Mental Illness and Public Health Care

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## Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors/Editors</th>
</tr>
</thead>
<tbody>
<tr>
<td>vii</td>
<td>Preface</td>
<td></td>
</tr>
<tr>
<td>ix</td>
<td>Contributors</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mental Illness and Commitment</td>
<td>Theodore Benditt</td>
</tr>
<tr>
<td>25</td>
<td>Involuntary Outpatient Commitment</td>
<td>Gerard Elfstrom</td>
</tr>
<tr>
<td>55</td>
<td>Cognitive Behavioral and Pharmacological Interventions</td>
<td>David Cruise Malloy and Thomas Hadjistavropoulos</td>
</tr>
<tr>
<td></td>
<td>for Mood- and Anxiety-Related Problems: An Examination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>from an Existential Ethical Perspective</td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Managing Values in Managed Behavioral Health Care: A Case Study</td>
<td>Mark E. Meaney</td>
</tr>
<tr>
<td>105</td>
<td>The Changing Form of Psychiatric Care</td>
<td>Wade L. Robison</td>
</tr>
<tr>
<td>127</td>
<td>Tarasoff, Megan, and Mill: Preventing Harm to Others</td>
<td>Pam R. Sailors</td>
</tr>
<tr>
<td>143</td>
<td>Index</td>
<td></td>
</tr>
</tbody>
</table>
The articles in this latest volume of *Biomedical Ethics Reviews* focus on three specific issues relative to the general topic heading, *Mental Illness and Public Health Care*. The first of these issues is whether or not the involuntary commitment of mentally ill persons can be said to be morally proper, or even morally permissible, in a society such as ours. The questions arising in connection with this issue are complex. For example, is dangerousness to oneself or others a sufficient ground for committing a mentally ill person to an institution contrary to their will? Are mental health professionals competent to predict dangerousness? Committing a person to an institution for their own good is paternalistic; can this paternalism be justified in a liberal society? In the first two essays in this text, Theodore Benditt and Gerard Elfstrom attempt to answer questions such as these. Although their approaches differ radically, the reader will find that they nevertheless come to quite similar conclusions.

The second topic of discussion in our text is a very broad one: How should we go about determining proper psychiatric care within the parameters of our present health care delivery system? Three articles are devoted to this issue. In the first essay, David Malloy and Thomas Hadjistavropoulos argue that whenever the use of cognitive behavioral therapy (CBT) and pharmacological interventions are both in accord with professional codes of conduct and approximately equal in terms of their effectiveness, CBT should be the treatment of choice because it possesses an ethical advantage. In the essay that follows, Mark Meaney argues that publicly funded managed care for behavioral health services can efficiently and effectively provide benefits for patients. What is needed, he says, is for health services to take care to integrate ethics into their operations. To show how this can be done, Meaney examines an actual case in which a Philadelphia-based public sector managed behavioral health care corporation used the services of an ethics center in Atlanta to implement a system-wide corporate ethics program. In the final essay, Wade Robison expresses concern that our current system of psychiatric care exhibits a shift away from the traditional Freudian model of open-ended, one-on-one therapy to fewer
doctor–patient consultations combined with greater use of pharmacological treatments. Robison acknowledges that this transformation in psychiatric care may have some benefits, but he is extremely troubled by the fact that the principal driving forces behind the change in treatment are economic rather than deliberations concerning what forms of treatment will most benefit patients.

The last issue in our text concerns what should be done when a mental health professional is convinced that one of his or her patients poses a threat to someone else in society. Here the primary concern is whether psychotherapists should break patient confidentiality and warn those whom they believe are in jeopardy at their patients’ hands. In 1976, in the case of Tarasoff v. Regents of the University of California, the California Supreme Court determined that psychotherapists have a duty of reasonable care to protect those whom they believe could be harmed by a patient. This decision has, in one form or another, been incorporated into most states’ laws. In “Tarasoff, Megan, and Mill: Preventing Harm to Others,” Pam Sailors argues that these laws contain some deficiencies and that the cure for these deficiencies is to modify Tarasoff laws so that they all more closely resemble “Megan’s Law”—a law that requires various law enforcement agencies to release relevant information in an attempt to protect the public from sexual offenders.

*Mental Illness and Public Health Care* is the nineteenth annual volume of *Biomedical Ethics Reviews*, a series of texts designed to review and update the literature on issues of central importance in bioethics today. For the convenience of our readers, each article in every volume of our series is prefaced by a short abstract describing that article’s content. Each volume in the series is organized around a central theme; the theme for the next issue of *Biomedical Ethics Reviews* will be *Care of the Aged*. We hope our readers will find the present volume of *Biomedical Ethics Reviews* to be both enjoyable and informative, and that they will look forward with anticipation to future volumes on topics of special concern.

