AFTER "MENTAL ILLNESS" WHAT? A PHILOSOPHICAL ENDORSEMENT OF STATUTORY REFORM

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The concept of mental illness has long played an important and, for the most part, constructive role in human affairs. And for this reason, if no other, it should not be discarded lightly or without good reason. It is, therefore, not surprising that in spite of some well reasoned attacks on this concept as being unduly identified with a "medical model" and as reifying a "myth," the statutes of almost every jurisdiction in the United States, including some of those most recently revised, persist in relying upon it as the basis upon which to articulate rules for confining those who, though not at fault, seem unable to behave or function "normally." That there are such persons in ours as in every society is beyond dispute. The focus of definitional controversy is elsewhere, namely, on the question of who not only fits into the designated category but fits so manifestly as to require intervention on the part of the state either under its police power or in its role as *parens patriae*.

That such intervention has come to be exercised primarily upon a finding of mental illness is largely a historical accident —one which, however, is readily understandable if one bears in mind the science-centered ethos of modern Western civilization. Current challenges to and doubts about the sufficiency of that ethos have had their counterpart in queries about the appropriateness of continuing to speak about "mental illness"; and these queries could readily be mined for reasons to abandon the medical model. Such reasons, however, would be as suspect as those which favor its retention if the purpose for expounding them is to diminish, if not totally to extirpate, society's sense of responsibility for its most unfortunate members. Accordingly, to suppose that the problem of "mental illness" is primarily methodological or epistemological is to risk distorting—indeed, skirting—the ethical, political, and economic interests that are at stake. In what follows, then, I assume that "mental illness" is a singularly pertinent example of a socially constructed reality. What I want to question is whether this particular social construction is still serving or can be expected to serve in the future as the most reasonable formulation of socially advantageous policy with regard to the exceptionally disturbed.

Assuming that a socially advantageous policy in this regard is one that produces the most judicious disposition of cases involving exceptionally dysfunctional persons, the question before us may be restated in terms of means: Are dispositions made under presently operative procedures sufficiently judicious? A totally unbiased answer to this question is hardly possible. But we may hope to approach objectivity by taking into account the most pertinent sources of controversy, three of which will be considered here. To locate these sources of controversy in their proper context, it will be useful first to state briefly the major issues in law to which the question of one's mental condition is relevant.

(1) Civil commitment of the "mentally ill," either voluntarily (which includes consent of a responsible adult) or involuntarily, for a period of time that may be very brief (emergency detention) or of longer duration (short-term e.g., 90 days, or long-term, determinate or indeterminate), through a process which may be administrative or judicial or some combination of the two, and is usually subject to some form of review or appeal.

(2) Civil determination of legal incompetency with regard to the performance of such acts as making a will, managing or disposing of property, suing and being sued, and exercising one's civil rights, a determination which is increasingly being dealt with as separate and distinct from commitment as such.

(3) Determinations under criminal law with regard to fitness to stand trial, to be sentenced or to be executed, and with regard to legal "insanity" as excusing from responsibility for alleged criminal acts, any one of which determinations will ordinarily result in an order for possible commitment under civil procedures and may result in an incompetency hearing as well.

The concept of mental illness is operative primarily with regard to civil commitment; but issues that arise with regard to incompetency and with regard to capability of submitting to criminal process may both draw upon and at times result in considerations with regard to mental illness. Because the protection of due process rights is more pervasive in the area of criminal law than it is in that of civil law, especially as regards the mentally ill, many constitutional questions have been raised in recent years about the manner in which a criminal defendant may be "diverted" for purposes of civil commitment.

Controversies relevant here arise out of (1) divergent interests of those who deal with "criminals" and those who deal with "patients"; *(2)* different, even if complementary, claims on the part of professionals who deal with "patients"; and (3) different emphases in statutory definitions of mental illness designed, among other things, to delineate the respective roles of pro-

fessionals (legal, medical, and others) and of the non-professional public with regard to the civil commitment decision-making process.

