Emerging Legal Rights for the Mentally Handicapped

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Several persons have indicated to me, since I arrived here last night, that the legal developments which I will be talking about are controversial. I suppose that depends upon your point of view. Would these legal developments be controversial to a group of institutional psychiatrists? Probably so. To a group of lawyers? Probably—although not certainly—not. To a group of patients and former patients? Certainly not.

This last conclusion suggests to me that mental health professionals should think twice before labeling "controversial" legal developments that are warmly endorsed by the clients they profess to serve. Of course, patients are not always right, but disagreement between patient and professional at least raises the troublesome possibility that the professional is acting not as agent of the patient, but as agent of the profession or as agent of the state.

Actually, my remarks will be much less controversial than they might have been. I would have liked to talk about psychiatry and the adversary process, but Judge Bazelon cornered that topic. I have been counsel in three of the major "right to treatment" cases, but Dr. Stone latched onto that one. "Dangerousness as a criterion for commitment" is a subject of special interest to me, about which I have written extensively, but Professor Dershowitz got there first. In so distinguished a group it is my lot, as the last scheduled speaker, to talk about the unwanted children of the lecture circuit—the subjects that are not, by themselves, sufficiently interesting to merit individual attention. But together, those little subjects, the nitty-gritty of law and psychiatry, are exciting enough, for like bubbles in the soup pot they let you know there is something boiling down below.

Five years ago I concluded an article on the rights of mental patients on a somewhat pessimistic tone: "for now, it is more true than false to say that mental patients have no rights." But so much has happened in the past five years that it now requires 1500 pages to catalogue the emerging rights of the mentally handicapped.[1]

These emerging rights are important in themselves, but are even more important for what they collectively reveal. Each of these rights has emerged because of judicial or legislative disenchantment with the basic assumptions underlying the way we have traditionally dealt with persons alleged to be mentally handicapped. And that is the important point—not the rights themselves, they are only symptoms of that disenchantment—but the willingness of judges and legislators to re-examine fundamental assumptions that for decades have gone unchallenged.

It is too early to tell where this process of re-examination will end, but it is important to recognize that it is a process. The emergence in Alabama of a right to treatment,

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the emergence in New Jersey of the right to a free expert witness, and the emergence in Hawaii of the patient's right to see his or her own hospital record are not discrete phenomena. Underlying each of the emerging rights I will talk about this morning is judicial or legislative recognition that the mental health system does not work the way it is supposed to work, and that psychiatry, or at least institutional psychiatry, has promised more than it can deliver.

Distinguished psychiatrists have been saying that for a long time. In 1958, for example, the then President of the American Psychiatric Association said that institutional psychiatry was bankrupt beyond repair. Judges and legislators have recently begun to agree. A few days ago I consulted the Annotated Bibliography to the Legal Rights of the Mentally Handicapped, which summarizes about 100 of the most important cases in this area, and found that ⅔ of those cases had been decided in the past five years. During that same period well over half the state legislatures substantially revised their mental hygiene laws, in each case expanding the rights of the mentally handicapped.

The rights of patients have been expanding at a remarkable rate, and there is good reason to believe that the rate of expansion will accelerate still more. We heard several persons say they think the pendulum has swung about as far as it will go, but I do not think that statement is accurate or realistic.

Two years ago, in *Jackson v. Indiana*,[2] the United States Supreme Court encouraged the lower courts to scrutinize the civil commitment process, and said it was "remarkable that the substantive constitutional limitations" on the civil commitment process had "not been more frequently litigated." A major reason why those issues had not been more frequently litigated was the almost total absence of a mental health bar. When *Jackson* was decided, there were probably no more than ten to fifteen lawyers in the entire country with the knowledge and ability to bring sophisticated civil commitment issues before the courts. That condition is changing rapidly. In the past six months the Mental Health Law Project and the Practising Law Institute have conducted four three-day training sessions which together reached more than 1,000 lawyers. Right now perhaps 30 major test cases on the rights of the mentally handicapped are pending in the courts. If a third of these 1,000 lawyers file just one case during the coming year, the mental health docket will increase from 30 to 300. What I'm saying is that if institutional psychiatrists have felt pressure from the legal system in the past three or four years, it is as nothing to the pressure they're going to feel in the years to come.

