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Developments in Law and Psychiatry

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DEVELOPMENTS IN LAW AND PSYCHIATRY[1]

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The Mentally Ill and the Civil Rights Movement

Historians who attempt to chronicle American life in the sixties will have to sort out the impact of the civil rights movement, not only as it affected the status of racial minorities, but also as it set patterns for organized advocacy on behalf of groups, such as the mentally ill, whose status seemed to bear no apparent relationship to these minorities. The civil rights movement, however, had at least three dimensions corresponding to aspects of "mental patients' liberation." The first was redress through the courts using constitutional litigation. The second was an ideological program that emphasized the dangers of paternalism and social stereotypes. Third was the development of self-help groups with a polemical orientation against the status quo. Only the first of these manifestations will be fully addressed here, but, as will become apparent, the ideological considerations are in some sense the "deep structure" of the constitutional litigation.

Central to the "deep structure" is the attack on paternalism. A political and philosophical rationale for this attack was formulated a century ago by John Stuart Mill in his famous essay, *On Liberty*:

> the only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others. His own good, either physical or moral is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinion of others to do so would be wise, or even right. These are reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise, [p. 197]

If one reads these sentences out of context, as is usually done, it is possible to conclude that Mill was opposed to every instance in which a citizen is coerced by law for his or her own good. That, of course, has been the traditional *parens patriae* (the state as parent) rationale invoked at the intersection between psychiatry and law. However, in the very next paragraph of the essay Mill writes, "It is perhaps hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties." Furthermore, a close reading of the entire essay will make it clear that the phrase "civilized community" was meant by Mill to exclude most of the nonwestern world. However, critics of modern psychiatry, if they acknowledge Mill's exception at all, maintain that in order to exclude the insane, they must first be identified, and this they claim psychiatry is incompetent to do.

During the 1960s critics of psychiatry made their voices heard. Their most extravagant thesis was that no one is mentally ill, that madness does not exist, that reality is a matter of personal choice, and that insanity is a political

invention. The apotheosis of these arguments in different versions is found in the writings of T. Szasz, R. D. Laing, and M. Foucault, writers who had enormous impact on the marketplace of ideas toward the end of the sixties. Aspects of these extreme arguments were taken up by a growing segment of the behavioral science community and made part of "deviance theory," "the existential approach," and so forth. Many who did not question the validity of such basic diagnostic categories as schizophrenia and affective disorder nonetheless raised questions about the objectivity and reliability of psychiatric diagnoses of these conditions. Whatever the underlying arguments might be, the essential thesis was that psychiatrists are incompetent to determine who should be declared not in "the maturity of their faculties."

A second thesis follows from the first: If madness does not exist or cannot be reliably identified, then psychiatric treatment is always or almost always either brainwashing or brain damaging.

These theses found intense support among many young lawyers and civil libertarians. The civil rights of the mentally ill and the mentally retarded were seen by them as the last battlefield of the great war for civil rights. Civil libertarians, including the American Civil Liberties Union, began to challenge every aspect of the legal status of the mentally ill, and the interface between law and psychiatry took on a new political and constitutional dimension as

the sixties came to an end.

Applying the Precedents of Civil Rights Litigation

The Supreme Court, under Chief Justice Earl Warren, had been perhaps the most powerful liberal/progressive force in America during the fifties and early sixties. The court fashioned a variety of new constitutional rights whose impact is still being felt to this day. Many of these new constitutional rights were intended to protect the citizen against state and local government, against police brutality, against racism, and against discrimination. For example, alleged criminals who were indigent were given lawyers at government expense, and new constitutional due process safeguards were set up to protect alleged criminals against "stop and frisk," coerced confessions, and other potentially brutal intrusions by law enforcement officers.

The Bill of Rights was the mainstay of legal reform in this area. But transcending the various narrow constitutional arguments in each instance was the basic principle that loss of liberty is the most grievous penalty in a democratic society. It is historically important to recognize that much of the new criminal law handed down by the Warren Court had, in fact, racial significance. A disproportionate percentage of those charged with crimes are members of America's racial minority groups. Thus, more procedural safeguards for alleged criminals meant more protection for minorities against

racially biased law enforcement. These procedural reforms of the criminal justice system can properly be considered part of the civil rights movement. Similar considerations continue to play a part in the efforts to abolish capital punishment, since it is thought that the imposition of the death penalty involves racial inequities.

Running parallel to these reforms in criminal law were many important explicit civil rights cases based on the Bill of Rights' guarantee of equal protection under the law, which stipulated that no citizen should be treated differently because of membership in a group whose members were determined on some suspect discriminatory basis. Most of these important constitutional decisions were in place by the middle of the sixties. Using these due process and equal protection arguments and the precedents that had been set by the Warren Court, the constitutional litigation on behalf of the mentally ill was packaged as part of the civil rights movement. But outstanding questions remain. Do the problems of the mentally ill really fit within that package? Do the procedural safeguards developed for the alleged criminal work when they are applied to the alleged patient? Is mental illness a suspect classification in the same sense that race is?

The Supreme Court's Invitation in Jackson v. Indiana

In 1972, the United States Supreme Court made its most significant

ruling regarding cases of mentally disabled individuals who faced criminal charges. In *Jackson* v. *Indiana,* the Court was faced with a troubling fact situation involving the potential indefinite confinement of a deaf mute who had the intelligence of a child. Jackson had been criminally charged with the crime of handbag snatching, but had been found incompetent to stand trial and, therefore, could not under law be tried, sentenced, and processed as a criminal. This meant that he would have been indefinitely and involuntarily confined in a mental health facility. Indiana had no capacity to provide Jackson with the training in sign language that might have made him competent to stand trial. The Supreme Court rejected such an indeterminate confinement, stressing that, competent to stand trial or not, there must be some reasonable relationship between the purpose of the disabled individual's confinement and the length of that confinement. In deciding this case, the court used the occasion to comment on the legal situation of the mentally ill:

> The states have traditionally exercised broad power to commit persons found to be mentally ill. The substantive limitations on the exercise of this power and the procedures for invoking it vary drastically among the states.