The first and, in some respects, the most serious controversy is already implicit in the conjunction of both police power and *parens patriae* as justifications for state intervention with regard to the mentally ill. For, what this conjunction indicates, as in the area of juvenile law, is that mental illness policy is situated at the interface between criminal and civil law, with the claim of the former being based on society's need for protection and the claims of the latter being based on society's obligation to care for those incapable of caring for themselves. The line between these two areas of law with regard to the mentally ill is clear only in theory, and becomes unclearer still the more our penal system is called upon to *rehabilitate* rather than punish while our mental health institutions are accused of *punishing* rather than treating those under their care. In both instances, apparently, society's expectations of beneficence, if such they are, tend not to be translated into a level of funding that allows for much program flexibility beyond that of custody. But society's ongoing problem of allocating institutional responsibilities in this area has not necessarily been made any more tractable by the inevitably self-serving jurisdictional claims of professional "treaters" on the one hand and professional "rehabilitators" on the other.

A second controversy with regard to policy arises out of intra- and interprofessional disagreement among "therapists" as to the utility and even the validity of a concept of mental illness, based as it is on a questionably applicable medical model. Even to speak of "mental illness" is, of course, to acquiesce in the claim that the disturbance phenomena in question are literally diseases like any other disease and therefore require the kind of treatment that only appropriately specialized medical experts can deliver. That this claim is historically altruistic in intent and at least partially founded in fact seems quite beyond dispute. What is being disputed, and not without reason, is the claim that *all* such disturbance phenomena are more than incidentally medical in nature, the point being that numerous other professional deliverers of care, including psychologists, social workers, and psychiatric nurses, among others, are professionally and, at least in some instances, personally capable of both recognizing ("diagnosing") and contributing to the improvement of ("treating") those afflicted with disturbance phenomena commonly identified as "mental illness." That all such "care" is generally referred to as "therapy" is another historically and sociologically understandable concession to the reality of medical hegemony in this area. What is less easy to understand is why even the most recently drafted mental health legislation still tends to rely for various

judicial purposes on the certification or testimony of a physician without any requirement that the physician have any specialized qualifications or even experience in the area upon which he or she is asked to function as an expert.

A third controversy with regard to policy is discernible especially in the stated objectives towards the attainment of which the state requires long-term or short-term commitment to a mental health facility. These objectives are commonly incorporated into a statutory definition of mental illness, which definition attempts to capture in words that condition of an individual which places him or her in a status justifying or requiring such state intervention.' The condition may be described broadly or narrowly, in terms ranging from the diagnostic (medieval or modern) to the ordinary, and from the metaphysical to the mundane. No one definition is favored in anything like a majority of the jurisdictions, nor does the definition in any jurisdiction include even most of the elements that are included in any of the others. Taken together, in other words, statutory definitions of mental illness in the United States constitute at best what philosophers sometimes call a family resemblance, with each definition utilizing only a subset of the general stock of definitional expressions. What must also be noted is that these definitions are intended to be not merely diagnostic or descriptive but operative; that is to say, they are intended both to authorize and at the same time to circumscribe a series of juridical or administrative acts leading to and/or legitimating some form of commitment.

This being the immediate objective, it is customarily couched in language which sets forth those broader objectives whose attainment will supposedly render an otherwise nocuous intervention innocuous. These broader objectives are stated partly in terms of values, partly in terms of disvalues, and partly in terms of needs, but usually in some combination. The values asserted are the welfare of the individual or of others or, in some instances, of the community. The disvalues rejected are danger (or harm) to the individual, or to the person or, sometimes, the property of others. Needs to be met are expressed operationally and include both implementation of the values (care, hospitalization, protection, treatment) and avoidance of the disvalues (observation or diagnosis, supervision, confinement, detention, restraint). In a small minority of states, statutory significance is given to the practical consequences of the individual's incapacity (e.g., "gravely disabled" or "unable to provide for food, clothing or shelter").

An individual found to qualify for one or more of these stated objectives might, absent further definition, be subjected to state intervention as varied as being incarcerated or being approved for welfare benefits. Some

statutes, however, make no mention of any of the foregoing objectives, whereas almost all statutes include some reference to the person's mental condition. This is variously described as involving disease or deficiency (or impairment) or disorder or defect, which condition is commonly stated as being "mental" and, in a large minority of jurisdictions as being psychiatric or psychotic, or some obsolete equivalent thereof, in nature. Moreover, such characterizations are with only a handful of exceptions put forth as a definition of "mental illness." Thus do the statutes sweep broadly over a wide range of problems in living and subsume them under the medical model.

