

Routledge Handbook of Mental Health Law

Edited by Brendan D. Kelly and Mary Donnelly

First published 2024

ISBN: 978-1-032-12837-5 (hbk)

ISBN: 978-1-032-12840-5 (pbk)

ISBN: 978-1-003-22641-3 (ebk)

Chapter 1

History and development of mental health law

Brendan D. Kelly

CC-BY-NC-ND 4.0

DOI: 10.4324/9781003226413-3

The funder of the Open Access version of this chapter is Trinity College Dublin.

I

HISTORY AND DEVELOPMENT OF MENTAL HEALTH LAW

Brendan D. Kelly

Introduction

This chapter examines the history and development of mental health law, with particular emphasis on legislation designed to govern the treatment of mental illness. Such legislation has traditionally focused on admission without consent to psychiatric inpatient facilities, treatment without consent in such settings, and mechanisms to ensure standards of care (e.g., inspection regimes). Certain jurisdictions have, on occasion, expanded the remit of mental health legislation to include such matters as authorising compulsory treatment in the community, articulating a right to mental health care, and various other matters.

This chapter starts with an overview of mental illness in history, presents an exploration of early efforts to control people deemed to be ‘mentally ill’, outlines the emergence of asylums and more focused legislation in the nineteenth century, documents increased emphasis on human rights during the twentieth century, uses Ireland’s and India’s current mental health legislation as examples of contemporary mental health law, and indicates likely future developments in this area.

Throughout this chapter, original language and terminology from the past and from various archives, reports, and publications have been maintained, except where explicitly indicated otherwise. This reflects an attempt to optimise fidelity to historical sources and does not reflect an endorsement of the broader use of such terminology in contemporary settings. Language evolves constantly in this field, as social attitudes change.

The history of mental illness: the emergence of psychiatry

Mental illness has been a constant feature of human history since records began. Every society has described conditions akin to ‘madness’, ‘lunacy’, or mental illness and has developed varied responses at the levels of individuals, families, communities, and countries. Early explanations often prioritised religious interpretations of hearing voices, having visions, or behaving strangely (Scull, 2015). Responses varied across societies and over time: while some people who ‘heard voices’ were hailed as saints or mystics, most were dismissed as ‘mad’,

persecuted, confined, ostracised, or constrained to lives of wandering, loneliness, destitution, and early death (Kelly, 2022).

There was a significant shift in this position in medical texts written in the tradition of Hippocrates (c.460–c.370 BCE), a Greek physician, developing the idea of four ‘humours’: black bile, yellow bile, phlegm, and blood. Health resulted when the humours were in balance; disease resulted when they were not. This approach linked health, including mental health, with the physical body. Hippocrates highlighted the particular importance of the brain in determining our responses to the world and, in turn, shaping ‘madness’:

by the same organ we become mad and delirious, and fears and terrors assail us, some by night, and some by day, and dreams and untimely wanderings, and cares that are not suitable, and ignorance of present circumstances, desuetude, and unskilfulness. All these things we endure from the brain, when it is not healthy, but is more hot, more cold, more moist, or more dry than natural, or when it suffers any other preternatural and unusual affection.

(quoted in Kelly, 2022; p. 10)

This paradigm located mental illness in the body and brain, rather than the heavens, and represented a key shift in thinking about those who were ‘mad and delirious’.

Even as Hippocratic theory grew in popularity, traditional and folkloric explanations often persisted alongside evolving medical thought. In China, demonic possession and disturbances to cosmic forces were commonly invoked to explain madness, while supernatural therapies also continued in the Islamic tradition, although the Islamic hospitals of the eighth century made additional medical provision for people with mental illness.

In England, Bethlem Royal Hospital (‘Bedlam’) was founded in the thirteenth century as the Priory of St Mary of Bethlehem and, by 1403, housed six insane men, among others (Shorter, 1997). Over subsequent centuries, private ‘madhouses’ emerged in many countries and were followed, in the nineteenth century, by an extraordinary wave of public asylum-building across much of the world. This trend stemmed from genuine concern about the mentally ill, philanthropic impulses to assist the afflicted, a burgeoning belief in the power of medicine to heal the mentally ill, and a desire for legitimacy among asylum doctors who were keen for professional recognition of their new branch of medicine: psychiatry.

This enthusiasm for large mental hospitals was misguided in retrospect, but was generally well intentioned at the time, seeking to correct a clear injustice against the mentally ill, many of whom were homeless, destitute, and profoundly neglected. Understandings of mental illness changed in parallel with evolving systems of care – systems that were driven by a perceived social need for containment as much as by medical discoveries, by a desire for control over the ‘insane’ rather than scientific understanding of their condition.

The desire to control the mentally ill stemmed in part from fear. In 1904, German psychiatrist Emil Kraepelin (1856–1926) wrote that ‘all the insane are dangerous, in some degree, to their neighbours, and even more so to themselves’:

Mental derangement is the cause of at least a third of the total number of suicides, while sexual crimes and arson, and, to a less extent, dangerous assaults, thefts, and impostures are often committed by those whose minds are diseased. Numberless families are ruined by their afflicted members, either by the senseless squandering of their means, or because long illness and inability to work have gradually sapped the power of

caring for a household. Only a certain number of those who do not recover succumb at once. The greater part live on for dozens of years, imbecile and helpless, imposing a heavy and yearly increasing burden on their families and communities, of which the effects strike deeply into our national life.

(Kraepelin, 1904; pp. 2–3)

Kraepelin was gravely mistaken about these risks, but his views were widely shared, resulting in mass institutionalisation of people with mental illness in certain countries and, later, their persecution and murder in Nazi Germany (Kelly, 2022).

