Unreasonable Rights: Mental Illness and the Limits of the Law

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Over the last twenty years, many progressive campaigns for reforms of the position of socially disadvantaged groups have articulated themselves in terms of rights. The language of rights has been adopted both to formulate defensive claims — rights not to be intruded upon — and to advance positive demands — rights to various kinds of social provisions and resources. The passage of the Mental Health (Amendment) Act 1982 — later consolidated into the Mental Health Act 1983 — was the culmination of a vigorous reforming campaign which was couched in these terms. In the forefront of this campaign was MIND — the National Association for Mental Health — led by its Legal Director Larry Gostin. In a plethora of publications, in evidence to official committees and in the courts, it was argued that many aspects of the treatment of those diagnosed as mentally ill were an abuse or denial of their rights, and that legal means should be used to right such wrongs.¹

The object of this comment is not to make a detailed critical appraisal of the provisions of the Act; undoubtedly pragmatic arguments could be made in favour of many of the changes introduced. Rather, through considering the strategy which culminated in the Act, I wish to disrupt two of the underpinnings of right based strategies for social reform. Firstly I will cast doubt upon the opposition to professional discretion and the belief that legalisation of decision making processes and their subjection to quasi-judicial review is an effective means of constraining professional power and ensuring its proper accountability. Second, I will question the politics of posing demands in terms of rights and entitlements as means of directing social resources to particular policy objectives. The weaknesses identified in this particular strategy of reform of provision for the mentally ill illustrate clearly some fundamental limitations of rights discourse in the formulation and advancement of progressive strategies of social reform.

THE IDEOLOGY OF ENTITLEMENT

Larry Gostin has termed the basis of this strategy for mental health reform ‘the ideology of entitlement’.² It has three axes. Firstly, to establish that

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health and social services for the mentally ill are not dependent upon the
discretion of politicians, administrators or professionals but are entitle-
ments, enabling the courts to be used to ensure that these rights are not
denied. It is argued that this would allow the development of effective
remedies — judicial, administrative or financial — where entitlements
created by statutes were not met by the appropriate authorities, and
provide a mechanism for enforcing the allocation of resources to the
mentally ill, for improving conditions in institutions, and for promoting the
development of services in ‘the community’ and the transfer of patients to
them.  
The second axis of this strategy has the objective of limiting the
discretion of psychiatrists and regulating psychiatric activity. It seeks to
involve non-medical expertise — principally social workers — in decisions
as to whether a person should be compulsorily committed to hospital, to
submit decisions as to compulsory detention to automatic and regular
quasi-judicial review, to limit to a minimum the administration of
treatment without the patient’s consent, and to constrain the non-
consensual use of treatment, thus protecting individuals against abuses of
their rights.  
These two axes are to be supported by a third — the maintenance of the
civil status of the mentally ill, in particular the right to vote and to have
access to the courts. Not only would such reforms challenge entrenched
paternalistic attitudes to the mentally ill, it is argued, but they would
enable them to exercise legal and political pressure to enforce their rights.
Enfranchisement would ensure access to the political process; access to the
courts would enable the detained patient to obtain legal redress for
detention or treatment which infringed legal or human rights.  
The ideology of entitlement thus seeks to provide a coherent basis for a
strategy which utilises the language of rights and the powers of the law to
minimise the use of psychiatric compulsion, curtail arbitrary professional
and administrative power, improve the quality and efficiency of services
and preserve the status and dignity of the mentally distressed. Many of the
provisions of the Mental Health Act 1983 and certain of the judgments
made by the European Court of Human Rights certainly provide new and
distinct forums in which compulsorily detained mental patients may have
the grounds for such detention reviewed, and this may indeed prevent
unwarranted detention to the benefit of the individuals concerned. The
newly established Mental Health Act Commission may prove an effective
instrument for monitoring practice in psychiatric hospitals. There can be
little justification for the continued civil and juridical disqualifications
suffered by those in mental hospitals or with a record of mental illness. But
the ideology of entitlement is fundamentally flawed as the basis of a
progressive strategy of mental health reform, in respect of its analysis of
the powers and social vocation of psychiatry, its capacity to formulate
objectives or to construct effective policies for their implementation.
The apparent opposition between 'legalism' and 'discretion' in public policy for the mentally distressed has been so often repeated that it has acquired the status of truth. 'Legalism' has been associated in particular with procedural formalisation and judicial determination in the civil commitment process, a concern with safeguarding sane persons against the danger of unwarranted detention. Proponents of an enlightened psychiatry have criticised such a concern with legal safeguards as unnecessarily obstructing a humanitarian therapeutic enterprise. Others have criticised such civil libertarianism on the grounds that it can only react to the activities of psychiatry, and this response can only be to seek limitations upon psychiatric activity. However Gostin argues that this strategy is a 'new legalism' which does not seek to re-erect a cumbersome structure of procedural regulation or to substitute legal for psychiatric discretion. Whilst a central focus is still the wish to control psychiatric authority, the concern now is not so much the liberties of the sane as the rights of the insane themself. This is grounded in a profound scepticism as to the scientific credentials and therapeutic efficacy of modern psychiatric medicine, located within a general opposition to the vesting of professional agents with discretionary powers.

