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Psychiatry and Law

The United States Supreme Court and Mental Health Law

A Retrospective

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Until 1972, the United States Supreme Court had paid scant attention to cases dealing with the legal rights of mentally handicapped persons. Due in large measure to the few lawyers available to represent such persons, cases involving their procedural and substantive rights rarely even appeared on the Court's docket.

After specialized programs were created, employing trained, skilled counsel retained exclusively to represent the mentally ill [1], and after the Court ruled in a 1972 criminal case that the "nature and duration of commitment [must] bear a reasonable relationship to the purpose for which the individual is committed" [2], the Court began to look more seriously at the constitutional contours of civil mental health law in at least three major subject matter areas: involuntary civil commitment; the right to treatment; and the right to refuse treatment. These rulings are of great importance to the full range of mental health practitioners; the cases' *impact* on their practice – especially in any institutional setting – cannot be overstated.

Basically, the guiding principles governing this area of the law are actually quite clear: courts will "take cognizance of valid constitutional claims whether arising in federal or state institutions" [3], and, in the specific context of mental hospitals, "where 'treatment' is the sole asserted ground of depriving a person of liberty, it is plainly unacceptable to suggest that courts are powerless to determine whether the asserted ground is present" [4]. This is so because "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection" [5]. This backdrop has been strengthened by more recent court decisions indicating that the United States Supreme Court will weigh treatment issues [6] and, at the least, will not reject out of hand the notion that the right to refuse treatment is a matter for court consideration [7]. An examination of each of the subject areas referred to above reflects how the Court has chosen to implement these guiding principles.

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Involuntary Civil Commitment

The first issue to be considered is the standard for involuntary hospitalization: under what circumstances may the state hospitalize a person against that person's will? In *O'Connor v. Donaldson* [8], the Court held that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends" [9], declaring the existence of a "constitutional right to freedom" [10]. In the body of its opinion, the Court asked rhetorically:

May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty [11].

Subsequently, state courts have held that "dangerous conduct is not identical with criminal conduct" [12], and that dangerous conduct "involves not merely violation of social norms enforced by criminal sanctions, but significant physical or psychological injury to persons or substantial destruction of property" [13]; it is also a given that "a risk of future conduct which is merely socially undesirable" [14] is not a sufficient basis upon which to order commitment [15].

Following its *O'Connor* decision, the Supreme Court subsequently turned its attention to the substance of the civil commitment hearing itself, deciding cases on the diverse questions of burden of proof, "voluntary" commitments of minors, and procedural rights at a penal facility-hospital transfer hearing. On the question of burden of proof, the court ruled that the appropriate standard was "equal to or greater than the 'clear and convincing' standard [of evidence]" [16], an echo of earlier state court decisions:

The burden should not be placed on the civilly committed patient to justify his right to liberty. Freedom from involuntary confinement for those who have committed no crime is the natural state of individuals in this country [17].

In the juvenile case, although the Court rejected the notion that minors were entitled to the same panoply of due process protections as were adults [18], it ruled that (a) the risk of error inherent in parental decision making as to institutionalization was great enough to mandate an independent inquiry by a "neutral factfinder," (b) the informal inquiry must "carefully probe the child's background using all available services," (c) the decision-maker could refuse to admit a child not meeting medical admission standards, and (d) need for continued commitment must be periodically reviewed by an independent procedure [19].

Finally, in a case involving the transfer of a convicted felon to a mental hospital, the Court substantially affirmed the decision of a district court judge ruling that procedural due process protections applied [20], holding that even a *prisoner* had a protected liberty interest implicated by a prison-hospital transfer; even though his freedom was obviously curtailed in the prison, he still retained a "residuum of liberty" [21] which would be infringed upon by such a transfer. The loss of liberty involved more than merely "a loss of freedom from confinement" [22]; the patient's potential exposure to "compelled treatment in the form of

mandatory behavior modification programs” [23] was a “major change in the conditions of confinement amounting to a grievous loss” [24] to the inmate.

Noted the court:

Were an ordinary citizen to be subjected involuntarily to these consequences, it is undeniable that protected liberty interests would be unconstitutionally infringed absent compliance with the procedures required by the due process clause. We conclude that a convicted felon also is entitled to the benefit of procedures appropriate in the circumstances before he is found to have a mental disease and transferred to a mental hospital [25].

The Court thus has made it clear that procedural due process protections apply to all aspects of the civil commitment hearing, and that it will carefully scrutinize the cases before it in order to ascertain whether the specific fact setting (*e.g.* juvenile, prison transers) causes it to modify its basic holdings. It is clearly comfortable with the due process model [26]; there should be no expectation that this will be drastically modified in the near future.