More broadly, at the start of the twentieth century, multiple countries had built large psychiatric hospitals that were now filled with patients whom doctors could not treat effectively. Other regions offered virtually no care to many people with severe illness who continued to be excluded, ignored, and neglected by their communities and societies. At this point, the problem of mental illness seemed intractable, diffuse, and widespread, with no ready solution to hand.

As a result of this situation, a series of novel biological therapies were introduced in the asylums during the first half of the twentieth century, fuelled primarily by a desire to discharge patients from the grossly outsized institutions – a desire informed more by therapeutic desperation than reliable science. New treatments included insulin coma therapy and lobotomy, both of which were eventually abandoned due to lack of efficacy and the extraordinary harm they caused. Other treatments from that era, such as electro-convulsive therapy (ECT), remained in use, but on a more limited scale. The introduction of anti-psychotic medication in the 1950s helped improve symptoms and discharge patients, but large institutions remained in place in many countries because anti-psychotics managed, rather than cured, severe mental illnesses.

One of the recurring problems was – and still is – the shifting definition of ‘insanity’ or ‘mental illness’. This dilemma stems from the fact that most diagnoses in psychiatry are based on symptoms rather than biological tests, and are therefore subject to change and re-definition over time.

In an effort to bring some reliability to this field, the World Health Organization (WHO) added mental disorders to the sixth edition of its *International Statistical Classification of Diseases, Injuries, and Causes of Death* in 1949 (World Health Organization, 1949). The American Psychiatric Association (APA) followed suit three years later with its *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952). Both of these symptom-based diagnostic systems have gone through several revisions over the past decades, but while they have facilitated research and treatment to a substantial degree, they remain imperfect, contested, and continually under revision (Katshnig, 2010). Diagnostic systems are necessary and better than nothing, but they manage rather than solve psychiatry’s core problem of symptom-based diagnosis, rather than definitive biological tests for mental illness.

In the meantime, and somewhat improbably, psychiatric treatments advanced substantially, with medications such as antidepressants proving effective for depression (among other disorders), psychological therapies such as cognitive-behaviour therapy (CBT) expanding their remit substantially, and various other approaches emerging over time, often by chance rather than design. The result is that treatments today are extremely useful but imperfect for most psychiatric conditions, mental health services exist but are often inadequate in many

parts of the world, and the biological basis of most mental illnesses remains stubbornly unclear, despite substantial research (Kelly, 2020).

Control and mental illness: the role of legislation

Throughout the historical evolution of these ideas about mental illness, the building of asylums, the emergence of psychiatry as a medical discipline, and the development of recent therapies, the idea of controlling the mentally ill has been the only constant feature of societal responses to mental illness. In the fourth century BCE, Plato, in his *Laws* (Book XI), emphasised the need for control of the ‘mad’ in ‘a well-ordered state’:

If a man is mad he shall not be at large in the city, but his relations shall keep him at home in any way which they can; or if not, let them pay a penalty – he who is of the highest class shall pay a penalty of one hundred drachmae, whether he be a slave or a freeman whom he neglects; and he of the second class shall pay four-fifths of a mina; and he of the third class three-fifths; and he of the fourth class two-fifths.

Now there are many sorts of madness, some arising out of disease, which we have already mentioned; and there are other kinds, which originate in an evil and passionate temperament, and are increased by bad education; out of a slight quarrel this class of madmen will often raise a storm of abuse against one another, and nothing of that sort ought to be allowed to occur in a well-ordered state.

This desire to manage and control all aspects of the lives of people with mental illness was widespread and sustained over many centuries, and persists today.

In Ireland, early laws specified the obligation of families to look after the insane, the elderly, and people with physical disabilities (Kelly, 2003). Legal texts from between the seventh and ninth centuries forbade exploitation of the insane, ruled that a contract with a person of unsound mind was invalid, and made provision for land owned by the insane. Early Irish law also dealt with offences committed by persons of unsound mind and made provisions governing childbirth and responsibility for offspring of the mentally ill (Kelly, 2016a).

The first piece of modern mental health law was, arguably, the *Statute De Prerogativa Regis*, introduced under Edward II of England in 1324 (Fennell, 2010). This statute gave the King wardship over the lands of ‘idiots’ and, later, ‘lunatics’. Subsequent legislation generally focused on criminals and the homeless, so the first law to deal specifically with the needs of ‘pauper lunatics’ in that jurisdiction was the Vagrancy Act, 1744, which provided for the incarceration of the ‘furiously mad’.

Following these developments, mental health law evolved at different rates and on slightly different trajectories in various jurisdictions around the world (Hayes et al., 1993). Despite these often subtle variations, the impulse to manage, control, and (to varying degrees) treat people with mental illness is evident in virtually every jurisdiction over the past two hundred years (Porter, 1991). During the nineteenth and twentieth centuries, the two key, linked mechanisms for achieving these goals in many countries were the building of asylums and the introduction of dedicated laws aimed at containing or treating people with mental illness in them.

Plato’s suggestion that ‘if a man is mad’, his ‘relations shall keep him at home in any way which they can’ is also reflected consistently throughout this history. In 1817, before a sys-

tem of public asylums was widely established in Ireland, a parliamentary committee heard evidence about the plight of the mentally ill in rural family homes:

There is nothing so shocking as madness in the cabin of the peasant, where the man is out labouring in the fields for his bread, and the care of the woman of the house is scarcely sufficient for the attendance on the children. When a strong young man or woman gets the complaint [mental illness], the only way they have to manage is by making a hole in the floor of the cabin not high enough for the person to stand up in, with a crib over it to prevent his getting up, the hole is about five feet deep, and they give this wretched being his food there, and there he generally dies. Of all human calamity, I know of none equal to this, in the country parts of Ireland which I am acquainted with.

