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RECOGNIZING OUR DANGEROUS GIFTS: APPLYING THE SOCIAL MODEL TO INDIVIDUALS WITH MENTAL ILLNESS

Rachael Andersen-Watts*

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INTRODUCTION

Sometimes we get called sick and sometimes we get called sacred, but no matter how they name us we are a vital part of making this planet whole.¹

Our society and laws allow a space for a multitude of identities and forms of expression. Many kinds of differences are legally protected in various ways, such as differences in race, religion, and gender. Sometimes protection takes the form of requiring social institutions to adapt to the unique needs of certain individuals or groups. Rights for disabled individuals, as exemplified by the Americans with Disabilities Act,² rest on the principle that impairment disables because the world is structured around an incompatible model of human ability; not because of a fundamental deficit within the individual. This conception, termed the social model of disability, functions well for the paradigmatic physical impairments such as a paraplegic in a wheelchair, but not all impairments fall so neatly into this framework. While the social model of dis-

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1. The Icarus Project, *Underground Roots and Magic Spells: Visions for Resisting Monoculture and Building Community*, <http://www.theicarusproject.net/articles/underground-roots-and-magic-spells-visions-for-resisting-monoculture-and-building-community> (last visited Feb. 20, 2007).

2. Americans with Disabilities Act, 42 U.S.C. § 12101 (2006).

ability has been essential in the evolution of disability rights law, those who are disabled by mental illness have been excluded from application of this progressive model.³ There are many reasons proffered for such exclusion, such as safety, and the so-called "right to cure."⁴ Nevertheless, a more critical look at the lives and experiences of individuals with mental illness reveals that their legal disadvantages have more to do stigma, fear, and discrimination than with altruistic goals, such as safety or a right to treatment. In a society in which sanism⁵ reigns, the medical model remains the lens through which the law views the mentally ill. By taking the side of doctors who believe that the mentally ill require medical treatment, lawyers and judges accept without question the invisible oppression of sanist ideology.

I argue that the current medical model of mental illness is deeply insufficient for mentally ill litigants. Under the guise of objective knowledge—that is, a psychiatric diagnosis—the medical model as it is applied in the law fails to recognize the dignity in the identities of the mentally ill and thereby perpetuates, if not worsens, their collective denigration as members of society.

Besides ignoring the potentially substantial role that social structures play in shaping the life of a mentally ill person, such as access to health services and employment, the medical model is particularly troubling in the case of a psychiatric patient as a litigant. Physical disabilities are much more likely than mental disease to have an agreed upon diagnosis, course of treatment and expected recovery time within the medical field.⁶ Furthermore, studies have shown that psychiatrists tend to err on the side of safety when predicting outcomes such as dangerousness, an important (though not necessarily decisive) issue in cases dealing with the liberty interests of a person with mental illness, such as civil commitment cases.⁷ In fact, the American Psychological Association published guidelines to aid legislatures in creating civil commitment statutes that did not even include danger to self or others as a necessary or recommended requirement for involuntary confinement.⁸ Since courts typically

3. Aaron A. Dhir, *Human Rights Treaty Drafting through the Lens of Mental Disability*, 41 STAN. J. INT'L L. 181, 193 (2005) ("While it can be argued that 'over time, this medical model of disability is being replaced' . . . with respect to mental disability, the prevailing zeitgeist in psychiatry is still rooted in the medical model, focusing on diagnostic approaches and biological explanations at the expense of social explanations.") (citations omitted).

4. MICHAEL L. PERLIN, *MENTAL DISABILITY LAW* (1999).

5. Legal scholar and Professor of Law Michael Perlin defines "sanism" as prejudice against the mentally ill. He asserts that: "Sanism is as insidious as other 'isms' [like racism and sexism] and is, in some ways, more troubling, since it is (1) largely invisible, (2) largely socially acceptable, and (3) frequently practiced (consciously and unconsciously) by individuals who regularly take 'liberal' or 'progressive.'" *Id.* at 24.

6. Karen Guiduli, *Challenges for the Mentally Ill: The "Threat to Safety" Defense Standard and the Use of Psychotropic Medication Under Title I of the Americans with Disabilities Act of 1990*, 144 U. PA. L. REV. 1149, 1158 (1996).

7. Bruce A. Arrigo, *Paternalism, Civil Commitment and Illness Politics: Assessing the Current Debate and Outlining a Future Direction*, 7 J.L. & HEALTH 131, 144 (1993).

8. *Id.* at 145.

rely on expert testimony of physicians and mental health professionals to make a determination of (in)sanity,⁹ the likely result is complicity of courts with doctors in the mantra of “better to be safe than sorry.”¹⁰

This Note will consider the possibility of a different legal approach that gives individuals with mental illness broader rights to make their own medical decisions. More broadly, it will examine the impact of the legal structure in shaping the identity of the mentally ill. To this end, I will explore issues that appear persistently problematic in the legal realm for individuals with mental illness. I will use the 2000 Ohio Supreme Court case, *Steele v. Hamilton County Community Health Board*¹¹ to highlight many of the difficult and provocative issues that arise when courts consider the lives, rights, and identities of individuals with mental illness. I will also draw from the 2001 Montana Supreme Court case, *In the Matter of the Mental Health of K.G.F.*¹² as an example of a decision that looks at mental illness in a more progressive manner, taking into account more than Western medicine’s insight, and is therefore an example of a case heading in the direction that I will advocate for in this Note. The *Steele* case clearly depicts the law’s blind adherence to the medical model and its effect on the identity of its litigants by the rights it grants, the legal principles it applies, and the voices and opinions the court deems meritorious. The *K.G.F.* case juxtaposes the *Steele* opinion, and demonstrates some of the considerations of a court that is conscious of society’s implicit sanist bias.¹³ These two cases provide compelling stories through which to view many complex and difficult questions: How do courts shape the identities of mentally ill litigants? How could alternative arguments and models improve the interaction between the law and individuals with mental illness? What is at stake for the lives of the mentally ill, whether their liberty is restricted or not?

The concepts of autonomy and liberty are fundamental to the discussion of why, which, and whether rights should be afforded to mentally ill individuals. It is a theme that runs throughout cases and legal scholarship concerning individuals with mental illness. Those living with mental illness are of particular interest due to the real risk to personal liberty that many of these individuals face under the law. Far from finding a world that is structured to be readily accessible to them, those who identify (or are identified) as mentally ill may be

9. *Id.* at 143.

10. *Id.* at 145.

11. *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10 (Ohio 2000).

12. *In re K.G.F.*, 29 P.3d 485 (Mont. 2001).

