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# THE CONTINUUM OF COERCION: CONSTITUTIONAL AND CLINICAL CONSIDERATIONS IN THE TREATMENT OF MENTALLY DISORDERED PERSONS

ROBERT D. MILLER\*

One dictionary defines coercion as the use of restraint, hindrance, compulsion, or force, but does not differentiate between internal and external coercion.<sup>1</sup> Furthermore, this definition does not resolve the differences between critics from the legal and mental health communities, the extreme (and typically most vocal) members of which tend to simplify the issues to the point that no meaningful dialogue is possible.

Coercion does not exist in a vacuum; it exists on a continuum upon which bright lines are arbitrarily placed to delineate acceptable uses of physical or psychological force. The perception of coercion by the various parties involved in the mental health and legal systems is similar to the fable of the elephant and the blind men: one's concept of coercion depends on one's perspective.

This article discusses coercion in the context of the public system of mental health care. While most law review articles limit their discussion of coercion to external physical control, this article considers both external *and* internal coercion from various sources as it affects all the actors in the system, and argues that all aspects of coercion must be considered before appropriate policy decisions can be made.

The introduction discusses the traditional legal rights driven concept of coercion. The second part discusses coercion experienced by mentally disordered persons, beginning with external clinical coercion, the most common subject of concern. A discussion follows of external legal coercion on patients (Part III), and then a discussion of external social coercion on patients (Part IV). The last section addressing patient issues discusses internal coercion experienced by mental patients (Part V).

The sixth part explores coercion of mental health professionals, a subject virtually ignored, at least in those terms, in the literature. The categories listed are somewhat arbitrary, in the sense that considerable overlap exists among them. Nevertheless, I believe that teasing them apart is essential if we are to develop a more comprehensive understanding of those overlaps, and of the

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1. WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY OF THE ENGLISH LANGUAGE 351 (1979).

(often unintended) effects of pressures brought to bear on all the actors in the mental health system. This article attempts to do so, albeit briefly, in Part VII.

## I. INTRODUCTION

This discussion begins with the assumption that ours is a nation founded on principles of individual liberty and autonomy, with a Constitution and laws crafted to protect those individual legal rights from infringement by government. As Stephen Morse states, courts today demonstrate "a preference for liberty,"<sup>2</sup> but the problem comes in defining "liberty." John Stuart Mill's virtual anthem for civil libertarians, if taken at face value, seems to say it all.

[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.<sup>3</sup>

But in the next paragraph Mill continues:

It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties . . . . Those who are still in a state to require being taken care of by others must be protected from their own actions as well as against external injury.<sup>4</sup>

Another passage often cited in support of the libertarian position with little recognition of the necessary correlation between rights and competence is Benjamin Cardozo's 1914 decision in *Schloendorff v. Society of New York Hospital*:<sup>5</sup> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."<sup>6</sup>

Coercion, and its perceived inverse, liberty, are not absolutes to be divined through abstract ideological dialogues but, rather, concepts that lack meaning out of context. Procedures evaluated in isolation reveal little about their potential as real alternatives in any given person's situation, taking all factors into account. These factors include prevailing cultural, social, and economic forces, in which homelessness, abuse, and suicide are very real possibilities.

Arguably the most important liberty speech in this nation's history was Patrick Henry's exhortation to the Virginia Assembly in 1775 to "[g]ive me liberty or give me death!"<sup>7</sup> Fewer may know, though, that as Henry spoke those words, his mentally disordered wife was chained in his attic, as was the prevailing custom in Revolutionary America.<sup>8</sup> Similarly, while Abraham Lin-

2. Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 55 (1982).

3. JOHN STUART MILL, ON LIBERTY 9 (Elizabeth Rapaport ed., 1978) (1859).

4. *Id.*

5. 211 N.Y. 125 (1914).

6. *Schloendorff*, 211 N.Y. at 129 (emphasis added).

7. See HENRY MAYER, A SON OF THUNDER: PATRICK HENRY AND THE AMERICAN REPUBLIC 245 (1991).

8. *Id.* at 171.

coln is hailed as the signer of the Emancipation Proclamation, few remember that after his death, Lincoln's son, Robert, had Mary Todd Lincoln committed in a proceeding which included the testimony of two doctors who had never met the woman.<sup>9</sup>

Today we do not routinely chain mentally disordered persons in attics: involuntary civil commitment procedures entail complex economic and legal restrictions which have significantly changed the number and character of mentally disordered persons hospitalized or treated against their professed wishes.<sup>10</sup> Libertarians widely hail legal protections as victories for the rights of the mentally disordered, but are they victories in a larger sense? The increasing legalization of the way society deals with the mentally disordered may appear to be in conflict with the clinical needs of the patient.

The law governing the mentally disordered, both civil and criminal (and the distinction between the two is becoming increasingly blurred<sup>11</sup>), is based on constitutional theories and implemented by attorneys trained in the criminal defense model.<sup>12</sup> The criminal justice model is a poor fit for cases involving mentally disordered persons.<sup>13</sup> Criminal defense attorneys are trained to represent the express wishes of their clients, and not to second guess those wishes unless they appear so irrational that competency to proceed must be questioned. Attorneys need not consider the consequences of their actions, either for their clients or for others. Their roles are clearly defined as adversarial, rather than as acting in the best interests of their clients.

This adversarial role of the criminal defense attorney has been crafted over centuries, but is based on several assumptions that are not always correct, even when applied to defendants who are not mentally disordered. First, the criminal defense model assumes that defendants will wish to avoid punishment for their actions.<sup>14</sup> More generally, the adversarial system assumes the participation of opposing attorneys, each vigorously arguing their positions, with "justice" the goal of the process.

While criminal prosecutions generally satisfy these assumptions, they rarely apply in civil cases involving mentally disordered persons. Most criminal defendants do in fact want to "get off," but the motivations of mentally disordered persons are much more complex. Clinicians are trained to look for every motivation in their patients, while attorneys are not. In addition, the

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9. Carol D. Rasnic, *America's First Woman Lawyer: The Biography of Myra Bradwell*, 4 TEX. J. WOMEN & L. 231, 236-37 (1995) (book review).

10. See generally ROBERT D. MILLER, INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL IN THE POST-REFORM ERA (1987).

11. See *infra* Part III.C.

12. Few law schools have courses in mental health law, and most of the courses that do exist are taught by legal professionals who lack any direct experience in the provision of mental health care.

13. ALAN A. STONE, *Psychiatric Abuse and Legal Reform: Two Ways to Make a Bad Situation Worse*, in LAW, PSYCHIATRY, AND MORALITY 133 (1984).

14. See generally Kenneth Appelbaum, *Criminal Defendants Who Desire Punishment*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 385 (1990); Robert D. Miller & Edward J. Germain, *Evaluation of Competency to Stand Trial in Defendants Who Do Not Want to Be Defended Against the Crimes Charged*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 371 (1987).

criminal defense attorney model ignores the consequences of a "successful" defense to persons other than the defendant, and also ignores the problems facing an acquitted defendant. This narrow scope of representation is not a luxury afforded clinicians. The criminal justice system, while vigorously protecting client privilege to ensure "justice," is only minimally concerned with continuity of care, while mental health professionals must ensure that treatment continues once a patient leaves a treatment facility.<sup>15</sup> Clinicians, particularly in inpatient settings, must provide a safe and therapeutic environment for all their patients, and cannot ignore the effects of a given patient's behavior on other patients.

There are other significant differences in the ways in which legal and clinical professionals approach problematic situations. Since constitutional law typically deals with principles rather than individuals, it is often a crude instrument with which to deal with individual mentally disordered persons. The law frequently abolishes a procedure or system, but rarely will the law attempt the difficult task of modifying or establishing new and more effective systems. In addition, legal thinking and decision-making are much more influenced by "horror stories;"<sup>16</sup> legal arguments tend to be ideological while clinicians tend to be concerned with all the effects of actions, and to rely more on scientific data than on anecdotal evidence.<sup>17</sup> A further distinction, particularly between legal and clinical writing, is that authors in the legal literature tend to criticize by comparing the practices of systems they do not like with the principles of systems of which they approve.<sup>18</sup>

The following discussions attempt to illuminate the different sources of coercion, types of coercion, and effects of coercion, so that the legal and clinical communities can better see how to collaborate and improve the system.

## II. EXTERNAL CLINICAL COERCION EXPERIENCED BY THE MENTALLY DISORDERED

### A. Hospitalization

The most often discussed aspect of the coercion of mentally disordered persons is that of external coercion by mental health professionals. Despite the fact that clinicians who hospitalize or treat mentally disordered persons against their express wishes do so under color of authorizing statutes,<sup>19</sup> and the fact

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15. See generally STONE, *supra* note 13; see also Leona L. Bachrach, *Continuity of Care for Chronic Mental Patients: A Conceptual Analysis*, 138 AM. J. PSYCHIATRY 1449 (1981); Nicholas Stratas et al., *The Future of the State Mental Hospital: Developing a Unified System of Care*, 28 HOSP. & COMMUNITY PSYCHIATRY 598 (1977).

16. For a collection of "horror stories," see generally BRUCE J. ENNIS, *PRISONERS OF PSYCHIATRY* (1972); JONAS B. ROBITSCHER, *THE POWERS OF PSYCHIATRY* (1980); and Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U. L. REV. 461 (1977).

17. See generally John Monahan & Laurens Walker, *Social Authority: Obtaining, Evaluating, and Establishing Social Science in Law*, 134 U. PA. L. REV. 477 (1986).

18. See STONE, *supra* note 13.

19. For a detailed (if now somewhat out-of-date) review of the provisions of state civil commitment statutes, see SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* (3d

that most states empower law enforcement officers to initiate involuntary hospitalization without clinical involvement, many still perceive the process as a clinical one. Involuntary hospitalization or treatment takes place in clinical facilities, and judicial authority is delegated to clinicians to carry out court orders.

The perception of commitment as a primarily clinical function is valid. Clinicians, for all practical purposes, had the sole authority for confining and treating mentally disordered persons until the 1970s, when courts assumed control of the process.<sup>20</sup> Despite the provision of most of the protections and procedures of the criminal justice system, in practice trial court judges continue to defer to clinical judgment in many cases.<sup>21</sup> Courts serve as gatekeepers for involuntary commitments of mentally disordered persons in both civil and criminal systems, but once they have determined that a person meets the commitment criteria, judges relinquish day-to-day control over the conditions faced by patients to the treating clinicians.

Historically, clinicians paid relatively little attention to the effects of clinical coercion, other than to acknowledge that an adversarial relationship between clinicians and patients interfered with the trust necessary for successful psychotherapy.<sup>22</sup> More recently, however, the MacArthur Foundation has sponsored a series of studies on patients' perceptions of the coerciveness of their hospitalizations.<sup>23</sup> At a number of sites, researchers asked newly admitted patients a series of questions about their experiences. Not surprisingly, involuntary patients were more likely to feel coerced, but a significant number of legally voluntary patients expressed similar feelings.<sup>24</sup> A major and somewhat surprising conclusion of the studies was that many of the study subjects expressed more concern with their perceived treatment than with the outcome

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ed. 1985).

20. See, e.g., *Addington v. Texas*, 441 U.S. 418, 426 (1979).

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.

*Id.*; see also MILLER, *supra* note 10.

21. In one case in which I testified, the trial judge opined, on the record, that competency to proceed was a clinical decision, and became upset that I wouldn't answer the difficult question in that case for him.

22. See generally WILFORD OVERHOLSER, *THE PSYCHIATRIST AND THE LAW* (1953); Marc Amaya & W. V. Burlingame, *Judicial Review of Psychiatric Admissions: The Clinical Impact on Child and Adolescent Inpatients*, 20 J. AM. ACAD. CHILD PSYCHIATRY 761 (1981); Henry Davidson, *Mental Hospitals and the Civil Liberties Dilemma*, 51 MEN. HYGIENE 371 (1966).

23. See generally Nancy S. Bennett et al., *Inclusion, Motivation and Good Faith: The Morality of Coercion in Mental Hospital Admission*, 11 BEHAV. SCI. & L. 295 (1993); Steven K. Hoge et al., *Patient, Family, and Staff Perceptions of Coercion in Mental Hospital Admission: An Exploratory Study*, 11 BEHAV. SCI. & L. 281 (1993); Charles W. Lidz et al., *Coercive Interactions in a Psychiatry Emergency Room*, 11 BEHAV. SCI. & L. 269 (1993); Charles Lidz et al., *Perceived Coercion in Mental Hospital Admission: Pressures and Process*, 52 ARCHIVES GEN. PSYCHIATRY 1034 (1995); John Monahan et al., *Coercion and Commitment: Understanding Involuntary Mental Hospital Admission*, 18 INT'L J.L. & PSYCHIATRY 249 (1995); John Monahan et al., *Coercion to Inpatient Treatment: Initial Results and Implications for Aggressive Treatment in the Community*, in *COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW* (Deborah L. Dennis & John Monahan eds., 1996).

24. See *supra* note 23.

of the commitment proceedings.<sup>25</sup> The central thesis of the procedural justice approach, as demonstrated in the studies reported, is that participants in formal decision-making processes are often more concerned with the perceived fairness of the processes than with the results. The more active a part they are permitted to play in the decision making, the more satisfied participants are with the outcome.

One problem with generalizing from most of these studies is that they involved newly admitted patients who presumably still suffered from acute and untreated mental disorders. Positive perceptions may have resulted, in part, from what Alan Stone has called the "thank-you" theory of treatment. According to Stone, patients, once treated (even against their stated wishes), acknowledge that they had been sick, and thank those who had treated them.<sup>26</sup> Stone based his theory on clinical experience, but others—both clinicians and sociologists—have tested it, and found that the great majority of successfully treated patients do in fact agree that involuntary hospitalization and treatment best served their interests.<sup>27</sup> The majority of patients who did not respond well to treatment<sup>28</sup> continued to feel negatively about their experiences.<sup>29</sup>

Voluntary hospitalization appears to be the consensus choice to avoid coercive hospitalizations, but a number of authors argue that to describe any such hospitalization as "voluntary" is at best misleading and, at worst, fraud. For instance, Reed and Lewis describe the situation that arose in Chicago's state hospitals when staff felt pressured to avoid involuntary commitment to ensure rapid patient turnover.<sup>30</sup> In 1985, involuntary admissions to four area hospitals constituted only one percent of total admissions, in part because staff usually persuade patients admitted involuntarily to sign in voluntarily before their court hearings.<sup>31</sup>

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25. See generally E. ALLAN LIND & TOM R. TYLER, *THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE* (1988); JOHN THIBAUT & LAURENS WALKER, *PROCEDURAL JUSTICE: A PSYCHOLOGICAL ANALYSIS* (1975); E. Allan Lind et al., *In the Eye of the Beholder: Tort Litigants' Evaluations of Their Experiences in the Civil Justice System*, 24 *LAW & SOC'Y REV.* 953 (1990); E. Allan Lind et al., *Voice, Control and Procedural Justice: Instrumental and Noninstrumental Concerns in Fairness Judgments*, 20 *J. PERSONALITY & SOC. PSYCHOLOGY* 952 (1990); Tom Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 *SMU L. REV.* 433 (1992).

26. See generally ALAN A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* (1975).

27. Sociologist Weinstein reviewed 18 quantitative studies of retrospective patient satisfaction with treatment. A rather large majority of patients voiced favorable attitudes toward mental hospitals in general as well as their own institution, and claimed that they had benefited from treatment. See generally Raymond Weinstein, *Patient Attitudes Toward Mental Hospitalization: A Review of Quantitative Research*, 20 *J. HEALTH & SOCIAL BEHAV.* 237 (1979). Subsequent authors have confirmed these findings. See, e.g., Virginia Aldige Hiday, *Coercion in Civil Commitment: Processes, Preferences, and Outcome*, 15 *INT'L J.L. & PSYCHIATRY* 359 (1992); Thomas Kalman, *An Overview of Patient Satisfaction with Psychiatric Treatment*, 34 *HOSP. & COMMUNITY PSYCHIATRY* 48 (1983); J. Toews et al., *Patients' Reactions to Their Commitment*, 26 *CANADIAN J. PSYCHIATRY* 251, (1981).

