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# Not ‘us’ and ‘them’: towards a normative legal theory of mental health vulnerability

Phil Bielby

School of Law and Politics and Institute of Applied Ethics, University of Hull, Cottingham Road, Hull, HU6 7RX, UK  
E-mail: [p.bielby@hull.ac.uk](mailto:p.bielby@hull.ac.uk)

## Abstract

In this paper, I develop the basis of a normative legal theory of mental health vulnerability. In [Section 2](#), I conceptualise mental health vulnerability by integrating a universal understanding of vulnerability with a subjective-evaluative, psychosocial and dimensional account of mental health. In [Section 3](#), I move on to consider the significance of mental health vulnerability for legal theory through an encounter with perspectives on vulnerability offered by MacIntyre, Fineman and Del Mar. This offers an insight into the normative foundations of mental health vulnerability. In [Section 4](#), I outline a normative framework for mental health vulnerability that involves a synergy of rights and care. This extends Engster’s idea of ‘a right to care’ to mental health and highlights the role of care and rights in mitigating power imbalances and inequality in relation to mental health. In concluding, I suggest future directions for research on mental health vulnerability.

**Keywords:** mental health; vulnerability; normative legal theory

## 1 Introduction

Mental health and vulnerability both lie at the heart of the human condition. Just as everyone experiences a state of mental health, ‘everyone is vulnerable’ (Herring, 2016, p. 7). Today, mental health also attracts considerable significance in terms of public health strategies (Mental Health Task Force, 2016), global policy initiatives and ‘sustainable development goals’ (United Nations General Assembly, 2017, para. 14). Yet the connection between mental health and vulnerability is surprisingly neglected in legal theory. Where legal theorists have addressed mental health at any length, this has taken place primarily in the context of free will, mental disorder and responsibility in criminal and tort law (e.g. Hart, 1968/2008; Moore, 1984; Hart and Honoré, 1985) or, from the perspective of therapeutic jurisprudence, in terms of the potential of legal phenomena ‘as a therapeutic agent’ (Winick, 1997b, p. 185) within and beyond mental health law (e.g. Winick, 1997c; Wexler and Winick, 1996, respectively). And, until recently, legal theorists have considered the idea of vulnerability in passing if at all (e.g. Hart’s brief discussion of physical vulnerability as a reason for rules against violence (1961/2012, pp. 194–195)). By contrast, during the last decade, the literature considering the relevance of vulnerability to legal theory has burgeoned (e.g. Fineman, 2008; 2010; Del Mar, 2012; Fineman and Gear, 2013; Philippopoulos-Mihalopoulos and Webb, 2015). This has been paralleled by a growing literature considering vulnerability in relation to specific concepts and debates across legal thought and doctrine, such as dignity (Neal, 2012), caring (Herring, 2013), negligence (Stychin, 2012), disability discrimination (Satz, 2008), family law (Collins, 2014), security and public protection (Ramsay, 2012), health-care law (Biggs and Jones, 2014) and the legal understanding of the ‘vulnerable adult’ in adult social care (Dunn *et al.*, 2008; Herring, 2016; Clough, 2017). This reflects a broader ‘vulnerability zeitgeist’ (Brown *et al.*, 2017, p. 497) that extends beyond legal studies. However, the nature of mental health vulnerability remains unexplored.

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In this paper, I develop the basis of a normative legal theory of mental health vulnerability. My focus on, and use of, mental health is as a fundamental aspect of *any* human life, encompassing good or satisfactory levels of mental health as well as common or severe mental health problems (i.e. those that are recognised in psychiatry as diagnosable mental disorders/illnesses).<sup>1</sup> As such, it is broader than legal understandings of mental disorder, mental (in)capacity, mental disability or the legal definition of vulnerable adulthood (for a discussion of these, see Dunn *et al.*, 2008; Bartlett and Sandland, 2014, pp. 13–17, 173–188; Herring, 2016; Clough, 2017) on which existing legal scholarship concerning mental health and vulnerability is typically focused. If legal theory is to fully address the nature of this inescapable psychosocial dimension of human existence – and, by implication, the needs and claims of *all* citizens on the basis of their mental health – mental health vulnerability cannot be ignored. It therefore offers a timely and important research direction for legal and political theory as well as advancing the debate about the nature of vulnerability itself. Most importantly, however, it yields insights to further solidarity, compassion and social justice in legal and political thought.

In Section 2, I begin by conceptualising vulnerability and mental health. Drawing on a universal understanding of vulnerability, in particular Martha Fineman’s vulnerability theory, I integrate this with insights from psychological theories of mental health. I argue that mental health vulnerability is part of our universal human vulnerability, involving differing levels of psychological and relational resilience, and based on an account of mental health that is subjective-evaluative, psychosocial and dimensional. This approach accommodates the range of influences upon, as well as different levels of, mental health within an account of universal vulnerability. In Section 3, I move on to consider the significance of understanding mental health vulnerability for legal theory through an encounter with perspectives on vulnerability offered by Fineman, Alasdair MacIntyre and Maksymilian Del Mar. This offers an insight into the normative foundations of vulnerability in general and of mental health vulnerability in particular. In Section 4, I outline the basis of a desirable normative framework for mental health vulnerability. This normative framework has two synergistic features – a rights-based element and a care-based element. This synergy involves a rationally justified ‘right to care’ (Engster, 2007, p. 53), which supports the solidaristic understanding of mental health vulnerability I develop and serves to mitigate imbalances of power in mental health and inequalities in the social determinants of mental health. Since my focus is theoretical and, for reasons of space, I have little to say here about specific instantiations of policy and law, I refer briefly to occasional examples drawn from public mental health promotion strategies like England’s 2016 Mental Health Task Force report and Improving Access to Psychological Therapies (IAPT) programme (Clark, 2012), the 2017 report by the UN special rapporteur on the right to health (United Nations General Assembly, 2017), the Health and Social Care Act 2012 in England and Wales as well as from the UN Convention on the Rights of Persons with Disabilities (CRPD – Art. 1, para. 2 of which includes people with enduring mental health problems within the definition of disability (United Nations General Assembly, 2006)). The choice of these examples reflects the fact that my universal account of mental health vulnerability is broader than mental disorder, mental capacity or mental disability. In concluding, I will suggest some future directions to take forward research on mental health vulnerability.

