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## COMPULSORY LEGAL MEASURES AND THE CONCEPT OF ILLNESS

LOUIS H. SWARTZ\*

### I. INTRODUCTION

We meet during a time when three modes of governmental efforts to deal with problem behavior and human problem conditions are in much ferment. I have in mind (1) criminal law and treatment of offenders, (2) civil commitment laws and programs, and (3) non-compulsory social welfare measures. Although I will not be able to deal in detail with this third category, for us to maintain a proper perspective in considering *compulsory* measures, we must keep non-compulsory alternatives well in mind. Indeed, Dr. Myerson has already dealt in specific terms with the matter of non-compulsory measures, reporting here detailed results of a long-term voluntary program for alcoholics in Boston.<sup>1</sup>

This paper discusses some of the implications of expanded concepts of mental health and mental ill-health or disorder for both the criminal and civil law. One need only to point to a few recent developments to demonstrate the relevance of recently extended notions of illness for the law relating to compulsory measures.

In *Robinson v. California*<sup>2</sup> in 1962, the Supreme Court of the United States ruled that a statute making it a misdemeanor to be a narcotic addict was contrary to the eighth amendment prohibition against cruel and unusual punishments. The court stated clearly, however, that states might properly apply civil commitment provisions to addicts.<sup>3</sup> In my own state, New York, a statute for the mandatory civil commitment of narcotic

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1. Myerson, *The Treatment of Alcoholism: A Physician's View*, 19 S.C.L. REV. 332 (1967), a reprint of D. J. Myerson & J. Mayer, *Origins, Treatment and Destiny of Skid-Row Alcoholic Men*, 275 NEW ENG. J. MED. 419 (1966).

2. 370 U.S. 660 (1962). The California Health and Safety Code § 11271, under which defendant had been convicted, made it a misdemeanor, punishable in no case by less than 90 days in jail, "to be addicted to the use of narcotics."

3. "California appears to have established just such a program in §§ 5350-5361 of its Welfare and Institutions Code. The record contains no explanation of why the civil procedures authorized by this legislation were not utilized in the present case." *Robinson v. California*, 370 U.S. 660, 665 n.7 (1962).

addicts for an indeterminate period up to three years, or in some cases up to five years, has just gone into effect.<sup>4</sup> The *Robinson* case also raised questions concerning what behavior associated with being a narcotic addict, such as use or possession of narcotics by addicts, might also be placed outside the criminal law and be reachable only through other modes of legal control. It left open, too, the question of what other patterns of maladjustment or poor mental health, regarded by many physicians as illness and by many legislators as crime, might be treated in similar fashion by the court.

Last year two federal courts of appeals, relying in whole or in part on *Robinson*, decided that a chronic alcoholic may not be convicted of the offense of public intoxication. These were the *Driver*<sup>5</sup> case in North Carolina, and the *Easter*<sup>6</sup> case in the District of Columbia. In *Driver*, the court clearly expressed the view that civil commitment might be used by the state.<sup>7</sup> In *Easter*, the District of Columbia already had commitment legislation of several years standing to which the court referred in its opinion,<sup>8</sup> but which had never become operational because of public failure to provide the legally required facilities. These cases also raised questions of a much broader nature concerning the extent to which aggressive or annoying behavior contrary to the provisions of criminal law might in the case of the chronic alcoholic be inappropriate for penal sanctions.

"Recognition" of addiction as disease is a recent development.<sup>9</sup> It was only in 1956 that the American Medical Association recognized alcoholism as a disease, that is to say, a condition hospital administrators should regard as warranting admission to

4. N. Y. MENTAL HYGIENE LAW §§ 200-213 (McKinney Supp. 1966) (commitment provisions effective April 1, 1967).

5. *Driver v. Hinnant*, 356 F.2d 761 (4th Cir. 1966). See 18 S.C.L. Rev. 504 (1966).

6. *Easter v. District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966).

7. "Of course, the alcohol-diseased may by law be kept out of public sight." *Driver v. Hinnant*, 356 F.2d 761, 764 (4th Cir. 1966). "[N]othing we have said precludes appropriate detention of . . . [the chronic alcoholic] for treatment and rehabilitation so long as he is not marked a criminal." *Id.* at 765.

8. D. C. CODE ANN. §§ 24-501-514 (1961). See *Easter v. District of Columbia*, 361 F.2d 50, 51 (D.C. Cir. 1966). Certification that proper and adequate treatment facilities had been provided as required by law had not been made, hence the commitment provisions had not gone into effect. *Id.* at 51 n.3.