It is argued that psychiatry is unwilling to put its diagnostic judgments to objective test and when it does so they are frequently found wanting. Psychiatry has adopted hazardous and intrusive methods of treatment without proper evaluation and where there is little evidence of beneficial effects yet considerable evidence of harmful 'side effects'. Psychiatrists are incapable of making judgments as to the 'dangerousness' of patients and demonstrably over-predict the likelihood that individuals are dangerous to themselves or others. Yet, despite these deficiencies, psychiatrists have been given, or have assumed, unique powers in determining the deprivation of the liberty of individuals and, once having so determined, in imposing somatic treatments upon them without their consent. These arguments strengthen a much more general opposition in rights strategies to professional and administrative discretion. Discretion, it is argued, allows state empowered agents to make decisions according to ad hoc, ad hominem, variable and unjustified criteria, within the very broad limits established by most legislation on welfare matters. But justice demands that decisions be made according to formalised, publicly available rules applying to large categories of persons and specifying in precise terms the decisions appropriate to particular circumstances. It also demands, where necessary, rights of appeal against decisions, together with procedures for the presentation of evidence, argument and proof regulated by due process. Hence the argument has led to demands for the establishment of rules to legalise decisions, and for forums of adjudication in which decisions can be judicialised.

It is claimed that legal mechanisms have a role which is not merely reactive and defensive. In refusing to accept psychiatric judgments
concerning the need for compulsory detention unless they can be backed by objective evidence and justified to lay persons and lawyers in Mental Health Review Tribunals, good practice can be promoted. In limiting the use of irreversible and hazardous methods of treatment, and those whose efficacy has not been fully established, by requiring the consent of the patient and/or second medical opinions and consultation with other parties (nurses and non-medical professionals) it can promote open discussion of treatment options with patients and the development of multi-disciplinary team work.14

We may single out four elements of this argument for criticism. Firstly its dependence upon a flawed sociological critique of the professionalisation and medicalisation of social control. Second, the concept of individual freedom which it uses to oppose or seek to limit the use of compulsion in psychiatry. Thirdly, the status of its critique of the scientificity of psychiatry. And, fourthly, the efficacy of the tribunal review which it advocates as a means of constraining and monitoring professional discretion.

1. Social control
The powers allocated to psychiatry under the 1959 Mental Health Act have often been understood in terms of the medicalisation of social control.15 It is argued that modern societies tend to allocate procedures of control of deviant and troublesome groups and individuals to 'experts'. These experts rationalise and legitimise such control by appeal to a specialised body of esoteric scientific knowledge — medical or psychological — which provides the basis and justification for their social role and power. This legitimises the moral enterprise of control by defining deviant behaviour as sickness, control as therapy, and the activities of the social controllers as scientific, rational and based upon objective judgements. It justifies control as enlightened at best, paternalistic at worst — motivated by humanitarian concern for the good of the sick individual rather than social and political concern for the maintenance of a docile population. It disables those who are the subject of these measures, leading them to accept a definition of themselves as sick and to enter a passive 'sick role', dependent upon professional expertise rather than having their fate in their own hands. Lastly, it provides lucrative employment, social status and great power for the agents on the borders of medicine and psychology who specialise in providing this enterprise of moral judgment and regulation with its theoretical codifications and technologies of control.

I have argued elsewhere that the critical pretensions of these exposes of social control are illusory.16 Given that any social and institutional arrangements form, shape and constrain human capacities and actions, the discovery of 'control' is hardly surprising. The hidden agenda of such strategies is usually a switch in control from one agency to another — from doctors to psychotherapists, social workers or lawyers — or the advocacy of a new alignment of professional sectors and powers. Analyses of psychiatry in these terms provide no basis for a politics of reform, for they
lack the means to conceptualise the nature, objectives and consequences of different mechanisms of control — who seeks to regulate what, by what means, in relation to what problems, in pursuit of what objectives, according to what distribution of powers.

Further, analyses in terms of social control possess only the crudest tools with which to evaluate the moral and political implications of different techniques of regulation and to formulate the objectives of reform. It is clearly inadequate to appeal to some fundamental opposition of coercion to liberty, freedom and privacy. For even the demarcation of space of personal autonomy which is 'not the law's business' does not constitute an absence of regulation so much as a change in its modality. Here one can point, on the one hand, to the proliferation of the psychotherapeutic technologies of marriage guidance, child rearing, sexual difficulties and the problems of everyday life, and, on the other hand, to the ever increasing use of pharmacological devices to assuage personal unhappiness. The contemporary psychiatric system operates predominantly not by coercion but by contractuality: personal life is adjusted through images 'freely' chosen and aspired to, and by means of assistance sought by choice and received with gratitude. Indeed, opposition to the 'coercive' aspects of modern psychiatry has been central to the modernisation and extension of the psychiatric system to new sites, problems and populations; hence it is not surprising that it cannot provide the means for an analysis of psychiatry's social functioning or political implications.

2. Freedom to choose
A familiar theme in civil liberation critiques of social regulation is the argument that danger to others is the only justification for state intervention, and the role of the law is to defend the freedom, liberty, privacy and autonomy of the individual, and to limit treatment to that occurring through free contractual relationships between consenting parties. Thus many advocate the 'right to be different' and to claim a continuity between the involuntary confinement of the disturbing eccentric, the quarrelsome alcoholic or the socially disruptive derelict and the Gulag. But the models of choice, intentionality and rationality which underpin the libertarian rejection of compulsion are partial. The individual free to choose — beloved of both 'radical' libertarians and 'reactionary' market conservatives — is no natural, universal or self-evident ground for analysis and critique. Indeed, as has been pointed out by authors from Karl Marx to Michel Foucault, this individual was invented by Western social and political discourse. It provided the basis for a historically specific mode of social organisation based on the disciplined subject, the isolated labourer, the contract and the market. It was invested with a soul and a conscience by Christianity, and it was liberal democracy which constituted it as a citizen with rights and duties.

