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SUBVERTING GOOD INTENTIONS: A BRIEF HISTORY OF MENTAL HEALTH LAW "REFORM"

Rael Jean Isaac† and Samuel Jan Brakel‡

INTRODUCTION

On December 7, 1981, Darrell Burch wandered along a Florida highway, bruised, bloodied, and disoriented.¹ A good Samaritan took him to a private mental health center in Tallahassee, where he was evaluated by the medical staff. They reported that Burch was hallucinating and confused — he said he was in heaven — and concluded that he was psychotic. Burch signed voluntary admission and consent-to-treatment papers. After performing a more intensive evaluation, the medical staff found him to be suffering from paranoid schizophrenia and in need of longer-term treatment.

On December 10, the Tallahassee center staff therefore referred Burch to Florida State Hospital in Chattahoochee which admitted him that day after he had signed forms (similar to those that he had signed at the Tallahassee center) requesting admission and authorizing treatment. Consent to treatment for schizophrenia in modern psychiatric practice means consent to treatment with anti-psychotic drugs, which were accordingly used to treat Burch. Hospital records indicate Burch persisted for some time in his belief that he was "elsewhere" and that he was often uncooperative and resistant to ministrations of the staff. He nonetheless signed another authorization-of-treatment form two weeks after his admission, and returned voluntarily from the two weekend furloughs with his family that he re-


‡ A.B. Davidson College, 1965; J.D. University of Chicago, 1968. Member of the teaching faculty at DePaul University College of Law, Director of Research at the College's Health Law Institute, and on the staff of the Isaac Ray Center in Chicago.

¹ Zinermon v. Burch, 494 U.S. 113, 118-121 (1990). Except where noted otherwise, the authors have used the description of the events surrounding Burch's admission from the Court's statement of the facts of the case.
ceived during the course of his stay.\footnote{Telephone Interview with Walter Meginnis, Florida State Attorney General's Office (June 6, 1991).} Burch remained at the hospital until his release five months after his admission.

Thus far the story of Darrell Burch is commonplace, repeated with minor variations many thousands of times each year.\footnote{See admission statistics cited in text infra.} Nothing in these events suggested that Burch's experiences would become the basis for a Supreme Court decision that would undercut the whole concept of voluntary admission and threaten much of the progress achieved through consensual treatment of mental illness. Of the "reforms" of mental health law in the 1960s — of which the hordes of homeless mentally ill are the most visible legacy\footnote{There is broad agreement among experts that the percentage of seriously mentally ill among the homeless population is between 33-40%. The number of homeless is a more contentious issue, with the 1990 U.S. census figures of 230,000 homeless (at a given moment in time) severely attacked by advocates for the homeless as far too low. A 1984 survey by the U.S. Department of Housing and Urban Development estimated between 250,000 and 350,000 homeless. The Urban Institute in 1987, in a study financed by the U.S. Department of Agriculture, estimated there were 600,000 homeless. Actually, the estimate seems to have been influenced by fears that the actual numbers were too low to be politically correct. One of the study's authors, Martha Burt, called the 600,000 figure deliberately high "based on our desire to err on the side — as a government study — of overestimating rather than underestimating." See Rael Jean Isaac and Virginia Armat, Madness in the Street, 3-4 (1990). The numbers of mentally ill homeless are rising. In 1991, on the basis of a 21 city survey, the Conference of Mayors reported that their number had grown by 7% since 1990. In 1991, in these 21 cities, there were 69,000 people both homeless and seriously mentally ill. See Rael Jean Isaac, A Detour Around Crazy Mental Health Laws, WALL ST. J., April 16, 1992. The link between the rising numbers of homeless mentally ill persons and changes in the mental health law can also be inferred from individual case studies. See Alexander Brooks, Law and Ideology in the Case of Billie Boggs, 26 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERV. 22 (1988).} — encouraging mentally ill persons to accept treatment voluntarily had been one of the few to work out as intended. In 1960, the overwhelming majority of mental patients in the United States were involuntarily committed to
state hospitals.\textsuperscript{5} Today, 73\% of the 1.6 million annual admissions (including to private hospitals) are voluntary patients.\textsuperscript{6}

Unlike countless otherwise similar patients, Burch did not slip quietly back into the community. Shortly after his release, Burch filed a complaint, stating that he had been inappropriately admitted and did not remember signing any admission or treatment forms. The complaint reached the Florida Human Rights Advocacy Committee, an entity within the State's Department of Health and Rehabilitation Services, which investigated and wrote a letter to Burch encouraging him to proceed with his grievance.\textsuperscript{7}

While he initially filed a legal action on his own behalf, Burch realized his chances of success were not good. He therefore elicited the help of a private attorney,\textsuperscript{8} and in February of 1985 — almost three years after the events — Burch and his attorney brought a formal section 1983 law suit in federal district court against the treatment and admission staff at both the Tallahassee Mental Health Center and Florida State Hospital.\textsuperscript{9}

Burch alleged in his complaint that the defendants had violated his constitutional rights when they admitted and

\textsuperscript{5} In Congressional hearings in 1961 and 1963 on the rights of the mentally ill, witnesses testified that only between 10-20\% of admissions to public and private mental hospitals were voluntary. In public hospitals the rates were very low, with some hospitals only accepting involuntarily committed patients. In the 1961 hearings Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital in Washington D.C., testified that only 265 of the 7,000 patients in that hospital were voluntary. \textit{Constitutional Rights of the Mentally Ill, 1961: Hearings Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, 88th Cong., 1st Sess. 36,47 (1961) [hereinafter 1961 Hearings]. To Protect the Constitutional Rights of the Mentally Ill, 1963: Hearings on S.935 Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, 88th Cong., 1st Sess. 61 (1963) [hereinafter 1963 Hearings].


\textsuperscript{7} Burch v. Apalachee Community Mental Health Serv., 840 F.2d 797, 799 (11th Cir. 1988).

\textsuperscript{8} Telephone Interview with Richard Powers, Burch's Attorney (June 14, 1991).

\textsuperscript{9} 42 U.S.C. § 1983 (1981). In its initial stages, Burch's suit also sought recovery from the county sheriff, who had transported him from the community center to the state hospital. Burch dropped this part of the suit early in the proceedings. Burch v. Apalachee Community Mental Health Serv., 804 F.2d 1549, 1551 n.2 (11th Cir. 1986).
treated him as a voluntary patient in the face of evidence that his mental condition made him incapable of giving voluntary consent. The central portions of the complaint, drafted in typical heavy-handed legal style, put it this way:

Defendants, and each of them, knew or should have known that Plaintiff was incapable of voluntary, knowing, understanding and informed consent to admission and treatment at FSH [Florida State Hospital]. Nonetheless, Defendants and each of them, seized Plaintiff and against Plaintiff's will confined and imprisoned him and subjected him to involuntary commitment and treatment for a period from December 10, 1981, to May 7, 1982. For said period of 149 days, Plaintiff was without the benefit of counsel and no hearing of any sort was held at which he could have challenged his involuntary admission and treatment at FSH. Defendants, and each of them, deprived Plaintiff of his liberty without due process of law in contravention of the Fourteenth Amendment to the United States Constitution. Defendants acted with willful, wanton and reckless disregard and indifference to Plaintiff's Constitutionally guaranteed right to due process of law.10

These charges no doubt surprised and upset Burch's caretakers at Tallahassee and Chattahoochee, who had, as they saw it, restored to a very sick man the ability to function in the community. But in the world of legal complaints, where a verbal kick in the teeth to one's "adversary" comes as naturally as the portrayal of the plaintiff as virtuous victim, this is unexceptional.

