The Commission on Judicial Action of the American Psychiatric Association: Origins and Prospects—A Personal View

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The Commission on Judicial Action of the APA was formed by then President Alfred Freedman at my urging, based on the following considerations:

First, there had been a recent proliferation of important legal decisions affecting the provision of mental health care. Those decisions reflected no input from organized psychiatry; indeed, they could not, since no such input had been offered. The tone and content of those new decisions were bitterly critical of institutional psychiatry and cynically distrustful of psychiatry as a discipline. I have in mind such judicial opinions as *Burnham v. Department of Public Health*,[1] *Lessard v. Schmidt*,[2] *Donaldson v. O'Connor*,[3] and *Wyatt v. Stickney*.[4]

Second, it was clear that a new mental health bar had emerged which was determined to litigate every question of patients' rights both before and after admission to the hospital without regard for the impact of such litigation on the provision of mental health care. If the APA remained inert, I feared that future generations of psychiatrists would be faced with a set of legal decisions and precedents which would sharply restrict their ability to care for patients and to practice psychiatry. Every significant psychiatric decision was to be recast and examined from the perspective of civil liberties—not only future psychiatric decisions, but past psychiatric decisions. Judges announced their views about psychiatry with quotations from Dr. Szasz and Bruce Ennis (cf. *Lessard v. Schmidt*), and from that perspective any kind of psychiatric hospitalization was deemed worse than prison. Any kind of psychiatric decision-making seemed to be arbitrary and destructive both of civil rights and of the patients' mental and physical health. The legal trends I describe were obvious and imminent not only in decisions, but in what law students and practicing lawyers were being taught. Law reviews and journals all over the country became interested in the civil rights of the mentally ill, but scant consideration was given to the provision of mental health care. Law reform groups offered clinical teaching sessions around the country, instructing public interest practitioners in the art of bringing 1983 actions against psychiatric facilities and the doctors who staffed them.[5]

The 1983 action was the legal procedure followed in *Donaldson v. O'Connor*. Decided by the Supreme Court this past summer,[6] it is the legal action now being brought against the Boston State Hospital and against mental hospitals in Mississippi and elsewhere. Nineteen-eighty-three actions are based on federal statutes which deal with the violation of civil rights under the color of law.[7] Doctors treating involuntary patients are, for reasons beyond this discussion, included among those who act under color of law. A 1983 action provides not only for the possibility of various kinds of injunctive relief, but also for damages against those who, acting under color of law, deprive persons of their civil liberties. Such deprivation may include seclusion (the Boston State case),[8]

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giving drugs to Christian Scientists (*Winters v. Miller*),[9] confining a person who can survive without treatment (*Donaldson v. O'Connor*),[3] and censoring patients' mail (*Brown v. Schubert*),[10] among others.

One sanguine reaction to the *Donaldson v. O'Connor*[3] case was to say, "Look, that jury found the psychiatrist liable under a standard for punitive damages. His behavior was so offensive that other psychiatrists need not worry." Such a view, I think, fails to account properly for the way the trial was conducted, the defense the state accorded the psychiatrists, or the evidence which convinced the jury of bad faith. Such a sanguine view also neglects the fact that the success of *Donaldson v. O'Connor*,[3] together with the teaching program for legal activists and lawyers' growing interest in pursuing a civil libertarian approach to the situation of the mentally ill, will likely culminate in a wave of 1983 litigation. Whether or not defendants are ultimately found liable for punitive damages, that litigation, through temporary restraining orders and injunctions, disrupts the practice of institutional psychiatry. In the long run, that disruption may not lead either to improvements in psychiatric care or to greater civil liberties for patients.

The attitude I want to convey is not that of opposition to any and all legislative and legal reform of the mental health care system. Far from it. The problem was that precedents were being set which were clearly unnecessarily and unwisely interfering with the provision of mental health care. For example, *Lessard v. Schmidt*[2] suggested that newly admitted psychiatric patients could not be given medically appropriate therapy until a legal hearing. No consideration was given to this prohibition's cost to the patient, to the other patients, to the staff, and to the general provision of mental health care.

