

Power and Mental Illness: a Foucaultian Analysis of the Newfoundland and Labrador Mental Health Care and Treatment Act

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ABSTRACT

Mental health legislation is put into place in an attempt to “protect, promote and improve the lives and mental well-being of citizens” (WHO, 2005:1). Newfoundland and Labrador’s Mental Health Care and Treatment Act (2006) takes a rights-based approach to providing care and treatment for individuals who are involuntarily admitted under the Act. Drawing from Michel Foucault’s theory of power, this article deconstructs power relations, authority, and surveillance in the province’s mental health legislation.

Introduction

Michel Foucault developed his theory of power by examining its use through the mundane practices of everyday life. Roger Deacon has described Foucault’s theory in this way:

“Foucault’s account of the historical interweaving of ‘relations of discourse, of power, of everyday life and of truth’ (Foucault, 1979d:89) not only revises the manner in which we might understand the past; it also sheds light on issues of contemporary political significance. It makes possible new multifaceted histories of relations of power which go beyond conventional, progressivist narratives to expose contingencies as much as necessities; it helps to explain – and demands that we rethink – long-standing tendencies to treat relations of power as separate from and opposed to knowledge, truth and freedom” (Deacon, 2002: 91).

British influence could be found in all Canadian provinces’ mental health legislation (with the exception of Quebec) until the 1970’s when some provinces began to mirror legislation with that from the United States, which tended to focus on the individual’s right to refuse treatment (Gray, Shone, & Liddle, 2008). Newfoundland and Labrador’s (NL) Mental Health Care and Treatment Act (MHCTA) takes a rights-based approach to providing treatment to those who are involuntarily admitted under the Act (MHCTA, 2006). In this article, I will draw upon NL’s MHCTA for a case study of Foucaultian themes (including power and authority, policing, and surveillance) as they are applied to Canadian mental health legislation.

Ship of Fools and Public Display

Foucault’s account of the history of mental illness is similar to his history of the prison he described in *Discipline and Punish* (Foucault, 1977). Just as the torture of prisoners was once on public display, madmen once served as entertainment for the public. Public performances often placed the madmen in a comedic role within a satire (Foucault, 1988). Madmen were, of course, also feared. Near the beginning of *Madness and Civilization* (1988), Foucault describes a time in the Renaissance period when a “Ship of Fools” (p.7) sailed with madmen as passengers. This ship served as a method of confinement for madmen who were taken from city streets. The crew of the ship were viewed as being moral and social heroes who took it upon themselves to assist in cleansing the streets of madmen.

Over the centuries, the display of madmen gradually moved inside the institutional setting and under the control of medical professionals. Some of the involuntary admission legislation that devolved in parallel has made it possible to strip away a patient’s individual rights and freedoms. This exercise of power focuses on the mind rather than the body.

NL’s Mental Health Care and Treatment Act (2006)

As stated in the MHCTA, SNL 2006, the purpose of the legislation is:

3. (1) a) to provide for the treatment, care and supervision of a person with a mental disorder that is likely to result in dangerous behaviour or in substantial mental or physical deterioration or serious physical impairment;
- b) to protect a person with a mental disorder from causing harm to himself or herself or another and to prevent a person with a mental disorder from suffering substantial mental or physical deterioration or serious physical impairment;
- c) to provide for the apprehension, detention, custody, restraint, observation, assessment, treatment and care and supervision

of a person with a mental disorder by means that are the least restrictive and intrusive for the achievement of the purpose set out in paragraphs (a) and (b); and

d) to provide for the rights of persons apprehended, detained, restrained, admitted, assessed, treated and cared for and supervised under this Act (MHCTA, 2006, Sec. 3(1)).

The Act takes a rights-based approach to guide involuntary admission to a health care facility and considers the patient's right to health and safety and the health care system's obligation to provide interventions and support services. Essentially, involuntary admission takes away the civil rights of an individual; however, safeguards have been put into place to decrease the likelihood of the violation of patient rights. Although involuntary admission impinges on a patient's rights and freedoms, it can prevent further physical and mental deterioration and the risk of harm to self and others.

