
Metaphor and Madness, Law and Liberty

Herbert A. Eastman

Follow this and additional works at: <https://via.library.depaul.edu/law-review>

Recommended Citation

Herbert A. Eastman, *Metaphor and Madness, Law and Liberty*, 40 DePaul L. Rev. 281 (1991)
Available at: <https://via.library.depaul.edu/law-review/vol40/iss2/2>

This Article is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Law Review by an authorized editor of Via Sapientiae. For more information, please contact digitalservices@depaul.edu.

METAPHOR AND MADNESS, LAW AND LIBERTY

Herbert A. Eastman

I. MENTAL ILLNESS AND THE COURTS: A BRIEF HISTORY OF REFORM	285
A. <i>The Nation's Beginning: The Individual's Moral Stain to be Accepted and Hidden</i>	285
B. <i>Jacksonian America and the First Reform: The Social Price of Civilization to be Treated</i>	286
C. <i>The Incurable Danger to be Controlled: the Failure of the First Reform</i>	288
D. <i>The Progressive Era and the Second Reform: The Individual's Corruption to be Prevented</i>	292
E. <i>The Corruption to be Eliminated: The Failure of the Second Reform</i>	296
F. <i>Postwar America and the Third Reform: The Social Wrong to be Righted</i>	300
G. <i>The Failure to be Dumped: The Failure of the Third Reform</i>	306
II. ON THE BRINK OF THE FOURTH REFORM	311
A. <i>The Unlikely Reform: Community Support</i>	311
B. <i>The Preconditions for the Likely Fourth Reform</i>	313
1. <i>Society and Government</i>	313
2. <i>Psychiatry</i>	315
3. <i>The Courts and the Legal Profession</i>	316
4. <i>Tumblers Falling into Place: The Medical Metaphor</i>	320
III. THE FOURTH REFORM: THE INDIVIDUAL ILLNESS TO BE TREATED	320
A. <i>Privatization</i>	320
B. <i>The Privatization Reform and the Courts</i>	321
1. <i>Relaxed Legislative Standards</i>	322
2. <i>The Supreme Court Sets the Stage</i>	327
3. <i>Lower Courts Follow the Lead</i>	331
C. <i>Drawing a Little Circle Around Reality</i>	337
1. <i>The Expertise of Psychiatry</i>	339
2. <i>The Impartiality of Psychiatrists</i>	343
3. <i>The Necessity for Compulsory Hospitalization</i>	345
4. <i>The Meaninglessness of Due Process</i>	347
5. <i>The Medical Nature of Mental Illness</i>	347
6. <i>The Example of Billie Boggs</i>	350

D. <i>Bending Doctrine as it Turns</i>	352
IV. UNMIXING METAPHORS, AGENDAS, FACT, AND LAW	356
V. THE TRADITIONAL ROLE OF THE COURTS: CLEARING THE AIR	360

METAPHOR AND MADNESS, LAW AND LIBERTY

*Herbert A. Eastman**

A reign of doctors will be inaugurated and in the name of science new classes will be added, even races may be brought within such regulation, and the worst forms of tyranny practiced. In the place of constitutional government of the fathers we shall have set up Plato's Republic.¹

[I]t is diseases thought to be multi-determined (that is, mysterious) that have the widest possibilities as metaphors for what is felt to be socially or morally wrong.²

INTRODUCTION

A series of Supreme Court decisions, most notably *Youngberg v. Romeo*,³ *Parham v. J.R.*,⁴ and last Term, *Washington v. Harper*,⁵ has fundamentally eroded due process protections of certain individuals. As a result of these decisions, psychiatrists are now left to make critical judgments which affect the liberty and well-being of persons labeled by those psychiatrists as "mental patients." Neither the logic of doctrine nor the discovered realities of mental illness drive this erosion of due process. Rather, history demonstrates that the courts' changing articulations of the legal status of mental patients reflect contemporary social and professional perceptions of mental illness. These percep-

* Herbert A. Eastman, J.D., 1976, University of Notre Dame. Assistant Professor of Law at Saint Louis University School of Law. The author expresses his heartfelt appreciation to his colleagues Professors Sandra Henneken Johnson of Saint Louis University School of Law and Clark Cunningham of Washington University School of Law for their valuable critiques of earlier drafts and Mark Peterson of Lewis and Clark College of Law for sharing in the author's initial experience of these issues in the commitment courts.

1. From the argument of plaintiffs' counsel summarized preceding the Court's opinion in *Buck v. Bell*, 274 U.S. 200, 202-03 (1927) (describing consequences of upholding a state law which would allow sterilization of the insane). In *Buck v. Bell*, the Supreme Court was faced with a challenge to a state statute which authorized the state to sterilize insane men and women. *Id.* at 205. The Court, in an opinion written by Justice Holmes, upheld the statute. *Id.* at 207. Justice Holmes reasoned that society should not be burdened with another generation of "incompetence." *Id.*; see *infra* notes 155-62 and accompanying text.

2. S. SONTAG, *ILLNESS AS METAPHOR* 61 (1978).

3. 457 U.S. 307 (1982).

4. 442 U.S. 584 (1979).

5. 110 S. Ct. 1028 (1990).

tions derive from a larger social and political agenda, an agenda aimed at redemption in some eras, social control in others.

These sociopolitical agendas are expressed in popularly communicated and embraced metaphors. Historically, insanity has served as a metaphor for our nation's fears of its own craziness. That is, the way society has reacted to, and dealt with, mental illness chronicles the evolving social challenges of our nation's historical eras, such as civilization,⁶ social dislocation following war,⁷ corruption through reproduction and immigration of defectives,⁸ social dislocation following a depression,⁹ stagnation and social unrest,¹⁰ and finally, failure from ill-advised government adventures that interfered with the natural competitive order of nature.¹¹ As eras came and passed on, the nature of the metaphors changed as well: alternating between explanations of insanity as an individual phenomenon and a social phenomenon, a medical problem and a political or economic problem.

These popular professional metaphors led to shifts in policy directions. The courts followed closely behind with their endorsement. Jacksonian courts extended the *parens patriae* doctrine¹² and committed people to asylums designed to redeem the patients and society.¹³ Post-Jacksonian courts tolerated abuses in the asylum because society needed the asylums for its protection.¹⁴ Progressive courts at first shuddered at the abuses previously tolerated, then acquiesced in the state hospital's persistence as a quarantine against social and moral corruption.¹⁵ During the same time, the courts approved of sterilization as a public health measure to protect the nation's bloodline.¹⁶ Courts of the mid-twentieth century expressed the preference for individual freedom. These courts took over the remaining institutions as part of the general effort to cor-

6. This was the view of the Jacksonians. See *infra* text accompanying notes 25-41.

7. This was the prevailing view during the post-Jacksonian era. See *infra* text accompanying notes 48-52.

8. This was the view of the Progressives and their contemporaries, the nativists. See *infra* text accompanying notes 80-111.

9. This was the prevailing view during the early part of this century (1900-1940). See *infra* text accompanying notes 116-37.

10. This was the prevailing view during the New Frontier and the Great Society periods (1945-1970). See *infra* text accompanying notes 164-80.

11. This was the prevailing view in the period after the Great Society era (1970-1980). See *infra* text accompanying notes 216-40.

12. Literally, *parens patriae* means "parent of the country." BLACK'S LAW DICTIONARY 1003 (5th ed. 1979). The *parens patriae* doctrine refers to the government's role as guardian of the legally incompetent. *Id.*; see also *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1207-09 (1974) [hereinafter *Civil Commitment of the Mentally Ill*] ("The *parens patriae* function can thus be viewed as a power which the members of the community have granted the state for the protection of [the incompetent's] well-being."). For an exhaustive discussion of the development and use of the *parens patriae* doctrine, see Curtis, *The Checkered Career of Parens Patriae: The State as Parent or Tyrant?*, 25 DEPAUL L. REV. 895 (1976).

13. See *infra* text accompanying notes 42-47.

14. See *infra* text accompanying notes 72-79.

15. See *infra* text accompanying notes 112-15, 138-54.

16. See *infra* text accompanying notes 155-62.

rect America's problems, including mental illness.¹⁷ More recently, along with much of the country, the courts have given up on the fix, seemingly convinced that our problems are beyond government's capacity to fix.¹⁸

What was true of our history remains true of our present. Under the prevailing medical metaphor, the courts entrust to psychiatrists the due process analysis of competing liberty and state interests. The correctness of the psychiatrists' treatment and custody decisions is presumed, and their decisions are insulated from any meaningful judicial review. Current developments—psychiatry's pursuit of new explanations for insanity and other medicalized behaviors, the seemingly intractable dilemma of homelessness, the recent trend toward privatizing social problems, and the courts' weariness with the thankless task of resolving social problems—are expected to converge. This convergence may push the courts past these recent Supreme Court decisions to an even greater delegation to psychiatric authority over people's lives, or, at least, over the lives of certain people.

The likely result of such judicial deference is that feared by plaintiff's counsel in *Buck v. Bell*: excessive delegation of authority to psychiatrists at the expense of liberty.¹⁹ No more so than in the past, neither doctrine nor fact demand this result. On the contrary, this delegation represents the abandonment of legal doctrine. Further, this result becomes possible only through judicial tunnel vision in which only a small portion of the world remains visible to the courts. This vision omits the underlying and surrounding realities of mental illness and psychiatry. Courts persist in their tunnel vision to further the larger social and political agenda of this time in our history, hidden within metaphors about mental illness.

This Article argues that current legal doctrine concerning the rights of mental patients and the authority of psychiatrists has not been defined by the logic of doctrine or the realities of mental illness. Rather, history demonstrates that the evolution of this law has been shaped by social and political events, the agendas resulting from those events, and the metaphors society uses to explain them. These powerful metaphors, including the medical model of today, have historically operated to justify twists in doctrine which cannot be supported by precedent or evidence.

Section I begins with a history of the courts and mental health law, describing the three great reforms of mental health policy—Jacksonian asylums, Progressive civic medicine, and the Community Mental Health Movement—and the failures of those reforms. That section explains, for each era, how the surrounding social and political context gave rise to public agendas unique to each era, such as redemption, social control, and so forth. It further explains how these contexts and their agendas gave rise to popular and professional metaphors about insanity which were used to explain the fears and hopes behind the agendas, for example, insanity as the price of civilization, as the cor-

17. See *infra* text accompanying notes 193-215.

18. See *infra* text accompanying notes 241-60.

19. *Buck v. Bell*, 274 U.S. 200, 202-03 (1927); see *supra* note 1 and accompanying text.

ruption of America, and so forth. Finally, Section I argues that the courts have embraced and changed the law to be consistent with those metaphors.

Section II analyzes the current state of the law and the latest reform, privatization in its social and political context (including psychiatry's medicalization of behavior). It examines how the currently prevailing medical metaphor shapes that reform and the courts' endorsement of it: by delegating to psychiatrists the power to decide critical liberty issues, such as civil commitment, treatment and its refusal, without any review by the courts. Section III critiques the privatization reform, arguing that judicial decisionmaking by metaphor ignores the realities of mental illness and psychiatry as well as the logic and precedent of doctrine.

Section IV further examines the power and function of metaphors in law and psychiatry. Section V argues for the traditional role of the courts and the adversary system as a check upon both the power of psychiatrists and the influence of metaphor.

I. MENTAL ILLNESS AND THE COURTS: A BRIEF HISTORY OF REFORM

The current judicial deference to psychiatry emerged from a historical context. Through history, development of our conceptions of mental illness and the rights of those called mentally ill have moved not in a straight line, but have flowed in twists and turns, often repeating courses already travelled. This course is marked by three great reforms in mental health policy. Each reform found its origins in social changes which then shaped popular fears and hopes for the country. These hopes and fears resulted in particular policies and found expression in particular metaphors, shaping judicial decisions.

A. The Nation's Beginning: The Individual's Moral Stain to be Accepted and Hidden

During the time the American colonies strained toward and achieved independence, the rights and needs of the mentally ill had yet to find a place on the public agenda. This invisibility was not due simply to the press of other issues, such as revolution. Rather, eighteenth century Americans saw humankind as essentially flawed and deviant. Human society could not hope to cure lunacy.²⁰ Rarely did the members of those communities resort to confining the mentally ill; rather, families cared for their own.²¹ Families could commit relatives with "the greatest of ease."²² Hence, little in the way of litigation preceded or followed the commitment. Still, families were reluctant to air their

20. D. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* 17 (1971).

21. Workhouses and poorhouses were the only "institutions" and they housed the stranger and the vagabond, those whose deviance was outside the web of the community's relationships. *Id.* at 25.

22. A. DEUTSCH, *THE MENTALLY ILL IN AMERICA* 420 (1949) (observing that no special laws safeguarding the personal liberty of the mentally ill were enacted until the late 1820s).

family problems in public, and so few were ever confined.²³ The few "hospitals" that admitted the insane rarely filled their beds.²⁴

B. Jacksonian America and the First Reform: The Social Price of Civilization to be Treated

After the turn of the century, as the new nation began to focus on its own development, the family problem of mental illness came to be seen as a problem for the new society as well. The insight of the Enlightenment was that society could improve. This insight, together with the growing popular sense that mental illness was increasing, offered a possible remedy to mental illness.²⁵ Jacksonian physicians agreed that brain lesions caused mental illness. Nevertheless, perhaps frustrated by the limited reach of their crude profession, they located the operative causes of mental illness outside the body and within the community.²⁶ The "price" of a new bustling civilization, marked by the stresses of mobility, complexity, and competition, was lunacy.²⁷

In this way, the Jacksonians' view of mental illness reflected the larger critique of the society's ill health.²⁸ The problem was not medical, and neither was the solution.²⁹ If society were to blame for mental illness, then the solution seemed clear. While few doubted that American society could be restabilized to its quieter past, the social obligation to "heal the wound it inflict[ed]" seemed apparent.³⁰ If society destabilized the orderly life of its citizens, then the remedy was to reform a community in which order was restored.³¹ This community would eliminate the cause of mental illness. Perhaps, this community would help reform society by reminding America of the virtues of order

23. D. ROTHMAN, *supra* note 20, at 15-16, 19.

24. N. DAIN, *THE DISORDERED MIND* 26 (1971).

25. N. DAIN, *CONCEPTS OF INSANITY IN THE UNITED STATES, 1789-1865*, at 11 (1964); D. ROTHMAN, *supra* note 20, at 109-10; P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 73 (1982).

26. D. ROTHMAN, *supra* note 20, at 110-11.

27. G. GROB, *EDWARD JARVIS AND THE MEDICAL WORLD OF NINETEENTH-CENTURY AMERICA* 119 (1978) (quoting Jarvis, *On the Supposed Increase of Insanity*, 8 *AM. J. INSANITY* 333 (1852)); D. ROTHMAN, *supra* note 20, at 112 (quoting Dorothea Dix advising the Pennsylvania legislature that the causes of mental disorder were to be found in "the habits, the customs, the temptations of civilized life and society").

28. G. GROB, *supra* note 27, at 118-19; D. ROTHMAN, *supra* note 20, at 113; P. STARR, *supra* note 25, at 73.

29. Democratic impulses early in the nation's history retarded the growth of a physician professional class generally, as Americans viewed medicine with a skeptical eye. P. STARR, *supra* note 25, at 55-57.

30. D. ROTHMAN, *supra* note 20, at 128 (quoting E. JARVIS, *ON THE SUPPOSED INCREASE OF INSANITY* 21 (1852) (pamphlet reprinted from the *American Journal of Insanity*)) (explaining that since society caused mental illness, society had an obligation to cure it).

31. N. DAIN, *supra* note 25, at 15. The author stated that Benjamin Rush, the father of modern psychiatry, "believed that good health depended upon social, political, and economic as well as physical environment and endorsed a stable and ordered society founded upon democratic and republic principles." *Id.*

and structure.

These new communities were the insane asylums.³² During the early 1800s and up to the Civil War, most states erected these new little Jerusalems³³ to cure both individuals and society of lunacy. The asylums isolated individuals and society, protecting one from the other. Physicians diagnosed insanity freely from a wide variety of symptoms commonly demonstrated by much of the community.³⁴ Institutionalization became the first, not the last resort. Consistent with the new country's optimism and desire to impress its European parents, the asylums were dedicated to no less than the cure of insanity.³⁵ The mode of cure was "moral treatment," which consisted of isolation from the community and its harmful effects, insistence on quiet and discipline to curb the socially induced excesses of the mentally ill,³⁶ and kind treatment.³⁷ The cure lay not in medicine but in the setting and its administration, hence the early title of psychiatrist as a "medical superintendent."³⁸ To facilitate the cure, family visits were discouraged; commitment procedures were simple and accessible.³⁹ In fact, the common and easily completed requirement of two physicians' certificates drew the criticism of medical superintendents as cumbersome.⁴⁰ Still, the medical superintendents found the asylum walls an effective protection for the unopposed exercise of their authority.⁴¹

Like the rest of society, the American courts cooperated with the cure. The doctrine of *parens patriae*, imported with the common law from England and originally devised to protect the estates of incompetents,⁴² was first used during this period by a Massachusetts court to authorize the confinement of the mentally ill to effect their cure.⁴³

The courts endorsed the medical superintendents' warning that mental illness was common and easily succumbed to: "no man can reckon on the continuance of his perfect reason. Disease may weaken, accident may disturb, anxiety may impair it . . ."⁴⁴ The courts also approved the efficacy of "moral and intellectual treatment of the insane. . ."⁴⁵ Similarly, the courts con-

32. D. ROTHMAN, *supra* note 20, at 129.

33. *Id.* at 130.

34. For example, physicians considered reticence or impulsiveness symptoms of insanity. *Id.* at 122-23.

35. *Id.* at 132.

36. N. DAIN, *supra* note 24, at 77, 92-93; D. ROTHMAN, *supra* note 20, at 133, 137-38.

37. D. ROTHMAN, *supra* note 20, at 149.

38. *Id.* at 134; P. STARR, *supra* note 25, at 73.

39. D. ROTHMAN, *supra* note 20, at 143.

40. *Id.*

41. P. STARR, *supra* note 25, at 73.

42. *Civil Commitment of the Mentally Ill*, *supra* note 12, at 1209.

43. *In re Oakes*, 8 Law Rep. 122 (Mass. 1845), cited in *Civil Commitment of the Mentally Ill*, *supra* note 12, at 1209. Deutsch noted that "[t]his was probably the first time that the therapeutic justification for [institutionalization] was explicitly handed down by an American court." A. DEUTSCH, *supra* note 22, at 423.

44. *Colby v. Jackson*, 12 N.H. 526, 533 (1842).

45. *Id.* at 531.

demned the "private madhouses" of England with their "nameless and unimaginable horrors."⁴⁶ Convinced of the need to cure society of lunacy, the courts approved the new asylums:

The object of discharging the prisoner under this statute was to provide for his care, maintenance and recovery; and this was to be effected by removing him to the asylum. This is to be inferred not only from the title of the act but from its other provisions, for the erection of extensive buildings for the reception of insane patients, containing accommodations for their comfort, and physicians, nurses and attendance [sic] for their treatment and cure.⁴⁷

C. *The Incurable Danger to be Controlled: the Failure of the First Reform*

Even during the early years of the first reform, before the Civil War, the reality of this reform hardly meshed well with the objectives of the asylums.⁴⁸ Still, most believed the asylums to be superior to the jails and workhouses.⁴⁹ However, the Civil War and its aftermath dramatically affected the nature and operation of the asylum. First, critically needed funds were diverted away from mental health services for the war and the subsequent post-war rebuilding effort. Second, society suffered major dislocation following a war fought on America's own territory.⁵⁰ The Civil War, Reconstruction, sectionalism, and other national issues crowded the public's agenda. The problem of deviancy became relatively less significant, and therefore, less entitled to public attention and dollars.⁵¹ The result was overcrowded, underfunded institutions.⁵²

The asylums filled past the brim with the chronically mentally ill: both those who were forced into the institutions because they disrupted the social system, and those who worsened while confined in the failing asylum. As a result, the more treatable cases lost the competition for scarce bed space.⁵³ Optimism about the future of moral treatment surrendered to the overwhelming realities of the asylums.⁵⁴ Professional consensus announced the failure of the asylum

46. *Id.* at 532.

47. *Bush v. Pettibone*, 4 N.Y. 300, 302 (1850).

48. Too few staff resulted in increased regimentation, application of mechanical restraints, and occasionally bizarre punishments, such as submersing the patient in hot, then cold water. Also, overcrowding and unsanitary conditions undercut the asylum's utopian aspirations. D. ROTHMAN, *supra* note 20, at 149-51.

49. *Id.* at 151.

50. *Id.* at 237-38.

51. *Id.* at 252.

52. G. GROB, *MENTAL ILLNESS AND AMERICAN SOCIETY, 1845-1940*, at 26-27 (1983) (describing the chaotic state of mental hospitals after the Civil War); D. ROTHMAN, *supra* note 20, at 238.

53. D. ROTHMAN, *supra* note 20, at 271.

54. David Rothman wrote:

The custodial qualities of the post-1850 asylums are easily described. The first and most common element was overcrowding and in its train came the breakdown of classification systems, the demise of work therapy, and an increase in the use of mechani-

to cure insanity.⁵⁵ In fact, medical superintendents and neurologists were among the most critical of the asylum's failures. Neurologist William Hammond wrote:

[T]he system of inspection of such institutions, when there is any at all, is so inefficient that the greatest abuses may spring up, and the world be none the wiser, till some day an exposure takes place; and then it is discovered that an asylum which has been the pride of the community is in reality a hot-bed of neglect and cruelty.⁵⁶

Medical superintendent Pliny Earle spoke for the profession and the public when he attributed moral treatment's failure to cure mental illness to the fact that it was "really becoming more and more an incurable disease."⁵⁷

While the still new mental health profession stood ready to abandon the asylum, the country remained committed to institutionalization.⁵⁸ The reasons for this are not difficult to discern. In the aftermath of the war, American society experienced further dislocation due to the rural exodus to the cities⁵⁹ and the wave of Irish immigration, which actually began just before the war in the wake of the potato famine.⁶⁰ This dislocation challenged the more stable social order that had settled in after the Revolution. The incentive to control these forces, especially to control the poor and immigrant classes, found a ready device in the institutions, such as prisons and asylums, built before the war for other purposes.⁶¹ The new immigrants found themselves constituting pluralities and even majorities of patient counts.⁶² Similarly, the new urban poor, both immigrant and native born, dominated the asylums after the war.⁶³ The available statistics suggest that institutionalization was often motivated by bias and the power of nativism; only forty-three percent of the native-born

cal restraints and harsh punishments to maintain order. . . . Visitors to state and municipal institutions told of seeing beds strewn about the hallways, because the space in the dormitories had long since been exhausted. . . .

. . . The raving and the furiously insane usually mixed freely with the more peaceable and well-behaved patients.

Id. at 265-66.

55. *Id.* at 268; see G. GROB, *supra* note 52, at 59-62.

56. W. HAMMOND, A TREATISE ON INSANITY IN ITS MEDICAL RELATIONS 721 (1883), *quoted in* D. ROTHMAN, *supra* note 20, at 269.

57. P. EARLE, CURABILITY OF INSANITY 58 (1886), *quoted in* D. ROTHMAN, *supra* note 20, at 268; see also G. GROB, *supra* note 27, at 121 (survey by Edward Jarvis indicated that an overwhelming majority of physicians and hospital superintendents believed that most mentally ill patients were incurable).

58. D. ROTHMAN, *supra* note 20, at 269. Construction of new institutions continued during this period. G. GROB, *supra* note 52, at 75 (reporting that 35 new institutions were built from 1850-1867, and 59 more were built from 1870-1890).

59. D. ROTHMAN, *supra* note 20, at 240.

60. *Id.* at 254.

61. Even just prior to the Civil War, the foreign-born made up a majority of the patient population. *Id.* at 273. This was true of prisons as well. *Id.* at 254.

62. *Id.* at 283.

63. *Id.* at 283-84.

poor identified as insane were institutionalized, whereas almost every foreigner identified as insane was confined.⁶⁴

The country told itself a number of things to justify this state of affairs. The medical superintendent of a Massachusetts asylum opined that the Irish were more susceptible to insanity, blaming them for the apparent failure of moral treatment:

The want of forethought in them to save their earnings for the day of sickness, the indulgence of their appetites for stimulating drinks . . . and their strong love for their native land . . . are the fruitful causes of insanity among them. As a class, we are not so successful in our treatment of them as with the native population of New England. It is difficult to obtain their confidence, for they seem to be jealous of our motives.⁶⁵

Other medical superintendents warned of the imminence of danger from the unpredictable insane and the futility of any alternative except confinement for the safety of the patient and the community.⁶⁶

By the 1870s, the reason for the asylum's existence had substantially shifted from the impossibility of cure to the convenience of custody.⁶⁷ Mental institutions evolved into "comfortable prisons"⁶⁸ rather than utopian communities. Nonetheless, even the seemingly cynical preeminence of custody as the primary purpose of asylums was wrapped in reform phraseology. While conceding that his institution was "little more than a retreat for incurables,"⁶⁹ one superintendent boasted that "[t]he filthy, ragged and disgusting objects brought here, from gloomy prisons and cheerless poorhouses would scarcely be recognized after a few days residence in the asylum."⁷⁰ The middle class and native social structure found a ready protection from the ill effects of foreigners. Not only that, but the public had a weapon against the lunacy of their neighbors, and even within their families.⁷¹

64. *Id.* at 283.

65. WORCHESTER LUNATIC HOSPITAL, FIFTEENTH ANNUAL REPORT 33 (1848) (statement by George Chandler, medical superintendent of Worcester State Hospital, in annual report for 1847), quoted in D. ROTHMAN, *supra* note 20, at 284. Norman Dain also expressed this widespread view. He stated that "[t]he middle class Protestant asylum superintendents, disillusioned, frustrated, and ineffective in obtaining more funds, tended to blame the patients themselves for their failure to recover, the urban poor and the allegedly unassimilable immigrants being particularly culpable . . ." N. DAIN, *supra* note 24, at 113; see N. DAIN, *supra* note 25, at 99-100. Interestingly, the immigrant Germans were seen as much healthier, *id.* at 100, but northern African-Americans were seen as prone to mental illness as the Irish. *Id.* at 104. Indeed, free African Americans were seen as ten times more likely to become insane as slaves. *Id.*

66. D. ROTHMAN, *supra* note 20, at 286.

67. *Id.* at 273; see G. GROB, *supra* note 52, at 15.

68. D. ROTHMAN, *supra* note 20, at 277 (quoting KENTUCKY EASTERN LUNATIC ASYLUM, ANNUAL REPORT FOR 1845, at 24 (1846)).

69. *Id.*

70. *Id.*

71. At least one study has concluded that the postwar years saw many American families using the asylums to resolve family problems by committing wayward children or spouses. J. HUGHES, ALABAMA'S FAMILIES AND INVOLUNTARY COMMITMENT OF THE INSANE, 1861-1900: NEW SOLU-

In the face of this public acquiescence in, and even enthusiasm for, custody, the courts deferred.⁷² Gone were the references in court opinions to moral treatment as the reason for institutionalization. Instead, in dispensing with procedural protections,⁷³ the courts adopted the argument of the medical superintendents that at least commitment was not prison. Courts explicitly held that commitment of a mental patient was for "the safety of himself and the public,"⁷⁴ and that mental patients needed the "protection and restraints of an asylum."⁷⁵

The lunatic, once endowed with the rights of citizenship, "ceased to be a man" through the onset of insanity.⁷⁶ Courts typically described the insane before them as "incurable" and "dangerous."⁷⁷ Additionally, the courts, much like the public, heeded the medical superintendents' alarm as to the risk posed by the volatile and erratic lunatic. During a time when the new republic felt threatened by immigration and the aftermath of war, the courts warned society as well:

[H]is condition is one . . . which may be said to oscillate between insanity and imperfect sanity, for any disturbance of health may cause him to cross the boundary. . . .

His life may be said to have been cast in the borderland of insanity. But as no chart has yet been made of the shadowy land that lies between the boundaries of sanity and insanity, we know nothing positively of its extent or the fluctuations which its area at times undergoes. A little more or a little less on this side or that may change the entire character of an individual, and convert him from a responsible into an irresponsible being. Like the limits of riparian ownership on turbulent streams, the borders of sanity may be encroached upon by every flood of passion without yet producing mental aberration; or again, they may be undermined by bodily disease inherited or acquired, until they finally crumble and are swept into the torrent of disorder.⁷⁸

TIONS TO OLD PROBLEMS, *passim* (Institute for Legal Studies Working Paper Series 2, 1987).

72. D. ROTHMAN, *supra* note 20, at 282.

73. Procedural obstacles were enacted by state legislatures just after the Civil War in response to notorious cases of "railroading" sane relatives into asylums for financial gain, A. DEUTSCH, *supra* note 22, at 425, but were relaxed again by the legislatures in the 1880s and 1890s. *Id.* at 432; *see also* R. SIMON, CLINICAL PSYCHIATRY AND THE LAW 175-76 (1987) (following the Civil War, the decision to commit shifted from the family and physicians to the courts; however, from 1900-1920, the physicians recaptured some of their lost influence).

74. *In re* Approval of Medical Certificates of Insanity, 7 N.Y.S. 671, 672 (City Ct. 1889) (ruling that the two physicians' certificates need not be executed on the same day); *Inhabitants of Amherst v. Inhabitants of Sherburne*, 77 Mass. (11 Gray) 107, 109 (1858) ("no illegality or irregularity" in the commitment of lunatic, even where commitment order not in writing or filed in court); *Armstrong County v. Overseers of the Poor*, Pittsburgh L.J., Aug. 25, 1875, at 86 col. 1 (Pa. Super. Ct. Nov. 15, 1875) ("Mere informalities and harmless errors must be disregarded.").

75. *Ayer's Case*, 3 Abb. N. Cas. 218, 222 (N.Y. State Comm'r in Lunacy 1877).

76. *Howard v. Howard*, 87 Ky. 616, 623, 9 S.W. 411, 413 (1888).

77. *Ayer's Case*, 3 Abb. N. Cas. at 221.

78. *Brush's Case*, 3 Abb. N. Cas. 225, 227 (N.Y. State Comm'r in Lunacy 1877). The court also spoke of "insuperable obstacles" appearing "at every stage of progress toward convalescence."

It is no wonder at all that the courts felt safer with the dangerous lunatic easily committed behind the walls of the asylum.

The courts expected that, even with the original purpose of treatment abandoned, the asylums would still be able to meet the medical superintendents' new standard; that is, the asylums provided better custodial care than the prisons. In a false imprisonment case, one court appeared willing to live with a lot of abuse:

The asylums were to be retreats for proper instruction and treatment, and not in any sense prisons or bedlams. . . .

