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ORIGINAL ARTICLE

"The expert and the patient": a discourse analysis of the house of commons' debates regarding the 2007 Mental Health Act

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ABSTRACT

Background: The Mental Health Act 1983 was amended in 2007. This legislation appears to be predicated on the assumption that an entity of "mental disorder" exists and that people who are designated mentally disordered require medical treatment, administered by force if necessary.
Aims: To explore the ways in which mental disorder is constructed and the possible practical effects of these constructions in the House of Commons' debates regarding the Mental Health Act 2007.
Method: Verbatim transcripts from the House of Commons debates on the Mental Health Act were studied through a discourse analysis.
Results: Two primary discursive constructions were identified: "The Expert" and "The Patient."
Conclusion: Mental disorder and associated roles, such as "The Expert," were constructed through particular selective rhetoric, which taken together, made particular psychiatric practices and the need for legislation, such as compulsory detention, seem normal, and necessary.

Introduction

The Mental Health Act 1983 is a unique piece of legislation in England and Wales, as it can remove an individual's freedom, principally through detention without trial and the administration of medication without consent. This Act was amended in 2007, but the amendments have been described as "draconian" (Rose, 2008) and criticised for over-emphasising public safety at the expense of service quality and human rights (Pilgrim, 2007). Vassilev and Pilgrim (2007) have suggested that the Act is not about protecting patients from themselves or others – it is about the government wanting to minimise the perceived risks of mental disorder. Other literature examining policies in mental health came to comparable conclusions about risk concerns. Harper (2008) undertook a scholarly analysis of proposals to reform the mental health legislation and had identified constructions of risk and danger within them. Similarly, Moon (2000) explored the mental health policy of the time and stressed the significance of discourses of protection, safety, risk, and dangerousness in the positioning of confinement as a respectable and strategic response.

The original legislation and amendments seem to be based on the assumption that a concrete entity called "mental disorder" exists and if a person diagnosed with a mental disorder is deemed a risk (to themselves or others) should be detained and treated by doctors. One way this assumption has been contested is on the understanding of mental disorder as a discursive construction, that it is a creation and product of language and historical, cultural and social circumstances rather than an objective medical fact. For definition, discursive construction can be understood to be a group of statements that produce social meaning and practices (Laclau, 1980; Parker, 1992).

In this study, we employed a Foucauldian-informed approach based on the work of Parker (1992). This allows researchers to critically engage with (Burr, 2003) and explore the broader context of the language used to construct mental disorder and related psychiatric and psychological practices. Parker's (1992) approach to discourse and its analysis focusses on coherent meanings and connotations, or the attempts at such, within language and how these interact. He asks what types of person, termed subject positions, talk about these meanings. Most important is his understanding of key Foucauldian concerns on identifying discourse as being historically located, the reinforcement of institutions, the ideological effects that sanction oppression and the reproduction of power relations. Foucault's (1965) ideas have been inextricably linked to mental distress following his seminal analysis of madness through time that presented mental illness as a construction rather than a natural fact. He suggested that the modern notion of mental illness is maintained through psychiatric practices – that "mad" persons/subjects are created by discursive practices centred on notions of "madness" and "reason."

Foucault conceivably recognised that historical analyses could often provide convincing critiques for taken-for-granted knowledge and practices. Mental distress has not always been described as a disorder or illness. It has been constructed differently throughout the ages, being regarded variously as a visitation or punishment from the gods, demonic possession, "madness," or "lunacy," or requiring rational inquiry (Porter, 2002). It was only in 1774 that British legislation on mental disorder first mentioned doctors when the Madhouse Act allowed doctors to visit asylums (Cromby et al., 2013). Hacking (1986) suggested that categorisations and different diagnoses have been created in relation to the different power-knowledge configurations that have emerged, for example, he claimed that the clinical phenomenon of the multiple personality was invented in 1875. Similarly, Davidson (as cited in Hacking, 1986), expanding on Foucault's (1978) argument regarding sexuality, proposed that the concept of a "pervert" did not exist before the nineteenth century, but that the ideas of perversion as a disease and the pervert as a diseased person were created from a new functional understanding of disease.

