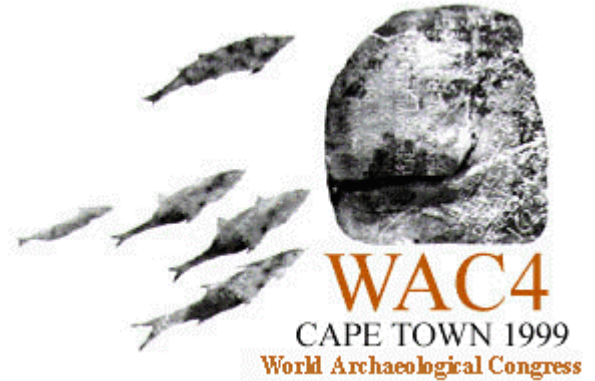


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'Official Madness': State Conceptions of Mental Illness for Purposes of Compulsory Admission

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Introduction

This paper will discuss how various states define mental illness (or similar relevant term) for purposes of compulsory admission. As used herein, "compulsory admission" [1] shall mean "compulsory or involuntary detention of a person in an institution designated as a mental [facility]" (Szasz 1963, p. 39). Compulsory admission laws usually have two components, the first containing a requirement that the person in question have a "mental illness" [2] or that the person be "mentally ill"; the second provides that certain further criteria must be met, such as that the person poses a danger to self or others, is in need of treatment, cannot manage his or her affairs, or cannot see to his or her basic necessities of life.

In English law, there was probably a common law right to detain a person thought to be "mentally ill" (Kruger 1980, p. 50). Various jurisdictions first enacted civil commitment statutes in the 1800's and 1900's. These early statutes, called by such names as "The Lunacy Act," showed little concern with the definition of mental illness, nor with considerations for patients' rights, whether substantive or procedural. Typically, such laws allowed the compulsory admission of persons upon certification by a physician that the person was "of unsound mind," or an "idiot" or "lunatic." The focus was on the preservation of law and order -- treatment was non-existent or minimal, and asylums were merely warehouses for those judged mentally ill. However, as psychiatric science became more sophisticated in the middle of the twentieth century (for instance, through the introduction of various medications), the emphasis turned toward treatment and rehabilitation.

In the 1960's and 1970's, in the West, there were major reforms of compulsory admission practices, policies, and laws. This "anti-psychiatry" movement was fueled by revelations of widespread abuse and deplorable conditions in various state mental hospitals; by the civil rights movement generally; and by withering attack from those

claiming that mental illness was purely a fictitious idea that functioned solely as a form of social control. Part of the reform efforts was to more clearly delineate what persons should be subjected to compulsory admission. Thus, diagnostic categories were sharpened -- those with epilepsy and mental retardation were now treated differently from those with "mental illness," and, in some cases, more specific criteria delineating "mental illness" were developed and introduced.

Another focus of this movement was to de-emphasize the *parens patrie* functions of the state (ensconced in the "treatment model") toward sole use of the state's police power -- to prevent physical harm to the person or to others (the "dangerousness" model). The role of the state is the subject of continuing debate in many jurisdictions. Some states in the United States have recently returned to the treatment model after experiencing widespread problems of the homeless mentally ill, which resulted from de-institutionalization policies, and perhaps, more stringent controls on the standards for compulsory admission. The treatment model continued to be hotly contested. Høyer 1988, p. 300, 301) notes that it has never been demonstrated that involuntary treatment improves the outcome or prognosis; in fact, compulsion would seem to mitigate against forming a positive therapeutic relationship). On the other hand, many claim that limiting commitment criteria to dangerousness has resulted in many mentally ill persons being diverted into the criminal justice system (Bonovitz and Bonovitz 1981; Miller 1992a).

Another goal of the movement was to enhance human rights. Many laws were reformed to grant patients greater rights, most of them procedural. Gostin (1983) calls this process the "new legalism," wherein procedural protections are enhanced, but decision-making remains largely with psychiatrists. The movement was felt all over the Western world, but took different paths in various countries.

At the same time, many developing countries either did not enact laws regarding the mentally ill, or enacted laws that were ineffective given the lack of available resources. [3] Some developing countries "inherited" the antiquated laws of their colonial forebears; some of those laws remain in effect today.

This paper will first explore psychiatric conceptions of mental illness, and will then take up the question of how compulsory admission legislation has described or defined mental illness. The paper will close with a discussion of how much impact changes in the precise wording of statutes has had upon the types of persons committed.

Psychiatric Conceptions of Mental Illness

Psychiatry is an inexact, and relatively recent, [4] science. Psychiatric systems of classification have evolved into elaborate mechanisms wherein a multitude of syndromes, illnesses, and disorders are defined, described, and explained. Yet still, there is no clear consensus as to what constitutes "mental illness" or "mental disorder." The DSM-IV that "no definition adequately specifies precise boundaries for the concept of 'mental disorder' . . . , but hazards a "definition" nonetheless, as follows:

Despite these caveats, the definition of mental disorder . . . is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (APA, pxxi). [5]

This "definition" would not appear to have a great deal of utility in application. Another issue concerns what criteria to use. Should "mental illness" be based upon one's behavior, affect, or internal conditions, or some combination? Should a person be said to be "mentally ill" when specific symptoms subside (Høyer 1988, pp. 296-97).

Mental illness must be viewed as being culturally, contextually, and temporally variant. Psychiatric science is constantly evolving -- new disorders are identified and old ones put to rest. For instance, homosexuality was officially included in the DSM as a mental illness until 1974 (see Bayer 1987). And concepts of mental illness are culturally imbedded and thus highly variant. The concept of mental health (or illness) also exists on many axes. Siegler and Osomond 1966, pp. 1193-1203 (cited in Murthy and Wig 1993) identify six such axes on which mental health can be viewed (and by extension, mental illness) -- they are medical, moral, psychoanalytical, family interactional, conspiratorial, and social.

All of these classification problems led Kendall (1988, p. 329) to claim that psychiatrists do not classify diseases or disorders; rather, psychiatrists classify "the kinds of problems which psychiatrists currently deal with" (quoted in Murthy and Wig 1993, p. 388). Others have been more even more explicit. Szasz (1974a, 1974b) and others claim that "mental illness," as such, is a "myth," a social construction designed for the control of persons deemed socially deviant:

"When I assert that mental illness is a myth, I am not saying that personal unhappiness and socially deviant behaviours do not exist; what I am saying is that we categorize them as diseases at our own peril.

The expression 'mental illness' is a metaphor that we have come to mistake for a fact. We call people physically ill when their body-functioning violates certain anatomical and physiological norms; similarly, we call people mentally ill when their personal conduct violates certain ethical, political, and social norms" (Szasz 1974a, p. 23).