. . . .
That the system has worked well thus far is demonstrated by the fact that this is the first instance in which complaint of it appears in our records. Nevertheless there are possibilities in it which must not and cannot be overlooked. . . . Indeed when we admit that such things are possible, we concede that other things still more dreadful are also possible; but we shall not stop to contemplate, or even to suggest them. If the law permits this, we must take it with all its possible evils and abuses.⁷⁹

The abandonment of treatment and of the mentally ill continued until the age of reform, the Progressive Era.

*D. The Progressive Era and the Second Reform: The Individual's
Corruption to be Prevented*

The Progressives of the 1890s sought to reform much of the perceived corruption in American life.⁸⁰ This reform movement included an attempt to conquer diseases which corrupted the human body through large scale vaccination and quarantine efforts.⁸¹

As the war against corrupting diseases eventually expanded to insanity, the overcrowded, understaffed, and purely custodial asylums again became an enemy. Once again, the community made a commitment to cure insanity, but on a case-by-case basis. The Progressives critiqued the Jacksonians' reform as too simplistic in assuming that all insanity could best be treated through utopian

Id.

79. Van Deusen v. Newcomer, 40 Mich. 90, 125 (1879). Other courts also forgot the warning of William Hammond of the horrors waiting behind the model asylum's walls. In *People ex rel. Norton v. New York Hosp.*, 3 Abb. N. Cas. 229 (N.Y. State Comm'r in Lunacy 1876), a man sued over his wife's mistreatment at the hands of asylum staff. The court entertained a "presumption derived from time[] and the history of that institution" that no one else had been mistreated, since no one had complained. *Id.* at 241. Also, while acknowledging that the traditional distrust of a lunatic's testimony needed re-evaluation in the age of asylums, *id.* at 248, the wife's testimony about intentional abuse was not credited. *Id.* at 255-56. Still, the court found some independent evidence of negligence and ordered daily record keeping and the employment of a supervisor of overworked attendants. *Id.* at 272-73.

80. See generally R. HOFSTADTER, *THE AGE OF REFORM* (1955) (discussing the political reform movement of the Progressives).

81. Merritt, *The Constitutional Balance Between Health and Liberty*, 16 HASTINGS CENTER REP., Dec. Supp. 1986, at 2, 3.

communities. From the Progressive perspective, some insanity was best cured within the community.⁸² Such an individualistic approach to deviancy required, in turn, broad discretion on the part of those deciding whether to institutionalize the individual, and a concomitant expansion of government and professional power.⁸³ The problem with the asylums, from the Progressive viewpoint, lay not in their existence, but in their uniformity and their repressiveness.⁸⁴

As 1890 approached, institutional care continued to decline. Overcrowding, beds filled with the chronic mentally ill, and violence among patients and between patients and staff were all relatively commonplace.⁸⁵ Custody and safety were the only governing rationale.

This state of affairs, unacceptable under most circumstances, continued without significant challenge for a number of reasons. These cruel warehouses confined the poor and alien. By 1890, in Illinois, half of the patient population was foreign-born; in one New York asylum, immigrants claimed eighty-six percent of the patient beds.⁸⁶ Most of these patients were unskilled or semi-skilled laborers, farmers or domestics; in Connecticut, ninety-four percent of the patients were considered paupers.⁸⁷ Moreover, the cost of these asylums, especially unsanitary and understaffed ones, stayed relatively low.⁸⁸

Even with all the faults associated with the asylum, mental health reformers continued to defend the insane asylum as superior to the prison or the poorhouse.⁸⁹ However, those most vociferous in their criticisms of the asylum, the neurologists, only wanted better institutions and proposed no alternatives.⁹⁰

The reality of the asylum, as known by the professionals,⁹¹ along with the public image of the asylums as cruel refuges,⁹² brought the insanity issue to the Progressive agenda. Sharing the optimism and missionary zeal of Progressivism, the new psychiatrists hoped to conquer insanity, and therefore tired of

82. D. ROTHMAN, CONSCIENCE AND CONVENIENCE, THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA 5 (1980).

83. *Id.* at 8. The close of the Jacksonian era also saw popular acceptance of the medical profession. P. STARR, *supra* note 25, at 80-82.

84. D. ROTHMAN, *supra* note 82, at 12.

85. *Id.* at 21-22.

86. *Id.* at 24.

87. *Id.*

88. *Id.* at 27.

89. *Id.* at 29.

90. *Id.* This was true, even though the neurologists recognized the harmful effects of institutionalization. William Hammond wrote that the asylum's protectors "fail entirely to appreciate the strength of the passion for liberty which is in the human heart. . . . All the comforts which the insane person has in his captivity are but a miserable compensation for his entire loss of liberty . . . the mighty suffering of lifelong imprisonment." W. HAMMOND, THE NON-ASYLUM TREATMENT OF THE INSANE 2, 7-12 (1879), *quoted in* D. ROTHMAN, *supra* note 82, at 38.

91. D. ROTHMAN, *supra* note 82, at 294.

92. *See, e.g.*, C. BEERS, A MIND THAT FOUND ITSELF (1917) (an autobiography of a patient, Clifford W. Beers).

the dominance of the failing asylums.⁹³

This bond between Progressives and physicians stemmed in part from the emergence of the physicians' status and power.⁹⁴ For example, the profession triumphed over patent medicine as an alternative, nonprofessional treatment for illness.⁹⁵ The physicians' improved status also reflected a popular belief in science and the inaccessibility of knowledge to the lay person,⁹⁶ particularly knowledge of the complexities of medical science.⁹⁷ "The assumptions of radicals, reformers and conservatives reflected the more general decline of confidence in the ability of the laymen to deal with their own physical and personal problems."⁹⁸ Some of the most impressive victories of the medical profession occurred in the regulation of public hygiene.⁹⁹ The medical profession's new position of influence is suggested by the physicians' assumption of the power of "gatekeeper," deciding who could and could not qualify for military service.¹⁰⁰ Similarly, psychiatrists medicalized and professionalized insanity. Mental illness was transformed from the Jacksonian's price of social dislocation to an individual malady treatable by a doctor, like any other malady.

Well-intentioned proposals to upgrade the asylum tended to be haphazard and vague. The proposals lacked any governing treatment principle until the mental hygiene movement and Adolf Meyer.¹⁰¹ Meyer emphasized the facts of each individual case of insanity.¹⁰² He shifted away from biological explanations in favor of a theory of "maladaptation": an examination of the highly individual manner in which the patient adjusted to life's difficulties.¹⁰³ Called "civic medicine," Meyer's theory proposed to bring psychiatry out from behind asylum walls and into the outside community.¹⁰⁴ The psychiatrist focused on both the particular facts of the individual patient and the patient's environment in hopes of eliminating mental illness through prevention and cure.¹⁰⁵

Civic medicine took concrete form in a variety of ways. Proposals for new outpatient clinics, new psychopathic hospitals for short-term confinement, new after-care programs, new alternatives such as family and boarding care, new professionals such as social workers, and a new community mental health edu-

93. G. GROB, *supra* note 52, at 110; D. ROTHMAN, *supra* note 82, at 293-94. The Progressives gave psychiatrists the power they needed: "As ardent believers in the value of medical care and the legitimate basis of professional authority, Progressive reformers had no basic quarrel with physicians." P. STARR, *supra* note 25, at 246.

94. See P. STARR, *supra* note 25, at 128-29.

95. *Id.* at 128-33.

96. *Id.* at 134-35.

97. *Id.* at 142.

98. *Id.* at 141.

99. *Id.* at 135, 246.

100. *Id.* at 137.

101. D. ROTHMAN, *supra* note 82, at 306 ("Adolf Meyer not only coined the term 'mental hygiene' but, more than any other single figure, defined and popularized its principles.").

102. *Id.* at 303.

103. *Id.* at 302-06; see G. GROB, *supra* note 52, at 112-15.

104. D. ROTHMAN, *supra* note 82, at 306-07.

105. *Id.*

cational program were all aspects of civic medicine.¹⁰⁶ Left in the equation was the old asylum, which was now intended only for the incurable patient who needed long-term or even lifetime care.¹⁰⁷ While the asylums had to be made over into therapeutic places to further the reform agenda, the Progressives even had a role for the warehouses, a eugenic purpose: to keep the incurable isolated and incapable of reproducing.¹⁰⁸

The Progressives were confident in science and the rightness of their cause. To quickly accomplish their ends and overcome procedural obstacles, the Progressives insisted upon simple and efficient commitment procedures.¹⁰⁹ The commitment courts cooperated by permitting those petitioning for the patient's confinement to dispense with notice of the commitment proceeding if notice would excite the patient.¹¹⁰ Consistent with the Progressive vision, government action in this arena was preferred over the less trustworthy acts of private individuals; "[a] wise administration of government does not leave it to private persons to decide when these restrictions [commitments] shall be exercised."¹¹¹

The courts could play little affirmative role in implementing the new components of the civic medicine program. Nonetheless, the courts shared the Progressive psychiatrists' abhorrence of the asylum, their faith in the possibility of cure, and their insistence upon careful review of the facts of each commitment case. In issuing a writ of mandamus for the discharge of a patient in *Statham v. Blackford*,¹¹² the Virginia Supreme Court of Appeals held:

Insane asylums are for the care and custody of the insane. There is no lawful place in them for the sane man. If, in such a case as this, an improving patient has been released temporarily for her improvement, and she has gone on to improve, as is conceded, and as is, moreover, distinctly proven in this case, until she is blessed by a complete recovery and a perfect restoration to health, ought this delicate lady, nearly three score and ten years old, to be released entirely, or should she be carried back against her will withal to the lunatic asylum before her just status can be recognized? We think, if she is sane, she is entitled to her freedom.¹¹³

106. *Id.* at 309-19.

107. G. GROB, *supra* note 52, at 107; D. ROTHMAN, *supra* note 82, at 319-23.

108. D. ROTHMAN, *supra* note 82, at 320-23.

109. *Id.* at 327-28.

110. *Simon v. Craft*, 182 U.S. 427, 436 (1901); *Brayman v. Grant*, 130 A.D. 272, 274, 276, 114 N.Y.S. 336, 338-39 (1909); *In re Andrews*, 126 A.D. 794, 799, 111 N.Y.S. 417, 420 (1908); *Emmerich v. Thorley*, 35 A.D. 452, 458, 54 N.Y.S. 791, 795 (1898); *People ex rel. Sullivan v. Wendel*, 33 Misc. 496, 498, 68 N.Y.S. 948, 949 (Sup. Ct. 1900). This judicial response is consistent with the general attitude of the courts toward the Progressive health agenda. Other courts similarly approved reformers' programs of quarantine and vaccination. *Merritt*, *supra* note 81, at 3. One court proclaimed that these public health measures represent "the highest law of the land," to which the Constitution must give way. *Beeks v. Dickinson County*, 131 Iowa 244, 248, 108 N.W. 311, 312 (1906).

111. *Porter v. Ritch*, 70 Conn. 235, 257, 39 A. 169, 176 (1898).

112. 89 Va. 771, 17 S.E. 233 (1893).

113. *Id.* at 776, 17 S.E. at 234.

An appellate court in Rhode Island affirmed the exclusion of available evidence that suggested insanity and also evidence of the propriety of commitment in the institution; the patient assured the court that she would remain in her sister's house and not go at large until cured.¹¹⁴

Similarly, the Supreme Court of Mississippi affirmed a trial court verdict for the purportedly insane plaintiff in a false imprisonment suit, writing eloquently of the facts of that case:

A sad, silent, and fragile little lady, now beyond middle life, wrongfully declared a lunatic, and that of the most repulsive style, shut up in a mad house, under the circumstances disclosed, and with a stigma branded upon her name and character which verdicts of juries and judgments of courts may never wholly efface, and with endurance of such shame, humiliation, and crucifixion of soul as happily does not often fall to women's lot, has appealed to the courts for redress of her wrongs, and we do not feel authorized to take from her the poor fruits of her victory.¹¹⁵

E. The Corruption to be Eliminated: The Failure of the Second Reform

The Progressive victories were short-lived. As David Rothman has observed, "Nowhere was the gap between Progressive ambitions and day-to-day realities greater than in the field of mental health."¹¹⁶ Few of the planned new psychopathic hospitals for the curable insane were even built, and those few served as diagnostic centers for the state hospitals. Psychiatrists faced the limitations of mental hygiene as a cure for the apparent maladaptations of actual patients brought to their door.¹¹⁷ Psychopathic hospitals were reduced to mere processing centers that offered only a transparent "milieu therapy."¹¹⁸ Boarding care and family care alternatives were quickly abandoned,¹¹⁹ as were outpatient clinics.¹²⁰

As the First World War approached, the asylums, now called state hospitals, remained entrenched, and even legitimized by the reformers' efforts.¹²¹ Yet, nothing changed.¹²² The case histories, important to a fact-based and individual approach to treatment, fell victim to the large volume of patients and the need to base treatment decisions on something more easily accessible, such as the patient's behavior upon admission.¹²³ Hospitals classified patients by

114. *Senft v. Carpenter*, 18 R.I. 545, 545, 28 A. 963, 964 (1894).

115. *Bacon v. Bacon*, 76 Miss. 458, 472-73, 24 So. 968, 971 (1899).

116. D. ROTHMAN, *supra* note 82, at 324.

117. *Id.* at 325-26.

118. *Id.* at 330.

119. *Id.* at 361-63.

120. *Id.* at 363-70.

121. *Id.* at 335.

122. P. STARR, *supra* note 25, at 146. At the same time, Progressive reformers had brought hospitals to the mainstream of nonpsychiatric medical care. *Id.*

123. G. GROB, *supra* note 52, at 190-91 ("A significant proportion of the total institutionalized population . . . were persons suffering from a variety of physical disabilities that also involved

their ease of control, not their treatment needs.¹²⁴ The many patients milling around the crowded wards received less treatment as their stays lengthened.¹²⁵ Treatment, administered to groups of patients, consisted of irrelevancies such as music therapy and a peonage system disguised as occupational therapy.¹²⁶ After America passed through one world war and moved toward a second, the state hospitals filled with those patients believed chronic and, increasingly, senile.¹²⁷ As before the reforms, the state hospitals bulged at the seams with patients. Meanwhile, construction of new hospitals crawled, and the new psychopathic hospitals essentially never began.¹²⁸

The other side of the overcrowding equation, insufficient staffing, contributed to the continued decline of the state hospitals. The American Psychiatric Association ("APA") issued standards that required one psychiatrist for every 150 patients, which, assuming ten patients seen per psychiatrist each day, resulted in patient-psychiatrist contact once every three weeks.¹²⁹ Yet, few institutions met even that standard. During the period from 1900 to 1940, the average physician to patient ratio was 1:250, with several institutions obviously faring much worse.¹³⁰ Turnover, low salaries, and poor working conditions meant poorly qualified staff which, in turn, resulted in a custodial facility.¹³¹ Efficiency in managing the custody of troubled human beings can require cruelty, and the state hospitals were, in that sense, efficient.¹³²

Much of the Progressive program failed because of community opposition to mental patients in the neighborhoods.¹³³ These communities rejected the community treatment alternative because they apparently believed the Progressives were going to protect them from physical and mental diseases by isolation and cure, not by putting the patient next door.¹³⁴ The increasingly powerful hospital superintendents also opposed the community treatment measures, insisting upon their share of staff and resources as well as patients.¹³⁵ The state hospitals became even more formidable, as the alternatives failed, and the state hospital bed count increased at five times the rate of growth in the general population.¹³⁶

No realistic alternative to the state hospitals presented itself as the domi-

behavioral symptoms."); D. ROTHMAN, *supra* note 82, at 338 ("What was relevant, what . . . determine[d] the responses of [the hospital] was the patient's behavior that very day, then and there, in the institution.").

124. D. ROTHMAN, *supra* note 82, at 340; see G. GROB, *supra* note 52, at 191.

125. D. ROTHMAN, *supra* note 82, at 342.

126. *Id.* at 344-48.

127. *Id.* at 349; see G. GROB, *supra* note 52, at 180-82, 184, 197.

128. D. ROTHMAN, *supra* note 82, at 351.

129. *Id.* at 353.

130. *Id.*

131. G. GROB, *supra* note 52, at 199; D. ROTHMAN, *supra* note 82, at 353-55.

132. D. ROTHMAN, *supra* note 82, at 356.

133. G. GROB, *supra* note 52, at 180.

134. Merritt, *supra* note 81, at 4-5.

135. D. ROTHMAN, *supra* note 82, at 371.

136. *Id.* at 374.

nant treatment for mental illness. The public accepted the continued dominance of the state hospitals.

As before, the statistics on patient demography exhibited disturbing trends. While the foreign-born patients' domination of the hospitals declined somewhat, fully one-third of the patients in 1920 were foreign-born—twice their percentage of the national population. Further, most patients came from lower economic classes.¹³⁷ Two world wars and the Depression had focused the attention of Americans living outside the asylum walls on their own survival. The state hospitals grew on their own without anyone to object and without a therapeutic vision, only the necessity of some place to put the insane.

Once again, the courts embraced custody as the state hospital's governing principle. One court explicitly added this purpose to the commitment statute: "[A]lthough the word 'custody' is not mentioned in defining the purposes of hospitals for the insane . . . , it is common knowledge that one of the most salient purposes of such institutions is custodial."¹³⁸ Interestingly, a Virginia court insisted upon compliance with a statutory four-month limit on the duration of commitment to a private facility, since the purpose of such places was to cure insanity.¹³⁹ Still, the court accepted without comment the absence of any such limit of commitment to a public mental hospital,¹⁴⁰ presumably because no such purpose defined the appropriate length of public commitment. Security and protection, principles usually attendant to a custodial purpose, became paramount once again. For example, in *In re Harcourt*,¹⁴¹ an appellate court affirmed a lower court commitment order even though the order violated the state commitment statute.¹⁴² The order premised confinement on the finding that the lunatic "possibly" posed a danger to others.¹⁴³ The court read the word "possibly" right out of the order because, "if allowed to remain at large, he would, by reason of such mental condition, endanger life, person, etc. or become a menace to the safety of the public."¹⁴⁴

Consistent with the Progressives' lack of concern for procedural protections, courts routinely followed the rule that "[l]unacy statutes should be liberally construed to the effect that no insane person may be permitted at large if the necessity of the case requires [that] they should be restrained."¹⁴⁵

137. *Id.* at 350-51. Many feared that foreign countries were dumping their insane on America's shores, and so immigration restrictions resulted. G. GROB, *supra* note 52, at 168-71.

138. *State ex rel. Bricker v. Griffith*, 36 N.E.2d 489, 491, 34 Ohio L. Abs. 95, 97 (Ohio Ct. App. 1941).

139. *Watkins v. Hall*, 161 Va. 924, 930, 172 S.E. 445, 447 (1934).

140. *Id.* at 929-30, 172 S.E. at 447.

141. 27 Cal. App. 642, 150 P. 1001 (1915).

142. *Id.* at 645-46, 150 P. at 1003 (the lower court's order stated that the insane party posed only a *possibility* of danger to others, yet the appellate court conceded that the commitment statute required more than a mere possibility of danger to others).

143. *Id.* at 645, 150 P. at 1003.

144. *Id.* at 646, 150 P. at 1003.

145. *In re Cash*, 313 Ill. App. 281, 285, 40 N.E.2d 312, 313 (1942), *aff'd*, 383 Ill. 409, 50 N.E.2d 487 (1943), *appeal dismissed sub nom. Cash v. Metropolitan Trust Co.*, 321 U.S. 747 (1944); *see also Payne v. Arkebauer*, 190 Ark. 614, 617-18, 80 S.W.2d 76, 77-78 (1935) (waiving

On the other hand, the deteriorating conditions in the state hospitals did not escape the courts' notice altogether. In a series of decisions, New York courts entertained damages suits brought on behalf of confined patients harmed by the dangerous environment of the state hospitals.¹⁴⁶ The courts repeatedly criticized the overcrowded conditions that resulted in poor attention from staff and patient injuries.¹⁴⁷ The courts found no excuse in the drain of funds to fight the Second World War.¹⁴⁸

Nonetheless, the courts did not attempt to reform the hospitals, although they noted that "very little was done in the way of treatment for [patients'] mental condition," and they criticized the peonage system.¹⁴⁹ Rather, in that "age of enlightenment when humanitarian principles are supposed to govern the State in its treatment of such unfortunates,"¹⁵⁰ the courts defined the state's duty solely in terms of "taking every reasonable precaution to protect their patients from injury either self-inflicted or otherwise."¹⁵¹

The courts shared the view of mental patients held by the rest of the country. Mental patients were "permanently insane"¹⁵² and "dangerous psychotics"¹⁵³ against whom the public was entitled to protection.¹⁵⁴ Given the attitude of the nation's highest court toward the rights of the mentally ill, the public obligation to protect hospital inmates from injury could scarcely expand to include any duty to cure the insane.

During this period, the Supreme Court rendered the notorious decision of *Buck v. Bell*.¹⁵⁵ In *Buck v. Bell*, Justice Holmes approved, almost enthusiastically

the requirement that the lunatic be present during the commitment proceedings).

146. *Luke v. State*, 253 A.D. 783, 783-84, 1 N.Y.S.2d 19, 20 (1937); *St. George v. State*, 203 Misc. 340, 349-50, 118 N.Y.S.2d 596, 605 (Ct. Cl. 1953), *rev'd*, 283 A.D. 245, 127 N.Y.S.2d 147, *rev'd*, 308 N.Y. 681, 124 N.E.2d 320 (1954); *Dowly v. State*, 190 Misc. 16, 21, 68 N.Y.S.2d 573, 579 (Ct. Cl. 1947); *Rossing v. State*, 47 N.Y.S.2d 262, 263 (Ct. Cl. 1944); *Shattuck v. State*, 166 Misc. 271, 273, 2 N.Y.S.2d 353, 355 (Ct. Cl.), *aff'd*, 254 A.D. 926, 5 N.Y.S.2d 812 (1938); *Curley v. State*, 148 Misc. 336, 338, 265 N.Y.S. 762, 764 (Ct. Cl. 1933). Just as false imprisonment and malicious prosecution cases had dominated during the early Progressive era, so these damage cases appeared as the most common context for court treatments of mental illness, with the malicious prosecution and false imprisonment cases disappearing from the court digests.

147. *Luke*, 253 A.D. at 784, 1 N.Y.S.2d at 20; *St. George*, 203 Misc. at 349-50, 118 N.Y.S.2d at 605; *Dowly*, 190 Misc. at 21, 68 N.Y.S.2d at 579; *Rossing*, 47 N.Y.S.2d at 263; *Curley*, 148 Misc. at 338, 265 N.Y.S. at 764.

148. *E.g.*, *Dowly v. State*, 190 Misc. 16, 21, 68 N.Y.S.2d 573, 579 (Ct. Cl. 1947).

149. *Shattuck v. State*, 166 Misc. 271, 272, 2 N.Y.S.2d 353, 354 (Ct. Cl.), *aff'd*, 254 A.D. 926, 5 N.Y.S.2d 812 (1938).

150. *Id.* at 272, 2 N.Y.S.2d at 354.

151. *Id.* at 273, 2 N.Y.S.2d at 355.

152. *Luke v. State*, 253 A.D. 783, 783, 1 N.Y.S.2d 19, 20 (1937) (referring to patients as "permanently insane").

153. *St. George v. State*, 203 Misc. 340, 349, 118 N.Y.S.2d 596, 604 (Ct. Cl. 1953) (referring to patients as "dangerous psychotics"), *rev'd*, 283 A.D. 245, 127 N.Y.S.2d 147, *rev'd*, 308 N.Y. 681, 124 N.E.2d 320 (1954).

154. *Id.* (speaking of the remission of illness, not recovery).

155. 274 U.S. 200 (1927).

cally, the sterilization of "mental defectives."¹⁵⁶ Holmes claimed that "experience has shown that heredity plays an important part in the transmission of insanity, imbecility, [etc.]"¹⁵⁷ Invoking the doctrine of *parens patriae*,¹⁵⁸ Holmes held that society may sterilize those declared "manifestly unfit . . . who already sap the strength of the State"¹⁵⁹ to prevent them from "continuing their kind."¹⁶⁰ The eugenic purpose of the state hospital included by the Progressives in their package of reforms,¹⁶¹ had taken its next logical step. Society would eliminate insanity by eliminating the mentally ill.¹⁶²

F. Postwar America and the Third Reform: The Social Wrong to be Righted

The state hospitals felt the effects of the Depression right along with the rest of the country. Even before pressure for a new reform movement could build, the state hospitals contemplated releasing patients to reduce operating costs.¹⁶³ However, the reform did not define and implement itself until the end of the Second World War. Psychiatrists returning to civilian life began their practice and research in the post-war atmosphere of optimism and belief in the power of technology. New therapeutic techniques were available, such as hypnosis, drugs, and shock therapy.¹⁶⁴ With the introduction of antipsychotic medications, psychiatrists believed that mental illness could be cured outside the state hospitals, and that the mentally ill could remain within the community and have their symptoms controlled by medication.¹⁶⁵

While these psychiatrists found new support for their belief in science, they emphasized the need for psychiatry to move "beyond its traditional one-to-one

156. *Id.* at 207.

157. *Id.* at 206.

158. *See supra* note 12.

159. *Buck v. Bell*, 274 U.S. at 207.

160. *Id.* Justice Holmes stated:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices . . . in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles are enough.

Id.

161. D. ROTHMAN, *supra* note 82, at 320-23.

162. Once again, these more extreme measures to deal with obstinate insanity parallel the more aggressive government intervention to defeat disease generally. Merritt, *supra* note 81, at 6.

163. *See Goldman & Morrissey, The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform*, 75 AM. J. PUB. HEALTH 727, 728 (1985).

164. A. DEUTSCH, *supra* note 22, at 479-80, 497-502. The postwar era saw a renewal in the popular belief in science and support for public financing of science. P. STARR, *supra* note 25, at 340.

165. National Institute of Mental Health Psychopharmacology Service Center, *Phenothiazine Treatment in Acute Schizophrenia*, 10 ARCHIVES GEN. PSYCHIATRY 246, 256 (1964); Goldman & Morrissey *supra* note 163, at 728.

therapy and its emphasis on individual adjustment"¹⁶⁶ left over from the mental hygiene movement. They believed psychiatry ought to "concern itself with large numbers of people and with the social conditions around them."¹⁶⁷

The reformers identified institutions as one of the causes of mental illness in those confined in the institutions for extended periods of time.¹⁶⁸ Popular exposés and professional critiques convinced the public and the psychiatrists that the state hospitals, once asylums and now snake pits,¹⁶⁹ had to go.¹⁷⁰ Some state hospitals implemented crisis intervention programs and aftercare service to prevent initial commitment and to plan for the release of those committed.¹⁷¹ Yet, many psychiatrists were skeptical of the ability and motivation of state hospital administrations to reform themselves.¹⁷²

These community mental health reformers pressed for an end to institution-alization and a new age of treatment in the community. The Joint Commission on Mental Illness and Health published its report in 1961, *Action for Mental Health*, which argued for federal leadership and financial support for mental health reform.¹⁷³ As part of the effort to get the country moving again to meet the challenge of the post-war era, President Kennedy expressed the New Frontier's technological optimism that "a concerted attack on mental disorder is now both possible and practical."¹⁷⁴

The flagship of this new community mental health movement was the Community Mental Health Centers Act¹⁷⁵ passed by Congress and signed by an enthusiastic President Kennedy in 1963.¹⁷⁶ The federal initiative defined five essentials for a reform program: inpatient services, outpatient services, partial hospitalization, emergency intervention, and consultation/education services. These proposals were all designed to be integrated along a continuum of care.¹⁷⁷ The acutely and the chronically mentally ill would all find treatment somewhere in this continuum; each patient would be treated according to his or her individual need, moving toward recovery and a full life as a member of the community.

166. Musto, *Whatever Happened to Community Mental Health?*, 39 PUB. INTEREST 53, 54 (1975).

167. *Id.*

168. Goldman & Morrissey, *supra* note 163, at 728.

169. The term "snake pit" refers to the title of a popular novel of the time. P. STARR, *supra* note 25, at 345 (discussing M. WARD, *THE SNAKE PIT* (1946)); see also Goldman & Morrissey, *supra* note 163, at 728 (describing state mental hospitals as "snake pits").

170. Goldman & Morrissey, *supra* note 163, at 728.

171. *Id.*

172. *Id.*

173. *Id.*; Musto, *supra* note 166, at 61-62.

174. Musto, *supra* note 166, at 65 (quoting President Kennedy's message to Congress on Feb. 5, 1963). This technological optimism was true of reforms in health care generally. P. STARR, *supra* note 25, at 367-69.

175. 42 U.S.C. § 2689 (1976), *repealed by* Omnibus Budget Reconciliation Act, Pub. L. No. 97-35, § 902(e)(2)(B), 95 Stat. 560 (1981).

176. Goldman & Morrissey, *supra* note 163, at 728.

177. *Id.*

In the years right after the Community Mental Health Centers Act, a range of problems connected to deviancy—poverty, crime, and delinquency—were believed to be rooted in unjust social conditions such as discrimination and inequality.¹⁷⁸ The resulting War on Poverty¹⁷⁹ followed the lead of the Community Mental Health Centers Act in acknowledging the primary role to be played by the federal government in correcting those injustices.¹⁸⁰

Predictably, the courts took note of the shift in attitude toward mental illness. Protection and safety were joined by a third institutional objective, the once familiar purpose of curing mental illness:

The state has frequently been held liable for the consequences of its breach of duty to protect others from the acts of the mentally ill confined to State institutions. In such cases, where the confinement is not in the nature of *punishment*, but rather of *restraint* and, where possible, cure, there is both a duty to the inmate to provide him with reasonable rehabilitational conditions under the circumstances and to the outside public to restrain the dangerous, or potentially dangerous, so that they may not harm others.¹⁸¹

In the long series of damages cases brought on behalf of mental patients injured in New York state hospitals, the court enunciated the "policy of the State to care for and protect mentally ill persons and, if possible, to cure them of disease."¹⁸² This line of cases did not cite the many cases decided during the 1930s which spoke only of the obligation to protect from injury. Rather, they skipped over those to the earlier Progressive era decision in *Sporza v. German Savings Bank*,¹⁸³ which dealt with a different problem but proclaimed

178. PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE, THE CHALLENGE OF CRIME IN A FREE SOCIETY 35-38 (1967).

179. The War on Poverty began in 1964 when President Johnson signed the Economic Opportunity Act of 1964 for the purpose of eliminating poverty in the inner-cities. Ferman, *Foreword to 385 ANNALS ix*. (1969) (The entire volume, titled *Evaluating the War on Poverty*, is devoted to the War on Poverty.). The Economic Opportunity Act provided \$350 million to community action programs. F. PIVEN & R. CLOWARD, REGULATING THE POOR 257 (1971). These programs "would 'call on all resources available to the community—Federal and state, local and private, human and material' to strike at poverty at its source, in the streets of the cities." *Id.* (quoting President Johnson). Other programs were developed in the 1960s to supplement existing welfare legislation. Ferman, *supra*, at ix. One commentator called the War on Poverty "creative federalism" because it relied on the joint efforts of federal and state governments to effectuate its purpose. Davidson, *The War on Poverty: Experiment in Federalism*, 385 ANNALS 1, 2 (1969). The War on Poverty grasped the news media's attention and became a major public issue. F. PIVEN & R. CLOWARD, *supra*, at 258 n.7.

