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TEN YEARS AFTER: EVOLVING MENTAL HEALTH ADVOCACY AND JUDICIAL TRENDS*

Michael L. Perlin**

I. Introduction

As today's symposium marks my tenth anniversary on the mental health law conference circuit, I thought I might take advantage of the coincidence by trying to survey the major mental health law developments over the past decade. I hope that this survey will identify: (1) the major legal trends in mental disability law (and where we can reasonably expect them to lead in the future);¹ (2) other social, economic, and political extra-legal developments that have influenced and will likely *continue* to influence these trends;² and (3) (to the extent that it can be done) the shifting ways the organized mental disability professions (especially, but not limited to, psychiatry) have influenced and responded to these developments.³ I am also going to try to look at all of these developments through one specific filter: that of the full-time mental health advocate, the attorney whose sole job it is to provide high-quality, regularized, specialized legal services to mentally handicapped persons.⁴

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1. See *infra* notes 12-36 and accompanying text.

2. See *infra* notes 37-59 and accompanying text.

3. See *infra* notes 60-72 and accompanying text.

4. See Perlin & Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161 (Summer 1982) [hereinafter Perlin & Sadoff]; Perlin, *Representing Individuals in the Commitment and Guardianship Process*, in 1 LEGAL RIGHTS OF MENTALLY DISABLED PERSONS 497 (P.L.I. 1979); Van Ness & Perlin, *Mental Health Advocacy—The New Jersey Experience*, in MENTAL HEALTH ADVOCACY: AN EMERGING FORCE IN CONSUMERS' RIGHTS 62 (1977).

II. Mental Health Trends

A decade ago, the notion of "patients' rights" had just taken its first quantum leap from the pages of the law reviews into the courtrooms and the official case reports. On two fronts, in the areas of involuntary civil commitment⁵ and the right to treatment,⁶ certain federal courts had shown a significant sensitivity to the issues involved in the ravages of mental illness and the desolation of the conditions to which the mentally ill were often consigned, and they evinced an intellectual boldness in being willing to apply the due process clause (and other constitutional provisions) to a variety of fact patterns never before subjected to the constitutional microscope. As a result, cases such as *Lessard v. Schmidt*⁷ and *Wyatt v. Stickney*⁸ established new sets of legal guidelines and, perhaps more important, laid down a moral imperative for other courts, litigators, legislators and mental health professionals to consider very, very carefully.

To top it off, the Supreme Court ruled ten years ago in *O'Connor v. Donaldson*⁹ that there was a "constitutional right to liberty"¹⁰ and that a "finding of 'mental illness' alone cannot justify a [s]tate's locking a person up against his will and keeping him indefinitely in simple custodial confinement."¹¹ As a business school dean would probably have put it, the notion of mental patients' rights appeared—as of 1975—to be "an idea in good currency."

What has happened, then, in the intervening decade? Was 1975, in retrospect, a high water mark? Was it an historical aberration? Or was it some sort of 1848, one of those critical revolutionary years that irrevocably altered the landscape for all future time? The answer, it seems to me, is all of the above. Let me try to sort out some of the trends in an effort to see if I can overlay any kind of doctrinal consistency in an attempt to bring some sort of order to the field.

5. The "lodestone case" is *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

6. See, e.g., *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *later op.*, 334 F. Supp. 1341 (M.D. Ala. 1971), *later op.*, 344 F. Supp. 373 (M.D. Ala. 1972), *later proceeding*, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part, remanded in part sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

7. See *supra* note 5 and accompanying text.

8. See *supra* note 6 and accompanying text.

9. 422 U.S. 563 (1975).

10. *Id.* at 573.

11. *Id.* at 575.

A. Developments in Mental Disability Law

The past decade has been an incredibly fertile one for the courts and for litigants in the whole area of "mental disability law." Over the past decade, we have seen the following developments:

(1) the creation of a coherent (well, mostly) body of civil commitment law in virtually every circuit and many state supreme courts. The United States Supreme Court seems to be content to allow the lower courts to serve as laboratories of experimentation¹² and I do not think it will attempt to deal with the question of "what procedure is due?" any more than it already has in cases such as *Jackson v. Indiana*,¹³ *O'Connor v. Donaldson*,¹⁴ *Addington v. Texas*,¹⁵ *Parham v. J.R.*,¹⁶ and *Vitek v. Jones*;¹⁷

(2) the proliferation of right to treatment cases and right to habilitation cases (mostly owing their spiritual development to *Wyatt*), culminating in the United States Supreme Court's 1982 decision of *Youngberg v. Romeo*,¹⁸ holding that at least *some* substantive treatment rights are mandated;

(3) the crafting of the constitutional right to *refuse* treatment (usually but not always focusing on the involuntary administration of psychotropic medication to institutionalized patients), following the leads of *Rennie v. Klein*¹⁹ and *Rogers v. Okin*,²⁰ again culminating in a Supreme Court decision in *Mills*,²¹ which, at the least, indicated that the Court was comfortable with the general contours of the right;

12. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory . . . and try novel social and economic experiments without risk to the rest of the country").

13. 406 U.S. 715 (1972). See *infra* notes 74-75 and accompanying text for a discussion of the Court's holding in *Jackson*.

14. 422 U.S. 563 (1975); see *supra* notes 9-11, *infra* notes 76-78, and accompanying text.

15. 441 U.S. 418 (1979); see *infra* note 83 and accompanying text.

16. 442 U.S. 584 (1979); see *infra* note 84 and accompanying text.

17. 445 U.S. 480 (1980); see *infra* note 82 and accompanying text.

18. 457 U.S. 307 (1982); see *infra* notes 90, 93-94 and accompanying text.

19. 462 F. Supp. 1131 (D.N.J. 1978), *modified*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

20. 478 F. Supp. 1342 (D. Mass. 1979), *modified*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982), *on state certification sub nom. Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983), *on remand*, 738 F.2d 1 (1st Cir. 1984).

21. 457 U.S. 291 (1982); see *infra* notes 91-92 and accompanying text.

(4) the creative expansion of both substantive and procedural rights into areas of "other" institutional rights²² (such as due process in hospital discipline,²³ payment for "therapeutic" hospital labor²⁴ and the right to adequate exercise²⁵), and into "other" institutions (for example, federal,²⁶ and private²⁷);

(5) the (still mostly unsuccessful) attempt to create a right to aftercare/right to deinstitutionalization. While the Supreme Court has appeared exceedingly uncomfortable with this notion,²⁸ other courts have begun (very vaguely) to draw the contours of such a right, usually via reliance on certain recent federal statutes;²⁹ and

(6) the first legal awakening of interest in the whole notion of economic rights, covering such disparate issues as the right of patients to control their own assets,³⁰ their right to be paid for work done while hospitalized,³¹ the interplay between a hospital's accreditation from the Joint Commission on Accreditation of Hospitals and hospital funding,³² and the implications of antitrust law for third-party payments to competing psychotherapists.³³

This brief overview does not even touch on tort-law developments,³⁴ the interplay, if any, between mental health law and the plight of

22. See generally Perlin, *Other Rights of Residents in Institutions*, in 2 LEGAL RIGHTS OF MENTALLY DISABLED PERSONS 1009 (P.L.I. 1979) (describing specific rights such as visitation, access to counsel, freedom from forced labor, use of mails, telephones, clothing, voting, freedom from reprisals, of institutionalized mental patients). See also Perlin, *Civil Rights of Hospitalized Mental Patients*, in 4 LESSON 29: DIRECTIONS IN PSYCHIATRY 3 (1984) (same).