A hard look at the substance of Burch's contentions, however, reveals them as more than a little baffling. On the one hand, Burch complained that, given the alleged legal worthlessness of his consent to be treated as a voluntary patient, he had in effect been treated as an involuntary one. On the other hand, the driving theory of his suit was that he should have been treated as an involuntary patient on the ground of his claimed legal ineligibility for voluntary status.

But the most troublesome aspect of the suit was its implication that persons like Burch, provided voluntary care when

found sick and hurt, are somehow better served by being subjected to some compulsory, costly, time-consuming, and anti-therapeutic legal process before they can be treated (if then).  

Originally drafted in 1871, the section 1983 law under which Burch filed his suit gave plaintiffs in civil rights cases direct access to the federal courts. The law was based on the theory that plaintiffs in such cases might not get justice in the state and local courts. Over the years, especially during the 1960s and 1970s, the reach of this civil rights law has expanded substantially beyond its original focus to where, today, the overwhelming number of its users are plaintiffs in institutional settings like prisons and mental hospitals, especially the former. But there are limits, procedural conditions to be met: not every grievance or complaint filed by an institutionalized person may be brought directly into federal court under section 1983.

11 The preference in medicine and law for voluntary admissions, and presumed competency to volunteer, that has dominated mental hospital intake since the mid-1960s is grounded in therapeutic reasons. See supra note 5 and infra text accompanying note 29. Compulsory intervention usually takes place in the later stages of mental illness and the compulsory process itself may be time consuming. The negative therapeutic consequences of delayed treatment are well documented. See generally Samuel Jan Brakel & John M. Davis, Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment, 25 IND. L. REV. 429 (1991). Finally, today's restrictive commitment, or substituted judgment, standards increase the likelihood that substantial numbers of mentally ill persons who would consensually seek treatment, or not object to it if prompted, would not qualify for involuntary hospitalization.


13 In 1991, there were 26,716 civil rights actions filed by prisoners alone (presumably all § 1983 actions) versus 20,236 filings from other sources (about half in areas — voting rights, housing, employment and public aid — that suggest use of federal provisions other than § 1983). FED. JUD. WORKLOAD STAT. (DEC. 31, 1991), prepared by Admin. Off. of the Fed. Cts., at 32-3.

14 The relevant precedents are mainly from the prison setting: Parratt v. Taylor, 451 U.S. 527 (1981); Hudson v. Palmer, 468 U.S. 517 (1984); Daniels v. Williams, 474 U.S. 327 (1986). These cases stand for the propositions that plaintiffs should not have direct access to the federal courts when (1) their complaints are trivial, (2) the official actions complained of are in the nature of random negligence, and (3) the states provide adequate "pre-deprivation" remedies or, due to the nature of the injuries or injurious actions, can only provide adequate post-injury remedies. The federal district court and the Circuit Court of Appeals read this line of cases to require initial dismissal of Burch's suit.
These limits stymied Burch at the district court level, where his complaint was summarily dismissed. Burch then appealed to the Federal Circuit Court of Appeals, but that court sustained the district court’s dismissal. The appeals court agreed with the trial court that Burch’s suit was not a proper section 1983 action because the State of Florida provided plaintiffs like Burch with a viable opportunity to obtain justice in its own state courts by way of its tort liability law. Though constitutionally disfavored as "postdeprivation" in nature, the tort option was held to be an adequate remedial procedure, indeed the only possible one, in a case of this kind.

Perhaps uneasy at having so easily side-stepped the merits of Burch’s complaint, the Circuit Court of Appeals took the unusual step of rehearing the case — this time "en banc" with a full complement of thirteen judges as distinct from the three-member panel which had rendered the initial decision. On the basis of this reconsideration, the court reversed itself. Burch’s section 1983 action was proper after all, and the substance of his troublesome claims and their implications would have to be considered.

Faced with this prospect, the State of Florida appealed. Under the name of Dr. Zinermon, Burch’s treating physician at the state hospital, it filed a petition for review with the United States Supreme Court. The Supreme Court granted this petition and in February of 1990, some eight years after Burch had been picked up and hospitalized, the High Court handed down its decision in Zinermon v. Burch. Responding to the procedural question that had dominated the litigation below concerning the propriety of Burch’s section 1983 route into the federal system, the Court concluded that the Circuit Court of Appeals’ second opinion was correct: Burch was indeed entitled to direct access to the federal courts.

Had the Supreme Court premised its holding strictly on technical grounds, Zinermon v. Burch might have raised some eyebrows among civil rights litigation specialists, but little else.

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15 Burch v. Apalachee Community Mental Health Serv., 804 F.2d 1549, 1551 (11th Cir. 1986).
16 Id.
17 Id.
18 Burch v. Apalachee Community Mental Health Serv., 840 F.2d 797 (11th Cir. 1988).
The larger, ominous implications for the mental health system would have taken years to unfold, as the Burch complaint reworked its way through the courts on the merits, assuming it did not die a merciful death somewhere along the route. (Indeed, the case was settled shortly after the Supreme Court decision for a total of $35,000, including damages, costs and attorney fees.) However, Justice Blackmun's opinion for the majority tipped the Court's hand on matters well beyond the procedural issues, intimating an agreement in principle with Burch's substantive position. Although the merits of the suit were never tried, they were in effect decided by the Court, thereby depositing Zinermon v. Burch squarely on the list of so-called landmark cases.

To justify its essentially counter-precedential holding that a section 1983 suit was proper in Burch's case, the Court had to find that the alleged violation by Florida officials (the doctors and the intake personnel) was not just a random event for which there can only be an after-the-fact ("postdeprivation") remedy, but rather that it was a predictable development which could and should have been prevented via a "predeprivation" procedure.

The Court managed this in the following fashion. It interpreted the Florida law to prohibit the treatment of "incompetent" persons as voluntary patients, a conclusion made relatively easy by virtue of Florida's atypical requirement that an applicant give his "express and informed consent" for voluntary admission to a mental facility. Having established what cannot be done, the Court then prescribed what Florida officials should do. Arguing, reasonably, that applicants for voluntary admission to mental hospitals might not be competent, the Court created an affirmative duty that their competency be investigated. Since Florida law failed to require such investigations, ergo, the violation of the duty was entirely predictable, and the state officials could be sued directly in the federal

\[20\] Telephone Interview with Louis Hubener, Florida State Attorney General's Office (June 12, 1991).

\[21\] FLA. STAT. ch. 394.465(1)(a) (1981). Most states do not have such an explicit consent provision. Rather, they operate on the theory that the patient satisfies his voluntary status through reasonable explanation and disclosure efforts, made in the absence of coercion or deceit, without need for the state to concern itself with the patient's rationality or "competency."
system, and found liable if at trial the plaintiff could prove their "dereliction."²²

Such is the tortuous majesty of the law. Via an awkward, technical argument that gives scant attention to practical consequences, the Supreme Court has ushered in the brave new world where Burch's ungrateful and graceless complaint is validated. While his case has been settled for a paltry sum that will barely cover the costs and fees, Burch's concept of competency has been endorsed by the Court, endorsed to the point where it eviscerates the voluntary treatment model. The rescue and treatment — on a voluntary basis — of a person who was clearly severely ill has resulted in a legal case which threatens to make involuntary treatment once again the norm. In the name of competency, treatment may once again be available only through the coercive apparatus of the state, whether by direct court order or via the fiction of substituted consent. For the many who will either resist this compulsory process or who fail to meet its strict "eligibility" criteria, treatment may not be available at all.²³

How did the law get to this absurd and profoundly antipatient point? It started — as it has ended — with changes in the competency law. And the law has developed as it has because an abolitionist movement that sees its mission as keeping people out of institutions was able to turn to its own end legal changes won by reformers hoping to encourage and improve treatment of the mentally ill.

