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The changing purpose of mental health law: From medicalism to legalism to new legalism

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ABSTRACT

The role of law in regulating mental health detention has come to engender great contention in the legal and sociological disciplines alike. This conflict is multifaceted but is centred upon the extent to which law should control the psychiatric power of detention. In this manner the evolution of law regulating mental health detention has been seen in terms of a pendulous movement between two extremes of medicalism and legalism. Drawing on socio-legal literature, legislation, international treaties and case law this article examines the changing purpose of mental health law from an English and Council of Europe perspective by utilizing the concepts of medicalism, legalism and new legalism as descriptive devices before arguing that the UN Convention on the Rights of Persons with Disabilities goes further than all of these concepts and has the potential to influence mental health laws internationally.

1. Introduction

In analysing the evolution of the legal powers to detain persons with psycho-social disabilities, it becomes apparent that various legal and sociological influences have had a determinate effect on the manner in which this is regulated. Society's understanding of the purpose of mental health law has changed significantly over time. The concepts of medicalism, legalism and new legalism provide differing explanations. It is argued that the purpose of mental health law has changed from the treatment of persons with psycho-social disabilities, as endorsed by medicalism, to protecting the rights of persons with psycho-social disabilities, as endorsed to differing degrees by legalism and new legalism. This article examines the applicability of these concepts to the Council of Europe and, in particular, the jurisprudence of the European Court of Human Rights (ECtHR) and the UN Convention on the Rights of Persons with Disabilities (CRPD). The seminal work on these concepts has argued that English legislation has followed the trajectory of a pendulum swing from medicalism to legalism (Jones, 1972). It is argued here that so has the Council of Europe which, through the case law of the ECtHR, has established comprehensive protections in the mental health detention and review process. However, it is arguable that neither English law nor the jurisprudence of the ECtHR has truly provided for the rights endorsed by new legalism. The CRPD opens a new chapter for the purpose of mental health laws. Going even further than new legalism the CRPD focuses on a broad spectrum of positive and non-discriminatory rights for all those with psycho-social disabilities. In analysing these sources of law the concepts of medicalism, legalism and new legalism are used as descriptive devices to examine how the purpose of mental health law has changed over time.

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2. Legalism and medicalism

In analysing the purpose of mental health laws, the academic literature has generally categorised such laws as either being consistent with legalism or medicalism. Additionally, Jones (1980) describes the history of mental health law as representing a pendulum swing between this legalism and medicalism while similarly, Allderidge (1979) believes that there have been cycles in the legal response to those with psycho-social disabilities. While the seminal work conducted on legalism and medicalism has focused on English mental health law, the concepts are applicable to other jurisdictions (Allderidge, 1979; Fennell, 1986, p. 35; Glover-Thomas, 2002; Gostin, 1983, p. 27–54; Jones, 1972, 1980, p. 1; McSherry & Weller, 2010; Rose, 1985, p. 199; Spaulding, 1989, p. 187; Unsworth, 1987).

For medicalism, the purpose of mental health law is to provide for the care and treatment of persons with psycho-social disabilities. Mental health laws that are consistent with medicalism can be said to be based on paternalistic considerations, or the 'best interests' of the person. As such, open textured law that is enabling and permits maximum medical discretion within a loose framework of rules is preferable. According to Jones, given that the mental health field is one of the least predictable it follows that it is one of the least appropriate for 'formalistic' or 'mechanistic' approaches of law that unnecessarily restricts the detention or treatment of persons with psycho-social disabilities. In this sense she believes that legal formalism results in an over emphasis on procedural correctness to the detriment of the substantive aim of treating persons with psycho-social disabilities (Jones, 1972, 1980). Opponents of medicalism, however, see it as providing the possibility for uncontrolled medical discretion, which cannot be ensured to always act in the best interests ofpersons with psycho-social disabilities (Fennell, 1996, p. 10).

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Alternatively, legalism:

> "*is focused upon relationships between mental health professionals, especially psychiatrists, and their patients, and entails the superimposition of legal duties and rights upon therapeutic and social responsibilities and expectations, principally for the protection of the patient or potential patient…the rule of law takes priority, if necessary at the expense of other considerations, including that which is deemed to be optimally therapeutic by professionals.*".
>
> [Unsworth, 1987, p. 20–21]

Mental health laws that are consistent with legalism prescribe due process safeguards, including the restriction of the statutory definition of mental disorder, strict statutory criteria for detention, recognition of the right to refuse treatment and a judicial review of the decision to detain. These safeguards along with statutory minimum standards should guide and restrict the discretion of those involved in the detention and treatment of persons with psycho-social disabilities (Fennell, 1996, p. 10). Those who support legalism argue that this framework of legal rules is essential for the protection of persons with psycho-social disabilities (Glover-Thomas, 2002, p.vi). Jones, however, believed that such legalism leads to cumbersome and unworkable procedural processes.

3. The changing perceptions of mental health detention

Initially, psychiatry's role in the detention of persons with psycho-social disabilities was commended and upheld as a significant reform on what went before (Alexander & Selesnick, 1967; Hunter & MacAlpine, 1973; Zilboorg & Henry, 1973). By the 1960s, however, the altruistic nature of the psychiatric profession came under significant scrutiny. The resulting "anti-psychiatry" movement questioned the very basis of psychiatry: the claim that mental disorder is an illness. Significantly, it was instigated by dissident psychiatrists such as Szasz (1960) in the US and Laing (1961, 1965) and Cooper (1967) in Britain. As the movement evolved psychiatry's role in the detention and treatment of persons with psycho-social disabilities was re-cast in terms of its social control and moral regulation of society (Baruch & Treacher, 1978; Bean, 1980; Becker, 1963; Cohen & Scull, 1983; Foucault, 1965; Goffman, 1961; Ingleby, 1981; Janowitz, 1975; Laing, 1965; Lemert, 1972; Parsons, 1951; Scheff, 1966; Scull, 1979; Szasz, 1960; Zola, 1972). Between the 1950s and the 1970s this issue came to the fore and dissatisfaction with psychiatry's role in the detention of persons with psycho-social disabilities emerged out of simultaneous developments.