180. COMPTROLLER GENERAL OF THE UNITED STATES, GENERAL ACCOUNTING OFFICE, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: GOVERNMENT NEEDS TO DO MORE, HRD-76-152, at 2, 4 (1977) [hereinafter COMPTROLLER]; Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 248-51 (1978).

181. *Williams v. State*, 308 N.Y. 548, 554-55, 127 N.E.2d 545, 549 (1955) (citations omitted) (emphasis in original).

182. *People ex rel. Anonymous v. La Burt*, 14 A.D.2d 560, 560, 218 N.Y.S.2d 738, 739 (1961); *accord Anonymous v. State*, 17 A.D.2d 495, 497, 236 N.Y.S.2d 88, 90 (1963).

183. 192 N.Y. 8, 84 N.E. 406 (1908).

that the state had an objective of curing insanity.¹⁸⁴

Only fifteen years earlier, the Illinois Supreme Court decided *In re Cash*.¹⁸⁵ Like other decisions of its time, *Cash* broadly interpreted commitment statutes to guarantee that no insane person needing confinement failed to receive it.¹⁸⁶ In sharp contrast, the courts of the third reform movement insisted upon a preferential option for liberty. The court in *In re J.W.* stated that "[e]ven the mentally abnormal have the right to personal freedom Where the right of liberty is involved, a reasonable doubt as to the applicability of the statute to the facts presented should be resolved in favor of the subject."¹⁸⁷ Other courts also selected a "reasonable doubt" standard.¹⁸⁸ A decision by an Ohio court declared that "one should be saved from restraint and incarceration with the accompanying stigma until some basis for such drastic procedure is reasonably apparent."¹⁸⁹ This opinion shared more with the 1899 Mississippi Supreme Court decision in *Bacon v. Bacon*,¹⁹⁰ and its worry over the stigma of inappropriate institutionalization, than with more contemporary cases. Similarly, another Ohio decision¹⁹¹ signaled the completion of the 180-degree turn begun by the Jacksonians for whom the asylum was the treatment of first resort. The court, in discussing the legislature's enactment of a commitment statute, stated that "[t]he purpose and intent of the legislature in enacting this Chapter was to make hospitalization of the mentally ill by court commitment a difficult and complex procedure to be used only as a last resort when all other means of getting the individual's illness treated have been exhausted."¹⁹² Commitment procedures bore tough scrutiny by courts concerned about the deprivation of individual rights.

The visible leadership role played by the federal government in enacting the Community Mental Health Centers Act was reflected as well in the newly active federal courts. The courts' new role was to protect federal constitutional and statutory rights against state encroachment.¹⁹³ The civil rights movement's invocation of the courts spread to the rights of prisoners. The next logi-

184. *Id.* at 19, 22, 84 N.E. at 410-11 (holding that an incompetent can waive a right to a jury trial).

185. 313 Ill. App. 281, 40 N.E.2d 312 (1942), *aff'd*, 383 Ill. 409, 50 N.E.2d 487 (1943), *appeal dismissed sub nom.* *Cash v. Metropolitan Trust Co.*, 321 U.S. 747 (1944).

186. *Id.* at 285, 40 N.E.2d at 313.

187. *In re J.W.*, 44 N.J. Super. 216, 226, 130 A.2d 64, 69 (Super. Ct. App. Div.), *certification denied*, 24 N.J. 465, 132 A.2d 558 (1957).

188. *See In re Pickles*, 170 So. 2d 603, 614 (Fla. Dist. Ct. App. 1965) ("A person under restraint of his liberty is entitled to liberation where reasonable doubt exists as to his mental condition.").

189. *State ex rel. Bles v. Merrick*, 2 Ohio St. 2d 13, 16, 205 N.E.2d 924, 926 (1965).

190. 76 Miss. 458, 472-73, 24 So. 968, 971 (1899) (citing the stigma of institutionalization as a justification for the plaintiff's damage award).

191. *In re Leitner*, 180 N.E.2d 438, 87 Ohio L. Abs. 467 (Ohio Prob. Ct. 1961).

192. *Id.* at 439, 87 Ohio L. Abs. at 469 (expressing a preference for voluntary admission to the hospital.).

193. *See generally* J. HANDLER, *SOCIAL MOVEMENTS AND THE LEGAL SYSTEM* (1978) (discussing the attempts of social movements to use court action to achieve change).

cal step was to protect the rights of those civilly confined.¹⁹⁴ The law invoked by the courts went beyond ancient doctrines of *parens patriae*, the provisions of state statutes, or the policies of protection or treatment. The courts turned to the Constitution.

The Supreme Court joined the reform movement by reviewing claims of mentally ill individuals who were generally considered the more dangerous of the mentally ill: addicts, criminal defendants, and convicted felons. In 1962, the Supreme Court held that states may not, under the eighth amendment of the Constitution, punish the status of narcotics addiction.¹⁹⁵ In dicta, the Court extended this protection to mental illness as well.¹⁹⁶ Four years later, the Court invalidated a commitment procedure for convicts on equal protection grounds, where the commitment procedure differed from that used for civil commitment.¹⁹⁷ Five years later, Justice Thurgood Marshall wrote, for a majority of the Court, that civil commitment of a sex offender was a "massive curtailment of liberty."¹⁹⁸ That same year, the Court forbade a state to commit indefinitely someone initially confined for an evaluation of the person's competency to stand trial:

[The individual] was not afforded any "formal commitment proceedings addressed to [his] ability to function in society," or to society's interest in his restraint, or to the State's ability to aid him in attaining competency through custodial care or compulsory treatment, the ostensible purpose of the commitment. At the least, due process requires that the nature and duration of commitment bear some reasonable relationship to the purpose for which the individual is committed.¹⁹⁹

By 1975, the Supreme Court ruled on the constitutional liberty interests of one civilly committed as a mental patient, not as a criminal defendant. In *O'Connor v. Donaldson*,²⁰⁰ Chief Justice Burger noted the emptiness of the milieu therapy provided in the state hospital: "a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness."²⁰¹ Nonetheless, Burger sidestepped the difficult right-to-treatment issues. In so doing, he expressed the rights of the mental patient in terms applicable to all members of society: "As we view it, this case raises a single, relatively simple, but nonetheless important question concerning every man's

194. The first federal courts to consider the constitutional rights of the mentally handicapped, in protecting the educational rights of mentally retarded children, cited the equal protection analysis of *Brown v. Board of Educ.*, 347 U.S. 483 (1954), as precedent. *Mills v. Board of Educ.*, 348 F. Supp. 866, 874-75 (D.D.C. 1972); *Pennsylvania Ass'n for Retarded Children v. Pennsylvania*, 343 F. Supp. 279, 297 (E.D. Pa. 1972).

195. *Robinson v. California*, 370 U.S. 660, 666 (1962).

196. *Id.* ("It is unlikely that any state at this moment in history would attempt to make it a criminal offense for a person to be mentally ill.")

197. *Baxstrom v. Herold*, 383 U.S. 107, 114-15 (1966).

198. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

199. *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

200. 422 U.S. 563 (1975).

201. *Id.* at 569.

constitutional right to liberty."²⁰²

Burger rejected both the state commitment statute and the committing court's initial order as justifications for the patient's commitment.²⁰³ The Court also rejected anything implicit in the concept of mental illness that would justify the indefinite commitment of a patient:

May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends.²⁰⁴

Burger limited his opinion by finding only that a state could not hold "without more, a nondangerous individual who is capable of surviving safely in freedom by himself"²⁰⁵ or with the help of his family and friends. Still, *Donaldson* represented the Supreme Court's acceptance of the lessons of the third reform—integration into the community and the irrelevance of the asylum—and the reform's metaphor of social justice.

In the 1960s and early 1970s, the federal courts actively intervened in the state mental health systems. The courts required strict observance of procedural due process before commitment.²⁰⁶ They also enacted complex standards for the treatment of those committed.²⁰⁷ On the other side of that issue, a few federal courts found a right to refuse unwanted treatment, such as psychotropic medication.²⁰⁸

The state courts followed the federal lead, requiring proof of dangerousness

202. *Id.* at 573.

203. *Id.* at 574.

204. *Id.* at 575 (citing *Shelton v. Tucker*, 364 U.S. 479, 488-90 (1960)).

205. *Id.* at 576.

206. *Sarzen v. Gaughan*, 489 F.2d 1076, 1086 (1st Cir. 1973) (requiring right to counsel); *Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968) (same); *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1127 (D. Haw. 1976) (requiring notice of commitment proceedings and the procedural rights available); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1087 (E.D. Wis. 1972) (requiring adequate hearings before commitment), *vacated on other grounds*, 414 U.S. 473 (1974).

207. *Gary W. v. Louisiana*, 437 F. Supp. 1209, 1219 (E.D. La. 1976) (determining that the proper standard varies with each child based on the child's own attributes and needs); *Welsch v. Likins*, 373 F. Supp. 487, 491 (D. Minn. 1974) ("Whether such commitment gives rise to a constitutional right to treatment is a difficult question, involving complex legal, medical, and 'political' considerations."); *Wyatt v. Stickney*, 344 F. Supp. 387, 392 (M.D. Ala. 1972) (ordering mental health facility to establish a committee that would oversee the treatment procedures of the facility).

208. *Rennie v. Klein*, 653 F.2d 836, 843 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983); *Scott v. Plante*, 532 F.2d 939, 946 (3d Cir. 1976); *see Mackey v. Procunier*, 477 F.2d 877, 878 (9th Cir. 1973) (finding right to refuse succinylcholine which is a "breath-stopping and paralyzing 'fright drug'").

prior to commitment²⁰⁹ and periodic judicial review to determine the necessity of continued confinement.²¹⁰ Significantly, the courts began applying the less restrictive alternative principle²¹¹ to the civil commitment process. This principle demanded that courts determine prior to permitting commitment that there were no alternatives in the community which would serve the state's purposes of treating the patient.²¹²

These litigated reforms culminated in the fateful decision, *Halderman v. Pennhurst State School and Hospital (Pennhurst I)*.²¹³ *Pennhurst I* dealt with the rights of the mentally retarded and attacked institutionalization itself. The federal district court in *Pennhurst I* ordered the phase out of the institution and the placement of its mentally retarded residents back in the community.²¹⁴ Other courts have also ordered state mental health departments to develop community alternatives to institutions.²¹⁵

G. *The Failure to be Dumped: The Failure of the Third Reform*

The reality, since nearer in history, is familiar. Since the 1960s, the "dumping" of mental patients back into the community has drawn criticism from all quarters, including psychiatrists²¹⁶ and the popular press.²¹⁷

At first blush, the numbers cannot fail to impress. In the thirty-year period following 1950, the state hospital census dropped by seventy-five percent, from over half a million to less than 140,000 nationally.²¹⁸ Outpatient services increased significantly.²¹⁹ More than 700 community mental health centers were

209. *E.g.*, *People v. Sansone*, 18 Ill. App. 3d 315, 323, 309 N.E.2d 733, 739 (1974).

210. *E.g.*, *Fasulo v. Arafah*, 173 Conn. 473, 476-77, 378 A.2d 553, 555 (1977).

211. *See Shelton v. Tucker*, 364 U.S. 479, 489 (1960).

212. *Lake v. Cameron*, 364 F.2d 657, 659 (D.C. Cir. 1966), *cert. denied*, 382 U.S. 863 (1965); *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974).

213. 446 F. Supp. 1295 (E.D. Pa. 1977), *aff'd in part and rev'd in part*, 612 F.2d 84 (3d Cir. 1979) (en banc) (the appellate court substantially affirmed on the merits), *rev'd*, 451 U.S. 1 (1981).

214. *Id.* at 1326. The court was critical of institutionalization itself. *Id.* at 1313.

215. *E.g.*, *Welsch v. Likins*, 373 F. Supp. 487, 500 (D. Minn. 1974). The court stated:

These cases demonstrate the widespread acceptance by the courts of a constitutional duty on the part of State officials to explore and provide the least stringent practicable alternatives to confinement of noncriminals. As applied to involuntary civil commitment these options [range] from placement of the committed person in the custody of a friend or relative to disposition within a private facility.

Id. (citing *Lessard v. Schmidt*, 349 F. Supp. 1078, 1096 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974); *Wyatt v. Stickney*, 344 F. Supp. 387, 386 (M.D. Ala. 1972)).

216. Bassuk & Gerson, *Deinstitutionalization and Mental Health Services*, 238 Sci. AM., Feb. 1978, at 46, 49 ("[C]hronic patients are being discharged to a lonely existence in hostile communities without adequate care.").

217. Koenig, *The Problem That Can't Be Tranquilized: 40,000 Mental Patients Dumped in City Neighborhoods*, N.Y. Times, May 21, 1978, § 6 (Magazine), at 14, 17.

218. Goldman & Morrissey, *supra* note 163, at 728; *see also* Musto, *supra* note 166, at 69 (average census dropped from 557,000 in 1957 to 249,000 in 1973).

219. Goldman & Morrissey, *supra* note 163, at 728.

developed.²²⁰

However, there are other, less appealing, statistics. Over this same period, 700,000 chronically mentally ill persons took up long-term residence in nursing homes.²²¹ A "revolving door" phenomenon doubled the number of annual admissions to state hospitals.²²² Only half of the planned community mental health centers were funded.²²³ Those mental health centers that were established found future funding uncertain.²²⁴

The new services available in the community tended to serve those already living in the community and in need of counseling or occasional acute care; the chronically mentally ill found their needs unmet.²²⁵ The "continuum" of services was fragmented and poorly managed, in part because the services operated without any coordination with the state hospitals.²²⁶

Although there is ample evidence that a carefully constructed community care program can successfully treat the mentally ill,²²⁷ well-run programs were not available to the vast majority of released patients.²²⁸ One psychiatrist described one view of deinstitutionalization visible to the rest of the community: "Patients often live under conditions of minimum supervision and poor drug management, so that they often may be over-drugged, heavily sedated, stuporous, or dulled. Their limited ability for social interaction means they often wander the streets or sit aimlessly looking at television."²²⁹ Exacerbating the problem, communities in which the mental patients found themselves did not welcome them.²³⁰

The antipsychotic wonder drugs also failed to deliver on their original promise. While some drugs demonstrated utility in controlling the symptoms of

220. *Id.*

221. *Id.*

222. Musto, *supra* note 166, at 70 (annual admissions rose from 200,000 in 1956 to 400,000 in 1972).

223. COMPTROLLER, *supra* note 180, at 68.

224. *Id.* at 75; Goldman & Morrissey, *supra* note 163, at 728 (Mental "[i]nstitutions . . . were a major item in state budgets."); Musto, *supra* note 166, at 71 (as of September of 1974, 591 centers had been funded, and 443 were actually operating).

225. COMPTROLLER, *supra* note 180, at 69.

226. *Id.* at 23-25, 72.

227. Braun, Kochansky, Shapiro, Greenberg, Gudeman, Johnson & Shore, *Overview: Deinstitutionalization of Psychiatric Patients, A Critical Review of Outcome Studies*, 138 AM. J. PSYCHIATRY 736, 747 (1981) [hereinafter Braun]; Searight & Handal, *Psychiatric Deinstitutionalization and Social Policy: Implications for Adult Foster Care*, 1 ADULT FOSTER CARE J. 7, 7 (1987); Searight & Handal, *Psychiatric Deinstitutionalization: The Possibilities and the Reality*, 58 PSYCHIATRIC Q. 153, 153 (1986).

228. COMPTROLLER, *supra* note 180, at 68.

229. Klerman, *Better but not Well: Social and Ethical Issues in the Deinstitutionalization of the Mentally Ill*, 3 SCHIZOPHRENIA BULL. 617, 628 (1977).

230. Most employers would refuse to hire any ex-patients, except for undesirable jobs. Farina, Felner & Boudreau, *Reactions of Workers to Male and Female Mental Patient Job Applicants*, 41 J. CONSULTING & CLINICAL PSYCHOLOGY 363, 370-71 (1972); Olshawsky, Grob & Malamud, *Employers' Attitudes and Practices in Hiring of Ex-Mental Patients*, 42 MENTAL HYGIENE 391, 393-94 (1958).

schizophrenia,²³¹ the profession remained uncertain as to which drug to prescribe for which symptoms and in which dosage.²³² Also, harmful and permanent effects resulting from prolonged use of antipsychotic drugs, such as involuntary muscle movements of tardive dyskinesia, became evident.²³³

Perhaps more disturbing, psychiatrists publicly challenged the authoritative-ness of their own science. Thomas Szasz, the most controversial of the anti-psychiatry psychiatrists, posed the critical question and supplied the notorious answer: "Let us launch our inquiry by asking, somewhat rhetorically, whether there is such a thing as mental illness. My reply is that there is not."²³⁴ In any event, psychiatry failed to have any observable effect on reducing the rising social unrest in the country. This failure cast doubt on the previously made argument that social conditions and mental illness were related.²³⁵ This crisis of confidence was not confined to psychiatry, but undercut the medical profession generally.²³⁶

As one might expect, the state hospitals did not disappear. For all the movement of patients back into the community, the new community mental health centers had little impact on institutional populations.²³⁷ Even before the Community Mental Health Centers Act, the hospitals began lowering their popula-

231. National Institute of Mental Health Psychopharmacology Service Center, *supra* note 165, at 253.

232. *E.g.*, Davis & Bethesda, *Efficacy of Tranquilizing and Antidepressant Drugs*, 13 ARCHIVES GEN. PSYCHIATRY 552, 561-62 (1965); Hollister, *Clinical Use of Psychotherapeutic Drugs: Current Status*, 10 CLINICAL PHARMACOLOGY & THERAPEUTICS 170, 171-72 (1969) ("The old adage that the lack of single effective treatment encourages multiple treatments is nowhere more evident."); National Institute of Mental Psychopharmacology Research Branch Collaborative Study Group, *Differences in Clinical Effects of Three Phenothiazines in "Acute" Schizophrenia*, 28 DISEASES & NERVOUS SYSTEM 369, 381 (1967).

233. See Gardos & Cole, *Overview: Public Health Issues in Tardive Dyskinesia*, 137 AM. J. PSYCHIATRY 776, 777-79 (1980) (summarizing medical literature on Tardive Dyskinesia); Opler, Katz, Kobayashi & Ruiz, *Tardive Dyskinesia and Institutional Practice: Current Issues and Guidelines*, 31 HOSP. & COMMUNITY PSYCHIATRY 239, 240 (1980) (same).

234. T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* 11 (1963). The author argues that the notion of mental illness is a myth. *Id.* at 16-17. He calls mental illness a metaphor, which mistakenly has been treated as a fact. *Id.* at 17.

We call people physically ill when their body-functioning violates certain anatomical and physiological norms; similarly, we call people mentally ill when their personal conduct violates certain ethical, political, and social norms. This explains why many historical figures, from Jesus to Castro, and from Job to Hitler, have been diagnosed as suffering from this or that psychiatric malady.

Id.; see also Temerlin & Trousdale, *The Social Psychology of Clinical Diagnosis*, 6 PSYCHOTHERAPY: THEORY, RES. & PRAC. 24, 28-29 (1969) (agreeing with Szasz that "psychiatric diagnosis is a process of labeling social behavior").

235. Musto, *supra* note 166, at 71. Conservative critics lambasted the social welfare programs "embodying the arrogance of social engineering by euphoric experts." *Id.* at 55. Radicals attacked psychiatry as repressive of those exercising a right to be different. P. STARR, *supra* note 25, at 409 ("Radicals . . . charged that . . . medical care . . . was basically a form of social control.").

236. P. STARR, *supra* note 25, at 378 (describing the lack of cohesiveness of the medical profession).

237. COMPTROLLER, *supra* note 180, at 69.

tion counts for their own purposes.²³⁸ The development of the community mental health centers did not mean that the state hospitals were used less²³⁹ and, in fact, admissions for inpatient confinement increased substantially after 1950, even though the total population on any given day dropped.²⁴⁰

The courts eventually stepped back from their initial commitment to reform. As part of a larger tendency for the federal courts to slow their judicial activism,²⁴¹ courts considering claims of mental patients constructed procedural barriers to institutional reform. The most notable example was the second Supreme Court decision in *Pennhurst State School and Hospital v. Halderman (Pennhurst II)*,²⁴² which overturned decades of precedent by reinterpreting the eleventh amendment.

The Supreme Court also called a halt to further reform of civil commitment procedures. In *Addington v. Texas*,²⁴³ the Court refused to demand proof beyond a reasonable doubt to support a commitment order.²⁴⁴ The Court found sufficient basis to commit in proof that was clear and convincing.²⁴⁵ The Court based its decision, in part, upon the inability of psychiatry to diagnose with certainty.²⁴⁶ This uncertainty could not satisfy a reasonable doubt standard.²⁴⁷ Writing for a unanimous Court, Chief Justice Burger identified the issues underlying the civil commitment process:

The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.²⁴⁸

Burger did not even mention the word "cure." On the contrary, Burger wrote of the unrestrained mental patient: "One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma."²⁴⁹

In other decisions, the Supreme Court declined to review the merits of the right-to-refuse-treatment cases, but did imply some reservations about the via-

238. *Id.*; Goldman & Morrissey, *supra* note 163, at 728.

239. Goldman & Morrissey, *supra* note 163, at 728.

240. *Id.*; Musto, *supra* note 166, at 70.

241. See C. BULLOCK III & C. LAMB, IMPLEMENTATION OF CIVIL RIGHTS POLICY 49-50, 61, 157 (1984) (describing the Supreme Court's lack of judicial activism when implementing civil rights policies).

242. 465 U.S. 89 (1984).

243. 441 U.S. 418 (1979).

244. *Id.* at 427-31.

245. *Id.* at 431-32.

246. *Id.* at 430.

247. *Id.* at 429.

248. *Id.* at 426.

249. *Id.* at 429 (citing Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496, 498 (1976); Schwartz, Myers & Astrachan, *Psychiatric Labelling and the Rehabilitation of the Mental Patient*, 31 ARCHIVES GEN. PSYCHIATRY 329, 334 (1974)).

bility of the right.²⁵⁰ The Supreme Court also sent a subtle message to the lower courts that the less restrictive alternative principle²⁵¹ had no place in mental health law; the court dismissed for want of a federal question a case posing that very issue.²⁵² The lower federal courts got the message.²⁵³ Some federal courts did find the less restrictive alternative test applicable to the mental health context;²⁵⁴ nonetheless, unlike earlier cases which ordered the development of new alternatives to the institution,²⁵⁵ those courts limited the remedy to placement in whatever alternatives already existed.²⁵⁶

Courts ruling on the commitment of individuals to the institutions also retreated from the previous preference for the community over the asylum. A recent and famous case arising from the New York City policy of confining "street people" serves as an apt example. After the trial court considered the conflicting testimony about the involuntary hospitalization of Billie Boggs, it ordered her released.²⁵⁷ The appellate court read the same evidence but concluded as follows:

In summary, less than two years ago, Ms. Boggs was a productive member of society, who had a continuous work history of almost a decade, in which she had been employed in responsible positions [B]esides a job, she had a home and a family; however, in 1985, she suffered a "severe psychosis," which resulted in her admission to East Orange, where, *inter alia*, she was placed in four-point restraints, and treated with large doses of Thorazine; thereafter, we find the clear and convincing evidence indicates that, while living in the streets for the past year, Ms. Boggs' mental condition has deteriorated to the point where she was in danger of doing serious harm to herself, when . . . she was involuntarily admitted to respondent Bellevue for treatment²⁵⁸

250. *Rennie v. Klein*, 458 U.S. 1119 (1982) (directing reconsideration in light of *Youngberg v. Romeo*, 457 U.S. 307 (1982)), *vacating* 653 F.2d 836 (3d Cir. 1981).

251. See *supra* notes 211-12 and accompanying text.

252. *Sanchez v. New Mexico*, 396 U.S. 276 (1970) (per curiam).

253. *E.g.*, *Lelsz v. Kavanagh*, 807 F.2d 1243, 1251 (5th Cir. 1987) (concluding that "the federal constitution does not confer on these [mentally ill patients] a right to habilitation in the least restrictive environment"); *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1249 (2d Cir. 1984) (after *Youngberg v. Romeo*, 457 U.S. 307 (1982), the focus is not on the "least restrictive environment," but rather on the community center's professional judgment); *Association for Retarded Citizens v. Olson*, 561 F. Supp. 473, 486 (D.N.D. 1982) (recognizing that after *Youngberg v. Romeo*, 457 U.S. 307 (1982), patients no longer have a constitutional right to the least restrictive method of care).

254. *Gary W. v. Louisiana*, 437 F. Supp. 1209, 1216-17 (E.D. La. 1976).

255. See *supra* notes 213-15.

256. *Gary W.*, 437 F. Supp. at 1217-18.

257. *In re Boggs*, 136 Misc. 2d 1082, 1091, 522 N.Y.S.2d 407, 413 (Sup. Ct.), *rev'd sub nom. Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1987), *appeal dismissed sub nom. Anonymous v. New York City Health & Hosps. Corp.*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988).

258. *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 366, 523 N.Y.S.2d 71, 87 (1987), *appeal dismissed sub nom. Anonymous v. New York City Health & Hosps. Corp.*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988).

The decision does not mention the word or concept "cure," either in the hospital or in the community. Boggs was committed,²⁵⁹ not because the hospital could treat her or because community treatment had failed, but because the court believed it had no alternative but to commit her.²⁶⁰

II. ON THE BRINK OF THE FOURTH REFORM

A. *The Unlikely Reform: Community Support*

Some quarters of psychiatry propose a new reform of mental health policy. This group diagnoses the problem of deinstitutionalization as the failure to provide community support.²⁶¹ The so-called "Community Support Movement" would offer a range of supportive services, including housing, employment, social services, and case management to the deinstitutionalized population receiving outpatient psychiatric services.²⁶² These reformers build upon the conclusions of a successful pilot project of the National Institute of Mental Health.²⁶³ Indeed, such projects have produced persuasive evidence that the deinstitutionalized mental patient can survive in the community with adequate support services.²⁶⁴ In addition, these reformers attempt to learn the lessons of past failures, by focusing on the usually ignored chronically ill.²⁶⁵

Without the perspective of time, these reformers understandably feel uncertain of the true nature of their proposals.

In some respects, the community support movement has been only a mid-course correction in the community mental health movement, an administrative fix for the problems of deinstitutionalization. However, the community support movement may be viewed as a fourth cycle of reform in that it advocates a new approach to treatment, in this case, a whole system of care.²⁶⁶

Perhaps they have learned the most important lesson, missed by their predecessors: the folly of using mental health policy as a device to resolve other social problems.²⁶⁷

259. *Id.*

260. *Id.* at 365-66, 523 N.Y.S.2d at 86-87.

261. Goldman & Morrissey, *supra* note 163, at 729.

262. Turner & TenHoor, *The NIMH Community Support Program: Pilot Approach to a Needed Social Reform*, 4 SCHIZOPHRENIA BULL. 319, 338 (1978).

263. *Id.*

264. See Searight & Handal, *Psychiatric Deinstitutionalization: The Possibilities and the Reality*, 58 PSYCHIATRIC Q. 153, 153 (1986) ("There is a substantial research data base which indicates that the majority of the chronically mentally ill can function outside of institutional settings.").

265. Goldman & Morrissey, *supra* note 163, at 729.

266. *Id.* (citation omitted).

267. The Jacksonians developed the asylum to help save the country from disorder, first by creating a utopia, later by controlling the Irish and the dangerously lunatic poor. See *supra* text accompanying notes 25-79. The Progressives introduced civic medicine to eliminate mental illness partially as a response to the popular fear of its growth through reproduction and immigration.

In a sense, the advocates of community supports [sic] have recognized that the problem of chronic mental illness is first and foremost a social welfare problem. They do not recommend mental health solutions to social problems; instead, they propose social welfare solutions to mental health problems. A community support system includes health and mental health services but also recognizes entitlement programs, income supports, transportation, and housing as critical elements.²⁶⁸

However, the truth of this lesson will help deliver this reform stillborn. To succeed, in the sense of proposals adopted and implemented, a reform requires certain preconditions. One of those preconditions is a popular perception that mental health policy reform necessarily furthers the solution of some other problem. The preceding history of reform demonstrates that in the competition for scarce space on the public's agenda and for scarce public resources, the mentally ill have not fared well. Other issues have dominated the popular mind: independence from England, civil war, world war. Only when tied metaphorically to the preservation of public peace and order from various threats—civilization, immigration, urbanization, the breakdown of race and class barriers—do mental health reforms find support among the general population and the policymakers.

While homelessness looms as a social problem and much of the public maintains an image of the homeless as a group of discharged mental patients, the public response to the homeless differs depending upon how the homeless are defined, as families or as the mentally ill.²⁶⁹ And even to the extent that some quarters of society consider homelessness a crisis,²⁷⁰ no major reform in the direction of community support is likely to emerge. A community support reform is unlikely for four principal reasons. First, the durability of the asylum through all waves of reform means any proposal which undermines the status and power of the institution will ultimately fail.²⁷¹ Second, the community support reformers will not likely win popular support for a mere "administra-

See *supra* text accompanying notes 80-111. The Community Mental Health Movement, allied with the War on Poverty, hoped to address social unrest through community mental health programs. See *supra* text accompanying notes 164-80.

268. Goldman & Morrissey, *supra* note 163, at 730.

269. Compare *Economic Recovery Not Helping Urban Poor, Homeless, Survey Finds*, Daily Report for Executives (BNA), at L-2 (Dec. 19, 1986) (discussing a recent survey by the U.S. Conference of Mayors which found increases in a portion of the homeless population consisting of families) with Krauthammer, *For the Homeless: Asylum*, Wash. Post, Jan. 4, 1985, at A15, col. 1 (stating that the "safety net" of social welfare and voluntary charity would be adequate if cities were not overwhelmed by the mentally ill, and advocating that the mentally ill homeless should be put in asylums if they cannot adequately care for themselves regardless of dangerousness to others).

