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Mental Health Legislation: An Unavoidable Necessity or a Harmful Anachronism

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Abstract: The article addresses the need for specific legislation in mental health, as opposed to other areas of medicine. Issues discussed include: patients' autonomy versus society's safety, insanity and its legal implications, compulsory modes of treatment in psychiatry, dangerousness and violence of psychiatric patients, the price and shortcomings of specific legislation in mental health, and the Israeli legal procedures for the treatment of mentally ill patients. The authors favor specific legislation in mental health, while supporting the need for proper checks and balances.

> "The mark of a civilization is how it treats those over whom it has power" (Sir Winston Churchill)

Introduction

Psychiatry is part of medicine and psychiatrists see themselves as physicians and members of the medical community. Yet from time to time psychiatry is looked upon as a stepdaughter of medicine. Some psychiatric patients are different from other patients: they may look different, speak differently, and behave in uncommon, even peculiar, ways. Their substantial caregivers are not always physicians, and a psychiatric patient may be treated mainly by a psychologist, a social worker or a psychiatric nurse. Psychiatric patients may be cared for in special community-based facilities or hospitalized in psychiatric hospitals. In short, psychiatry can be conceptualized more as a part of mental health than as a branch of medicine (1).

Psychiatry is also the only medical profession whose practice is guided and directed by special legislation in different countries and almost since its birth. Thus, for example, in a comparative analysis of mental health legislation in 1976 in 43 countries (2), it was found that 11 of these countries, all of them developing nations, had no formal mental health legislation, and they relied on various criminal and civil law provisions, administrative directives, and customary practices to operate the mental health services in their nations. The remaining 32 countries operated under formal and specific legislative enactments.

Is it really necessary for psychiatry in the 21st century to have a specific legislation of its own? Does mental health legislation reinforce discriminatory stereotypes (3) and is it no more than "a harmful anachronism" (4)? This phrase was used by Szmukler and Holloway since a specific legislation for psychiatric patients implies that mental illness is different from other illnesses and may be associated with incompetence and dangerousness for example.

Some critics have recommended abolishing special legislation for the mentally ill, arguing that the ethical basis of the category "mental health law" is problematic: mental illness as such is not a reason for differential treatment, and there is no reason to accept that mental illness in itself warrants favorable or unfavorable treatment (5).

Mental Health Legislation and the Conflict Between Patient's Autonomy and Society's Duty to Protect Itself

Several decades ago, mental health law did not exist as a separate and identifiable field of specialized practice or research. Although special legislation regarding care and treatment for the mentally disabled has been known, at least in the French Law, as early as 1838 (6), psychiatric hospitals and facilities for

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people with mental disorders performed their activities without much guidance or limitation by the law, and the interests of such persons had relatively skimpy legal protection (7).

Mental health legislation has mostly been concerned with separating the health risk and civil interests of the patient from the risk posed by him to society. There is almost a built-in conflict between a psychiatric patient's autonomy and his human rights and society's welfare. The control and management of mentally disordered people has created tensions between the law and psychiatry, and attempts to allay public anxiety through legal measures have been finely balanced against professional opinion (8).

The mental health domain is not unique in medicine in having conflicts between patients' rights and the safety of society. For example, there are Israeli laws that prefer public safety to patients' confidentiality in regard to contagious diseases including HIV. This is a clear example of legislature's invasion of patients' privacy, preferring public interest to the individual one. Other examples include the duty of treating physicians to report to the proper authorities about patients who may endanger others while driving a vehicle or using a weapon.

Pilgrim and Rogers consider that the law was used in the past to safeguard people from "the deficits of medical management," while, at other times, the medical perspective has been used when the legal perspective was deemed to have failed (9).

Paternalism is an issue in the physician/patient relationship, referring to practices of treating individuals in the way a father treats his children. In ethical theory the word has a far more restricted meaning: "practices that restrict the liberty of individuals, without their consent, where the justification for such actions is either the prevention of some harm they will do to themselves or the production of some benefit for them that they would not otherwise secure" (10). Medical paternalism means "the interference with a person's liberty of action justified by reasons referring to the welfare, good, happiness, need, interests or values of the person being coerced" (11). The medical paternalistic model was still dominant in modern times, and is concerned with the health interests of a patient. It is accepted in medicine that certain others are empowered to act only when the patient lacks capacity and there is reason to believe that treatment without consent, or against a patient's objections, is in the patient's best interests (12). In psychiatry, the paternalistic model was even more dominant and was the foundation of the first mental health laws.

