International Journal of Law in Context (2023), **19**, 456–474
doi:10.1017/S1744552323000174

ARTICLE

‘Informed consent is a bit of a joke to me’: lived experiences of insight, coercion, and capabilities in mental health care settings

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Abstract

The Independent Review of the Mental Health Act 1983 found that people’s experiences and self-knowledge were mislabelled as a ‘lack of insight’. Insight, a psychiatric concept, is defined as an ability to recognise one’s mental illness, awareness of one’s symptoms and compliance with treatment. Across different jurisdictions, legal scholars have raised concerns about the influence of insight on legal provisions for psychiatric care and mental capacity assessments, given its prevalent use in psychiatry and its absence from statutory criteria. However, outside of these findings, little is known about people’s lived experiences of ‘insight’ and the law. This article draws on narrative and photo-elicitation interviews with psychiatric survivors to argue that insight is an extra-legislative proxy for regulating involuntary detention and other coercion masked as consent. Finally, this article draws on the capabilities approach to deliver a justice argument for creating real opportunities to provide informed consent in mental health settings.

Keywords: mental health law; psychiatry; insight; informed consent; narrative and photo-elicitation methods; the capabilities approach

1. Introduction

The psychiatric concept of insight is a weaselly term that does not map onto statutory criteria in any obvious manner. Yet, it has been repeatedly suggested that insight is used as an extra-legislative criterion for paternalistic interventions in mental health care (e.g. O’Keefe, 2022; Radovic *et al.*, 2020; Gurbai, Fitton and Wayne, 2020; Guidry-Grimes, 2019; Case, 2016; Feckelton, 2010; Dawson and Mullen, 2009; Diesfield and Stojstrom, 2007). In England, the Independent Review of the Mental Health Act 1983 (2018, p. 37) concluded that people’s experiences, knowledge and reasoning are overlooked by mental health professionals and ‘mislabelled as lack of insight or aspect of their disorder’, while the study conducted by Owen *et al.* (2009) found that lack of insight is the most significant predictor of incapacity in psychiatric care. Recognising the problematic relationship between insight and mental capacity, the Independent Review of the Mental Health Act (2018) urged for more research on this area.

However, defining insight is a difficult task. Insight has been deemed one of the most important and troubling concepts in psychiatry since the nineteenth century (Markova, 2005, pp. 3–32) and ‘the absence of a consistent definition of insight and means by which it is assessed’ became a dominant aspect of its problematic status (Markova, 2005, pp. 66–67) along with questions concerning insight’s scientific validity (e.g. Perkins and Moodley, 1993). Case (2016, p. 366) established that Lewis’s (1934) definition of insight appears particularly influential in its development and understanding. According to Lewis (1934, p. 333), insight is a ‘correct attitude toward a morbid change of self'. The strong emphasis on the 'correctness' of psychiatric patients' perceptions of their illness suggests that 'disagreement with the psychiatric diagnosis and treatment would require "correction"' (Case, 2016, pp. 366–367), giving way to a lazy justification for coercive and paternalistic intervention in an individual's mental health care.

However, Markova (2005, p. 71) contends that it is David's (1990) definition that has had the most influence on contemporary psychiatry. It comprises three characteristics indicative of the presence of insight in a mental health patient, including the recognition of own mental illness, compliance with treatment and the ability to relabel unusual mental events (like delusions and hallucinations) as pathological (David, 1990). More recently, David and Ariyo (2021, p. 186) have encouraged researchers and practitioners to view insight as 'self-knowledge' and recognise that acknowledgement of illness and the need for help is 'necessary for living an authentic life'. However, as David (2020) admits, the efforts to refine the meaning of insight in psychiatry have not impacted the original definition in practice.

Thus far, studies that scrutinise the relationship between insight and the law are restricted to the analysis of already limited case law where psychiatrists are expert witnesses called for an assessment of mental capacity, or they are based on the views of psychiatrists. This results in a noticeable gap whereby the views and lived experiences of 'insight' are marginalised or insufficiently addressed in medico-legal or other socio-legal studies. In an attempt to address this gap, this article explores the relationship between insight and the relevant law by grounding it in original empirical data comprising twelve narratives and nine photo-elicitation interviews with people who have experienced mental health treatment. The analysis of this data is driven through the lens provided by the capabilities approach (Sen, 2009: 1999; Nussbaum, 2011; 2006). This more nuanced analysis suggests that the legal inadequacies surrounding consent to mental health treatment have allowed the concept of insight to filter through decision-making processes in mental health care. This results in a disparity between how the law should work and what happens in practice, resulting in some experiences of coercion being invisible to the law.

I begin by setting out the capabilities approach, developed by Sen (2009; 1999) and Nussbaum (2011; 2006), as a theoretical framework for this paper. In line with contemporary socio-legal scholarship (e.g. Lindsey and Harding, 2021), I argue that the capabilities approach provides a justice argument for minimising coercion and providing better support for decision-making processes. I then provide a methodological overview of this paper, utilising narrative, and photo-elicitation methods, which presents a novel approach to studying mental health law and socio-legal inquiry more broadly.

Following on from this, I argue that insight is used as an extra-legislative proxy for the legal regulation of involuntary admission. Drawing on the capabilities approach and the data, I argue that the processes surrounding the provision of mental health care are just as important, if not more important, than the health-related outcomes. I then explore the relationship between insight as a clinical concept and mental capacity as a legal concept. I argue that mental capacity might not be helpful in securing capabilities because it cannot capture the needs of individuals in a mental health crisis. Moreover, I suggest that greater use of mental capacity assessments in psychiatric contexts could lead to an overreliance on the concept of insight, which might negatively impact the bodily integrity of psychiatric patients. Finally, I suggest that the capabilities approach delivers a justice argument for creating real opportunities to provide informed consent in mental health settings. This approach changes the emphasis, moving the debate away from paternalistic interventions towards processes that encourage freedom and thus minimise coercion and, in turn, respect the individual's bodily integrity. In conclusion, I point to the limitations of this study and endeavour to set an agenda for further debates and research.

2. Theoretical lens: the capabilities approach

Over the last decade, the capabilities approach founded by Sen (2009; 1999) and Nussbaum (2011; 2006) has gained popularity amongst socio-legal scholars who use it to conceptualise disability rights, mental health and capacity law and medical law (e.g. Stavert, 2022; Lindsey and Harding, 2021; Thompson, 2021; Harnacke, 2013). It has also been used by psychology and health sciences researchers who discuss recovery in mental illness (e.g. Hopper, 2007), making it a relevant and attractive framework for a socio-legal exploration of the relationship between clinical concepts and the law. Sen's (1999) work has been particularly influential in the context of international human rights and development and global mental health initiatives. Vergunst *et al.*, (2014) argued that the capabilities approach is a practical and culturally appropriate framework for improving experiences of mental health in the UK population.