²² It may be worth noting, as the dissenting opinion does at Zinermon v. Burch, 494 U.S. 113, 142 (1990), that Burch's allegation of the defendant's willful, wanton and reckless disregard of his rights contradicts the majority's findings that the state's violation was predictable. Another small irony of the case is that despite the majority's conclusion that the Florida law was defective, Burch's suit explicitly disavowed any challenge to the validity or constitutionality of the law, id. at 36, 149.

²³ See supra note 6. Dr. Paul Appelbaum, director of the law and psychiatry program at the University of Massachusetts Medical School, notes that what little research there is on the capacities of patients to consent to hospitalization suggests that a large majority of presently voluntary patients would have difficulty making competent decisions about their treatment. According to Appelbaum, almost 1.2 million admissions are voluntary. If two-thirds had difficulty making competent decisions, that would mean 800,000 patients who would have to go through the commitment process, overwhelming the courts. And of course a great many of these patients would not meet the "dangerousness to self or others" criterion for involuntary commitment. See Appelbaum, supra note 6, 1060.
I. CIVIL RIGHTS FOR MENTAL PATIENTS

The initial salvo in the battle for these legal changes were hearings on protecting the rights of the mentally ill conducted by the Senate Subcommittee on Constitutional Rights in 1961 and 1963.24

A series of exposés in the late 1940s had focused attention on the terrible conditions in many state mental hospitals.25 Nonetheless, until the mid-1950s, the number of patients in state hospitals continued to rise, peaking at over 550,000 in 1955. Many of these patients were warehoused in mental hospitals for life. Yet the law imposed few obstacles to involuntary commitment. Vague statutes such as those of Massachusetts were not unusual: a person could be committed who was subject to a "character disorder" rendering him so deficient in "judgment or emotional control" that he was "likely to conduct himself in a manner which clearly violates the established ... conventions ... of the community."26

Once committed, the patient was likely to suffer constricting civil disabilities. By law in some states, by custom in others, he was automatically deemed to be "incompetent" — to write a will, marry, dispose of property, enter into contracts, vote — even to drive a car. This status clung to him even after he left the hospital.27

Once civil rights became a major issue in the 1950s, the absence of civil rights for mental patients inevitably gained

24 See supra note 5.
25 See ALBERT DEUTSCH, THE SHAME OF THE STATES (1949), MIKE GORMAN, OKLAHOMA ATTACKS ITS SNAKE PITS (1948) and MIKE GORMAN, EVERY OTHER BED (1956) and the report on conditions in state hospitals by Albert Q. Maisel, Bedlam 1946, LIFE, May 6, 1946, at 102.
27 1963 Hearings, supra note 5, at 41. Senator Sam Ervin noted that in North Carolina, for example, the court automatically appointed a guardian to a committed patient and deprived the patient of virtually all his rights. Patients were often discharged on probation or conditionally. Therefore, it could be a long time before the court issued a certification of sanity restoring the former patient his rights. Even then, moreover, individuals gave testimony that in some jurisdictions, when a former patient tried to regain his driving license, the Department of Motor Vehicles official asked him if he had ever been in a mental hospital. If he said no, he had perjured himself and if he said yes, he would probably be denied a license.
attention. As Albert Deutsch, whose The Shame of the States\textsuperscript{28} had been the most influential of all the exposés, put it at the Senate committee's 1961 hearings: "In a period when civil rights for minority groups constitute a major national issue, theirs remain the most ignored and neglected of all."\textsuperscript{29}

The Senate committee described its goal as paving the way for "sound, effective legislation . . . so that the patient's constitutional rights can be protected without unduly hampering his medical needs."\textsuperscript{30} Unfortunately, this characterization of the patient's plight as a civil rights/minority issue easily resulted in the second part of the committee's statement being forgotten — the caveat about his medical needs.

Much of the testimony at both hearings concerned the mental patient's loss of civil rights as the price paid for treatment. The hearings also focused on the importance of encouraging patients to enter treatment voluntarily. Many of the psychiatrists who spoke at the hearings saw an intrinsic connection between voluntary treatment and preservation of patients' civil rights. Speaking on behalf of the American Psychiatric Association (APA) at the 1963 hearing, Dr. Zigmond Lebensohn testified that mental hospitals should be "looked upon as treatment centers for sick people in the same sense that general hospitals are still viewed."\textsuperscript{31} For mental patients to lose their civil rights was not only practically, but also psychologically, disabling. It was anti-therapeutic.\textsuperscript{32}

In 1963 the Senate drafted a model bill for the District of Columbia addressing both major concerns of the 1961 hearings.\textsuperscript{33} It used both carrot and stick to encourage greater use of voluntary treatment. The bill made voluntary treatment more accessible by mandating that any public hospital in the District (in practice St. Elizabeths) take any patient who requested admission for evaluation, diagnosis or treatment. The bill further specified that patients would not lose any of their civil rights by virtue of hospitalization.

\textsuperscript{28} See supra note 5. Both Deutsch and Gorman (even more vigorously) followed up on their exposés by becoming advocates for changing the laws and improving treatment of the mentally ill.

\textsuperscript{29} 1961 Hearings, supra note 5, at 41.

\textsuperscript{30} Id. at 9.

\textsuperscript{31} 1963 Hearings, supra note 5, at 61.

\textsuperscript{32} Id. at 66.

\textsuperscript{33} Id. at 1-5, 6-11.
Wielding the stick, the bill discouraged involuntary hospitalization by making it more difficult. The bill sought to base involuntary commitment exclusively on the state's police power, limiting its use to the individual who, because of mental illness, was "likely to injure himself or others if allowed to remain at liberty." Part of the subcommittee's rationale was that the benevolent parens patriae power lent itself too readily to overreaching and abuse.

The District of Columbia adopted a modified form of the Senate's bill in 1964. Within little more than a decade almost all states had incorporated the bill's two distinctive features into their commitment law: that patients retain all civil rights upon hospitalization, i.e., are presumed to be legally competent, and that they be found dangerous to others or to themselves (or at least so gravely disabled as to present such an overt danger) before they could be involuntarily committed.

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34 Id. at 3.

35 Richard Arens, speaking on behalf of the ACLU, and Raymond Chasan, a New Jersey attorney, emphasized this point in the 1961 Hearings. 1961 Hearings, supra note 5, at 207-31.

36 1963 Hearings, supra note 5, at 1-5. The model bill had a provision (albeit a weak one, in the view of Morton Birnbaum, who originated the concept) for recognition and enforcement of "the right to treatment":

Each patient hospitalized in any public hospital for a mental illness, shall, during his hospitalization, be entitled to medical and psychiatric care and treatment . . . . [T]he administrator of each public hospital shall submit . . . a report giving a detailed account of the type of medical and psychiatric care and treatment which . . . has been provided by such hospital to each patient hospitalized therein for a mental illness.

