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“May You Stay Forever Young”: Robert Sadoff and the History of Mental Disability Law

Michael L. Perlin, JD

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I am honored to have been asked to participate in the symposium honoring Bob Sadoff. He has been one of my closest friends for over 30 years and has been an inspiration to me at every stage of my career. I was especially gratified that I was asked to speak about the history and development of mental disability law, in large part because of Bob’s (to a great extent, unknown) influence on that development. I hope that this article, based on my speech, helps to illuminate that influence and to make the connection explicit.

I was a rookie public defender in Trenton, New Jersey, in December 1971 when I first met Bob. He was, at the time, the immediate past-President of the American Academy for Psychiatry and the Law (AAPL). I was 25 and he was 35. He had agreed to serve as an expert witness in an insanity-defense case of mine, in which my client had stabbed his treating psychiatrist in the neck—a fact that had made many forensic witnesses reluctant to involve themselves in the case. After this initial experience, Bob became an unofficial advisor to me, and he was my first “go-to guy” when I needed to consult someone who could offer me wisdom about the global matters that involve the criminal trial process and defendants with serious mental disabilities.

Within months of my meeting Bob, the Supreme Court decided the case of *Jackson v. Indiana*,¹ in which it ruled that

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...[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed [Ref. 1, p 738],

and that

... a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future [Ref. 1, p 738].

By its decision, the Supreme Court in *Jackson*, per Justice Blackmun, created modern mental health law.

When I first read *Jackson*, I thought instantly of the clients I had been representing fruitlessly at the Vroom Building (New Jersey’s maximum security facility for the “criminally insane”)—individuals who had been institutionalized, some for 5, 10, or 15 years, without a hearing and without a trial. *Jackson* appeared to give me hope, but how to apply it?² How could I convince the bored trial judges who sat on these cases weekly to implement *Jackson*? Bob was in my office one day while I was mulling all this over, and he said to me (after I explained my frustration), “So, why don’t you file a class action?” What I have never told Bob before is that his suggestion set in motion a course of events that would eventually change the history of mental health law across the nation.

I listened to Bob and filed *Dixon v. Cabill* to implement *Jackson*, the first case in the nation to do so, and the mental health world literally changed. When the dust cleared, the court ruled that the indefinite incarceration of individuals in the Vroom Building violated *Jackson* and ordered individual hearings for

each inmate.³ This was in 1973, and we quickly discovered cases of individuals who had been awaiting trial since 1963, 1953, 1948, and, in one case, 1928!⁴ The courts ultimately found that 185 of our 225 clients were illegally detained (Bob testified in many of their remand cases over the next year or so), and *Dixon* received international publicity.

It also led New Jersey's Governor-elect, Brendan Byrne, to create, as part of the newly established New Jersey Department of the Public Advocate, a Division of Mental Health Advocacy, specifically empowered to represent individuals on all matters related to their commitment to, retention in, and release from psychiatric hospitals.⁵ An argument can be made that, with the creation of the New Jersey Division of Mental Health Advocacy, in an operational sense, modern mental health law was born. Certainly, there is no question that the Division of Mental Health Advocacy served as the impetus for the late Federal Mental Health Systems Act of 1980,⁶ the predecessor of the Protection and Advocacy for Mentally Ill Individuals Act of 2000, which insured the presence of some sort of legal services office for persons with mental disabilities in every state.⁷

Now, if that sounds a bit self-serving, I'm certainly willing to back off from that position a bit and say that there were several other "birth moments" of mental health law that must be considered. First, as already stated, was the decision in *Jackson*. Second, and perhaps equally important, was the decision in the Alabama case of *Wyatt v. Stickney*,⁸ both as it transformed institutional mental health law and how it reflected the courage of Federal District Court Judge Frank Johnson, who made it clear that, for the purposes of the due process clause, institutionalized persons with mental disabilities were simply human beings (Ref. 3, § 3A-3,1, at 25–6, n 161). Third was the influence—both through his legal opinions and his other writings—of Federal District Court Judge David Bazelon, who, it has been said, "invited the world of mental health professionals and criminologists into his courtroom" and "extended his courtroom back into the world."⁹ I will address all of these, but I am convinced that, when we look, not at the headlines and the hoopla, but at the lives of the tens and hundreds of thousands of unknown, faceless, nameless persons institutionalized because of mental illness, the sea of change that led to the creation of specialized and organized legal services offices em-

powered to represent such persons was the true birth of modern mental health law.

