NEW PARADIGM, SAME DILEMMA: CIVIL COMMITMENT REFORMS IN POLAND (1972-1994)

by

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ABSTRACT

The rights-based reform of the law relating to civil commitment in Poland began in the early 1970s on the heels of similar reforms in North America and Western Europe. Poland's reformers aimed to advance the situation of 'mentally ill' people and prevent their social marginalization. This thesis examines the discourses of rights within Polish civil commitment reforms, and in their outcome, the *Mental Health Protection Act*, 1994 (MHPA). Although the MHPA provided civilly committed patients with more procedural rights, these rights-based reforms were grounded in liberal discourses of the 'rational subject', and in the premises of the capitalist market economy that relegate to an inferior status those incapable of engagement in contractual relations. Thus, reformers failed to challenge systemic sources of oppression and the exclusion of mentally ill people from the community of equal-rights bearers. As a result, the MHPA only mediates the worst symptoms of oppression, while perpetuating its causes.

Keywords: liberal rights; civil commitment reforms; Poland; law; marginalization and social exclusion

For my darling partner Jeff,

For his faith and wise words

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INTRODUCTION

> The force of law resides in its mythical claim to universal neutrality within particular context of the nation. Through universalistic claims to a naturalized and rationalized state justice, law provides an overarching frame, a totalizing narrative, by which to structure, organize and idealize the possibilities of future actions. (Darian-Smith, 1996, p. 296)

Human rights discourses have been an integral part of contemporary anti-stigma activism. Reforms to the law of civil commitment in Poland and elsewhere aimed to alleviate the social marginalization of people deemed mentally ill,[1] in line with the argument that "substantive improvements in the lot of the mentally disordered will follow from a recognition of their rights" (Rose, 1986, p. 177). Accordingly, procedural rights have been presented as legal remedies that can enhance the capacity of mentally ill people to effectively challenge psychiatric authorities and fight instances of abuses of rights.[2] Using legal mechanisms to increase procedural rights for civilly committed patients, reformers were also able to restore patients' legal subjectivity (even though only partially) and hence make inroads into the problem of social marginalization and exclusion of mentally ill people grounded in their perceived lack of capacity for decision-making.[3] In the process of civil commitment reforms, however, Polish reformers, much

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[1]The term 'mental illness' is regarded in this thesis as a contested term. Extended discussion about the construction of this term and of the label 'mentally ill is provided in Chapter 2, section 3.

[2]Generally, 'civil commitment' is defined as a "detention of persons, against their will to mental health facilities under a formal legal process" (Brooks, 2000, p. 23).

[3]'Procedural rights' are those rights that are exercised by parties during court proceedings, or during prior related proceedings. These rights include, for example, the right to counsel, the right to review records being used as evidence, the right to due process, the right to notice in sufficient time to prepare a defence, etc. (Failer, 2002, p. 169).

as their Western precursors, have failed to critically reflect on the actual potential of liberal rights to advance the situation of civilly committed people.[4]

In this thesis, I undertake this project of critical reflection on the regime of rights in Polish civil commitment reforms (1972-1994) and in the Polish *Mental Health Protection Act 1994* ("MHPA," 1994). I aim to examine the model of rights adopted by Polish civil commitment reformers and assess the extent to which this model of rights has the potential to offer equal legal protection to mentally ill people. Such examination, however, requires, exploring not only the symptoms, but the causes, of the social marginalization of civilly committed people. I adopt Bhambra and Shilliam's (2009) claim that "the contemporary address of past injustices (...) requires an acknowledgement of the ways in which the historical denial of subjecthood is integral to processes of subjection that continues into the present" (p. 9). Thus, my objective is to address the systemic and institutional causes of the subjugation of mentally ill people that results in the diminished rights of those who are civilly committed. My thesis engages with the processes of exclusion of mentally ill people from the community of equal rights-bearers. Through the analysis of legal reforms and the legal regime of rights of civilly committed people in Poland, I hope to demonstrate the "dark side" of liberal rights and liberal law that function through their pervasive rationales of 'univeralism', 'rationality, and 'individuals' as tools of social exclusion (Kapur, 2007, p. 564) of people deemed mentally ill.

I will deconstruct the model of liberal rights to uncover the premises on which liberal rights rest, given that they emerged with the development of the capitalist mode of production to secure rights of property owners and reflect the values and interests of market economies. The study of the relationship between the system of private property

[4] In my thesis, I distinguish liberal rights from rights in general. While rights in general reflect a mode of production, liberal rights reflect the capitalist mode of production.

and the social marginalization of mentally ill people will reveal that liberal rights are neither neutral nor universal entities. Property relations determine who can make rights claims, what kinds of claims can be made, and with what implications. The basis of liberal rights in private property also legitimizes the hierarchical organization of liberal rights; those rights that respond to the needs of the capitalist market, particularly civil rights, have greater value.

Liberal rights are not distributed equally to all members of society, but their redistribution is conditioned by the premises of the system of private property and is governed by capitalist logic. Thus, those members of society with more social power grounded in property will receive more state protection than those who own nothing and have nothing to sell on the capitalist market. Since the state upholds the prevailing property relations, those with social power will, by definition, receive state protection, while those who do not have social power, but only pose a potential threat to the system, are excluded from such protection. The exclusion of mentally ill people is intrinsic to their conceptualization, since the rights-bearing capacity of a person depends upon possession of private property and the ability to engage in contractual relations.

This complex relationship between the system of private property and the exclusion of mentally ill people in 'market economies' determines the potential of rights to address structural and instructional causes of marginalization of the mentally ill and to guarantee their legal protection on the level received by other citizens. Thus, the relationship between liberal rights and law illustrates the way in which social relations constituted by capitalist markets are institutionalized and fixed. It also demonstrates how liberal law operates as a mechanism of discrimination which furthers the interests of dominant groups and plays an important role in the processes of marginalization of mentally ill people.

Liberal law, with its built-in assumptions about what it means to be human and a fully-developed legal subject, provides the justification for the state's differentiated treatment of mentally ill people on the basis of their utility to the capitalist economy. Legal provisions that measure a person's actions against the 'rational man' standard have fixed the notion of rationality as an essential feature of human beings, while at the same time obscuring its particular ideological character and its alliance with market needs.[5] The liberal notion of rationality is based on the assumption that, at the age of majority, one is in a position to make rational decisions about the use and disposal of goods and services, i.e. to enter into contracts. At the same time, by grounding the notion of rationality in human biology and psychology, liberal law is able to resolve the conflict between the universalism of rights and the diminishment of rights of persons who lack this rationality and thus the capacity to exercise rights.

In my thesis, I will argue that the institution of civil commitment is embedded in the processes of social exclusion and marginalization of the mentally ill in contemporary capitalist societies, and that law and discourses of rights play an important role in the legitimization of that exclusion. Liberal law and rights, although claiming features of abstractness and universality, actually have fixed social and political meanings which reveal their embeddedness in capitalism and (neo)liberalism. By elevating capitalist discourses to universal and absolute status, law has valorized and legitimized these discourses as objective and thus obscured the capitalist logic that naturalized an inferior status for mentally ill people in marketplace societies. Thus, legal reforms which do not address the foundations of the social marginalization of mentally ill people in liberal societies, and are only concerned with the symptoms of psychiatric abuses, relegate mentally ill people to the margins of society as members of an inferior status and

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[5] The problematization of the concept of 'rationality' and the term of 'a rational man' and 'rational subject' is provided in the Chapter 2 section 2 of this thesis.

become tools of “upholding and advancing the prevailing relations of power” (Teeple, 2005b, p. 71).

Research questions

The questions central to this thesis are framed to problematize the relationships between private property, law and civil commitment and to unveil the embeddedness of the rights discourse in liberal philosophy and capitalism. These questions are posed in order to assess the potential of Polish civil commitment laws to provide the same legal protection for people deemed mentally ill as they do for other people. I will ask three main questions:

1. What is the relationship between economy, liberal rights, and civil commitment?
2. What is the legal model of rights under the Polish MHPA 1994 and how was it enacted?
3. Does the current Polish civil commitment law allow for equal treatment of people deemed mentally ill?

To answer my main questions, I will follow with a set of subsidiary questions: What is the relationship between capitalism, liberal rights and the status of mentally ill people? What is the relationship between mental illness and rights-bearing subjectivity? What is the relationship between civil commitment and liberal rights? What are the grounds of civil commitment and is there a conflict between them and liberal rights? Is Polish law regarding civil commitment based on liberal rights and what are the implications of this model for the legal and social position of civilly committed people?

Hence, the purpose of my study is two-fold: 1) to contribute to the emerging dialogue regarding liberal rights and the marginalization of mentally ill people (Arben,

1999); and 2) to bridge the gap in the literature between critical rights scholarship and scholarship on civil commitment.

The conceptualization of civil commitment in critical literature

In the civil commitment literature[6] a dominant understanding of the term 'civil commitment' is as the "detention of persons against their will to mental health facilities under a formal legal process" (Brooks, 2000, p. 23).[7] Grounds for civil commitment vary between jurisdictions. The most common grounds include mental illness, being a danger to self or others, the need for treatment or inability to provide for basic needs (Arrigo, 1993; Brooks, 2000; Collins, 2009). These grounds need to be met cumulatively.[8]

However, the conceptualization of the grounds of civil commitment and the legacy of civil commitment are contested and problematized by critical scholars interrogating the fields of civil commitment and psychiatry. For example, it has been argued that incarceration in psychiatric facilities is one of the strategies of social control exercised in modern societies (Chunn & Menzies, 1998; Collins, 2009; Hubert, 2000a; Menzies, 1986). Brooks (2000) have claimed that the legal criteria for involuntary commitment result from political pressure to classify and manage 'deviant' behaviours that are subsumed under various classifications of mental illness. Additionally, Foucault (1977/1995, 1972/2006) suggested that enclosed institutions employ disciplinary

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[6] Spanning the disciplines of law, psychiatry, psychology, sociology, etc.

[7] Since my thesis is limited to the period between 1972 and 1994, my discussion will only concern inpatient civil commitment. This is the most predominant form of civil commitment in the Western world and the only one existing in the Polish legal system. I am aware of the other forms of civil commitment that emerged in North America in the late 1980s and 1990s, such as outpatient civil commitment, or the commitment of drug-using mothers or sexual offenders. However, since those forms have not been transplanted into Polish law, they will be excluded from the scope of my discussion and investigation.

[8] In the civil commitment literature, involuntary admission to psychiatric facilities and compulsory or mandatory detention in those facilities are often used interchangeably with the term 'civil commitment.' However, since these former terms only emphasize one aspect of civil commitment as a legal institution – non-voluntary admission – in my thesis, I will use the term "civil commitment" to encompass a broader meaning that includes legally sanctioned coercive admission as well as mandatory psychiatric treatment.

techniques on the bodies of institutionalized persons and, thus, construct patients as ‘docile’ subjects. Further, at the same time, the broader goal of the hegemonic normalization of society is achieved. Psychiatric and penal institutions stand as warnings of potential exclusion for those who dare to transgress prevalent norms, particularly economic and social norms (Foucault, 2003). The marginalization and exclusion correlated with psychiatric institutionalization demarcates a new social status for individuals, disconnects them from their past lives, erases their past identities, dehumanizes them and excludes them from any social community (Hubert, 2000b, p. 197). This is an irreversible process. However, mentally ill people are already differentiated as ‘other’ when they are constituted as subjects with limited capacity to hold liberal rights. Thus, the process of differentiation occurs even before psychiatric hospitalization and finds its expression in the restricted rights of mentally ill people.

In investigating the regime of rights of civilly committed people in Polish civil commitment reforms and in the 1994 MHPA, I will draw from this critical scholarship. However, I hope to advance the discussion by approaching it from the critical political economy perspective, critical rights scholarship, and critical legal theory. The foci of my analysis will be on examining the rights of civilly committed people in the context of the system of private property and the logic of marketplace society. Civil commitment is a legal institution that provides a legal framework for the processes of social marginalization of groups who, generally, do not participate in the marketplace by selling their labour power (Collins, 2009). For this reason, the liberal state perceives the mentally ill and the homeless as burdens on the state and on the ‘interests’ of other citizens. The lack of equal legal protection against state intervention into liberties of mentally ill people, which occurs in the process of civil commitment, only reaffirms and ratifies the inferior legal status of institutionalized psychiatric patients under the law.

However, gaining a complex understanding of the social marginalization of civilly committed people and the lack of success of civil commitment reforms in Poland and elsewhere requires a prior attempt to deconstruct the “initial paradigm that produced and reproduced certain abuses” (Bhambra & Shilliam, 2009). Thus, the deconstruction of the model of liberal rights as employed in civil commitment reforms in Poland and elsewhere will reveal the premises underlying the construction of liberal rights that have defined the position of mentally ill people to this day. With this understanding, I will be able to critically assess civil commitment reforms and the rights regime for civilly committed people in Poland and point to their limitations.

Rights in civil commitment literature

The Western literature on civil commitment has informed Polish professional debates regarding civil commitment and has shaped the discussion regarding the rights of civilly committed people and civil commitment reforms.[9] However, this literature lacks a critical perspective on rights and rights discourses. Most civil commitment scholarship fails to problematize the model of liberal rights and the relationships between civil commitment, property relations, and rights. Important exceptions in this respect are pieces written by Colllins (2009) and Rose (1986).[10]

Generally, civil commitment scholars, in their discussion of rights in the context of psychiatric institutionalization, draw on the liberal conceptualization of rights. They refer to the traditional conceptualization of rights as either positive or negative, and as the

[9] I reviewed the Anglo-Saxon civil commitment literature that discusses the rights of civilly committed people and aims to assess civil commitment reforms in Great Britain, the United States and in Australia.

[10] This literature review is limited to research concerned with the inpatient form of civil commitment, because this is the only form of civil commitment that exists in Poland, the focus of my case study. Therefore, outpatient civil commitment, voluntary commitment or psychiatric commitment as part of the correctional system will not be discussed.

rights of individuals, or rights of the state to act on behalf of its citizens.[11] In the discussion of negative rights and civil commitment, scholars are usually concerned with the individual's right to bodily integrity (Irvin, 2003; Richardson, 2008), liberty and security (Dickens & Sugarman, 2008; Høyer, 2008; Richardson, 2008), and freedom of speech (Perlin, 2008).[12] This is because these rights are directly affected by compulsory institutionalization in psychiatric facilities. In terms of positive rights, civil commitment researchers mainly focus on the right to mental health services, appropriate standards of mental health services (Arrigo, 1993; Arrigo & Williams, 2000; Busfield, 2006), patients' welfare (Kapp, 1994; Winick, 2002) and the right to mental health (Kress, 2006).[13] Within civil commitment scholarship, an important role is attached in to the concept of liberty as a universal ground against which the equality of patients' rights needs to be measured, and from which rights of civilly committed people need to be delivered (Høyer, 2008; Kress, 2006; Pearson, 2006; Richardson, 2008).[14]

In civil commitment scholarship, the discussion of rights is organized around the analysis of the legal position of civilly committed people in the context of admission to psychiatric hospitals and coercive treatment. The most common concerns of scholars are the conflicts among 1) individual rights to self-determination, 2) autonomy, 3) rights to treatment, and 4) the rights of the state (Fistein, Holland, Clare, & Gunn, 2009; McKenna, Simpson, Coverdale, & Laidlaw, 2001). Scholars have been preoccupied with

[11] While negative rights, in terms of their roots, are grounded in the negative conception of liberty, positive rights refer to their positive conception understood as "an absence of intentional interference by others" (Bellamy, 1993, p. 49). Negative rights include civil and political rights. This category of rights incorporates the right to life, security of property, freedom of speech, to bodily integrity, and to engage in economic activity free from the intervention of the state or of others (Bellamy, 1993).

[12] However, the distinctions between categories often vary or blur due to the interdisciplinary nature of civil commitment scholarship. For example, the same right may be referred to as a positive right, a negative right, or something in between.

[13] The positive rights view of liberty is in terms of possessing capacity to undertake certain action, where the state's assisting actions are needed in order to acquire this capacity (Bellamy, 1993).

[14] The discussion regarding the balance of rights also extends to the rights of people who were deinstitutionalized, including those who went from receiving mental health services to receiving only social services.

competing rights of the state and mentally ill individuals and of parties to patient-doctor relationships. The aim has been to achieve a balance between protection of individual rights and the state's right to interfere in individual liberty (Fistein, et al., 2009; Kapp, 1994). In this respect, for example, Kress argues that coercion is justifiable in order to gain a patient's compliance with treatment on the condition that "the restriction of liberty is not too great in relation to the expected gains from the intervention" (Kress, 2006, p. 537).

The disciplinary discrepancies are evident in civil commitment literature on rights; scholars from different disciplinary backgrounds employ different lenses to view problems and imagine solutions. In the medical field, the dominant view of civil commitment is as an institution that serves patients' interests and as a means of executing the right to medical care and treatment (Kress, 2006; Zemishlany, 2007). On the other hand, civil libertarians argue that civil commitment and coercive treatment are performed in the interest of the state and its controlling functions (Arrigo, 1993; Arrigo & Williams, 2000). However, the latter group of scholars imagines that civil commitment can be made less coercive by providing voices to patients and by building 'consumer-friendly' services. Such scholars believe this would reduce the existing paternalism and, in turn, contribute to the improvement of services received by mentally disordered persons (Arrigo, 1993). However, to reconcile the legalism with treatment needs, therapeutic jurisprudence is promoted as the optimal model for mental health law reforms and civil commitment practice. In this respect, Winick (2002) argues that therapeutic jurisprudence balances patients' rights and the "therapeutic needs of patients" through international human rights legislation (p. 540).

Due to the prevailing concern that civil commitment reforms have not met their goals in truly advancing the situation of civilly committed patients, a number of scholars have critically analyzed these reforms (Arben, 1999; Arrigo, 1993; Pearson, 2006; Perlin,

2008). These scholars point out that multiple instances of professional malpractice still occur in civil commitment practice despite changes to civil commitment laws. Hence, they posit that legal changes have failed to improve the situation for institutionalized people because there was no real societal will for change that went beyond the declarations expressed in legal provisions. Still persisting “sanist” attitudes of society and legal and medical professionals are visible in the enacted legal changes in which mentally ill patients are still guaranteed lesser standards of juridical scrutiny than employed in other types of judicial proceedings (Arben, 1999; Collins, 2009; Dallaire, McCubbin, Morin, & Cohen, 2001; Perlin, 2008). These scholars stress that any attempts to advance the situation of people undergoing civil commitment will provide only a façade of rights instead of making any real change, unless psychiatric coercion is banned and mentally ill patients are similarly treated (Høyer, 2008; Pearson, 2006). As long as the differentiation persists, no effective solution to social abandonment and no social interest in investigating the violations of rights of civilly committed people can be expected (Arrigo, 1993; Busfield, 2006; Høyer, 2008). However, these critical insights are not accompanied by critical investigation of the causes of social marginalization and its links to liberal ideology and to the model of liberal rights promoted in civil commitment reforms.

This literature review demonstrates that, even though rights are discussed in current civil commitment scholarship, the latter body of work lacks a critical analysis of rights and rights discourses and of the relationships between property relations, rights, and civil commitment. With very few exceptions (Arrigo, 1993; Collins, 2009; Failer, 2002), the foundation of civil commitment as a social and legal institution has remained unquestioned. Furthermore, the connection of civil commitment to the system of private property and the legal and social implications of psychiatric institutionalization have

found only marginal expression. Therefore, there is a need for critical study that will expose the links between rights, civil commitment and the economy. Such an analysis has the potential to destabilize the foundation of civil commitment and the model of liberal rights and, thus, expose the underpinning of societal attitudes towards mentally ill people and the unproblematic acceptance of hegemonic liberal discourse in modern societies.

The definitions of rights

Rights are historically constructed, legally or non-legally binding entitlements or claims to goods, services or specific actions (Teeple, 2005b). Since both *liberal* and *(neo)liberal* rights are grounded in the premises of the liberal system in my thesis, I will refer to them as liberal rights. Since the institution of civil commitment primarily violates civil rights such as the right to liberty, security, property, bodily integrity and self-determination, the discussion in this thesis will mostly concern this group of rights.

Liberal rights

I define 'liberal rights' as the civil and political rights that grow out of a market-based economy. Liberal rights envision a human being as an autonomous and atomized individual who functions optimally in a market society. Liberal rights are related to the capitalist mode of production and system of private property. Liberal rights are individualistic rights that are grounded in the premises of private property such as the unobtrusive exercise of individual property. Civil rights, according to Teeple (2005b) reflect property relations found in the emerging marketplace society. At the same time, the economy sets standards against which human rationality, morality and well-being are

measured (Somers, 2008a; Teeple, 2005b). Therefore, one's rights-bearing capacity in liberalism rests on one's economic position within the market economy.