Then after briefly describing the variations, the Court commented:

> Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated, [p. 738]

Many read these words as suggesting that the Supreme Court was ready and perhaps eager to examine the constitutional implications of confining the mentally ill. It seemed the Burger Court was ready during the seventies to consider the whole panoply of civil rights arguments advanced by the critics of psychiatry and to extend the Warren Court precedents to the mentally ill.

Patient's Rights and Patient's Needs

By the end of the seventies it was clear that the Burger Court was either unwilling or unready to follow the lead suggested by the Jackson decision, at least not without an opportunity to explore and define its own positions on the troublesome issues raised. On the other hand, the lower federal courts were aggressively going forward on the issues. Under the rubric of due process, the "alleged" mentally ill were given lawyers, and the medical model of civil commitment was repudiated. The psychiatrist was defined as the agent of the state and therefore as an adversary of the "alleged patient."

Mental health litigation can be divided roughly into two categories. The first emphasizes the civil rights of the patient and ignores any conflict that the exercise of these rights might have with the patient's need for treatment. A major emphasis of this litigation is to ignore potential benefits and to construe the relationship between psychiatrist and patient as analogous to policeman and criminal. Included in this category is litigation seeking to bar all medical

reasons for involuntary confinement in favor of such supposedly objective legal criteria as "dangerousness." Recent litigation also seeks to give those patients who are legally confined a right to refuse treatment, particularly drugs and electroconvulsive therapy.

A second kind of mental health litigation has sought to improve the quality of care and treatment provided the mentally ill. This is the so-called "right to treatment," under which federal courts have attempted massive reforms of institutions and, in some cases, of whole state mental health systems. As one reads the judicial opinions in these cases, it is clear that the federal courts feel that state and local government have failed in their basic responsibility and that decades of legislative inertia have produced a harvest of human tragedy. Many psychiatrists would agree with judicial activists who feel their intervention is justified whatever constitutional theory is employed in the particular case. During the past two decades these increasingly progressive lower federal courts have gradually assumed a crucial new role in our society as they seek to remedy legislative abdication of responsibility. The traditional role of judges in our legal system was to resolve disputes between two parties in favor of one or the other. But the contemporary federal judge involved, for example, in a constitutional right to treatment case now takes responsibility for working out complicated solutions over long periods of time. The federal judge no longer simply lays down the law but—just as in school desegregation cases —will take it upon himself to establish an

"ongoing regime" that will constantly regulate the future interactions of the parties to the suit and subject the parties to continuing judicial oversight. The judge typically becomes the de facto superintendent of the mental institution and in some cases the de facto commissioner of mental health.

The Due Process Model of Civil Commitment

Due process arguments have been invoked in all mental health litigation: they have been used to attack the psychiatrist's role in civil commitment and to reject every element of the psychiatrist's discretionary authority over patients. Civil commitment in the past typically in practice gave great weight to the psychiatrist's expert opinion, and the statutes authorizing it leaned toward the medical model. Mental illness and need for treatment was an acceptable justification for civil commitment in many states.

In *Lessard* v. *Schmidt*, the benchmark case, a special three-judge district court dealt with a Wisconsin civil commitment statute that embraced this medical approach and allowed involuntary confinement if the person was "mentally ill" and "a proper subject for custody and treatment." The court held that in order for this statute to be constitutional, it must be interpreted as requiring that the state bear the burden of proving "that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others." Proof of such dangerousness must be "based upon a

finding of a recent overt act, attempt or threat." Furthermore, where the state attempts to confine on the basis of these criteria, due process requires the following: (1) timely notice of the charges justifying confinement; (2) notice of right to a jury trial; (3) an initial hearing on probable cause for detention beyond two weeks; (4) a full hearing on the necessity of detention beyond two weeks; (5) aid of counsel; (6) the Fifth Amendment protection against self-incrimination; (7) proof of mental illness and dangerousness "beyond a reasonable doubt"; (8) An inquiry into less drastic alternatives before commitment for inpatient care; and (9) no treatment until the alleged patient has had a probable-cause hearing. This decision, citing the most radical critics of psychiatry as authority for the inadequacies of psychiatric diagnosis and treatment, in effect rejected the medical model and imposed all of the due process safeguards of a criminal trial on civil commitment. There is now considerable evidence that the *Lessard* approach not only creates chaos in psychiatric hospitals, which must hold patients without treatment, but also has led to more violence by psychiatric patients. Thus, it fails to protect society and leads to needless suffering by psychotic patients in the name of liberty.

The federal district court decision in *Lessard* took place in 1972, the same year the Supreme Court decided *Jackson* v. *Indiana.* It became a model for other federal courts reaching a similar result, many of which attacked the credibility of psychiatric expertise as the basis for any legal decision.

For example, in reviewing *Lessard*-type decisions (and concurring with them), one federal judge noted that along with his concern about personal freedom "a close second consideration has been that the diagnosis of mental illness leaves too much to subjective choices by less than neutral individuals."

The consistent thrust of constitutional reform in the federal court is to reject the medical model, replace psychiatric opinion by "objective" evidence of dangerous behavior, and attack the *parens patriae* justification for confinement. This has been the approach adumbrated by the American Civil Liberties Union (ACLU). It adopted as a matter of constitutional right a due process model that gives short shrift to the needs of psychotic patients, the vast majority of whom are not dangerous. It is worth noting that *Lessard,* the benchmark case, was appealed to the Supreme Court, which had the chance to face these issues squarely. Instead, the court returned the case to the lower court on a technicality. The lower court met that technicality and it was appealed again. Again, the Supreme Court returned it on a technical issue. Again, the lower court stood its ground; and there it remains.