28. Bad responses typically involved treatment with psychiatric medications, which can be effectively administered involuntarily.

29. See Hiday, *supra* note 27.

30. See generally Susan C. Reed & Dan A. Lewis, *The Negotiation of Voluntary Admission in Chicago's State Mental Hospitals*, 18 *J. PSYCHIATRY & L.* 137 (1990).

31. *Id.* at 143. Staff use persuasion/coercion (threatening commitment, despite statutory pro-

Anne Rogers reports that "voluntary" patients in England can be retained after requesting discharge if staff file commitment petitions, with the result that nearly half the patients who signed in voluntarily stated that they did not feel that their admissions were truly voluntary.<sup>32</sup> While some patients reported that they felt internally coerced by their disorders, others said that they signed in "voluntarily" after being threatened with commitment, and/or were threatened with commitment if they tried to sign out before the staff thought that they were ready. Gilboy and Schmidt report that in a majority of cases studied, voluntary admission was used to hospitalize persons already in some type of official custody. They argued that voluntary procedures were used primarily for the convenience of the professionals, and enforced by threats of commitment. Because of staffing shortages, the admitting clinician did not have time to go through the required procedures for involuntary admission for all patients.<sup>33</sup> The most extreme view is that of Thomas Szasz, who argues simply that hospitalization is not voluntary when patients are forced to sign in under threat of commitment, or when they are not free to leave the hospital on demand.<sup>34</sup>

While these critics argue that legally voluntary hospitalizations are in reality coerced, they do not consider the inverse—that some legally involuntary admissions may in fact be voluntary: some patients have found that getting themselves committed presents advantages. Many hospitals have been forced to reduce the rate of voluntary admissions, and the lengths of stay for those patients admitted voluntarily, frequently for purely economic reasons. Indeed, a little-noted result of dangerousness criteria and reductions in voluntary admissions is that some patients now have to deliberately do something dangerous in order to be hospitalized.<sup>35</sup> If patients commit "dangerous" acts that satisfy the criteria for involuntary hospitalization, they are assured admission, and get free transportation to the hospital and longer stays. Sometimes the motivation to get oneself committed is unconscious; at other times it is quite conscious.<sup>36</sup> In addition, some patients recognize their need for hospital-

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hibitions against such coercion); bartering (promising privileges for signatures), and stalling (asking the court for continuances to stall so that persuasion, coercion, and bartering have longer time to work—sometimes long enough so that the patient can be discharged). "Voluntary" patients can be retained if they request discharge by filing commitment petitions.

32. See generally Anne Rogers, *Coercion and "Voluntary" Admission: An Examination of Psychiatric Patient Views*, 11 BEHAV. SCI. & L. 259 (1993).

33. See generally Janet A. Gilboy & John R. Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429 (1971).

34. See, e.g., Thomas Szasz, *Voluntary Mental Hospitalization: An Unacknowledged Practice of Medical Fraud*, 287 NEW ENG. J. MED. 277 (1972).

35. See generally John Monahan et al., *supra* note 23. In my experience as an admitting clinician, I have seen patients commit crimes deliberately in order to gain hospital admission. One patient, realizing that her borderline personality disorder was deteriorating, arranged for herself to be committed to prevent her from harming herself and to ensure effective treatment. Her adversarial attorney argued with her to "fight" her commitment at her hearing, but (fortunately, from the clinical from the clinical standpoint) she was still in sufficient control to reject that advice. Such situations have been likened to "Ulysses contracts." See generally Robert Miller, *Voluntary "Involuntary" Commitment: The Briar Patch Syndrome*, 8 BULL. AM. ACAD. PSYCHIATRY & LAW 305 (1980).

36. See, e.g., Miller, *supra* note 35. I have received calls from mentally disordered persons asking what crimes they should commit in order to be hospitalized.



ization, but also realize that if their conditions deteriorate, they are likely to demand discharge and may not meet the state's criteria for commitment. I have had patients arrange for involuntary hospitalization as a "Ulysses contract,"<sup>37</sup> to ensure that they receive the required treatment. Finally, some persons will use hospitalization to avoid criminal arrest, or to build a case for mitigation if they are arrested.

### B. Seclusion and Restraint

Another major form of external coercion on mentally disordered persons involves seclusion and restraint. Seclusion (also called "isolation") is the removal of a patient from the general milieu on a ward, into a single room, with or without a locked door. Restraint is physical restriction of movement; it is most commonly used to restrain limbs on a specially designed bed ("four-point" or "five-point" restraint), but can also be used to restrain a person to a chair, or to limit movement of arms or legs ("ambulatory restraint").

The American Psychiatric Association's Task Force on Seclusion and Restraint lists three indications for using seclusion and restraint together: 1) to prevent imminent harm to the patient or other persons where other means of control are not effective or appropriate; 2) to prevent serious disruption of the treatment program or significant damage to the physical environment; and 3) to assist in treatment as part of ongoing behavior therapy. Two additional indications exist for seclusion alone: 1) to decrease the stimulation a patient receives; and 2) to comply with a patient's request.<sup>38</sup> Once a patient's behavior is well known to staff, restraint and/or seclusion may be used to prevent loss of control, rather than waiting until the patient has become actively aggressive.<sup>39</sup> The Task Force cautions that seclusion should not be used when medical conditions exist that require close monitoring, organic conditions exist that would be exacerbated by sensory deprivation, or merely for the convenience of staff.<sup>40</sup> Full (four- or five-point) restraint should not be used without seclusion, to protect a patient's dignity and safety.<sup>41</sup>

Seclusion and restraint may also be used as part of a carefully designed individualized treatment plan, to weaken or eliminate inappropriate aggressive

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37. When Ulysses sailed past the Sirens, whose songs no man could resist, he had his men bind him to the mast so that he could not be enticed. See *THE ODYSSEY OF HOMER* 186 (Richmond Lattimore trans., 1965). The name "Ulysses contract" has come to refer to situations in which persons subject themselves to coercion in advance, to prevent themselves from acting against their interests.

38. Thomas Gutheil & Kenneth Tardiff, *Indications and Contraindications for Seclusion and Restraint*, in *THE PSYCHIATRIC USES OF SECLUSION AND RESTRAINT* 12 (Kenneth Tardiff ed., 1984).

39. Patients often recognize at some level that they are out of control and need to have external controls administered, but because of their disorders are unable to articulate those realizations. One patient that I treated kept destroying curtains in the ward day room. After each episode, the staff secluded and briefly restrained him, which quickly calmed him down. When this pattern became apparent, I suggested to the patient that he felt out of control at those times. He readily agreed, and thereafter was able to ask to be secluded briefly when those feelings came on him again.

40. See generally Gutheil & Tardiff, *supra* note 38.

41. *Id.*

behaviors.<sup>42</sup> They are used in conjunction with reinforcing strategies for appropriate behaviors, and along a continuum of less restrictive approaches. Clinicians refer to this as "time out" rather than seclusion. In addition, physical restraint is used to prevent debilitated patients from harming themselves, by falling out of beds or chairs, for instance. Such physical support should not be confused with the use of restraints for behavioral control.

Since the character of the inpatient populations (particularly in public hospitals) has changed with the dangerousness criteria,<sup>43</sup> the commitment process now selects for dangerous persons. Therefore a higher proportion of hospitalized patients is likely to be aggressive or out of control, and thus require some type of physical restraint. Although clinicians continue to feel that seclusion is necessary, both for physical control and as part of treatment, several studies indicate that the majority of patients who have been secluded and/or restrained did not feel that the experience was beneficial.<sup>44</sup> Those studies must be evaluated in light of the fact that many committed patients deny illness and, thus, would also deny the need for restrictions to prevent behavior caused by those illnesses.

Critics of the use of seclusion and restraint argue that they are used chiefly for the convenience of the staff or to intimidate patients. It has been demonstrated<sup>45</sup> that when staffing is increased to more adequate levels, when staff are given appropriate training in behavioral techniques,<sup>46</sup> and when facility policies and external regulations are made stricter,<sup>47</sup> the use of seclusion and restraint decreases, generally without a concomitant increase in aggression or other behavioral problems. The fact that seclusion and restraint can (and certainly have been) abused does not mean, however, that they are not appropriate when less restrictive techniques have failed. Again, one must evaluate their use in the context of the realistic alternatives. For example, ambulatory restraints are still restrictive and may reduce the wearer's sense of dignity,<sup>48</sup>

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42. See Robert P. Liberman & Stephen E. Wong, *Behavior Analysis and Therapy Procedures Related to Seclusion and Restraint*, in *THE PSYCHIATRIC USES OF SECLUSION AND RESTRAINT* 35 (Kenneth Tardiff ed., 1984).

43. See *infra* note 67 and accompanying text.

44. See generally Renee Binder & Susan McCoy, *A Study of Patients' Attitudes Toward Placement in Seclusion*, 34 *HOSP. & COMMUNITY PSYCHIATRY* 1052 (1983); Kathleen Hammill et al., *Hospitalized Schizophrenic Patient Views About Seclusion*, 50 *J. CLINICAL PSYCHIATRY* 174 (1989); Robert Plutchik et al., *Toward a Rationale for the Seclusion Process*, 166 *J. NERVOUS & MENTAL DISEASE* 571 (1978); Stanley Soliday, *A Comparison of Patient and Staff Attitudes Toward Seclusion*, 173 *J. NERVOUS & MENTAL DISEASE* 282 (1985); Harriet Wadson & William Carpenter, *Impact of the Seclusion Room Experience*, 163 *J. NERVOUS & MENTAL DISEASE* 318 (1976).

When allowed to speak directly, ex-patients have been particularly negative about having been secluded. See, e.g., Judi Chamberlain, *An Ex-Patient's Response to Soliday*, 173 *J. NERVOUS & MENTAL DISEASE* 288 (1985).

45. See Paul H. Soloff, *Historical Notes on Seclusion and Restraint*, in *THE PSYCHIATRIC USES OF SECLUSION AND RESTRAINT* 5 (Kenneth Tardiff ed., 1984).

46. See Gary Maier et al., *A Comprehensive Model for Understanding and Managing Aggressive Inpatients*, 2 *AM. J. CONTINUING EDUC. NURSING* 89 (1987).

47. See, e.g., STATE OF COLO. DEP'T OF HUMAN SERV., *RULES AND REGULATIONS NOS. 108, 109* (setting forth several pages of restrictions on the use of seclusion and restraint).

48. Ambulatory restraints consist of belts attached with adjustable length leather straps leading to padded wrist cuffs. Ankle hobbles can also be used. See, e.g., Gregory Van Rybroek et al.,

but they certainly permit more freedom and autonomy than seclusions and four-point restraints.

### C. *Involuntary Administration of Psychotropic Medications*

A third treatment approach for both voluntary and committed patients involves the use of psychotropic medications. Before the civil rights reforms of the late 1960s and 1970s, involuntarily hospitalized patients had no say about their treatment with medications. As one federal judge said, "Nonconsensual treatment is what commitment is all about."<sup>49</sup> Before the reforms, committed psychiatric patients automatically lost virtually all their civil rights. They could not marry, divorce, enter into contracts, vote, or make treatment decisions.<sup>50</sup> In the 1970s, however, a series of courts began to recognize that a decision that patients met criteria for involuntary hospitalization (i.e., lacked competency to make decisions about hospitalization) did not also determine that they lacked competency to make decisions about treatment in the hospital.<sup>51</sup>

While patients already had, at least in theory, a right to refuse nonpsychiatric medications, with the reforms, courts identified a qualified right for involuntarily hospitalized patients to refuse psychiatric medications as well. Courts differed on the constitutional basis for the right, but they agreed that patients competent to make treatment decisions could not be forced to take psychotropic medication.<sup>52</sup> A few states<sup>53</sup> acknowledge patients' rights to refuse antipsychotic medication, but permit clinicians to determine patients' competency.

Although these court decisions and the legislative enactments that codified them would appear to provide significant protections for involuntary patients (voluntary patients have an absolute right to refuse treatment, absent an emergency<sup>54</sup>), in practice judges are extremely reluctant to second guess

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*Preventive Aggression Devices (PADS): Ambulatory Restraints as an Alternative to Seclusion*, 48 J. CLINICAL PSYCHIATRY 401 (1987). In fact, in the author's experience some patients wear ambulatory restraints as badges of how "tough" they are.

49. *Stensvad v. Reivitz*, 601 F. Supp. 128, 131 (W.D. Wisc. 1985) (Shabaz, J.).

50. See, e.g., Note, *Developments in the Law, Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1198-99 nn.19-28 (1974).

51. In two early cases, *Rennie v. Klein*, 462 F. Supp. 1131, 1145 (D. N.J. 1978), and *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), federal district court judges found that competent patients had a constitutional right to give informed consent before being treated with antipsychotic medications, although they differed on the constitutional bases for the new right, and on the procedures required to override refusal. See Paul Appelbaum & Thomas Gutheil, "Rotting with Their Rights On": *Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306 (1979).

52. With the exception of the Supreme Court's decision in *Washington v. Harper*, 110 S. Ct. 1028 (1990), the overwhelming majority of state and lower federal courts have found a constitutional right for competent patients to refuse nonemergent treatment. See *Rogers*, 478 F. Supp. at 1368. The Supreme Court, in a case involving mentally disordered prison inmates, however, held that even competent inmates could be involuntarily medicated for their own good or for the security needs of the prison, as long as professional judgment had been exercised (i.e., that they had been prescribed by a physician). *Washington v. Harper*, 494 U.S. 210 (1990).

53. See Opinion of the Justices, 465 A.2d 484 (N.H. 1983); *Rennie*, 462 F. Supp. at 1131; *Large v. Superior Ct.*, 714 P.2d 399 (Ariz. 1986).

54. See *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), which not only recognized a

psychiatrists' decisions and permit involuntary patients to refuse prescribed treatment.<sup>55</sup> Interestingly, contrary to the protestations of civil libertarians that clinicians cannot make unbiased decisions in such cases,<sup>56</sup> one study from a jurisdiction that permitted clinical decisionmaking revealed that clinicians allowed significantly more patients to refuse medications than did tribunals in jurisdictions requiring judicial hearings.<sup>57</sup>

In addition to the purely constitutional bases for decisions to permit patients to refuse medications under certain circumstances, many legal scholars (and some nonmedical mental health professionals as well) are convinced that medications are unnecessary at best and poison at worst; and their views have found their way into many court opinions.<sup>58</sup> Much of the heat that this debate has generated stems from erroneous concepts of what the medications do, and from horror stories of their inappropriate use.<sup>59</sup> A second (and also erroneous) assumption underlying many legal criticisms of forced medication is that patients refuse medication chiefly because of the medications' side effects; the research data demonstrate, however, that the majority of patients who refuse medication do so because they deny that they are ill, rather than because of side effects or for other reasons.<sup>60</sup>

A final legal question concerning the involuntary administration of medication is whether medications are more or less restrictive than seclusion and restraint. There is no judicial or legislative consensus on this question, and legal scholars also disagree.<sup>61</sup> What is clear, unfortunately, is that few courts

constitutional right for voluntary patients to refuse medications in nonemergency situations, but explicitly held that the hospital could not discharge voluntary patients merely because they refused treatment considered essential by their treaters. *Rogers*, 478 F. Supp. at 1368.

55. Studies report that in between 90% and 100% of cases, judges override patients' refusals. See Robert D. Miller et al., *The Impact of the Right to Refuse Treatment in a Forensic Patient Population: Six-month Review*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 107 (1989).

56. In *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Haw. 1976), the court opined that "the diagnosis and treatment of mental illness leave too much to subjective choices by less than neutral individuals" to serve as the basis for the loss of liberty involved in civil commitment. *Id.* at 1135.