Radical changes in mental health legislation as well as in the perceptions of mental health and illness have been brought about by changes in the spirit of time (*zeitgeist*) and by modernization. As an example, the English Law — the oldest law of its kind — in its first version, the Lunacy Act (1890), was of a legalistic kind, and it emphasized the need to protect the public. In doing so, this Act preserved the stigma associated with certification that has permeated attitudes to mental illness throughout the last century. In its next version, the Mental Treatment Act (1930), an attempt was made in order to reduce stigmatization by providing for voluntary admission status. The trend towards voluntary admission was increased following the Mental Health Act of 1959. This Act removed the role of the magistrate from detaining patients and led to greater medical control of admission and discharge procedures (8). The Mental Health Act of 1983 represented a return to a more legalistic approach. Involuntarily hospitalized psychiatric patients were entitled to appeal against such admission and forced treatment. These changes represented a revived form of legalism — setting limits to medical discretion.

It can be seen that "transformation" of mental health legislation expresses a kind of trial and error experiment that reflects a power balance between medical and legal systems and social and cultural trends.

The current Israeli Act for the treatment of mentally ill patients, which will be discussed later, is quite different from the English Law. At the establishment of the State of Israel in 1948, the Ottoman Law of 1892 was in effect, and only in 1955 did the Israeli Parliament change the law. A unique and specific Act was enacted, which included for the first time the institution of the District Psychiatrist. This Act was different from earlier mental health laws, and in 1991 a revision was made reflecting the *zeitgeist* of that time in Israel.

Modern revisions in mental health law include the principles embodied in disability management, which require adequate facilities and resources

within the community. Reform is necessary in order to protect the rights of people with mental health problems although this will inevitably meet with opposition, not least of which is due to the historical legacy of mental health legislation reinforcing the link between dangerousness and mental disorder (8).

However, medical control is equally problematic. The vagueness about the nature of compulsory treatment and the absence of adequate checks and control mechanisms in mental hospitals in England led to a series of scandals involving abuse and medical neglect (13, 14). It was Bean's (15) belief that these problems stemmed from what he called "therapeutic law," which is legislation that possesses too many open-ended clauses in favor of medical demands rather than legal requirements. Medical control of treatment and detention issues, therefore, are increasingly viewed as having shifted too far from the legalistic approach adopted in England in the Acts of 1890 and 1930 (9).

Insanity and Legal Fiction

Legal fiction is defined as "something assumed to be true, although it may be false, in order to avoid a difficulty" (16). Fiction in law is actually a legal technique presuming the existence of a fact or situation that is false, for the sake of obtaining a legal result or convenience.

Legal fictions are common in Jewish Law (i.e., the issue of Erub laws, symbolical acts instituted by the rabbis, by which permission of some Halachic prohibitions is made possible), and they were known in almost every system of law. The notion of legal fictions was commented on in the 18th century by Sir William Blackstone (1723–1780), the first professor of the Laws of England at Oxford, and whose influential writings gave the moral and legal foundation for the opposition of slavery. According to Fuller (17), Blackstone argued that legal fictions were "highly beneficial and useful," although in relation to the character of such fictions, the means by which the ends were met could not be over-estimated (8).

Insanity, like "sane" and "insane," are not medical terms, but legal ones. Insanity is a social judgement founded upon, but not precisely representing, a medical diagnosis. The idea that some people are "insane" and hence not responsible for their actions was unknown in ancient Greece, and it has been held only during certain periods (18). The issue is whether the mental faculties of an accused were impaired by illness, not whether he or she was suffering from a recognized mental illness. Whether a particular medical condition amounts to a disease of the mind is a question of law for the judge (19). Insanity was officially admitted as a legal excuse for a criminal action during the reign of Edward I (1272–1307) in England. The most famous and important forensic-psychiatric case in the history of Anglo-American law is that of Daniel McNaughton, who in 1843 shot and killed the private secretary of the English Prime Minister, who was the man McNaughton had really wanted to kill. The defense was insanity, and the jury found the murderer "Not guilty on the ground of insanity" (20, 21).