*(Select Committee on the Lunatic Poor in Ireland,
1817; p. 23)*

As in many other countries, the governmental response to this dreadful situation was to pass a series of laws governing the management of people with mental illness and directing the erection of public institutions designed to house, contain, and treat them. This belief in institutional solutions was unshakeable. In 1858, the Lunatic Asylums, Ireland, Commission emphasised that ‘it is of the utmost importance that cases of insanity should as speedily as possible be removed to an asylum’ (Lunatic Asylums, Ireland, Commission, 1858; p. 12). Attitudes were similar in other jurisdictions.

As a consequence of this position, multiple laws were introduced across Europe, Asia, the Americas, Africa, Oceania, and elsewhere, generally providing for public asylums to contain people with mental illness and govern their management and treatment (see, for example, Grob, 1973; Somasundaram, 1987; Swartz, 1995; Kirkby, 1999; Scull, 2015; Kelly, 2016a). To take just one example, relevant legislation in Great Britain (and its various constituent jurisdictions as they evolved) included the Madhouses Act (1774), County Asylums Act (1808), Lunatics Act (1845), Lunacy Act (1890), Mental Deficiency Act (1913), and, later, Mental Treatment Act (1930) and the Mental Health Acts of 1959, 1983, and 2007 (Fennell, 2010).

The end result of this frenzied legislative zeal, which reached fever pitch in the mid-nineteenth century, was that, at the start of the twentieth century, the legal situation of the mentally ill in many countries was enormously complicated owing to multiple pieces of overlapping legislation that were poorly understood and often contradictory. People with mental illness were in an impossible situation. In many parts of the world, majorities still received no care whatsoever, while in countries with large mental hospitals, their position was more complex but no less distressing. Patients in these hospitals were abandoned by communities that would not accept them back, stranded in institutions that now focused on custody rather than care (let alone cure), and lacked any clear avenue for redress. Even if patients could access the courts, virtually nobody understood the relevant laws and fewer cared. Asylum patients were both captive and lost at the same time.

To compound matters, and despite the surfeit of obscure legal instruments, families often remained central to managing the mentally ill outside the formal institutions. George Fielding Blandford (1829–1911), a relatively enlightened English asylum doctor, argued, in 1871, that ‘common law’ permitted restraint of the mentally ill by their families or friends.

He wrote that ‘a man [sic] does not necessarily come under the cognizance of the lunacy laws because he happens to be a lunatic’:

He may be a lunatic for years, and may be tended and restrained in his own house, or in that of a relative or friend, provided that his own friends or relations take care of him, and take care of him properly. It is the common law of the land that a man’s friends may restrain him from harm, or protect him, if he is unable to protect himself. But if the lunatic is not taken care of by his own friends, or if they neglect him, and he is found to be wandering at large or improperly confined or maintained, then the Lunacy Acts reach him.

(Blandford, 1871; p. 381)

This situation was replicated in many countries around the world: families remained central to day-to-day management and control of the mentally ill who were not placed in mental hospitals, prisons, poor houses, or other institutions. Blandford emphasised the importance of early treatment to avoid admission to an asylum:

Now, in the earliest stages, insanity is a very curable disorder; but through the obstinacy of friends it happens over and over again that the curable stage is past and gone long before any remedial measures have been taken, and the patient is brought to us a confirmed and hopeless lunatic, requiring care not cure, to be shut up in restraint for the term of his natural life.

(Blandford, 1871, pp. 360–361)

The emergence of complicated mental health legislation throughout the nineteenth century served the mentally ill poorly. This was not the intent of such initiatives, but it was their effect. One Irish report stated, in 1891, that ‘good lunacy laws should make it possible to obtain care and treatment in asylums with ease, but they should make unnecessary detention difficult’ (Committee on Lunacy Administration (Ireland), 1891; p. 36). That is not how mental health legislation operated in practice for much of the nineteenth and twentieth centuries, as the social hunger for institutions pushed up admission rates across the world, resulting in the large asylums of the early and mid-twentieth century and asylum doctors’ increasingly desperate efforts to find a cure.

Continual changes in legislation constituted a form of social control that affected not only patients but also staff in mental hospitals over this period (Leiba, 1998). After treatments such as insulin coma and lobotomy were eventually abandoned in the mid-twentieth century, and new forms of medication started to arrive, the issue of institutional reform became more urgent. Discharge was increasingly possible, and many societies became less tolerant of institutions of all kinds including mental hospitals.

Change was uneven over the following decades, with certain jurisdictions remaining essentially static, others opting for incremental reform, and some implementing dramatic measures to dismantle their psychiatric institutions in one fell swoop. In Italy, psychiatrist Franco Basaglia (1924–1980) was dismayed by what he saw in Italian mental hospitals: grossly untherapeutic environments, indiscriminate physical restraint, and routine disempowerment of patients (Kelly, 2022). In 1964, Basaglia presented a report to the First International Congress of Social Psychiatry in London, titled ‘The Destruction of the Mental Hospital as a Place of Institutionalisation’. Basaglia continued to work and campaign in this vein for a

sustained period, seeking profound changes to the treatment of mental illness and psychiatric institutions in Italy.