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<sup>1</sup>I use the terms ‘mental health problems’ or ‘mental distress’ in preference to ‘mental disorder’ in order to avoid valorising a problematic medicalised conception of mental health suffering and any implication that these experiences lack meaning (Bolton, 2008, p. 247; Tew, 2011, pp. 4–5). Bolton also notes that the term “‘mental health problems’ ... is probably neutral to aetiology’ and minimises stigma (2008, p. 248). Although the terminology of mental disorder is often utilised in law, such as in s. 1(2) of the Mental Health Act 1983, reference to ‘severe’ mental health problems is sufficiently broad to be capable of encompassing those which fall within typical legal definitions. It follows that ‘mental health problems’ also has the advantage of referring to the experience of less severe forms of mental distress for which mental health legislation would not usually be invoked. See Bolton (2008, pp. 22–29, 247–253) and Tew (2011, pp. 4–5) for discussion of these terminological debates.

## 2 What is mental health vulnerability?

To understand the nature of mental health vulnerability, we need to consider first the idea of vulnerability itself. This is especially important given the ‘vagueness and malleability’ surrounding uses of vulnerability (Brown *et al.*, 2017, p. 498). At its core, vulnerability is a propensity shared equally by all human beings to physical, psychological and developmental harm, rooted in shared human fragility, fallibility and finitude (Bielby, 2008, p. 52; Rogers *et al.*, 2012, pp. 12, 19; Herring, 2016, p. 6). This is reflected in the etymology of ‘vulnerable’ in the Latin verb *vulnerare*, meaning to wound (Bielby, 2008, p. 52; Turner, 2006, p. 28). Vulnerability can therefore be understood as pertaining to a range of basic interests universally held amongst human beings – such as in life, food, shelter, physical and psychological health (Gewirth, 1978, p. 1158; Griffin, 2008, p. 90) – which can be met, denied or undermined by the action or inaction of others, and/or by factors beyond human control (Bielby, 2008, p. 52). It is a ‘universal’ and ‘ontological’ experience of the human condition inherent within and experienced by us all (Bielby, 2008, p. 53; Turner, 2006, p. 109; Fineman, 2008, p. 8; Gear, 2010, p. 135; Rogers *et al.*, 2012, p. 12; Gilson, 2014, p. 15; Herring, 2016, p. 10). I will refer to this subsequently as ‘universal vulnerability’.

Understanding vulnerability as a universal experience of the human condition ‘unites us across all our differences’ (Fineman, 2014, p. 311). This is because it associates it in relevantly similar respects with lives characterised by considerable advantages and independence, such as that of a highly educated, affluent individual in excellent health, as well as with lives where advantages and independence are significantly constrained, such as that of an individual living in poverty with multiple health conditions. Put starkly, both can be killed, injured, starved, abused or oppressed, despite the glaring personal and structural inequalities between them that offer differing levels of resilience (Fineman, 2010, pp. 269–273) to those threats. In this way, recognition of our shared vulnerability focuses on the fundamental similarities rather than the differences between oneself and the situation of others who experience particular adversity through, for example, the experience of poverty, discrimination, violence, abuse or mental distress. This recognition fosters solidarity and an appreciation of what unites humanity rather than divides it (Rogers *et al.*, 2012, pp. 31–32). Yet, while some question an understanding of vulnerability deriving principally from a predisposition to harm (Gilson, 2014, p. 8), it does not follow that the experience of vulnerability is necessarily undesirable or negative (Gear, 2010, pp. 129–130; Herring, 2013, p. 55; Heaslip, 2013, p. 20; Herring, 2016, p. 1). Indeed, given the unavoidable possibility and probability of experiences that threaten these basic interests, the experience of our shared vulnerability is personally and socially transformative, providing a foundation for self-awareness and self-acceptance, interpersonal understanding and moral imagination (Nussbaum, 1996, p. 35; Hoffman *et al.*, 2013, p. 8; Beyleveld and Brownsword, 2001, pp. 114–117; Bielby, 2016, pp. 176–178; Gilson, 2014, pp. 15–16; Herring, 2016, p. 43) thus ‘enabling the development of empathy, compassion, and community’ (Gilson, 2014, p. 8).

As the above example illustrates, some human beings experience elements of this universal vulnerability more acutely, and in some cases more onerously, than others. Fineman observes that ‘[v]ulnerability ... is both universal and particular; it is experienced uniquely by each of us ... our individual experience of vulnerability varies according to the quality and quantity of resources we can command’ (Fineman, 2010, p. 269). This may lead to a greater likelihood that one’s basic interests could be undermined, denied or jeopardised in some way compared to others, amounting to a ‘reduced capacity, power or control to protect [one’s] interests relative to other persons’ (Mackenzie and Rogers, 2013, p. 52, n. 3). We can explain this greater exposure to not having basic interests met in terms of limited resilience, which includes constraints on support and resources, to withstand or protect oneself from these threats (Fineman, 2010, pp. 269–273). On this account, resilience co-exists with vulnerability (ten Have, 2016, pp. 27–28; Lotz, 2016, p. 55), rather than opposes it (Ostrowski, 2014, p. 14) because resilience prevents our universal vulnerability from becoming all-consuming whereas our universal vulnerability highlights the contingency, susceptibility and conditionality of resilience. The contingency of resilience on social, political and legal factors points to a normative and relational

understanding of resilience (Höfler, 2014, pp. 36, 45; DeMichelis, 2016, pp. 1–2) that is responsive to social injustice (Lotz, 2016, pp. 57–58). It follows that the common experience of universal vulnerability and the common challenge to our resilience to deal with the shared threat to our basic interests provides the source of the ethical justification for appropriate social, political and legal responses to vulnerability that reflect this solidarity (Fineman, 2010; Rogers *et al.*, 2012, p. 23; Lotz, 2016, pp. 57–58; Bielby, 2016). This distinguishes the meaning of resilience from a neoliberal ‘responsibilised’ resilience (Evans and Reid, 2013; Howell and Voronka, 2012, pp. 4–5; Lotz, 2016, p. 57) where the individual is expected ‘to take responsibility for the emotional damages that marketisation causes’ (Ecclestone and Brunila, 2015, p. 494). It also contests analyses that doubt the role that vulnerability can play as a distinct normative concept (Wrigley, 2015).