23. See *Davis v. Balson*, 461 F. Supp. 842, 875-78 (N.D. Ohio 1978).

24. See *Souder v. Brennan*, 367 F. Supp. 808, 812-14 (D.D.C. 1973).

25. See *Johnson v. Brelje*, 701 F.2d 1201, 1208-10 (7th Cir. 1983).

26. See *Falter v. Veterans' Admin.*, 502 F. Supp. 1178 (D.N.J. 1980) (suit against medical center operated by Veterans' Administration).

27. See *Ruffler v. Phelps Memorial Hosp.*, 453 F. Supp. 1062 (S.D.N.Y. 1978) (suit against both county and private hospitals).

28. See *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89 (1984); see *infra* notes 121-26 and accompanying text for the Court's holding.

29. See, e.g., 29 U.S.C. § 794 (1982); 42 U.S.C. § 6010 (1982).

30. See *Vecchione v. Wohlgemuth*, 377 F. Supp. 1361 (E.D. Pa. 1974), *aff'd*, 558 F.2d 150 (3d Cir.), *cert. denied*, 434 U.S. 943 (1977).

31. See *Souder*, 367 F. Supp. at 812-14.

32. See *Cospito v. Heckler*, 742 F.2d 72 (3d Cir. 1984), *cert. denied*, 471 U.S. 1131 (1985).

33. See *Blue Shield v. McCready*, 457 U.S. 465 (1982). See generally Perlin, *Recent Developments in Mental Health Law*, 6 PSYCHIATRIC CLINICS OF NORTH AMERICA 539, 546-47 (1983) (discussing business law decisions by Supreme Court that may ultimately affect mental health providers).

34. See *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (patient's psychotherapists breached duty to protect

the homeless,³⁵ or the implications of recent post-*Hinckley* insanity defense developments.³⁶ In short, I can think of no other new area of the law that has seen such extended growth and refinement in the past decade.

B. Legislative Change

These *judicial* developments have been paralleled by important *legislative* changes both in the state capitals and in Congress. While trends may be a bit murkier here, certain principles have been established.

(1) In the wake of (and, in many cases, in direct response to) the *Wyatt* case,³⁷ virtually every state now has *some* kind of an operative "Patients' Bill of Rights,"³⁸ legislatively mandating those rights that were at the heart of the *Wyatt* decree: the right to a humane physical and psychological environment, to qualified staff personnel, and to individualized treatment plans for each patient.³⁹ In many states, these bills of rights also provide at least minimal substantive and procedural due process protections to patients wishing to refuse the imposition of unwanted medical treatment.⁴⁰ Patients' rights advocates are increasingly turning their attention to these statutes as

intended victim by failing to warn victim after patient confided to therapists his intention to kill victim); *Clites v. State*, 322 N.W.2d 917 (Iowa Ct. App. 1982) (state hospital negligent in administering major tranquilizers to mentally retarded resident without first obtaining written, informed consent from patient or guardian).

35. See generally THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION (1984).

36. See Rodriguez, LeWinn & Perlin, *The Insanity Defense Under Siege: Legislative Assaults and Legal Rejoinders*, 14 RUTGERS L.J. 397 (1983) (discussing role of insanity defense and results after it is pleaded); see also Perlin, *Whose Plea Is It Anyway? Insanity Defense Myths and Realities*, 79 PHILADELPHIA MEDICINE 5 (1983) (same).

37. See, e.g., *The Wyatt Standards: An Influential Force in State and Federal Rules*, 28 HOSP. & COMMUNITY PSYCHIATRY 374 (1977) (many new state laws providing for patients' rights "contain provisions similar to the standards for adequate care and treatment of the mentally ill and retarded in . . . the *Wyatt v. Stickney* court order of 1972") (emphasis in original).

38. See, e.g., CAL. WELF. & INST. CODE §§ 5325-5331 (West 1984); CONN. GEN. STAT. ANN. § 17-206(a)-(k) (West Supp. 1986); FLA. STAT. ANN. § 394.459 (West 1986); MICH. COMP. LAWS ANN. §§ 300.1700 to -.1754 (West 1980); N.J. STAT. ANN. § 30:4-24.2 (West 1981); OHIO REV. CODE ANN. § 5122.29 (Anderson 1981); PA. STAT. ANN. tit. 50, § 4423 (Purdon 1969); WIS. STAT. ANN. § 51.61 (West Supp. 1986).

39. See *Wyatt*, 334 F. Supp. at 1343.

40. See, e.g., CAL. WELF. & INST. CODE § 5326.7 (West 1984); N.J. STAT. ANN. § 30:4-24.2d(1) (West 1981).

potential sources of relief;⁴¹ for many reasons, I expect this reliance on state statutory law to grow exponentially in the future.

(2) The picture in Washington is, as usual, more confusing. While Congress has been at least mildly vigorous in protecting the rights of the developmentally disabled⁴² and those physically and mentally handicapped persons receiving vocational rehabilitation services,⁴³ its track record in matters involving the mentally ill is, for lack of a more descriptive word, somewhat schizophrenic. Inspired by the 1978 President's Commission on Mental Health Report,⁴⁴ Congress passed the Mental Health Systems Act of 1980⁴⁵ in a comprehensive effort to upgrade community-based mental health services on a national level.⁴⁶ As part of that Act, it enacted—for the first time—a Patients' Bill of Rights.⁴⁷ While that Act was a drastically watered down version of the suggestions embodied in the President's Commission Report,⁴⁸ it still included two key sections: the first federal patients'

41. See, e.g., *Smith v. Shapiro*, 197 N.J. Super. 320, 484 A.2d 1282 (App. Div), *certification denied*, 101 N.J. 325, 501 A.2d 912 (1984) (patient in psychiatric hospital brought action under New Jersey's patients' "Bill of Rights" to receive mail).

42. See, e.g., 42 U.S.C. §§ 6000-6081 (1982 & Supp. III 1985). Section 6000 of title 42 of the United States Code describes the purpose of the sections:

It is the overall purpose of this chapter to assist States to (A) assure that persons with developmental disabilities receive the care, treatment, and other services necessary to enable them to achieve their maximum potential through increased independence, productivity, and integration into the community, and (B) establish and operate a system which coordinates, monitors, plans, and evaluates services which ensures the protection of the legal and human rights of persons with developmental disabilities.

Id. § 6000 (Supp. III 1985).

43. See, e.g., 29 U.S.C. §§ 701-796 (1982 & Supp. III 1985). The congressional declaration of purpose is "to develop and implement, through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living." *Id.* § 701 (1982). See *infra* note 107 for the text of § 794 of title 29 of the United States Code, which prohibits discrimination under federal programs.

44. 1 REPORT TO THE PRESIDENT FROM THE PRESIDENT'S COMMISSION ON MENTAL HEALTH (1978) [hereinafter REPORT].

45. 42 U.S.C. §§ 9401-9523 (1982).

