

The Role of the Lawyer in Mental Health Advocacy*

MICHAEL L. PERLIN, ESQ. and
WALTER W. SIGGERS, PH.D. **

Just as a book or movie may be given a mildly (or not so mildly) salacious or sexy cover or title to ensure readership and/or paying customers (an illusion that often fails to deliver what it appears to promise), so may a conference be given a particularly provocative theme in, presumably, an effort to draw participants and/or spectators. If the phrase "Psychiatry Under Siege" were not sufficiently provocative for this annual meeting, the panel discussion we are now participating in is similarly titled "Legal Challenges to Psychiatry," gilding the lily a bit more. I expect by now that if you were expecting hand grenades, red flags or other such cheap thrills, you know that — just as at the luridly advertised movie — you are going to be disappointed. For that, I offer my apologies. On the other hand, if you feel (as I expect you must do, at least on an unconscious level) that the interplay between lawyers, psychiatrists, other mental health professionals and consumers is worth discussing, then perhaps you will agree with me that the topic for this panel should not be seen even as an unduly provocative one, but rather as one whose time is simply long overdue.

At the outset, it is with a great deal of irony — pleasant irony, to be sure — that I approach the discussion of "The Role of the Lawyer in Mental Health Advocacy" before an audience predominantly made up of forensic psychiatrists and other allied forensic professionals. While it is true that, when confronted with an analysis of the interstices between law and psychiatry, other predominantly psychiatric audiences have displayed some resistance, denial, and the rest of the whole range of ego defenses we all use on a daily basis, surely, of all psychiatric specialists, it should be the forensicist who is the lawyer's strongest ally (a perception which is only heightened by the news that the Forensic Sciences Foundation has recently received planning money from LEAA for certification study of fields including Forensic Psychiatry and Forensic Jurisprudence).¹ Certainly, of all psychiatric specialists, it is the forensicist who is the most comfortable with the adversary/advocacy model and process, and with the true adversarial approach of the criminal law; he is the one who should be most at home with the idea of equal-counsel-fighting-it-out.² Although some fear has been expressed over what is perceived by some — including, for instance, Alan Stone — as the over-criminalization of the involuntary civil commitment process,³ it seems that *that* criticism subtly misses the point: the forensic psychiatrist is and should be familiar with the adversary process, and should, in fact, be in the forefront of those who welcome the attorney's involvement in mental health advocacy.

My thesis is a simple one: the role of the lawyer in the mental health arena is both a

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**Mr. Perlin is Director and Dr. Siggers is Supervisor of Field Representatives of the Division of Mental Health Advocacy, Department of the Public Advocate, 10-12 North Stockton Street, Trenton, New Jersey 08625.

proper and a necessary one, and it is one which both must and should expand. Although some rear-guardists still suggest that mental health commitment issues are not proper ones for the courts, that argument is — to put it not-too-gently — a loser. On the other hand, however, it is impossible for *only* lawyers to do the job; in order to be effective, we must present (and participate in) a multi-professional approach (a schemata extending far beyond the boundaries of the legal and medical professions). We do not see ourselves as “antagonistic” to the psychiatric profession; rather, we see ourselves as advocates for those caught up in the psychiatric system, and as facilitators on behalf of our clients, attempting to marshal the best evidence, expert witnesses and arguments on our clients’ behalf. We are not psychiatrists, nor do we profess to be; on the other hand, we do make frequent and regular access to psychiatric (and other) independent expert testimony⁴ to challenge decisions regularly made by hospital staff.

Clearly, legal involvement in the worlds of medicine and psychiatry is nothing new. Doctors have been testifying since time immemorial in personal injury cases, workers’ compensation actions, contractual competency matters and the like. Indeed, although malpractice is much in the news these days, it may surprise you to learn that next February 13 will be the 600th anniversary of the first successfully litigated malpractice action (a British case holding a doctor liable for improperly treating a leg injury).⁵ Although lawyers may be latecomers to the field of mental health matters, their presence there is certainly consistent with a history of involvement in medical matters; if Andrew Watson is correct when he suggests that “Lawyers . . . frequently come in contact with individuals whose problems originate from their internal emotional conflicts,”⁶ then involvement will appear even more explicable.

Beyond this, of course, it is clear that problems involving what can be called system-wide service delivery are defined legally; if a statutory framework did not exist, the power to civilly commit and detain persons who have not committed criminal acts would similarly not exist. More specifically, questions involved in the mental health system involve substantive and procedural issues like those which lawyers have been dealing with relatively regularly in the parallel fields of civil rights, consumer rights, criminal procedure, and inmates’ rights. Finally, the mental health system is a system of change: it is the “fluxiness” of the system that is in many ways its most distinguishing characteristic.⁷ Change involves basic shifts in balances of political, social and economic conditions and powers, and, clearly, attorneys are natural players in this arena. This final point highlights another basic premise: lawyers who advocate system-wide change on behalf of both individual and class clients do not operate antithetically to mental health professionals, but merely to those aspects of the mental health service delivery system which resist change. I think this is not a merely semantic distinction, but rather one which is crucial to the entire process: Lawyers have taken a leadership advocacy role only because of the void left by mental health professionals.