At the heart of this approach are people's capabilities. Capabilities are real opportunities, choices and options that allow individuals to be who they want to be and do what they have a reason to value. Realising these capabilities requires positive state action and allocation of appropriate resources. States and societies must then develop capabilities for everyone because this is the absolute minimum of what respect for human dignity needs (Nussbaum, 2006). The main concepts of the capabilities approach are 'functionings' and 'capabilities'. Functionings are actions or ways of being (Sen, 2002), such as being illness-free or being treatment-free. Capabilities are the real opportunities individuals have to achieve particular functionings (Sen, 2002). Capabilities needed to achieve higher-level functioning like agency are dynamically shaped by interactions between individuals and their environments, including their social relationships (Nussbaum, 2011). The approach encourages an evaluative focus on the extent to which people are free and able to be and do what they have reason to value being and doing (Nussbaum, 2011; Sen, 1999).

The emphasis on 'agency freedom' is significant in the capabilities framework (Sen, 2009; 1999). It is defined as 'the ability to act in accordance with one's chosen goals and values' (Sen, 2009, p. 289). Sen emphasises the need to explore systematic socioeconomic and political barriers that curtail individuals' freedom, often referred to as sources of 'unfreedom' (Sen, 2009). In accounts of participants that inform this paper, current laws were often portrayed as a source of 'unfreedom'. Law was perceived as disabling independent decision-making, preferential towards using force in psychiatric care and fetishising the freedom of powerful groups in this context (mental health professionals).

Building on the capabilities approach, I argue that 'lack of insight' is an example of unfreedom mapping onto negative experiences of coercion denying agency freedom. The approach recognises that autonomy co-exists with personal relationships, institutions and societal structures. It is based on relational and communitarian underpinnings, stating that individuals are only as free as the environment allows them (Sen, 1999). In applying the capabilities approach, I am sensitive to its limitations, especially the challenges posed by Nussbaum's (2011) support for substituted decision-making in individuals with severe cognitive disabilities. In this paper, I do not seek to claim that the capabilities approach can change English mental health law as it exists in statute, but rather that the potential of this approach lies in its premise to change how the law is implemented and experienced on the ground. I argue that people with mental ill-health, as a matter of justice, should be supported and given opportunities to develop capabilities that are attuned to their circumstances, values, needs and bodily integrity. Here, I understand social justice, through the lens of capabilities, as a practical alternative to the *status quo* or any source of unfreedom.

3. Methodology

3.1 Participants

In this article, I draw on original empirical data from a study with twelve psychiatric survivors (people with prior experiences of receiving mental health treatment) exploring experiences of

Table 1. Demographic Information

Pseudonym	Gender	Ethnicity or Nationality	Age Group	Diagnosis
Edward	Male	English	55–64	Post-traumatic stress disorder
Helen	Female	English	65–74	Schizophrenia
Fred	Non-binary	Portuguese	25–34	Generalised anxiety disorder and attention-deficit/ hyperactivity disorder
Katie	Female	English	25–34	Generalised anxiety disorder
Lucy	Female	English	35–44	Schizoaffective disorder
Millie	Female	English	25–34	Clinical depression and generalised anxiety disorder
Eliza	Female	Swedish/German/ English	55–64	Bipolar disorder
Michael	Male	English	25–34	Clinical depression
Sophie	Female	English	34–44	Bipolar disorder
Eve	Female	English	55–64	Bipolar disorder (previously)
Albert	Male	Turkish	55–64	Depression and bipolar disorder
Robert	Male	English	45–54	Depression, bipolar disorder and previously anorexia nervosa

mental health treatment. Psychiatric survivors may be regarded as a closed-off or even hidden community as their experiences and lives are perpetuated by continuous experiences of stigma (Kalathil, 2015; Ward, 2012). Kalathil (2015) suggests that this poses a difficulty in recruiting participants outside of those who are 'active' within mental health communities, like charities and local groups of those who engage in any form of self-activism. Taking this into account, this research followed a mixed recruitment method using self-selecting, strategic, opportunistic and snowball sampling to account for, at the very least, some diversity of experience (Ward, 2012, p. 192). As a result, I recruited twelve participants. Demographic information is presented in Table 1.

All twelve participants participated in narrative interviews, and all but Helen, Katie and Millie took part in the follow-up photo-elicitation interview. The research aimed to explore lived experiences of mental health treatment to provide evidence on the desirability, benefits, and disadvantages of creating a legal framework allowing for advance consent making (a form of the self-binding directive). The issues discussed in this paper form part of incidental findings which are more relevant to broader mental health law. Narrative in-depth interviewing requires a smaller number of participants, usually varying between five to nine participants (Czarniawska, 2004). The goal of this research design is not to generalise from data but to explore lived experiences and personal stories in detail. Ethical approval was granted by the relevant Research Ethics Committee and followed appropriate processes for obtaining informed consent to research.

3.2 The rationale for two-stage interviews

Mental health researchers, such as Erdner *et al.*, (2002) and Erdner and Magnusson (2011), have established that people with experiences of mental health distress struggle to articulate their encounters with treatment candidly. Experiences of stigma and trauma might mean that participants are uncertain of new people and may lack confidence in their views. They may also question their memory when the events they recall could have occurred in a heavily medicated state (e.g. Sandhu *et al.*, 2013; Erdner *et al.*, 2009; Erdner *et al.*, 2002). In addition, they may manifest mistrust in the research process (Sandhu *et al.*, 2013). Consequently, participants in verbal interviews tend to adopt a 'wait and see approach' and passively await guidance or assistance from the researcher in answering questions (Erdner and Magnusson 2011, p. 145). As a result, Erdner and Magnusson (2011, p. 147) argue that unstructured, individual (rather than group) and verbal interviews are the most appropriate research methods in this context.

Additionally, scholars (Cabassa, Nicasio and Whitley, 2013; Sandhu *et al.*, 2013; Erdner and Magnusson, 2011) encourage plural forms of methods in the context of mental health experiences and suggest that some form of an unstructured interview with the use of visuals is thought to be of particular benefit in this context. Studies which have followed this guide for research design, especially with the use of visuals, have demonstrated an improvement in rapport in the qualitative interview and help with memory triggering, plus facilitating time for reflection and opportunities for a greater openness (Sandhu *et al.*, 2013; Erdner *et al.*, 2002). Despite this evidence, photo-elicitation remains a unique method for mental health research (Erdner and Magnusson, 2011) and in qualitative paradigms more generally (Close, 2007; Prosser and Loxley, 2008; Erdner and Magnusson, 2011; Glaw *et al.*, 2017). Despite the emerging use of visual methods in law (e.g. Goodrich, 1991; Moran, 2009; Mulcahy, 2017), photo-elicitation for socio-legal research into mental health law is a novel approach.