Beyond arguments about the existence of mental disorder, it is important to review its characterisation, and two discourses seem dominant in the literature. The first discourse is 'violence, risk, dangerousness, and criminality' (the characters and actions of the "Mentally Ill"). People with mental disorder are often discursively constructed as being violent, risky, dangerous, or criminal particularly in newspaper accounts (e.g. Allen & Nairn, 1997; Bilić & Georgaca, 2007; Coverdale et al., 2002; Hazelton, 1997; Nairn, 1999; Nairn et al., 2001; Nairn & Coverdale, 2005; Olstead, 2002). In these studies, reporting of violence perpetrated by people with mental health problems were seen as newsworthy and appealed to sensationalism. Bilić and Georgaca (2007) and Olstead (2002) both identified in media text the conflation of the mentally ill with other stigmatised and "deviant" groups, such as drug addicts and HIV-positive patients. Furthermore, Bilić and Georgaca (2007) conceived the portrayal of people with mental illness as devoid of individual and social characteristics, which the authors see as a unified and less humanising category that can also have stigmatising implications.

The second discourse is medical. This discourse classifies mental illness as a medical disorder, with psychiatrists as experts in its interpretation and management (Bilić & Georgaca, 2007). Various discursive strategies have been identified by the researchers to serve to construct mental illness as a medical matter. Rowe et al. (2003) noted that depression is compared with physical diseases like diabetes and was mentioned in the same sentences. Physical health associations acted rhetorically as an explanation rather than only as a description. Rowe et al. (2003) noted a lack of precision when scientific and medical terminology was used – a rhetorical device called "studied use of vagueness" (Edwards & Potter, 1992). Bilić and Georgaca (2007) also highlighted the use of vagueness in the application of scientific terminologies, such as "ions" and "cells," which can make it unclear to the reader the exact detail underpinning a biological explanation for mental illness. The authors argued that this serves to deepen the difference between the psychiatrist and the reader constructing the former as an authority and an expert.

Psychiatrists have featured in many of the texts studied, giving their professional opinions in matters of mental illness. Johnstone and Frith (2005), Nairn (1999), and Bilić and Georgaca (2007) all noted the use of category entitlement (Edwards & Potter, 1992) of doctors who are expected to have certain kinds of knowledge due to their position. Bilić and Georgaca (2007) noticed that in the reports from Serbian newspapers, psychiatrists had their professional titles reported and institutional position stated, whereas service users were less precisely described and quotations from them were used to support the psychiatrists' opinion.

The literature reviewed has focussed on media and government texts in examining mental disorder. However, there are many texts that could be of interest in examining the issues of mental disorder and society. Parliamentary debate transcripts have been used in other research areas to examine assumptions and discursive strategies in discussions about law reform, for example, homosexuality (Baker, 2004), European Refugee Crisis (Kirkwood, 2017) and human fertilisation (Kettell, 2010). These studies provided insightful analyses of the impact of language on the course of the debates. House of Commons' debates on the Mental Health Act could be seen as an essential way in which speech constructed a particular version of mental distress and helped to shape legal powers. The language used at this time point has created the future realities of professionals, service-users and families alike.

Of course, over time, all discursive constructions are likely to change, including mental disorder. However, the Hansard transcripts on the Mental Health Act debates will always be of importance as a socio-historical document relating to the construction of mental disorder.

In the context of the debate about the construct of mental disorder and associated practices, the current study aimed to critically examine the House of Commons debates with respect to the Mental Health Act 2007. The aim was to explore the ways in which mental disorder is constructed within the debates and the possible practical effects of these constructions.

Method

Context and text

In 1998, the Labour government announced its intention to review the 1983 Mental Health Act. Several consultative papers and draft bills were presented before the amendments were introduced into the House of Lords on November 2006. The bill then transferred to the House of Commons (Department of Health, 2010) and the House of Commons Public Bill Committee debated the proposed Mental Health Act in 12 sittings between 24 April and 15 May 2007. The Commons debates have been selected for analysis because of its legislative supremacy over the House of Lords. The current research utilised electronic verbatim

reports of the debates, which are freely accessible to the general public online from the Parliament UK website (Parliament UK, 2007).

Ethical considerations

This study received written confirmation of ethics compliance from Canterbury Christ Church University (reference number correspondence: 12/SAL/249C). No further ethical review was required under the terms of this University's Research Ethics and Governance Procedures due to the data being a public text. The British Psychological Society (2018) Code of Ethics and Conduct was also carefully considered in relation to the research.