In addition, as I mentioned a minute ago, there can no longer be any question as to the inevitability or propriety of judicial involvement in all matters involving patients’ commitments to and releases from hospitals, and their treatment while institutionalized. This issue was firmly put to rest by the United States Supreme Court in its recent historic opinion in *O’Connor v. Donaldson*,⁸ where it characterized the argument that the court should not be involved as “unpersuasive,” adding:

Where “treatment” is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present.⁹

This argument should, then, put to rest the cries that courts should stay out of mental health areas. As Federal Judge David Bazelon has noted:

No judge would claim the ability to prescribe a particular therapy for a “chronic undifferentiated schizophrenic.” But neither would any judge allocate [broadcasting] frequencies to avoid [radio] interference. That is not his task in

either case; his role rather is to determine whether a capable expert has studied the problem fully and reached a defensible result.¹⁰

Having set this down as a basic outline of legal involvement, I would like to shift the focus of my talk to the specific and discuss the role of the Division of Mental Health Advocacy in the mental health system in New Jersey, looking specifically at the meaning of advocacy in the context of our Division, the types of cases in which we have become involved, our reasons for becoming involved in them, and our procedures in handling them. I hope that my explanation will clarify my thesis a bit, and point out why I do not believe that the "adversary role" need necessarily lead to "adversary relationships."

The Department of the Public Advocate was established by the New Jersey Legislature in 1974 in an attempt to create an agency for those persons either disenfranchised, institutionalized and/or puzzled by the whole mass of governmental rules, procedures and folkways, to make the government more responsive to the individual, and to reverse the trend of what a sociologist might call "bureaucratic *anomie*."¹¹ The Department includes Divisions of Citizens' Complaints¹² (an ombudsman-type office which negotiates and settles disputes between individuals and any branch of the government), Rate Counsel¹³ (which represents the public in matters involving utility rates), Public Interest Advocacy¹⁴ (which represents the public in class actions on the full range of statutory and constitutional issues in which a broad public interest is involved), and the Office of the Public Defender¹⁵ (a previously-existing office¹⁶ which had, for seven years, represented indigent individuals on indictable criminal charges, now expanded to include Offices of Inmate Advocacy¹⁷ — representing classes of jail and prison inmates — and Child Advocacy¹⁸ — representing individual juveniles whose parents or guardians are the subject of child abuse or child neglect proceedings, and institutionalized juveniles as a class), as well as the Division of Mental Health Advocacy.¹⁹

The Division of Mental Health Advocacy has two primary statutory functions: it "may provide . . . legal representation . . . for any indigent mental hospital admittee²⁰ in any proceeding concerning the admittee's admission to, retention in or release from confinement in . . . [a mental hospital or a similar facility],"²¹ and it "may represent the interests of indigent mental hospital admittees in such disputes and litigation, as will . . . best advance [their] interests as a class on an issue of general application to them."²² This dual responsibility is an indicia of a legislative feeling that the problems of persons involved with the mental health system have two dimensions: on the one hand, the threshold issue of whether a person should be committed (and, if committed, whether he should be retained there), a question which turns on the facts peculiar to the patient's own case; and, on the other, the broader inquiry of whether a group of patients have a specific right, and, if they do, whether they have been deprived of it — it is only through the mechanism of the class action that this right can be properly litigated.

In this regard, it is worth noting that the individual-versus-class-advocacy issue is one which has been vexing the advocacy community of late. Although it is clear that class actions create more of an impact than many individual actions,²³ it has been suggested by prominent citizen advocates — including Dr. Elizabeth Boggs — that strategies based upon "systems advocacy"²⁴ run the danger of "sacrific[ing] the good of the individual to the welfare of the group."²⁵ Obviously, a proper balance must be achieved.

In any event, given its discretionary grants of power, the Division of Mental Health Advocacy has established Field Offices in Mercer County (where Trenton, the State capital, is located) and Essex County (where Newark, the State's largest city, is located), and a Class Action office in Trenton with state-wide jurisdiction. Our offices, by the way, are staffed by equal numbers of mental health professionals and lawyers: the non-lawyers include a Ph.D. in psychology, a Ph.D. candidate in that field, three M.S.W.'s, a Master's in Divinity, a psychiatric nurse, four persons with B.A.'s in social work or a related field, and one person with an A.A. with many years of mental health experience. Such a professional mixture was seen, by the way, as absolutely vital. In addition, funds are

made available for the hiring and retention of psychiatric and other medical expert witnesses for both individual and class actions. We are proud that many of the most prominent psychiatrists in the area (and in the country as well) have chosen to testify on behalf of our clientele.

The field offices have been primarily involved in representation at involuntary civil commitment hearings,²⁶ at *habeas corpus* release hearings,²⁷ at periodic review hearings,²⁸ and on selected individual right to treatment/patients' rights complaints.²⁹ Of the 2,461 individual cases litigated to a conclusion in fiscal 1975 and 1976, the Division was successful in 1,777, or 72% — if periodic reviews are excluded, staff attorneys prevailed in 1,631 of 2,078 cases, or 78%.³⁰

Similarly, the class action office has litigated cases establishing a right to counsel at both involuntary commitment hearings and periodic review hearings,³¹ the right to an independent psychiatric examination at county expense prior to commitment proceedings,³² the right to exercise control over one's assets while institutionalized,³³ and the right of a resident at a state school for the retarded to register to vote.³⁴ Litigation is currently ongoing in matters involving the right to treatment, freedom from harm and right to least restrictive alternative form of treatment,³⁵ the right to participate in voluntary, therapeutic, compensated work programs while institutionalized,³⁶ the right to be free from certain aversive behavioral procedures prior to the implementation of less drastic alternatives,³⁷ the right of a patient at a hospital deaccredited by the Joint Commission on the Accreditation of Hospitals to individual SSI payments,³⁸ the right of a formerly-hospitalized person to make application for governmental employment,³⁹ and the privacy right of an otherwise-successful candidate for the bar to refuse to answer questions as to prior treatment for "emotional disorder" prior to her certification by a county character committee as fit to practice law.⁴⁰ In addition, our Division has been active in the legislative drafting process in matters involving a substantial rewrite of the laws governing criminal incompetency and responsibility,⁴¹ the creation of a Patient Treatment Review Board,⁴² a bill of rights for the Developmentally Disabled,⁴³ and a restructuring of the entire civil commitment process.⁴⁴ Finally, we have just been awarded a federal grant to provide advocacy services for the developmentally disabled⁴⁵ similar to those now available to the mentally ill.