Due in part to such recognition of socio-cultural factors, in recent years there has been more emphasis placed toward fostering mental health rather than treating mental illness (Desjarlais, Eisenberg, Good, and Kleinman 1995). Socio-environmental factors have been emphasized over "egocentric" ones (Murthy and Wig 1993, p. 395). This process can be seen as taking some power away from psychiatrists and granting it to other social actors interested in promoting mental health (Symonds 1998).

Legal Definitions of Mental Illness

Introduction

As Salzberg (1993, p. 174) notes, "[o]ne of the basic functions of any mental health law is the definition of mental illness and concomitant identification of persons deemed to be mentally ill." Given the above discussion, it should be apparent that this is no simple task; however, law as a normative science requires a definition (Kruger 1980, p. 50).[6] Obviously, an adequate definition is of great importance given that a person's liberty (and frequently their estate as well) is at stake. This is one place where law and psychiatry must collide, and not always gently. [7]

In nearly all jurisdictions, legal definitions of "mental illness" differ from strict psychiatric criteria. [8] This is because the purposes for which a definition is made are very different. The law, in theory, desires to minimize the detention of persons. The goal of psychiatry, on the other hand, is to identify and treat all persons who appear to be suffering from a mental illness. This definitional disparity has been recognized by both courts [9] and psychiatrists. [10]

The Response of Various Jurisdictions

Two prior studies have attempted to catalogue the civil commitment laws of various jurisdictions (Curran and Harding 1978; World Health Organization 1955).[11] Neither study was apparently concerned extensively with definitions of mental illness. Since the two studies, the United Nations adopted the "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" ["U.N. Principles"]. [12] The thrust of the U.N. Principles is assuring the human rights of persons thought to be, or determined to be, mentally ill. However, the U.N. Principles do not define mental illness. [13]

Jurisdictions have responded in one of four ways to this question, by providing: (1) no definition; (2) a broadly worded, vague, or tautological definition; (3) a definition based upon scientific or quasi-scientific criteria; or, much less frequently (4) a definition which refers directly to psychiatric diagnosis criteria. But first we will turn to a discussion of some jurisdictions that have no civil commitment law (and frequently, no mental health law), whatsoever.

Jurisdictions with no civil commitment law

Curran and Harding (1978, p. 20) found that 12 of the 43 countries they surveyed had no civil commitment law. Eight of the twelve were countries in the Middle East (id.). China continues to be one such country without a law. In fact, there is no comprehensive law for the mentally ill generally in China, although its need is acknowledged by many (Pearson 1996, 1992).[14] Pearson notes that it has been widely reported that there are no involuntary commitments in China. [15] Pearson (1992, p. 418) conceded that there is not a civil commitment law; however, she adds "it is wrong to assume that there are no compulsory admissions." After having read through many files at a state psychiatric institution, Pearson concluded that many people had been admitted against their will. Pearson (1992, pp. 419) writes: "It is not the individual who is consulted about his admission, but his family. If the family agrees to it, then he is admitted." Pearson (Pearson 1996, p. 452) [16] writes that Chinese families are willing to endure great hardship to avoid committing a family member; however, once the family identifies a member as "crazy," the decision is sealed. A law, but no definition

Jurisdictions with civil commitment statutes, but no definition of mental illness

Pakistan's 1912 Lunacy Act lacks a definition of "lunacy," and a new mental health act proposed in 1992 (see Rehman 1994) to replace it still contains no definition of mental illness, as well as no standards for civil commitment. (Yousaf 1997, pp. 299-300). Uruguay's law also provides no definition, notwithstanding that the great majority (98-99%) is admitted on medical compulsory grounds, which requires a finding of mental illness. Not surprisingly, some researchers (e.g., Moncada 1994) have found that most admittees in Uruguay do not have a mental illness. Moncada (1994, p. 617) calls them "social patients."

In Australia, there is no common definition for the entire country -- each state or territory has its own mental health laws. As of 1990, there was no statutory definition of mental illness in the laws of Northern Territory and Queensland. This lack of definiteness was explained in the law in Queensland by the then Minister of Health when introducing the Act:

"The question of mental illness is not decided on whether a person can be given a certain diagnostic label. Mental illness can refer to any degree of mental or emotional defect or aberration, whether from physical or psychological causes. Whether the provisions of the Act should apply depends on a medical assessment of the nature and degree of the disorder, and its effects on the person and on other people" (Queensland Parl. Debs., vol. 263, p. 2205, quoted in Errington, 1987, p. 185).

The laws of at least the states of Pennsylvania and California in the United States also contain no definition. Pennsylvania's states that a person who is "severely mentally disabled" may be committed under certain conditions. One such condition is that they must be suffering from a mental illness and " However, "mental illness" is not defined.

The results of such a lack of definition are discussed at the end of the next section.
Jurisdictions with broad, circular, or vague definitions.

When civil commitment laws first came into being in the 1800s and early 1900s, there was little apparent concern with defining mental illness under those statutes; the statutes were either silent on the topic, or contained very broad or tautological definitions. For example, South Africa's Cape Lunacy Act in 1891 defined an insane person as also being an "idiot" and a "mentally defective person" (Kruger 1980, p. 48). The succeeding law, the 1916 Mental Disorders Act, listed seven categories of insane persons; however, the umbrella clause included "a mentally disordered person is a person suffering from mental disorder (and therefore incapable of managing himself or his affairs)" (Kruger 1980, p. 48).

Similarly, the "Lunacy Act" of New South Wales (1898) defined an "insane person" to be "any person who has been found, or declared, whether by inquisition or under this Act, or under any Act hereby repealed, to be insane or of unsound mind and incapable of managing his affairs" (Lunacy Act 1898 (NSW), quoted in Errington 1987, p. 188). [17]

However, some legislatures have responded by changing definitions in response to four related forces: (1) advances in psychiatric science; (2) attention to patients' rights, and (3) orders from a court; or (4) changing attitudes and increased sophistication among the general public toward the mentally ill. However, efforts to create workable definitions was frequently less than effective. Some laws contain definitions that are infinitely flexible, or are tautological or vague. Under England's current law, "mental disorder" is defined as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind . . ." Mental Health Act 1983, §1(2). However "mental illness" is not defined " (see Errington 1987, p. 183). [18], and "psychopathic disorder" is defined very broadly as "a persistent disorder or disability of mind . . . which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned." Similarly, in Ontario "mental disorder" means "any disease or disability of the mind" (Ontario Mental Health Act, §1(1)). [19]

In Singapore, the law defines a "mentally disordered person" as "any person found by due course of law to be of unsound mind"; however, the law continues by adding the provision that such person be "incapable of managing himself or his affairs." [20] A draft of Taiwan's first law was submitted in 1983, and eventually became law in 1990. While the definition of mental illness includes fairly specific quasi-psychiatric criteria, it also includes the catchall "and such other mental illnesses as shall be recognized by the central organ having authority with respect to health. [21] The Indian Lunacy Act of 1912 defines a "lunatic" as "an idiot or person of unsound mind" (Mestrovic 1986, 431). [22]

