groups during the last fifteen years. Whilst involvement has risen on the policy makers agenda, and the numbers of service users represented in forums determining service delivery issues has increased, the proportion who participate in service user-led groups, campaigns and services appears to still be very small. At the same time surveys looking at public attitudes to mental illness in England and Wales have noted very little improvement in public opinion over the last decade or so, with attitudes to care in the community actually deteriorating (DH 2003 pp.6-8, Shift 2007 pp.17-26, Shift 2008 p.5) As Peter Campbell puts it:

> *"The great irony about service user action in the past 15 years is that, while the position of service users within services has undoubtedly improved, the position of service users in society has deteriorated."* (Campbell 2001).

One explanation of this irony could be that the success of any emerging social movement is always the result of historical accident. It relies not just on individuals emerging capable of demonstrating a coherent voice but also on the existence of other social conditions within which the movement can flourish. Barnes and Bowl (2001) suggest that in the 1960s and 1970s public mistrust of institutions after a number of scandals, coupled with the development of an anti-psychiatry movement from within the profession, created the conditions which enabled service users to speak out and be taken seriously. Several commentators have observed that the growth of user involvement forums in the 1980s coincided with the birth of a consumerist perspective in healthcare, based on the neo-liberal view that the availability of choice within a free market of healthcare providers was the best way to drive up standards (Harrison and Mort 1998, Crinson 1998, Crossley 1999). The move towards greater service user involvement in this area could only come about because changes which affected all of healthcare policy occurred. Inclusion of mental health service users within the consumer led services agenda was never a priority for policy makers, instead it was an inadvertent consequence of a wider policy of reconstructing the patient as consumer. This dependence upon external support and historical contingency means that the service user movement has never been able to determine its goal independent of the wider movement for better mental health services or to generate its own system of internal meaning. To this extent it is not a social system:

> *"Only if a theory of movement is rich enough no longer to need initial or concomitant causes can one meaningfully speak of "social movements" and intend by this a self-activating process."* (Luhmann 1995/1984 p.400)

There is of course an influential social movement which exists to promote the interests of mad people. But membership of this movement is not defined by having an identity as mad or as a service user.

5.7.2 Identity and involvement

The ambivalence people feel about an identity as mad is well documented (see above pp.210-3). As outlined in Chapter Four (pp.165-7) psychic systems are able to make selections about the aspects of their identity they choose to present to others. From a systems perspective we can see that concealment is sometimes the only strategy available to people keen to retain some space for communication within which they are accredited as capable of making meaningful utterances.

This need for concealment may help to explain the absence of a stable social movement promoting the social status of mad people. Furthermore the fact that we can choose how we present ourselves to others in modern societies can also help to explain why this movement has had difficulties transforming its observations from a collection of assertions into a common goal. Fuchs argues that one object of most social movements is to construct a coherent identity for their concerns which can be readily be communicated to others: the disparate voices of those concerned about the environment become the green movement for example (Fuchs 2006). Madness is typically understood as an absence rather than a presence, as a force which suppresses the 'real' or 'core' identity of the individual. Indeed this is how some mad people describe their experience of madness. In these circumstances it is difficult to construct a positive identity for a movement which seeks to assert the validity of a mad individual's self-understanding of their condition.

The problem of the fragmentation of social identity does not simply undermine the coherence and feasibility of the service user movement. It also creates problems within private settings such as care planning meetings. Luhmann observes that in modern societies identity is constructed around a seemingly endless set of social distinctions rather than linked to a small number of fixed labels such as commoner/gentleman or man/woman (Luhmann 1997 p.627). Individuals now understand their social identity as the product of freely made 'career' choices (ibid p.742). As a result the individual is constantly testing her identity against the world and learning who she is from the subtle (and not so subtle) hints she picks up from those around her.

This complicates the promotion of new forms of involvement based around new and positive identities for service users. To unsettle the stable role of patient by asserting a new expertise based on experience creates a new dynamic within the setting. The 'expert by experience' (formerly consumer, service user, client and patient, see McLaughlin 2008) has to relearn her identity. She may find that her social identity has not changed that much; that the expectations of those around her remain largely unaltered despite the change of name. Or she may find the change is significant and that suddenly she has to live up to a new set of expectations about her behaviour. These changes in expectation give rise to what Moeller terms 'identity stress' (Moeller 2005 p.92). The following quotes from an interview with a mental health service user on the topic of being consumer gives an illustration of this:

> " *'...I decided I'd take this stuff and asked specifically for it they didn't sort of suggest it to me...but I asked specifically if I could take this stuff and they gave it to me and it did work you know it sort of countered ehhm my anxiety'*
>
> [and later in the same interview]
>
> *'so I've started, sort have, more or less half come off it, and half not come off it. I wasn't getting, I was trusting in my psychotherapist and he says well maybe you're coming off it too quick and so I sort of went back on it.'*" (Brian quoted in Speed 2007 p.312)

In the many other extracts quoted from Speed's interview with Brian it is clear that Brian is someone with strong views on the usefulness of psychiatric medicine. It is only when it comes to discussing his own care that Brian's engagement with an identity as a consumer appears to be ambivalent. He is keen to assert that he is capable of making an informed choice about appropriate medication whilst later lacking the confidence to make an independent decision about whether to come off the same medication. Speed analyses this in terms of the degree of empowerment Brian enjoys. But this scenario could also be understood as resulting from the shifting sand of what is expected from those who use or consume mental health services. Brian may not be sure of what he wants himself from services, and he certainly is not sure what service providers expect from him.

5.7.3 Knowledge as a limitation on involvement

One function of involvement might be to increase the possibilities for generating knowledge within the psy-system (and also the medical, economic and political systems which are all implicated in the decision-making processes within which involvement is typically sought). Luhmann argues that learning is dependent upon a belief that information can be generalised about (Luhmann 1995/1984 p.328). Psychic systems and social systems are not motivated to learn unless they have the expectation that having absorbed information they will be able to employ this to guide future decisions and thus generate stability over time. However, at the same time learning relies on an ability to adjust one's judgment in the face of new information. The generation of knowledge is dependent upon those two conditions being met: – an expectation of stability and an openness to change:

> *"Knowledge is therefore the condition for and regulator of learning processes, more precisely, for building learning possibilities into the existing structure of expectations."* (ibid.)

In order to describe the implications this has for service user involvement it is necessary to return to the distinction between cognitive and normative expectations. Cognitive expectations are, of course, more readily adjusted in the face of new information than normative expectations. Promoting communication between service users and psy-system professionals can also promote opportunities for adjusting cognitive expectations. Indeed, psy-system knowledge is largely dependent upon the possibility of such communication occurring because, as I described in Chapter Three (pp.115-7), it has few other sources of evidence on which to found the distinction between madness and sanity. To take the example of a communication around whether or not a medication is effective, it will be easier for a service user to describe how a medication affects her if information about medication choices has been shared with her, her participation in discussions is encouraged and the professionals involved make it clear that an utterance has been heard by indicating a response to it. The psy-system has the possibility of learning from the service user about the usefulness of the medication and the specific circumstances which make it desirable or undesirable. The service user may also revise her cognitive expectations about treatment on the basis of the information shared with her by professionals.

Normative expectations are harder to adjust because their usefulness is in large part predicated upon their seeming stability. Psychic systems generate normative expectations in order to render the social world safer (ibid. pp.325-6). The evolution of social norms is necessary for social order, and knowledge of these norms is swiftly transformed into 'law', not necessarily law ordained by the state, but at least understood through the social codes which govern interaction (ibid. pp.339-41). Social systems are in turn normatively closed which means that any adjustment of normative expectations has to occur from within in relation to the system's self-reference. No assault from the outside will result in a radical re-alignment of the norms of the legal or political or economic systems (Luhmann 2004/1993 pp.464-74). This is where the effectiveness of involvement in promoting communication between service users and professionals becomes limited. The psy-system typically retains the normative expectation that it holds the most advanced knowledge available of the operation of the code madness/sanity. This is not blind arrogance, but an inevitable consequence of functional differentiation; if the system was not able to assert the validity of its own distinction it would be unable to continue to operate. For the psy-system, the person making the mad utterance is not in a privileged position when it comes to determining whether or not she is mad. Her assessment of her madness is not inevitably better than an assessment performed by another. And in areas where psy-knowledge is perceived to be robust her personal assessment may well be worse. As a result the psy-system has a particular normative expectation about whose utterances should be understood as most credible. Or, in other words, who counts.

The problems caused for involvement practices by the dominance of the evidence based medicine paradigm in mental health research (Faulkner and Thomas 2002) result from a combination of cognitive and normative expectations overlapping. To define an evidence base is to define the limits of generalisability of certain cognitive expectations. The function of doing this is to enable these limits to be communicated about more easily. The evidence base in medicine is meant to ensure that doctors are readily able to share knowledge about what does not work. However, in order to establish an evidence base the medical system has to generate normative expectations about what counts as evidence. These normative expectations in turn make it harder to communicate about the limits of knowledge, because successful communications must be founded upon shared norms. The difficulties doctors describe of communicating the value of evidence based medicine to the general public provide a good instance of one of the inherent limitations of this approach. As noted in Chapter Three (pp.118-9) the psy-system is itself engaged in a continuous internal debate over what should count as evidence. However, in the context of psy-system decision-making, the existence of the evidence based medicine paradigm provides another example of a normative expectation which can conflict with the promotion of involvement. If what the service user says conflicts with the evidence base the normative expectation of the psy-system is, typically, that the service user's views should be treated as weaker evidence than that which has already been endorsed through clinical research.

5.8 Conclusion

This chapter has outlined some of the different meanings and values applied to the term involvement in the context of research into the effectiveness of involvement policies and practices. However defined, the research literature has identified that involvement practices often fail to achieve meaningful changes in decision-making processes from the perspective of mad people. This has been linked to underlying problems of power-differentials, unstable or discredited social identity and unequal knowledge bases.

Using the theoretical framework described in Chapters One to Four it has been possible to argue that these difficulties reflect some of the properties of interaction between social systems and between social systems and individuals. The issue of identity is manifested in two ways: the problem that mad people have not been able to generate a stable collective identity which could be accredited as meaningful, and the problem that individuals labelled mad may feel ambivalent or even fearful about the consequences of owning madness as a component of their personal identity. The first of these can be explained through descriptive accounts of the emergence of protest movements and the conditions necessary for such movements to achieve their own self-reference. The second arises from the fluid nature of identity in modern society, which places continual demands upon the individual. As a result, generating a new positive identity for service users through the promotion of involvement throws up new challenges. But a further major problem is created for involvement by the fact that the psy-system has still not decided what meaning to apply to utterances made by service users.

The literature on service user involvement has largely been generated within the psy-system. Most of the research cited above has been conducted by psychiatrists, psychologists, mental health nurses and mental health social workers and much of it has been published within the professional journals of these disciplines. This reflects the fact that normative adjustments are possible from the inside. The psy-system appears to at least acknowledge the possibility that changing its expectations about who should be heard may enhance its ability to perform the function of alleviating madness. This system also acknowledges that there are structural limitations placed upon involvement in practice. Different disciplines may respond differently to the challenge of promoting involvement, but the fact that these efforts to communicate about involvement are structured around the promotion of meaningful communication as a therapeutic goal means that there is at least scope for a meaningful debate to take place.

However, when involvement is discussed within the political system the same possibilities for debate do not appear to arise. The logic of promoting service user involvement is underpinned by an evident belief in the need to accredit service users. People who use services have a specific knowledge of the care they receive and as a consequence should be treated as meaningful contributors to decisions made about these services, whether at the level of personal care planning, or at the level of service planning. To accredit an utterance purely on the basis that a service user has said it is not to say that everything she says is automatically to be believed or acted upon. Otherwise, there would be no possibility of a highly accredited professional such as a psychiatrist ever being perceived to have lied. Instead, it is to assert that everything she says is *potentially* capable of being meaningful and is worthy of attention. This directly challenges the discreditation of mad people and as such demands that considerable social change be effected. But the issue of discreditation is never discussed in policy documents. At present no one has acknowledged the significance of the question of what it means to accredit an utterance simply by dint of the fact that it was made by someone who had previously made mad utterances.