57. Julie M. Zito et al., *The Treatment Review Panel: A Solution to Treatment Refusal?*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 349 (1984). The Minnesota Supreme Court, in *Price v. Sheppard*, 307 Minn. 250, 262-63 (1976), ultimately rejected clinical decision-making and required judicial hearings. Fewer patients were then permitted to refuse medications. Personal Communication with William H. Routt, M.D. (Apr. 24, 1984).

58. See Plotkin, *supra* note 16; Thomas Zander, *Prolixin Decanoate: Big Brother by Injection?*, 5 J. PSYCHIATRY & L. 55 (1977).

59. For an antidote to the misinformation that characterizes much of the legal literature on the subject, see generally Thomas G. Gutheil & Paul S. Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77 (1983).

60. See generally Xavier Amador et al., *Awareness of Illness in Schizophrenia and Schizoaffective and Mood Disorders*, 51 ARCHIVES GEN. PSYCHIATRY 826 (1994); William Michaux, *Side Effects, Resistance and Dosage Deviation in Psychiatric Outpatients Treated with Tranquilizers*, 133 J. NERVOUS & MENTAL DISEASE 203 (1961); Allen Raskin, *A Comparison of Acceptors and Resisters of Drug Treatment As an Adjunct to Psychotherapy*, 25 J. CONSULTING CLINICAL PSYCHOL. 366 (1961); Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 HOSP. & COMMUNITY PSYCHIATRY 1049 (1988); Theodore Van Putten et al., *Drug Refusal in Schizophrenia and the Wish to Be Crazy*, 33 ARCHIVES GEN. PSYCHIATRY 1443 (1976); Theodore Van Putten, *Why Do Schizophrenic Patients Refuse to Take Their Drugs?*, 31 ARCHIVES GEN. PSYCHIATRY 67 (1974).

61. Law professor George Dix feels that medication is the more restrictive. George Dix,

have considered the therapeutic effects of either treatment modality. Clinicians, as well as the majority of patients, prefer medications unless the time necessary for them to become effective is too long to manage an acute crisis. There is a correlation between the two approaches, however; studies demonstrate that when patients are granted the right to refuse medication, the use of seclusion and restraint goes up, at least initially.<sup>62</sup>

### III. EXTERNAL LEGAL COERCION ON PATIENTS

The types of coercion discussed in the previous section exist under the authority of law, but in these cases, courts delegate the implementation of the law to clinicians, the majority of whom accept the responsibility in order to be able to provide treatment for severely disordered patients. This section discusses situations in which social and/or economic pressures, as implemented through laws, coerce mentally disordered persons. As the coercion is indirect, it generally goes unnoticed, particularly by libertarians, who focus chiefly on direct governmental coercion. And unlike the types of clinically motivated coercion discussed in Part II above, mental health professionals do not support much of this coercion, considering it antitherapeutic.

#### A. *Involuntary Commitment*

As discussed above, mental health professionals have utilized involuntary hospitalization, and more recently involuntary commitment to outpatient treatment,<sup>63</sup> to provide effective treatment to patients whose mental disorders prevent them from seeking treatment on their own. But there are a growing number of situations in which the law coerces mentally disordered persons in non-therapeutic ways which clinicians generally oppose.

The first such change was the advent of dangerousness requirements for involuntary hospitalization. In reaction to the perception that clinicians exerted too much control over the involuntary commitment process—which utilized clinical criteria—courts and legislatures in the 1970s added a requirement that patients be dangerous to themselves or to others before they could be hospitalized against their stated wishes.<sup>64</sup> Immediately, critics of involuntary hospital-

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*Legal and Ethical Issues in the Treatment and Handling of Violent Behavior*, in CLINICAL TREATMENT AND MANAGEMENT OF THE VIOLENT PERSON 178 (Loren Roth ed., 1984). Clinician Paul Soloff disagrees. Paul Soloff, *Physical Control: The Role of Seclusion and Restraint in Modern Psychiatric Practice*, in CLINICAL TREATMENT AND MANAGEMENT OF THE VIOLENT PERSON, 119 (1984).

62. See Paul S. Appelbaum & Thomas G. Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340 (1980); Miller et al., *supra* note 55.

63. See generally ROBERT MILLER, ET AL., AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE REPORT NO. 26, INVOLUNTARY COMMITMENT TO OUTPATIENT TREATMENT (1987); see also Gustavo A. Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 HOSP. & COMMUNITY PSYCHIATRY 1001 (1990); Virginia Aldige Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT'L J.L. & PSYCHIATRY 215 (1987); Robert Miller, *Outpatient Civil Commitment of the Mentally Ill: An Overview and an Update*, 6 BEHAV. SCI. & L. 99 (1988).

64. See generally MILLER, *supra* note 10. While no final court has required dangerousness as

ization or treatment, who had been notably responsible for the added criteria, reacted by attacking mental health professionals for their lack of ability to predict future dangerousness.<sup>65</sup>

The advent of dangerousness criteria has had an impact on the character of persons committed, but not necessarily in the way intended by their creators. While a number of mentally disordered persons who would previously have been committed no longer are,<sup>66</sup> a number of demonstrably dangerous but questionably mentally disordered persons, who would not have been committed before the "reforms," are now being committed. With commitment based largely on dangerousness, psychiatric facilities, particularly public hospitals, are filling up with aggressive and frequently untreatable "patients."<sup>67</sup> Not only do such persons require more restrictive measures that take staff time away from treatable patients, but they frequently intimidate the more traditional psychiatric patients and directly interfere with their treatment. Thus, the laws that were intended to protect mentally disordered persons have actually forced many of them to be hospitalized in facilities that are less safe and less therapeutic than prior to reforms.

Another unforeseen complication introduced by the dangerousness criteria was noted by the Supreme Court in a 1990 case, *Zinerman v. Burch*.<sup>68</sup> In considering the necessity for informed consent for voluntary psychiatric hospitalization, the Court majority held in dicta that "[p]ersons who are mentally ill

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a criterion for involuntary commitment, a number of judges have rejected the existing need-for-treatment criteria as being too vague and too broad, and have approved dangerousness criteria. See, e.g., Paul Appelbaum, *Is the Need for Treatment Constitutionally Acceptable as a Basis for Civil Commitment?*, 12 LAW, MED. & HEALTH CARE 144 (1984).

65. The most colorful of such attacks is Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693 (1974). A more balanced assessment can be found in the writings of Professor Monahan. See, e.g., JOHN MONAHAN, *PREDICTING VIOLENT BEHAVIOR: AN ASSESSMENT OF CLINICAL TECHNIQUES* (1981). Monahan points out that dangerousness cannot be accurately predicted without considering the context in which the person acts. See generally, John Monahan, *Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration*, 135 AM. J. PSYCHIATRY 198 (1978). Most early studies involved predicting community behavior of patients who had been hospitalized for years; those studies demonstrably overpredicted violent behavior. The American Psychiatric Association, in its *amicus* brief to the Supreme Court in *Estelle v. Smith*, 451 U.S. 454 (1981), argued that while psychiatrists could accurately predict short-term dangerousness, they could not predict the type of very long-term behavior called for in capital sentencing hearings. *Id.* at 472 (citing, among others, brief for the American Psychiatric Association as *Amicus Curiae* 11-17). The Supreme Court rejected this argument on policy grounds, ignoring the research data presented. *Id.* at 472-73. More recently, short-term studies during the initial period of hospitalization have proved significantly more accurate. See generally Jeffrey S. Janofsky et al., *Psychiatrists' Accuracy in Predicting Violent Behavior on an Inpatient Unit*, 39 HOSP. & COMMUNITY PSYCHIATRY 1090 (1988); Dale E. McNiel & Renee L. Binder, *Predictive Validity of Judgments of Dangerousness in Emergency Civil Commitment*, 144 AM. J. PSYCHIATRY 197 (1987); Dale E. McNiel & Renee L. Binder, *Relationship Between Preadmission Threats and Later Violent Behavior by Acute Psychiatric Inpatients*, 40 HOSP. & COMMUNITY PSYCHIATRY 605 (1989); Steven P. Segal et al., *Civil Commitment in the Psychiatric Emergency Room: I. The Assessment of Dangerousness by Emergency Room Clinicians*, 45 ARCH. GEN. PSYCHIATRY 748 (1988); Kenneth Tardiff, *A Model for the Short-term Prediction of Violent Potential, in CURRENT APPROACHES TO THE PREDICTION OF VIOLENCE* (David A. Brizer & Martha Crowner eds., 1989).

66. See *supra* notes 64-65 and accompanying text.

67. See generally John Oldham & Andrew E. Skodol, *Personality Disorders in the Public Sector*, 42 HOSP. & COMMUNITY PSYCHIATRY 481 (1991).

68. 494 U.S. 113 (1990).

and incapable of giving informed consent to admission would not necessarily meet the statutory standard for involuntary placement."<sup>69</sup> Under the current rule of law, patients seeking hospitalization, but incapable because of their mental disorders of giving truly informed consent and not dangerous enough to satisfy the revised criteria, are barred from receiving the treatment which they request.<sup>70</sup>

### B. Criminalization

Marc Abramson coined the term "criminalization of the mentally ill" in 1972.<sup>71</sup> He observed that as a result of more restrictive civil commitment laws, more mentally disordered persons are arrested and placed in the criminal justice system. Some have used the term to refer to the application of the procedural protections of the criminal justice system to persons at risk for civil commitment.<sup>72</sup>

Taking the latter definition first, in addition to the grafting of dangerousness criteria onto the substantive criteria for involuntary hospitalization, the same reforms addressed procedural issues as well. Commitment hearings, although held in court, rarely provided any of the protections afforded other groups facing loss of liberty. Federal courts required that respondents facing involuntary hospitalization be provided with all the protections provided to criminal defendants who also face loss of liberty.<sup>73</sup> The most significant component of these changes was the requirement for active, adversarial attorneys representing respondents.

Concerning the first definition, there continues to be controversy about whether, in fact, mentally disordered persons are increasingly likely to be processed through the criminal justice system rather than the mental health system.<sup>74</sup> One problem is that most studies lack a baseline—i.e., most reports of

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69. *Zinermon*, 494 U.S. at 133.

70. See Robert Miller, *Zinermon v. Burch: No Entrance?*, 15 NEWSL. AM. ACAD. PSYCHIATRY & L. 37 (1990).

71. Marc Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101, 101 (1972).

72. See generally John Monahan, *The Psychiatrization of Criminal Behavior: A Reply*, 24 HOSP. & COMMUNITY PSYCHIATRY 105 (1973) (responding to Abramson's article).

73. The first major decision was *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084 (E.D. Wisc. 1972). Another decision highly critical of the existing clinical dominance in involuntary hospitalization was *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Haw. 1976).

74. Sociologist Linda Teplin has done much of the methodologically sound research in this field; her data support the hypothesis that more mentally disordered persons were being arrested after passage of reform commitment laws, although not to the extent reported by others. See generally Linda A. Teplin, *The Criminalization of the Mentally Ill: Speculation in Search of Data*, 94 PSYCHOL. BULL. 54 (1983); Linda A. Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 AM. PSYCHOLOGIST 794 (1984) [hereinafter Teplin, *Criminalizing Mental Disorder*]; Linda A. Teplin, *The Criminality of the Mentally Ill: A Dangerous Misconception*, 142 AM. J. PSYCHIATRY 593 (1985); see also Jennifer C. Bonovitz & Jay S. Bonovitz, *Diversion of the Mentally Ill into the Criminal Justice System: The Police Intervention Perspective*, 138 AM. J. PSYCHIATRY 973 (1981); M. Borzecki & J. Wormith, *The Criminalization of Psychiatrically Ill People: A Review with a Canadian Perspective*, 10 PSYCHIATRIC J. U. OTTAWA 241 (1985); Darold A. Treffert, *Legal "Rites": Criminalizing the Mentally Ill*, 3 HILLSIDE J. CLINICAL PSYCHIATRY 123 (1979). But see Virginia A. Hiday, *Civil Commitment and Arrests: An*

significant numbers of mentally disordered persons in jails and prisons do not have data predating the advent of restrictive civil commitment laws. Regardless of etiology, however, large numbers of mentally disordered persons are in fact being jailed, often for misdemeanors which would have led to hospitalization rather than arrest before commitment required overt dangerousness.<sup>75</sup> Police officers, frustrated at the refusal of the mental health system to accept responsibility for mentally disordered misdemeanants, have learned to "go straight to jail," rather than even taking such persons to hospital emergency rooms.<sup>76</sup> As a result of these policies, the largest collection of incarcerated mentally disordered persons in history is now the Los Angeles County Jail system, with nearly 20,000 such admissions a year, far more than the largest state hospital ever held.<sup>77</sup> Table One demonstrates the distribution of mentally disordered persons who are currently involuntarily detained in Colorado.

TABLE ONE  
COMMITTED/INCARCERATED MENTALLY ILL ADULTS IN COLORADO

| <u>Site</u>          | <u>Legal Status</u>    | <u>Census</u> |
|----------------------|------------------------|---------------|
| Colo. MHI Ft. Logan  | Civil Certification    | 91            |
| Denver General       | Civil Certification    | 22            |
| Univ. of Colorado    | Civil Certification    | 24            |
| Colo. MHI Pueblo     | Civil Certification    | 107           |
| Colo. MHI Pueblo     | Forensic               | 308           |
| Jails                | Correctional           | 980           |
| Dep't of Corrections | Correctional - SMI     | 734*          |
| Dep't of Corrections | Correctional - on meds | 945           |

\* based on projected increases since 1993 Fuller-Torrey report of 534.

When the mentally disordered break the law and their arrests and convictions involve the full panoply of procedural protections, their incarcerations

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*Investigation of the Criminalization Thesis*, 180 J. NERVOUS & MENTAL DISEASE 184 (1992). Professor Hiday's data, from following 1,226 involuntarily hospitalized patients, demonstrated that those patients who were arrested were not generally charged with the minor crimes that the criminalization hypothesis predicts. *Id.*

75. See Abramson, *supra* note 71; see also H. Richard Lamb & Robert William Grant, *The Mentally Ill in an Urban County Jail*, 39 ARCHIVES GEN. PSYCHIATRY 17 (1982); Steve Stelovich, *From the Hospital to the Prison: A Step Forward in Deinstitutionalization?*, 30 HOSP. & COMMUNITY PSYCHIATRY 618 (1979). Several authors have explained the increased arrest rates for mentally disordered persons on the basis of overrepresentation by a small number of patients with prior histories of arrests. See Larry Sosowsky, *Crime and Violence Among Mental Patients Reconsidered in View of the New Legal Relationship Between the State and the Mentally Ill*, 135 AM. J. PSYCHIATRY 33 (1978); Henry Steadman et al., *Explaining the Increased Arrest Rate Among Mental Patients: The Changing Clientele of State Hospitals*, 135 AM. J. PSYCHIATRY 816 (1978).

76. See Teplin, *Criminalizing Mental Disorder*, *supra* note 74.

77. In 1955, there were 559,000 patients in state mental hospitals (virtually the only hospitals for involuntarily committed patients at that time). It has since fallen to under 100,000, although many psychiatric patients are in general hospitals or in nursing/rest homes. See GERALD N. GROB, *MENTAL ILLNESS AND AMERICAN SOCIETY 1875-1940* 316 (1983).



appear justified under the state's police power. Civil libertarians would seemingly have little cause for concern. But what is the effect on the mentally disordered persons themselves of this "protection"? Despite the evidence that at least some prefer jail to hospitals,<sup>78</sup> few jails have the resources with which to provide adequate treatment for mental disorders.<sup>79</sup> Patients in prisons fare somewhat better than their counterparts in jails, chiefly as a result of law suits, and because larger systems can provide more resources. But mentally disordered inmates are at a significant disadvantage in correctional facilities. Their behavior exposes them to ridicule at best and abuse at worst, from both other inmates and from guards. They are more frequently placed in maximum security facilities, are systematically denied placements at minimum security facilities, and are denied the opportunity to reduce their sentences significantly by participation in boot camp programs.<sup>80</sup>

Placement in correctional facilities drastically compromises continuity of care for such persons. The majority of community mental health centers do not, as a matter of policy, provide mental health services to inmates in local jails, although there is evidence that this situation is changing gradually.<sup>81</sup> When mentally disordered persons are released from jails and, especially, from prisons, local treatment facilities frequently refuse to provide aftercare services for them. This refusal, in turn, often delays release, because parole boards are reluctant to release such inmates unless effective treatment is available to control mental disorders, and thus minimize recidivism.