The clearest consequence of Basaglia's work was the 'closure' of the Italian asylums as a result of the Italian Mental Health Act of 1978, also known as the 'Basaglia Law'. This legislation directed the closure of psychiatric hospitals throughout Italy and their replacement with community-based services, although some acute inpatient care was retained, chiefly in general hospitals. The changes in Italy were dramatic and remain controversial today, not least owing to the emergence of private psychiatric facilities in areas where public beds are scarce (Amaddeo and Barbui, 2018). It is also notable that, despite his appeal in Italy, Basaglia's work was relatively neglected in Anglophone countries (Burns, 2019). Basaglia's international impact might have been greater if more of his writings had been translated from Italian and if biological ideas had not emerged as a dominant theme in psychiatry over the relevant decades.

Even so, Basaglia's work showed that mental health law could be changed substantially over a relatively short period of time, and that this could have significant impact, even if some of the consequences in Italy remain unclear or even paradoxical. This realisation was followed by a new era of activism on the topic of mental health law and rights by the United Nations (UN) and WHO (as an agency of the UN). These developments underscored both broader social changes in the 1980s and 1990s, and the power of mental health law to produce changes to mental health systems, as Basaglia had shown in Italy.

The United Nations and World Health Organization

In 1991, the UN published its *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (United Nations, 1991). These principles endorse a human rights approach to mental health legislation, stating that 'there shall be no discrimination on the grounds of mental illness' (Principle 1(4)) and 'every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments' (Principle 1(5)).

This was a welcome, overdue endorsement of the rights of people with mental illness and an implicit admission that the observance of these rights requires additional protection, owing to historical mistreatment and neglect. With this in mind, the UN *Principles* go on to address a number of areas of particular concern to the mentally ill.

In relation to admission without consent, the *Principles* state that:

a person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4 ['Determination of mental illness'], that that person has a mental illness and considers:

- (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

- (b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

(United Nations, 1991; Principle 16(1))

In the case of (b), ‘a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs’. This position and even some of this wording are now reflected in specific pieces of mental health legislation around the world (World Health Organization, 2005; see below).

In relation to treatment without consent, the *Principles* state that, subject to specified exceptions:

a proposed plan of treatment may be given to a patient without a patient’s informed consent if the following conditions are satisfied:

- (a) The patient is, at the relevant time, held as an involuntary patient;
- (b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above [regarding diagnosis, treatment, alternatives, and adverse effects], is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient’s own safety or the safety of others, the patient unreasonably withholds such consent; and
- (c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient’s health needs.

(United Nations, 1991; Principle 11(6))

The UN *Principles* contain various other provisions, including a requirement for reviews of involuntary admissions ‘as soon as possible’ after admission occurs (paragraph 17(2)).

Overall, the UN *Principles* sought to influence and inform national mental health legislation in order to better safeguard rights while also permitting admission and treatment without consent under specific circumstances and subject to independent review. While the idea of ‘best interest’ is no longer as prevalent as it was, many of these UN *Principles* are still clearly reflected in national mental health law today (see below).

Five years after the 1991 UN *Principles*, the WHO Division of Mental Health and Prevention of Substance Abuse provided more detail on this theme in *Mental Health Care Law: Ten Basic Principles* (Division of Mental Health and Prevention of Substance Abuse, 1996a). This document is based largely on the UN *Principles* as well as ‘a comparative analysis of national mental health laws in a selection of 45 countries worldwide conducted by WHO in recent years’ (p. 1).

The WHO’s *Ten Basic Principles* include ‘promotion of mental health and prevention of mental disorders’; ‘access to basic mental health care’; ‘mental health assessments in

accordance with internationally accepted principles'; 'provision of the least restrictive type of mental health care'; 'self-determination'; 'right to be assisted in the exercise of self-determination'; 'availability of review procedure'; 'automatic periodical review mechanism'; 'qualified decision-maker' (i.e., official or surrogate decision-makers should be qualified for the role); and 'respect of the rule of law' (p. 1).

In relation to mental health legislation more specifically, the *Ten Basic Principles* take a broad approach and recommend 'maintaining legal instruments and infrastructures (human resources, sites, etc.) to support community-based mental health care involving settings for patients with various degrees of autonomy' (paragraph 4). For decisions 'affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact', however, 'there should be an automatic periodical review mechanism' (paragraph 8).

In respect of the 'rule of law',

decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis nor on an arbitrary basis [...]

1. Depending on the legal system of the country, the body of law may be found in different types of legal instruments (e.g. constitutions, international agreements, laws, decrees, regulations, orders) and/or in past court rulings (precedents);
2. The law applicable is the law in force at the time in question, as opposed to retroactive or draft legal instruments;
3. Laws should be public, accessible and made understandable.

(Division of Mental Health and Prevention of Substance Abuse, 1996a; paragraph 10)

One of the most interesting aspects of the UN *Principles* (1991) and the WHO's *Ten Basic Principles* (1996) is their implicit acceptance of admission and treatment without consent in certain circumstances and their acceptance that such practices are governed by national mental health legislation. Similar assumptions underlie later WHO publications, including their *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, which note that 'international instruments supporting even the most basic rights of persons with mental disorders have been very long in coming' (p. v) and which provide guidance about implementing the relevant principles at national level (Division of Mental Health and Prevention of Substance Abuse, 1996b). Many of these rights-based considerations were underscored in the 2001 WHO World Health Report which was devoted to *Mental Health: New Understanding, New Hope* (World Health Organization, 2001) and the 2005 *WHO Resource Book on Mental Health, Human Rights and Legislation* (World Health Organization, 2005).