46. See *id.* § 9401(1)-(9) (congressional statement of findings).

47. *Id.* § 9501.

48. Compare 1 REPORT, *supra* note 44, at 42-45 with 42 U.S.C. § 9501 (1982) (patient's bill of rights). The Report from the President's Commission recommended that:

Each State review its mental health laws and revise them, if necessary, to ensure that they provide for:

a) a right to treatment/right to habilitation and to protection from harm for involuntarily confined mental patients and developmentally disabled individuals;

bill of rights of *any* sort for mental health patients,⁴⁹ and an advocacy provision that provided grants to select experimental pilot programs to provide regularized mental health advocacy services to the mentally disabled.⁵⁰

A diversion is necessary here to provide a bit of background: one of the President's Commission's major recommendations had been to mandate a national system of such advocacy programs.⁵¹ This recommendation reflected: (1) the paucity of such legal services then generally available to the institutionalized mentally disabled;⁵² (2) the shoddy track record of most lawyers who had provided such services on a sporadic or occasional basis;⁵³ and (3) the recognition that, without such programs, the promise of the right to counsel—a right found by a host of federal courts and state supreme courts⁵⁴—would be little more than a hollow shell. The second prong of the federal law I have just mentioned was specifically crafted to respond to this set of circumstances.

- b) a right to treatment in the least restrictive setting;
- c) a right to refuse treatment, with careful attention to the circumstances and procedures under which the right may be qualified; and
- d) a right to due process when community placement is being considered.

1 REPORT, *supra* note 44, at 44. Congress couched the patients' rights in this language: "It is the sense of the Congress that each State should review and revise . . . its laws to ensure that mental health patients receive the protection and services they require" 42 U.S.C. § 9501 (1982).

49. 42 U.S.C. § 9501 (1982).

50. See *id.* § 9502 (*repealed by* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 902(e)(1), 95 Stat. 357, 560 (1981)).

51. See 1 REPORT, *supra* note 44, at 42 ("[i]n adversary or judicial settings [the Commission] recognize[s] the importance of counsel to represent not only the mentally disabled . . . but also the State or provider against which a claim is made").

52. See generally 4 TASK PANEL REPORTS SUBMITTED TO THE PRESIDENT'S COMMISSION ON MENTAL HEALTH (Appendix) 1359, 1366 (1978) ("[t]he President's Commission should support legislation which would establish and adequately finance a system of comprehensive advocacy services for mentally handicapped persons") [hereinafter TASK PANEL REPORTS].

53. See Perlin & Sadoff, *supra* note 4, at 164 ("record of counsel providing services to the mentally ill has never lived up" to the standard of "the ardent defender of the client's rights and freedoms'") (quoting Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and A Proposal*, 45 MISS. L.J. 43, 46 (1974)).

54. See *Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968); *Dixon v. Attorney General*, 325 F. Supp. 966, 974 (M.D. Pa. 1971); *In re Hop*, 29 Cal. 3d 82, 94, 623 P.2d 282, 289, 171 Cal. Rptr. 721, 728 (1981); *In re Fisher*, 39 Ohio St. 2d 71, 72, 313 N.E.2d 851, 858 (1974). See generally Perlin, *Rights of the Mentally Handicapped*, 4 BULL. AM. ACAD. PSYCHIATRY & L. 77, 82-83 n.1 (1976) (discussing right to counsel at involuntary civil commitment proceedings) [hereinafter Perlin, *Mentally Handicapped*].

The advocacy title was short lived; it expired but a few months after its enactment, as one of the first victims of the Reagan budget juggernaut.⁵⁵ Since this expiration of the advocacy title appeared to be but one tiny pebble sinking to the bottom of the ocean in the tidal wave of the (alleged) "New Federalism" emanating from Washington, few voices were heard in opposition; as a friend mordantly observed at the time: "It's like complaining that the band on the Titanic was playing 'Nearer My God to Thee' in the wrong key."

Over the past four years, however, there have been signs (albeit slim ones) that the tide may be ready to turn: recent hearings before a Senate Subcommittee on the Handicapped have turned up the same deadnally familiar stories of abuse, mistreatment, and negligence⁵⁶ that Congress has been hearing for at least fifteen years.⁵⁷ In response to the testimony adduced at these hearings, Senator Lowell Weicker (R. Conn.), long a congressional champion of the handicapped, has introduced new legislation (the Protection and Advocacy for Mentally Ill Persons Act of 1985),⁵⁸ which would mandate the provision of legal advocacy services "to ensure the protection of mentally ill persons" who are receiving treatment in state facilities.⁵⁹ In short, as a local ex-manager used to note: "It ain't over, 'til it's over," and it still ain't over.

55. See *supra* note 50.

56. See 131 CONG. REC. S4508 (daily ed. Apr. 23, 1985) (statement of Sen. Weicker) ("we recognize the illness of these [mentally disabled] patients, yet we would not allow cancer patients or leukemia victims to suffer such deprivation").

57. The court in *Lessard v. Schmidt* relied heavily upon hearings before the Senate Subcommittee on Constitutional Rights that were held during the ninety-first Congress in 1969-70. See 349 F. Supp. at 1087, 1089-90, 1102.

58. S. 974, 99th Cong., 1st Sess., 131 CONG. REC. S4509-11 (1985) [hereinafter S. 974]. After this speech was given, the bill introduced by Senator Weicker was signed into law. See Protection and Advocacy for Mentally Ill Individuals Act of 1986, Pub. L. No. 99-319, 100 Stat. 478 (codified at 42 U.S.C.A. §§ 10801-10851 (1986)).

59. S. 974, *supra* note 58, § 5(b)(1)(A), 131 CONG. REC. S4510 (1985). The congressional purposes of the enacted bill are:

(1) to ensure that the rights of mentally ill individuals are protected; and

(2) to assist States to establish and operate a protection and advocacy system for mentally ill individuals which will—

(A) protect and advocate the rights of such individuals through activities to ensure the enforcement of the Constitution and Federal and State statutes; and

(B) investigate incidents of abuse and neglect of mentally ill individuals if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.

42 U.S.C.A. § 10801(b) (1986).

C. Influence and Response of Organizations

In addition to considering these legal trends, it is also important to pay attention to the roles of the other "players in the game"—organizations representing the mental health professional and those speaking for ex-patients.

Over the past decade, for example, the increase in the influence of the American Psychiatric Association (APA) on the development of mental disability law has been little short of astonishing. From its nadir—when it declined the court's invitation to participate in the post-adjudication order-crafting in *Wyatt v. Stickney*⁶⁰—to its current status (in which it participates regularly in the most significant cases dealing with such important doctrines as the right to treatment, the right to refuse treatment, and the right to aftercare), the APA has become a major force in shaping the contours of mental health law at the Supreme Court level. While at first blush, this change in influence might appear merely to reflect Chief Justice Burger's long-term fascination with psychiatry,⁶¹ a closer look at the ledger—

60. While it is not absolutely clear *why* the APA did not participate, the suggestion raised by Dr. Robert L. Sadoff, past president of the American Association of Psychiatry and the Law, has never been repudiated:

Psychiatrists trained as physicians have always been concerned that the courts will usurp their medical functions by telling them how they must treat their patients. Apparently for this reason, the APA chose not to consult with Judge Johnson in the *Wyatt* case . . . when he asked for standards for hospitalized psychiatric patients.