When I was a law student (in the late 1960s), the course in Psychiatry and the Law mostly covered the legal regulation of psychiatric practice. There was some discussion of *Baxstrom v. Herold*¹⁰ (the case in which the Supreme Court held as unconstitutional a New York statute that authorized, through administrative decision, the civil commitment of mentally ill, sentence-expiring convicts and their continued confinement in a maximum-security mental institution operated by the Department of Corrections without benefit of a jury trial) and some conversation about theoretical arguments to abolish the insanity defense.¹¹ By and large, though, the course was about how the law treats psychiatrists (on questions such as privilege and confidentiality, tort liability, and licensure). Once *Jackson v. Indiana* was decided, and once *Wyatt v. Stickney* was decided, and once mental health advocacy offices were created, something very different—something called "mental disability law"—was created. And that is the focus of this article.

There are an infinite number of ways in which we can categorize modern mental health law, but, for the purposes of this article, I am going to discuss these three broad categories: civil commitment, right to treatment, and right to refuse treatment. When we think about the categories that I have listed, there are two filters through which all of these developments must be read: the availability of adequate counsel and the availability of adequate expert assistance. For, just as I believe that none of modern mental health law could have developed as it has without the presence of organized, trained counsel, I also believe that none of it could have developed as it has without the collaboration and cooperation of forensic mental health professionals such as Bob Sadoff, whose fingerprints are on just about all the important litigation in this area.

Let me turn to the categories I have enumerated.

Involuntary Civil Commitment

The Supreme Court's first two modern mental health law decisions—*Jackson* in 1972 and *O'Connor v. Donaldson*¹² in 1975—and the federal district court case of *Lessard v. Schmidt*¹³ (first decided in 1971) established the template for all involuntary civil commitment law. First, as I have already indicated, *Jackson* incorporated the due process clause

into all commitment decision-making, by finding that the “nature and duration” of commitment were constitutionally bounded, which meant that both the substantive and procedural aspects of the commitment power had to be subjected to the constitutional lens. Especially important was the *Jackson* case’s “cue bid” to lawyers, urging them to bring more such cases to the Court. Justice Blackmun noted: “Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated (Ref. 1, p 737).

The importance of this announcement—that the courts were open and ready for more business—cannot be underestimated or overstated.

Next, the decision in *O’Connor*—finding a constitutional “right to liberty” of those who were not dangerous and “could survive safely in freedom”—made it clear that a “need-of-treatment” standard was not constitutionally permissible. And finally, the multi-textured *Lessard* decision—applying a dangerousness standard for commitment and establishing a panoply of procedural rights at the commitment hearing (including, but not limited to, the right to notice, the right to a statement of reasons precedent to commitment, the right to invoke the privilege against self-incrimination, and the applicability of the rules of evidence)—began to connect the dots in a way that is still, in most jurisdictions, good law today (Ref. 3, vol. 1, § 2A-4.4a, at 126–33 (2d ed. 1998)). Perhaps most important of all, the *Lessard* court constitutionalized the right to the “least restrictive alternative,” endorsing Judge Bazelon’s decision in *Lake v. Cameron* (364 F.2d 657 (D.C. Cir. 1966))¹⁴:

We believe that the person recommending full-time involuntary hospitalization must bear the burden of proving (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable. These alternatives include voluntary or court-ordered outpatient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services [Ref. 13, p 1096].

To a great extent, all individual decision-making in involuntary civil commitment cases flows from the invocation in *Lessard* of Judge Bazelon’s decision in *Lake*.¹⁵ And, although there did not appear to have been any forensic witnesses before the *Lessard* court, the court did rely heavily on the expertise of psychiatrists, quoting Dr. Sherman Kieffer, Director, National Center for Mental Health Services, Training

and Research, St. Elizabeth’s Hospital, Washington, D.C., who had recently testified before Congress that “most mental illness can be treated more effectively when detected and diagnosed early and properly, and when the positive relationships between the individual and his family, his job, and his community are not severed” (Ref. 13, p 1087 n 10).