This research might also be relevant to scholars who engage with legal consciousness approaches (Halliday, 2019). It should, however, be noted that when referring to 'everyday lived experiences' in this paper, I refer specifically and primarily to the lived experiences of receiving mental health treatment, and only then do I consider how these experiences inform how mental health law works in practice and how we could use the subjective experience to develop an agenda for future law-making. This approach bears similarities with legal consciousness studies (e.g. Ewick and Sibey, 1998; Harding, 2011) as it explores and examines the place of law in the experiences of mental health treatment. Undoubtedly my work remains inspired by the in-depth understanding of everyday life and law that legal consciousness studies offer (e.g. Ewick and Silbey, 1998; Harding, 2011; Halliday, Kitzinger and Kitzinger, 2014). In particular, my methodology might interest those engaging in interpretative approaches to legal consciousness, which Halliday (2019, p. 865) suggests are 'motivated by the simple desire to understand how ordinary people's behaviour responds to their subjective perceptions of law.' For now, my research remains grounded in the framework explicitly informed by the capabilities approach and driven by the interdisciplinary methods used.

3.3 Photo-elicitation interviews: conduct

The primary aim of using photographs was to elicit stories (Tinkler, 2013). Participants were encouraged to use photographs taken specifically for the interview or ones they already owned. This was to ensure that any photos chosen or taken by participants acted as stimuli for narrative data which emerged around images. The potential of participant-generated photographs rests upon the implication that they will likely be particularly significant for the participants (Walker and Weidel, 1985, p. 143).

Each photo-elicitation interview began with participants showing their photographs while telling their narratives. These photographs captured more spontaneous storytelling. People also told new stories which did not emerge during the previous narrative interview. As a result, they have expanded their accounts with new details.

The photographs were performative in eliciting important stories rather than serving as empirical data in their own right (Tinkler, 2013). They were used to build rapport, gain greater insight into individual and subjective experiences, and complement the narratives told in the first interview. The vast majority of photographs were incredibly private and depicted important people in psychiatric survivors' lives, or they depicted the participants themselves. Some photographs were of various personal documents. The topics pursued during this stage related to specific stories told by an individual; positive and negative experiences of treatment; experiences of coercion; experiences of loved ones acting as support or hindrance; doctor-patient relationships; advance decision-making; consent and mental capacity.

3.4 Analysis

All interviews were transcribed verbatim, and thematic coding was used for preliminary data analysis. The thematic approach has been chosen for a variety of reasons. Firstly, thematic analysis caters for theoretical freedom, which allowed me to analyse complex, rich and detailed data in a meaningful and systematic way (Braun and Clark, 2006). The theoretical freedom in analysing the narrative is characterised by the discovery of both deductive and inductive codes generating anticipated and unanticipated results. Secondly, using in-depth methods, I have collected large amounts of data, which meant that thematic analysis provided me with a rigorous way to summarise findings effectively.

Thematic coding was followed by a narrative analysis informed by the work of Strauss (1959), Czarniawska (2004), Nussbaum (2011) and Ward (2012). Czarniawska's (2004) approach suggests that each narrative is constructed around equilibrium, action, and complication. Equilibrium is the life or part of the narrative that is undisturbed. Then, a complicating event disturbs the equilibrium, so action is taken to restore the equilibrium.

However, instead of looking at actions to restore equilibrium, I used Strauss's (1959) notion of turning points, with the overall approach being influenced by Ward (2009; 2012). Turning points are critical events/situations in people's stories which lead to a period of reflection and re-evaluation of an individual's life, values, beliefs and attitudes. I adopted this approach to include looking at the central list of capabilities (Nussbaum, 2011). I was, therefore, able to evaluate the reasons behind actions and complications and the development of the disruption of capabilities that support crucial functionings. This approach was critical to identifying which capabilities psychiatric survivors value and have a reason to value and identifying sources of unfreedom in peoples' lives. I focused on the micro, meso and macro structures, relationships, institutions, and laws that shaped various mental health treatment experiences. Each of those experiences was then evaluated regarding how it enabled or hampered a specific capability/capabilities and what it meant about justice (including agency). There, I included a thick description analysis to describe the realities and complexities of mental health lived experiences through the lens of capabilities. A thick description is considered a mode of capabilities analysis (Robeyns 2017, p. 134) and has been successfully used by scholars to analyse narrative data (e.g. Conradie, 2013; Unterhalter, 2003).

4. Formal legal coercion and the role of Insight

4.1 Involuntary detention – the law

For a person to come within the remit of the Mental Health Act 1983, they must be suffering from a mental disorder, defined in the Act as 'any disability or disorder of the mind' (s 1.2. Mental Health Act 1982). The length of each detention is determined by the clinician's reliance on specific provisions of the Mental Health Act 1983. For instance, patients detained under section 2 are detained for 28 days for assessment and six months for treatment, with a possibility of this being renewed under section 3 of the Act. Detaining patients under sections 2 and 3 allows doctors to treat them without their consent under section 63 of the Act.

There are two justifications for formal legal coercion in the psychiatric context. The first is the notion of 'dangerousness' whereby a patient poses a danger to themselves or others (s 2(a) Mental Health Act 1983). This ground has survived the test of time despite overwhelming and growing evidence that mental illness is a poor predictor of violence towards others and may be no greater than among the general population; the risk of violence is much greater towards oneself than others, and the risk towards others is unlikely to be a result of mental illness and is more commonly a result of substance abuse (e.g. Monahan, 1988; Peay, 2007). Nonetheless, the consequence of this justification is that, impliedly, the role of coercion validated through the prevention of violence includes some form of social control, and so this ground has been met with scepticism among mental health professionals (Eldergill, 2002; Bartlett and Sandland, 2014). The second legal justification for legitimate coercion is the need for care and treatment due to the degree of mental disorder that an individual is suffering (s 2(a)) and that appropriate medical treatment is available to that patient (s 3(2)(d) as amended by the Mental Health Act 2007).

Contrary to the first ground, this notion of the need for care and treatment suggests that formal legal coercion is there for the alleviation of suffering and the provision of treatment rather than for social control. However, the notion of 'appropriate treatment' introduced by the Mental Health Act 2007 is problematic. Appropriate treatment does not need to be a treatment that is successful, but only that is considered by clinicians as appropriate, 'which is for the purpose of alleviating or preventing a worsening of the patient's mental disorder or its symptoms or manifestations' (Mental Health Act Code of Practice 2015, para.6.8).