For these reasons, it seems likely to me that the rights that have emerged to date are only the tip of the iceberg. Each of these rights is important—and some are very important—but as I discuss them I think it is useful to keep in mind, as I have said, that they are only symptoms of a much more fundamental disenchantment with institutional psychiatry.

1. *The right to counsel*

Several courts have now ruled that indigent persons facing involuntary commitment to a mental hospital or school for the retarded *have a constitutional right to a free lawyer*,[3] and it seems safe to say that the right to counsel, at least in principle, is firmly established. I say "in principle" because there are many aspects of the right to counsel that have *not* been firmly established. For example, when does the right attach? Certainly at the judicial hearing stage, or a reasonable time before the hearing. But what about earlier? Does a patient hospitalized on medical certification have a right to a free lawyer at that point to help the patient decide whether to request a hearing? Does the patient have the right to have a lawyer present at psychiatric examinations? We do not know for sure, but there is growing authority that the right to counsel attaches well before the judicial hearing stage,[4] and there is now some authority that in order to ensure meaningful cross-examination, the state should permit the patient's lawyer to be present at psychiatric examinations, or furnish a videotape or transcript of the entire examination.[5]

The most important question is whether the patient must request a lawyer, or whether appointment of a lawyer will be automatic. In most states, even though a patient has a "right" to a lawyer, he (or she) will not actually get a lawyer unless the patient affirmatively requests one. If the patient does not affirmatively request a lawyer she (or he) will be deemed to have waived that right. Many patients, even among those who vigorously protest hospitalization, fail to request a lawyer. Why? Some of them are confused and don't know they have the right to request a lawyer. Others are afraid to incur the displeasure of their keepers. Some, because of heavy medication or shock therapy, are literally unable to request a lawyer. Many patients are so depressed that everything seems hopeless—"What good could a lawyer do?" And so on.

Persons charged with crime, juvenile delinquency or narcotics addiction are automatically assigned lawyers, whether they ask for them or not. But mental patients, who are by definition thought to be unable to protect their own interests, must make an affirmative request not required of any other class of persons facing loss of liberty. That does not make sense. Recently, a few courts[6] and at least one legislature[7] have specified that lawyers must automatically be assigned to all involuntary patients. Surely that specification is right. If the statute said that patients have the right to careful and thorough psychiatric evaluation, *but only on written request*, we would all be appalled. Either the psychiatric evaluation is important or it is not. If it is, it should be automatic. Similarly, if the assistance of counsel is an important right, it should be automatic. Consider what that would mean to the systems in most states. In New York, with which I am most familiar, in 1969 there were approximately 12,000 involuntary admissions to Bellevue Psychiatric Hospital. Of those 12,000 admissions, all had the theoretical right to a lawyer and a court hearing, but only 531 actually received that hearing. If appointment of a lawyer and a court hearing were mandatory unless affirmatively waived by the patient, the system in New York would probably collapse because there are not enough judges in the whole state to try all of those cases.

This suggests to me that the whole system for confinement of the mentally ill rests on the assumption that they are second class citizens not entitled to the same legal protection they would get as of right if they were charged with a crime, delinquency, or addiction.

Another aspect of the right to counsel that has yet to be resolved is the scope of counsel's duties. Patients have the same legal problems non-patients have—divorce, child custody, eviction, repossession of the family car or the living room furniture, lost welfare checks, etc. If those patients were not confined, they could walk to their neighborhood legal aid or legal services office and obtain free legal assistance. But they are confined, and the state should therefore make available in the hospital the same routine legal services that would be available in the community. To do less would raise serious questions under the equal protection clause of the constitution. But in most states the legal assistance available to patients is limited to problems arising directly from their hospitalization. I think that limitation is going to change, and largely because psychiatrists and hospital administrators want it to change. They realize that providing routine legal services can reduce patient anxiety and thereby facilitate treatment. Preventing an eviction or settling a welfare problem can aid the hospital staff in planning a discharge or after-care program.