The vast bulk of U.S. Supreme Court decisions in this area of the law in the past 30 years have dealt with what I call “special populations” (juveniles,¹⁶ prisoners,¹⁷ voluntary patients,¹⁸ persons with mental retardation,¹⁹ sexually violent predators^{20,21}), the one important exception being the Court’s 1979 decision in *Addington v. Texas*,²² establishing an intermediate “clear and convincing” evidence standard as the burden-of-proof quantum in commitment cases. *Addington* is historically important for several reasons:

- It reflects how the court truly sees commitment cases as different in important ways from both civil cases (which are basically just about money), and from criminal cases (which are inspired by a need to punish).
- It reflects the core value of the Burger Court (one that the Rehnquist Court has passively accepted): there may be a dispute about whether a person facing civil commitment is dangerous, but there is no question that any such person is, at the least, mentally ill (an assumption, by the way, that does not reflect the database of individual case law at all).
- It reflects the assumption—perhaps based on a fact not in evidence—that persons committed to mental hospitals get some sort of treatment that makes them ultimately more mentally healthy than they would have been had they not been institutionalized.²³

This snapshot is an incomplete one for many reasons: the Supreme Court has never decided an outpatient commitment case (and there is no *Lessard*-type case from the states or the intermediate federal courts that rises to a *Lessard*-type level on that important question), nor has it decided cases involving temporary or emergency commitments. Even more important, the central legal question in involuntary civil commitment that has never been considered by the Supreme Court (or by any other court in other than the most cursory and conclusory way) is the extent to which a patient’s invocation of his or her constitutional right to refuse treatment (more about

this later) can be used as evidence to support involuntary commitment (a dilemma that raises profound philosophical, constitutional, and social questions, but one that has completely evaded the Supreme Court's radar screen).²⁴

One final word on the commitment process. When I discuss this in lectures, I frequently get skeptical glances from audience members who are quick to tell me how the question of commitment is no longer important, and how, since hospital populations have plummeted, this was a problem that was fixed in the 1970s. Simply put, they are wrong. More than 227,000 individuals remain institutionalized in inpatient psychiatric hospitals, more than 5 million are admitted to such facilities each year, and thousands of involuntary civil commitment cases are still contested annually.²⁵ Moreover, there is great intra-jurisdictional disparity in the use of the process. By way of example, a recent survey found that, in Philadelphia County, 3,000 civil commitment hearings occur each year, while in Allegheny County 8,000 occur each year.²⁶

Granted, most of the individuals in question are institutionalized for days or weeks and not months or years (though there still are thousands of chronic patients who will, no doubt, spend the remainder of their days "behind the walls of Red Wing" (this is both an obscure allusion in a Bob Dylan song and a slightly less obscure Minnesota allusion).²⁷ This diminution of census is irrelevant to the mental health law question that has remained on the table since the *Jackson* decision in 1972: to what extent does the due process clause authentically and meaningfully apply to those facing commitment? This is a question that still has not been answered.

One final thought on this area of the law. Bob and I wrote an article together in 1982 entitled "Ethical Issues in the Representation of Individuals in the Commitment Process."²⁸ In it, we argued that there are matters of ethics that the lawyer and the expert witness must consider in the civil commitment process. Sometimes, things take a while to percolate. In 2001, in a thoughtful and scholarly opinion, *In the Matter of the Mental Health of K.G.F.*,²⁹ the Montana Supreme Court relied on state statutory and constitutional sources to find that:

. . . [T]he right to counsel. . . provides an individual subject to an involuntary commitment proceeding the right to effective assistance of counsel. In turn, this right affords the individual with

the right to raise the allegation of ineffective assistance of counsel in challenging a commitment order [Ref. 29, p 491].

In assessing what constitutes effectiveness, the court—startlingly, to my mind—eschewed the *Strickland v. Washington* standard³⁰ (used to assess effectiveness in criminal cases) as insufficiently protective of the "liberty interests of individuals such as K.G.F., who may or may not have broken any law, but who. . . must indefinitely bear the badge of inferiority of a once 'involuntarily committed' person with a proven mental disorder" (Ref. 29, p 491). The court, in an interesting conclusion, stated that "reasonable professional assistance" (Ref. 30, p 689)—the linchpin of criminal procedure decisions in this area of the law—"cannot be presumed in a proceeding that routinely accepts—and even requires—an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation" (Ref. 29, p 492).

In assessing the contours of effective assistance of counsel, the court emphasized that it was not limiting its inquiry to courtroom performance. Even more important was counsel's "failure to fully investigate and comprehend a patient's circumstances prior to an involuntary civil commitment hearing or trial, which may, in turn, lead to critical decision-making between counsel and client as to how best to proceed." Such prehearing matters, the court continued, "clearly involve effective preparation prior to a hearing or trial" (Ref. 29, p 492). The court further stressed state laws guaranteeing the patient's "dignity and personal integrity" (Ref. 29, p 493) and "privacy and dignity" as a basis for its decision. "[Q]uality counsel provides the most likely way—perhaps the only likely way—to ensure the due process protection of dignity and privacy interests in cases such as the one at bar" (Ref. 29, p 494).³¹

To bring this part of the discussion full circle, modern and mature mental health law could not have developed as it has had there not been forensic psychiatrists such as Bob Sadoff, taking seriously the role of the lawyer and the role of the expert at the individual civil commitment hearing.

