

'With a FEROCITY unimagined'

Lawrence McNamara

Thinking about mental illness and discrimination law

Fuck!

Fuck!

I fucking hate this.

'Tim'

Tim is in his twenties and has schizophrenia. In the next room he sobbed, screaming intermittently, in anger and despair, to no one. The voices which — there is no other word — tormented him had left him alone. At least for a short time.

I write for Tim, who struggles on; and for Sarah, who struggled to the end.

This article critically examines the role of anti-discrimination laws in combating the ubiquitous discrimination encountered by sufferers of mental illness in Australia. Crucial to this discussion is the notion that what it means to be mentally ill has not only a legal definition, but also social meaning that is best discovered through the eyes of the sufferers themselves. This social meaning is in part created by the discriminatory practices and attitudes which pervade our society.

My core argument is that discrimination against people with mental illness is entrenched and embedded in Australian society and that our anti-discrimination laws, while not flawless, are an important preventive and pro-active tool in a project of eliminating that discrimination. These laws have the dual roles of legal means of redress and the focus of constructive action in social practice. Moreover, the significance and impact of these laws is increased if we view them in broader terms than conventional 'objective' legal analysis might suggest. A critical and interdisciplinary approach to discrimination in both method and substance can offer new insights and, of itself, form a part of an emancipatory project.

Foundations of anti-discrimination laws

The normative premises which underpin discrimination laws lie in human rights. Though contentious in detail, there are basic rights to minimum standards of housing, health care and employment, for instance, which are (or should be) beyond debate. Expressions of these rights can be found in United Nations conventions such as the International Covenant on Civil and Political Rights and the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. It is not necessary that these principles be binding on Australia for them to be implemented in legislative form, or to use them as a background against which we may critique mental illness discrimination in Australia. Despite arguments which concern competing claims to rights, the unquestionable reality is that people with mental illness are so powerless and so far behind the benchmark that suggestions that they are impinging on the rights of 'mainstream'

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society are untenable. This is borne out on almost every page of the report of the National Inquiry by the Human Rights and Equal Opportunity Commission (HREOC) into the Human Rights of People with Mental Illness: *Human Rights and Mental Illness* (the Inquiry; the Report).¹ The Report is a landmark document for its comprehensive coverage of the issues and the scope of its inquiries. Almost 1000 pages, it is a revelatory — if sometimes harrowing — description of the state of the mentally ill in Australia in the 1990s.

What is it to be mentally ill?

Legally

Definition in Australian discrimination statutes is minimal. The *Disability Discrimination Act 1990* (Cth) (s.4) and the *Anti-Discrimination Act 1977* (NSW) (s.4) include as a disability 'a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour'. Thus, while mental illness is not used as a term, the Acts clearly encompass psychiatric disability.

Under the *Mental Health Act 1990* (NSW) which is concerned with the 'care, treatment and control of persons who are mentally ill or mentally disordered':

mental illness means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

- (a) delusions;
- (b) hallucinations;
- (c) serious disorder of thought form;
- (d) a severe disturbance of mood;
- (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d). [ss.3–4, Schedule 1]

Controversy has centred around the extent to which psychiatrists have controlled the determination of who is mentally ill. While they are the people who administer the *Mental Health Act* with regard to voluntary and involuntary admission, they have effectively been the legal determiners as well; the courts have consistently deferred to the medical profession.² The outcome has been a legal definition which relies on psychiatric criteria, but is intended 'to limit the ambit of psychiatric opinion in the civil commitment process'.³ This has two main advantages. First, it eliminates the inherent prejudice in 'commonsense' determinations of mental illness which have been known to dominate the courts intermittently — this is crucial given the prejudice surrounding mental illness. Lawton J in *W v L* [1974] 1 QB 711 expressed this as follows:

... ordinary words of the English language should be construed in the way that ordinary sensible people would construe them ... [T]he right test [is] what would the ordinary sensible person have said about the patient's condition in this case ...? In my judgment such a person would have said: 'Well, the fellow is obviously mentally ill'. [at 719]

This has been described as 'the man-must-be-mad test'.⁴ The second advantage in limiting the legal definition is that it makes the courts and the psychiatric profession more expressly accountable by specifying consistent symptomatic criteria. In sum, the legal definitions rely on the identification of manifest symptoms which correspond to psychiatric criteria for the presence of mental illness. Importantly, illnesses are not all the same, though a significant taxonomic divide

may be drawn between psychotic illnesses (including schizophrenia) and non-psychotic illnesses (including depression).