2. *Burden of proof*

No person can be deprived of liberty in a *criminal* proceeding unless the judge or jury is persuaded "beyond a reasonable doubt" that the deprivation of liberty is justified. But because commitment proceedings have been thought of as "civil" rather than "criminal," commitment proceedings have traditionally applied the normal "civil" standard of proof. Under that standard, a person may be committed if the judge or jury is persuaded by a "preponderance" or majority of the evidence that commitment is justified.

As you know, whether a person should or should not be committed is often a close question. In those close cases, a more rigorous burden of proof would result in freedom

for many persons who would have been committed under a "preponderance" standard. In fact, it would be an unusual case indeed in which a vigorous defense counsel could not raise at least a reasonable doubt about the necessity of commitment.

Several courts have now ruled that a civil commitment proceeding is like a criminal proceeding in three critical respects: both entail loss of liberty; both create stigma; and in both there is a substantial risk of error. Accordingly, they say, civil commitment should also require proof beyond a reasonable doubt.[8] Other courts, not willing to go quite that far, have nevertheless ruled that commitment can be justified only by "clear, cogent and convincing" proof, a standard that falls somewhere between the civil standard and the criminal standard.[9]

The United States Supreme Court has not yet resolved this issue. One member of the Court, Justice Douglas, is on record as favoring the "beyond a reasonable doubt" standard in all civil commitment cases.[10] And the full Court has ruled in an analogous context that a youth cannot be committed as a juvenile delinquent—a "civil" proceeding—without proof beyond a reasonable doubt.[11]

3. *Privilege against self-incrimination*

Many persons are hospitalized not because of what they do but because of what they say. If the privilege against self-incrimination were fully applicable to civil commitment proceedings, many of those proceedings would come to a grinding halt. Judges know that, and they are therefore reluctant to enforce that particular right in the civil commitment context. Some judges, including Supreme Court Justice Douglas,[12] would make the privilege against self-incrimination fully applicable in a civil commitment proceeding.

In *Lessard v. Schmidt*,[13] for example, the court ruled that statements made by a prospective patient to a psychiatrist cannot be used as grounds for commitment unless the patient is first told, both by the psychiatrist and by his lawyer, that he (or she) has the right to remain silent, and that whatever she (or he) says may be used as grounds for commitment. But having taken that hard-line position, the court then backed off somewhat and ruled that such statements *can* be used if the prospective patient "willingly" consents to talk, after being warned. That qualification is going to cause a lot of trouble for the courts. Can a person alleged to be mentally disabled ever "willingly" waive his (or her) rights? What if the psychiatrist says: "I am probably going to commit you anyhow, but perhaps you might have something to say to change my mind." Would statements made in that context be considered "willing"? What impact do medication, shock therapy or confinement have on the patient's ability to make an uncoerced judgment whether to exercice his (or her) right to be silent? And so on.

One way to avoid many of these problems would be to rule that no statements made by a patient could be used in a commitment proceeding unless both the patient and his (or her) lawyer consent.

One court has suggested that the privilege against self-incrimination should not be applicable in an emergency commitment proceeding, but might be applicable in a non-emergency proceeding.[14]

The applicability of the privilege is clearly a most difficult issue. It is unlikely that judges will either fully reject or fully embrace its application. Rather, they are likely to move cautiously towards some as yet undefined compromise position.

4. *Durational limitations*

No state except California has placed an absolute time limit on the permissible period of involuntary hospitalization. Several states now limit involuntary commitment to periods of 60 days, 6 months, or a year, but those periods can be renewed indefinitely for the duration of the patient's life.

It now seems likely, at least with respect to patients who are not demonstrably dangerous to themselves or others, that the Supreme Court will soon rule that patients committed for treatment can be confined only for a limited and reasonable period of time, after which they must be released or treated on a voluntary basis. I say it seems

likely because of two recent Supreme Court decisions, both of which were decided unanimously—an increasingly rare occurrence.

In *Jackson v. Indiana*, the Court said "at the least, due process requires that the nature *and duration* of commitment bear some reasonable relation to the purpose for which the individual is committed."[15] Jackson had been committed because he was incompetent to stand trial. He had been "confined for three and one-half years" and the Supreme Court said "that's too long."

Two weeks later, in *McNeil v. Director, Patuxent Institution*, the Court ruled that the due process clause "limits the permissible length of a commitment 'for observation.' "[16] In that case, the purpose of the observation was to determine whether the subject was or was not a "defective delinquent."