Whilst rights-based moral discourse is fundamentally dogmatic, there
may be pragmatic reasons for opting for an ethics framed in terms of the freedom of the individual and the Rights of Man. But it is just as consistent to use such a choice as a justification for compulsory social intervention as it is to use it to proscribe such intervention. For far from those designated mentally ill in our culture being free individuals equipped with rights, the reverse is the case. In our culture it is precisely the inability of persons to conform to or support this conception of free, rational, consistent, unified, choosing individual that is frequently the ground for making an ascription of insanity. And the objective of much modern institutional psychiatry is to take those who have lost their sense of freedom, who feel at the mercy of circumstances, of outside forces, of thought insertions or inexplicable mood swings beyond their control, and to work upon them so as to rebuild individuality. Thus many modern psychiatric practices seek to promote autonomy, to encourage the acceptance of responsibility, the re-establishment of control over previously uncontrollable aspects of existence. Libertarian arguments are ill-equipped to weigh up the choice between a short period of 'coercion' leading to a long period of 'autonomy', and radical non-intervention leading to a life permanently at the mercy of the fates. Contemporary psychiatry — including much of its use of compulsory treatment — is based upon the modern conception of the individual and seeks, not to destroy it, but to construct it.  

3. Scientificity
The rights strategy bases itself upon a further set of criticisms of psychiatry. These concern the validity of its claim to scientificity. It is argued that diagnoses in psychiatry have a status which is, in principle, different from those in other fields of medicine, given that 'objective' correlates of mental disorder — demonstrable organic lesions, abnormalities of cells or tissues, physiological or biochemical malfunction — are rarely present. Hence the particular need to subject such 'clinical' judgments to scrutiny and to require psychiatry to justify itself to those who have no vested interest in preserving the dubious powers and mystique of the profession.

But there is no difference in principle between diagnosis in psychiatry and diagnosis in the rest of medicine. Firstly, many conditions currently diagnosed in non-psychiatric medicine have no established organic correlates — for example migraine. Many diseases now considered to have biological foundation were characterised long before their mechanisms were worked out — for example epilepsy and tuberculosis. If clinical medicine was to limit its treatments to those where there was a clear knowledge of organic mode of action, most available drugs and technique would have to be rejected — we do not even know how aspirin works. And, of course, it is paradoxical that the critics of psychiatry frequently advocate alternative forms of therapy which have not even attempted to justify their efficacy according to the canons of science.

Further, the process of diagnosis in non-psychiatric medicine involves far more than the demonstration of identifiable organic malfunction. Clinical
judgment involves the constitution of phenomena as symptoms, a process necessarily dependent on culturally variable norms. It entails the organization of symptoms into meaningful patterns, the elimination of certain interpretations and the selection of others, the construction of prognoses and the choice of treatment. Accounts of this process demonstrate how little it is amenable to rational reconstruction, either at the level of its formal codes or at the level of the forms of medical reasoning at work in clinical practice. Clinical medicine entails an explicit rejection of medical philosophy and metaphysical systematisation, in favour of a method of training, practice and judgment based upon experience at the bedside. The inability of clinicians to formulate commonly agreed protocols of diagnosis which would be intelligible and convincing to non-doctors is not, therefore, grounds for denying medicine its professional status but the reverse — for it is this which underpins the claim for the special competence of the trained clinician.23

Thus psychiatric diagnosis is not differentiable from other clinical diagnoses on grounds of 'lack of objectivity'. But perhaps it can be distinguished because of its particular inability to make diagnoses in a clinically useful manner. For a diagnosis to be clinically useful it must be made according to formal and agreed upon categories which both classify and communicate the problem and have a bearing upon the remedy. It is frequently suggested that psychiatric diagnoses are suspect on these grounds because of their low reliability — the low level of agreement between trained clinicians upon how a particular case should be classified.24 But diagnostic reliability is similarly low in non-psychiatric medicine. Further, there is evidence that high levels of diagnostic concordance in psychiatry can be produced by improved training, definitions of symptoms and diagnoses, and better interview techniques.25 Hence problems of diagnostic reliability are not peculiar to psychiatry, and they cast no specific doubts upon its scientificity.

Rather than grounding a strategy of psychiatric reform upon allegations of spurious scientificity, attention and resources would be better directed to analysing the specific problems of diagnostic processes and classificatory systems. Issues of diagnosis, of the strengths and weaknesses of different classificatory systems, and of the validity of certain diagnostic categories have been matters of discussion within psychiatry since its inception.26 There is no reason that such discussion should be confined to those trained as psychiatrists — indeed it has not been so confined. But it is unlikely that these issues will be effectively opened up for scrutiny by constraining psychiatric decision making with procedural safeguards, or subjecting it to tribunal review. In the debates leading to the new Act, psychiatrists objected vociferously to proposals to subject their clinical decisions to review by lay persons, and demands for tribunal review of treatment decisions were ultimately rejected in favour of certain procedural formalisations involving intra- and inter-professional consultation before the administration of certain classes of treatment.27 But it is important to
recognise, firstly, that this defence of clinical privilege is more than merely professional hauteur. The correlation of the diagnostic powers of the clinician with professional exclusivity are fundamental elements of modern clinical medicine; a strategy to transform these powers needs to think its objectives and mechanisms with more care than is evident in rights-based opposition to professional discretion. Further, at a practical level, there is no evidence to suggest that hedging the diagnostic process about with procedural safeguards, legally encoding substantive criteria or subjecting psychiatric judgments to judicial review will improve the reliability of diagnoses, their validity or therapeutic utility or transform the relations between expertise and those subject to it. Nothing in this strategy will improve psychiatric training, make the discussion of classification more sophisticated, or affect the organisational and economic factors — availability of time, staffing levels, case loads, treatment and so forth — which frequently have as much influence upon decision making in psychiatric settings as its formal codes.