Morton A. Birnbaum, A Rationale for the Right, 57 Geo. L.J. 752, 758 n.23 (1969). Birnbaum observed that the final bill dropped any reference as to how the right should be enforced: "A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment." Id. (citing D.C. Code Ann. § 21-562 (1967)). Nonetheless the D.C. Court of Appeals in Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), found there was a statutory right to treatment under the D.C. Act; Birnbaum felt this was a strained reading of the Act because the language was "similar to that used in public mental hospital statutes of ten other jurisdictions: in none of these other jurisdictions has this precatory phrasing been interpreted to mean that there exists a recognized enforceable right to treatment." Id. For a discussion of the provisions of the D.C. Act and its subsequent interpretation, see generally id.

The problem with these "reforms" was that they were built upon false premises. Mental patients are not the equivalent of heart or cancer patients. When psychotic patients present themselves or are sent to the hospital, they are usually confused, disorganized, hallucinating, delusional — incompetent, by strict legal standards, to make "informed" decisions about many things, including treatment. Their presumed competency is a fiction. Dangerousness is no more apposite as the guiding criterion for hospitalization. As psychiatrist Stephen Rachlin has stated, dangerousness is not a disease or any form of diagnostic entity. When a patient is dangerous, it is often because he has inappropriately been allowed to deteriorate, untreated. Hospitalization should come before a person slips to this point.

II. THE MENTAL HEALTH BAR'S ANTI-TREATMENT AGENDA

If everyone involved in shaping mental health policy had shared the goal of encouraging treatment for the mentally ill, the introduction of false premises into mental health law might not have mattered: they would have served as white lies to advance useful social purposes. Permitting patients to keep their civil rights was clearly desirable on public policy grounds, and the definition of dangerousness, "likely to injure himself or others" was sufficiently flexible to permit the broadest of interpretations — "injury" could be psychological as well as physical.

But in the decade following the Senate hearings, a movement emerged that denied the very existence of mental illness. Sparked by maverick psychiatrists and politically radical therapists and adopted by mainstream sociologists, it flourished in the militantly anti-institutional climate of the 1960s counterculture. British psychiatrist Ronald Laing, a countercultural guru, popularized the view of schizophrenia as a natural LSD trip, a "voyage of discovery" leading to higher forms of percep-

39 1963 Hearings, supra note 5, at 3.
tion. The New Left provided a political twist: in an insane society, insanity was the true sanity, the mad rejecting the unacceptable, irrational reality of a rotten social system, while those called sane conformed to the sick values of the culture. Insanity, in this view, was a lofty form of political dissidence.

Sociologists gave these notions academic respectability. Mental illness was a "label," and who was labeled an accident, if not an act of malice: those brought by their families or other authorities into the purview of official agencies for control of so-called mental illness were stigmatized and isolated simply because their behavior was offensive to prevailing tastes, politics or morals. In his famous 1961 study Asylums, sociologist Erving Goffman described how much of mental illness was institutionally "learned behavior" and how mental hospitals produced "deculturation," the loss of habits needed to survive in the wider society.

The logical conclusion was that mental patients needed lawyers, not doctors. Accordingly, in the late 1960s and early 1970s, a group of public interest lawyers — without knowledge of or interest in mental illness as such — established an informal mental health bar. Many of these attorneys worked in

41 ISAAC & ARMAT, supra note 40, at 30 (citing RONALD D. LAING, THE POLITICS OF EXPERIENCE 167 (1967)).

42 ISAAC & ARMAT, supra note 40, at 26-27. The most uncompromising voice of all was that of libertarian psychiatrist Thomas Szasz, an unlikely countercultural hero in that he despised the left. Szasz has called psychiatry a form of 'quackery because it offers cures for which there are no diseases.' Leonard R. Frank, Tom Szasz: Freedom Fighter, MADNESS NETWORK NEWS, Nov. 1972, at 13. Szasz disposes of mental illness by verbal sleight of hand. "Mental illnesses do not exist; indeed they cannot exist, because the mind is not a bodily part or bodily organ." THOMAS SZASZ, THE THERAPEUTIC STATE 15 (1984).

43 ISAAC & ARMAT, supra note 40, at 46. Asylums was based on fieldwork Goffman had done in 1955-56 at St. Elizabeths Hospital in Washington, D.C., then a federal institution with 7,000 inmates. Goffman argued that the institution caused the very deviant behavior it was meant to cure. Id. at 46-47. In Interaction Ritual (1967), he made the same points even more strongly. The inmate was exposed to relentless "abasements, degradation, humiliation and profanations of self." Goffman observed: "If you rob people of all customary means of expressing anger and alienation and put them in a place where they have never had better reason for these feelings, then the natural recourse will be to seize upon what remains — situational improprieties." Id. at 47 (citing ERVING GOFFMAN, INTERACTION RITUAL 147 (1967)).

44 Bruce Ennis, the founder of the mental health bar, has described how he became involved. He applied for a position as staff attorney at the New York
government-funded legal services programs. The bar's ideological and logistical center became the Mental Health Law Project, founded in 1972, which for years functioned as a Legal Services Corporation backup center.

A 1973 symposium in The Santa Clara Lawyer set forth the goal of the emergent mental health bar as the abolition of involuntary mental hospitalization. In his introduction, Thomas Shaffer, then dean of Notre Dame Law School, described institutional confinement of the mentally ill as a "festering evil" and declared that "[t]hese authors . . . have a target in their sights, and they are not out primarily to analyze the target; they are out to destroy it." Shaffer noted that "[t]he ultimate objective really, is to abolish institutional psychiatry." In an interview the following year, Bruce Ennis, who inaugurated the New York Civil Liberties Union's special project on the rights of mental patients in 1968 and is widely regarded as the "father" of the mental health bar, was similarly candid: "My personal goal is either to abolish involuntary commitment or to set up so many procedural roadblocks and hurdles that it will be difficult, if not impossible, for the state to commit people against their will."47

A. THE MENTAL HEALTH BAR FOCUSES ON THE DANGEROUSNESS STANDARD

The mental health bar quickly saw the potential of the "dangerousness standard" for realizing its agenda (recognition of the usefulness of the competency reforms came later). In state after state, the mental health bar pushed vigorously to make

Civil Liberties Union: "I was told there were no openings for staff attorneys but that the New York Civil Liberties Union was thinking of starting a special project on the rights of the mentally handicapped and would I be interested. My initial reaction was 'I don't know anything about that and I don't know if I'd be interested or not.' I went home and then I went to a library and I looked under 'law and psychiatry' and found some books by a man named Thomas Szasz which I found interesting from a civil liberties perspective and I read more and I realized this was a very, very big problem about which most people, including myself, knew nothing." ISAAC AND ARMAT, supra note 40, at 109-10.

45 Symposium, Mental Illness, the Law, and Civil Liberties, 13 SANTA CLARA L. 367 (1973).


47 ISAAC & ARMAT, supra note 40, at 111 (citing Leonard R. Frank, An Interview with Bruce Ennis, MADNESS NETWORK NEWS READER 163 (1974)).
dangerousness the sole standard for commitment, to narrow the
definition of danger, and to graft criminal procedure safeguards
onto civil commitment procedures. Once commitment was based
upon the state's police power, the mental health bar could argue
cogently that it assumed a quasi-criminal character. Under
those circumstances, those "accused" of being "dangerous"
because they were mentally ill deserved all the protections of
the criminal justice system.

The single most significant case was Lessard v. Schmidt, brought by Milwaukee Legal Services. In 1972, a federal
district court declared Wisconsin's civil commitment statutes
unconstitutional. Ruling that "the interests in avoiding civil
commitment are at least as high as those of persons accused of
criminal offenses," the court called for the same due process
safeguards against unjustified deprivation of liberty that are
accorded those accused of crime. These included effective
and timely notice of "charges" justifying detention; adversary
counsel; impermissibility of "hearsay evidence"; the privilege
against self-incrimination; and a standard of proof beyond a
reasonable doubt. The court also defined dangerousness very
narrowly: "the state must 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."