The Right to Treatment

The second aspect of mental disability law I want to address is the right to treatment. Again, it traces its lineage to two cases: *Jackson* (recall the "nature. . . of commitment" line; Ref. 1, p 738) and *Wyatt v. Stick-*

ney, the first case to apply the U.S. Constitution to the conditions of hospital confinement (Ref. 8, p 784). Of course, as I will stress in a minute, the spiritual predecessor of *Wyatt* was Judge Bazelon's decision in *Rouse v. Cameron*.³²

First, some history. By 1960, social reformers had become a major voice in the call to restructure state public mental hospitals. The president of the American Psychiatric Association called the facilities "bankrupt beyond remedy" (Ref. 33, p 7). The social critic Albert Deutsch testified before Congress regarding his earlier investigations of state hospitals with these chilling words:

Some physicians I interviewed frankly admitted that the animals of nearby piggeries were better housed, fed and treated than many of the patients on their wards. I saw hundreds of sick people shackled, strapped, straitjacketed, and bound to their beds. I saw mental patients forced to eat meals with their hands because there were not enough spoons and other tableware to go around—not because they couldn't be trusted to eat like humans. . . . I found evidence of physical brutality, but that paled into insignificance when compared with the excruciating suffering stemming from prolonged, enforced idleness, herdlike crowding, lack of privacy, depersonalization, and the overall atmosphere of neglect. The fault lay. . . with the general community that not only tolerated but enforced these subhuman conditions through financial penury, ignorance, fear and indifference [Ref. 34, pp 40–2].

At about the same time, Morton Birnbaum (a physician and attorney) published his seminal article in the *ABA Journal* calling for a declaration of "the recognition and enforcement of the legal right of a mentally ill inmate of a public mental institution to adequate medical treatment for his mental illness" (Ref. 35, p 499) and for courts to consider openly the question of whether "the institutionalized mentally ill person receives adequate medical treatment so that he may regain his health, and therefore his liberty, as soon as possible" (Ref. 35, p 502). Birnbaum located the constitutional basis of this right to treatment in the due process clause: "Substantive due process of law does not allow a mentally ill person who has committed no crime to be deprived of his liberty by indefinitely institutionalizing him in a mental prison" (Ref. 35, pp 502–3). This article was widely acknowledged as "supplying much of the theoretical support for the subsequent development of the right-to-treatment litigation" (Ref. 25, p 98).

The existence of a statutory right to treatment had first been judicially recognized by the District of Columbia Circuit Court of Appeals in the unlikely setting of a *habeas corpus* case brought by an insanity

acquittee. In *Rouse v. Cameron*, the court—per, of course, Judge Bazelon—found that a District of Columbia hospitalization law established such a statutory right, reasoning that "the purpose of involuntary hospitalization is treatment, not punishment," quoting a statement by the act's sponsor that when a person is deprived of liberty because of need for treatment, and that treatment is not supplied, such deprivation is "tantamount to a denial of due process." The hospital thus needed to demonstrate that it had made a "bona fide effort" to "cure or improve" the patient, that inquiries into the patient's needs and conditions be renewed periodically, and that the program provided be suited to the patient's "particular needs" (Ref. 32, p 455).

Rouse was the subject of considerable academic and scholarly commentary—most of which was favorable—but was nonetheless criticized sharply by the American Psychiatric Association for interfering with medical practice: "The definition of treatment and the appraisal of its adequacy are matters for medical determination" (Ref. 36, p 1458). This position, to be sure, was not unanimously held by the psychiatric establishment, but it provides a context through which some of the incessant criticisms of the mental health advocacy movement can be reexamined: that the trade association for the service providers most closely linked with inpatient mental health care took the position that the hands-off doctrine required a policy of judicial nonintervention in the relationship between institutionalization and constitutional rights.

The most important case finding a constitutional right to treatment was, without doubt, *Wyatt v. Stickney*.³⁷ *Wyatt* was clear:

The purposes of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment. This is the only justification from a constitutional standpoint, that allows civil commitment to [a state hospital]. . . . To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process [Ref. 8, pp 784–5].