Chapter Six

The role of the legal system in accrediting and discrediting mad people

6.1 Introduction

The last chapter demonstrated that the political, economic and psy-systems (and to a far lesser extent the legal system) have actively engaged with the accreditation of mad people, through the promotion of service user involvement. In practice, the effectiveness of involvement policies and practices in changing the status of mad people is limited because the processes of discreditation which affect how systems respond to utterances made by mad people are still in place. In effect these systems are attempting to simultaneously accredit and discredit madness.

This chapter will examine how the structural coupling of the legal and psy-systems in the context of mental health law can further serve to discredit and undermine mad people. It will examine these issues through a case study of the Mental Health Review Tribunal. But it starts with an examination of Luhmann's description of the social function of the legal system.

6.1.1 The significance of the law to Luhmann's theory-building

Luhmann originally trained as a lawyer. Throughout his work on developing a social description of society capable of accounting for both order and complexity he retained an especial interest in the function of the legal system within the context of a wider social order. Luhmann's descriptive account of the social function performed by the legal system was first outlined in 'A Sociological Theory of Law' (Luhmann 1985/1974). But, as was made clear in Chapter One (p.36), his theoretical development does not proceed along chronological lines. He described 'Social Systems' (Luhmann 1995/1984) as his first book and stated that whilst his earlier work remained correct in its essentials it lacked sufficient focus upon the nature of communication and its role within systems . Luhmann returned to the law in 'Law as a Social System' (Luhmann 2004/1993) which needs to be read alongside 'A Sociological Theory of Law' and Luhmann's numerous articles upon the subject in order to understand how the law is functionally differentiated from other social systems and how it sustains that differentiation in the face of a complex environment.

6.2 The function of the legal system

In 'A Sociological Theory of Law' Luhmann argues that the law evolves as a way of stabilising counterfactual normative expectations over time (Luhmann 1985/1974 pp.31-40). He reaches this conclusion by first returning to the question of how psychic systems form expectations about the social world. As discussed in Chapters Four (pp.152-4) and Five (pp.228-30), individual psychic systems must generate expectations in order to be able to interact with and test the properties of their environment. When these expectations are met with a sufficient degree of consistency they may begin to condense into claims. Psychic systems generate both cognitive and normative expectations about the other psychic systems they encounter. When her normative expectations are not met in some way the individual may experience herself as disappointed or even threatened. Consequently, she may act upon these emotions in ways which generate further conflict and consequent social complexity. It is therefore in the interests of the social system to regulate the conduct of psychic systems in order to ensure that normative expectations are, typically, met. The forms that this social regulation takes are not inevitably legal. Luhmann discusses how a range of interaction systems including the family and the workplace are capable of exerting a regulatory influence over psychic systems (Luhmann 1985/1974 pp.49-61).

Regulation is not an exclusive function of the legal system, which is why Luhmann goes on to ask what uniquely differentiates the law from other systems (Luhmann 2004/1993 p.143). He distinguishes theories which argue that the law operates as a form of social control, since social control is clearly a function exercised by a number of social systems. He also distinguishes theories which emphasise the integrative function of the law such as the work of Habermas (ibid. and see also Luhmann 2002c pp.187-93), since neither achieving consensus nor harmony is an observable function of the law, nor a probable outcome given the closed nature of legal communication. Instead, he identifies the maintenance and stabilising of norms over time as a function unique to the legal system.

Law achieves this maintenance of norms through its time-binding effects and, unexpectedly, through its operative closure. By making communications as to what will be normatively approved in the future, the legal system, more than any other system, generates certainty about conduct in the present (Luhmann 2004/1993 pp.147-56). But, the law's ability to make communications with time-binding effects depends on legal closure and upon its blindness to norms which have not previously been identified as legal. By asserting that only some norms count the law is insulated from the vagaries of ongoing social debates about 'right' behaviour (ibid. pp.156-62).

The identification of this function alone does not explain the existence of an autopoietically closed legal system (Luhmann 1992a). Instead, we have to look at the attributes of social systems as described in the Introduction to understand how and why the legal system attains and maintains autopoietic closure. Luhmann's account of autopoiesis asserts that partial autopoiesis is impossible. How then do systems arise at all? Teubner supports an alternative view to Luhmann's: that it is possible to think of self-referential systems in terms of degrees of autonomy (Teubner 1993 pp.31-46). In order for autopoiesis to arise the system must be able to reproduce its own elements. So legal acts are constitutive of further legal acts, the reporting of medical diagnoses informs future diagnoses and participation in monetary exchanges makes future monetary exchanges possible. But Teubner also argues that all of the components of the system: the acts, boundaries, structures and processes it employs, must be cyclically interlinked for total autopoietic closure to occur. Thus autonomy increases as the system recognises its components, engages in reflexive communication about them (self-observation), is able to act to alter its operations on the basis of these communications (self-constitution) and links these processes together in a hypercycle (autopoiesis). Thus legal autonomy begins to emerge at the point at which legal communications are distinguished from other communications. At this point the legal system has to distinguish lawful and unlawful acts on the basis of a self-reference, which forces it to engage in reflexive accounts of its operations. These accounts generate norms for legal operations - principles which govern the internal operations of the code for example - and which in turn lead to the constitution of new elements. Eventually, the law itself becomes the arbiter of what kind of act or event can be constituted legally.

6.3 The function of mental health law

In most jurisdictions there exist documents in the form of statutes and cases which describe when it may be lawful to detain or force treatment upon someone who has a mental disorder, how and by whom such decisions are to be reached and how mentally disordered individuals can challenge decisions made about them. When we refer to mental health law this is what we are typically referring to. However, the law in the systems theory context does not refer to texts or to institutions but to communications organised around the distinction between what is lawful and what is unlawful. When I refer to the function of mental health law here I am not asking what the function of these documents is, but I am asking what function maintaining a distinction between lawful and unlawful decisions relating to mentally disordered people performs for society as a whole and how this function can be differentiated from functions delivered by other systems.

For example, social control may be achieved through law but it is exercised across systems. In relation to madness it is typically promoted through a structural coupling of the political and psy-systems. Mental health law certainly does play a role in determining when certain professionals may exercise social control (see Bartlett 2003), but if communications which purport to refer to mental health law are to be functionally differentiated from policing and psy-system communications then we need to ask if they are performing any functions beyond social control.

It has also been argued that mental health law is necessary to protect fundamental rights, such as the right to liberty or the right to freedom from inhuman and degrading treatment. The effectiveness of mental health law in achieving this protection has been questioned (Fennell 2005), as has the usefulness of the European Convention on Human Rights and the jurisprudence of the European Court of Human Rights as they relate to mad people (ibid. and Richardson 2005). But these arguments suggest that the authors hold two normative expectations: that human rights law should protect the interests of mentally disordered people, and that mental health law should be grounded in securing the human rights of those it affects. Again, whilst it is clear that the law may play a role in ensuring that the expectation that fundamental rights will be protected is maintained, fundamental rights as expectations are definitively pre-legal. Luhmann defined fundamental rights as a multi-functional institution (Luhmann 1999/1957, quoted in Verschraegen 2002). That is their operations are not functionally differentiated, nor are their implications limited to affecting the operations of one system. Instead fundamental rights generate claims that all individuals should be able to participate across a range of social systems such as the economy, politics, law and education. By enabling diverse participation in the social system, fundamental rights actually contribute to the maintenance of functional differentiation. Luhmann argued that the operations of the political system tended to have a colonising effect on other spheres of social activity. If the political system has the power to make binding decisions in respect of social life and uses this power indiscriminately, it jeopardises the functional differentiation of other social systems such as the economy and consequently risks causing social collapse. The constitutionally enshrined protection of individual liberty actually helps to sustain the operative closure of the political system. By enabling individuals to challenge the authority of the state, constitutional rights act as a subtle and highly effective corrective upon operations of the political system which threaten to disturb the effective functional differentiation of society (Verschraegen 2006). This analysis is suggestive, but leaves open large questions about the operation of human rights, which unlike constitutional rights, are expected to exercise their functions in relation to all states, but in the absence of a unified political system. In a later short paper, Luhmann argued that fundamental rights are inherently paradoxical since their function is to positivise pre-positive law (Luhmann 1995b, quoted in Verschraegen 2006). This paradox can also be observed in the fact that the protection of fundamental rights continues to rely on their acceptance by states, despite their formulation at an international level.

This description of fundamental rights makes clear that communications around the code right/not right perform functions distinct from those performed by the legal system. Mental health law, as it extends beyond the protection of fundamental rights, must be performing some further function for society. If we return to the view that law serves to ensure that normative expectations are preserved over time, and despite disappointment, we can see that certain normative expectations are clearly indicated by the content of mental health law. These include the expectation that individuals will not be arbitrarily deprived of their liberty: they have freedom to make choices regarding their bodies and their lives, and that if individual liberty or freedom is compromised individuals will be entitled to protest their treatment. They also include expectations that the state will intervene beneficently in the interests of people unable to identify what is in their own best interests, and will exert control over those who may act to harm others. But these normative expectations have *not* been generated by the body of people who are already deemed to be mentally disordered. Instead, they are the expectations of the non-mentally disordered population who typically feel confident that their own expectations of liberty, beneficence and personal security will not be suddenly disappointed. By maintaining a seemingly coherent distinction between lawful and unlawful decisions in these matters, the mental health legal system seeks to ensure that the majority of the population feel able to rely upon the system to operate fairly and judiciously in relation to the minority it applies to, and consequently to operate effectively in relation to themselves if they were to become mentally disordered. The existence of evidence that the operation of the law is in practice arbitrary or excessive or inadequate only becomes problematic once belief in these shortcomings in the law widespread enough to undermine these expectations.

The protection of fundamental rights and the maintenance of social control are both relevant to the operations of mental health law. Evidence of abuses on the one hand, or of inadequate control on the other may be the disturbance which generates a structural coupling between law and the psy-system or the political system which can then result in legal communications being made about madness. But the law's distinctive function from a systems perspective is to maintain expectations about how control will be exercised and rights protected, not to either exercise that control itself or ensure the protection of those rights.

6.4 Discreditable witnesses – legal responses to service user testimony

The legal system lacks any immanent account of madness by which it could distinguish mad and sane utterances. In addition, having discredited mad people themselves, the legal system tends to rely primarily on psy-system evidence. To this extent the legal and psy-systems are structurally coupled. For example, an operation within the psy-system to ensure that a person receives treatment in hospital becomes a legal operation at the same time. The legal system has not developed a description of when madness demands a response which can be operated independently of the psy-system. The complexity and fragility of psy-system knowledge and the inherent incomprehensibility of madness help to explain this. However, this generates a double-bind for mad people seeking to challenge decisions reached about their lives. In order to determine whether or not the psy-system has applied the legal distinction correctly, the legal system has to have recourse to the expertise of the psy-system. The decisions involved rarely involve an appraisal of evidence which can be determined objectively. Since it is the psy-system and not the mad person which is of greatest relevance to the determination of the correct application of the law, the expectations of mad people, when they are widely discredited across other social systems, are also largely irrelevant to the legal system.

Testimony from mad people about aspects of their own lives becomes evidence for the purposes of the legal system in a variety of contexts. When we discuss mental health law we are typically referring to bodies of civil and criminal jurisprudence and statute which explicitly relate to the distinction between madness and sanity. Mad people's evidence may therefore be relevant to the Mental Health Review Tribunal (MHRT) when deciding whether or not to order that a service user be discharged from a compulsory order. It is relevant to the judicial review of administrative decisions made by agents of the state when deciding how to apply the provisions of mental health statute. This section will examine what happens to the testimony of mad people in the context of the tribunal and of the judicial review. However, the testimony of mad people may also be relevant in other circumstances. It may be relevant to the criminal justice system when deciding whether a defendant is fit to stand trial, or is capable of being criminally responsible for the act in question, or is not guilty by reason of insanity. The question of the weight to apply to the testimony of a mad person may also arise if the complainant or another witness has a mental disorder. And under tort law the court may sometimes be called upon to decide whether a certain psychiatric injury was the foreseeable consequence of a tortious act and may therefore need to ascertain from the victim the extent of her injury and the nature of the harm she suffered (see Chapter Four p.197).