270. Appleby & Desai, *Documenting the Relationship Between Homelessness and Psychiatric Hospitalization*, 36 HOSP. & COMMUNITY PSYCHIATRY 732, 732-33 (1985).

271. Rothman argues that the fatal flaw in the Progressive reform package was the continued existence of the asylum. D. ROTHMAN, *supra* note 82, at 373. For a similar history of correctional reform, see Eastman, *Triumph of the Prison: The True Limits of Prison Reform Litigation*, 20 U. TOL. L. REV. 69 (1988) (discussing literature on correction reform).

tive fix," especially such a costly one.²⁷² Reformers achieved success, as measured in terms of proposals adopted and implemented, by crusading against social evils, not administrative difficulties.

Third, the public resources needed to solve the problem of homelessness, or even homelessness of the mentally ill, are not available, or at least, not perceived to be available. The community support reformers recognize the difficulty of advocating reform at a time when

[r]ecent fiscal policy and resource restraints have threatened the community support reform movement: the repeal of the Mental Health Systems Act, the termination of disability benefits to tens of thousands of mentally ill beneficiaries of [Supplemental Security Income and Social Security Disability Income], and prospective payments systems that may increase admissions to state mental hospitals have all compromised the care of the chronic mentally ill in the community. In addition, the Community Support Program, each year, struggles to maintain its appropriation.²⁷³

Meanwhile, the budget deficit has surpassed most other social problems in the minds of the populace and on the agendas of government.²⁷⁴

Fourth, as subsequent sections of this Article will argue, the metaphor of the time is a medical one, finding defect in the individual, without social implications. At such a time, a proposed reform which contradicts the prevailing metaphor stands little chance of success.

B. *The Preconditions for the Likely Fourth Reform*

Trends in society and the response of government to social problems, psychiatry, and the courts and legal profession converge to form the preconditions for a shift in mental health policy.

1. *Society and Government*

The wars against poverty, racism, and social injustice have worn weary on the homefront, in other words, the middle class. American society lacks any consensus on a commitment to remove social inequities.²⁷⁵ This failure of con-

272. For the homeless mentally ill population in one community alone, St. Louis, the cost of a comprehensive community service project approached one million dollars. MALCOLM BLISS MENTAL HEALTH CENTER, ST. LOUIS STATE HOSPITAL & METRO COMPREHENSIVE MENTAL HEALTH CENTER, A PROPOSAL TO DEVELOP A COMPREHENSIVE COMMUNITY SERVICE PROGRAM FOR THE SERIOUSLY AND CHRONICALLY MENTALLY ILL IN THE CITY OF ST. LOUIS (1987) (abstract) (proposal submitted to the Mental Health Services Development Program of the Robert Wood Johnson Foundation).

273. Goldman & Morrissey, *supra* note 163, at 729 (citation omitted).

274. Rauch, *The Invisible Issue*, 18 NAT'L J. 2050, *passim* (1986); *Voters Found Doubtful of '86 Deficit Decline*, N.Y. Times, Sept. 8, 1985, § 1, Part 1, at 30, col. 1 (reporting that the general public did not believe that the federal budget deficit would decline).

275. See *Fear of Military Threats Plummets but Nation Worries About Japan: Most in U.S. Favor Pentagon Cuts, Poll Finds*, L.A. Times, Mar. 9, 1989, Part 1, at 18, col. 1 (describing continual stalemate on important economic policy questions); *Regan, Domenici Urge Curtailment*

sensus extends to health policy as well.²⁷⁶ The phenomenon of blaming the victim, a much criticized corollary of some earlier government programs, retains its power today.²⁷⁷ An editor of the *New Republic* has blamed the failure of the Reagan "safety net" on the homeless mentally ill: "Were our cities not overwhelmed by the mentally ill, the traditional safety nets of social welfare and voluntary charity would be adequate to handle the relatively small number of 'new poor' cases."²⁷⁸ A new social syndrome has emerged: the NIMBY ("Not In My Back Yard") syndrome. The syndrome reflects community opposition to residential facilities for the mentally ill and other groups, such as paroled convicts.²⁷⁹

Cynical about the government's ability to solve social problems, Reagan era governments, both state and federal, have turned to deregulation of social injustice by seeking answers in the marketplace.²⁸⁰ The privatization approach includes selling housing projects to tenant-run management companies, issuing housing vouchers instead of building publicly operated housing,²⁸¹ and contracting with profit-making corporations to run prisons.²⁸² Both major political

of *Entitlements*, Wash. Post, Nov. 30, 1981, § 1, at A1, col. 4 (discussing need to curtail welfare programs to reduce budget deficit).

276. P. STARR, *supra* note 25, at 416. ("By the end of the 1970s, equal access to health care was no longer a governing concern for those who governed.")

277. See generally W. RYAN, *BLAMING THE VICTIM* (1971) (discussing society's proclivity for blaming the victims of societal problems instead of the conditions that exist in society itself).

For example, today's society points away from discrimination or economic conditions as a cause of social injustice. Instead, society blames alleged deficiencies in the African-American family as the cause of racial differences in economic prosperity and poverty. *Id.* at 63-85. See generally *Scapegoating the Black Family: A Special Issue*, 249 NATION, July 24/31 1989 (discussing how racial discrimination in America places the blame on African-American families for their poverty). The War on Poverty was perceived as a frustrating failure to eradicate social injustice. In this environment of frustration, Ronald Reagan could claim a mandate for his impressive assault on the Great Society programs. See generally F. PIVEN & R. CLOWARD, *THE NEW CLASS WAR* (1982) (discussing how the attempts by the upper class to eliminate state programs aiding the poor have caused friction among the classes).

278. Krauthammer, *supra* note 269, at A15, col. 1.

279. English, *Neighbors Fears Stall New Homes for Mentally Ill*, Boston Globe, Apr. 11, 1989, (Metro/Region), at 22, col. 5; English, *The NIMBY Syndrome*, Boston Globe, Nov. 16, 1988, (Metro/Region), at 25, col. 1. See generally Salsich, *Group Homes, Shelters and Congregate Housing: De-institutionalization Policies and the NIMBY Syndrome*, 21 REAL PROP. PROB. & TR. J. 413 (1986) (discussing the role of zoning in solving social tensions around the location of group homes for deinstitutionalized mental patients).

280. Paul Starr explained society's attitude as follows:

Although the public did not exactly understand, much less endorse, the larger program of reprivatization, much of the public—a majority in 1980—clearly shared a general antipathy to government. Inflation gave arguments against deficit spending a seemingly urgent rationale, and interventionist liberal social policies, such as affirmative action and school busing for desegregation, had burned up much of the good will [that] liberalism had inherited from the New Deal.

P. STARR, *supra* note 25, at 418.

281. *Abolish HUD*, NEW REPUBLIC, Aug. 21, 1989, at 7-8, col. 1.

282. Robbins, *The Impact of Delegation Doctrine on Prison Privatization*, 35 UCLA L. REV. 911, 912 (1988).

parties seek remedies in the marketplace and heavily rely on privatization to solve old social problems.²⁸³ Privatization has arrived in health policy as well.²⁸⁴ The Bush Administration's response to homelessness, aside from support for the patchwork of the Stewart B. McKinney Homeless Assistance Act,²⁸⁵ to this point consists of calls for volunteerism from the private sector, churches and charities.²⁸⁶ The seemingly overwhelming budget deficit makes new federal initiatives unlikely regardless of which major political party holds power.²⁸⁷

If there is a climate for reform, it blows in this direction. Ronald Reagan identified the popular belief that big government limited America's growth. Far from a program of despair, his deregulation of American life promised a brighter future. In a 1984 campaign speech, Mr. Reagan pronounced that "[o]ur optimism has once again been turned loose. And all of us recognize that those people who keep talking about limits are really talking about their own limitations, not America's."²⁸⁸ The theme of the Reagan administration was that if the government cannot help resolve social problems, it should not try. Such big government efforts pervert the natural order of things. If people are limited (by whatever impediment, presumably including mental illness), then those are the appropriate limits on social justice.

2. Psychiatry

Psychiatrists did not respond warmly to the due process revolution in the law of mental health. Protecting the legal rights of mental patients limited and impeded the exercise of the psychiatrists' professional judgment. "Rotting with their rights on" became a popular slogan among psychiatrists.²⁸⁹ The slogan reflected the psychiatrists' frustration with being forced to withhold treatment that they deemed necessary, in order to respect the rights of patients to a

283. See *Parties Reassess Role of Government in Prelude to '88 Vote*, L.A. Times, Sept. 8, 1986, Part 1, at 16, col. 1 (citing various examples of successful privatization reforms).

284. P. STARR, *supra* note 25, at 417-20 (discussing the shift in burden of medical care from the government to private individuals in the late 1970s).

285. 42 U.S.C.A. §§ 11301-11472 (West Supp. 1990).

286. *Bush Sets Budget Talk with Congress; Senate, House Leaders Invited to Discuss Spending Cuts at White House Meeting*, L.A. Times, Feb. 17, 1989, Part A, at 2, col. 5 (late final desk ed.).

Today's address also stressed volunteerism in the private sector—one of Bush's pet themes. "My friends, from now on in America any definition of a successful life must include serving others," he said, "in a child-care center, in the corporate board room, at the Rotary, at Little League, or a tutoring program, and in a church or synagogue."

Id. (quoting President Bush).

287. *Reagan Debt Legacy: His Trap for Democrats?*, N.Y. Times, Dec. 2, 1988, § B, at 7, col. 1.

288. P. ERICKSON, *REAGAN SPEAKS: THE MAKING OF AN AMERICAN MYTH* 100 (1985) (quoting a 1984 Ronald Reagan campaign speech).

289. Guthell, *In Search of True Freedom: Drug Refusal, Involuntary Medication, and "Rotting With Your Rights On"*, 137 AM. J. PSYCHIATRY 327, 327 (1980) (editorial).

hearing before commitment and to refuse treatment.²⁹⁰ In the mid-1970s, the APA proposed guidelines for a reformed civil commitment process. The guidelines would relax the rigor with which courts guarded a patient's legal rights at the expense of treatment.²⁹¹ Several states adopted the guidelines, at least in part.²⁹²

Despite the iconoclastic opinions of psychiatrists such as Thomas Szasz,²⁹³ most psychiatrists still regard mental illness as a medical problem, not simply as a behavioral adjustment or social justice issue. Research continues to search for, and occasionally finds, tentative biological explanations for mental illness.²⁹⁴

3. *The Courts and the Legal Profession*

The courts and the legal profession share the executive branch's frustration with governmental efforts to solve social problems. The frustration of some segments of the legal community stems from the apparent "success" of judicial activism and its perceived negative consequences of "chilling" the decisionmaking process of the other two branches of government.²⁹⁵ On the other side of the issue, others feel the frustration of those who share the litigation's objective, but see the lawsuits fall short of fulfilling them.²⁹⁶

The Supreme Court has also called for greater restraint by the courts as they act as social engineers. This was evidenced most dramatically in the prison litigation context. In *Atiyeh v. Capps*,²⁹⁷ a prison overcrowding case,

290. *Id.*

291. American Psychiatry Association, *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*, 140 AM. J. PSYCHIATRY 672 (1983).

292. See R. SIMON, *supra* note 73, at 176-77, 180-81.

293. See *supra* note 234 and accompanying text.

294. For example, explanations for the cause of schizophrenia have identified the blood or the brain's structure. Mesulam, *Schizophrenia and the Brain*, 322 NEW ENG. J. MED. 842, 842-43 (1990) (editorial) (concluding that at least some schizophrenics have abnormalities of the brain); Wagemaker & Cade, *The Use of Hemodialysis in Chronic Schizophrenia*, 134 AM. J. PSYCHIATRY 684, 684-85 (1977) (noting the efficacy of hemodialysis in decreasing the symptoms of schizophrenia). *Contra* Malek-Ahmadi, Davis, Sorkin & Callen, *Effect of Hemodialysis on Hallucinations*, 73 S. MED. J. 520 (1980) (concluding that hemodialysis has no effect on decreasing the symptoms of schizophrenia). Dr. Peele reports that the effect of hemodialysis remains to be conclusively proven. Peele, *Report of the Speaker-Elect*, 143 AM. J. PSYCHIATRY 1348, 1351 (1986). Still, the popular press has reported the positive finding. Pennisi, *Complete Change of Blood is Lifesaver for Some*, L.A. Times, Apr. 21, 1985, Part 2, (Metro), at 9, col. 1 (adv. desk ed.).

295. Williamson, *Judicial Activism: Section 1983 and Antitrust Liability Chills Decision Making by State and Local Officials*, 6 HARV. J.L. & PUB. POL'Y 149, 149 (1983) ("When the courts preempt [the legislature], accountability is lost—not only between the citizens and their elected officials, but also between the federal government and the states, and the states and their subdivisions. Whether intentional or not, this infringement has created an unhealthy imbalance in our federal system.").

296. D. MONTI, *A SEMBLANCE OF JUSTICE* (1985) (chronicling the failures of school desegregation litigation).

297. 449 U.S. 1312 (1981).

Justice Rehnquist wrote that "nobody promised them a rose garden."²⁹⁸ From affirming the power of the federal courts to draft broad remedies overhauling unconstitutional prisons in 1978,²⁹⁹ the Court shifted three years later to instructing the lower federal courts to defer to the discretion of prison officials in general prison management questions.³⁰⁰ Tired of persistent demands for federal courts to reform prisons and other social institutions, the Court has also formulated a variety of limitations on the reach of civil rights litigation.³⁰¹

To fully appreciate how courts have intentionally limited their own reach, the metaphors surrounding this phenomena deserve attention as well. According to one metaphor, the courts function as the independent arbiters of truth. They fearlessly examine the facts and base their decision on the law.³⁰² The courts utilize a metaphor to define the scope of their concern: the marketplace of individual actors, individuals contracting with and committing torts against one another as individuals. These metaphors permit and even encourage the cynical manipulation of doctrine and concealment of facts to further the social and political agendas at the root of the metaphors.

A notorious historical example illustrates this point. In the midst of the last century's rapid economic growth, particularly in the rail industry,³⁰³ the New York Court of Appeals decided *Ryan v. New York Central Railroad*.³⁰⁴ The court held a railroad, whose employees had negligently started a fire, liable only to the owner of a razed home immediately adjacent to the railroad. The court relieved the railroad of liability to the owners of neighboring homes also destroyed by the spreading fire.³⁰⁵ The court invoked the accepted language of causation in torts, drawing a bright line between the damages proximately caused, the first house, and those more remote, the second house.³⁰⁶

Nonetheless, practically every contemporary court and scholar has rejected the *Ryan* decision as a distortion of tort causation doctrine.³⁰⁷ The decision

298. *Id.* at 1315-16.

299. *Hutto v. Finney*, 437 U.S. 678, 693-94 (1978).

300. *Rhodes v. Chapman*, 452 U.S. 337, 361-62 (1981) (Brennan, J., concurring).

301. See generally Eastman, *Draining the Swamp: An Examination of Judicial and Congressional Policies Designed to Limit Prisoner Litigation*, 20 COLUM. HUM. RTS. L. REV. 61 (1988) (describing the Supreme Court's various limitations on civil rights suits brought by prisoners).

302. Certainly, most in our profession claim a healthy skepticism about the metaphor. That does not rob the metaphor of its significance. On the contrary, that we continue to use the metaphor, by invoking or critiquing it, demonstrates its continuing power. Even while we claim to see past it, we still measure the reality we see by the metaphor.

303. In the years following the Depression of 1857, the railroad industry played a "crucial role" in the development of the American economy. C. HESSON & H. SARDY, *ASCENT TO AFFLUENCE, A HISTORY OF AMERICAN ECONOMIC DEVELOPMENT* 278 (1969). The postwar years, in particular, witnessed massive capital formation in manufacturing and in the railroads, as the rails knit the country's economy together. *Id.* at 417, 436-37.

304. 35 N.Y. 210 (1866).

305. *Id.* at 212-13.

306. *Id.* at 213.

307. Shearman and Redfield remarked that this decision had been "overruled everywhere else." 1 T. SHEARMAN & A. REDFIELD, *A TREATISE ON THE LAW OF NEGLIGENCE* § 30 (4th ed. 1888); see also 2 T. SHEARMAN & A. REDFIELD, *supra*, § 666 (listing cases in other states contrary to

ignored not only doctrine but reality as well. Nothing in the case suggested that anything stood in the way of the fire's spread from the first house to the second house.³⁰⁸

This was not the first time a court made a mistake. But the reason for the mistake matters more than the mistake itself. Not only have critics and defenders of the decision agreed that the *Ryan* court decided the issues to further the growth of capitalism, but the court itself explicitly admitted to this agenda.³⁰⁹ As the *Ryan* court itself conceded, a contrary result "would . . .

Ryan). They reaffirmed the "true doctrine" as holding a defendant responsible for "even extraordinary damage, if it is the result of his negligence, operating in a natural and continuous sequence." 1 T. SHEARMAN & A. REDFIELD, *supra*, § 30. Cooley agreed that *Ryan* differed from the law of most states in the union. 1 T. COOLEY, A TREATISE ON THE LAW OF TORTS 117-18 (3d ed. 1906).

308. As Cooley also observed, the *Ryan* court's decision ignored the seemingly self-evident fact that "[p]roximity of cause has no necessary connection with contiguity of space or nearness in time." 1 T. COOLEY, *supra* note 307, at 118. However, Francis Wharton disagreed. Wharton imagined the facts which might justify the bright line drawn by the *Ryan* court between one house and another: "If a house is properly built, if it is properly watched, if a proper fire apparatus is in operation, it can be prevented, when a fire approaches from a neighboring detached house, from catching the fire." F. WHARTON, A TREATISE ON THE LAW OF NEGLIGENCE § 150, at 125 (2d ed. 1878). In fairness to Wharton, he did not attribute these facts to the *Ryan* case, but did argue that the railroad was properly relieved of liability since the fire had to travel a considerable distance and the causes of the spread were atmospheric conditions and the flammability of materials in between the railroad and the plaintiff's home. *Id.* § 151, at 127-28.

Wharton earlier had written:

A locomotive engine . . . drops a spark on a mass of rubbish which the recklessness of a wood-cutter has left on a field over which the railroad company has no control. The fire thus kindled, under an unprecedentedly high wind, is whirled off some hundred feet, and a frame building, partially built, and surrounded by shavings, on the outskirts of a city, is consumed. From this building the fire readily passes to a block of houses whose owners ultimately sue the railroad for the damages.

Wharton, *The Liability of Railroad Companies for Causing Fires*, 1 S.L. REV. 729, 743-44 (1878) [hereinafter Wharton, *Liability of Railroad Companies*]. Wharton and the *Ryan* court, in essence, would blame the plaintiff or the plaintiff's neighbor nearer the railroad for the fire which destroyed the plaintiff's home. The only real object between the two homes was a distortion of doctrine.

309. *Ryan v. New York Cent. R.R.*, 35 N.Y. 210, 216 (1866). Wharton wrote that the question of "[w]hether a railroad company is to be liable for all fires of which its locomotives are the occasion, is a question . . . important to the industrial interests of the land . . ." Wharton, *Liability of Railroad Companies*, *supra* note 308, at 729. Wharton answered the question:

The very fact that when a suit for damages is brought, I [the owner of adjacent property] am skipped over, and the rich corporation behind me is attacked, while it assures me, if I am poor, a position of irresponsibility, increases the recklessness of myself and other non-capitalists, and thus increases the risks by which the capitalist, who is alone held liable, is beset.

Capital, by this process, is either destroyed, or is compelled to shrink from entering into those large operations by which the trade of a nation is built up.

Id. at 730. Cooley, although unlike Wharton, a critic of *Ryan*, also noted the agenda promoted by the court: "[T]he court [was] apparently[] more influenced in this decision by the fact that the opposite doctrine 'would subject to a liability against which no prudence could guard, and to meet which no private fortune would be adequate' than by a strict regard to the logic of cause and

create a liability which would be the destruction of all civilized society."³¹⁰

While *Ryan* is considered bad law in every jurisdiction,³¹¹ tort law still succumbs to the same tendency to draw tight little circles around a problem. When courts circumscribe an issue, they exclude material facts and manipulate legal doctrine to maintain the tightness of the circle. For example, courts faced with automobile accident claims draw that circle around the litigants. Their analysis is limited to facts within that circle, despite the general acknowledgement that factors other than the behavior of individual drivers significantly affect the frequency and extent of highway injuries.³¹²

Saying that another driver's negligence caused a driver's death on the highways of this country is a little like saying Ahab died of defectively designed harpoon ropes. Our culture and ideology may command that analysis, but we should not pretend to rely upon the imperatives of law or logic.

effect." T. COOLEY, *supra* note 307, at 115-17 (quoting *Ryan v. New York Cent. R.R.*, 35 N.Y. 210, 216 (1866)). A more recent author put it more bluntly:

The decision in *Ryan* is one of many in the period after 1840 limiting the liability of the agents of economic growth, especially the railroad. Yet, the typical judicial strategies for extending entrepreneurial immunity had rarely dealt so cynically with the idea of causation. While virtually all judges and jurists of the nineteenth century had also promoted limiting entrepreneurial liability, the *Ryan* decision nevertheless remained an outcast through the entire period.

Horwitz, *The Doctrine of Objective Causation*, in *THE POLITICS OF LAW* 208 (D. Kairys ed. 1982). Much of the material discussed in this section is derived from the Horwitz article.

310. *Ryan v. New York Cent. R.R.*, 35 N.Y. 210, 213 (1866).

311. *See supra* note 307.

312. These factors include vehicle design, highway construction, and emergency services availability. D. KLEIN & J. WALLER, *CAUSATION, CULPABILITY AND DETERRENCE IN HIGHWAY CRASHES* 209-10 (1970) (U.S. Department of Transportation Automobile Insurance and Compensation Study). Looked at even more broadly, a trier of fact might consider the policy decision to allocate resources into a highway system for private automobiles rather than a mass transportation system. Within that circle, causation and responsibility are analyzed with limited results possible—blaming one of the drivers. The court either ignores the other forces at play or takes them as given, with no analysis.

A recent symposium on causation in the *Chicago-Kent Law Review* presents a collection of scholarly and thoughtful articles on causation issues. All these articles, whether from a libertarian, corrective justice, or other school of thought, limit the causal possibilities by virtue of their shared ideology—the liberal marketplace of atomized actors and separable, if not isolated, events. *Symposium on Causation in the Law of Torts*, 63 *CHI-KENT L. REV.* 397 (1987). Robert Cooter's contribution to the symposium is telling. Cooter, *Torts As the Union of Liberty and Efficiency: An Essay on Causation*, 63 *CHI-KENT L. REV.* 523 (1987). He illustrates causation principles by the familiar nursery rhyme: "for want of a nail, the shoe was lost" leading up to the fall of the kingdom. For Cooter, the lost horseshoe nail is not a cause, but a background condition for the fall of a kingdom. *Id.* at 528-29. Richard Wright's criticism of Cooter's treatment of the nursery rhyme analogy is even more revealing since he rejects Cooter's dismissal of the shoe as a cause of the kingdom's demise as "absurd" only because it is, in the nursery rhyme, a cause without which the kingdom would still stand. Wright, *The Efficiency Theory of Causation and Responsibility: Unscientific Formalism and False Semantics*, 63 *CHI-KENT L. REV.* 553, 555 (1987). Only in an atomized universe does such a dialogue make sense. If the kingdom fell, it certainly did so in response to powerful social and economic forces. The nursery rhyme draws a series of little circles to further a logic which ignores facts.

More recently, frustration with the limitations of the litigation process has led many legal reformers to propose and implement alternative dispute resolution mechanisms. Mediation, arbitration, and the like are examples of this trend to remove disputes from the courtroom. These devices aim to resolve disputes with greater efficiency, harmony, and informality. This "informalization" of justice looks for a place to resolve problems outside of the courts.³¹³

4. *Tumblers Falling into Place: The Medical Metaphor*

The body politic feels pressure at two points: the embarrassing and annoying rash of homeless people on the streets, many of them mentally ill; and the pinch of a massive federal deficit combined with a weariness of government solutions. After flirtation with a variety of remedies, from the strange and untested³¹⁴ to the more familiar,³¹⁵ society will likely choose a medical solution. If government will not solve these problems, then the private sector will try. Psychiatry wants dominion over mental illness, and hints that it has the technology to deal with it. Society is accepting that what we have already labeled as "mental illness" is just that—an individual's "illness," purely and simply. It is no longer the price of civilization, a corruption, or the product of social injustice. It is a medical illness. Therefore, there is no justification for withholding the appropriate treatment: medical treatment. And the courts, once again, are joining the reform.

III. THE FOURTH REFORM: THE INDIVIDUAL ILLNESS TO BE TREATED

A. *Privatization*

The likely fourth reform of mental health policy will delegate responsibility and authority to define and treat mental illness to the private sector. The mental health profession will debate whether dealing with mental illness means treatment and prevention or confinement and control. To be sure, state and federal governments will still decide what kind of care they will subsidize through Medicaid.³¹⁶ And, certainly, state governments will continue to operate some mental institutions.³¹⁷ Finally, the state courts may still enter orders

313. C. MOORE, *THE MEDIATION PROCESS* 34 (1986); Greenwald, *Dispute Resolution Through Mediation—An Alternative to Adjudication*, 64 A.B.A. J. 1250 (1978).

314. *H.R.A. Urges Using Ships as Shelters*, N.Y. Times, Oct. 10, 1987, at 33, col. 4 ("The Koch administration announced yesterday that it was seeking proposals for 'floating shelters for homeless adults' to be built on surplus troop ships, ocean liners, oil rigs or barges and moored at waterfront piers.").

315. Krauthammer, *supra* note 269, at A15, col. 1 (referring to the asylum).

316. The Medicaid scheme demands a "presumption in favor of the medical judgment of the attending physician," in determining what treatments are medically necessary and, therefore, must be covered by Medicaid. *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989).

317. See *supra* note 271 (discussing the durability of the institution). See generally F. PIVEN & R. CLOWARD, *supra* note 277 (discussing the power of the welfare bureaucracy to survive external assault).

committing people to institutions, public and private.³¹⁸ All the privatization proposals of the past few years leave some role for government, principally a limited financing responsibility. Mental health policy will not differ in this regard.

New public institutions will not be built.³¹⁹ Private institutions will admit those who can pay; the few public institutions, nursing homes,³²⁰ boarding homes, and the homeless shelters operated by charities will admit the rest on a first-come-first-housed basis. Some of those shelters, running on shoestring budgets and offering no therapy, will resemble the private madhouses of eighteenth-century England.³²¹ Those reinstitutionalized in public institutions can expect custodial care, but little else.³²² Housing vouchers are of little help to those who need far more than a roof.

B. *The Privatization Reform and the Courts*

As for the courts, the reform is likely to drastically curtail their involvement as well, although mental health cases will still undoubtedly appear in the digests. The nature of the causes of action should reflect the reform, as history has shown true for previous reform eras. As the Jacksonian era closed, most of the mental health decisions were concerned with the allocation of financial responsibility between local governments for the cost of treatment of residents of one jurisdiction who were confined in another jurisdiction.³²³ During the early Progressive era, the cases tackled other subject matters including false

318. State commitment laws cover private institutions as well as public ones. *E.g.*, MO. REV. STAT. § 632.005(11) (1986 & Supp. II 1990).

319. This remains true even despite the arguments of a few that new, improved state hospitals can succeed. Gralnick, *Build a Better State Hospital: Deinstitutionalization Has Failed*, 36 HOSP. & COMMUNITY PSYCHIATRY 738, 740 (1985). Costs are a certain consideration against reinstitutionalization. Aside from the initial construction expense, the operating costs of state hospitals should exceed the average of \$11,250 per resident of a mental hospital incurred in 1974. COMPTROLLER, *supra* note 180, at 5.

320. Most studies estimate that one-half of the chronically mentally ill population of the United States resides in public mental hospitals or private nursing homes. MISSOURI ASSOCIATION FOR SOCIAL WELFARE TASK FORCE REPORT, THE HOMELESS MENTALLY ILL IN MISSOURI 11 (1988).

321. As Krauthammer describes these shelters:

Revolving door shelters are not the answer. The care they provide is haphazard. As a rule, they are open only at night. Their staffs are rarely trained to deal with severe, disabling illness. Medical, let alone psychiatric, problems go untended. And since the guests are free to drift in and out, no one can keep track of their care anyway.

Krauthammer, *supra* note 269, at A15, col. 2. The more knowledgeable shelter providers agree that they cannot meet the treatment needs of these clients. Lauriat & Whittey, *Implementing the Recommendations: The Shelter Context*, 8 PSYCHOSOCIAL REHABILITATION J. 25, 26, 30 (1985) (part of a symposium issue responding to the Recommendations of the American Psychiatric Association's Task Force on the Homeless Mentally Ill).

322. In his proposal, Krauthammer can only imagine the minimum level of care for the homeless mentally ill: "The idea of asylum is to provide protection and care. In some historical periods (in the 19th century, in particular) the asylum offered just that. It cannot be beyond our wit to redesign humane custodial institutions." Krauthammer, *supra* note 269, at A15, col. 3.

323. See *supra* text accompanying notes 72-79.

imprisonment, malicious prosecution, and mandamus actions seeking release.³²⁴ In the first half of this century, personal injury actions dominated the digests.³²⁵ The community mental health years witnessed a shift to appeals from civil commitment decisions, and civil rights challenges to treatment and conditions.³²⁶

We can expect a continued retreat by the federal courts from civil rights claims.³²⁷ While the state courts may keep their doors open to a variety of claims, neither appeals from commitments nor challenges to treatment, even in the form of tort actions, are likely to occupy much space on the dockets.³²⁸ This is for two reasons. First, legislation, recently enacted and proposed in the various states, permits the commitment of persons on the authority of mental health professionals.³²⁹ This legislation provides for relaxed procedural safeguards and minimal oversight by the courts. Second, to the extent that courts become involved, the judicial inclination to defer to psychiatrists in commitment and treatment decisions means that courts will simply rubber-stamp decisions already made.