13. Professor Perlin has discussed this case as well, looking specifically at the Montana Supreme Court’s progressive approach to the standard for counsel in involuntary commitment hearings, but stating also that “the [K.G.F.] decision remains the exception to the usual practice. K.G.F. has only been cited once outside of Montana, and in that case, the Washington Court of Appeals took issue with the K.G.F. court’s [opinion].” Michael L. Perlin, *And My Best Friend, My Doctor Won’t Even Say What It Is I’ve Got*, 42 SAN DIEGO L. REV. 735, 741 (2005). Thus, while *K.G.F.* is very useful as a tool for analysis, it does not represent a legal trend.

involuntarily institutionalized,¹⁴ denied the right to vote,¹⁵ afforded less protection than individuals with physical disabilities under the ADA,¹⁶ and forced to take psychotropic drugs to be rendered competent to stand trial.¹⁷ The use of psychotropic medication¹⁸ is an issue that uniquely faces the mentally ill. While all medications have the potential to alter the state of the user in some way, this class of drugs is meant to change thoughts, behavior, and emotions, which are all, in theory, affected by symptoms of mental illness.¹⁹ These same thoughts, behavior, and emotions are also at the heart of what it is to be human and their expression in an individual is central to personal identity.

Of course, many justifications are proffered for such intrusions made in the name of the law, from public safety to the state's interest in prosecuting individuals for crimes. Such justifications, however, are not so black-and-white.²⁰ Moreover, there are clear risks of the state having such broad authority over the rights of the mentally ill besides risks to individual liberty; by allowing the medical model to speak for the mentally ill, they are denied valid identities in the eyes of the law. Since mental illness affects mental processes, is the true person simply masked by the illness, or do antipsychotics medicate individuals who simply view the world through a different lens, forcing them to assimilate to conventional mental processes? If the latter is true, is it ethical to take a hands-off approach to the mentally ill, or would this simply be giving mentally ill individuals the "right to rot"?²¹ Shouldn't we listen to those who live with mental illness before traveling down either path? In order to challenge the current legal view, the interaction of individuals with mental illness and the law must be examined from the perspective that has been neglected by the law thus far; that is, from those who live with mental illness. Accordingly, my analysis will center around the voices of these individuals.

This Note sets out to do the following. First, it will lay out the groundwork for my critique of the law's approach to the mentally ill. I offer a brief historical account of such treatment and some of the problematic medical issues, focusing on the ways in which law compromises the rights of the men-

14. Arrigo, *supra* note 7, at 142.

15. Judi Chamberlin, *Citizenship Rights and Psychiatric Disability*, 21 PSYCHIATRIC REHABILITATION J. 405, 405 (1998); Kay Schriener, Lisa A. Ochs & Todd G. Shields, *The Last Suffrage Movement: Voting Rights for Persons with Cognitive and Emotional Disabilities*, 27 PUBLIUS: J. FEDERALISM 75, 75 (1997).

16. Guiduli, *supra* note 6, at 1158.

17. *Sell v. United States*, 539 U.S. 166, 169 (2003).

18. The term "psychotropic medication" encompasses antidepressants, antimanic, antianxiety medication, and antipsychotics. See Guiduli, *supra* note 6, at 1160-61.

19. Brendan D. Kelly, *Structural Violence and Schizophrenia*, 61 SOC. SCI. & MED. 721, 722 (2005).

20. Professor Perlin argues that mental illness law is pretextual in its application. He argues that "the mental disability law system often deprives individual of liberty *disingenuously* and for reasons that have no relationship to case law or to statutes." PERLIN, *supra* note 4 at 27 (emphasis added).

21. Arrigo, *supra* note 7, at 133.

tally ill. Next, it will offer a critical account of the medical model of mental illness, examining how medicine and the judiciary currently frame the legal rights and identity of individuals with mental illness. I then discuss the concept of the social model and how it may account for mental illness. I will draw upon the disability scholars and advocates of the patient movement to evaluate an alternative framework for shaping the legal and social identities of the mentally ill. Throughout the preceding parts, I will turn to the *Steele* and *K.G.F.* cases as illustrative narratives in the analysis.

Finally, I conclude by considering the application of the social model of disability to the law in the context of mental illness. Through the application of the social model, I argue that we can get beyond the dichotomy of hands-on or hands-off in the law's role in the lives of mental illness by using a more complete and nuanced approach. Beyond the black and white landscape of the medical model, the social model will allow lawyers and judges to confront the social inequalities facing individuals with mental illness, ensuring that these citizens have identities and therefore dignity in the eyes of the law.

I. FOUNDATIONS OF THE DEBATE: LEGAL HISTORY AND MEDICAL BACKGROUND

The history of the law's regulation of the lives of individuals with mental illness in the United States sheds light on the intent and purpose of these legal interventions. Significantly, the state has frequently invoked *parens patriae* power in legal interactions with individuals with mental illness. In contrast to police power, which is invoked to protect society at large, a state's rights as *parens patriae* are deeply rooted in paternalism,²² allowing it to make decisions that protect an individual according to what the state thinks she needs. Originally utilized to protect the property rights of heirs of "idiots and lunatics" in English law, *parens patriae* has since been extended to include a state's duty to protect the insane from themselves.²³ For example, in the *Steele* case, this protection came in the form of involuntary commitment and forced medication, a serious interference with liberty; indeed criminal law sets the evidentiary bar at "beyond a reasonable doubt" to ensure that no individuals unjustly suffer only the intrusion of imprisonment. But, there are real world implications of living with mental illness that could be alleviated by large-scale medical intervention, paternalistic though it may be. For example, schizophrenic individuals have high rates of homelessness in comparison to the general population in many countries,²⁴ and are also over-represented in prison populations.²⁵ Nevertheless, statistics must be differentiated from inevitabilities. The disproportionate use of the states' *parens patriae* power in cases involving individuals with mental

22. *Id.* at 137.

23. *Id.*

24. Kelly, *supra* note 19, at 724.

25. *Id.* at 725-26.

illness exposes the law's assumption that the mentally ill must be more heavily regulated than the sane. The question is, then, to what (or whose) end?

The success of traditional medical treatment for mental illness is questionable, making the link between medical intervention and quality of life for the mentally ill tenuous at best. The Lester and Tritter study, in which authors drew from interviews with multiple focus groups of between five and twelve people with serious mental illness, ranging from serious depression to psychoses such as schizophrenia, suggests not only that drugs are not as effective as one may presume, but that the mental health structure in general may be inappropriate for the needs of individuals with mental illness.²⁶ Psychiatric patient participants complained of their healthcare providers not believing them that drugs negatively impacted their quality of life.²⁷ In fact, users reported serious side effects such as severe exhaustion, with one person reporting a need for thirteen hours of sleep a night due to medication.²⁸ Another participant suffered lockjaw as a result of his psychotropic drug prescription, and reported doctors simply told him that he would "get over it."²⁹ There was also stress associated with seeking treatment, from busy waiting rooms aggravating symptoms of anxiety,³⁰ to the fear of being "outed" as a psychiatric patient by fellow community members.³¹ When they *do* seek treatment for mental illness individuals face, daunting possibilities of social stigma, debilitating side effects of treatment, involuntary confinement, and even denial of the right to vote in the majority of states.³² Thus, not only does a paternalistic approach to the mentally ill deprive these individuals of important liberties, but the protection or help that paternalistic intervention provides may do more harm than good.