Since the universal vulnerability we all experience exposes everyone to resilience challenges, a greater exposure to resilience challenges tends towards a heightened lived experience of our universal vulnerability (Dunn *et al.*, 2008, pp. 245–246; Spiers, 2000, p. 719; Bielby, 2016, p. 178). Because the predisposition we all share to heightened lived experiences of vulnerability lies in our universal vulnerability, it is irrelevant if we individually happen never to experience particular forms of enhanced threat to our basic interests, such as starvation or homelessness – what matters is that we can because it is *conceivable* we could experience such adversity (Hoffman, 2014, p. 74). And, plainly, during the course of life, we are all highly likely to encounter serious threats to our basic interests in some forms (e.g. a severe illness), however much we may wish otherwise. In other words, while our unique experience of vulnerability is contingent on the resilience to withstand what happens to us during our life, what we are vulnerable to is not contingent, as it is rooted in our universal vulnerability, which is constant (Fineman, 2008, p. 1). The recognition that aspects of universal vulnerability are experienced more acutely or onerously due to limitations on resilience that we all encounter further entrenches a solidaristic understanding of vulnerability (Rogers *et al.*, 2012, pp. 31–32). Yet it also helps us to identify those who are more exposed to constrained resilience, addressing the objection that ‘[i]f everyone is vulnerable, then the concept becomes too nebulous to be meaningful’ (Levine *et al.*, 2004, p. 46; see also the similar point made by Wrigley, 2015, p. 482). With this in mind, the right question to ask is how constraints on one’s resilience to cope with universal vulnerability are causing one’s lived experience of vulnerability to be more acute or onerous than that of someone else, rather than whether one is vulnerable or not, or how vulnerable one is. This question can be explored vividly in the context of mental health.

Mental health is a core element of our universal vulnerability. It is central to our sense of self and capacity to have purposes that we choose and are of value to us (Bielby, 2016, p. 175). However, for a term that is used widely in public discourse, there is little agreement on what mental health actually means, especially when it is separated from medicalised concepts like ‘disease’ and ‘illness’ (Tengland, 2002, pp. 2–3; Seedhouse, 2002, pp. 33–34; Pilgrim, 2017, p. 3). When used in a positive sense, mental health can be understood variously as akin to self-esteem, well-being, self-identity, coping, social acceptance and integration, and, somewhat circularly, not experiencing psychological ill-health (Seedhouse, 2002, p. 36). Additionally, some have observed that mental (ill)health cannot be understood in isolation from physical (ill)health (Seedhouse, 2002, pp. 45–46; Matthews, 1999, p. 55) or from cultural values (MacDonald, 2006, p. 15). The existence of a multiplicity of definitions along with the interconnection between mental and physical health have led to scepticism that any plausible definition can be offered at all (Seedhouse, 2002, Chapter 3).

Although it is not possible to explore these debates fully here, for present purposes, I will understand mental health as the subjective experience of psychological and emotional well-being that involves ‘individuals’ perceptions and evaluations of their own lives in terms of their affective states and their psychological and social functioning’ (Keyes, 2002, p. 208). This takes into account the experiences of ‘the whole person’ – including their feelings, beliefs, embodiment and social context – rather than merely symptoms (Ladd and Churchill, 2012, pp. 22–23, 25; Seedhouse, 2002, Chapter 4). The idea of good mental health – which can also be understood as mental health ‘flourishing’ (Keyes, 2002, p. 208) – depends upon self-worth, self-trust and self-acceptance/self-compassion that

facilitates personal growth (associated in particular with the humanistic psychology of Carl Rogers) (Tengland, 2002, pp. 41–44; Neff, 2003, p. 91) as well as resilience (Joubert and Raeburn, 1998; Tew, 2011, pp. 61–62) and hope (Snyder, 2002). Yet it is important to emphasise that experiences of unhappiness, dissatisfaction, sadness, fear and anger are ‘part of a mentally healthy life’, as our engagement with them enables personal growth and positive change (Tew, 2011, p. 19). This synergy between mental health and psychological well-being resonates with the World Health Organisation’s definition of health, which extends to ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 1948) as well as with aspects of the World Health Organisation definition of mental health framed as ‘a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’ (WHO, 2014). It also shapes definitions of mental health endorsed by the English mental health charity Mind (Warin, 2013, p. 4) and the British government’s *No Health without Mental Health* outcomes strategy (HM Government/Department of Health, 2011, p. 87). Most recently, the UK’s Mental Health Foundation affirms the subjective-evaluative experience of psychological and emotional well-being, highlighting ‘the ability to feel, express and manage a range of positive and negative emotions’ and ‘the ability to form and maintain good relationships with others’ as components of good mental health (Mental Health Foundation, 2018).

A corollary of this account of mental health as subjective-evaluative well-being is that it is psychosocial (or ‘psychobiosocial’ (Kinderman, 2014, p. 4)) and dimensional. It is psychosocial insofar as it recognises the complex interaction of psychological and social factors that have primary influence on mental health over the biological factors emphasised by traditional psychiatry (Kinderman, 2014, pp. 24–25, 38; Johnstone, 2000, p. 35; for a discussion of the ‘biomedical’ model and its dominance, see Davidson *et al.*, 2016, Chapter 1; United Nations General Assembly, 2017, paras 18–20). On this account, ‘mental well-being is fundamentally a psychological and social phenomenon, with medical aspects ... not, fundamentally, a medical phenomenon with additional psychological and social elements’ (Kinderman, 2014, pp. 24–25, 38). By extension, mental health problems ‘are fundamentally social and psychological issues’ (Kinderman, 2014, p. 38). Psychological influences include ‘past and present relationship difficulties, and sometimes a spiritual crisis of values and beliefs’ (Johnstone, 2000, p. 35), whereas social influences ‘are the result of social injustices, inequalities and health-demoting policies that need to be challenged and improved’ (MacDonald, 2006, p. 17; see also Friedli, 2009). These social influences are especially prominent in highly unequal, neoliberal societies (Wilkinson and Pickett, 2010, Chapter 5; James, 2008). Most recently, the centrality of psychosocial influences has been recognised in the report by the UN special rapporteur on the right to health (United Nations General Assembly, 2017, paras 13, 19–20). The primacy of psychosocial over biological factors also ‘removes ... the categories of “us” and “them” that arise from viewing experiences as “normal” and “psychopathological”’, leading to ‘a more sophisticated approach in which all manifestations of mental distress may be understood as part of a continuum of potentially understandable responses to challenging life situations’ (Tew, 2011, p. 26). Mental health is dimensional insofar as it involves degrees of the presence or absence of psychological well-being, avoiding ‘a sharp dividing line between mental health and mental illness’, which allows us to ‘recognise that all of us, sometimes, have distressing and unusual experiences in our lives’ (Cromby *et al.*, 2013, p. 4). This reaffirms that everyone always experiences a state of mental health – irrespective of whether this involves well-being or distress – since the ebb and flow of one’s mental health are, like one’s physical health, inexorable and pervasive elements of the human condition.