A more critical stance became apparent in the WHO's 2004 document on *The Role of International Human Rights in National Mental Health Legislation* (Department of Mental Health and Substance Dependence, 2004). In relation to 'informed consent and the right to refuse treatment', this document states that:

the common practice in many countries of permitting family members to consent on behalf of the patient, without any formal process for determining the legal incapacity of

the patient consistent with these requirements, violates the human rights of dignity and autonomy as recognized in the Universal Declaration of Human Rights as elaborated upon in [the 1991 UN] Principles.

(Department of Mental Health and Substance Dependence, 2004; p. 35)

This document also noted that the UN *Principles* outlined ‘a number of major exceptions’ to UN Principle 11, that ‘no treatment shall be given’ without informed consent:

A meeting of disability rights experts convened by UN Special Rapporteur Bengt Lindqvist at Almåsa, Sweden in November 2000, pursuant to UN Human Rights Commission Resolution 2000/51 to recommend improvements in international human rights protections, has called into question whether Principle 11 may violate the anti-discrimination provision of international human rights conventions. The conference members adopted a resolution finding that any law is ‘inherently suspect’ as a form of discrimination if it permits coercive treatment for individuals with disabilities and not all other people. This is an issue that has yet to receive additional attention by international human rights oversight bodies.

(Department of Mental Health and Substance Dependence, 2004; pp. 36–37)

Two years later, the UN *Convention on the Rights of Persons with Disabilities* (CRPD) stated, among other provisions, ‘that the existence of a disability shall in no case justify a deprivation of liberty’ (United Nations, 2006; article 14(1)(b)). Differing interpretations of this and other sections of the CRPD are explored in various contributions to this volume. For the present chapter, focused on the evolution of mental health legislation, it is sufficient to note the incremental shift in tone from the UN and WHO over past decades, moving from acceptance of admission and treatment without consent (provided certain conditions are met under national mental health legislation) to the current, somewhat ambiguous position reflected in the CRPD.

This lack of clarity in the CRPD has led to highly diverse interpretations of its provisions (Doyle Guilloud, 2019). This is unfortunate and divisive in itself, but also has the regrettable consequence of diverting attention away from other parts of the Convention which are more widely agreed upon, and which affect far greater numbers of people. These include the CRPD’s broader protections of other rights and its extensive requirements in relation to equality and non-discrimination. It is a matter of regret that these areas are often overshadowed by diametrically opposed views about specific parts of the CRPD which are, in any case, likely to defy definitive interpretation on the basis of their wording.

Human rights in mental health legislation

To summarise so far, mental health legislation has, for most of its history, generally focused on managing and controlling people with mental illness, rather than treating their conditions. The idea of institutional care based on national legislation emerged most strongly in the nineteenth century and declined in the twentieth but left a mark on legislation and services in many countries. At the international level, the language of the UN and WHO shifted in recent decades, but national legislation is slower to change and will likely continue

to reflect national positions, rather than international ones, for the foreseeable future (i.e., continue to provide for admission and treatment without consent in certain circumstances and subject to review, among other provisions).

Even so, there is evidence that certain aspects of UN and WHO publications are reflected in national legislation but are drawn upon in a selective fashion rather than implemented to the letter. Ireland is a good example of this growing influence of international bodies, including not only the UN and WHO, but also the European Court of Human Rights and the European Convention on Human Rights (ECHR) of the Council of Europe. With this in mind, it is useful to look at Ireland as an example of the historical development of transnational influences on national mental health law.

In 1995, the Irish Government sought to reform mental health legislation explicitly to ‘ensure full compliance with our obligations under the European Convention’ (Department of Health, 1995; p. 15). The need for reform in Ireland came more urgently into focus in 2000 when the lack of automatic review of detention under Ireland’s Mental Treatment Act, 1945, was the focus of a landmark case in the European Court of Human Rights.¹ Under a ‘friendly settlement’, the Irish Government undertook to compensate the applicant and noted its obligations under the ECHR. Ireland’s subsequent Mental Health Bill, 1999, was the culmination of a lengthier process of reform, which had commenced prior to this case, but which was pursued with considerably greater urgency afterwards, confirming the ECHR as a key driver of reform (Kelly, 2016b).

Ireland’s Mental Health Bill, 1999, led to the current Mental Health Act, 2001, which, in common with most national mental health legislation, permits admission and treatment without consent under certain circumstances. Even the detailed criteria for involuntary admission in Ireland, however, clearly reflect international recommendations, especially the 1991 UN *Principles*. Ireland’s legislation permits admission without consent when a person has:

mental illness, severe dementia or significant intellectual disability where:

- (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
- (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

(Mental Health Act, 2001; Section 3(1))

These wordings closely echo those of the UN *Principles*, which permit admission without consent if the ‘person has a mental illness’ and (a) ‘because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons’, or (b)

1 *Croke v Ireland* 33267/96 [2000] ECHR 680 (<http://www.bailii.org/eu/cases/ECHR/2000/680.html>).

in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

(United Nations, 1991; Principle 16(1))

While the Irish wording is similar to that of the UN, it is not identical, owing to other influences on Irish mental health law including domestic legislation, case-law, the ECHR, and various other considerations, Nonetheless, the imprint of the UN is clear not only in the criteria for involuntary admission, but also in the broader principles of the Irish Act, which include ‘the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy’ (Section 4(3)) and ‘best interests’:

In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.

(Mental Health Act, 2001; Section 4(1))

This is consistent with both broader Irish law and the 1991 UN *Principles* which require ‘that the proposed plan of treatment is in the best interest of the patient’s health needs’ (Principle 11(6)).