It subsequently found three "fundamental conditions for adequate and effective treatment": (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment, and (3) individualized treatment plans (Ref. 8, 344 F.Supp., p 390). Following a hearing (to which the court had invited a broad cross

section of interested professional associations to participate), the court issued supplemental orders detailing the “medical and constitutional minimums . . . mandatory for a constitutionally acceptable minimum treatment program” (Ref. 8, 344 F.Supp., p 376). These standards covered the full range of hospital conditions, including environmental standards, civil rights, medical treatment criteria, staff qualifications, nutritional requirements, and the need for compliance with life safety code provisions.

As has been well documented, the course of right-to-treatment litigation changed significantly after the U.S. Supreme Court’s 1982 decision in *Youngberg v. Romeo*.³⁸ Although the Court acknowledged that institutionalized persons retain certain constitutional rights—to food, shelter, clothing, and medical care—it stopped short of finding a constitutional right to treatment (Ref. 38, pp 315–17). The failure of the Court to endorse a robust right to treatment in *Youngberg* led—unfortunately, in my view—to a slow and steady cessation of constitutional litigation in this area of the law—a cessation abetted, I am sure, by the recognition on the part of plaintiffs’ lawyers that states frequently do not live up to their ends of the bargains when they enter into consent decrees in constitutional cases. It was not, in fact, until 2000—nearly 30 years after Judge Johnson’s first epochal decision—that the final consent decree was entered, and the state fully complied with the court’s order.³⁹ I believe, however, that the Court’s tepid decision in *Youngberg*—and its articulation of a nearly impossible-to-fail “substantial professional judgment” test in that case (Ref. 38, p 323)—is the primary culprit.

Having said this, I do not want to conclude this section on this note. I believe it is important to consider the Supreme Court’s 1999 decision in *Olmstead v. L.C.*⁴⁰ *Olmstead* qualifiedly affirmed an Eleventh Circuit decision that had ruled that the Americans with Disabilities Act (ADA) entitled plaintiffs (residents of Georgia Regional Hospital, Augusta, GA) to treatment in an integrated community setting, as opposed to an “unnecessarily segregated” state hospital (Ref. 40, p 597). In writing the majority opinion, Justice Ginsburg stressed that “unjustified isolation . . . is properly regarded as discrimination based on disability,” and ordered that states be required to maintain “a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings” (Ref. 40, pp 605–6). As written, *Olmstead* has the potential to infuse new life

in the right-to-treatment body of law, but on a statutory, rather than on a constitutional, basis, through its explicit endorsement of the ADA’s “integration mandate.” Implementation of *Olmstead* has been spotty (a condition that I have bemoaned in a series of law review articles^{14,15,41,42}), but I am persuaded that the right to treatment will develop with new and creative constructions of the ADA.

The Right to Refuse Treatment

The matter of the right to refuse antipsychotic medication remains the most important and volatile aspect of the legal regulation of mental health practice. It raises questions about the autonomy of institutionalized mentally disabled individuals to refuse the imposition of treatment that is designed (at least in part) to ameliorate their symptomatology, the degree to which individuals subjected to such drugging are in danger of the development of irreversible neurological side effects, the evanescence of terms such as “informed consent” or “competency,” and the practical and administrative considerations of implementing such a right in an institutional setting.

These questions mark the litigation that has led to the articulation of the right to refuse treatment as “a turning point in institutional psychiatry” and “the most controversial issue in forensic psychiatry today.”⁴³ Perhaps the most compelling issues raised by the right to refuse antipsychotic medication are the potential infringement of individuals’ constitutional rights, including the First Amendment rights to privacy and mentation, the Sixth Amendment right to a fair trial, the Eighth Amendment right to freedom from cruel and unusual punishment, and the Fourteenth Amendment’s due process guarantee. Given the multiplicity and gravity of the issues involved in these cases, their significance frequently transcends the narrow focus of a “mental disability law” case.

The conceptual, social, moral, legal, and medical difficulties inherent in the articulation of a coherent doctrine on the right to refuse treatment have been made even more complicated by the U.S. Supreme Court’s reluctance to confront most of the underlying issues in cases arising in civil settings. As a result of the Supreme Court’s 1982 decision in *Mills v. Rogers*⁴⁴ to sidestep the core constitutional questions and its concomitant articulation of the doctrine that a state is always free to grant more rights under its constitution than might be minimally mandated by

the U.S. Supreme Court under the federal Constitution, two parallel sets of cases have emerged.