The insanity defense in the criminal justice system is very controversial, perhaps more than any other aspect of that system. Nowhere else does the successful employment of a defense regularly bring about cries for its abolition. When the defense is successful in a high-level publicity case, and especially when it involves a defendant whose "factual guilt" is clear, the acquittal triggers public outrage and serves vividly as a screen upon which society projects its fears and concerns (22).

The claim that insanity is a legal fiction is assisted by the often-used definition of the phrase "unsound mind," which as an abstract concept can only be understood metaphorically (8). Szasz (23) states that there are "two fundamental misconceptions: one is a misunderstanding of the differences between the literal and metaphorical meanings of words; the other is a misunderstanding of the relationship between chemical processes in the body and human experiences or so-called mental states" (p. 345). Szasz (23) goes on to assert that the metaphorical use of words can be employed "to deceive others," and to "insinuate wrong ideas, move the passions, and thereby mislead the judgment."

Legal fiction and the insanity defense are not interchangeable. However, it should be mentioned that the supposed potential for misuse by criminals who actually are not mentally ill patients, at least in Israel, was proved to be minimal as shown by court rulings since the enactment in 1995 of the legal possibility of

diminished punishment in Israeli Criminal Law. This possibility can be applied in murder cases, and since 1995 most of the defendants in murder trials have tried to use this legal argument of being severely mentally disordered in order to get a diminished punishment. The Israeli courts did not accept these arguments in the majority of cases. Even the legal possibility of psychiatric hospitalization of addicted defendants whose crimes were proved to be done out of an impulse to get illegal drugs, that was used in the past by criminals who preferred a psychiatric hospitalization for weaning from such an impulse and addiction to being in jail, was cancelled due to misuse of the procedure.

The question that should be asked is whether the social control function included in the psychiatric health care system is fair, just and reasonable in comparison with other social control institutions and agencies that have the power to restrict individual liberty. The most obvious difference between psychiatry and the penal system is the legal provisions within the psychiatric system that allow treatment regardless of consent.

Compulsory Treatment

According to Pilgrim and Rogers (9), mental health legislation exists mainly to protect the rights of mentally disturbed patients. From the perspective of the "anti-protectionists," the use of specific legislation provides an ideological weapon that strengthens the dominant norms regulating acceptable behavior for all people within a given society, while also applying sanctions against those who deviate most from the accepted norms. The sanctions contained in mental health law allow for psychiatric examination and treatment (without consent) for (mainly but not always) behavior considered to be a danger to self or others.

The Israeli Mental Health Act of 1991 enables a District Psychiatrist to issue an order for compulsory psychiatric examination under certain conditions. The District Psychiatrist must receive apparent evidence that a certain person is a mental patient ("suffering from a mental disease"), that he may cause, due to his mental disease, imminent harm to himself or to others, and that he refuses a psychiatric examination. Everybody can appeal to the District Psychiatrist, but it is accepted that information about a person given to him by mental health or medical professionals has more weight than information given by the person's neighbors, friends or relatives. However, the validity of a "definition" of mental disturbance (or disorder or disease), as regards to mental health laws, based on an "immediate" assessment may appear problematic. It should also be mentioned that the definition of mental disorder provided by relatives, colleagues and friends is usually based on observing abnormal changes in a "known" person's behavior over time, and it may be of value to the District Psychiatrist. The validity of the "referral agent" is therefore important in considering a compulsory examination.

An order for compulsory psychiatric treatment, be it hospitalization in a psychiatric ward or ambulatory, community-based treatment, can be issued by a District Psychiatrist only on the basis of the findings of a psychiatric examination that was performed on the person involved.

The District Psychiatrist has no obligation to personally examine the person in question, or even to see him and hear his position. This is quite different from a judicial process where the judge should personally see the person and hear his opinion, and the person should have a lawyer who legally represents him along the legal process.

The need for client/patient advocacy is an important issue, that was only recently recognized and addressed by Israeli Law, at least with regard to legal representation of mentally ill patients before the Israeli District Psychiatric Committee, a quasi-legal forum of appeal for the decisions of the District Psychiatrist (24). Psychiatric patients still have no one to act as their advocate before compulsory admission. Patients' advocacy requires well-trained representatives who are highly knowledgeable of the rights, entitlements and services available (25).