Right to Treatment

The right to treatment was first constitutionally articulated in the historic Alabama case of *Wyatt v. Stickney* [27], where the court ruled that involuntary committed patients had a constitutional right to receive such treatment as would give them a reasonable opportunity to be cured or to improve their condition [28]. To fulfill this right, there need be (1) a humane physical and psychological environment, (2) qualified staff personnel in sufficient numbers, and (3) individualized treatment plans for each patient [29]; to further *these* standards, detailed environmental standards were established, ranging in subject matter from the global to the specific [30]. The right to treatment was seen as coming within the due process clause; the promise of treatment would provide the necessary “reasonable relationship” [31] to the purpose of commitment to satisfy that purpose [32]. It was not until 1982, however – a full decade after the first *Wyatt* decisions – that the Supreme Court decided it would hear a right to treatment appeal [33].

There, in *Youngberg v. Romeo*, a damages case involving a *mentally retarded* resident of a state school who alleged violation of his constitutional right to protection from harm (after being injured seriously more than 60 times) [34], the Court ruled that such persons have substantive constitutional rights to “adequate food, shelter, clothing and medical care” [35], to “personal security” [36], to “freedom from bodily restraint” [37], and to minimally adequate or reasonable training to ensure safety and freedom from undue restraint” [38]. In determining whether a patient’s training was “reasonable” the court imposed the following standard:

[L]iability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible did not base the decision on such a judgment [39].

The plaintiff in this case enjoyed, the court concluded, “constitutionally protected interests in conditions of reasonable care and safety, reasonably non-restrictive confinement conditions and such training as may be required by these interests” [40].

The case leaves open many questions: how would the court rule in a case (unlike this one, where only *limited* relief was sought) which raised the question of a broad *per se* right to treatment? Is a mental patient entitled to broader or narrower rights (or the *same* rights) than a mentally retarded person? What will the impact on practice of the new liability standard be? How would the court rule in a case in which money damages had not been raised? Although the answers to these questions are not clear, it is significant that the Court did issue an affirmative statement on the right to treatment; it can be expected that future decisions will build on the *Youngberg* case.

Right to Refuse Treatment

The area of the right to refuse treatment is often seen as the cutting edge of the relationship between mental health professions and the law. It encompasses virtually all other patients' rights and raises the most persistent and macrocosmic questions as to the extent of *control* which can be exerted by a treater over a person who may not wish to participate in the treatment process in question. Its resolution may well sketch the further contours of *all* relationships between patients and mental health professionals, especially in hospital settings.

Two recent cases have set the stage for the legal debate on the extent of the right. In the first, *Rennie v. Klein* [41], the Federal Third Circuit Court of Appeals substantially affirmed a district court decision from New Jersey, holding that involuntary patients retain the constitutional right to refuse the administration of antipsychotic drugs that may have permanently disabling side effects [42]. In making this finding, the court cited "dramatic" evidence in the record that "the risk of serious side effects stemming from the administration of antipsychotic drugs is a critical factor in our determination that a liberty interest is infringed by forced medication" [43]. To vindicate this right, compliance with informal requirements of a state administrative policy – calling for treatment team consultations with outside psychiatrists – were sufficient [44]; more stringent protections (such as formal hearings) were not mandated. The other case, *Rogers v. Okin* [45], had also held that patients had a constitutionally protected interest in being left free by the state to decide whether to submit to "serious and potentially harmful medical treatment represented by the administration of antipsychotic drugs" [46].

In both cases, the Supreme Court was asked to take the matter on appeal. It immediately granted *certiorari* in *Rogers*, and subsequently issued its decision, *sidestepping* the constitutional questions and *remanding* the case to the First Circuit Court of Appeals for *that* court to consider the impact of an intervening Massachusetts *state* court decision [47]. *That* case had held that a non-institutionalized but mentally incompetent person *did* have the right to assert his right to refuse treatment with antipsychotic drugs at a judicial hearing, a decision based strongly on state common law [48].

However, in the course of its opinion, the Supreme Court noted that all parties agreed that "the Constitution recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs" [49]. With this as a baseline, the court underscored a major principle of constitutional litigation: a state is free,

under its *own* constitution or common law, to create liberty or due process interests *broader* than those mandated under the federal constitution [50]. It thus remanded the case for reconsideration. Finally, just a week after the court issued this decision, it granted *certiorari* in *Rennie*, the New Jersey case, and immediately remanded it for reconsideration in light of its decision in *Youngberg*, the right to treatment case [51].

Again, there are unanswered questions: Is the court likely to ever take another right to refuse treatment case? If it does, how far will it go in finding a right? Does its allusion in a footnote in the Massachusetts case to the issue of the drugs' "significant risk of side effects" [52] give a sense that it will be sympathetic to patients' claims? However the court ultimately defines the right, how *much* procedural due process will be necessary to vindicate it? It will clearly be some time before these questions are all answered satisfactorily; until then, it is expected that this area of the law will remain in a severe state of flux. One thing, though, is certain; the court had the opportunity in *Rogers* to reject out of hand the notion of a constitutional right to refuse treatment; the fact that it did not do that – that it, in fact, assumed that such a right *did* exist – should give some sense to the idea that the court is comfortable, at the least, with the theoretical underpinnings of the right.