An apparent paradox should be noted here. The criminal justice system is antitherapeutic for most patients whose serious mental disorders prevent them from being able to control their behaviors. However, patients with personality disorders are able to exercise such control, albeit with more difficulty than nondisordered persons. Several authors have argued that prosecuting or credibly threatening to prosecute such persons is actually therapeutic, by setting external limits that reinforce the appropriate assumption of responsibility.<sup>82</sup> When clinicians, particularly those practicing in hospitals, attempt to use this approach, however, they are typically met with massive resistance from the

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78. Most preferences for jail are due to denial of illness, but some are due to realistic estimates of the time that will be spent incarcerated. See *infra* note 89 and accompanying text.

79. For a methodologically detailed survey of selected jails, see generally HENRY J. STEADMAN ET AL., *THE MENTALLY ILL IN JAIL: PLANNING FOR ESSENTIAL SERVICES* (1989). For a more polemic account that reports data from every state, see E. FULLER TORREY ET AL., *CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS* (1992).

80. See, e.g., Robert D. Miller & Jeffrey Metzner, *Psychiatric Stigma in Correctional Facilities*, 22 BULL. AM. ACADEMY PSYCHIATRY & L. 621 (1994).

81. See generally STEADMAN ET AL., *supra* note 79.

82. See Kenneth L. Appelbaum & Paul S. Appelbaum, *A Model Hospital Policy on Prosecuting Patients for Presumptively Criminal Acts*, 42 HOSP. & COMMUNITY PSYCHIATRY 1233 (1991); S. Kenneth Hoge & Thomas G. Gutheil, *The Prosecution of Psychiatric Patients for Assaults on Staff: A Preliminary Empirical Study*, 38 HOSP. & COMMUNITY PSYCHIATRY 44 (1987); Robert D. Miller & Gary J. Maier, *Factors Affecting the Decision to Prosecute Mental Patients for Criminal Behavior*, 38 HOSP. & COMMUNITY PSYCHIATRY 50 (1987); Linda Phelan et al., *Prosecuting Psychiatric Patients for Assault*, 36 HOSP. & COMMUNITY PSYCHIATRY 581 (1985); Leonard I. Stein & Ronald J. Diamond, *The Chronic Mentally Ill and the Criminal Justice System: When to Call the Police*, 36 HOSP. & COMMUNITY PSYCHIATRY 271 (1985).

criminal justice system. Many prosecutors apparently believe acting out patients are "right where they belong" and decline to press charges.<sup>83</sup>

### C. Forced Evaluation and Treatment in the Criminal Justice System

The public perceives that criminal defendants who "plead" incompetence to proceed, or plead insanity, have gotten away with something,<sup>84</sup> and the tensions between legal and therapeutic interests are quite evident in three settings within the criminal justice system. First, criminal defendants may be incompetent to proceed, in which case the appropriate length of commitment presents problems. Second, the relationship between the insanity defense and the length of commitment or imprisonment has not been resolved. Third, recent attempts to tie incarceration to the successful completion of treatment programs raised even more questions.

The criminal law permits (indeed requires) defendants whose competency to proceed is in question for any reason to be psychiatrically evaluated before trial. Historically, defendants found incompetent to proceed could be (and frequently were) hospitalized indefinitely, regardless of the nature of the criminal charges against them; as a result, the issue of incompetence was generally raised by prosecutors rather than defense attorneys. After the Supreme Court's 1972 decision in *Jackson v. Indiana*,<sup>85</sup> most states limited the length of confinement to the maximum term of imprisonment for the crime(s) charged. With prosecutors charging the most severe crimes, and given no opportunity to plea bargain charges until a defendant is found competent to proceed, the maximum period of commitment is typically tied to that of the most serious crime charged.<sup>86</sup> In addition, the majority of pretrial forensic evaluations are still carried out in inpatient facilities, so that defendants who would otherwise be free on bond are incarcerated during the evaluation period, which can be a number of months. That incarceration, in most states, is effected in maximum security forensic hospitals, in which the environment and clientele are largely indistinguishable from those found in jails, in spite of the fact that the staffing reflects a hospital rather than a correctional facility.<sup>87</sup>

Insanity is conceptualized legally as an affirmative defense in those forty-

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83. See *supra* note 82.

84. See generally HENRY J. STEADMAN, BEATING A RAP?: DEFENDANTS FOUND INCOMPETENT TO STAND TRIAL (1979).

85. 406 U.S. 715 (1972)

86. For this reason, Professor Norval Morris, among others, has argued that when significant procedural issues exist, or when a defense on the merits has a high probability of success, states should permit incompetent defendants to proceed to trial. If convicted, then the trial judge should conduct a retrospective determination of the effects of the defendant's incompetency on the conviction. See generally Robert A. Burt & Norval Morris, *A Proposal for the Abolition of the Incompetency Plea*, 40 U. CHI. L. REV. 66 (1972). The American Bar Association (ABA) does not go so far, but has recommended that "[t]he fact that the defendant has been determined to be incompetent to stand trial should not preclude further judicial action, defense motions or discovery proceedings which may fairly be conducted without the personal participation of the defendant." AMERICAN BAR ASSOC., CRIMINAL JUSTICE MENTAL HEALTH STANDARDS Standard 7-4.12 (1984).

87. See generally Robert D. Miller & Edward J. Germain, *Inpatient Evaluation of Competency to Stand Trial*, 9 HEALTH L. IN CANADA 74 (1989).

seven jurisdictions in the United States that retain the defense.<sup>88</sup> While other affirmative defenses, such as duress, must in practice be entered by competent defendants on their own behalves, at least seventeen jurisdictions permit insanity defenses to be entered over the active objections of defendants; in twelve of those jurisdictions it can be imposed on defendants who are judged competent to proceed.<sup>89</sup> Since, contrary to popular belief, commitment of defendants found insane frequently exceeds the terms of imprisonment which would have been imposed with a guilty verdict,<sup>90</sup> such legal coercion, which by definition can only be imposed on mentally disordered defendants, sacrifices the rights and autonomy of competent defendants to protect the dignity of the law.

While mental health professionals are of necessity involved in the evaluation and treatment of defendants found incompetent to proceed and not guilty by reason of insanity, these systems were created by the law, not by mental health professionals, who have opposed the use of mental health commitments for purposes other than the provision of treatment. Unlike the situation with involuntary hospitalization, in which clinicians have the authority (and often are required) to discharge patients when they no longer require hospitalization for treatment, patients hospitalized under the criminal laws can generally be discharged only by courts, who are under increasing political pressure not to release mentally disordered persons who have committed serious crimes, regardless of the current mental status of the perpetrator.<sup>91</sup>

Another legal innovation, crafted in response to public outrage at the insanity defense, is the verdict of guilty but mentally ill (GBMI). Under this verdict, defendants adjudged mentally ill at the time of commission of the criminal act, but not sufficiently ill to meet the criteria for the insanity defense, can be found GBMI. Such defendants are sentenced to criminal punishment, just like any other convicted person. These defendants are supposed to

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88. See, e.g., Barbara A. Weiner, *Not Guilty by Reason of Insanity: A Sane Approach*, 56 CHI.-KENT L. REV. 1057, 1057 (1980).

89. See Robert D. Miller et al., *Forcing the Insanity Defense on Unwilling Defendants: Best Interests and the Dignity of the Law*, 24 J. PSYCHIATRY & L. 487 (1996).

90. The research data conflict on this point. The earliest studies, before due process reforms affected the commitments of insanity acquittees, indicated that insanity acquittees and felons convicted of the same crimes spent comparable periods of time incarcerated. See generally MARK PANTLE ET AL., *COMPARING INDIVIDUAL PERIODS AND SUBSEQUENT ARRESTS OF INSANITY ACQUITTEES AND CONVICTED FELONS* (1980) (analyzing data from 1965-1971). Later studies, after the libertarian reforms, indicated that convicted felons were locked up longer; see, e.g., Richard A. Pasewark et al., *Detention and Rearrest Rates of Persons Found Not Guilty by Reason of Insanity and Convicted Felons*, 139 AM. J. PSYCHIATRY 892 (1982) (analyzing data from 1971-1973); Betty L. Phillips & Richard A. Pasewark, *Insanity Plea in Connecticut*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 335 (1980) (analyzing data from 1970-1972). As the "law and order" mentality gained ascendancy, the trends in many states changed back to longer commitments for insanity acquittees. See generally Grant T. Harris et al., *Length of Detention in Matched Groups of Insanity Acquittes and Convicted Offenders*, 14 INT'L J.L. & PSYCHIATRY 223 (1991) (analyzing data from 1975-1981); Mark Pogrebin et al., *Not Guilty by Reason of Insanity: A Research Note*, 8 INT'L J.L. & PSYCHIATRY 237 (1986) (analyzing data from 1980-1983).

91. See generally Abraham L. Halpern et al., *New York's Insanity Defense Reform Act of 1980: A Forensic Psychiatric Perspective*, 45 ALB. L. REV. 661 (1981); see also Robert D. Miller et al., *Judicial Oversight Over Release of Patients Committed After Being Found Not Competent to Proceed or Not Guilty by Reason of Insanity of Violent Crimes*, 28 J. FORENSIC SCI. 839 (1983).

receive mental health treatment, but courts have held that they are entitled to no more treatment than any other inmate.<sup>92</sup>

Michigan initially created the GBMI verdict in response to a state court decision that freed a number of insanity acquittees.<sup>93</sup> The verdict was specifically designed as an alternative to the insanity defense, with the hope that many mentally disordered defendants would be imprisoned rather than hospitalized (and subsequently released sooner than if they had gone to prison).<sup>94</sup> Eleven other states followed suit, most following the *Hinckley* verdict.<sup>95</sup> Although there is some evidence that the verdict has in fact reduced the number of insanity defenses in two states,<sup>96</sup> the overwhelming majority of the data indicate that there is little change in the overall number of insanity acquittals. Most authors have been critical of the defense, reporting that it does not reduce insanity defenses, and disadvantages those found GBMI relative to those simply found guilty.<sup>97</sup>

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92. See INGO KEILITZ ET AL., *THE GUILTY BUT MENTALLY ILL VERDICT: AN EMPIRICAL STUDY* 1-50 (1984).

93. In *People v. McQuillan*, 392 Mich. 511 (1974), the Michigan Supreme Court held that the state must release defendants found not guilty by reason of insanity unless they met criteria for involuntary hospitalization at the time of sentencing. After that ruling, trial courts determined that a number of acquittees did not meet this requirement, and thus released them. See Lynn Blunt & H. Stock, *Guilty but Mentally Ill: An Alternative Verdict*, 3 BEHAV. SCI. & L. 49 (1985).

94. Many authors have been critical of the Michigan experience. See, e.g., Lynn W. Blunt & Harley W. Stock, *Guilty but Mentally Ill: An Alternative Verdict*, 3 BEHAV. SCI. & L. 49 (1985); John Klofas & Ralph Weisheit, *Pleading Guilty but Mentally Ill: Adversarial Justice and Mental Health*, 9 INT'L J.L. & PSYCHIATRY 491 (1986); Gare A. Smith & James A. Hall, *Evaluating Michigan's Guilty but Mentally Ill Verdict: An Empirical Study*, 16 U. MICH. J.L. REFORM 77 (1982). These authors report that insanity defenses did not decrease, that GBMI inmates did not receive increased mental health services (and indeed did not need them), and that GBMI inmates were not paroled as early as defendants convicted of the same crimes without the GBMI label.

Petrella and his colleagues criticized these conclusions, pointing out that the *McQuillan* decision, and the change from *McNaghten* to ALI criteria for insanity, might have combined to increase the number of insanity pleas and, therefore, the fact that the actual number of successful pleas remained constant after introduction of the GBMI plea indicates that the number would have gone up but for the new verdict. These detractors acknowledge Smith and Hall's observation that the guilty but mentally ill inmates did not resemble insanity acquittees, but attempt to explain it away by noting that no data indicate what percentage of those pleading guilty but mentally ill would have pled insane in the absence of the alternative verdict. See Russell C. Petrella et al., *Examining the Application of the Guilty but Mentally Ill Verdict in Michigan*, 36 HOSP. & COMMUNITY PSYCHIATRY 254 (1985).

95. See ALASKA STAT. § 12.47.030 (Michie 1992); CONN. GEN. STAT. § 53a-47 (Supp. 1983) (repealed 1983); DEL. CODE ANN. tit. 11, §§ 401(b), 408 (1987); GA. CODE ANN. § 17-7-131 (Supp. 1993); 38 ILL. COMP. STAT. § 5/115-2(b) (West 1993); IND. CODE § 35-36-2-3 (Supp. 1982); KY. REV. STAT. ANN. § 504.120 (Michie Supp. 1982); N.M. STAT. ANN. § 31-9-3 (Michie Supp. 1983); S.C. CODE ANN. § 17-24-20 (Law Co-op 1985); S.D. CODIFIED LAWS § 23a-7-2 (Michie Supp. 1983); UTAH CODE ANN. § 77-13-1 (Supp. 1983). Nevada recently abolished its insanity defense and replaced it with a GBMI statute. NEV. REV. STAT. ANN. § 174.041 (Michie 1995).

96. See generally R.D. MacKay & J. Kopelman, *The Operation of the "Guilty but Mentally Ill" Verdict in Pennsylvania*, 16 J. PSYCHIATRY & L. 247 (1988). Insanity defenses in Alaska dropped from six to one in the year following enactment of a GBMI statute, but at the same time the insanity criteria were made more restrictive. See, e.g., INGO KEILITZ ET AL., *THE GUILTY BUT MENTALLY ILL VERDICT: AN EMPIRICAL STUDY* (1984).

97. See generally KEILITZ ET AL., *supra* note 96, Linda C. Fentiman, "Guilty but Mentally Ill": *The Real Verdict is Guilty*, 26 B.C. L. REV. 601 (1985); Klofas & Weisheit, *supra* note 94; Donald W. Morgan et al., *Guilty but Mentally Ill: The South Carolina Experience*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 41 (1988); Christopher Slobogin, *The Guilty but Mentally Ill Verdict: An*

Recently, there has been a resurgence of interest in another state method of incarcerating allegedly mentally disordered persons—the mentally disordered sex offender (MDSO) laws. In the 1950s, a number of states passed MDSO laws, but as alternatives to criminal imprisonment. Commitment under these laws was initially indeterminate, because it was tied to treatment rather than to an arbitrary fixed term of punishment. The laws were attacked in the 1970s on civil rights grounds, as well as because of lack of evidence of treatment effectiveness, and most were repealed or fell into disuse.<sup>98</sup> In the late 1980s, however, public fears about criminals in general and sex offenders in particular resulted in the passage of new MDSO laws in several states.<sup>99</sup>

Unlike the previous laws, however, the new wave of statutes provides for “civil” commitment of sex offenders *after* they have served criminal sentences for the same crimes that serve as the basis of predictions that they will commit future sex crimes. Two of these laws are currently before the federal courts. Washington State’s Sexually Violent Predator statute was upheld by its state supreme court,<sup>100</sup> but found to be unconstitutional by the federal district court.<sup>101</sup> Kansas’ Sexually Violent Predator law<sup>102</sup> was found unconstitutional by its state supreme court,<sup>103</sup> but on appeal, the U.S. Supreme Court reversed.<sup>104</sup> The third, Wisconsin’s Sexual Predator Law, was upheld by its state supreme court, and the U.S. Supreme Court denied *certiorari* to hear the case.<sup>105</sup>

Unlike the insanity defense and commitments for treatment to restore competency to proceed, mental health professionals have opposed sexual predator laws, recognizing them for what they are: a return to indefinite commitments in a (not so) covert attempt to alleviate public fear of sex offenders, not to provide adequate time for treatment;<sup>106</sup> an incapacitation of offenders, cloaked in the appearance of beneficence. The American Psychiatric Association and its district branches have provided *amicus* briefs to the courts in all three states opposing the laws.<sup>107</sup> If the duty to protect third parties turns clinicians into cops, sexual predator statutes turn them into gaolers,<sup>108</sup> and ultimately the system selects for the kinds of clinicians who are comfortable in *being* gaolers.