Sadoff, *Changes in Mental Health Law: Progress for Patients, Problems for Psychiatrists*, in 4 NEW DIRECTION IN MENTAL HEALTH SERVICES: COPING WITH THE LEGAL ONSLAUGHT 1, 2 (1979).

According to Dr. Alan Stone, there were three main reasons why the psychiatric establishment chose to "remain aloof":

First, there was the problem of the APA's defensive response to [*Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966)]. Second, Alabama's Commissioner of Mental Health, Dr. Stonewall Stickney, had, before the suit, called on the APA to try to help him improve conditions. The APA knew what was happening in Alabama's hospitals, but preferred to try to help Dr. Stickney persuade, rather than to resort to legal action. Third, the psychiatric establishment had very little structural capacity to take any action, and certainly not a controversial action like naming a colleague as defendant.

Stone, *The Right to Treatment and the Medical Establishment*, 2 BULL. AM. ACAD. PSYCHIATRY & L. 159, 162 (1974).

For a list of those professional organizations which *did* participate in the *Wyatt* standard-setting, see *Wyatt*, 344 F. Supp. at 375 n.3 (American Orthopsychiatric Association, American Psychological Association, American Civil Liberties Union, and American Association on Mental Deficiency were amici in the case).

61. Chief Justice Burger has written various articles on psychiatry and the law.

no other Justice joined Burger's concurrence in *O'Connor v. Donaldson*⁶² in 1975; no other joined in his concurrence in *Youngberg v. Romeo*⁶³ in 1982; no other joined his concurrence in *Ake v. Oklahoma*⁶⁴ in 1985—makes it more likely that it is rather a reflection of the good judgment of former APA President Alan Stone in retaining Joel Klein, former clerk to Judge Bazelon and Justice Powell and former litigator at the Mental Health Law Project, as the APA's lead counsel.⁶⁵ In an area as discrete, as young, as self-contained, and—to dredge up my own favorite neologism one more time—as “fluxy”⁶⁶ as mental health law, the retention of one skilled, expert litigator as counsel to a professional association may have a dramatic (and lasting) effect on the development of the law.

The APA, of course, is not the only professional association concerned with mental disability law developments: the American Psychology Association, the National Association of Social Workers, and other groups of mental health professionals have all turned to the courts in recent years on matters of patients' rights⁶⁷ and professional “turf” divisions (particularly on questions of eligibility for third-party insurance payments).⁶⁸ This inter-professional competition shows no sign of abating,⁶⁹ and we can reasonably expect future litigation to reflect the heightened involvement of these and other alternative psychotherapists in the future.

It is also necessary to point out that several organizations are

See, e.g., Burger, *Psychiatrists, Lawyers and the Courts*, 28 FED. PROBATION, June, 1964, at 3.

62. 422 U.S. 563, 578 (1975).

63. 457 U.S. 307, 329 (1982).

64. 470 U.S. 67, 80 (1985).

65. For an account of Mr. Klein's involvement in the *O'Connor* case, see Robitscher, *Commitment and the Courts: The Addington Case*, 4 J. PSYCHIATRIC TREATMENT & EVALUATION 57, 59 (1982) (citing R. WOODWARD & S. ARMSTRONG, *THE BROTHERS* 369-83 (1979)).

66. See Perlin, *Mentally Handicapped*, *supra* note 54, at 77 (using “fluxiness” to describe changes and advances, particularly within prior three years, in area of rights of mentally handicapped).

67. See *supra* note 60.

68. See *Blue Shield v. McCready*, 457 U.S. 465 (1982).

69. Cf. Post, *And Now the Age of the Barefoot Psychotherapist*, N.Y. Times, May 19, 1985, § 4 (Week in Review), at 20 (letter to editor) (“[t]he growth of lay psychotherapy in the United States . . . threatens to denude the country of its only wholly qualified line of defense against mental and emotional illness: the physician trained both in biological and psychodynamic psychiatry”); Goleman, *Social Workers Vault into a Leading Role in Psychotherapy*, N.Y. Times, Apr. 30, 1985, at C1, col. 3 (describing “revolution” in psychotherapy due to increasing number of “nonmedical professionals,” who do largest portion of psychotherapy).

dramatically opposed to the positions invariably taken by organized psychiatry. These organizations are self-help, ex-patients' groups that have become increasingly involved in litigation, mostly, but not exclusively, in opposition to involuntary civil commitment statutes⁷⁰ and in support of mental patients' rights to refuse the administration of psychotropic medication.⁷¹ These groups—provocatively titled, as the Alliance for the Liberation Front, the Network Against Psychiatric Assault, and Project Release—reflect more than the national tide of consumerism launched by the Nader movement of the seventies. They also reflect an important concept more lasting than most “evolving trends”: the notion that ex-patients, like all other “discrete and insular minorities,” isolated from the majoritarian, democratic political process, will exercise their right to self-determination and, to the greatest extent possible, control their own destinies.⁷² This development cannot be overlooked.

III. The Attitude of the United States Supreme Court

This survey, is, of course, still incomplete, since I have (intentionally, to be sure) left the most important part for last: the attitude of the United States Supreme Court towards each of these trends and towards the whole gestalt of mental health law. For if we look at the Supreme Court's record over the past decade, we can identify three basic, relatively discrete phases through which the Court has passed in its treatment of substantive and procedural constitutional issues affecting civilly committed mental patients. This trifurcation consciously excludes cases based on: (1) issues of federal pleading, procedures, and jurisdiction; (2) interpretation of federal statutes; and (3) the criminal law/mental health intersection. Although I will

70. See, e.g., *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983). In this case, Project Release, a not-for-profit corporation composed of persons who were or had been in New York State mental hospitals as either voluntary, involuntary, or emergency patients, brought suit alleging that New York State Mental Hygiene Law violated appellants' fourteenth amendment substantive and procedural due process rights.

71. See *Rennie v. Klein*, 653 F.2d 836, 838 (3d Cir. 1981) (*Alliance for the Liberation of Mental Patients* served as *amicus curiae*), *vacated and remanded*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

72. See, e.g., J. CHAMBERLIN, *ON OUR OWN: PATIENT-CONTROLLED ALTERNATIVES TO THE MENTAL HEALTH SYSTEM* xiii (1978) (“[i]n the mental patients' liberation movement . . . [w]e came together to express our anger and despair at the way we were treated. Out of that process has grown the conviction that we *must* set up our own alternatives, because nothing that currently exists or is proposed fundamentally alters the unequal power relationships that are at the heart of the present mental health system”) (emphasis in original).

speak of these as well (in some cases, they reflect even more eloquently the Supreme Court's attitudes towards the underlying issues), for purposes of pigeonholing, I will limit myself to the constitutional decisions arising from cases involving the civilly committed. This division also lets me do what I have always wanted to: set up a tripartite baseball/opera/rock'n'roll metaphor.⁷³

A. The Supreme Court of 1972-1975

First is what I would characterize, in baseball parlance, as the "Rookie Phenomenon" stage: a teenage Dwight Gooden shattering strikeout records; Willie Mays up from Triple A making barehanded catches while crashing into outfield walls; Mickey Mantle reaching "Death Valley" in the old Yankee Stadium from both sides of the plate. The Supreme Court of 1972 to 1975 fits into this framework, including its first pronouncement in *Jackson v. Indiana*⁷⁴ that the due process clause applies to all aspects of the commitment process,⁷⁵ and its later declarations in *O'Connor v. Donaldson*⁷⁶ that: (1) mental patients have a constitutional right to liberty if they are not dangerous and can "live safely in freedom";⁷⁷ and (2) treatment matters *are* cognizable in federal courts under the Constitution.⁷⁸ *Jackson* and *O'Connor* together let mental health advocates know that their pleas would, for the first time in jurisprudential history, be taken seriously by the federal courts.