Whatever the ground, involuntary detention under sections 2 and 3 has two main distinct effects. Firstly, an individual cannot leave the psychiatric hospital without permission, and patients can now be treated without their consent under section 63 of the 1983 Act. There is an important safeguard under section 58, which limits the non-consensual treatment with medication for three months after the initial detention. After this time has elapsed, the patient can only be treated with medication on their valid consent (s 58(3)(a)) or if a Second Opinion Appointed Doctor (SOAD) confirms that the patient lacks capacity under the Mental Capacity Act 2005, or, if the patient has refused treatment, then the treatment can be given if the SOAD deems it to be appropriate (s 58(3)). Thus, despite its safeguards, section 58 still allows for Second Opinion Appointed Doctors to override capacitous refusals of treatment with medication. Notwithstanding these rules, treatment may always be provided without consent in cases of emergency, as the doctrine of necessity applies to mental health treatment. It is worth noting that the SOAD system is generally regarded to be the most important procedural safeguard under the MHA 1983 for those patients who are involuntary, but scholars have questioned its efficacy for a long time (e.g. Fennell, 1998) as well as following the MHA 2007 (Bartlett, 2011).

This is only a brief overview of the law relating to involuntary detention, but it demonstrates that the law is incredibly technical and complex. This law is being implemented by medical or other relevant professionals with little legal oversight. At the same time, the statute itself is designed in a manner which affords significant legal agency and authority to mental healthcare professionals who may not necessarily have legal training to grasp the complexities of the statute. All this translates to practice that is largely invisible to the law.

4.2 Insight as an extra-legislative proxy for the legal regulation of involuntary care and capabilities

The way in which the mental health law in England and Wales is designed means that clinicians or approved mental health professionals are the gatekeepers of legal regulation. Worryingly, stories told by participants in this research reveal that insight may be used in practice instead of available legal justifications for formal coercion. In the subjective experiences of my participants, insight also matches David's (1990) definition:

> 'The psychiatrist said "It's like this. Either you think you are ill, so that means you aren't too ill really." … So, he said "if you take this medication, you will show me insight, and this means you are getting better".'
>
> (Eliza, narrative interview)

> 'They want you to say, "I'm mentally ill, that was a hallucination and oh I suddenly realised that was a delusion, I've been mentally ill, and I have to take medication." They have a very fixed definition of what insight is and insight is agreeing with them, with their belief systems.'
>
> (Eve, narrative interview)

The excerpt from Eliza embodies two elements of David's (1990) definition. Firstly, by acknowledging her own illness, Eliza would show that she has an ability to recognise her own condition, which would be indicative of insight being present. Eliza also recalls being told directly that compliance with medication is not just a sign that her mental health is improving but that she has insight. Eve's understanding of what she refers to as 'a fixed definition of insight' – acknowledging the illness, complying with medication and showing an ability to recognise unusual mental events like delusions and hallucinations as pathological – meets all three characteristics of David's (1990) definition.

Eliza was involuntarily detained seventeen times, each time for a period no longer than twenty-eight days, which would suggest she was most likely sectioned for assessment under section 2 of the Mental Health Act 1983. However, she did not appear able to justify why each of her hospitalisations lasted precisely twenty-eight days but thought that this was because the psychiatrist who was seeing her would only be able to see each patient once a month. Even though section 132 of the Mental Health Act 1983 requires that a patient be informed of their section, Eliza's experience suggests that she was not informed of her legal rights nor of the legalities surrounding her section. The two legal justifications which would trigger detention under section 2 – dangerousness or need for treatment – are not obvious decisive factors for deciding whether Eliza should have been sectioned or become an informal patient. Instead, the perceived lack of insight acted as the reason for involuntary detention. In recalling the first time she was sectioned, Eliza stated the following:

> 'The psychiatrist came following the police and she said "it's like this. Either you think you are ill, so that means you aren't too ill really. You think you're ill and you need to be in the hospital, that means you're not too ill and you don't need to be in the hospital but we will take you there, to be on the safe side, or you think you're just ill and don't need the hospital which means you are ill and we need to take you to the hospital". So, it was a complete Catch 22. I explained I knew I was ill and wanted help but did not want to go to the hospital because I had two small children. So, I got sectioned.'
>
> (Eliza, narrative interview)

Applying the capabilities approach to Eliza's experience requires an evaluation of the extent to which she was able to be and do what she values. What Eliza describes as a 'Catch 22' was essentially a choice given by a psychiatrist between voluntary and involuntary admission. This choice was dependent on the presence of insight and Eliza's unwillingness to show it by not agreeing to hospital admission effectively resulted in involuntary detention. Scholars have already likened the use of insight to the novel *Catch-22* (*see* O'Keefe, 2022) to emphasise the power this concept denotes. In her story, Eliza contends that her reason for not wanting to go to the hospital – because of her worry about her two small children – was disregarded and her non-compliance was seen as a lack of insight. Insight, in the current case, meant that Eliza was not able to act in accordance with her chosen goals and values, namely looking after her children, meaning that her agency freedom was severely limited. A capabilities-informed approach to such a situation would place a legal requirement on the clinician to consider the personal values and circumstances of an individual who meets the requirements for involuntary commitment.

Ultimately, in Eliza's story, it appears that insight was also used as an extra-legislative proxy for involuntary detention. The finding is consistent with the wider literature on insight and the law across many jurisdictions. Radovic *et al.* (2020) found that insight is frequently used in Swedish mental health proceedings but remains legally undefined. In addition, it exists in Swedish law as an 'extra-legislative catch-all argument' used to justify involuntary detention. Dawson and Mullen (2009) derived a legal definition of insight based on the case law in New Zealand to be understood as compliance with treatment. Similar to Radovic *et al.*'s (2020) findings, the lack of insight was the most significant factor in justifying involuntary treatment decisions.

Eliza's experience can be readily contrasted with Sophie's whose concern for her young child meant that she avoided involuntary detention. In the midst of a psychotic episode, a psychiatrist informed Sophie that the best course of action would be involuntary detention. Petrified by that option, Sophie explained that this did not align with her responsibilities as a single mother. The psychiatrist asked Sophie to explain *how* she was taking care of her daughter despite an intense psychotic episode. It became clear that looking after her child meant that Sophie had a sense of purpose and a structure to her day that she managed to maintain. Considering Sophie's personal circumstances, the psychiatrist decided not to detain Sophie but to offer a cocktail of medications to control her symptoms, warning Sophie that it was necessary for her to comply with treatment in order to avoid hospitalisation. Similarly to Eliza's psychiatrist, Sophie's psychiatrist used the lack of insight, understood as non-compliance with treatment, as an extra-legislative criterion for involuntary detention, of which Sophie was directly informed.