Neoliberal rights

With the expansion of neoliberal ideology since the 1970s, the construction of liberal subjectivity has gained a new dimension. Somers (2008a) points out that "social inclusion and moral worth [are] no longer inherent rights but rather earned privileges that are wholly conditional upon the ability to exchange something of equal value" (p. 3). With strong emphasis on business needs, the neoliberal state has promoted processes of privatization, deregulation and economic globalization. The language of flexibility, accountability, cost-effectiveness and self-management has become a predominant feature of neoliberal discourse. While greatly reducing the availability of social services, the state began to highlight the importance of one's responsibility for economic success. The "social success or failure [has been] therefore interpreted in terms of personal entrepreneurial virtues or failings rather than attributed to any systemic properties" (Harvey, 2006, p. 27). Within neoliberal discourses, one's personal responsibility includes the need to solve one's individual problems – for example, through the courts – therefore, the discourses of rights, including procedural rights, have flourished with the expansion of neoliberal ideology (Harvey, 2006).

Civil commitment reforms in Poland

Since the 1960s, a number of European and North American countries have implemented reforms to civil commitment laws in order to reduce the extent of psychiatric abuses, such as unnecessary detention in psychiatric facilities, overuse of physical restraints, etc., and to ensure fair admission and treatment decisions. These

legal reforms have heralded the creation of tougher standards of committability, combined with judicial safeguards of due process, in order to advance patients' rights (Arben, 1999; Brooks, 2000; Collins, 2009; Høyer, 2008). Patients' participation in civil commitment processes, together with judicial supervision of admission decisions, was meant to ensure procedural and substantive standards in civil commitment decisions (Arrigo, 1993; Pearson, 2006). Accordingly, these 'progressive' statutory reforms provided an impetus to change civil commitment laws and implement similar regulatory standards in Poland (Gostin, 1978; Paprzycki, 1996).

My thesis provides an analysis of Polish civil commitment reforms and of the Polish *Mental Health Protection Act* of 1994 to critically reflect on the potential of liberal rights to adequately address the social and legal marginalization of mentally ill people. Through the case study of Polish laws and civil commitment reforms, I aim to address the broader problem of the legacy of diminished rights of mentally ill people that determines their legal and social position in liberal democratic societies. The notion of diminished rights is another form of social marginalization that finds its legitimization and rationalization in legal discourses regarding rights, the protection of society, and scientific discourses on mental illness.

Polish civil commitment reforms were lengthy (1972-1994) and complicated. They involved many different stakeholders – various governmental agencies, professional bodies and psychiatric and legal practitioners – and lasted throughout the transition to a (neo)liberal market economy, which commenced after the collapse of Soviet-based state socialism in Poland in 1989. Beginning in 1952, the *Instruction of the Ministry of Health and Social Welfare* ("Instruction," 1952) governed involuntary admission to psychiatric facilities in Poland along with the medical model. Since the early 1970s, civil commitment reforms began to enact a new statute that would regulate civil

commitment. The discourse of rights and the rule of law became the dominant narratives when a 'new' generation of Polish psychiatrists assumed the lead in civil commitment reforms. [15]

The reforms proceeded in the changing political, economic and social landscape of Poland. From the 'politics of openness' to the West, through the initiatives to decentralize the organization of health-care delivery in the 1980s Poland, to the introduction of (neo)liberal economic reforms and the process of accession to the European Union. It took over three decades to complete the legislative process and enact the Mental Health Protection Act in 1994. The rights discourses and the goals of implementing the legal model of civil commitment in Poland as a way of 'advancing' the situation of people deemed mentally ill and reducing the potential psychiatric abuses, were, to some extent, used instrumentally to rationalize the need for a separate mental health legislation and the broader reorganization of the psychiatric care system toward its financial and organizational autonomy. Thus, through the analysis of civil commitment reforms in Poland, I hope to reveal a more complex picture of Polish rights-based civil commitment reforms and its links to the functioning of the broader political economy.

An analysis of Polish reforms will also contribute to an understanding of how the changes in law grounded in the liberal model of rights constructed the inferior status of mentally ill people as individuals incapable of exercising liberal rights. The analysis of the MHPA, it will also illustrate the extent to which marginalization of mentally ill people is ingrained in the legal discourses of rights and the rule of law that persists despite changes in the economic and political systems. Finally, this analysis will speak to the uncritical acceptance of liberal rights as neutral legal remedies in worldwide social

[15] Teeple (2005b) explains that 'the rule of law' "refers to a form of governance in which the citizenry is ruled under the authority of a constitution and associated law and not by arbitrary or unaccountable rules" (p.11). The principles that guide 'the rule of law' include, among others, equality under the law, a judiciary independent of the executive and of non-public remuneration, and the assertion that "civil rights are the source of a nation's constitution and the object of judicial enforcement" (p.11).

justice campaigns that aim to advance the situation of people deemed mentally ill without taking into account the role of the system of private property and market economy in the construction and the functioning of liberal rights.

Methodology

Methodological position

This study employs textual analysis of legal texts and professional publications that concern the rights of civilly committed people in Poland. Key texts include the *Mental Health Protection Act* (MHPA) of 1994, the transcripts of Senate committee hearings held in September 1994 ("Patients' rights hearing," 1994) that preceded the enactment of the MHPA, as well as legal and psychiatric publications of experts involved in the reform process from the early 1970s to the mid-1990s.

My analytical focus on texts builds on my ontological position: I regard texts as an important element of the social world where texts organize institutional practices, such as legal and psychiatric practices. That is, texts act as an expression and representation (Mason, 2002, p. 106) of dominant discourses about civilly committed patients and their position in society and under the law. With respect to my epistemological position, I take the stance that texts can serve as a source of information about the professional understanding of rights and about the discourses that circulate in the legal and psychiatric professions regarding civilly committed patients and their rights.

Data collection

Documents for this study were collected during my preliminary research in Poland in October-November 2009. I have searched the Warsaw University library

database as well as the Polish National Library database for academic and non-academic sources on civilly committed patients' rights. I have searched the legal information systems of Lex Polonica and Lex for primary legal documents. I accessed transcripts of parliamentary hearings online.

The collected data will allow me to explore: how the rights and rights-bearing capacity of civilly committed patients are constructed in legal acts and in experts' debates; what the related thematic issues are; how civil commitment reforms proceeded; and what kinds of discourses circulated and what kind of debates arose during civil commitment reforms in Poland with respect to civilly committed people's rights.

Data analysis

In my analysis of law, I will adopt an interdisciplinary Law and Society framework that combines attention to law with attention to broader political, economic and social processes.[16] A characteristic of this particular perspective in terms of its analytical framework is "the focus of attention (…) to the results or outcomes of legal processes" (Hunt, 1993, p. 302).

I will conduct my textual analysis on three levels:

1. Analysis of broader discourses underpinning the model of liberal rights, including discourses about the 'absolute' character of rights, rights-bearing subjectivity, rationality and mental illness;
2. Analysis of national and international processes that have interacted with and provided interpretation of civil commitment law and, as such, have influenced the

[16] Law and Society scholarship emerged in the 1960s and currently includes a variety of scholarly approaches. The overarching feature of law and society scholarship is its attention to social embeddness of law and the interaction between the legal and the social (Banakar & Travers, 2005).

outcome of civil commitment reforms, particularly when they concern the social and legal position of mentally ill people;

3. Analysis of the construction and operationalization of rights in the MHPA, professional debates and parliamentary discussions.

The organization of the thesis

In Chapter 1, I will deconstruct the liberal rights paradigm and critically analyze the relationship between rights and the capitalist system. Liberal rights are embedded in and reflect the premises of the capitalist system despite of their claims to be universal, inherent, inalienable and indivisible. The premises underlying liberal rights illuminate how they participate in the construction of a particular vision of humanity and society. This vision, and its rationalization, legalizes the processes of exclusion of those not 'fit' to exercise rights and to engage in contractual relations as equal rights-bearers. Grounded in the system of private property and reflecting the premises of the capitalist marketplace, liberal rights perpetuate social and economic inequalities inherent in the capitalist system (Teeple, 2005b, p. xxxvii).

Chapter 2 will focus on the construction of rights-bearing subjectivity in liberal theory and its implications for the social and legal position of the mentally ill in capitalist societies. Rights-bearing subjectivity is closely linked to the notion of rationality, which is, in turn, based on participation in the capitalist economy. In this chapter, I will aim to explain the connections between capitalism, rationality, law and the exclusion of mentally ill people from the full benefit of liberal rights.

Following on from the analysis, chapter 3 discusses the practice of state intervention into the liberties of mentally ill people under the auspices of paternalism, as exemplified in the institution of civil commitment. I will provide an analysis of the modern

state's justification of its paternalistic actions toward the mentally ill. This analysis will illuminate the rationale for and consequences of a person's subjugation to involuntary commitment based on legal status, and will investigate the broader implications of the realization of procedural rights as guaranteed by civil commitment reforms. I will discuss the extent to which the pioneering Western European and North American civil commitment reforms, guided by the framework of liberal rights, were able to address the problem of abuses of civilly committed people. Ironically, this particular construction of liberal rights provides justification for the state's intervention in the civil liberties of those who threaten or disrespect the norms of the capitalist order (Evans & Ayers, 2006), while, at the same time, it purports to sustain the abstract principle of universality and equality of rights as the cornerstone of modern liberal democracy.

Informed by such theoretical and conceptual analysis, chapter 4 provides an overview of the national and international factors that shaped the Polish civil commitment reforms that began in the early 1970s and ended in 1994 and influenced the model of civil commitment reforms adopted by Polish reformers and the process of the creation of MHPA. Moreover, this chapter will examine the changes in Polish political, economic and social contexts over the same period to assess to what extent they affected the regime of rights of civilly committed people in Poland as enacted in the *Mental Health Protection Act* of 1994.

Building on the findings of previous chapters, in the final chapter I will critically analyze the provisions of the 1994 MHPA regarding the construction of rights of civilly committed people. I will argue that the institution of civil commitment represents a continuation of processes of exclusion and marginalization of mentally ill people in contemporary capitalist societies and that liberal law and discourses of liberal rights play an important role in this exclusion. Such law, with its built-in assumptions about what it means to be human and a fully developed legal subject, provides the justification for the

state's differentiated treatment of mentally ill people on the basis of their utility to the capitalist system.

1: DECONSTRUCTING THE MODEL OF LIBERAL RIGHTS

1.1 Introduction

This chapter begins with a discussion of the historical and social development of liberal rights in order to deconstruct their inherent character, and to challenge assumptions about their universal, indivisible, and inalienable nature. Through exposing the contradictions embedded in the construction of liberal rights, I hope to reveal the lack of potential of liberal rights to address causes of subordination of mentally ill people in Western democracies and in Poland.

Liberal rights emerged with the development of the capitalist mode of production to secure rights of property owners. Even though they were subsequently extended to new groups (e.g.. workers, women) that became crucial for the development of capitalist production, they did not lose their exclusionary character. This extension has only exposed a continuing dependence of rights on the individual wealth to exercise those rights (Teeple, 2005b, p. 28).

Presented as absolute, liberal rights reflect the atomized nature of possessors of private property, whereby everyone is seen as formally equal; however, their examination exposes contradictions underlying the construction of liberal rights. These contradictions undermine the potential of liberal rights to advance the situation of mentally ill people. Liberal rights construct a liberal individual who functions optimally in market society as the normative model against which mentally ill people have been assessed. The liberal conceptualization of rights and liberal subjectivity is the articulation

of the exchange/production relations of the capitalist market that produces a hierarchical social order. Thus, an examination of the imbrication of the concepts of liberal rights with those of the capitalist market economy will provide a foundation for the understanding of the notion of diminished rights and the problems related to the rights-based reforms of civil commitment laws.

1.2 The capitalist foundation of liberal rights

Various international declarations, national constitutions and legal doctrines construct civil and political rights as absolute. These essential liberal rights are claimed to be inherent in all humans, and to have a universal, indivisible and inalienable character. However, analysis of the development of rights illustrates that rights have a relative character, and emerge in particular political and economic circumstances.

Contemporary scholars contest the 'natural' character of rights, arguing that rights are constructed through historical and social processes. Marxist scholars stress the connection between the emergence of civil and political rights and the changes in modes of production.[17] For example, Teeple (2005a, 2005b) argues that liberal rights, which he defines as claims or entitlements to goods and services, "came into existence as the reflection of a particular mode of production" (2005a, pp. 12-13). He conceives the emergence of liberal rights within the context of the development of capitalist social relations. The introduction of the capitalist mode of production gave rise to liberal rights. The market restraints of feudal absolutism made it impossible for the bourgeoisie to exercise property rights needed for commodity exchange and capital accumulation. Civil and political rights emerged as privileges attached to the ownership of private property

[17] For example, world system theorists such as Balfour and Cadava (2004) and Wallerstein (2003) emphasize the emergence of rights, particularly citizenship rights, in relation to changes in the political landscape of the nation-state.

and served as tools for resource allocation (Teeple, 2005a, p. 2). Constructed as individual claims grounded in private property, liberal rights reflected the characteristics of the system of private property, such as their individual and exclusionary character (p.3). They served to protect property owners from any intrusive intervention into their property rights.

The concept of property has two meanings. The first refers to the "relationship to a thing" – or, possession of a thing (Teeple, 2005, p. 33). The second is the legal understanding of "property" as a set of claims or entitlements "to use or disposal of goods and services" (Teeple, 2005, p. 33). Thus, the concept of property understood as rights sets limits on the extent to which one can exercise his or her rights. Thus, the "enjoyment of personal possession" (Teeple, 2005, p. 34) is restricted by premise of non- interference with rights of others. Along with political rights, civil rights constructed the foundation of legal personhood, defined by one's ability to possess as an individual (Teeple, 2005, p. 13).

As a result of political struggle between classes, liberal rights were extended in the nineteenth and twentieth centuries to groups other than the bourgeoisie (Teeple, 2005b; Wallerstein, 2003). For example, in the nineteenth century, civil and political rights were extended to workers who were able to sell their labour power. Based on the rationale that labour-power is a form of private property, which one can feely dispose of, this extension did not challenge the foundation of liberal rights in the system of private property (Teeple, 2005b). Also, in this sense, an individual became a personification of private property. Given the necessity to struggle for rights, Teeple (2005a) suggests that: "Rights that have to be fought for (…) cannot be universal, absolute or integral to the human being" (p. 5).

Notwithstanding that the historical development of rights challenges their supposed inherent and universal character, modern human and citizenship rights discourses construct rights as natural and inherent to all humans (Teeple, 2005b, p. 23). This conceptualization of inherent rights is grounded in the liberal premise that a 'human' is a non- social individual, who is born with rights (Shafir & Brysk, 2006; Teeple, 2005b; Tweedy & Hunt, 1994). Basok, Illcan and Noonan (2006) argue that in "human rights and modern Western conceptions of citizenship, rights are entrenched in the idea of natural rights as "inalienable rights of man"" (p. 268). Therefore, these natural rights of 'man' are "supposed to be independent of citizenship and nationality" (Arendt, 1966, p. 293) because they are acquired by a person through birth. Consequently, liberals perceive civil rights as a formalization of the naturally acquired rights of a person (Arendt, 1966, p. 293).

In addition to the claim regarding the time-bounded character of rights, changes in the spectrum of particular categories of rights, their broadening and elaboration, challenge their inherent and natural character (Balfour & Cadava, 2004, p. 278). Throughout history, new categories of rights were added to existing civil and political rights. New categories of rights emerged, such as "children's rights, gay and lesbian rights, human beyond citizens' rights, the rights to education, the rights to work, the rights to political participation, the rights to resistance, the rights to development, and a wide spectrum of economic and cultural rights", and these have been incorporated under the concept of rights (pp. 277-287). Balfour and Cadava (2004) explain that the ever-growing catalogue of human rights has been broadened in the contemporary world as a response to the abuses, violence and injustices that people have suffered over time. Since rights are an expression of social and political conflicts, the new emerging categories illustrate the existence of a spectrum of conflicts that exist in modern capitalist societies (Teeple, 2005b). Thus, the changes in the catalogue of rights and in

their definitions challenge the supposedly inherent character of rights. On the other hand, the inclusion of identity rights obscures the grounding of liberal rights in the system of private property and their role in the construction of the modern model of an individual.

1.3 Processes of exclusion

Liberal rights make claims to universality despite the fact that they are time-bounded and relative to capitalist modes of production (Teeple, 2005b). The critical scholars of rights, however, have argued that the universal character of rights is merely a 'mirage' or an 'oxymoron' (Arendt, 1966; Evans & Ayers, 2006; Teeple, 2005b), because processes of exclusion are embedded in the construction and expansion of liberal rights. Declaring liberal rights as natural and inherent to all human beings, according to Teeple (2005b), was a way of "portraying them as timeless, immanent, and independent of external causes, to establish them as absolute" (p. 23). Since the French *Declaration of the Rights of Man and of the Citizen* proclaimed that all citizens were equal, concurrent processes of exclusion have been underway that have limited access to citizenship rights by "dangerous classes" (Wallerstein, 2003, p. 650). The processes of differentiation of citizens into distinct and hierarchical categories (fully participating citizens, non-participating citizens, etc.) enabled the dominant class to "retain the principle [of universality and inclusiveness] in theory" while at the same time limiting the full benefits of citizenship (civil and political rights) only for particular groups (Kapur, 2007; Wallerstein, 2003). These modes of differentiation included strengthening of the binary categories, containment of the dominant class of rights-bearers, "crystallization" of ideologies, and construction of new scientific discourses around biological and human psychological differences (Wallerstein, 2003, p. 657). In practice, the principle of

universality of rights has been refigured to legitimize the diminished rights of a number of social groups such as women, children, sexual minorities, and mentally ill people who did not possess the 'qualifications' to be legitimate holders of private property (Collins, 2009; Failer, 2002, Scott, 1987; Teeple, 2005b).

Exclusionary discourse operated on various levels of social organization, not only on the level of state politics; it involved activities from 'below'. Balibar (1994) argues that the processes of universalization "appear to be inseparable from processes of exclusion and (…) inner exclusion" (p. 314). Groups that had already gained rights, and wanted to prevent other groups from gaining them, used categories of differentiation as strategies to restrain other groups' claims to rights (Wallerstein, 2003, p. 661).[18] In order to ensure that rights of 'privilege' maintained their value, it was imperative to prevent the universal extension of rights. Thus, the acquisition of rights by one group often limited the access of other groups to the same rights.

Another problematic aspect of arguing that rights are inherently universal in character is that their meaning is specific to historical contexts and that the capitalist mode of production but their meanings have been universalized. Teeple (2005b) argues that rights take their meaning from the specific historical, geographical, and social contexts in which they emerged (p. 6). Thus, to attribute to liberal rights the characteristic of universality "is simply to assert something as being universal when it is actually historically specific" (Teeple, 2005b, p. 21). Also, Balfour and Cadava (2004) assert that "circumscribed by (...) the given language in which very terms are formulated, human rights discourse speaks of universal in a mode that is always less and other than universal" (p. 282). The conversion of rights into abstract and universal concepts allows

[18]The state, by constructing an abstract and normative notion of the "individual" (which reflects the values and norms promoted by the dominant class) created space for processes of exclusion of those who did not fit into this abstraction, i.e. women who were differentiated biologically from the normative man (Scott, 2005).

them to be constructed as neutral entities, even though their language carries meanings anchored in a particular philosophical tradition. For example, the terms of ‘citizens’ or ‘citizenship rights’, already indicate that these discourse operates within the framework of a nation-state and state sovereign power (Balfour & Cadava, 2004, p. 282). Thus, the presentation of liberal rights as universal and neutral masks their relative character and their embeddedness in capitalist social relations.

1.4 The hierarchical organization of rights

Despite the promoted assertion of the unity of rights, in practice, different categories of rights prove to be easily divisible. One rationale for such divisions is the argument that some categories of rights are more essential than others to the functioning of a human being. For example, civil rights often exclude social rights from the national and international agenda and from human rights discourses even though all civil, political, and social rights are considered human rights (Evans & Ayers, 2006, p. 292). Liberal democracies with capitalist markets prioritize civil and political rights, which secure private ownership and capital accumulation (Evans & Ayers, 2006). The hierarchical organization of rights finds its justification in the claim that only civil and political rights respond to the fundamental needs of human beings. Teeple (2005b) argued that:

> Implied in the concept of human rights is an unspoken presupposition about what it means to be *human*. In the context of human rights, to be human is merely to possess rights – and not just any rights, but the civil and political rights spelled out in liberal – democratic charters and declarations. (p. 21)

Since social rights contradict the very principles of liberalism because they illustrate the problems of capitalist economics and depend upon re-distributive policies to

provide for the poor and those disadvantaged through the capitalist processes of wealth accumulation (Evans & Ayers, 2006), they are relegated to a lower level of importance. Interestingly, Harvey (2006) pointed out that changes in the priority of rights are linked to changes in the political economy. Since the language of flexibility, accountability, cost-effectiveness and self- management became predominant features of neoliberalism, procedural rights have gained more prominence in rights discourses (Harvey, 2006, p. 27).[19] Social success or failure interpreted in terms of personal entrepreneurial virtues was extended to people's ability to manage their own affairs with tools provided by law. Thus, one's personal responsibility also included the need to solve one's individual problems – for example, through the courts (Harvey, 2006). However, these discourses obscure the fact that the possibility of exercising individual rights merely relies on the possession of financial means to undertake legal action (Teeple, 2005b).

Since not all rights have similar importance to the liberal state, their hierarchical organization reflects the quality of obligation imposed on a state to act according to claims formulated in rights. Hence, social rights are placed lower on the scale of importance in national and international politics; they are constructed by states as claims and entitlements that are often seen as less imperatively binding when compared to civil and political rights.