B. The Supreme Court of 1979-1980

Second is what opera fans recognize as the "middle period": Verdi's *Trovatore-Rigoletto-Traviata* years, Puccini's *Fanciulla—Tritico* stage, or Wagner's *Meistersinger-Tannhauser* time. In short, a period of some retrenchment producing works neither as provocative as their predecessors (in the case of Puccini) nor as complete as their successors (in the cases of Verdi and Wagner), but yet worthy of significant attention. The Supreme Court reached this middle period in 1979 and 1980, deciding *Addington v. Texas*,⁷⁹ *Parham*

73. See *infra* notes 74-97 and accompanying text.

74. 406 U.S. 715 (1972).

75. *Id.* at 738 ("due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed").

76. 422 U.S. 563 (1975).

77. *Id.* at 573-76.

78. *Id.* at 574 n.10 ("[w]here '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") (emphasis added).

79. 441 U.S. 418 (1979).

v. *J.R.*,⁸⁰ and *Vitek v. Jones*,⁸¹ thus shaping the procedural contours of the involuntary civil commitment process. When read together, these cases reflected a specific vision on the part of the Court: while most basic procedural due process protections applied to the commitment hearing,⁸² and while more than the simple traditional civil burden of proof of "preponderance of the evidence" was necessary for commitment (as a reflection of the "weight and gravity" of the individual's interest in the outcome of the commitment proceeding),⁸³ it was also clear that the Court was willing (almost eager) under certain circumstances (for example, the commitment of juveniles by their parents) to give far greater discretion to psychiatric judgments than one might have thought from its earlier *Jackson* and *O'Connor* opinions.⁸⁴ The Chief Justice's caustic (and misguided) characterization of commitment hearings as "time-consuming procedural minuets"⁸⁵ indicated that, for the mental health advocate, the halcyon days of the early seventies were perhaps over.

C. The Supreme Court of 1982

For the third phase—"moment" might be more accurate than "phase," since I am referring to about two weeks in late June of 1982—let's turn to the spectacle of rock'n'roll "oldies" revivals: singers and groups whose biggest hits are a decade or two behind them, attempting to "turn back the hands of time" and give an expectant audience (willing to suspend disbelief) the illusion of *status quo ante*. Here, in *Youngberg v. Romeo*,⁸⁶ *Mills v. Rogers*,⁸⁷ and their seeming *doppelgangers* (*Plante v. Scott*,⁸⁸ and *Rennie v. Klein*⁸⁹), the Court appeared to be breaking new ground on several fronts: (1) in setting out for the first time in *Youngberg* some substantive treatment rights possessed by the institutionally mentally handicapped to adequate food, shelter, clothing, medical care, safety, freedom from bodily restraint and such minimally adequate or reasonable

80. 442 U.S. 584 (1979).

81. 445 U.S. 480 (1980).

82. See *id.* at 488-92.

83. *Addington*, 441 U.S. at 427.

84. See *Parham*, 442 U.S. at 607-08. The Court stated: "The mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case." *Id.*

85. *Id.* at 605.

86. 457 U.S. 307 (1982).

87. 457 U.S. 291 (1982).

88. 458 U.S. 1101 (1982).

89. 458 U.S. 1119 (1982).

training to ensure safety and freedom from undue restraint;⁹⁰ and (2) by appearing in *Mills* to be at least comfortable with both the notion of the constitutional underpinnings of the right to refuse treatment⁹¹ and the importance of evaluating a drug's potential side effects in calibrating a constitutional calculus.⁹² Nevertheless, there is more than a bit of a *trompe l'oeil* effect at play here: in *Youngberg*, the defendants had conceded most of the rights⁹³ (no doubt in a successful effort at loss-cutting), while the Court had previously recognized the other rights in prison conditions cases,⁹⁴ and simply extended these cases to the "easier" fact setting of mental retardation facilities. Also, while the right-to-refuse foundation of *Mills* was novel, the Court's decision *not* to reach the merits (but rather to certify the case *back* to the First Circuit in light of an intervening Massachusetts *state* court case⁹⁵) tends to give a hollow tone to much of the opinion's precatory language. Similarly, the Court's decision merely to vacate and remand *Scott*⁹⁶ and *Rennie*⁹⁷ in light of *Youngberg* seems to reflect a bit of its exhaustion (or at least mild ennui) with the once novel notion of patients' rights.

D. Response of Lower Courts

Other courts, however, have not been quite so exhausted. In the three years since *Youngberg* was decided, other federal courts have expressed a clear willingness to interpret this case expansively on the question of adequacy of medical care,⁹⁸ propriety of appointing a special master to oversee court decree monitoring,⁹⁹ and the court's power to order reduction of a specific institutional population.¹⁰⁰

90. See *Youngberg*, 457 U.S. at 315-19.

91. See *Mills*, 457 U.S. at 298-99.

92. See *id.* at 293 n.1.

93. See *Youngberg*, 457 U.S. at 315 ("[s]tate concedes that respondent has a right to adequate food, shelter, clothing, and medical care").

94. See *id.* at 315-16 (citing, *inter alia*, *Hutto v. Finney*, 437 U.S. 678 (1978) (right to safe conditions); *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18 (1979) (right to freedom from bodily restraint) (Powell, J., concurring and dissenting in part)).

95. See *In re Roe*, III, 383 Mass. 415, 421 N.E.2d 40 (1981) (person has protected liberty interest in refusing treatment involving antipsychotic drug).

96. 458 U.S. at 1101.

97. 458 U.S. at 1119.

98. See *Lombard v. Eunice Kennedy Shriver Center for Mental Retardation*, 556 F. Supp. 677, 678-679 (D. Mass. 1983).

99. See *New York State Ass'n for Retarded Children v. Carey*, 706 F.2d 956, 962-65 (2d Cir. 1983).

100. See *Association for Retarded Citizens v. Olson*, 713 F.2d 1384, 1391-92 (8th Cir. 1983).

Most important, in the Second Circuit case of *Society for Good Will to Retarded Children v. Cuomo*,¹⁰¹ the court specifically adopted the position suggested by Justice Blackmun's concurrence in *Youngberg*—that, in addition to the rights articulated in the majority's opinion, the institutionalized also have a "due process right to training sufficient to prevent basic self-care skills from deteriorating,"¹⁰² regardless of whether the residents are characterized as "voluntary" or "involuntary."¹⁰³

In the area of right to refuse treatment, lower courts have continued to follow the dictates of *Rennie* and *Mills*,¹⁰⁴ and at least one circuit¹⁰⁵ has adhered to that earlier aspect of *Rennie* that had mandated a "least restrictive alternative" analysis in dealing with drugging questions,¹⁰⁶ even *after* the Supreme Court had declined to apply that analysis to *treatment* issues in *Youngberg*. In short, the heart of the mental disability law is still beating.