It may be concluded from the foregoing that the socially constructed concept of mental illness functions in our society in at least three different, but mutually interrelated, ways: (1) to describe and delimit the disturbance phenomena that justify a commitment type of state intervention; (2) to describe and delimit the scope of authority and responsibility of medical (and medically related) professionals with regard to persons displaying such disturbance phenomena; (3) to provide a mechanism whereby the concerned citizen, professional or lay, can bring such disturbance phenomena to the attention of responsible authorities for the purpose of obtaining help. Where the statutory language and/or interpretation if overbroad (as seems to be more often the case), the resulting procedure and practice may open medical professionals to charges of overreaching their authority, but not without at least tacit judicial consent. Where narrower language and/or interpretation is operative, medical professionals may find themselves open to charges of failing in their responsibility, again with at least the tacit consent of the courts. In either case, the medical profession, if not its cooperating counterparts in law, is open to criticism and blame, the severity of which depends on the priorities, the resources and the values of society during any particular period of time.

Given, however, the realities of at least our public institutions for the "mentally ill," including the kind of funding and other support they receive from the public, it may be argued that the medical profession simply serves as a convenient scapegoat or second-level victim to blame for the overall indifference and carefully circumscribed concern of society as a whole. From this point of view, both "myth" and "model" critiques of mental illness are largely beside the point, unless what the critics thereby intend is not to narrow the scope of society's beneficiaries but to broaden the scope of its professionally responsible benefactors. And in this regard it seems that it would be eminently in the interest of physicians in general and of psychiatrists in particular to dissociate themselves from any claim to singular hegemony

over problems in living which the humanitarianism of an earlier day found it tactically advantageous to identify generically as illness or disease, Correspondingly, it seems that it would be equally advantageous to the courts if—as, indeed, has already begun to happen on a piecemeal basis—legislatures were to eliminate from mental illness statutes any reference to mental illness as the overarching category that justifies state intervention in behalf of gravely disturbed persons.

The task of developing a more equitable and yet serviceable alternative definition would not be easy, to be sure, but it does not appear to be inipossible. By way of suggesting a general direction, I would recommend a (hopefully) neutral *definiendum* such as "extraordinary functional disability" (EFD, hereafter) and would tentatively propose as the *definiens "persistent or suddenly changed behavior (I) which clearly indicates a seriously disabling and presently uncontrolled physical or emotional condition and (2) an effect of which is actual or probable harm of a serious nature to the person or property of self or Others in the community."*

A definition of this kind would allow for what I might call generic diagnosis,.the implementation of which could and, I think, should be interdisciplinary and, insofar as possible, community based. This definition includes both a *(parens patriae)* gravely disabled test and a (police power) danger test, and as such may arguably take too much into account for what I am calling a generic definition. I assume here, however, that this definition would serve as a first but necessary hurdle to surmount before undertaking any kind of subject-opposed state intervention, judicial or administrative. The 1952 Draft Act definition, by comparison, though based on the medical model, is in this respect more generic; but it is suspect — and arguably, creates a constitutionally suspect category—precisely because it is being used to justify involuntary commitments.[2] It is, accordingly, more defensible if viewed only as a statutory basis for *permitting* hospitalization of *voluntary* patients. However, the first, or gravely disabled, test in the proposed definition would probably suffice in and of itself — or, better, as fleshed out with judicious administrative guidelines—to justify both voluntary admissions and even emergency detentions, not necessarily in a "mental hospital" but in the least restrictive appropriate facility. For purposes of making subsequent determinations with regard to the nature, duration, and conditions of commitment and/or treatment, the second, or danger, test should be triggered at least if hospitalization, and probably if any sort of subject-opposed intervention, is under consideration. Depending upon the circumstances which have engendered a need to evaluate an individual's functional stability, any of a number of additional tests might he made a

prerequisite to such further determination. For example, advisory medical diagnosis and prognosis would ordinarily be an important factor to take into consideration before recommending any particular modality of treatment, especially in the case of community-initiated generic diagnosis. Other kinds of specific diagnoses would, however, also need to be taken into account, especially where the issue is competency or fitness to stand trial on a criminal charge or exculpation on a defense of insanity. In other words, each of these and other related issues that are subject to judicial determination should presuppose (1) an appropriate generic finding of EFD and (2) an additional specific finding appropriate to the issue at hand. Thus, for example, a person might be found EFD but fit to stand trial, EFD and legally incompetent to sue or be sued, EFD to the point of being exculpated of criminal charges, EFD and requiring chemotherapy, EFD and requiring surgery, and so on. It should be mentioned in passing that provision would have to be made to allow for appeal from either a generic or a specific diagnosis through an appropriate administrative and/or judicial process.