It follows that mental health vulnerability involves the psychological and relational resilience needed to withstand the perennial threat to our mental well-being and integrity in the face of life’s challenges and adversities. A subjective-evaluative, psychosocial and dimensional approach to mental health is consistent with this, since one’s unique experience of mental health vulnerability lies in one’s evaluation of one’s affective and socio-psychological experiences and is shaped by one’s social circumstances and life history (and, to a lesser extent, biology) as well as the psychological and social resources one can draw upon to cope with pervasive challenges to one’s mental well-being and

integrity. These influences are common to all but their lived experience varies, just as one's mental health can vary. While everyone faces challenges to their psychological resilience, it is typically limited or diminished (though not necessarily absent) in heightened lived experiences of mental health vulnerability. In particular, where adverse social circumstances have a hostile impact on psychological well-being and/or one's psychological resilience is constrained due to, for example, internalised shame, feelings of worthlessness or hopelessness, our mental health distress increases and thus our lived experience of mental health vulnerability is heightened (Tew, 2011, Chapter 7; Bielby, 2016, p. 176). At their most pronounced, these deleterious psychosocial influences *may* – though not necessarily will – render one less able than usual to safeguard one's own interests (Mackenzie and Rogers, 2013, p. 52, n. 3) and/or expose one to a range of potentially intrusive or disempowering social, medical and legal responses. These range from social harms such as stigmatisation, discrimination, exclusion and exploitation to distressing subjective experiences such as a disrupted or 'challenged' sense of self (Dunn *et al.*, 2008, pp. 245–246; Spiers, 2000, p. 719; Tew, 2011, p. 28) as well as to the possibility of coercive medical treatment under mental health legislation. Within mental health law, therapeutic jurisprudence has already considered the harmful 'anti-therapeutic' effect of many coercive approaches to severe mental distress (Winick, 1997a, pp. 1162–1163, 1166). But it is precisely because *everyone* faces challenges to their resilience needed for good mental health to greater or lesser degrees that no one is immune from heightened lived experiences of mental health vulnerability. This is reflected in Johnstone's observation that 'the roots of mental distress are intimately interwoven into every aspect of our daily lives' (2000, p. 258). By understanding mental health vulnerability as based on universal vulnerability and an account of mental well-being that is subjective-evaluative, psychosocial and dimensional, mental health vulnerability is better equipped to avoid accusations that it is a stigmatising label – rather, it is simply a fact of life.

### 3 Why mental health vulnerability matters to legal theory

In *Dependent Rational Animals*, MacIntyre observes that '[f]rom Plato to Moore and since there are usually, with some rare exceptions, only passing references to human vulnerability and affliction and to the connections between them and our dependence on others' (1999, p. 1). A likely explanation for this across much contemporary legal and political philosophy is the enduring influence of the rational, independent person of liberal individualism and classical social contract theory (Hoffmaster, 2006, p. 42).<sup>2</sup> Such focus marginalises or negates vulnerability – an idea captured by Dodds, who observes that 'human vulnerability and dependency have come to be viewed as evidence of a failing to attain or retain autonomous agency, rather than as conditions for agency and autonomy among humans' (Dodds, 2007, p. 501). An explicit acknowledgement of vulnerability, beyond the recognition that co-operation with others in society is necessary in order to maximise one's interests and security, thus creates a tension with ideas of autonomy and self-sufficiency on which such theories depend (Hoffmaster, 2006, p. 42). Yet, as we have seen, the facts of human vulnerability are pervasive and inescapable. Fineman expresses the point in a way that resonates powerfully with the impetus behind this paper:

'The vulnerable subject thus presents the traditional political and legal theorist with a dilemma. What should be the political and legal implications of the fact that we are born, live, and die within a fragile materiality that renders all of us constantly susceptible to destructive external forces and internal disintegration? Bodily needs and the messy dependency they carry cannot be ignored in life, nor should they be absent in our theories about society, politics, and law.' (Fineman, 2008, p. 12)

<sup>2</sup>Kottow, on the other hand, takes the view that '[v]ulnerability has been on the mind of European thinkers for over 200 years' (2004, p. 282). However, the sense in which Kottow discusses vulnerability appears to be as the product of competing and irreconcilable interests in a state of nature for which the idea of the social contract is a response. This is different from the idea of universal vulnerability used here.

Fineman's question rightly directs our attention to debating the implications that universal vulnerability has for legal and political theory, repudiating the unrealistic and overly abstracted view of human beings that fails to emphasise the mutual reliance to which our basic, shared needs give rise (Fineman, 2008, p. 12; Dodds, 2007). As part of accepting these '[b]odily needs' and potential for 'internal disintegration' (Fineman, 2008, p. 12) as central features of a theory of universal vulnerability, it is important that they extend explicitly to encompass those of mental health and well-being to fully account for these central features of the human condition and to avoid a problematic Cartesian mind/body distinction (see further Grear, 2010, p. 117). In this way, theorising universal vulnerability becomes as inclusive as possible in its scope.

This inclusivity is also evident in MacIntyre's work. MacIntyre (1999, Chapter 7) highlights the significance of vulnerability in our development and flourishing agents as well as the relevance of constrained resilience in determining the obligations we owe to others:

'We need others to help us avoid encountering and falling victim to disabling conditions, but when, often inescapably, we do fall victim, either temporarily or permanently, to such conditions as those of ... psychological disorder, we need others to sustain us, to help us in obtaining needed, often scarce, resources, to help us discover what new ways forward there may be, and to stand in our place from time to time, doing on our behalf what we cannot do for ourselves.' (MacIntyre, 1999, p. 73)

Such webs of support on which we all must rely as part of mitigating constrained resilience help us avoid or minimise the impact of experiences that impair or disrupt our well-being, autonomy and identity or bring about other forms of suffering and disadvantage. In mental health vulnerability (which I take MacIntyre's reference to 'psychological disorder' (*ibid.*) to be partly addressing), these webs of support can be understood as more specific instantiations of those that universal human vulnerability requires. They can be intimate and informal, as in the case of family and friends, as well as professional and formalised, such as access to counselling, psychotherapy or psychiatric care. In this regard, MacIntyre's observations chime with Goodin's arguments in an earlier (and similarly important) work that the wide reach of the 'special responsibilities' we have, which are broader than those to family and friends, finds its origin in the vulnerability of others to how we act and choose (Goodin, 1985, pp. 11–12). But, given the universality of mental health vulnerability, these webs of support cannot be limited to experiences of mental health suffering – as discussed above, it is precisely because good mental health is precarious that it requires mutual support to elicit and sustain it.