E. Other Supreme Court Decisions

Having said all of this, I want to devote a few minutes to those categories of Supreme Court cases that I have intentionally (and arbitrarily) excluded from this overview: statutory cases, criminal cases, and jurisdictional cases. Briefly, the Court has indicated a willingness to scrutinize the meaning and the implications of Section 504 of the Rehabilitation Act of 1973¹⁰⁷ (arguably the most important

101. 737 F.2d 1239 (2d Cir. 1984).

102. *Id.* at 1250.

103. *Id.* Since the date of this speech, courts have split sharply on the question of the right to community treatment following *Youngberg*. Compare *Clark v. Cohen*, 794 F.2d 79 (3d Cir.) (applying the right), *cert. denied*, 55 U.S.L.W. 3358 (1986) and *Thomas S. v. Morrow*, 781 F.2d 367 (4th Cir.) (same), *cert. denied*, 106 S. Ct. 1992 (1986) with *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239 (2d Cir. 1984) (refusing to apply the right) and *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983) (same).

104. See, e.g., *Project Release v. Prevost*, 722 F.2d 960, 977-81 (2d Cir. 1983) (involuntarily committed patients have right under New York State law to refuse medication).

105. See *Bee v. Greaves*, 744 F.2d 1387, 1396 n.7 (10th Cir. 1984) (distinguishing case at bar from *Youngberg v. Romeo*, 457 U.S. 307 (1982), in which Court declined to apply "less intrusive means" analysis), *cert. denied*, 469 U.S. 1214 (1985).

106. *Rennie v. Klein*, 653 F.2d 836, 847 (3d Cir. 1981) ("at least thirty-five jurisdictions explicitly or implicitly acknowledge the least restrictive doctrine"). This aspect of the opinion was deleted following the Supreme Court's remand in light of *Youngberg*. See *Rennie*, 720 F.2d at 269-70 (on remand).

107. 29 U.S.C. § 794 (1982). This section states:

No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation

statute yet enacted to combat discrimination against the mentally and physically handicapped), and the Education of the Handicapped Act,¹⁰⁸ but a reluctance to delve into the nuances of the Developmental Disabilities Act¹⁰⁹ (after its initial 1981 decision in *Pennhurst State School & Hospital v. Halderman (Pennhurst I)*¹¹⁰ that the Act merely expressed a congressional "preference" for a certain kind of treatment¹¹¹ rather than a mandate requiring the states to provide " 'appropriate treatment' in the 'least restrictive environment' ").¹¹²

In the area of mental health issues in a criminal law setting, the Supreme Court's behavior has been, excuse the expression, maddening. First, it dealt severe blows to insanity acquittees and defendants facing the death penalty by holding: (1) in *Jones v. United States*¹¹³ that, when a criminal defendant establishes that he is not guilty by reason of insanity, he may be constitutionally confined to a mental institution on the basis of a burden of proof lesser than that needed to sustain the commitment of civil patients;¹¹⁴ and (2)

in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.

Id.

The Supreme Court reviewed this statute in *Alexander v. Choate*, 469 U.S. 287 (1985) (Section 504 of Rehabilitation Act of 1973 (29 U.S.C. § 794 (1982)) does not include claims in which state reduced from 20 to 14 the number of annual inpatient hospital days that state medicaid would cover on behalf of medicaid recipient).

108. 20 U.S.C. §§ 1400-1461 (1982 & Supp. III 1985). Section 1400(c) provides:

It is the purpose of this chapter to assure that all handicapped children have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs, to assure that the rights of handicapped children and their parents or guardians are protected, to assist States and localities to provide for the education of all handicapped children, and to assess and assure the effectiveness of efforts to educate handicapped children.

Id. § 1400(c) (1982).

The Court scrutinized this statute in *Irving Indep. School Dist. v. Tatro*, 468 U.S. 883, 890-91 (1984) (clean intermittent catheterization procedure necessary for handicapped 8-year-old girl to avoid injury to kidneys is "related service" under the Education of the Handicapped Act; thus school receiving federal funds under Act must provide service).

109. 42 U.S.C. §§ 6000-6083 (1982 & Supp. III 1985). See *supra* note 42 for the congressional declaration of purpose of this Act.

110. 451 U.S. 1 (1981).

111. *Id.* at 19.

112. *Id.* at 18 (quoting *Halderman v. Pennhurst State School & Hosp.*, 612 F.2d 84, 107 (3d Cir. 1979) (lower court proceeding)).

113. 463 U.S. 354 (1983).

114. *Id.* at 366-68.

in *Barefoot v. Estelle*¹¹⁵ that it is permissible at a death penalty hearing for a psychiatrist to testify about a defendant's probable "future dangerousness" in response to a hypothetical question even when that psychiatrist never examined the defendant.¹¹⁶ Then the Court came back in *Ake v. Oklahoma*¹¹⁷ to hold that when a defendant has made a preliminary showing that his sanity at the time of the offense is likely to be a significant factor at trial, he is constitutionally required to have access to psychiatric assistance on this issue.¹¹⁸

This change of form in mid-stride is all the more remarkable when one considers the depth of the split—on the issues of: (1) psychiatric ability to predict dangerousness; and (2) the degree of deference to be paid to psychiatric judgments—between the majority opinions and the dissents in both *Jones* and *Barefoot*.¹¹⁹ In less than two year's time, the Court *philosophically* reversed itself, and adopted the position urged by a coalition of mental health advocates and mental health professionals (most notably the APA)—bedfellows that seem now to couple on most criminal law issues but on few (if any) civil matters—that, without an independent defense witness, "the risk of an inaccurate resolution of sanity issues is extremely high."¹²⁰ In short, the only trend to discern here is that the pattern of case developments appears to defy trend setting.

I have left, though, the most important development for last: the Court's monumental decision of January, 1984 in *Pennhurst State School & Hospital v. Halderman (Pennhurst II)*,¹²¹ holding that the eleventh amendment bars the granting of relief against a state official

115. 463 U.S. 880 (1983).

116. *Id.* at 903-04.

117. 470 U.S. 68 (1985).

118. See *id.* at 76-85. On the question of the relationship between *Barefoot* and *Ake*, see Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, Psychiatric Testimony in Death Penalty Cases, and the Power of Symbolism: Dulling the Ake in Barefoot's Achilles Heel*, 3 N.Y.L. SCH. HUM. RTS. ANN. 91 (1985). On the Supreme Court's jurisprudence in cases involving mentally disabled criminal defendants in general, see Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, and Symbolic Values: Random Decisions, Hidden Rationales, or "Doctrinal Abyss"?*, 29 ARIZ. L. REV. — (1987) (in print).

119. Compare *Barefoot*, 463 U.S. at 896 (majority opinion) ("[t]he suggestion that no psychiatrist's testimony may be presented with respect to a defendant's future dangerousness is somewhat like asking us to disinvent the wheel") with *id.* at 916 (Blackmun, J., dissenting) ("[t]he Court holds that psychiatric testimony about a defendant's future dangerousness is admissible, despite the fact that such testimony is wrong two times out of three").