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Abstract

A central question regarding mental illness and civil commitment is whether a person who is not violating any laws may be involuntarily committed and treated. After a lengthy period of time during which very erratic behavior was regarded as sufficient, civil liberties concerns led to the tightening of grounds for commitment and treatment; dangerousness to self and/or to others became the standard. The consequent appearance in our communities, however, of noticeable numbers of apparently mentally ill people produced a reaction: Many people came to believe that the good of such individuals, our capacity to treat them effectively, should be the standard, whether those being treated wanted it or not.

This chapter tries to mediate the conflict between civil libertarian and paternalistic concerns, between people’s rights and our desire to help. The chapter tests our thoughts about the issues by exploring a continuum of hypothetical cases that vary, on the one hand, the degrees to which individuals are harmed by their mental illnesses and, on the other, the extent to which their behavior imposes on others. The chapter’s conclusion is that if we are going to go beyond dangerousness as the standard, we need to ground our interference on behavior we are willing to proscribe. If we are not willing to make certain behavior legally unacceptable, we cannot use it as a basis for committing someone to an institution.

The chapter also takes issue with the contention that there really is no such thing as mental illness because “real” illness involves a detectable underlying pathology. It is argued, to the contrary, that the medical profession regularly, and correctly, deals with conditions in which this is not the case.
Mental Illness and Commitment

Theodore Benditt

“... many people ... are profoundly ambivalent in their attitudes toward the mentally ill. We are frightened by them and we seek distance and protection from them, yet we also feel compassion toward them and we urge sympathetic care and protection of them.”

“In the end it is up to society to determine which statistically abnormal states and conditions to regard as illnesses according to the assessment of desirable human experiences and functioning.”

“Involuntary mental hospitalization is imprisonment under the guise of treatment; it is a covert form of social control. . . .”

“. . . schizophrenia is a housing problem rather than a medical problem. . . .”

“To solve the problem of mentally ill street people, we are going to have to revive some form of mental asylum.”

Over the past several decades, attitudes toward mental illness and the way we deal with it have undergone change, from
great confidence in the capacity of psychiatry to respond to mental problems, to doubts about this and about the propriety of forcing treatment on those thought to need it, to a resurgence of belief in psychiatry’s ability to help people and in civil commitment. The first of these alterations came in the context of the civil rights movement in the United States, which was extended, through judicial action, to the rights of those seen as mentally ill. The reaction reflected both a concern with the consequences of the civil libertarian approach to mental illness—a concern both for those seen to be mentally ill and for the larger society—and the belief that new drugs could cope with some of the most serious mental illnesses.

Accordingly, many issues in mental illness are contests between those having more and those have less expansive views about what mental illness is, our capacity to treat it, and the propriety of doing so against the wishes of those held to be mentally ill. On one side are those who think that many people suffer from mental illnesses, that we have the ability to treat them, that treatments, though they may not (always) cure, at least improve people’s lives, and that mentally ill people have a right to treatment even when they cannot understand that they will benefit from it. These views are contested by those who think that the problems are not genuine medical problems but rather problems in living, that most people with so-called mental illnesses are making choices for which they should be held responsible, that involuntary commitment is simply a form of social control that is not a legitimate part of medical practice, and that the right to liberty is violated by involuntary commitment and treatment.

Is There Such a Thing as Mental Illness?

Over the course of 40 years, the case against the very idea of mental illness has been strenuously argued by Dr. Thomas Szasz, a psychiatrist. He believes that so-called mental illness does not genuinely qualify as illness, that the behavioral problems associated with so-called mental illnesses should be dealt with, if at all,
through various forms of social control but not by medicine or psychiatry, and that the use of civil commitment in dealing with the so-called mentally ill turns psychiatrists into agents of the state for the control of certain people. Many have credited Szasz (not always approvingly) with having had a considerable impact on the reduction of the number of people in mental institutions and on the procedures used to commit and to treat the mentally ill.