Consequently, specific instantiations of support for mental health vulnerability encompass a range of practices. To sustain good mental health and prevent mental health suffering, mental health promotion is required (Tudor, 1995; Cattani and Tilford, 2006; Pilgrim, 2017, pp. 50–53), including public mental health frameworks providing access to preventive measures (Brown *et al.*, 2015, p. 13; Pilgrim, 2017, p. 49; United Nations General Assembly, 2017, para. 91(a)). In greater levels of mental health distress, it involves 'multidisciplinary teams' (Kinderman, 2014, p. 28) of psychologists, psychiatrists and social care professionals as well as carers sustaining, affirming and empowering individuals who are suffering to facilitate recovery (*ibid.*). This could also involve peer-led forms of support (United Nations General Assembly, 2017, para. 83). But, in keeping with the insights of the psychosocial approach, mental health cannot and should not be seen in isolation from deeper structural influences. To this end, a theory of mental health vulnerability must incorporate recognition of diverse social influences that serve to militate against good mental health, such as (but not limited to) inequality (Allen *et al.*, 2014; Brown *et al.*, 2015, pp. 52–55; Friedli, 2009; Wilkinson and Pickett, 2010, Chapter 5), unemployment (Paul and Moser, 2009), 'high demands, low control' employment conditions (Marmot, 2016, Chapter 6), early-life trauma such as child abuse or neglect (Plumb, 2005), educational under-attainment (Brown *et al.*, 2015, pp. 44–45), economic crises (WHO, 2011), loneliness and social isolation (Brown *et al.*, 2015, pp. 72–74; Monbiot, 2016) and living conditions (Brown *et al.*, 2015, pp. 42–44). The evidence that supports these social determinants of mental health underpins

how mental health vulnerability and one's resilience to it are inextricably influenced by social harms and social values. And, since mental health vulnerability is universal despite it being experienced in ways that are particular to the individual (Fineman, 2010, p. 269), no one is invulnerable to these challenges to our mental health resilience, as one could conceivably suffer as others do (Hoffman, 2014, p. 74), even if one has never experienced, or will never experience, certain of these factors. The interaction of social determinants of mental health with individual psychological factors in the psychosocial model avoids 'the individualisation and psychologisation of social problems' (Brown *et al.*, 2017, p. 505) whilst fostering an appreciation that the level of psychological resilience, and thus the experience of mental health vulnerability, is likely to differ between individuals who experience very similar social challenges. In doing so, it addresses concerns that understanding universal vulnerability should avoid generalisations that are oblivious to context or circumstance (e.g. Dunn *et al.*, 2008; Luna, 2009).

Within legal theory itself, Del Mar and Fineman have, separately, sought to address the relevance and significance of vulnerability. Del Mar argues for a 'relational jurisprudence' (2012, p. 64) that, similar to MacIntyre, recognises human interdependence (*ibid.*, p. 74) whereby vulnerability can be employed 'as a device to study law's role in the quality of relations, thereby enabling both understanding and criticism of law' (*ibid.*, p. 73). Del Mar characterises vulnerability as 'a factual-evaluative complex' (*ibid.*, p. 63), observing that 'to characterise someone as vulnerable is to take an evaluative stance, i.e. to think that someone who is in danger of harm or suffering is worthy of being protected against such a danger being actualised' (*ibid.*), where such worthiness is seen in terms of the particular context that gives rise to this susceptibility (*ibid.*). Since the factual dimension simply provides a concrete point of reference for the experiential context of vulnerability, evaluation appears to function as the more significant dimension. This normative approach, which Del Mar claims to obviate a rigid fact-value distinction (*ibid.*), is foregrounded elsewhere in the very basis of Fineman's 'vulnerability thesis', which is a moral argument 'for a more responsive state and a more egalitarian society' (2008, p. 1) and is echoed in theoretically orientated substantive legal scholarship, such as by Collins, who suggests in the context of family law 'that identifying vulnerability requires an evaluative judgment' (2014, p. 29), and by Stychin in the context of tort law, who observes that vulnerability can enlarge 'our legal imagination in terms of how we approach the fundamental ethical question of our responsibilities towards others in law' (2012, p. 351).

As part of the critical potential of vulnerability, Del Mar goes on to suggest:

'we can criticise law 1) by examining what vulnerabilities we think the law ought to protect that it does not currently, including vulnerabilities that have either already been recognised (except not by law) or by proposing new vulnerabilities as worthy of law's attention; and 2) by being on the lookout for ways in which the law might itself create and / or exacerbate vulnerabilities, and thus reduce the quality of relations in different relational contexts.' (Del Mar, 2012, p. 73)

Mental health would seem to be precisely one such aspect of vulnerability that justifies the focus of legal theory. Indeed, Del Mar gestures towards it when he refers to 'harms or forms of suffering that are psychological' (*ibid.*, p. 74) as an increasingly frequent use of vulnerability (citing Turner, 2006, p. 28, who offers a similar view), claiming 'we must overcome the theoretical bias to associate vulnerability with purely physical terms' (Del Mar, 2012, p. 74). Del Mar's claim about law causing or inflaming vulnerability (*ibid.*, p. 65) echoes other views on the potential problematic impact of legal frameworks and reasoning in mental health, capacity and adult social care (e.g. Dunn *et al.*, 2008; Clough, 2015), as well as the central claim behind therapeutic jurisprudence that legal phenomena 'impose consequences on the mental health and emotional wellbeing of those affected' (Winick, 2006, p. 32). Yet, what is perhaps most relevant within Del Mar's argument for a theory of mental health vulnerability is the observation that 'the law manages vulnerability, rather than simply protects it' (2012, p. 76). This suggests a deeper and more nuanced engagement with vulnerability than conventional jurisprudential understandings of vulnerability offer (Hart, 1961/2012, pp. 194–195) or which neoliberal understandings of resilience allow ('in which vulnerable subjects must train to be

adaptable' (Schott, 2013, p. 211)) and does not suppose an unattainable quest towards eliminating vulnerability (Gilson, 2014, p. 16). Instead, it offers a more 'proactive' (Del Mar, 2012, p. 75) basis for the relationship between law and vulnerability, paralleling Fineman's 'responsive state' argument (Fineman, 2010, pp. 255–256, 260, 273–275). For example, opportunities for this proactivity exist in the legislative requirement enshrined in the Health and Social Care Act 2012, section 1(1)(a–b) in England and Wales to promote a health service that has the explicit aim of 'secur[ing] improvement ... in the ... mental health of the people of England' (s. 1(1)(a), emphasis added) as well as 'the prevention, diagnosis and treatment of ... mental illness' (s. 1(1)(b), emphasis added). As such, approaches to managing mental health vulnerability in law can be understood as extending to mental health promotion and preventive measures that are applicable to all citizens (such as those indicated in the report by the UN special rapporteur on the right to health (United Nations General Assembly, 2017) and by the Mental Health Task Force in England (2016) rather than being overwhelmingly focused on conventional 'reactive' legal frameworks regulating the use of civil detention powers and psychiatric treatments for people with severe mental health problems, such as the Mental Health Act 1983.