9. See, e.g., Lindesmith, *Introduction*, in JOINT COMMITTEE OF AMER. BAR ASS'N & AMER. MEDICAL ASS'N, *DRUG ADDICTION: CRIME OR DISEASE?* vii-viii (1961).

the hospital.<sup>10</sup> One can readily see by referring to the "Krystal-Moore Discussion", a recent illuminating exchange of views in the *Quarterly Journal of Studies on Alcohol*,<sup>11</sup> that although there is consensus that properly qualified physicians may treat, and should treat, alcoholics, there is considerable divergence of views even among medical men as to whether alcoholism is a disease, and also as to whether any but certain medical specialists are qualified to deal with the problems of alcoholism.

I see alcoholism as a violation of conduct norms, norms against drinking "too much".<sup>12</sup> A wide variety of people drink too much; and some may be mentally ill in the more conventional sense. Most are not. Violation of conduct norms, whether concerning drinking, using narcotics, stealing or assaulting others, would in my view not, of itself, constitute disease.<sup>13</sup> In some cases such violations may be accompanied by disease, just as disease may accompany conformity to and non-violation of social and legal conduct norms.

Traditionally, *disease* has meant the disturbance of some subdivision of total human functioning, such as respiration or cognition, rather than total human functioning or conduct.<sup>14</sup> Indeed Dr. Myerson's explanation to this audience of his own view that alcoholism is not a disease was based on this ground, referring specifically to one of the notable versions of this position,

10. See *Hospitalization of Patients with Alcoholism*, 162 J.A.M.A. 750 (1956). See also Fox, *Alcoholism in 1966*, 123 AM. J. PSYCHIATRY 337 (1966):

It has taken 20 to 30 years of persistent effort by the National Council on Alcoholism, Alcoholics Anonymous, the Rutgers (formerly Yale) Center of Alcoholic Studies, the Christopher D. Smithers Foundation, and the North American Association of Alcoholism Programs to change the public image of the alcoholic . . . from that of a worthless, weak-willed skid row derelict to that of a worthwhile person suffering from an illness which can be successfully arrested so that he (or she) can take his rightful place in society—a good parent, good spouse, good neighbor, good worker, and a productive citizen with a social conscience.

11. Krystal & Moore, *Who Is Qualified to Treat the Alcoholic? A Discussion*, 24 Q. J. STUDIES ON ALCOHOL 705 (1963); Comments, 25 *Id.* 347, 558 (1964); 26 *Id.* 118, 310, 506 (1965).

12. See, e.g., Fox, *A Multidisciplinary Approach to the Treatment of Alcoholism*, 123 AM. J. PSYCHIATRY 769, 770 (1967):

Alcoholism is a behavioral disturbance in which the excessive drinking of alcohol interferes with the physical or mental health of the individual.

13. See Swartz, "Mental Disease": *The Groundwork for Legal Analysis and Legislative Action*, 111 U. PA. L. REV. 389, 404, 414-16, 420 (1963).

14. See Lewis, *Health as a Social Concept*, 4 BRIT. J. SOCIOLOGY 109, 117-18 (1953); Swartz, "Mental Disease": *The Groundwork for Legal Analysis and Legislative Action*, 111 U. PA. L. REV. 389, 404 (1963).

namely, Virchow's dictum that all disease must be traced to pathology in the cell.<sup>15</sup>

However, we are attempting in this paper to describe certain social views. The expanded concept of illness or poor mental health, which is our main subject, is at odds with the view just expressed by the writer and expressed also by Dr. Myerson.

We lawyers have a great need for structure and definiteness. We like to "tangle" with something solid—a statute, cases, a specific fact situation, either as found by a competent tribunal or as stated hypothetically. One need not be surprised, therefore, that we show reluctance to embark on discussions of social attitudes, cultural norms, expectations and beliefs, even though we admit their possible relevance to the resolution of legal problems. Yet, it seems to me that these informal and often somewhat vague facets of social reality are just as important to understand, when we talk about compulsory measures under the criminal law and the law of involuntary civil commitment, as other social facts for which we think we have "hard" reliable statistical data—the number of crimes committed, the amount of property damage involved, the number of arrests made, the clinical findings of physicians, and so on.

Thus, I aim this paper at the analysis of some aspects of social reality which I believe we should better understand when considering the future shape of compulsory legal measures as they relate to a wide range of types of "problem" behavior, including the excessive drinking behavior of the chronic alcoholic.

I wish to call attention to two related developments. The first is the harnessing of the prestige of science to value preferences in the form of mental health frames of reference. Second is the increased social tendency to resolve problems of norm violation with the aid of mental health frames of reference. In conclusion I refer to the need to work out legal principles adequate to the challenges posed by these developments.