Furthermore, the litigation opened up the psychiatrist to all sorts of new liability, not only in terms of monetary damages, but in terms of time spent in court, or in paper work, or with human rights committees instead of with patients. Mental health funds were being diverted from patient care to legal fees. It was clear that the Commission on Judicial Action of the APA would never be able to halt the landslide which was occurring, but we could at least begin to give courts information about the consequences of precedents for the provision of mental health care. That has been a guiding principle for the Commission, or at least for my work on it.

Where new litigation impacts on the provision of mental health care in a destructive way, organized psychiatry has a duty and a responsibility to participate. That is a central but not the sole premise of the Commission. From that perspective, look at the *O'Connor v. Donaldson*[3] case. Two primary considerations led us to participate as *amicus curiae* in that case. First, we were concerned that the type of liability it imposed would drive psychiatrists from the already understaffed state hospital system. For those who wish to see the destruction of the state hospital system that, of course, is not a cost, but for us it was. Second, we thought it was important for the Supreme Court to be aware of the practices and the realities of the state hospital context of the south in the 1950's and 60's in which Dr. O'Connor worked—realities vastly different from those of current practices of community mental health. These were obviously significant issues which should have been brought forward forcefully at trial. Since they had not been, we used our role as *amicus* to bring them to the Court's attention.

The contextual aspect was particularly important because we wanted the Supreme Court to judge Dr. O'Connor in perspective. In my view, what in the jury's mind constituted bad faith, justifying punitive damages, was the result of a historical disjunction. Dr. O'Connor's tradition was that of custodial care of chronic schizophrenics and he treated Donaldson in that perspective. Even more important, Dr. O'Connor had acted in a manner consistent with the information provided to him by the courts. Donaldson had more than a dozen times sought his release, and judges all the way to the Supreme Court had ignored him. Thus, it seemed to us Kafkaesque at best, and unbelievable hypocrisy at worst, for the courts to turn around and hold the psychiatrist liable for

damages for denying freedom they had themselves denied repeatedly. Both the majority and Justice Burger addressed this issue raised in the APA brief, the majority saying it should have been brought up at trial and Justice Burger saying it was relevant no matter when it was brought up in considering Dr. O'Connor's liability.

The last thing I shall mention about our *amicus* brief was that we wanted to suggest to the court that to the extent this was a right to treatment case, the power to improve conditions rested not with the medical staff of the state hospital system, but rather with the executive and legislative branches of government, where power in fact resides. We felt the psychiatrist was being made the scapegoat of a tension between resource decisions of the legislature and judicial decisions based on a theory of rights. Aspects of this same scapegoating are obviously apparent in the Boston State litigation now ongoing.

In the *O'Connor* case generally, we were clearly concerned about the damages awarded, and at first glance this concern may seem like trade association self-interest and nothing more. But that was not our sense of it. First, we felt that because money is an important incentive in legal actions, precedent for such damages would further escalate the war of litigation. We also learned in the course of our work, as others have learned, that legal assistance provided by State Attorney Generals' offices to psychiatrists can be less than adequate when matched against the bright, eager advocates of law reform. It also became clear to us that psychiatrists being sued for damages might often be afforded inadequate protection, particularly in law suits involving a potential conflict of interest between the psychiatrist and the state on questions like basic responsibility for conditions in state hospitals. The fact that any punitive damages awarded in such actions might in some states as a matter of public policy come out of the psychiatrist's pocket compounded our concern. We felt that the risk of such law suits would not only drive psychiatrists from the state hospitals, but also lead psychiatrists to abdicate responsibility for patients out of fear of incurring legal liability. Thus we felt we were in a situation where patients, even more than psychiatrists, would eventually pay the price. These are the types of consideration which guide the Commission in all its activities.