*Idea Whose Time Should Not Have Come*, 53 GEO. WASH. L. REV. 494 (1985); *The Insanity Defense: ABA and APA Proposals for Change*, 7 MENTAL DISABILITY L. REP. 136 (1983).

98. See Barbara A. Weiner, *Sexual Psychopath Laws*, in THE MENTALLY DISABLED AND THE LAW 739-43 (Samuel Jan Brakel et al. eds., 3d ed. 1985).

99. John G. LaFond, *Washington’s Novel Sexual Predator Commitment Law*, 18(1) NEWSL. AM. ACAD. PSYCHIATRY L. 4 (1993).

100. *In re Young*, 122 Wash. 2d 1(1993).

101. *Young v. Weston*, 898 F. Supp. 744 (W.D. Wash. 1995).

102. KAN. STAT. ANN. §§ 59-29(a)(01) to 29(a)(15) (1995).

103. *In re Hendricks*, 259 Kan. 246 (1996).

104. *Kansas v. Hendricks*, 117 S. Ct. 2072 (1997).

105. *State v. Carpenter*, 197 Wis. 2d 252 (1995), *cert. denied sub nom.*, *Schmidt v. Wisconsin*, 117 S. Ct. 2507 (1997); *State v. Post*, 197 Wis. 2d 279 (1995), *cert. denied sub nom.*, *Post v. Wisconsin*, 117 S. Ct. 2507 (1997).

106. The Kansas statute defines MDSOs as untreatable. KAN. STAT. ANN. § 59-29a01 (1995).

107. See, e.g., *Kansas v. Hendricks*, 117 S. Ct. 2072 (1996).

108. The obsolete form of this word is used here on purpose, to suggest the regressive thinking that supports sexually violent predator laws.

#### D. Paternalistic Advocates and Attorneys

Mental health professionals have been (accurately) accused of being paternalistic towards their patients,<sup>109</sup> believing that the provision of effective treatment<sup>110</sup> justifies temporary restriction of external physical liberty for those patients incompetent to make treatment decisions.<sup>111</sup> Less discussed in the literature, however, is that many self-appointed advocates for the mentally ill are just as paternalistic, valuing liberty and due process at the expense of treatment.<sup>112</sup>

Just as clinicians utilize the existing laws to impose treatment on patients, these advocates frequently use their authority to undermine it. Many advocates, particularly when hospital-based advocacy programs were in their infancies, took the position that clinicians were their enemies, and adopted a strictly adversarial posture toward hospital staffs. Appalled at the conditions in some hospitals, concerned only that their clients—who had no more choice about their advocates than about their treaters—be granted “freedom” from physical restraint, and rejecting the proposition that psychiatric treatment conferred any benefit, many argued against the use of involuntary hospitalization or treatment under any circumstances.<sup>113</sup> Few of these early advocates had any clinical training or sophistication, and they operated from the criminal defense attorney model, which teaches concentration on one client at a time, to the exclusion of all others. As a consequence, protection of the legal rights of one patient often resulted in loss of the same rights for others. Mental health professionals do not have the luxury of such tunnel vision; they are responsible for the safety and treatment of all their patients.

Patricia Wald and Paul Friedman have classified advocates into “rights-oriented” and “treatment-oriented.”<sup>114</sup> The former are those who concentrate only on patients’ legal rights (as interpreted by the advocates), while the latter use their advocacy skills to improve patients’ access to effective treatment. The rights-oriented advocates would prefer to abolish all involuntary treatment;

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109. See generally Robert D. Miller, *Involuntary Civil Commitment: Legal Versus Clinical Paternalism*, in LEGAL ENCROACHMENTS IN PSYCHIATRIC PRACTICE, NEW DIRECTIONS FOR MENTAL HEALTH SERVICES (Stephen Rachlin ed., 1985).

110. A plethora of studies have demonstrated the effectiveness of antipsychotic medication. Most significant, several studies demonstrate that this efficacy is the same for voluntary and involuntary patients. See Donald R. Gorham & Lewis J. Sherman, *The Relation of Attitude Toward Medication to Treatment Outcomes in Chemotherapy*, 118 AM. J. PSYCHIATRY 830 (1961); Gerard Hogarty & Solomon Goldberg, The NIMH Collaborative Group, *Drug and Psychotherapy in the Aftercare of Schizophrenic Patients: One-Year Relapse Rates*, 28 ARCHIVES GEN. PSYCHIATRY 54 (1973); National Inst. of Mental Health Psychopharmacology Serv. Ctr. Collaborative Study Group, *Phenothiazine Treatment in Acute Schizophrenia*, 10 ARCHIVES GEN. PSYCHIATRY 246 (1964).

111. See *supra* notes 51-52; see also Miller, *supra* note 109. The sociological data reported *supra* note 27 also supports the view that after effective treatment, the majority of patients feel that the temporary restriction of their rights was justified.

112. See generally Morse, *supra* note 2.

113. See generally H. Richard Lamb, *Securing Patients' Rights—Responsibly*, 32 HOSP. & COMMUNITY PSYCHIATRY 393 (1981); Alan Stone, *The Myth of Advocacy*, 30 HOSP. & COMMUNITY PSYCHIATRY 819 (1979).

114. See generally Patricia Wald & Paul Friedman, *The Politics of Mental Health Advocacy in the United States*, 1 INT'L J.L. & PSYCHIATRY 137 (1978).

but understanding that they are unlikely to accomplishing this goal, they frequently use litigation as a means to implement their covert agendas. A leading example can be found in the landmark "right-to-treatment" law suit, *Wyatt v. Stickney*,<sup>115</sup> in which lead counsel for the plaintiff made it plain that he was not particularly interested in improving treatment in Alabama's substandard hospitals for the mentally ill and mentally retarded, but rather hoped to force the state to discharge as many "inmates" as possible.<sup>116</sup> Activist attorneys have not only tried to close hospitals, but also to prevent mentally disordered persons from seeking to stay in them voluntarily or to gain access to them.

The majority of attorneys who actually represent persons facing civil commitment in court do not share the activist agenda of the hospital-based advocates and members of the national mental health bar.<sup>117</sup> In fact, many are quite reluctant to adopt a full adversarial stance with respect to their clients, preferring a "best interests" role because of the obvious mental disorders from which their clients suffer.<sup>118</sup> One example of this paternalism is the use of plea bargaining techniques learned from criminal defense work. Many attorneys, convinced that their clients will be hospitalized as a result of their hearings, argue for a less restrictive alternative—commitment to outpatient treatment—even if neither their clients nor the hospital staff approve of that alternative. Unlike the situation in criminal court, such attorneys frequently enter such compromise pleas over the strenuous objections of their clients.<sup>119</sup> Some advocates have actually filed suit to prevent their "clients" from receiving potentially effective treatment.<sup>120</sup>

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115. 325 F. Supp. 781 (M.D. Ala. 1971).

116. The lead plaintiff's attorney in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), wrote:

Indeed the strategy in a case like *Wyatt* is to make it too expensive to run large mental institutions and encourage the development of non-institutional alternatives. . . . In recent years, right-to-treatment litigation has emerged as a potent new tool to attack the system by which the mentally ill are confined against their will and incarcerated indefinitely.

Lawrence Schwartz, *Litigating the Right to Treatment: Wyatt v. Stickney*, 25 HOSP. & COMMUNITY PSYCHIATRY 460, 461 (1974).

117. See Lawrence P. Galie, *An Essay on the Civil Commitment Lawyer: Or How I Learned to Hate the Adversary System*, 6 J. PSYCHIATRY & L. 71 (1978). Norman Poythress, an experienced forensic psychologist, attempted to train attorneys to represent commitment respondents effectively, but reported that his efforts had little impact on their "best interests" philosophy. Norman G. Poythress, *Psychiatric Expertise of Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUM. BEHAV. 1 (1978).

118. In *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wisc. 1982), a federal district court held that individuals facing commitment were constitutionally entitled to counsel acting in an adversarial role and as advocates for freedom. *Id.* at 1090 ("[T]he interests in avoiding civil commitment are at least as high as those of persons accused of criminal offenses.") One attorney has expressed his frustration with the adversarial role in civil commitment hearings in print. See Lawrence P. Galie, *An Essay on the Civil Commitment Lawyer: Or How I Learned to Hate the Adversary System*, 6 J. PSYCHIATRY & L. 71 (1978).

Poythress and colleagues have attempted to train attorneys to represent respondents facing commitment in an adversarial fashion, but found little change from the usual "best interests" role after the training. Norman G. Poythress Jr., *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUM. BEHAV. 1 (1978).

119. See generally Robert D. Miller, *The Use of Plea Bargaining in Involuntary Civil Commitment*, 7 INT'L J.L. & PSYCHIATRY 395 (1984).

120. In *Kaimowitz v. Michigan Dept. of Mental Health*, 42 U.S.L.W. 2063 (Cir. Ct. Wayne

Recently, David Wexler and Bruce Winick, two law professors experienced in both mental health law and practice, have been advocating a concept they call "therapeutic jurisprudence."<sup>121</sup> Professor Wexler has written that "[t]he task of therapeutic jurisprudence is to identify—and ultimately to examine empirically—relationships between legal arrangements and therapeutic outcomes."<sup>122</sup> He goes on to state that it involves four overlapping areas of inquiry: 1) the role of the law in producing psychological dysfunction; 2) the therapeutic aspects of legal rules; 3) the therapeutic aspects of legal procedures; and 4) the therapeutic aspects of judicial and legal roles. He assumes that the law seeks expressly to promote therapeutic objectives, such as a meaningful right to treatment, but that the law often does not recognize the antitherapeutic aspects of even that concept in practice.<sup>123</sup> It would seem that this approach, which continues to be rejected by extremists in both the legal

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Cty., Mich. 1973), a mentally disordered sex offender gave consent to experimental psychosurgery, in order to help him control his violent behavior. He had been told that he would never be released from maximum security as long as his aggressive behavior continued, and he had not responded to any other treatment. A libertarian attorney filed suit, without support from his "client," to block the treatment. The trial court held that because the treatment was experimental, irreversible, and affected the brain, no incarcerated person was capable of giving informed consent.

Although this decision has no technical precedential value, it has been cited by attorneys to prevent willing patient/clients from accepting nonstandard treatment. For example, when the author developed a voluntary treatment procedure for committed sex offenders involving the use of anti-androgen medication to reduce (but not eliminate) abnormally high sex drive, the attorney for a state advocacy program objected, citing *Kaimowitz* to support her contention that no incarcerated person could give consent to the experimental (and reversible) use of an FDA-approved medication. Letter from Dianne Greenley, Project Director, Advocacy for Institutionalized Persons, Wisconsin Coalition for Advocacy, to Robert D. Miller (May 3, 1985) (on file with the author). Had her objections been voiced in court, they might well have prevented patients from receiving the only treatment that would permit them to gain sufficient control over their sexual arousal to be released.

Another example of overreaction to past abuses involves research with institutionalized populations. There is no question that such populations have been abused in the past—the Tuskegee syphilis experiments come to mind. But the current guidelines of the American Correctional Association, the standards for practices in prisons and jails, prohibit *all* medical research with inmates, whether the treatment may be life-saving or not. "Written agency policy prohibits inmates/juveniles/residents from participating in medical or pharmaceutical testing for experimental or research purposes." AMERICAN CORRECTIONAL ASSOC., STANDARDS FOR ADULT CORRECTIONS/INSTITUTIONS, Std. 2-CO-1F-14 (Mar. 1, 1996).

121. See, e.g., DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* (1991); David B. Wexler & Bruce J. Winick, *The Potential of Therapeutic Jurisprudence: A New Approach to Psychology and the Law*, in *LAW AND PSYCHOLOGY: THE BROADENING OF THE DISCIPLINE* 211 (James R.P. Ogloff ed., 1992); David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. MIAMI L. REV. 979 (1991).

122. David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, in DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* 8 (1991).

123. See, e.g., David B. Wexler, *An Introduction to Therapeutic Jurisprudence*, in DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* 17 (1991). Attorneys can tell patients the same things that their treaters tell them, but are heard differently. See generally Robert D. Miller et al., *Litigiousness as a Resistance to Therapy*, 14 J. PSYCHIATRY & L. 109 (1986). This approach requires treatment-oriented advocates who can see the whole picture and who know something about mental disorder. Since few attorneys receive adequate experience with mentally disordered persons in law school, and the legal literature is heavily biased against psychiatric treatment, I am not arguing here for co-option of attorneys, but for attorneys operating based on accurate information rather than ideology.



and mental health camps, represents the best hope for reconciliation, which would remove the supposed clients of both from the current crossfire between them.

#### E. *Coercion in Correctional Facilities*

This article has discussed the increased incidence of mentally disordered persons in the criminal justice system. Rights-oriented advocates have not complained vociferously about this situation, in part because the civil rights of criminal defendants are scrupulously protected. Unfortunately, however, most advocates lose interest once defendants are convicted and incarcerated.<sup>124</sup> Of course, correctional systems are all about coercion; what concerns us here are the additional problems that exist for inmates *because* they are mentally disordered. For example, although correctional inmates are the only population in this country that have a constitutional right to treatment,<sup>125</sup> including mental health treatment,<sup>126</sup> inmates are also the only group of mentally disordered persons officially and openly discriminated against because of their status. Courts have required correctional systems to develop effective screening<sup>127</sup> and tracking systems for their mentally disordered inmates<sup>128</sup> and to provide adequate treatment for those with serious mental illnesses.<sup>129</sup> But those inmates so identified are concomitantly disadvantaged by their very classification.

In a national survey of all state correctional systems,<sup>130</sup> forty-eight of fifty-one responded that they use psychiatric diagnosis in placement decisions; twenty of fifty-one states use maximum security placements for seriously mentally ill inmates, regardless of their actual behavior. Some states bar seriously mentally ill inmates from many, if not all, minimum security facilities. Twenty-two of the thirty states that have them prohibit inmates with major mental disorders, or those who are taking psychotropic medications, from participating in boot camp programs, perhaps the most significant advantage a

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124. Most of the legal advocacy programs concentrate their efforts in the civil system, and correctional systems—especially prisons—have been more successful in fending off attempts to place advocates or ombudspersons in their facilities. The chief exception is the National Prison Project, affiliated with the American Civil Liberties Union, that directs all its efforts toward state prison systems. Since it is a private organization, it is not subject to the cutbacks and restrictions that have increasingly prevented federally-funded advocacy programs from filing class action suits, and its efforts have led to major improvements in over half the nation's prison systems. It does not restrict itself to mental health issues, but those issues are invariably litigated as part of class action suits. See Robert D. Miller, *Current Status of Prison Mental Health Litigation*, 20 *NEWSL. AM. ACAD. PSYCHIATRY L.* 57 (1995).

125. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (“[D]eliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ . . . proscribed by the Eighth Amendment.” (citation omitted)).

126. *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977).

127. Jeffrey Metzner et al., *Mental Health Screening and Evaluation Within Prisons*, 22 *BULL. AM. ACAD. PSYCHIATRY & L.* 451 (1994).