The Supreme Court's Contribution to Due Process

The Supreme Court stood silent on all these crucial issues until 1979 when it accepted the case of *Addington* v. *Texas*, which asked the Supreme Court to decide only one very narrow issue: not what is an acceptable

justification for civil commitment, not what procedural safeguards are required, but only what is the standard of proof—beyond a reasonable doubt, clear and convincing evidence, or preponderance of the evidence. To decide what the standard of proof is without deciding what is to be proved is an extraordinary exercise. The court had clearly been avoiding the more difficult questions it had itself raised in *Jackson,* and in *Addington* it dealt with the narrowest issue possible. The court opted for the intermediate standard: clear and convincing proof.

If there was any rationale to the court's decision in *Addington,* it was perhaps the classical medical nostrum—do no harm. Many states had already adopted the "beyond a reasonable doubt standard," and the Supreme Court's decision did not require them to reduce that standard. Almost no state had been using preponderance of the evidence, the lowest standard, and thus the Supreme Court's decision had no impact other than to signal its own caution in this area of constitutional reform. But, as already noted, the lower courts were well on their way to imposing all of the procedural due process of a criminal trial. By ignoring the issues in *Lessard* and by dealing with the narrowest issue possible in *Addington,* the Supreme Court allowed these developments to continue.

The Due Process Rights of Children

Adults can, of course, be voluntary or involuntary patients. Children, if they meet the state's statutory criteria, may be involuntary patients—but how can a child who does not have the legal capacity to consent enter the hospital as a voluntary patient? The traditional answer was that the parents or someone standing *in loco parentis* could consent for the child. The special status of parents to make decisions for their children has always been recognized in law and in constitutional interpretations of law, but where a social worker or some agent of the State Human Services' bureaucracy makes such decisions his authority is, at least in principle, more dubious. Certainly in the latter instance there is little reason to assume that the child's best interests are given full consideration. Often the state institution for children is used as a dumping ground for unwanted or troublesome children, and many times there is no prospect of adequate treatment. The plaintiffs in *Bartley* v. *Kremens* challenged the constitutionality of both kinds of substituted consent, parents and those *in loco parentis.*

In the *Bartley* case, a federal court declared that the voluntary provisions for children of the Pennsylvania Mental Health and Mental Retardation Act of 1966 were unconstitutional under the due process clause of the Fourteenth Amendment. The court enjoined enforcement of the following sections of the state statutory scheme until the state legislature provided juveniles the *Lessard* type of procedural due process safeguards upon entering the hospital:

1. A probable cause hearing within seventy-two hours from the date of initial detention.

2. A full-blown post-commitment hearing within two weeks of the initial detention if probable cause was in fact found at the first hearing.

3. Juveniles were to have their own individual attorneys, and these attorneys as well as the juveniles were to receive notice forty-eight hours prior to the original probable cause hearing. If a juvenile was indigent, the state had to provide an attorney. Juveniles and their attorneys had to be provided with written reasons for the juvenile's initial admission.

4. Juveniles had the right to be present at the hearings with the caveat that the juvenile's attorney could waive this due process procedural right on behalf of the juveniles.

5. Juveniles had the right to a finding by clear and convincing proof of their need of institutionalization.

6. Juveniles had the criminal law rights of confrontation of witnesses, cross-examination, and the right to offer evidence in their own behalf.

The lower federal court in *Bartley* acknowledged the established tradition of parental authority in the rearing of children. But it emphasized that the decision to admit children to mental health facilities involved serious conflicts of interest between parent and child. The court noted that parents

could not control a juvenile's right to abortion as a matter of constitutional law, and it ruled that parental admission of a juvenile to a mental health or mental retardation facility should be considered a similar exception to the parental control rule. It further justified this exception to parental authority on the basis of the stigma involved, the unreliability of psychiatric diagnosis, and the loss of liberty. The sweep of the court's perspective on conflict of interests is demonstrated by the fact that it cited the respite program, which allows parents who keep retarded children at home the opportunity to place the child in a facility for a brief period, as an example of a conflict of interests that should entitle the child to a lawyer and a hearing to contest the respite program. Obviously a court willing to push that far had no trouble dismissing the authority of those acting *in loco parentis.*

The United States Supreme Court did not decide the *Bartley* case the first time it was appealed. Instead, as with *Lessard,* it avoided it on a technicality and remanded the case to the lower court.

However, on remand, the federal court did not budge. Instead, it reinstated its previous holding that plaintiffs had a liberty interest in not being institutionalized without due process of law and that interest could not be constitutionally waived by parents or guardians.

Finally, in 1979, the Supreme Court decided the *Bartley* case on the

merits, consolidating that appeal with a similar appeal from Parham, Georgia, where a federal court had declared that Georgia's procedures for juvenile admission at the request of parents or state violated due process. The Supreme Court, although it acknowledged a due process problem, held that due process required only that a staff physician, acting as a neutral fact finder, evaluate the admission. Its description of that evaluation is not much different from what is generally accepted as good psychiatric practice. The decision maker, in addition, must have the authority to refuse to admit any child who has not satisfied medical standards for admission. After admission, a child's commitment must be reviewed periodically by an independent procedure similar to that required for initial admission; for example, a case conference review.