In one, state courts have generally entered broad decrees in accordance with an expanded due process model, in which the right to refuse treatment has been read broadly and elaborately, generally interpreting procedural due process protections liberally on behalf of the complaining patient. These cases have frequently mandated premedication judicial hearings and heavily relied on social science data focusing on the potential impact of drug side effects, especially tardive dyskinesia. In the other, federal courts have generally entered more narrow decrees in accordance with a limited due process model. These provided narrower administrative review and rejected broad readings of the Fourteenth Amendment's substantive and procedural due process protections, relying less on social science data (which were frequently ignored or dismissed as part of an incomprehensible system allegedly beyond the courts' self-professed limited competency). In general (but not always), the state cases involved civil patients; more frequently, the federal cases dealt with individuals originally institutionalized because of involvement in the criminal trial process.⁴⁵

This division became somewhat more hazy, however, following the U.S. Supreme Court's 1992 decision in *Riggins v. Nevada*.⁴⁶ *Riggins* reversed a death sentence in the case of a competent insanity-defense pleader who sought to refuse the administration of antipsychotic medications during the pendency of his trial—the Court finding a violation of the defendant's right to a fair trial. In *Riggins*, although the Court did not set down a bright-line test articulating the state's burden in sustaining forced drugging of a detainee at trial, it found that this burden would be met had the state demonstrated medical appropriateness and, either (1) considering less intrusive alternatives, that antipsychotic drugs were “essential for the sake of Riggins' own safety or the safety of others”; or (2) a lack of less intrusive means by which to obtain an adjudication of the defendant's guilt or innocence (Ref. 46, p 135).

Most recently, in 2003, the Supreme Court returned to this topic—again in a criminal law context—and decided *Sell v. United States*,⁴⁷ a case involving the government's right to medicate an incompetent defendant to make him competent to stand trial. After finding that the defendant had a liberty interest in avoiding the involuntary adminis-

tration of antipsychotic drugs, and this interest was protected by the Fifth Amendment's due process clause against all but “essential” or “overriding” state interests (Ref. 47, p 2182) the Court held that:

The Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests [Ref. 47, p 2183].

What *Sell* and *Riggins*—and to a lesser extent, the Supreme Court's 1990 prison drugging decision in *Washington v. Harper* (establishing a limited due process right in the case of convicted prisoners who wish to refuse medication)⁴⁸—tell us is that the game, for all practical purposes, is over. When read together, these three cases make it clear that a qualified right to refuse medication is located in the Fourteenth Amendment's due process clause, that the pervasiveness of side effects is a key factor in the determination of the scope of the right, that the state bears a considerable burden in medicating a patient over objection, and that the “least restrictive alternative” mode of analysis must be applied to right-to-refuse cases.⁴³ Although the Supreme Court's only decisions in this area of the law in the past 20 years have come in the criminal context, it is a losing argument to suggest that civil patients somehow have fewer rights. Indeed, in the aftermath of the Supreme Court's decision in *Mills v. Rogers*⁴⁴ in 1982, every state high court that has considered this question has ruled that there is such a right.

Irony time. Recall that, when I was discussing the involuntary civil commitment process, I pointed out an irresolvable dilemma: that it is the decision by patients facing commitment to invoke this constitutional right to refuse that is frequently interposed as the reason that civil commitment should be ordered. As I have said, although there are many individual commitment cases that show this, the anomaly itself has never been the topic of subsequent litigation. I hope, in the post-*Sell* universe, that such litigation will be undertaken.

Conclusions

As I wrote this article, I reflected back on my 13 years as a “real” lawyer, before I became a full-time academic (I was a deputy public defender in Tren-

ton, New Jersey, from 1971 to 1974; Director of the New Jersey Division of Mental Health Advocacy from 1974 to 1982; and Special Counsel to the New Jersey Public Advocate from 1982 to 1984). I thought about my work with Bob—not just on the Vroom Building cases and the individual insanity and incompetency cases I mentioned at the beginning of the paper, but in all aspects of mental disability law.

When I was with the New Jersey Division of Mental Health Advocacy, we filed *Doe v. Klein*, a *Wyatt*-type case seeking to enforce a constitutional right to treatment at Greystone Park Psychiatric Hospital in Morristown, New Jersey. After the case was settled,⁴⁹ we created a monitoring committee, and, of course, Bob was the forensic psychiatrist chosen for that committee. During his work in that position, Bob brought to our attention drugging practices that were, to say the least, extraordinarily troubling. These insights turned into the decision to investigate drugging practices more comprehensively, which led us to file *Rennie v. Klein*,⁵⁰ one of the first two class action cases brought in federal courts as a constitutional challenge of the institutional drugging policies. Bob had also served as one of the experts in *Scott v. Plante*,⁵¹ the Third Circuit's predecessor to *Rennie*. In short, as I said at the beginning, Bob's fingerprints are all over the development of mental health law in New Jersey, and, by incorporation, throughout the United States.