II. MEDICAL MODEL IN THE COURTS: WHY ARE JUDGES AND DOCTORS ON THE SAME TEAM?

The law has largely adopted the medical model in its approach to individuals with mental illness. This model follows the framework accepted within Western medicine that treats impairment as an individual's malfunction, calling for a treatment or a cure. Medical doctors speak for people with mental illness in the legal realm, since the medical model holds that the thoughts, behavior and words of the mentally ill are symptoms of disease and not the legitimate sentiments of that person.³³

26. Helen Lester & Jonathan Q. Tritter, "Listen to My Madness": *Understanding the Experience of People with Serious Mental Illness*, 27 SOC. HEALTH & ILLNESS 649, 649-69 (2005).

27. *Id.* at 658.

28. *Id.*

29. *Id.*

30. *Id.* at 661.

31. *Id.* at 659.

32. Schriener et al., *supra* note 15, at 76.

33. *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 14 (Ohio 2000).

The case of *Steele v. Hamilton* provides a useful factual framework to illustrate the unspoken and unchallenged use of the medical model in the law. Jeffrey Steele's encounter with the law was shaped by the medical model from the beginning. Mr. Steele is an adult man, diagnosed with paranoid schizophrenia, who was deemed to have no right to refuse antipsychotic medication despite the fact that his psychiatrists agreed that he posed no imminent danger to himself or others.³⁴ Mr. Steele was taken to a state hospital by a police officer after his family reported that he was "seeing things and trying to fight imaginary foes."³⁵ A hospital physician assessed Mr. Steele and determined that he needed to be hospitalized for treatment of psychosis.³⁶ Three days after his arrival at the facility, a physician, Dr. Rohs, filed an affidavit with the probate court that concluded that Mr. Steele most likely suffered from paranoid schizophrenia.³⁷ This psychiatric diagnosis, that is the perhaps questionable label of schizophrenic,³⁸ laid the groundwork for his involuntary commitment.

The case went up to the Supreme Court of Ohio, which held that a state may exercise its *parens patriae* power to justify forced administration of antipsychotic medication to a non-dangerous, committed mentally ill patient, overturning a prior case that held the contrary.³⁹ The Court further modified Ohio case law by holding that a mental patient would no longer have to be adjudicated incompetent to receive antipsychotic medication against his or her will, but instead would only have to be found specifically incompetent to make a medical decision.⁴⁰

The medical model presumes that the problem arises within the patient, and therefore the focus is on the cure, i.e. alleviating symptoms of the diagnosed disorder. In the case of mental health, the treatment often means psychotropic drugs.⁴¹ In the *Steele* case, it is implicit that the Court perceives Mr. Steele's difficulties to be within his own body; there is no discussion of the social obstacles that he must endure as a schizophrenic person. The opinion

34. *Id.* at 13.

35. *Id.*

36. *Id.*

37. *Id.*

38. The use of the label "schizophrenic" has recently been criticized for its overbroad application and stigmatizing effect. BBC News quoted Richard Bentall, Professor of Experimental Clinical Psychology at the University of Manchester, as stating: "We do not doubt there are people who have distressing experiences such as hearing voices or paranoid fears. But the concept of schizophrenia is scientifically meaningless. It groups together a whole range of different problems under one label --the assumption is that all of these people with all of these different problems have the same brain disease." Schizophrenia Term Use 'Invalid', BBC NEWS, Oct. 9, 2006, <http://news.bbc.co.uk/2/hi/health/6033013.stm> (last visited November 1, 2007).

39. *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 18 (Ohio 2000).

40. *Id.* at 20. (holding that the standard would be one of clear and convincing evidence that the patient lacks the capacity to give or withhold informed consent involving treatment).

41. Lester & Tritter, *supra* note 26, at 650.

came down on December 18, 2000, and we are told in the statement of the facts that Mr. Steele was first committed on July 26, 1997.⁴² No mention is made of the almost three and a half years that Mr. Steele was involuntarily committed. The Court, although recognizing that Mr. Steele is non-dangerous, non-suicidal, and non-disruptive in general, nonetheless points to his own refusal to accept a "cure" as the circumstance that precludes his release, rather than questioning the system that would hold such a person against his will for such a prolonged duration.⁴³

The *Steele* opinion demonstrates the medical model's inability to conceive of a mentally ill individual as having a valid identity that includes his or her mental illness. In *Steele*, the magistrate found that Mr. Steele's schizophrenia "resulted in 'a substantial disorder of thought [that] grossly impair[ed] his behavior and judgment.'"⁴⁴ This statement spells out the court's opinion that Mr. Steele's expressions were not, in and of themselves, to be taken as authentic or legitimate, but were viewed as skewed by his affliction. Moreover, the magistrate made his findings upon the testimony of three psychiatrists,⁴⁵ revealing the unquestioning acceptance of the medical model as a neutral framework. Interestingly, there is evidence that the psychiatric community saw the *Steele* case as a substantial victory in that the law adopted psychiatry's own view of mental illness. Former chair of the APA's Commission on Public Policy, Litigation, and Advocacy, Richard Ciccone, M.D., a forensic psychiatrist and Director of the Psychiatry and Law Program at the University of Rochester,⁴⁶ said that he was "impressed with the judges' insightful approach to mental illness and its treatment in *Steele v. Hamilton*, adding that this decision should "send a message to psychiatrists in other states that we must clearly articulate the facts about mental illness, and when we do, judges will get the message."⁴⁷

Paternalism in the law, such as use of *parens patriae* by the courts, is facilitated by the medical model, which silences the voices of the mentally ill and presumes that only a non-mentally ill identity is sufficiently legitimate to retain full autonomy.⁴⁸ The justification for invocation of *parens patriae* is that a person is unable to care for himself.⁴⁹ After this judgment, rendered upon medi-

42. *Steele*, 736 N.E.2d at 13.

43. *Id.* at 14.

44. *Id.*

45. *Id.*

46. Richard Ciccone's curriculum vitae, available at

http://www.urmc.rochester.edu/smd/psych/fac_staff/ciccone_richard.html.

47. Ken Hausman, *Legal News: State Can Forcibly Medicate Nonviolent Patients, Court Rules*, PSYCHIATRIC NEWS, Jan. 5 2001, at 8.

48. *See id.*

49. *See Arrigo*, *supra* note 7, at 137; *see also Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 19 (Ohio 2000) ("A state's *parens patriae* power allows it to care for citizens who are unable to take care of themselves.") (citing *Addington v. Tex.*, 441 U.S. 418, 426 (1979)).

cal opinion, the court will balance the benefits of the involuntary treatment sought with side effects of such treatment.⁵⁰ Since the courts rely upon testimony of physicians,⁵¹ benefits and side effects are judged in the medical sense,⁵² and social “side effects” and potential benefits of abstaining from intervention are neglected. The *Steele* case depicts how the sanist tradition prevails, and how the medical model provides yet another vehicle for the law’s heavy hand to constrain the choices of mentally ill litigants.