The Supreme Court ruled that the current Georgia and Pennsylvania statutory and administrative procedures already comported with these minimum due process requirements. The Supreme Court also refused to make any distinction between parents and those acting *in loco parentis.* Thus, the Supreme Court rejected the complex due process approach of *Lessard.* Clearly, there now exists a radical disjunction between the Supreme Court's perspective on mental health law and that of the lower federal courts. Until some resolution of these differences is achieved, litigation will doubtless continue. Furthermore, there has been a remarkable proliferation of legislation seeking to obtain the same goals reformers have sought in the

courts.

The Right to Refuse Treatment

The most important current development in mental health litigation placing rights ahead of needs is the right to refuse treatment. Proponents of this right claim that it should operate even after a patient has been involuntarily confined as mentally ill and dangerous. The best example for their argument runs as follows: Let us assume that an involuntary psychiatric patient is a sincere Christian Scientist and offers that as the basis of a refusal to accept drug treatment for his schizophrenia. The federal courts in New York in *Winters* v. *Miller* concluded that to impose somatic treatment over the valid religious objections of a patient is a violation of the patient's constitutional rights.

The religious issue, however, is rarely the real question in the right to refuse treatment. That kind of case simply allows us to begin to reflect on the constitutional considerations, for example, religious convictions, that judges have in mind when they examine what might justify a constitutional right of a mental patient to refuse treatment.

More radical civil libertarian arguments go much further than the clash between religious tenets and good medical practice. Such arguments urge that involuntary treatment be considered a violation of the First Amendment.

Since the mind is the source of mentation and since freedom of speech originates in mentation, to influence anyone's mind against his or her will is a violation of that person's First Amendment rights. This formulation of a First Amendment right to refuse treatment was adopted by a federal court in Massachusetts in *Rogers* v. *Okin*, now being appealed.

The right to refuse treatment has also been premised on the Eighth Amendment protection against cruel and unusual punishment and on the constitutional right to privacy. Even without rolling up the heavy artillery of constitutional argument, there has traditionally been at common law a right to refuse treatment. The crucial problem is not whether the right exists, but under what circumstances can it be waived. The state cannot send doctors into the streets to inject citizens with neuroleptic drugs against their will. But does a legally valid admission to a mental hospital, be it voluntary or involuntary, constitute a waiver of the right to refuse treatment? Advocates of the right to refuse claim that voluntary patients do not waive any such right, and they further claim that involuntary confinement, in effect, demonstrates only that the patient is committable and not that he lacks the capacity to refuse treatment. The court in *Rogers* v. *Okin* agreed with this extreme argument, ruling that involuntary confinement is not enough; the state must, except in an emergency defined narrowly by the courts, prove incompetency in a guardianship hearing, a lengthy proceeding that may take weeks to complete. The *Rogers* court has held that every person is presumptively

competent to exercise individual autonomy even after being found mentally ill and dangerous. The court insisted that the burden to overcome that presumption should be on the physician or the state. There was substantial evidence in *Rogers,* ignored by the judge, that the limits set on treatment by the right to refuse had led to assaults, arson, sexual molestation, and other abuses of patients by patients, as well as self-destructive activity. Other judges have suggested less cumbersome and more practical alternatives. For example, in *Rennie* v. *Klein* the court decided that the objecting patient is entitled to an independent second opinion about the proposed treatment by a psychiatrist who is asked to keep in mind the balance between needs and rights.

Individual autonomy is an important value in a democratic society, and it is important to consider what values are served by allowing psychiatrists to override a patient's refusal of treatment. The most obvious value is the relief of needless suffering. There are patients, particularly schizophrenics, whose suffering can be relieved but whose mentation is so disturbed that they cannot choose to accept the treatment that will help them.

Second, although it is usually ignored in the libertarian calculus, the suffering and the behavioral manifestations of the mentally ill do have a deleterious effect on those around them, even when no physical injury occurs. The courts have long been willing to acknowledge the reality of psychic

trauma. When a grossly disturbed mentally ill patient is admitted to a hospital, his or her disturbance has an impact on the other patients and their treatment. Allowing a patient to go on traumatizing other patients needlessly as a result of a refusal to accept treatment may make it impossible to treat others.

Finally, the value of freedom of mentation, freedom of choice, and privacy are not sacrificed when we impose reasonable treatment on a person who is unable to exercise his or her autonomy.

Some judges, although not unaware of these considerations, give different weight to them. For example, in *Rogers* the judge gave no weight at all to the effect of psychic trauma on other patients and the staff. He would allow emergency involuntary treatment only where there is an immediate risk of physical injury. He took that position knowing that in a mental hospital such a standard cannot be reliably applied and that considerable physical injury may in fact result. Thus, this judge in effect permits the opportunity for both physical and psychic trauma in the effort to protect the right to refuse treatment. This places such extraordinary burdens in the way of nonemergency involuntary treatment that it almost precludes all sensible clinical intervention.

Although the *Rogers* decision nowhere discusses the issues set out

earlier in this chapter (for example, that mental illness is a myth and that treatment is brain washing or damaging), it is clear that the judge assumed that psychiatrists lack the ability and/or cannot be trusted with the responsibility of identifying those who are incompetent to refuse treatment. Hence, he is, in effect, condoning an elaborate legal procedure to protect patients from psychiatrists. The enthusiastic reception of decisions like this by the media must say something about the widespread perception that patients' rights are more important than their needs. Surely it also suggests a growing popular impression that psychopharmacologic treatment is coercive, punitive, abusive, and potentially more dangerous than mental illness.

The Right to Treatment

Ironically, the radical criticism of psychiatry began during the 1960s when the scientific foundations of psychiatry had achieved a new respectability. New biological and psychological treatment methods had reduced the populations of state mental institutions by 50 percent, and the average length of stay of patients had been drastically shortened. All this was well underway long before mental health litigation began.