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15. *Comments to Myerson Speech*, 19 S.C.L. REV. 347, 348 (1967).

## II. VALUE PREFERENCES AS MENTAL HEALTH

Kingsley Davis,<sup>16</sup> Barbara Wootton,<sup>17</sup> Thomas Szasz,<sup>18</sup> and others<sup>19</sup> have each in his own way called attention to the contemporary translation of morals into the language of mental health. This translation has been explained on the ground that traditional sources of moral authority—namely, religion and custom—have become much less powerful in their ability to command allegiance, their ability to move men to action, and their ability to fulfill men's desire for an emotionally and intellectually satisfying basis for the "rightness" (legitimacy)<sup>20</sup> of social value systems.

Disguising its valuational system (by means of the psychological position) as rational advice based on science, . . . [mental hygiene] can conveniently praise and condemn under the aegis of the medico-authoritarian mantle.<sup>21</sup>

Davis pointed out thirty years ago that mental hygiene (more recently called mental health) has taken over the dominant class ethic, namely, the Protestant ethic, "as the unconscious system of premises upon which its 'scientific' analysis and its conception of mental health itself are based."<sup>22</sup> In keeping with this

16. Davis, *Mental Hygiene and the Class Structure*, 1 PSYCHIATRY 55 (1938).

17. Wootton, *Sickness or Sin?*, 159 TWENTIETH CENTURY 433 (1956); Wootton, *The Law, the Doctor, and the Deviant*, 2 BRIT. MED. J. 197 (1963).

18. T. SZASZ, LAW, LIBERTY, AND PSYCHIATRY (1963), *passim*.

19. See Swartz, "Mental Disease": *The Groundwork for Legal Analysis and Legislative Action*, 111 U. PA. L. REV. 389, 403-09 (1963).

20. The meaning of *legitimacy* as used in this article is illustrated, in other contexts, in N. GROSS, W. MASON & A. McEACHERN, EXPLORATION IN ROLE ANALYSIS (1958). See, e.g., *id.* 248: "A legitimate expectation is one which the incumbent of a . . . position feels others have a right to hold. An illegitimate expectation is one which he does not feel others have a right to hold." Sociological discussions of legitimacy usually build upon the treatment of the subject by Weber. See Rheinstein, *Introduction*, in MAX WEBER ON LAW IN ECONOMY AND SOCIETY xxxix-xl (Rheinstein ed., transl. by Rheinstein & Shils, 1954).

21. Davis, *Mental Hygiene and the Class Structure*, 1 PSYCHIATRY 55, 65 (1938).

By the psychological approach is meant the explanation of human conduct in terms of traits originating within the individual, as over against traits originating within society . . . [P]sychologism is a means whereby an unconsciously held ethic may be advantageously propagated under the guise of 'science'. It protects the hygienist from a disconcerting fact—the relativity of moral judgments.

*Id.* at 60.

22. Davis, *Mental Hygiene and the Class Structure*, 1 PSYCHIATRY 55, 56 (1938).

interpretation, a psychiatrist defines *health* according to the "physical and mental processes which seem to be desirable to the system in power."<sup>23</sup>

Thus in an age when the prestige of science is high, some have in large areas of human conduct avoided explicit talk about values, and have spoken instead in terms of health and ill-health, good adjustment and poor adjustment—as if they were referring to empirical facts rather than to covert moral norms. Preferences about right conduct, and statements concerning the range within which groups are willing to tolerate nonconformity, have been disguised, and have been put forth dressed in the white laboratory coat of medical science. Speaking of the mental hygienist, Davis observed: "[H]is social function is not that of a scientist but that of a practicing moralist in a scientific, mobile world."<sup>24</sup> Or as Lady Wootton puts it: "The medical profession has . . . inherited the mantle of the church in an age in which profound religious conviction is exceptional and intimations of immortality are seldom taken seriously."<sup>25</sup>

The expanded concept of ill health is, of course, not just an academic matter. People take action in accord with the concept by bringing a great range of their problems to psychiatrists.<sup>26</sup>

23. Inasmuch as health is defined in each culture in terms of *those physical and mental processes which seem to be desirable to the system in power*, the American concept of health can be derived from that which will be said about the American culture as a whole. To be able to compete and to successfully grasp the opportunity which equality provides for the individual defines the essential meaning of living in America. In order to do these things, an American citizen must be strong, self-reliant, independent, free of physical disease, able to get along in a group, ready to adapt to emergencies, capable of caring for children and the family, and not a public liability. The healthy individual is expected to use his power for his own benefit with restraint and wisdom.