1. *Relaxed Legislative Standards*

In 1982, the APA adopted its Guidelines for Legislation on the Psychiatric Hospitalization of Adults.³³⁰ Psychiatrists had been sensitive to criticism that they were blameworthy for the clutter of homeless mental patients on city streets.³³¹ In response, the guidelines propose relaxation of several prevalent procedural requirements for commitment and an enhancement of the role of psychiatrists in the commitment process. First, in most states, an individual may be taken into custody and transported to a mental hospital for emergency detention and evaluation either after a warrant or order by a court,³³² by a

324. See *supra* text accompanying notes 112-15.

325. See *supra* text accompanying notes 138-54.

326. See *supra* text accompanying notes 181-215.

327. Some federal courts continue to entertain claims under the civil rights statutes. *Burch v. Apalachee Community Mental Health Serv.*, 840 F.2d 797, 801 (11th Cir. 1988) (finding that a complaint of unlawful commitment stated due process claim).

328. State courts have recently been asked to perform the function previously served by federal courts, that is, hearing broad-based claims of substandard treatment and conditions in the institutions. *E.g.*, *Klostermann v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984). Also, state courts have entertained creative new tort theories such as "institutionalization syndrome" for those wrongfully confined. See *Sherman, Paying for a Lost Lifetime*, 11 NAT'L L.J. 41 (1989) (citing the unpublished 1989 Texas district court case, *Petty v. Texas Dep't of Mental Health & Mental Retardation*, as a recent example).

329. See *infra* notes 330-56 and accompanying text.

330. American Psychiatric Association, *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*, 140 AM. J. PSYCHIATRY 672 (1983) [hereinafter *Guidelines*].

331. Cohen & Marcos, *Psychiatric Care of the Homeless Mentally Ill*, 16 PSYCHIATRIC ANALS 729 (1986).

332. *E.g.*, GA. CODE ANN. § 37-3-41.2(b) (1981); see S. BRAKEL, J. PARRY & B. WEINER, *THE MENTALLY DISABLED AND THE LAW* 101-05 (1985) [hereinafter S. BRAKEL] (presenting table listing all the states' emergency detention procedures).

police officer with probable cause to believe the individual poses a danger to self or others,³³³ or on certification by a defined number of physicians—often two—attesting that the individual poses a danger.³³⁴

Under the APA guidelines, a doctor may issue a certificate for emergency commitment simply on the basis of the physician's belief that the individual "lacks capacity to make an informed decision concerning treatment" and either poses a danger or is likely to "suffer substantial mental or physical deterioration."³³⁵ After the individual is in custody, the only check on the appropriateness of the commitment is a determination by another psychiatrist.³³⁶

Second, most states require a judicial hearing within twenty-four to ninety-six hours after the initial emergency admission.³³⁷ Conversely, the APA guidelines propose only that an informal hearing be held within five business days.³³⁸

Third, after a petition for a longer commitment is filed, some states require that patients already hospitalized under emergency procedures receive a prehearing examination by a psychiatrist.³³⁹ The APA adds an automatic outpatient examination for those still in the community.³⁴⁰

Fourth, while most states require dangerousness to self or others as the criterion for commitment,³⁴¹ the APA guidelines permit thirty-day commitments without such a finding if the patient is likely "to suffer substantial mental or physical deterioration."³⁴² The APA guidelines broaden the more common criterion, "substantial inability to care for oneself,"³⁴³ in its definition: "[The person] . . . will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own."³⁴⁴

Fifth, the commitment hearing is transformed from an adversary hearing into an informal meeting. While the rules of evidence typically apply in commitment proceedings,³⁴⁵ the APA guidelines explicitly make hearsay admissi-

333. *E.g.*, MASS. GEN. L. ch. 123, § 12(a) (1988 & Supp. 1990); see S. BRAKEL, *supra* note 332, at 101-05.

334. *E.g.*, TENN. CODE ANN. § 33-6-103(a) (1984 & Supp. 1990); see S. BRAKEL, *supra* note 332, at 101-05.

335. *Guidelines*, *supra* note 330, at 673.

336. *Id.* at 674.

337. See S. BRAKEL, *supra* note 332, at 101-05.

338. *Guidelines*, *supra* note 330, at 674.

339. *E.g.*, W. VA. CODE §§ 27-5-2(b)(4), 27-5-4(f)(1) (1986); see S. BRAKEL, *supra* note 332, at 114-19 (presenting table listing all the states' prehearing procedures).

340. *Guidelines*, *supra* note 330, at 674.

341. *E.g.*, GA. CODE ANN. § 37-3-1(12)(A) (1981 & Supp. 1990); MASS. GEN. L. ch. 123, § 12(a) (1988 & Supp. 1990); see S. BRAKEL, *supra* note 332, at 101-05.

342. *Guidelines*, *supra* note 330, at 674.

343. See S. BRAKEL, *supra* note 332, at 101-05.

344. *Guidelines*, *supra* note 330, at 673.

345. S. BRAKEL, *supra* note 332, at 66.

ble.³⁴⁶ The guidelines omit mention of the right to independent psychiatric examination, to subpoena witnesses, to cross-examine adverse witnesses, and to remain silent.³⁴⁷ These rights are commonly protected by state commitment laws.³⁴⁸

Under the guidelines, a psychiatrist may commit an individual for five business days simply on the medical opinion that the individual is getting worse, even though the patient does not concur with the doctor's opinion that treatment is appropriate.³⁴⁹ A psychiatrist may then commit a patient for lengthier periods for exactly the same reason. These guidelines have been criticized elsewhere.³⁵⁰ Still, pressure to relax commitment standards and procedures builds as society tires of street people sleeping in cars and on the sidewalk.³⁵¹ Other proposals for change urge less laxity and less deference to psychiatrists.³⁵² Perhaps because of the nature of those proposals, the APA guidelines have earned more attention.

The APA has continued to advocate adoption of their guidelines,³⁵³ using the dilemma of the homeless mentally ill as a persuasive argument for their necessity.³⁵⁴ Some among the legal profession have been persuaded. Samuel Jan Brakel advocates a more informal process because "[t]he [current] procedure is dysfunctional—overprotective and overly technical when observed, a block to achieving generally desired results in some cases, mere wasteful and empty ritual in others."³⁵⁵

Some of the states have adopted provisions consistent with many of the

346. *Guidelines*, *supra* note 330, at 675; *see infra* note 365 and accompanying text for a discussion of the ineffectiveness of hearsay rules in commitment proceedings.

347. *Guidelines*, *supra* note 330, at 675.

348. S. BRAKEL, *supra* note 332, at 66-71.

349. *Guidelines*, *supra* note 330, at 674.

350. *See* Parry, *Civil Commitment: Three Proposals for Change*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 334, 336 (1986); Rubenstein, *The American Psychiatric Association's Proposals on Civil Commitment*, 17 CLEARINGHOUSE REV. 558, 558-59 (1983). Rubenstein says of the compulsory pre-hearing examination: "The Supreme Court has held that more due process than this is required to repossess a refrigerator." *Id.* at 559.

351. Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*, 39 VAND. L. REV. 83, 83-84 (1986); Parry, *supra* note 350, at 337.

352. *E.g.*, National Center for State Courts, *Guidelines for Involuntary Civil Commitment*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 409 (1986) (presenting guidelines which give the psychiatrist less deference).

353. Roth, *Official Actions: The Council on Psychiatry and Law*, 142 AM. J. PSYCHIATRY 412, 412 (1985) (APA Council Report).

354. The recommendations of the APA's Task Force on the Homeless Mentally Ill argue that "[i]nvoluntary commitment laws must be made more humane to permit prompt return to active inpatient treatment for patients when acute exacerbations of their illnesses make their lives in the community chaotic and unbearable." AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE ON THE HOMELESS MENTALLY ILL, *THE HOMELESS MENTALLY ILL* (1984), *reprinted in Recommendations of APA's Task Force on the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 908, 909 (1984); *see* Lamb & Talbott, *The Homeless Mentally Ill: The Perspective of the American Psychiatric Association*, 256 J. A.M.A. 498, 501 (1986).

355. S. BRAKEL, *supra* note 332, at 28.

APA guidelines.³⁵⁶ Failing the widespread adoption of the APA guidelines, the APA has also proposed to extend the reach of psychiatrists to treat involuntarily those patients falling outside the ambit of the civil commitment laws through outpatient commitment laws. The APA would allow courts to order involuntary outpatient care where the patient will deteriorate without treatment.³⁵⁷ Many states have complied with the APA proposals, but typically have retained the traditional inpatient commitment criterion of dangerousness. In these states, a new provision is crafted as another option for a court considering involuntary commitment.³⁵⁸ A few states have enacted outpatient commitment procedures bearing greater resemblance to the APA's suggestions. These states have established a separate process for those who have been involuntarily committed in the past and experience difficulty living with their illness in the community.³⁵⁹ Missouri has adopted legislation providing for involuntary outpatient commitment for those who initially entered the institutions voluntarily.³⁶⁰ Some might characterize Missouri's legislation as a "bait and switch" since a patient agreeing to institutional care may find herself trapped in coerced therapy.

Psychiatrists might insist that, under the due process regime still prevailing in civil commitment,

[i]t is extremely important for mental health professionals to understand that they do not make long-term commitment decisions about patients. Commitment is a judicial decision that will be made by a judge, jury, or commission. Clinical decisions surrounding involuntary commitment are difficult enough without laboring under the illusion of having judicial responsibility [I]n recent times, the psychiatrist's discretion in long-term civil commitment has been abolished.³⁶¹

Nonetheless, a persuasive case can be made that despite whatever procedural requirements are in place, the psychiatrist effectively makes the commitment decision. Most studies of the conduct of counsel representing the patient conclude that lawyers typically follow the "passive best interest approach," wherein they conduct minimal cross-examination in hearings lasting but a few minutes.³⁶²

356. *See id.* at 101-05, 110-12, 114-19.

357. Roth, *Official Actions: The Council on Psychiatry and Law*, 144 AM. J. PSYCHIATRY 411, 411-12 (1987) (APA Council Report).

358. Keilitz & Hall, *State Statutes Governing Involuntary Outpatient Civil Commitment*, 9 MENTAL & PHYSICAL DISABILITY L. REP. 378, 378 (1985).

359. *E.g.*, HAW. REV. STAT. § 334-121 (1985). *See generally* J. OWENS, INVOLUNTARY OUTPATIENT COMMITMENT: AN EXPLORATION OF THE ISSUES AND ITS UTILIZATION IN FIVE STATES ii (1985) (studying five states' involuntary commitment procedures).

360. MO. REV. STAT. § 632.385 (1986 & Supp. II 1990).

361. R. SIMON, *supra* note 73, at 178.

362. *See* D. HERMANN, REPRESENTING THE RESPONDENT IN CIVIL COMMITMENT PROCEEDINGS 25-29 (American Bar Association Center for Professional Responsibility 1985); Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C.L. REV. 1027, 1030 (1982). Presumably, Brakel would not object too strenuously to this passivity, as he argues for a non-adversarial model

Even where lawyers act as patients' advocates, courts appear to adopt the psychiatrists' recommendations regarding commitment in almost all cases.³⁶³ The persuasive power of psychiatric testimony is understandable, although later sections of this Article will suggest that such judicial deference is inappropriate given the state of the psychiatric art and the realities of psychiatric practice. The power of psychiatric testimony exceeds the expertise or authority of the psychiatrist. In formulating their opinions, psychiatrists rely on patient history derived from conversations with acquaintances of the patient and entries in the patient's medical records.³⁶⁴ This information would surely be characterized as rank hearsay in most trials. Nonetheless, all of this evidence becomes admissible in a commitment hearing as the basis for psychiatric opinion.³⁶⁵

In recent years, the Supreme Court and the lower federal courts have accorded such deference to psychiatric opinion that the opinion of the expert usually becomes the decision of the court. The belief of patient counsel and the commitment courts that "doctor knows best" is shared by the higher chambers of our judiciary.

for lawyers representing mental patients in cases related to institutional conditions other than commitment. Brakel, *Legal Aid in Mental Hospitals*, 1981 AM. B. FOUND. RES. J. 21, 78.

363. See Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L.J. 43, 54-64 (1974); Badger & Shore, *Psychiatric and Nonmedical Decisions on Commitment*, 137 AM. J. PSYCHIATRY 367, 368-69 (1980); Simon & Cockerham, *Civil Commitment, Burden of Proof, and Dangerous Acts: A Comparison of the Perspectives of Judges and Psychiatrists*, 5 J. PSYCHIATRY & LAW 571, 585 (1977); Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. HEALTH & SOC. BEHAV. 66, 68 (1969); Special Project, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 60 (1971). Some studies have concluded otherwise. Hiday, *supra* note 362, at 1045 (studying involuntary commitment in North Carolina). In the experience of the author, courts vary substantially. In some commitment courts, psychiatric testimony functions as a conveyor belt between court and institution. In others, judges take seriously the responsibility to scrutinize expert testimony.

364. S. BRAKEL, *supra* note 332, at 66.

365. Federal Rule of Evidence 703 provides:

The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.

FED. R. EVID. 703. States have adopted similar rules. *E.g.*, MO. REV. STAT. § 490.065 (1986 & Supp. II 1990). The type of data reasonably relied upon in these cases includes patient history, *Sharkey v. Penn Central Transp. Co.*, 493 F.2d 685, 690 (2d Cir. 1974), statements made by the respondent, *United States v. Lechoco*, 542 F.2d 84, 88 (D.C. Cir. 1976); *Price v. Department of Labor and Indus.*, 101 Wash. 2d 520, 528, 682 P.2d 307, 311 (1984); *State v. Eaton*, 30 Wash. App. 288, 294-95, 633 P.2d 921, 924-25 (1981), statements made by third persons, *Conservatorship of Isaac O.*, 190 Cal. App. 3d 50, 56-57, 235 Cal. Rptr. 133, 136 (1987), and the reports of other nontestifying psychiatrists, *United States v. Fountain*, 840 F.2d 509, 517 (7th Cir. 1988) (holding that psychiatric testimony based on reports by other non-testifying experts was not excluded from evidence on hearsay grounds, but was excluded on other grounds).

2. *The Supreme Court Sets the Stage*

In 1979, the Supreme Court decided *Addington v. Texas*.³⁶⁶ In *Addington*, the Court specifically held that the appropriate standard of proof in civil commitment proceedings is "clear and convincing proof."³⁶⁷ The Court rejected the preponderance of evidence³⁶⁸ and reasonable doubt³⁶⁹ standards because the first standard would permit too many false positives,³⁷⁰ and the second standard would lead to too many false negatives.³⁷¹ One of the concerns underpinning the Court's holding was the inability of psychiatric testimony to satisfy a reasonable doubt standard.³⁷²

The potential impact of the Court's ruling on the appropriate standard of proof in subsequent commitment hearings³⁷³ is not the primary focus of this Article. The symbolic meaning of the ruling and its message about the value the Court places on the individual liberty of mental patients are of concern here. As the Court noted, "standards of proof are important for their symbolic meaning as well as for their practical effect,"³⁷⁴ and "[t]he standard of proof [at a minimum] reflects the value society places on individual liberty."³⁷⁵ The Court renewed its often expressed understanding that civil commitment both "constitutes a significant deprivation of liberty,"³⁷⁶ and "can engender adverse social consequences"³⁷⁷ that can have a "significant impact."³⁷⁸ Also, the Court observed that any person can demonstrate unusual behavior that might implicate mental illness but does not warrant commitment.³⁷⁹ The risk of an unwarranted or "false positive" commitment decision should not fall disproportionately on the individual.³⁸⁰

Nonetheless, the Court remained willing to accept an unknown number of

366. 441 U.S. 418 (1979).

367. *Id.* at 432-33.

368. *Id.* at 426-27.

369. *Id.* at 427-31.

370. *Id.* at 426. A false positive is the risk that an individual who should not be committed is in fact erroneously committed.

371. *Id.* at 428-29. A false negative is the risk that an individual who should be committed is erroneously not committed. Thus, under the Supreme Court's view, the preponderance of the evidence standard would allow commitment too frequently, and the reasonable doubt standard would prevent commitment too frequently.

372. *Id.* at 429.

373. The Court noted that at the time of the decision, 13 states used the reasonable doubt standard and approximately 25 states applied a variation of the clear and convincing standard. *Id.* at 431-32.

374. *Id.* at 426.

375. *Id.* at 425 (second set of brackets by the *Addington* Court) (quoting *Tippett v. Maryland*, 436 F.2d 1153, 1166 (4th Cir. 1971) (Sobeloff, J., concurring in part and dissenting on part), *cert. dismissed sub nom. Murel v. Baltimore City Criminal Court*, 407 U.S. 355 (1972)).

376. *Id.*

377. *Id.* at 426.

378. *Id.*

379. *Id.* at 426-27.

380. *Id.* at 427.

false positives, although it admitted that an "erroneous commitment is sometimes as undesirable as an erroneous conviction."³⁸¹ The Court enunciated three reasons for its willingness to accept false positives. First, individuals are protected from unnecessary commitment by "layers of professional review and observation"³⁸² as well as the concern of family and friends.³⁸³ No fact in evidence or legal authority was cited for this proposition. Second, even if the commitment is unnecessary, the mentally ill individual in the community is no better off for his or her freedom.³⁸⁴ For this proposition, the Court cited neither facts in evidence about the plaintiff in *Addington* nor any principle of law. As authority, the Court relied upon two articles written by psychiatrists and published in psychiatric journals.³⁸⁵ Third, even acknowledging the "lack of certainty and fallibility" of psychiatry, the Court was obliged to accept an unknown number of false positives since only psychiatrists can interpret the evidence for the judge or jury.³⁸⁶

In the same Term, the Supreme Court decided *Parham v. J.R.*³⁸⁷ In *Parham*, the Court decided that an adversary proceeding is not required for a parent or guardian to commit "voluntarily" a child for whom the parent or guardian is responsible.³⁸⁸ One of the *Parham* plaintiffs was admitted to a hospital by his parents based on the admitting physician's acceptance of the parents' claim that their child was previously diagnosed as emotionally disturbed.³⁸⁹ Another of the *Parham* plaintiffs was admitted by a state agency on the basis of a "complete sociomedical history."³⁹⁰ The district court noted the unreliability of such sources of information in overturning the statutory scheme that permitted such commitments.³⁹¹ The Supreme Court reversed the district court and upheld the commitment proceedings.³⁹²

381. *Id.* at 428.

382. *Id.*

383. *Id.* at 428-29.

384. The Court stated:

Moreover, it is not true that the release of a genuinely mentally ill person is no worse for the individual than the failure to convict the guilty. One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma.

Id. at 429.

385. *Id.* (citing Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496, 498 (1976); Schwartz, Myers & Astrachan, *Psychiatric Labeling and the Rehabilitation of the Mental Patient*, 31 ARCHIVES GEN. PSYCHIATRY 329, 334 (1974)). Paul Chodoff admitted to a policy argument based upon "horror stories." Chodoff, *supra*, at 496, 500. Schwartz, Myers, and Astrachan simply reviewed the stigma accompanying mental illness. Schwartz, Myers & Astrachan, *supra*, at 333.

386. *Addington v. Texas*, 441 U.S. 418, 429-30 (1979).

387. 442 U.S. 584 (1979).

388. *Id.* at 587.

389. *Id.* at 589.

390. *Id.* at 590.

391. *J.L. v. Parham*, 412 F. Supp. 112, 138 (1976), *rev'd sub nom. Parham v. J.R.*, 442 U.S. 584 (1979).

392. *Parham v. J.R.*, 442 U.S. 584, 620-21 (1979).

The Supreme Court, in its due process analysis, recognized the child's interest in liberty and the avoidance of stigma.³⁹³ Moreover, the Court abandoned its initial insistence that the interests of parent and child were coterminous. Citing only *Addington*, the Court took a step beyond *Addington* and posited that "what is truly stigmatizing is the symptomatology of a mental or emotional illness."³⁹⁴ Still, for purposes of analysis, the Court accepted that the child had an interest in not being committed³⁹⁵ and that the parents may, in the rare case, act other than in the best interests of their child.³⁹⁶

The Court distinguished commitment from the abortion context where a parent could not exercise an absolute veto over a child's abortion.³⁹⁷ The Court focused on the one check on an otherwise absolute parental power to commit: the exercise of independent professional judgment by the institution's admitting psychiatrist.³⁹⁸ This admitting psychiatrist is the "neutral factfinder" which satisfies due process limits on the deprivation of the child's liberty interest.³⁹⁹

Due process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. Surely, this is the case as to medical decisions, for "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments." Thus, a staff physician will suffice, so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment.⁴⁰⁰

The deprivation of a constitutional right to liberty has thus become a "psychiatric judgment" left to the discretion of the psychiatrist. Citing *Addington*, the *Parham* Court reaffirmed its prior view that other facts surrounding the decision to commit an individual to a state hospital are meaningless without the interpretation of the psychiatrist.⁴⁰¹

Parham expanded upon *Addington* in two critical respects. First, while *Addington* looked to the family and psychiatrist as protection against false positives,⁴⁰² *Parham* relied upon the psychiatrist as the check on the family. Moreover, *Parham* made clear the essential irrelevance of the family in its view. The same psychiatrist enjoys the same decisionmaking power where the committing agent is not the parent but a state agency; no family can check for

393. *Id.* at 600.

394. *Id.* at 601. The Court also cited to the same two journals supporting its decision in *Addington*. See *supra* note 385.

395. *Parham*, 442 U.S. at 601.

396. *Id.* at 602-03.

397. *Id.* at 603-04.

398. *Id.* at 604.

399. *Id.* at 606-07.

400. *Id.* at 607 (citations omitted) (quoting *In re Roger S.*, 19 Cal. 3d 921, 942, 569 P.2d 1286, 1299, 141 Cal. Rptr. 298, 311 (1977) (Clark, J., dissenting)).

401. *Id.* at 608.

402. *Addington v. Texas*, 441 U.S. 418, 428-29 (1979).

false positives.⁴⁰³

Second, the psychiatrist, the expert in *Addington* to whom the trier of fact must turn, now becomes the trier of fact. In their "trial of the facts," psychiatrists were freed by *Parham* to rely on "all sources of information that are traditionally relied on by physicians and behavioral specialists . . ." ⁴⁰⁴ In the Court's view, further formality of procedure would mean nothing because such procedural formalities mean nothing in commitment trials where the hearings typically last but a few moments.⁴⁰⁵

In the next Term, the Court decided *Vitek v. Jones*,⁴⁰⁶ in which it held that due process required an independent decisionmaker and other procedural guarantees, such as adequate notice, opportunity for hearing, and the availability of appointed counsel before a convicted felon could be transferred to a mental hospital.⁴⁰⁷ Some hoped that *Vitek* meant that some due process procedures would have to be respected by the institution psychiatrists—for instance, insistence upon a psychiatrist other than the treating psychiatrist as the independent decisionmaker, despite the difficulty of asking one decisionmaker to exercise independent scrutiny of a colleague's treatment decision.⁴⁰⁸

At best, these hopes were postponed two years later when the Court decided *Youngberg v. Romeo*.⁴⁰⁹ Romeo was a mentally retarded but not mentally ill individual. He did not challenge his commitment;⁴¹⁰ rather, he sought vindication for a liberty interest in training or treatment.⁴¹¹ Writing for the Court, Justice Powell found such a right, but limited the right to "minimally adequate or reasonable training to ensure safety and freedom from undue restraint."⁴¹² The majority declined to find a constitutional right to training suf-

403. *Parham v. J.R.*, 442 U.S. 584, 619 (1979). The Court ruled that the trained psychiatrist can discern the parent committing a child for improper motives: "It is unrealistic to believe that trained psychiatrists, skilled in eliciting responses, sorting medically relevant facts, and sensing motivational nuances will often be deceived about the family situation surrounding a child's emotional disturbance." *Id.* at 611-12.

404. *Id.* at 608.

405. *See id.* at 609-10 & n.17.

406. 445 U.S. 480 (1980). In *Vitek*, a convicted felon challenged, on procedural due process grounds, the constitutionality of a state statute which provided that if a physician found that a prisoner with mental illness could not be given proper treatment in prison, he could be transferred to a mental hospital. *Id.* at 483-84. The Supreme Court held that the convicted felon's due process rights were violated because he did receive adequate notice and an opportunity for a hearing. *Id.* at 491. Thus, the Court required the prison to give certain procedural protections to prisoners who were involuntarily transferred because these prisoners were deprived of their liberty interests. *Id.* at 495-96.

407. *Id.* at 491, 495-96.

408. *Rennie v. Klein*, 653 F.2d 836, 868 n.1 (3d Cir. 1981) (Gibbons, J., dissenting), *vacated*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

409. 457 U.S. 307 (1982). This case arose out of the same controversy that was the subject of *Pennhurst State School & Hosp. v. Halderman*, 457 U.S. 1131 (1982).

410. *Romeo*, 457 U.S. at 315.

411. *Id.* *Romeo* also argued for a right to freedom from bodily restraint and safety, with which the Court readily agreed. *Id.* at 315-16.

412. *Id.* at 319.

ficient to warrant release from the institution or to rehabilitate Romeo.⁴¹³ In determining whether such training is provided, Powell instructed the lower courts to "show deference to the judgment exercised by a qualified professional."⁴¹⁴ Powell endorsed the language of the Third Circuit Court of Appeals that all the Constitution required was that "'professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made.'"⁴¹⁵ From *Romeo* onward, a treatment decision,

if made by a professional, is presumptively valid; liability 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 actually did not base the decision on such a judgment.⁴¹⁶

As authority for this limitation on the patient's rights, Powell cited only *Parham* and the earlier prison cases, such as *Rhodes v. Chapman*,⁴¹⁷ which also called for a "hands off" policy for the courts.⁴¹⁸ The justification for such a deferential policy lay in its alleged necessity. The deferential policy "is necessary to enable institutions of this type—often, unfortunately, overcrowded and understaffed—to continue to function. A single professional may have to make decisions with respect to a number of residents with widely varying needs and problems in the course of a normal day."⁴¹⁹ *Romeo* extended *Parham* and *Addington* past the admitting room of the institution. Without doubt, these cases removed the Constitution and the courts from practically all aspects of the operation of a mental institution, from admission, through treatment, and all the way to discharge. The psychiatrist is the trier of fact, and his or her decisions are presumptively correct.

3. Lower Courts Follow the Lead

The state and lower federal courts have acted correspondingly. Deference to professional judgment means, of course, deference to the judgment of institution psychiatrists, since the courts will not decide between that judgment and the competing opinions of psychiatrists retained by the mentally ill litigants.⁴²⁰

413. *Id.*

414. *Id.* at 322.

415. *Id.* at 321 (quoting *Romeo v. Youngberg*, 644 F.2d 147, 178 (3d Cir. 1980), *vacated*, 457 U.S. 307 (1982)).

416. *Id.* at 323. It is important to realize that this decision, while in the context of a damages case, applies to injunctive actions as well. In the context of damage cases, an additional protection to the doctor is available through good faith immunity. *Id.*

417. 452 U.S. 337 (1981).

418. *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982) (citing *Rhodes v. Chapman*, 452 U.S. 337 (1981)).

419. *Id.* at 324.

420. *Lelsz v. Kavanagh*, 815 F.2d 1034, 1036 (5th Cir. 1987); *Doe v. Gaughan*, 617 F. Supp. 1477, 1487 (D. Mass. 1985) (holding that the mere difference of opinion between psychiatric

Still, a few courts have used the documented opinions of hospital psychiatrists against the mentally ill to impose relief the doctors themselves have designed.⁴²¹

Some courts have construed *Romeo's* silence on the least restrictive alternative analysis as its opinion that no such right exists.⁴²² Others have gone farther to extend deference to psychiatrists beyond medical matters, finding that freedom of movement can be restrained "to the extent [that] professional judgment deems it necessary to assure security or to provide needed treatment."⁴²³

While some courts in applying *Parham* draw a line between commitment of children and adults,⁴²⁴ other courts have found in *Parham* no principle separating the two. In approving the short-term commitment of an adult alcoholic on the authority of a doctor without a precommitment hearing, the Colorado Supreme Court wrote:

In our view, a judicial hearing as a prerequisite to commitment of a clearly dangerous intoxicated person would hinder the government's efforts in controlling alcohol abuse without providing additional procedural safeguards. Due process demands only that a neutral factfinder independently determine that the statutory requirements for commitment and release are satisfied. . . . An independent factfinder strikes the proper balance between the public's right to protection from alcohol related tragedies and the individual's right to be protected from unjustified commitment.⁴²⁵

In similar fashion, courts have approved the short-term commitment of adults where the adult could request a hearing through a court-appointed lawyer.⁴²⁶

[The New York Mental Hygiene Law] contains stringent requirements concerning who may be subject to commitment, provides for multiple levels of medical review, imposes a duty of review on a State agency, and invites the involvement of the patient, his family and friends. All these safeguards certainly do not substitute for an individual's due process right to have an im-

experts is insufficient for plaintiffs to prevail), *aff'd*, 808 F.2d 871 (1st Cir. 1986).

421. *Thomas S. v. Morrow*, 781 F.2d 367, 375 (4th Cir. 1986). In *Thomas S.*, the court stated: "The presumption of validity accorded the professionals' decision about appropriate treatment has not been rebutted. Consequently, in the absence of evidence that the decision is a 'substantial departure from accepted professional judgment, practice, or standards,' the district court was required to accept the recommendations of the qualified professional" *Id.* (quoting *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982)).

422. *E.g.*, *Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983); *see supra* notes 211-12 and accompanying text (explaining the least restrictive alternative analysis).

423. *Johnson v. Brelje*, 701 F.2d 1201, 1209 (7th Cir. 1983); *see also* *Concerned Citizens for Creedmoor v. Cuomo*, 570 F. Supp. 575, 576-77 (E.D.N.Y. 1983) (extending *Romeo* to finding the requisite exercise of professional judgment in the accreditation decisions of the Joint Commission on the Accreditation of Hospitals).

424. *E.g.*, *Clark v. Cohen*, 613 F. Supp. 684, 698 (E.D. Pa. 1985), *aff'd*, 794 F.2d 79 (3d Cir. 1986).

425. *Carberry v. Adams County Task Force on Alcoholism*, 672 P.2d 206, 210 (Colo. 1983) (citing *Parham v. J.R.*, 442 U.S. 584, 607 (1979)).