Out of curiosity, I did a simple WESTLAW search for "Dr. Robert Sadoff" or "Dr. Robert L. Sadoff" in the ALLCASES database, and came up with 99 reported appellate cases in which Bob had testified. I scanned the cases quickly: they included criminal,⁵² tort,⁵³ civil rights,⁵⁴ attorney misconduct,⁵⁵ adoption,⁵⁶ employment discrimination,⁵⁷ jail and prison conditions,⁵⁸ judicial misconduct,⁵⁹ and institutional rights (including, as I have just indicated, cases of the right to treatment and the right to refuse treatment).⁵¹ These cases range from the very obscure to the very famous, to the very, very famous.⁶⁰ When you read them, you realize the connection—the tight connection—between Bob Sadoff and the history of mental disability law (the areas that I have discussed in depth, as well as the others). So, what more fitting venue for an article about the history of this area of the law than in the *Journal* issue about the program that honored Bob?

I conclude by thanking Bob for coming to Trenton that snowy morning 33+ years ago. You changed my life. You changed all of our lives. You changed the world. In the words of my other favorite Minnesota native, "May you stay forever young."⁶¹

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References

1. Jackson v. Indiana, 406 U.S. 715 (1972)
2. Perlin ML: The Hidden Prejudice: Mental Disability on Trial. Washington, DC: American Psychological Association, 2000
3. Perlin ML: Mental Disability Law: Civil and Criminal (ed 2, vol 5). Newark, NJ: Lexis-Nexis Co., 2002, p 1191
4. Perlin ML: Patient advocacy by a public advocate. *Psychiatr Q* 54:169–76, 1982
5. N.J. Stat. Ann. § 52-27E-21-27 (1985)
6. 42 U.S.C. § 9401 et seq. (1980), repealed by P.L. No. 97-35, § 901(e) (1), 95 Stat. 560 (1981)
7. 42 U.S.C. § 10801 et seq
8. Wyatt v. Stickney, 325 F.Supp. 781, 785 (M.D. Ala. 1971), Suppl., 334 F.Supp. 1341 (M.D. Ala. 1972), 344 F.Supp. 373 (M.D. Ala. 1972), 344 F.Supp. 387 (M.D. Ala. 1972), aff'd sub. nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974)
9. Wales H: The rise, the fall, and the resurrection of the medical model. *Georgetown Law J* 63:87, 104, 1974
10. Baxstrom v. Herold, 383 U.S. 107, 110 (1966)
11. Goldstein J, Katz J: Abolish the "insanity defense"—why not? *Yale Law J* 72:853–46, 1963
12. O'Connor v. Donaldson, 422 U.S. 563 (1975)
13. Lessard v. Schmidt, 349 F.Supp. 1078 (E.D. Wis. 1971)
14. Perlin ML: "For the misdemeanor outlaw": the impact of the ADA on the institutionalization of criminal defendants with mental disabilities. *Alabama L Rev* 52:193–239, 214–15, 2000
15. Perlin ML: "Their promises of paradise": will *Olmstead v. L.C.* resuscitate the constitutional "least restrictive alternative" principle in mental disability law? *Houston Law Rev* 37:999–1054, 2000
16. Parham v. J. R., 442 U.S. 584 (1979)
17. Vitek v. Jones, 445 U.S. 480 (1980)
18. Zinermon v. Burch, 494 U.S. 113 (1990)
19. Heller v. Doe, 509 U.S. 312 (1993)
20. Kansas v. Hendricks, 521 U.S. 346 (1997)
21. Kansas v. Crane, 534 U.S. 407 (2002)
22. Addington v. Texas, 441 U.S. 418 (1979)
23. Perlin ML: "There's no success like failure/and failure's no success at all": exposing the pretextuality of *Kansas v. Hendricks*. *Northwestern Univ Law Rev* 92:1247–77, 1998
24. Perlin ML: Pretexts and mental disability law: the case of competency. *Univ Miami Law Rev* 47: 625–88, 1993
25. Perlin ML, Gould K, Dorfman DA: Therapeutic jurisprudence and the civil rights of institutionalized mentally disabled persons: hopeless oxymoron or path to redemption? *Psychol Public Policy Law* 1:80–119, 1995
26. Public Defender's Office/Solicitor's Office Report: Roddey transition team examines county solicitor's and public defender's offices. *Lawyers J* 2:5–10, 2000
27. "Walls of Red Wing." Words and music by Bob Dylan. © 1963 Warner Chapell Music renewed in 1991 by Special Rider Music