Overall, Irish legislation is a good example of the substantial impact of international bodies and standards on national mental health legislation in certain countries, even if such impact is necessarily incomplete, tempered by other aspects of national law, and subject to interpretation and change over time. Similar influences are evident in other jurisdictions (World Health Organization, 2005); Ireland is simply presented here as one example to illustrate the history of this trend over recent decades.

The systematic impact of the CRPD on national mental health legislation is not yet fully clear, although it is likely to be similar to the impact of previous UN and WHO documents, at least in certain jurisdictions. Hopefully, the CRPD itself, rather than some of its interpretations, will have widespread impact, chiefly because the Convention offers a once-in-a-generation opportunity to improve the lives of people with mental illness and re-shape mental health legislation in an historically positive way.

Giving effect to the CRPD in national mental health legislation is, however, a complex task. India’s Mental Healthcare Act, 2017, is a good example of some of the opportunities and ambiguities that can be involved in this process (see Kapoor and Shastri, this vol.).

India’s new mental health legislation was commenced on 29 May 2018 and introduces many changes, including a new definition of ‘mental illness’; revised measures governing ‘capacity’, ‘advance directives’, and ‘nominated representatives’; revised procedures for ‘independent admission’ (voluntary admission) and ‘supported admission’ (admission and treatment without patient consent); and *de facto* decriminalization of suicide. Overall, India’s 2017 Act is a comprehensive, encouraging piece of law, albeit with inevitable complications, caveats, and possible paradoxical effects.

Most interestingly, India's new legislation seeks explicitly to comply with the CRPD, which gives it particular relevance to the present chapter and to the history of mental health legislation in general. The preamble to the 2017 Act notes that 'India has signed and ratified the said Convention on the 1st day of October, 2007', and 'it is necessary to align and harmonise the existing laws with the said Convention'. This is an historic, ambitious undertaking, not only because of the content of the CRPD itself, but also because of the diversity of interpretations that exist. As a result, any commitment to implement the CRPD is a considerable, if admirable, task.

The full content of India's legislation is explored in detail elsewhere, including its headline articulation of a right to mental health care, which is consistent with both the CRPD and previous documents from the UN and WHO (Duffy and Kelly, 2020; Kapoor and Shastri, this vol.). The legislation also accords with the CRPD in many other ways that are frequently innovative, constructive, subtle, and useful for other jurisdictions to study. As a result, India's 2017 Act is, arguably, the best effort to date to give effect to the Convention in national mental health legislation and, as such, merits close attention.

Despite these achievements, the Indian legislation demonstrates certain limitations to its adherence with the CRPD, which point to potentially similar issues elsewhere. For example, the 2017 Act includes a model of supported decision-making that is consistent with the CRPD in principle, but which, if taken to its logical conclusion, can result in substitute decision-making. In relation to 'Admission and treatment of persons with mental illness, with high support needs, in mental health establishment, up to thirty days (supported admission)', the Act states:

If a person with the mental illness admitted under this section requires nearly hundred per cent support from his nominated representative in making a decision in respect of his treatment, the nominated representative may temporarily consent to the treatment plan of such person on his behalf.

(Section 89(7))

This constitutes a form of substitute decision-making and therefore might not comply with the CRPD, at least according to the interpretation of the UN Committee on the Rights of Persons with Disabilities (Committee on the Rights of Persons with Disabilities, 2014). This position is by no means agreed, but the Committee has expressed a clear view along these lines.

This issue illustrates the dilemma presented by the CRPD to national mental health legislation, even when such legislation tries to accord with the Convention as best as possible. Other contributions to the present volume explore this issue further and in different ways, but the fundamental question is: To what extent should the diversity of interpretations of the CRPD impede progressive realisation of its core provisions? India chose to move ahead with implementation, despite uncertainties of this nature and despite resource challenges across mental health services on the ground. Notwithstanding the linguistic ambiguities of parts of India's 2017 Act (and, indeed, the CRPD), it is difficult to argue against India's model of pragmatic realisation. Even if progress is imperfect, some progress is better than none – and India has made considerable advances with its legislation.

From an historical perspective, and in addition to the influence of international bodies on national legislation, it is notable that mental health law in Ireland, India, and many other jurisdictions continues to reflect one of the most controversial features of the history of such

laws: the role of perceived dangerousness as a justification for involuntary admission and treatment. The inclusion of risk in these criteria is hugely questionable, not least because future behaviour is essentially impossible to predict (Large et al., 2008; Large et al., this vol.). This issue, too, is explored elsewhere in the present volume, so, for this chapter which focuses on history, it is sufficient to note that the persistence of dangerousness criteria continues to present cause for concern.

The root issue here is that psychiatry's evidence base rests on treating mental illness, not identifying or managing risk (Kelly, 2022). This is – strangely – reflected to a degree in some aspects of national legislation, including Ireland's criteria for involuntary admission. Under the Mental Health Act, 2001, the requirement that treatment 'would be likely to benefit or alleviate' mental disorder applies *only* to involuntary admissions of persons with mental disorder that occur on the basis that 'failure to admit [...] would be likely to lead to a serious deterioration [or] prevent the administration of appropriate treatment' (Section 3(1)). It does *not* apply to involuntary admissions of persons with mental disorder that occur on the basis of 'a serious likelihood of the person concerned causing immediate and serious harm' (Section 3(1)). For the latter, there is no treatment requirement.

As a result, it is legally possible to involuntarily admit someone with mental disorder in Ireland on the basis of risk even if treatment will not benefit them. This needs to change because it would be unethical and because it reflects one of the many unwelcome legacies of the history of mental health legislation: an excessive focus on 'risk' which we cannot measure.