Social rights demonstrate that the capitalist market economy cannot sufficiently provide for everybody and that state intervention in the form of welfare is crucial for the well-being of needy citizens. Again, Teeple (2005b) is instructive: "Social rights (…) reflect the contradiction within the [capitalist] system," centred on the argument that the 'free' market is a market unable "to reproduce the system" (p. 40). Social rights signify the necessity of a state's intervention into the private sphere to alleviate the worst effects

[19] I will use the term of (neo)liberal to encompass liberalism and neoliberalism.

of capitalism (Teeple, 2005b).[20] Thus, the emergence of social rights undermine the assumption that ‘free markets’ and economic freedoms create sufficient resources for individuals to be able to protect themselves against various forms of injustice, including economic hardship (Brown, 2004a; Evans & Ayers, 2006). To make social rights more consistent with the system of private property, modern (neo)liberal states use a form of “charity discourse” that transforms these rights so that “rights become the privileges of donors” instead of becoming justifiable claims for the state’s assistance (Teeple, 2005b, p. 15).

The hierarchical organization of rights also qualifies the level of protection one receives from the state in case of rights violations. Thus, the protection of civil and political rights remains high on government agendas. Nevertheless, even in such cases, the quality and accessibility of legal protection is differentiated depending on one’s status in society. Arendt (1966) demonstrates that an individual’s legal protection is dependent on belonging to a community willing to recognize and guarantee the fundamental rights of that person. Various examples illustrate that supposedly inalienable civil rights can be taken away and violated while the international community and particular states do nothing about it (Arendt, 1966; Failer, 2002; Somers, 2008a; Teeple, 2005b). For instance, in terms of the experiences of minorities and Jews in Europe following the First World War, Arendt (1966) argued that: “The world found nothing sacred in the abstract nakedness of being human” (p. 299). She suggested that the legal status of a person as a rights-bearer is connected to membership in a social community (p. 298). Similarly, the civil rights of mentally ill people receive less state protection than the civil rights of other citizens. The civil rights of the mentally ill can be

[20]It is imperative to understand that, although social rights contradict individualistic premises of civil and political rights, all of these categories operate within the system of private property (Teeple, 2005b, p. 39).

taken away when the supposed 'dangerousness' of such people is claimed to threatens the rights of the broader community.

Balfour and Cadava (2004) maintained: "Who gets to claim rights, how, when, where, and in what conditions of enunciation and reception (...) encourages us to focus our attention on matters of authority and politics in a domain – human rights – that ought to be, in principle, universal, and to that extent beyond politics" (p. 292). In this sense, the system of rights protection reflects power relations within society. The conundrums of access to legal protection reflect the internal contradictions underlying the construction of liberal rights. First, one is forced to make a claim for the restitution of something that ought to be inalienable and indivisible. Second, legal protection in anchored in one's ability to make rational rights claims, in spite of the supposed 'universality' and 'equality' of such protection. Third, even when a claim for protection is formulated, protection mechanisms often prove unsuccessful in enforcing the inalienability of rights. Teeple (2005b) argued that this is evidence that "capitalism never could honour the rights it has claimed as its ideals" (Preface). Further, it can be said that the hierarchical organization of rights and unequal access to rights protection only perpetuates social inequality and the oppression of people who fall outside the liberal system.

1.5 The vision of an individual within the system of private property

This conceptualization of liberal rights resonates with social contract theory, which assumes that states are not founded on commonality of fate but, rather, on the self-interested purposes of atomized individuals who come together to enter into social contracts (Somers, 2008, p. 67). Liberal rights and their recognition are inseparable from

the capitalist market economy; they emerged with the development of the capitalist mode of production to secure rights of property owners. Because the aim of capitalism is to maximize the accumulation of wealth through the intensification of production and the ever-increasing sale of commodities, civil rights serve to frame the relationships between civil society, the state, the market, and between individuals as members of civil society in ways that facilitate the achievement of these goals (Robbins, 2011; Somers, 2008a).

Liberal rights have two major functions. First, by entering into contracts with the state, individuals become entitled to state protection of their individual interests. The state's role is to secure a functional "free market" by ensuring that each individual can freely realize self-interested economic activities without any interference from other members of society. Second, liberals fear that extensive intervention of the state in civil society and in the private sphere of the market may also endanger individual freedoms (Somers, 2008), rights are also perceived as protection against the state's intervention into private spheres (Evans & Ayers, 2006, p. 301). Bakan (1997) contends "anti-statism is manifested in the traditional conception of rights as protection for individuals from public (state) interference in their private affairs but not requiring positive assistance by the state" (p. 47).

Teeple (2005b) argues that liberal rights are individualistic rights that regulate social relations in the capitalist market. He elaborates that "human", in liberal rights discourses of capitalist societies, is defined "as isolated individual (...) it is not the human as a social being, as a product of social relations, whose chief characteristic is the relation to others" (p. 21). In liberal theory, members of civil society have no collective ties except "the social bond of exchange and communication based on the interests and autonomous enterprise of individuals" (Balibar, 1994, p. 320). A liberal individual prioritizes self-interest and autonomy over collectiveness and responsibility for the well-

being of members of civil society (Somers, 2008a). Thus, it is only as a member of society that an individual is obliged to respect the freedom and liberties of others. Such a human being is an individualized atom abstracted from social ties (Teeple, 2005b). Civil rights that enhance the protection of the private sphere of an individual accelerate social separation. They convey a message that the only way to secure individual liberty in the private sphere is to ensure that the separation of individuals occurs at the community level (Evans & Ayers, 2006, p. 302). Therefore, civil rights have an individualistic dimension that can only lead to a focus on individualistic goals (Brown, 2004; Teeple, 2005b). Those goals are only achievable through political self-determination grounded in economic empowerment, and in this sense Somers (2008a) argued that "free and self regulating markets [are] considered the only requisites for individual rights and social justice" (p. 30). By protecting individualistic freedom to engage in market relations on competitive terms, rights protect market interests by preventing members of society from pursuing collective justice (Brown, 2004a, p. 459).

Along with such a vision of freedom and justice, liberal rights discourses create a particular vision of an individual and prescribe specific conditions under which this individual can achieve her or his full potential (Brown, 2004; Evans & Ayers, 2006). Critical rights scholars point out that, in liberal discourses, the possession of civil and political rights not only defines one's humanity, but also provides the foundation upon which human empowerment is framed (Arendt, 1966; Balfour & Cadava, 2004a; Evans & Ayers, 2006; Teeple, 2005b). Consequently, human empowerment is realized through economic independence and the ability to make political claims. Therefore, liberals envision individual advancement (often stressed in human rights projects) and the "alleviation of suffering" (Brown, 2004) through the achievement of economic autonomy and political self-determination (Evans & Ayers, 2006). Moreover, Brown (2004)

contends that human rights projects that emphasize individual economic empowerment promote not what human beings need, but rather what the liberal market needs to prosper and expand (p. 457). While liberals locate human rights (individual choice as to how one wants to live her or his life) in the sphere of the private, not in the space of politics, they intentionally disconnect the subject from politics and from “collective determination of ends” (Brown, 2004b, p. 456).

1.6 Conclusion

In this chapter, I set out to critique the notion of the absolute character of liberal rights. I contested the assertion that civil rights are inherent to all humans, inalienable, and indivisible, by presenting the historical development of rights, offering examples of instances in which rights were alienated from humans, and by demonstrating the hierarchical organization of rights. This analysis demonstrates that the content and meaning of civil rights reflect the underlying premises of liberalism and the capitalist market economy, and illuminate the processes of social inclusion and exclusion that are intrinsic to the construction of liberal rights.

This critique of liberal rights lays the foundation for my arguments in the following chapters. I will build on this critique to examine the diminished rights of mentally ill people and to illustrate how unequal treatment of people who do not meet the standards of the liberal individual (that are entrenched in this model of liberal rights) legitimizes the institution of civil commitment and its oppressive practices. Inability to meet the liberal standards of personhood and rights-bearing capacity is naturalized as an individual pathology (mental illness), which in turn, legitimizes the paternalistic intervention of the state into the civil liberties of the mentally ill.

2: RESTRICTED RIGHTS OF PEOPLE DEEMED MENTALLY ILL

2.1 Introduction

The liberal theory of rights links rights-bearing capacity to one's capacity for rational thought and ability to function within capitalist society. Although the liberal notion of rationality is informed by a particular set of capitalist values, in modern Western societies, this notion of rationality has acquired a 'universal' status. In addition, rationality has come to be conceived as an inherent characteristic of human beings. Thus, rationality has begun to serve as an unquestioned rationale for various forms of social exclusion, including those experienced by mentally ill people. That is, a liberal rational subject is a subject who is capable of engaging in contractual relations and of exercising property rights in line with capitalist interests. 'Unproductive' members of society have found themselves exposed to social exclusion, breaches of their rights, even confinement in psychiatric institutions, with the supposed aim of treatment and 'correction'.

Liberal law plays an important role in these processes of exclusion. It provides a concrete rationale for the functioning of institutions of exclusion such as the institution of civil commitment, but it also serves as an overarching narrative, upholding universal claims to the equality of all humans in terms of their rights, while still undergirding processes of exclusion (Kapur, 2007). Consequently, Kapur (2007) points out that such reconciliation of "the premises of universality with exclusion" is possible in practice "through a clear and persuasive logic" (p. 541). In the case of diminished rights of civilly

committed persons, this logic is embedded in constructing human beings as subjects in capitalist marketplace societies (Rabinow, 1984, p. 7). Therefore, the analysis of the means through which law, grounded in liberal premises, constructs mentally ill people as 'inferior' legal subjects, needs to engage in examination of how diminished rights-bearing capacity is constructed through references to the absolute notions of rationality and mental illness. The diminished rights-bearing capacity of mentally ill people has far-reaching consequences; it impacts the quality and quantity of legal protection acquired by mentally ill people from the state, as well as the broader social position of the mentally ill.

In this chapter, I will illuminate the relationships between the normative conceptions of rationality, mental illness and rights. In investigating these relationships, I will provide an understanding and critique of the construction of diminished rights of mentally ill people. First, I will analyze the notion of the normative character of rationality and its links to the capitalist marketplace economy. Following that, I will critique the notion of the absolute character of mental illness and its role in constructing diminished rights-bearing capacity. Finally, I will engage in a discussion regarding the notion of diminished rights of mentally ill people and its operationalization in liberal laws.

2.2 The notion of rationality as a foundation of liberal rights

The Enlightenment conception of rationality has informed liberal notions of legal subjectivity. Prominent liberal thinkers, such as Locke, J.S. Mill, and Kant, all attached a person's rights-bearing capacity to the capacity for reason (Failer, 2002), which acquired in modern societies both a universal and an absolute character. For Locke, reason meant that "men can recognize natural law, apply it to their own lives, and thereby live in freedom" (Failer, 2002, p. 30). For Mill, rationality was associated with maturity of

“faculties” that ensured one’s capacity for achieving self-determination and conducting an independent life. Mill envisioned a human as a “progressive being” who advances to the stage of maturity through reflexive realization and cognitive activities such as discussion (Failer, 2002). Lastly, for Kant, a person’s capacity to reason meant “to act according to his concept of laws”, which Failer (2002) explained as the “ability to guide his action by employing the logic of the categorical imperative” (p. 37). Although there is no unified definition or understanding of rationality, nonetheless, there are common traits shared by some definitions that include traits of intellectual functioning that enable a person to conduct herself/himself lawfully, to make ‘logical’ decisions, and to live an independent life.[21] With these characteristics, liberal theorists have constructed the image of a liberal individual, universalized as a human being, “consistent in thought and emotions, unified in capacities and beliefs, autonomous in the sense of [being] free from interventions from alien forces or spirits” (Rose, 1986, p. 201). Since such a person has the capacity to make and carry responsibility for personal choices, an individual’s advancement depends on his/her constant drive for improvement and on constructing favourable conditions for autonomous and individualistic life.

Rose (1986) argued that liberal theory created a “legal fiction of a freely choosing, rational subject with rights to personal autonomy” (p. 201); liberal theories suggest that “all people are born equal, free, and rational, that the subject is atomized and existing prior to history and social context” (Kapur, 2007, p. 541). Locke points to the intellectual faculties that constitute a human and allow him or her to reason (in Porter, 1991, p. 24). Capacity to reason has also acquired the status of an essential characteristic of humans and a criterion that distinguishes humans from animals and elevates humans to a superior status (Deckha, 2008; Foucault, 1972/2006; Porter,

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[21] Porter (1991), in his anthology *The Faber book of madness*, points not only to the problems with finding a single, unified definition of reason, but also with differentiating the right reason from the wrong reason, and with differentiating between madness and irrationality.

1991). By assuming that rationality is a universal feature of humans, rationality has come to be conceived through “the notion of biological [and] psychological’ determinism” (Kapur, 2007, p. 541).

This normative character of rationality as a basis for constituting a ‘human’, however, has been contested in the critical literature. Maslan (2004) argues that only with the rise of modernism was the concept of human linked to the ability for rational thought; the man of the ‘old regimes’ (before the French Revolution) was constituted by his ability to feel. Hence, the construction of a human as a rational being is a relatively recent phenomenon. Other critical scholars, including feminist scholars, have been forceful in deconstructing the biologically determined character of rationality (Astbury, 1996; Chesler, 2005; Ussher, 1992). They have exposed power relations involved in the production of a particular conception of rationality and of the normative rational subject. Further, they have posited political and social implications of normative rationality for the construction of women as ‘deficient’ subjects. Accordingly, they have argued that deficiency located in an individual’s biology or psyche legitimizes the social exclusion of women through references to the ‘natural biological order’. The presumed biological lack of rationality in women predisposes them to remain in private spaces such as the home. For example, Astbury (1996), who analyzed the process of knowledge production involved in constructing scientific theories regarding women’s deficient biology, argues that science, which makes claims to being based on a universal human subject, constructs normative humanity based on male standards; males are the norm from which women can only depart. Thus, while scientific knowledge establishes a norm, it concurrently creates a hierarchy of those who meet the norm and those who depart from it through the perceived fault of their biology or actions.

The process of knowledge production that constructs the scientific understanding of a pathological individual and qualifies her or him as lacking the

rational quality provides a ‘neutral’ language for processes of exclusion and marginalization. Foucault sees “scientific classification” as one of the methods for turning a human being into an “objectified” subject. This method also coexists with practices of social or spatial differentiation, such as those related to the institutionalization of the mentally ill (Rabinow, 1984, pp. 7-9). Scientific categorization legitimizes a ‘natural’ social order in which deficient individuals acquire lower social positions, and are individually responsible for their status when acting against normative standards.[22] In this context, scientific knowledge justifies the exclusion of irrational individuals in biologically and psychologically determinist ways, obscuring the political underpinnings of the notion of rationality that reflect values promoted by liberal-capitalist systems, and ignoring that rationality is used to regulate human relations so that they conform to capitalist marketplace rationales.

A number of critical rights scholars posit that, in marketplace societies, “the economy” sets standards against which human rationality, morality and well-being are measured (Somers, 2008a; Teeple, 2005b). For example, Western capitalist societies often equate the concept of an individual’s rationality with that person’s ability to engage in contractual relations (Teeple, 2005b). Since liberals believe that an individual functions optimally in market economies and that a system of private property best ensures individual freedoms, individuals’ rationality is measured against their ability to function in liberal markets – to engage in contractual relations and to embrace the dynamics and rules of the market economy (Teeple, 2005b). People who do not meet these economic standards are constructed as ‘other’ and, thus, ‘dangerous’, particularly

[22]Here, a considerable body of feminist literature provides a basis for the critique of the ‘objective’ notion of rationality and its role in the legitimization of gender ordering. For example, Asbury (1996) exposes the androcentrism in the process of knowledge production that constructs the scientific understanding of woman as lacking the rational quality, which, in turn, legitimizes gender order as natural, with women’s place at home. She also questions the assumption that rationality can be treated as a universal norm while it is based on male standards and defined from only a partial perspective.

when their behaviours challenge the foundational premises of capitalist societies. For Locke, a person who betrays human values (understood as liberal values) contributes to his or her own exclusion from the political community and from the possession of liberal rights (Balibar, 1994).

The responsibility for one's success or failure in the market economy gained a new, individualized dimension with the emergence of neoliberalism. In neoliberalism, dependency on social services is perceived as an individual deficiency, rooted in one's inability to cope with the demands of the market economy. Hence, the assumption persists that the need for support is more exceptional than it is normal (Evans & Ayers, 2006). Good citizens and rational individuals should aim to become self-sufficient and self-reliant and, as well, to contribute to the common good defined in terms of optimizing market prosperity (Brodie, 1996). The exclusion of 'irrational' subjects – who are unproductive and cannot advance the purposes of the market economy or contribute to capitalist production and capital accumulation – in liberal thought, legitimizes the legal exclusion of these unproductive groups from receiving full benefits of rights. One's economic independence makes possible claims to self-determination, since success as an autonomous and self-sufficient human being within the framework of the market economy speaks to one's "degree of civilizational maturity" (Kapur, 2007, p. 542), associated with rational thinking. Thus, a person's lack of capacity for independent economic functioning and for making economically sound decisions presumes that that person also lacks ability to make decisions determining the course of his or her life. Often, such people are subject to correctional practices that may include extensive state supervision, as in the case of welfare recipients, or even institutionalization in psychiatric facilities on the grounds of mental illness.

To summarize, in modern societies, the economically-defined notion of rationality functions as a way of ordering the world and making sense of social relationships,

including those relationships that lead to marginalization and exclusion of certain members of society. Rationality has served as a norm through which classification of people into various categories can be achieved: rational/irrational (thus, autonomous/dependent) or sane/insane (Rabinow, 1984, pp. 7-9). In the next section, I will discuss the concept of mental illness as irrationality and the implications of this for the construction of the capacity to exercise rights.

2.3 The construction of mental illness as irrationality

Foucault argues that the history of reason is always entangled with the history of madness, since the notion of rationality determines the conception of madness and mental illness (Foucault, 1972/2006; Porter, 1991, p. 11). The analysis of the notion of rationality and the processes of the exclusion of mentally ill people from the full benefit of rights suggests that the economic underpinning of rationality is obscured under the notion of biological or psychological deficiencies. According to Foucault, the conceptualization of these deficiencies as mental illness emerged with the medicalization of madness for economic and social purposes (Foucault, 2003). He links such change with the emergence of the capitalism in Europe and the need for a larger labour force to sustain capitalist mode of production. At this time, mad people became distinguished from other asylum residents. While those people unwilling to work were discharged from asylums, the people who could not work because of physical or psychological disturbances were transferred to general or psychiatric hospitals that emerged concurrently. Foucault argues:

> It is said that Pinel liberated the madmen in 1793, but those he liberated were only sick people, old people, idlers, prostitutes; he left the madmen in the institutions. This took place when it did because, at the beginning of the

nineteenth century, the speed of industrial development accelerated, and, in accordance with the first principle of capitalism, the hordes of unemployed proletarians were regarded as a reserve army of power. For this reason, those who did not work but were able to work were let out of the establishment (Foucault, 2003, p. 375).

During this transformation, mental illness gained scientific and absolute character. It came to be perceived as a biological deficiency affecting rational thinking, such as brain pathology or a lack of cognitive skills. Even among the 'new' liberal thinkers, some variations were pointed to with respect to the capacity to reason. For example, Locke noted that "mad Men put wrong Ideas together, and so make wrong Propositions, but argue and reason right from them; But Idiots make very few or no Propositions, but argue and reason scarce at all" (Locke cited in Porter, 1991, p. 24). The critical scholarship of psychiatry has suggested that, even though "mental illness is seen as an objective disorder arising within the person that may be diagnosed and treated (or cured) through therapeutic intervention" (Brooks, 2000, p. 9), the biological origins and character of mental illness is questionable (Porter, 1991). Porter, in his anthology *The Faber Book of Madness* (1991), documents that the definition of mental illness has changed over time, as did the categories of behaviours that were perceived as symptoms of mental illness (e.g. homosexuality). Similarly, other critical scholars suggest that the concept of mental illness is a socio-cultural concept, which varies across geographical locations, historical periods, social strata, and gender (Brooks, 2000; Foucault, 1954/2008, 1972/2006; Porter, 1991; Ussher, 1992; Whitaker, 2002).

Scholars who employ socio-cultural perspectives argue that the label of 'mental disorder' is attached to those "behaviours that are bizarre, irrational, or unusually distressful" (Brooks, 2000, p. 11). As such, mental illness is a 'quality' that others

attribute to a person whose behaviour does not match normative standards prevailing in a given society. “Mental illness has its reality and its value qua illness only within a culture that recognizes it as such” (Foucault, 1954/2008, p. 60). For Brooks (2000), mental illness does not exist in reality but is a negative value judgment (p. 11). Even today, despite the fact that the dominant “‘medical model’ of mental illness claims that psychological disorders are ‘sicknesses’” (Brooks, 2000, p. 9) and thus objective entities, concepts of ‘health’ and ‘illness’ are themselves far from being objective scientific concepts (Canguilhem, 1989). Emerging scientific categories referring to pure and objective biological and medical knowledge actually reflect the values of their creators and the philosophical trends of the epoch (Nicolson, 1991, p. 368). Appignanesi (2008) makes a similar claim, positing that new categories of psychiatric disorders, which organize modern understandings of normality and pathology invented by medical professionals, mirror “the time’s order – its worries, limits, border problems, and fears” (p. 5).