What I am here suggesting is that the range of social problems that society has come to deal with under the aegis of mental illness, with all the stigma that that still entails, goes quite beyond the bounds of any specifically medical expertise. But they remain social problems for all that, and for the most part do, as they should, imply a level of behavior dysfunction that cannot ordinarily be remedied merely by some form of welfare assistance as that is usually understood. Such problems may be due to specifically medical factors, but this is not the case generically. And for this reason society as a whole and each community in particular should share the responsibility for determining and disposing of cases as they present themselves for solution.

Several positive results that might reasonably be expected from a serious implementation of such a policy are the following: (1) the longstanding feud between spokesmen for psychotherapy and spokesmen for civil and criminal process would be significantly defused; (2) interprofessional disagreements among those responsible for treatment could be more equitably and responsibly resolved; (3) problems created by the opposition of members of a community to a community mental health center seemingly controlled from "above" would be less likely to arise and in any event more manageable through appropriately structured participatory democracy.

With regard to the first expected result, it is especially a recognition of and provision for the diversity of functions now assigned to diagnosis of "mental illness" that would contribute most to both a clarification and a safeguarding of the often competing values of health, freedom and respon

sibility. In particular, it should be recognized that the respective roles of physician and psychiatrist with regard to expert opinion have been and should remain quite different before the law. The psychiatrist, first of all, is more likely to be perceived as an expert in mental health, and as such is more likely to exercise the role of authority-figure both in an institutional setting and in a criminal trial where, for example, the issue of insanity has been raised. The physician, on the other hand, has traditionally been the professional in the community most likely to be consulted about behavior suggestive of "mental illness," and as such has quite naturally come to have a legally significant if not determinative diagnostic role in these matters. But now, especially with the emergence of community mental health facilities, an increasingly stronger case can be made for supplementing such medical opinion with that of others, both expert and lay, who would serve as a community-based and insofar as possible, community selected, team responsible for threshold review of community-initiated EFD proceedings.

Such team approaches to diagnosis and treatment are already commonplace if not universally practiced in institutional settings, where even other patients on a ward sometimes play a decision-making role, especially with regard to discharge. It is, however, especially the professional therapeutic team, as a team, which makes decisions both as to diagnosis and as to treatment and processing of patients. Thus, one appropriate way in which the law might recognize such collective decision-making would be by permitting any institutionally approved representative, not necessarily a physician, to submit treatment plans and progress reports and, when necessary, testify in court on behalf of the team.

One advantage of having an analogous community-based team, with lay representation, has already been suggested, namely, that it would serve to take some of the decision-making "heat" off the physician. In addition, such a team (or board or committee or, possibly, jury) approach would serve two other socially desirable functions: (1) it would help to diminish taxpayers' concerns about unnecessary expenditure of public funds for commitment; (2) it would help to allay concerns, especially of attorneys hut also of community representatives, about the inadequate protection of due process rights in civil commitment procedures as traditionally practiced. At least one judge has indicated that his role in these matters is not to develop philosophy but to "translat(e) the accepted philosophy into practical rules of action for everyday use in the courtroom."' He undoubtedly was looking to lawmakers for his "philosophy." But, as we have seen, there is probably no better example of philosophical confusion than that of statutory definitions of mental illness. The philosopher, accordingly, may be excused for

scrutinizing realities beyond words for otherwise undiagnosed symptoms of philosophical deficiency.. .or defect.. .or disorder.

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NOTES

I. A convenient, although now somewhat dated, summary of the kinds of statutes here in questioewill be found in S. J. Brakel and R. S. Rock, eds., *The Mentally Disabled and the*

Law, rev. ed., Chicago and London: University of Chicago Press for American liar Founda tion, 1971. The analysis which follows had drawn extensively on this work, especially Table 3.

2. The document in question here, whose full title is *A Draft Act Governing Ilovituhzatiun of the Mentally III,* was prepared in the Federal Security Agency by the National Institute of Mental Health and the Office Of General Counsel and was issued in revised form as Public Health Service Publication No. 51, Washington, D.C.: U. S. Government Printing Office, 1952. This proposed legislation defines a "mentally ill individual" as "(a)n individual having a psychiatric or other disease which substantially impairs his mental health" (p. 1). Such medical model language has since been adopted almost verbatim by thirteen states, and with some significant modification or qualification by five other jurisdictions. Sec Brakel/Rock, *supra,* pp. 454-473.

3. Carter v. United States, 252 F. 2d 608, 616 (D.C. Cir. 1957).