Just as Plato insisted that the 'mad' should 'not be at large in the city' in the fourth century BCE, just as Blandford urged families and friends to 'restrain' the mentally ill in the nineteenth century, and just as Kraepelin argued that everyone with mental illness was 'dangerous, in some degree' at the start of the twentieth century, current legislation still over-emphasises the risk purportedly presented by people with mental illness. This injustice remains apparent in mental health legislation across most jurisdictions today and is no more defensible in the twenty-first century than it was in the times of Plato, Blandford, and Kraepelin. This, and much else, needs to change.

Future directions for mental health legislation

In 2017, the WHO published a report titled *Advancing the Right to Health: The Vital Role of Law* (World Health Organization, 2017). In the document, the WHO 'aims to raise awareness about the role that the reform of public health laws can play in advancing the right to health and in creating the conditions for people to live healthy lives' (p. 1). The WHO emphasises the importance of the 'rule of law':

The rule of law refers to the principle that law-making processes should be transparent, laws should be enforced fairly, courts and tribunals should be independent, and the administration of law and its substantive content should be consistent with international human rights standards.

(World Health Organization, 2017; p. 7)

While the WHO sees a 'vital role' for law across all areas of health, law already has an established role in the field of mental health, albeit a controversial, contested, but nonetheless persistent role. In order to better understand current mental health legislation, and to plan for the future, it is useful to reflect on the history of such legislation, especially its unintended

consequences (e.g., disproportionate growth of asylums in the nineteenth century) and its positive potential (e.g., re-shaping legislation to protect rights, rather than just limiting them).

Most of the history of mental health legislation presented in this chapter reflects the geographical and language biases across much of the literature on this topic. Legislative developments in Ireland and India are presented as examples, reflecting one high-income country in the Global North and one lower middle-income country in the Global South. Other examples might equally have been chosen to illustrate these and other points, especially in low-income countries.

It is a matter of regret that many jurisdictions are still under-represented in the historiography of mental health legislation and in the current literature about mental health law in general. The present volume seeks to address this imbalance, at least in part, by including contributions from regions that are commonly under-represented. This does not address biases and omissions in the historiography, but will hopefully help minimise such biases and omissions in the future.

This chapter has focused chiefly on traditional roles of mental health legislation, concerning admission and treatment without consent, and the contexts in which these occur. Mental health legislation in various jurisdictions also deals with other topics including, but not limited to, mechanisms to ensure standards of care (e.g., inspection regimes), authorising compulsory treatment in the community, articulating a right to mental health care, and various other matters. Many of these issues are explored in other contributions to this volume.

Future work on the history of mental health legislation could usefully focus on dimensions of this history that have been relatively neglected to date (e.g., gender, sexuality, race, language, religion, colonialism, etc.), jurisdictions and regions that remain under-represented in the literature (e.g., Africa), the use of institutions other than mental hospitals for containment of people with mental illness (e.g., prisons), and the relationship (if any) between the recent emphasis on human rights (e.g., by the UN and WHO) and personal experience of mental illness: Even when human rights statements clearly inform mental health legislation, does this make a positive difference in the lives of people with mental illness and their families?

Finally, the issue of human dignity, which is central to rights, has not received the attention it merits in the history of mental health legislation or considerations of its current effects (Kelly, 2016c; Plunkett and Kelly, 2021). An enhanced focus on dignity could help ensure that decisions made under mental health legislation actively facilitate people with mental disorder to exercise their capabilities, promote human rights, and deliver much-needed mental health care (Kelly, 2014). Dignity matters.

The history of mental health legislation supports the over-arching importance of laws that are just and fair, but also suggests that some rights might be better protected, and some needs better met, through mental health policy, social policy, and broader societal awareness and reform. Mental health legislation matters deeply, but it is just one part of a social system of care that has, too often, failed the mentally ill. We can and must do better.

References

- Amaddeo, F. and Barbui, C. (2018) 'Celebrating the 40th anniversary of the Italian mental health reform', *Epidemiology and Psychiatric Sciences*, 27(4), pp. 311–313. <https://doi.org/10.1017/S2045796018000112>
- American Psychiatric Association. (1952) *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Association.