426. *See Curnow v. Yarbrough*, 676 P.2d 1177, 1183 (Colo. 1984).

partial factfinder determine the propriety of his confinement. Due process does not, however, require that the focus of State energies and moneys be shifted from the evaluation and treatment of the mentally ill to strict compliance with detailed procedural requirements.⁴²⁷

These same arguments led to court approval of a system whereby mentally retarded adults were committed for long periods of time without any judicial review.⁴²⁸ Similarly, *Parham* and *Romeo* have combined to permit "review by an independent medical expert" prior to compulsory treatment.⁴²⁹

This past Term, the Supreme Court advised lower courts that they were moving in the right direction. In *Washington v. Harper*,⁴³⁰ Justice Kennedy, writing for the Court, upheld the constitutionality of a state procedure formulated to apply the Court's prior decision in *Vitek*⁴³¹ to the forcible medication of prisoners with antipsychotic drugs.⁴³² The decision to medicate involuntarily was approved where it was made by a panel consisting of a psychiatrist, a psychologist, and the administrator of the facility, without any court involvement.⁴³³

Harper not only confirmed the new line of authority, it expanded upon it. At least under *Romeo*, one could theoretically ask the courts to see that professional judgment was, in fact, exercised.⁴³⁴ At least in *Parham*, the parents theoretically were a check on the discretion of the psychiatrist.⁴³⁵ *Harper* may also depart from *Vitek*. At first blush, *Harper* could be read as telling the lower courts and the states what procedure is necessary for a decision by a medical trier of fact to satisfy *Vitek*. The relatively extensive procedural protections provided by the prison's involuntary medication policy in *Harper*⁴³⁶

427. *Project Release v. Prevost*, 551 F. Supp. 1298, 1307 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983) (citations omitted).

428. *In re Desmond*, 381 N.W.2d 57, 59 (Minn. Ct. App. 1986). Civil libertarians can find no solace in the context of this case; that is, the mentally retarded who will always be retarded, and a hoped-for application of the *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), principle that the nature and duration of confinement should bear some rational relationship to its purpose. The expected duration of a condition warranting confinement is, after all, a matter within "professional judgment."

429. *Project Release*, 551 F. Supp. at 1309.

430. 110 S. Ct. 1028 (1990).

431. *Vitek v. Jones*, 445 U.S. 480 (1980) (holding that due process requires procedural guarantees such as a hearing and notice before an inmate may be involuntarily transferred to a mental hospital).

432. *Harper*, 110 S. Ct. at 1033.

433. *Id.*

434. *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982).

435. *Parham v. J.R.*, 442 U.S. 584, 604 (1979). The *Harper* dissenters see this decision as an expansion of *Parham*. *Washington v. Harper*, 110 S. Ct. 1028, 1053 n.24 (1990) (Stevens, J., concurring in part and dissenting in part).

436. These included the right to advance notice of the intent to medicate, together with a statement of the factual basis for the diagnosis and prescription, and rights at the hearing such as the right to attend, present evidence, cross-examine, use a lay advisor, and appeal to the Superintendent of the facility. *Harper v. State*, 110 Wash. 2d 873, 879, 759 P.2d 358, 362 (1988), *rev'd sub nom.* *Washington v. Harper*, 110 S. Ct. 1028 (1990).

could form the floor below which the courts must not let the Constitution sink. However, Justice Kennedy passed on the opportunity to formulate any constitutional minimums, referring only vaguely to "fair procedural mechanisms."⁴³⁷ Remarkably, that reference is not tied to any citation to *Vitek*, but instead to *Parham* and *Romeo*.⁴³⁸ Moreover, Justice Kennedy's allusion to "fair procedural mechanisms" is followed by a reference to *Parham's* concerns for meaningless procedures restricting what the doctors must do anyway.⁴³⁹

Justice Kennedy dwelled on the patient's argument that the hearing panel cannot be impartial or independent since it consisted of institution doctors, colleagues and even subordinates of the treating psychiatrist. In the Court's view, due process was satisfied if the panel members were new to the inmate's current treatment.⁴⁴⁰ The members' history with the patient, their role in the prison, and their relationship with the treating doctors all were left outside the Court's circle.

More critically yet, the Court made plain its presumption that psychiatrists always act in the patient's best interests, even where the patient is a prisoner. The Court's presumption rested upon the ethical obligation of psychiatrists to prescribe drugs only for the medical interests of the patient.⁴⁴¹ As the dissent illustrated, this presumption would even exclude from the circle the prison's own policy to permit coerced medication solely because the patient's behavior could cause damage to institution property.⁴⁴² In his dissent, Justice Stevens observed that Justice Kennedy had misread the policy:

[T]he patient's medical interest in reducing his own violence or in altering his mental condition may be often outweighed by the risk or onset of severe medical side effects. Finally, the qualitative judgment of what is a patient's best interest cannot be made without reference to his own preferences. The Policy does not account for either a physician's determination of medical interest or the inmate's wishes.⁴⁴³

Harper may be limited to its facts, an impressive array of procedural protections directed by state law to a convicted felon, in a prison holding other felons with "a demonstrated proclivity for antisocial criminal, and often violent, conduct."⁴⁴⁴ Justice Kennedy wrote that "[t]he extent of a prisoner's right under the [due process clause] to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's

437. *Washington v. Harper*, 110 S. Ct. 1028, 1042 (1990).

438. *Id.* (citing *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Parham v. J.R.*, 442 U.S. 584 (1979)).

439. *Id.*

440. *Id.* at 1043-44.

441. *Id.* at 1037 n.8 (citing the Hippocratic Oath).

442. *Id.* at 1049 n.11 (Stevens, J., concurring in part and dissenting in part) (Justice Stevens dissented from the majority's evaluation of the merits, but concurred with the majority's analysis of why the case was not moot).

443. *Id.* (citation omitted).

444. *Id.* at 1038 (quoting *Hudson v. Palmer*, 468 U.S. 517, 526 (1984)).

confinement."⁴⁴⁵

Nonetheless, in its frequent invocation of *Parham*, its discussion of the trustworthiness of psychiatrists, and its curious misreading of the state policy, the *Harper* Court threatens further developments.⁴⁴⁶ From the understandable, but risky, reliance upon a union of interests between parent and child in *Parham*, the Court has now leapt to find a similar union of interests between convicted prisoner and prison doctor.

The distance covered by these cases suggests that the American Psychiatric Association may have been too conservative in its reform proposals.⁴⁴⁷ These cases do not simply erode the liberty rights of mental patients; they are progressively privatizing liberty. It is important to note that the courts are not

445. *Id.* at 1037.

446. *Harper* has already had an impact. The Supreme Court, in *Perry v. Louisiana*, 59 U.S.L.W. 4007 (1990), recently ordered Louisiana courts to reconsider a state court ruling that a psychotic inmate on death row could be forced to take medication to make him mentally competent before being executed.

In March of 1990, the Supreme Court in *Perry* agreed to decide the "question of whether a state can, in effect, make a prisoner eligible for execution by administering anti-psychotic medication against his will." *Perry v. Louisiana*, 110 S. Ct. 1317, *vacated* 59 U.S.L.W. 4007 (1990). However, in November of 1990, after listening to arguments from both sides on the issue, the Supreme Court vacated the grant of certiorari and remanded *Perry* in light of *Washington v. Harper*. *Perry v. Louisiana*, 59 U.S.L.W. 4007 (1990). The effect was that the Justices avoided "a decision they had committed themselves to make." Greenhouse, *New Hearing for Inmate on Forced Medication*, N.Y. Times, Nov. 14, 1990, at A13, col. 1.

Surprisingly, *Harper* apparently was read to provide *more* protection for prisoners:

The reason the Court gave for its order made the action particularly puzzling. The Justices instructed the Louisiana courts to reconsider the case in light of [*Washington v. Harper*, which] established at least a limited constitutional right for prisoners to refuse mind-altering drugs.

But that decision . . . was issued before the Court granted review in the Louisiana case. . . .

If the decision in the Washington case substantially changed the constitutional landscape, that would presumably have been apparent to the Justices at the time, and they could have sent the Louisiana case back to the state courts for reconsideration then rather than accept jurisdiction themselves, as they did the next week.

Id.

The briefs filed in *Perry* differed "over how the Court should apply its ruling in *Washington v. Harper* to the *Perry* case, in which the state's goal is not to attend to the inmate's medical needs but to execute him." *Id.* at A13, col. 2.

According to the brief for the inmate, "[u]sing forced medication solely as a means to groom [Perry] for execution, without in any way limiting that order or considering [Perry's] interests and medical needs, violates the limits set forth in *Harper*." *Id.* (quoting the inmate Perry's brief). Not surprisingly, the brief for the Louisiana Attorney General came to the opposite conclusion. According to the Attorney General, a death sentence justifies "'restrictions on liberty which are required to effectuate the death penalty.' . . ." In short, the *Harper* right to be free from involuntary medication was extinguished by Perry's sentence of death." *Id.* (quoting the Louisiana Attorney General's brief).

447. Even where the courts simply review court commitment decisions, the principles of *Parham* encourage them to approve lax procedural safeguards. See, e.g., *W.J.C. v. County of Vilas (In re W.J.C.)*, 124 Wis. 2d 238, 241, 369 N.W.2d 162, 164 (Ct. App. 1985) (psychiatrist can testify in favor of commitment by telephone).

saying that mental patients have no liberty rights. On the contrary, they ritualistically cite the community mental health reform era cases for the proposition that commitment is a significant deprivation of liberty.⁴⁴⁸ Rather than extinguishing the right to liberty, the courts insist upon the traditional balancing of state and individual interests to devise an accommodation of those interests. However, the protection and interpretation of the patient's constitutional right to liberty have been reassigned to the psychiatrists.⁴⁴⁹

Some might argue that delegation to psychiatrists of the traditionally judicial power of interpreting and enforcing constitutional rights does not constitute privatization since the psychiatrists are, for the most part, state employees. This reservation overlooks both the presence of private psychiatrists who commit and treat, even at state facilities, and the absence of any such private/public distinction in the cases. More importantly, the professional role of the psychiatrist hired by the state remains essentially unchanged. Whatever the source of the psychiatrist's remuneration, professional obligations to the patient insulate the psychiatrist from the direction of the state mental health system. Ironically, the Supreme Court has acknowledged the private function served by other state-employed professionals. In finding that public defenders do not act under color of state law, the Supreme Court noted in *Polk County v. Dodson*⁴⁵⁰ that while "[s]tate decisions may determine the quality of his law library or the size of his caseload. . . . a defense lawyer is not, and by the nature of his function cannot be, the servant of an administrative superior."⁴⁵¹ The lawyer's role of "advancing 'the undivided interests of his client' . . . is essentially a private function"⁴⁵² Similarly, the state-employed psychiatrist, while feeling the influence of the state budget on his facilities and equipment and the pressure of public demand on his caseload, has a primary obligation to the patient.⁴⁵³

448. *E.g.*, *Project Release v. Prevost*, 722 F.2d 960, 971 (2d Cir. 1983) (citing *Vitek v. Jones*, 445 U.S. 480, 491-92 (1980); *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)).

449. *See* *United States v. Bryant*, 670 F. Supp. 840, 844 (D. Minn. 1987) (right to refuse treatment). The *Bryant* court stated that "it is necessary to balance [the patient's] liberty interest against the competing governmental interests. . . . It is not the court's duty, however, to perform the balancing." *Id.*; *see also* *Vitek v. Jones*, 445 U.S. 480, 495-96 (1980) (requiring an independent decisionmaker to conduct an adversary hearing; that decisionmaker may be an institution psychiatrist); *cf.* *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984) (forcible medication only justifiable based upon professional judgment of treatment needs), *cert. denied*, 469 U.S. 1214 (1985).

450. 454 U.S. 312 (1981).

451. *Id.* at 321.

452. *Id.* at 318-19 (quoting *Ferri v. Ackerman*, 444 U.S. 193, 204 (1974)).

453. THE PRINCIPLES OF MEDICAL ETHICS §§ 9-10 (American Medical Association 1973), reprinted in *Official Actions: The Principles of Medical Ethics*, 130 AM. J. PSYCHIATRY 1057, 1063-64 (1973) (with annotations especially applicable to psychiatry). Section 9 states:

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Id. § 9. Section 10 states:

The honored ideals of the medical profession imply that the responsibilities of the

Nonetheless, the Supreme Court has not extended to doctors the same recognition given to lawyers in *Dodson*. A state hospital medical superintendent "owes no duty of undivided loyalty to his patients," because of the added obligation to serve the public interest in safety.⁴⁵⁴ The Supreme Court has not found the commonality of professionalism shared by public defenders and state psychiatrists a sufficiently persuasive analogy to exempt doctors from liability under 42 U.S.C. § 1983.⁴⁵⁵ Instead, the Court distinguishes the public defender on the basis of the adversariness of that function.⁴⁵⁶ Still, the professional obligation is not irrelevant, in the Court's view, if the actor is private but acts in concert with the state.⁴⁵⁷

Whether or not a state psychiatrist can avoid liability under section 1983, the function of the psychiatrist, like that of the lawyer, is "essentially a private function."⁴⁵⁸ The burden of sorting out the competing interests for an adjudication of liberty rights has been added to the traditional medical function, making it even less likely that doctors could avoid section 1983 liability.⁴⁵⁹ Still, this governmental function, now folded within the practice of medicine, operates without any government involvement or review. It is a privatized function.

C. Drawing a Little Circle Around Reality

Historically, the courts accepted, implicitly if not explicitly, the factual assumptions underlying the three great waves of reform and their three consequent retreats. The Jacksonians thought lunacy was caused by the disturbances of civilization and increased as civilization inevitably spread.⁴⁶⁰ They were wrong.⁴⁶¹ Just prior to the Progressive Era, Americans believed that insanity was untreatable,⁴⁶² the Irish were more susceptible to insanity than native-born Americans,⁴⁶³ and the asylum was demonstrably better than the

physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Id. § 10.

454. *Polk County v. Dodson*, 454 U.S. 312, 320 (1981). Curiously, in a case in which the public defender is sued under 42 U.S.C. § 1983 by her client for actions taken consistent with her duty as an officer of the court, the Supreme Court spoke of the state doctor as a double agent, but continued to portray the lawyer's duty as simple and singular. *Id.* at 314-15.

455. *West v. Atkins*, 487 U.S. 42, 50-51 (1988).

456. *Id.* at 52.

457. *Id.* at 52 n.10.

458. *Id.* at 46 n.6; *Blum v. Yaretsky*, 457 U.S. 991, 1012 (1982).

459. In fact, however, the professional deference extended in *Romeo* will insulate them from liability in almost all cases.

460. See *supra* text accompanying notes 25-41.

461. "[T]here has been no increase in the frequency of the psychosis during the past one hundred years [from 1840 to 1940]." H. GOLDHAMER & A. MARSHALL, *PSYCHOSIS AND CIVILIZATION* 11 (2d ed. 1953) (studying period of 1840-1940).

462. See *supra* text accompanying notes 53-57.

463. See *supra* text accompanying note 65.

prison.⁴⁶⁴ They were wrong. The Progressives hoped that individualized treatment, based upon extensive case histories, would develop a range of community treatments, with the state hospital only one option among many.⁴⁶⁵ They were wrong. Early in this century, society thought insanity was genetic.⁴⁶⁶ Society was wrong.⁴⁶⁷ The community mental health movement expected anti-psychotic medications to conquer mental illness and thought socioeconomic disparities were attributable to mental illness.⁴⁶⁸ They were wrong.⁴⁶⁹ Now, the public believes that the community mental health movement has caused the homelessness phenomenon.⁴⁷⁰ Again, the public is wrong.⁴⁷¹

These misperceptions, expressed in metaphors, shaped mental health policy in all three branches of government. Jacksonians built asylums and courts developed new doctrine to commit people to them.⁴⁷² Post-Jacksonian society and its courts tolerated abuses in the asylum.⁴⁷³ Progressives quarantined and vaccinated, and the courts limited their oversight of the mental hospitals to compensating those patients experiencing physical injury and, also, enthusiastically approved of sterilization.⁴⁷⁴ Deinstitutionalization courts took over the remaining institutions as the nation waged war on its social problems, including mental illness.⁴⁷⁵ In recent years, along with much of the country, the courts have abandoned the government's role as counter to the best of our traditions.⁴⁷⁶ Certainly these reformers and their successors are entitled to their time. Even equipped with the advantage of hindsight, we should not assess their failures too harshly. Still, the courts of those times enforced policies contradicted by facts lying outside the circle the courts drew around the problem of mental illness as they defined it.

Likewise, the cooperation of the courts with the privatization reform likewise requires drawing a circle around the reality of mental illness in order to justify the policies of this reform. The privatization reform, as articulated by

464. See *supra* text accompanying notes 67-70.

465. See *supra* text accompanying notes 101-08.

466. See *supra* text accompanying notes 157-60.

467. Available evidence, supporting a causal relationship between adverse social conditions and mental illness, suggests some continuing relationship between genes and insanity, such as, perhaps, genetic predispositions activated by hardship. See Kohn, *Social Class and Schizophrenia: A Critical Review and a Reformulation*, 1 SCHIZOPHRENIA BULL. 60, 69 (1973).

468. See *supra* text accompanying notes 164-68, 178.

469. If anything, mental illness may be attributable to socioeconomic inequalities. See *infra* notes 531-40 and accompanying text.

470. See *supra* text accompanying notes 216-17, 229.

471. Not only did deinstitutionalization begin before the reform, see *supra* text accompanying notes 163, 238, but the number of mentally ill patients among the homeless is commonly exaggerated. F. STEVENS, *RESPONDING TO AMERICA'S HOMELESS: PUBLIC POLICY ALTERNATIVES* 82 (1986).

472. See *supra* text accompanying notes 42-47.

473. See *supra* text accompanying notes 72-79.

474. See *supra* text accompanying notes 112-14, 138-54.

475. See *supra* text accompanying notes 193-215.

476. See *supra* text accompanying notes 241-60.

the courts, rests upon five assumptions not supported, and even contradicted, by the facts available to the courts. When distilled from the decisions, these assumptions are:

1. that psychiatrists have the requisite skill to determine the necessity of involuntary commitment and only they can interpret the material facts;
 2. that psychiatrists may be counted upon to function as independent and impartial triers of fact;
 3. that involuntary treatment is necessary because the mentally ill will get worse without treatment which they will not voluntarily seek;
 4. that the adversarial process is meaningless and even harmful to the mentally ill;
 5. that mental illness is a medical, not a social problem.
- The error of each assumption will be considered in turn.

1. *The Expertise of Psychiatry*

Psychiatrists are plagued with differences of opinion on diagnostic standards.⁴⁷⁷ Their self-criticism should inspire doubts about their ability to arrive at valid and reliable conclusions about mental illness. A sampling follows:

The need to improve diagnostic reliability in schizophrenia is so obvious as to not require additional confirmation. . . . Improved diagnosis will almost certainly not increase our understanding of what schizophrenia is. An increase in reliability does not affect validity. We can standardize our misconceptions in such a way that the same person will be identically mislabeled by an even larger number of colleagues.⁴⁷⁸

Throughout the helping professions it is unfortunately true that diagnoses are often made and therapy prescribed on the basis of inadequate case study. That is, inadequate even in the light of our limited knowledge. [sic] The major reason for this premature closure is the unwarranted belief that an arbitrary stereotyped formulation implies dynamic understanding. Such formulations served as ritualistic guardians of ignorance for those who cannot stand the anxiety engendered by the ambiguity inherent in our present ignorance.⁴⁷⁹

Any number of studies have indicated that psychiatric diagnosis at present is so unreliable as to merit very serious question when classifying, studying, and treating patients' behavior and outcomes.

. . . .

. . . Clinicians . . . may be selectively perceiving and emphasizing only

477. See 1 J. ZISKIN & D. FAUST, *COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY* 160-81 (4th ed. 1988) (reviewing the literature discussed in this section along with many others).

478. Cancro, *Increased Diagnosis Reliability in Schizophrenia: Some Values and Limitations*, 11 INT'L J. PSYCHIATRY 53, 54-55 (1973).

479. 1 J. ZISKIN & D. FAUST, *supra* note 477 (quoting Thorne, *Clinical Judgment*, in CLINICAL ASSESSMENT IN COUNSELING AND PSYCHOTHERAPY 12 (R. Woody & J. Woody 1972)).

those characteristics and attributes of their patients which are relevant to their own preconceived system of thought. As a consequence, they may be overlooking characteristics which would be considered crucial by colleagues who are otherwise committed. This makes it possible for one psychiatrist to diagnose nearly all patients as schizophrenic while another equally competent clinician diagnoses a comparable group as psychoneurotic.⁴⁸⁰

Other studies similarly conclude that there is no accuracy among psychiatrists.⁴⁸¹ Nor does the diagnostic standard for the profession, the Diagnostic and Statistical Manual III Revised ("DSM-IIIR"),⁴⁸² provide security.⁴⁸³

Nonetheless, the trial judge may insist that whether or not psychiatrists can diagnose with any degree of validity or reliability, they are still better equipped than courts to assess the material facts to see if the individual suffers from some kind of mental illness, however vaguely defined and poorly diagnosed. The literature does not support that insistence. In the famous Rosenhan Study, nonpsychotic people presented themselves at the doors of mental hospitals faking hallucinations.⁴⁸⁴ After their admission with the diagnosis of schizophrenia, they stopped simulating symptoms, but continued to bear the diagnosis and to be hospitalized for periods of time ranging from seven to fifty-two days. While only one study, the error rate was an impressive one hundred percent.⁴⁸⁵

The studies suggest that a psychiatrist's superior experience does not relate

480. Pasamanick, Dinitz & Lefton, *Psychiatric Orientation and Its Relationship to Diagnosis and Treatment in a Mental Hospital*, 116 AM. J. PSYCHIATRY 127, 127, 131 (1959).

481. Temerlin & Trousdale, *The Social Psychology of Clinical Diagnosis*, 6 PSYCHOTHERAPY: THEORY, RESEARCH & PRACTICE 24, 26-29 (1969). The author conducted an experiment in which a mentally healthy man (a professional actor) was diagnosed by psychologists and psychiatrists after a well-known psychologist suggested (according to the experiment's instructions) that the patient looked psychotic. *Id.* at 24-25. Even though they observed a perfectly healthy man, 88% of the psychologists and 100% of the psychiatrists diagnosed the man as having "mental illness." *Id.* at 27. The authors agreed with Thomas Szasz that "psychiatric diagnosis is a process of labeling social behavior." *Id.* at 28-29.

482. AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE ON NOMENCLATURE AND STATISTICS, *DIAGNOSIS AND STATISTICAL MANUAL OF MENTAL DISORDERS* (3d ed., revised 1987). The Diagnostic and Statistical Manual of Mental Disorders Revised ("DSM-IIIR") provides a "medical model" for many behavioral disturbances and also circumstantially defines mental disorders. McReynolds, *DSM-III and the Future of Applied Social Science*, 10 PROF. PSYCHOLOGY 123, 123 (1979). DSM-IIIR also provides diagnoses according to many separate categories of disturbances. *Id.*

483. McReynolds, *supra* note 482, at 125. McReynolds criticizes the manual:

No recognizable process of scientific discovery is evident with regard to the scores of new disorders in DSM-III. . . .

. . . The processes whereby they have come to occupy a new place in psychiatric nosology are social and political, not scientific, in nature. It is just these defining and labeling processes that social scientists should study and explain.

Id. at 125-26.

484. Rosenhan, *On Being Sane in Insane Places*, 179 SCIENCE 250, 251 (1973).

485. *Id.* at 252.

at all to the accuracy of his or her conclusions.⁴⁸⁶ Nor does the available research indicate that psychiatrists possess any superior qualifications to discern credibility.⁴⁸⁷ Given the reliance of psychiatric opinion on stale and multi-authored case histories and the untested reports of family, the psychiatrist is substantially disadvantaged in determining the truth of a patient's situation.

Psychiatry claims even less expertise in predicting dangerous conduct. The journals are replete with studies confirming the unreliability of psychiatrist's predictions as to dangerousness.⁴⁸⁸ The American Psychiatric Association's

486. Goldberg, *The Effectiveness of Clinicians' Judgments: The Diagnosis of Organic Brain Damage from the Bender-Gestalt Test*, 23 J. CONSULTING PSYCHOLOGY 25, 32 (1959) ("diagnostic accuracy . . . does not depend on experience or training in psychology" (emphasis in original)); Goldsmith & Mandell, *The Dynamic Formulation—A Critique of a Psychiatric Ritual*, 125 AM. J. PSYCHIATRY 1738, 1738, 1741 (1969) ("The ability to select the correct diagnosis was not significantly influenced by the participants psychiatric experience.").

Another commentator has stated:

[C]linical judges tend to handle information differently and . . . many are purely idiosyncratic in their decisions as to weighting and assessing cues. The general research finding is that there will be almost as many judgments as there are clinicians. This is a deplorable state of affairs from the standpoint of establishing clinical practice as being "scientific." Until higher reliabilities may be demonstrated among clinical judges interpreting the same data it must be concluded that most clinicians are in a prescientific state of professional competency.

Thorne, *Clinical Judgment*, in CLINICAL ASSESSMENT IN COUNSELING AND PSYCHOTHERAPY 61 (R. Woody & J. Woody 1972).

487. Albert, Fox & Kahn, *Faking Psychosis on the Rorschach: Can Expert Judges Detect Malingering?*, 44 J. PERSONALITY ASSESSMENT 115, 118 (1980); Goldstein, *Credibility and Incredibility: The Psychiatric Examination of the Complaining Witness*, 137 AM. J. PSYCHIATRY 1238, 1240 (1980).

488. Monahan, *Risk Assessment of Violence Among the Mentally Disordered: Generating Useful Knowledge*, 11 INT'L J. PSYCHIATRY & L. 249, 250 (1988); Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10, 10-11 (1984); Shah, *Dangerousness and Civil Commitment of the Mentally Ill: Some Public Policy Considerations*, 132 AM. J. PSYCHIATRY 501, 504 (1975); Steadman, *The Right Not to Be a False Positive: Problems in the Application of the Dangerousness Standard*, 52 PSYCHIATRIC Q. 84, 90-91 (1980); Werner, Rose & Yesavage, *Reliability, Accuracy, and Decision-making Strategy in Clinical Predictions of Imminent Dangerousness*, 51 J. CONSULTING & CLINICAL PSYCHOLOGY 815, 822 (1983); see also J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 41-62 (1981) [hereinafter J. MONAHAN, CLINICAL PREDICTION] (explaining that research on clinical prediction of violent behavior has been criticized because the research did not actually test the accuracy of the prediction, the predictions tested were out of date, and much of the violence that occurred was not detected); H. STEADMAN & J. COCOZZA, CAREERS OF THE CRIMINALLY INSANE 175-76 (1974) (explaining that relying on dangerousness as a justification for involuntary civil hospitalization is based on the apparent assumption that psychiatrists and psychologists are capable of making such predictions); Haynes, *The Predictive Value of the Clinical Assessment for the Diagnosis, Prognosis, and Treatment Response of Patients*, in DANGEROUSNESS, PROBABILITY AND PREDICTION, PSYCHIATRY AND PUBLIC POLICY 54-55 (C. Webster, M. Ben-Aron & S. Hucker eds. 1985) ("[T]he reliability and predictive value of many clinical assessments are unknown, a sad state of affairs when one considers the potential value of some clinical findings."); cf. McNiel & Binder, *Predictive Validity of Judgments of Dangerousness in Emergency Civil Commitment*, 144 AM. J. PSYCHIATRY 197, 197-200 (1987) (finding a relatively high degree of short-term predictive validity of judgments of dangerousness made in the context of

Task Force on Clinical Aspects of the Violent Individual issued a report in 1974 which agreed.⁴⁸⁹ The APA has consistently taken the official position that its members cannot predict long-term dangerousness.⁴⁹⁰ Still, the APA has filed amicus briefs which distinguished between predicting long-term and short-term dangerousness, declining to admit that they could not offer expert testimony in civil commitment cases.⁴⁹¹ Even the more recent psychiatric literature, however, places a "ceiling on the level of accuracy" of these short-term predictions of approximately fifty percent.⁴⁹² John Monahan, after reviewing the more recent literature, concluded that "[w]e may be of some help in assessing the probability of future violence, at least in some cases. But whether a person is dangerous 'enough' to justify preventive confinement is not for us to say. That buck should stop at the judge's bench, not at the witness box."⁴⁹³ For any expected improvement in the capacity to predict dangerous behavior, we should look to statistical and actuarial techniques relating to family environment, work environment, and peer group environment.⁴⁹⁴ However, psychi-

emergency civil commitment). Saleem Shah succinctly summarized the psychiatrist's inability to predict dangerous behavior as follows:

Given the numerous court proceedings in which the dangerousness of a mentally ill person is at issue and the very serious decisions affecting life and liberty that must be made, one might assume that some reasonably accurate means of predicting dangerous behavior are available. This assumption would be false. No instrument has yet been developed that can predict violent and other dangerous behavior in a reasonably accurate and satisfactory manner.

Shah, *supra*, at 504.

489. AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE REPORT NO. 8, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 23-30 (1974).

490. The APA takes this position in cases where psychiatrists may be held liable for failing to make the prediction, Brief for Amicus Curiae in Support of Petition for Rehearing at 7-9, *Tarasoff v. Regents of Univ. of Cal.*, 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974) (No. S.F. 23042), and in death penalty cases, Brief for Amicus Curiae for the APA at 12, *Barefoot v. Estelle*, 463 U.S. 880 (1983) (No. 82-6080); Brief for Amicus Curiae for the APA at 11, *Estelle v. Smith*, 451 U.S. 454 (1981) (No. 79-1127). The Supreme Court has accepted their argument, but refuses to stop relying on the testimony. *Estelle v. Smith*, 451 U.S. 454, 472 (1979).

491. The APA's briefs cited to Monahan, *Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration*, 135 AM. J. PSYCHIATRY 198 (1978). But this article does not support a conclusion of greater accuracy for short-term predictions. Monahan, in this article, offered only theoretical possibilities for a greater accuracy in predicting short-term dangerousness, without any data. *Id.* at 198, 200. "Whether [short-term predictions] are in fact better and, if so, how much better, is not now known." *Id.* at 200. Monahan also asserts that "[t]here is no a priori reason to assume that psychiatrists or psychologists would be any better at prediction in emergency situations than other observers or participants (e.g., a police officer or a potential victim)." *Id.*

492. J. MONAHAN, CLINICAL PREDICTION, *supra* note 488, at 11. One of the principal studies discussed by Monahan is Rofman, Askinazi & Fant, *The Prediction of Dangerous Behavior in Emergency Civil Commitment*, 137 AM. J. PSYCHIATRY 1061 (1980), which, while it does find a greater level of accuracy, still concludes that psychiatric predictions are more often wrong than right. *Id.* at 1063.

493. J. MONAHAN, CLINICAL PREDICTION, *supra* note 488, at 14 (citation omitted).

494. *Id.*; R. SIMON, *supra* note 73, at 185.

atrists possess no special qualifications to conduct such statistical analyses.