Our early experiences, then, have led to some early conclusions: there is a clear need for comprehensive reform; institutional care is still often sadly substandard; there exist insufficient community alternatives, and those that exist cannot reach a significant percentage of the state hospital population; the need for deinstitutionalization programs at state hospitals is acute; gross deprivations of civil rights are still all too common; and the high percentage of "victories" (a word meant to be read with quotes around it) merely underscores the depths of the need for procedural reform and the significance of the presence of counsel in the system, an unescapable fact clearly documented by our early experiences.⁴⁶

Although these experiences help *explain* the type of advocacy practiced in New Jersey, I am afraid they do not truly *define* it. In order for any explanation to be really meaningful, it is necessary, I think, to go beyond this summary in an effort to deal with some of the critical questions I discussed a bit earlier: the meaning of advocacy in our Division, the role of counsel in the advocacy setting, and our perspectives on litigation.

A multiplicity of definitions and explanations of advocacy is available to cover the full spectrum of advocacy programs; everyone can say, with little fear of contradiction, "I am the advocate." Douglas Biklen includes, within his definition of types of advocacy, such activities as community organization, demonstrations, letter writing, lobbying, mass communications campaigns and even boycotting⁴⁷; on the other hand, Marie Moore focuses on the different sorts of advocates: the citizen advocate, the ombudsperson, the legal advocate, the case manager, and the protective service deliverer, among others.⁴⁸ Jane Knitzer has distinguished between advocacy as a *heightened concern* for an interest

group and advocacy as a *catalytic process* for change,⁴⁹ Wolf Wolfensberger simply defines citizen advocacy as "a mature, competent citizen volunteer representing, as if they were his own, the interests of another citizen who is impaired . . . or who has major expressive needs which are unmet and which are likely to remain unmet without special intervention."⁵⁰

In the context with which we are currently concerned, however, it appears that advocacy means, at its base, representing a client's wishes (wherever such wishes are ascertainable) and upholding the individual civil, legal and human rights of individuals and groups of individuals,⁵¹ in order to give a handicapped individual the means of reaching outside the system for an examination of situations in which his rights as an individual citizen may have been violated.⁵² Even where the client's wishes are not so readily ascertainable, the advocate must make an effort to perceive the client's interests, as guided by the legal and constitutional framework. Explicitly, in a legal context, a legal advocate should also attempt to insure that an incompetent person is afforded an individual guardian (as well as a legal guardian) for certain areas of decision-making.

Of course, any further analysis of counsel's role in this setting must consider the general approach to advocacy that counsel brings to the proceedings. Although, clearly, a lawyer is ethically bound to represent each client to his fullest abilities, within this ethical proscription, it is evident that at least four different philosophies of representation can emerge.

A lawyer can take the approach that the hospital knows best, that his client really doesn't know what he wants, and that the whole case can and should be handled as perfunctorily as possible: such position is one which is inimical to true legal representation and is very likely violative of the Canons of Professional Ethics.⁵³ On the other hand, a lawyer can take the approach that has been characterized as the Thomas Szasz/Bruce Ennis position: that there should be total abolition of involuntary commitment on non-criminal grounds.⁵⁴ Although this position may have some intellectual appeal, at its base it is premised on two assumptions which I do not find valid: the emerging and continuing reform of the criminal justice/penal system, and the widespread availability of alternatives to hospitalization in the community.

A lawyer can also take the approach that the issue is really one of "welfare entitlements." Cases which have developed over the years make it clear that persons are entitled to certain welfare benefits and the range of what used to be characterized as "governmental largesse" as a right, and not as a privilege.⁵⁵ One view of counsel's role is that otherwise-qualified hospitalized persons have a right to all such governmental entitlements and that the lawyer's role is to maximize such gains. Certainly, several of the significant cases in which our Division has recently become involved mirror this approach.⁵⁶

Finally, a lawyer can take the approach exemplified by Judge Bazelon's due process model: a court sits to adjudicate among competing expert positions. Such a position does not mean that judges are "playing psychiatrist." Far from it: judges sit on psychiatric cases as they do on any other matter involving expert testimony. As Judge Bazelon has dryly commented:

. . . Diffidence in the face of scientific expertise is conduct unbecoming a court. Very few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed dam on fish life, while they reject a similar scrutiny on the effect of psychiatric treatment on human lives . . . It can hardly be said that we are more concerned for the salmon than the schizophrenic.⁵⁷

Another commentator has noted, "The properly functioning civil commitment system requires the presentation of conflicting testimony and argument from which the judge is to synthesize the fairest, most humane decision. When the defense lawyer leaves his

adversary role and assumes a paternalistic or passive stance, the balance of the system is upset, the defense attorney usurps the judicial role, and the defendant's position goes unheard."⁵⁸

In this context, it is worth questioning whether psychiatrists (and other mental health professionals) know the law. The results of a test given to various mental health workers on basic questions involving the legal rights of mental patients revealed distressing results: in a community setting, psychiatrists received a score of 61.6%, social workers 34.27% and psychologists 25.0%; in a hospital context, psychiatric nurses scored 60.75%, psychiatrists 51.25%, attendants 46.25%, social workers 42% and psychologists 38.2%, on a test where random guessing would have resulted in a base of at least 33.3%.⁵⁹ Without any further comment, I think this is food for thought for us all.