But reform initiated by the mental health profession depends on both competent leadership and substantial state support. During the sixties some states lagged behind in initiating these reforms in the care of the mentally ill,

and it was in one of those states that the first right to treatment suit was brought. Alabama was last among the states in providing funds to care for mental patients. Its large state institutions were by all reports grossly inadequate by any standard of evaluation. Legal reformers, supported by many of the associations that represent the mental health professions, sought to force the state of Alabama to improve conditions in its state hospitals and retardation facilities through constitutional litigation. They brought a class action suit, *Wyatt* v. *Stickney*, claiming a constitutional right to treatment on behalf of all patients in the state mental institutions in Alabama. This effort was almost simultaneous with *Lessard,* but *Lessard* focused on rights while *Wyatt* focused on needs of patients. The legal theory behind *Lessard* emphasized procedural due process whereas in *Wyatt* it was substantive due process. This difference between substantive and procedural due process is a crucial distinction in constitutional law.

If one reviews the few right-to-treatment cases prior to the *Wyatt* case, it turns out that none had been predicated on constitutional grounds. For the most part they had involved individual patients who had been diverted from the criminal justice system and confined with an implicit expectation that the state was to treat them rather than punish them. For example, like Jackson, they had been confined as incompetent to stand trial or were found not guilty by reason of insanity. Without treatment they claimed the state was in reality punishing them. Some judges had agreed, but their rulings were based on the

promise implicit in the specific state statutes authorizing non-penal confinement and not on any constitutional right. The case of *Wyatt* v. *Stickney* attempted to push the right to treatment further in every respect: It was a class action on behalf of all civilly committed patients, it asked for a constitutional holding, and it finally directed attention to the plight of the large group of mentally ill and mentally disabled patients who had committed no crimes and who were confined in less than adequate hospitals.

After lengthy argument and many legal briefs, Judge Frank Johnson of the Alabama General Court held that: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane and therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process."

Although this decision, like the decisions already discussed, emphasizes deprivation of liberty, it does not adopt a narrow due process solution for the situation of patients confined without treatment. For example, an alternative might have been a more limited holding as in *O'Connor* v. *Donaldson,* where the Supreme Court ruled that all non-dangerous patients who were involuntarily confined in these institutions and not getting treatment must be released. But Judge Johnson apparently realized that most of these patients were chronically disabled and, if given the legal right to leave, either had no capacity to exercise it or would be just as badly off if they did. Judge Johnson

took a bold step, therefore, and asserted what was, in effect, a substantive right.

A more conservative judge would have hesitated before making such a ruling for reasons that go back to the distinction between procedural and substantive due process. It is one thing for a judge to tell a state what procedures it must employ when it confines a patient—even when those procedure are costly. This is accepted judicial practice as exemplified in *Lessard.* It is quite another thing to tell the state *how* it must take care of mental patients when it confines them, since this implicitly creates new substantive rights and imposes on the state the duty to meet those rights (needs) of patients. The latter substantive approach involves a critical legal entanglement; namely, the separation of powers. How far can the judiciary go in setting standards of institutional practice that require the legislature and the executive branch to raise new tax revenues or reorder the fiscal priorities of social needs that have been established through executive and legislative decision making? For these and other reasons a more conservative judge would have rejected the substantive due process argument. Judge Johnson, of course, did not give all of the citizens of Alabama a new substantive right; he ruled that the state must meet the treatment needs only of those patients it involuntarily confines. However, in establishing treatment standards Judge Johnson expanded somewhat the class of patients entitled to the right by making no distinction based on the legal status of the patients. He insisted

that the needs of all patients in these Alabama institutions be met whether they were there voluntarily or involuntarily.

Other judges subsequently have had to confront the constitutional basis for the right to treatment more directly, looking to theories that can less easily be construed as creating new and substantive rights. One of the most unassailable approaches to a right to treatment would have been to ground it on the Eighth Amendment, which forbids cruel and unusual punishment. Stated in simplest terms, state institutions for the mentally ill and mentally retarded should not be allowed to perpetuate conditions similar to those that had already been declared unconstitutionally cruel in prisons. Other courts, building on this approach, have talked about the right not to be harmed. Given the conditions in some of our state institutions, mere compliance with that standard requires enormous expenditures.

However, in the *Wyatt* case, although this kind of Eighth Amendment argument was acknowledged, Judge Johnson sought to reach a higher standard of treatment; he sought to insure adequate treatment. To accomplish this, the *Wyatt* order detailed that minimum "medical and constitutional" requirements be met with dispatch. The decree set forth requirements establishing staff-to-patient ratios, adequate floor space, sanitation, and nutrition. The court also ordered that individual treatment plans be developed, that written medication and restraint orders be filed, and that they

be periodically reviewed. Outside citizen's committees were appointed to monitor enforcement of patient's rights under the order.

The *Wyatt* decree was far from a generalized array of commands arrived at arbitrarily. It was formulated from study of testimony of institutional personnel, with outside experts and representatives of national mental health organizations appearing as *amici curiae.* Most of the specifics of the order were taken from a memorandum of agreement signed by the parties. The most critical specifics—the model staffing ratio—approximate those recommended at the time by the American Psychiatric Association. However, the case proceeded without the participation of the American Psychiatric Association, although most other mental health professional groups were involved. Not surprisingly, the court's decree authorized that qualified nurses, psychologists, and social workers be allowed to take clinical responsibilities that had traditionally been limited to physicians. The dethronement of the psychiatrist as the head of the mental health team has been emulated in subsequent litigation and legislation.

The *Wyatt* decree reads like a judicial translation of the kind of document that the Joint Commission on Accreditation of Hospitals (JCAH) might be expected to promulgate. But seven years have gone by and despite Judge Johnson's continuing oversight, the decree he formulated has never been fully implemented. In 1979, the judge concluded that it was necessary to

place the entire mental health system of Alabama in the hands of a receiver, a step that removed all authority from state officials.