Courts, at least implicitly, have considered psychiatrists better equipped to balance the legal interests involved. Grant Morris found that legally trained hearing officers were more inclined than clinical factfinders to consider legal issues such as burden of proof, to care about procedural matters, and to extend credibility to the patient's testimony.⁴⁹⁵ This is not surprising. The profession's own literature suggests the severe limitations of psychiatrists' ability to make these critical liberty determinations. One psychiatrist has argued against the special qualifications of his profession:

The physician is not essentially different from other authorities, such as the clergyman or the lawyer I see no justification for physicians in general, or psychiatrists in particular, to have more power than such other experts to override the expressed wishes of people or to have greater responsibility for harm to self or the public caused by the intemperate behavior of clients.⁴⁹⁶

The Supreme Court in *Addington* acknowledged the "lack of certainty and the fallibility of psychiatric diagnosis."⁴⁹⁷ But rather than scrutinize the usefulness of the diagnoses in applying legal standards, the Court changed the standards to accommodate the uncertainty and fallibility.⁴⁹⁸

2. *The Impartiality of Psychiatrists*

No more or less than any other profession, psychiatrists see and react to individuals through a filter of biases. Accordingly, they make decisions about patient care for a variety of reasons, only some of which derive from the needs of the patient. The danger to liberty posed by the biases and mixed motivations of psychiatrists arises from both the presumption that psychiatrists remain somehow immune to biases and the lack of opportunity to test the credibility of their opinions through cross-examination.

Even when testifying as expert witnesses and not as litigants, psychiatrists are susceptible to responding as advocates for one side or the other in ways that are hard to detect given the murky basis of their opinions.⁴⁹⁹ As a general

495. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 345-51 (1988). Another attitudinal study of psychiatrists found them impatient with procedural requirements and confident that their clinical judgments were sufficient to make the commitment decision. ENKI RESEARCH INSTITUTE, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW 210-11 (ENKI Corp., California 1972) cited in Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 729 n.126 (1974).

496. Reiser, *Refusing Treatment for Mental Illness: Historical and Ethical Dimensions*, 137 AM. J. PSYCHIATRY 329, 331 (1980).

497. *Addington v. Texas*, 441 U.S. 418, 429 (1979).

498. *Id.*

499. Diamond, *The Psychiatrist As Advocate*, 1 J. PSYCHIATRY & L. 5, 18-19 (1973); Pollack, *Psychiatric Consultation for the Court*, in 3 MEDICAL & PSYCHIATRIC TESTIMONY IN CRIMINAL CASES 177, 187-88 (Practising Law Institute Vol. 3 1968).

matter, psychiatrists are more authoritarian than nonmedical mental health professionals and more comfortable with compulsory commitment.⁵⁰⁰ Factors other than the apparent symptoms of possible mental illness frequently lead to underdiagnosis and overdiagnosis of mental illness.⁵⁰¹ To spare patients the stigma of psychosis, nonmedical mental health professionals commonly diagnose a condition as a so-called "adjustment disorder."⁵⁰²

On the side of overdiagnosis, fifty-five percent of the respondents to a recent survey of mental health professionals reported that patients frequently received a psychiatric diagnosis when the patient's primary problem was in the family; twenty-seven percent reported that patients frequently received a more serious diagnosis than clinically indicated; twenty-five percent reported that a psychiatric diagnosis was frequently made when clinically unwarranted.⁵⁰³ The reason driving the overdiagnosis was the need of mental health care providers to obtain reimbursement from insurance providers for the treatment.⁵⁰⁴ Overdiagnosis is also a common problem for the prediction of dangerous behavior. An APA Task Force Report noted that "[p]sychiatrists, in order to be safe, too often predict dangerousness, especially in the case of the mentally ill offenders. Absence of treatment resources, administrative oversights, and excessive reliance on conservative release policies have rather clearly resulted in severe injustice being done to such persons."⁵⁰⁵

Sadly, psychiatrists also encounter socioeconomic and even racial barriers to truthful and impartial assessment of patients. Studies reflect that black women are more often diagnosed as schizophrenic than white women, and therefore,

500. Mendel & Rapport, *Determinants of the Decision for Psychiatric Hospitalization*, 20 ARCHIVES GEN. PSYCHIATRY 321, 327 (1969) (finding that psychiatrists are more likely than social workers to commit patients and over longer periods of time).

501. *Id.* at 327-28 (finding that many psychiatrists are influenced by factors other than the patient's symptoms, such as their professional background and like or dislike of the patient).

502. Kirk & Kutichins, *Deliberate Misdiagnosis in Mental Health Practice*, 62 SOC. SERV. REV. 225, 229 (1988) (finding that 82% of the social workers surveyed admitted that they diagnosed patients as having "adjustment disorders" when in fact they knew that a more serious diagnosis would be more appropriate).

503. *Id.* at 231 (Table 2).

504. *Id.* at 230 ("Seventy-two percent of the respondents [to the survey were] aware of cases where more serious diagnosis [were] used to qualify for reimbursement."). The authors further argued:

In particular, misdiagnosis is used so that the therapist's services will qualify for third-party reimbursement. Here the rationale is also nonclinical, but the argument that the therapist is acting only for the client's benefit is strained. The rationale that it is being done so that the client can obtain needed service is colored by the obvious self-interest of the therapist. Agencies, both public and private, also benefit when they obtain reimbursement as a result of such diagnostic practices.

Id. at 232. Also, the commitment decision may be influenced by the psychiatrist's desire to continue a treatment regimen to see if it works. See *Law's Labor Lost*, 40 PSYCHIATRIC Q. 150, 156 (1966) (editorial comment) ("Research in psychiatry depends upon enough hospital population to provide statistical validity with matched subjects, controlled in a variety of ways . . .").

505. AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE REPORT NO. 8, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 25 (1974).

are more likely to be hospitalized;⁵⁰⁶ black patients admitted to an institution were diagnosed as schizophrenic more often than white patients;⁵⁰⁷ and rehospitalization of black patients is predicted more often than for white patients, reversing the reality.⁵⁰⁸ The force of culture also displays its power in influencing psychiatric determinations.⁵⁰⁹

Finally, as the arbiter of liberty interests, the psychiatrist will likely view the patient's insistence on liberty as resistance to treatment and use that to darken the diagnosis and prognosis.⁵¹⁰ While doctors may characteristically assume that those patients who exercise their right to refuse treatment are actually the sickest,⁵¹¹ the studies also suggest that "the more persistent refusers may retain a greater sense of control over their lives" and thus have "a better prognosis for treatment."⁵¹² Nonetheless, where the decision to honor or deny the refusal of medication rests in nonmedical hands, more refusals are honored than when doctors make the decision.⁵¹³

3. *The Necessity for Compulsory Hospitalization*

The assumptions underlying compulsory treatment—that patients will deteriorate without hospitalization and will not enter the hospital voluntarily—are not supported by the literature.⁵¹⁴ The few studies of the homeless mentally ill

506. Gross, Herbert, Knatterud & Donner, *The Effect of Race and Sex on the Variation of Diagnosis and Disposition in a Psychiatric Emergency Room*, 148 J. NERVOUS & MENTAL DISEASE 638, 640-41 (1969).

507. Watkins, Cowan & Davis, *Differential Diagnosis Imbalance as a Race-related Phenomenon*, 31 J. CLINICAL PSYCHOLOGY 267, 268 (1975).

508. Stack, Lannon & Miley, *Accuracy of Clinicians' Expectancies for Psychiatric Rehospitalization*, 11 AM. J. COMMUNITY PSYCHIATRY 99, 107-08 (1983) (finding that white patients are actually readmitted more often than black patients, even though black patients are expected to be readmitted more often than white patients).

509. Phillips & Draguns, *Classification of the Behavior Disorders*, 22 ANN. REV. PSYCHIATRY 447, 467 (1971).

[T]he influence of the client's socioeconomic class in facilitating the attribution of some, and impeding the application of other, nosological designations is particularly well documented [T]he findings converge in suggesting social distance is the mediating variable. Across socioeconomic or other subcultural lines, the middle class diagnostician is prone to assign categories of severe psychopathology

Id. (citations omitted); see also Lee & Temerlin, *Social Class, Diagnosis, and Prognosis for Psychotherapy*, 7 PSYCHOTHERAPY: THEORY, RESEARCH & PRACTICE 181 (1970) (lower socioeconomic class means more severe diagnosis and bleaker prognosis independent of clinical features).

510. Wallach & Strupp, *Psychotherapists' Clinical Judgments and Attitudes Toward Patients*, 24 J. CONSULTING PSYCHOLOGY 316, 322 (1960).

511. Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340, 343, 345 (1980).

512. Appelbaum & Hoge, *Empirical Research on the Effects of Legal Policy on the Right to Refuse Treatment*, in THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION 90 (American Bar Association Commission on the Mentally Disabled 1986).

513. See Zito, Lentz, Routt & Olson, *The Treatment Review Panel: A Solution to Treatment Refusal?*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 349, 355-57 (1984).

514. Arce, Tadlock, Vergare & Shapiro, *A Psychiatric Profile of Street People Admitted to an Emergency Shelter*, 34 HOSP. & COMMUNITY PSYCHIATRY 812, 812 (1983); Morse & Calsyn,

reflect a general willingness to obtain therapy, especially among those with chronic illness,⁵¹⁶ although psychiatrists commonly assume otherwise. The barriers keeping most of the homeless mentally ill population from receiving treatment lie less in rigorous commitment standards⁵¹⁶ than in patients' fears of involuntary confinement, over-medication, the stigma associated with mental hospitals,⁵¹⁷ and the systemic unavailability of services.⁵¹⁸ One of these same studies reports a high rate (eighty-six percent) of compliance with medication.⁵¹⁹

Once committed, the therapeutic value of involuntary treatment is unclear. While there is empirical evidence of modest benefits from psychotherapy,⁵²⁰ few mental hospitals provide psychotherapy since patient numbers overwhelm the numbers and qualifications of staff.⁵²¹ Similarly, studies of drug therapy report widely varying but generally positive results.⁵²² The principal limitation of all these studies is their failure to specify their population as voluntary or involuntary patients.⁵²³ Although the efficacy of involuntary commitment remains cloudy, one fact appears rather clear. Even among those receiving care in hospitals, most patients voluntarily cooperate with treatment.⁵²⁴

Studies indicate that long-term hospitalization is of little help and, in fact, enhances the probability of more hospitalization.⁵²⁵ Conversely, the literature

Mentally Disturbed Homeless People in St. Louis: Needy, Willing, But Underserved, 14 INT'L J. MENTAL HEALTH, Winter 1985-1986, at 74, 80 (finding that vast majority of chronic mentally ill patients indicated willingness to receive mental health care); Morse, Shields, Hanneke, McCall, Calsyn & Nelson, *St. Louis' Homeless: Mental Health Needs, Services and Policy Implications*, 9 PSYCHOSOCIAL REHABILITATION J. 39, 40, 47 (1986) [hereinafter Morse, *St. Louis' Homeless*] (finding that 57.7% of mental patients surveyed were willing to receive mental health services).

515. See, e.g., Putnam, Cohen & Sullivan, *Innovative Outreach Services for the Homeless Mentally Ill*, 14 INT'L J. MENTAL HEALTH, Winter 1985-1986, at 112, 114 (describing a mobile psychiatric outreach team for the chronically mentally ill which would provide housing medical care, food, and clothing while avoiding the stigma of the medical hospitals; this outreach team was the backdrop for the *Boggs* case).

516. See *id.* at 123.

517. Morse, *St. Louis' Homeless*, *supra* note 514, at 45; Putnam, Cohen & Sullivan, *supra* note 515, at 123.

518. Bachrach, *The Homeless Mentally Ill and Mental Health Services: An Analytical Review of the Literature*, in THE HOMELESS MENTALLY ILL 32-33 (H. Lamb ed. 1984); Morse, *St. Louis' Homeless*, *supra* note 514, at 47-48;

519. Arce, Tadlock, Vergare & Shapiro, *supra* note 514, at 816.

520. See Durham & Lafond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 330-41 (1988) (reviewing literature discussing the benefits of psychotherapy).

521. In a study discussed by Durham and Lafond, only 10% of patients received any psychotherapy. *Id.* at 341 n.158.

522. *Id.* at 346.

523. *Id.* at 348.

524. Appelbaum & Gutheil, *supra* note 511, at 342 (finding that 22% of patients refused treatment); Appelbaum & Hoge, *supra* note 512, at 87-89 (surveying several studies and concluding that approximately five percent of patients consistently refused treatment).

525. Mattes, *The Optimal Length of Hospitalization for Psychiatric Patients: A Review of the Literature*, 33 HOSP. & COMMUNITY PSYCHIATRY 824, 827 (1982).

suggests that patients receiving care in the community have fared at least as well as those hospitalized.⁵²⁶

4. *The Meaninglessness of Due Process*

The premise is as follows: since all the nonpatient participants think an adversarial commitment process is meaningless, they respond in nonadversarial ways, rendering the process meaningless; therefore the process is meaningless. The patent circularity of the premise should end the discussion. Such logic has doomed many ventures. Fortunately, research contradicts this premise as well. For example, the mere presence of a lawyer for the patient dramatically reduces the likelihood of commitment,⁵²⁷ particularly when the lawyer functions as an advocate, rather than a self-appointed guardian ad litem.⁵²⁸

Additionally, there is reason to think that insistence upon the adversary process may afford some therapeutic benefit to the patient. This type of process allows the patient to retain some role in the decisions affecting him or her in such significant ways.⁵²⁹ "[T]he hearing should be a confrontation with reality [for the patient]. It should be an occasion where he can see something of the social reaction to his behavior. As such, it should be a learning experience."⁵³⁰

5. *The Medical Nature of Mental Illness*

Certainly, the moderate success of medication in controlling symptoms suggests some biological basis for psychosis. Now that societal causal agents are discounted in favor of individual medical agents, psychiatry has acquired a powerful motivation to prove that insanity is illness. Research supporting bio-

526. Braun, *supra* note 227, at 747; see also Searight & Handal, *Psychiatric Deinstitutionalization: The Possibilities and the Reality*, 58 PSYCHIATRIC Q. 153, 154 (1986) (finding community treatment to be associated with less hospital recidivism and to be less expensive than hospital care).

527. Perlin, *An Invitation to the Dance: An Empirical Response to Chief Justice Warren Burger's "Time-Consuming Procedural Minuets" Theory in Parham v. J.R.*, 9 BULL. AM. ACAD. PSYCHIATRY & L. 149, 161 (1981) ("clear that counsel plays a critical, and in some cases, nearly dispositive role"); Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. HEALTH SOC. BEHAVIOR 66, 69-70 (1969) (finding that 91% of patients without lawyers were committed, while only 26% of patients with lawyers were committed).

528. Durham & La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395, 440 (1985); Miller & Fiddleman, *Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes*, 60 N.C.L. REV. 985, 1002-04, 1007-09 (1982).

529. Appelbaum & Gutheil, *supra* note 511, at 344-45; Cumming & Goyer, *Therapeutic Consequences of the Involuntary Commitment Process*, 1 AM. J. FORENSIC PSYCHIATRY 37 (1979); see Perlin, *supra* note 527, at 157.

Further, if Melvin Kohn, *supra* note 467, at 73, is correct, then the due process hearing can afford the poor mental patient an avenue for influencing the previously uncontrollable forces that dominate his life.

530. Ensminger & Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5, 12 (1978).

logical theories of insanity should dominate the professional journals. Still, the high correlation between poverty and mental illness demands reconsideration of the medical nature of insanity.

Hollingshead and Redlich, in their classic study,⁵³¹ demonstrated the close relationship between social status and mental illness: the lower the socioeconomic status, the greater prevalence of identified mental illness and the greater severity of illness.⁵³²

There are a variety of possible explanations for these findings. One is that psychiatrists are more likely to diagnose the lower classes as indicating serious psychosis, as illustrated earlier.⁵³³ A second explanation is that treatment modes vary by class as well, with psychotherapy more available as one climbs the social ladder, leaving the less successful therapies for the lower classes. Hollingshead and Redlich confirm that possibility.⁵³⁴ A third explanation is that mental illness makes people poor, since the mentally ill are less capable of succeeding economically. Although this possibility undoubtedly explains the situation of some patients, this "drift hypothesis" is not supported by the available evidence.⁵³⁵

Hollingshead and Redlich suggest a fourth possibility: that poverty contributes to the onset of mental illness.⁵³⁶ However, this possibility could not be established based on the research at that time. More recent research confirms the durability of the correlation and lends support to this causal relationship.⁵³⁷ Melvin Kohn concludes that "these life conditions [of poverty] may adversely affect people's ability to deal, not only with situations that . . . are stressful, but also with many other dilemmas and uncertainties in a rapidly

531. A. HOLLINGSHEAD & F. REDLICH, *SOCIAL CLASS AND MENTAL ILLNESS* (1958) (research study conducted by social scientists and psychiatrists on the "interrelations between social stratification and mental illness in the urbanized community").

532. *Id.* at 216-17, 248-49; see also Gift, Strauss, Ritzler, Kokes & Harder, *Social Class and Psychiatric Outcome*, 143 AM. J. PSYCHIATRY 222, 223-24 (1986) [hereinafter Gift] (summarizing literature on the effect of socioeconomic status on mental illness); Wheaton, *The Sociogenesis of Psychological Disorder: Reexamining the Causal Issues with Longitudinal Data*, 43 AM. SOC. REV. 383, 383, 402-03 (1978) (same).

533. See *supra* text accompanying notes 506-08.

534. A. HOLLINGSHEAD & F. REDLICH, *supra* note 531, at 300-02; see also Mollica, *From Asylum to Community: The Threatened Disintegration of Public Psychiatry*, 308 NEW ENG. J. MED. 367, 370, 372 (1983) ("Most notably, the state hospital continues to be the principal facility for the acute inpatient care of the lower-class patient. . . . This situation is alarming, since state hospitals continue to bear the brunt of fiscal cutbacks and professional neglect.").

535. Kohn, *supra* note 467, at 64.

536. See A. HOLLINGSHEAD & F. REDLICH, *supra* note 531, at 359, 366.

537. Dohrenwend & Dohrenwend, *Social and Cultural Differences in Psychopathology*, 25 ANN. REV. PSYCHOLOGY 417, 418 (1974); Fried, *Social Differences in Mental Health*, in POVERTY AND HEALTH: A SOCIOLOGICAL ANALYSIS 135, 135 (Kosa & Zola eds. 1975); Gift, *supra* note 532, at 224; Kohn, *The Interaction of Social Class and Other Factors in the Etiology of Schizophrenia*, 133 AM. J. PSYCHIATRY 177, 178 (1976); Lee, *The Causal Priority Between Socioeconomic Status and Psychiatric Disorder: A Prospective Study*, 22 INT'L J. SOC. PSYCHIATRY 1, 1 (1976); Wheaton, *supra* note 532, at 398-99.

changing, complex society."⁵³⁸ These life conditions include the poor person's value system, which emphasizes conformity to external authority and the inflexibility that such conformity implies.⁵³⁹ At the same time, the poor person constantly confronts the unpredictable and uncontrolled nature of life on the street. Another psychiatrist vividly describes the dynamics:

I do not believe it is possible to pursue the concept of madness until we understand what adversity can do to human beings.

. . . The poor have no control over the events of their lives.

There is more illness, more injury, more death, more pollution, more family disruption, more unemployment, more homelessness, more harassment, more alienation, more crowding and more danger among them. Living in urban poverty is like living in a turbulent ocean, trying to hang on to a child with one hand and a sodden piece of driftwood with the other. There is a whole ecology of bitterness, envy and suspicion.

Every assault from the environment increases the intensity and frequency of other assaults.⁵⁴⁰

The medical model does not lack for eager defenders. Professor Gerard is typical in his defense; he essentially asserts that the medical model has utility to legal decisionmaking, specifically decisions about civil commitment.⁵⁴¹ Gerard claims the model's value only for a judicial decision that the person to be committed has a mental illness, not the separate decision that the person poses a danger to self or others.⁵⁴² His defense argues that the model provides a scientific basis for sifting through the numerous diagnoses available in the psychiatric profession's Diagnostic and Statistical Manual ("DSM-III").⁵⁴³

The limitations of the defense are two. First, it has little to do with the law of civil commitment as it operates. The defense does not answer the dangerousness question, which remains, for the time being, critical to the commitment decision. More importantly, while the medical model may eliminate

538. Kohn, *supra* note 467, at 71.

539. *Id.* at 73.

540. H. DRUMMOND, DR. DRUMMOND'S SPIRITUAL GUIDE TO HEALTH CARE IN A DYING EMPIRE 99, 101 (1980). Kohn puts it less graphically:

People at the bottom of the class hierarchy experience great economic insecurity and far more than their share of serious ill health, degradation, and the afflictions attendant on inadequate, overcrowded housing, often in overpopulated, underserved areas.

. . . [A]t any given level of stress, people of lower social class position are more likely to become mentally disturbed than are people of higher social class position. In fact, the more sources of stress, the greater the class difference in the proportion of people who manifest psychotic symptoms.

Kohn, *supra* note 467, at 70-71.

541. Gerard, *The Usefulness of the Medical Model to the Legal System*, 39 RUTGERS L. REV. 377, 402 (1987).

542. *Id.* at 379.

543. *Id.* at 400.

ninety percent of DSM-III diagnoses,⁵⁴⁴ the model leaves the vaguely defined and ubiquitous diagnosis schizophrenia⁵⁴⁵ as a basis for commitment.⁵⁴⁶ Second, the defense misapprehends the criticisms of the medical model by assuming that the critics demand unreachable certainty.⁵⁴⁷ Since certainty from psychiatry is impossible, so the argument goes, we must settle for what psychiatry has to offer.⁵⁴⁸ This Article does not expect certainty, nor does it deny the usefulness of the medical model as one means of attempting to understand and respond to the mysteries of mental illness. This Article simply insists that before we defer to expert opinion in the denial of individual liberty, we must have more confidence in that expert opinion from the community of those experts than psychiatry can provide.

6. *The Example of Billie Boggs*

The epidemic of homelessness in New York City so troubled some quarters that a new program, Project HELP, began policing the streets for the homeless mentally ill, taking them to shelters and mental institutions.⁵⁴⁹ One such homeless person was Billie Boggs. Her case serves as an apt example of the operation of the premises of the privatization reform.⁵⁵⁰

At the hearing on Billie Boggs' petition to be released from the hospital, eight psychiatrists testified; five from the hospital and three from the New York Civil Liberties Union ("NYCLU"). As the trial judge noted, the diagnoses of the two teams of psychiatrists stood "nearly at complete variance" with each other.⁵⁵¹ The hospital psychiatrists supported their commitment recommendation with examples of her behavior and delusions: tearing up money given to her by passersby, urinating and defecating outside with stains from both on her clothing, refusing food offered to her by Project HELP, running

544. *Id.* at 402.

545. As E. Fuller Torrey has stated:

This [number of those diagnosed with schizophrenia, i.e., 1.2 million people] is the same number of persons who live in Nebraska or Utah, or who live in Alaska, Delaware, and Wyoming put together. Every year another 43,000 persons are diagnosed with schizophrenia for the first time. Every day another 118 persons are diagnosed with schizophrenia for the first time.

E. TORREY, *SURVIVING SCHIZOPHRENIA* 4 (1988).

546. Gerard, *supra* note 541, at 407 (describing "schizophrenia" as a qualifying disorder for commitment).

547. *Id.* at 405.

548. *Id.*

549. See generally Putnam, Cohen & Sullivan, *supra* note 515 (describing a New York mobile psychiatric outreach team for the chronically mentally ill, called "Project HELP," which would provide housing, medical care, food, and clothing while avoiding the stigma of the medical hospitals).

550. *In re Boggs*, 136 Misc. 2d 1082, 522 N.Y.S.2d 407 (Sup. Ct.), *rev'd sub nom. Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1987), *appeal dismissed sub nom. Anonymous v. New York City Health & Hosps. Corp.*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988).

551. *Id.* at 1084-86, 522 N.Y.S.2d at 408-09.

into the street, suffering from delusions about other people, evidencing hostility to the doctors, and finally refusing to voluntarily seek treatment.⁵⁵² The opposing psychiatrists from the NYCLU interpreted the refusal of food and destruction of money as efforts to maintain some dignity and control over her life, as well as a security measure against carrying too much money on the dangerous streets. The lack of public restrooms accounted for the urination and defecation. Her running into the streets without injury, in New York, where jaywalking is not uncommon, testified to her survival skills. What the hospital doctors viewed as a delusion, the opposing psychiatrists regarded as a simple lie.⁵⁵³

The trial court chose to rely upon its own appraisal of Boggs' testimony and demeanor.⁵⁵⁴ The court found her to be lucid and rational. Boggs' hostility to the doctors and refusal to submit to treatment or shelter "may reveal more about conditions in shelters" than about her and "might, in fact, prove that she's quite sane."⁵⁵⁵ The court found partial explanation for the experts' disagreement in the different ways they viewed Boggs: "the hospital psychiatrists and staff treated a coerced, uncooperative, agitated patient, and a filthy one as well. On the other hand, when examined by psychiatrists . . . whom she did not view as enemies, she was, as described by them, 'warm,' coherent, and logical."⁵⁵⁶ The trial court wrote that the "logical inference to be drawn from" her filthy clothes "is that she is poor."⁵⁵⁷ For the dilemma of the homeless mentally ill, "[t]he blame and shame must attach to us, not to them. The predicament of . . . the countless homeless raises questions of broad social, economic, political and moral implications not within the purview of this court. . . . There must be some civilized alternatives other than involuntary hospitalization or the street."⁵⁵⁸

The trial court's opinion touched all five of the premises underlying the reaction of other contemporary courts to the mentally ill: the decision recognized the lack of either specialized expertise or impartiality among psychiatrists, it acknowledged the pointlessness of coerced treatment and the relationship between poverty and mental illness, and it affirmed the value of the adversary method in arriving at the truth of a problem. Still, the court found itself limited in its solutions to the little circle drawn around the hospital and Boggs. Consequently, the court was powerless to devise a solution consistent with the realities of the problem.

The court of appeals reversed, abandoning the traditional deference to the trial court's findings of fact.⁵⁵⁹ The court curiously chastised the trial court for

552. *Id.* at 1084-85, 522 N.Y.S.2d at 408-09.

553. *Id.* at 1085-86, 522 N.Y.S.2d at 409.

554. *Id.* at 1086, 522 N.Y.S.2d at 410.

555. *Id.* at 1091, 522 N.Y.S.2d at 412.

556. *Id.* at 1089, 522 N.Y.S.2d at 411.

557. *Id.* at 1090, 522 N.Y.S.2d at 412.

558. *Id.* at 1090-91, 522 N.Y.S.2d at 412-13.

559. *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 362, 523 N.Y.S.2d 71, 84 (1987), *appeal dismissed sub nom.* *Anonymous v. New York City Health & Hosps. Corp.*, 70

placing great weight on Boggs' testimony because there had been no determination that her demeanor in court resembled her behavior on the street, according to descriptions from the hospital psychiatrists. The court of appeals deferred to the hospital psychiatrists' testimony in its entirety and rejected the competing testimony of the patient's doctors.⁵⁶⁰ Concluding, the court wrote:

We reject, as against the weight of the evidence, the Hearing court's conclusion that, in substance, Ms. Boggs' homelessness is not a result of serious mental illness, but, rather, is the result of New York's lack of housing for the poor. . . . The sole issue before us is whether Ms. Boggs is so severely mentally ill that, unless she continues to receive hospital treatment, she is in danger of doing serious harm to herself.⁵⁶¹

The appellate court's decision represents the triumph of the privatization reform—abdicating responsibility for social problems, limiting the issue to the medical problem before it, totally deferring to the hospital psychiatrists, and trusting in their expertise and impartiality. All that is left is for courts to stop hearing such cases altogether.

D. Bending Doctrine as it Turns

The courts reformulated the rights of the mentally ill with each wave of mental health reform and retreat. The Jacksonian courts construed the *parens patriae* power of the state to authorize commitment to the new asylums.⁵⁶² As the asylums failed, the courts began articulating a basic right to safety.⁵⁶³ With the arrival of the Progressive era, the courts discovered a right not to be in the state hospital.⁵⁶⁴ As the reform again failed, the courts found new police power to eliminate insanity by sterilizing and "quarantining" the mentally ill in institutions.⁵⁶⁵ In the community mental health era, the courts found a panoply of rights: to treatment and to refuse treatment, to be deinstitutionalized, and to receive rigorous due process before commitment.⁵⁶⁶ Hardly before the ink dried on those opinions, the courts narrowed or eliminated each of those rights.⁵⁶⁷

In each era, the shift in doctrine followed a shift in the social and political agenda, not the logic of doctrine. Until recently, the manipulation of doctrine

N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988).

560. *Id.* at 364-65, 523 N.Y.S.2d at 86.

561. *Id.* at 365, 523 N.Y.S.2d at 86-87. Boggs had testified that she would live in an apartment, rather than the street, if she had such an apartment. *In re Boggs*, 136 Misc. 2d 1082, 1087-88, 522 N.Y.S.2d 407, 410 (Sup. Ct.), *rev'd sub nom.* *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1987), *appeal dismissed sub nom.* *Anonymous v. New York City Health & Hosps. Corp.*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988).

562. *See supra* text accompanying notes 42-47.

563. *See supra* text accompanying notes 74-75.

564. *See supra* text accompanying notes 112-15.

565. *See supra* text accompanying notes 138-54.

566. *See supra* text accompanying notes 181-215.

567. *See supra* text accompanying notes 241-60.

and precedent had not reached the level of *Ryan v. New York Central Railroad*⁵⁶⁸ in cynicism and transparency.