Nonetheless, Sophie's story serves as a potential example of what capabilities-informed decision-making regarding treatment might look like if the reliance of insight is taken out of the equation. It requires an appreciation of extra-medical aspects of the individual's life and a more nuanced understanding of their values and pursuits. This example reiterates the importance associated with the facilitation of treatment. The different processes that were used to achieve the same outcome are significant when viewed through the capabilities lens. Sen (2002) highlights that the process through which an outcome is obtained is more important than the outcome itself. This means that an individual who is forced into detention to receive treatment, which they would have accepted under different, less coercive circumstances, is no longer a free agent because of the 'violation of the process aspect of [their freedom], since an action is being forced on [them] even though it is an action they would have chosen freely' (Sen, 2002, p. 331) under different circumstances. The process is deemed more important than the outcome because, if the process does not allow an individual to act in accordance with their values and choices, the 'good' outcome could be offset entirely by the negative experiences of force, which is apparent in Eliza's example. Eliza's choice would be to undergo treatment which would not prevent her from looking after her children. Despite the fact that Eliza was coerced into detention, it was the lack of insight that appears to be the main, or final, reason for coercion, meaning that her supposed lack of insight was experienced as a major source of unfreedom.

It appears that, in this account, the psychiatrist believed that Eliza probably had a serious need for care or treatment, but it was the insight or lack thereof that would be the ultimate determiner as to whether that need could be fulfilled with formal coercion or voluntary detention, which makes insight an extra-legislative justification for coercion. Ostensibly, the need for treatment and care was sufficient to involuntarily detain Eliza. Insight added an extra layer of gatekeeping where its presence would result in 'the least restrictive' form of detention being used. Arguably, Eliza did show insight by admitting she needed help and that she was not well. It was her lack of compliance with the suggested treatment (detention) that ultimately meant she lacked insight in the opinion of her psychiatrist. This might suggest that compliance with treatment is the strongest predictor of the presence of insight which is consistent with the clinical literature (e.g. Kemp and David, 1996) as well as with the legal literature examining how the concept of insight features in law (e.g. Case, 2016; O'Keeffe 2022).

Clearly, how compulsory measures are implemented in practice remains largely invisible to the law. Psychiatrists may rely on familiar concepts like insight rather than legal criteria for involuntary detention because this agrees with their clinical opinion. Capabilities-informed mental health law might require the removal of involuntary detention and replacing it with capabilities-enhancing alternatives wherever possible – but these alternatives cannot be imposed on individuals, they must be freely chosen. However, the capabilities approach might be more helpful in facilitating change in the law as it occurs in everyday life rather than in statute by bridging the gap between the law and practice. This is because it encourages professionals to step away from the assessment of insight and consider the possibility of other, more everyday reasons why an individual might not wish to be detained but still wish to be treated. The decision-making processes around treatment would instead be encouraged to focus not simply on medical outcomes but also on the consequences of treatment decisions on personal circumstances, values and bodily integrity. The capabilities lens, therefore, encourages the use of processes that are the least restrictive on an individual's ability to pursue their capabilities while also enhancing agency freedom.

4.3 Performing insight as a matter of bodily integrity

Another caveat is that participants talked about 'performing insight' in order to preserve their bodily integrity. Bodily integrity forms part of Nussbaum's (2011, p. 33) list of central capabilities, and its definition includes the following non-exhaustive (Nussbaum 2011, p. 35) components: 'being able to move freely from place to place; to be secure against violent assault ... having opportunities for sexual satisfaction and for choice in matters of reproduction'. Many participants adopted an attitude well expressed by Lucy in her narrative interview with the slogan, 'if you can't fight them, join them'. This assumes that the only way for a person's voice to be taken into consideration is for them to 'perform insight'. For instance, when Eliza was released from the hospital, she lied to her mental health team about taking prescribed medications that she did not want to take because of their disabling side effects. After two weeks of daily check-ins, the team reduced their contact, stating that Eliza was showing very good insight because she was complying with the medication and therefore becoming visibly well. Thus, by performing insight, Eliza managed to avoid forced treatment. Furthermore, Robert claims to have performed insight on every occasion when seeing a community treatment team. Robert said he used to prepare for those appointments by ensuring he was dressed well, presented well and always appeared compliant, knowing that this would prevent him from being sectioned. In reality, Robert's symptoms were poorly managed, resulting in rapid devastation to his family and work life. Reflecting on those situations, Robert expressed disbelief in how easy it was to mislead healthcare professionals when, in hindsight, he had thought he would meet the criteria for detention. By performing insight, my participants highlight the futility of this concept, which in their hands becomes both a tool and a barrier to bodily integrity.

This is because, by complying with medications, people were able to preserve parts of their bodily integrity in the sense that treatments were not physically forced upon them. Having insight or performing insight meant that Eve was able to 'move freely' again by avoiding prolonged detention and the same tactic also allowed Eliza to avoid yet another section, which she had previously experienced as abusive and coercive. In Eliza's case, insight was used as a tool for the preservation of bodily integrity, but because it is experienced as a source of unfreedom, it cannot actually become one of the components of bodily integrity. Accordingly, by performing insight, psychiatric survivors compromised their bodily integrity by complying with medications or treatment they did not agree with. Sources of unfreedom are human constructions and designed to control the level of agency and opportunities, namely the capabilities available to an individual. In a subtle way, insight masks experiences of coercion, making those experiences invisible to the law. However, the law here is as much to blame for the negative experiences of insight as is psychiatry.

This is because experiences of insight remain largely unexamined in and by the law, and gaps between how the law is intended to work and how it is applied in practice effectively mean that the law allows the concept of insight to permeate mental health law in practice. Thus, the influence of law deserves to be scrutinised as much as that of psychiatry.

5. Insight and capabilities: informed consent and the relevance of mental capacity

In this section, I will argue that the law has failed psychiatric patients by not developing the capability to provide meaningful consent, compromising the achievement of bodily integrity. This is because the law provides mechanisms to override capacitous non-compliance with treatment. In this way, the law has created a situation in which treatment refusals and non-compliance – lack of insight – are pathologized, leading to lived experiences of force and coercion.