Socially

Tim found it difficult to leave the house, even to go to the shop to buy cigarettes. The owner was 'out to get him', talking about him to other customers, following him on occasion. The other customers were talking about him too. Watching certain television programs became an obsession as he watched for signs that the actors were giving him.

'Rachel' was visited by a social worker as part of a follow-up after hospitalisation. The visitor inquired as to how she was. Rachel replied — with insight into her illness and no small amount of humour — 'My shoes have started talking to me again, but my slippers are much more interesting'. The humour was not lost on either party. The serious side cannot be forgotten; Rachel was in hospital after eating gravel in her driveway. [Personal communication to author]

A debate central to all work on mental illness is the sociology versus psychology conflict. That is, to what extent is mental illness a social construct and to what extent a biochemical reality? From the 19th century it was accepted that madness was a medical phenomenon, though approaches diverged across psychology and psychiatry, through psychoanalysis and physiology. The 1960s, however, saw a reaction in the 'anti-psychiatry movement' which focused on the normative bases of mental illness as a concept: deviance from social norms, perception, behaviour, learning and labelling were the sources of mental illness. Bottomley cites Thomas Szasz as a key figure:

Mental illness, he argued, is a normative abstraction; his aim was to show that the phenomena which we call mental illness should be looked at afresh and, once removed from the category of illness, they should be regarded instead as individual struggles with 'problems with living'. [p.286]

Scully, like Bottomley, is ultimately unconvinced and focuses on the lived experience of mental illness:

Whatever the outcome of the controversy, it surely cannot alter the social reality that there exists a substantial number of people — be they victims of endogenous disease processes or of 'problems in living' — who lack basic social capacities and who manifest extreme helplessness and dependency.⁵

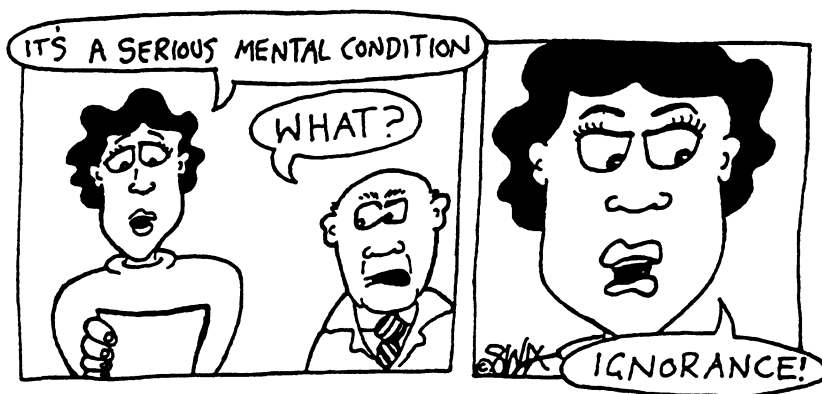
The Report emphasises the importance of the social dimension of mental illness, but clearly considers mental illness as a medical phenomenon. It is filled with evidence which supports this position. Consumers document their experiences and the social, medical and legal context in which they occur. In its entirety, the Report offers a concrete perspective on what it is to be mentally ill.

Discrimination

People with mental illness experience stigma and discrimination in almost every aspect of their lives. [Report finding, p.925]

The stigma of mental illness and the ubiquity of discrimination actually make discrimination a part of what it is to be mentally ill. It is almost a defining condition of mental illness and is indicative of the power of the social context. Stigma is a theme in all the literature; it pervades the evidence that is quoted throughout the Report and gives rise to constant public perceptions of violence and dangerousness which have no justification.⁶ The opposite is more likely:

The sporadic violence of so-called 'mentally ill killers' as depicted in stories and dramas is more a device of fiction than a



fact of life. Patients with serious psychological disorders are more likely to be withdrawn, apathetic and fearful.⁷

According to the Report, one of the most debilitating aspects is not the illness itself, but the social stigma it attracts: 'It erodes confidence, damages self-esteem, and contributes to an overwhelming sense of isolation and fear' (p.443).

The horrendous consequences of my illness have been [a result of] public attitudes of ignorance, fear, discrimination and neglect and professional indifference. [Report, consumer evidence, p.443]

The Report documented two aspects to discrimination which are most suffered by people with mental illness. The first is within the community, especially in housing and employment. The second is in the health care system, in hospitals and community care where mental illness is a low priority.