The Court in *Steele* conceded that police power, which may be invoked to protect public safety and welfare, could not be asserted absent a finding of imminent danger to self or others.⁵³ Therefore, it invoked its *parens patriae* power. On its face, the use of *parens patriae* to regulate the mentally ill is clearly paternalistic and thus directly impinges on personal autonomy in an obvious way. On the other hand, proponents of the medical model might argue that forced treatment vindicates the interests of the “sane” Mr. Steele who would appear with drug treatment. While no claims can be made on the likelihood, perhaps once forcibly medicated, Mr. Steele would opt to continue his treatment.⁵⁴ Whose truth is more important, in this case, that of Mr. Steele pre-medication, or that of a hypothetically cooperative and satisfied Mr. Steele post-medication? Does this argument delve too far into the unknowable to justify a type of affirmative legal prevention that is not generally imposed on the population?

What about the argument that the medical model is protecting individuals with mental illness from themselves? As stated above, the mentally ill are over-represented in populations such as among the homeless, and surely many other grim statistics are available. Patient rights activist and psychiatric survivor⁵⁵ Judi Chamberlin points out that paternalistic oppression of the mentally

50. See *Steele*, 736 N.E.2d at 21 (“The additional findings required by our holding, *i.e.* whether the medication is in the patient’s best interest and whether a less intrusive treatment would be as effective . . .”).

51. Arrigo, *supra* note 7, at 143.

52. See Hausman, *supra* note 47, at 8.

53. *Steele*, 736 N.E.2d at 19; Arrigo, *supra* note 7, at 136.

54. In a footnote to the case, the Court states that “the question of forcing [Mr. Steele] is now moot because he is voluntarily taking antipsychotic medications.” *Steele*, 736 N.E.2d at 21 n.8. The Court adds if Mr. Steele were to refuse in the future, an action to force administration of the medication would be reasonable. In spite of Mr. Steele’s acceptance of drugs, the Court states that there is no evidence in the record to suggest that he has recovered or been released from the treatment center. *Id.*

55. I use the title “psychiatric survivor” based on Chamberlin’s own preference for the terminology. I take it to indicate Chamberlin’s own agency and identity, and in turn life dealing with psychiatry and her own mental health, and not a reference to a state of being cured or past psychiatric treatment. This preference is much like the preference for the term “domestic violence survivor” on the part of advocates and feminists over “battered woman” or “victim of domestic violence,” not necessarily because a survivor does not, or will never, experience domestic violence, but instead as reflective of her life as someone who has endured domestic violence, instead of a passive receiver of abuse.

ill may purport to look out for the safety of such individuals, but even if it is accomplishing that, it is not balancing the very real and important concern of the right of these individuals to pursue happiness,⁵⁶ which may not be achievable if their liberty is so paternalistically impinged upon. As Chamberlin eloquently reminds us: “[t]he struggle for freedom has always been seen by the powerful as a denial of the obvious truth of superiority of the rulers.”⁵⁷ This rings true all the more when one considers the rhetoric of protection of the mentally ill in other contexts. Police officers do not pre-imprison individuals with a high likelihood of criminal behavior in hopes of teaching a lesson before real harm is done, nor can a court order involuntary medical treatment for a condition such as cancer based on the premise the subject will be happier in the long run. These things are simply not done – it is not illegal for an adult to act against her own best interest.

The murky concept of autonomy is enshrined in our Bill of Rights, and concerns about potential violations of autonomy are central to the application of law under the medical model. Thus, the interpretation of autonomy dictates the ways in which the law restrains and shapes the lives, and thus identities, of individuals with mental illness.⁵⁸ When looking at cases like *Steele* that involve forcing the court’s will on a person, it is clear that the law has intruded upon that individual’s personal autonomy to at least some degree.

Patient activist and psychiatric survivor Judi Chamberlin asserts that a value central to autonomy is that an adult may “make choices that diverge from social norms or expectations, so long as those choices do not bring the individual into conflict with established civil or criminal law.”⁵⁹ It is possible, however, to conceive of this intervention as actually *protecting* autonomy, if credence is given to the medical model. That is, if one believes that the true self lies beneath the symptoms of mental illness, then court intervention which mandates treatment, be it medication, therapy, or even involuntary institutionalization, would aim to help the underlying self realize autonomy by freeing it from the symptoms which alter its decision-making process. The focus on autonomy looks at whether the state’s interference in the lives of the mentally ill truly represents an erosion of personal liberty. That is, the idea of autonomy assumes that there is a kernel of truth within an individual and that if we can get to this truth, we will know what the right answer is.⁶⁰ This idea is only useful under the black and white assumptions of the medical model; that is diseases versus sane, medicated or unmedicated. It is, however, far too simplistic with respect to the mentally ill.

56. Chamberlin, *supra* note 15, at 406-07.

57. *Id.* at 406.

58. JUDYTH LYNN FAILER, WHO QUALIFIES FOR RIGHTS? 57-58 (2002).

59. Chamberlin, *supra* note 15, at 405.

60. For a critique of the wisdom of mandatory autonomy in the field of bioethics, see CARL E. SCHNEIDER, THE PRACTICE OF AUTONOMY (1998).

In this view, the paternalistic protection invoked by the state would foster the ability of these individuals to better live within society as it is structured. But this is precisely where the medical model fails. It confronts the following conundrum: should we protect the autonomy of persons with mental illness by allowing them to do what they want, or should the law, presuming that we know what is best for their health and well-being, dispense with consent? This is frequently referred to as the “right to cure” versus “right to refuse” debate.⁶¹ It arises because of the medical model’s understanding of a mentally ill individual as someone who is objectively dysfunctional. I will return to this crucial point in my discussion of the application of the social model, and how it could bring us out of this paradox by reframing the question from intervention or status quo, to a more complete account that dignifies the identity of the individual.

The medical model also affects the quality of court proceedings. In the *Steele* case, the Court relied exclusively on the expert testimony of three psychiatrists in finding that Mr. Steele was in fact insane.⁶² Furthermore, the Court stated that it would not require a full adjudication of incompetence in forced medication cases in the future, but would instead require a showing of the patient’s specific incompetence to give or withhold informed consent.⁶³ While the Court asserts that by not adjudicating the incompetence issue, it is avoiding use of an onerous procedure that, if successful, would curtail a wide range of rights belonging to the mentally ill individual in question,⁶⁴ I am quite suspicious about such tidy justification. The ability to give or refuse valid informed consent relies on a patient’s ability take in all relevant information, and then she must apply that information to the situation at hand. In the *Steele* case, testimony came from three psychiatrists, all of whom concurred that Mr. Steele was suffering from paranoid schizophrenia, but that he was *not* an immediate danger to himself or others.⁶⁵ The psychiatrists testified that Mr. Steele lacked the capacity to give or withhold informed consent, that the medication was the only effective treatment for his illness, that the benefits of medication outweighed costs of side effects, and that his illness prevented his release from the hospital.⁶⁶ In light of the realities of court proceedings implicitly dictated by the medical model, meaning that the judge is listening often exclusively to testimony from medical doctors it is nearly impossible to imagine a case wherein a doctor testifies that someone like Mr. Steele made a decision that suggests the ability to give valid informed consent. That is, asking a doctor, who by hypothesis believes that mental illness is a condition that can be treated with medication, whether a patient who is refusing treatment has

61. JUDITH LYNN FAILER, WHO QUALIFIES FOR RIGHTS? 138-41 (2002).

62. *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 14 (Ohio 2000).