5.1 The relationship between the lack of insight, incapacity and capabilities: inadequacies of the law

As lack of insight has been found to be the strongest predictor for incapacity (Owen et al., 2009), it is likely to find its way into mental capacity assessments and consent-making in psychiatric care. In addition to involuntary treatment, patients may also be voluntarily detained, known as 'informal detention' under section 131(1) of the Mental Health Act 1983. This means that, under the law, the patients may leave the hospital whenever they wish to do so, and they may refuse any treatment. This is because informal patients, under section 131 of the Mental Health Act 1983, can only be treated with their valid consent. In order to be able to consent to treatment or to refuse to consent to treatment, a patient needs to have mental capacity. Both at common law (*Re MB (Medical Treatment)* [1997] 2 F.L.R 426, at 437) and under the Mental Capacity Act 2005 (MCA), anyone is presumed to have capacity until the contrary is shown. The MCA 2005 opens with a statement of principles (s.1) designed to guide the interpretation of the remainder of the Act. The MCA 2005 then defines what it means to lack capacity. Section 2(1) of the Act imposes a diagnostic threshold stating that incapacity must stem from 'an impairment of, or a disturbance in the functioning of the mind or brain' and that impairment might be permanent or temporary (s.2(2) MCA 2005). Section 3(1) of the MCA 2005 adopts a functional approach to capacity stating that an individual would be unable to make a decision for themselves if they are unable to understand the information relevant to that decision, retain that information (even if only for a short period of time: s.3(3)), to use or weigh the information and to communicate that decision. The capacity test is decision specific, which means that the law recognises that an individual may have the capacity to make some decisions but not others at the same point in time.

Hale (2017, p. 15) suggests that voluntary patients exist in theory only and, in reality, there are two types of voluntary patients that can be distinguished in practice. First, some are regarded as 'truly voluntary'. These patients agree with doctors' advice and comply with all treatments. The second type of voluntary patient is a patient who refuses treatment or wishes to leave the hospital. In those situations, patients may be 'persuaded' to stay or to take medication because otherwise, they will be sectioned under sections 2 or 3 of the Act so that the treatment in question can be provided without consent (Hale 2017, p. 15). In addition to preventing patients from leaving the hospital, section 5 may be applied, which allows voluntary patients to be sectioned for up to seventy-two hours. However, section 63 (non-consensual treatment) would not apply in this situation.

Following Hale (2017), it appears that whether a patient has the rights and privileges of informal detention depends on whether they show insight – i.e. compliance – rather than whether they have the relevant mental capacity. Owen *et al.*, (2008) found that 97 percent of psychiatric patients admitted to a psychiatric hospital in England had the mental capacity to make treatment-related decisions even when the majority of patients were detained involuntarily. Hale (2017) also notes that the majority of psychiatric patients have the relevant mental capacity providing that the test is applied accurately and its provisions are not abused. In line with those arguments, the narratives from some of my participants suggest that the absence of formal legal coercion in informal detention does not necessarily mean that admission is voluntary 'in the sense of being freely chosen' (Hale, 2017, p. 15) and mental capacity assessments appear to be replaced or conflated with the assessment of one's insight.

Similarly, to Eliza, Lucy had been given a choice between a section or voluntary detention for treatment. Lucy had chosen to become an informal patient, unlike Eliza, and although she felt this was truly her choice, the treatment that was administered during an informal stay was still experienced as coercion because it was not consensual:

> 'I didn't refuse treatment in the hospital, but I saw people who did, and it terrified me. And so, I was very much like "'no, thank you very much, I will take my tablets even though they made me feel awful". So, I was never restrained in the hospital which I am very grateful for. My treatment wasn't consensual, I feel ... I can remember the doctor sort of saying "you need this, you need this right now" and me being like "oh okay" and then not remembering anything until the next day. I don't remember ever being asked if I would like a medication. That was never asked of me. It was never a question, it wasn't like "we can give you some antipsychotics, or you can choose not to have them, this is what they do and this is what they are" they would just go "we are going to start you on clozapine".
>
> It felt very invasive and abusive ... I felt like my choice was to take the medication and not question it or die.'
>
> (Lucy, photo-elicitation interview)

Lucy's excerpt demonstrates that the experiences of informal patients might be more complex than previously discussed in Hale's (2017) typology of voluntary patients. Lucy's hospital stay was truly voluntary, as she emphasised on a number of occasions throughout her narrative and photo-elicitation interviews. However, despite 'agreeing' to treatment, her consent was an illusion. To preserve her bodily integrity by avoiding physical force and restraint, Lucy obeyed all treatment that was given to her. Additionally, Lucy's treatment did not just lack consent but lacked any participation by Lucy herself in the decision-making process about the treatment, thus blurring the lines between formal legal coercion and what was supposed to be a voluntary treatment plan.

5.2 Insufficient information and insight

In the accounts of my participants, insufficient information about their treatment led to experiences of treatment which, although compliant, was experienced as non-consensual and thus forced. After five years of effective mental health treatment, Lucy decided that she would like to have a child but became worried about possible side effects that the medications she was taking would have on her potential pregnancy and so decided to discuss this with her psychiatrist but the reaction of her psychiatrist shocked Lucy:

> 'She said to me "you probably won't get pregnant because you've been on medical castration medication for so long and on such high dose that you're probably infertile. Anyway, being pregnant whilst suffering with schizoaffective disorder would not be good for your mental health. You might find it all very hard".'
>
> (Lucy, narrative interview)

Lucy pinpointed this memory as a stark realisation that she had been on a potentially life-altering treatment without her consent. The psychiatrist explained that certain side effects had not been disclosed to her because they could have severely impacted her 'insight', and it had been more important at that time to alleviate the severity of her symptoms and reduce the possibility of relapse through the use of that particular medication. Clinical research has shown that adherence to psychiatric medications, especially antipsychotic medication, is poor outside of hospital settings where the treatment can be administered with force if needed (Corrigan *et al.*, 2008). It has been suggested that compliance with medication and the associated presence of insight is closely related to the information that the patient has about the perceived risks and benefits (i.e. presence of insight) of any given treatment (Corrigan *et al.*, 2008). Thus, current psychiatric practice encourages practitioners only to disclose important side effects proportionately to the risk that the patient presents (Weiden, 2007; Corrigan *et al.*, 2008). Kane, Kishimoto and Corell (2013, p. 221) also found that psychiatric patients suffer from 'the lack of information as to what to expect from treatment in terms of side effects and the risk of specific side effects' and suggest, in line with other studies (e.g. Lacro *et al.*, 2002), that adherence to medication should be achieved through meaningful trusting relationships between the psychiatrist and the patient where there is a mutual discussion about side effects and perceived benefits. Lack of disclosure or the provision of insufficient information have been associated with concerns over insight, not just in the stories told here but also acknowledged in other research (Owen *et al.*, 2009; Tessier *et al.*, 2017).