Finally, most studies omit the attitudes of the most important participants of all: those who are hospitalized. Although there has been virtually no empirical work done in this area, at least one major survey has shown that a majority of patients studied indicated the need for legal aid in both court-related hospitalization proceedings and in non-hospital related matters, and that the effects of legal aid would include a diminution of the numbers of persons involuntarily committed, heightened efficiency of hospital operations (counsel serving as an effective check to insure the presence of therapy), and a change in the image of the hospital as a "total institution."⁶⁰ Again, insofar as the Division can say that it practices "an approach" to advocacy, it finds that it is most comfortable with a hybrid of the "welfare entitlement" and the "due process" models, an attitude heightened by studies such as those just cited.

The role of counsel is also significant in the type of case selected for litigation; thus, in addition to those thousands of persons we have represented on a daily basis, we have selected certain areas in which to concentrate our limited class action and test case resources. The selection of these areas probably tells as much about our perceptions of the system on an unconscious level as could any philosophical or jurisprudential explanation. In this context, then, cases should be looked at from three separate perspectives: the *type of right* being enforced (procedural, substantive or economic); the *posture of the case* when we became involved (did we represent plaintiff, defendant, or *amicus curiae*?), and the *extent of a multi-disciplinary approach* (was it a "lawyer's case" or were expert witnesses utilized?). An examination of the significant cases in which litigation is either concluded or under way indicates that if a grid chart could be imagined on which the three perspectives just referred to could be plotted out, virtually all spaces on the grid could be filled in. More interestingly, though, such an analysis shows at least one clear pattern in our early involvement: a progression from procedural cases to substantive cases to economic cases.⁶¹

Thus, our earliest litigation involved the basic procedural rights of counsel⁶² and access to independent expert evaluations:⁶³ the cases alluded to above clearly demonstrate the need for these rights to be established as a "baseline" before further reforms can be made. Interestingly, entry into these cases has been embarked upon from varying postures: in one of the counsel cases we entered as *amicus curiae*,⁶⁴ in another, our role was that of defendant.⁶⁵ In the independent expert case, our client was the plaintiff.⁶⁶ Because of the nature of these cases, there was no need for expert evidence — the courts' decisions were rendered solely as a matter of applicable case, statutory and constitutional law.

Our subsequent litigation was directed towards the enforcement of substantive rights involving both institutional (treatment, freedom from harm)⁶⁷ and community (voting) rights.⁶⁸ Although we represented plaintiffs in affirmative actions in both these matters, it should be noted that our adversary in the voting case was not the institution, but the township election registrar and the county board of elections; in that case, in fact, the state school was entirely cooperative and even helped provide expert psychologists to testify. In the right to treatment action, however, the hospital officials have assumed a

totally adversarial role, and we have consulted with a dozen of the leading psychiatrists in the country, in addition to two psychologists and a rehabilitation specialist, in preparation of our case.

Our next major efforts were directed towards financial issues: the questions involving patients' rights to control their own assets⁶⁹ and the right of other patients to SSI payments following the hospital's loss of accreditation.⁷⁰ Interestingly, in the assets case, our clients were the defendants – the Board of Freeholders had sued them in an effort to attach their funds, and we were informed of the case only after the entry of the initial order; although our clients are the claimants in the SSI case, the action was specifically precipitated by the government's decision to take away a previously-existing benefit from the patients. Again, expert witnesses were retained for both of these cases.

Although subsequent litigation has not fit into any neat pattern, it does point out that the entire gamut of issues will inevitably be litigated by an advocacy office with as broad statutory jurisdiction as ours. Although there has been some debate as to whether greater emphasis should be placed on right-to-treatment or right-to-refuse-treatment issues, for instance,⁷¹ our office's experience indicates that both must be litigated in the appropriate instance.

What then are our conclusions? Although we enter the arena ostensibly cloaked in an "adversary" role, we do not feel that the usual "adversary" relationships need apply; we hope that we can work with the practitioners of each relevant discipline to produce a better system of mental health care and delivery. Although we approach matters through the avenue of legal rights, no jurisdictional disputes with other disciplines need arise. Any fearfulness of the use of the courts as a mechanism through which to enforce rights should be obviated by the litany of rights developments in recent years (in New Jersey and elsewhere) – the use of litigation as a positive developmental tool is unquestioned.⁷²

Although the cases which I have discussed are primarily the outgrowth of litigation, litigation is seen as the last resort: we would prefer to negotiate and settle on our clients' behalf wherever possible. In matters covering a whole range of issues such as revocation of drivers' licenses of former patients, treatment of alcoholics at a psychiatric institution, transfer procedures between county jails and hospitals, availability of psychiatric benefits to participants in State-chartered Health Maintenance Organizations, and others, we have entered the negotiation process and successfully settled disputes without the need to resort to suit. Beyond this, though, is an even more significant point: although advocacy is usually seen in a litigation context, litigation must be seen as only one tool in the advocate's arsenal. There are other mechanisms by which to bring about true amelioration of institutional conditions, and it is the advocate's duty to explore all of them short of litigation.

Perhaps because of this approach, we have been able to develop excellent working relationships with local psychiatric and psychological associations and have worked jointly with their representatives on many issues of mutual interest, including, *e.g.*, availability of insurance benefits for psychiatric care; confidentiality in processing of third-party insurance claims; accessibility of all citizens to quality mental health services, and the streamlining of court proceedings. We hope that such cooperation between all concerned will insure that our aim is met: to make available a better system of service delivery to those who need such a system, and to insure a better life for our mutual clientele.

As I indicated when I began, I felt the title "Psychiatry Under Siege" was a bit precipitous. Perhaps if psychiatrists realize that mental health advocates do not necessarily view the issue in that perspective, the atmosphere of siege will begin to lift.