Design and data analysis

These parliamentary transcripts were subjected to a discourse analysis drawing on social constructionist epistemology. The analysis in this paper is based on guidelines presented by Parker (1992) – his approach to discourse is described earlier. These give flexibility for what is of analytic interest but also allows the researcher to engage with key Foucauldian ideas.

The text (a 215,500-word transcript of the Public Bill Committee debates) was carefully read, re-read, and annotations or "codings" were made on the text, based on the above guidelines. One thousand and twenty-six annotations were generated from the text using the above criterion. These were used to inform the analysis (Wood & Kroger, 2000) alongside the reading of broader literature. Relevance to the research aims, coherence, and dominance were central considerations in the selection. The procedures suggested by Mays and Pope (2000) were followed to ensure the "quality" of the results: second and third authors periodically reviewed data coding, a reflexive diary was written, and an audit trail was compiled.

The first author has worked as a mental health clinician in acute inpatient wards, and service users' sometimes spoke to him of their distress directly due to their detention and treatment. He questions the *uniform* benefit of psychiatric and psychological practices based on the understanding of mental distress as a medical condition but understands this can be useful for many people.

Analysis and discussion

Two main constructions were identified from the analysed text – "The Expert" and "The Patient."

"The Expert"

The first overarching construction of mental disorder was identified as that of the "Expert," which was primarily formed by knowledge, training and assumed trustworthiness.

The idea of the expert appears central to the debates. The position is often spoken in relation to the psychiatrist and their assumed trained competence – it is: "*what they do*" (Angela Browning, Conservative MP, line 2244). Knowledge seemed to be divided by expert and layman, which has an effect on who can claim to possess sufficient knowledge about mental disorder to assess and interpret the law. In the text, the creation of the expert, particularly the psychiatrist, is discursively constructed by the MPs rejection of their expert status and deference to clinical experts:

> "After all, as lay people we are, in this Bill, relying on psychiatrists to make that decision as to whether judgment is impaired. Making that decision is what they do" (Angela Browning, lines 2243–2244).

> I do not claim to be an expert (Angela Browning, line 9850)

> I am not an expert on that (Rosie Winterton, Labour Minister of State, line 8740)

> … the Secretary of State for Justice is not medically qualified, competent or expected to judge somebody's medical condition. That is why we have experts to do so. That is what the legislation is all about. (Tim Loughton, Conservative MP, lines 10250–10252)

The denial of expertise can not only be seen in terms of defining roles, i.e. expert and layman, but also as having the effect of promoting expert advice – arguably making it more likely for it to be employed.

The idea of an expert suggests exclusivity, implying that others may not have sufficient knowledge and therefore the right to make decisions in this area and that psychiatrists' knowledge is authoritative and final. One rhetorical device used to justify their authoritative position was citing their long training and contrasting other professions:

For a full-blown consultant psychiatrist, however, we are talking about 13 years, which means that considerable training, expertise and experience go into the specific job that psychiatrists are put in place to do. It is different from what a psychologist and consultant nurse will do. (Tim Loughton, lines 4769–4771)

At this juncture, it may be worth acknowledging the power of the psychiatrist's role in the mental health act, that the legal framework relies primarily on psychiatric opinion. "Mental illness" is considered the same in the legal sense as in its psychiatric definitions and psychiatric opinion has been positioned as the expert view (Davies & Bhugra, 2004).

The equating of expertise with psychiatrists can serve to obscure and devalue other types of expertise and knowledge such as patients' own expertise by experience (McLaughlin, 2009) or a personal knowledge which Marzillier (2010, p. 260) described as "tacit and grounded in feeling." In the quotation below, special knowledge and practices appeared to be needed to help children – there seems to be an implicit assumption that the knowledge to help them is not in their friends, families or communities:

> "Children's services require appropriate settings, assessments by people who are clinically approved and who have an appropriate qualification in treating children, and clinical supervision in all cases. By definition, such services require specialism" (Angela Browning, lines 6610–6612).