Ruesch, *Communication and Mental Illness: A Psychiatric Approach*, in RUESCH & BATESON, *COMMUNICATION* 71-72 (1951) (emphasis added).

24. DAVIS, *Mental Hygiene and the Class Structure*, 1 *PSYCHIATRY* 55, 65 (1938). See also Wootton, *The Law, the Doctor, and the Deviant*, 2 *BRIT. MED. J.* 197, 202 (1963):

[I]t is reasonable, as the supernatural sanction of moral systems fades, to seek an identification of morality and mental health. As a personal and social goal health has much to commend it. It is in harmony with science, and science is in harmony with the age. Besides, failure to achieve the goal of health evokes pity and sympathy: failure to attain virtue merely provokes censure. Goodness, too, is often priggish: health never. So if we once owed it to God to be good, we now owe it to science to be healthy.

25. Wootton, *The Law, the Doctor, and the Deviant*, 2 *BRIT. MED. J.* 197, 202 (1963).

26. See, e.g., Swartz, "Mental Disease": *The Groundwork for Legal Analysis and Legislative Action*, 111 *U. PA. L. REV.* 389, esp. 399-401 (1963).

Even apart from taking action about one's own problems, or those of his family, people are more aware of the mental health frame of reference, and are more likely to perceive the "problems" of others as illness.<sup>27</sup>

### III. RESOLVING PROBLEMS OF NORM VIOLATION WITH THE AID OF MENTAL HEALTH FRAMES OF REFERENCE

Any basic discussion of the criminal law and of punishment (treatment of offenders)<sup>28</sup> in modern times starts with a reference to widespread social criticism and doubts concerning these institutions. Thus Wechsler says:

[I]n no other area of law have legal purposes and methods been subjected to a more sustained and fundamental criticism emanating from without the legal group—especially the psychological and social sciences—but buttressed also from within.

The challenge is, in substance, that the penal law is ineffective, inhumane and thoroughly unscientific.<sup>29</sup>

A conflict or strain has developed between certain cultural norms and the norms of the traditional institution of criminal punishment. Norms having to do with rationality (especially efficiency and effectiveness),<sup>30</sup> the application of science to

27. "Persons who a generation ago would hardly have been thought of as mentally ill or mentally disabled are today perceived even by policemen and jailers as 'sick people', a perception with ramifications throughout the criminal process." A. MATTHEWS, *MENTAL ILLNESS AND THE CRIMINAL LAW: IS COMMUNITY MENTAL HEALTH AN ANSWER?* 2 (Research Contributions of the Amer. Bar Foundation, No. 2, 1967).

28. On the matter of definition and terminology concerning the modern institution of "how we deal with offenders," see Swartz, *Punishment and Treatment of Offenders*, 16 *BUFFALO L. REV.* 368 (1967).

29. Wechsler, *The Challenge of a Model Penal Code*, 65 *HARV. L. REV.* 1097, 1102-03 (1952) (footnotes omitted). Hart, *Prolegomenon to the Principles of Punishment*, 60 *ARISTOTELIAN SOC. PROC.* 1 (1959): "General interest in the topic of punishment has never been greater than it is at present and I doubt if the public discussion of it has ever been more confused."

30. More clear cut than many other problems of social control is the inefficiency and ineffectiveness of the criminal law in dealing with the chronic alcoholic offender. See, e.g., *PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE, THE CHALLENGE OF CRIME IN A FREE SOCIETY* 235 (1967): "The criminal justice system appears ineffective to deter drunkenness or to meet the problems of the chronic alcoholic offender."

human affairs,<sup>31</sup> the value of the individual life, and antipathy to the conscious infliction of suffering upon others, have made it increasingly difficult to legitimate punishment. Traditional moral values, with respect to notions of right and wrong, have also undergone great change and are in a considerable state of uncertainty. One aspect of this moral uncertainty is that there is less conviction that an individual can be considered responsible for what he does in the clear-cut "old-fashioned" sense of the terms responsibility and blameworthiness.<sup>32</sup>

Nevertheless, there would appear to be strongly felt social demands for legal institutions which will perform, approximately, certain of the functions we have traditionally associated with criminal law and punishment, namely: (a) normative definition

31. In modern societies purely moralistic or legal interpretations of delinquency appear unsatisfactory and out of tune with the scientific ethos of the times. If it can be determined that the offender is sick, his deviance is at least made explicable in principle, like other diseases, although there may still be some undiscovered 'virus'.