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- (available at <http://www.bobdylan.com/songs/redwing.html/> last accessed, April 1, 2005)
28. Perlin ML, Sadoff RL: Ethical issues in the representation of individuals in the commitment process. *Law Contemp Problems* 45:161–92, 1982
 29. *In the Matter of the Mental Health of K.G.F.*, 29 P.3d 485,491 (Mont. 2001)
 30. *Strickland v. Washington*, 466 U.S. 668 (1984)
 31. Perlin ML: “You have discussed lepers and crooks”: sanism in clinical teaching. *Clinical Law Rev* 9:683–729, 2003
 32. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966)
 33. Solomon H: Presidential Address: the American Psychiatric Association in relation to American psychiatry. *Am J Psychiatry* 115: 1–9, 1958
 34. Constitutional Rights of the Mentally Ill, Hearings Before the Senate Subcommittee on Constitutional Rights of the Judiciary on 87th Cong., 2nd Sess. (1961) (statement of Albert Deutsch)
 35. Birnbaum M: The Right to Treatment. *ABAJ* 46:499–505, 1960
 36. Council of the American Psychiatric Association: Position Statement on the Question of the Adequacy of Treatment. *Am J Psychiatry* 123:1458–61, 1967
 37. Rhodes SL: Prison reform and prison life: four books on the process of court-ordered change. *Law Soc Rev* 26:189–218, 1992
 38. *Youngberg v. Romeo*, 457 U.S. 307 (1982)
 39. Wyatt ex rel. *Rawlins v. Sawyer*, 105 F.Supp.2d 1234 (M.D. Ala. 2000)
 40. *Olmstead v. L.C.*, 527 U.S. 581 (1999)
 41. Perlin ML: “I ain’t gonna work on Maggie’s farm no more”: institutional segregation, community treatment, the ADA, and the promise of *Olmstead v. L.C.* *TM Cooley Law Rev* 17:53–90, 2000
 42. Perlin ML: “What’s good is bad, what’s bad is good, you’ll find out when you reach the top, you’re on the bottom”: are the Americans with Disabilities Act (and *Olmstead v. L.C.*) anything more than idiot wind? *Univ Mich Law J* 35:235–61, 2001–02
 43. Perlin ML: “And my best friend, my doctor/won’t even say what it is I’ve got”: the role and significance of counsel in right to refuse treatment cases, *San Diego Law Rev*, in press
 44. *Mills v. Rogers*, 457 U.S. 291 (1982)
 45. Perlin ML: “Make promises by the hour”: sex, drugs, the ADA, and psychiatric hospitalization. *DePaul Law Rev* 46:947–85, 1997
 46. *Riggins v. Nevada*, 504 U.S. 127,146 (1992)
 47. *Sell v. United States*, 539 U.S. 166 (2003)
 48. *Washington v. Harper*, 494 U.S. 210 (1990)
 49. See *Doe v. Klein*, No. L-12088–74P.W. (N.J. Super. Ct., Law Dic. 1977), reported in *Ment Dis L Rep.* 1:425, 1977
 50. *Rennie v. Klein*, 462 F.Supp. 1131 (D.N.J. 1978), supplemented, 476 F.Supp. 1294 (D.N.J. 1979), modified, 653 F.2d 836 (3rd Cir. 1981), vacated, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3rd Cir. 1983)
 51. *Scott v. Plante*, 641 F.2d 117 (3rd Cir. 1981)
 52. *Com. v. Bomar*, 826 A.2d 831 (Pa. 2003)
 53. *Subacz v. Sellars*, 1998 WL 720822 (E.D. Pa. 1998)
 54. *Blakey v. Continental Airlines, Inc.*, 992 F.Supp. 731 (D.N.J. 1998)
 55. *Matter of Greenberg*, 714 A.2d 243 (N.J. 1998)
 56. *In re Adoption of A.S.H.*, 674 A.2d 698 (Pa. Super. Ct. 1996)
 57. *Goodwin v. Seven-Up Bottling Co. of Philadelphia*, 1998 WL 438488 (E.D. Pa. 1998)
 58. *Littlejohn v. City of Philadelphia*, 1993 WL 79600 (E.D. Pa. 1993)
 59. *Matter of Yaccarino*, 1502 A.2d 3 (N.J. 1985)
 60. *U.S. v. MacDonald*, 640 F.Supp. 286 (E.D. N.C. 1985)
 61. “Forever Young.” Words and music by Bob Dylan. ©1973 Ram’s Horn Music (available at <http://bobdylan.com/songs/forever.html/>, last accessed, May 24, 2004)