63. *Id.* at 19-20.

64. *Id.* at 19.

65. *Id.* at 14.

66. *Id.*

properly weighed all of the information at hand to make an informed decision seems like an odd, if not entirely disingenuous, procedure.

Since doctors conceive of mental illness as an individual malfunction requiring a medical, generally chemical, cure, a vision of a valid identity of a person like Mr. Steele is effectively precluded. If an individual's thoughts, perceptions and preferences are mere manifestations of a disease that the individually is reversibly afflicted with, the illness is simply a distortion of the real person beneath it. The reliance on medical doctors within the law, as expert witnesses or for guidance in the legislative process, then necessarily infuses many aspects of the medical model into the legal construction of individuals with mental illness. This view unchallenged purports to do justice for individuals like Mr. Steele by advocating for their "sane selves" that are rendered unable to communicate because of mental disease. This view, however, is sharply challenged outside legal discourse by both academics and activists. If this alternative viewpoint has merit, then and justice is compromised when substantive arguments are omitted in litigation.

The medical profession is without a doubt entitled to pursue what it believes to be legal justice through such advocacy. But it also goes without saying that the law is not merely an extension of science but a rich and complex body of thought unto itself. When, as in the case of individuals with mental illness, courts appear to be wearing the hat of another profession, it is necessary to question the law's allegiance to ensure that it is society, and not an elite group of medical doctors, that benefits from its process.

III. THE SOCIAL MODEL OF DISABILITIES AND MENTAL ILLNESS

Though the courts favor the medical model's of mental illness, it has been sharply challenged by many scholars, who argue that the mentally ill are more fairly accounted for within the social model of disability.⁶⁷ The social model demedicalizes disability by distinguishing impairments, caused by factors such as genetics or disease, from the social barriers that turn the impairment into a disability.⁶⁸ While the medical model understands disability as a dysfunction arising within the individual, the social model looks at a world structured for a specifically-abled subset of the population, and thus views the problem as existing in social structures and not in the individual who encounters a world unprepared to accommodate her.⁶⁹ There is significant tension

67. Elizabeth J. Donaldson, *The Corpus of the Madwoman: Toward a Feminist Disability Studies Theory of Embodiment and Mental Illness*, 14 NWSA J. 99, 111 (2002); Lester & Tritter, *supra* note 26, at 650-51.

68. Lester & Tritter, *supra* note 26, at 651.

69. *Id.* at 653-54. See also Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 653-57 (1999) for further discussion of the definition of the social model of disability: In contrast to the medical model of disability, which views disadvantages as flowing naturally from a defect located in an individual, the social model of disability sees disadvantages as flowing from social systems and structures. Because members of society historically have not viewed

among disability scholars as to the inclusion of mentally ill individuals within the discourse of the disability movement.⁷⁰ Those who advocate for the mentally ill, however, point out that these individuals suffer from many of the same obstacles that all disabled people face, from social stigma to employment barriers, and argue that they deserve full legitimacy as well.⁷¹ It is perhaps the invisibility of mental illness, which affects the way one feels, thinks or perceives, in contrast to the outward stigma associated with a physical impairment, that accounts for the sometimes outsider status of the mentally ill within disability discourse.⁷² Whether or not people with mental illness fit neatly into the disabilities discourse, their unique issues merit discussion as they undeniably face substantial difficulties in comparison to non-mentally ill people. They should have the same legal protection, at least in theory, as people with other types of disabilities under statutes such as the Americans with Disabilities Act.⁷³

Scholars have used the position of the cognitively impaired within disability discourse, using it to examine the social model's premise that many differences often labeled as inferior are in fact valuable existences that represent diversity, not malfunction. Though cognitive disabilities are distinct from mental illness in many ways,⁷⁴ cognitive impairment may provide a useful analogy to mental illness. Individuals with mental illness *do* share some traits with the cognitively impaired, such as a history of isolation and institutionalization. Moreover, both groups have unique capacities for understanding the world around them in comparison to the so-called norm. Given these similarities, the framing of the cognitively impaired within the social model may be useful in conceptualizing individuals with mental illness within the model.

Advocates of the social model have analogized Down Syndrome to gender in order to blur the lines of correctness versus defect in humans. In earlier times, being a woman was a condition thought to leave the afflicted wrought with physical weakness and frailty of the mind.⁷⁵ While sexism certainly persists, it is no longer medically valid to conceive of a female as genetically inferior. Thus, this analogy gave rise to the argument that Down Syndrome has

persons with disabilities as part of the societal norm, no attempts have been made to avoid the creation of physical and attitudinal barriers built into the very framework of society - barriers that prevent persons with disabilities from fully participating in society. Thus, the disadvantaged status of persons with disabilities is the product of a hostile (or at least inhospitable) social environment, not simply the product of bodily defects. *Id.* (citations omitted).

70. Lester & Tritter, *supra* note 26, at 653.

71. Chamberlin, *supra* note 15, at 405; Schriener et al., *supra* note 15.

72. Chamberlin, *supra* note 15, at 405.

73. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 (2006).

74. For example, cognitive impairments may have more clear phenotypic markers and onset of impairment is typically at birth, whereas onset of mental illness may not occur until adulthood.

75. Sophia Isako Wong, *At Home with Down Syndrome and Gender*, 17 HYPATIA 89, 98 (2002).

the potential to be transformed in a similar manner to gender if it were re-framed as a concededly different, but natural and valid state, as many scholars argue that it is.⁷⁶ Could this argument extend to mental illness as well?

In the case of Mr. Steele, this would require asking whether his state as a paranoid schizophrenic person represents a natural and valuable state of difference within humanity, legitimating his identity as a schizophrenic individual, instead of a disease that necessitates a cure. Mental illness certainly occurs naturally, but the real issue becomes whether or not it can be conceived of as a state that does not need rectification. In contrast to Down Syndrome, which is not alterable, mental illness can be treated with medication that can thereby changing the mentally ill individual's thoughts and behaviors and rendering her, by medical standards, normal. The idea of curing mental illness becomes quite problematic in light of the serious side effects that frequently accompany consumption of antipsychotic drugs, which may include nausea, headaches, muscle stiffness and spasms, and the serious and incurable condition of tardive dyskinesia, whose symptoms include involuntary movements of the head, face, or extremities, and may affect up to twenty-five percent of patients.⁷⁷ In light of the fact that there is no way to treat a person with antipsychotic medication without putting her health at great risk, mental illness could be framed much like a cognitive impairment such as Down Syndrome. That is, mental illness could be re-conceptualized within the social model as a non-alterable state that is not objectively wrong but merely constructed as such. Thus, if the social model were introduced in litigation, forced administration of medication could be framed as drugging instead of treatment. This frame offers a very different vantage point than the medical model, which would have the court simply balance potential side effects against the state's interest in medicating the mentally ill person at issue, as the Court did in *Steele*.⁷⁸

Among social model proponents, the role of impairment has been hotly contested.⁷⁹ Some argue that discussions of pain and limitations should be left out so as to keep the focus on social structures, and off of the bodies of the impaired. Many feminists, however, critique this view because it ignores the reality that impairment does restrict activity.⁸⁰ Silencing this part of the conversation could undermine the need for social care and accommodation.⁸¹ For example, in the case of Mr. Steele, should social model proponents focus solely on the fact that a non-dangerous adult should be allowed to live free from state intervention? Or should they also consider the fact that many of his symptoms, including self-induced vomiting and the belief that he must

76. *Id.*

77. Guiduli, *supra* note 6, at 1185; *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 17 (Ohio 2000).

78. *Steele*, 736 N.E.2d at 17-18.