4. Quasi-judicial review

Of course there is a very significant difference between psychiatric decisions and most of those in general medicine. The consequence of a psychiatric decision may be that an individual is detained in hospital against his or her will. Hence given the contentious and non-consensual nature of these decisions, and their consequences for the liberty of individuals, there are strong grounds for ensuring that such commitment decisions are subject to review. The MIND strategy sought to extend the scope and powers of Mental Health Review Tribunals. Whilst such tribunals had been introduced in the 1959 Act, upon the abolition of judicial commitment, they were explicitly conceived as predominantly non-judicial in their function, acting as a therapeutic back-up providing a ‘second opinion’. Hence rights strategists argued that they functioned to legitimate the therapeutic enterprise, not contest it; they sought to turn such tribunals into quasi-judicial review bodies, subjecting professional discretion to an independent review which would protect the rights of patients. They saw them as forums within which the legality of psychiatric judgments as to the need for detention could be scrutinised, and their objectivity and justification evaluated. But such tribunals do not, in fact, operate effectively to regulate professional decision making. Nor do they make their decisions on the basis of a review of whether the legal criteria for detention are satisfied. And even if tribunals were more effectively legalised, this would neither resolve the problem of discretionary judgment nor act effectively to improve psychiatric practice. These considerations suggest that a more effective strategy of reform might seek to further de-legalise tribunals, and increase their efficacy as forums for inter- and intra-professional review of diagnoses, treatments and prognoses.28

Firstly, it is by no means clear that the involvement of lawyers and lay persons in tribunals makes them more competent, objective or rational in
making judgments concerning commitment than are psychiatrists. Research suggests that non-medical tribunal members are more likely than doctors to conceive of bizarre behaviour as resulting from mental illness, and more likely to associate mental illness with potential dangerousness. It is thus not surprising that medical members of tribunals are relatively more disposed to discharge than others. Secondly, the belief that such bodies make their judgments according to legally specified rules is also ill founded. As has been shown in relation to other tribunals, Mental Health Tribunals frequently do not operate according to legal criteria, and indeed their members are often ignorant or wrong about the nature of the law. Their decisions are more often guided by ‘common sense’ understandings of madness, dangerousness and beliefs concerning the need for containment. They are influenced more by therapeutic goals — what they consider to be in the best interests of the patient — than by legalistic application of rules. Hence tribunals neither remove discretion from decision making, nor subject it to an ‘objective’ review. They shift discretion to a different place, involve different agencies and establish new powers. There may indeed be advantages in the involvement of different types of professional expertise in such decision making, but these clearly cannot be analysed in terms of an opposition between professional discretion and the rights of the detained patient.

Rights strategists, in England and the United States, have often laid much blame for the growth of discretionary power upon loosely framed legislation. The new Mental Health Act, like its predecessor and many similar measures, is indeed framed in loose terms. Mental illness is not defined, other conditions (severe mental impairment, mental impairment, psychopathic disorder) are defined ambiguously, and the terms on which detention must be justified — the interests of the person’s own health or safety or for the protection of others — allow enormous scope for discretionary judgment. Given these medical and therapeutic criteria, it is not surprising that tribunals rely upon, and defer to medical expertise. But however codified and precise the criteria, discretion and judgment would still be involved in their application to cases. We can see this clearly if we consider the issue of ‘dangerousness’.

MIND’s original proposal, which was not adopted in the legislation, sought to resolve problems of the subjectivity of diagnosis by substituting a clear, objective and demonstrable criterion of judgment. They proposed that ‘formal admission to hospital be based upon behavioural criteria of dangerousness alone. Only grave and genuinely probable future harm to others should form the basis of compulsory admission . . . ’. The dangerousness standard was one which was compatible with the libertarian principle that harm to others is the only justification for state curtailment of individual liberty. But such a standard would not resolve the problem of decision making. Dangerousness is not a clinical category nor a type of personality, but an uncertain prediction; not surprisingly, neither lay persons, nor clinical or legal expertise have proved adept at making
such a prediction. Whether or not a particular individual will perform dangerous acts in the future cannot be extrapolated from an analysis of the person concerned or even their past history, for it depends upon a host of present and future inter-personal, social and environmental circumstances. Judgments about commitment and discharge will always have to be made by fallible individuals subject to non-rational anxieties and on the basis of incomplete knowledge. Such decisions will always involve weighing up complex ethical issues as to whether it is preferable to err on the side of over-caution or risk harm to others for the possible benefit of the individual. Trained and experienced clinicians and other involved professionals are more likely to be able to make such judgments sensitively and in response to changing public mores than are lawyers disguising their values and ethics under the cover of rights.