Definition of a Mental Disorder

According to the MHCTA (2006), a mental disorder is defined as "a disorder of thought, mood, perception, orientation or memory that impairs (i) judgment or behaviour, (ii) the capacity to recognize reality, or (iii) the ability to meet the ordinary demands of life, and in respect of which psychiatric treatment is advisable" (MHCTA, 2006, Sec. 2(1)). This definition might appear contentious if we consider how its application would be influenced by the DSM IV (American Psychiatric Association [DSM-IV-TR], 2000). The guidelines in the DSM IV diagnostic manual involve a checklist approach and leaves room for interpretation. Language such as 'often' and 'easily' are used without any definition or explanation, therefore leaving the psychiatrist to make a subjective judgement. The manual also uses a cut-off approach; for example, an individual must meet five of seven criteria to be diagnosed with a certain mental illness. Critics of this approach argue that some psychiatric disorders may be present in a range of severity and degree and therefore this approach may dismiss lesser degrees of the illness (Davis, 2006). This guide also leaves little room for cultural influences over behaviour and subjectivity. Therefore, the power lies in the interpretation by the individual psychiatrist; in other words it relies on clinical judgment. This subjectivity may lead to differences in certification from psychiatrist to psychiatrist; also possible misdiagnoses or over diagnosis in a population. Foucault (1988) views such classification systems as a way of alienating the patient and further objectifying him or her within the structure that is dependent upon the psychiatrist. He states that the psychiatrist has to:

"act not as the result of an objective definition of the disease or a specific classifying diagnosis, but by relying upon that prestige...of Authority...it is by bringing such powers into play, by wearing the mask of Father and of Judge, that the physician, by one of those abrupt short cuts that leave aside mere medical competence, became the almost magic perpetrator of the cure" (Foucault, 1988: 273).

As an involuntary patient, the individual does not have a choice in the matter and is forced to submit to the system and the orders given by the psychiatrist. Foucault (1988) suggests that the "madman" loses his identity and falls further into the role of the "insane" person. As Blondeau (2009) puts it, "the insane is insane

because others see him as insane" (p. 37). Foucault (1988) further explains, "...the act of the madman never oversteps the image presented, but surrenders to its immediacy, and affirms it only insofar as it is enveloped by it" (p. 94).

Authority and the Psychiatrist

The MHCTA (2006) states that a physician, nurse practitioner or other authorized person may sign the first certificate of involuntary admission. A psychiatrist, or where a psychiatrist is not available, a physician other than the physician who signed the first certificate may sign the second certificate. The following criteria must be met for a certificate of involuntary admission. The person:

17(1)(b) (i) Has a mental disorder, and

(ii) As a result of the mental disorder

(A) Is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration or serious physical impairment if he or she is not admitted to and detained in a psychiatric unit as an involuntary patient,

(B) Is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision, and

(C) Is in need of treatment or care and supervision that can be provided only in a psychiatric unit and is not suitable for admission as a voluntary patient; (MHCTA, 2006, Sec. 17(1)).

Blondeau (2009) suggests that "the mad person will become a distinct object of analysis" (Blondeau, 2009:37). The psychiatrist becomes the scientist who sets rules and therapeutic measures based on classification systems that attempt to make sense of the "mad person" (Blondeau, 2009, p.37). Metaphorically speaking, Blondeau (2009) describes the asylum as being a judicial system in which "the physician is the judge, where treatment is punishment and where moral is legislated" (Blondeau, 2009:37).

Foucault (1988) contends that the institution itself is not the focus of power, but rather the relationships that are behind the operations of the institutions are the focus of power. In *Discipline and Punish* (1977), Foucault describes this power as a form of "hierarchical observation" or "techniques of multiple and intersecting observations, of eyes that must see without being seen; using techniques of subjection and methods of exploitation" (Foucault, 1977: 171).

The measures found in the MHCTA (2006) regarding the relationship between the patient and the psychiatrist provide an example of this power dynamic. The psychiatrist has the power to certify the individual with a mental disorder and "provide treatment, care and supervision..." The attending physician is directed by the Act to take the best interests of the involuntary patient into account when making treatment decisions and also to take previous wishes made by the patient when competent into account. Ultimately however the psychiatrist is responsible for the treatment and care of the patient.