128. See, e.g., *Austin v. Pennsylvania Dep’t of Corrections*, 876 F. Supp. 1437, 1451, 1457, 1460 (E.D. Pa. 1995).

129. See *Bowring*, 551 F.2d at 47.

130. See generally Robert D. Miller & Jeffrey Metzner, *Psychiatric Stigma in Correctional Facilities*, 22 *BULL. AM. ACAD. PSYCHIATRY & L.* 621 (1994).

corrections system can confer on an inmate. Many of these policies, to be sure, are based on lack of mental health resources to monitor the effects of medication at many facilities. Not discrimination per se, but the effect is the same. At a time when the incidence of mentally disordered inmates is growing rapidly,<sup>131</sup> such discrimination is particularly problematic.<sup>132</sup>

#### IV. EXTERNAL SOCIAL COERCION ON PATIENTS

##### A. Stigma

In addition to the legal coercion discussed above, mentally disordered persons are increasingly exposed to more diffuse social pressures which are more difficult to protect against. Despite a plethora of educational programs aimed at the general public, the stigma associated with being mentally disordered continues unabated. Since the effects of social coercion are often not direct acts of the state, legal advocates tend to ignore them, except to list the existence of stigma as a factor militating keeping mentally disordered persons out of the mental health system altogether. But because of the stigma, mentally disordered persons have difficulty obtaining the specialized housing that they require,<sup>133</sup> and also have difficulty in obtaining employment.<sup>134</sup>

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131. See generally Henry J. Steadman & Stephen A. Ribner, *Changing Perceptions of the Mental Health Needs of Inmates in Local Jails*, 137 AM. J. PSYCHIATRY 1115 (1980). Approximately 670,000 mentally ill inmates are admitted to jails each year, or nearly eight times the number admitted to state mental hospitals. See CENTER ON CRIME, COMMUNITIES & CULTURE, RESEARCH BRIEF: MENTAL ILLNESS IN U.S. JAILS: DIVERTING THE NONVIOLENT, LOW-LEVEL OFFENDER (1996).

132. In *Gates v. Rowland*, 39 F.3d 1439 (9th Cir. 1994), inmates challenged a California prison's blanket policy of prohibiting HIV-positive inmates from working in food service. The trial court held that the policy violated section 504(a) of the Rehabilitation Act of 1973. The Ninth Circuit reversed, holding that while HIV-positive status was a disability under the ADA and, therefore, the Rehabilitation Act, *id.* at 1446, and the prison's acceptance of federal funds placed it under the Act, *id.*, the Rehabilitation Act was not specifically designed to apply to prisons, and inmates do not possess the same rights as noninmates. *Id.* at 1446-47. It accepted the prison's argument that because of the fact that many inmates believed (however falsely) that they would be placed at risk by having to eat food prepared by HIV-positive inmates, the prison had a legitimate security reason to deny food service jobs to HIV-positive inmates. *Id.* at 1447-48.

133. Since zoning laws are governmental actions, the courts have been willing to address their alleged discrimination against the mentally disabled. The Supreme Court ruled in *City of Edmonds v. Oxford House, Inc.*, 514 U.S. 725 (1995), that Edmonds' zoning ordinance requiring occupants of a single-family dwelling to be "persons related by genetics, adoption, or marriage, or a group of five or fewer [unrelated] persons," violated the 1988 Fair Housing Act (FHA), which prevents housing discrimination based on disability. The Court held that since an unlimited number of related people could live together under the ordinance, it was intended to discriminate against unrelated people, and thus did not fall under the "maximum occupancy" exception to the FHA. *Id.* at 1781-82.

Lower courts have subsequently denied housing permits for facilities for disabled persons, however, when the ordinances in question were more carefully crafted to avoid the problems found in *City of Edmonds*. A federal district court in Maryland, see *Bryant Woods Inn, Inc. v. Howard Cty., Md.*, 911 F. Supp. 918, 931 (D. Md. 1996), and the Eighth Circuit, see *Oxford House v. St. Louis*, 77 F.3d 249, 252 (8th Cir. 1996), both held that maximum occupancy ordinances expressed legitimate governmental interests in regulating traffic and other problems.

134. This article does not discuss the burgeoning literature on the application of the Americans with Disabilities Act to mentally disordered persons in the workplace. It is interesting to note, however, that at least two federal courts have held that questions concerning past mental disorder on applications to take bar examinations may constitute impermissible discrimination. See

Perhaps the most telling example of the stigma associated with being mentally ill comes as the result of a 1966 Supreme Court case, *Baxstrom v. Herold*.<sup>135</sup> That decision led to the discharge or transfer of 989 patients hospitalized in a New York maximum security correctional facility.<sup>136</sup> Henry Steadman and his colleagues followed the patients' progress for ten years. As part of the study, researchers collected newspaper articles about the patients, all of whom were both ex-mental patients ("mad") and ex-convicts ("bad"). In every one of the hundreds of articles Steadman reviewed, the subject was described as an ex-mental patient—never an ex-convict.

### B. *Economic Coercion*

Economic factors have been inadequately studied as indirect but powerful sources of coercion upon mentally disordered persons. When asylums were first built in this country in the 1800s, a major argument in legislatures for hospitalizing mentally disordered persons was that the facilities would be self-sustaining and, in fact, many were in those early years. The larger institutions grew their own food, made their own clothes, and generally operated as self-contained communities, largely on (free) patient labor. This practice depended, of course, on keeping the higher-functioning patients for long periods of time (the seriously mentally ill patients in the back wards were of no economic value, which was why many of them had been committed in the first place).<sup>137</sup>

With the increased dumping of dysfunctional persons into asylums, the basic costs of running the institutions increased to the point that they became economic liabilities to the administering governments. During the civil rights revolution of the 1960s and '70s, unpaid patient labor was attacked as "institutional peonage," and states were forced to pay minimum wages to patients for their work.<sup>138</sup> When the lack of resources and even minimally adequate treatment programs was litigated, federal courts mandated significant im-

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Clark v. Virginia Bd. of Bar Examiners, 880 F. Supp. 430 (E.D. Va., 1995); Ellen S. v. Florida Bd. of Bar Examiners, 859 F. Supp. 1489 (S.D. Fla. 1994). In response, the American Bar Association approved a compromise resolution that rejected existing practices of detailed inquiry into an applicant's past mental health history, but permitted inquiry into an applicant's current functioning. Similar suits have been filed against medical licensing boards, and the American Medical Association has recommended that inquiries be permitted only as to disabilities that require reports concerning competence to be made to the board, or that may reasonably be expected to affect a physician's current practice. See Robert D. Miller, *Licensing and Mental Disability*, 20 NEWSL. AM. ACAD. PSYCHIATRY L. 21 (1995). It also stressed the importance of confidentiality in these matters. See *id.*

135. 383 U.S. 107 (1966).

136. See generally HENRY J. STEADMAN & JOSEPH J. COCOZZA, *CAREERS OF THE CRIMINALLY INSANE* (1974).

137. DAVID J. ROTHMAN, *CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA* 346-50 (1980).

138. As an unfortunate result of this appropriate determination, patients were subsequently denied the opportunity to perform truly therapeutic work, because state departments of mental health would not provide the necessary funds in their budgets. See ANDREW T. SCULL, *DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT—A RADICAL VIEW* 139 (2d ed. 1984). Scull also argues that another purpose of the civil rights litigation was to force discharges from hospitals by making it economically infeasible to hold patients. *Id.*

provements in staffing and other resources,<sup>139</sup> thus further increasing the costs of operating state mental hospitals.

States responded by supporting advocates' efforts to limit admissions to state hospitals, and to "deinstitutionalize" those patients who were already there.<sup>140</sup> The original plan had been to take money saved from down-sizing state hospitals and transfer it to community-based treatment facilities—the "money follows the patient" plan.<sup>141</sup> For many reasons, this plan never worked in practice. The major reason was that while the census in state facilities has dropped by over eighty-five percent over the past forty years, improvements in court-mandated conditions and staffing have increased the cost per patient to the extent that relatively little actual savings have occurred. In addition, civil rights advocates filed suits to block needed improvements in hospitals, fearing states would merely divert funds so utilized from essential programs for community-based treatment.<sup>142</sup> In addition, the due process protections mandated by the courts took much needed funds from clinical resources.<sup>143</sup>

Another initial economic incentive for deinstitutionalization was the influx of federal money into community mental health centers beginning in the 1960s, giving state governments the opportunity to cost-shift by transferring patients to those facilities. Some states passed laws requiring local governments to reimburse the state for their residents who were hospitalized in state facilities.<sup>144</sup> When the federal monies that had supported treatment of the chronically mentally ill dried up, however, local governments felt the financial pinch, and their community mental health centers had to look to paying or insured clients to continue operating.<sup>145</sup>

One beneficiary of the deinstitutionalization movement was the nursing

139. The leading case is *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971). For a discussion of subsequent cases, see Stephen Rachlin, *Litigating a Right to Treatment: Woe is Me*, 58 PSYCHIATRIC Q. 182 (1988).

140. See Lawrence H. Schwartz, *Litigating the Right to Treatment: Wyatt v. Stickney*, 32 HOSP. COMM. PSYCHIATRY 460, 462 (1981).

141. *Id.*

142. From 1964 until 1980, costs per patient per day at Bryce State Hospital rose from \$3.50 to \$65. See *Conference Report, Wyatt v. Stickney: Retrospect and Prospect*, 32 HOSP. COMMUNITY PSYCHIATRY 123, 125 (1981) [hereinafter *Conference Report*]. Morton Birnbaum, the creator of the concept of a right to treatment, see Morton Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499 (1960), continued to pursue his creation in the courts for nearly 30 more years. His litigation through the state and federal courts, primarily *Woe v. Cuomo*, 801 F.2d 627 (2d Cir. 1986), ultimately resulted in the accreditation by the Joint Commission on the Accreditation of Health Care Organizations of all New York's state mental hospitals, at a tremendous cost to the state. See Stephen Rachlin, *Litigating a Right to Treatment: Woe Is Me*, 60 PSYCHIATRIC Q. 182 (1988).

143. Ronald Schouten & Thomas G. Gutheil, *Aftermath of the Rogers Decision: Assessing the Costs*, 147 AM. J. PSYCHIATRY 1348, 1351 (1990) (reporting that the budget of the Massachusetts Department of Mental Health increased by over a million dollars during an 18-month period following *Rogers*). The cost of compliance includes, of course, the costs to the judiciary and others in the judicial system, as well as the thousands of hours of clinical time taken away from patients in order to prepare and testify in involuntary treatment hearings.

144. See, e.g., WIS. STAT. § 51.42(3)(as) (1976); see also Robert D. Miller, *Economic Factors Leading to the Diversion of the Mentally Disordered from the Civil to the Criminal Commitment Systems*, 15 INT'L J.L. & PSYCHIATRY 1 (1992).

145. See generally FRANKLIN CHU & SHARLAND TROTTER, *THE MADNESS ESTABLISHMENT: RALPH NADER'S STUDY GROUP REPORT ON THE NATIONAL INSTITUTE OF PUBLIC HEALTH* (1974).

home industry. A large number of mental patients that had been hospitalized for years were "transinstitutionalized"<sup>146</sup> to these facilities, which were supported in part by federal money. Because these were not state facilities, many civil rights activists were not concerned, despite the fact that many chronically mentally ill patients had been better off in hospitals which had programs specifically designed for their needs—programs almost totally lacking in nursing homes. Once the federal government caught on to what was happening, it threatened to cut off all funding to nursing homes with above a certain percentage of chronically mentally ill residents, because its support of medically ill home inhabitants did not include those with mental illnesses.<sup>147</sup> As a result of patients being thrown out of hospitals and then out of nursing homes, patients who would have been hospitalized in the past had nowhere to live. Again, since this is not the direct result of state action, patients' constitutional rights were not violated, and their injuries are difficult to articulate in tort litigation.<sup>148</sup>

This latter discrimination against mentally disordered persons is not the sole province of the federal government, however. Most private insurance companies, and now managed care corporations, have always refused to provide equal coverage for persons with mental disorders, as compared with

146. See generally H. Richard Lamb & Roger Peele, *The Need for Continuing Asylum and Sanctuary*, 35 HOSP. & COMMUNITY PSYCHIATRY 798 (1984); Leonard J. Schmidt et al., *The Mentally Ill in Nursing Homes: New Back Wards in the Community*, 34 ARCHIVES GEN. PSYCHIATRY 687 (1977); William R. Shadish & Richard R. Bootzin, *Nursing Homes and Chronic Mental Patients*, 7 SCHIZOPHRENIA. BULL. 488 (1981); Darold A. Treffert, *Sane Asylum: An Alternative to the Mental Hospital*, 17 CURRENT PSYCHIATRIC THERAPY 309 (1977).

147. Connecticut Dep't of Income Maintenance v. Heckler, 105 S. Ct. 2210 (1985).

148. The majority of legal efforts to require the provision of community mental health services have resulted in consent decrees. See Michael S. Lottman, *Enforcement of Judicial Decrees: Now Comes the Hard Part*, 1 MENTAL DISABILITY L. REP. 69 (1976). Courts have been reluctant to create a right to treatment for voluntary patients in the community, and many of the decisions have been based on state laws that guarantee such services or guarantee services in the least restrictive environment. *Id.* Enforcing such orders has proved problematic in many instances, and courts have had to continue their monitoring for years in some cases (e.g., *Wyatt* is still under court supervision after 26 years). *Id.*

For a discussion of specific consent decrees, see Barbara Armstrong, *St. Elizabeths Hospital: Case Study of a Court Order*, 30 HOSP. & COMMUNITY PSYCHIATRY 42 (1979); Jeffrey L. Geller et al., *Second-Generation Deinstitutionalization, II: The Impact of Brewster v. Dukakis on Correlates of Community and Hospital Utilization*, 147 AM. J. PSYCHIATRY 988 (1990); and Stonewall B. Stickney, *Problems Implementing the Right to Treatment in Alabama: The Wyatt v. Stickney Case*, 25 HOSP. & COMMUNITY PSYCHIATRY 452 (1974).

One frequent consequence of court decisions based on statutory rights to treatment is a legislative attempt to thwart the decision (or preempt future ones) by removing the rights. When the Colorado Supreme Court held, in *Goebel v. Colorado Dept. of Institutions*, 764 P.2d 785 (Colo. 1988), that the state Act for the Care and Treatment of the Mentally Ill, 11 COLO. REV. STAT. §§ 27-10-101 to 129 (1982 & Supp. 1988) created a statutory right to appropriate treatment in the community for patients who had been voluntarily or involuntarily hospitalized, the state legislature amended the Care & Treatment Act by inserting "subject to available appropriations" in sections 27-10-101, -108, -109, and -116, and 27-10.5-101, -103, -105, -106 and -206. The legislature subsequently introduced further legislation (Senate Bill 94-221) that would have made it explicit that voluntary patients have no right to mental health services. That bill was defeated, largely through organized opposition by advocacy groups (including the Colorado Alliance for the Mentally Ill Forensic Network Taskforce, the Colorado Mental Health Association, and the Colorado Protection and Advocacy for Individuals with Mental Illness Program), but has continued to be introduced in subsequent legislative sessions.

"medical" illnesses.<sup>149</sup> "Parity" in insurance coverage has become a major political agenda for the American Psychiatric and American Psychological Associations.<sup>150</sup> While the self-serving nature of such agendas is apparent, the ultimate effect is on the mentally disordered persons, many of whom are no longer provided with treatment from any source. Parity legislation has passed the U.S. Congress, and is currently before a number of state legislatures.<sup>151</sup> Other similar forms of discrimination include the recent exclusion of persons convicted of drug-related felonies from social security payments,<sup>152</sup> and the exclusion of alcoholics from Veterans' Administration educational benefits.<sup>153</sup> The public mental health system, including state hospitals and local community mental health centers, used to provide the safety net for those with serious mental illnesses, most of whom can not obtain private insurance. Now that capitation plans are sweeping the country, that net is becoming as riddled with holes as is the private system.