Even in legal provisions, one finds that mental illness has different definitions (Brooks, 2000). Brooks (2000), who compared civil commitment laws in 32 international jurisdictions, found that mental illness does not have a single unified legal definition across various jurisdictions. Similarly, legal definitions of mental illness differ from definitions in psychiatric systems (Brooks, 2000). In addition, changes in classification of ‘mental disorders’ find their reflection in the changes to legal provisions regarding civil commitment (Brooks, 2000, p. 12).

Madness is not a recent phenomenon, but it only became a form of exclusion in the seventeenth century. Before the mid-seventeenth century, “madness was allowed free reign; it circulated throughout society, it formed part of the background and language of everyday life that one sought neither to exalt nor to control” (Foucault,

1954/2008, p. 67). Foucault (1954/2008) described the shift which occurred in the conceptualization of madness:

> Throughout Europe, great internment houses were created with the intention of receiving not simply mad, but the whole series of individuals who were highly different from another, at least according to our criteria of perception – the poor and disabled, the elderly poor, beggars, the work-shy, those with venereal diseases, libertines, people whose families or royal power wished to spare public punishment, spendthrift fathers, defrocked priests; in short, all those who, in relation to the order of reason, morality, and society, showed signs of 'derangement.' (p. 67)

Critical scholars have asserted that the concept of mental illness has been used to control individuals through various psychiatric surveillance strategies. In particular, feminist and critical scholars have exposed how scientific discourses have provided justification for sustaining the hierarchical order as natural, and for colonizing the freedom and the bodies of marginalized populations by imposing medical and legal control over their lives and enacting intrusive treatment (Astbury, 1996; Chunn & Lacombe, 2000; Ussher, 1992; Whitaker, 2002). In times of social, political and economical turbulence, medical science is especially called upon to uphold, for example "rigidly demarcated sexual division in the society" (Astbury, 1996, p 41). Through labelling certain behaviours as 'pathological,' the ruling elite has sustained its power by excluding those who transgress so-called natural social norms (Foucault, 1954/2008).[23]

With their authority based in the 'objectivity' of modern science, psychiatric discursive practices play a significant role in pathologizing bodies and behaviours. When, in the mid-seventeenth century, madness became a category of differentiation

[23]Foucauldian scholarship on madness and deviancy illustrates broadly the use of differences and abnormalities to reinforce the power of elites through the violence of exclusion.

and exclusion, it was transformed into individual pathology. Foucault argued that the construction of an individual as a pathological subject is the highest form of alienation experienced by people in modern societies (in Dreyfus, 2008 p. XXXVII). Mad people came to be perceived as 'beasts' who needed to be isolated and from whom society needed to be defended (Foucault, 1972/2006; Porter, 1991, p. 11). This physical isolation, for Foucault, is another process of differentiation through which mentally ill people have been objectified (Rabinow, 1984, pp. 8-9). In the circumstances of the mentally ill, processes of scientific categorization are interlinked and play into the processes of physical differentiation in psychiatric institutions.

2.4 The diminished rights-bearing capacity of people deemed mentally ill

The concepts of rationality and mental illness, the latter understood as biological or psychological deficiency, provide rationalization for the diminished rights-bearing capacity of mentally ill people. Busfield (2006) suggested "reason is central to our notion of humanity and assumptions about the capacity for reason underpinning many human rights" (p. 210). The classical liberal theorists excluded mentally ill people from access to liberal rights based on their inability to follow the law and to demonstrate orderly conduct due to the lack of capacity for rational thought.

Since rationality was constructed in biological terms, liberals argued that not all people were considered as having been born with the faculty of possessing rights essential to freedom. To the groups without this faculty, "Lunatics and Idiots" were included (Locke in Failer, 2002, p. 30) Hence, Locke, Mill and Kant directly excluded mentally ill people from the community of equal rights-bearers, possessors of liberal rights (Failer, 2002, p. 30), because, in their opinions, mentally ill people lacked

rationality and, consequently, the ability to maintain ‘orderly conduct’ and to function properly in market societies. In this sense, rights were recognized as being owned only by those who were “fully liable in contractual relations in civil society” (Teeple, 2005b, p. 22).

This suggests the existence of a close relationship between rights-bearing subjectivity and an economically informed notion of rationality; it also suggests the entanglement of civil commitment laws with property rights (Collins, 2009; Evans & Ayers, 2006; Teeple, 2005b). Collins (2009) investigated the connection between economic rights and the idea of sanity, looking at the evolution of civil commitment law in the United States. In her research, she discovered that, in judicial practice, the notion of a ‘sound mind’ stands for ‘proper’ attitudes toward the capitalist market and the system of private property. These attitudes are exhibited in the use of property rights that limit “individual liberty and the human rights of economic freedom” (Collins, 2009, p. 436). Thus, the proper management of economic affairs means not only managing property, but also ensuring that one provides for one’s dependants. For example, in 1894, a court in Pennsylvania civilly committed a man because he was thought to be of “unsound mind” after “he sold his possessions and attempted to place his land in trust” (p. 440).

Courts in civil commitment cases in the United States have also interpreted reason and soundness as being related to economic productivity. ‘Productivity’ predominantly referred to one’s contribution to the prosperity of society and the ability to provide for one’s material needs. It also signified a person’s proper attitudes toward the system of private property, conceived as a necessary condition for the well-being of society and the economic prosperity of others (Collins, 2009). Further, in scholarship that focuses on current political and economic situations, it has been noted that the socio-economic status of a person mediates his or her rights as a citizen. For example, Failer (2002) argues that being homeless disqualifies a person from the full benefit of rights

and from equal state protection of civil rights. “Those perceived as a threat to the principles manifest in civil society are marginalized either by labelling them mad and therefore not worthy of rational consideration or by mobilizing official violence if that fails” (Evans & Ayers, 2006, p. 303).

The notion of diminished rights-bearing capability is provided to justify the exclusion of mentally ill people from the full benefit of rights in marketplace societies. However, while full civil rights-bearing capacity is denied, there is some recognition (to various extents) of the capacity of mentally ill people to carry procedural rights.[24] Since not all rights are equally valued in liberal democratic societies (Collins, 2009; Failer, 2002), civil rights, which include the rights to liberty, bodily integrity and self-determination, are essential for defining individualistic liberal personhood and, as such, are placed ‘higher’ in the rights hierarchy than, for example, procedural rights. Particularly in the case of mentally ill people, procedural rights are conceptualized as “paternal rights” by which the state assures itself that legal procedures have been properly conducted. Here, the state exercises such procedural assessments against itself “on behalf of people who cannot exercise them by themselves” (Failer, 2002, p. x). These self-assessments, according to Failer, are grounded in the logic of *parens patriae*, according to which governments should care and provide assistance for mentally ill people because they are too sick to care for themselves” (Failer, 2002, p. 47). Judith Shklar argues that procedural rights are “rights in a metaphorical way; they evoke the image of regular rights in that they protect the intrinsically helpless in a way reminiscent of the way regular rights protect citizens against the government” (in Failer, 2002, p. 47). Thus, similar to social rights, procedural rights given to mentally ill people (i.e. the right to legal representation or to informed consent for treatment) are treated as the state’s services for needy citizens (Arrigo, 1993; Collins, 2009; Failer, 2002). In this sense,

[24] For the definition of procedural rights see footnote nr 3.

paternal rights differ from conventional civil rights, which are claims formulated by individuals who bear these rights against government actions. Hence, in Failer's opinion (2002), liberal theory constructs a bifurcated vision of rights; it distinguishes "regular rights", associated with full citizenship, from "paternal rights". In short, one set of rights is not equivalent to the other, as the paternal right acquired though civil commitment reforms does not have the potential to restore one's personhood, the loss of which results from the loss of civil rights.

2.5 Conclusion

The rationale for restricting rights based on the incapacity to reason masks the real impetus for the social marginalization of mentally ill people in capitalist societies: their inability to participate in the marketplace and sell their labour power. In market societies "not all humans qualify as possessors of rights; those who are marginal to or outside capitalist relations or dependent on others (...) are often excluded" (Teeple, 2005b, p. 23). Since, historically, possession of the full benefit of liberal rights rested on the legitimate possession of property, the liberal rights framework, in fact, legitimizes the inequality of rights as they reflect class relations (Benton, 2006; Brown, 2004a; Evans & Ayers, 2006; Teeple, 2005b). Thus, the exclusion of those mentally ill from full legal subjectivity has been the product of economically informed notions of rationality and of the law that has provided a legal framework for the diminishment of rights of the mentally ill.

Rose (1986) argues that psychiatry and law (as well as associated rights regimes) are able to approach mentally ill people in commensurable ways, because "despite [law and psychaitry] apparent differences contemporary psychiatry and rights-mindedness share a rationale for the contractualization of subjectivity" (p. 178), and because the

vision of a human is modelled on a liberal subject. Therefore, there is no significant disjuncture in how law and psychiatry approach the rights of mentally ill people; on the contrary, as we have seen so far in this thesis, psychiatry and law remain in organic relationship and support each other's legacies, which are both grounded in liberalism and capitalist relations.

3: CIVIL COMMITMENT, STATE PATERNALISM, AND RIGHTS

3.1 Introduction

Civil commitment is an institution that reflects the practical consequences of the diminished rights of mentally ill people. Legitimized by the paternalistic rhetoric of protection and care, commitment intervenes into the civil liberties of mentally ill people when it is argued that they pose a danger to self or others, or are unable to provide for their own basic needs. However, as I will demonstrate in this chapter, the notion of 'dangerousness' that constitutes, along with mental illness, grounds for civil commitment has a political character and its interpretations reflect the premises of capitalist economics and the system of private property. Civil commitment is based on assumptions about the normative character of the liberal legal order and on the construction of a liberal subject who respects the liberal legal order and exercises rights in a way that does not endanger the prosperity and well-being of society.

Civil commitment law plays an important role in the process of institutionalization of diminished rights of civilly committed people. It legitimizes the state's role in the deprivation of mentally ill people of important rights to liberty and self-determination (Failer, 2002). Physical confinement in psychiatric facilities changes the legal status of institutionalized people and thereby attenuates the terms and nature of their legal protection. Even when civilly committed people gain some 'special rights,' such as procedural rights, which happened as a result of Northern American and Western European civil commitment reforms, this bundle of rights does not restore the full legal personhood or his/her membership in the community as an equal rights-bearer.

I begin this chapter with a discussion of paternalistic state interventions into the rights of mentally ill people, and of police power and the *parens patriae* function of the state in the context of civil commitment. Next, I proceed to an analysis of the legacy of civil commitment in capitalist societies, and its close links with the system of private property. In the last section of this chapter, I analyze and assess civil commitment reforms implemented in the United States and Western European countries that claim to advance the legal situation of civilly committed people through providing them with procedural rights and enacting stricter grounds of involuntary confinement to psychiatric institutions. The discussion will suggest that, even though access to procedural rights has changed the legal status of civilly committed people, in effect their situation has changed little. As research shows, they are still abused and silenced while hospitalized, and are marginalized by society outside the hospital walls. They are left by the state without the legal protection that is available to other 'non-mentally ill' people when their rights are violated.

3.2 State police power and *parens patriae*

The institution of civil commitment represents the state's intentional coercive intervention into the individual rights of citizens regarded as dangerous and incapable of 'orderly' conduct due to a diagnosis of mental illness. The state draws legitimacy for such intervention from two sources: police power and *parens patriae* (Arrigo, 1993; Collins, 2009). Through its police power, a state acquires the authority to protect society from 'dangerous' individuals. This legitimizes the state's intervention when mentally ill people are thought to be a danger to themselves (Arrigo, 1993; Collins, 2009). With *parens patriae* power, the state obtains the legitimacy to involuntarily commit people

against their will when they are regarded as incapable of providing for themselves (Arrigo, 1993; Collins, 2009).

State paternalism in the context of civil commitment takes three distinct forms: social control, custody, and treatment. In terms of social control, the state's actions are grounded in the argument that "involuntary hospitalization is a necessary and acceptable response to a disabled person's lack of behavioural control" (Arrigo, 1993, p. 153), and in the potential for the mentally ill to disobey the law. In this case, it is assumed that mentally ill people cannot, because of their functional brain pathology, "knowingly be deterred from engaging in violent or dangerous conduct" (p. 157). In this context, the state argues that it takes on responsibility for the welfare of the individual and for the well-being of society. In terms of custody, Arrigo (1993) argued that the state's police power is replaced by the *parens patriae* power. This form presumes that mentally ill persons should be committed to custodial confinement for treatment purposes due to mental illness. In terms of treatment, "identifying those activities which fall outside the boundaries of normative conduct" accompanies the concern about treatment (Arrigo, 1993, p. 160).[25] Foucault suggests that the "theoretical organization of mental illness is bound up with a whole system of practices: the organization of the medical network, the system of detection and prophylaxis, the type of assistance, the distribution of treatment, the criteria of cure, the definition of the patient's civil incapacity" (Foucault, 1954/2008, pp. 79-80).

In the modern age, the assessment of the boundaries of 'normality', and the need for the treatment of mental disorders, has been subjected to the expertise of the new psychiatric field. The contemporary debates regarding the power of psychiatry expose its "engagement in moral enterprises of control, rationalized and legitimized though the

[25] Arrigo (1993), in his discussion of normative conduct, refers to the Diagnostical and Statistical Manual that, for the purposes of the medical community, determines the boundaries of normative conduct.

appeal to a specialist body of esoteric knowledge" (Rose, 1986, p. 179). According to Foucault, the emergence of psychiatry as a discipline that engaged in the function of social control of deviant populations relates to the expansion of capitalism and the reorganization of confinement institutions at the end of eighteenth century (Foucault, 2003, p. 375).[26]

As with mental illness, dangerousness became a category of social exclusion and a strategy of political control, exercised though the psychiatric apparatus, over populations that did not conduct themselves "in a certain manner", and, therefore, needed to be excluded or corrected (Rose, 1999, p. 254). Menzies, in his article 'Psychiatry, Dangerousness and Legal Control', claimed that:

> The history of dangerousness has run parallel to the histories of power (society's capacity to eradicate its most threatening members), knowledge (the development of "experts" in the identification of danger), and ideology (the mobilization of legitimating images and messages that strengthen the perceived need for official actions). (1986, p. 183)

Psychiatry became a discipline involved in social control of populations marginal to the capitalist systems of production or who threatened the foundations of the dominant ideology (Menzies, 1986; Pearson, 1994). Dangerous people were located in a grey zone between mad and bad, between healthy and ill (Menzies, 1986, p. 185). Psychiatrists claimed interchanability of violence and madness, and claimed ability to forecast dangerous individuals and manage potentially violence groups (Menzies, 1986). The scientific underpinning of the construction of 'dangerousness', according to Kendall,

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[26] It is imperative to remember that Foucault's analyses are very situated; hence, in his discussion, he mostly refers to France. This was the case as well in this discussion. For another analysis of the development of psychiatric discipline, see *The psychiatric persuasion: Knowledge, gender, and power in Modern America* (Lunbeck, 1994).

helped lay people to create moral distance between normalcy and criminal deviancy (2005, p. 50) and to separate themselves from behaviours that transgressed the ideological foundations of modern society. Kendall (2005) further argues that “the application of a scientific framework to otherwise incomprehensible criminal actions enabled positivist citizens to believe that human nature was essentially self-governing, free will and moral” (p. 52), and that criminality and other social transgressions were the result of sick or pathological minds.

Psychiatric institutionalization is one of the most drastic forms through which the social control role of psychiatry has been exercised (Appelbaum, 1994, p. 135). Such institutionalization occurs “irrespective of any offence being committed, on the basis that [mentally ill people] pose an unacceptable level of risk of violence to the public” (Corbett & Westwood, 2005, p. 122). However, such confinement has several far-reaching consequences. The spatial and social exclusion it creates changes the legal status of a person (Hubert, 2000b). This is because “the civilly committed lose important rights to liberty (even as they gain some special rights, including procedural protection and, in some jurisdictions, the rights to treatment)” (Failer, 2002, p. 4). Hubert (2000b) notes that the vulnerability increased through institutionalization often results in further vulnerability to institutional abuses. She argues that psychiatric hospitalization, particularly if it is long-term, deprives a person of links to community and erases her/his social identity while creating her/him as a medical subject. A “medical subject” is defined by medical records, dehumanized and objectified (p. 199). Rabinow (1984) points out that Foucault also understands spatial exclusion as a technique through which a subject becomes objectified. Through dividing practices, such psychiatric diagnosis, a person acquires a new social and personal identity (Rabinow, 1984, p. 8). Thus, the process of institutionalization in psychiatric facilities has severe consequences for the institutionalized person; it affects her/his social identity and legal subjectivity.

In terms of law, the deprivation of civil rights constructs institutionalized people as subjects undeserving of legal protection or as deserving lower standards of protection than those enjoyed by 'full' citizens. Civil commitment thereby formally deprives a person of the right to liberty, self-determination and autonomy and, hence, officially justifies the subordinated legal status of the civilly committed. Consequently, the change in the legal status of the civilly committed person serves as a reason for not protecting that person's other rights. In short, the fact that the state does not equally protect the rights of the mentally ill constitutes them as less than human, as inferior to other citizens, and this, in turn, justifies the state in neglecting their rights (Cohen, 1935).[27]

3.3 The economic foundations of civil commitment

Legal norms regulating civil commitment draw on the underlying premises of the liberal legal order and the construction of notions of liberal subjectivity and rights-bearing capacity. The rhetoric of treatment and paternalistic care present in legal civil commitment provisions justifies the need for psychiatric incarceration and, at the same time, obscures its violent character.

According to Collins (2009), who analyzed the evolution of civil commitment law in the United States, the political character of paternalistic state intervention into the freedoms of mentally ill people actually has economic underpinnings. Collins further argues: "Not only does the practice of civil commitment have its origins in property rights, the very justifications used for civil commitment, along with other government actions, have their origins in property rights" (p. 436). In her article, Collins contends that

[27] I base this point on Cohen's (1935) model of reasoning about the 'vicious circle' inherent in legal reasoning. Through this model, Cohen exposes the falsity of the claim that legal protection available to a trademark is grounded on the economic value of this device, when, in fact, the economic value of this device is created through acquiring the legal protection (Cohen, 1935, p. 815). Here, I apply *a contrario* reasoning to his model; when he argues that protection raises value, I argue that the lack of protection decreases value.

capitalist ideology legitimizes 1) the foundation of the institution of civil commitment and coercive methods used in involuntary commitment, and 2) economic prosperity and engagement in contractual relations as a measurement of one's sanity. With regard to the first point, she argues that the legacy of the institution of civil commitment reveals state protection of capitalist relations. Through examining US court cases, Collins illuminates how the discourses of "public safety" mask the language of particular economic interests. The term public safety often is paired with the term "general welfare", which has been interpreted as economic well-being or the protection of a country from economic ruin (p. 424). Hence, the government, through police power, has a right and an obligation to restrain such use of individual property that endangers the property of others who pursue individualistic interests in capitalist society (p. 429). The US court cases regarding civil commitment, detailed in Collins' article (2009), provide examples of persons civilly committed to psychiatric institutions when they were found unable to manage their own economic affairs (property, business transactions, etc.) or when they undertook activities that could have threatened the economic well-being of their families.

Even though modern civil commitment statutes do not explicitly state economic criteria as grounds for civil commitment, the application of economic criteria is well established in judicial practice (Collins, 2009): "An individual's ability to function in the economic sphere often becomes a central issue in deciding whether to civilly commit an individual" (Collins, 2009, p. 441). Similarly, Failer (2002) noted that, if a particular citizen has low social status and does not engage in contractual relations (for example is associated with homelessness), this contributes to the likelihood that she or he will be subjected to involuntary commitment. While economic prosperity often serves as a signifier of one's sanity, homelessness is read as a sign of mental illness (Failer, 2002).

Economic values presented in processes of civil commitment as standards for assessment of one's sanity reaffirm the diminished rights-bearing capacity of mentally ill people, thereby affecting the legal status of institutionalized persons with regard to the spectrum of their rights and the availability of legal protection.

3.4 Civil commitment reforms and the 'advancement' of legalism through rights

The civil commitment reforms that began in the 1960s in the United States, Australia and in a number of Western European countries were a response to extensive psychiatric abuses toward mentally ill people evidenced in previous decades (Arben, 1999; Collins, 2009). The first civil commitment reforms that began in Great Britain in the 1960s received broad attention in other countries, including the United States, and, at the end of the 1960s and the beginning of the 1970s, a number of other countries implemented similar reforms.[28] Civil commitment reformers attempted to reverse the trend of severe violations of the civil rights of the mentally ill (Collins, 2009). Through the advancement of the rights of civilly committed people, reformers sought to prevent further psychiatric maltreatment in the context of civil commitment, such as extensive use of coercion or arbitrariness in involuntary admission (Arben, 1999; Arrigo, 1993; Busfield, 2006; Collins, 2009). Reformers in the United States sought to enact tougher standards for committability in order to prevent unnecessary involuntary commitment to psychiatric facilities (Arben, 1999; Brooks, 2000; Collins, 2009; Høyer, 2008). These goals propelled changes to the grounds for civil commitment, including the narrowing of such grounds through the enactment of more complex admissions criteria, which went

[28] In this section, my analysis and critique is mostly directed to US civil commitment reforms for two reasons. First, they have received broad attention from academic communities that also provided substantiated critiques of reform outcomes. Second, these reforms were and are still referred as a model in the context of Polish reforms to civil commitment law.

beyond arbitrary reasoning solely listing a need for treatment. In this sense, civil commitment reforms were successful in enacting legal changes to the grounds for civil commitment. Collins (2009) argued that: “by the end of 1970s [in a number of jurisdictions in the US] commitment was no longer based on the needs for treatment alone and every state had sort of additional substantive criteria for civil commitment”, such as dangerousness or grave disability, or a combination of both (p. 419).