120. *Ake*, 470 U.S. at 82.

121. 465 U.S. 89 (1984).

on the basis of state law.¹²² The Court stated that to hold otherwise would not "vindicate the supreme authority of federal law."¹²³ The eleventh amendment bar would be inapplicable only when: (1) a plaintiff sought monetary damages against a defendant in his individual capacity; or (2) a defendant acted " 'without any authority whatever.' "¹²⁴ The bitterly split five-four decision prompted a searing dissent by Justice Stevens, who characterized the majority as having reached a "perverse result"¹²⁵ via a "voyage into the sea of undisciplined lawmaking."¹²⁶

While the commentators have just begun to come to grips with the enormity of this decision,¹²⁷ it is clear that the *Pennhurst* case will have an incalculable effect on the future of mental health advocacy far beyond the specific legal issue at its heart: whether patients at that facility have a right to be deinstitutionalized in the least restrictive alternative environment (an issue, ironically, upon which the case was ultimately settled for almost the precise terms sought by plaintiffs when the case was filed during the early days of Gerald Ford's Presidency).¹²⁸

As a result of *Pennhurst*, mental health advocates (and other lawyers representing institutionalized and incapacitated individuals) will turn their attention more and more to state court as a preferred forum.¹²⁹ In doing so, they will replicate the strategy choices of *other* public interest lawyers representing clients in zoning, health care, discrimination, and similar matters, who, for the last decade, have been regularly beating a path to the state courthouse door,

122. *See id.* at 97-124.

123. *Id.* at 106.

124. *Id.* at 101 n.11 (quoting *Florida Dep't of State v. Treasure Salvors, Inc.*, 458 U.S. 670, 697 (1982) (opinion of Stevens, J.)).

125. *Id.* at 127 (Stevens, J., dissenting) (Court's "new pronouncement will require the federal courts to decide federal constitutional questions despite the availability of state-law grounds for decision, a result inimical to sound principles of judicial restraint").

126. *Id.* at 166 (Stevens, J., dissenting).

127. *See, e.g.,* Shapiro, *Wrong Turns: The Eleventh Amendment and the Pennhurst Case*, 98 HARV. L. REV. 61 (1984) (assessing impact of recent Supreme Court decisions on eleventh amendment).

128. *See Halderman v. Pennhurst State School & Hosp.*, 610 F. Supp. 1221 (E.D. Pa. 1985). *See supra* note 103 for a discussion of the split in circuits in applying the right to treatment to community settings.

129. *See, e.g.,* *State v. Fields*, 77 N.J. 282, 390 A.2d 574 (1978) (addressing question of entitlement to automatic periodical judicial review of validity of restraints placed upon persons found not guilty by reason of insanity and subsequently committed); *State v. Krol*, 68 N.J. 236, 344 A.2d 289 (1975) (establishing minimal constitutional requirements that must be met before defendant acquitted on grounds of insanity may be committed).

seeking relief in a wide variety of public law areas, recognizing that state constitutions may provide a higher level of protection of personal rights than those guaranteed by the federal counterpart.¹³⁰

This phenomenon is, of course, no secret. Interestingly, it received its biggest philosophical and tactical boost about eight years ago from United States Supreme Court Justice William Brennan. In an often-cited article in the *Harvard Law Review*,¹³¹ Brennan laid down the gauntlet: "The legal revolution which has brought federal law to the fore must not be allowed to inhibit the independent protective force of state law—for without it, the full realization of our liberties cannot be guaranteed."¹³²

While, at first, mental disability advocates did not appear to pay too much attention to Justice Brennan, more recent events, such as the *Pennhurst* opinion, have caused them to sit up and take notice. Some courts—notably New Jersey's¹³³ and New York's¹³⁴—have responded nobly and have shown a willingness to interpret both state statutes and state constitutions in ways that make it clear that the "equal access to justice"¹³⁵ sought by the handicapped can, indeed,

130. See, e.g., *Oregon v. Kennedy*, 456 U.S. 667, 668-69 (1982) (Oregon Court of Appeals "took an overly expansive view of the application of the Double Jeopardy Clause following a mistrial resulting from the defendant's own motion"); *Pruneyard Shopping Center v. Robins*, 447 U.S. 74, 88 (1980) ("neither appellants' federally recognized property rights nor their First Amendment rights have been infringed by the California Supreme Court's decision recognizing a right of appellees to exercise state-protected rights of expression and petition on appellants' property"). On the specific applicability of state constitutional provisions to the rights of the mentally disabled, see Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 *LOYOLA L.A.L. REV.* 1249 (1987).

131. Brennan, *State Constitutions and the Protection of Individual Rights*, 90 *HARV. L. REV.* 489 (1977).

132. *Id.* at 491.

133. See, e.g., *In re S.L.*, 94 N.J. 128, 139-40, 462 A.2d 1252, 1258 (1983) (although patients in mental hospitals were no longer committable, they were incapable of survival on their own; thus state may continue confinement "on a provisional or conditional basis to protect their essential well-being, pending efforts to foster the placement of these individuals in proper supportive settings outside the institution").

134. See, e.g., *Klostermann v. Cuomo*, 61 N.Y.2d 525, 531-34, 463 N.E.2d 588, 591-92, 475 N.Y.S.2d 247, 250-51 (1984) (question of whether discharged patients "are entitled to appropriate residential placement, supervision, and care, including follow-ups to verify that their placement remains appropriate" is justiciable controversy, contrary to lower courts' rulings that controversy was not justiciable "because it would require the court to oversee a long series of continuous acts . . . [and] the relevant statutory duty involves the exercise of judgment and discretion").

135. S. HERR, *ADVOCACY UNDER THE DEVELOPMENTAL DISABILITIES ACT 88* (1976) (quoted in 4 *TASK PANEL REPORTS*, *supra* note 52, at 1366 n.1).

become a reality in the state court arena. The recent decisions of New Jersey's and New York's highest courts on behalf of the "discharged pending placement"—patients who no longer meet the criteria for commitment but who have "nowhere else to go"¹³⁶—bear eloquent testimony to this new reality. It is inevitable that other courts will follow.

IV. Conclusion

At least five separate (but somewhat overlapping) trends appear to be present.

First, the Supreme Court is excruciatingly ambivalent about mental disability law issues: on the one hand, it discusses the imprecision of psychiatric diagnosis;¹³⁷ on the other, it allows the admission into evidence of the most wildly speculative testimony as to predictions of future dangerousness.¹³⁸ On one hand, it acknowledges the brutal conditions still prevalent in so many public mental institutions;¹³⁹ on the other, it raises procedural roadblocks so as to curtail the use of the federal court forum as an arena in which institutionalized citizens can vindicate their constitutional rights.¹⁴⁰ And while on one hand it characterizes due process hearings as "time-consuming procedural minuets,"¹⁴¹ on the other, it continues to adhere to the notion that procedural due process applies to all matters touching on the entire commitment process.¹⁴²

Beyond these ambivalences, the Court remains fascinated with the whole notion of mental disability law: like the moth drawn to the flame, it continues to grant *certiorari* so as to grapple with yet-

136. See *supra* notes 133-34 and accompanying text.

137. See *Addington v. Texas*, 441 U.S. 418, 429 (1979) ("[g]iven the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous").