Judge Johnson's difficulty in implementing his decree demonstrates a number of very real problems. First, just as happened with federal judicial intervention in school desegregation, recalcitrant state bureaucracies can place enormous impediments in the way of such complex institutional reforms. Second, reforming some of the worst state mental facilities in the country requires enormous resources and financial aid. Meeting the decree required Alabama to alter many of the fiscal priorities and tax strategies its legislative and executive branches had decided on. Not surprisingly, they were extremely resistant. Third, Judge Johnson's decree sought to upgrade facilities that, in these days of deinstitutionalization, might more appropriately be closed. Thus, enormous capital expenditure was being poured into outmoded facilities. Furthermore, the cheapest way to begin to approximate the mandated staff-to-patient ratios was to discharge patients without adequate aftercare and without alternative treatment settings. Judge Johnson's original decree did not clearly foresee these possibilities.

Fourth, the judge's decree deprived the mental health professions of their own flexibility in establishing independent policy and treatment strategy. This was true not only within the institutions involved but also outside, since so much money and resources had to be directed toward the

judge's priorities.

Fifth, the litigation in *Wyatt* and in subsequent cases has intensified interprofessional tensions and rivalries. Obviously, litigation did not create these problems, but there are no longer clear lines of authority among the mental health professions responsible for the care of patients, and a great deal of energy is being wasted in struggles over status and control. The Oversight Committee appointed by the judge, albeit necessary, added to the disarray of authority by establishing a shadow administration. These difficulties have made it difficult to recruit good people for leadership positions. All of these problems are to be expected when a judge becomes *de facto* commissioner of mental health. But before rejecting the judge's activism, responsible mental health professionals must take a hard look at the alternative, or the situation that existed in Alabama before *Wyatt.* Obviously, Judge Johnson concluded that the Alabama situation was so bad that legal intervention to meet the needs of patients could not make matters worse.

Subsequent right to treatment litigation has been able to learn from the experience of *Wyatt.* For example, judges have attempted to get the state to negotiate with the plaintiffs so that they might set their own goals and standards rather than having the judge assume this task. Thus, a consent decree arrived at by the parties replaces the judicial decree. However, most lawyers who are experienced in this kind of litigation realize that the real

struggle arises in the efforts to implement the decree, whether it has been arrived at by consent or by the judge's own findings. Although the Supreme Court has never endorsed the right to treatment, such litigation and particularly consent decrees have proliferated all over the country. This proliferation has given rise to suits even in those states that had been in the vanguard of reforming their large state institutions. As one reviews this kind of right-to-treatment litigation, one cannot help wondering if patients' real needs (as opposed to their mere rights) are being met.

It has become generally accepted psychiatric policy that state hospitals, which have a large census, which keep patients a long time, and which are often set at a distance from the community, are not desirable. Deinstitutionalization has, therefore, become the order of the day. But communities have become increasingly resistant to the opening of community-based facilities. Zoning restrictions, neighborhood protests, and political pressures have all been mounted against such needed facilities as halfway houses, sheltered living situations, and so forth. Increasingly, the "community" is the major opponent of the "community mental health approach." Furthermore, the problems of continuity of care are intensified when deinstitutionalization is compounded by revolving door policies. There is accumulating evidence that chronic patients are being lost in the shuffle and are subject to abuses at least as serious as those found in the "backwards." Nonetheless, right-to-treatment litigators are demanding that the pace of

deinstitutionalization be increased under the legal theory that patients are entitled to treatment in the least restrictive setting. Of course, the setting that least restricts a patient may not be the setting in which treatment needs are most effectively met. And when, as is increasingly the case, the good alternatives to total institutions are overwhelmed by applicants and the quality of the service available is suffering, the demand for the least restrictive setting will begin to place the abstract right to liberty above the concrete need for care.

The Least Restrictive Alternative at the Time of Admission

"The least restrictive alternative" seems to be one of the most confused and confusing phrases in mental health litigation. The concept arose in an entirely different kind of constitutional context; it has been wrenched out of that context and applied to the mentally ill and disabled. The argument asserts that the state's interest in confining the patient must be met by that treatment approach that will produce the least loss of liberty. Like the right to treatment, the least restrictive alternative, as it has been applied to the mentally ill, has not been recognized by the Supreme Court. It is another extension of the procedural due process theory, which at least potentially seems to involve substantive rights. There are many potential patients whose hospitalization could be avoided by immediate crisis intervention.

Demonstration projects have, at least, suggested that a massive reduction in the need for hospitalization whether voluntary or involuntary can be achieved. A few treatment centers have the capacity to provide such crisis resources; most do not. Does the least restrictive alternative mean, with regard to civil commitment standards such as *Lessard,* that the state must provide such resources? Alternatively, many patients are committed because they have no family or anyone else to see to their needs, to supervise their taking of medication, and to keep them from wandering the streets. These "gravely disabled" might be cared for in their homes by a nurse or a housekeeper. Does the least restrictive alternative mean the state must provide such a caretaker? If answered affirmatively, these first two questions interpret the least restrictive alternative as establishing a substantive due process right requiring the state to create new services.

Or does the least restrictive alternative mean only that, given the treatment facilities the state has available, the patient must be placed in the one which is least restrictive? This interpretation is more in the nature of a procedural due process requirement. But even this latter requirement is beset by confusion. Is the patient entitled to the least restrictive alternative in light of the dangers he or she poses to self or community, or to the least restrictive alternative in which effective treatment can be provided? Few, if any, of the court's ruling on the least restrictive alternative have dispelled these confusions.