The supporters of civil commitment reforms also sought to change the existing model of civil commitment from a medical to a judicial model. This meant changing the procedural criteria of civil commitment. Reformers proposed that judges should adjudicate decisions by psychiatrists regarding involuntary admission or coercive treatment. These judicial safeguards, in the form of judicial review of patients’ claims, were intended to guarantee due process and eliminate abuse of psychiatric discretion. Patients’ participation in civil commitment decision-making and the rights to appeal initial psychiatrists’ decisions were to ensure the just outcome of civil commitment processes (Arrigo, 1993; Pearson, 2006). These postulates found broad recognition in newly drafted civil commitment statutes in the United States and Australia.

However, in the decades after these reforms were implemented, scholars have reported that these reforms have tended not to change judicial or psychiatric practices surrounding civil commitment (Arben, 1999; Arrigo, 1993; Perlin, 2008). A significant number of studies conducted in English-speaking countries (Arrigo, 1993; Busfield, 2006; Collins, 2009; Dallaire, et al., 2001; Pearson, 2006; Perlin, 2008) have documented the failure of civil commitment reforms and provided specific examples of the failure of higher procedural standards (enacted because of civil commitment reforms) to substantively improve the situations of civilly committed people. Legal and psychiatric practitioners have notoriously breached the procedural rights acquired by people subjected to civil commitment (Brooks, 2000; Høyer, 2008; Pearson, 2006; Perlin, 2008).

European human rights scholars working on civil commitment have also pointed out that procedural safeguards have not been an adequate solution for the problem of psychiatric coercion in civil commitment (Høyer, 2008; Richardson, 2008). Høyer (2008) and Richardson (2008) argued that civil commitment reforms have not decreased the extent of psychiatric coercion toward civilly committed patients because these reforms did not encapsulate the complex reality of coercion in psychiatric hospitals.[29] Therefore, it is clear that, even though psychiatric coercion is under the legal supervision of the courts, non-physical coercion and verbal or psychological pressure placed on patients to submit to psychiatric decisions is excluded from such supervision.

In addition, courts tend to interpret broadly the terms of the application of psychiatric coercion as a medical necessity, since judges rely heavily on psychiatric justification for the use of coercion (Dallaire, et al., 2001; Høyer, 2008; Pearson, 2006; Perlin, 2008; Richardson, 2008). For example, Richardson (2008) argued, “the threshold of illegality currently set by the ECHR is too high as it legitimizes the use of too much coercion” (Richardson, 2008, p. 252). Therefore, coercion’s legal boundaries have tended to be extended in civil commitment cases to the point that courts fail to protect individuals from psychiatric coercion (Arben, 1999; Dallaire, et al., 2001; Høyer, 2008; Pearson, 2006; Richardson, 2008). In practice, strong collaboration, interdependence and solidarity between psychiatric and legal professionals involved in the commitment process prevent judicial supervision from working (Collins, 2009; Dallaire, et al., 2001; Perlin, 2008).[30] Such cross-professional collaboration serves to undermine procedural justice mechanisms and destabilizes the balance associated with judicial control of psychiatric coercion within the context of civil commitment (Høyer, 2008; Perlin, 2008).

[29] Høyer (2008) and Richardson (2008) argue that civil commitment laws in general do not address the imbalance of power between individuals and psychiatric professionals, which contributes to the vulnerable position of psychiatric patient.

[30]By juridical supervision I mean the process of adjudication of civil commitment decisions of psychiatrists by courts (about coercive admission or coercive treatment).

Hence, civilly committed persons are left without effective legal protection against psychiatric violence, despite the fact that, according to norms, they possess the right to appeal to an independent juridical body against unjustified psychiatric coercion. In the context of civil commitment, the juridical scrutiny of psychiatric coercion or involuntary admission seems to serve as a façade of justice in civil commitment processes.

Another problem with the realization of civil commitment reforms centres on the failure of the juridical supervision of psychiatric decisions to ensure tougher standards for committability to psychiatric hospitals (Arben, 1999). For example, Arben (1999), who studied the practice of civil commitment laws in the state of Michigan after almost three decades of civil commitment reforms, and Pearson (2006), who conducted research on civil commitment appeal hearings in Australia, both argue that appeal courts reject more than 90 percent of patients' appeals against involuntary admission decisions. There is a general tendency among courts to agree with psychiatric assessments with little or no further investigation. Scholarly literature from the United States and Australia details instances in which patients' voices are dismissed in civil commitment hearings, or in which patients, found incompetent to represent themselves, were not provided with adequate legal representation, as representing lawyers did not take patients' arguments seriously (Arben, 1999; Arrigo, 1993; Pearson, 2006; Perlin, 2008).[31] Currently, the notion of the incapability of mentally ill people to understand the world and/or make rational decisions is commonly highlighted in the literature as a rationale used to dismiss their voices, to deny them autonomy and to impose upon them various forms of coercive treatment (Arrigo, 1993; Dallaire, et al., 2001; Pearson, 2006). Hence, individual freedoms are breached and then this violation is legitimized, along with the declaration

[31]When patients protest against psychiatric treatment or express their concerns about the side effects of such treatment, their critiques are perceived as symptoms of mental illness, or an inability to self-reflect on illness and the benefits of treatment (Kress, 2006; Winick, 2005).

that institutionalization would putatively bring better benefits to civilly committed patients (Arrigo, 1993).[32]

Arrigo (1993) recognizes the complexity of the problem of marginalization of 'mentally ill' populations, which is legalized in confinement laws and policies. He points to an uncritical acceptance of paternalistic approaches by legal and psychiatric professionals that shape the practice of civil commitment. He finds that paternalistic values are underlying an assumption of negative consequences if a person who is dangerous or in need for treatment is not hospitalized. He asserted that "it is precisely this value which places mentally disordered persons outside the normative social order, subjecting them to [ineffective mental health laws] and a neglectful system of care" (Arrigo, 1993, p. 147). Collins (2009) also pointed to the paternalistic values embedded in civil commitment laws that, in the United States, "allow for different treatment of the mentally ill and physically ill by subjecting the mentally ill to mandatory treatment while allowing the physically ill to decide whether to seek treatment" (p. 435). State paternalism is also inscribed in the lenient standards of proof necessary to proceed with civil commitment processes when those standards are compared with standards of proof in criminal procedures. Even though, in both cases, the decision results in similar consequences – confinement – the rationale for enacting different standards of committability has not been challenged during civil commitment reforms; the inferior status of mentally ill people is accepted without question.

Scholars such as Arben (1999), Arrigo (1993), Collins (2009) Dallaire, et al. (2001), and Hubert (2000) linked paternalistic legal frameworks and practices to the problem of the marginalization of mentally ill people. Arrigo (1993) calls this phenomenon the "politics of abandonment" whereby the interests, needs and problems

[32]Pearson (2006) and Whitaker (2002) have pointed out that people are coerced and submitted to mandatory treatment even while there is a lack of empirical evidence that shows that such treatment actually works.

of mentally ill people are ignored by the state and by society. He argues that: “while cyclical patterns of institutional reform have been the hallmark of America’s response to the mentally ill, the politics of abandonment has been and continues to be its legacy” (Arrigo, 1993, p. 133). He understands this abandonment as the physical isolation of mentally ill people in psychiatric institutions, where psychiatric abuses and the lack of adequate financial resources are constant problems. However, he also sees this abandonment in inadequately financed and poorly organized processes of deinstitutionalization, wherein the patients of psychiatric institutions are left without any services in communities that do not accept them.

Despite the fact that civil commitment reforms were heralded as successful in stopping institutional abuses toward people committed to psychiatric institutions and in improving a patient’s legal position during civil commitment processes (Arben, 1999; Arrigo, 1993; Collins, 2009; Failer, 2002), these reforms did not challenge the orgins of civil commitment itself. Collins (2009) argues that civil commitment reforms in the United States only addressed the symptoms, not the origins of institutional abuse of mentally ill people and, hence, were not able to improve the legal situation of civilly committed people. Grounded in the liberal model of rights and the paternalistic power of the state, civil commitment reforms instead reinscribed the inferior status of people mentally ill and contributed to their further exclusion from the community of liberal rights-bearers. Collins (2009) argued that the legal establishment is unwilling “to examine the system [of civil commitment] with critical eyes” (p. 408) and therefore to question the legacy of civil commitment as an institution of social control. She claimed that the reformers and psychiatric and legal professionals’ lack of recognition of civil commitment’s entanglement with property rights is responsible for the failure of civil commitment reforms and the sustained oppression of the mentally ill. While civil commitment reforms

aimed to establish a balance between “duties of care and protection and the right to self-determination” in the regulations for involuntary treatment (Fistein, et al., 2009, p. 147), they in fact reaffirmed the legality of separate treatment of mentally ill people and diminished protection offered to civil rights.

3.5 Conclusion

Civil commitment as an institution illustrates how people who do not meet the standards of the liberal individual experience the legal diminishment of their civil rights. This lack of protection of the civil rights of mentally ill people undermines their legal subjectivity and constructs them as less than human subjects who do not merit equal legal protection. The economic rationality and liberal discourses that constitute the foundation of civil rights serve to justify the exclusion of mentally ill people from the community of rights-bearers and the paternalistic intervention into their liberties. This undermines the legal subjectivity of persons mentally ill and, in turn, renders them more vulnerable to institutional abuses.

Critiquing the framework of liberal rights helps to reveal the problem of basing civil commitment reforms on liberal-capitalist theories. In this chapter, I illustrated the “dark side” (Kapur, 2007, p. 564) of rights-based strategies employed in civil commitment reforms in Western and Northern American countries in the 1960s and onwards. Civil commitment reforms did not deconstruct the basis of oppressive practices related to involuntary detention in psychiatric institutions or the rhetoric of liberal rights that sustains and legitimizes the political control of marginalized populations. Instead, these reforms “depoliticize[d] the debate over priorities in the allocation of resources and over different mechanisms of social regulation” (Rose, 1986, p. 208) that should not be separated from the analysis of the functioning of psychiatry as a social institution and the

marginalization of the mentally ill in modern marketplace societies. Rose (1986) argued that the problematic effects of civil commitment reforms become intelligible as soon as we recognize that both the paternalistic power of the state and rights-based strategies find their legitimacy in the same sources. These sources include the liberal conceptualization of an individual as an autonomous and independent economic being whose behaviour is informed by capitalist rationality and the contractualization of relations between citizens, between the private sphere and citizens and between the state and citizens.

4: CIVIL COMMITMENT REFORMS IN POLAND

4.1 Introduction

In this chapter, I will discuss Polish civil commitment reforms that were implemented between 1972 and 1994. These reforms aimed to change the law regulating the institution of civil commitment and to improve legal standards in civil commitment processes. By recognizing and entrenching the procedural rights of civilly committed people, reformers hoped to advance the situation of people institutionalized in mental health facilities. However, similar to their Western precursors, Polish reformers adopted the model of liberal rights as a remedy for psychiatric abuses, without taking into consideration the appropriateness of this model for achieving the purported goals.

This chapter will trace the trajectory of civil commitment reforms in Poland. It will contextualize Polish civil commitment reforms within the changes in the Polish political, economic, and social systems, including changes in the organization of the health care system. In my analysis, I will try to answer the following questions: How did Polish civil commitment reforms emerge? How were they conducted? To what extent did changes in the Polish political economy affect the regime of rights for civilly committed people? I will refer to the situation before the rights-based civil commitment reforms in 1972 through references to the 1952 *Instruction of the Ministry of Health and Social Welfare,* to illuminate how the foundation for the new legal act was constructed and what changes reformers aimed to implement in relation to the existing provisions.

4.2 The political and economic contexts of Polish civil commitment reforms

In this section, I provide an overview of changes that occurred in the Polish political climate in the 1970s, in order to contextualize the process of drafting civil commitment legislation. I will also provide a discussion of the broader context of the Polish political economy and the changes that occurred during the transition to a liberal democracy and neoliberal market economy after the collapse of the Soviet-backed regime in Poland.

4.2.1 Post-World War II changes in the Polish political and economic systems

The installation of 'socialism'[33] in Poland began in 1944 and was characterized by the systematic consolidation of political power in the hands of the Polish Workers' Party (PWP), which enjoyed support from the Soviet Union.[34] In 1949, the stabilization of socialist governance in the country was complete, as was the monopolization of political power in the hands of the successor to the PWP, the Polish United Workers' Party (PUWP).[35] Between 1949 and 1956, the socialist regime achieved constitutional legitimization.[36] In this period, terror accompanied the imposition of socialist ideology in Polish society (i.e. terror related to the Amnesty 1947 or to the Trial of the Sixteen). The

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[33] This term is contested in the scholarly literature (i.e. Teeple, 2005b).

[34]Through extensive repression against anti-communist political opposition and the corrupt elections of 1947, the PWP became a dominant actor on the Polish political scene. Together with its supporting and satellite parties, the PWP won majority of votes in the Polish parliament and subsequent exclusive representation in the governing bodies.

[35]In December of 1948, the Polish United Workers' Party was founded through the unification of the membership of The Polish Workers' Party and the Polish Socialist Party.

[36]The *Constitution of 1952* officially declared Poland to be the "Polish People's Republic", also implementing the principles of "people's democracy", organized around workers' and farmers' alliance and state interventionism in the economy ("Konstytucja Polskiej Rzeczypospolitej Ludowej [The Constitution of the Polish People's Republic]," July 22nd, 1952)

aforementioned political changes were conducted concurrently with the gradual installation of a state-run socialist economy. Between 1944 and 1948, the PWP introduced a centrally planned economy in Poland. At the same time, the PWP initiated the collectivization of private agricultural lands, the nationalization of Polish industry, and the elimination of private enterprise from the economic system.[37]

After Stalin's death in 1953, the political climate in Poland changed, and some political and economic reforms were introduced that 'loosened the totalitarian organization of the state. However, at this point, Poland was still isolated from the international economy (Shields, 2001). The economic problems that started to arise contributed to the Polish workers' revolt in 1970, which the police brutally suppressed. The societal dissatisfaction linked to this bloody show of force prompted the ruling party to implement a series of reforms to stabilize the political situation. Consequently, in 1970, Edward Gierek was nominated to the position of the First Secretary of the PUWP.

Gierek turned to the West for loans to bolster the Polish economy. New export agreements between Poland and a number of western European countries were put in place as a condition for providing monetary assistance to Poland. With the release of loans, Poland became less economically isolated from Western countries. At the same time, Gierek declared a policy of political openness to the West that fostered many forms of cooperation between Poland and a number of Western countries.[38] For example, as intellectual and academic cooperation started to blossom, "young academics obtained various grants to participate in exchanges with Western universities" (Shields, 2001, p. 30). Shields argues that (neo)liberal ideas introduced to young Polish intellectuals

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[37] Along with this came state interventionism and protectionism in the form of economic planning and anti-market regulation of prices and wages.

[38] The process of change in the economy and in social systems occurred in spite of attempts at the ideological and political level to confirm socialism as the official doctrine of the Polish state introduced through the constitutional amendment of 1976.

throughout the 1970s “shaped the framework within which the [economic] transition model was embedded” (Shields, 2001, p. 22). Various exchange programs between medical students had a similar impact. Through such exchanges, Polish scholars and students gained opportunities to learn about various ‘progressive’ reforms, including those of civil commitment law. Thus, in this context, ideas that shaped civil commitment reforms in Western Europe and in the United States travelled to Poland and influenced the direction a new generation of psychiatrists schooled in conducting civil commitments in Poland. In this sense, ‘Gierek’s era’ created an opportunity for the introduction of a broad range of Western ideas to Poland. Despite the fact that Gierek’s era only lasted a decade and resulted in a serious debt crisis, it formed part of the impetus for the future implementation of (neo)liberal reforms in Poland, including civil commitment reforms.

The (neo)liberal transformation in Poland officially began in 1989 with the collapse of ‘socialism’ in Poland. The political, economic, and social situation in Poland changed with the official introduction of a (neo)liberal market economy. Further (neo)liberal-inspired changes in the organization of the state’s political, economic and social systems accompanied Polish aspirations to enter the European Union. External pressures emerged to adopt (neo)liberal logic in the organization of social services and to make changes in the legal system necessary to meeting the standards required by international institutions. Such pressure to reorganize services according to (neo)liberal standards had significant impacts on the process of civil commitment reform. It impacted the reorganization of psychiatric care. It also contributed to shifts in the framing of rights of civilly committed people by informing the concept of the individual in Polish post-socialist society.

4.2.2 The organization of health care in Poland

The organization of the welfare system in the Polish People's Republic reflected socialist political premises and the centralized organization of the economic system. Correspondingly, the Polish state guaranteed universal health care to all of its citizens, with a broad spectrum of services financed by public resources.[39] The organization and financial functioning of this system were coordinated and administered at the national level. According to Kozierkiewicz, Trąbka, Romaszewski, Gajda, & Gilewski (2005), the health care system in socialist Poland represented a "public integrated model," in which "the government was both the principal insurer and the major provider of services, via health facilities owned and administered by regional representatives of the government" (Kozierkiewicz, et al., 2005, p. S 58). Sokołowska and Moskalewicz (1987) claimed that, in the late 1980s, the public health sector embraced "95% of [the] country's health personnel, resources and services" (p. 764). However, even though they were few in number, private practice and cooperative health providers existed as well (Sokołowska & Moskalewicz, 1987). Nonetheless, the state only funded from public money services provided by the socialist sector and delivered them to citizens without additional payment.

In the early 1980s, initiatives toward the decentralization of the health care system emerged as a response to its malfunctioning (Sokołowska & Moskalewicz, 1987). The final stage of these reforms occurred after 1989 when, with the collapse of socialism in Poland, the country shifted its ideological position towards 'liberal democracy' and the 'market economy.' These reforms established the basis for health care reforms, implemented in the 1990s, to decentralize both responsibility and

[39]The principles of social justice were asserted in the 1952 Polish Constitution ("Konstytucja Polskiej Rzeczypospolitej Ludowej [The Constitution of the Polish People's Republic]," July 22nd, 1952), and realized in the form of universal access to social services and the broad scope of these services.

management of health care and to redefine the role of the state (Kozierkiewicz, et al., 2005, p. S 58). The collapse of the socialist regime in Poland, and the resultant socio-legal transformation that unfolded during the first few years afterwards did not immediately bring any substantive changes to the health care system (Krajewski-Siuda & Romaniuk, 2008; Sitek, 2008).

These two distinct reforms provided competing visions for the organization of the national health care system. The inherent contradictions involved: 1) the implementation of decentralized or centralized models of health care; 2) the understanding of the right to universal health care; and 3) the organization of the health delivery system around "free competition" between service providers. Despite these differences, the health care reforms aimed to "reduce the role of the state and break with the legacy of bureaucratized and unaccountable structures of [the socialist] system" (Sitek, 2008, p. 40).

The health care reform of 1997, implemented in 1998, restructured the financing of health care in Poland. Until 1998, the health care system in Poland was predominately funded from the state budget (Sitek, 2008, p. 41). This reform envisioned "decentralization both on the level of payers and on the level of the organization of health service providers, where the role of the local government was significantly increased" (Krajewski-Siuda, et al., 2008, p. 154). This Act on Public Insurance of 1997 introduced 16 regionalized "sickness" funds and one branch fund for uniformed services (such as military, police, etc.), which assumed the state's responsibilities for the financial management of health care delivery (Krajewski-Siuda, et. al, 2008; Sitek, 2008).[40] Those "sickness funds" contracted service providers to deliver health services (Sitek, 2008, p. 41). Due to the problems with implementation of this reform and shifts in political

[40]Krajewski-Siuda, et al. (2008) argued that decentralization was primarily achieved "through devolution and to smaller extent by delegation and privatization" (p. 154).

representation, between 2001-2003 this model was re-centralized.[41] A single central agency, the National Health Fund (NHF), was established to distribute public funds through contracts with service providers and to define a catalogue of services (a so-called basket of services) funded with public money (Kozierkiewicz, et al., 2005). This meant more interventionist state policies in contracting the delivery of health services. Along with the claim of the "rationalization of purchasing", which was primarily understood in terms of cost-cutting, service providers were chosen on a competitive basis (Sitek, 2008, p. 44). The selected providers signed contracts to deliver publicly-funded health care services, up to the limits established in these contracts.[42] The decrease in state expenditures for public heath care and the strict fiscal discipline imposed on NHF and on the service providers created problems with reconciling the principles of universal health care and equal access to health services, as enacted in art. 68, par. 1 of the 1997 *Constitution* (Sitek, 2008; Śliwka, 2008).[43]

Significant shifts in the restructuring of the ownership of health care facilities also accompanied changes in the financial organization of Polish health care. Beginning in 1991, the ownership of facilities gradually became decentralized, and local and municipal governments became responsible for financial maintenance of facilities under their ownership (Sitek, 2008).[44] Privatization of primary care facilities proceeded more quickly than the restructuring of hospital networks. State-owned hospitals received the

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[41]The *Act on Universal Insurance from the National Health Fund*, 2003. Dz.U. 2003, no 45, item 391.