138. See *Barefoot v. Estelle*, 463 U.S. 880, 903-04 (1983). See *supra* notes 115-16 and accompanying text for a discussion of the Court's holding.

139. See *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 7 (1981) ("[district court's] findings of facts are undisputed: Conditions at Pennhurst are not only dangerous, with the residents often physically abused or drugged by staff members, but also inadequate for the 'habilitation' of the retarded").

140. See *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89 (1984). See *supra* notes 121-26 and accompanying text for a discussion of the Court's holding.

141. *Parham v. J.R.*, 442 U.S. 584, 605 (1979).

142. See *Jones v. United States*, 463 U.S. 354, 361 (1983) (" 'commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection' ") (quoting *Addington v. Texas*, 441 U.S. 418, 425 (1979)).

unanswered questions. It has already decided the *Ake* case on the question of a defendant's right to an independent expert to proffer an insanity defense;¹⁴³ within the next month, it is expected to decide the constitutionality of a municipal ordinance that "zones out" group homes for the mentally disabled¹⁴⁴ and the implications of the eleventh amendment—the heart of its most recent *Pennhurst II* decision—for law suits filed under section 504 of the Rehabilitation Act.¹⁴⁵ In short, we can expect even more ambiguity in the future.

Writing last year in *The American Journal of Psychiatry*, Paul Appelbaum charged that these ambivalences reflected nothing more than "factual inconsistency in the service of a transcendent ideological goal,"¹⁴⁶ the "limit[ation on] judicial involvement in institutional affairs."¹⁴⁷ While Appelbaum may well be right, my sense is that the Court's ambivalence is deeper, and is at least partially caused by the Justices' ambivalent (but familiar) feelings of awe, fear, and revulsion towards the mentally handicapped, towards the facilities

143. See *supra* notes 117-18 and accompanying text.

144. See *Cleburne Living Centers v. City of Cleburne*, 726 F.2d 191 (5th Cir.), cert. granted, 469 U.S. 1016 (1984).

After this speech was given, the Supreme Court affirmed the Fifth Circuit's judgment insofar as it held that a special use permit for the construction of a group home for the mentally retarded was invalid. See *City of Cleburne v. Cleburne Living Centers*, 105 S. Ct. 3249, 3258-60 (1985). While recognizing that the "mentally retarded as a group are indeed different from others not sharing their misfortune," *id.* at 3259, the Court also noted that "this difference is largely irrelevant unless the [group] home and those who would occupy it would threaten legitimate interests of the city in a way that other permitted uses such as boarding houses and hospitals would not." *Id.* The Court found that the group home would not threaten the city's legitimate interests. See *id.*

145. See *Scanlon v. Atascadero State Hosp.*, 735 F.2d 359 (9th Cir. 1984), cert. granted, 469 U.S. 1095 (1984).

After the date of this speech, the Supreme Court reversed the Ninth Circuit's holding that a state implicitly consents to be sued when it receives funds under the Rehabilitation Act of 1973. See *Atascadero*, 105 S. Ct. 3142, 3147-50 (1985). In reversing, the Court stated that "Congress may abrogate the States' constitutionally secured immunity from suit in federal court only by making its intention unmistakably clear in the language of the statute. The fundamental nature of the interests implicated by the Eleventh Amendment dictates this conclusion." *Id.* at 3147. The Court concluded that there was not "unequivocal statutory language sufficient to abrogate the Eleventh Amendment." *Id.* at 3149.

This decision has been legislatively "overruled" by the Rehabilitation Act Amendments of 1986, P.L. 99-506, § 1003(a)(1), 100 Stat. 4532, 4570 ("[a] State shall not be immune under the Eleventh Amendment of the Constitution of the United States from suit in Federal court for a violation of section 504 of the Rehabilitation Act of 1973").

146. Appelbaum, *The Supreme Court Looks at Psychiatry*, 141 AM. J. PSYCHIATRY 827, 831 (1984).

147. *Id.* at 834.

in which the institutionalized mentally handicapped live, and especially towards the mentally ill who commit what would otherwise be "criminal acts." Whether or not C.G. Schoenfeld is correct when he suggests that "one of the main unconscious reasons for punishing criminals—assuaging the guilt of law-abiding persons—does not come into play [in the way we treat the criminally insane],"¹⁴⁸ it seems to me that the Justices of the Supreme Court have just as difficult a time rationalizing their unconscious feelings as do the rest of us.

Second, in response to all of this, the federal district courts and circuit courts appear generally reluctant to "roll over and play dead." In the areas of both the right to treatment and the right to refuse treatment, at least some circuits have shown a willingness to go beyond the more narrow limits of *Youngberg* and *Mills* by building a definition of minimally acceptable treatment,¹⁴⁹ by selectively applying right to treatment concepts to community settings,¹⁵⁰ and by resuscitating the notion of the "least restrictive alternative" in treatment refusal decisions.¹⁵¹

Third, because of jurisdictional decisions such as *Pennhurst*, mental health advocates will be turning to state courts with greater frequency, especially in areas such as the right to community aftercare, in which the Supreme Court has appeared to be particularly unsympathetic. This new interest in state courts appears to me to be a major growth area for all aspects of public interest law¹⁵² in the future, and I think mental disability cases will be riding the crest of the wave.

Fourth, both state legislatures and Congress have firmly placed the whole spectrum of legal issues affecting the mentally disabled on their debating agendas over the past decade. Thus, we can reasonably expect newer and more comprehensive regulatory statutes to emerge over the coming years (although, most likely, without much in the way of supplemental funds).

148. C.G. SCHOENFELD, *PSYCHOANALYSIS APPLIED TO THE LAW* 32 (1984).

149. See *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239 (2d Cir. 1984). See *supra* notes 101-03 and accompanying text for a discussion of the court's holding.

150. See *supra* note 103 and accompanying text.

151. See *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985); *supra* note 105 and accompanying text.

152. Cf. *State v. Gilmore*, 199 N.J. Super. 389, 396-97, 489 A.2d 1175, 1179 (App. Div. 1985) ("[w]hile the United States Constitution remains the primary source of fundamental rights, it is now well established that we may look to our State Constitution to provide a higher level of protection of personal rights than those guaranteed by the federal constitution"), *aff'd*, 103 N.J. 508, 511 A.2d 1150 (1986).

Finally, the past decade has made it clear that there are more "players in the game" besides the attorneys involved. Professional associations, including, but not limited to, the American Psychiatric Association, and ex-patient groups, have made it clear that *they* have an important stake in the outcome of the various court cases, and that they do not plan to sit passively by while the lawyers argue over abstract notions of due process.

While this survey has been, alas, cursory, I think it underscores the one point I want to make: the notion of mental disability law as an important and discrete legal specialty is an idea that is being taken seriously by the United States Supreme Court, by the federal and state courts, by legislatures, and by all participants in the mental health process. It is an area marked by considerable and rapid change and peppered with internal ambivalences. The showman Billy Rose used to say: "Say what you want about me, but be sure you spell my name right." I do not think there is any question that over the last decade, we have all learned how to spell.