Direct testimony is, of course, not the only way in which people who have been determined as mad provide information which may generate legal communications. Legal communications around the lives of the mad are typically made outside the courts, through decisions made under the civil mental health system. This section will not look at how these legal communications affect the lives of the mad. Instead, it will examine whether and how the legal system accredits evidence given by mad people as information relevant to drawing a distinction between lawful and unlawful conduct. It will argue that testimony provided by people with mental health needs is discredited to a greater degree than testimony provided by other applicants, defendants or witnesses.

6.5 The Mental Health Review Tribunal and the assessment of applicants

In England and Wales, decisions to detain people with mental health needs under the civil jurisdiction are not made by the courts. Instead, in a move intended to both normalise admissions and enhance their relevance, most decisions to admit a service user to hospital without his or her consent must be made by two independent doctors (one of whom must be approved under s.12 of the Mental Health Act 1983 (MHA)), an approved social worker, and the service user's nearest relative (s.2 and s. 3 MHA 1983). After admission however, the service user has the right to challenge this decision at a Mental Health Review Tribunal (MHRT). The MHRT sits within the hospital, and conducts its hearings in a quasi-inquisitorial fashion. It asks both the service user and the professionals responsible for her care to justify their reasons for seeking or opposing discharge. The service user is entitled to non-means tested legal aid in order to fund legal representation in order to counter the evidence advanced by the hospital as to why detention is necessary.

The MHRT provides a useful case-study for examining how the law evaluates the evidence provided by mad people. Do MHRT decisions reflect the discreditation of madness? And is psy-system expertise favoured over the service user's account of herself?

6.5.1 Describing the MHRT

The creation of a specialist tribunal to hear mental health cases in England and Wales was recommended in the Report of the Percy Commission (Royal Commission 1957). The Commission advocated a wholesale overhaul of existing mental health laws in the process abolishing the existing processes for civil commitment and placing responsibility for the decision to admit in the hands of doctors. The MHRT was intended to ensure that service users who had been admitted at the behest of doctors were nonetheless able to challenge their detention. It was intended as an appeal procedure additional to the power service users have to complain of their detention to the managers of the hospital they are detained in. When the Mental Health Act was reformed in 1983 the powers of the MHRT were extended so that it was able to hear cases relating to service users detained under s. 2 of the MHA and cases relating to restricted service users; service users who could otherwise not be discharged without the approval of the Home Secretary. In effect, tribunals have powers to hear cases relating to any service user liable to be detained in hospital except those detained under short-term emergency admission procedures, or those remanded by the courts pending a hearing.

S. 65 of the MHA provides the legal basis for the MHRT, and Schedule 2 of the Act broadly specifies the structure and administration of the MHRT, but more detailed guidance on the procedures tribunals must follow is laid down in the Mental Health Review Tribunal Rules (SI 1983/942). The Tribunal panel typically consists of a President, who must be legally qualified; a medical member and a lay member. On the day of the hearing, the panel will convene before the hearing to discuss the application. The medical member will also conduct a brief assessment of the service user before the hearing. During the hearing the service user and the hospital may both employ legal representation to make their case. The hearing is intended to be fairly informal and not adversarial, and the tribunal president takes responsibility for ensuring that all parties are given an opportunity to make their case and question those giving evidence (Perkins 2003 p.75). All three members of the panel may raise questions about the evidence presented before retiring to make their decision. Perkins found that the time taken for deliberations was typically brief, in more than 40 of a sample of 61 tribunals observed she found that the deliberations were conducted and the decision and the reasons for it written up within 15 minutes (Perkins 2003 p.79). The panel must decide between ordering a discharge or not. If ordering a discharge they also have to consider whether it should be absolute or deferred until a specific date. In the case of service users who are detained subject to a restriction order under s.41 MHA the MHRT may also place conditions upon the discharge, such as the need for ongoing supervision in the community. In 2006, 8778 applications were made to the tribunal of which 11% resulted in a discharge being ordered. Of these discharges 48% were absolute (Mental Health Act Commission 2008 p.170).

6.5.2 What does a tribunal hearing achieve?

The tribunal ostensibly exists to ensure that service users who may be unnecessarily or unjustifiably detained have access to a hearing with a power to discharge them (Eldergill 1997 p.20). However, in addition to its ostensible function it is clearly the case that the tribunal is capable of securing a range of quite disparate ends.

Legally, granting service users access to an independent hearing ensures that the powers to detain under the MHA are nonetheless compliant with Art 5.4 of the European Convention on Human Rights which guarantees a right to speedy determination of the lawfulness of ones detention by a court in the event of a deprivation of liberty. Practically, the possibility of independent scrutiny places an additional pressure upon the detaining authorities to ensure that their decisions are both justifiable and that they can be communicated effectively. As with the other safeguards afforded to service users under the MHA, the fact that a right to a tribunal hearing exists serves to reassure the wider population that the imposition of compulsion should not pose a threat to them (unless and until they are properly mad). Although the evidence on service user's views of the tribunal is scanty, the tribunal does not appear to ensure that service users themselves perceive either the original decision to detain or their continued detention as legitimate (Peay 1989 pp.52-3, Ferencz 2003). In addition, the tribunal does not appear legitimate in the eyes of doctors, many of whom express concerns that the hearing will have an adverse impact upon the service user in circumstances where discharge is in any event an unlikely outcome (Peay 1989 p.65-6, Obomanu and Kennedy 2001)

In system terms the tribunal maintains the general public's expectation that arbitrary or unjust detention will not be imposed upon sane individuals.

The decision to detain is inevitably massively discrediting in the eyes of others. It indicates not only that the person is mad, but also that her madness could lead to risky or dangerous conduct. It also indicates that the person, in resisting admission, does not recognise the severity of her own symptoms. So one further possibility is that the Tribunal acts as a body capable of re-accrediting the service user after she has been discredited in the eyes of those caring for her. A tribunal hearing resulting in a discharge *could* be a powerful way of communicating that the service user is either not-mad or not-dangerous. However, it does not appear that the tribunal achieves this end in practice. The tribunal panel base their decision upon a limited knowledge of the service user, which cannot be compared to the knowledge enjoyed by the professionals caring for her. A tribunal decision to discharge will not normally convince those caring for the service user that her detention is unnecessary, only that they have not made their case sufficiently clearly to the panel (Peay 1989 p.65-6). Similarly, a tribunal decision to allow continued detention will not typically convince the service user that her detention is necessary (Peay 1989 pp.47-9, Ferencz 2003).

6.5.3 Views of service users on the MHRT

Relatively little work has been conducted into the views of the service user on the MHRT in England and Wales. Peay, in a study of MHRT practice in a special hospital setting, found that the service users she interviewed recognised that their chances of success were small (Peay 1989 pp.42-5). They were aware that success depended heavily upon whether or not their psychiatrist supported their application, and they expressed frustration with their psychiatrist's opinion but not with the MHRT panel for following it. Perhaps most significantly some of them voiced the opinion that making an application was still worthwhile because it allowed them to show hospital staff that they were serious about being discharged. Consequently, being refused a discharge did not necessarily amount to a setback. Even more intriguingly, many of them wanted their files to reflect that they had made every effort to secure a discharge, because to fail to make these efforts would be *"really crazy"* (ibid. p.44). This is intriguing because it suggests that service users did not view MHRT decisions in and of themselves as having an impact on their accreditation and consequently their freedom. But they did believe that engagement with the MHRT might accredit them in the eyes of others, particularly those others who really had the power to order their discharge. All of the service users in Peay's sample were resident in a setting where periods of admission were typically very long (a two-year admission was described as short, ibid. p.47), and many of them had attended multiple tribunal hearings in the past. By contrast, in a study examining the experience of service users in other settings as well, Ferencz found that service users (most of whom had no prior experience of the tribunal) typically had high expectations of the tribunal process in advance and felt confident that once their case was made they would be discharged (Ferencz 2003). As a consequence they described their feelings of disappointment after the hearing as particularly acute. In particular, service users reported feeling that they were not listened to or that they were not understood, they found the tribunal process confusing and they felt powerless and distressed afterwards. The views of service users contrasted sharply with the views of the panel members who were interviewed for the same study, most of whom felt that service users were listened to. Although the panel members acknowledged that the process was often distressing for service users, they did not see the distress as something they could address.

These are significant findings for two reasons. Firstly, it would seem that some service users experience tribunal practice in England and Wales as anti-therapeutic. The study in question doesn't suggest that the hearing process causes long-term distress, but the short-term distress the tribunal process causes to people who are already experiencing mental illness requires justification in itself. However, identifying how tribunal practice would need to alter in order for service users to avoid this distress is no easy task. Freckelton has described, with reference to tribunal practice in the State of Victoria, Australia, how panels can address the therapeutic needs of service users (Freckelton 2003). And the Mental Health Review Tribunal for New Zealand has explicitly stated that it sees its role as protecting rather than undermining therapeutic relationships (Diesfeld and McKenna 2006). But the guidance available from these jurisdictions may have limited applicability to the situation in England and Wales. For example, Freckelton emphasises that the length of time allotted to hearing cases places considerable limitations on ensuring that service user's therapeutic needs are met. An MHRT panel in Victoria, for example, may hear and reach a decision upon up to 10 cases in one day. The MHRT in England and Wales allows far longer for hearings, with most taking longer than an hour (Perkins 2003 pp.126-7), and yet it would seem that even with these more favourable conditions, service users still report feeling confused and ignored.

Secondly, these findings suggest that more work needs to be done to identify whether the MHRT actually makes service users feel that their hospital admission is reasonable and justified or whether it simply adds to their sense of resentment. Findings from coercion studies conducted in the US have shown that perceived coercion correlates strongly with the degree of perceived procedural justice service users encounter (Monahan et al. 1995, Hiday 1997, Poythress et al. 2002). In contrast to the courts in most US states, the MHRT does not get to review the decision to admit, only the decision to discharge. Perhaps this means that the service user has already developed a firm view on the coercion she has suffered before her MHRT hearing. The ability of the MHRT to challenge this view and suggest that the 'system' is still fair and reasonable is therefore heavily compromised. This is purely speculative however, because so little data on service user views of the tribunal exists at present. All that can be said confidently on the basis of the little evidence available is that service users sometimes describe the MHRT as a location within which they are unable to communicate, and that they do not see it as playing a significant role in accrediting them as experts on their own lives.

6.6 Evaluating the role of discreditation processes in the reasoning of the MHRT

Tribunal decisions in England and Wales are made available to the service user and to the detaining hospital, but they are not published. This means analysing the adequacy of tribunal reasoning as it relates to evaluating the service user is a difficult task. There have been some empirical studies conducted in England and Wales which look at MHRT practices and at their reasoning (Peay 1989, Machin and Richardson 2000, Perkins 2003). Close analyses of tribunal reasoning have also been conducted in jurisdictions where tribunal decisions are published (Diesfeld and McKenna 2006, Diesfeld and Sjöström 2007). The evidence from these sources will be examined here. Tribunal reasoning is also discussed in the context of judicial review hearings relating to tribunal decisions. These discussions only imperfectly reflect the content of the tribunal's decision, and the role of the discreditation and accreditation of service user evidence in judicial review will be discussed more fully in the next section.

6.6.1 The medical member

The role of the medical member in what is ostensibly a legal hearing appears immediately anomalous. Although one of the alleged advantages of specialist tribunals over courts in general is their perceived ability to draw upon both legal knowledge and specialist expertise (Leggatt 2001, para.1.12), most tribunal panels in England and Wales consist of lawyers. The lawyers in question will be expected to have specialist knowledge of the types of dispute the tribunal addresses but this knowledge is expected to be specialist knowledge of the law, and not of a related discipline. There are other exceptions to this general rule beside the MHRT including the Special Educational Needs and Disability in Schools Tribunal (SENDiST), which consists of a chair who must be legally qualified and two specialist members, typically people with experience of special education (s. 5 Special Educational Needs Tribunal Regulations 2001) and the Care Standards Tribunal which requires two lay members experienced in the provision of social care (s. 3 and s.5 Protection of Children and Vulnerable Adults and Care Standards Tribunal Regulations 2002). But the role of the medical member remains distinctive, because in no other tribunal are members with specialist expertise expected to conduct their own independent assessment of the person the review concerns. Lay members of the SENDiST for example, may well have the professional qualifications necessary to assess a child's special educational needs, but they nonetheless do not carry out this task.