Thus these complex problems of judgment would not be assisted by making tribunals more 'legalistic', codifying the rules, increasing the level of legal representation and operating according to legal forms of reasoning. Legal reasoning is only one possible mechanism for decision making and can claim no special privileges. Firstly, while belief that legal reasoning is rule governed may be the spontaneous philosophy of the lawyer, it does not adequately describe such reasoning. All legal judgments involve discretion, and the appeal to the rules by an advocate or a judge is no less a choice within a set of available and justifiable legal tactics than is the attempt to claim the existence of discretion. Secondly, legal reasoning from the lowest courts to the highest is far from the ideal of logic which it purports. Thirdly, legal reasoning utilises specific techniques of argumentation to support truth claims, techniques which are neither self-evidently superior to others nor unproblematic. Legal reasoning appeals to 'objective evidence' whilst choosing to forget that what counts as evidence is itself a matter of judgment, and that, in the case of mental distress, what is at stake is, constitutively, a subjective phenomenon. Legal reasoning seeks simple chains of argument where causations may be complex and overdetermined and cleaves to procedural formulations where no consistency may, in fact, exist in cases, contexts and consequences — nowhere less so than in instances of mental distress.

Recent trials have demonstrated clearly the differences between, psychiatric conceptions of evidence, modes of argument, techniques of judgment and notions of proof and those employed in the law. Psychiatric reasoning depends upon the interpretation of fundamentally ambiguous aspects of language, behaviour, belief, emotion and understanding. It depends upon the application of a clinical gaze trained not through the study of scholarly texts or logical procedures, but through clinical experience. It is not surprising, then, that psychiatric decision making is anathema to lawyers, for the two modes of thought start from different problems and seek different solutions, find them by different means and evaluate them by different criteria. Of course psychiatric judgment depends upon historically contingent bodies of knowledge, is subject to vagaries of fashion and the availability of techniques, and is dependent
upon the skill, conscientiousness and commitment of individual practitioners. And, of course, we can ask how psychiatry establishes its claims to truth, by what means and with what consequences. But we must not fall victim to the jurists’ blindness to the social conditions and interpretive characteristics of their own discourse. There is no epistemological privilege of legal thought which justifies it seeking to extend its hegemony by denying the ‘objectivity’ of other modes of judgment.

THE LIMITS OF ENTITLEMENTS

The notion of entitlement in rights based strategies for reform of social welfare derives from the wish to transform conditions of individual access to social resources. It is argued that where such access is not by right but is in the gift of powerful authorities, in the form of charity, privileges or gratuities, recipients are deterred, demeaned and stigmatised. Establishing entitlements will ensure that access is by right, with dignity and without stigma, and enable the provision of resources to be enforced upon state agencies through the mechanisms of the law. Hence the ideology of entitlement in mental health reform claimed to provide the basis of a strategy capable of achieving substantive gains in public provision for a disadvantaged group through the combination of a campaign for the enactment of statutory provisions and the combative use of the courts to enforce the recognition of entitlements and the allocation of resources to meet them.

As far as such a transformation of provision is concerned, the most significant consequences are thought to flow from the claim that a person has a right to treatment in the least restrictive settings. This is derived from the principle that the use of compulsory powers must always be the least invasive of personal liberty necessary for the achievement of valid public objectives. Gostin argues that such a principle ‘would require the Government to create a full range of community services . . . [and] require the social worker to explore community alternatives before making an application to hospital and to refuse to make an application where the person could be supported at home or in a non-institutional setting’. Let us consider this claim and its implications.

In the United States, litigation has persuaded the courts that the constitutional rights of the mentally ill are manifold. As far as treatment is concerned, they include the right to treatment and the right to refuse treatment, the right to protection from harm and from forced administration of hazardous or intrusive procedures. In relation to confinement, these rights include that to treatment in the ‘least restrictive’ settings and to procedural and substantive protections during the civil commitment process. But the consequences of these developments have been equivocal. Legal mechanisms have proved competent at the limiting of civil commitment, the closure of wards, the discharging of patients from hospital and upholding the ‘right’ to refuse treatment. In the American
context, where some eighty per cent of hospital admissions were under compulsion, the consequences of the rights movement have thus been considerable, especially in conjunction with a more general movement for de-institutionalisation supported from a range of different political positions.

But when it comes to the positive changes upon which the strategy bases its claims for progressive mental health policy reform — improving buildings, staffing levels and proficiency, conditions, standards of conduct or treatment regimes, or providing the ‘alternatives to institutionalisation’ the results have not been promising. In the United States the courts and the legal apparatus have not, in general, proved to be effective mechanisms for specifying, enforcing or monitoring changes in substantive provisions. In many cases the proposed community facilities were not planned, funded or implemented. Those patients de-institutionalised were merely transferred to other institutions, frequently in the private sector, often run for considerable profits, usually providing an environment more ‘institutional’ and less stimulating, congenial, secure and private than the much criticised asylum. Hence the numerous articles arguing that the effects of such a strategy were that mentally ill people were ‘dying with their rights on’, decarcerated through the self-righteous actions of the civil libertarians only to wander the streets and accumulate in the ghettos, exploited by private landlords, without care or assistance, enjoying formal but not substantive liberty. The civil libertarian strategy can constrain and delimit the activities of professionals and, at its extreme, reduce social intervention into the lives of mentally distressed people to that minimum provided by the criminal law — emptying the mental hospitals and denying psychiatry its social mandate. But it is impotent when it comes to debating or securing positive policy alternatives.