What is striking in the rhetoric of the expert is the assumed trustworthiness. Giddens (1990) suggests that

laypeople trust in systems designated "expert," assuming them to be trustworthy, competent and ethical. Clinicians are thought of as safeguards and that they will do the right thing and make the right decisions, including decisions on detention and treatment:

"As always, the clinician makes the decision on what is right for the patient" (Rosie Winterton, line 8992).

"The SOAD (Second Opinion Appointed Doctor) is a safeguard. That is its purpose" (Angela Browning, lines 9977–9978).

The construction of trustworthiness has the effect of making the questioning of psychiatric practices as unnecessary. Little mention is made of any limits or challenges to medical expertise. The combination of expert knowledge and training and assumed trustworthiness could be seen to have the result of inviting us to accept their authority to make decisions on our behalf.

Ultimately, it could be argued that the idea of the expert and expertise rests on the construction of mental disorder as an undisputed entity. Knowledge and practices, particularly psychiatric, rest on the concrete nature of mental disorder as something "real." The quotations below illustrate underlying ontological claims about mental disorder by using realist language. We have added emphases to draw the reader's attention the vocabulary used:

"the *fact* [emphasis added] of a mental disorder" (Chris Bryant, Labour MP, line 1893);

"…except *genuine* [emphasis added] mental disorder" (Rosie Winterton, lines 1456–1457);

"…there must be *reliable evidence of a true* [emphasis added] mental disorder" (Sandra Gidley, Liberal Democrat MP, line 1874).

Boyle (2002) has written about how casual, uncritical assertions in texts can promote the idea of mental illness. In the above quotes there are casual words, such as "fact," asserting the "taken for granted" status of mental disorder (McCann, 2016), which could be seen to silence other understandings of mental distress and, again, reinforce the need for psychiatric expertise.

"The Patient"

The second construction identified was the "Patient". There were various descriptions given about patients – that they could be non-compliant when it comes to treatment, potentially risky to the public, and their decision-making could be impaired. These concepts will be considered in turn.

The first concept of the patient to be considered is the idea of them being non-compliant with their medication. Medication and particularly non-compliance with medication formed the cornerstone of the justifications presented for detention and Community Treatment Orders[1] (CTO). The effectiveness of psychiatric medication and the need for

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[1]The person diagnosed with a mental disorder can be treated in the community, instead of staying in hospital. However, the responsible clinician can return the patient to the hospital and give them immediate treatment if necessary.

people to continue taking it appeared to be taken-for-granted, positioning its administration by force as self-evidently necessary in cases where patients did not comply. Homicide and suicide were named as possible consequences of medication non-compliance, constructing it as highly dangerous:

"The last confidential inquiry into suicide featured 56 people who had stopped taking their medication" (Rosie Winterton, line 2266)

"Non-compliance with medication was a contributory factor in 57 per cent of cases of breakdown of care that led to homicide" (Madeleine Moon, Labour MP, lines 5215–5217).

The implication is that compliance with medication prevents such tragedies but that people with mental disorders tend to be non-compliant and therefore need close monitoring and control:

Very often, the issue is not that the treatment is not available, but that the individual does not turn up for a depot injection, for example. (Rosie Winterton, lines 9031–9033)

Deterioration in a patient's condition was constructed as a result of his or her failure to take medication or have contact with professionals:

Unfortunately, parents, carers and others would often have to stand by and watch as the patient deteriorated to such an extent that they had to go back to hospital for another detention. That could happen time after time. It often happened because people had failed to take medication and to stay in touch with health care professionals. (Rosie Winterton, lines 8881–8883)

The contributors to the debate suggested that compliance with a CTO could ensure that a patient is less likely to be detained in hospital. The need for continued observation was presented through the terminology of medication non-compliance and its consequences (potential suicide and homicide).

The second concept of the patient to be considered is the idea of mental disorder equating with risk. Mental disorder appeared to be constructed as posing a threat to wider society and increased powers of compulsion as essential to maintain order. Highly selected, high profile but unusual historical events are presented as evidence that mental disorder is associated with risk and threat. The case of Michael Stone who was convicted for double murder and diagnosed with a severe anti-social personality disorder and multiple drugs and alcohol abuse (Prins, 2007) was cited alongside with the need to "deal with people like him":

I remind the Minister that around the time of the Michael Stone case, when there was great public discussion on how we should deal with people like him …it is about finding a way around the difficulty that the Labour Government met when they bravely told the world out there that they were going to find a solution to the problem of locking up people like Michael Stone. (Angela Browning, lines 4903–4911).