Other jurisdictions have somewhat more specific criteria, but their definitions remain not useful. The law of British Columbia defines a "mentally disordered person" as "a mentally retarded or mentally ill person," and in turn defines a "mentally ill person" as "a person who is suffering from a disorder of the mind that seriously impairs the person's ability to react appropriately to his or her environment and to associate with others." (R.S.B.C. 1979, c. 256, §1). Terms such as "disorder of the mind," "appropriately," and "seriously impair" are not defined. [23] Israel's former law, enacted in 1955, was ambiguous in defining mental illness, mentally ill people, and the conditions that allow involuntary hospitalization (Aviram 1996). However, the new law enacted in 1991 [24] is not much more specific, providing that a mentally ill person is one who "is suffering from an illness as a result of which their capacity for judgment or for assessment of reality is severely impaired" (quoted in Bar El, et al 1998, p. 65). Other jurisdictions require a finding that the person suffers from "psychosis." [25] However, psychosis is ill defined.

This definitional vacuum results in the power to define being effectively delegated to one of three decision-makers: administrative agencies, the courts, or psychiatrists. [26] (This can be done explicitly or implicitly, as shown below). Thus, administrators, the psychiatric "community," or judges and juries may be left to define "mental illness" for the purposes of compulsory admission.

For example, the California courts, in the absence of a statutory definition, have held that the term "mental disorder" is limited to those disorders listed by the American Psychiatric Association in its "Diagnostic and Statistical Manual of Mental Disorders" now DSM-IV), thus giving full power to define to the medical community. [27] In

many other jurisdictions, the power to define has been delegated to the psychiatric community, albeit less overtly. For instance, in the case of Denmark, which defines mental illness as psychosis or states of mind analogous to psychosis, Vestergaard (1994, p. 194) notes that "a considerable degree of deference to professional discretion has been maintained." In Israel, the former law was based purely on a medical system. It was ambiguous about what mental illness was, as well as the reasons for confinement. Although the most recent law provides more protection for patients, the system remains based on the medical model, and physicians have broad discretion [28]. Psychiatrists also hold broad power in Norway because of the vagueness of definitions (Høyer 1988, p. 298), and in Russia the responsibility for diagnoses of mental disorder and recommendations for involuntary treatment are the exclusive prerogative of psychiatrists (Polubinskaya and Bonnie 1996, p. 154, citing Laws of the Russian Federation, p. 81), as it was under the Soviet system.

In jurisdictions with a common law history, courts are more likely, in the absence of explicit statutory definition, to utilize a "lay definition" of mental illness. Such is the case in England [29] and parts of Australia. This "common-sense" approach has been termed variously the "man on the Clapham omnibus" test or the "man-must-be-mad" test (Errington, p. 184). In the famous English case of *W v. L*, a judge wrote [30]:

The answer in my judgment is . . . that ordinary words of the English language should be construed in the way that ordinary sensible people would construe them. [Therefore] I ask myself what would the ordinary sensible person have said about [the respondent's condition and behavior]? In my judgment such a person would have said: "Well, that fellow is obviously mentally ill."

In Australia, the courts generally apply the "man must be mad" test [31] and rely on expert opinion as well.

Psychiatric or quasi-psychiatric definitions

Utah (U.S.) is one of the few jurisdictions that refers directly to psychiatric diagnostic criteria, defining mental illness as "a psychiatric disorder as defined by the current [APA] Diagnostic and Statistical Manual of Mental Disorders which substantially impairs a person's mental, emotional, behavioral or related functioning." [32] More typical are laws that set out certain psychiatric symptomatology as conditions for the existence of mental illness. In New South Wales, for example, "psychiatric illness" is defined as a

Condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterized by the presence in the person of any of the following symptoms:

- (a) delusions;
- (b) hallucinations;
- (c) serious disorder of thought form;
- (d) a severe disturbance of mood;
- (e) sustained or repeated irrational behavior indicating the presence of the symptoms referred to in paragraph (a), (b), (c), or (d).[33]

A "composite" definition can be constructed from other jurisdictions' definitions that rely on psychiatric or quasi-psychiatric factors. Generally, definitions of mental illness may be said to be composed of some of the following five parts:

- (1) a "substantial" or "significant" [34] or "gross" disorder, "impairment," [35] "abnormal state of mind," [36] or "psychiatric illness," [37] which affects
- (2) thought, [38] mood, [39] perception, [40] orientation [41], memory, [42] emotion, [43] control, [44] or volition, [45] which
- (3) "grossly impairs" [46] or "substantially interferes with" [47] a person's
- (4) judgment, [48] thinking, [49] feeling, [50] behavior, [51] capacity to recognize reality, [52] or to reason and understand, [53] or
- (5) impairs the person's ability to function [54] or to meet the ordinary demands of life. [55]

There are dangers in leaving the defining of mental illness solely in the hands of psychiatrists. Heginbotham (1987, p. 2) discusses several of these dangers. First, there is no "check" on doctors' authority -- the legislation "tends to put the doctor in a pre-eminent and unassailable position" In addition, such "medicalization" of mental illness tends to ignore social, familial, and biological origins. In addition, other options for treatment, and involvement of other professionals, may be thwarted. Rogers (1994) [56] presents a more cynical argument against psychiatric authority, claiming that psychiatrists are unable to appreciate that their interventions may not be wanted; he claims that psychiatrists are unable to properly balance their patients' competing interests. Last, as noted elsewhere, psychiatry is an inexact science; there is frequent revision to categories of mental illness (Errington 1987, p. 191).