The Least Restrictive Alternative in Class Action Right-to-Treatment Litigation

Where the least restrictive alternative is demanded in right-to-treatment litigation, as is increasingly the case, the plaintiffs want the state to provide new community-based facilities. But an additional goal of the litigants at times seems to be to close down the state mental hospital. For example, the plaintiffs in *Rone* v. *Fireman* demanded that an eight-hundred-bed facility, which had been tentatively accredited by the JCAH for one year, be closed down and replaced by a fifty-bed unit, with all other patients transferred to less restrictive alternatives. This may be a good thing—indeed eventually all of the state hospitals should probably be closed—but a question of timing has become a central concern. Does it make sense to close down a decent state hospital facility at a time when available alternatives in the community are overwhelmed? It may be true that a good foster home is a less restrictive alternative—but is a bad foster home or a rundown welfare hotel in the inner city a less restrictive alternative? Even where the litigants have no intention of closing down the institution, the difficulties inherent in finding alternatives have made this litigation problematic. If the patients are pushed into the community without suitable alternatives, then the abstract right ignores the concrete reality of the patients' needs.

Nowhere have these problems been more intense than in litigation seeking to achieve the least restrictive alternative for the mentally retarded. A

dominant treatment approach to the mentally retarded is "normalization." It is a comprehensive philosophy, and its goal is to see that the mentally retarded are given the opportunity to live a life as close to the normal as possible. Most of the professionals involved in the care of the retarded see deinstitutionalization and the least restrictive alternative as essential to "normalization." Some parents and relatives of the mentally retarded object to this and not always on purely selfish grounds, as is sometimes alleged. Less restrictive alternatives in the community frequently are organized and run by activists, many of them young. Parents are concerned that this activism and idealism will wane, as has happened with other social endeavors. They believe that the young people will move on and that the mentally retarded will be lost and exploited in the community. Whatever inadequacies there may be in the large brick institutions built by the state, they do seem to promise continuity of care—a continuity that will last after the parents die or become unable to look after their retarded offspring. These are deep divisions in attitude and they portend deep divisions in policy. Already there has been dispute concerning the least restrictive alternative litigation applied to the mentally retarded, with parents contesting the lawyers who claim to represent their children.

The Justice Department of the United States has participated in a number of right-to-treatment suits on the side of the plaintiffs. Its participation allows the FBI to become involved in the investigation phase,

helping to document inadequate conditions and allegations of abuse. The Justice Department also brings to the problem the resources of a massive federally funded agency geared to litigation. The standing of the Justice Department to participate in these suits has been challenged, and some federal courts have ruled that the Justice Department does not, in fact, have the legal standing to bring such suits. But many federal courts have invited the Justice Department to participate with other plaintiffs as *amicus curiae,* and the Congress has enthusiastically supported legislation that would give the Justice Department the legal standing that the courts deny it. The role of the Justice Department is crucial since it seems to have adopted the least restrictive alternative as a goal of this litigation, even where concrete needs will be sacrificed for abstract rights.

It must be emphasized that despite a great deal of rhetoric to the contrary, the least restrictive alternative has not been less expensive than institutional care when quality care is involved. Neglect is the only way to achieve real savings be it inside or outside the hospital. The appearance of savings has been achieved in effective deinstitutionalization only by budget manipulation. For example, if patients are transferred from mental hospitals to good nursing homes the mental health budget will go down, showing an apparent savings; however, the Medicaid and/or welfare budget will go up. Often the burden is merely shifted from the state to the federal government, or in some instances a new obligation is placed on cities and towns. The point

to be emphasized is that the objectives to be sought in responsible deinstitutionalization do not include overall cost savings.

Rone v. *Fireman* forced a federal judge to confront all the difficulties of the least restrictive alternative. In his decision, the judge described the community's resistance to the good-faith attempts of the Department of Mental Health to create alternatives to the large state hospital. He noted that even the plaintiffs acknowledged that patients would need the same kinds of services they were getting in the hospital. In light of these and other considerations, he responded to the plaintiffs' demand for the least restrictive alternative as requiring only that the patients be provided with transportation from the hospital back and forth to the city (the hospital was located some distance away and there was no public transportation). This decision, if it did nothing else, demonstrated how flexible the least restrictive alternative can be as a meaningful constitutional doctrine. But it did more—it advanced a nonpolemical analysis of the many problems that now beset any unyielding policy of deinstitutionalization.

The remarkable thing that emerges from an even cursory review of the right to treatment litigation is the expanding cast of characters whom litigation has involved in decisions affecting the situation of the mentally ill. There are the federal judges, the Justice Department, various public interest lawyers, state officials, and various bureaucracies. Others often become

deeply involved; for example, the Department of Health, Education and Welfare (now the Department of Health and Human Services), the various professional associations, the Joint Commission on Accreditation of Hospitals, the American Civil Liberties Union, the National Associations for Mental Health and for Retarded Citizens, many advocacy groups, various planning and systems consultants, and many others. All these participants are in addition to the responsible mental health professionals, the relatives, and the patients themselves. It is no wonder that the state commissioner of mental health now serves on the average only eighteen months.

The Supreme Court and the Right to Treatment

During the mid-seventies while the *Lessard* case was bouncing back and forth between the federal court and the Supreme Court, and while federal courts all over the country were becoming involved in right-to-treatment cases, the Supreme Court decided its first important mental health case, *O'Connor* v. *Donaldson*. This was the first time in the history of the Supreme Court that it had dealt with a straightforward instance of civil commitment. But equally important, the case had involved the right to treatment at lower court levels.

For fifteen years Kenneth Donaldson was a patient at Chattahoochee State Hospital in Florida. He was diagnosed as a chronic paranoid. Dr. J. B.