This dual role has attracted legal criticism for failing to conform to the requirements of natural justice (Richardson and Machin 2000). By acting as both a witness and a judge in the same hearing the medical member undermines the independence and perceived impartiality of the MHRT. In addition, because the medical member's assessment of the applicant takes place almost immediately before the hearing, the applicant does not always get the opportunity either to learn the outcome of the assessment or to challenge it. It has been argued that this situation breaches the service user's Article 5 rights. According to this argument, the presence of the medical member undermines the ability of the MHRT to qualify as a court capable of making an independent and fair determination of the service user's status. However, in R(S) v Mental Health Review Tribunal [2002] it was held that the Mental Health Review Tribunal Rules make clear that the medical member is expected to assess the service user in order to form an opinion, but not to prejudge the outcome of the hearing. The role of the medical member, therefore, is only a threat to the impartiality of the tribunal if there is evidence that she has formed a concluded opinion prior to the hearing. Irritatingly, this ruling does not evaluate the symbolic impact that having a possibly, if not actually, biased panel member has upon the service user's perception of the fairness of the tribunal. And it also ignores the fact that the service user is not in a position to demonstrate at what point the medical member reaches her concluded opinion. But the case does demonstrate that whilst the human rights argument is plausible it has not yet been endorsed by the courts.

The position of the medical member also causes practical problems. The Mental Health Act Commission has reported that tribunal hearings are frequently delayed because of difficulties in convening a panel with a full set of specialist members (MHAC 2008 para.4.66-69 and MHAC 2006 para.4.108). The particular difficulty of recruiting medical members has also been referred to in case-law, as one of the many explanations offered by the MHRT for delays in holding hearings (see R (KB, MK, JR, GM, LB, PD and TB) v. MHRT and Secretary of State for Health [2003] para.65-75). Although the medical member cannot work for the hospital within which the service user is detained, these difficulties in recruitment mean that it is sometimes impossible for the MHRT to ensure that the medical member is not also employed by the NHS Trust which runs the hospital within which the service user is detained. The Court of Appeal has held that this degree of proximity does not give rise to an appearance of bias which undermines the independence of the Tribunal (R (PD) v. MHRT [2004] EWCA Civ 311), but this practice may also reduce the credibility of the MHRT in the eyes of applicants.

So the role of the medical member is already legally and practically problematic. From a systems theoretical perspective it is also necessary to ask what function this position on the panel performs. Tribunal decisions have to communicate a legal distinction; they have to distinguish between lawful and unlawful detention. But they can only do this by reference to a therapeutic distinction. The tribunal's role is not to determine the legality of the original decision to detain, but whether or not continued detention is necessary. They can only answer this question by asking whether or not the service user's therapeutic interests will be better served by continued detention or not. In effect they have to observe the psy-system distinction between madness and sanity.

The law itself is structured around this distinction. Before admission is possible the service user must have a mental disorder for the purposes of s.1 MHA, the other conditions which must be met in cases of compulsory admission must in turn flow from the evidence that the service user meets this requirement first and foremost. Regardless of where the burden of proof lies in the hearing, the terms have already been established by the psy-system. Whether it is for the service user's doctor to demonstrate that she has a mental disorder for the purposes of s.1 MHA or for the service user to demonstrate that she does not, the hearing turns upon a psy-system distinction. But this psy-system distinction translates only imperfectly into a coherent legal distinction. To find a language within which to express this distinction coherently relies on the ability of the panel members to move between legal and medical terms. The professional knowledge held by the medical member can therefore be a useful tool for the panel in transforming medical evidence into adequate reasons for a legal decision (Richardson and Machin 2000).

This view of the role of the medical member may help to explain why the medical member in practice tends to communicate her views on the service user's mental state earlier in the process than is advised. Rule 11 of the MHRT Rules states that the medical member shall conduct an assessment of the service user prior to the hearing, but the Guide for Members of the Tribunal (DH 1996) advises the medical member not to disclose the results of her assessment at the pre-hearing meeting. The results may however, be discussed during the hearing and in the subsequent deliberations. Studies of MHRT practice have found that it is extremely common for the medical member's assessment to be discussed at the pre-hearing meeting (Richardson and Machin 2000, Perkins 2003 p.43). The reason for the guidance is that the findings of the assessment represent new evidence which the service user is unable to challenge if it is raised before the hearing. But Richardson and Machin suggest that it is unrealistic to expect the medical member to suppress her views upon the service user, and the other members of the panel interviewed in Perkins' study all reported finding the medical members evidence extremely useful. This would tend to confirm the view that the legal and lay members of the panel find the availability of specialist psy-knowledge especially persuasive in reaching their own decisions about the facts at hand.

6.6.2 Credibility and the tribunal

Perkins found that during the tribunal hearing the panel questioned the service user in a manner quite different to that of other witnesses. In some cases efforts were made to catch the service user out in order to expose the service user's underlying beliefs. This implies that the panel started with the assumption that the service user had not fully disclosed her motivations for seeking discharge and that there was more information available 'under the surface'. The same assumption was not made about the reasons given by the service user's psychiatrist or social worker reasons for opposing discharge (Perkins 2003 pp.72-3). Similarly, during their deliberations she found that a key issue for the panel was in deciding whom to believe. In most cases the bulk of the evidence lay in the conflicting accounts provided by the service user and by those who had assessed her. It was rare for more tangible evidence to be available. As a result, the panel had to determine the credibility of all those who gave evidence and in the process consider what motivation each witness had for providing a false account. In these circumstances it was common for the service user not to be believed, since her motive for lying was assumed to be self-evident. It was also common for family and friends of the service user to be seen as non-credible. It was rare for the same consideration to be given to the motivations of doctors and other professionals, but where it was considered it was inferred that they would wish to discharge the service user if possible in order to conserve scarce resources for others (ibid. pp.89-93).

Whilst this is a rational assessment, it is also only partial. It is clear that in assessing credibility the panel has multiple resources to draw upon when reaching a decision about the service user. They can examine her previous medical history, the reports of two or more medical experts plus evidence from social workers and nursing staff. By contrast, the panel may know little or nothing about the past history of the other witnesses. No quasi-independent evidence about their credibility is presented. They are typically accredited on the basis of their professional qualifications and the panel must form its judgement on the basis of what they believe to be true about people who perform the professional role in question, and what they can infer from the nature of any written evidence provided and the behaviour of the witness during the hearing. Perkins did find one example of a professional being discredited on the basis of her behaviour during the hearing but this was exceptional (ibid. p.92).

So credibility is central to the decision reached by the tribunal. As Peay found, credibility may also influence the decision of the service user to seek a tribunal hearing. But the tribunal decision is not in itself seen as credible, either by service users or by those caring for them. Nor does a favourable tribunal decision appear to confer credibility upon the service user.

6.6.3 Problems with insight

Another major criticism of the tribunal has turned upon the way in which non-legal terms such as 'insight', 'compliance' and 'best interests' are employed in their reasoning. The use of these terms can be seen as indicative of the problem of pretextuality (Perlin 1999, Freckelton 2003). These terms act as pretexts for justifying continued detention, and in the process allow the panel to avoid the more complex task of trying to describe in precise terms how the specific symptoms the service user exhibits map on to the legal criteria for detention. By way of contrast, Peay points out that if law and the psy-system are autopoietic, terms such as 'best interests' offer a useful communicative resource around which 'creative misunderstandings' can emerge (Peay 2005). By employing the same term, whilst applying different meanings to it, the legal and psy-systems can maintain the appearance of normative coordination whilst remaining effectively closed to each other. The inherently subjective dimension of any assessment of best interests then becomes invisible, as both systems layer their own interpretations upon the term and ignore its defects. Something similar may happen with the term insight, which is a notoriously imprecise concept with quite different lay and clinical meanings (Diesfeld 2003). Even the clinical significance of insight is heavily contested (Høyer 2000).

The problem of 'insight' is raised by Perkins. She found that in the 61 MHRTs she observed; insight was the single most commonly discussed symptom during both hearings and deliberations (Perkins 2003, p.104). Insight in this context raises two problems for service users. In most cases the panel seemed willing to accept the medical assessment of the service user's level of insight (ibid. p.65). It is perhaps difficult for the service user to counter this assessment because any assertion that her symptoms are different to those being outlined may in itself be interpreted as evidence of a lack of insight. Secondly, Perkins found that even where insight was not identified as an issue by the clinicians giving expert evidence it was still raised during deliberations. She cites one case in which the lay member asserted during deliberations that the service user evidently lacked insight, and this view was supported by other panel members despite the fact that no medical evidence suggesting this had been introduced during the hearing. Insight, then, is sufficiently vague that even lay members of the panel may feel confident in their gut assessment of this symptom.

The Mental Health Review Board (MHRB) in the State of Victoria, Australia, publishes some of its decisions. These decisions have been used to analyse the ways in which insight is employed to make explicit the reasons behind the panel's decision (Diesfeld and Sjöström 2007). There are of course, big differences in practice between the Victorian MHRB and the MHRT in England and Wales. In particular, the knowledge that their reasoning will be made available to a wider audience may well influence the panel to reach for more objective terms to describe their reasoning than is the case in England

and Wales. However, Diesfeld and Sjostrom's study of the use of insight in MHRB reasoning is still instructive because it demonstrates very clearly how insight can be used to mean more than one thing even within the same decision. In their analysis of 25 decisions they noted that insight was referred to in 19 cases. Of these 19 cases, 13 concerned the application of s. 8(1)d of the Victorian MHA 1986, which asks whether the service user refuses or is unable to consent to treatment. They describe how, in employing insight to justify or explain a decision, the panel reasoned about its relevance in two distinct ways. Firstly, the panels reasoned that lack of insight causes non-compliance with treatment, in effect meaning that the service user is at high risk of refusing treatment in the future. Secondly, they reasoned that a refusal to take treatment or to comply with a treatment regime indicated a lack of insight and perhaps ongoing mental health needs. Most notably, they found two cases in which both sets of reasoning were applied:

> *"In RD, the board first discusses insight as the cause of non-compliance:*
>
> *'She lacked sufficient insight into her illness to comply with the treatment that was required for the alleviation of mental illness.'*
>
> *However, later in the same decision the board construed non-compliance as evidence of lack of insight:*
>
> *'Her denial of the existence of a major mental illness and her continuing refusal to take antipsychotic medication unless constrained*

> *to do so are further illustrations of the absence of a requisite degree of insight into the nature of her mental condition.'"*

As the authors point out, it is impossible for the service user to escape from this circular reasoning. They also note that insight tended to be understood as an absolute attribute; either the service user had it or she did not. This does not reflect either the clinical or lay meanings applied to the term. In lay discussions of insight a person has insight into something specific; it is not a general description. And in clinical discussions, insight is understood as occurring along a scale, with most service users displaying considerable variation in the degree of insight they exhibit over time (Cuesta et al. 2000). So what work is this circular and conceptually anomalous term doing in such a decision?

Insight is inherently imprecise because, like many psy-terms, it refers to a state of mind which is inevitably invisible to the panel. As a result, it can only be discussed through reference to behaviours or utterances which are visible. Such visible conduct might include a failure to take medication, or unwillingness on the part of the service user to agree that she has a mental illness. But these behaviours are open to more than one possible interpretation. Non-compliance with treatment may indicate that the service user has (correctly) assessed that it is not helping her, or it may indicate that she is incapable of understanding that the treatment will help her. A failure to agree with a diagnosis may be a symptom of a mental illness, but it may also be an assertion that the service user is fully aware of the possibility of mad interpretations being placed upon her utterances, but that she does not agree with this interpretation.