79. Lester & Tritter, *supra* note 26, at 651-52.

80. *Id.*

81. *Id.*

fend off enemies visible only to him, may well be terribly unpleasant for him? I return to this issue in a discussion of the practical application of the social model to mental illness in the law.

Another concept in the social model theory is that of embodiment, or the elimination of the false dichotomy between mind and body, in favor focusing on how, in the case at hand, one *lives* mental illness.⁸² The medical model, on the other hand, implicitly rejects this concept by viewing an individual with mental illness as having a sane mind that is separate from the disease. Chamberlin states that we must look at the whole cohesive package to do justice to the individual: "Defining a person's difficulties as psychiatric is a rejection of people's experiences. Psychiatric diagnosis ... den[ies] the real meaning that supposedly dysfunctional behavior has to the individual."⁸³ Lester and Tritter report that some patients with serious mental illness express the importance of "owning" their impairment. They see mental illness as intrinsic to their unique identity, and report that they do not believe that they should be presumed to have shameful feelings toward it.⁸⁴ The Icarus Project,⁸⁵ a mental illness support group with a global network comprised primarily of individuals with bipolar disorder, sees theirs as a "condition as a dangerous gift to be cultivated and taken care of rather than as a disease or disorder needing to be 'cured' or 'eliminated.'"⁸⁶

The concept of embodiment presents some difficulties in considering the lives of mentally ill individuals. In the *Steele* case, Dr. Rohs reported that Mr. Steele's history of "odd and paranoid behavior" included "refusing to eat food prepared by his family, talking to himself, making threats to his family, [and] forcing himself to throw up every morning."⁸⁷ While in the University Hospital, Mr. Steele was withdrawn, neglected his hygiene, and refused medication.⁸⁸ In the case of Jeffrey Steele, can a man suffering from delusions, unable or unwilling to care for himself in very basic ways, be asked to embody his illness in a useful way? He is clearly embodying it in a very literal sense. In the Lester and Tritter study, authors report that living with mental illness was "almost universally described as frightening."⁸⁹ Though the theory of embodiment is centered on the idea of blurring the mind/body duality, it assumes that one has the capacity to observe and reflect on oneself as a sort of observer. If it did account for Mr. Steele, should we praise him for his flawless embodiment, or do we find ourselves battling the gut reaction that his case

82. *Id.* at 653.

83. Chamberlin, *supra* note 15, at 407.

84. Lester & Tritter, *supra* note 26, at 658-59.

85. The Icarus Project, *The Icarus Project: Navigating the Space Between Brilliance and Madness*, <http://www.theicarusproject.net> (last visited Feb. 20, 2007).

86. Icarus Project, *Origins and Purpose*, <http://www.theicarusproject.net/icarus-organizational/origins-and-purpose> (last visited Feb. 20, 2007).

87. *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 13 (Ohio 2000).

88. *Id.*

89. Lester & Tritter, *supra* note 26, at 657.

goes too far? I will return to this issue in the following section, wherein I will discuss the potential for the practical application of the social model, which need not and indeed *should* not lose sight of the potentially negative aspects of mental illness if it is to work for people and not merely for theory's sake.

So, the question is what potential the social model has to interact with the law to more appropriately and comprehensively represent the identity of the mentally ill. Unlike the medical model, which conceives of the mentally ill person as manifesting symptoms of a disease that obscures the true self that lies beneath, the social model presents the possibility of an identity that embodies the mental illness as one aspect of the self. This is not to say that the presumption is refusal of medication. In a case like that of Jeffrey Steele, where the individual with a mental illness at issue is despondent and unable to fully communicate his personal preferences, it would not be prudent to assume under the social model that every person with a mental illness would refuse treatment. What the social model shows is that the voices of the mentally ill are silenced not because of the illness itself, but because of the very medical model that renders them invisible as people with legitimate identities until they are medicated.

IV. APPLYING THE SOCIAL MODEL TO MENTAL ILLNESS

*A person may behave in ways that other people can't understand, but in ways that have meaning and value for that person in the context of his or her life.*⁹⁰

The social model offers great promise as an alternative, and validating, framework for the identities of individuals with mental illness that would give such individuals ownership of their condition and resulting existence without presuming that a life with mental illness lacks value simply because it is not understandable by the non-mentally ill. In order to achieve justice for people with mental illness, the social model must be applied in a practical and complete manner, accounting for the full spectrum of factors that affect the lives of the mentally ill, from the value of identity, stigma and social barriers, to lived suffering and danger to oneself or others.

The debate should be less about what patients have a right to do or have done to them and more about treating them in a way that will feel fair to the very same patients – not theoretical fairness, but fairness on the ground. The medical model, however, precludes this vision of fairness because of the fundamental conundrum they are placed in by the biomedical model, which conceives of their voices as mere symptoms of a disease. Thus, the social model affords a new lens through which to look at what's best for individuals with mental illness: by looking and listening closely to their lived experiences, without assuming that they are unable to express themselves in a meaningful way. On the contrary, the social model's focus on societal barriers, such as stigma

90. Chamberlin, *supra* note 15, at 407 (emphasis added).

and institutional barriers, with an emphasis aspects of living with mental illness that have largely gone ignored in the law, such as the importance of embodiment, gives respect and dignity to the voices of individuals with mental illness. This alternative model can help the law learn from individual and organizational advocates to better understand mental illness, toward the ultimate end of exposing and combating sanism in society, creating a world that is more manageable and hospitable to this neglected and oppressed sector of the population. This section endeavors to do just that, albeit in a cursory manner. Its purpose is not to provide a comprehensive catalogue of every non-medical consideration, but instead to ground the theory of the social model in the real life of mental illness, to highlight its promise in the law and to suggest some ways that the law, counsel and judges alike, can put the social model to use.