In focusing on some of the highlights of our amicus brief in *O'Connor v. Donaldson*,[6] I have discussed only a small part of the work of the Commission. We have been active as *amici* in a substantial number of other cases; many of which are familiar to readers of this *Bulletin*. The Commission was responsible for the APA's *amicus* role in the later stages of the *Wyatt* case.[4] We were *amicus* to the Supreme Court in *Roe, Poe, Coe*[11] and in *Anonymous v. Kissinger*,[12] and to the state courts in the *Tarasoff* case[13] and in *Doe v. Younger*,[14] which was brought following California's passage of the Vasconcellos bill. These last two cases were spearheaded by the local district branches; similar participation is essential in the future.

Additionally, we are constantly involved in evaluating prospective litigation. The APA's regional branches often contact us about cases involving or directly affecting their members. We evaluate the underlying legal issues and indicate whether we find them significant enough to merit involvement. If we do, we offer assistance in developing an *amicus* stance which will offer the most effective positive input. Often the mental health bar asks for our reactions to litigation they have brought or plan to pursue. We encourage them to frame their cases in terms which best address the basic psychiatric issues they claim as their concern. At times they agree with our views on the significance or handling of particular issues, and at other times we feel there is sufficient divergence on an important question to merit our seeking independent in[illegible]t as *amicus*.

Most of the monitoring of mental health litigation and involvement as *amicus* has been by the APA on a national level. Given the Supreme Court remand of *Lessard v. Schmidt*[2] to avoid preempting a state court decision, and the narrow delineation of its holding in *O'Connor v. Donaldson*,[6] there is likely to be a much greater need in the future for participation by the APA's district branches. The Court has expressed its inclination to have questions of state mental health care resolved initially through

state court proceedings. If appropriate standards are to be developed in state-by-state litigation, the APA's district branches as exemplified by California will have to assume a much more active role in local judicial actions.

There is an enormous task ahead for American psychiatry; court intervention, legislative action, and executive decree will all influence our future ability to practice. One can only hope that our profession will find a way to deal with these many pressures.

References

1. 349 F Supp 1335 (ND Ga 1972), rev'd and remanded 503 F 2d 1319 (5th Cir 1974)
2. 349 F Supp 1073 (ED Wis. 1972), vacated and remanded 414 US 473, 94 S Ct 713 (1974), 379 F Supp 1376 (ED Wisc. 1974) vacated and remanded 95 S Ct 1943 (1975) sub nom Schmidt v Lessard
3. 493 F 2d 507 (5th Cir 1974), vacated and remanded 95 S Ct 2486 (1975) sub nom O'Connor v Donaldson
4. 325 F Supp 781, 334 F Supp 1341 (MD Ala), affm'd in part, rev'd in part, remanded in part 503 F 2d 1305 (5th Cir 1974), sub nom Wyatt v Aderholt, continuing to be heard in MD Alabama sub nom Wyatt v Hardin
5. 1983 actions are brought under the authority of 42 USC §1983, passed in 1871
6. O'Connor v Donaldson 95 S Ct 2486 (1975)
7. The action is brought under 42 USC 1983. Federal jurisdiction is established under 28 USC 1343 (3) and (4)
8. Rogers v Macht, Civ. Act. No. 75–1610–T in the US District Court for the District of Massachusetts, currently pending
9. 306 F Supp 1158 (EDNY 1969), rev'd and remanded 446 F 2d 65 (2nd Cir 1971) cert den'd 404 US 985, 92 S Ct 450 (1971)
10. 389 F Supp 281 (ED Wisc 1975)
11. Roe, Poe, Coe, v Doe, 310 NE 2d 539 (Ct of Appls NY, 197–), cert granted 417 US 907 44 S Ct 2601 (1974), cert dismissed 420 US 307 95 S Ct 1154 (1975)
12. Anonymous v Kissinger, 499 F 2d 1097 (US App D DC 1974) cert denied 95 S Ct 1424 (1975)
13. In re Tarasoff v Regents of the University has been heard by the California State Supreme Court
14. Doe v Younger, 4th Cir 14407, decision pending, Cal Ct of Appeals, 4th Appellate District