So an assessment of insight is a complicated task since it relies on being confident of three separate things: that the behaviour or utterance being made is capable of indicating a lack of personal insight, that no other reasonable interpretation can be placed upon the behaviour, *or*, if other interpretations are available that these are less convincing than the preferred version and that reasons for this can be made explicit. In clinical practice, the assessment and engagement of insight may well form part of an ongoing therapeutic dialogue with the service user. By attempting to convince the service user of the correctness of her assessment, the therapist is also exposed to the different interpretation the service user has placed upon her own behaviour. Like most psy-terms, insight is not something of which a wholly objective assessment can be achieved, although there has been a trend within psychiatry to medicalise insight and attempt to define its absence, and the implications of this absence more precisely (David 1990). Insight, then, has some value as a classification of one visible dimension of psychotic illness; when the service user acts in a way which indicates that she does not understand that the world places an interpretation of madness upon her conduct. The difficulty the MHRT has in engaging with this term is in appraising the significance of such a slippery concept within their decision-making. This difficulty does not arise because panel members are incapable of understanding the slipperiness of the concept, but because the format of the tribunal and the demand that a legally binding decision be reached in every case is simply not conducive to ongoing dialogue. In this context we can see a discreditation logic very clearly at work. By employing insight in an undifferentiated fashion: the service user either has insight or she does not; the panel is able to effectively discredit the insight-less service user's own testimony about her life. This discreditation is not performed because of any underlying negative agenda, but simply because there are inherent internal and external constraints placed upon the tribunal which considerably weaken its ability to engage critically with testimony from mad people.

6.7 Judicial review and the mad person as applicant

There is no appeal mechanism from the MHRT but service users who wish to challenge a tribunal decision can make an application for a judicial review of the decision in question. However, a judicial review offers only a limited remedy in most circumstances. It can review the legality of the decision reached, but it cannot substitute its own decision for that reached by the Tribunal. The court is only empowered to quash the original decision and remit it to another hearing. In addition, the court is expected to review the case on the basis of the evidence available to the hearing at the time, and new evidence cannot be adduced at the hearing, although in cases concerning Convention rights the power to assess the merits of the case will be interpreted broadly.

6.7.1 Content analysis

A brief content analysis cannot tell us much about the way in which the legal system in these cases responded to evidence from mad people. But it can help to describe the wider context within which individual decisions are reached. To this end, this section analyses all of the judicial reviews made of decisions reached by the MHRT between January 1998 and January 2008. For the purpose of this analysis two databases of English caselaw were searched, LexisNexis and the JUSTIS Mental Health Law Reports. The terms MHRT and Mental Health Review Tribunal were both searched for in the casename field. The search identified 83 cases of which one involved the MHRT as an applicant, seeking a review of a Home Office decision. This decision was not included in the analysis. Of the remaining 82 cases 68 had been heard at the High Court and a further 14 had been appealed to the Court of Appeal (a complete list of all cases is provided as Appendix One). Breakdowns of the outcomes for applications for judicial review and for appeals from these decisions are provided in Tables One and Two.[7] From this crude analysis alone it is notable that service user applicants are on average much less likely to be successful at first instance than other applicants, apart from their relatives, although they enjoy greater success on appeal.

Review initiated by	**Applicant successful**	**Applicant unsuccessful**	**Total**
Service user	16	33	49
Home Secretary	10	0	10
Hospital/health authority	4	2	6
Relative	0	3	3
			68

Table 1: Applications for judicial review heard by High Court.

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[7] It should be noted that where applications on similar facts were decided together these have been disaggregated. One case in particular; R (KB, MK, JR, GM, LB, PD and TB) v. MHRT and Secretary of State for Health, should be noted because in this case (which concerned the time taken for an MHRT hearing to be arranged) all seven applicants were successful. If these seven applications are identified as a single case and the same is done with a linked claim for damages (R (KB, MK, JR, GM, LB, PD, TB and B) v MHRT and Secretary of State for Health) then the figures appear considerably less favourable to service users as applicants. 37 cases were heard relating to applications taken by service users of which just 4 were successful. To make sense of these numbers it should be noted that two of the applicants who were successful in the first time limits ruling suffered only minimal distress and were consequently not awarded damages.

Appeal taken by	Appeal successful	Appeal unsuccessful	Total
Service user	5	4	9
Home Secretary	1	1	2
Hospital/health authority	1	1	2
MHRT	1	0	1
			14

Table 2 Appeals from decisions reached by the High Court

Overall the numbers are small, and the numbers of cases taken by classes of applicant other than the service user are particularly small. It is not possible to draw any predictive inference from these figures, but the broad pattern they display is nonetheless notable. The Home Secretary is always successful when challenging an MHRT decision at judicial review; service users are only successful on one in three or maybe one in four occasions (see footnote 2). In order to assess whether the courts treat service user and non-service user applicants differently it is necessary to look more closely at the form the rulings take in these cases and at the reasoning they apply.

The largest single group of applications lodged on behalf of service users concerned the adequacy of the reasons given by the Tribunal for its decision (n=18). It was also the case that four of the cases taken by the Home Secretary concerned reasons for the decision. Twelve cases concerned the time taken to organise a hearing, and whether or not this breached the service users Article 5 rights, and a further nine challenged the tribunal for failing to follow its own procedures either before or during a hearing. Seven of the cases taken by service users concerned natural justice, and raised problems such as whether the standard of proof (which is the civil not the criminal standard in MHRT cases) is the appropriate one.

The relevance of evidence is harder to assess. New evidence relating to the decision cannot be introduced to the court for the review, since they are not meant to review whether or not the decision made was correct, but simply whether or not it was reasonable or rational on the basis of the evidence available to the panel at the time. However, in *R (Wilkinson) v. RMO Broadmoor Hospital [2002]* the court held that it was appropriate, in cases involving Convention rights, to conduct a full merits hearing including cross examination of expert witnesses. The case in question concerned the decision to administer forced treatment. Even with this more stringent standard of review, the court held that the decision to administer treatment under compulsion was lawful, and the European Court of Human Rights later upheld the view that Wilkinson's rights had not been compromised (Wilkinson v. UK [2006]). The Wilkinson approach has only been followed in a small number of subsequent cases all of which concerned treatment decisions (R (PS) v RMO [2003], R(B) v. Haddock [2006]). Merits reviews of cases concerning the service user's Article 5(4) right to a speedy determination of the lawfulness of her detention are included in the reasoning in Wilkinson but they have not been performed in practice. None of the cases concerning MHRT decisions considered here adopted this level of review. Nevertheless in examining the adequacy of the reasons given by the MHRT for its decision the courts have had to examine the evidence available to the panel in question. It is problematic for the mad applicant that her evidence to the Tribunal will normally have been given orally and that it is therefore not available for the courts to review. Occasionally a statement made by the service user may be referred to by the court. But this occurs in only nine of the 82 cases considered here. By contrast statements made by psychiatrists are referred to in 33 of these cases.

Simply describing the types of decision reached and the evidence referred to by the courts in reviewing MHRT decisions may be doing the courts in question an injustice. Overall only a small proportion of judicial reviews result in the original decision being overturned. Even the discrepancy between the high probability of success enjoyed by the Home Secretary compared to the low probability of success enjoyed by service users may be accounted for by the fact that the decisions questioned by the Home Secretary concern dangerous offenders with mental health needs and do not reflect decisions relating to mad service users as a whole. To establish whether the courts actually exhibit a consistent bias against accrediting the evidence of people as relevant and in favour of discrediting their accounts, it is necessary to look far more closely at the substance of the decisions reached. Three specific subsets of these cases will be considered here: those in which the adequacy of the tribunal's reasons are challenged in some way; those in which it is asserted that the tribunal misdirected itself in deciding whether the service user's mental disorder was of a nature or degree to warrant continued detention; and those cases in which evidence of service user consent is adduced.

6.7.2 Adequacy of reasons

The tribunal is required to provide reasons for its decision (MHRT Rules, r.23). Typically these reasons are provided on a pro forma, which will be circulated to everyone involved. However the MHRT Rules allow the panel not to fully disclose their reasons to the service user if they feel that this might *"adversely affect the health or welfare of the service user"* (MHRT Rules, r.24). Machin and Richardson (2000) sum up the findings of the case law on the MHRT's duty to give reasons as follows:

> *"...in order to be adequate the tribunal's written reasons must comply with the following:*
>
> *(i) they must not merely recite the statutory criteria;*
>
> *(ii) they must deal with the substantive points raised;*
>
> *(iii) they must give sufficient material for the parties to know if an error of law has occurred;*

> *(iv) they must make it clear whether they are dealing with the presence of mental disorder or the issue of risk;*
>
> *where there is a conflict of medical opinion it may be necessary to indicate why one view was preferred over another."*

The cases from which these principles were derived were all decided in the 1980s, and yet the adequacy of the reasons provided by the MHRT for their decision continues to be the single most frequently raised ground for review. In some respects this is not surprising, since reasons will always contain elements of subjective judgment and will therefore always be more contestable than other aspects of tribunal practice. However, it is significant that when the Home Secretary and health or hospital authorities challenge the tribunal on the basis that it has provided inadequate or irrational reasons for its decision they are far more likely to meet with success than service users. In this sample, the Home Secretary won on all four of the occasions upon which he challenged the adequacy of tribunal reasoning; hospital authorities won five out of seven 'reasons cases' whilst service users won only four out of 18 such cases.

In examining the cases in more detail, even more discrepancies come to light. There is a consistent thread in judicial reasoning that where a Tribunal is faced with conflicting expert accounts they have discretion as to which account to favour. Furthermore when the reasons stated for their decision do not seem to cover the facts, judges in some cases seem quite willing to 'read-in' justifications for their decision from the other evidence available to the reviewing court. The practice of 'reading-in' sometimes favours the service user. In the case of D (*R (Mersey Care NHS Trust) v MHRT [2003]*) a health authority had challenged the decision of the MHRT to discharge D on the grounds that the medical evidence available supported D's continued detention and that the reasons stated did not address all of the evidence provided. The court held that the reasons were themselves brief but adequate and that in any event it was possible to elucidate from the surrounding witness statements precisely why the Tribunal had reached the decision that it did. A similar line of argument was adopted in the case of W (*R (Epsom and St Helier NHS Trust) v MHRT [2001]*), in which it was held that it was possible to infer from the phrase 'taken in the round' that the Tribunal had considered both the service user's past history and her future prognosis in deciding to order her discharge. However, in most cases where the adequacy of the tribunal's reasons are questioned by the service user, the practice of elucidating the reasonableness of the panel's decision from the surrounding evidence works against the service user's interests. Because the courts interpret the existence of evidence which *could* support the tribunal's decision as evidence that the tribunal's decision *is* reasonable (see *R v MHRT ex p.Manns [1999]*, *R (N) v MHRT [2001]*, *R(PW) v MHRT [2002]*, *R (CS) v MHRT [2004]* and *R (RD) v MHRT [2007]*). To give just one example, in the case of *PW* the service user argued that the tribunal had been mistaken as to his legal status, and had failed to distinguish between whether or not he had a mental disorder requiring treatment and whether or not he posed a threat to public safety, in reaching their decision not to discharge him. The court ruled that the reasons given were nonetheless adequate because it was clear that the decision they made could be rationally reached even had the MHRT been aware of the full facts. This was despite the fact that the error the tribunal panel had made was in assuming that PW was still required to serve a prison sentence upon discharge (the sentence had in fact expired, so an order for discharge would mean that he returned to the community) and that this error was clearly implicated in their reasoning because they stated that they were concerned that a return to prison would jeopardise his health. It is not hard to imagine that they might have reached a different conclusion with regard to discharge had they been apprised of the facts.