References

- 1 Forensic psychiatry board proposed. *Am Acad Psych & L Newsletter*, 1:2 (July 1976), at 5.
- 2 See, *e.g.*, *State v. Whitlow*, 45 N.J. 3, 210 A. 2d 763 (1965); *State v. Obstein*, 52 N.J. 516, 247 A.

- 2d 5 (1968); Sadoff R: The psychiatrist and criminal law, 5 J Operational Psychiat 95, 100 (1974) (referring to the "expanding role" of the psychiatrist in "criminal-legal" situations); Sadoff R: The psychiatrist as consultant in civil and criminal law, 43 Pa Bar Assn Q 176, 177 (1972) (arguing that the traditional psychiatric examination is "insufficient" for the psychiatrist involved in a criminal case).
- 3 See, e.g., Stone A: Mental Health and Law: A System in Transition 51-59 (1975) (discussing *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded 414 U.S. 473 (1974), reinstated on remand 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded 421 U.S. 957 (1975), reinstated on remand - F. Supp. - (E.D. Wis. 1976)).
 - 4 See, e.g., *In re Alfred*, 137 N.J. Super. 20, 347 A. 2d 539 (App. Div. 1975).
 - 5 *Hill v. Cbeyndut*, London Guild Hall Plea and Memoranda Rolls (Roll A. Feb. 13, 1377), cited in Ficarra: The hospital emergency room and the law, 12 Cal W L Rev 223, 231, n. 24 (1976)
 - 6 Watson: Psychiatry for Lawyers 16 (1968)
 - 7 See Perlin M L: Rights of the mentally handicapped. 98 N J L J 1057 (1975).
 - 8 - U.S. -, 45 L. Ed. 2d 396 (1975)
 - 9 45 L. Ed. 2d at 406, n. 10
 - 10 Bazelon: Implementing the right to treatment. 36 U Chi L Rev 742, 745 (1969)
 - 11 See N.J.S.A. 52:27E-1 *et seq.* The Department is discussed more fully in Note: The Office of Public Counsel: Institutionalizing public representation in state government, 64 Geo L J 895 (1976); Penn: Advocate from within, 12 Trial Mag 20 (February 1976); Heffner: Legislative oversight: An analysis of L. 1974, Chapter 27, Department of the Public Advocate Act, Seton Hall Leg J 1:2 (Summer 1976), at 75.
 - 12 N.J.S.A. 52:27E-33 *et seq.*
 - 13 N.J.S.A. 52:27E-16 *et seq.*
 - 14 N.J.S.A. 52:27E-28 *et seq.*
 - 15 N.J.S.A. 52:27E-9
 - 16 N.J.S.A. 2A:158A-1 *et seq.*
 - 17 N.J.S.A. 52:27E-10 *et seq.*
 - 18 The Child Advocacy program combines the child abuse-law guardian program established under N.J.S.A. 9:6-8.21 *et seq.*, and a portion of the Inmate Advocacy program, established under N.J.S.A. 52:27E-10 *et seq.*
 - 19 N.J.S.A. 52:27E-21 *et seq.*
 - 20 The phrase "indigent mental hospital admittee" means, within this statute, *inter alia*, "a person who . . . is the subject of an action for admission as provided by R.S. 30:4-27 [New Jersey's commitment statute] and who does not have present financial ability to secure competent legal representation and to provide all other necessary expenses of representation." N.J.S.A. 52:27E-23. Means of determination of indigency are specified at N.J.S.A. 52:27E-27.
 - 21 N.J.S.A. 52:27E-24
 - 22 N.J.S.A. 52:27E-25
 - 23 For graphic cases of such class actions, see, e.g., *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub. nom. Wyatt v. Aderholt*, 503 F. 2d 1305 (5 Cir. 1974); *New York State Association for Retarded Children v. Rockefeller*, 357 F. Supp. 752 (E.D. N.Y. 1973), supplemented *sub. nom. New York State Association for Retarded Children v. Carey*, 393 F. Supp. 715 (E.D. N.Y. 1975).
 - 24 See Eklund: Systems Advocacy. Kansas U. Affiliated Facil. Publ., 1976
 - 25 Boggs E: Collective advocacy (systems advocacy) vs. individual advocacy (paper prepared for presentation at the Conference on Developmental Disabilities, Advocacy and Protective Services, Washington, D.C., October 13, 1976), at 2
 - 26 See N.J.S.A. 30:4-27 *et seq.*; N.J. Ct. R. 4:74-7(c) (revised September 8, 1975)
 - 27 See N.J.S.A. 2A:67-13 (e)
 - 28 See New Jersey Supreme Court, Administration Memorandum #4-74 (November 1974); N J Ct. R 4:74-7(f) (revised September 8, 1975)
 - 29 See e.g., N.J.S.A. 30:4-24.1 (1975), and *In re D.D.*, 118 N.J. Super. 1, 285 A. 2d 283 (App. Div. 1971).
- Although this category has been numerically small, it has included matters in which patients have petitioned courts to stop unwanted treatment, *In re Kolodka*, ESCC #398-75 (Essex Cty. Ct. 1975), and in which patients have requested that they be allowed to receive specific treatment, *In re G.G.*, MECC #164-75 (Mercer Cty. Ct. 1975). These cases are discussed in some depth in Perlin ML: The right to refuse treatment in New Jersey. 6 Psychiatric Annals 300 (1976).
- 30 Illustratively, not counting periodic reviews, in the 2585 cases closed by the Mercer and Essex Field Offices as of July 1, 1976, of the 2078 patients on whose behalf matters were litigated beyond the referral state, some form of relief was obtained for 78% of those represented. Thus, excluding the 507 cases in which clients were advised and assisted, referred to other

agencies, or in which counsel was waived, in 933 cases, patients were released to the community following the entry of counsel but prior to the final commitment hearings; in 152, clients were transferred to less restrictive alternative institutions; in 508, petitions for *habeas corpus* were granted or applications for commitment were denied; and, in 6, the hospital agreed to stop unwanted treatment. In 447 cases, *habeas corpus* petitions were denied, or commitment was ordered.