V. AUBERT, *ELEMENTS OF SOCIOLOGY* 145 (1967).

32. See W. MOBERLY, *RESPONSIBILITY* 3 (1951); Hart, *Prolegomenon to the Principles of Punishment*, 60 *ARISTOTELIAN SOC. PROC.* 1 (1959).

Speaking of the modern "crisis in valuation", Karl Mannheim notes that a conflict of philosophies exists in every major aspect of modern life, including the treatment of criminals. "We hesitate whether to treat the law-breaker as a sinner or as a patient, and cannot decide whether he or society is at fault." K. MANNHEIM, *DIAGNOSIS OF OUR TIME* 13 (1943).

"[I]n an increasing number of instances in modern society there is dispute over whether 'criminality' or 'illness' has led to a particular behavior sequence." V. Aubert & Messinger, *The Criminal and the Sick*, 1 *INQUIRY* 137, 138 (1958).

One might note also that some of the humane recent recommendations of the President's Commission may indirectly contribute to the increased blurring of the moral distinction between criminal and civil (or indeed between criminal, civil and voluntary) measures. PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE, *THE CHALLENGE OF CRIME IN A FREE SOCIETY* 133-34 (1967) (*Italics added*):

Procedures are needed to identify and divert from the criminal process mentally disordered or deficient persons. Not all members of this group are legally insane or incompetent to stand trial under traditional legal definitions . . . . It is more fruitful to discuss, not who can be tried and convicted as a matter of law, but how the officers of the administration of criminal justice should deal with *people who present special needs and problems*. In common prosecutorial practice this question is, and the Commission believes should be, decided on the basis of the kind of correctional program that appears to be most appropriate for a particular offender. The Commission believes that, if an individual is to be given special therapeutic treatment, he should be diverted as soon as possible from the criminal process. [The Commission recommends] early identification and diversion to other community resources of those offenders in need of treatment, for whom full criminal disposition does not appear required.

*Id.* 134.

of some conduct as seriously unacceptable; (b) vigorous expression of social disapproval of such conduct, including also the venting of feelings of hostility which exist concerning norm violators who harm or annoy us by engaging in such conduct; (c) deterrence of potential norm violators; (d) incapacitation or segregation of some troublesome norm violators; (e) rehabilitation of norm violators to the extent possible without too great economic cost or social inconvenience; (f) reassurance of the public that adequate measures are being taken to preserve order and safety.

Modern thinking has changed in various ways and degrees, with respect to the view, formerly widespread, that (1) we the public have a duty to punish the offender for his offense,<sup>33</sup> and that (2) the offender (a) deserves to be punished for his offense, and (b) for his own sake ought to desire punishment as a means of expiation.<sup>34</sup> Thus, under the historic or traditional view, punishment in whatever form and for whatever ends—as prescribed at the time—was mandated by social norms that laid down, in theory at least, complementary obligations on the part of both society and the offender.

We do believe, however, that sick people (a) *ought* to be treated, and (b) ought to seek and cooperate with competent

33. Against the doubt as to whether the state has any right to punish at all, . . . [the retributive, expiratory or retaliatory] theory maintains it to be a positive moral duty. . . . Kant . . . expressed an undoubtedly wide sentiment when he urged that we could not regard a world as moral if in it virtue went unrewarded or sin unpunished.

Cohen, *Moral Aspects of the Criminal Law*, 49 *YALE L.J.* 987, 1009-10 (1940).

Shoham provides the following translation of a well-known passage from Kant: "[E]ven if civil society should dissolve with the consent of its members . . . the last murderer found in prison must first have been executed, so that each may receive what his debts are worth." S. SHOHAM, *CRIME AND SOCIAL DEVIATION* 36 (1966) (detailed citation therein).

34. Dostoevsky passionately believed that society was morally justified in punishing people simply because they had done wrong; he also believed that psychologically the criminal needed his punishment to heal the laceration of the bonds that joined him to his society. So, in the end, Ras-kolnikov the murderer thirsts for his punishment. Many of us here today—perhaps most of us—may hate these ideas . . . [Yet] In an attenuated form they still have a place among the now complicated and partly inconsistent set of ideas that jostle together in the mind of an English judge when he sentences the criminals convicted in his court.

H. L. A. HART, *PUNISHMENT AND THE ELIMINATION OF RESPONSIBILITY* 4 (1962).

help in getting well,<sup>35</sup> and further that we the public should not allow sickness in the community to go untreated, untended.

Thus, under the contemporary view, widely shared in modern society, treatment of the sick is mandated by social norms that lay down complementary obligations in this direction on the part of both society and the sick individual.