This willingness to 'read-in' the reasons which the tribunal should have stated is also not applied consistently. There are a number of cases where the court demands that the MHRT explicitly justifies its decision in its statement of reasons, and is willing to issue a quashing order if reasons are not stated, even in cases where a reading in might be possible. The leading case in this area found that the guidance to tribunals:

> *"...does not expressly state, but it does imply, that reasons must be given for the acceptance or rejection of disputed evidence, although it*

> *is not usually necessary for these to be lengthy."* (*R (Ashworth Hospital Authority v MHRT [2002]* para.78)

This has been interpreted as requiring that where an account given by a medical expert is rejected, the tribunal has a duty to explain why (*R (Home Secretary v MHRT (CH) [2005]*). There is no corresponding obligation upon the tribunal to explain precisely why it disbelieves the service user's account in favour of her doctors. Significantly, this strict approach to requiring that reasons explicitly state why one opinion has been favoured over another has only been followed in cases where the Home Secretary or health authorities are challenging the MHRT decision. In the case of *BR* (*R (Home Secretary) v MHRT (BR) [2005]*), it was clear that the tribunal had considered evidence from two medical experts, one of whom had recommended an absolute discharge, whilst the other had recommended a conditional discharge. They had ordered an absolute discharge, but had failed to explain in their reasons why they had not favoured a conditional discharge. The court held that the failure to consider a conditional discharge amounted to a misdirection and quashed the decision. The court appears to treat cases where the service user's account is treated as credible as particularly dubious. In the case of CH *[2005]*, the tribunal had ordered discharge on the grounds that the service user had indicated that she was willing to comply with future treatment. They had not explained precisely why they had rejected the view of her treating psychiatrist that she should continue to be detained. The Home Secretary's application to quash this decision succeeded on the basis that the tribunal had not explained why it had favoured the service user's own account:

> *"...it is not sufficient for a Tribunal to say it prefers one witness to another. It follows from that it is equally insufficient that it appears from the reasons that they did so...they accepted the evidence of the service user as to the risk or lack of risk of her accepting medication, if discharged into the community, and implicitly rejected the views of her RMO and her nurse."* (ibid. para.34)

A similar line of argument was followed in the case of KW (*R (KW) v Avon and Wiltshire Mental Health Partnership NHS Trust [2003]*), where the tribunal had concluded on the basis of their assessment of the service user that he was not suffering from a mental disorder, but had not explained why they disagreed with the views of his treating psychiatrist.

Tribunal reasons appear to be inadequate if they either acknowledge the service user's account of herself as more credible than that of her doctor without saying why, or if they order discharge in circumstances where the Home Secretary or the hospital opposes discharge without explicitly stating why they have rejected all possible alternatives. By contrast, their reasons are likely to be construed as adequate in cases where a service user has challenged the decision in question and the court feels that on balance the tribunal probably drew the right conclusions even if it is not clear precisely why. It is notable that judges sometimes express regret if the consequence of deciding that the tribunal's reasoning was adequate is that the service user will be discharged (see for example *R (Epsom and St Helier NHS Trust v MHRT [2007]* para.62) and that they also express relief if they are able to reach a conclusion which will result in continued detention (*R (KW) v Avon and Wiltshire Mental Health Partnership NHS Trust [2003]* para.22).

6.7.3 The disjunctive interpretation of the 'nature or degree' test

There are further heads of review which exhibit discrepancies when applications taken by service users and those taken by others are compared and contrasted. S.72(1)(b) of the MHA requires that the MHRT discharge a service user where they are satisfied that she is not suffering from a mental disorder to *"a nature or degree which makes it appropriate for him to remain liable to be detained"*. The meaning of this section was tested in *R v. MHRT ex p.Smith [1998]* where it was held that it should be read disjunctively; that is, that the panel may decide not to discharge if the service user's condition is of a nature, although not of a degree, which requires continued detention. In this case, which concerned a service user with a diagnosis of paranoid schizophrenia, the judge held that whilst Smith's illness was not of a *degree* necessary to require detention since it was well controlled by medication it was, nonetheless, of a *nature* requiring detention since it was liable to recur if the service user was discharged and ceased to take his medication. The problem of how s.72(1)(b) is to be read is most likely to arise in cases where the service user in question has a diagnosis of a condition which is liable to relapse without medication and where there is uncertainty about whether or not the service user will continue to take this medication after discharge: compliance cases in other words.

The significance of the nature or degree test has clearly not been made crystal clear to tribunal panels. Both Perkins (2003) and Machin and Richardson (2000), in their studies of tribunal reasoning, found that panel members frequently found the test difficult to apply. Problems with the phrase arise in subsequent case law. In this sample, the failure to apply the 'nature or degree' test disjunctively was raised as a ground for review in four of the cases brought by the Home Secretary (*R (Home Secretary v. MHRT (G) [2001], R (Home Secretary v. MHRT (PG) [2002], R (Home Secretary) v MHRT (DH) [2003], R (Home Secretary) v MHRT (CH) [2005]*). In all four cases the court ruled in favour of the Home Secretary. The issue of nature or degree is also raised in *Smith* (see above) and in two further cases brought by service users (*R v. MHRT ex p.Moyle [1999], R (PW) v MHRT [2002]*). The judge quashed the tribunal decision under review in *Moyle*, but not in *PW*. However these cases differ considerably in the significance they attach to the distinction between the conjunctive and disjunctive readings. In the original judgment in *Smith*, the judge held that although the phrase should be read disjunctively, this distinction was primarily of academic interest since in most cases the nature and degree of the disorder the person suffers from will overlap. The judge in the case of *CS [2005]* seemed to see the point similarly, he ruled that although the panel had misdirected themselves in this case by reading nature or degree conjunctively, this did not seem a significant enough error to require him to set aside their decision and order a new hearing. The decision was, however, set aside on the grounds that the reasons the Tribunal stated for ordering a discharge were inadequate. Similarly, in the cases of *Moyle [1999]* and *G [2001]*, the issue of 'nature or degree' was sidelined by arguments that the panel in question had misdirected itself in other more serious ways. In the case of *PW [2002]* where the applicant was the service user, the judge agrees that the reasons given by the panel fail to answer the question of 'nature or degree' but rules that this failure is not relevant because there was agreement amongst the experts who gave evidence to the panel that PW had a mental illness and that his discharge would pose a threat to public safety, that is to say the evidence supported the view that both nature and degree were present anyway. In all four of these cases, then, the issue of nature or degree is agreed to be relevant but not central to the decision reached. By contrast in the cases of *PG [2002]* and *DH [2003]* (both brought by the Home Secretary) the failure of the panel to apply the correct test was deemed sufficiently serious to require that a new hearing be conducted.

All of these cases are remarkably similar on their facts, they all concern service users detained under a restriction order with a mental illness (schizophrenia). It is hard to predict when the courts will find that a failure to issue a correct direction as to the meaning of s.72(1)(b) will be of sufficient seriousness to justify a quashing order. At present, it looks like the argument will only be relied upon if other grounds for granting a quashing order are not made out.

The problem with a disjunctive reasoning is that taken to its logical conclusion it allows the MHRT almost complete discretion over ordering discharge. Since all service users detained under s.3 of the MHA will have received a diagnosis of a mental disorder, they could all be described as having a condition of a nature requiring detention. And, if a stable response to medication does not demand discharge, then the inclusion of 'degree' in the wording of the law becomes largely irrelevant. Underlying the problems with this test is the problem of predicting how an individual is likely to behave in the future. Non-compliance is difficult to measure and difficult to assess (Travis 2002). It is also a term which does not have a stable meaning attached to it within medical and psy-system discourse. Indeed, it is now seen as an actively unhelpful way of characterising the problem of service users who choose not to follow treatment plans (Greene 2004). Consequently it is a term, like insight, which may lead to a wide range of interpretations and consequent instability within the context of MHRT deliberations. By determining that the phrase 'nature or degree' is to be read disjunctively, the court has given the MHRT panel a way to avoid the issue of specifying just how great the problem of non-compliance actually is. Provided the service user has a disorder of a nature which requires admission (and almost all service users will) the MHRT is able to determine independently whether or not the degree to which the disorder is present is relevant. This reduces the burden on the MHRT to justify its reasoning. It is only necessary that they can assert that *a* risk exists for them to be able to order continued detention. By contrast, a conjunctive reading massively increases the burden on the MHRT to be able to point to the evidence (which will typically be ambiguous and highly contested) that could justify further detention.

6.7.4 The meaning of consent

Given the context of these cases the issue of service user consent is rarely raised. It is assumed that the service user consent is not relevant to the decision reached by the MHRT. However, in some cases service users raise the argument that an intervention in question is rendered either lawful or unlawful by dint of the fact that they consent to it. In *R (SH) v MHRT [2007]* the service user challenged a decision of the MHRT to maintain his conditional discharge from hospital. SH had been conditionally discharged for two years and adhered to the conditions imposed upon him throughout that period. The conditions included requirements that he take medication and that he continue to live at a specific address. When he applied for the conditions to be lifted the MHRT panel decided not only not to lift the discharge order, but also to add further conditions on to those with which he was already complying. It was not contested that SH had been a model service user for the intervening two years, indeed SH had made a statement to the Tribunal in which he stated that *"...if the doctors suggested that I stop the medication I would be concerned about this."* (ibid. para.6). One argument raised by SH was that it was important that the condition that he comply with his medication regime be lifted so that he could demonstrate that he was willing and able to adhere to this requirement even without the threat of compulsion. He further asserted that the power of the MHRT to impose conditions upon discharge was limited, and could not be used to impose conditions which overrode his independent right to autonomously comply with treatment, and by extension his Article 8 rights to respect for privacy. The judge ruled, however, that since SH had shown himself to be willing to consent to treatment the conditions in question could not be characterised as coercive and that in consequence they could not be deemed to undermine his fundamental rights. So in this case the presence of the service user's consent was used as evidence that the imposition of conditions upon discharge was not coercive, and did not consequently infringe the rights of service users.

The presence of consent was reasoned to imply the exact opposite in the cases of G (*R (G) v MHRT [2004]*) and MP (*R (Home Secretary) v MHRT [2004]*). G was a restricted service user who had been granted a conditional discharge. A placement identified for him as satisfying these conditions fell through and staff at the hospital had suggested an alternative placement at a rehabilitation unit located within the hospital. In a hearing to monitor the progress towards meeting the conditions set by the MHRT panel it was decided that since the rehab unit was still part of the hospital, transfer to it would not amount to a discharge under the MHA and therefore this was not a move they could order. Since the Home Secretary opposed the move G was required to remain in his current unit. The case of MP was similar. MP had also been granted a conditional discharge by the MHRT and the conditions included a requirement that he reside at a specific address and not leave this setting unaccompanied. A setting which could comply with these conditions had been found, however, the Home Secretary successfully challenged this decision on the grounds that the conditions applied were so restrictive of MPs freedom that they amounted to a mere continuation of detention. Since the MHRT did not have the power to order detention in another setting it followed that in this case it had acted outside its powers and consequently the decision was overturned (and MP was required to remain in the special hospital where he was already a service user). Both G and MP raised the argument that they were willing to consent to the conditions imposed upon their discharge. And in both cases (which were heard jointly) the judge ruled that consent was irrelevant since neither service user was in a position to become a voluntary service user. The presence of consent did nothing to change the underlying fact of their detention.

In all three cases the reasoning applied to the issue of consent enabled the court to decide in favour of the most restrictive outcome. And in all three cases the point about consent is dealt with in just one paragraph. These decisions at the very least provide evidence for the view that evidence from service users is treated in a cursory fashion. But they also suggest an underlying systematic bias against accrediting the views of service users on their treatment as being relevant to the decisions made about them.

6.8 Discrimination against mad people in case law

There are a number of ways to make sense of this data about judicial reviews. It could be argued on the basis of these discrepancies that the court is fundamentally paternalistic or bigoted in its attitudes towards mad people. But this explanation is unsatisfactory because it does not explain why on some issues the service user enjoys a more than usual chance of success. Applicants who argued that delays in hearing their tribunal were unlawful were typically successful, 8 out of 11 applications on these grounds were successful (although seven of them were decided at one tied hearing).

Another explanation is that service users are most likely to succeed in cases where the unlawful decision in question is easy to evidence, such as a failure to hold a hearing within a fixed time limit, and less likely to succeed in cases where the flaw in the decision is harder to evidence, such as where the tribunal panel have not expressly mentioned why they favoured one expert account over another. However, it is important not to overstate the degree of success enjoyed by service users in applications taken on grounds of unlawful procedures. Service users lose consistently when they allege that the tribunal panel was biased (*R (C) v MHRT [2003], R (PD) v MHRT [2004], R (M) v MHRT [2006]*) and when they allege that the medical member provided evidence to the rest of the panel and this rendered the hearing unfair (*R (S) v MHRT [2002], R (RD) v MHRT [2007]*). In both these circumstances, the evidential problem is not that great, it is not that an appearance of bias or unfairness is not possible, only that the court has to decide what weight to attach to it.