In *Discipline and Punish* (1977) Foucault describes Jeremy Bentham's plans for a type of prison which he called the Panopticon. The Panopticon creates a "power relation" (Foucault, 1977, p.201) in which the prisoner cannot see the observer (located in a watch tower), but knows that he or she may be watched at any time. The use of restraint becomes unnecessary as the prisoner knows that at any time someone may be observing him or her (Foucault, 1977). He states that the Panopticon "...automatizes and disindividualizes power" (Foucault, 1977, p. 202).

There are similarities between the power exercised in the Panopticon prison and the power of surveillance given to psychiatrists and hospital staff by the MHCTA (2006). Constant surveillance becomes increasingly more powerful for those who hold others involuntarily at a psychiatric facility.

Foucault also suggests that this type of ultimate power is also present in everyday life throughout other systems (i.e. in education, hospitals, and places of work).

Policing and Fear

The purpose of the MHCTA (2006) further requires that without treatment, the individual living with a mental disorder is likely to partake in "dangerous behaviour" (MHCTA, 2006, Sec. 3(1)). The purpose of the Act is also to "provide for the apprehension, detention, custody, restraint, observation..." (MHCTA, 2006, Sec. 3(1)). The wording of this particular statement conjures the image of policing and punishment. If one did not know the medical context of the Act, this wording could be taken from criminal or judicial legislation. As Foucault (1988) suggests, confinement has been used as a form of social control or a means of getting the poor, homeless, unemployed, sick and insane individuals out of sight and off the streets. Such people were housed in madhouses, often taken there by police officers. This image of policing is evident throughout the MHCTA (2006) today. The images Foucault (1988) presents of madmen described as savages and primitive animals reflects the fear that is felt by many in society. Under the Act, peace officers are required to observe and restrain where necessary until the individual is assessed by a psychiatrist. This means that peace officers have had to provide surveillance in waiting areas of a medical facility until a psychiatrist has assessed the individual. This observation and surveillance may be witnessed by other patients and members of the public in the emergency room waiting area. Foucault (1977) might argue that there are similarities between this public display of restraint and observation and the public display of the punishment of criminals in the seventeenth century. Power is not only displayed through physical restraints, but also through psychological restraints or knowing that one may be involuntarily admitted and treated against one's will.

Surveillance and the Review Board

The MHCTA (2006) has several safeguards to prevent abuse against the involuntary patient and preserve a degree of respect for patient rights. One such safeguard is the review board. This board reviews cases of involuntary admission upon request from the

patient or patient representatives. The review board also reviews certifications after a specific time period following initial certification to indicate whether a renewal of certification is acceptable. The review board, although put in place as a safeguard to assist in protecting patient rights, has a surveillance role. The power to continue involuntary admission or to discharge a patient or to determine that the individual does not meet the certification criteria is given to the individuals on the review board. The panel (made up of a psychiatrist, lawyer and lay person) hears evidence much like a judicial case and then votes to determine their verdict. Although a lay person is included on the panel, the majority of members are generally of high socioeconomic class and hold a higher degree of social power than the patient. Wildman refers to "white privilege" (Wildman, 2005: 245) as a metaphor for power. The privileged members of the board, while intending to protect the rights of the consumer, unknowingly reinforce a power imbalance. Much like the power relation described by Foucault (1988) between the psychiatrist and the patient, and also in his description of the observer in the central tower of the Panopticon, the review board (although originally put in place to protect patient rights) is an intimidating power that can take away or protect an individual's rights and freedoms. As Foucault (1977) suggests, this kind of power shifts from the physical restraint to a power that exerts control over the "soul". This form of power can induce fear and insecurities within a patient.

Conclusion

Although legislation has been devised in an attempt to protect the rights and freedoms of those who live with mental illness, power remains primarily in the hands of the highest on the hierarchical ladder - the psychiatrist. While we have made some strides in the overall treatment of individuals living with mental illness, we continue to have some basic struggles with power differentials. Just as crew members on the "Ship of Fools" (Foucault, 1988, p.7) were considered to be moral and social heroes for apprehending, confining and segregating madmen, to some degree psychiatrists of today may be perceived as the heroes of mental health acts. While legislation has been devised in an attempt to safeguard against the abuse of individuals living with mental illness, the visible and not-so visible forms of power continue to underlie the procedures around certification and treatment.

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