Most of the psychiatric profession, which is more and more pharmacologically based, is arrayed against Szasz’s views as to the nature of mental illness and the propriety of civil commitment. Taken as a whole, the profession maintains that many mental illnesses are genuine even in Szasz’s sense (i.e., that they are brain diseases) and that they are treatable. The American Psychiatric Association publishes a massive volume entitled *Diagnostic and Statistical Manual of Mental Disorders* (usually referred to as DSM, it is now in its fourth edition) in which hundreds of mental disorders and the bases for diagnosing them are identified. For his part, Szasz regards many of these not as illnesses, but as problems in living that are not the province of medicine. However, although one can sympathize with the worry that the extravagant list of disorders in DSM-IV inflates and perhaps diminishes the idea of mental illness, it is hard not to accept that there are genuine mental illnesses, although Szasz continues to reject it. In a recent interview, he was asked the following:

The psychiatrist E. Fuller Torrey has written that “studies using techniques such as magnetic resonance imaging and positron emission tomography scans have proved that schizophrenia and manic depressive illness are physical disorders of the brain in exactly the same way as Parkinson’s disease or multiple sclerosis.” Is that true? If not, what do these studies actually show?

Szasz answered:

Most educated people, if they think about it, know how real disease is diagnosed. Take anemia. If a person comes
in and says he is tired, he has no energy, and he looks very pale, the physician may think he is anemic. But the diagnosis is not made until there is a finding in the laboratory that there is a diminished blood count, a diminished hemoglobin level. Conversely, a laboratory technician can blindly make a diagnosis of anemia simply on the basis of vials of blood submitted to him or her—without having any idea of whose blood it is. As soon as that can be done with schizophrenia, it will be a brain disease, exactly as neurosyphilis was recognized as a brain disease.

By Szasz’s account, mental disease (or illness) is not real disease (or illness). In a real illness, he says, we can distinguish between outward manifestations or occurrences (lack of energy, pale looks, tiredness) and an underlying problem, an underlying physiological state of affairs, an organic pathology (such as diminished hemoglobin level) that is responsible for the outward manifestations. With respect to most so-called mental illnesses, however, Szasz says this distinction does not hold—there are certainly outward occurrences, but in most cases there is no organic pathology that is the mark of real illness. For this reason, he says, most so-called mental illness is not a medical problem. Szasz identifies illness with the underlying pathological situation, which is what medical treatment is typically directed toward correcting.

People seek medical attention when they experience things (what I have been calling outward manifestations or occurrences) that are uncomfortable and/or out of the ordinary and/or worrisome. A physician makes a diagnosis. Sometimes the diagnosis reveals an underlying state of affairs that is regarded as a disease or illness; sometimes it does not. What makes the underlying pathology an illness is that it not only is the cause of the outward manifestations but also poses a threat to future health and well-being. In such a case, the outward occurrences are symptoms of the illness. Another way of putting Szasz’s contention, then, is that, in genuine illness, the outward occurrences that lead people to seek medical attention are symptoms of an underlying problem
that has an existence and can be identified independent of them. (Indeed, according to Szasz, an illness can exist and be identified independent of symptoms—in principle, there need not be any symptoms when the illness is discovered.) By this criterion, Szasz believes, most so-called mental illness is not illness: The outward manifestations are not symptoms. Despite this, though, the public and the psychiatric profession insist, with no foundation (as Szasz sees it), that so-called mental illnesses really are illnesses or diseases—so-called brain diseases.\(^9\)

Szasz overstates his case, though—for there are many sorts of legitimately medical situations in which outward manifestations are not symptoms of an underlying pathology posing a threat to future health and well-being. Consider something like a rash. Although a rash might be both caused by and a symptom of an underlying illness, it need not be. It might be a local or transitory occurrence, the product of an irritation or a passing internal state of affairs that does not qualify as disease or illness (as that has been characterized earlier). Although it is caused by some state of the body, it need not be a symptom of an illness. So too with mental and emotional difficulties.

Contrary to what Szasz implies, medicine is not limited to dealing with illnesses in the strict sense on which his argument depends. Medicine also deals with outward occurrences. For example, physicians deal with broken limbs, rashes, and a variety of aches and pains. They try to ascertain whether there is anything going on that portends further difficulty. If there is, they try to deal with it, although dealing with it may mean only monitoring it as it runs its course or corrects itself. Frequently, however, they respond to the outward occurrences quite independently of whether there is known to be (or even is at all) a problematic pathology underlying it.