[42]Art. 68 par. 1 of the *Constitution* ("The Constitution of the Republic of Poland," April 2nd, 1997) guaranteed to citizens, among other social rights, the right to universal health care and equal access to publicly-funded facilities (Kozierkiewicz, et al., 2005).

[43] The decision about the contents of "the basket" was previously within the sphere of competence of the Regional Insurance Health Funds, and is now under the competence of the NHF. For example, the NHF can deny reimbursement to a care provider if a claim is over the contracted limit. Correspondingly, the Polish Constitutional Tribunal and the Supreme Court have reaffirmed that universal health care should no longer be equated with unlimited health care, but rather with a basket of services, determined in consideration of the state's fiscal and budgetary limits.

[44]The *Health Care Centres Act*, 1991, Dz.U.1991, no. 91, item 408.

status of non-profit organizations, which allowed them to compete for state contracts (Sitek, 2008, p. 42).

Although the post-1989 reforms of the Polish health care system proceeded in a unified direction toward the privatization of the public health system, they were poorly designed, provided inconsistent solutions, and were reflective of political fluctuations (Filinson, Chmielewski, & Niklas, 2003; Śliwka, 2008). Nonetheless, the organization of the health care system in Poland shifted towards a market and consumer driven (neo)liberal model despite state interventionism in the form of the NHF.[45] The changes also encouraged an increased emphasis on self-management and self-sufficiency, which pressed the need for specialization and professionalization. The adaptation of (neo)liberal ideology in Poland, and the concurrent dismantling of the system of social services financed by the state, also influenced the discussion about the rights of mentally ill people in the later stages of civil commitment reforms. The ongoing changes in the political economy and the restructuring of health care also put pressure on reformers working in the field of civil commitment to intensify the work on the draft *Mental Health Protection Act* in the early 1990s and to establish psychiatry as an organizationally independent sector of the health care system (distinguished form other medical fields) with its own financial needs ("Patients' rights hearing," 1994).

4.3 The *Instruction of the Ministry of Health and Social Welfare* of 1952

Beginning in 1952, the *Instruction of the Ministry of Health and Social Welfare* ("Instruction," 1952) governed involuntary admission to psychiatric facilities in Poland.

[45]The Polish Supreme Court has predominantly argued that the contracts between the NHF and service providers have the attributes of civil contracts between equal parties; however, some legal theorists argue that these contracts exhibit features of administrative obligatory relations (Śliwka, 2008, pp. 60-67).

The regulation of psychiatric admission in the 1952 Instruction constituted a departure point for Polish civil commitment reforms. It took more than three decades to enact a new provision that would reorganize the civil commitment process in Poland.

The 1952 Instruction promoted a medical model of civil commitment that was based on “preventive social medicine” ("Instruction," 1952; Rose, 1986, p. 184). This model tended not to differentiate between treatment of mental and physical illness, arguing against the necessity for legal formalities during the admission process. Such formalities were seen as only preventing the early voluntary admission of patients for treatment and creating unnecessary stigmatization of psychiatric treatment (Rose, 1986, p. 185).

Thus, the 1952 Instruction did not distinguish between involuntary and voluntary admission to psychiatric hospitals in Poland (“Instruction,” 1952). A patient was admitted to psychiatric hospitals at her or his own request, at the request of her or his family, or of a person having custody over the patient, or at the request of a prosecutor or a court (para. 1 of the “Instruction,” 1952). Admission to psychiatric hospitals was based upon a general practitioner’s statement of the need for psychiatric hospitalization. Only in emergency cases, if a patient was particularly dangerous to him or herself or to other people, could a doctor from a psychiatric hospital issue an initial decision (para. 2). The admission decision of a hospital psychiatrist was authorized later by the principal director of the hospital or authorized doctor (para. 3). Similarly, release from hospital was granted at the request of the patient or at the request of her or his family, and needed confirmation from the hospital director or doctor that the patient no longer required in-patient care. A release was also issued in cases in which the treatment was not completed but the patient was no longer seen as particularly dangerous (para. 6). The director or the authorized doctor had the right to reject a patient’s request for release if that patient was particularly dangerous (para. 6(4)). The Instruction did not regulate

psychiatric coercion or general justifications for using medical coercion, nor it did include provisions regarding patients' procedural rights in the process of admission and coercive treatment. Along with the Instruction regulations, medical professionals held powers to make independent decisions on a broad spectrum of matters, including diagnosis of mental illness or the need for psychiatric in-patient care. At the same time, throughout the process, the patient could withdraw from any medical treatment and request release from the hospital. However, the 1952 Instruction did not provide any procedure to appeal from psychiatrists' decisions, nor did it provide any procedural guidance for civil commitment admission and release decisions ("Instruction,"1952).

The Polish 1952 Instruction, similar to the "open door policy" discussed by Rose (1986), tried to integrate the psychiatric field with the field of general medicine and, thus, to avoid stigmatization and social marginalization of mentally ill patients (Rose, 1986). This approach was reflected particularly in the structure of the Polish health care system at that time, within which psychiatric care belonged organizationally to general hospitals. This created financial and organizational unity between psychiatric and general health care delivery in Poland. Psychiatric care was organized using: 1) a system of psychiatric outpatient clinics in local health centres; 2) a network of large- and medium-sized psychiatric hospitals and psychiatric wards in general hospitals; 3) short-stay hospitals and "domiciliary [home] care facilities"; 4) "sheltered workshops for mentally and severely retarded patients"; and 5) nursing homes (Dąbrowski, 1978, p. 128). This unity became predominately contested by psychiatrists involved in civil commitment reforms causing the finically disadvantaged situation for psychiatric health facilities, which claimed to be underfinanced, and thus in very poor physical condition (Sokołowska & Moskalewicz, 1987). Enacting separate mental health legislation was seen as a way of

improving the financial condition of the psychiatric care system and of providing better standards of care for patients, as envisioned by Polish psychiatrists.

4.3.1 Critiques of the 1952 Instruction

The Instruction was criticized with respect to: the established model of civil commitment and its legality.

Specifically, in the 1970s the critiques centred on:

(1) the Instruction's lack of protocols for voluntary and involuntary admission;

(2) the role extended family played in the process of initiating hospital admission;

(3) the Instruction's failure to meet constitutional and conventional standards for preventing deprivation of personal liberty and to provide for an independent appeal body; and

(4) the fact that legal standards of specialization required from doctors making admission decisions were too low (Dąbrowski, 1978, 1997; Gostin, 1978).

Particularly, such critiques was issues by the 'new' generation of Polish psychiatrists who due to the Polish political climate of openness became exposed to ideas circulating in Western psychiatry and who established affiliations with Western academic networks. This group of psychiatrists became the leading power in Polish rights-based reforms.[46]

The psychiatrists who took the lead in the Polish civil commitment reforms in 1972 Polish reformers perceived Western civil commitment reforms as models for reforms in Poland. They proposed a move from a strictly medical model to a legal or mixed model. The medical model of civil commitment, in contrast to the legal model, is concerned with "the treatment needs of mentally ill" (Appelbaum, 1984, p. 133). The

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[46] For example, Stanislaw Dabrowski, a leading person of Polish civil commitment reforms, published broadly in international journals (Gostin, 1978; Hoffman, 1978).

medical model of civil commitment reform frames patients' rights predominately in terms of treatment efficiency, and adequate medical standards of care.

The critique pointed to the need to reformulate the grounds for civil commitment by narrowing those grounds and monitoring admission decisions. Reformers proposed to distinguish the grounds of voluntary and involuntary admission, and to establish distinct procedures for each kind of admission. Seeing involuntary admission as a serious departure from the principle of self-determination and as a deprivation of personal liberty, reformers proposed to enact strict criteria, listed and defined, for this type of admission. Proposed regulations were to ensure the protection of patients' rights and to limit unnecessary admissions (Dąbrowski, 1978).

According to the legal model of civil commitment reforms, strong claims to legality were embraced. The lack of civil commitment law was perceived as constituting a state of lawlessness that endangered the interests of both patients and practitioners (Dąbrowski & Kubicki, 1994; Paprzycki, 1996). Poland's ratification of the *International Covenant on Civil and Political Rights* in 1977, and of the European *Convention for the Protection of Human Rights and Fundamental Freedoms* in 1994,[47] and the need to comply with convention obligations, further bolstered the reformers' insistence on the formalization of involuntary admission procedures by way of a separate legislative act. Reformers argued also that the 1952 Instruction was not a law-ranked regulation, but rather an administrative provision.[48] In this sense, Polish law did not have provisions for the deprivation of liberty in the context of psychiatric hospitalization that would meet

[47]Poland joined the Council of Europe in 1990, and four years later officially ratified the *Convention for the Protection of Human Rights and Fundamental Freedoms.*

[48]In the legal system in Poland, an instruction was a source of administrative law that regulated the administrative functioning of institutions. It did not have the status of a legal source that established citizens' rights and obligations. Such sources could only be created by legal acts of Parliament. The *Constitution of 1952* stated that one's personal liberty could only be violated under conditions established by law. In the 1990s, the statutory requirement for the deprivation of liberty was also transferred into art. 87 of the *Polish Provisional Constitution* ('the Petite Constitution of 1992') (Dąbrowski & Pietrzykowski, 1997, p. 16).

international standards, for example, of the International Covenant on Civil and Political Rights of 1966 (Dąbrowski, 1997; Dąbrowski & Kubicki, 1994; Paprzycki, 1996; "Patients' rights hearing," 1994).[49] Also, according to art. 5-1 of the European *Convention on the Protection of Human Rights and Fundamental Freedoms* of 1994, which Poland became a signatory to in 1993, a person can be deprived of liberty only within the procedures prescribed by law (Niveau & Materi, 2007, p. 60). At this time reformers suggested that the Polish state was at risk of breaching provisions because of illegal psychiatric detention and could be liable to pay financial remuneration to those illegally committed (Dąbrowski & Pietrzykowski, 1997, p. 16).

Additionally, reformers pointed out that the 1952 Instruction did not have inscribed legal tools to ensure procedural justice and assess psychiatric coercion. Therefore, they argued for the necessity of enacting a new legal framework to civil commitment processes based on the model of liberal rights and the rule of law. Reformers hoped to equip patients with legal remedies to fight psychiatric abuses. They envisioned the new regulation as ratification of the formal rights of patients that would ensure patients' dignity and autonomy and limit abuses of psychiatric discretion. However, they also aimed to establish boundaries of psychiatric professional responsibility that would prevent psychiatrists from being accused by patients of illegally using physical restraints (Dąbrowski, 1978; Kiejna, 1997).

It was imagined that the new law would also have broader implications and would go beyond the regulation of civil commitment and the rights of civilly committed people. Reformers wanted the new act to encompass provisions concerning the reorganization of psychiatric service delivery systems, the rehabilitation of people suffering from mental illness, and the coordination of a broad range of activities related to the promotion of

[49] In Poland, treaties ratified by Parliament are legally binding for Polish authorities, but for citizens provide grounds for legal claims against the state for not following the letter of international provisions. Such ratified treaties become part of the Polish legal system.

mental health (Kiejna, 1997). The new act was also meant to provide a financial and organizational framework for a system of community and outpatient psychiatric care. [50]

This reorganization of the psychiatric system was presented as a way of advancing patients' rights to quality treatment, rather than as a way of professionalizing Polish psychiatry and establishing it as an autonomous and specialized branch of medical care. However, the initial ambitions of reformers to create a comprehensive psychiatric act were subjected to various modifications and adjustments. This was particularly due to organizational shifts in the supervision of civil commitment reforms and the political and economic pressure towards civil commitment reforms that emerged in the early 1990s. One of the major incentives toward narrowing the scope of mental health services resulted from changes in the Polish political, economic and social systems with the transition to a (neo)liberal market and liberal democracy. In line with this, in the early 1990s pressure to reduce and partially privatize social services, gained momentum in the context of Polish aspirations to join the European Union and subsequent economic adjustments. Enacting separate mental health legislation was seen as a way of improving the financial condition of the psychiatric care system and of providing better standards of care for patients, and at the same time responding to the (neo)liberal pressure toward self-sufficiency of medical facilities.

4.4 The trajectory of civil commitment reforms

The trajectory of Polish reforms of civil commitment law is closely linked to the above-noted broader systemic changes in Poland. These processes have shaped the direction of reforms to psychiatric civil commitment and have impacted the framework of

[50] Rose (1986) points to a similar tendency in England and Wales to broaden outpatient services though reforms to civil commitment processes. Community services were intended to provide an alternative to the institutionalization method of psychiatric treatment; there was also an argument that patients had the right to receive psychiatric treatment in the least restrictive setting (p. 189).

rights of civilly committed people. Polish civil commitment reforms were lengthy and complicated. They involved stakeholders from various governmental agencies, professional bodies and psychiatric and legal practitioners. They also lasted throughout the transition from a planned economy to a (neo)liberal market and the collapse of the Soviet regime in Poland in 1989.

The changes in Poland's political climate constituted fruitful grounds for "innovative" reforms to emerge and for the transplantation of Western solutions within Poland. By 1970, ministerial agencies had already taken initial steps toward changing Polish civil commitment regulations; however, dissatisfaction arose within the psychiatric establishment (Dąbrowski, 1978, 1997).[51] Civil commitment reforms took a new turn, when, in the context of increasing Polish political and economic openness towards the West, the "new" generation of psychiatric professionals took over responsibility for conducting reforms and drafting new laws regarding civil commitment. In 1972, a "Commission of Experts" (the Commission) was appointed to lead the reform process.

The Commission included psychiatrists and some members of the judiciary, and was a professional body independent of ministerial agencies. The role of the Commission was to propose new draft legislation on civil commitment (Dąbrowski, 1978). The Commission was also a central body that organized and coordinated work on civil commitment reforms in Poland. However, when the Ministry of Justice took over the ministerial supervision of civil commitment reforms, to some extent ministerial officials became more involved in the process of legal drafting (Dąbrowski, 1997).

The Commission pushed Polish civil commitment reforms in a new direction that reflected the civil commitment reforms in Western and Northern American countries (Dąbrowski & Kubicki, 1994; Dąbrowski & Pietrzykowski, 1997). The Commission's

[51] It was pointed out by reformers that the 1970 bill prepared by the government was ill-fated due to the many problematic provisions it contained regarding patients' rights.

primary goal was to replace the 1952 administrative regulation, the Instruction, with a statue, of a higher legal rank, since the fact that the Instruction was of such low rank contradicted national and international legal standards required for laws depriving people of their liberty. To ensure the success of reforms, the Polish Association of Psychiatrists organized a public debate about the proposed draft at the very beginning of the reform process. The year-long debate took place between June 1974 and July 1975. It included educational meetings with psychiatrists, whom the reformers met in person. They also met members of legal or religious groups. The judiciary and the public prosecutor's office had representatives at all of these meetings. The broader public discussion was conducted through the press, radio and television.

According to the key person in Polish reforms, psychiatrist Stanisław Dąbrowski, the debate was "to crystallize the primary assumptions underlying the new legislation, for overcoming resistance, and for developing a common alliance between competing parties" (Dąbrowski, 1978, p. 125). In addition to gaining acceptance and feedback on the existing drafts of civil commitment legislation from interested professionals, the function of the public debate was also to gain broader social acceptance for the new framework of reforms.

After the end of the debate, the Committee argued that the 'public' debate proved several things. It demonstrated: 1) the need for separate legislation; 2) the need for a complex regulation that included the promotion of mental health and service delivery; 3) juridical control of civil commitment and the need for narrowed grounds of civil commitment; and, 4) the need to increase the safeguarding functions of the new legislation. In fact, these were ideas that reformers promoted; they were a reflection of a broader trend in civil commitment reforms. However, the public debate also revealed multiple points of opposition to the legislation. The reformers dismissed the oppositional voices, suggesting that they came from a group of 'old' psychiatrists preferring medical

discretion and personal judgments in decision-making regarding civil commitment (Dąbrowski, 1978). Nevertheless, the disagreement between the old' and the 'new' generation of psychiatrists shows that the new civil commitment framework modelled on foreign civil commitment reforms did not receive broad nation-wide support as it has been suggested.

In 1975, the Commission submitted the first draft of the new legislation to the Ministry of Health and Social Welfare (MHSW) for revisions and comments; discussions surrounding the project continued for five years. Until 1985, the MHSW took a critical stance toward the need for separate mental health legislation. Nevertheless, the third version of the draft made its way to the legislative council, where it received positive feedback. However, it never became a law due to opposition from the Solidarity movement, which criticized it for providing tools for the control of political dissidents (Dąbrowski & Kubicki, 1994).

During the final phase of the reform process, between 1985 and 1994, the fourth and fifth (final) versions of the act were prepared. In 1989, due to long inaction on the legislative project, the Ministry of Justice took over coordination of the reform process. Work in the Ministry of Justice was plagued by difficulties due to conflicts between ministerial lawyers and other legal and medical experts in the late 1980s regarding the need for separate legislation on civil commitment (Dąbrowski, 1978). Thus, conflict emerged between ministerial lawyers and other legal and medical experts regarding the need for separate legislation on civil commitment occurred (Dąbrowski, 1997). Legal experts proposed including procedural provisions regarding civil commitment among other procedural provisions regulated by the Polish *Civil Procedure Code* of 1964 (CPC). This meant that a significant number of issues, particularly the organization of the system of mental health promotion, as well as the system of community care, would

remain without a separate legal enactment. This initiative from the Ministry of Justice created strong opposition from psychiatric care stakeholders as not providing a comprehensive solution to the problem (Paprzycki, 1996). For one thing, this proposal tended to undermine psychiatrists' efforts toward having separate psychiatric legislation and could have disqualified future claims for separate psychiatric legislation that would allow for the expansion of mental health services.

As a defence, the psychiatrist reformers pointed to the high specificity of the psychiatric domain as what distinguished it from 'general medicine' and thus justified the reification of separate legislation and a distinct legal framework appropriate to the psychiatric field. For example, Dąbrowski (1978) argued:

> The general principles regarding the examination, treatment and rehabilitation of mentally disturbed individuals (...) that define the legal contours of the physician-patient relationship in order to safeguard the constitutional rights of individuals as well as the ethical mandate of the medical professions (...) require expression in a mental health act because, even though they are commonly observed for medical patients generally, their applicability to mentally disturbed individuals has been questioned in actual practice and in psychiatric hospitals where they have often been ignored. (p. 130)

In the end, reformers managed to enact separate legislation; however, the scope of the new act had been narrowed. Such 'necessary' reductions included the scaling back of provisions regarding the establishment of the General Council for the Protection of Mental Health, and of provisions regarding rehabilitation, employment and social security for mentally ill people due to the fact that those matters had been already regulated in

other concurrently enacted legislation (Dąbrowski & Pietrzykowski, 1997).[52] There were a number of recently enacted acts in the field of health care that overlapped with issues covered by the draft of MHPA. For example, the *Health Care Centres Act* 1992 already regulated patients' rights, as well as the doctor-patient relationship, and competed with provisions that were proposed as being essential to the new *Mental Health Protection Act*. The *Health Care Centres Act*, as well as other similar legislative initiatives, threatened to jeopardize Polish psychiatric professionals' efforts toward ratification of the mental health act that had already been 25 years in the making. Psychiatric reformers were under pressure to immediately finalize and ratify the MHPA, despite the recognition that there were still many shortcomings in the draft (Paprzycki, 1996; Patients' rights hearing," September 5th, 1994). After months of intensive work, beginning with the draft's initial submission to the Polish Parliament in January 1994, the Sejm (lower chamber) proclaimed the act in August 1994. The MHPA was ratified on August 19, 1994. One month later, the Senat – the higher chamber of Parliament – accepted the MHPA without additional adjustments. On January 21, 1995, after three months of *vacatio legis*, the MPHA came into force (Dąbrowski & Kubicki, 1994).[53]

4.5 Conclusion

In this chapter, I have presented the trajectory of civil commitment reforms in Poland in order to illuminate how a particular framework of rights emerged in Polish civil commitment reforms and why it took a particular shape in the 1994 MHPA. I demonstrated that the Polish civil commitment reforms that resulted in the enactment of the MHPA did not occur in a political, economic or social vacuum. They occurred in

[52] The goal of the fourth version was to make the project compatible with the new project of the *Health Care Centres Act*, 1992.

[53] In Polish civil law systems, the term *vacatio legis* refers to the period between the ratification of an act and the date it comes into force.

favourable political conditions that made possible the implementation of a particular vision of reform. Civil commitment reforms lasted almost three decades. They came to completion on August 19th, 1994 in the context of economic pressures inspired by Polish aspirations to join the European Union and adjustments to a (neo)liberal economy (Patients' rights hearing, 1994). The civil commitment reforms, adopted by Polish psychiatrists engaged in the drafting process, were modelled on reforms introduced in Western Europe and North America which aimed to provide legal standards of civil commitment and to formalize patients' rights.