The compulsory admission process in the former Soviet Union serves as an extreme example of placing decisions in the hands of psychiatrists. Ironically, the U.S.S.R. is credited with having had perhaps the most precise definition of mental illness (Heginbotham 1987, p. 2, citing Curran and Harding 1978, pp. 138-39). [57] Thus, someone with a genuine mental illness might be well served by the system (Heginbotham, p. 2). However, Bloch and Reddaway (1984) criticize seriously many Soviet criteria for mental illness as being vastly overbroad, and leading to rampant abuse. [58]

Exclusions

Some jurisdictions have decided to clarify what mental illness is by stating what it is clearly not. In some cases the motivation appears to be based upon diagnostic criteria and the desire to separate some organic illnesses from other mental illnesses. Mississippi's (U.S.) statute excludes epilepsy, mental retardation, and "brief periods of intoxication caused by alcohol or drugs," [59] while California's law excludes epilepsy and chronic alcoholism. [60]

Other statutes' exclusions are based more upon an interest in patients' rights, protecting people who hold anti-status quo views. The exclusions in the U.N. Principles are one example; they state that, in making a determination of a person's mental health, that person's political, economic, or social status is not to be considered, nor is the person's "non-conformity with community moral or political values or religious beliefs" to be an issue. [61]

Jurisdictions in Australia have been quick to take the U.N.'s lead. The laws of the Australian Capital Territory and New South Wales each provide that a person is not to be considered mentally ill by virtue of the fact that the person:

- (1) expresses or refuses to express a particular political or religious option [sic] or belief, philosophy or sexual preference or orientation;
- (2) engages in or refuses to engage in particular political or religious activity;
- (3) engages in sexual promiscuity, immoral conduct or illegal conduct;
- (4) takes drugs or alcohol; or
- (5) has an anti-social personality. [62]

In Russia the diagnosis of a mental disorder "may not be based only on the citizen's disagreement with socially accepted moral, cultural, political, or religious values or on other grounds not directly connected with the state of the citizen's mental health" (Polubinskaya and Bonnie 1996, p. 157, quoting Law of the Russian Federation, p. 76). This provision is motivated of course by the Soviet Union's longstanding record of using compulsory admission against political dissidents.

England's exclusion is much less broad; it prohibits consideration of a person's "promiscuity or other immoral conduct, sexual deviancy, or dependence on alcohol or drugs." [63] The courts in some jurisdictions have offered further refinements. In Pennsylvania (U.S.), mental illness cannot be inferred from the fact that a person has acted tortiously, criminally, or in a manner displaying delinquency. [64]

Other Criteria: Dangerousness and Need for Treatment

As noted above, a finding of mental illness is insufficient grounds for compulsory admission of a person. A further finding (dangerousness, need for treatment, etc.) must occur.⁶⁵ The U.N. Principles provide the following grounds for compulsory admission:

A person may be admitted involuntarily to a mental health facility . . . if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4 . . . , that that person has a mental illness and considers:

- (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
- (b) That, in the case of person whose mental illness is severe and whose judgment is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative . . . (U.N. Principle 16(1), emphasis supplied).

The UN Principles thus use both the "need for treatment" and the "dangerousness" standard. [66]

Dangerousness to self or others

Almost all statutes include some sort of "harm" or "dangerousness" criterion. [67] However, the laws differ somewhat in at least three ways: (1) the level of specificity or level of proof; (2) the object of the danger; and (3) whether worded as protecting the patient or preventing harm.

Illinois' law (U.S.) provides perhaps a "standard" version; in that state, a mentally ill person may be compulsorily admitted if he or she is "reasonably expected to inflict serious physical harm upon himself or herself or another in the near future." [68] Other laws are worded more paternalistically in terms of "protecting" the person or other persons from harm. [69]

Some laws contemplate a greater range of protection. The Netherlands considers the danger "to the public order" (Smit 1987, p. 254); the same is true of Japan's law (Salzberg 1991). Many statutes have increased evidentiary requirements or standards, for example, requiring a "clear" showing of danger,[70] or requiring evidence of prior violent acts.[71]

However, the U.N. Principles and most statutes do not further clarify or define what "dangerousness" means. Both the legal and medical system have struggled for many years with predictions of dangerousness. [72] As Rogers (1994, p. 409) makes clear, "[t]he stark fact is that it is impossible to make certain predictions of future human behaviour. Notwithstanding the greatest care and judgment there can be no certainty in the prediction of human affairs. Mestrovic (1986, pp. 447-48) goes further in his criticism, analogizing the Western model's prediction of dangerousness to the Indian idea of possession by demons. Both cases involve "magic," Mestrovic claims, and "these phenomenon cannot be 'observed,' predicted or exorcised. "Dangerousness" is constrained by chemical means in the West and 'possession' by chains in India -- both means have been criticized as being inhumane, at least in part. The 'treatment' for either affliction is unscientific" (id., p. 448).

Need for treatment

Currently, the pendulum appears to be swinging back to the "need for treatment" standard. The U.N. Principles, quoted above, reflect this sea change. New South Wales,[73] Queensland, [74] Denmark (see Vestergaard 1994, p. 195), and several U.S. states [75] include need for treatment criteria.

Unable to care for self (or "grave disability").

California is one of many jurisdictions that provide for commitment of the mentally ill if they are unable to provide basic needs.[76] This provision appears to be the one under which a majority of persons are involuntarily committed. Turkheimer and Parry (1992, p. 647) reviewed seven studies and found that more than three quarters of persons were involuntarily committed under such a provision.

Incapable of managing one's own affairs

In Singapore, a person may be committed if found to be "of unsound mind and incapable of managing himself or his affairs." [77] In Uruguay, one form of commitment (judicial commitment) resembles an incompetency hearing, wherein the

mental illness must be shown to interfere with the person's inability to handle their estate (Moncada 1994, p. 606). Similarly, Taiwan's law defines a "seriously mentally ill" person based in part upon the person's ability to manage his own affairs (see Salzberg 1993, App. p. 188). However, a person may not be involuntarily committed on this basis. As Salzberg notes, inability to manage one's own affairs appears to be a relatively low standard (Salzberg 1993, p. 188, n. 5), more appropriate for guardianship than for forced medical treatment (*id.*, p. 175).

Compulsory Admission in the Real World: Do Definitions Matter?

Clearly, definitions of mental illness as well as the conditions under which persons may be compulsorily admitted have been subjects of intense debate. Laws have been revised, and then re-revised, reflecting the constant tug of war between competing ideologies. In the midst of all this *Sturm und Drang*, it may be useful to pause and ask whether the specific wording of a statute has an actual effect on decision-making by judges, juries, and psychiatrists.

Many commentators have argued that extra-legal social structural factors, such as administrative concerns, fiscal constraints, specifics of locale, and organizational settings, have significant effects upon decision-making (Aviram 1990, p. 165, citing studies). In addition, such "micro" factors as education and training of judges and attorneys, and the interactional process between the putative patient and the court, contribute to decision-making as well.[78] Turkheimer and Parry (1992) state that solutions are "unlikely to be found in the minutiae of legal requirements for civil commitment hearings, because the conduct of those hearings is governed as much by the system in which they operate as in the statutes that regulate them" (p. 653, citing Hoge et al 1988). Thus, Applebaum (1984) and others have discovered that it is not clear that changes in laws (i.e., from need for treatment to dangerousness) have resulted in changes in result. [79]

Cultural standards of what "mental illness" is, or what "ought to be done" with the mentally ill may be deeply imbedded and relatively impervious to change through the medium of statutory language. For example, in many cultures, such as those of India, China, Japan, and Singapore, the role of the family dictates what "ought to be done" with the mentally ill. Less savory cultural pressures, such as the profit-driven private hospital system in Japan, concerned with filling as many beds as possible, may influence outcomes regardless of the letter of the law. And as noted above in depth, vaguely worded statutes, regardless of their good intent, can result in varying interpretations. "Dangerous to oneself" may mean imminent threat of suicide or other major harm, or may mean a suspected major deterioration in the person's mental condition (Rogers 1994, p. 410) collapsed). For instance, the "need for treatment" standard has been interpreted as "prevention of relapse," which might appear to exceed the statutory intent (Høyer 1988, p. 297). And if statutes do not provide for some sort of check on individual decision-making (many statutes contain recourse provisions against wrongful commitment), there may be little incentive to prevent individuals from making "bad" decisions.