- Blandford, G.F. (1871) *Insanity and its treatment: Lectures on the treatment, medical and legal, of insane patients*. Edinburgh: Oliver and Boyd.
- Burns, T. (2019) 'Franco Basaglia: A revolutionary reformer ignored in Anglophone psychiatry', *Lancet Psychiatry*, 6(1), pp. 19–21. [https://doi.org/10.1016/S2215-0366\(18\)30426-7](https://doi.org/10.1016/S2215-0366(18)30426-7)
- Committee on Lunacy Administration (Ireland). (1891) *First and second reports of the committee appointed by the lord lieutenant of Ireland on lunacy administration (Ireland)*. Edinburgh: Neill & Co. for Her Majesty's Stationery Office.
- Committee on the Rights of Persons with Disabilities. (2014) *General comment no. 1. Article 12: Equal recognition before the law*. New York: United Nations.
- Department of Health. (1995) *White paper: A new mental health act*. Dublin: The Stationery Office.
- Department of Mental Health and Substance Dependence. (2004) *The role of international human rights in national mental health legislation*. Geneva: World Health Organization.
- Division of Mental Health and Prevention of Substance Abuse. (1996a) *Mental health care law: Ten basic principles*. Geneva: World Health Organization.
- Division of Mental Health and Prevention of Substance Abuse. (1996b) *Guidelines for the promotion of human rights of persons with mental disorders*. Geneva: World Health Organization.
- Doyle Guilloud, S. (2019) 'The right to liberty of persons with psychosocial disabilities at the United Nations: A tale of two interpretations', *International Journal of Law and Psychiatry*, 66, p. 101497. <https://doi.org/10.1016/j.ijlp.2019.101497>
- Duffy, R.M. and Kelly, B.D. (2020) *India's mental healthcare act, 2017: Building laws, protecting rights*. Singapore: Springer.
- Fennell, P. (2010) 'Mental health law: History, policy, and regulation', in Gostin, L., Bartlett, P., Fennell, P., McHale, J. and Mackay, R. (eds), *Principles of mental health law and policy*. Oxford: Oxford University Press, pp. 3–70.
- Grob, G.N. (1973) *Mental institutions in America: Social policy to 1875*. New York: Free Press.
- Hayes, R., Boerma, B. and Ovadia, F.T. (1993) 'Mental health and the law: An introduction', *International Journal of Mental Health*, 22(4), pp. 3–21.
- Katshnig, H. (2010) 'Are psychiatrists an endangered species? Observations on internal and external challenges to the profession', *World Psychiatry*, 9(1), pp. 21–28. <https://doi.org/10.1002/j.2051-5545.2010.tb00257.x>
- Kelly, B.D. (2014) 'Dignity, human rights and the limits of mental health legislation', *Irish Journal of Psychological Medicine*, 31(2), pp. 75–81. <https://doi.org/10.1017/ipm.2014.22>
- Kelly, B.D. (2016a) *Hearing voices: The history of psychiatry in Ireland*. Dublin: Irish Academic Press.
- Kelly, B.D. (2016b) *Mental illness, human rights and the law*. London: RCPsych Publications.
- Kelly, B.D. (2016c) *Dignity, mental health and human rights: Coercion and the law*. Abingdon, Oxon: Routledge.
- Kelly, B.D. (2020) 'Psychiatry's future: Biology, psychology, legislation, and "the fierce urgency of now"', *Indian Journal of Psychological Medicine*, 42(2), pp. 189–192. https://doi.org/10.4103/IJPSYM.IJPSYM_492_19
- Kelly, B.D. (2022) *In search of madness: A psychiatrist's travels through the history of mental illness*. Dublin: Gill Books.
- Kelly, F. (2003) *A guide to early Irish law*. Dublin: School of Celtic Studies, Dublin Institute for Advanced Studies.
- Kirkby, K.C. (1999) 'History of psychiatry in Australia, pre-1960', *History of Psychiatry*, 10(38), pp. 191–204. <https://doi.org/10.1177/0957154X9901003802>
- Kraepelin, E. (1904) *Lectures on clinical psychiatry*. New York: William Wood and Company.
- Large, M.M., Ryan, C.J., Nielssen, O.B. and Hayes, R.A. (2008) 'The danger of dangerousness: Why we must remove the dangerousness criterion from our mental health acts', *Journal of Medical Ethics*, 34(12), pp. 877–881. <http://doi.org/10.1136/jme.2008.025098>
- Leiba, T. (1998) 'The effects of mental health legislation 1890–1990', *International History of Nursing Journal*, 3(4), pp. 12–18.
- Lunatic Asylums, Ireland, Commission. (1858) *Report of the commissioners of inquiry into the state of the lunatic asylums and other institutions for the custody and treatment of the insane in Ireland: With minutes of evidence and appendices (part 1 – report, tables, and returns)*. Dublin: Thom and Sons, for Her Majesty's Stationery Office.

- Plunkett, R. and Kelly, B.D. (2021) 'Dignity: The elephant in the room in psychiatric inpatient care? A systematic review and thematic synthesis', *International Journal of Law and Psychiatry*, 75, p. 101672. <https://doi.org/10.1016/j.ijlp.2021.101672>
- Porter, R. (ed.) (1991) *The Faber book of madness*. London: Faber and Faber.
- Scull, A. (2015) *Madness in civilization: A cultural history of insanity from the Bible to Freud, from the madhouse to modern medicine*. London: Thames & Hudson, Ltd.
- Select Committee on the Lunatic Poor in Ireland. (1817) *Report from the select committee on the lunatic poor in Ireland with minutes of evidence taken before the committee and an appendix*. London: House of Commons.
- Shorter, E. (1997) *A history of psychiatry: From the era of the asylum to the age of Prozac*. New York: John Wiley and Sons, Inc.
- Somasundaram, O. (1987) 'The Indian Lunacy Act, 1912: The historic background', *Indian Journal of Psychiatry*, 29(1), pp. 3–14.
- Swartz, S. (1995) 'The Black insane in the Cape, 1891–1920', *Journal of Southern African Studies*, 21(3), pp. 399–415.
- United Nations. (1991) *Principles for the protection of persons with mental illness and the improvement of mental health care*. Geneva: Office of the United Nations High Commissioner for Human Rights.
- United Nations. (2006) *Convention on the rights of persons with disabilities*. New York: United Nations.
- World Health Organization. (1949) *International statistical classification of diseases, injuries, and causes of death. Sixth revision of the international list of diseases and causes of death*. Geneva: World Health Organization.
- World Health Organization. (2001) *Mental health: New understanding, new hope*. Geneva: World Health Organization.
- World Health Organization. (2005) *WHO resource book on mental health, human rights and legislation*. Geneva: World Health Organization.
- World Health Organization. (2017) *Advancing the right to health: The vital role of law*. Geneva: World Health Organization.