Accommodation

Persons discharged from psychiatric hospitals . . . have been declared mentally fit by their doctors, but mentally ill and probably dangerous by their neighbours. [Report, p.342, Submission by P. O'Brien]

Living with a mental illness — or recovering from it — is difficult even in the best circumstances. Without a decent place to live it is virtually impossible. [Report, p.337]

The policy of deinstitutionalisation and community care relies on the assumption that people will have somewhere to live, and this is simply not borne out in fact. This is partly because of insufficient funding for community care and accommodation, and partly the result of discrimination and poverty. People are denied housing because of their illness or history, or supported accommodation and community housing is blocked by residential opposition. They may not fit into the categories for which other accommodation is provided (for example, intellectual disability). The Report devotes a separate chapter — perhaps the saddest chapter of all — to boarding house accommodation, and is scathing in its criticism. Hygiene, diet, privacy, theft, health, rent practices: in 14 pages there is barely a positive word (pp.386-99).

Employment

The major social mechanism which individuals in our society use to maintain themselves both independently and financially is employment. This is also the major social mechanism through which we define who we are — that is, where we belong and how we contribute in society. [Report, p.404, Submission by M. Mead]

People with mental illness find it extremely difficult to obtain work. This is partly due to disadvantages which stem from the nature of psychiatric disabilities. This can include the nature of treatment: for instance, medication can have

dramatic side effects which restrict co-ordination or concentration. However, discrimination which derives from social stigma and public perceptions is the major reason for the difficulty. HREOC concluded that the reluctance to hire individuals with disabilities is largely based on ignorance: employers make assumptions about the disability rather than an assessment of the person's capacity.

Health care

We are unwanted and neglected . . . You want to be loved when you are sick.

[Report, consumer evidence, p.444]

Much of the human rights debate has centred around concerns of substantive and procedural justice in processes of civil detention of 'involuntary patients'. There is without doubt discrimination in terms of the civil and political rights that the mentally ill enjoy as opposed to the rest of society.

The Report documents all manner of inadequacies in care, including crisis response and difficulties in gaining voluntary admission to a psychiatric hospital. Forced admission and transport to hospital are frequently shocking:

He just sat there and they physically had to pick him up. Now, why should he be degraded like this? Us, four police cars outside, five police officers into the home, him screaming, 'Mum, help me! Dad! Help me!' Now, why should they be degraded and we be degraded like that, really? . . . [It happens] because that person is allowed to deteriorate to such an extent that this has got to happen . . . [I]t is really bad — absolutely — it is disgusting. [Report, carer evidence, p.232]

The hazards of treatment are endless: being watched for signs of insanity; the neglect of physical well-being in psychiatric hospitals; inadequate emergency procedures at general hospitals; the effects and side effects — wanted and unwanted — of psychotropic drugs (mind-affecting and mood-altering); lack of information about and consent to medication; mistreatment by hospital staff of all levels; a lack of privacy, safety and security in hospitals; risk of assault and sexual assault from both staff and patients in hospital;⁸ the poor planning of discharge and post-hospital arrangements.

The Report concludes:

The evidence presented to the Inquiry concerning the alienation, indignity and frequent violence experienced by psychiatric in-patients indicates that we still lack a system of institutional care which adequately protects the rights of the mentally ill. There are [also] fundamental and widespread inadequacies in the 'community care' available . . . These deficiencies are incompatible with the rights . . . to appropriate care, treatment and rehabilitation and in some instances compound the ignorance and stigma still commonly associated with mental illness. [pp.287, 328]

Families and carers

It is heartbreaking. You watch your son in a crisis and there is nothing you can do. Often, he won't or can't help himself. I can't help him. Do we have the CAT team [Crisis Assessment Team] and the police come out? I just couldn't do that. It would devastate him . . . But we had to tell our other children where the phone number for the CAT team was kept in case it was needed. What else could we do? It is heartbreaking. It is just heartbreaking. [Personal comment to author]

The impact of the inadequate health care system is not felt only by the consumer. Families are forced into providing (perhaps inadequate) care, with high financial and emotional cost. On top of this they are caring — as the Report so often notes — for their loved ones. To reach out to the health care system is to declare the existence of a mental illness and take on the stigma that goes with it; they find themselves in a social context where hospitalising a family member is to do perhaps still more damage to the person they care about. Evidence given to the Inquiry expresses the emotional impact:

Each person with schizophrenia has a family, a mother, a father, perhaps a spouse, brother, sister or child. Schizophrenia ransacks their lives with a ferocity unimagined outside the family circle. Because they love someone whose illness shows itself not as a tumour, not as a heart gone bad or blood sugar gone wrong, but as bizarre and unpredictable behaviour, these families are robbed of peace . . . and of the humblest but most necessary of pleasures: something to look forward to. [Report, carer evidence, p.468, Submission by M. Leggatt and R. Webster]

These families often cannot publicly seek help, either because the disclosure of mental illness or its degree, will attract stigma to the person for whom they care, or to themselves: "Guess who's got a mad sister?" the kids scream' (Report, carer evidence, p.472).