5: A PARADIGM OF RIGHTS IN POLISH CIVIL COMMITMENT REFORMS AND UNDER THE *MENTAL HEALTH PROTECTION ACT*, 1994

5.1 Introduction

In this chapter, I will provide an analysis of rights discourse that circulated within civil commitment reforms in Poland and found their crystallization in the rights framework of the *Mental Health Protection Act* of 1994 (MPHA, 1994). In my analysis, I will pay particular attention to the narratives of reformers that rationalized the introduction of rights-based reforms to civil commitment regulation. I will try to answer the following questions: What kinds of rights discourse circulated throughout the reform period and which ones later informed the shape of legal changes? What model of rights was enacted in the MHPA and what are the implications of this model for people deemed mentally ill? In this way, I will attempt to unveil the underlying rationalization for the use of liberal regimes of rights in the quest to improve the situation of mentally ill patients in Poland.

This chapter will be organized in three sections. The first section will present the discourse of rights that circulated during Polish civil commitment reforms while the second section will outline the MHPA rights provisions with respect to the rights of civilly committed people. The last section will contain a critique of the contemporary Polish rights regime in the mental health law and an analysis of the potential of Polish civil commitment regulations to ensure equal treatment of mentally ill people. My focus is on the legal regime of rights and the discourse that accompanied civil commitment reforms in Poland and reflected a particular vision of the individual which was then enacted in the

1994 MHPA.[54] I hope to illuminate the discrimination and marginalization of mentally ill people inherent in the foundation of modern law by exposing the liberal conceptions underpinning the construction of rights of civilly committed patients in Poland.

I argue that the institution of civil commitment represents a broader process of exclusion and marginalization of mentally ill people in contemporary capitalist societies, in which mentally ill people are relegated to less-than-fully-human status. Liberal law, with its intrinsic assumptions about what it means to be human and a fully-developed legal subject, provides justification for the differential treatment of mentally ill people based on their utility to the capitalist system, and their capacity to meet the standards of a liberal individual crucial to the functioning of liberal democracy. I will suggest that, while the changes that were implemented in civil commitment law in Poland did change the status of people undergoing civil commitment by providing them with procedural rights, this fact did not change their inferior social position. These reforms did not challenge the premises of the capitalist system or of liberal rights that established the normative model of an individual though which the subordination of the mentally ill in modern Western societies is rationalized.

5.2 The discourse of rights in Polish civil commitment reforms

With the Polish politics of openness to the West and multiple forms of academic collaboration during the 1970s, young Polish scholars were exposed to the ideas circulating during Western civil commitment reforms (Frydman, 1983; Gostin, 1978; Hoffman, 1978). Similar to Western civil commitment reformers, Polish reformers emphasized the role of statutory changes that would formalize the procedural rights of civilly committed patients and provide legal safeguards for civil commitment processes.

[54] Thus, a critical analysis of the provisions of the MHPA prescribing the rights of civilly committed people in Poland will constitute the main part of this chapter.

Polish reformers adopted a rights-based model of reforms that was grounded in liberalism and, as such, set the 'liberal individual' as the normative model for civilly committed people. Liberal rights discourse constructed reformers' understandings of the concept of the human and the conditions that would ensure the optimal functioning of that individual human. The unquestioned acceptance of the liberal model in the conceptualization of rights and legal reforms indicates that, beyond reformers' declarations, the problem of the equality of mentally ill people was not taken seriously. The prominence of liberal rights discourse throughout the entire process of Polish civil commitment reforms, despite the influence of diverse political, economic and social regimes, speaks to the depth of the marginalization of mentally ill people and how ingrained it is in modern societies.

In the narratives of the reformers, rights have been presented as remedies that enhance individuals' capacity to effectively challenge instances of psychiatric discretion, limit the use of psychiatric coercion and provide possibilities for patients to participate in decisions regarding their admission to mental hospitals and subsequent treatment. Accordingly, they argued that the advancement of a patient's rights, modelled on Western reforms, could be only achieved through the implementation of legal procedural safeguards and separate protective legislation (Dąbrowski, 1978). Thus, it was thought that enacting a protective law that would regulate the process of involuntary admission and construct clear standards for the use of psychiatric coercion would reduce psychiatric abuses in civil commitment. Reformers particularly highlighted the existing wrongful practices of admitting to patients psychiatric facilities involuntarily, without first examining them; carrying out treatment without patients' consent, persuading patients to undertake work without pay; controlling their correspondence; using restraints on difficult patients for the convenience of hospital personnel; and distributing patients' personal

information against their will (Dąbrowski, 1978;Dąbrowski, 1988; Dąbrowski & Kubicki, 1994, p. 7).

This rationale presented by Polish reformers correlated with debates that were already circulating in the international community regarding the situation of psychiatric patients. For example, in the recommendation released by the Parliamentary Assembly of the Council of Europe in 1977 (the Parliamentary Assembly), this international body urged states to re-evaluate their legal statutes and administrative acts regarding the deprivation of liberty of people diagnosed as mentally ill, and to enact changes in national legislation that would severely decrease the number of long term involuntary commitments, cease control of patients' correspondence, and establish procedures of juridical control and of preventing the distribution of patients' personal information (Eur.Parl. Ass., Recommendation on the situation of the mentally ill, 12thSess., Doc. Nr 818 (1977), art. 13 par I and art. II.I). The correlation between international rhetoric and claims made by Polish reformers confirms the impact of the international environment on Polish civil commitment reforms.

Similar to international reformers, Polish reformers strongly emphasized the role of statutory changes and legal safeguards in achieving positive changes in civil commitment procedures. Polish reformers argued that procedural formalism and judicial supervision of civil commitment processes would ensure a proper level of accountability for psychiatrists when making their decisions. The necessity of legal accountability was directed at curbing psychiatrists' professional discretion, which, in the reformers' opinion, affected the fairness of decisions made with respect to involuntary admission to psychiatric hospitals (Dąbrowski, 1978, 1997; Dąbrowski & Kubicki, 1994; Dąbrowski & Pietrzykowski, 1998). The legal model of civil commitment reforms also relied strongly on the framework of rights, envisioned as remedies that could alleviate psychiatric

abuses (Dąbrowski, 1978; Hoffman, 1978). Procedural rights offered to civilly committed people stood as a panacea for psychiatric abuses because they created the possibility for questioning admissions and coercive treatment in court (Dąbrowski & Kubicki, 1994). At the same time, the legal model of civil commitment emphasizes the importance of rights in ensuring patients' autonomy and self-determination, which aligns with the vision of the liberal individual (Appelbaum, 1984).

From the later stages of the Polish civil commitment reforms, the rhetoric of rights shifted toward that of custody and treatment, and toward patients' rights to effective and quality care. The framing of patients' rights began to be based on a more medical model of civil commitment ("Patients' rights hearing," 1994). This shift was linked to financial changes in the Polish psychiatric system. Arguments based on the medical model dominated the discussion during the final legislative debate in the Senate committee before the MHPA was ratified in 1994 hearings ("Patients' rights hearing," 1994). However, 'effective treatment' was understood in terms of (neo)liberal standards of self-management of psychiatric institutions, financial accountability, and the limitation of the duration of psychiatric institutionalization to the necessary minimum ("Patients' rights hearing," 1994). Thus, the poor financial condition of psychiatric institutions was presented as undermining rights to effective and quality care ("Patients' rights hearing," 1994).

To summarize, despite differences in the discourse of rights that were prevalent during Polish civil commitment reforms, rights were promoted as having the potential to advance the situation of mentally ill people. Hence, the changes in the Polish political economy did not impact the course of Polish reforms in terms of their commitment to a liberal rights framework; they only contributed to changes in the framing of rights based (neo)liberal discourse. The shift from the emphasis on rights of autonomy and self-

determination to an emphasis on rights to determine treatment illustrates that reformers treated rights of civilly committed patients in an instrumental way and employed discourses of rights strategically. What is particularly suggestive of this argument is that, even though rights were meant to ensure greater engagement of patients in decisions regarding their treatment, through civil commitment reforms, patients' voices began to be excluded and patients' 'best interests' came to be defined by professional psychiatrists and lawyers. This speaks unequivocally to the disjuncture between the rhetoric of rights and the actual practice of rights during civil commitment reforms.

5.3 Rights regime under the 1994 MHPA

With the ratification of the MHPA, Polish reformers took pride in placing Poland at a level comparable with Western European democracies in terms of protecting the human rights of civilly committed patients, and in incorporating procedural justice solutions into the new civil commitment provisions.

The Polish reformers aimed to achieve goals of advancement of the situation of civilly committed patients through implementing changes to civil commitment provisions though the ratification of a new statute – the 1994 Polish *Mental Health Protection Act* (MHPA). Procedural formalism and judicial supervision were thought to ensure the accountability of psychiatrists and, at the same time, ensure that patients' rights were protected. It was hoped that a separate legal regime for psychiatric hospitalization would establish a legal framework that would regulate patient-psychiatrist relations. However, while protecting patients from abuse by psychiatrists, such as unnecessary use of coercion, it also legalized psychiatric coercion and thus established limits for patients' claims.

The Polish 1994 MHPA organizes the framework of rights around three domains: patient's liberties, the grounds for civil commitment, and the juridical supervision/control of civil commitment processes.

5.3.1 Patients' liberties

With regard to patient's liberties, the reformers argued for the reconfiguration of the principles of self-determination, informed consent, free contact and correspondence, and the principle of respect for the whole patient's needs. The principle of self-determination emphasized a patient's right to consent to all treatment, examination, and care activities. The principle of informed consent required a physician to provide sufficient information regarding treatment, procedures, and their consequences for the patient in order to guarantee her or him the opportunity to make a rational decision. Free contact and correspondence concerned aspects of patient privacy and the balance between treatment needs and other patient interests, including moral, professional, and intellectual needs (Dąbrowski, 1978, p. 130).

In spite of the broad scope of the above-mentioned catalogue, there were certain individual liberties that drew more attention from legislators in terms of possible violations. Psychiatric coercion and informed consent, for instance, were concerns that provoked particularly extensive debate during civil commitment reforms and were a source of jurisprudential controversies after the 1994 MHPA was enacted.

Rights in the context of psychiatric coercion

The common awareness that psychiatric coercion is a controversial issue, not uncritically accepted in society, motivated the reformers to implement procedural justice in civil commitment procedures (Dąbrowski & Kubicki, 1994). While the psychiatrists argued that coercion was closely tied to the function of psychiatry and that the social

control role involved with psychiatry distinguished it from other medical disciplines, they were aware that coercion needed to gain social legitimacy in order to function.[55] One of the ways to achieve this goal was to subsume psychiatric coercion under the legal framework that equipped it with the features of accountability and legalism. Alongside these claims, the psychiatric experts pointed to the necessary implementation of procedural changes to civil commitment procedures that would place psychiatric coercion under judicial supervision and create a legal framework for its exercise.

By ensuring the proper functioning of psychiatry, patients were to be protected from the extensive use of coercion and other forms of psychiatric malpractice (Paprzycki, 1996). References to legal formalism and the rule of law also accompanied the claim for the need to extend the legal framework to encompass professional relationships between psychiatrists. The experts pointed to the high specificity of the psychiatric domain as what distinguished it from general medicine and, thus, justified enacting separate legislation and a distinct legal framework appropriate to the psychiatric field.

Article 18 of the MHPA ("MHPA," 1994) provides a legal framework that regulates conditions of the legal use of psychiatric coercion. This article allows the use of direct coercion against patients with mental disorders who are seen as a threat to themselves, other people, or who destroy material items from their surroundings, or seriously interfere with the proper functioning of psychiatric facilities. The act requires that a person against whom coercion is going to be used needs to be informed in advance about such possibility (para. 18(4)). However, before psychiatrists undertake

[55] By the term social control, Dąbrowski and Kubicki (1994) mean control that is exercised through coercion and thus interferes with individual liberties, autonomy and constitutional rights. The authors do not familiarize the reader with the more direct meaning of the term 'social control'.

coercive actions against patients, the MHPA requires that patients be informed about planned coercive activities.[56]

Scholars and lawyers disagree about whether coercion can be legally used in the context of psychiatric examination of a patient. In the Polish context, the medical and legal doctrines tend to answer this question in the affirmative (Dukiet-Nagórska, 2004, p. 17). The MHPA also enables the use of psychiatric coercion even when a patient poses only an indirect threat to his/her life or the lives of other people ("MHPA," 1994, Dukiet-Nagórska, 2004, p. 17).

The MHPA does not provide an appeal procedure to adjudicate the legality of the use of psychiatric coercion in specific instances ("MHPA," 1994). According to the administrative framework for the control of psychiatric coercion - an administrative guideline promulgated by the Minister of Justice, on February 22, 1995 - visiting judges appointed by the court can assess the correctness of the medical documentation in instances of coercion, but cannot assess the legality of the use of coercion itself (Duda, 2009, pp. 111-112).

Informed consent

Closely linked to psychiatric coercion is the regulation of patients' consent in the context of psychiatry. Polish reformers adopted a conception of consent that departed from the understanding of consent under the Polish *Civil Procedure Code* of 1964. The CPC provides that a statement issued by a person who is unable freely and consciously to make decisions and express his or her will is invalid (Duda, 2009, p. 37). Reformers argued, however, that the adoption of the CPC's definition of consent would excessively restrain psychiatric patients' scope for autonomous decision-making within civil commitment. Hence, they argued that the conceptualization of consent as proposed

[56]Polish jurisprudence accepts that the goal of such information delivery is to gain a patient's consent to planned activities or treatment (Balicki, cited in Duda, 2009, p. 111).

throughout reforms and implemented in legal provision of the MHPA better responds to the needs of mentally ill patients.

Article 3(4) of the MHPA defines the meaning of 'consent' for psychiatric patients. Such consent is valid when it is expressed freely by patients with mental disturbances and is based on the understanding of information provided to the patients. Valid consent is expressed by a person who has the ability to understand the meaning of the information he or she is provided with, particularly information on the purpose of the treatment, the potential benefits of such treatment, the place and aim of psychiatric admission, etc. (Duda, 2009, p. 38). However, Dukiet-Nagórska (2004) argues that it has not been directly stated in the MHPA that every action taken with respect to a psychiatric patient requires his or her consent. Thus, a psychiatrist who has taken an action not enumerated as requiring consent can effectively defend such action based on this loophole in the law (Dukiet-Nagórska, 2004).

The lack of consent of a patient who is incapable at the time of admission to give valid consent opens the possibility for using legitimate coercion and for involuntarily admitting such a patient. The circumstances warranting the use of coercion in the process of admission also constitute the grounds for civil commitment, which need to be met cumulatively (Milik, 2007, p. 120).

5.3.2 Grounds for civil commitment in Poland

Involuntary admission to psychiatric hospitals in Poland is warranted in cases of mental illness (or mental disturbance), dangerousness posing a threat to self or others, or inability to provide for one's basic needs ("MHPA," 1994). These grounds reflect similar solutions that were enacted in other countries because of civil commitment reforms. However, similar to foreign legislation, the Polish act does not define

dangerousness or mental illness. The grounds for involuntary admission in Poland correspond with the legacy of the state's intervention into the liberty of people mentally ill under the narratives of state police power and *parens patriae*.

Along with the liberal model of civil commitment, reformers framed civil commitment as a deprivation of liberty that needed to be treated similarly to other forms of deprivation of liberty. Firstly, such framing underlined the distinction between involuntary admission to psychiatric hospitals and other general medical situations in which patients were physically restrained in hospitals (e.g. in cases of contagious disease). Secondly, reformers fostered the argument that, because civil commitment was similar to other forms of deprivation of liberty, mental health patients should have the right to equal treatment and procedural safeguards. The incorporation of the rule of law and formal patients' procedural rights was meant to ensure the principles of equality. However, the Polish reformers failed to recognize the fact that the very reforms which inspired their own efforts largely ignored the problematic underpinnings of civil commitment and, thus, the legal framework they championed as protective and progressive only obscured further systemic violence toward mentally ill people.

Currently, involuntary admission to psychiatric facilities in Poland is conducted pursuant to articles 23, 24, 28 and 29 of the MHPA ("MHPA," 1994), which refer to different types of involuntary admission. Article 23 regulates cases of involuntarily admitted individuals who are 'mentally ill'. It states that a mentally ill person can be involuntarily admitted to psychiatric facilities if that person's illness-related behaviour poses a danger to her/his life and health, as well as to the lives and health of other people. By contrast, article 24 regulates involuntary admission of a person exhibiting mental disturbances (but not mentally ill). Such an individual can also be admitted without consent if he/she poses a direct threat to his or her life and health, as well as to the lives and health of others. The purpose of admission under article 24 is to diagnose

whether the person detained involuntarily is mentally ill. Article 28 regulates instances in which a person has previously consented to her/his hospital admission but has subsequently withdrawn this consent. Finally, involuntary admission is possible if a person's health would significantly deteriorate unless she or he is admitted to hospital or when a person is incapable of autonomous living, but psychiatric treatment can improve her or his health (para. 29).

Judicial control over psychiatric decisions in civil commitment is very limited and relies heavily on psychiatric assessment. Nevertheless, a patient has a right to participate in a hearing, to access legal files, and to have an attorney represent him/her. Judicial supervision under the MHPA centres mostly on adjudication of admission decisions made without patients' consent. In a case regulated by article 23, the doctor that made the admission decision informs the hospital director. If the director approves this decision within 48 hours, then he or she is obliged to inform the Guardianship Court within 72 hours. The court then schedules a hearing to assess the admission decision. In case the director fails to inform the court, the patient himself or herself, or the patient's representative, can request such a hearing. The court adjudicates on the soundness of the decision. A similar hearing is held in cases regulated by article 29 of the act. In this situation, the court assesses the necessity of admitting a person to psychiatric hospital upon the request of his or her relatives. In instances regulated by article 28, when a person has withdrawn his or her consent, the court decides whether the person should remain in the hospital or be released (Wilkowska-Płóciennik, 2004, pp. 25-27).

The MHPA was heralded as a major departure from the model of civil commitment regulated by the 1952 Instruction. Reformers argued that the MHPA (1994) brought law and legal standards into psychiatric practices and, hence, introduced some accountability and procedural justice within the civil commitment process (Dąbrowski,

1978; Paprzycki, 1993). Claims were made that this would significantly improve the situation of mentally ill people. Rose (1986), however, points out that the legalistic approach to civil commitment needs to be problematized. It is based on the assumption that "legal reasoning provides a more just, equitable, objective, neutral and accurate mode of judgement than psychiatric reasoning; hence the latter should be subordinated to the former" (Rose, 1986, p.197). However, Western scholarly research on the functioning of judicial review in civil commitment processes provides evidence that judges depend greatly on psychiatrists' opinions, and take paternalistic positions toward the mentally ill (Arben, 1999; Pearson, 2006). According to Rose (1986),

> The move to legalize and judicialize decision-making in matters of psychiatry does not eliminate professional discretion or redress the power of expertise over those subject to it; it merely shifts discretion and power around the psychiatric system. (p. 197)

The separate legal framework of the MHPA inevitably differentiates patients of psychiatric hospitals as patients of "different categories" or "special cases" and, hence, contributes to their further marginalization and social ostracism. It has also "freed doctors from accusation of wrongful confinement and minimized the contentious nature of commitment decisions," in this sense reaffirming the legacy of civil commitment and the power of psychiatrists within civil commitment (Rose, 1986, p. 2003)

5.3.3 Legalism and the rule of law

The Polish *Mental Health Protection Act* of 1994 is grounded in a liberal conception of rights. This framework of rights was promoted during the civil commitment reforms in Poland and was later partially translated into the provisions of the MHPA. Despite the changes that occurred during the Polish civil commitment process, the rights

framework promoted by reformers sustained a particular vision of liberal rights and maintained the unquestioned legitimacy of paternalistic state intervention into the rights of the mentally ill.

Regardless of differences in the rhetoric of rights at the beginning of that final stage of reforms, discourses of legalism and the rule of law existed throughout the whole reform process. The formalist approach to rights, as enacted by the MHPA, has become a persistent and unifying feature of Polish commitment reforms. Reference to the obligation to comply with international legal standards was extensively discussed among reformers drafting the act, as well as during parliamentary and scholarly debates (Dąbrowski, 1997; Dąbrowski & Kubicki, 1994; Paprzycki, 1996; "Patients' rights hearing," 1994). The obligation to meet the international and national legal standards for the deprivation of liberty was a persistent impetus throughout the civil commitment reform process ("Patients' rights hearing," 1994, pp. 1, 36). For example, the lack of a dedicated mental health protection statute was even evoked as the most shameful gap in Polish medical law ("Patients' rights hearing," 1994, p. 1).

The formal legalization of the rights of mentally ill patients was grounded in liberal principles of the rule of law that promoted formal equal access to justice and to the protection of individual rights. Drawing on conceptions of universal rights to fair process and to bodily integrity, the experts formulated mental health patients' rights primarily in terms of procedural rights. These included, among others, the right to judicial control of psychiatric decisions, the right to informed consent, the right to participate in one's own hearing, and the right to a legal representative (Dąbrowski, 1978; Dąbrowski, Frydman, & Żakowska-Dąbrowska, 1986; Dąbrowski, Gerard, Walczak, Woronowicz, & Żakowska-Dąbrowska, 1979; Gostin, 1978; Hoffman, 1978).