Fineman's seminal contribution also encompasses the idea of law's management of vulnerability (2008, p. 1), though by focusing upon the relationship between universal vulnerability – specifically, the vulnerable citizen or 'subject' – and substantive (in)equality in order to construct a justification of how and why the state should respond (*ibid.*; Fineman, 2010). Although questions relevant to mental health vulnerability are not addressed directly, Fineman's distinction between vulnerability and dependency is particularly relevant for developing a theory of mental health vulnerability, as the constrained resilience of heightened lived experiences of mental health vulnerability can often involve forms of dependence that persist over time – for example, on psychotherapeutic, psychopharmacological or community mental health-care support and provision. This may lead one to question whether mental health vulnerability can be distinguished from dependency.

Fineman's distinction between vulnerability and dependency turns upon the difference between universality and constancy: on this account, vulnerability is universal *and* constant, whereas dependency is universal but not constant (2008, p. 9, n. 25). Rather, dependency occurs in an intermittent and unpredictable way and is 'largely developmental in nature' (*ibid.*). Mental health vulnerability may still be seen as distinct from dependency for three reasons. First, the dimensional element of mental health in which psychological well-being is present or absent by degrees means that dependency will not always take the same form, be required to the same extent or even be needed in certain forms at all. By contrast, mental health vulnerability is a constant feature of our universal vulnerability, irrespective of whether our mental health happens to be good, average or poor at any time. Second, the psychosocial element of mental health vulnerability draws attention to the social determinants of mental health that require sustained collective political and legal action to address rather than dependency on mental health care. As Kinderman puts it, '[i]f we are to protect people's mental health, we need wider social or even political change' (2014, p. 39). Since the universality of our common vulnerability provides the moral impetus for political and legal action required to address mental health vulnerability, this suggests a progressive normative direction for Del Mar and Fineman's idea of law's role in vulnerability management, echoing Fineman's claim that 'analyses centered around vulnerability are more politically potent than those based on dependency' (2008, p. 12). Third, the subjective-evaluative nature of mental well-being is necessarily a first-person experience in which we apprehend our own identity and its positive and negative changes over time. While others are needed to create and maintain the resilience to engage in this process, their involvement cannot be explained wholly in terms of dependence but instead by facilitating 'positive interactions between the personal and the social' (Tew, 2011, p. 20). When combined with law's role in vulnerability management, a constructive social context opens the possibility of giving *all* citizens – including but not limited to people who use mental health services – influence in terms of how their subjective-evaluative experience of mental health can be used to improve law and policy (e.g. United Nations General Assembly, 2017, para. 42).

What emerges from the above discussion is a clear normative dimension to universal vulnerability in general and to mental health vulnerability in particular. Mental health vulnerability builds upon MacIntyre's emphasis on webs of support in helping people live through heightened experiences of vulnerability (1999, p. 73) to encompass mutual support to nurture and sustain good mental health. Mental health vulnerability also harnesses Del Mar's account of the critical potential of vulnerability for law (2012, p. 73) and Fineman's use of universal vulnerability in the pursuit of equality (2008, pp. 8–9, 17–22) alongside the idea of 'proactive' vulnerability management (Del Mar, 2012, p. 75) by a 'responsive state' (Fineman, 2010, pp. 255–256, 260, 273–275) to focus particular attention on the role of law in advancing social justice in mental health. This is manifested in relation to ensuring widespread availability of mental health promotion measures, timely access to meaningful and high-quality health and social care services, and the wider collective efforts needed to address the social determinants of mental health. These collective efforts include non-discrimination and de-stigmatisation policies (Bielby, 2016, pp. 179–180; Brown *et al.*, 2015, p. 13), policies to reduce social and economic inequalities and related social injustice (Barry, 2005, Part V; Mental Health Task Force, 2016, pp. 15–20) as well as to efforts to maximise citizens' participation in the development of law and policy relating to mental health.

In this way, a universal, normative theory of mental health vulnerability is capable of justifying appropriate legal and political responses to support the mental health of *all* citizens. It is also equipped to facilitate a critical evaluation of – rather than a mere explanation for – proposed legal and policy initiatives in mental health (e.g. Mental Health Task Force, 2016) and the use of the state's legal powers in relation to people with severe mental health problems. In this sense, it supports the creation of resilience-conferring institutions through law (Fineman, 2010, p. 272) and resonates with law's crucial function in delivering social justice more generally (Campbell, 1988, p. 18) – a function that is frequently downplayed due to inadequate explanations of the relationship between social and legal justice and 'highly misleading' attempts to distinguish them (*ibid.*, pp. 10, 18). Indeed, such a normative approach is significant in its own right to justify claims about the desirable aims and values of law (West, 2011). For these reasons alone, mental health vulnerability matters considerably to legal theory. With this in mind, we can now turn attention towards the need for justifiable 'normative framing' in relation to vulnerability discourse (Brown *et al.*, 2017, p. 502). This process grounds the 'progressive' meaning of vulnerability (*ibid.*) in substantive moral and political theory to justify the values that a desirable theory of mental health vulnerability should embody. In order to do this, in the final section, I turn to two mutually reinforcing normative features of mental health vulnerability – rights and care.

#### 4 The normative features of mental health vulnerability: rights and care

Despite their alleged tensions (Brown, 2011, p. 316; Herring, 2016, p. 1), vulnerability and rights are related conceptually insofar as the former can ground the latter. Turner, one of the few writers who have directly addressed this relationship, takes up this idea, affirming powerfully that 'human and social rights are juridical expressions of social solidarity, whose foundations rest in the common experience of vulnerability and precariousness' (2006, pp. 26–27). This resonates strongly with the account of universal vulnerability introduced earlier, as it points to our shared experience of the fragility of human embodiment (Turner, 2006, pp. 26–27; Grear, 2010, pp. 113, 130–136) as well as the vulnerability of our agency (Beylveled and Brownsword, 2001, pp. 114–117; Bielby, 2016) as the justifying ground for holding rights. Insofar as '[t]heories of moral rights are inherently theories about what the basic content of ... legal rules *should be*' (Steiner, 2007, p. 460, emphasis in original), it is important that we consider how universal vulnerability may deepen our understanding of moral rights as they apply to the context of mental health. This is due to the status of mental health as a fundamental interest common to all human beings (Bielby, 2016, pp. 175–176) and in order to harness their empowering and protective legal and political benefits for individuals experiencing *any* level of mental health – good, average or poor (*ibid.*).