More basically, as Bottomley (1989, p. 294) posits, there may exist a collective consensus as to what constitutes mental illness (citing Warren 1982, p. 140).

"[P]sychiatric or legal models of madness merely add to, and do not cancel out,

commonsense concepts. [In fact, commonsense conceptions] are as legitimate as the use of unproven psychiatric or genetic theories, or contextually absurd legal assumptions concerning rationality, choice, and free will" (Bottomley, p. 294, quoting Warren 1982, p. 139). However, at least one problem with this conception is that research has shown that lay conceptions of mental illness differ widely based upon factors such as education, socio-economic status, exposure to the mentally ill, and place of residence (urban-rural) (Murthy and Wig 1993, p. 392).

Other practical concerns also influence decision-making. The availability of alternate forms of treatment, and the extent of the person's actual resources, may well "trump" strict statutory criteria (Mestrovic 1986, p. 434; Vestergaard 1994, p. 200) Turkheimer and Parry (1992, p. 647) in reviewing a number of studies concluded that "an important reason for the gap in civil commitment hearings is the unwillingness of hearing participants to release patients into a community that is unable to care for them." Moncada (1994, p. 617) concurs: People subject to compulsory detention in Uruguay "are usually disabled, elderly, socially outcast, or homeless."

On a more situational level, practitioners may lack competence. Turkheimer and Parry (1992) reviewed studies and found that attorneys are often poorly prepared and do not cross-examine witnesses (p. 647, citing Lelos 1991), "and often appear to have limited experience with mental health law" (p. 647, citing Koch, Mann, and Vogel 1987). Clinicians may fail to adhere to strict legal definitions in their everyday work. Engelman, Jobes, Berman, and Langbein (1998, p. 941) cite four studies in which clinicians' judgments were consistent with legal standards and six where they were not. They concluded that "the decision-making process is influenced by multiple factors, such as the evaluation setting, the clinician's tendency to detain patients, and the availability of detention beds."

The interactional process in the courtroom has also been the subject of sociological debate. "Labeling theory" would suggest that the designation of a person as mentally ill (or even potentially mentally ill) is more important than the person's actual mental condition (Holstein 1987, pp. 147-48). Holstein (1987) concluded in his study that judges' decision making was indeed strongly influenced by assumptions of mental illness. Smit (1987) also studied the courtroom interactional process, and found that the conversation was structured by the judge, who performed a monologue for the patient rather than engaging in real questioning.

There is also the issue of intersubjectivity. Different psychiatrists (and judges) sometimes come to different conclusions with respect to the same person. Where there is only one doctor making a determination, which is the case in some statutes, or where a person is denied a jury (which is true in most cases), there is a potential for great error (or chicanery).

Notwithstanding all of these doubts, most conclude that laws do matter. Specifically, some have found that the orientation of the system which defines the criteria for admission does result in a different mix of patient population (e.g., Segal 1989). More generally, laws "set up the boundaries within which we may operate and attempt improvements" (Aviram 1990, p. 174). And they frequently represent at least our collective ideals for the treatment of the mentally ill.

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Notes

[1] Civil commitment is the term used in the United States, while "compulsory admission" is favored in Britain. Operationalizing the concept is more complicated than it may at first seem. Black's Law Dictionary definition ("a form of non-criminal confinement for persons who are judicially found mentally ill") is too narrow because some countries' laws do not provide for a judicial hearing or review, putting the power solely in the hands of psychiatrists (Russia), and/or the person's family (Japan). Other countries, such as China (Pearson 1996) and Thailand (see Soothill et al 1981) do not have a civil commitment law at all. Nonetheless, such countries can be said to have compulsory admission practices; this will be discussed further below. A study by Soothill et al (1981) included one such country (Thailand), and chose to define compulsory admittees as including "only patients who, if they left the hospital without permission during the their stay, would be regarded as having 'escaped.'" (p. 330).

[2] The term "mental illness" will be used herein when speaking in general terms, while recognizing that many statutes use alternative terminology.

[3] This is not to suggest that Western jurisdictions have devoted, or are devoting, sufficient energy, thought, and resources to mental health policies, treatment, and education. In fact, many Western mental health systems are woefully inadequate and under-funded.

[4] Relatively new; Kraepelin in 1896 was the first major attempt to classify disorders (Murthy and Wig 1993, p. 388).

[5] The DSM-IV then states that the "syndrome or pattern" must not be merely an "expectable and culturally sanctioned response to a particular event." It also must be a current manifestation in the individual. Equally important is what it is not: "Neither deviant behavior . . . nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above" (APA, pp. xxi-xxii).

[6] The law may provide different definitions for different purposes. For instance, the definition of "insanity" in a criminal trial is very different from the definition of "mental illness" or "mental disorder" for the purpose of compulsory admission. The law may also include an additional, different, definition of "mental illness" for purposes of disability.

[7] The relationships between lawyers and psychiatrists is sometimes a very tense one. Rogers (1994) is one attorney highly suspect of psychiatric diagnoses. He writes (at p.

406) 'It is fair to say that of any branch of medicine, psychiatry has been clothed in a particular mystique (I suspect not because it is so complex but because it is so inexact) and psychiatrists perhaps more than any other group of medical practitioners have been consequently less vulnerable to scrutiny and accountability' (Rogers 1994, p. 406).

[8] One exception is the state of Utah, which expressly relies upon the DSM.

[9] One court famously held: "This may be a remarkable result, but I can see no escape from the conclusion that an insane person is not necessarily a 'mentally ill person' as that expression is used in the Mental Health Act" (quoted in Errington 1997, p. 183).

[10] The DSM-IV states: "[T]he clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder,' 'mental disability,' 'mental disease,' or 'mental defect'" (APA, p. xxiii).

[11] It is obviously not the intent of this paper to attempt such a comprehensive effort, nor is this paper intended to reflect the most recent law of each jurisdiction under discussion. Rather, the focus herein is particularly on the definitions which various statutes have employed, and some possible effects of those choices.