Here, it might be worth considering how the misguided focus on insight, in the guise of compliance with medication, and the need for greater information disclosure could be remedied by the law. The aforementioned clinical studies do not discuss the need for doctors to adhere to relevant legal provisions on the disclosure of relevant information. Some studies report that in many jurisdictions psychiatrists' knowledge of mental health legislation and associated relevant laws may be patchy and poor, emphasising the lack of sufficient legal training in psychiatry (e.g. Humphreys, 1998). Prior to 2015, consent did not have to be as informed in terms of its risks and benefits. However, in *Montgomery* v *Lanarkshire Health Board (General Medical Council intervening)*, [2015] UKSC 11, 87 (Lord Kerr and Lord Reed) the Supreme Court held that:

> 'an adult person of sound mind is entitled to decide, which if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor, therefore, has a duty to take reasonable care to ensure that patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatment. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should be aware that the particular patient would be likely to attach significance to it.'

Hale (2017, p. 211) states that 'by sound of mind the Supreme Court meant a patient with the capacity to decide their own medical treatment'. This is problematic because it is not clearly inferred from the judgment that this is what the Supreme Court did actually mean. Therefore, it does not necessarily follow that this is how *Montgomery* is or will be applied in practice. Instead, it is possible that by 'sound of mind' psychiatrists might infer someone who does not suffer a mental illness and that those who do might not be afforded the privilege of sufficient information given about their treatment, as promised by this landmark case law.

Looking back on Lucy's story, it is unlikely that she lacked the capacity to decide whether or not to undergo the treatment because it was given to her during a routine appointment following a weight gain from her previous medication. Lucy also appeared to have a good understanding of the mental capacity assessment and stated that she did not think she had ever lost her functional capacity to make decisions. It is, therefore, difficult to imagine a situation in which a doctor prescribing treatment for a young woman knowing that it carries the risk of chemical sterilisation, does not consider this to be relevant information and a material risk pertinent to disclosure. Lucy's story, however, is one of the shattering symptoms that caused serious danger to her life and health and the lives of others.

The standard created by the Supreme Court in *Montgomery* also requires that the doctor informs the patient of suitable alternatives. It is also unclear whether there was an alternative medication that Lucy could have been given, and it is also entirely possible that Lucy's story is a prime example of bad practice. Another participant, Sophie, specifically recalls being asked if she was planning to have any more children in the future because the psychiatrist needed to know whether a medication that can cause fertility issues should be avoided. Nonetheless, the outcome of Lucy's experience was that she considered informed consent in psychiatry to be 'a bit of a joke' – a sentiment which was shared by all twelve participants.

In the view of psychiatric survivors, it is insufficient information that is strongly interfering with their capability for bodily integrity. The interference with the capability for bodily integrity is especially striking in Lucy's story. Nussbaum (2011, p. 33) considers reproductive health and choice within that to be central to this capability, and in Lucy's story that part of bodily integrity was hampered not directly by the medication but by the lack of information. Here, impeding on bodily integrity means impeding on agency freedom too. The capabilities approach is concerned with providing people with the minimum threshold of capabilities, but the minimum threshold remains undefined in the approach. It is, however, suggested that the threshold should be enough to accommodate people's opportunity for developing relevant capabilities like bodily integrity that support associated functionings like agency freedom. The psychiatric survivors highlighted that side effects should be disclosed in accordance with individuals' needs, and therefore the standard created by *Montgomery* appears to be compatible with the development of capability for bodily integrity in the psychiatric context. However, for this capability to be supported it would need to be sufficiently applied in clinical practice. This again highlights the difficulty of requiring psychiatric professionals to apply new and quite complex laws in their psychiatric practice. Consequently, psychiatrists rely on clinical concepts like insight to aid adherence and consent to treatment by patients.

5.3 Mental capacity and insight

Everyday experiences of psychiatric care reveal little reliance on the concept of mental capacity. In general, they had some awareness of the mental capacity test and expressed opinions on its application in the psychiatric context. As Lucy had experienced several informal hospital stays, I asked her directly if her capacity was ever assessed. When asked about her experiences of mental capacity assessments, Lucy said she did not realise they were relevant to mental health settings and that she does not think her capacity was ever assessed. She stated that she had read all her medical notes, and she had not come across any information about her capacity status. However, as an informal patient, Lucy could only have been treated on her valid consent, which means that her capacity should have been assessed, at least in theory. Instead, Lucy said that her medical notes presented plentiful information about the presence or absence of insight when notes were made about her adherence to rather than her consent to medication. Similarly, other participants stated that they did not remember having had their mental capacity assessed and that decision-making appeared always to have been dependent on the presence of insight.

Brown *et al.* (2013), found that only 9.8 percent of capacity assessments were documented in almost 18,000 admissions to a psychiatric hospital in England. Within those, only 14.7 percent relied on the Mental Capacity Act criteria for assessing capacity and other criteria used were described as arbitrary (Brown *et al.*, 2013, p. 122). Yet, assessments based on insight appear common. If, as suggested by this data and other research, psychiatrists conduct capacity assessments arbitrarily or rely on the concept of insight in capacity assessments, it is worrying to note that psychiatrists make up over 50 percent of mental capacity expert witnesses in the Court of Protection (Case, 2016). It is not clear why psychiatrists are so often called for their perceived expertise in capacity assessments, but Case (2016) suggests this is linked to the perception that, as psychiatrists *cure* minds, there might be an impression that they are also well placed to assess capacity. Also, this might or might not be related to the history of the development of mental capacity law. In *Re C (Refusal of Medical Treatment)* [1994] 1 F.L.R. 31 (at 295), Thorpe J found helpful a forensic psychiatrist's analysis of the decision-making process broken down into three stages: comprehending and retaining treatment information; believing it; and, finally, weighing it in the balance to arrive at a choice. This suggests that mental capacity is not purely a legal concept, and its legal development has been influenced by the discipline of psychiatry (Ruck-Keene *et al.*, 2015). This interrelatedness between mental capacity and insight provides an explanation as to why insight so easily seeps into capacity assessments conducted by psychiatrists. This further explains why, for instance, expert witnesses in the Court of Protection commonly use medicalised approaches to assess capacity (Ruck Keene *et al.*, 2015: Lindsey 2020), as Lindsey and Harding (2021, p. 19) point out:

> 'this is arguably because capacity is often considered to be a clinical question, which can be assessed through cognitive tests or other quasi-objective measurements used by psychiatrists to aid diagnosis.'

However, other studies suggest simply that mental capacity is a complex legal concept and professionals require more training to fully understand it (Jayes, Palmer and Enderby, 2017). In 2018, the National Institute of Health and Care Excellence (NICE 2018, para 1.4.24.) released guidelines on assessing mental capacity in practice, stating that:

> 'Practitioners should be aware that a person may have decision-making capacity even if they are described as lacking 'insight' into their condition. Capacity and insight are 2 distinct concepts. If a practitioner believes a person's insight/lack of insight is relevant to their assessment of the person's capacity, they must clearly record what they mean by insight/lack of insight in this context and how they believe it affects/does not affect the person's capacity.'