Similarly, vulnerability is also a concern that lies at the heart of care ethics (Herring, 2013, pp. 50–53, 55–56). This is perhaps unsurprising given that caring can be defined as ‘everything we do directly to help individuals to meet their vital biological needs, develop or maintain their basic capabilities, and avoid or alleviate unnecessary or unwanted pain and suffering, so that they can survive, develop, and function in society’ (Engster, 2007, pp. 28–29, emphasis in original), which comprehensively acknowledges the ways in which we are all vulnerable. Yet much thinking in care ethics is reticent about harnessing rights in support of care (Engster, 2007, p. 53). This is a consequence of the moral primacy of relationships and interdependence, particularity and attention to context in care ethics above supposedly more abstract principles such as justice and rights (Held, 2006, pp. 9–13; Engster, 2007, p. 2; Herring, 2013, pp. 46–47). But, far from being ‘antagonistic’ with rights (Held, 2006, p. 140), rights and care in the context of mental health vulnerability are mutually supportive, rather than mutually opposed, for the two reasons I set out below. In bringing together rights and care, the normative foundations of mental health vulnerability are less exposed to the criticism that rights tend towards unhelpful abstraction and inattentiveness to context (Held, 2006, p. 140) and, by emphasising the particular, less inclined to overlook the subjective-evaluative experience of mental health vulnerability. In pursuing this aim, to echo Grear, we can bridge universal ethical and legal human rights norms and particular lived experiences (2010, p. 167).

The first ground in which rights and care can be brought together as normative features of mental health vulnerability draws upon Engster’s account of having a rationally justified obligation to care founded on the moral right to be cared for (2007, Chapter 1, esp. pp. 45–53). The advantage of this is that it has greater epistemological force to justify the moral imperative of caring to those who may be otherwise doubtful of its moral significance (Engster, 2007, p. 37). By the same token, those who believe that the moral motivation to care derives from empathy rather than obligation (Engster, 2007, p. 36) may be reluctant to accept such a justification. But the ‘spotlight’ that empathy shines can be limited to those who are close to us (Bloom, 2016, p. 34) – indeed, as Kultgren points out, ‘[c]are is too important to be left to the vicissitudes of family affiliation and friendship’ (1995, p. 30). In the context of mental health vulnerability, despite noticeable improvements in recent years, ignorance, bigotry and stigma still all too often taint attitudes towards mental health, especially mental health distress (Dean and Phillips, 2016), highlighting an ongoing dearth of empathic and compassionate attitudes that can influence negative outcomes for those experiencing mental health problems (Goldie *et al.*, 2016, pp. 29–31). This lack of compassion is most starkly reflected in the levels of discrimination against, and the continuing social exclusion of, people with severe mental health problems in law and in society (Randall *et al.*, 2012). Here, ‘a right to care’ (Engster, 2007, p. 53) becomes especially urgent. Since this draws upon a rationalist rather than an intuitive moral epistemology, its explanatory power to persuade us why care should be a feature our moral relationships beyond those closest to us is enlarged (Engster, 2007, p. 37), remedying ‘parochial applications of our sympathy and compassion’ (*ibid.*). This furthers the solidaristic understanding of vulnerability outlined earlier (Rogers *et al.*, 2012, pp. 31–32) through highlighting the fundamental connection that exists between us all in terms of our mental health.

Although Engster’s ‘right to care’ theory demonstrates one important connection between rights and care, he locates the origin of our moral duties to care in the nature of dependency as opposed to vulnerability (2007, p. 40). But, as explained in the previous section, dependence lacks the constancy of vulnerability, even though both are universal (Fineman, 2008, p. 9, n. 25). Vulnerability has a broader reach as the justificatory ground for a right to care in mental health contexts for three reasons. First, the dimensional element of mental health means that a right to care arises both in cases of low of levels of dependency, such as in counselling or psychotherapy for transient and less severe mental distress, as well as in high levels of dependency, such as in psychiatric treatment for severe and enduring mental health distress. Second, a right to care also arises in relation to the psychosocial element of mental health. It does so in terms of vulnerability management strategies that do not involve dependency on mental health care, such as those that aim to address the social determinants of poor mental health or minimise the prevalence of social harms such as stigma and discrimination. Third, a right to

care supports the development of psychological and relational resilience by enabling individuals to understand and cope with their own subjective-evaluative lived experiences of mental health and well-being. Rather than involving dependency as such, it is instead concerned with ‘the internalisation and re-enactment of positive experiences of *empowerment, affirmation, achievement and connection*’ in ‘*co-operative*’ social environments (Tew, 2011, p. 62, emphasis in original). These reasons highlight how a right to care can be justified more extensively by the universal nature of mental health vulnerability rather than the contingent nature of dependence. Accordingly, the basis of the ‘further argument ... necessary in order to show why vulnerability should generate an obligation to care’ (Engster, 2007, p. 40) can be shown to exist in relation to mental health.

The second ground on which rights and care can be brought together as a normative feature of mental health vulnerability fuses rights and care as a means to mitigate the imbalances of power in mental health and to reduce inequalities in the social determinants of mental health. These power imbalances are present across many aspects of mental health, such as in psychiatric classification and psychiatric dominance in mental health (Kutchins and Kirk, 1999; Bentall, 2010; Rapley *et al.*, 2011, pp. 1–5), to experiences of labelling, stigma, discrimination and the marginalisation of service user narratives (Johnstone, 2000; Sayce, 2016) along with the differential impact of mental health policy and practice on gender, race, sexuality and socio-economic background (Tew, 2005; Ferns, 2005; Williams, 2005; Carr, 2005; Morgan *et al.*, 2016, Chapters 5, 6). As we saw in Section 3, inequalities in relation to the social determinants of mental health arise in terms of obstacles that undermine good mental health or prevent mental health thriving. Taken together, their influence has been acknowledged recently in the report by the UN special rapporteur on the right to health, which notes that ‘[t]he crisis in mental health should be managed not as a crisis of individual conditions, but as a crisis of social obstacles which hinders individual rights. Mental health policies should address the “power imbalance” rather than “chemical imbalance”’ (United Nations General Assembly, 2017, para. 86). This approach reinforces the psychosocial understanding of mental health introduced in Section 2.