A further attribute which may influence the reasoning of the court, is the consequences which will follow from the decision reached. Ruling that an excessive delay in conducting a hearing was unlawful will not alter the fact of the service user's detention, although it will give rise to an action in damages under the Human Rights Act (*R (KB, MK, JR, GM, LB, PD, TB and B) v MHRT [2003]*). In contrast, as noted above, judges express anxiety about decisions which will result in a potentially vulnerable service user being discharged. Because the reviewing judge is making her decision upon the basis of a small fraction of the evidence, it is natural that she will wish to be circumspect in reaching her conclusions. But this conclusion still suggests an underlying bias: judges favour continued detention over discharge because they feel that more harm may result from a wrongful discharge than from wrongful detention. However, only a small handful of cases will result in a judicial review leading to discharge (it would only occur in cases where a tribunal had ordered discharge and either the Home Secretary or hospital had sought an injunction preventing immediate discharge whilst a review is conducted; then, if and when the court finds in favour of the Tribunal, the injunction is lifted and the discharge goes ahead). In most cases where a successful application is brought by a service user the remedy favoured by the court is to quash the original tribunal decision and remit it for another hearing, which is a significant administrative burden but it does not implicate the court in any subsequent decision to order a discharge.

Underlying these discrepancies in judicial reasoning lurks the problem of credibility. This analysis of case law indicates that the parties involved in a judicial review hearing are placed upon a ladder of credibility by the courts. At the bottom of this ladder are mad people and at the top is the Home Secretary, whilst the tribunal itself, health service providers and relatives of mad people stand on the middle rungs. All of these people enjoy a greater or lesser chance of influencing the court towards their way of thinking because their statements or utterances are mediated through a series of wider social understandings which affect the degree to which they will be heard.

6.9 Conclusion

The function which mental health law exclusively performs is that of maintaining the social expectation that individuals will not be subject to arbitrary or unjust detention. The legal system, like all systems, struggles to define what an appropriate response to madness might be and as a result relies heavily upon psy-system operations in order to sustain an observable distinction between legally relevant and legally irrelevant madnesses.

The problem this generates for mad people is illustrated effectively by the example of the MHRT. A service user who seeks to appeal against the decision to detain her in hospital will face a sequence of challenges. One of the panel members will provide medical evidence about her condition which she may not be empowered to challenge. The evidence available to the MHRT panel will largely consist of medically accredited testimony and the unaccredited testimony of the service user, who is already believed to be mentally ill. And in reaching their decision, the panel may employ reasoning based on imperfectly defined terms, which cannot readily be challenged. If she wishes to seek a further review of the decision reached as a result of this process, she will probably be unsuccessful. Claims that the process was unfair, that the reasoning was inadequate or that the law was incorrectly applied are all unlikely to succeed.

These defects can be comprehended by reference to the inadequacy of the legal definition of madness, the drive to discredit and the fragility of all knowledge of madness (psy-knowledge may be weak but it is better than nothing). They are not the *fault* of individual actors, but a consequence of system operations which inevitably generate distinctions surrounding what constitutes information for their purposes. This raises a significant question. There is a growing body of references to the involvement of mad people in international legal documents, statutes and policy documents. But this chapter has demonstrated that the law, as it operates currently, plays an imperfect role in promoting the accreditation of mad people, and at times actively sustains their discreditation. Can the law adjust its operations to change this?

Chapter Seven
Conclusion

7.1 The ambitions of policy makers

In a report published in 2004 the Social Exclusion Unit laid out its vision for reducing the degree of social exclusion mad people suffer:

> *"Our vision is of a future where people with mental health problems have the same opportunities to work and participate in the community as any other citizen. This will mean:*
>
> - *communities accepting that people with mental health problems are equal;*
> - *people receiving the support they need before they reach crisis point;*
> - *people having genuine choices and a real say about what they do and the support they receive in order to fulfil their potential;*
> - *people keeping their jobs longer and returning to employment faster, with real opportunities for career progression;*
> - *recognition of the fundamental importance of people's relationships, family and caring responsibilities, a decent home, and participation in social and leisure activities; and*

- *health and social care services working in close partnership with employment and community services, with fair access regardless of ethnicity, gender, age or sexuality."* (Social Exclusion Unit 2004 para.15)

The Social Exclusion Unit then goes on to lay out its agenda for achieving these changes. The 27 point Action Plan they lay out is notable both for the types of change it demands, and the breadth of social institutions it identifies which will need to reform their practice. The following institutions are specifically identified in the Plan: children's social services, childcare providers, schools, local education authorities, careers advisory services, vocational training bodies, universities, job centres, volunteering agencies, small businesses, the welfare benefit system, local authority housing departments, housing associations, adult social services, health service providers, transport services, the police, the probation service, government departments, independent regulatory bodies such as OFCOM, the Legal Services Commission and the media (ibid. pp.96-110). But the theory I have outlined in this thesis suggests we have every reason to be circumspect about the likelihood of such an ambitious agenda for policy reform delivering meaningful change to people who have made mad utterances.

As Chapters Two and Three outlined, Luhmann himself did not address the questions either of what madness is, or what the psy-disciplines are. I have argued that madness is characterised by utterances which appear to lack a meaning content and to defy attempts to enter into chains of communication. Mad utterances are statements which can only be communicated about rather than with. Mad acts are those which cannot readily be explained by those who have carried them out or those who have observed them. Individuals who commit very extreme mad acts, or make multiple mad utterances may be deemed to be mad themselves, but it is crucial to remember that madness is only properly a characteristic of certain acts or utterances, and that the vast majority of things said by mad people remain comprehensible and therefore meaningful. As I argued in Chapter Four, the fact that mad people experience a high degree of social exclusion results from the fact that they experience a dual process of exclusion. They are often excluded from the operations of interaction systems because their conduct leads them to fall foul of the disdain/esteem code which operates in these systems to determine which actors are worthy of attention. And their utterances are further excluded from the operations of both interaction systems and social systems such as law, politics and the economy because their utterances are discredited in advance. In these cases the exclusion does not result from an assessment that the individual is not morally worthy, but from the needs these systems have to maintain their boundaries, reduce the complexity of their environment and manage redundancy.

At the same time as this exclusion is observed, it is also notable that a powerful humanising discourse exists within our society which has made pronounced efforts to redress the social exclusion mad people face and restore their dignity and their freedom to participate in society. But when the products of this discourse are examined closely a curious dissonance is observable. Whilst policies intended to promote the involvement of people with mental health needs in the decisions which affect their lives are widespread, their impact seems to be low, and the empirical evidence on the operations of these policies suggest that whilst the attitudes of those implementing them are often good, service users nonetheless continue to report that their efforts to achieve influence over these decisions are unsuccessful. Similarly within the legal system in England and Wales there is a clear perception that one objective of mental health law is to allow mad people to challenge the wrongful application of the law. However, in practice we can observe that mad people consistently lose legal challenges to decisions made about their care, even in situations where their arguments directly parallel arguments employed successfully by other applicants. This dissonance can be explained as resulting from the powerful effects of discreditation processes. Even where an individual experiences esteem within interaction systems they may nonetheless be discredited by social systems.

This leaves us with the question of what we can do with Luhmann's theory. King (2006) suggests that legal researchers have responded to systems theory in four main ways. The first has been complete dismissal. The second has been to use it in a normative fashion to indicate the direction the law should take. King suggests that Paterson and Teubner's work on empirical legal autopoiesis provides an instance of this (Paterson and Teubner 1998). The third is to suggest a playful response which takes an interest in the new worlds of potential meaning the theory generates but does not take them too seriously (such as Teubner et al. 2002 p.919), and the fourth (and the approach King takes) is to use systems theory to demonstrate the pretensions and delusions of those who would use the law to try to steer or control the operations of other systems. King is highly critical of all approaches other than his own.

However, using systems theory as a technique for defining critique without engaging either playfully or seriously in debates about social reform is neither an inevitable nor a desirable position to adopt. King is right to assert that there are serious defects in the first three positions he outlines, but wrong to suggest that selecting not to make a selection or to define oneself as a mere bystander represents some kind of advance over these alternatives.

7.2 What *should* one do with systems theory?

It is true that Luhmann's concern was with what he described as a scientific description of society, and that systems theory is intended to be a-normative (Luhmann 1997 p.17). Luhmann is scathing in his critique of humanist theories of society which he believes are founded in anthropocentric assumptions about the significance of individual common sense (ibid. p.30).

And he argues robustly that humanist theories are inherently inadequate to the task of describing society because they start with an assumption about the ethical significance of the individual which is in itself a construction (Luhmann 2002a). Systems theory, by contrast, calls the individual into question and explores how, despite a widespread belief to the contrary, human beings exist in the environment of society.

However, in Luhmann's writings specifically upon morality it becomes clear that he also had a profound mistrust of the effects of moralising discourse upon society:

> *"Morality repels, quarrels and impedes the resolution of conflicts – an experience that has resulted, among many other things, in the separation of law and morality. In any event, the function of morality is not determined adequately by referring to the need for social integration.* ***Society, fortunately, is not a moral state of affairs."*** (Luhmann 1995/1984 p.235, my emphasis)

Luhmann's observation that morality does not perform an integrative function for society is coupled with his view that the establishment of norms is always a local matter, specific to the system within which the norms in question are intended to operate. Even norms which are intended to function across the whole of society have to be established first within a discourse of fundamental rights or human rights, which may generate communication around these norms but which can never wholly direct the operations of other operatively closed social sub-systems. Luhmann argues that observing the operations of the moral code in society is an empirical matter, and does not require taking a position on how that code should be operated (Luhmann 1996). And he makes a further suggestive point with regard to normativity in an interview he gave shortly before his death. When asked whether a theory of society which was not founded upon normative principles was possible he replied that he thought it was, largely for the reasons given above. But he also makes the point that if one defends a theory upon the basis that it is morally correct then one is also indicating that one's opponents are not merely incorrect but that their opposition is immoral or amoral (see Hagen 2005 p.44). Whilst a minor consideration in relation to those above, this nonetheless suggests rhetorical reasons for Luhmann's refusal to engage with normative accounts of society: he felt that debate founded upon a good/bad distinction was unproductive.

The problem of making normative assertions on the basis of observations founded upon systems theory is not that such assertions are wrong in any simple sense. It is that having accepted the logic of systems it can be difficult to see how normative claims can form part of subsequent communications, without ending up in petty entanglements over the direction society *should* take which fail to take into account how improbable it is that society ever *will* take the direction specified. The theory's greatest strength is also its greatest weakness; in providing a description of social order which is not defined in relation to a normative conception of the ideal society the theory is able to provide a very satisfying description of society without beginning with the assumption that the operations of any one particular system are morally suspect. We can, for example, observe that the legal system obscures what mad people have to say to a greater degree than it excludes the contributions of other actors, without simultaneously challenging the moral legitimacy of the legal system. However, one then encounters a significant problem when one identifies an outcome that seems highly problematic, such as the exclusion from decision-making mad people describe. If the roots of this exclusion lie in the differentiation and boundary maintenance operations of social systems then can anything be done to redress this? And if it can what role can observers of this blind-spot play in bringing it to the attention of the legal system?

In what follows I will conclude this thesis by arguing that systems research can aspire to something more than critiquing the efforts of policy-makers from the sidelines; that by observing the blind-spots of excessively ambitious policy-makers and law-makers it may still be possible to inform communication about more attainable and perhaps more meaningful objectives to pursue.

7.3 Systems theory and social reform

Luhmann was not only sceptical about the effectiveness of policy reform measures but also about the possibility of social theory informing the work of policy reformers:

> "*...we may ask again whether theories of this kind and this degree of sophistication can have any influence on the practical job of designing and modifying self-descriptions which are able to gain recognition and circulation outside of narrow intellectual circles. As a first reaction it seems safe to say* **no.**" (Luhmann 1984, original emphasis)

However, in the same article he goes on to observe that whilst theory cannot directly inform the first order activities of social systems such as politics and law, it is nonetheless the case that second order theories have historically had a considerable impact upon society. He cites the influence of Montesquieu, Kant, Marx, Freud, and Keynes as instances of this. And he points out that we cannot predict how and why such influence is attained, we can only retrospectively examine the circumstances in which certain theory formulations gained credibility and speculate, on this basis, as to the preconditions necessary for society to embrace a new theory form. He concludes that sociologists should not seek to achieve such influence by packaging their theories in palatable forms, but should instead use their position on the outside of society to reflect upon the conditions of their own self-reference.