Much mental illness is in certain respects like a rash, at least at the present state of our knowledge (although the comparison is not meant to diminish the seriousness of mental illness). Certain outward occurrences are presented which are thought to be prob-
lematic either by the person manifesting them or by others. They are (we believe) in some way caused by the brain and nervous system. Whether they are symptoms of a problematic underlying pathology remains to be seen—some are and others are not (or are not yet known to be). However, even when they are not, there is no reason not to see them as medical issues, just as we see rashes and broken limbs as medical issues, for the medical profession deals with many outward occurrences that may betoken nothing beyond themselves. There is this difference between rashes and broken limbs, on the one hand, and many mental illnesses: The former are disorders of the body, whereas mental illness is often behavioral, affective, and cognitive. However, this in itself is no ground for denying medicine a role, if medicine, in fact, has any capacity to deal with these difficulties.

Civil Commitment: A Historical Sketch

Having said that there are genuine mental illnesses and a legitimate medical role for the psychiatric profession (however pharmacological it has become) only resolves a threshold issue with respect to the problem of civil commitment, for the psychiatric profession as a whole believes that certain individuals need, and indeed have a right to, treatment and that, therefore, civil commitment is needed and justified.

There was a time in our history when civil commitment was not the problematic issue it has become. For a long time, our society has felt a need to “deal” with the mentally ill. Either for their own good or to relieve families of the burden of dealing with mentally ill family members, states in the United States established institutions for the long-term housing and care of the mentally ill. Once called asylums, or insane asylums, they later came to be called state hospitals, or state mental hospitals. People were typically sent to these institutions at the instigation of their families or the police, on the basis of the affirmation of physicians
that they needed treatment and were likely to benefit from it. Although minimal hearings were frequently required for making these determinations, such procedures were sometimes deemed too slow and cumbersome and expedited commitment procedures were often used.

This was the state of affairs up to the 1960s when concern began to grow, fueled in part by Szasz’s writings, about the reality of mental illness, the capacity of the medical profession to deal with it, and the effect of institutionalization on those committed to the state hospitals. Questions about civil rights and the legitimate reach of state power that were being asked in other areas of social life came to be asked about the treatment of the mentally ill, and as in other areas, these questions found their way into the courts. In Lessard v. Schmidt (1972), a federal district court in Wisconsin held that in a civil commitment hearing, it must be shown that the mentally ill person risks causing immediate harm to others or to himself and also held that more rigorous, criminal-style, procedural safeguards are required. “Lessard came to symbolize a desire to subordinate the therapeutic impulse that once drove civil commitment law to the civil libertarian concerns that were then in ascendance.” At the same time, another series of cases, beginning with Wyatt v. Stickney (1972) in Alabama and O’Connor v. Donaldson (1975), arising in Florida, held that committed mental patients could not be kept in mental hospitals if they were not being treated—whether because of insufficient resources or because no useful treatment was known. Finally, yet another series of decisions held that mental patients, even though properly committed, may refuse treatment and may be treated against their will only following a judicial-like inquiry into their competence.

The upshot of all of these civil liberties rulings and of the advent of new psychotropic drugs was a massive “deinstitutionalization”—mental patients were turned out of state hospitals to be dealt with instead by community mental health facilities, a move that was initially welcomed by many psychiatrists. Over time, however, many in the mental health professions came to
have second thoughts about the changes. Community mental health facilities did not materialize; many people deemed to be mentally ill wound up in jails or on the streets (according to some, deinstitutionalization had become merely “transinstitutionalization”); their presence in our cities became noticeable. Among many, both lay and professional, the belief took hold that something could and should be done for these people (even if they themselves did not want treatment), that people were “dying with their rights on.” By the early 1980s, the American Psychiatric Association proposed a basis for commitment that focused more on the need for treatment than on dangerousness (commitment would be allowed if the patient “will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own”).

Joyce Brown

The case of Joyce Brown is a good point of reference for conflicting ideas about civil commitment, for it raises both the question of whether someone is mentally ill and the difficult issue of the intersection of mental illness and homelessness. In response to growing numbers of homeless mentally ill people, New York City established a program called Project Help to determine whether such people could benefit from psychiatric treatment. At first, the program was voluntary except for those who were dangerous to themselves or others. In 1987, under then-Mayor Ed Koch, the criteria were expanded to include “need to be treated” and “self-neglect.” Using the new criteria, Project Help picked up Joyce Brown. Mayor Koch was aware of this woman’s situation, believed she could be treated, and wanted to help her (critics attributed other motives to the mayor). Joyce Brown lived on a
steam grate on New York City’s Upper East Side. She took
money from passersby, with which she bought food, although
sometimes she tore up the money. She talked to people who
passed by, often shouting obscenities. She urinated on the side-
walk and defecated in the gutter and (some claimed, although she
denied it) on herself. She sometimes ran into the street where
there was traffic. She often wore little clothing despite cold
weather, although she kept sheets and blankets in which to wrap
herself when she slept.