In England, the strategy of utilising the courts to enforce substantive changes in patterns of spending by health and social service authorities will be even less successful. Whilst some rulings of the European Commission of Human Rights have led to the allocation of resources to improve hospital conditions, no indigenous body of constitutional rights exists to appeal to. Whilst the English courts have occasionally overturned decisions of authorities to refuse benefits, in general the courts are reluctant to usurp the power of the legislature and the executive in determining the nature and pattern of state provision. In any event, the English situation differs markedly from that which prevailed in the United State prior to the movement for the rights of the mentally ill. Since the Mental Treatment Act 1930, the proportion of compulsory admissions to hospital has been decreasing. Prior to the introduction of the 1983 Act, compulsion was involved in only around ten per cent of admissions. For the vast majority of those in hospital as informal patients, not to mention the many thousands more who are in receipt of psychiatric attention as out-patients, day-patients, in clinics, in local authority and voluntary establishments, obtaining psychoactive drugs from their general prac-
tioner or psychotherapy on a private basis, these provisions of the new Mental Health Act, are irrelevant, and the campaigns which led up to it were diversionary.⁴¹

Indeed, this strategy should itself be seen as in line with, and contributing to, the direction of modernisation of psychiatry. It contributes to the modernisation of psychiatry by seeking to free it from those aspects of its social role which de-legitimise it. The use of mental hospitals as a repository for those whose only ‘illness’ is that they are unable to cope with the demands of a life outside casts doubt upon the therapeutic potential of psychiatry; their use as custodial institutions for those whose only ‘illness’ is that they are a ‘danger to society’ casts doubt upon the medical legitimacy of psychiatry. Hence the strategy forms one element in the annexation of psychiatry to general medicine, the limitation of the role of hospitalisation, the reduction in numbers of in-patient beds and length of stay, the minimisation of compulsory detention and the utilisation of non-medical institutions (from the prison to the social service group home) for the containment of those populations not amenable to therapy. Yesterday’s scandals of the institution are replaced by today’s scandals of ‘the community’.⁴²

THE POLITICS OF RIGHTS

But we should not confine ourselves to a criticism of the inability of rights based strategies to deliver the social resources which they promise; we should also consider the politics underlying the discourse of rights.

The ideology of entitlement argued that the minimisation of the use of the psychiatric institution and the promotion of mental health services ‘in the community’ was a consequence of the recognition of the ‘right’ to treatment in the least restrictive settings. This appears to be based upon an evident fact: that detention in a psychiatric institution is the most restrictive of all the forms of provision for the mentally distressed. However this assertion clearly depends upon the criteria according to which ‘restriction’ is evaluated. Many different criteria may be offered as candidates: physical confinement, intellectual confusion, emotional relationships, personal happiness, productive activity and so forth. It is by no means clear that existence in hospital, in physical comfort and institutional stability, is any more ‘restrictive’ that the ‘liberty’ to remain in ones own home unable to reach the shops because of anxiety or depression, visited once weekly by the ‘community psychiatric nurse’. Nor are local authority group homes, or private establishments, necessarily ‘less restrictive’ than hospitals — even when they are ‘in the community’ in the sense of being in the same administrative area as that where the inmate once lived. But whilst this shows the impossibility of resolving questions about the nature of provision — let alone its efficacy or preferability — in terms of an appeal to rights, it also illuminates the politics of rights strategies. For the
psychiatric reforms urged in the name of the least restrictive alternative did not flow from the discovery of a right. On the contrary, the ‘right’ was invented as the ground for the desired outcome. The language of rights disguises a social judgment and a political strategy — to curb the professional powers of psychiatry and hence reduce the role of the institutions controlled by the psychiatric profession. To forward such a strategy by appealing to a right, appears to remove the necessity for the basis and implications of this judgment to be argued out.

This is significant, for the advocates of the move away from medicine seem to have no similar reservations about the discretionary powers of the professions of the social, and the apparatus which they control — ‘the community’. Yet at the very time when a welcome is being extended to the increased role and powers of social workers in the field of mental health, in child care policy and the juvenile courts the knowledge claims and professional motives of the welfare apparatus are being scrutinised and challenged. On the one side, this social sector is castigated by legalists for its normativity and bias and its involvement with a paternalistic system of surveillance and social control. Yet, simultaneously, the new legalists of mental health seek to allocate this sector new powers in judgments as to confinement, and a new role in mental health services. The social reality of rights based strategies is not to transform the relations of dominance between professionals and those subject to them, but to effect a redistribution of status, competence and resources amongst the many sectors involved in the professionalisation of unhappiness.

These issues lead on to some more fundamental problems with rights based strategies. To argue for a right is to make a claim that the satisfaction of a perceived need be regarded as a legitimate obligation by a government or its agencies. But different claims may be formulated in terms of rights, and these may be contradictory or compete for attention or resources. There is, of course, a venerable literature in moral philosophy and jurisprudence concerning the existence and nature of rights and the appropriate forms of their recognition, construction and/or protection. There are unresolved debates concerning the relationship between ontological rights, grounded in the nature of humans as individuals, or of society, and legal rights, enacted in positive law or constituted through procedural formalities. Moral philosophers have devoted considerable attention to how rights may be ranked in order of priority, whether rights can conflict and, if so, how such conflicts might be resolved. Such questions are unresolved and the debate over them is, in a literal sense, interminable; rights discourse is incapable of providing authoritative solutions to the problems of our contemporary fragmented moral order. Hence the appeal to rights can provide no effective means of substantiating demands that particular claims are valid and should have priority over others.