Anti-discrimination laws

What can our statutory mechanisms do about the discrimination that is suffered by people with mental illness, and those affected by it? As discussed above, the legislation clearly protects people with psychiatric disabilities through the definitions of 'disability'. The *Disability Discrimination Act 1990* (Cth) prohibits unlawful discrimination in the provision of accommodation (s.25), employment (s.15) and goods and services (s.24), which would include the provision of health care and psychiatric services (s.4). Direct and indirect discrimination are covered by ss.5-6. The *Anti-Discrimination Act 1977* (NSW) has similar provisions under Part 4A.

Case law is scarce in this area. It appears there is only one relevant discrimination case: *X v McHugh, Auditor-General for the State of Tasmania* (1994) EOC 92-623. In that case the plaintiff suffered from schizophrenia and was dismissed by his employer because of the manifestation of his disability. That is, his performance was argued to be unsatisfactory because of his illness. Under the Commonwealth Act this was held to be unlawful discrimination. The case addresses psychiatric disability as one type of disability covered under the Act, but does not go into any consideration of the specific nature of mental illness or the issues to which it gives rise as a category. The decision indicates that people with mental illness have clear and enforceable rights under anti-discrimination laws. In spite of this, there are two key barriers which obstruct them from making use of their rights.

First, there are the practical difficulties of making a complaint and proving it. Consumers are generally powerless and, as the Report emphasises, have enough trouble coping with day-to-day life, let alone mounting a discrimination complaint. Second, discrimination is embedded in social practices. While the Inquiry recommended that providers of goods and services 'must be made aware of their legal obligations to people with psychiatric disabilities under Federal disability discrimination legislation' (p.925), it does not alter the reality of the powerlessness of consumers and their almost total neglect by mainstream society which is derived from unjustified fear and ignorance.

Discrimination is structural in its nature. This is especially so with regard to the impact of mental illness on carers and families, and the standards of health care which are available for people with mental illness. The lack of understanding of mental illness in the general hospital system and the classification of disabilities into different categories (physical, intellectual, psychiatric) work against the just provision of services to the mentally ill. Discrimination is a part of our social concepts of work, family and citizenship. What it is to work and be a worker is tied up with our concept of the workplace and the socially constitutive role of work in our identities. The places we live — in a family home, in a shared household, alone and independently — are essential to our collective and individual sense of self. Supported accommodation in the community is a novel and feared idea: 'they should be put on a one-way bus and taken to some place where they belong'.⁹ What it means to take part in our society is dependent on what we *are* — on what we are as a citizen. This identity is constructed by our interaction with others in work and social life, and this is determined to a large extent in the case of mentally ill people not by themselves but by others. Their power to control and shape their own identity is limited by a social context which leaves them powerless. Discrimination laws as mechanisms of redress for wrongs done to the individual have limited scope in such a context.

The next step is to address this social dimension, which has been a crucial part of the defining, experiential and discriminatory aspects of mental illness. Discrimination laws do have a role beyond their function of redress for the individual. We must challenge the norms of law and legal scholarship and expand the conventional boundaries of legal analysis in order to bring out the realisation of human rights which is the foundation of this article.

Expanding the boundaries of law

It is a basic tenet of this article that as active human beings we constitute our social world, within the limits of social structures.¹⁰ There are compelling arguments of history and theory which lend weight to the proposition that we can alter those structures as well. The processes of acting and being acted upon are continuous and interactive. We construct the meanings and mores which govern our interaction; since the Enlightenment, the 'givens' have become fewer and fewer as 'meta-narratives' of religion and science (or, more accurately, scientism) have collapsed as we seek to include in the realm of social actors those who have been unjustifiably excluded. I argue that anti-discrimination laws which give rights to people with mental illness are not merely mechanisms for the achievement of equality, but should be conceived as a part of the way in which we are changing our world. This has implications for the way we view more generally the law and legal scholarship.

The discrimination which is currently embedded in social practice is a structure, but we act within it and as we are conscious of it we can also act *upon* it. Discrimination law is also a structure, a formal set of rules within which we interact. These rules are points of reference which have meaning, and it is we — as active, moral agents — who can give meaning to these rules. My point is that the very creation of express standards and mechanisms is a part of the way in which we combat discrimination as a social practice.