Given those rulings, it seems to me only a matter of time before the Court limits the permissible period of commitment for treatment, at least with respect to nondangerous persons. It is impossible to predict what period of time will be considered reasonable, but I think it relevant to note that the American Psychological Association, the American Orthopsychiatric Association, and several prominent psychiatrists and psychologists are on record as favoring a six-month absolute limit on the confinement of allegedly mentally ill persons.[17]

5. *Access to hospital records*

The almost unvarying rule, throughout the United States, is that no patient or former patient will be granted access to her (or his) own hospital record. There are exceptions. At one of the two state hospitals in the State of Washington, for example, the director has routinely permitted all patients, former and current, to inspect their own records for the last three and one-half years and has found no adverse consequences and, in fact, some therapeutic benefits. And Hawaii has recently passed a statute which authorizes most patients to see their own records.

The issue is now beginning to come before the courts. It will be difficult, in that forum, to justify a blanket rule which denies all patients access to their records, regardless of the individual circumstances of each case. In three recent cases, for example, the Supreme Court has ruled, in widely different circumstances, that conclusive or irrebuttable presumptions are inherently suspect, and that due process requires an *individualized* determination of the propriety of applying a general rule to the facts of an individual case.[18]

Under that test, the fact that some patients might become severely depressed because of information contained in their records, if it is a fact, would not justify a rule denying *all* patients access to their records. Eventually, I think all patients will be permitted, on demand, to inspect and copy their own records unless, within a reasonable time after demand, the custodian of the record applies for, and thereafter obtains, a court order in which a court, for good cause, denies access to the records.

Short of that, there seems to me to be at least one area in which access to records will have to be permitted. Many former patients apply for government jobs—as teachers, bus drivers, etc. Most of those public employers require the former patient to sign a release authorizing the employer to inspect the applicant's hospital records. The applicant does not know what is in the records and is thus unable to rebut inaccurate information, or to qualify accurate but misleading information. It seems to me unconscionable for a state agency to require an applicant to sign such a release, as a condition of employment, and then deny the applicant the opportunity to discover what it is he (or she) is asked to release.

6. *The right to live in the community*

As you well know, the population of mental hospitals and schools for the retarded is declining rapidly, and "right to treatment" cases will accelerate that decline. Where are all those former patients going to go? Unless decent homes and services are provided

in the community, they will wind up on park benches, in shabby welfare hotels, or back in the institutions.

Forcing states to provide those homes and services is clearly the most important and the most difficult challenge we face today. So far, there is little to report. Several courts have ruled that both mentally ill and mentally retarded persons have a constitutional right to be treated in the least restrictive setting consistent with their treatment needs.[19] Usually, that will mean a small, home-like community facility. But it is one thing to require states to utilize existing community alternatives, and quite a different thing to require states to *create* those alternatives. To date, no court has gone that far. My colleagues at the Mental Health Law Project are working on that. In a case called *Robinson v. Weinberger*, in which we represent, among others, the American Psychiatric Association, the American Psychological Association, the American Orthopsychiatric Association and the American Public Health Association, we are asking a federal court to order the District of Columbia to create enough community facilities to accommodate the approximately 1,800 patients at St. Elizabeth's Hospital who are considered suitable for community placement. Unless that case and similar ones are won, much of what has been accomplished in the past five years will be, at best, a paper victory.

But even where community facilities exist, some communities are making it difficult, or impossible, for former patients to use them. The City of Long Beach, for example, has recently passed an ordinance which makes it illegal for any person who requires continuous psychiatric medication to register at a public hotel. Before that ordinance was passed, my colleagues and I at the mental health law project wrote a letter to the City Council of Long Beach and asked them not to pass that ordinance but rather to let us represent them in a suit against the state of New York to force adequate provision of community service for the mental patients who had been discharged indiscriminately into their city. The city declined, and passed the ordinance, which left us no choice but to challenge it.