An attempt in Wisconsin to use economic pressure to force change in the delivery of mental health services backfired badly; as part of the reforms in civil commitment following the *Lessard* decision, the state legislature made counties financially liable for the costs of hospitalizing their severely mentally disordered citizens in state facilities. This legislation did have the desired effect of forcing counties to develop their own local inpatient facilities, but as the legislation did not affect the state's responsibility for forensic patients (those being evaluated for competency to proceed and those found either incompetent or insane), the result was an increase in the numbers of patients admitted through the criminal justice system, the majority of whom were charged with misdemeanors.<sup>154</sup>

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149. See *Two Presidents Agree to Work Together for Parity*, 31(18) PSYCHIATRIC NEWS 1 (1996).

150. See *Capitol Hill Continues to Hear About Need for Parity*, 31(21) PSYCHIATRIC NEWS 1 (1996).

151. The Mental Health Parity Act of 1996, Pub. L. 104-204, tit. VII, 110 Stat. 2944 (codified in scattered sections of 29 U.S.C. and 42 U.S.C.) provides parity for yearly and lifetime caps between mental disorders and other medical disorders. The Colorado House debated House Bill 1192 during the 1997 Legislative Session, which would provide complete parity for specified mental disorders—schizophrenias, affective disorders, obsessive-compulsive disorder, and post traumatic stress disorder.

152. Pub. L. 104-12, § 105(a), 110 Stat. 851, 852 (enacted Mar. 29, 1996), denies SSI and SSDI benefits to anyone disabled by substance abuse if convicted of a substance abuse related felony.

153. In *Traynor v. Turnage*, 485 U.S. 535 (1988), the Supreme Court held that the Veteran's Administration's irrebuttable presumption that all primary alcoholism is attributable to willful misconduct did not violate section 504 of the Rehabilitation Act. *Id.* at 551. The Court did not find it necessary to decide whether alcoholism is a disease. *Id.* at 552.

154. See generally Miller, *supra* note 144; see also Walter Dickey, *Incompetency and the Non-dangerous Mentally Ill Client*, 16 CRIM. L. BULL. 22 (1980); Stephen Rachlin, *Incompetent Misdemeanants—Pseudocivil Commitment*, 14 BULL. AM. ACAD. PSYCHIATRY & L. 23 (1986); Darold A. Treffert, *Legal "Rites": Criminalizing the Mentally Ill*, 3 HILLSIDE J. CLINICAL PSYCHIATRY 123 (1979).

## V. INTERNAL CLINICAL COERCION ON PATIENTS

A. *Capacity to Give Informed Consent and Denial of Illness*

Many civil rights activists behave as if mental disorders don't exist. Deriving sustenance from the voluminous (and repetitive) works of Thomas Szasz, which denied the very existence of mental disorder,<sup>155</sup> and the more sophisticated writings of Stephen Morse<sup>156</sup> and Ennis and Litwack,<sup>157</sup> who did not deny the existence of mental disorder, but argued that psychiatrists could not adequately diagnose or treat it. These advocates rejected clinicians' arguments that mentally disordered persons could not make competent decisions about their treatment because of their disorders, and also rejected the possibility that mentally disordered persons' expressed wishes might be due to their disorders and thus not represent their true feelings. Clinicians, who follow their patients over long periods of time rather than at specific points along a time line, recognize that serious mental disorders significantly affect patients' abilities to understand and accept that they are ill and, thus, that they need treatment.<sup>158</sup>

The right to refuse psychiatric treatment—which is more accurately characterized as the patient's right to make treatment decisions to either accept or refuse proposed treatment—has often centered around the legal concept of informed consent. For such consent to be accepted, the clinician must provide adequate information upon which a patient can base a decision: the patient must have the capacity to make a decision; and the decision must be free from external coercion.

Mental health and legal professionals have often differed in their interpretations of the capacity issue. Loren Roth<sup>159</sup> and Laurence Tancredi<sup>160</sup> have discussed the spectrum of levels of capacity displayed by patients in informed consent paradigms, displayed in Table Two.

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155. See generally THOMAS S. SZASZ, *LAW, LIBERTY AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES* (1963); THOMAS S. SZASZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* (1961).

156. See Morse, *supra* note 2. Morse argues that mentally disordered persons are no more incompetent than other groups that exhibit poor judgment, such as smokers and overeaters; and that nonmentally ill persons with poor judgment are as treatable as those with mental illnesses. *Id.* at 61. He simply asserts these propositions without the evidence that he expects mental health professionals to provide for their arguments; and he ignores the powerful effects of some mental disorders on reality testing and cognitive functioning. While treatment (such as smoking cessation clinics, diet programs and Alcoholics Anonymous) do have beneficial effects for some addicted persons, their success rates do not begin to compare with the effects of medication on psychotic or severely depressed patients. A good comparison can be made with the behavioral treatment of volitional obesity versus the biological treatment of obesity secondary to metabolic disease.

157. See Ennis & Litwack, *supra* note 65.

158. See, e.g., Loren H. Roth et al., *The Dilemma of Denial in the Assessment of Competency to Refuse Treatment*, 138 AM. J. PSYCHIATRY 910 (1982).

159. See generally Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977); see also Alan Meisel et al., *Toward a Model of the Legal Doctrine of Informed Consent*, 135 AM. J. PSYCHIATRY 285 (1977).

160. Laurence R. Tancredi, *Competency for Informed Consent: Conceptual Limits of Empirical Data*, 5 INT'L J.L. & PSYCHIATRY 51 (1982).

TABLE TWO  
LEVELS OF INFORMED CONSENT

1. The Capacity to Evidence a Choice
2. The Capacity to Base a Choice on "Rational" Reasons
3. The Capacity to Understand Information Relevant to the Choice
4. The Capacity to Apply that Understanding to One's Own Situation

For many advocates, Level One is sufficient—that is, they accept their clients' stated wishes without further inquiry as to the bases of those decisions, since advocates do not acknowledge the internal conflicts experienced by seriously mentally disordered persons. Clinicians, on the other hand, look to the reasons for the decisions. Patients who are capable of accurately reciting the objective risks and benefits of a proposed treatment are still not considered competent either to refuse *or* to accept the treatment unless they accept that they are suffering from the disorder for which the treatment is proposed. Cognitive knowledge alone, or a "factual" understanding in the Dusky model, is insufficient to serve as a basis for meaningful informed consent.

This approach assumes great significance because the clinical research literature demonstrates that denial of illness is the most common reason for refusal of clinically appropriate treatment by psychiatric patients.<sup>161</sup> Thus, serious mental disorders—which are the ones for which psychiatric medications are prescribed—rob patients not only of their abilities to function autonomously, but also of their capacities to make truly informed choices about treatments that would restore their capacities and autonomy.

Alan Wertheimer distinguishes between negative freedom (absence of external constraints) and positive freedom (in which one can act autonomously).<sup>162</sup> He agrees that mental disorders can rob patients of positive freedom. The consequentialist position would be that if coerced treatment is the best objective alternative, it should be employed regardless of the patient's wishes. The rights position is that patients cannot be coerced for their own good. Wertheimer suggests that advocates often base this position on their own distrust of the therapeutic establishment, rather than on their clients' wishes. He cautions that paternalism can be justified only if patients are not capable of autonomous or voluntary action. Wertheimer further argues that Stone's "thank you theory"<sup>163</sup> does not replace initial consent, but does suggest the reasonableness of the coercive action taken. In addition, while it may be, and certainly has been, argued that society can coerce a person only to protect others,<sup>164</sup>

161. See *supra* note 60 and accompanying text.

162. Alan Wertheimer, *A Philosophical Examination of Coercion for Mental Health Issues*, 11 BEHAV. SCI. & L. 239 (1993).

163. See *supra* note 26 and accompanying text.

164. This argument is a central tenet of libertarian philosophy, most eloquently expressed by John Stuart Mill: "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant." JOHN STUART MILL, ON LIBERTY 9 (1978). Those citing Mill, however, generally ignore the subsequent statement that "[i]t is, perhaps, hardly neces-



it could also be argued that a person who is temporarily irrational may be prevented from harming his "normal self," and thus can be coerced under the danger-to-others rationale.

### B. *Judicial Concepts of Voluntariness and Consent*

Although the courts have not provided comprehensive discussions of the capacity prong of the test for informed consent, they have discussed voluntariness at some length, albeit not in the context of informed consent.<sup>165</sup> Most of the decisions have come from criminal cases, particularly in the context of capacity to waive constitutional rights.<sup>166</sup> Before the current ascendancy of conservatives on the Supreme Court, the Court defined voluntariness in subjective terms, i.e., what defendants themselves experienced in the situation, with their own unique capacities.<sup>167</sup> Former Chief Justice Burger recognized in 1979 that "[o]ne who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty or free of stigma."<sup>168</sup>

More recently, however, the Court has rejected its own precedents and allowed police to use deceit to obtain confessions.<sup>169</sup> More significant, it has changed from a subjective to an objective test of voluntariness, at least in the criminal system. In its recent decision in *Colorado v. Connelly*,<sup>170</sup> the majority not only defined voluntariness to mean solely the lack of intentional police misconduct, but rejected the entire concept of free will, at least in the context of police interrogations.<sup>171</sup> This result suggests that the legal system is simply unprepared or unwilling to tackle the problem of voluntariness as applied to mentally disordered persons. By focusing on the conduct of others, the individual's autonomy may simply be ignored.

## VI. EXTERNAL COERCION OF CLINICIANS

Discussions of coercion rarely concern themselves with service providers. It is assumed that providers have chosen their professions and can, therefore, leave their jobs if the conditions become unpleasant. This view was unfortunately reinforced by the president of the American Psychiatric Association in 1958, when he called for psychiatrists to abandon the state hospital system because of its (admitted) deficiencies.<sup>172</sup>

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sary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties." *Id.*

165. See generally Robert D. Miller, *The U.S. Supreme Court Looks at Voluntariness and Consent*, 17 INT'L J.L. & PSYCHIATRY 239 (1994).

166. *Id.*

167. *Id.*

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

169. In *Illinois v. Perkins*, 496 U.S. 292 (1990), the Court upheld a confession obtained through police deception, stating that "*Miranda* forbids coercion, not mere strategic deception." *Id.* at 297.

170. 479 U.S. 157 (1986).

171. *Connelly*, 479 U.S. at 169. In ruling admissible a confession obtained from an obviously psychotic person who said that he confessed under the commands of auditory hallucinations, the court concluded that "notions of 'free will' have no place [in this area of constitutional law]." *Id.*

172. Harry Solomon, *Presidential Address to the American Psychiatric Association*, 115 AM.

It is true that good clinicians can always elect to leave bad facilities or systems. Many, however, choose to remain in the public systems that provide mental health services to the most severely disordered patients, and continue to treat the majority of involuntarily committed patients. The focus here is not the coercion that they experience themselves, but rather the effects of that coercion on the patients they treat.

#### A. *Legal Constraints on Clinicians*

##### 1. Negligent Release and the Duty to Protect Third Parties

In the past several decades, the law has characterized clinicians as undercover law enforcement officials. As mental health professionals adapted to changes in involuntary civil commitment laws and began to offer the required predictions of dangerousness in court in order to be able to provide their services to severely mentally disordered persons, the law has taken them at their word, and held them responsible for such predictions in other areas. Mental health professionals practicing in inpatient settings have for years been held responsible for not discharging involuntary patients considered to still be dangerous, and for petitioning for commitment of voluntary patients they consider dangerous but who request discharge. The fact that they had assumed legal custody of those patients placed upon them a concomitant burden to maintain custody until the patients were no longer felt to be dangerous.<sup>173</sup>

What is new is the law holding psychotherapists increasingly responsible for controlling or reporting outpatients' behavior. The ground-breaking case was *Tarasoff*,<sup>174</sup> in which the California Supreme Court held that the special relationship exception in the *Second Restatement of Torts* applied to the psychotherapist-patient relationship, and that when patients make threats of violence to identifiable victims, therapists have an obligation to protect those victims.<sup>175</sup> Most other states have reached similar conclusions, although not always on the same legal rationale.<sup>176</sup> Many clinicians predicted the death of psychotherapy as we know it,<sup>177</sup> but the research data, indirect though they are, have not supported those predictions.<sup>178</sup> One result that has been demonstrated anecdotally but not, to date, through methodologically sound research, is that clinicians feel compelled to initiate involuntary commitment and to delay release of patients who they likely would have released before *Tarasoff* and its progeny.

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J. PSYCHIATRY 1 (1958).

173. See, e.g., Robert D. Miller et al., *Emerging Problems for Staff Associated with the Release of Potentially Dangerous Forensic Patients*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 309 (1988).

174. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425 (1976) (*Tarasoff II*).

175. *Tarasoff*, 17 Cal. 3d at 431.

176. See generally ALAN R. FELTHOUS, *THE PSYCHOTHERAPIST'S DUTY TO WARN OR PROTECT* (1989); *CONFIDENTIALITY VERSUS THE DUTY TO PROTECT: FORESEEABLE HARM IN THE PRACTICE OF PSYCHIATRY* (James Beck ed., 1990).

177. ALAN STONE, *The Tarasoff Case and Some of Its Progeny: Suing Psychotherapists to Safeguard Society*, in *LAW, PSYCHIATRY AND MORALITY* (1984).

178. See Daniel J. Givelber et al., *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 497 (1984).

## 2. Requirements to Report Child, Domestic, and Therapist Abuse

Two types of reporting laws designed for primary care physicians rather than psychotherapists have also led to some concern. The earlier and more common type is the child abuse reporting laws. While versions in the fifty-one jurisdictions vary, most require a variety of professionals to report if they have "reason to believe" that child physical or sexual abuse has occurred.<sup>179</sup> More recently, several states have added a requirement to report sexual abuse by previous psychotherapists,<sup>180</sup> and domestic abuse as well.<sup>181</sup>

The child abuse reporting laws are relatively noncontroversial, as they apply to clinicians such as pediatricians and emergency physicians who see the victims. The problems arise when therapists treat the perpetrators, or treat adults who were abused as children. Few child abuse reporting laws have statutes of limitations, so the laws may mandate reporting even when the perpetrator is dead.

Instead of serving society by treating abusers, these laws force clinicians to betray their patients by making reports to the police, and in most states subsequently testifying against their patients in criminal court.<sup>182</sup> Some treating therapists even feel compelled to give *Miranda*-type warnings to patients at the onset of therapy, warning them about all the situations in which confidentiality must be breached. Such warnings hardly provide the environment

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179. See, e.g., COLO. REV. STAT. § 19-3-304(1) (Supp. 1990):

Any person specified in subsection (2) who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect shall immediately report . . . such fact to the county department or local law enforcement agency.

Subsection (2) includes physicians, nurses, and mental health professionals. *Id.* §§ 19-3-304(2)(a), (i), (n). Several authors argue that mandated reporting of child abuse may give therapists leverage with resistant patients, at the cost of upsetting the balance even more away from patients and toward therapists. See Elizabeth Anderson et al., *Coercive Uses of Mandatory Reporting in Therapeutic Relationships*, 11 BEHAV. SCI. & L. 335 (1993). Anderson and her co-authors interviewed 30 therapists who had made child abuse reports concerning children or families already in treatment with them during the previous 12 months. They found that therapists had mixed feelings about the mandate to report: many therapists resented the forced role of policeman, were concerned about their legal liability, and/or blamed the patient for the predicament; other therapists welcomed the authority under the law to effect changes in dysfunctional family systems. *Id.* at 342-44.