[12] G.A. Res. 119, U.N. GAOR, 46th Sess., Supp. No. 49, Annex, at 188-192, U.N. Doc. A/46/49 (1991). The principles were adopted by General Assembly Resolution on November 18, 1991, 46th Session, Item No. 98b.

[13] However, they do provide that such determination be according to internationally accepted medical standards. U.N. Principle 4(1).

[14] "Legislation and regulation for protection of social order against mental illness should be formulated soon. . . . For example, there are no clear guidelines to define the boundary, operational procedures, treatment means, period of detention for compulsory custodial treatment. There are also no clear guidelines regarding rights of the mental patients" (Pearson 1992, p. 410, quoting Wu 1995, p. 43). However, in 1995 a "disability initiative" was reported -- central planning, but funds must be raised locally (Pearson 1996).

[15] Pearson (1992, p. 418, citing Bloomingdale 1980, Visher and Visher 1979, and Breger 1984).

[16] Pearson does not believe that the Chinese have used the IC process to silence political dissenters: "[A]buse of the psychiatric system by the state has not become institutionalized, and political dissent has not been redefined as a symptom of mental disorder" (Pearson 1992, pp. 421-22). "There are other ways of dealing with political dissidents that do not require the inappropriate utilization of a scarce and expensive hospital bed" (Pearson 1992, p. 421).

[17] Other jurisdictions in Australia were equally vague. Tasmania's former law defined "mental disorder" as "mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of the mind," and

"mental illness" was not defined. (Mental Health Act 1963 (Tas), §4(1)). Under Victoria's former law, "mentally ill" was defined as "suffering from a psychiatric or other illness which substantially impairs mental health" (Mental Health Act 1959 (Vic), §3, quoted in Errington 1987, p. 185). Several statutes in the United States were very initially broadly worded, and many have been held to be unconstitutional on the grounds of vagueness. Stromberg and Stone (1983, p. 313) cite several, including those of Arkansas (Ark. Stat. Ann. §59-101 (1979): "any person [who is] an idiot, lunatic, or of unsound mind"); Colorado (Colo. Rev. Stat. §27-10-102 (1982): person "of such a mental condition that he is in need of medical supervision, treatment, care or restraint"); Texas (Tex. Rev. Civ. Stat. Ann. art. 5547-4(k)(Vernon Supp. 1982-1983): "person whose mental health is substantially impaired")

[18] The Butler Committee had defined "mental illness" as a "disorder which has not always existed in the patient but has developed as a condition overlaying the sufferer's usual personality" (Report of the Committee on Mentally Abnormal Offenders (Butler Committee) Cmnd 62 (1975), quoted in Peng, Cheang, and Tsee 1994, p. 21). The Department of Health and Social Services in Britain contends that mental illness comprises one or more of the following:

- (i) more than temporary impairment of intellectual function shown by a failure of memory, orientation, comprehension, or learning capacity.
 - (ii) more than a temporary alteration of mood of such degree as to give rise to the patient having a delusional appraisal of his situation, his past or his future or that of others or to the lack of any appraisal.
 - (iii) delusional beliefs, persecutory, jealous and grandiose.
 - (iv) abnormal perspectives associated with delusional misinterpretations of events.
 - (v) thinking so disordered as to prevent the patient making a reasonable appraisal or having reasonable communication with others.
- (Peng, Cheang, and Tsee 1994, p. 21-21, quoting DHSS (1976 -- no citation).

[19] Other jurisdictions using such a definition include South Australia ("any illness or disorder of the mind," The Laws of Australia, p. 42, citing Mental Health Act 1993 (SA), §3). This appears to be a carryover from the 1976 Act (see Errington 1987, p. 185); Norway ("serious mental disease" (usually understood as identical to a psychosis) (Høyer 1988, p. 290); South Africa (in the 1973 Act, "any disorder or disability of the mind" (see Kruger 1980, p. 49)).

[20] (Peng, Cheang, and Tsee 1994, p. 14, quoting The Mental Disorders and Treatment Act (1985) [Singapore], p. 3). Neither "unsound of mind" nor "mental disorder" is further defined (Peng, Cheang, and Tsee 1994, pp. 14-15). Thus, it is unclear whether the Singapore law "refers to any type of mental disorder or only to the more major ones" (id.).

21Mental Health Law [Taiwan], Article 3 (quoted in Salzberg 1993, App., p. 188). Until 1980, there was little official attention paid to issues of mental health. Indeed, "there were no laws whatsoever regulating admission procedures, treatment modalities, patient care practices, discharge from hospital, or other aspects of psychiatric care" (Salzberg 1993, p. 171).

[22] A new law, which has been under consideration by the Indian Parliament since 1949, refers to "mental disorder" rather than "lunacy," and provides for a sharper

differentiation between voluntary and involuntary admission (Mestrovic 1986). The new law still gives the magistrate much more power in the decision than a psychiatrist (id.).

[23] New York's Mental Hygiene Law employs a similar two-step pattern, defining "mental disability" as "mental illness, mental retardation, developmental disability, alcoholism, substance dependence, or chemical dependence. A mentally disabled person is one who has a mental disability." 34A McKinney's Consol. Laws of New York, §1.03(3). In turn, "[m]ental illness' means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation." Id., §1.03(20).

[24] See "Israeli Treatment of Mental Patients Law" (5751-1991), cited in Bar El, et al (1998).

[25] Japan's law which took effect in 1988 (1987) -- continued the definition of "mentally disordered person" from the 1950 Act, which defined such person as follows: 'a psychotic person (including those who are psychotic due to intoxication), a mentally retarded person or a psychopathic person.' (Salzberg 1993, p. 175, n. 61, citing Mental Hygiene Law (Law No. 68, 1987), art. 3). Denmark's law is even less specific, authorizing commitment of person whose states of mind "are analogous to psychosis" (Vestergaard 1994, p. 194).

[26] Of course, courts and administrative agencies may in turn defer to psychiatric judgment, as discussed infra.

[27] See Estate of Chambers, 71 Cal. App. 3d 277, 139 Cal. Rptr. 357 (1977).

[28] Bar El, et al 1998, pp. 336-37, citing Levy (1992).

[29] The Royal Commission which adopted the Mental Health Act 1959 accepted a lay definition (Errington, p. 184, citing Report of the Royal Commission, Cmnd 169, ¶17(a)).

[30] Errington (1987, p. 184, citing 1 Q.B. 711 (1974)).

[31] The Laws of Australia, §30, p. 42, citing Hogget (1990).

[32] Utah Code Ann. §64-7-28 (Supp. 1981). As noted above, California has reached the same result through court decision. Even the American Psychiatric Association Model Statute (which no U.S. state has adopted in its entirety) does not rely so heavily upon the DSM, defining mental illness more broadly (cited in Stromberg and Stone 1983, p. 312).