The limited but important parallel I am suggesting between legitimization of traditional punishment of the offender and modern treatment of the sick is now almost complete. Traditionally, the offender "deserved" punishment. Today, as well as historically, the sick person "deserves" treatment, and is "in need of help." However, this parallel yet lacks one element of crowning importance—that of legal compulsion.

Where because of his ill health the sick person cannot appreciate or effectively act upon knowledge of the fact that he is sick and needs competent help in getting well, (a) the obligation of various people around him, and the obligation of the community at large, to furnish competent help to him becomes greater, and (b) the use of coercion in furnishing care and treatment to the sick person becomes legitimate ("right," "proper") to the extent that it is necessary to protect others or the sick person himself

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35. The socially institutionalized expectations of others with respect to the sick person, which tend also to be his expectations of himself, have been termed the "sick role".

There seem to be four aspects of the institutionalized expectation system relative to the sick role. First, is the exemption from normal social role responsibilities, which of course is relative to the nature and severity of the illness. . . .

The second closely related aspect is the institutionalized definition that the sick person cannot be expected by "pulling himself together" to get well by an act of decision or will. In this sense also he is exempted from responsibility—he is in a condition that must "be taken care of." His "condition" must be changed, not merely his "attitude." Of course, the process of recovery may be spontaneous but while the illness lasts he can't "help it." . . .

The third element is the definition of the state of being ill as itself undesirable with its obligation to want to "get well." . . .

Finally, the fourth closely related element is the obligation—in proportion to the severity of the condition, of course—to seek technically competent help, namely, in the most usual case, that of a physician and to cooperate with him in the process of trying to get well. . . .

T. PARSONS, *THE SOCIAL SYSTEM* 436-37 (1951). See also Parsons, *Illness and the Role of the Physician: A Sociological Perspective*, 21 *AM. J. ORTHOPSYCHIATRY* 452 (1951); Parsons, *Definitions of Health and Illness in the Light of American Values and Social Structure*, in E. G. JACO, *PATIENTS, PHYSICIANS AND ILLNESS* 165 (1958).

from serious harm because of his illness.<sup>36</sup> It is a role obligation of the sick person to seek competent help and cooperate in getting well. Where he is incapacitated by his illness itself from doing these things—witness the harm, to himself or others, that is imminent or has already occurred (as a result of his alcoholism, his narcotic addiction, his sex deviance, his psychopathy, etc.) due to his failure to seek or obtain adequate help for his illness—then, under some circumstances at least, others must provide the “help” to him on an involuntary basis.

For convenience we can give labels to the different modes of legitimating public use of coercion in the case of some norm violators, as briefly described above. The traditional set of norms and values we will call the *wrongdoing-punishment model*. To the extent that belief in these elements of the historic legitimation of punishment has weakened or disappeared entirely, a new and somewhat functionally equivalent belief has either reinforced the weakened older belief or has replaced it. The new belief, applicable to compulsory measures under both the criminal law and recent laws of civil commitment, might be called the *illness-involuntary care model*. In modern times the wrongdoing-punishment model and the illness-involuntary care model both employ the highly flexible word *treatment*. In one case the word is used to refer to treatment of offenders; in the other to treatment of patients, psychopaths, sociopaths, addicts, etc.

We now find the illness-involuntary care model informally superimposed over the wrongdoing-punishment model as a supplementary, or alternative, rationalization of the criminal law institution of treatment of offenders.<sup>37</sup> We will also find the

36. See, e.g., Parsons, *Illness and the Role of the Physician: a Sociological Perspective*, 21 AM. J. ORTHOPSYCHIATRY 452, 457 (1951): “This conception of lack of responsibility leads to the justification of coercion of the insane, as by commitment to a hospital.” Parsons distinguishes between the sick role and the role of the insane, but does not elaborate upon the differences, which would make a very interesting subject for analysis.

37. [T]he idea of reform was in the beginning conceived of as a moral change, a conversion or a gradual moral enlightenment. Solitary confinement was introduced with the rationale that it would give the criminal a chance to repent . . . . It was inevitable, however, with increasing secularization and rationality that the process of reform should be viewed as a question of improvement or recovery in more ethically neutral terms. The analogy with the sick was near at hand and probably the only one available.