Thus, as Pilgrim and Rogers (9) argue, the discrimination against psychiatric patients is not implicit or covert, but is explicit and even legitimized. Campbell and Heginbotham (26) went even further, alleging that the law in this case legitimizes "the institutionalization of society's unfounded prejudice and fear regarding madness." They argue that there is little justification in maintaining a separate legislative framework for those considered mentally disor-

dered. Symonds (8) contends that the case for such a view dates back to Szasz (18), who "showed how psychiatric patients are discriminated against in relation to notions of being a danger to self or others."

Struggling with Dangerousness and Violence Due to Mental Illness

The argument that legal discrimination exists in relation to those people defined as mentally disturbed is primarily concerned with the issue of dangerousness. The reasoning is that harm to self and/or others has an adverse influence upon the majority of people with mental problems, although there are many groups within society who show dangerous behaviors but are not subject to legal restraint.

The degree to which being irrational, irresponsible and/or unpredictable are predictive of actual harm to self or others appears minimal, although the anxiety created by such behaviors appears much more disruptive to the values and beliefs shared by western societies (8).

Monahan has observed that, in comparison with other groups, the risk of violence from mentally disordered people is modest and that "mental health status makes at best a trivial contribution to the overall level of violence in society" (27). A recent study (28) even showed that persons who are seriously mentally ill are far more likely to be the victims of violence than its initiators. However, there is agreement that there is a subgroup of mentally disordered people who are more dangerous (29, 30). This has led to research into the extent to which the risk of violence can be predicted, to identify factors related to violence and mental illness and establishing accurate risk assessment techniques. Sociodemographic and environmental variables have been identified as significant predictors of violence, as has the presence of substance abuse (31). Assessment of the risk of violence is required from general psychiatrists as frequently as from forensic psychiatrists, and patients need to be involved in the process of risk assessment for improving the value of the assessment as well as for proper management and reduction of risk (32).

Some professionals resent and resist predicting dangerousness because it is tied to social control functions and is incompatible with a caring and therapeutic role. However, they believe that although the concept of dangerousness prediction is at least controversial, a more accurate prediction for the minority of patients who are dangerous and violent could lead to more adequate and less restrictive therapeutic regimes for that minority (9, 33). This position appears to be central to any debate that would allow radical reform of mental health law (8).

In recent years mental health professionals have sought to re-conceptualize assessments of dangerousness in terms of clinical concerns about possible future violence. The test for clinicians has become how well they can assess the risk of engaging in violent behavior that a patient poses. Yet, as Greig (34) notes, "dangerousness" has a cultural resonance expressed in the public idiom, which brings "law and psychiatry together in a mutual task, which cannot override ordinary, common-sense perceptions." It is the law's concern with the public question of an individual's danger to society, not the degree of risk he poses, which informs the law's response (19).

Moreover, dangerousness is a subjective concept, which is attributed to individuals taking account of calculable actuarial risk and the subjective fear that they invoke (35). Psychiatry's conflict with legal ascriptions of responsibility stems from the reification of this legal construct.

The Price of Mental Health Legislation: Relative Reduction of Individual's Freedom, Labeling and Stigma

According to the mental health policy of the World Health Organization (36), the fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well being of citizens. It is argued that in the undeniable context that every society needs laws to achieve its objectives, mental health legislation is no different from any other legislation.

Yet people with mental disorders are, or can be, particularly vulnerable to abuse and violation of rights. Legislation that protects vulnerable citizens, including people with mental disorders, reflects a society that respects and cares for its people. Furthermore, progressive legislation can be an effective tool to promote access to mental health care as well as to promote and protect the rights of persons with mental disorders.

The presence of mental health legislation, however, does not in itself guarantee respect and protection of human rights. Ironically, in some countries, particularly where legislation has not been updated for many years, mental health legislation has resulted in the violation, rather than the promotion, of human rights of persons with mental disorders. This is because much of the mental health legislation initially drafted was aimed at safeguarding members of the public from "dangerous" patients and isolating them from the public, rather than promoting the rights of persons with mental disorders as people and citizens. Other legislation permitted long-term custodial care of persons with mental disorders who posed no danger to society but were unable to care for themselves, and this too resulted in a violation of human rights. In this context, it is interesting to note that although 75% of countries around the world have mental health legislation, only half (51%) have laws passed after 1990, and nearly a sixth (15%) have legislation dating back to the pre-1960s. Legislation in many countries is therefore outdated and, as mentioned above, in many instances takes away the rights of persons with mental disorders rather than protecting their rights (36).