Though it deals with the narrow issue of the right to effective counsel for defendants in involuntary commitment hearings, the *K.G.F.* case provides an excellent launching point for applying the social model to mental illness in the law. Based on what it saw as historical and systemic inadequacies of legal advocacy for the mentally ill due to societal and therefore judicial prejudice, the Court held that the mentally ill merited heightened protection with respect to the effective standard for appointed counsel.⁹¹ In this case, *K.G.F.* was a voluntary inpatient in a Montana hospital who wanted to end her stay, and was then met with a state petition to keep her there involuntarily.⁹² In evaluating the issue at hand as to how effective counsel must be in involuntary commitment hearings, the Court held that it would not accept a standard for effective counsel in involuntary commitment cases that *presumed* effective representation because such proceedings historically have a very low threshold for advocacy on behalf of the (mentally ill) individual. The Court looks to its state Constitution for guidance on the appropriate standard, holding that: Respect for a person's dignity invokes Article II, Section 4, under this state's constitution, which provides that "dignity of the human being is inviolable."⁹³ In focusing on dignity, the Montana Supreme Court implicitly recognizes dignity's absence in the law's interaction with the mentally ill. Though the term is an elusive one, it seems here to point toward the over-arching flaw of the medical model, which silences those who live with mental illness, thereby depriving them of an identity that incorporates their mental illness, in spite of the fact that many of these individuals feel deeply marginalized and ignored by such

91. *In re K.G.F.*, 29 P.3d 485, 494 (Mont. 2001).

92. *Id.* at 488. (Unfortunately, neither the trial nor the appellate decisions are published or otherwise available, so the only facts available are those as outlined in the Montana Supreme Court opinion).

93. *Id.* at 493 ("[R]espect for the dignity of each individual—a fundamental right, protected by Article II, Section 4 of the Montana Constitution—demands that people have for themselves the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives and the intrinsic value of life in general, answering to their own consciences and convictions") (quoting *Armstrong v. State*, 989 P.2d 364 (Mont. 1999)) (emphasis added).

treatment. Recognizing someone as fully human, not as a walking manifestation of symptoms is a denial of dignity at a very basic and intuitive level.

As for the issue of social barriers, especially that of stigma and sanism, the Court in *K.G.F.* had some insightful discussion that merits consideration in any cases wherein mental illness is a factor. It cited a California Supreme Court case, holding that “[d]ue to the potentially ‘socially debilitating’ stigma that results from the ‘irrational fear of the mentally ill,’ the court held that ‘it is implausible that a person labeled by the state as so totally ill could go about, after his release, seeking employment, applying to schools, or meeting old acquaintances with his reputation fully intact.’”⁹⁴ The Court held, to this end, that “[t]he use of such stereotypical labels—which, as numerous commentators point out, helps create and reinforce an inferior second-class of citizens—is emblematic of the benign prejudice individuals with mental illnesses face, and which are, we conclude, repugnant to our state constitution.”⁹⁵ So, while the Court in *K.G.F.* did more contemplation than application of the social model, as is the role of a Supreme Court, it is pedagogically useful in considering what a trial court or legal counsel would focus on in a practical strategy to use the social model.

To begin to use the knowledge and wisdom of advocates for greater rights for the mentally ill, it is important to consider first their compelling counterarguments to the ideas that underlie the use of the medical model, such as benevolence toward or protection of the mentally ill, and the value – or existence – of a “sane” mind beneath the mental illness. These voices argue that the results of this legal philosophy strip them of an identity that they value and embrace.⁹⁶ Judi Chamberlin states:

The fundamental question is this: Why do we take one group of people, those labeled “mentally ill”, and deny them basic rights? . . . I believe that my views about choice . . . are applicable to any person, regardless of label (or lack of label), who can express his or her own wishes and desires, no matter how irrational they may appear to others.⁹⁷

The social model would account for voices such as Judi Chamberlin’s. A space within the law for the social model would offer a poignant and important counter to the medical model by presenting a viewpoint, utterly neglected by the medical model, that people with mental illness possess individual selves that incorporate the mental illness as a part of them.

So, with all of the preceding taken into consideration, how would a court go about applying the social model? That is, of course, a simple question with a complex answer. The mentally ill have unique legal vulnerabilities in numerous aspects of the law. They have been categorically neglected in international

94. *K.G.F.*, 29 P.3d at 494 (quoting *Conservatorship of Roulet*, 590 P.2d 1 (Cal. 1979)).

95. *K.G.F.*, 29 P.3d at 495 (citing generally to Michael L. Perlin, *On “Sanism,”* 46 *SMU L. REV.* 373, 374 (1992)).

96. Chamberlin, *supra* note 15, at 406.

97. *Id.*

human rights law, in spite of the growing trend of international protections that have evolved since World War II.⁹⁸ A psychiatric label also has serious implications in family law, especially in child custody proceedings and the best-interests of the child standards that are used therein.⁹⁹ Such a label can, alternatively, have mitigating effects in a criminal law context, allowing a criminal defendant to submit evidence about his or her mental state to better explain the acts committed.¹⁰⁰ These are only a handful of the many ways that mental illness and/or a psychiatric label effect an individual's interaction with the law.

If the law were to use the social model, it would hear the discontent, reasoning and knowledge from sources such as Judi Chamberlin and the Icarus Project, and it could use these perspectives in order to improve these interactions to ensure that they are not borne of ignorance nor prejudice. The law would consider social structures, such as poverty, access to employment and healthcare; it would contemplate non-medical forms of treatment and look for non-medical experts to testify and inform the court; it would ensure a high standard for appointed counsel in cases such as involuntary commitment hearings. For example, in the family law context, a parent who has been given a psychiatric label would benefit from the judge's education on the many forms of treatment that may be successfully used in order to cope with mental illness, such as diet and exercise,¹⁰¹ as well as peer and familial support.¹⁰² In the criminal law realm, the social model could enhance our understanding of the social obstacles that exacerbate the negative symptoms of mental illness so that a mentally ill defendant has the best defense possible.

The Icarus Project, a group comprised of individuals that have been labeled as or identify as mentally ill, take the medical model to task, stating in no uncertain terms that they value their own existence, and do not see their conditions as simply diseases requiring treatments or cures, calling mental illness instead a "dangerous gift."¹⁰³ The Icarus Project seeks a world in which information about medical treatment is available regarding mental illness so that the *individual* can make choices about how and what methods to use, stating to their reader that: "You need to define for yourself what healthy means, what an appropriate level of functioning is for you and your beliefs, and then try to

98. Dhir, *supra* note 3, at 182.

99. Emily J. Caplan, *Psychiatric Diagnosis in the Legal System*, in BIAS IN PSYCHIATRIC DIAGNOSIS 49-50 (Paula J. Caplan & Lisa Cosgrove eds., 2004).

100. *Id.* at 51-52.

101. See, e.g., *Nutrition Affects Outcome of Schizophrenia Therapy*, OBESITY, FITNESS & WELLNESS WEEK, June 26, 2004, at 876.

102. See LINDA J. MORRISON, TALKING BACK TO PSYCHIATRY 15-16 (2005) for a discussion of self-help methods that have been embraced by many psychiatric survivors, such as peer groups.