In the wake of the Lessard decision, state legislatures
around the country hastened to change their commitment
statutes to ensure that their laws provided mental patients with
the new court-defined constitutional rights. In addition, courts
increasingly required "overt acts" to prove dangerousness to
others. In states where remnants of the parens patriae pow-
er survived, courts came to define "grave disability" as imminent
dangerousness to self. In some jurisdictions, in practice the
patient was committable only if it could be shown that, failing
commitment, he would die within thirty days.

49 Id. at 1090.
50 Id. at 1093 (emphasis added).
51 1 PERLIN, MENTAL DISABILITY LAW § 2.13 (1989). Perlin notes that the
requirement for "overt acts" to prove dangerousness is not uniform, with case
law in some states supporting the position that psychiatrists can determine
dangerousness through clinical examination without need for a recent overt
act.
52 This is the case, for example, in Philadelphia. The county solicitor
The effect of all this was to shift authority in the mental health system from psychiatrists to lawyers, at the expense of the mental patient. Lawrence Galie, a disillusioned civil commitment attorney, complained that often, the more effective the attorney, the worse off the client. He noted that the adversarial system was simply inappropriate to civil commitment, where the patient's release could have a devastating impact first and foremost on the client, whom the lawyer was supposed to serve and protect.\(^5\)

Many in the civil libertarian bar thought that abolition of all civil commitment was around the corner. Having narrowed the criterion for commitment to dangerousness, they hoped to invalidate that last basis on both practical and constitutional grounds. This was a reasonable expectation in that the logical arguments against the dangerousness standard were in fact much better than those against the need-for-treatment standard which had crumbled so easily. While psychiatrists could diagnose psychosis with reasonable reliability, they could not predict dangerousness with comparable confidence.\(^4\) Violence is an event with a low base rate, i.e., comparatively rare, which makes overprediction inevitable. Suppose one person out of a 1000 will kill and a 95% accurate test for predicting who would

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do so existed. That would mean if 100,000 people were tested, out of the 100 who would kill, 95 would be detected. But so too would an additional 4,905 people who would not kill be identified as potential killers.\textsuperscript{55} Since not even the best psychiatrist could be expected to achieve a 95\% prediction accuracy with respect to dangerousness, the application of this standard to civil commitment resulted in casting the net far too wide.

But if the dangerousness standard thus led to the commitment of many people who would neither imminently commit suicide nor immediately attack others if they were free, the standard arguably was nothing more than unconstitutional preventive detention. An article in the \textit{Santa Clara Lawyer},\textsuperscript{56} declared that confinement for "dangerousness" was "an arbitrary and unreasonable deprivation of liberty" that was "incompatible with the tenets of liberal democracy and more particularly with the constitutional order."

Nonetheless, seeing the dangerousness standard as a protection for society, legislators and judges alike have been unwilling to dispense with it. The dangerousness standard has held firm even though the attack on it received support from an unexpected quarter. Organized psychiatry endorsed its critics' claim that psychiatrists were unable to predict violence and advised its members to avoid such predictions.\textsuperscript{57} The motivations for this concession were diverse. One was the fear of malpractice suits.\textsuperscript{58} Also, psychiatrists had been stung in


\textsuperscript{57} The American Psychiatric Association informed the U.S. Supreme Court in an amicus brief in Barefoot v. Estelle, 463 U.S. 880 (1983), that two out of three predictions of long term future violence made by psychiatrists are wrong. Eminent forensic psychiatrist Robert L. Sadoff said: "[A] psychiatrist has no expertise in the prediction of dangerousness." \textit{See} 1 PERLIN, \textit{ supra} note 51 at 121, 126. And Alan Stone, past president of the American Psychiatric Association, declared: "It can be stated flatly... that neither objective actuarial tables nor psychiatric intuition, diagnosis and psychological testing can claim predictive success when dealing with the traditional population of mental hospitals." \textit{Id.}

\textsuperscript{58} In 1976, a California Supreme Court case sent tremors throughout the psychiatric profession. The parents of Tatiana Tarasoff, a University of California student murdered by her mentally ill, rejected boyfriend, successfully sued a college therapist for failing to warn her of his homicidal fantasies.
particular by criticism of their death-dealing role in capital sentencing cases. 59 Finally, practitioners in institutional settings disliked the dangerousness standard because it forced them to devote most of their efforts to individuals least likely to benefit: young, violent males who moved between prisons and mental hospitals and did not respond to anti-psychotic medication.

Unable to eliminate the dangerousness standard, the mental health bar has resorted to entangling the system with procedural wrangles and in a "never-ending battle in the courtrooms to determine precisely what sort of an 'overt act' justifies a finding of dangerousness, or exactly how much evidence of self-neglect and self-damage is required to prove grave disabi- lity." In view of the plethora of real problems afflicting the mentally ill and the agencies designed to assist this population, this is an appalling waste of resources, serving "neither the public's interests nor the client's," as "spurious disputes are raised to ostensibly constitutional levels and taken to the highest courts." 60

The boyfriend had confided them to him and he notified the campus police, urging that the young man be hospitalized. Although it was the police, operating under the rigors of California law, who refused to press for his hospitalization, the court ruled the therapist—not the police—could be held liable. Tarasoff left psychiatrists eager to give up any claims to expertise in predicting dangerousness. Tarasoff v. Regents of University of California, 131 Cal. Rptr. 14 (1976).


60 Samuel Jan Brakel, Legal Schizophrenia and the Mental Health Lawyer: Recent Trends in Civil Commitment Litigation, 6 BEHAV. SCI. & L. 3 (1988). The article cites a Minnesota case, In the Matter of Bruce Carlton Wollan, as illustrative. Id. at 12-13. Wollan had attacked his sister with a meat cleaver. After being released from confinement for this offense, he had stabbed his mother to death. The jury found him not guilty by reason of insanity. A few years later, the hospital proposed to make him eligible for a pass, allowing him to leave the hospital alone for up to ten days. Wollan's sister argued she was an "interested person" under the law and had a right to participate in a special review board hearing. Incredibly, Wollan's attorney argued that Wollan's sister was not an interested party, appealing the case right up to Minnesota's highest court, at which point seven attorneys were involved in the
B. CREATING A LEGAL RIGHT TO REFUSE TREATMENT

As the mental health bar realized that it could not end commitment as readily as it once thought, it turned its attention to the possibility of a more indirect attack, on the purpose of commitment, namely treatment. If individuals committed to hospitals for treatment could not in fact be treated, the very basis for their confinement would vanish. The mental health bar soon realized that the dangerousness standard could be used to assert a legal right to refuse treatment, a right hitherto undreamed-of in the context of involuntary hospitalization for mental illness.

As long as patients were hospitalized on the ground that they needed treatment, it seemed a contradiction in terms to advance a "right to refuse treatment." Indeed, reformers like Morton Birnbaum, who in 1960 first advanced the concept of a "right to treatment," explicitly defined treatment as the quid pro quo for commitment. Birnbaum argued that since the civilly committed individual was guilty of no crime, the only basis on which the state could deprive him of liberty was if he received, in return for that deprivation, treatment for his illness.