The anti-psychiatry work influenced and coincided with the deinstitutionalization movement which launched a sustained analysis and critique of the mental hospital system (Rogers & Pilgrim, 2005, p. 172). During this time growing concern was publicly expressed about the conditions of large mental hospitals. Notably, Goffman's work analysed the adverse effects of detention in mental hospitals which resulted in the institutionalization of both persons with psycho-social disabilities and staff (Goffman, 1961). Mental hospitals were dehumanising places whereby the "inmate" experienced obvious abuses such as unwarranted or disproportionate detention, forced treatment and degrading living conditions. Less obvious but equally affecting were the power imbalances, the lack of pleasure and comfort, the monotony of scheduled life and the increased inability to live independently outside the mental hospital (Goffman, 1961). Other studies into the effects of mental hospitals reinforced Goffman's theory of institutionalization (Brown, 1959, p. 105; Brown & Wing, 1962, p. 145; Wing & Freudenberg, 1961, p 311). Wing highlighted the social withdrawal and passivity of persons with psycho-social disabilities that were unconnected to their particular diagnosis but correlated to their length of stay in such mental hospitals (Wing, 1962, p. 38). The impacts of institutionalization continued to be studied throughout the latter half of the twentieth century and to this day remain relevant (Braginsky, Braginsky, & Ring, 1973; Martin, 1985; Scott, 1973, p. 45). Simultaneously, in Britain revelations of serious institutional malpractice in a series of inquiries into abuses in psychiatric hospitals were emerging (Rogers & Pilgrim, 2005, p. 174). Martin (1985) reviewed the failures of caring in British mental institutions during this period and attributed it to the isolation that is associated with institutionalization.

This critique of mental hospitals began to impact upon psychiatric ideology and thus began the deinstitutionalization movement, starting in the US in the 1960s. American President John F. Kennedy signed the Community Mental Health Centres Act in 1963 as a means of facilitating the transition from inpatient psychiatric care to community care. In 1966, it was held by the US Supreme Court in Lake v. Cameron (1966) that all psychiatric treatment must be carried out in the least restrictive setting possible. What initially began in the US spread to Europe about a decade later. The most successful of these movements was in Italy. Here, Basaglia, an Italian psychiatrist, became the main proponent of a very successful anti-psychiatry movement that culminated in the 1978 Italian National Reform Bill that banned all asylums and compulsory admissions and established community hospital psychiatric units, which were restricted to 15 beds (Rissmiller & Rissmiller, 2006).[1]

4. Legalism, mental health detention and the European Court of Human Rights

The anti-psychiatry and de-institutionalization movements provided an ideological platform for the rejection of medicalism and the emergence of legalism. A significant contributing factor to the development of legalism was that this sociological work emerged at a time when mass civil rights movements saw a worldwide resistance to all forms of political, racial and sexual oppression in the 1960s. For example, in the US alliances were formed between anti-psychiatry and gay activists. In 1970 and 1971 they prevented psychiatrists from entering the American Psychiatric Association's (APA) annual meeting on account of its classification of homosexuality as a psychiatric disorder. In 1973, homosexuality was removed from the DSM manual as a mental illness by the APA (Rissmiller & Rissmiller, 2006, p. 864).

By the 1980s, the Council of Europe began moving towards a view of mental health detention that was consistent with legalism. The Council of Europe is the continent's leading human rights organisation and provides a framework of rules and widespread guarantees on the subject of human rights in general (Bates, 2010; Harris, O'Boyle, & Warbrick, 2009; Jacobs, White, & Ovey, 2010; Van Dijk & Van Hoof, 2006). Given what was occurring via the anti-psychiatry and de-institutionalization movements in the 1970s, the Committee of Ministers of the Council of Europe turned their attention to the situation of persons in psychiatric detention in Recommendation 818 (1977); the situation of the mentally ill (12th Meeting, October 8, 1977) and Recommendation No. R (83) 2; the legal protection for people suffering mental illnesses and admitted as involuntary patients (356th Meeting, February 1983).[2] The

[1] At the same time there was a revolution in pharmacology in the 1950s with the discovery of major tranquillisers that facilitated the treatment of psychotic disorders outside of the mental hospital system (Fennell, 1996, p. 148–167). However, the theory that the pharmacological revolution instigated the de-institutionalization of the mental hospitals has been contested on numerous grounds. A number of studies demonstrate that an increased level of discharges occurred prior to the widespread use of tranquillizers and the introduction of psychotropic drugs did not appear to accelerate the rate of discharges (Rogers & Pilgrim, 2005, p. 177). While the pharmacological revolution may not have instigated the de-institutionalization movement, according to Scull (1977) it did help manage deviance post-deinstitutionalization through the control of symptoms. Importantly, however, the development and use of psychotropic drugs allowed psychiatry to maintain their control in the treatment of mental illness and therefore the shift to community care did not undermine its jurisdiction (Hyde, Lohan & McDonnell, 2004, p. 192).

[2] One of the ways the Council of Europe attempts to establish human rights standards is through Recommendations. These Recommendations are adopted by the Committee of Ministers of the Council of Europe and addressed to the governments of the Council of Europe Member States. Although they are not legally-binding Recommendations do represent important standard setting documents. The ECtHR has drawn on such documents for inspiration in interpreting ambiguous provisions of the ECHR.

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