103. *Id.*; Icarus Project, *Origins and Purpose*, <http://www.theicarusproject.net/icarus-organizational/origins-and-purpose> (last visited Feb. 20, 2007).

take what you can from any tradition...whether it's Western medicine of Chinese herbs."¹⁰⁴ The Icarus Project emphasizes getting sufficient sleep and exercise, learning about and perhaps taking traditional medicines when needed, and the importance of community and communication.¹⁰⁵ This organization is not only a testament to a proud and cultivated group identity that embraces mental illness, but is also a testament of survival and evolution of a group of individuals that the law may deem ill and in need of medical treatment.

Medication as a rule is not precluded under the social model;¹⁰⁶ it is merely not privileged as a "cure" or as the gateway to the underlying "sane self." To deny the positive potential for drugs would ignore the experiences of people who live with mental illness. For example, Beate Braun, a woman diagnosed as schizophrenic who has spoken about her experiences with mental illness and mental health treatment, reports that she currently uses psychiatric drugs as one aspect of her recovery methods.¹⁰⁷ To this end, the medical model could remain useful to inform a course of medical treatment, if drugs are incorporated into an individual's treatment plan. However, Braun reports that she also utilizes, among others, peer support, one-on-one therapy, meditation, activism, exercise in order to lead a healthy life.¹⁰⁸ Ms. Braun says of her use of medication that "[r]ight now, my dose of Risperdal is not too much. ... I take a walk with my dog, to hold the drugs as low as possible. I don't drink of smoke, or take other drugs anymore either, which helps."¹⁰⁹

104. The Icarus Project, *Taking Charge of Our Mental Health*, <http://www.theicarusproject.net/articles/taking-charge-of-our-mental-health-committing-to-taking-care-of-ourselves> (last visited Feb. 20, 2007).

105. *Id.*

106. See e.g., MORRISON, *supra* note 102, at 157-59. Morrison discusses the complexity of the subject of psychiatric medication within the consumer/survivor/ex-patient movement in chapter six, entitled "The Politics of Identity, Power and Knowledge." She brings up the hard line stance in opposition to all medication espoused by some in favor of greater rights for the mentally ill, while others see medication as a useful treatment tool. However, she states that in spite of these sometimes divisive differences in viewpoints, "[t]heir *common goal of achieving voice for consumers and survivors and ex-patients*, rather than being spoken for by others, ultimately trumps their competing views of the appropriate relations with psychiatry." *Id.* at 159 (emphasis added).

107. MindFreedom International, Personal Stories, <http://mindfreedom.org/personal-stories/braunbeate/> (last visited Dec. 18, 2006). MindFreedom International is a nonprofit organization that unites both individuals and other grassroots organizations in order to fight for rights in the mental health system.

108. *Id.*

109. *Id.* Beate Braun spent about ten years of her life in and out of mental hospitals, and had been out of any such facilities for two years at the time of her interview in 2002. While in the hospital, she was forcibly medicated, endured serious side effects, and reports to have been ignored by her doctor when reporting her difficulty with the side effects. Of her encounters with the law, Braun reflects: "One of the sad things is, they couldn't have done what they did to me without the state's approval. They had to get approval from a judge to force these drugs on me." *Id.* While Ms. Braun lives in Germany, her story mirrors that of many psychiatric survivors

Applying the social model in the real world would incorporate a holistic vision of what constitute treatment options.

In the case of Mr. Steele, testimony framed in the social model of disability, whether from academics, psychiatric survivors or patient rights activists, would have brought many factors into view that the Court did not consider. For example, it may have looked more critically at how Mr. Steele's isolation in the mental institution aggravated some of his symptoms, thus considering how social structures may play a large part in creating the problems that are then purportedly alleviated by more state intervention in the form of forced medical treatment. This type of analysis would complicate the seemingly clear decision rendered in the name of helping such individuals, and would limit the court's ability to reasonably decide such cases under a blind adherence to the medical model.

Even in the brief filed on behalf of Mr. Steele, his counsel did not argue that a person who was not dangerous to himself or others had a right to live his life with mental illness.¹¹⁰ Thus, Mr. Steele's own advocacy took the medical model as a given, depriving him of even a discussion of his rights as a valid person without medical intervention. Steps should be taken to challenge the medical model in court, perhaps with more diverse expert witnesses, to get beyond a vision that distinguishes a person from her mental illness, and towards the possibility of an individual with a valid identity that includes her mental illness. An analysis of the social model of disabilities frames many important issues that come to bear outside of the medical model, and offers a vision of what arguments should be considered in the legal realm, in cases such as *Steele*, in order to provide a more balanced discussion of the appropriate relationship between the state and citizens with mental illness.

V. CONCLUSION

There is no doubt that mental illness is a serious issue. Neither patient rights activists nor medical doctors would dispute that. What is at issue is whether or not the law provides a fair and accurate account of individuals with mental illness when it relies on the medical model in framing the issues. Many scholars as well as activist groups such as the Icarus Project would argue that it does not. The social model could proffer a strong counter to limit the use of paternalistic forces, such as the invocation of *parens patriae* by the state. It could also get us out of the puzzle created by the medical model, in which the argument focuses on treatment or no treatment, by framing the issues around legitimating and protecting the identities of the mentally ill. Incorpora-

in the United States, in terms of her reported side effects, feelings of being ignored, as well as discontent with the law's role in the process.

110. Brief for Appellee at 2-12, *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10 (Ohio 2000) (No. 99-1771). See Perlin, *supra* note 13, for greater discussion on the inadequacy of counsel in involuntary commitment cases.

tion of the social model into legal discourse would broaden the considerations considered by courts and legislatures in determining what course of action to take, and would blur the lines around the labels of "mental illness" to better treat those so-designated as complete entities, and not people simply wearing a mask of a disease.

By looking at mental illness as an identity that deserves to be legitimated under the law, instead of merely a disease that can and should be cured, the state's interest in health and safety will be fairly balanced. If the law becomes informed with through the social model, the voices of the mentally ill and other patient rights advocates will be heard, and the law will both do accomplish justice for the individual, as well as confront the pervasive prejudice against the mentally ill by not silencing them. I do not envision the application of the social model as psychiatry vs. anti-psychiatry. Instead, use of this nuanced and complex framework this is about unmasking an unjustified prejudice against a group of people that is couched in terms of science; not about rejecting science altogether. Thus, while using the social model would not preclude drug use, it would not equate drugs with a cure, and it would look at an incompatible world, and not brain chemistry, as the central problem.

Most importantly, challenging what courts and legislators claim to know about mental illness would give a voice and face to those who actually live with mental illness. The total medicalization of mental illness does not offer a space for individuals with mental illness that choose to embrace their identities and control their destinies. By listening to those who live with this condition, who have these "dangerous gifts," we make it possible for them to gain visibility and community, which is a necessary step to fight the undercurrent of stigma that silences them. We may find that forced administration of antipsychotic medication is all too often a manifestation of a society that fears and pities these individuals. It would certainly not foreclose circumstances where involuntary treatment of some sort was necessary. But it would treat individuals with mental illness as complex and whole, better protecting their rights as individuals with a discernible identity, with the ability to define life and health in a way that is right for them.