In addition to the obvious suffering due to mental disorders, there exists a hidden burden of labeling, stigma and discrimination faced by those with mental disorders. In both low- and high-income countries, stigmatization of people with mental disorders has persisted through history, manifested by stereotyping, fear, embarrassment, anger and rejection or avoidance (37). Violations of basic human rights and freedoms and denial of civil, political, economic, social and cultural rights to those suffering from mental disorders are a common occurrence around the world, both within institutions and in the community. Physical, sexual and psychological abuse is an everyday experience for many with mental disorders. In addition, they face unfair denial of employment opportunities and discrimination in access to services, health insurance and housing policies. Much of this goes unreported and therefore this burden is unquantified (38).

It should be added that that freedom might actually be taken away in the guise of *voluntary* psychiatric hospitalization. A patient can in reality forfeit his rights and find himself in a so-called voluntary psychiatric hospitalization, without clearly understanding his situation and without the legal supervision that exists in involuntary psychiatric hospitalization. It is our opinion that voluntary psychiatric hospitalization, carried out of the patient's free will and informed consent, should not be a legal fiction but reflect a true voluntary act. It should be clear that every patient who voluntarily enters a psychiatric hospital or ward understands his rights. Should such a patient wish to end his hospitalization or argues that he did not completely understand the meaning of his consent, he may have the possibility to declare his consent null and void.

Mechanisms of Checks and Balances under the Current Israeli Act for the Treatment of Mentally Ill Patients

Since the first Act for the Treatment of Mentally Ill Patients was passed in the Israeli parliament in 1955, there are three authorities who legally examine and confirm all the therapeutic maneuvers towards persons with mental diseases who refuse to receive psychiatric treatment or even be examined. These authorities are not the treating professionals and they regularly inspect and supervise mental health professionals. These authorities are the District Psychiatrist, the District Psychiatric Committee and the District Court of Law.

The District Psychiatrist is a governmental psychiatrist who was appointed by the Minister of Health to be a District Psychiatrist according to the Act for the Treatment of the Mentally Ill Patients. The District Psychiatrist, who is not a treating psychiatrist or a manager of any mental health facility, has a lot of legal authorities, among them the right to issue orders for a forced psychiatric examination, for a forced commitment of a patient in a psychiatric ward or in a psychiatric hospital, and a forced psychiatric community (ambulatory) treatment in a community mental health center. The decisions of the District Psychiatrist in regard to forced hospitalization and community treatment are time-limited, being for two weeks and six months, accordingly.

The District Psychiatrist's decisions are subject to an appeal within a strict time limit before the District Psychiatric Committee. This authority is composed of three members: a chairperson, who is a lawyer

who has the credentials of being a magistrate or justice of the peace, and two psychiatrists, one working in the governmental service and the other working in private practice or in a non-governmental agency. All of these members are appointed by the Minister of Health. Apart from hearing the appeals against the District Psychiatrist's decisions, the Psychiatric Committee has the authority to prolong the time of enforced hospitalization or community-based psychiatric treatment.

Any decision of the District Psychiatric Committee is subject to an appeal within 45 days before a District Court of Law, which can also take a decision on the District Psychiatrist's decisions.

Thus Israeli law enables a policy of checks and balances regarding decisions in issues such as involuntary treatment of the mentally ill, ensuring the right to refuse psychiatric treatment, and guarding the civil liberties of persons with mental disorders.

Discussion and Recommendations

Mental health legislation and human rights are cardinal issues in every society. Israeli society is characterized by multiple tensions that have existed since the establishment of the State of Israel almost six decades ago. A country that has an ongoing legal state of emergency cannot afford to relate to dangerous behavior lightly. Yet Israel is a democratic society that has an inherent duty to protect and promote the human rights of all its citizens, including those suffering from mental disorders.