V. AUBERT, *THE HIDDEN SOCIETY*, 44 (1965).

[I]n a society where science is used to make predictions and control the future in ever increasing areas of life, the lack of predictability of the

illness-involuntary care model applied to certain categories of norm violators and violations separated from the criminal law and placed in the civil law.<sup>38</sup>

For some lawmakers seeking greater incapacitation than the conventional wrongdoing-punishment model allows, there is a willingness to designate certain troublesome categories of offenders as "pathological" in some substantial sense that differentiates them from "ordinary" offenders, and to provide greater security through civil measures or special correctional measures for these.<sup>39</sup> Belief in the soundness of the criminal law may in general remain undiminished or may perhaps even be strengthened because of the above exception, or parallel structure, created.

The illness-involuntary care model accommodates well our conflicting feelings about what public steps to take concerning those who harm or annoy us. What conflicting feelings about treatment of norm violators are we talking about, and how does the illness-involuntary care model resolve these conflicts? Two specifics, using the individual as a means, and purposely inflicting pain, may suffice for purposes of illustration.

#### A. *Using an individual as a means*

We shrink from ordering the individual against his will or regardless of his consent to sacrifice his life, or any substantial part of his life, for the social good. (The conscription of men into the armed forces, and their assignment to combat, are extra-

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criminal's future behavior cannot easily be tolerated . . . [The definition of the criminal as sick] brings his deviant behavior into the scope of comprehensive theories, whose predictions are based upon a biological and psychological model of man. In principle, the behavior of the offender appears now to be predictable.

Aubert & Messinger, *The Criminal and the Sick*, 1 *INQUIRY* 137, 151 (1958).

38. See, e.g., Logan, *May a Man Be Punished Because He is Ill?*, 52 *A.B.A.J.* 932, 934 (1966), quoting principles agreed to at the National Conference on Legal Aspects of Alcohol and Alcohol Use, held June, 1965, at Swampscott, Massachusetts, under the aegis of the Boston University Law-Medicine Institute: "[After establishment of adequate facilities,] alcoholics should be directed to treatment. Those who fail to respond to treatment should not continue to be subjected to arrest procedures, but should be provided an institutional environment for as long as necessary" (emphasis added).

39. Examples are the sex psychopath laws, see F. LINDMANN & D. McINTYRE, *THE MENTALLY DISABLED AND THE LAW*, ch. 10 (1961), and the one day to life sentence for certain sex offenders, as provided by N. Y. *PENAL L.* §§ 690, 2010.

ordinary but well-institutionalized exceptions to this.)<sup>40</sup> Thus we shrink from depriving a man of years of his life through imprisonment as a direct means (individual prevention) or an indirect means (general prevention)<sup>41</sup> of promoting the well-being of others, namely, ourselves.

On the other hand, the illness model as well as the "rehabilitative ideal",<sup>42</sup> permits us to accept compulsory expenditure of a portion of the individual's life where a major aim is said to be that of benefiting the individual himself. Of course, he is "benefited" according to our notions of benefit rather than his own.

### *B. Purposely inflicting pain*

We shrink from the fact that compulsory measures cause pain to those to whom they are applied. The pain results from deprivation of liberty, including physical confinement, loss or reduction of personal autonomy, loss of privacy, and loss of many of the satisfactions of free life. The pain in addition may include the harshness of institutional life, or (for those on probation or parole) the painful threat of being sent or returned to an institution, and possibly the pain of some specific effort applied by others to the individual to make him change in the direction they desire.

We shrink from deliberately inflicting pain on an individual as a way of making him better, or, as a way of using him to make others better. Thus we shrink from intentionally inflicting the pain of imprisonment as a device for inducing law-abidingness in the individual himself or in others.

The illness-involuntary care model, however, as well as the incapacitative-rehabilitative aim,<sup>43</sup> posits health or rehabilitation as the goal. Such care or correction is defined as not "hurting" the individual. Perhaps this is because the production of

40. Compare the analogy expressed by Justice Holmes:

If I were having a philosophical talk with a man I was going to have hanged (or electrocuted) I should say, I don't doubt that your act was inevitable for you but to make it more avoidable by others we propose to sacrifice you to the common good. You may regard yourself as a soldier dying for your country if you like. But the law must keep its promises.

HOLMES, HOLMES-LASKI LETTERS 806 (Howe ed. 1953), as quoted in PAULSEN & KADISH, CRIMINAL LAW AND ITS PROCESSES 75 (1962).

41. See, e.g., Andenaes, *General Preventive Effects of Punishment*, 114 U. PA. L. REV. 949 (1966).

42. See F. ALLEN, *THE BORDERLAND OF CRIMINAL JUSTICE* 25, 37 (1964).

43. See P. TAPPAN, *CRIME, JUSTICE AND CORRECTION* 259-61 (1960).

suffering is definitely excluded as a conscious objective of such care, even if it is a known accompaniment of it.