For example, the ‘right’ of a patient to refuse to enter hospital may impose ‘duties’ upon their relatives who have to tolerate bizarre behaviour and provide nurturance at the expense of their own ‘rights’ to liberty. Such
relatives might, with some justification, claim a 'right' to measures which would promote the rapid recovery of their loved one and their return to social and interpersonal competence. And, of course, persons in the community can, and do, claim their 'right' to be left in peace from bizarre and frightening behaviour. And governments, or individual taxpayers, might claim a 'right' to take measures which would promote the maximum efficiency of a system of psychiatric care and the rapid restoration of disabled individuals to a condition where they can exist without additional social support. The doctrines of rights and entitlements cannot resolve the issue of whose 'rights' shall prevail; it merely dissimulates the grounds upon which choices are made.

Whether the language of rights is deployed in respect of individuals or, as more recently, in an attempt to formulate theories of collective rights, its reality is to disguise the moral and political grounds upon which interests are construed to exist and their satisfaction demanded. For example, by utilising the courts to establish a right and to demand that it be met, rights strategists are seeking to direct resources to those sectors which they are currently supporting, at the expense of other who have no such advocates. For a court to order improved conditions or set specified standards according to which an institution ought to be run, or for a court to demand that a state authority establish certain provisions in order not to infringe the constitutional rights of its citizens for treatment in 'least restrictive' settings, effectively constitutes a legal arrogation of discretion in choices as to allocation of funds amongst competing priorities. The appeal to rights thus substitutes legal rhetoric for political argument, and grounds an attempt to shift powers from the political apparatus to the legal apparatus; paradoxically it de-politicises the debate over priorities in the allocation of resources and over difference mechanisms of social regulation. In specific circumstances there may be pragmatic tactical reasons to adopt such an approach. But this is very different from seeking to base a political strategy upon the morality of rights.

RIGHTS MINDEDNESS IN SOCIAL REFORM

The new legalism in mental health reform is a strategy which is both limited and limiting. It is unlikely to further the interests of the majority of those suffering mental distress. For the bulk of those who are desperately unhappy, bleakly depressed, disabled by anxiety, anguished or crippled by madness, the problems they face are not those of an abuse of rights. The focus on compulsion is misleading. The virtues of a transfer of expert power from medicine to law and social work are disputable. The benefits of transferring individuals from institutions to 'the community' are questionable. The solutions proposed are unlikely to achieve the desired effects. And the very terms in which the strategy is conceived are problematic.

To formulate political arguments and demands in terms of rights is to
seek to mobilise on behalf of one's cause a discourse which has considerable potency in our current social and political climate. Arguments in terms of rights depend for their power upon a conflation of three levels of argument. They run together a moral discourse concerning the nature and worth of humans, a political discourse about the obligations of, and limitations upon, the power of the state, and a 'technological' discourse concerning the appropriate mechanisms and agencies of regulation. But whilst this amalgam accounts for the attraction of rights, the direct appeal which rights discourse makes to our notions of the obvious basis for morality, politics and government is not a ground for adopting its perspective but for questioning it.

Of course, socialists have long been suspicious of notions of rights. They have argued against their association with liberal moral humanism, their compatibility with the ideology of bourgeois individualism inaugurated by capitalism, their acceptance of the illusions of liberty and equality in the sphere of distribution whilst ignoring fundamental inequalities and coerciveness at the level of production, the ineffectivity of legal mechanism to constrain or regulate basic economic power. Hence critics have drawn attention to the moral utopianism of rights arguments, their incompatibility with socialist belief in the need for collective and social struggles for liberation. They have argued that notions of rights, liberties and justice are incapable of conceptualising the objectives of struggles to transform the conditions of production and appropriation of the surplus, to democratise enterprises and social institutions, or to challenge structural features of power as opposed to individual abuses.45

Yet recently a certain ambivalence has entered this opposition to rights. Not only have socialists and feminists posed their struggles in terms of rights, but writers have drawn attention to the powerful mobilising capacities of rights arguments, to the extent to which rights provide a basis for the defence of political liberties, and to the possibility of using the language of rights to span the apparent divide between collective claims for the advancement of certain social policy objectives and the requirement for the capacities and competences of appropriate agencies to be legally constituted and regulated.46

The example of mental health reform suggests that socialists and other progressive reformers should look elsewhere to provide the conceptual and moral foundation for their politics. There might be an argument for the tactical use of the language of rights because of its consonance with the common sense of western social and political thought. But it is clear that such language provides no means of formulating objectives for substantive reforms or for implementing such reforms. It is not effective in the calculation of priorities or the resolution of conflicts, for conceptualising or defending freedoms, for characterising or evaluating decision making processes, for regulating or improving them, or for analysing or transforming the powers of expertise over those subject to it. It sidesteps the ethical issues, by smuggling in an unanalysed morality concerning the value and
attributes of humans and the rules of just conduct. It evades the political
issues by its inability to confront the question of the distribution of scarce
resources amongst priorities and by disguising the politics of its own
utilisation of legal mechanisms for the exercise of political power.

The mechanisms and forums provided by the law may allow symbolically
significant 'guerilla' assaults on particular practices and institutions. There
are undoubtedly tactical reasons for using legal means to challenge
particular instances of institutional power, and for seeking changes in the
legal specifications of the powers and competences of professional and
other authoritative agents. Changes in the law may be one element in an
effective programme of social reform. But rights strategies do not provide
a useful basis for those who would wish to transform the social position of
the mentally ill — or any other group for that matter. On the contrary, they
illustrate the limited conceptions held by many legal activists of the nature
of law and legal mechanisms vis-à-vis other mechanisms of organising,
monitoring and transforming social provisions. The weaknesses identified
in the 'new legalism' in mental health reform serve also to illustrate some
of the unfortunate consequences of the current tendency to re-cast
socio-political discourse in legal terms.