The idea of "locking up" people as a solution to mental health and crime is forefronted. Arguably medication and detention become the "go-to" answer to societal difficulties with disorder that is associated with mental health. During the debate, an MP expressed concern regarding a previous comparison with the high profile event of the Virginia Tech

Massacre that could be predictive of a future event in England:

> I am particularly alarmed by comments by Labour Members on the recent tragic shootings at Virginia Tech. One right hon. Member who spoke on the Second Reading drew a close parallel between what happened in Virginia and what could happen here … " (Tim Loughton, lines 119–120).

The reiteration of danger and risk ideas, as illustrated by the above quote, could be seen as having the effects of reinforcing the constructions rather than negating them – even though this may not be the intention of the speaker.

The third and last concept, concerning the patient, to be considered is the idea that they are "decision- impaired." The debates contained assumptions about a person's actions and decisions, particularly about suicidal and parasuicidal behaviour – their agency is questioned. Marsh (2010) has identified assumptions in research and practice that suicide is pathological and the action of an unwell individual. The politicians in the debates appear to select this understanding of certain behaviours, such as suicide, as "disordered" and related to notions of reason, thus, obscuring other understandings of these behaviours. The decision impaired construction of mental disorder and the patient positions the need for doctors to make decisions on their behalf. The following quotations illustrate this:

> "Clearly, in a clinician's professional judgment, if somebody was going to self-harm that would automatically raise the question of impaired judgment" (Angela Browning, lines 2240–2242);

> "If a person is in crisis and wishes to commit suicide, at that point their decision-making is clearly impaired and they would be subject to coercion under the provisions" (Tim Loughton, lines 2368–2369).

Conclusion

This study has suggested ways in which mental disorder is constructed through particular selective rhetoric, which taken together, construct roles such as "The Expert" and legitimise psychiatric practices such as compulsory detention. While no intentions or motivations of the MPs can be ascribed, they drew upon the common taken-for-granted knowledge of mental disorder – for example about safety, risk, and dangerousness (e.g. Nairn & Coverdale, 2005, Vassilev & Pilgrim, 2007) or mental illness being generated by process of expert definition (e.g. Bilić & Georgaca, 2007, Ussher, 1991). Mental distress is considered to need specialist knowledge and expertise by trained professionals. It could be said to obscure how "everyday" people and knowledge could help respond to distress and understand the broader socio-economic contexts in which people live. The constructions of the patient could be seen as particularly problematic. If patients do not make decisions that are considered appropriate by experts and institutions, then they can be construed as being non-compliant or impaired. These constructions make enforced treatment and detention seem necessary and normative. Practices such as confinement can be positioned as a respectable and strategic response as Moon (2000) has previously suggested.

While only one possible reading of the text, it is striking how the mental disorder constructions hang on two distinct subject positions, i.e. the Expert and the Patient. When occupying subject positions, it is suggested that we can only speak, think or write about an idea or practice in specific ways (Arribas-Ayllon & Walkerdine, 2008). Therefore, parliamentary constructions create limiting speech and acts for experts and patients alike, including what interactions are possible.

In thinking about future possibilities, Kinderman (2019) has argued – regarding the Mental Health Act – that decisions should be based on risk to the self or others rather than whether a person is "mentally ill" or not. He suggests that a human rights approach should be at the heart of these decisions. While not suggesting that enforced treatment and detention should be abolished altogether, it paves the way for the concept of mental illness to be decentred from responses to issues of risk.

Indeed, decentring mental disorder from risk could make it possible to have a debate about risk management in society in totality – where the risks in mental disorder are considered in relation to other societal health risks and harms (e.g. unprotected sex, binge drinking, smoking) that do not have the same levels of restriction.

Despite the above proposal, discourse analytic studies often serve the function of critiquing and deliberately resisting conclusions about "what needs to be done" (Foucault, 1981, p. 84). Therefore, it is hoped that this paper can disrupt normative tendencies of linking expertise, danger, non-compliance, and lack of agency with mental illness by providing the reader with a critique of the some of the taken-for-granted assumptions.

Disclosure statement

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