33 (Mental Health (Treatment and Care) Act 1994)ACT) §4. New South Wales has a similar provision (see Mental Health Act 1990 (NSW), Sch 1, quoted in The Laws of Australia, §27, p.39).

[34] The Northwest Territories Mental Health Act, c. 6 (2d) (1985), §2; Ind. Code §16-14-9.1-1(a).

[35] Fla. Stat. Ann. §394.455(18) (Supp. 1997); Miss. Code Ann. §41-21-61(e) (supp. 1998); Mental Health Act 1986 (Vic), §8(1A), quoted in *The Laws of Australia*, p. 43

[36] New Zealand: *The Mental Health (Compulsory Assessment and Treatment) Act 1992*, §2, quoted in Rogers 1994, p. 404)

[37] Ind. Code §16-14-9.1-1(a); Miss. Code Ann. §41-21-61(e) (supp. 1998).

[38] (Salzberg 1993, p. 175, n. 61, quoting *The Northwest Territories Mental Health Act*, c. 6 (2d) (1985), §2; Miss. Code Ann. §41-21-61(e) (supp. 1998); *Mental Health Law [Taiwan]*, Article 3 (quoted in Salzberg 1993, App., p. 188); *Mental Health Act 1986 (Vic)*, §8(1A), quoted in *The Laws of Australia*, p. 43

[39] (Salzberg 1993, p. 175, n. 61, quoting *The Northwest Territories Mental Health Act*, c. 6 (2d) (1985), §2; Miss. Code Ann. §41-21-61(e) (supp. 1998); New Zealand: *The Mental Health (Compulsory Assessment and Treatment) Act 1992*, §2, quoted in Rogers 1994, p. 404); *Mental Health Act 1986 (Vic)*, §8(1A), quoted in *The Laws of Australia*, p. 43

[40] (Salzberg 1993, p. 175, n. 61, quoting *The Northwest Territories Mental Health Act*, c. 6 (2d) (1985), §2; Miss. Code Ann. §41-21-61(e) (supp. 1998); New Zealand: *The Mental Health (Compulsory Assessment and Treatment) Act 1992*, §2, quoted in Rogers 1994, p. 404); *Mental Health Act 1986 (Vic)*, §8(1A), quoted in *The Laws of Australia*, p. 43

[41] Salzberg 1993, p. 175, n. 61, quoting *The Northwest Territories Mental Health Act*, c. 6 (2d) (1985), §2; Miss. Code Ann. §41-21-61(e) (supp. 1998)..

[42] Salzberg 1993, p. 175, n. 61, quoting *The Northwest Territories Mental Health Act*, c. 6 (2d) (1985), §2; Miss. Code Ann. §41-21-61(e) (supp. 1998); *Mental Health Act 1986 (Vic)*, §8(1A), quoted in *The Laws of Australia*, p. 43

[43] *Mental Health Law [Taiwan]*, Article 3 (quoted in Salzberg 1993, App., p. 188)

[44] Fla. Stat. Ann. §394.455(18) (Supp. 1997)

[45] New Zealand: *The Mental Health (Compulsory Assessment and Treatment) Act 1992*, §2, quoted in Rogers 1994, p. 404)

[46] (Salzberg 1993, p. 175, n. 61, quoting *The Northwest Territories Mental Health Act*, c. 6 (2d) (1985), §2; Miss. Code Ann. §41-21-61(e) (supp. 1998).

[47] Fla. Stat. Ann. §394.455(18) (Supp. 1997)

[48] Salzberg 1993, p. 175, n. 61, quoting *The Northwest Territories Mental Health Act*, c. 6 (2d) (1985), §2; Miss. Code Ann. §41-21-61(e) (supp. 1998); [ISRAEL, quoted in Bar el, et al. 1998, p. 65).

[49] Ind. Code §16-14-9.1-1(a); Mental Health Law [Taiwan], Article 3 (quoted in Salzberg 1993, App., p. 188)

[50] Ind. Code §16-14-9.1-1(a).

[51] Salzberg 1993, p. 175, n. 61, quoting The Northwest Territories Mental Health Act, c. 6 (2d) (1985), §2; Ind. Code §16-14-9.1-1(a); Miss. Code Ann. §41-21-61(e) (supp. 1998).

[52] Salzberg 1993, p. 175, n. 61, quoting The Northwest Territories Mental Health Act, c. 6 (2d) (1985), §2; Fla. Stat. Ann. §394.455(18) (Supp. 1997); Miss. Code Ann. §41-21-61(e) (supp. 1998).

[53] Miss. Code Ann. §41-21-61(e) (supp. 1998).

[54] Ind. Code §16-14-9.1-1(a).

[55] (Salzberg 1993, p. 175, n. 61, quoting The Northwest Territories Mental Health Act, c. 6 (2d) (1985), §2; Fla. Stat. Ann. §394.455(18) (Supp. 1997); Mental Health Law [Taiwan], Article 3 (quoted in Salzberg 1993, App., p. 188)

[56] See also Høyer (1988).

[57] Heginbotham (1987, p. 2) recognizes that this precise definition did not stop Soviet psychiatrists from "treating" "perfectly ordinary sane" people.

[58] For instance, they ask (p. 24): "What is one to make of 'psychomotor excitement with a tendency toward aggressive actions?' This is merely dressed-up jargon which refers to nothing more than it states, and no particular psychiatric connotation can be extracted from it. This vagueness appears to pave the way for the security organs to 'persuade' psychiatrists that a dissenter's behavior is a risk to society." Bonnie (1990) found many patients committed under such sweeping definition, a process which he called "hyperdiagnosis."

[59] Miss. Code Ann. §41-21-61(e)(1), (3) (Supp. 1998).

[60] Cal. Welfare and Inst. Code §5002. On the other hand, other jurisdictions broaden the criteria. Taiwan's law states that mental illness "shall include psychosis, neurosis, alcohol and drug addiction" (Salzberg 1993, App., p. 188, Mental Health Law [Taiwan], Art. 3).

[61] U.N. Principles 4(1)-(3).

[62] The Laws of Australia, §20.8, quoting Mental Health (Treatment and Care) Act 194 (ACT, §5; Mental Health Act 1990 (NSW, §11(1); Mental Health Act 1986 (Vic), §8(2). In Victoria, a person is not to be considered mentally ill "because they have a particular economic or social status or they are a member of a particular cultural or racial group" (The Laws of Australia, §20.8, p. 45, citing Mental Health Act 1986 (Vic), §8(2)).

The Northern Territory and Queensland legislation contained more limited exclusion clauses, protecting a person's "particular political, anarchic, religious, irreligious, legal or illegal or moral or immoral opinion or activity" from consideration (Mental Health Act 1979 (NT), §4(2); Mental Health Act 1974 (Qld), §6(d)). The Northern Territory legislation also provided that the evidence of taking or addiction to a drug or psychotropic substance is not of itself evidence of mental illness (Mental Health Act 1979 (NT), §4(3)).