Conclusion

After nearly two centuries of inaction, the United States Supreme Court has acted in over a half-dozen cases dealing squarely with the constitutional rights of mental patients [53]. Although both plaintiffs and defendants could rightfully claim victory in several of the mitigated cases, in final analysis, it appears clear that the Court has chosen to take seriously the claims of mental patients that they are entitled to that "equal access to justice" [54] which other American citizens have traditionally taken for granted. As a result, the mentally disabled person can no longer be perceived as "... someone to whom attention need not be paid" [55]. The Supreme Court, to be sure, is paying attention.

Notes

1. See, eg, 4 App (1978) Task panel reports submitted to the President's commission on mental health 1359, 1367–1369
2. *Jackson v Indiana*, 406 US 715, 737 (1972)
3. *Procunier v Martinez*, 416 US 396, 405 (1974)
4. *O'Connor v Donaldson*, 422 US 563, 575, n 10 (1975)
5. *Addington v Texas*, 441 US 418, 425 (1979)
6. See, eg, *Youngberg v Romeo*, – US –, 102 S Ct 2452 (1982)
7. See, eg, *Mills v Rogers*, – US –, 102 S Ct 2442 (1982)
8. 422 US 563 (1975)
9. *Id* at 576
10. *Id*
11. *Id* at 575
12. *State v Krol*, 68 NJ 236, 259 (1975)
13. *Id*
14. *Id*

15. *See, eg, State v Fields*, 77 NJ 282 (1978); *Fasulo v Arafah*, 378 A 2d 553 (Conn Sup Ct 1977)
16. *Addington*, 441 US, above, at 433
17. *Fasulo*, 378 A 2d, above, at 557
18. *Parham*, 442 US, above, at 616–617
19. *Id* at 606–607
20. *Vitek v Jones*, 445 US 480, 488–492 (1980)
21. *Id* at 491
22. *Id* at 492
23. *Id*
24. *Id* quoting *Miller v Vitek*, 437 F Supp 569, 573 (D Neb 1977), remanded *sub nom Vitek v Jones*, 436 US 407 (1978)
25. *Id* at 492–493
26. *See, eg, Lessard v Schmidt*, 349 F Supp 1078 (ED Wis 1972), vacated on other procedural grounds 414 US 473 (1974), on remand 379 F Supp 1376 (ED Wis 1974), vacated and remanded on other grounds 421 US 957 (1975), reinstated 413 F Supp 1318 (ED Wis 1976); *French v Blackburn*, 428 F Supp 1351 (MD NC 1977), *aff'd* 443 US 901 (1979)
27. 325 F Supp 781 (MD Ala 1971), 334 F Supp 1341 (MD Ala 1971), 344 F Supp 373 (MD Ala 1972), 344 F Supp 387 (MD Ala 1972), *aff'd sub nom Wyatt v Aderholt*, 503 F 2d 1305 (5 Cir 1974)
28. *Id* 325 F Supp, above, at 784
29. *Id*, 334 F Supp, above, at 1343
30. *Id* 344 F Supp, above, at 379–386, 394–407
31. *Jackson*, above
32. *Wyatt*, 503 F 2d, above, at 1312–1314
33. *Youngberg*, above
34. *Id* at 2455
35. *Id* at 2458
36. *Id*
37. *Id*
38. *Id* at 2460
39. *Id* at 2462
40. *Id* at 2463
41. 653 F 2d 836 (3 Cir 1981), vacated and remanded – US –, 102 S Ct 3506 (1982)
42. *Id* at 843–845
43. *Id* at 843, n 8
44. *Id* at 848–851
45. 634 F 2d 650 (1 Cir 1980), vacated and remanded *sub nom Mills v Rogers*, – US –, 102 S Ct 2442 (1982)
46. *Id* at 653
47. *Mills*, 102 S Ct, above, at 2452
48. *See In re Roe III*, 412 NE 2d 40 (Mass Sup Jud Ct 1981)
49. *Mills*, 102 S Ct, above, at 2448
50. *Id* at 2449
51. *Rennie*, 102 S Ct, above
52. *Mills*, 102 S Ct, above, at 2445, n 1
53. This term the Court will again deal with *Pennhurst State School v Halderman*, 673 F 2d 643 (3 Cir 1982), cert granted – US –, 102 S Ct 2957 (1982), on the question of whether a state must make individualized determinations that community living arrangements or other less restrictive environments would not be suitable prior to commitment of mentally retarded patients to state schools. In an earlier phase of that litigation, the Supreme Court had held that the Federal Developmental Disabilities Bill of Rights Act did not give plaintiffs the broad relief they had sought. 451 US 1, 22–23 (1981)
54. Herr (1976) Advocacy under the developmental disabilities act 88
55. Wald (1976) Basic personal and civil rights. In: Kindred et al (eds) *The mentally retarded citizen and the law* (p 18). Free Press, New York, p 3