This approach pushes at the perimeters of conventional perspectives on law. Such an approach challenges and denies the objectivity of legalism, and not only claims that law is

not an independent structure, but celebrates its interconnect- edness with our social world. The law is not merely a struc- ture, it is an agent; by this I mean that as an institution, it turns back on our social structures and on individuals to challenge and question the values with which we have infused it. Hence, we need to see law not only as constituting (that is, a part of society), but constitutive (that is, as creative of society).

Legal scholarship must be critical in its substance, and also in its method. Law as an institution is a structure and practice over which we can — and must — take control; it is one way that, as a society, we define ourselves.¹¹ As a whole and in its parts it obtains meaning from the narratives in which it is located.¹² Our sense of rights, of justice and of discrimination is highly contextual and contestable. We are now operating at the margins of legal scholarship, and at the margins of society. To this end, this article has attempted to imbue the law with a social meaning in its approach to the expression of mental illness, through the statements of the mentally ill and their carers. The definitions of the statutes and case law are insufficient. We need also to draw our meanings from experience, especially the experiences of those for whom mental illness has a meaning that views discriminatory practices in a different light from mainstream society.

With us is Stephen Bottomley, who draws on the critical legal studies school in analysing the concept of mental illness in New South Wales.¹³ He highlights the social nature of mental illness, especially with regard to 'commonsense' approaches to defining the term. In structure–agency terms, he looks at the impact of psychiatry and its place in society as both structured and structuring:

Mental illness is an inter-subjective construct . . . Social rela- tions . . . become 'animated by psychiatric themes' . . . 'Com- monsense' understandings about what behaviours, attributes, etc. should be grouped under the heading 'mental illness' are not *a priori* concepts, but are the product of the psychiatrically affected perceptions which percolate through to individuals in everyday life. [pp.296-7]

Quite simply, mental illness does not exist 'out there'. It is not something we can look for, and then discover and observe. It is within our interactive social world and we engage with it, consciously or unconsciously, in many di- mensions of our lives. We must draw it into our conscious- ness and place it in our world: at the moment, it is *people* with mental illness who exist 'out there'. And that — as HREOC observed time and again — is nothing less than scandalous.

Conclusion

. . . I am a champion. I have to support myself every day in ways so many have never dreamt.¹⁴

Discrimination laws are a useful avenue for redress for those 'aggrieved people' who can gain access to the system. People with mental illness are at the margins of our society and least likely and least able to obtain (or frequently even cope with) such access. Our consciousness of the signifi- cance of discrimination and the ways in which it permeates our society is the first and most fundamental step forward. We must understand mental illness as it exists for the men- tally ill. We must obtain insights not only into the disease, but into their perspective on the world, and in doing so we gain an insight into our own place in the social world. We must look to expand our conceptions of law and legality if

we are to give meaning to our laws which will not exclude those they were designed to protect.

References

1. AGPS, Canberra, 1993. Throughout the article page references are to this Report, unless otherwise specified.
2. See Errington, M., "'Mental Illness" in Australian Legislation', (1987) 61 *ALJ* 182; Bottomley, S., 'The Concept of Mental Illness and Mental Health Law in New South Wales: A Critical Argument', (1989) *UNSW LJ* 284.
3. Bottomley, above, pp.299-300.
4. Errington, above, p.184.
5. Scull, A., 'The Theory and Practice of Civil Commitment', (1984) 82 *Michigan LR* 793, at 805.
6. Webb-Pullman, J., 'Violence, Dangerousness and Mental Illness', (1994) *Law Inst Jnl* 1166; Hamilton, J.L., 'New Protections for Persons with Mental Illness in the Workplace under the Americans with Disabilities Act of 1990', (1992) 40 *Cleveland State LR* 63, at 91-2.
7. The President's Commission on Mental Health (1978), cited in Hamilton above.
8. The Report notes the significant difficulties of violent patients and the need for adequate staff support, p.271.
9. Comment by a local government official at a public meeting opposing a suburban housing project for people with psychiatric disabilities. Report, p.343, submission by P. O'Brien.
10. The relevant debate in social theory is that of 'structure versus agency'. My approach draws on the work of sociologists such as Pierre Bourdieu and Anthony Giddens. While they have vastly different conceptual apparatus, they both maintain that we act within and upon social structures.
11. Hutchinson, A., 'And Law (or Further Adventures of the Jondo)', (1987) 36 *Buffalo LR* 285.
12. Cover, R., 'Nomos and Narrative' (1983) 97 *Harvard LR* 4.
13. Bottomley, ref. 2 above, p.297. The critical legal studies approach highlights the active nature of human beings and the 'indeterminacy and contradictions embedded in liberal legal thought'.
14. A contributor to the *Sydney Morning Herald* 'Relations' column, 27 February 1995.

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