If periodic reviews are included (where the offices were successful in 146 of 383 cases), the Division prevailed in 1777 of 2461 litigated matters, or 72%. All figures are on file with the Division.

- 31 In *In re Geraghty*, 68 N.J. 209, 343 A. 2d 737 (1975), the State Supreme Court both dismissed as moot a county's appeal from a lower court ruling finding a right to counsel at commitment hearings, and simultaneously promulgated revised N.J. Ct. R. 4:74-7, mandating counsel at all such hearings, as well as at periodic reviews, and establishing a range of procedural due process safeguards at such hearings.
In *Marin v. Yaskin*, A-2274-74 (App. Div. 1976), where the Division had been sued by Camden Regional Legal Services for not providing counsel in Camden County, the Superior Court held that there was a constitutional right to counsel (a position urged by the Division), and that the Division was the proper agency to provide representation of a seven-county area of South Jersey. On appeal, the Appellate Division vacated the decision in light of the intervening promulgation of N.J. Ct. R. 4:74-7.
- 32 In *re Alfred*, 137 N.J. Super. 20, 347 A. 2d 539 (App. Div. 1975)
- 33 In *Board of Chosen Freeholders of Hudson County v. Connell*, Docket #83870 (Hudson Cty. Ct. 1975), the County Court granted the Division's motion to vacate its previously-entered order which would have attached all funds and assets of all patients at the Hudson County (Meadowview) Psychiatric Hospital (excepting \$25 per month), and ordered that all patients would be entitled to an individual hearing comporting with procedural due process before any such monies could be so attached. Interestingly, the Division was appointed as counsel on behalf of each one of the approximately 300 individuals who would be affected by the ruling.
- 34 In *Carroll v. Cobb*, 139 N.J. Super. 439, — A. 2d — (App. Div. 1976), the Appellate Division affirmed a Superior Court ruling, holding that a person could not be barred from registering to vote in a State election merely because of residence at a State school for the retarded.
- 35 *Doe v. Klein*, L-12088 P.W.-74 (Super. Ct., Law Div. Morris Cty. 1974). This omnibus case, certified as a class action on behalf of all 2000 adult patients at Greystone Park Psychiatric Hospital (the State's largest), and currently pending pre-trial discovery, is roughly structured on the litigation in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub. nom. Wyatt v. Aderholt*, 503 F. 2d 1305 (5 Cir. 1974).
- 36 In *Schindewolf v. Klein*, Docket No. L41293-75 P.W. (Super. Ct., Mercer Cty. 1976), the Division filed suit on behalf of residents at all four state hospitals, two county hospitals and one state facility for the retarded, challenging the decision of the Department of Institutions and Agencies to terminate all patient work programs following the Federal court decision of *Souder v. Brennan*, 367 F. Supp. 808 (D.D.C. 1973), which held that the Federal Fair Labor Standards Act applied to patients working in all state facilities for the mentally ill and mentally retarded if the State were to derive any consequential economic benefit from the work. The complaint filed by the Division alleges, *inter alia*, that the right to participate in voluntary, compensated, therapeutic work programs is part of each patient's constitutional right to treatment.
- 37 In *In re C.B.*, Docket #AM 774-75 (App. Div. 1976), the Division is representing a nine-year-old girl who had been ordered to receive electro-prod "treatments" as part of an aversive therapy "program." The Division contends that less drastic treatment (*i.e.*, positive reinforcement and less intrusive aversive therapy) must be tried prior to the use of the more drastic electro-prod modality. The appeal alleges that the use of the electro-prod at this time would violate the juvenile's rights to least restrictive alternative treatment and privacy.
- 38 Following the deaccreditation of Trenton Psychiatric Hospital by the Joint Commission on the Accreditation of Hospitals, and the hospital's concomitant loss of Medicaid funding eligibility — see 45 C.F.R. § 249.10 (b) (14); 42 U.S.C.A. § 1395x(f) (5); 42 U.S.C.A. § 1396d(h) (1) (A) — the Social Security Administration announced that the payment of SSI benefits to otherwise eligible patients at the hospital — see 42 U.S.C.A. § 1382(e) (1) — would be terminated. The Social Security Administration and an Administrative Law Judge have denied the Division's motion for a reconsideration of that decision, and an appeal from those denials will be taken to the Federal Appeals Council. *In re Gaestel*.
- 39 *JX v. Department of Civil Service*, Docket No. A4279-75 (App. Div. 1976)
- 40 *In re J.R.* (Comm. on Character, State of N.J., 1976)
- 41 New Jersey Senate Bills S. 1675 and S. 1676 (1976)
- 42 New Jersey Senate Bill S. 1032 (1975), passed by both Senate and Assembly, but not signed by the Governor.