For instance, in *Addington*,⁵⁶⁹ the Supreme Court recalled, as it had several times in the past, the near total unreliability of psychiatric opinion.⁵⁷⁰ In other times, such unreliability might lead a court to insist upon greater legitimacy to psychiatric testimony before finding it sufficient to carry the burden of proof. In this time, however, the Supreme Court lowered the commitment standards to a level attainable by the state of the psychiatric art, explicitly to allow the process of involuntary institutionalization to continue.⁵⁷¹

In *Parham*,⁵⁷² the Supreme Court found that the stigma previously recognized as attendant to commitment⁵⁷³ attaches not because of commitment, but because of the mental illness itself.⁵⁷⁴ This devalued stigma clinging to committed children helped Chief Justice Burger dilute the procedural protections for children.⁵⁷⁵ Yet, in the next Term, commitment to a mental hospital was perceived as so stigmatizing to a convicted felon, whose liberty interest had already been essentially extinguished, that Justice White insisted upon notice and an adversary hearing prior to commitment.⁵⁷⁶ In *Vitek v. Jones*,⁵⁷⁷ the Court refused to allow a psychiatrist to serve as decisionmaker, stating that "Nebraska's reliance on the opinion of a designated physician or psychologist for determining whether the conditions warranting a transfer [to a mental hospital from prison] exist neither removes the prisoner's interest from due process protection nor answers the question of what process is due under the Constitution."⁵⁷⁸

The specialized expertise of psychiatrists envied by the Court in *Parham* was less significant in *Vitek*. After recalling the observation in *Addington* that these essentially medical decisions involve facts that can only be interpreted by the psychiatrist, Justice White nonetheless wrote in *Vitek* that "[t]he medical nature of the inquiry, however, does not justify dispensing with due process requirements. It is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings."⁵⁷⁹ The adversary process, meaningless in *Parham*, was essential in *Vitek*. While the Court was satisfied with an independent decision by another psychiatrist,⁵⁸⁰ it nonetheless

568. 35 N.Y. 210 (1866); see *supra* notes 303-11 and accompanying text (discussing *Ryan*).

569. *Addington v. Texas*, 441 U.S. 418 (1979).

570. *Id.* at 429-30.

571. *Id.*

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

573. *Addington*, 441 U.S. at 424-26.

574. *Parham*, 442 U.S. at 600.

575. *Id.* at 601.

576. *Vitek v. Jones*, 445 U.S. 480, 495-96 (1980).

577. 445 U.S. 480 (1980).

578. *Id.* at 491.

579. *Id.* at 495 (second set of brackets by *Vitek* court) (quoting *Addington v. Texas*, 441 U.S. 418, 430 (1979)).

580. *Id.* at 485, 495.

cautioned against the unfettered exercise of medical judgment effectively unloosed in *Parham*.⁵⁸¹

The Court did not even attempt a doctrinal reconciliation of *Vitek* and *Parham*. None is possible.⁵⁸² *Parham* stood on empty precedent, citing a number of cases emphasizing the flexibility of due process, all of which insisted upon more due process than that afforded in *Parham*, some of them for lesser interests.⁵⁸³ In *Parham*, the gravity of the liberty interest involved and the risk of error from uncertain psychiatric diagnosis—the very factors traditionally leading to more rigorous due process—all failed to convince the Burger Court of the necessity for greater limits on the psychiatrist's power. The reason was made explicit:

[A]s most states have expanded their efforts to assist the mentally ill, their actions have been subjected to increasing litigation and heightened constitutional scrutiny. Courts have been required to resolve the thorny constitutional attacks on state programs and procedures with limited precedential guidance. . . .

The State also has a genuine interest in allocating priority to the diagnosis and treatment of patients as soon as they are admitted to a hospital rather than to time-consuming procedural minuets before the admission.⁵⁸⁴

In *Romeo*,⁵⁸⁵ the Court legitimized the psychiatric opinion under suspicion and deferred to psychiatry, with none of the *Vitek* safeguards in place. In that portion of the Court's *Romeo* decision defining the deferential standard, Justice Powell cited no law other than *Parham*.⁵⁸⁶ No authority was cited for the new presumptive validity given to psychiatric opinion. For authority, the Court

581. *Id.* at 495.

582. The cases cannot be distinguished on the basis of the minority status of the children in *Parham*. After discussing the possible unity of interests between parents and children, Chief Justice Burger noted the possibility of conflict and assumed a separate liberty interest vested in the children. *Parham v. J.R.*, 442 U.S. 584, 600 (1979).

583. *See, e.g.*, *Mathews v. Eldridge*, 424 U.S. 319, 349 (1976) (finding due process satisfied, in the context of disability benefits, by notice, evidentiary hearing, and appeal opportunities); *Goss v. Lopez*, 419 U.S. 565, 581 (1975) (demanding a notice and some meaningful opportunity to be heard prior to a ten-day school suspension); *Wolff v. McDonnell*, 418 U.S. 539, 562-70 (1974) (providing prisoners facing loss of good time credits for rule infractions a written notice and a hearing with the right to call witnesses, and, if the prisoner suffers from some deficit, to lay representation to help prepare his defense); *Morrissey v. Brewer*, 408 U.S. 471, 486-87 (1972) (insisting upon prior written notice and a hearing offering the right to confront adverse witnesses at parole violation hearing); *Goldberg v. Kelly*, 397 U.S. 254, 268-69 (1970) (protecting welfare benefits with a written notice and pretermination evidentiary hearing with the right to confront and cross-examine as well as present evidence).

584. *Parham v. J.R.*, 442 U.S. 584, 599, 605 (1979) (citation omitted).

585. *Youngberg v. Romeo*, 457 U.S. 307 (1982).

586. *Id.* at 322-23 (citing *Parham v. J.R.*, 442 U.S. 584, 605 (1979)). Justice Powell also cited the cases directing a deference to prison administrators, *id.* (citing *Rhodes v. Chapman*, 452 U.S. 337, 352 (1981); *Bell v. Wolfish*, 441 U.S. 520, 539 (1979); *Wolff v. McDonnell*, 418 U.S. 539, 556 (1974)), but stepped far beyond requiring deliberate indifference to constitutional rights before warranting court intervention.

offered only the following logic: since there "is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions,"⁵⁸⁷ there is a reason to think the appropriate professionals are so much better qualified to make those decisions as to render their decisions virtually unimpeachable.⁵⁸⁸

The Court in *Romeo* invoked the tenuous authority of *Rhodes v. Chapman*⁵⁸⁹ and *Bell v. Wolfish*⁵⁹⁰ for the proposition that courts are to leave state institutions to the state's administration.⁵⁹¹ While those cases do stand for that sweeping proposition, those cases cannot span the difference between letting a prison warden decide the necessary square footage for the cells of those convicted by a criminal court and letting a psychiatrist commit, treat or refuse to protect whomever he or she sees fit. That expanse cannot be sustained, especially after *Vitek*.

Romeo also made the Court's agenda clear: "Such a presumption is necessary to enable institutions of this type—often, unfortunately, overcrowded and understaffed—to continue to function."⁵⁹²

While *Romeo* repeated familiar dogma that the mentally ill are entitled "to

587. *Id.* at 323.

588. *Id.* This assumption also marks a substantial departure from medical malpractice law, in which the opinion of a treating psychiatrist may be challenged by the opinion of the plaintiffs' expert, and the court, through judge or jury, will choose who is correct, rather than defer. *E.g.*, *Dillman v. Hellman*, 283 So. 2d 388, 389 (Fla. Dist. Ct. App. 1973); *Pettis v. State*, 336 So. 2d 521, 528 (La. Ct. App. 1976); *Hammer v. Rosen*, 7 N.Y.2d 376, 379-80, 165 N.E.2d 756, 757, 198 N.Y.S.2d 65, 66-67 (1960). The malpractice claim is not an avenue around the barriers of *Romeo* for those confined in state hospitals, since state laws commonly wrap their psychiatrists in immunity. *E.g.*, MO. REV. STAT. §§ 537.600, 632.440 (1986 & Supp. II 1990).

Recently, some have proposed judicial deference to physicians in medical malpractice cases as well. *See generally Leahy, Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 CALIF. L. REV. 1483 (1989).

589. 452 U.S. 337 (1981). In *Rhodes*, several prisoners brought a class action § 1983 claim against state officials alleging that confining two prisoners in a single cell violated the Constitution. *Id.* at 339-40. The district court ruled that "double celling" was unconstitutional, in part because it provided each prisoner with less square feet of cell space than was recommended by several studies. *Chapman v. Rhodes*, 434 F. Supp. 1007, 1021 (S.D. Ohio 1977), *aff'd*, 624 F.2d 1099 (6th Cir. 1980), *rev'd*, 452 U.S. 337 (1981). The Supreme Court reversed, holding that the "restrictive and even harsh" conditions of the cells did not rise to the level of cruel and unusual punishment. *Rhodes*, 452 U.S. at 347.

590. 441 U.S. 520 (1979). The facts of *Bell* closely resemble those in *Rhodes*. Inmates brought a class action suit challenging the constitutionality of the conditions at a short-term custodial facility which housed pretrial detainees. *Id.* at 523. The district court found a constitutional violation in the facility's practice of housing two inmates in a single room. *United States ex rel. Wolfish v. Levi*, 439 F. Supp. 114, 137 (S.D.N.Y. 1977), *aff'd sub nom. Wolfish v. Levi*, 573 F.2d 118 (2d Cir. 1978), *rev'd sub nom. Bell v. Wolfish*, 441 U.S. 520 (1979). The Supreme Court held that the practice of "double-bunking" pretrial detainees did not violate the fifth amendment. *Bell*, 441 U.S. at 542-43.

591. *Youngberg v. Romeo*, 457 U.S. 307, 322 (1982) (citing *Rhodes v. Chapman*, 452 U.S. at 352; *Bell v. Wolfish*, 441 U.S. at 539).

592. *Id.* at 324.

more considerate treatment and conditions of confinement than criminals,"⁵⁹³ the decisions in *Romeo* and *Parham* deny to the mentally ill a basic right modestly protected for felons in *Vitek*: liberty from psychiatry.

The decision in *Washington v. Harper*⁵⁹⁴ does not resolve this anomaly. *Vitek's* concern for the "subtleties and nuances" of psychiatry, recognized by the Washington Supreme Court,⁵⁹⁵ is forgotten by the Supreme Court. Even greater trust is placed in psychiatrists to follow their ethical obligation to treat in the patient's best interest,⁵⁹⁶ despite procedures which allow them to treat for the prison's best interests, that is, in control.⁵⁹⁷ The Washington state procedures mean little to the decision other than as examples of how a state can exceed the constitutional minimums. Since due process procedures are meaningless rituals, psychiatric judges are relieved of their burden.

IV. UNMIXING METAPHORS, AGENDAS, FACT, AND LAW

To develop sound doctrine, the courts must lay bare our metaphors to expose the reality hidden inside them: the facts the metaphors distort and the agendas they reflect. We must not underestimate the power of our metaphors: "[o]ur behavior is a function of words we use. More often than not, our thoughts do not select the words we use; instead, words determine the thoughts we have. We can say with some assurance that language develops out of social conditions and in turn influences social behavior."⁵⁹⁸

Variouly called lunacy, insanity, and mental illness, the phenomena of madness functioned metaphorically to express the nation's fears, of civilization,⁵⁹⁹ social dislocation following war,⁶⁰⁰ corruption,⁶⁰¹ social dislocation following a depression,⁶⁰² stagnation and social injustice,⁶⁰³ and finally failure from ill-advised government adventures perverting the marketplace.⁶⁰⁴ The

593. *Id.* at 322.

594. *Washington v. Harper*, 110 S. Ct. 1028 (1990).

595. *Harper v. State*, 110 Wash. 2d 873, 880, 759 P.2d 358, 363 (1988), *rev'd sub nom.* *Washington v. Harper*, 110 S. Ct. 1028 (1990).

596. *Harper*, 110 S. Ct. at 1037 n.8.

597. *Id.* at 1049 n.11 (Stevens, J., concurring in part and dissenting in part) (Justice Stevens dissented from the majority's evaluation of the merits, but concurred with the majority's analysis of why the case was not moot).

598. Embler, *Metaphor and Social Belief*, in *LANGUAGE, MEANING AND MATURITY* 125 (S. Hayakawa ed. 1954).

599. This was the view of the Jacksonians. *See supra* text accompanying notes 25-41.

600. This was the prevailing view during the post-Jacksonian era. *See supra* text accompanying notes 48-52.

601. This was the view of the Progressives and their contemporaries, the nativists. *See supra* text accompanying notes 80-111.

602. This was the prevailing view during the early part of this century (1900-1940). *See supra* text accompanying notes 116-37.

603. This was the prevailing view during the New Frontier and the Great Society eras (1945-1970). *See supra* text accompanying notes 164-80.

604. This was the prevailing view in the period after the Great Society era (1970-1980). *See supra* text accompanying notes 216-40.

phenomena of madness functions as a metaphor even today.⁶⁰⁵

The presumed power of medically trained and professionally cultured psychiatrists to define mental illness for the rest of society does not remove psychiatrists' conceptions beyond the reach of social beliefs about insanity, whatever their origin. Psychiatrists live in this society and reach adulthood and professional status while in communion with the greater culture around them. In 1861, Doctor Oliver Wendell Holmes wrote:

The truth is, that medicine, professedly founded on observation, is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to the changes of atmospheric density. Theoretically it ought to go on its own straightforward inductive path, without regard to changes of government or fluctuations of public opinion. [Actually there is] a closer relation between the Medical Sciences and the conditions of Society and the general thought of the time, than would at first be suspected.⁶⁰⁶

As a metaphor, mental illness explains that what is wrong with America today is not its soul or its structure, not its mission or its power. The trouble is the weakness of the few, drawing on the strength of the many. The many can survive and prosper if they do not suffer the limits the few would impose on their growth.⁶⁰⁷ While Sontag is undoubtedly correct in her assertion that "[i]llnesses have always been used as metaphors to enliven charges that a society was corrupt or unjust,"⁶⁰⁸ mental illness now has its most metaphoric vitality, even as we currently pretend to disassociate it from its political and social connections and reduce it back to a medical problem:

Order is the oldest concern of political philosophy, and if it is plausible to compare the polis to an organism, then it is plausible to compare civil disorder to an illness. The classic formulations which analogize a political disorder to an illness—from Plato to, say, Hobbes—presuppose the classical medical (and political) idea of balance. Illness comes from imbalance. Treatment is aimed at restoring the right balance—in political terms, the right hierarchy. The prognosis is always, in principle, optimistic. Society, by

605. Susan Sontag writes of insanity as a metaphor for "the contemporary prestige of irrational or rude (spontaneous) behavior (acting-out), of that very passionateness whose repression was once imagined to cause [tuberculosis], and is now thought to cause cancer." S. SONTAG, *supra* note 2, at 36. This may reflect the time the first edition of her book was written, the mid-1970s. It hardly seems true today, at least with respect to mental illness.

606. O. HOLMES, *CURRENTS AND COUNTER-CURRENTS IN MEDICAL SCIENCE* 7 (1861).

607. Recall the quote from President Reagan: "Our optimism has once again been turned loose. And all of us recognize that those people who keep talking about limits are really talking about their own limitations, not America's." P. ERICKSON, *supra* note 288, at 100 (quoting a Ronald Reagan 1984 campaign speech). Recall as well that the Irish were blamed for the failure of moral treatment, *see supra* text accompanying note 65, the genetically insane were blamed for sapping the state of its reform efforts, presumably including civic medicine, *see supra* text accompanying notes 157-60, and the discharged mentally ill have been blamed for the failure of the welfare "safety net," *see supra* text accompanying note 278.

608. S. SONTAG, *supra* note 2, at 72.

definition, never catches a fatal disease.⁶⁰⁹

Mental illness is no longer a metaphor for what is wrong with this country. It is a metaphor for what would be wrong if we upset the natural order. Holding to our traditional principles—order, limited government, and the rule of the marketplace—promises the best treatment and prevention. The efficacy of this metaphor demands that mental illness be viewed not as a social problem, with causal connections to poverty or inequality to which government might respond. Rather, it demands that mental illness remain just that, an illness afflicting individuals, for which “doctor knows best.”

The courts' limited role of resolving private disputes, even where it means reducing public issues to private disputes between specific litigants,⁶¹⁰ serves as a perfect vehicle for this metaphor's communication to society and its implementation. The court draws the customary little circle around the litigants, here the psychiatrist and the patient or would-be patient. Within that circle the court defines the problem and “resolves” it. Given the circle, the court's judgment should come as no surprise. Of the two players inside, only one is believed and has power. Since society's surrogate (the psychiatrist), cannot be crazy, someone else must be. And that someone must be treated. As long as we treat the patient, America stays healthy. The court's circle guarantees that the victim will be blamed for his or her own mental illness. The victim will be blamed at least in the sense that society remains blameless, unjust social conditions are irrelevant, and treatment is imposed on the patient.⁶¹¹ There is no one else to blame.⁶¹²

We must expose the metaphor's hidden agenda of social control. The appeal of the metaphor and the popularity of the privatization reform cannot be explained away as simply a belief in the power of science. An ideology or culture of science fails to explain why, when we defer to medical expertise, we defer only to the expertise of the institutional psychiatrist, not to those the patient might enlist to support her release. Widening the circle to include the context of mental illness can help our understanding.⁶¹³ A renewed investigation of the

609. *Id.* at 76-77.

610. Chayes, *The Role of the Judge in Public Law Litigation*, 89 HARV. L. REV. 1281, 1295 (1976).

611. This variant of “blaming the victim” is consistent with other approaches to public health problems, such as changing the patient, not the patient's illness-inducing environment. W. RYAN, *supra* note 277, at 5, 8.

612. Clearly, we have evolved past blaming the patient, in the moral sense. Insanity is, presumably, no longer a sign of moral deficiency. Still, our marketplace metaphor's insistence upon individual causes and consequences leaves us with few choices—the problem must be in the individual, if not in the soul, then in the body.

613. W. RYAN, *supra* note 277, at 147. The author states:

[T]he investigation of the mental health problems of the poor was distorted and, as a result, the facts were subtly reformulated in a way that permits and encourages the oversimplification: the problems of the poor are, at bottom, manifestation of neurosis or character disorder. That is, they are *intrapsychic* problems that can only be corrected by therapeutic intervention in the psychic processes of the poor person himself.

problem must account for the relationship of poverty and inequality to mental illness. Hollingshead and Redlich concluded that while the mentally ill affluent were induced to seek treatment in "gentle and 'insightful' ways,"⁶¹⁴ the mentally ill poor were subjected to "direct, authoritative, compulsory, and, at times, coercively brutal methods."⁶¹⁵ Today still, most of the mentally ill poor receive treatment, if at all, in overcrowded and underfunded state hospitals.⁶¹⁶ Most of the rest are in nursing homes, shelters, jails, or on the street.⁶¹⁷ The treatment choices are simple: no treatment on the streets or coerced treatment in the institution. Failure to examine this reality legitimizes the use of mental health law for the agenda of social control.

Just as critically, we must examine the agenda of the other player in the circle, the psychiatrist. If it is true that psychiatrists have not generally committed to care for the poor or the marginal members of our society,⁶¹⁸ the explanation for the APA's commitment proposals may lie in their ideological view of the world:

[M]ost psychiatrists . . . see[] social stratification, not so much in terms of inequality of power and money, but in terms of status, prestige, and such questions as life style, values, behavior patterns, and child-rearing practices. This view is highly compatible with a psychodynamic and psychopathological outlook. . . .

In terms of delivery of care, the intrusion of this ideology into the mental health field creates a situation of gross injustice. Through excessive concern with the classical questions of "motivation," "suitability for treatment," and "ability to profit from therapy," the poor person with *genuine* intrapsychic problems is blithely screened out and does not have anything like equal access to mental health resources. . . . It almost seems to boil down to the simple fact that middle class and upwardly mobile professionals don't *like* the poor, don't intend to help them, and do intend to husband mental health resources for their own kind.⁶¹⁹

Perhaps the explanation is simpler yet; an explanation that reconciles the APA's position that psychiatrists cannot predict dangerous conduct and so should not be held liable for releasing patients from institutions⁶²⁰ and the APA's other position that they can predict dangerous conduct and so should be able to involuntarily commit patients to those same institutions. Such a

Id. (emphasis in original).

614. A. HOLLINGSHEAD & F. REDLICH, *supra* note 531, at 192.

615. *Id.*

616. Mollica, *supra* note 534, at 370; Rubenstein, *Access to Treatment and Rehabilitation for Severely Mentally Ill Poor People*, 20 CLEARINGHOUSE REV. 382, 384 (1986).

617. MISSOURI ASSOCIATION FOR SOCIAL WELFARE TASK FORCE REPORT, THE HOMELESS MENTALLY ILL IN MISSOURI 11 (1988).

618. Estroff, *Medicalizing the Margins: On Being Disgraced, Disordered, and Deserving*, 8 PSYCHOSOCIAL REHABILITATION J. 34, 37 (1985); Mollica, *supra* note 534, at 372.

619. W. RYAN, *supra* note 277, at 147-48 (emphasis in original).

620. See *supra* note 490 and accompanying text.

simpler explanation might implicate psychiatry's need to retain power.⁶²¹

That power should concern more than just mental patients. Chodoff, in one of the two articles on which the Supreme Court premised *Addington*⁶²² and *Parham*,⁶²³ would expand the regulatory scope of the medical model beyond disease to other social conduct:

Sophisticated definitions of the medical model do not require only the demonstration of unequivocal organic pathology. A broader formulation . . . extends the domain of illness to encompass certain forms of social deviance as well as biological disorders. According to this definition, the medical model is characterized not only by organicity but also by being negatively valued by society, by "nonvoluntariness," thus exempting its exemplars from blame, and by the understanding that physicians are the technically competent experts to deal with its effects.⁶²⁴

The medical profession has succeeded in "medicalizing" a variety of behaviors previously considered antisocial or immoral, such as alcoholism, eating disorders, and "everything from cigar smoking to love."⁶²⁵ When this success converges with deference to medical judgment, a number of inevitable consequences result. While an end to the unnecessary punishment of alcoholics and other substance abusers may be one of those consequences, the threat to individual liberty is yet another.

V. THE TRADITIONAL ROLE OF THE COURTS: CLEARING THE AIR

The courts cannot and perhaps should not lead reform movements. In mental health policy, they never have. Rather, they reflected their times and espoused the metaphors of their times, metaphors of reform and of defeat. Still, if courts simply reflect the realities of their times, perhaps we still can and should expect more than the distorted reflection of a funhouse mirror.⁶²⁶

621. Embler argues that psychiatrists are also subject to the power of metaphor and have taken literally Freud's metaphor of the Id, Ego and Super-Ego. Embler, *supra* note 598, at 135.

622. *Addington v. Texas*, 441 U.S. 418, 429 (1979).

623. *Parham v. J.R.*, 442 U.S. 584, 601 (1979).

624. Chodoff, *supra* note 385, at 498.

625. The quoted material is from an editorial in a psychoanalytic journal criticizing the "recent forceful biologization of everything from cigar smoking to love (a deficiency of phenylalanine treatable by chocolate in the absence of a loved person)." *Editorial*, 37 J. AM. PSYCHOANALYSIS A. 3, 4 (1989); see also *Traynor v. Turnage*, 485 U.S. 535, 538 n.2 (1988) (recognizing that secondary alcoholism is not willful misconduct but rather a psychiatric disorder); Morrow, *Doctors Helping Doctors*, 14 HASTINGS CENTER REP., Dec. 1984, at 32, 32-33 ("medicalizing" the problem of alcoholism among the medical profession).

626. Both law and psychiatry deal with reality indirectly, with a constructed reality. For law, this means defining what is true by what other people say is true, for example, in the opinions of other lawyers now sitting as judges, and by what is admitted into evidence. For psychiatry, this means diagnosis based upon the reports of other doctors found in the patient's chart and upon the reports of other lay witnesses. The "rights" and the "illness" commonly are not observed or experienced directly. This feature, which distinguishes both from sociology or the hard sciences might result in a natural affinity between the two professions, or at least a shared affinity for metaphor.

Society has yet to accept Sontag's point "that illness is *not* a metaphor, and that the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphorical thinking."⁶²⁷ Still, there is more available to the court's investigation than metaphor. There is the reality of mental illness, psychiatry, the history of mental health policy, and the courts' own role in that history.

The court is in a perfect place to look at mental illness in "the most truthful way." Our traditional perception of the role of the court puts it in that location of independence and integrity where truth can be looked at plainly. The dispelling of social metaphors which interfere with the task of just government is precisely the function of the courts in our system. Alexander Hamilton wrote that "the independence of judges may be an essential safeguard against the effects of occasional ill humors in the society."⁶²⁸

Until recently, the determination of facts material to the question of liberty belonged in the courts. Those facts are not simple medical judgments. Psychiatrists, after all, base their judgments upon facts, for example, information about the patient's behavior beyond the senses of the psychiatrist but contained in the reports of others, family and friends, and strangers. Nor are the material facts simply those related to the individual's mental illness. The facts include the conditions under which people acquire the symptoms of what we continue to call, in metaphor, mental illness, as well as the conditions under which people might be freed from them. They include the manner in which people bearing the metaphor's label are treated—the powerlessness of those deprived of free movement and control over their lives.

This Article calls for a return to the traditional role of the court, as the arena for the adversary process and its great engine for truth, cross-examination.⁶²⁹ It calls for putting the fallibility and uncertainty of psychiatry to the

Given that predilection, it might be necessary to call upon other metaphors, for example, the clean air or the Republic's cave walls mentioned below, in order to expose the power of the targeted metaphor and open it up for examination. The dilemma is not in using metaphors, but in forgetting that they are only metaphors.

One commentator has stated:

Figures of speech, when they are fitting and felicitous, and especially when they occur in print, give poetic sanction, as it were, to hitherto dimly felt, inarticulated beliefs. When metaphor is new, and when the reader does not enjoy the perspective vouchsafed by time, the metaphor is taken literally, and its function is not that of rhetorical device, but of statement of fact, prescribing certain kinds of behavior. Indeed, it may be said that the habit which sees the germane metaphor as a statement of identity is a habit which changes the character of civilizations.

Embler, *supra* note 598, at 128 (emphasis omitted).

627. S. SONTAG, *supra* note 2, at 3 (emphasis in original).

628. THE FEDERALIST NO. 78, at 494-95 (A. Hamilton) (B. Wright ed. 1961).

629. The courts might also again endorse another wave of reform in a future time, one shaped by a metaphor, perhaps, of community instead of competition. Still, a new communal metaphor might promise little change. Our history has reflected a tension between individualism's values—with the consequence of an atomized society allowing each to participate, compete, and to assume responsibility only for one's own life—and communal values, which permit the group to dictate individual conduct, for example, a duty to be well.

test before allowing this pre-science to deprive anyone of liberty. The Supreme Court seemed to understand this role of the courts in *Vitek*,⁶³⁰ a case which appeared briefly after *Parham*⁶³¹ and seemingly disappeared before *Romeo*.⁶³² The *Vitek* Court wrote that "[t]he medical nature of the inquiry, however, does not justify dispensing with due process requirements. It is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirements of adversary hearings."⁶³³ Although this insight only led the Court to require an independent prison psychiatrist as decisionmaker, such limited due process is consistent with scores of precedent defining minimal due process protections for those whose liberty interest has been effectively extinguished by conviction and sentencing for crime.⁶³⁴ As even *Romeo* acknowledged, the mentally disabled have rights superior to those convicted of crimes.⁶³⁵ The mentally disabled enjoy the full protection of the liberty guaranteed by the Constitution; it is to be denied or limited only in accord with traditional principles of due process.

The original understanding of the rights of the mentally ill recognized by the Supreme Court in *Humphrey v. Cady* has not lost its truth: "In making this determination [of the rights of the mentally ill], the jury serves the critical function of introducing into the process a lay judgment, reflecting values generally held in the community, concerning the kinds of potential harm that justify the State in confining a person for compulsory treatment."⁶³⁶ If metaphors distort those community values, the courts must sift through them and separate out fact from metaphor from agenda. Whether drawn by jury or judge, any circles drawn must encompass reality, not exclude it. While government by the Platonic guardians, feared by plaintiff's counsel in *Buck v. Bell*,⁶³⁷ may decide the fate of liberty after simply examining shadows on the walls of caves, the "constitutional government of the fathers" insists upon no deprivation of liberty not justified by facts.

After recognizing the realities of the problem, the courts may decide to release the patient or to commit the patient who requires safe confinement and care, depending upon the court's analysis of the facts. Those facts must include the impact of poverty, the benefits of treatment, the limitations of psychiatry and the preferences of the patient. Those facts may justify the courts' injunction to the mental health system to create an alternative to the institu-

630. *Vitek v. Jones*, 445 U.S. 480, 495-96 (1980).

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

632. *Youngberg v. Romeo*, 457 U.S. 307 (1982).

633. *Vitek*, 445 U.S. at 495 (second set of brackets by *Vitek* court) (quoting *Addington v. Texas*, 441 U.S. 418, 430 (1979)).

634. *E.g.*, *Wolff v. McDonnell*, 418 U.S. 539, 562-70 (1974) (holding that state jails must provide certain minimal due process requirements to prisoners in disciplinary proceedings, such as advance written notice, written statements by factfinders as to evidence, and the ability to call witnesses).

635. *Romeo*, 457 U.S. at 321-22.

636. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

637. 274 U.S. 200, 202-03 (1927); see *supra* note 1 and accompanying text.

tion. Courts have done it before.⁶³⁸

Even if our system will no longer tolerate this degree of judicial activism, the court that cannot devise a proper remedy need not distort the analysis to lead away from the truth. The trial court in *Boggs*⁶³⁹ felt constrained by the rules of our system in devising a solution to the dilemma of Billie Boggs, but did not surrender its role as arbiter of truth. Boggs needed a home in the community, and neither confinement in the hospital nor freedom on the streets offered any answers. The need to arrive at a particular result, such as the protection of the railroads in *Ryan v. New York Central Railroad*⁶⁴⁰ or the protection of the institution in *Romeo*,⁶⁴¹ does not justify cynical manipulation of doctrine and concealment of facts.

The alternative of government by metaphor is unacceptable, even with the comfort that the medical metaphor gives the rest of us, and even if the metaphor's pervasiveness persuades its victims:

The grimmest aspect of this whole grim scene is the willing acceptance of the label ["psychotic"] by those already beaten down by the world. It is the final violence, the victims blaming themselves for their own powerlessness. The circle closes; lawyers, cops and doctors drive off, convinced that they have made society work. But the air smells bad.⁶⁴²

Law, if and as it changes, must move in response to reality. If the courts can't change the reality, at least they can clear the air. Bad metaphors make for worse law.

638. *E.g.*, *Welsch v. Likins*, 373 F. Supp. 487, 500 (D. Minn. 1974); *see supra* note 195 and accompanying text.

639. *In re Boggs*, 136 Misc. 2d 1082, 522 N.Y.S.2d 407 (Sup. Ct.), *rev'd sub nom.* *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1987), *appeal dismissed sub nom.* *Anonymous v. New York City Health & Hosps. Corp.*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988).

640. 35 N.Y. 210, 216 (1866); *see supra* note 309 and accompanying text.

641. *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982); *see supra* note 419 and accompanying text.

642. H. DRUMMOND, *supra* note 540, at 89.