NOTES AND REFERENCES

1 See especially L. Gostin, A Human Condition (2 vols., 1975, 1977); MIND, Evidence to
the Royal Commission on the NHS with Regard to Services for Mentally Ill People (1977).
For official discussions see D.H.S.S., A Review of the Mental Health Act 1959 (1976);
D.H.S.S., Review of the Mental Health Act 1959 (1978, Cmnd. 7320); D.H.S.S., Reform of

2 L. Gostin, "The ideology of entitlement: the application of contemporary legal approaches
to psychiatry" in Mental Illness: Changes and Trends (1983a; ed. P. Bean) p. 27. See also L.
Gostin, "Contemporary social historical perspectives on mental health reform" (1983b) 10
J. Law and Society 47.

of the concept of 'community' in debates around psychiatry, see N. Rose "British
psychiatry society and community in the twentieth century" in The Powers of Psychiatry
(1986); ed. P. Miller and N. Rose.

"The merger of incompetency and certification: the illustration of unauthorised medical
contact in the psychiatric context" (1979) 2 Int. J. Law and Psychiatry 126; L. Gostin,
"Psychosurgery: a hazardous and unestablished treatment? A case for the importation of

5 L. Gostin, op. cit., n. 2, 1983a, pp. 46-50 and op. cit., n. 2, 1983b, pp. 61-66; L. Gostin,
op. cit., n. 1, 1975, chap. 8; L. Gostin, "Unimpeded access to the courts" (1979) 129 New

6 B. Hoggett, Mental Health Law (2nd. ed.; 1984) is the best general account of the current
state of the law. See also D. Carson, "Mental processes: the Mental Health Act 1983"

7 In this paper I do not discuss issues concerning mentally disordered offenders. For a
critical analysis of the role of psychiatry in the criminal justice system, see the papers by P. Carlen and S. Ramon in Miller and Rose ed., *op. cit.*, n.3.


12 Id., p.37.


18 Especially, of course, Szasz, *op. it.*, n.15.

19 For a careful discussion of these issues, see P. Hirst and P. Woolley, *Social Relations and Human Attributes* (1982), chap. 7. See also A. Maclntyre, *After Virtue* (1982).


A number of these studies are discussed in Clare, 1980, *op. cit.* n. 9, pp. 138–9.

For a good overview of issues see R. E. Kendell, *The Role of Diagnosis in Psychiatry* (1975). Diana Adlam and I have shown elsewhere (*op. cit.*, n. 16) that the view that pathologies of the mind are in principle not amenable to diagnosis cannot be sustained.

See the discussion in Clare, *op. cit.*, pp. 371–377.

For an account of the new powers of Mental Health Review Tribunals, see Hoggett, *op. cit.*


The obvious example is the trial of Peter Sutcliffe 'The Yorkshire Ripper' which took place in May 1981. But note that while H. Fingarette in *The Meaning of Criminal Insanity* (1972) sees the accounts given by law and psychiatry as incompatible M. S. Moore in *Law and Psychiatry* (1984) seeks to show fundamental commonalities between them. However such analyses at the level of theoretical codes are not adequate to characterise the practical relationships between legal and psychiatric discourses. For an incisive discussion of the question of criminal responsibility see H. Allen, "At the mercy of her hormones: pre-menstrual tension and the law" (1983) 9 *m/f* 19.


As Gostin now seems to recognise: Gostin, 1983a, *op. cit.*, n. 2, p.36. See also M. S. Lottman, "Enforcement of judicial decrees: now come the hard part" (1976) 1 *Mental Disability Law Reporter* 69.
For some analyses of de-institutionalisation in the USA see A. Scull, *Decarceration* (2nd ed., 1985) and the papers gathered together in *57 Milbank Memorial Fund Quarterly* (1979). See also Wald and Friedman, *op. cit.*, p. 145.

Gostin cites a number of successful cases in *op. cit.*, n.2 1983a pp.31–34.

For example *R v Secretary of State for Social Services West Midlands Regional Health Authority and Birmingham AHA (Teaching) ex parte Hincks and Others* reported in *The Lancet* (1984) No. 8413, p. 1224.

S. 57 of the Act requiring consent and a second opinion before the administration of certain very serious treatments such as psychosurgery applies also to informal patients.


For criticisms of professional discretion in social work see for example the contributions to H. Geach and E. Szwed, *Providing Civil Justice for Children* (1983). A useful discussion of problems with the notion of the ‘community care’ is P. Abrams, “Community care” (1977) 6 *Policy and Politics* 125. S. Cohen, in "The punitive city: notes on the dispersal of social control” 3 *Contemporary Crises* 339 analyses analogous trends towards ‘community alternatives to imprisonment’ in terms of a widening of the net of social control, thinning the mesh and blurring the boundaries between the normal and the abnormal, and between the institution and society. These issues are discussed further in Rose, *op. cit.*, n. 3.

The best discussion of these issues is in MacIntyre, *op. cit.*

T. Campbell, *The Left and Rights* (1983) provides a useful overview of the criticisms whilst himself seeking to rebut them.