The Tasmanian legislation provided only that a person will not be taken to be suffering from a mental disorder by reason of promiscuity or other immoral conduct (Mental Health Act 1963 (Tas), §4(5) (The Laws of Australia, §20.8, p. 45). The Australian legislature declared that all Australian jurisdictions must have adopted the U.N. Principles by January 1, 1998.

[63] Mental Health Act 1983, §1(3).

[64] Com. V. Hubert, 494 Pa. 148, 430 A.2d 1160 (1981).

[65] New Zealand's law is slightly different. The definition of (in this case) "mental disorder" rests upon quasi-scientific criteria as well as a finding of dangerousness or need for treatment (Rogers 1994, p. 404, citing The Mental Health (Compulsory Assessment and Treatment) Act 1992). Thus, absent a finding of dangerousness or need for treatment, a person is not deemed mentally ill.

[66] Some statutes add a provision that the person be suffering from a mental illness "to such a degree" that he or she ought to be hospitalized." See, e.g., Mental Health Law 1974 (Qld), §18, Mental Health Law 1983 [England], §3(2). In a similar vein, New York's law provides that a person may be confined if he or she is "in need of involuntary care and treatment." Mental Health Law §9.27(a)(i). In turn, "'in need of involuntary care and treatment' means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." Mental Hygiene Law, §9.01. These provisions appear to add little to the criteria.

[67] Jurisdictions which do not have such a requirement include India (Mestrovic 1986). Nevertheless, the is understood to serve a police power function:

"In tune with the times in which it was enacted, the ILA views mental illness as a 'law and order' problem. Therefore, the procedure of involuntary commitment is required to be activated in order to protect society from the disruptive and dangerous manifestations of mental illness. Mental hospitals, are in the main, required to function as custodial housed and not treatment centers" (Dhanda 1993, p. 98).

Uruguay's law also contains no "dangerousness" requirement for medical commitment, which is the route by which the vast majority of persons are compulsorily admitted. "Emergency commitments, based on the standard "dangerousness to himself or others" or "imminent danger" to the peace and public morals, last only one day, after which a medical commitment must take place if the person is to be detained (Moncada 1994, pp. 603-04). Thus, this form of "compulsory

admission" "resembles an arrest for disorderly conduct more than it resembles proper commitment of a mental patient" (Moncada 1994, p. 604).

Japan's law provides three different routes to compulsory admission. The route taken by the great majority of persons -- the so-called "consent admission" (whereby the party consenting is a family member and not the patient) -- does not require a finding of dangerousness (Salzberg 1991).

[68] 405 Illinois Compiled Statutes Annotated 5/1-119 §§1,2 (1997). Some other jurisdictions with similarly worded provisions include: Canada (Ontario) (Mental Health Act, §32); Denmark (see Vestergaard 1994, p. 195); Germany (see Rössler, Salize, and Riecher-Rössler 1996, p. 405); Israel (see Bar El, et al 1998, p. 65); Japan [by regulation] (see Salzberg 1991, p. 150); Norway (see Høyer 1988, p. 290); Taiwan (see Salzberg 1993, App. p. 188); U.S. (California) (Cal. Welf. & Inst. Code § 5213); U.S. (Florida) (Fla. Stat. Ann. §394.467(1) (Supp. 1997)); U.S. (Mississippi) (Miss. Code Ann. §41-21-61(e) (supp. 1998)); U.S. (Pennsylvania) (50 Penn. Stat. §7301(a); U.S.S.R (see Bloch and Reddaway 1977, p. 152).

[69] Other jurisdictions with similar provisions include: New South Wales (Mental Health Act 1990 (NSW), §9(1)) Queensland (Mental Health Law 1974 (Qld), §18); British Columbia (R.S.B.C. Chap. 288, Section 22(2)); England (Mental Health Act §3(2)); Singapore (see Peng, Cheang, and Tsee 1994, p. 19).

[70] Such standards include "serious physical harm" (Mental Health Act 1990 (NSW), §9(1); "serious bodily harm" (Ontario Mental Health Act, §32); "manifest and substantial" threat (Vestergaard 1994, p. 195, citing law of Denmark); a "clear danger" (Bloch and Reddaway 1977, p. 152, citing law of the U.S.S.R.); "acute danger to self or others" (Rössler, Salize, and Riecher-Rössler 1996, p. 405, quoting law of Germany).

[71] See, e.g., Fla. Stat. Ann. §394.467(1) (Supp. 1997) [Florida (U.S.) ("There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm). Pennsylvania requires a "clear and present danger" to exist, which "can mean threatened or committed serious bodily harm on another and clear evidence that such conduct will be repeated (50 Penn. Stat. §7301(b)(1); that the person attempted suicide or took acts in furtherance of plans to commit suicide, or threatened suicide (50 Penn. Stat. §7301(b)(2)(ii)); or that the person has substantially mutilated himself, or has attempted to do so and will likely do so (50 Penn. Stat. §7301(b)(2)(iii). Japan has enacted a very detailed set of requirements, by regulation. See Salzberg 1991, p. 150. However, some of acts listed therein include such seemingly minor offenses as eating at a restaurant without paying. Id.

[72] A further problem is that such statutes reinforce the erroneous equating of mental illness with violence (see Rogers 1994, p. 410).

[73] Mental Health Act 1990 (NSW), §9(2).

[74] Mental Health Law 1974 (Qld), §18(b).

[75] These include at least Alaska, which made its change in 1985, Arizona (1990), Colorado (1989), Kansas (1986), North Carolina (1981), South Carolina (1975), and Texas (1987) (Miller 1992b).

[76] "'Gravely disabled' means . . . a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter" Cal. Welf. & Inst. Code §5008(h)(1).

[77] Peng, Cheang, and Tsee 1994, p. 14, quoting The Mental Disorders and Treatment Act (1985) [Singapore], p. 3. "Unsoundness of mind" is not defined.

[78] Turkheimer and Parry (1992, pp. 646-67) note that "attorneys, judges, and clinical examiners do not perform in a manner consistent with revised commitment standards and procedures" (citing Koch, Mann, and Vogel 1987; Peters, Miller, Schmidt and Meeter 1987; Warren 1977). Høyer (1988) also found that patients were admitted or retained where statutory criteria are not present.

[79] Applebaum states (at p. 41): "Thus, current evidence does not permit even a tentative answer to the question of whether changes in substantive standards have any effect at all!" Miller (1992b) studied changes in compulsory admissions in several laws which returned to "need for treatment" criteria. He concluded (p. 1383) that "[c]hanges in admission and census rates are multidetermined and cannot be simplistically attributed to a single cause, such as changes in commitment criteria."