Not only is it impossible to determine in advance what influence systems theory either should or will have upon the operations of social systems at first order, but it is also difficult to see how systems theory can inform our understanding of the social world at second order. Whilst we can use systems theory to structure our descriptive account of the social world, the theory does not specify a necessary relationship between abstract theoretical constructs and first order data about the social world. And although Luhmann states that systems theory is consistent with empirical research (2002d), and even that an agenda for such research exists (1989b), he does not explicitly tell us what methods we should employ to analyse the findings of data about the first order operations of social systems. Luhmann merely observes the problems posed by systems theory for empirical research. He argues that all social theory is in effect the observation of the differences or codes being observed by those making first order observations from within a system. In the process social theories unsettle the 'natural' assumptions implicit in first order observations. Marx, for example, demonstrated that there was nothing inevitable about class difference (Luhmann 2002e). Such observations can, therefore, have a radical impact upon society. The unpredictable consequences of unsettling established order may be what King means when he argues that to use systems theory as a 'guide' to the best direction for law to take could have unforeseen and undesirable consequences (King 2006), but this is probably to grant social theories a greater influence than they are capable of having in isolation. Utterances about law reform may or may not be structured around a distinction which is meaningful to the political system. They may be expressed in terms which enable them to readily enter into a political discourse about law-making; for example, the statement that a policy will be popular (or unpopular) with the electorate can readily be parsed according to the political code. But they may equally be expressed in terms which mean that the political system has to translate them before deciding whether to act upon them. A policy reform that will deliver improvements in terms of health or efficiency or public safety has to be transformed into a political distinction before a decision can be made as to whether or not to act upon it. This can mean that policy-makers appear highly resistant to learning from the findings of empirical research (see Peay 2003 pp.169-70). Kane (2002) describes the limitations of the evidence-based approach to policy-making as resulting from a group of factors including the complex dynamics of policy making processes, the difficulty of evaluating evidence, and the fact that researchers and policy-makers belong to distinct communities which do not necessarily speak the same language. These difficulties could also be understood as arising from the different systems of meaning these practitioners are attempting to operate within. These problems are frustrating for researchers who can readily observe, at second order, the shortcomings or failings of first order legal or political communications about mental health policy. But they also suggest that the danger of second order observations actually undermining the operations of the legal system is remote.

Luhmann describes second order observations as inherently unstable, since the social world is not capable of carrying meanings which inhere. However, he does not view them as meaningless, since they can allow us to ask where the blind spot of the first order observer lies (Luhmann 2002a p.74). In the case of the law, the question of what legal operations fail to observe is clearly a highly significant one. In his view however, what this creates is an endless recursion, since second order observations can be observed in their turn: *"any attempt to designate a unity requires new distinctions and, in turn, renders the ultimate goal invisible"* (ibid). Luhmann is writing here about the goal of providing a complete description of the natural world, which he decides is impossible, since the set of facts to be known about the natural world contains its own self-description, and thus is always incomplete. This paradox of observing systems has yielded some diverse strategies for employing systems theory to guide the analysis of empirical data about the operations of social and interaction systems. Paterson, for example, employs cognitive mapping techniques to analyse first order accounts of the impact of new regulations upon regulated actors in order to explore how the legal system's coding of the world corresponds or maps onto the codes of other systems (Paterson 2000 pp.67-80). Gibson et al. (2005) suggest that systems theory can be used to inform grounded theory analysis of qualitative data if some of the theory constructs of the grounded theory approach such as 'core categories' are reformulated in systems theoretical terms as 'primary distinctions'. In both cases, the authors are grappling with the problem that with a theory as thoroughly fleshed out as systems theory, and one which is founded upon paradox and indeterminacy, the task of gathering and analysing empirical data about the world can seem irrelevant. And both authors agree that their approaches may allow systems theory to inform empirical research, but they do not allow empirical research to inform systems theory.

So we have a triple dilemma. Systems theory can observe the blind-spots of policy makers, but cannot reasonably aspire to informing better policy work, because the theory is pitched at a level of abstraction which means that it cannot readily be transformed into information for the purposes of first order system observations. The analysis of data gathered through empirical social research can also be informed by systems theory and the resulting findings structured around systems theoretical distinctions. But these findings will only ever yield a second-order reconstruction of first order operations, and whilst they may observe some blind spots of the system, they will generate their own blind spots in turn. Finally, Luhmann's elaborate theory construction relies on the assumption of circularity and self-reference and cannot itself be informed or modified by the emergence of new empirical data. Leydesdorff (forthcoming) identifies this as a wrong turn in Luhmann's theory building, because by defining communication (for example) in such general terms as to obviate the need for grounded empirical inquiry into the nature of communication, Luhmann cuts himself off from developing a more nuanced account of these crucial social processes and as a result undermines his own project of offering a scientific description of society. It should be noted that Leydesdorff locates this wrong turn as occurring specifically within the last stages of Luhmann's theory development and culminating in his final and most ambitious work 'Die Gesellschaft der Gesellschaft' ('The society of society') (Luhmann 1997).

To return to King's question: *"what's the use of Luhmann's theory?"*, none of the possibilities he outlines seem particularly attractive. However, a fifth possibility remains, which he does not explore. That is the possibility that in observing system blind-spots and by engaging (whether playfully or otherwise) in the building of new descriptions of the creation of social meaning, second order observers provide a degree of provocation which is capable of altering the first-order operations of social systems. Lee (2000) suggests that Luhmann is arguing for just such a conceptualisation of the value of second-order observation in 'The society of society'. To employ an analogy which Luhmann favoured, we cannot expect our second order observations to steer the operations of other systems as a driver steers a car, but our observations might act like crash barriers, helping to refine the direction of traffic, and highlighting where efforts at steering have badly backfired. Systems theoretical research forms part of the environment of social systems. As the legal and political systems respond to research findings, dismissing them or adapting to their conclusions, they move forward in new and inevitably unpredictable directions.

7.4 Moving forward?

So to conclude this thesis I will outline some of the ways in which the ideas I have outlined could be employed to provoke action within the legal and political systems.

It is clear from the report quoted at the beginning of this chapter that there is a widespread acceptance that the degree of discreditation mad people suffer is socially problematic. Internally, social systems acknowledge this. For example, the exclusion of mad people from decisions made about their own care jeopardises therapeutic relationships and in the process undermines the achievement of the psy-system goal of securing recovery from mental illness. Similarly, the economic efficiency of the welfare system is undermined by the high degree of economic discreditation mad people suffer, and their consequent reliance upon welfare benefits to support themselves. However, the perceived goals of a policy affect the ways in which it is implemented by practitioners, and this in turn will determine its effectiveness. Currently policies which state that they promote involvement are messily organised and structured around a group of disparate values including allocative efficiency in healthcare provision (DH 2000), therapeutic effectiveness (DH 2004), risk minimisation (DH

1999a), the protection of fundamental rights such as autonomy and the achievement of empowerment and political justice (UN Convention on the Rights of Disabled People 2007). All of these documents are, or will be, intended to influence the operations of psy-system practitioners and others involved in promoting the welfare of mad people in England and Wales. And yet each of these underlying values marks a different distinction. The distinction between freedom and oppression on the one hand cannot be collapsed into the distinction between risk and public safety or between efficiency and waste in service delivery. The realisation of one value cannot automatically generate the realisation of another value. It is not feasible for a policy to be all things for all people. As a result current policies are not merely limited by the difficulty of steering the operations of other systems, but by the fact that there is a fundamental lack of agreement within the political system concerning which direction these systems should be steered in.

Turning to the legal system, attempts to influence this system from outside are complicated by the fact that the legal system's operative closure is understood as one of its virtues. The legal system exerts a crucial influence over the effectiveness of policy. Bingley and Heginbotham (1999) describe how the mental health legal system in England and Wales has historically followed rather than led changes in public attitudes to mad people. This is not surprising when one considers that the legal system's function is to maintain expectations in the face of counterfactual evidence to the contrary. For as long as society expected, for example, that people who had been diagnosed as mad would ordinarily live in long-stay hospitals, there was no functional reason for the legal system to challenge lengthy incarceration as a practice. Once expectations shifted the legal system had to adjust to catch up. Currently, the legal system in England and Wales fairly consistently excludes the substance of most of what mad people have to say about their care from its operations. The system is instead structured around a small number of procedural distinctions relating to when and for how long mad people can be detained in hospital and who gets to make this decision. Mental health law also plays a small role in determining when compulsory treatment in the community may be lawful, but it says little or nothing about the rights of service users to be included in, or consulted upon decisions about their care. Even when the law would appear to offer mental health service users the opportunity to challenge a decisions reached about their care, for example at the Mental Health Review Tribunal, these forums, in practice, sometimes serve to exclude the very voices they were intended to facilitate.

Discreditation of mad people is practiced by the legal system when it determines that, for example, they are not qualified to speak as the experts upon their own lives and that their evidence can only be mediated through psy-system experts. But it is the effects of discreditation across other social systems which sustain the legal system's current operations. Society as a whole tends to operate a crude distinction between mad/not-mad which is applied indiscriminately to the utterances made by someone who has made mad utterances. The crudeness of the distinctions operated within the legal system thus appear adequate to the task of identifying and 'protecting' the interests of mad people, and the wider expectation that individuals will be protected from arbitrary deprivation of their liberty is thus maintained. Efforts to achieve laws which reflect a more nuanced account of madness and promote a more sophisticated model of rights protection have to start by challenging this discreditation.

By observing the exclusion of mad people from the legal system, and contributing to the perception that the legal system is inadequate, a systems theory analysis highlights the necessity of challenging the impact of discreditation across society, rather than expecting legal reforms to be in the vanguard of social change. Involvement policy is unlikely to effect much change from the top-down. But changes to the social order can and do arise from the bottom-up. There is evidence of a growing commitment amongst psychiatrists, mental health nurses and psychologists to promote possibilities for communication between service users and psy-professionals (Wadsworth and Epstein 1998, Repper 2000, Tee et al. 2007). And the role of service users in defining research objectives and refining the evidence base for healthcare is increasingly being promoted (Boote et al. 2002). Innovations like these are more likely than major programs for policy reform to deliver the changes which service users themselves state they want to see:

"I feel that no real progress will be made until givers of the services and users of the services can sit down together as equals and have a discussion about treatments and how they feel about each other more generally. For me one of the biggest frustrations in having a mental health problem is the way it is perceived by some as having the effect of making me unable to make decisions about what is best for me."'

(Antoniou 2004)

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R (on the application of SH) v MHRT [2007] EWHC 884 Admin

Statutes and statutory instruments

Mental Health Act 1983

Mental Health Review Tribunal Rules (SI 1983/942, amended by SI 1996/314 and SI 1998/1189)

Human Rights Act 1998

Health and Social Care Act 2001

Special Educational Needs Tribunal Regulations 2001(SI 2001/600)

Protection of Children and Vulnerable Adults and Care Standards Tribunal Regulations 2002 (SI 2002/816)

NHS Reform and Healthcare Professionals Act 2002

Health and Social Care Commission Healthcare and Standards Act 2003

The National Health Service (Complaints) Regulations 2004

Local Government and Public Involvement in Health Act 2007

Mental Health Act 2007

Australian statutes

Mental Health Act 1986 (Victoria, Australia)

European and international legislation

European Convention on Human Rights 1951

UN Convention on the Rights of Disabled People 2006

Appendix One

Judicial reviews of Mental Health Review Tribunal decisions, January 1998 – January 2008

High Court decisions

R v MHRT, ex parte Smith [1998] 47 BMLR 104

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R (on the application of Wirral Health Authority and Wirral Borough Council) v (1) MHRT (2) Dr Finnegan acting as RMO; DE as interested party [2001] EWHC 312 Admin

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R (on the application of B) v MHRT [2002] EWHC 1553 Admin

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R (on the application of the Home Secretary) v MHRT; DH as interested party [2003] EWHC 2864 Admin

R (on the application of C) v MHRT [2003] EWHC 3467 Admin

R (on the application of LI) v MHRT [2004] EWHC 51 Admin

R (on the application of the Home Secretary) v MHRT [2004] EWHC 650 Admin

R (on the application of the Home Secretary) v MHRT [2004] EWHC 1029 Admin

R (on the application of Mersey Care NHS Trust) v MHRT [2004] EWHC 1749 Admin

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