At a commitment hearing after she was picked up, Joyce
Brown said she was a “professional street person.” Her American
Civil Liberties Union (ACLU) attorneys said she did not want
help, did not need help, and was entitled to live as she pleased.
They said her homelessness was a matter of choice and that, in
that context, her behavior was rational. The outcome was that the
judge declined to honor Project Help’s new criteria and ruled that
Joyce Brown was not a danger to herself or others. This ruling
was overturned on appeal, resulting in her commitment in
Bellevue Hospital. She refused treatment, however, thus trigger-
ing another hearing at which the court ruled she was competent
and could not be medicated without consent—so the hospital
released her. Later, Brown said “The only thing wrong with me
was that I was homeless, not insane. . . . I need a place to live; I
don’t need an institution. . . .”17 For a while after her release she
lived in a hotel room and looked for a job. She became a celebrity
of sorts, appearing on talk shows and addressing a class at
Harvard Law School. After a while, she was seen back on the
streets; later she lived in a residence setting, was in and out of
hospitals, and had problems with illegal drugs.18

Widespread knowledge of the Joyce Brown case makes it
particularly useful in discussing principles governing civil com-
mitment; I will use it to discuss bases for civil commitment other
than dangerousness. Many other issues are raised by the case that
cannot be pursued here: both the general problem of home-
lessness and the part of the homelessness problem that can be traced to deinstitutionalization; the role of illegal drugs as they relate either to mental illness or homelessness; the legal criteria (dangerousness to self or others) that dominate discussion at the present time. What will be discussed is whether there is a suitable basis for civil commitment other than dangerousness.  

The central conundrum of civil commitment is: For whose good are people being coerced on the ground that they are mentally ill—theirs or ours? Although some questioned his motives, Mayor Koch insisted that he wanted to help Joyce Brown. A great many commentators, claiming motives similar to Mayor Koch’s, have expressed concern that the dangerousness standard is overprotective and should be replaced by need-for-treatment criteria along the lines of the American Psychiatric Association’s model law, mentioned earlier. Thomas Szasz, on the other hand, says

Joyce Brown was not demented; she knew what she was doing and, as a reward for her exploits, was invited to lecture at Harvard Law School. . . . Brown was not committed “for her own safety,” but for the benefit of the community. . . . [T]he Brown case . . . illustrates our collective enthusiasm for avoiding the use of the criminal justice system as a means of controlling a large class of lawbreakers. . . . Protecting liberty and property from those who disrespect or destroy them ought to be the task of judges, juries, and prison guards, not psychiatrists, psychologists, and social workers. And the means of enforcing such protection should be the criminal justice system, not the mental health system.  

What I want to propose is a rationale for civil commitment that does not have to confront the stark contrast between us and them—between committing the mentally ill for their benefit or for ours. One of the ideas I want to advance is that behaviors that we find objectionable can in themselves be evidence of mental illness. Hospitalization in such cases benefits the mentally ill by enabling them to cope with exactly these behaviors.
A Case for Commitment

Consider the following (mostly hypothetical) cases.

Case 1

Arno Blocher is 28 years old and suffers from schizophrenia, although the subtype is unclear. At times he has delusions, and at other times, he seems to be disorganized in speech and behavior. He is clearly better at some times and worse at others. Arno lives with and is well taken care of by his family (i.e., his parents). He is not being treated for his illness—he does not want treatment and his family does not want it for him (largely because he does not want it). His family is willing, as most are not, to put up with whatever problems the mental illness involves.

Arno’s mental illness is treatable, at least in the sense that there are well-understood treatments that are available, recommended, and regularly used by the psychiatric profession. These treatments are regarded by (most) psychiatrists as helping people with their delusions, disorganized speech, anxiety, depression, or whatever. However, they do not effect cures. Symptoms are either diminished or eliminated for periods of time, with perhaps recurring episodes. On the other hand, there are often unwelcome side effects, ranging from insomnia to potentially dangerous conditions. Arno and his family do not think the benefits of treatment are worth the downsides: Arno would rather have the illness untreated than a diminished form of the illness along with the side effects, and his family goes along with this. Arno has a job that he can do reasonably well; he works in his father’s machine shop. He can function socially to some extent, or at least periodically.

It is important to bear in mind that despite his illness, Arno is competent. Advocates for the mentally ill have worked hard, and successfully, to make the point that mental illness is not the same as incompetence and that mentally ill people can be competent to do many things, including making decisions about their