The guideline highlights that 'capacity' and 'insight' are distinct and not interchangeable concepts. Nonetheless, it still permits the use of insight in capacity assessments providing that the reasons for its relevance are clearly recorded. But using insight in this context is using extra-legislative criteria which might result in the denial of rights for those who, in fact, have the capacity. It is clear that the mental capacity test may be severely underused or misused in practice, and when it is applied, it tends to be invisible to the law. I am, therefore, hesitant to argue that there should be a greater reliance on the concept of mental capacity in psychiatric practice.

Finally, participants questioned the validity of mental capacity and its wider application in the psychiatric context:

> 'I think mental capacity is hard to think about. I swear different professionals assess it differently. Isn't there a unified training? I don't know it is potentially creating a dangerous situation … I don't think I ever lost capacity … Risk assessments are better because I genuinely posed a risk to my own life and my mum's, but I am sure I could appear as someone who could still have capacity. Risk is real, this capacity test is not. I don't think your capacity is assessed much in mental health settings, maybe they do it and don't tell us? This might be another concept that ends up being abused by most professionals.'
>
> (Lucy, photo-elicitation interview)

> 'On the flip side, what if I have capacity, don't get sectioned because of that, go home and kill my neighbour? Not that I would but hypothetically speaking.'
>
> (Eliza, photo-elicitation interview)

In the above excerpts Lucy and Eliza share parallel sentiments about the mental capacity test not being able to take into account the issue of safety. Lucy is the only participant who described symptoms that drove her into potential danger, recalling visual hallucinations and a persistent voice telling her she needed to kill her mother. In an attempt to appease the voice, Lucy wanted to harm herself in order to save her mum but admits that, on a few occasions, if it had not been for the intervention of the mental health services, she would have hurt her mum. However, she then backtracks and suggests that she would probably harm herself to avoid harming her mother.

Despite the intensity of her symptoms, Lucy contends she could have shown she had mental capacity and would have been able to present 'well' to others, especially if she had wanted to. Eliza, who did not exhibit dangerous behaviour towards others, raises an important question that might arise from a potentially perilous situation created in circumstances where mental health provisions are replaced with reliance on the MCA 2005. However, participants felt that the legal obligation attached to mental capacity assessments or the MCA 2005 could mean that there was a greater potential for creating space in which professionals are not encouraged but required to take patients' views into account. Additionally, participants believed it to be unlikely that they had ever lost their mental capacity and that reliance on the test would mean that doctors could 'wash their hands off of [patients]' (Katie, narrative interview) and that people who needed help would be 'left on their own' (Eve, photo-elicitation interview) or that insight is used in the place of capacity assessment.

Capacity as a legal concept is not tailored enough to capture the complex experiences of mental health and needs around treatment and is a poor tool for guaranteeing psychiatric patients' wishes be given greater consideration. This is because it is unlikely to triumph over the paternalistic provisions in the MHA 1983. However, as Lindsey and Harding (2021) note, the capabilities approach:

> 'requires that opportunities are not denied on the basis of a lack of necessary (or combined) capabilities – in fact, quite the opposite; a person should be given the opportunity to develop such capabilities on the basis of a human entitlement to having that capability.'

This means that respecting the views and needs of psychiatric survivors could not be denied even in situations where they lack capacity or insight. Overall, my approach would suggest a greater focus on the views of the patient in relation to their care that is fostered by the capabilities-informed shift in culture where law meets everyday practice and everyday needs of people who experience mental ill-health. Adopting a capabilities analysis justifies a provision of support to achieve the capability to consent and closely associated bodily integrity (Nussbaum, 2011). This, however, is a matter of justice rather than a legal obligation (Lindsey and Harding, 2021). Even if the capabilities approach does not dictate how the law should be changed, it highlights areas for policy considerations and highlights that informed voluntary and competent consent is a matter of justice.

6. Conclusion

The findings of this empirical research highlight that psychiatric survivors experience formal legal coercion and extra-legal coercion in mental health settings that can be attributed to the excessive reliance on the concept of insight. These experiences of coercion could be minimised by providing mental health patients with meaningful opportunities to give informed consent and consider the needs of individuals facing compulsory treatment. Legal inadequacies explored in this paper create a legal landscape full of gaps through which the concept of insight can find its way. This leads to experiences of force, coercion and abuse. Rather than discrediting the validity of insight in psychiatry, I argued that insight masks legal and extra-legal coercion when used to justify legal interventions and acts as an extra-legislative measure. Mental health laws place major infringements on individual's rights; therefore, these deserve as much scrutiny as clinical concepts. As a matter of justice, there must be a clear definition and guidance concerning clinical concepts that professionals operationalise in practice to reach a consensus amongst different actors on the use and appropriateness of those concepts.

Using the capabilities approach as a lens to view these issues highlights that negative experiences in mental health settings can, in turn, overshadow successful treatments leaving psychiatric survivors feeling dissatisfied with the care and strong feelings of injustice. For example, lack of meaningful opportunities for providing informed consent is experienced as an abuse of bodily integrity. The capabilities approach provides a justice argument for resources to be allocated to improve the experiences of psychiatric survivors through support, research, policy and law-making. I contend that the capabilities approach can change how professionals apply the law in everyday settings and how it can benefit those at the heart of relevant debates – people who experience mental ill-health. The capabilities lens can be a valuable measure for assessing legal initiatives currently on the law-making agenda, like advance consent/decisions, advance choice documents and the appropriateness of mental capacity assessments in psychiatric care. In thinking about the mechanisms for independent decision-making, it is imperative that we do not create frameworks which allow insight to seep in and add further to experiences of coercion and paternalism.

Acknowledgements. I want to acknowledge the support of the Economic and Social Research Council (MGS ESRC DTP). In addition, I would like to thank the anonymous peer reviewers for their thoughtful comments, which allowed me to improve and sharpen this paper. I would also like to thank Professor Rosie Harding, the Global Legal Studies research group at the University of Birmingham, the SLSA Mental Health and Mental Capacity Law Stream and the SLS Health Law Section for comments on the earlier drafts of this paper.

Competing interests. None declared.

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Cite this article: Furgalska M (2023). 'Informed consent is a bit of a joke to me': lived experiences of insight, coercion, and capabilities in mental health care settings. *International Journal of Law in Context* **19**, 456–474. https://doi.org/10.1017/S1744552323000174