The authors' experience of more than a quarter of a century in the mental health field supports the argument that special mental health legislation is essential and should not be revoked because of the unique vulnerabilities of people with mental disorders. It seems that these vulnerabilities exist for two reasons. Firstly, mental disorders can affect the way people think and behave, their capacity to protect their own interests and, on rare occasions, their decision-making abilities. Secondly, persons with mental disorders face labeling, stigma, discrimination and marginalization in most societies. Stigmatization increases the probability that they will not be offered the treatment they need or that they will be offered services that are of inferior quality and not sensitive to their needs. Marginalization and discrimination also increase the risk of violation of their civil, political, economic, social and cultural rights by mental health service providers and others (38). A good example of this statement can be found in the lingering insurance reform in the mental health services in Israel; psychiatric services, unlike other medical services, are still being supplied to the citizens of Israel mostly by the State and not by the various sick funds (39).

Specific mental health legislation is necessary for protecting the rights of people with mental disorders, who are a vulnerable section of society. Mental disorders, unlike physical ones, can sometimes affect people's decision-making capacities and they may not always seek or accept treatment for their problems. Rarely, people with mental disorders may pose a risk to themselves and others because of impaired decision-making abilities. The risk of violence or harm associated with mental disorders is relatively small. Common misconceptions on this matter should not be allowed to influence mental health legislation.

Mental health legislation when properly applied can provide a legal framework for addressing critical issues such as the community integration of persons with mental disorders, the provision of high quality care, the improvement of access to proper care and treatment facilities, the guarding and assurance of civil rights and the protection and promotion of rights in other critical areas such as housing, education and employment. Mental health legislation is thus more than care and treatment legislation that is narrowly limited to the provision of treatment in institution-based health services.

It appears that legislation for protecting the rights of people with mental disorders may be either concentrated or dispersed within other health legislation. Most countries have concentrated mental health legislation in which all the relevant issues are incorporated in a single legislative document. This has the advantage of ease of adoption and enactment. Moreover, the process of drafting, adopting and implementing such legislation provides a good opportunity for raising public awareness and educating policy-makers and society in general. The alternative, dispersed, legislation is difficult to enact as it requires amendments and changes to multiple legislative documents. Moreover, the potential exists for

unique and important issues to be omitted from a general health legislation covering the mental health domain.

It is common opinion that mental health legislation should be viewed as a process rather than as an event that occurs just once in many decades. This allows it to be amended in response to advances in the treatment of mental disorders and developments in service delivery systems (38).

At the beginning of a new millennium, mental health legislation still seems essential for complementing and reinforcing mental health policy and providing a legal framework for meeting its goals. Such legislation, properly and wisely applied with due balances, such as legal representation of every involuntarily hospitalized patient or setting time limits to forced hospitalizations, can protect human rights, enhance the quality of mental health services and promote the integration of persons with mental disorders into the community, goals that should be an integral part of any national mental health policy.

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Commentary: Mental Health Legislation

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The article by Margolin and Witztum deftly sets out one of the core dilemmas (perhaps, *the* core dilemma) of law and public psychiatry: the extent to which the underlying questions of commitment and "dangerousness," of autonomy and paternalism, of liberty and institutionalization can and should be regulated by legislative enactment. In writing this piece, Margolin and Witztum have done an important service for Israeli lawyers and psychiatrists by contextualizing these important issues, by presenting the evidence in a clear and coherent way, and by prodding legislators to take this often-neglected area of the law far more seriously than they ordinarily do.

Several years ago, I wrote a book that I titled, *The Hidden Prejudice: Mental Disability on Trial* (1). I chose that title because I wanted to focus on "the invisibility of the prejudice against persons with mental disability" (2). Articles such as the one written by Margolin and Witztum have the capacity to shine sunlight on that "hidden prejudice," and for that, we all should be grateful.

In this commentary, I want to supplement their article by adding a few points that I believe are deserving of further emphasis. I hope that, by doing this, I am able to bring focus on some issues that I believe are deserving of greater attention:

- the reasons *why* mental disability law is different from any other area of "law and medicine";
- the extent to which mental disability law is infected by "sanism" and "pretextuality";
- the significance of international human rights law to this entire subject-matter;
- the importance of regularized, organized counsel in the representation of persons with mental disabilities;
- the possible impact of "therapeutic jurisprudence" on the resolution of the underlying issues;

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