Mental patients' rights were constructed based on the premises of legal formalism and the rule of law doctrine. Experts insisted on formal legal rights available to

people undergoing processes of admission and those exposed to psychiatric coercion. The legal formalization of rights was one of the goals to be achieved through the new legislation. Along with the adopted formalistic legal approach to rights (which was consistent with the adopted principles of modern legalism under the phrase of the rule of law), rights can acquire effective legal protection from state institutions when formally codified. Thus, from the point of view of legal formalism, only officially recognized rights provide real guarantees against psychiatric abuses and coercive treatment of psychiatric patients (Paprzycki, 1996, p. 34). Thus, to prevent an overuse of such oppressive power, reformers argued that psychiatrists needed to be held accountable for their decisions to use coercion. At the same time, within the regulatory legal framework of psychiatric coercion, psychiatrists were to be protected against potential accusations of using unnecessary physical restraint or other coercive treatment, such as involuntary admission to psychiatric hospitals. Hence, the subsuming of civil commitment within a legal framework had multiple functions that were to serve both patients and doctors.

The juridical model of civil commitment only provides possibilities for juridical procedural control of the safeguards as prescribed by law because, in practice, concepts of mental illness remain beyond the scope of courts' jurisdiction. Courts presume the correctness of psychiatric diagnosis and rely heavily on this diagnosis in civil commitment cases. Judges often feel unqualified to verify psychiatric assessment because of the need for specialized knowledge. This presumption is evident in the writing of legal scholars who claim that psychiatric literature and the regulation of the MHPA are unintelligible to persons other than psychiatrists or lawyers who are interested in psychiatry (Paprzycki, 1996, pp. 6-7). Therefore, the juridical form of civil commitment remains effective only on paper.

Gaps in procedural guarantees were already known when the act was undergoing the ratification process. During one of the final legislative debates in 1994, a number of

discussants argued that the standards for procedural justice had not actually been met by the draft of the MHPA. For example, a psychiatrist Janusz Monasiewicz, during the committee debate, pointed to the lack of provisions that usually oblige judges to adjudicate psychiatric detentions and that allow patients to appeal psychiatric decisions (which is the norm in the Polish legal framework), and of provisions governing the juridical control of involuntary psychiatric examinations of persons not diagnosed as mentally ill (Patients' rights hearing, 1994, p. 19). Regulation of involuntary admission and psychiatric coercion in the MHPA did not meet international standards as intended (Eur.Parl. Ass., Recommendation on the situation mentally ill, 12th Sess., Doc. No. 818, 1977). However, despite the contradictions and gaps in the regulation of juridical supervision that belied the draft's readiness for enactment, the majority of parliamentarians supported the ratification without requiring any further amendments.

5.3.4 The notions of empowerment and autonomy

The reformers' legal model envisioned the law as playing a significant role in the civil commitment process, incorporating the formal legal rights of mentally ill people into statutes, and relying on the rule of law and procedural justice.[57] Rights were perceived as tools for empowerment.

The advancement of liberal rights was featured as the primary goal of civil commitment reform and the narratives accompanying these reforms highlighted the importance of the right to self-determination for mentally ill patients, to judicial review of psychiatric decisions, and to stricter grounds for admission to psychiatric hospitals. The legal model relied strongly on the vision of a liberal individual for whom civil liberties and legal protection were considered fundamental values. "Empowered by entitlement and

[57] The meaning of the term of 'the rule of law'' is discussed in footnote no. 15.

utilizing the mechanisms of the law, [civilly committed people] could demand and obtain their rights. Hence, they would acquire the capacity, and responsibility, to effect change in their own condition” (Rose, 1986, p. 190). The rhetoric of autonomy and self-determination shows that the institution of informed consent depends on the liberal discourses of subjectivity based on “the legal fiction of a freely choosing, rational subject with rights to personal autonomy” (Rose, 1986, p. 200). Rose (1986) further argued that both law and psychiatry operate within the same intellectual formation of rationality “that gave birth to the concept of the individual free to choose” (p. 200). In both law and psychiatry, a person’s degree of maturity is measured by his or her ability to employ self-determination and rational thought (Kapur, 2007). Nevertheless, even the limited scope for consent expressed by mentally ill people was thought to bring them closer to the ‘ideal’ of the rational and mature liberal individual. In this sense, informed consent itself served as an empowering strategy, which was nevertheless presented in a way that obscured its underpinning values.[58]

The notion of valid consent in psychiatric civil commitment processes is also problematic in another sense. Under the rhetoric of autonomy, psychiatric persuasion and paternalism is minimized. The idea of consent was heralded and proposed by reformers as an advancement of patients’ opportunity for self-determination. In reality, this autonomy relied heavily on psychiatric decision-making regarding the validity of such consent. Hence, before a patient is provided with the right to express informed consent, the psychiatrist assesses the patient’s ability to understand the meaning of such consent and other relevant information. This assessment is conducted against the standards of the rational person who can choose between different options (Dąbrowski & Kubicki, 1994, p. 17). In addition, physicians are allowed to initiate ‘indispensable’ therapeutic

[58]Rose (1986) also claims that “the role of much compulsory civil commitment and treatment in contemporary psychiatry is not to destroy autonomy of the subject but to construct autonomous subjects” (p. 202).

procedures and, if necessary, to even use physical restraints in order to remove an immediate threat to the health or life of either the patient or of others (Dąbrowski, 1978, p. 132). Hence, a patient's lack of consent can be overridden by a psychiatrist's decision regarding the existence of circumstances that 'justify' pursuing activities to which the patient did not consent. In particular, this situation exists in the involuntary admission of dangerous patients. This regulation reinforces the presumption that coercion is justified in emergencies because patients would recognize the benefits of involuntary treatment once their mental health improved. Thus, regardless of the rhetoric of respect for patient autonomy, a paternalistic vision informs the professional understanding of the 'patient's best interests' and shapes the practice of civil commitment.

The rhetoric of respect for patient autonomy and self-determination was also co-opted, in Poland as well in the USA, into the strategies for the advancement of effective treatment for mentally ill people (McKenna, et al., 2001). Patients' involvement in civil commitment procedures made them more compliant with treatment. Dąbrowski (1978) argued that:

> The need to define the requisite criteria narrowly results from the necessity to respect the autonomy of the individual as well as from an appreciation of the therapeutic imperative which holds, generally speaking, that consent for treatment is a fundamental prerequisite for its effective treatment (p. 132).

Hence, the right to consent was also a way of empowering patients to realize the 'benefits' of their treatment (Dąbrowski & Kubicki, 1994, p. 17). In this sense, rights served treatment ends, assuming that patients would comply better when persuaded that the decision to undergo treatment was their own. The language of liberal rights was used as a framework that had the potential to empower mentally ill people, even though the voices of those who were supposed to benefit most from the MHPA were silenced.

5.4 Liberal rights as tools for social change

Dąbrowski and Pietrzykowski (1997) argued that, with the ratification of the MHPA, Poland was placed on a level comparable with countries that had specific legislation to guarantee the rights of civilly committed patients and which secured adequate treatment responses for the needs of the mentally ill; such treatment was to be issued with respect to the dignity and autonomy of patients. In Poland, optimism towards rights as a framework to guarantee justice in civil commitment procedures was expressed despite exposure to the failure of advancing patients' rights in practice following North American and Western European civil commitment reforms. As argued above, Western civil commitment reforms that heralded the advancement of psychiatric patients' rights were also grounded in the liberal model of rights and the state's paternalistic power over mentally ill persons. As discussed in previous chapters, critical psychiatric and legal scholars have exposed the shortcomings of the rights approach for perpetuating marginalization through the legitimization of diminished rights for civilly committed patients.

A critical analysis of the construction of rights during the Polish civil commitment reforms, and of the legal formulation of rights adopted in the MPHA, reveals the falsity of the assertion that modern rights are absolute and that their application brings positive changes to the situation of oppressed persons. Instead, it is important to be aware of what Kapur (2007) called "the dark side of human rights," (p. 564) which includes a specific conception of universalism coupled with exclusion, the notion of a human that is grounded in liberal-capitalist rationality, and a rule of law that allows legal non-protection of rights in very specifically defined cases of emergency. Polish civil commitment

reforms did not question the foundation of civil commitment and the diminished rights of mentally ill people. In fact, these civil commitment reforms reaffirm the idea that mentally ill people lack the capacity to bear liberal rights and relegate the mentally ill to the status of 'inferior' humans.

Paternalism is inherent in the construction of liberal rights and shapes practices toward mentally ill people. Patients' voices were excluded from the process of drafting even though rights were intended to serve as tools to empower patients in their process of self-determination. As was demonstrated in Chapter 4, the consultation process regarding rights mostly involved psychiatric practitioners, and also, to some extent, representatives of the legal establishment. Patients' input was requested for the first time only shortly before the draft of the act was submitted to Parliament in January 1994. Years into the process of the civil commitment reforms, the voices of patients and interested groups were excluded from the drafting process (Dąbrowski & Kubicki, 1994; Paprzycki, 1996). The presumption about 'the best interests of the patients' was based on the paternalistic professional approach to the best interests of mentally ill people ("Patients' rights hearing," 1994).

The Polish example also demonstrates how freedom from coercion ended up being dependent on whose voices were heard during civil commitment debates. Intellectually challenged people, for instance, managed to achieve such freedom through the involvement of a non-profit organization representing their interests in the reform process and distinguishing themselves as a group from people considered mentally ill ("Patients' rights hearing," 1994). The presence of that organization within civil commitment reforms, and in the final parliamentary debate in the Senat (higher chamber) of the Polish Parliament, significantly affected the shape of regulations regulating the use of psychiatric coercion. The fact that Polish civil commitment law differentiated the protection from violence inflicted upon mentally challenged people and

that inflicted upon mentally ill people shows how “the subjectivity of the other [the dangerous and mentally ill] became constructed though law as distinct and external to the liberal circumstances of rights and entitlements” (Kapur, 2007, p. 542). The Polish case additionally confirms that inclusion of one group in terms of the benefit of rights runs parallel to the process of exclusion of another group. Unfortunately, a hierarchy of access to rights now exists with respect to the differentiated legal treatment of people diagnosed as mentally ill or as intellectually challenged.

The legal subjectivity of mentally ill people is modelled on a liberal subject, capable of possessing rights as an individual (Teeple, 2005b, p. 13) Therefore, no disjuncture exists in psychiatric and legal approaches to rights of mentally ill people and processes of coercive institutionalization. These two systems draw on the same liberal discourses of personhood, rights, rationality and ‘mental illness’ in a way that supports each other’s legitimacy and perpetuates inequalities embedded in liberalism and the capitalist system.

The reformulation of law that promised to improve the position of the mentally ill was fundamentally limited in the social change it claimed to bring. Changes that were implemented to civil commitment law in Poland, even though they changed the status of people undergoing civil commitment by providing them with procedural rights, did not actually change their inferior social position. Similarly, these reforms did not challenge the premises of the capitalist system and of liberal rights that subordinate mentally ill people in modern Western societies.

Nevertheless, the rhetoric of rights and the rule of law provided a pervasive legal logic that allowed the exclusion of the mentally ill to be reconciled with liberal claims to the equality of rights of all citizens. Legalistic moves by Polish psychiatric reformers to provide legal boundaries for psychiatric coercion in fact reaffirmed and obscured the

problematic legacy of civil commitment and psychiatric coercion. Similar to previously analyzed claims to formal legality, which obscured the problematic legacy of civil commitment as a paternalistic institution, deliberation regarding justice in the process of coercive psychiatric interventions masked the inferior status of mentally ill people and their further vulnerability to psychiatric abuses.

CONCLUSION

Darian-Smith argued that “in any analysis of law, it is critical to acknowledge how law operates, by necessity, as a mechanism of discrimination” (1996, p. 297). Through my analysis of the Polish *Mental Health Protection Act* of 1994, I hoped to illustrate how liberal law – with its built-in assumptions about what it means to be a human – works as a mechanism of oppression against mentally ill people in Poland. My analysis has demonstrated that the notion of the diminished rights of mentally ill people and the institution of civil commitment are based on the premises of the marketplace and of liberal democracy and that diminished rights act as a mechanism for subjugation of mentally ill people. Consequently, to ground legal reforms in the model of liberal rights is “to struggle to be equal as individuals possessing individuals’ rights” (Teeple, 2005b, p. 53); that is, to fight for a model of personhood and legal subjectivity that contributes to the legitimization of the oppression of mentally ill people (Teeple, 2005b, p. 53). Such a struggle for equal rights, as Teeple (2005b) indicated, “does not encompass the structural and intuitional reasons for continuing subordination” (p. 53), in this case, of mentally ill people.

In my thesis I have sought to expose the contradictions embedded in the construction of liberal rights and rights-based reforms to civil commitment in order to reveal the lack of potential of these rights to eliminate subordination of mentally people. By critiquing the notion of the absolute character of liberal rights, I aimed to contest the assertion that civil rights are inherent to all humans, inalienable, and indivisible, by presenting the historical development of rights, offering examples of instances in which rights were alienated from humans, and by demonstrating the hierarchical organization

of rights. Within the narratives of universality and the ability of all liberal citizens to equally access rights, ongoing processes of differentiation and exclusions are obscured. The principle of universality of rights has been refigured historically to legitimize the diminished rights of a number of social groups such as women, children, and sexual minorities, who have been as possessing the qualifications of legitimate holders of private property (Scott, 1987; Teeple, 2005b). In this way, groups who do not contribute to the prosperity of capitalist systems find their rights qualified in various ways. In the particular case that my analysis is concerned with, mentally ill people have had their civil rights restricted. Based on the presumption of dangerousness to self or others, they can be legally deprived of liberty and placed in mental health institutions.

Law here provides a persuasive rationale for paternalistic state interventions into the rights of civilly committed people. First, drawing on the underlying premises of the liberal legal order and the construction of notions of liberal subjectivity and rights-bearing capacity, liberal law constructs mentally ill people as subjects unable to care for themselves, and this rationalizes state intervention into their rights. The lack of ability of the mentally ill to care for themselves and to exhibit 'orderly conduct' is linked to the (neo)liberal notion of rationality. The rational liberal subject is one that functions optimally in market society. Hence, liberal rationality is informed by a particular set of capitalist economic values, such as autonomy, self-sufficiency, ability to manage property, individualism, etc. Subjects who disrespect these values or exercise rights in a way that contradicts the standards of capitalist market society find themselves labelled as irrational and may potentially be diagnosed with mental illness. The construction of mentally ill people as subjects unable to care for themselves was also acquired through the legitimization of diminished rights of mentally ill people. Along with the argument that only purportedly fully mentally capable individuals are able to exercise all rights

(meaning they have full capacity in contractual relations and in property relations), mentally ill people are seen as only being able to exercise some restricted rights that do not require full mental capacity. Secondly, abstract legal concepts have provided a narrative that mediates the universal claims of rights by highlighting the ongoing exclusion of groups from access to rights. Hence, my analysis suggests that, despite the rhetoric of the universality of rights, mentally ill people have been alienated from their fundamental rights.

These processes of alienation from rights (commensurable with the factual hierarchical organization of liberal rights) have far-reaching consequences for individual legal subjectivity. As legal personhood is constructed though one's right to possess as an individual, the process of alienation of civil rights from civilly committed people qualifies their legal subjectivity (Teeple, 2005b, p. 13). These processes have at least two kinds of effects on mentally ill people. First, since their rights are divisible, mentally ill people lacking property with which to exercise civil rights, still may be found capable of holding some procedural rights, such as the rights to participate in hearings, raise their concerns, access case files, and review relevant evidence. However, Failer (2002) points out that those procedural rights acquired by civilly committed people as a result of reforms exhibit features of paternalistic rights. For example, as a result of Polish civil commitment reforms, patients have acquired the right to legal representation in hearings, and to participate personally or though their appointed council; nevertheless, they do not have the right to initiate, *ex lege*, reviews of civil commitment decisions. This example illustrates that the state exercises such procedural assessments against itself "on behalf of people who cannot exercise them by themselves" (Failer, 2002, p. x). According, Failer (2002), such right is grounded in the logic of *parens patriae*, that governments

should care and provide assistance for mentally ill people because they are too sick to care for themselves" (p. 47).

Second, the deprivation of civil rights constructs institutionalized people as subjects undeserving of legal protection or as deserving lower standards of protection than those enjoyed by full citizens. Civil commitment thereby formally deprives a person of the right to liberty, self-determination and autonomy and, hence, officially justifies the subordinated legal status of the civilly committed. Consequently, the change in the legal status of the civilly committed person serves later as a reason for not protecting that person's other rights. In short, the fact that the state does not equally protect the rights of mentally ill persons constitutes them as less than human, as inferior to other citizens, and this, in turn, justifies the state in neglecting their certain of rights.

The central focus of this thesis was the investigation of civil commitment reforms in Poland. The analysis was conducted to find out what the rationale, narratives and processes were that shaped the MHPA, which regulates civilly committed people in Poland. My analysis has revealed that Polish reformers adopted a rights-based model of reforms that was grounded in liberalism and, as such, set the 'liberal individual' as the normative model for civilly committed people. Liberal rights discourses underpinned reformers' understandings of the concept of the human and the conditions that would ensure the optimal functioning of that individual human. The unquestioned acceptance of the liberal model in the conceptualization of rights and legal reforms indicates that, beyond reformers' declarations, the problem of the equality of mentally ill people was not understood, and therefore taken seriously. The prominence of liberal rights discourses throughout the entire process of Polish civil commitment reforms, despite the influence of diverse political, economic and social regimes, speaks to the depth of the

marginalization of mentally ill people and the ingratiation of hegemonic liberal constructions in modern societies.

Similar to international reformers, Polish reformers strongly emphasized the role of statutory changes and legal safeguards in achieving positive changes in civil commitment procedures. Polish reformers argued that procedural formalism and judicial supervision of civil commitment processes would ensure a proper level of accountability for psychiatrists when making their decisions. The legal model of civil commitment reforms relied strongly on the framework of rights, envisioned as remedies that could alleviate psychiatric abuses (Hoffman, 1978). Procedural rights offered to civilly committed people constituted a panacea for psychiatric abuses because they created the possibility for questioning admissions and coercive treatment in court (Dąbrowski & Kubicki, 1994).

The contemporary Polish legal regime of rights of civilly committed people reflects a particular liberal vision of an individual that mentally ill people are expected to emulate. This only confirms what Rose (1986) argues – that psychiatry and law are able to approach mentally ill people in commensurable ways, because “despite their apparent differences contemporary psychiatry and rights-mindedness share a rationale for the contractualization of subjectivity” (p. 187). Hence, the subjugation of the mentally ill, inherent in the foundation of the liberal theory of rights, was transferred to Polish legal civil commitment law and was operationalized *inter alias* in the provisions of the MHPA through the concept of consent, the need for treatment, and rights as tools for empowerment and self-determination.

Although Dąbrowski and Pietrzykowski (1997) claimed that the ratification of the MHPA placed Poland on a level comparable with countries that had specific legislation to guarantee the rights of civilly committed patients and to secure adequate and

respectful treatment of the mentally ill, critical analysis of the Polish rights regime reveals the populist character of this argument. Instead, I suggest that, even though changes that were implemented to civil commitment law in Poland improved the status of people undergoing civil commitment by providing them with procedural rights, this did not change their inferior social position. Thus, the reforms failed to address the source of the subordination of mentally ill people.

It is intended that my case study will serve as an example of how the rhetoric of rights and the rule of law provides a problematic but pervasive legal logic that reconciles the exclusion of the mentally ill with liberal claims to equality of rights for all citizens. The main objective of this thesis was to describe the connections between the system of private property contractualization that prevails in capitalist societies, liberal rights, and the social marginalization of people categorized as mentally ill. I hope to have demonstrated the problematic nature of civil commitment as an institution of social exclusion. Since rights are conceptualized as “the heart and the goal of constitutional order” (Balibar, 1994, p. 311), it is important to be aware of their “dark side” (Kapur, 2007, p. 564), such as their potential to further marginalize already socially disadvantaged populations though rights-based activism. Liberal rights obscure the paternalism intrinsic in the institution of civil commitment that only confirms the inferior status of mentally ill people in liberal democracies and exposes them to further vulnerability to psychiatric abuses.

In spite of their “dark side,” as rights-based activism has demonstrated (e.g disability-rights movement, ‘mad’ movement or the movement of Aboriginal people) liberal rights also have a potential to bring a temporary relief for disadvantaged populations. The paradox of liberal rights lies in their contradictory potential to address some of the symptoms of oppression while perpetuating its sources. Teeple argues that:

“the continuing defence of human rights becomes an important means of protecting subordinated classes and peoples in the face of the expansion of corporate rights. Yet, at the same time, human rights in themselves cannot be the real good of these struggles” (2005b, p. 160). Rights can be used as means but not as the ends. Along with this argument, scholars from capabilities scholarship try to creatively use rights for the contemporary political, economic and social struggles while acknowledging rights' systemic limitations. The paradox of rights opens possibility for social scientists to fully understand “the character, prevalence, institutionalization, and impact of rights” in order to construct a “new sociology of rights” (Somers, 2008b, p. 412).

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