Just last week we won that challenge in a case called *Stoner v. Miller*, 377 F. Supp. 177. (EDNY 1974). A federal court ruled that the Long Beach ordinance was unconstitutional. I think the prefatory remarks of the judge are significant. He said "It is apparent that this ordinance can effectively frustrate the movement towards de-institutionalization in the treatment of the mentally ill. Also, the issues herein bear directly on the rights of citizens who are mentally ill to be treated in the least restrictive setting appropriate to their needs and upon the right of such persons to choose their own places of residence without unreasonable governmental interference." The court in that case found that the ordinance was unconstitutional on three grounds: (1) it violated the patient's right to privacy and (2) the right to travel, and (3) was also unconstitutionally vague.

That ordinance is symptomatic of a nation-wide and growing backlash against the mentally disabled. That backlash will spawn a broad range of restrictive zoning ordinances designed to fence out or to regulate the mentally disabled. Zoning, not right to treatment, may well be the major issue of the next few years.

7. *The reliability and validity of psychiatric judgments*

Before I close these remarks with a miscellany of emerging rights, I want to mention briefly a subject that I believe will receive a great deal of attention in the next few years—the low reliability and validity of psychiatric judgments. I have just finished, with Tom Litwack, a law review article, to be published this September by the California Law Review, which summarizes the literature concerning the reliability and validity of psychiatric judgments.* You have heard from Professor Dershowitz that clinical predictions of dangerous behavior are not very accurate. The same can be said, though to a

* Psychiatry and the Presumption of Expertise; Flipping Coins in the Courtroom, 62, Cal. L. Rev. 693 (1974).

lesser extent, of psychiatric judgments in general. The studies indicate, for example, that the rate of psychiatric agreement, even for the broad diagnostic categories of psychosis, neurosis, character disorder or normal, is only about 60%, and the rate of agreement for more specific diagnostic categories such as schizophrenia, or manic depressive reaction, is only about 40%.

What does that mean? Well, it means, for example, that psychiatric judgments are not as reliable, or accurate, as judgments made by polygraph or lie detector operators, which seem to be accurate about 90-95% of the time. No appellate court has ever approved the use in court, over objection, of lie detector reports—they are considered too untrustworthy. Why, then, are psychiatrists permitted to testify as experts when their judgments are not as scientific, reliable, or accurate as the judgments of polygraph operators?

Similarly, if the diagnostic rate of agreement is as low as it appears to be, does that not cast considerable doubt on the legitimacy of "medical certification" and other non-judicial hospitalization procedures? It seems likely that as judges learn that, at present, psychiatry is more art than science, they will severely circumscribe all non-judicial commitment procedures. For example, they may well outlaw two-physician commitments or at least limit them to a period of hospitalization necessary to begin a judicial proceeding.

Similarly, if any two psychiatrists can sign a person into a mental hospital, two other psychiatrists, perhaps retained by the patient or her lawyer, ought to be able to sign the patient out. The law should not presume that psychiatric judgments recommending hospitalization are more valid than psychiatric judgments recommending release.

8. *Miscellaneous*

I began by noting that a great deal has happened in the past five years. Let me close by listing, without much elaboration, a few of the more significant developments.

(a) In *Souder v. Brennan*,[20] a federal court ruled that working patients are covered by the Fair Labor Standards Act and must be paid a minimum wage, whether or not the work they do is therapeutic.

(b) In *In Re Kesselbrenner*,[21] the New York Court of Appeals ruled that no matter how fair the *procedures*, a civilian mental patient cannot be transferred to a mental hospital operated by the Department of Correction.

(c) In *Stewart v. Pearce*,[22] a federal court ruled that a college teacher cannot be forced to submit to a psychiatric examination unless he or she is first given reasons why the examination is thought necessary, notice of a hearing, and a proper hearing before the examination.

(d) In *Hawks v. Lazaro*,[23] the Supreme Court of Appeals of West Virginia ruled that a statute which permitted the involuntary hospitalization of any person who was "in need of custody, care or treatment in a hospital and, because of his illness or retardation lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization" was unconstitutionally vague.

(e) In *Saville v. Treadway*,[24] a three-judge federal court ruled that a statute which authorized the hospitalization of mentally retarded persons upon the "voluntary" application of their parents, guardians or others, accompanied by the certificate of a licensed physician (or a psychologist), was unconstitutional because of "the possible conflicts of interest" between the retarded persons and the persons making the "voluntary" applications.