Not surprisingly then, the notion of a "right to refuse treatment" at first seemed bizarre. In 1974, Ennis himself, while declaring that obtaining such a right was his "goal," said: "I think we are a long way from getting the judges to go that far." That same year Harvard Law Review, in a major case. At every level, the court ruled what was painfully obvious — that Wollan's sister was indeed an interested party. In the Matter of Bruce Carlton Wollan, 390 N.W.2d 839 (Minn. Ct. App. 1986).

In 1976 Congress created a Protection and Advocacy program for the mentally ill, which in some states has become a federally funded playground for the mental health bar. These programs, as prominent mental health bar member Michael Perlin says, promise to "exponentially" increase suits for "substantive rights of the institutionalized." See 1 PERLIN, supra note 51, at 799. In addition, they are likely to add to the "procedural junk" (to paraphrase Ralph Slovenko, a rare lawyer-critic of the mental health bar) already obstructing care of the mentally ill.

Birnbaum's seminal article was Morton Birnbaum, The Right to Treatment, 46 A.B.A. J. 499 (1960).

ISAAC & ARMAT, supra note 40, at 167.

Note, Developments in the Law — Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1344-1358 (1974). While conceding the incongruity of failing to treat patients hospitalized under the parens patriae power, the article argued for extending a right to refuse to legally competent patients,
review of civil commitment law permeated by anti-psychiatric assumptions, nonetheless declared that treatment was inherent in the decision to commit a mental patient involuntarily under the parens patriae power, for it would be incongruous if an individual could frustrate the very reason for the state's action by refusing treatment.

Courts dismissed the notion that hospitals could absolve themselves of the duty to treat by citing the patient's refusal of treatment. In 1969, in *Whitree v. State*, a New York court granted an ex-patient $300,000 damages on the ground that if he had been treated adequately he could have been released in two years, not the twelve years for which he was confined. The court dismissed the hospital's argument that the patient had refused all medication, on the grounds it was "illogical, unprofessional and not consonant with prevailing medical standards." Similarly, in that same year, in *Nason v. Superintendent of Bridgewater State Hospital*, the Massachusetts Supreme Court condemned as poor practice the hospital's failure to medicate a patient involuntarily.

But once the parens patriae basis for treating the patient was abandoned, and the state committed the individual only because he was dangerous, commitment and treatment were divorced. In a series of "right to refuse treatment" cases in the 1980s, the mental health bar argued that society had accomplished its purpose by segregating the individual from the community and had no right to further intrude upon his liberty by imposing treatment against his will. Courts endorsed this reasoning. In *Rennie v. Klein*, a pioneering right to refuse case, the trial judge ruled that "[t]he fact that the patient is dangerous in free society may give the state power to confine, hospitalized under the state's police power.

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64 290 N.Y.S.2d 486 (1968).


but standing alone it does not give the power to treat involuntarily. Once confined, the patient cannot hurt those outside."^{68}

As it drew out the implication of the dangerousness doctrine, the mental health bar began to realize that it had another important tool in the separation of commitment from competency. Although instituted as a means to encourage patients and their families to seek treatment, the mental health bar realized that the assumption of legal competency could be used, in conjunction with the dangerousness standard, to block treatment.

By the mid-1970s the statutes of virtually all states provided that hospitalized mental patients retained all of their rights, i.e., that the law considered them to be legally competent, unless a court specifically judged otherwise.^{69} But if they were legally competent, argued the mental health bar, why should not mental patients enjoy the same rights as any other patient? Courts increasingly affirmed the patient's right of informed consent to medical treatment.^{70} (It is noteworthy that the decision most often cited as precedent has been Judge Benjamin Cardozo's ruling in a 1914 case, *Schloendorff v. Society of N.Y. Hospital,*^{71} that "every human being of adult years and sound mind has a right to determine what shall be done with his own body." [Italics added] The mental health bar argued that since the law now assumed mental patients to be competent, they were legally of "sound mind," thus falling under the purview of a decision that specifically excluded them!) The very legal rights which reformers had bestowed upon patients in order to foster treatment became an argument against treatment. Thus in *Rogers v. Okin,*^{72} another pivotal right to refuse case, the court stated that a patient was "presumed competent to manage his affairs, dispose of property, . . . and even to vote," but that

^{68} Id. at 1145.

^{69} See Brakel et al., supra note 37, at 369-433.


^{71} 105 N.E. 92, 93 (1914).

"such rights pale in comparison to the intimate decision as to whether to accept or refuse psychotropic medication."\footnote{73}

In creating, at the instigation of the mental health bar, a right to refuse treatment, courts were clearly influenced by their perception that antipsychotic drugs were "dangerous." Beginning in the late 1960s, law journal articles on mental illness almost without exception were permeated by anti-psychiatric doctrine.\footnote{74} Judicial decisions quoted most frequently two of the most egregious articles: Robert Plotkin's \textit{Limiting the Therapeutic Orgy}\footnote{75} and Eugene DuBose's \textit{Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia}.\footnote{76} Such articles ignored or minimized the proven effects of medication in controlling the symptoms of psychosis, elaborated all possible side effects,\footnote{77} and offered sinister — and false — portraits of the drugs as a species of "mind control."\footnote{78}

Relying on such "authorities," judges described the drugs in the most lurid terms. In a seminal right to refuse case, the Massachusetts Supreme Court declared that anti-psychotic medications were "mind-altering," "powerful enough to immobilize both body and mind," and that their impact was "sufficient to undermine the foundations of personality."\footnote{79} In vain, the

\footnote{73 Id. at 1361.}
\footnote{74 See Brakel & Davis, \textit{supra} note 11, at 437-441.}
\footnote{76 60 MINN. L. REV. 1149 (1976) (citing cases including \textit{Watson}, 893 F.2d at 973 n.5; In re Jamie M., 184 Cal. Rptr. 778, 783 n.16 (Cal. Ct. App. 1982)).}
\footnote{77 Like virtually all drugs, the neuroleptic drugs have side effects, most of which doctors can control with additional medications. The most troublesome side effect is tardive dyskinesia, an uncontrollable movement disorder that affects between 20-30% of all long-term users of this drug. Fortunately, in the vast majority of cases the disorder is not progressive and takes a mild form, so that it is noticeable neither to the patient nor to those around him. However, approximately five percent of those who develop tardive dyskinesia will experience its severe disfiguring and disabling forms. See ISAAC & ARMAT, \textit{supra} note 40, at 235. Clozapine, approved by the FDA in 1989, apparently does not produce tardive dyskinesia, but has a potentially fatal side effect, agranulocytosis, requiring close monitoring. See \textit{id.} at 237.}
\footnote{78 See Brakel & Davis, \textit{supra} note 11, at 437-441.}
American College of Neuropsychopharmacology filed an amicus brief, stating that "[p]sychotic disease alters the mind of afflicted patients; antipsychotic medication is mind-restorative."80

Courts outdid one another in expressing horror at the supposed evil of the drugs. In 1986 an Arizona court81 described medications as "insubstantially different from the shackles of old." It conceded that the state could forcibly inject a patient in emergencies "just as it may shoot him if justified in an emergency." Presumably the first was a fate little preferable to the second.

Starting with Massachusetts, a series of state courts ruled that, except in emergencies, before a psychiatrist could treat an involuntarily committed patient against his will, a court would have to find him, in a new adversarial hearing with the full trappings of the criminal law, incompetent to make a treatment decision.82 Even then, under the Massachusetts ruling, treatment would not necessarily follow: the court would decide not on the basis of the patient's best interests, but rather would use a "substituted judgment" standard.83 The ruling required courts to try to decide what the incompetent mental patient would want if he were competent, taking into account the fact that he is incompetent. However mind-boggling, time-consuming, or costly, the law required that the exercise be done.