Again, universal vulnerability offers a promising starting point in terms of bestowing rights to combat power imbalances and inequality. Turner argues that ‘the language of human rights is ultimately the only plausible language for expressing the needs of people with impairment and disability’ (2006, p. 90), since ‘such rights are based on ... an idea of human vulnerability that we all share ... as human beings’ (*ibid.*, p. 109). This universality is all the more important in the account of mental health vulnerability proposed here, since it does not track psychiatric diagnosis or mental disability alone, but extends beyond this as a subjective-evaluative, psychosocial and dimensional experience of the human condition. It therefore supports the idea that mental health rights include, but just as importantly reach beyond, those conventionally associated with compulsory mental health treatment, mental disability and adult social care (Bielby, 2016, p. 179). But, for mental health rights to embody the qualities of attentiveness, responsiveness and respect associated with care (Engster, 2007, p. 30; see further Tew, 2011, p. 14), we need to focus on the specific context in which the duties associated with mental health rights are fulfilled. This better accounts for the normative significance of these rights as an ethical response to the unique lived experience of mental health vulnerability.

As a consequence of the psychosocial influences on mental health identified in Section 2, mental health rights should include rights to access mental health promotion and prevention strategies (Bielby, 2016, pp. 179–180) that are available to all citizens. Care is central to the success of these rights. For example, public health psychotherapeutic initiatives such as the IAPT programme in England (Clark, 2012) require attentive concern for the unique lived experience of each individual’s mental health distress in the client–therapist relationship. This involves a more particularistic understanding of what fulfilling rights amounts to than simple talk of a duty owed to an abstract rights holder allows. Additionally, aspects of care are visible in international legal human rights provisions relevant to mental health. For example, Article 16, paragraph 4 of the UN CRPD pertaining to protective measures to support the recovery of people with disabilities who are subjected to violence and abuse includes a requirement to consider ‘gender- and age-specific needs’ (United Nations General Assembly, 2006), as well as references to ‘the health, welfare, self-respect, dignity and autonomy of

the person' (*ibid.*), which, by definition, must be receptive to the particular circumstances of the individual to support their recovery. While the CRPD breaks new ground in how it recognises psychosocial disability rights (Lewis, 2010, p. 98), the broader implications of a care- and rights-based approach to universal mental health vulnerability are all the more politically and legally far-reaching. As Kinderman argues, for a society to foster 'genuine mental health and well-being we need to protect and promote universal human rights' (2014, pp. 191–192), which means we need to view the scope of mental health prevention strategies broadly to address deep-rooted structural issues such as inequalities in life chances and parenting quality, opportunities for meaningful secure employment and efforts to improve housing and the environment (*ibid.*; Mental Health Task Force, 2016, pp. 15–20). This highlights a very clear way in which current liberal legal systems would need to change radically to properly accommodate the values of care (Herring, 2013, p. 5) in mental health vulnerability. And, of course, such radical changes would require considerable political will in moving beyond socially and economically entrenched neoliberal values that have prevailed across much of the world for the last forty years (Schrecker and Bamba, 2015, Chapter 6). Although the practical implications of this cannot be explored here, we can acknowledge that the relational approach that care brings to rights allows a richer understanding and justification of strategies to address overlapping psychosocial influences on mental health vulnerability. While a focus on rights that negates or downplays care misrepresents what respecting rights involves (see further Bielby, 2016, pp. 181–185), by contrast, a fusion of rights and care can allow rights to 'be used in progressive ways to protect and promote values of community and mutuality' (Herring, 2016, p. 15).

## 5 Conclusion

Mental health vulnerability matters to legal theory so we can understand a universal and fundamental dimension of human existence that shapes the psychological needs of all citizens. But, equally importantly, it provides a normative foundation for how law should respond to mental health vulnerability as well as highlighting the challenges it faces in doing so. This makes the dearth of previous work bringing together vulnerability and mental health in this way all the more surprising. In response, I have sought in this paper to develop the basis of a universal account of mental health vulnerability. I have endorsed a universal and evaluative conception of vulnerability, drawing on insights from legal theory offered by Fineman and Del Mar, and have integrated this with a model of mental health understood as subjective-evaluative well-being that is psychosocial and dimensional. The common source of mental health vulnerability in terms of the challenges to psychological and relational resilience that everyone encounters explains how we *all* experience mental health, whether this is good, average or poor, as well as why some can be exposed more than others as a result to having their basic interests undermined, denied or jeopardised.

The universal and normative account of mental health vulnerability I have developed consolidates MacIntyre's emphasis on webs of support in helping people through heightened lived experiences of vulnerability (1999, p. 73), Del Mar's account of the critical potential of vulnerability for law (2012, p. 73), Fineman's use of universal vulnerability in the pursuit of equality (2008, pp. 8–9, 17–22) and the idea of 'proactive' vulnerability management (Del Mar, 2012, p. 75) by a 'responsive state' (Fineman, 2010, pp. 255–256, 260, 273–275) to ground a socially just legal and political vision for mental health. This encompasses the promotion of good mental health as well as preventing the onset of mental health distress and acknowledges the social determinants of poor mental health associated with neoliberal societies. The substantive normative features of mental health vulnerability I have proposed involve a synergistic rather than antagonistic fusion of rights and care. A 'right to care' (Engster, 2007, p. 53) overcomes limitations of empathy (Bloom, 2016, p. 34) in ways particularly relevant to combatting stigma and discrimination in mental health. Because such a right can be grounded more robustly in the constancy of universal vulnerability rather than contingency of dependency (Turner, 2006, pp. 26–27; Fineman, 2008, p. 9, n. 25), it affirms the fundamental connection that exists between everyone in terms of mental health. Care is also a means to realise to the content of

rights concerned with addressing power imbalances and inequality in mental health, complementing the universality of rights with the particularity of care and highlighting the tension between mental health promotion strategies and the social and economic values of neoliberalism. Accordingly, this normative theory of mental health vulnerability represents an important way in which legal theory can contribute towards, rather than hinder, ‘a vision of a just society which is informed by moral indignation’ (Hillyard, 2002, p. 656).

Clearly, this paper can only offer a first step in developing a theory of mental health vulnerability. Directions for future research include a more detailed consideration of how mental health vulnerability can be brought to bear on specific ethico-legal questions of social justice in mental health, such as evaluations of mental health promotion and prevention strategies and attempts to improve access to appropriate mental health-care services, as well as consideration of how mental health vulnerability interacts with cognate ideas in legal and political theory such as equality, compassion and the right to health. And, beyond the conventional focus of legal and political theory, phenomenological understandings of the experience of vulnerability (e.g. Stanghellini and Rosfort, 2013) may illuminate the subjective-evaluative dimensions of mental health in relevant ways to mental health vulnerability. But what is clear already is how understanding mental health vulnerability deepens an appreciation of our universal vulnerability in legal theory and can contribute towards progressive social change in relation to improving psychological well-being. In doing so, it highlights what unites rather than divides us in terms of our mental health.

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