9. *Right to treatment*

I was not going to talk about the right to treatment because that was Dr. Stone's subject, but I understand that there has been some discussion of the Donaldson case, and, from what I've heard, much of it is inaccurate and misleading, so I think if there's no objection, I'll take a couple of minutes to talk about that case, in which I represented Mr. Kenneth Donaldson.

If you look at the opinion closely in that case, and the pleadings, and the way the

whole case was structured, it was not, strictly speaking, a right-to-treatment case. The issue was the right to treatment *or release*. There is nothing in the U.S. Constitution which gives anyone a right to treatment. Treatment, or right to treatment, is really just a shorthand way of describing a complex of other specific constitutional rights.

To date, the most important other constitutional right has been the right to liberty. There is a constitutional right to liberty. And what the right-to-treatment cases are really saying is that no person can be deprived of liberty, which is a specific constitutional guarantee, unless the state is providing something substantial, a *quid pro quo*, in return for that deprivation of liberty. In other words, there's no right to treatment, but there is a right to treatment or release. In that case, we did not sue the doctors because they had failed to treat Mr. Donaldson; we sued them because, knowing that he was not receiving treatment, and knowing that he was not dangerous to himself or others, they blocked his release and refused to discharge him. Now, that's an important distinction.

I think you should also know that I probably have received four or five requests a week, for the past five years, from patients who want me to sue on their behalf for money damages against psychiatrists who have not given them adequate treatment. I never brought such a case, except for the Donaldson case. And the reason I brought the Donaldson case was that I was convinced—and, on the basis of the evidence we presented to the jury, the jury was ultimately convinced—that the doctors we sued in that case literally went out of their way to deny Mr. Donaldson the right to use those treatment modalities which were available in the hospital, and went out of their way to block his release to a halfway house which requested him, to an old college classmate, and to friends. The jury found that the two doctors in that case acted willfully, maliciously, and oppressively against Mr. Donaldson.

Now, we sued three doctors. But one of the doctors, the jury found, was not liable, because the jury found that that third doctor did the best he could with the available resources of Florida State Mental Hospital. But the other two doctors did not do the best they could with available resources. There was expert testimony to that effect, and, if you want, in the discussion period, I can go into some of the really malicious acts those doctors performed.

Now, what Donaldson means (and it's now the law for the fifth circuit, which includes all the southern states) is that a psychiatrist who has in his or her custody a patient who is not physically dangerous to self or others, and who is receiving only custodial care, either has to treat that patient, or, if the psychiatrist does not have and is not given by the legislature the resources to treat the patient, then he has to let the patient go. And if he does neither of those two things, he can then be sued, and I think quite properly so, for money damages.

Well, another possible brief aside, very brief, is the problem of money. The more I get involved in this area, the more I become convinced that it is not really a problem of money. In order to develop the community facilities and resources we need, I don't think we have to appropriate a significantly greater amount of money than the legislatures have already appropriated. I think we simply have to reallocate the moneys that are already there. In New York state, with which I'm most familiar, for example, the New York State Department of Mental Hygiene just finished building two brand new state schools for the retarded: Broom State School and Oswald D. Hect State School. Those two schools, together, cost the taxpayers $50 million. They built them and found they had no need for the 1,500 beds those hospitals now have. They have activated 100 of those beds, and have, at present, no plan to activate more. What does that mean? Well, it cost the taxpayers $500,000 per bed to build those state schools for the retarded. It costs in New York, even in Manhattan, only $11,000 per bed to build or acquire and renovate a hostel, or a halfway house for the retarded. Quite clearly, if that money had simply been spent in a different manner, for community facilities rather than for institutional facilities, we'd be a lot better off.

10. *Conclusion*

I could go on for several hours. But the point is clear. The days of *parens patriae* are over. Mentally handicapped persons do not lose the rights that others take for granted. Those rights will be protected—sometimes by legislatures, and sometimes by courts—but they will be protected. The mentally handicapped live in a world that is, for them, difficult, and often painful. Too often there is little we can do about that. But there is one thing we can do—and one thing we will do. We can seek for them the same dignity and respect we would *demand* for ourselves.

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