O'Connor was the superintendent of the institution where Mr. Donaldson was a patient. During Mr. Donaldson's stay the institution had a ratio of one doctor per eight hundred patients. Mr. Donaldson applied more than a dozen times to various state and federal courts for his release from involuntary confinement. Each time the courts rejected his plea. Finally, he turned for assistance to Morton Birnbaum, a physician and lawyer, who is considered today the father of the right-to-treatment litigation. Dr. Birnbaum initiated a right-to-treatment suit on behalf of Mr. Donaldson and other patients. Eventually, however, Bruce Ennis, a lawyer with the Mental Health Law Project, took over the case. During this time Dr. O'Connor suffered a coronary and resigned as superintendent. The new superintendent subsequently discharged Mr. Donaldson. Mr. Donaldson had never been dangerous, had refused medication, and during the fifteen years of his hospitalization never received anything that a responsible clinician would consider treatment. After Donaldson's discharge, and with Ennis's legal input, the lawsuit took a different direction. Rather than a class action right-to-treatment suit, it became a suit for damages under the Civil Rights Act. Dr. O'Connor was to pay for Mr. Donaldson's loss of constitutional rights.

But as the case progressed from the lower federal courts to the Supreme Court it was not clear what constitutional right Dr. O'Connor had deprived Mr. Donaldson of. If Dr. O'Connor had violated Mr. Donaldson's right to be treated, then Mr. Donaldson indeed had such a constitutional right and so did every

other involuntary patient. This was the view taken by the federal district court and the Court of Appeals.

However, the Supreme Court took a much narrower view of the case. It decided only that those patients who were not dangerous to themselves or to others, who could survive outside the hospital, and who were not getting treatment within the hospital had a right to be discharged. The court was silent on the right to be treated, but in a footnote it emphasized that it was vacating the lower court's decision of a constitutional right to treatment. Chief Justice Burger in a concurring opinion scathingly criticized the lower court's reasoning in reaching a right to treatment. (As of this writing, the Supreme Court has never endorsed the right to treatment, and Chief Justice Burger has in subsequent mental health cases made clear his opposition to substantive due process decisions, in which lower court judges have attempted to meet the needs of the mentally ill as opposed to their procedural due process rights. But as we have seen, the Supreme Court has not even been generous in providing procedural due process rights as is apparent in *Donaldson, Addington, Parham,* and *Bartley*.)

Donaldson was a unanimous decision. In effect, it said that if Mr. Donaldson had been dangerous, he had no right to be discharged; if he had been unable to care for himself, he had no right to be discharged; and if he was getting treatment, he had no right to be discharged. Only when there is

absolutely no possible justification for confinement has a patient the right to be discharged.

Because the Supreme Court held that Mr. Donaldson had been deprived of his constitutional right to liberty, the decision was hailed as a great triumph for civil libertarians. However, *Donaldson* was in reality little more than a restatement of *Jackson.* The Supreme Court, in effect, simply announced once again that it was constitutionally impermissible to incarcerate a human being forever without some reasonable legal justification.

But the Supreme Court gave no guidance as to what reasonable legal justification would be necessary in order to justify initial confinement. Its decision was applicable only to the grounds for discharge. This is a matter of some interest. Almost all states have laws on the books that regulate civil confinement; some of them, as has been demonstrated, are very complex and set stringent standards. But once the patient is confined, the psychiatrist has almost total discretion over discharge, although many states now require periodic review. The Supreme Court's decision in *Donaldson* did impose on psychiatrists the responsibility to discharge non-dangerous custodial patients who could survive outside the hospital. If psychiatrists did not comply, they risked a suit for damages under the Civil Rights Act.

But in deciding that Mr. Donaldson had been deprived of his right to be

discharged, the Supreme Court, in light of its intervening opinion in *Woods* v. *Strickland,* instructed the lower courts to reconsider their finding that Dr. O'Connor had been liable for damages. *Woods* had established criteria for determining the liability of persons acting under color of law, such as Dr. O'Connor, and included a criterion that, in effect, prevents retroactive liability for depriving a person of a constitutional right not yet established. The lower courts never decided this issue of liability. Instead, Mr. Donaldson settled for a minimal sum of $10,000 with a written agreement in which no admission of liability on the part of Dr. O'Connor was conceded. Perhaps the most important aspect of the *Donaldson* case is that it marked the first time that any patient had succeeded at even a lower court level with this kind of civil rights action against a psychiatrist.

Although the judgment was vacated, remanded, and settled, federal legislation makes it possible for lawyers to be compensated for their efforts in such litigation. The basic theory of such compensation is that lawyers who press for the constitutional right of citizens are functioning as a kind of private attorney general. If they win their case, even to the extent that Mr. Donaldson won his, the defendant must compensate them. Thus, the lawyer is not dependent on a contingency fee arising from damages, or on representing wealthy clients. This, of course, removes one of the major obstacles to litigation in the mental health area, since cases such as *Donaldson* entail vast sums in legal fees. Similar private attorney general statutes in some states,

other provisions of pending federal legislation, and the growth of advocacy programs for mental patients guarantee that mental health litigators will be a continuing reality, shaping the practice of psychiatry in the United States.

Conclusion

The rights of mental patients have been linked to the civil rights movement. This conception emphasizes due process and equal protection as the essential constitutional doctrines. When applied to the psychiatric context these doctrines have produced two kinds of litigation. One emphasizes rights even where they interfere with the patient's needs. The other emphasizes needs and attempts to express those needs as rights. The lower federal courts have taken a much more activist approach to this litigation than has the Supreme Court. Thus, there exists a profound disequilibrium and uncertainty about future judicial decisions. However, many states through legislative action have already adopted new mental health statutes that provide all of the due process safeguards sought by reformers. Therefore, whatever decisions the Supreme Court ultimately makes, we can expect that for the next few decades law and legal intervention will remain a central concern of American psychiatry.

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Notes

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