43 New Jersey Senate Bill S. 1384 (1976)

44 New Jersey Senate Bill S. 1677 (1976)

45 P.L. 94-103 (amending 42 U.S.C.A. § 6001 *et seq.*)

46 The right to counsel at involuntary civil commitment proceedings has been found in, *inter alia*, *Heryford v. Parker*, 396 F. 2d 393, 396 (10 Cir. 1968); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated on other procedural grounds 414 U.S. 473 (1974), on remand 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded, 421 U.S. 957 (1975), reinstated on remand, — *F. Supp.* — (E.D. Wis. 1976); *In re Barnard*, 455 F. 2d 1370 (D.C. Cir. 1971); *Dixon v. Attorney General of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971); *Lynch v. Baxley*, 386 F. Supp. 1085 (M.D. Ala. 1974); *Bell v. Wayne County General Hospital*, 387 F. Supp. 1085 (E.D. Mich. 1974); *Denton v. Commonwealth*, 383 S.W. 2d 681 (Ky. App. 1964); *State ex rel Hawks v. Lazaro*, 202 S.E. 2d 109 (W.Va. Sup. Ct. App. 1974); *In re Fisher*, 39 Ohio St. 2d 71, 313 N.E. 2d 851 (Sup. Ct. 1974); *In re Hayes*, 18 N.C. App. 560, 197 S.E. 2d 582 (Ct. App. 1973); *In re Collman*, 9 Ore. App. 496, 497 P. 2d 1233 (Ct. App. 1972); *In re Adams*, 497 P. 2d 1080 (Okla. Sup. Ct. 1972); *State ex rel Richey v. Superior Court*, 59 Wash. 2d 872, 371 P. 2d 51 (Sup. Ct. 1962).

It is clear that counsel plays a critical and, in some cases, nearly dispositive role in involuntary commitment proceedings — where active attorneys are employed, fewer persons are committed. See Developments in the law — civil commitment of the mentally ill. 87 Harv L Rev 1190, 1285 (1974).

Two clear conclusions may be drawn from statistical surveys: a large percentage of state hospital patients can be safely treated elsewhere (the number varying from 43% to 68% to 75%), and, where counsel is operative, the number of committed persons plummets, especially when compared with persons not represented by counsel. See, *e.g.*, Scheff: Being Mentally Ill, 168 (7th ed. 1973) (the presence of 43% of patients in hospitals studied could not be explained in terms of their psychiatric condition); Abraham and Bucker: Preliminary Findings from the Psychiatric Inventory. 3 (1971) (68% of patient population at St. Elizabeth's Hospital in Washington not considered dangerous to themselves or others), and Mendel: Brief hospitalization techniques, 6 Current Psychiatric Therapies 310 (1966) (75% of patients with diagnosis of schizophrenia studied could be suitably discharged), as cited in Ferleger: A patients' rights organization: Advocacy and collective action by and for inmates of mental institutions. 8 Clearinghouse Rev 587, n. 1 (1975).

Perhaps even more significant are studies showing that psychiatrists are no more significantly predictively accurate than non-psychiatrists (*e.g.*, lawyers). See Rappeport, Lassen and Gruenwald: Evaluation and follow-up of hospital patients who had sanity hearings, in Rappeport ed.: Clinical Evaluation of the Dangerousness of the Mentally Ill, 89 (1969) ("The comparison between court released and hospital released adjustment rates shows no significant difference in the predictive accuracy of either institution"); and Ennis and Litwack: Psychiatry and the presumption of expertise: Flipping coins in the courtroom, 62 Calif L Rev 693, 749 (1974) (no evidence found that a psychiatrist can predict dangerousness more accurately than a lawyer). In fact, a recent report prepared by the American Psychiatric Association concludes that "no reliable means exists for predicting whether an individual is likely to perform a violent act." APA, Clinical Aspects of the Violent Individual 23-30 (1975).

And, of course, in the famous study of the so-called "Baxstrom patients" (those persons ordered released from New York's maximum security facilities for "insane criminals" following the decision in *Baxstrom v. Herold*, 383 U.S. 107 (1966)), it was found that, of the 969 *Baxstrom* patients who had previously been statutorily incarcerated in maximum security facilities, within one year, only seven were recommitted to such a facility on a finding of dangerousness (although it had been predicted by hospital officials that nearly 250 would need that type of security), and, of the 147 patients released to the community, only one had been arrested within that time period (for petty larceny). Hunt and Wiley: Operation Baxstrom after one year, 124 Am J. Psych 124 (1968), reprinted in Association of the Bar of the City of New York: Mental Illness, Due Process and the Criminal Defendant, 224 (1968). For a more recent evaluation and survey of the relevant literature, see Steadman and Cocozza: We can't predict who is dangerous, *Psychology Today* 32 (January 1975). See also Wenger and Fletcher: The effect of legal counsel on admissions to a state mental hospital: A confrontation of professions, 10 J Health and Soc Behav 66, 69 (1969), in which 74% of represented persons were released, while only 9% not represented were discharged.

Thus, whereas approximately 50% of all persons picked up in Washington, D.C., had been committed in the past, the intervention of the Patient Advocacy Service of the Washington, D.C. Public Defender reduced that number to 1%. Silverberg: The civil commitment process: Basic considerations, in 1 Legal Rights of the Mentally Handicapped 103, 109 (P.L.I. ed. 1973). Studies of the Mental Health Information Service of New York reveal that 40.4% of all patients who had requested hearings through counsel were released by psychiatrists prior to the hearing — Kumasaka and Stokes: Involuntary hospitalization: Opinions and attitudes of psychiatrists and lawyers, 13 Comprehensive Psych 201 (1972); Kramer: Protective legal services for the mentally ill, 23 Hosp and Commun Psych 41, 42 (1972) — and that "intervention by counsel acting as patient's attorney

tremendously increases chances of discharge, not to mention the other alternatives to hospitalization that may also be worked out to the patient's satisfaction." Gupta: New York's Mental Health Information Service: An experiment in due process, 25 Rutgers L Rev 405, 438 (1971) (emphasis added)