A study by the Massachusetts Department of Mental Health84 of the first eighteen months under the new procedures found millions of dollars in direct (i.e., money that had to be appropriated by the legislature for lawyer and expert witness fees) and indirect costs. Psychiatrists and other clinical staff spent thousands of hours preparing affidavits, diverting effort from patient care. There were delays as long as eleven months before hearings, with waiting periods of eight to ten weeks common. In the end, however, the courts ruled in favor of treating involuntarily 97% of the patients.

80 Brief for the American College of Neuropsychopharmacology as Amicus Curiae at 11 n.10, Mills v. Rogers, 457 U.S. 291 (1982) (No. 80-1411).
81 Large v. Superior Court, 714 P.2d 399, 406 (1986).
83 In the Matter of Guardianship of Roe, 421 N.E.2d at 56-59.
In New York, the situation is even worse. Legal procedures have been grafted on top of existing administrative ones, with the latter having to be exhausted before the former can begin. At one institution studied, the additional cost simply for keeping untreated patients in the hospital waiting for legal procedures to begin averaged over $10,500 per patient.\(^{85}\)

Why are so few refusals upheld in court hearings, particularly when, as in both Massachusetts and New York, even if it finds the patient incompetent, the court uses a substituted judgment standard? Psychiatrist Paul Appelbaum\(^{86}\) has found that in practice, judges, to their credit, are primarily interested in finding out if the patient is likely to respond to medication. Expecting courts to make substitute judgments for patients without regard to the patient's or society's best interest has fortunately proven to be unrealistic. A study conducted at Bridgewater State Hospital (for the criminally insane) confirms this result; it found that judges were chiefly interested in how "violent" the refusing patient was.\(^{87}\)

C. ABOLITIONISTS NOW IN SIGHT OF GOAL

The mental health bar had viewed the right to refuse treatment as a backdoor way of attacking involuntary commitment: if an individual could not be treated, there would be no point in hospitalizing him. But like the mental health bar's previous victories, widespread adoption of the right to refuse did not achieve this broader purpose. The majority of involuntarily committed patients do not reject proffered treatment. Exploitation of the abstract logic of the dangerousness standard and separation of competency from commitment had damaged the mental health system, but had not brought it to a halt.

But with Zinermon v. Burch the anti-psychiatric bar may have its goal in reach. Unknowingly,\(^{88}\) the Supreme Court has


\(^{86}\) Appelbaum, supra note 82, at 417.


\(^{88}\) It is doubtful the Supreme Court understood the implications of its decision. Although the initial successes of the mental health bar had been in federal court, in the latter part of the 1980s it concentrated as much as possible on state courts and regarded an increasingly conservative Supreme Court as especially unfriendly territory. In the same year it decided Zinermon
struck at the heart of the fiction on which all state mental health systems rest. The vast majority of mental patients are not competent in any strict sense. By applying a reductive logic to a structure depending upon false premises, the Supreme Court has exposed the well-intentioned sham behind the "reformed" mental health system. But in doing so, it may well kill the system.

Given their questionable capacity to give "informed consent," huge numbers of presently voluntary patients would have to go through the procedures for involuntary commitment. Then, the second misguided underpinning of our mental health laws will again assume importance: that a patient must be imminently "dangerous" in order to be involuntarily committed. Apart from the enormous expense of requiring these large numbers of commitment hearings, many of the voluntary patients in today's system would not even meet the statutory standards for involuntary treatment in most states and would have to be turned away.

On the surface Zinermon v. Burch applies only to states that require patients to be able to give "informed consent" to their admission and treatment in mental hospitals. Florida is one of only a few states — although California, with the largest population, is among them — to provide this by statute. But in his decision Justice Blackmun strongly implied that in every state voluntary patients would have to be screened for competence before hospitalization. In addition, though the Zinermon Court rendered judgment only against the state hospital, the private clinic having dropped out of the suit before the final appeal, there is little question that the case's competency inquiry mandate applies against all entities — public and private — involved by virtue of state law and/or funds in the administration of the state's mental health system.

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v. Burch, the Supreme Court ruled against court intervention in a right to refuse case involving a mentally ill prisoner. See Washington v. Harper, 494 U.S. 210 (1990). Writing for the court, Justice Kennedy maintained that the inmate's interests were "adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge." Id. at 231. Interestingly, the decision did not focus upon the issue of patient competence.

89 494 U.S. at 133, 137-38.
D. PROSPECTS FOR FURTHER DAMAGE

Nor is this all. The Supreme Court's decision concerned itself primarily with pre-admission duties and violations, though Burch's initial complaint also challenged the validity of his post-admission consent to treatment. It cannot be long before a case focusing squarely on the latter issue will be brought. The argument will go like this: "Patients have a right to refuse treatment. Courts will honor their decision if they are competent, and if they are incompetent, the court must provide a substitute decision maker. My client may have signed a consent to treatment form, but he was psychotic and had no idea of what he was doing. The hospital had no right to take advantage of my client's incompetence; he was entitled to a court hearing, legal counsel, and a judicial decision based on substituted judgment."

If this argument succeeds, the mental health bar will have gained the procedural roadblocks it has long sought to immobilize the system.

III. RESTORING COMMON SENSE TO MENTAL HEALTH LAW

The only way out of the present morass is to rewrite our laws to address the realities of mental illness. Above all, this means restoring the need for treatment as a ground for commitment. A few states have done so, although, in some cases, the way they have done it may prevent the desired effect from being achieved.

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90 For example, North Carolina's law authorizes commitment of one who is dangerous to himself or others or "in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness." N.C. Gen. Stat. § 122C-261(a) (Supp.1991). In 1980, Washington broadened its "gravely disabled" standard. See BRAKEL ET AL., supra note 37, at 23 n.14.

A new Texas statute permits both "temporary" (90 days) and "extended" (12 months) commitment of a patient who "will, if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress, will continue to experience deterioration of his ability to function independently, and is unable to make a rational and informed decision as to whether or not to submit to treatment." The other two criteria for involuntary hospitalization — likely to cause serious harm to (1) self and (2) others — remain in place, with the new standard representing a third alternative. Moreover, a jury or judge must base a commitment decision under any of the three criteria only on
Paradoxically, once states reinstitute the "need for treatment standard," treatment in the community will also become much more feasible. Many of the mentally ill lying in our public places respond to treatment: they were discharged from hospitals because they did so, and deteriorated when they stopped taking medication. There are a wide variety of legal mechanisms (e.g., conditional release, outpatient commitment and limited guardianship) that could be used to enforce treatment in the community once the "need for treatment standard" is reinstituted. Under the dangerousness standard the individual is "free" to deteriorate in the community until he becomes actively dangerous.