Recapitulating, then, the sick role and an expanded concept of mental disorder or ill-health, involve the following features of importance for the legitimation of coercive measures: (a) there is an obligation to help the mentally disordered person, against his will if necessary, not only for the protection of others, but for his own good; (b) the treatment and care of such persons is to be turned over to specialists who will deal with the disordered person by the use of scientific methods; (c) the status of the mentally disordered is negatively valued, and involves status-reduction; (d) because of its negative valuation and the possible loss of liberty involved, as well as the suffering caused by the "illness" itself, the role of the mentally disordered is to be perceived as involving discomfort and deprivation; (e) ideas of proportionality between harm caused and the length of loss of liberty do not apply; (f) compulsory measures of treatment do not "hurt" the individual subjected to them.

The sick role and an expanded concept of mental disorder thus provide a new legitimation of the use of legal compulsion, both with respect to the criminal law and an expanded category of compulsory measures in the civil law.<sup>44</sup>

#### IV. CONCLUSION

In many ways the aspects of reality under discussion do not make a pretty picture. They indicate the present lack of provision, within mental health frames of reference, for direct moral discourse.

A basic dilemma of any system of social and legal ordering is how it shall relate what Pound has called the social interest in the individual life to the social interest in the general security.<sup>45</sup> This dilemma runs throughout the criminal and correctional law

44. "[W]hereas until lately violations of the social norms that are generally approved were treated as matters that lay between a man's conscience and the criminal law, such violations are now more and more commonly held to involve questions of mental health or mental disorder." Wootton, *The Law, the Doctor, and the Deviant*, 2 BRIT. MED. J. 197 (1963).

"If people believe that health values justify coercion, but that moral and political values do not, those who wish to coerce others will tend to enlarge the category of health values at the expense of the category of moral values. We are already far along this road." T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* 6-7 (1963).

45. See Pound, *The Rise of Socialized Criminal Justice*, 10 CRIME & DELINQUENCY 475-79 (1964); Pound, *The Juvenile Court in the Service State*, 10 CRIME & DELINQUENCY 516, 520 (1964).

and the civil law of involuntary commitment. Pressures in favor of both of these interests in our society are very strong.

Existing balances between these interests have been placed in doubt by the weakening of traditional moral frames of reference and the increasing popularity of mental health frames of reference. The rise of the latter presents the possible occasion and opportunity for renegotiating institutionalized definitions of, and ways of dealing with, problem behavior and problem people. A somewhat analogous, but more limited, movement to renegotiate was forwarded in the late nineteenth century and thereafter by the Italian criminological positivists and their followers.<sup>46</sup>

The crucial challenge concerning institutional changes probably does not lie in the substantive value preferences of mental health frames of reference, for here in spite of a strong tendency toward conformity we find flexibility and, indeed, indeterminacy. The potential of psychoanalysis for justifying both conventionality and unconventionality is a partial illustration of the point. These frameworks use a somewhat unfamiliar and evolving grammar which can be manipulated to reach a wide variety of conclusions. Much more substantial and enduring difficulties, however, lie in an increased tendency to make unwarranted assumptions as to existing knowledge, resources, and practical capabilities,<sup>47</sup> the masking of values as scientific fact, and a tendency by means of a benign rhetoric to cover over the morally problematic aspects of the use of compulsion.

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III POUND, JURISPRUDENCE 23 (1959): "Social interests are claims or demands or desires . . . thought of in terms of social life and generalized as claims of the social group."

I share the basic point of view so well stated by Professor Allen. "[T]he central problem of the criminal law is and will remain political in character. It is the problem of achieving the objectives of public order through the use of power so regulated as to preserve and nourish the basic political values." F. ALLEN, *THE BORDERLAND OF CRIMINAL JUSTICE* viii (1964).

46. The deterministic position [of the late nineteenth century Italian positivists] . . . called for a system of criminal prophylaxis. . . . The 'state of danger' of the criminal was to be the decisive criterion in selecting the appropriate method of dealing with him. Since the appropriate response of society to dangerousness was not punishment but defence, the very term punishment, paradoxical as it might seem, should be expunged from all penal codes. In its place there should be a network of measures of social defence, elastically conceived to serve the purposes of reformation, cure, incapacitation or even elimination, as the case might require. L. RADZINOWICZ, *IDEOLOGY AND CRIME* 55 (1966).

47. "[T]he values of individual liberty may be imperiled by claims to knowledge and therapeutic technique that we, in fact, do not possess and by our failure to concede candidly what we do not know." F. ALLEN, *THE BORDERLAND OF CRIMINAL JUSTICE* 37 (1964).