- 47 Biklen: Advocacy comes of age. 42 Exceptional Children, 308 (1976)
- 48 Moore: Systems change advocacy. Amicus 13 (May 1976)
- 49 Knitzer: Child advocacy: A perspective. 46 Amer J Orthopsychiat 200, 203 (1976)
- 50 Wolfensberger: Citizen Advocacy for the Handicapped, Impaired, and Disadvantaged: An Overview 12 (1972)
- 51 See, for an interesting analysis of the traditional lawyer/client (and doctor/patient) relationships, Rosenthal: Lawyer and Client: Who's In Charge? ch. 1 (1974).
- 52 See Herr: Advocacy Under the Developmental Disabilities and Facilities Constructions Act, As Amended by P.L. 94-103: A Summary Report of A Discussion Paper on Section 113 and its Implications, 6 (1976), citing Sen. Rept. 94-160, at p. 38.
- 53 See, e.g., Cohen: The function of the attorney and the commitment of the mentally ill. 44 Tex L Rev 424 (1966); Zander: Civil commitment in Wisconsin: The input of *Lessard v. Schmidt*. Wisc L Rev 503 (1976)
- 54 See, e.g., Szasz T: Law, Liberty and Psychiatry (1973); Frank: An interview with Bruce Ennis, in Hirsch ed.: Madness Network News Reader 162, 167 (1974).
- 55 This concept is discussed in such cases as *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Morrisey v. Brewer*, 408 U.S. 471 (1972).
- 56 See cases discussed at nn. 33, 36, 38, 39, above, and accompanying text.
- 57 Bazelon: 36 U Chi L Rev, above, at 743. See also Bazelon: Psychiatrists and the adversary process. Scientific Am 230: 6 (June 1974), at 18, 23.
- 58 Zander [1976] Wisc L Rev, above, at 515. See also, Note: The role of counsel in the civil commitment process: A theoretical framework. 84 Yale L J 1540 (1975).
- 59 Laves and Cohen: A preliminary investigation into the knowledge and attitude toward the legal rights of mental patients. 1 J Psych & L 49 (1973)
- 60 Epstein and Lowinger: Do mental patients want legal counsel? A survey. 45 Am J Orthopsychiat 88, 91-92 (1975)
- 61 The chart at Appendix A illustrates this point.
- 62 *In re Geraghty*, 68 N.J. 209, 343 A. 2d 737 (1975); *Marin v. Yaskin*, A-2274-74 (App. Div. 1976)
- 63 *In re Alfred*, 137 N.J. Super. 20, 347 A. 2d 539 (App. Div. 1975)
- 64 *In re Geraghty*, 68 N.J. 209, 343 A. 2d 737 (1975)
- 65 *Marin v. Yaskin*, A-2274-74 (App. Div. 1976)
- 66 *In re Alfred*, 137 N.J. Super. 20, 347 A. 2d 539 (App. Div. 1975)
- 67 *Doe v. Klein*, L-12088-74 P.W. (Super. Ct. Law Div., Morris Cty. 1974)
- 68 *Carroll v. Cobb*, 139 N.J. Super. 437, - A. 2d - (App. Div. 1976)
- 69 *Board of Chosen Freeholders of Hudson County v. Connell*, Docket No. 83870 (Hudson Cty. Ct. 1975)
- 70 *In re Gaestel* (discussed at n. 38, above)
- 71 See, e.g., Peck: Current legislative issues concerning the right to refuse versus the right to choose hospitalization and treatment. 38 Psychiat 303 (1975). See cases discussed at n. 29, above.
- 72 See, e.g., Johnson: Court decisions and the social services. 20 Social Work 342 (1975); Ennis: New York signs far-reaching consent decree in Willowbrook case. Mental Retardation and the Law 1 (Summer 1975); Kirp, Buss and Kuriloff: Legal reform of special education: Empirical studies and procedural proposals. 62 Calif L Rev 40 (1974); Rubin: An Economic Analysis of Litigation and Legislation for the Handicapped (1976).

Appendix

| <u>Case¹</u> | <u>Posture²</u> | <u>Type of Right³</u> | <u>Use of Experts⁴</u> |
|-----------------------------|----------------------------|----------------------------------|-----------------------------------|
| <i>In re Geraghty</i> | <i>Amicus Curiae</i> | procedural | No |
| <i>Marin v. Yaskin</i> | Defendant | procedural | No |
| <i>In re Alfred</i> | Plaintiff | procedural | No |
| <i>Doe v. Klein</i> | Plaintiff | substantive | Yes |
| <i>Carroll v. Cobb</i> | Plaintiff | substantive | Yes ⁵ |
| <i>Board v. Connell</i> | Defendant | economic | Yes/No ⁶ |
| <i>In re Gaestel</i> | Footnote 7 | economic | Yes ⁵ |
| <i>Schindewolf v. Klein</i> | Plaintiff | substantive; economic | Yes |
| <i>In re J.R.</i> | <i>Amicus Curiae</i> | substantive | No |
| <i>In re C.B.</i> | Defendant | substantive | Yes |

1 Only those cases addressed elsewhere in this paper have been included in this chart.

2 "Posture" refers to the Division's representation of its clients as plaintiffs or as defendants, or its

entrance into a case as *amicus curiae*.

- 3 "Type of right" refers to the broad classifications of procedural, substantive and economic rights.
- 4 "Use of experts" includes planned use of experts in cases still awaiting litigation.
- 5 In *Carroll v. Cobb* and *In re Gaestel*, professionals employed by state schools and hospitals testified on the Division's clients' behalf.
- 6 Experts were used in the class aspects of *Board of Freeholders v. Connell*, but not in the individual matters.
- 7 The class in *Gaestel* can best be classified as claimants, appealing from an order of the Social Security Administration. At this posture, the terms "Plaintiff" and "Defendant" are meaningless in this context.