How to deal with the competency barrier to hospital admission erected in Zinermon v. Burch is a more difficult question. A sensible approach would seek to retain much of the sense and efficiency of voluntary admission schemes as they operated before Zinermon. While requiring competency inquiries, the Supreme Court has not spelled out either their procedural or substantive details. An American Psychiatric Task Force,91 appointed to do damage-control in the wake of Zinermon, has

91 Telephone Interview with Paul Appelbaum, A.F. Zelenik Distinguished Professor of Psychiatry; Director, Law and Psychiatry Program, University of Massachusetts (June 12, 1991). Having difficulty coming to agreement on precise language, the Task Force is presently field-testing a formula. Letter from Appelbaum to Samuel Jan Brakel (Jan. 3, 1992) (on file with the Cornell Journal of Law and Public Policy).
reportedly recommended in-hospital administrative decisions (as opposed to full-blown judicial hearings) predicated on easy-to-meet substantive standards. A patient expressing agreement with admission and treatment in any way, verbal, behavioral or written, and displaying some minimal understanding of where he is and why, would meet the competency requirements for admission and initial treatment. Those individuals not competent even by such non-exacting standards would require substitute decisionmakers (family members whenever possible).92

But while such an approach could solve, or at least minimize the problems posed by Zinermon, the obvious danger is that in establishing liberal competency standards so as to permit voluntary patients to obtain treatment, the APA will be paving the way for the mental health bar to achieve equivalent easy competency standards for involuntary patients to refuse treatment. All along, as we have seen, it has been the modus operandi of the anti-psychiatric bar to misuse reforms designed to achieve treatment to impede it for those most in need.93

92 Guardianships can be very valuable as a buffer-cum-information source between the patient and the medical and legal system. The problem is that persons with the desired ties to and concerns for the mentally ill patient are often not available. Public guardianship is a poor substitute in the absence of family guardians, inserting another inefficient bureaucratic layer without providing the patient the benefit of a personal protector.

A new alternative is the health care proxy or the psychiatric living will. Decisions about treatment preferences would be made by the patient while in a state of good mental health or by the guardian-like designees. This would be advantageous in that it gives greater control to the individual and because it might make treatment more available to him. When their psychosis is in remission, mentally ill people who recognize their potential need for future treatment could arrange for an agent to authorize their hospitalization, even though they had not deteriorated to the point of "dangerousness." However, experience is lacking for an assessment of the medical value and legal validity of treatment decisions made in periods of good health, before the psychiatric crisis occurs.

A cautious approach may be in order, especially with respect to directives that ban all treatment under certain circumstances or that bar certain treatments under all circumstances. The law may need to provide a mechanism for overriding such treatment "refusals," as has been proposed for example to the legislature in Saskatchewan, Canada in a paper prepared by the British Columbia Schizophrenia Society. Response of the British Columbia Schizophrenia Society to the British Columbia Ministry of Health Discussion Paper on Mental Health Regulation 18 (1991) (paper is available from British Columbia Schizophrenia Society, 6011 Westminster Highway, Richmond, B.C. V7C484).

93 Through the article we have referred to the anti-psychiatric bar (or,
The only way to avoid this predictable outcome is for state legislatures to recognize the critical distinction between voluntary and involuntary patients. Only in the case of the latter do refusals pose a real problem. A voluntary patient should indeed have a readily assertable right to refuse treatment. It would be exercised, the empirical evidence suggests, in relatively rare instances, at which point the hospital has the option to persuade, to discharge, or to institute involuntary commitment proceedings.

By involuntarily committing a patient, a court in effect finds that individual incompetent to make treatment decisions. If because of impaired judgment the individual cannot make a decision on admission, neither can he make an informed decision to refuse treatment. In a decision departing from the "lemming school of jurisprudence" that has characterized so much recent mental health law, a Wisconsin district court in 1985 said bluntly: "Nonconsensual treatment is what involun-

interchangeably, the mental health bar) as if it had an identified membership pursuing a set of defined goals and strategies. Lest we be challenged as seeing more cohesion than there is, we wish to make clear that there is no organized "mental health bar" and in this sense our writing is more metaphorical than literal. However, we believe the term is a valid one, describing attorneys who have a common perspective on the role of law in addressing the needs of the (so-called) mentally ill. For these attorneys, regardless of its nature (and the mental health bar would include everything from believers in the mental-illness-is-merely-a-label school to those who recognize it as a medical illness), mental illness is to be treated legally as essentially a civil rights issue and the role of law is to steadily expand the rights of patients, including the right not to be a patient at all (regardless of how "sick" he may be from a medical point of view). And while not formally organized, the mental health bar has a variety of informal ties that are effective in promoting this ideology and directing the path of legal action. In the 1970s legal services groups funded by the Legal Services Corporation took a major role, and the Mental Health Law Project, which had a clear-cut mental-health-as-civil-rights ideology, was the Legal Services Corporation backup center providing research and other aid to the local groups on mental illness cases. Law journals have been hospitable to articles advancing these ideas to the point that it is rare to find an article expressing a different view. The Mental and Physical Disability Law Reporter is particularly important in disseminating what is essentially an anti-medical perspective. In the last few years the lawyers funded by Protection and Advocacy programs have taken a leadership role and many attend annually (at government expense) the meetings of NARPA (National Association of Rights Protection and Advocacy) which takes an extremely radical anti-psychiatric line and where speakers suggest the kinds of lawsuits they believe will most advance the cause of patients' rights.

94 See Brakel & Davis, supra note 11.
tary commitment is all about." Involuntary hospitalization without involuntary treatment is a sham, turning commitment into a police operation and hospitalization into incarceration.

By virtue of the judge's ruling to commit a patient, his treatment rights and needs are placed in the hands of the hospital physicians, subject to periodic administrative (i.e., medical) review. Competency to refuse treatment does not survive the commitment decision. That is the law today in a small number of states. It should be the law in all states.

Today the mental health bar, by inexorably drawing out the implications of the 1960s reforms so as to wholly vitiate their intent, has brought the law full circle. Psychiatrist Alan Stone, comments on this reductio ad absurdum: "A legal system that orders people into mental hospitals and then orders psychiatrists not to treat them seems to make Kafka's vision of the law a reality." Equally, it is a perversion of the reason of the law to draw out its logic to where a concept of competency, designed to free patients to seek treatment, is turned against them, to inhibit, if not prohibit this goal.

If we want, as the news media keep urging, to "reclaim our streets," and more important, to reclaim the lives of the mental-

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96 The right to periodic administrative review is an important one for all patients, whether involuntary or voluntary. It ought to be provided by a board whose membership guarantees an adequate measure of independent judgment, an existing practice in many institutions, to be made mandatory where it is not. This should suffice to monitor the patient's continuing treatment needs and keep the treating physicians on their toes after the entry period.

The right to a final, judicial review remains of course intact. But it should be available only after all administrative options for resolving the treatment conflict have been exhausted. Even then the case should be reviewed under the doctrine of the right to (proper) treatment, as opposed to the contextually inapposite right to refuse.

97 In Utah, only the patient who the court finds "lack[s] the ability to engage in a rational decisionmaking process regarding the acceptance of mental treatment" can be involuntarily committed. UTAH CODE ANN § 62 A-12-234(c) (Supp.1992). Several other states have similar language in their commitment statutes, but not necessarily as the sole criterion for involuntary hospitalization. See DEL. CODE ANN. tit. 16, § 5001(1) (1983); IOWA CODE ANN. § 229.1(14) (West Supp. 1992); KAN. STAT. ANN. § 59-2902(e), (h) (Supp.1989); MICH. COMP. LAWS § 330.1401(c) (1991) (MICH. STAT. ANN. § 14.800(401)(c) (Callaghan 1989)); S.C. CODE ANN. § 44-17-580 (1991).

ly ill, it is time to return to first principles — and common sense.\textsuperscript{99}

\textsuperscript{99} It is our view that the law, by virtue of its roots in adversarial process generally, and in particular its proclivity to depict the psychiatrist-doctor as the patient's enemy, grossly shortshifts common interests between server and served. In doing so, the law frequently defies common sense. This is not just the doctor's complaint. It is shared by patient's families as well as by many lay observers knowledgeable of the law's "finer" points.