180. California requires only that psychotherapists who become aware that a patient has sexual contact with a previous therapist provide the patient with a brochure prepared by the state which describes, among many other things, administrative, civil, and other complaint procedures and remedies. CAL. BUS. & PROF. CODE §§ 337, 728 (1990). Wisconsin requires that a therapist who has reason to believe that a current client had sexual contact on or after May 16, 1996, with a previous therapist, ask the client if he or she wants the contact reported. WIS. STAT. ANN. § 940.22(3)(a) (West 1996). Reports cannot be made without client consent, and clients can decide whether to have their identities revealed in the report. *Id.* Immunity from liability for good faith reporting is provided. *Id.* at § 940.22(5). Failure to follow the statute's requirements is a Class A misdemeanor. *Id.* at § 940.22(3)(d).

181. See COLO. REV. STAT. ANN. § 12-36-135(1) (West 1996) (requiring reporting of domestic abuse as well as gunshot wounds and other injuries or illnesses that appear to result from criminal behavior).

182. See generally Robert D. Miller & Robert Weinstock, *Conflict of Interest Between Therapist-patient Confidentiality and the Duty to Report Sexual Abuse of Children*, 5 BEHAV. SCI. & L. 161 (1987).

of safety and trust so essential to successful psychotherapy.

In cases in which therapists are treating adult victims of child or domestic abuse, mandatory reporting can force patients to deal with their histories of abuse publicly before they have been able to resolve their feelings in therapy. The same is true in those states that require therapists to make reports when patients tell them of abuse by previous therapists.<sup>183</sup>

### 3. Antitrust Litigation

Courts had traditionally stayed out of the regulation of intraprofessional disputes, basing their position on the "learned professions" exception.<sup>184</sup> More recently, however, courts have decided that since medical facilities receive equipment and supplies through interstate commerce, the federal courts have jurisdiction under antitrust law.<sup>185</sup> This change of policy has been used by clinicians, including psychiatrists and psychologists, to overturn disciplinary actions by hospital credentials and peer review committees, as well as by licensing boards. Sanctioned clinicians, particularly those who lost privileges or licenses, have argued successfully, and sometimes unfortunately, that their disciplinary actions had economic bases, to reduce competition with established clinicians in the field. This use of antitrust litigation for covert purposes subverts those legitimate efforts to improve the quality of clinical practice, and the public has been justifiably concerned that internal regulatory agencies in all professions do not adequately police their professions. Even where litigation does not overturn a disciplinary action, regulatory boards—especially hospital-based boards, whose member clinicians are understandably reluctant to spend their time in court rather than treating patients—are increasingly intimidated and less willing to implement their professional judgment.

Another type of institutional coercion of both clinicians and their patients involves competency to be executed. The Supreme Court has interpreted the Eighth Amendment's bar on cruel and unusual punishment to proscribe execution of the incompetent.<sup>186</sup> This raised the issue of which methods states could use to restore a death row inmate's competency so that the state could execute him. Clinicians who evaluate death row inmates for competency for execution, particularly those required to treat incompetent inmates, are placed in an ethical dilemma,<sup>187</sup> although one can argue that for physicians to refuse

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183. See generally Larry Strasburger et al., *Mandatory Reporting of Sexually Exploitative Psychotherapists*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 379 (1990).

184. *Arizona v. Maricopa Med. Soc'y*, 457 U.S. 332, 348-49 (1982) (explaining that challenged conduct of professionals is subject to "the rule of reason" versus a per se analysis under the Sherman Act where acts are "premised on public service or ethical norms"); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975) (finding that while the professions were not immune from prosecution under the Sherman Act, the "public service aspect" versus "a pure business aspect" of a profession justified treating acts which technically violate the law "differently").

185. Robert D. Miller, *Recent Developments in Antitrust: Challenges to Medical Autonomy*, in LEGAL IMPLICATIONS OF HOSPITAL POLICIES AND PRACTICES 70-71 (Robert D. Miller ed., 1989).

186. See *Ford v. Wainwright*, 477 U.S. 399, 410 (1986).

187. See, e.g., Michael L. Radelet & George W. Barnard, *Treating Those Found Incompetent for Execution: Ethical Chaos with Only One Solution*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 297 (1988); see also Robert D. Miller, *Evaluation of and Treatment to Competency to Be Executed: A National Survey and an Analysis*, 16 J. PSYCHIATRY & L. 67 (1988).

to evaluate inmates who may be incompetent for execution denies the inmates the chance to be found incompetent and avoid execution.<sup>188</sup> Professor Barbara Ward argues that treating incompetent death row inmates perpetuates their suffering, denies those who would prefer execution that right, and denies those few who might have the ability to make substantial contributions to postconviction procedures.<sup>189</sup>

One position statement, co-authored by physician and antideath penalty groups, refers to involvement in the physical aspects of execution (inserting intravenous lines, pronouncing death, etc.), but there is a section on psychiatric participation that holds evaluation of competence for execution to be unethical and treatment to restore competence for execution unethical except for cases of "extreme suffering or immediate danger to life."<sup>190</sup> The International Academy of Law and Mental Health, the world's largest interdisciplinary mental health organization, adopted the position as its own in June of 1994.<sup>191</sup>

Some courts and legislatures have dealt substantively with the issue of competence for execution. In *Perry v. Louisiana*,<sup>192</sup> the Supreme Court remanded the case of an incompetent inmate who the state wanted to forcibly medicate back to the Louisiana Supreme Court to consider the case in light of *Harper*.<sup>193</sup> The Louisiana court subsequently held that the state may not involuntarily medicate a prisoner to render him competent for execution.<sup>194</sup> The court found that such practices constituted cruel and unusual punishment under Louisiana's constitution, and violated an inmate's right to privacy.<sup>195</sup> The court stated that "forcing a prisoner to take antipsychotic drugs to facilitate his execution does not constitute medical treatment but is antithetical to the basic principles of the healing arts."<sup>196</sup> Citing the Hippocratic Oath, the court argued that forcing a physician to medicate an incompetent death row inmate forces him to act unethically and contrary to the goals of medical treatment.<sup>197</sup>

The South Carolina Supreme Court has also held that forced medication violates inmates' privacy rights,<sup>198</sup> and in addition two state legislatures have also addressed the issue. The Maryland legislature stated:

If the court finds [an] inmate to be incompetent [to be executed] it shall stay any warrant of execution . . . and remand the case to the court in which the sentence of death was imposed, which shall strike

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188. See generally Barbara A. Ward, *Competency for Execution: Problems in Law and Psychiatry*, 14 FLA. ST. U.L. REV. 35 (1986).

189. *Id.*

190. AMERICAN COLLEGE OF PHYSICIANS ET AL., BREACH OF TRUST: PHYSICIAN PARTICIPATION IN EXECUTIONS IN THE UNITED STATES 31, 33 (1994) (emphasis in original).

191. Personal Communication with Gregg Bloche (July 15, 1994).

192. 498 U.S. 38 (1990).

193. *Perry*, 498 U.S. at 38.

194. *Perry v. Louisiana*, 610 So. 2d 746, 758 (La. 1992).

195. *Id.* at 761.

196. *Id.* at 751.

197. *Id.* at 752.

198. *Singleton v. State*, 313 S.C. 2d 75, 87-90 (1993).

the sentence of death and enter in its place a sentence of life imprisonment without the possibility of parole.<sup>199</sup>

Montana law does not provide for automatic commutation of a death sentence upon a finding of incompetence for execution, but does state that "[i]f . . . the court is of the view that so much time has elapsed since the commitment of the defendant that it would be unjust to proceed with execution of the sentence, the court may suspend the execution of the sentence and may order the defendant to be discharged."<sup>200</sup>

Regardless of a particular state's approach to execution of incompetent inmates, however, the process is fundamentally a powerful example of clinicians being coerced to be agents of the state, with their "patients" again the ultimate sufferers.

### B. *Involuntary Civil Commitment*

While it is apparent that involuntary civil commitment coerces the patient, it is less often recognized that it also coerces therapists. That can serve a positive purpose—patients who have fears of abandonment report that they are reassured when they are committed to treatment by a particular therapist.<sup>201</sup> But it can also place additional burdens on outpatient therapists, particularly in the post-*Tarasoff* era. Courts are more likely to hold outpatient therapists responsible for patients that are committed to their care than to purely voluntary patients.<sup>202</sup> For this, as well as ideological reasons, a significant number of outpatient therapists do not accept committed outpatients, with the usual result being an involuntary hospitalization that could in most cases have been avoided if the therapist had accepted the challenge in spite of the increased risk of liability.<sup>203</sup>

### C. *Economic Coercion*

This article considered direct economic coercion on patients above;<sup>204</sup> but pressures that affect patients are increasingly applied to their treaters. As state mental hospitals became economic liabilities, and as the private psychiatric hospitals and psychiatric units in general hospitals rejected indigent patients, public hospitals assumed the character and function of warehouses. Clinicians were still responsible for providing adequate treatment with dwindling resources, and assumed the liability when it was not provided.<sup>205</sup>

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199. MD. CODE ANN. art. 27 § 75A(d)(3) (1996).

200. MONT. CODE ANN. § 46-19-202(3) (1995).

201. See generally Katherine Schneider-Braus, *Civil Commitment to Outpatient Psychotherapy: A Case Study*, 14 BULL. AM. ACAD. PSYCHIATRY & L. 273 (1986).

202. See, e.g., *Cain v. Rijken*, 300 Or. 706 (1986).

203. See Robert D. Miller & Paul B. Fiddleman, *Outpatient Commitment: Treatment in the Least Restrictive Environment*, 45 HOSP. & COMMUNITY PSYCHIATRY 147 (1984).

204. See *supra* notes 22-25 and accompanying text.

205. See generally Robert Gibson, *The Rights of Staff in the Treatment of the Mentally Ill*, 27 HOSP. & COMMUNITY PSYCHIATRY 855 (1976); Stephen Rachlin, *One Right Too Many*, 3 BULL. AM. ACAD. PSYCHIATRY & L. 99 (1975).

Just when the right to treatment suits appeared to have effected significant improvements in public hospitals, however, states found ways to create new classes of "patients" without providing the resources to provide even minimal treatment. One example comes from Wisconsin, previously hailed for its attention to patient rights and its willingness to provide sufficient resources to ensure adequate treatment. Recognizing that some insanity acquittees were in effect political prisoners, and others were refusing to participate in any treatment, the state mental health authority proposed legislation that would classify acquittees as either "patients" or "detainees." "Patients" would be provided with the full range of appropriate treatment, while "detainees" would be warehoused. The clinicians at the forensic facility initially supported the concept, as the plan allowed them to concentrate their resources on treatable patients. But when staff learned that the mental health authority, without consultation with the staff responsible for treatment, had classified seventy-five percent of the 200 acquittees as "detainees" (the staff put the number at twenty-five percent) in order to cut costs, the staff openly opposed the proposed classification. They were able to convince advocacy groups (which had also initially supported the proposal) to oppose the legislation, and it was defeated.

More troubling is the fact that the legislatures that have created the new sexual predator laws have not attempted to provide adequate funding for meaningful treatment.<sup>206</sup> These programs place clinicians in the conundrum of having to provide treatment to a population which engenders, arguably, the most public and political concern, without providing the resources necessary to effect any changes—a virtual guarantee that treatment will fail. Predictions that sex offenders are inevitable treatment failures become self-fulfilling prophecy, seemingly justifying indefinite commitments.

An allied offensive against sex offenders that attempts to legitimize its punitive intent by involving psychiatrists is forced "chemical castration" of child molesters. California Assembly Bill No. 3339, signed by Governor Wilson on September 17, 1996, authorizes judges to require convicted child molesters to take medroxyprogesterone acetate (Depo-Provera),<sup>207</sup> a medication that reduces the level of testosterone, the male hormone, in a dose-dependent fashion. The FDA has not approved the medication for use with male sex offenders. The California law requires no medical evaluation to determine if the medication is safe to administer, or clinically indicated. Depo-Provera has been shown to be effective with perhaps ten percent of sex offenders—those with abnormally high sexual arousal or sexual fantasy levels.<sup>208</sup>

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206. Washington State opened its unit with virtually no staff. See *Young v. Weston*, 898 F. Supp. 744 (W.D. Wash. 1995). One of the reasons that the Kansas Supreme Court rejected its state's law, see *Matter of Hendricks*, 912 P.2d 129 (Kan. 1996), was because when the first "patient" was committed, there was no program at all in place. See American Psychiatric Ass'n, *Position Statement on the Adequacy of Treatment*, 123 AM. J. PSYCHIATRY 1468 (1967). Proposed legislation in Colorado also has woefully inadequate funding.

207. CAL. PENAL CODE § 645(a) (West 1988 & Supp. 1997). The law mandates treatment for parolees convicted of a second offense involving a child under 13. *Id.* § 645(b).

208. See, e.g., David Barry & J. Richard Ciccone, *Use of Depo-Provera in the Treatment of Aggressive Sexual Offenders: Preliminary Report of Three Cases*, 3 BULL. AM. ACAD. PSYCHIATRY & L. 179 (1975); John M.W. Bradford, *The Hormonal Treatment of Sexual Offenders*, 11

The Colorado legislature is currently debating a bill based on the California law. It adds a number of medications as possible alternatives to Depo-Provera, none of which are FDA-approved for male sex offenders, most of which have not been shown to have any efficacy with such patients, and one of which is not even legal to prescribe in the United States. Like the California law, it requires judges to sentence child molesters to treatment without following any clinical evaluation, for the purposes of "chemical castration."<sup>209</sup>

In similar circumstances, the Michigan Court of Appeals in *People v. Gauntlett*<sup>210</sup> overturned a judge's sentence of forced Depo-Provera treatment as a condition of probation, finding the condition punitive, unlawful, and coercive,<sup>211</sup> as well as virtually impossible to perform with informed "consent."<sup>212</sup> Further, the court held that "Depo-Provera treatment fails as a lawful condition of probation because it has not gained acceptance in the medical community as a safe and reliable medical procedure."<sup>213</sup> Apparently this court's reasoning did not impress California or Colorado legislators.

Luckily, few mental health professionals will fall into the legal quagmire of determining "competence" to "consent" to Depo-Provera treatment. Many more, however, will face issues of providing adequate care in the world of managed care. Parity for insurance coverage was discussed above,<sup>214</sup> but here I am concerned with the pressures that many managed care corporations place on employee/clinicians and the concomitant inferior care received by the supposed clients of the corporation. Managed care, in its single-minded attention to the bottom line, has "deprofessionalized" mental health care to an unprecedented degree. Front line mental health services are typically provided by therapists with bachelor's or at best master's degrees, with access to psychiatrists (who remain the only practitioners capable of diagnosing biological mental disorders and providing medications and other physical treatments that such patients require) severely limited by financial penalties for "excess" referrals.<sup>215</sup>

Edward Hanin and Harold Schwartz cite data on medication reimburse-

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BULL. AM. ACAD. PSYCHIATRY & L. 159 (1983); John Money, *Use of an Androgen-depleting Hormone in the Treatment of Male Sex Offenders*, 6 J. SEX RES. 165 (1970). These articles are representative of the literature which fails to condone using anti-androgen medication for "chemical castration." Note that a California parolee can avoid Depo-Provera treatment by voluntarily undergoing a "permanent, surgical alternative." CAL. PENAL CODE § 645(e).

209. See Robert D. Miller, *The Forced Administration of Sex-drive Reducing Medications to Sex Offenders: Treatment or Punishment?*, in PSYCHOLOGY, PUBLIC POLICY AND LAW (forthcoming 1998).

210. 134 Mich. App. 737 (1984).

211. *Gauntlett*, 134 Mich. App. at 747-50.

212. *Id.* at 751.

213. *Id.* at 750.

214. See *supra* note 151 and accompanying text.

215. See, e.g., Edward Hanin, *The Regulating Effect of the Managed Care Movement*, in PSYCHIATRIC PRACTICE UNDER FIRE: THE INFLUENCE OF GOVERNMENT, THE MEDIA AND SPECIAL INTERESTS ON SOMATIC THERAPIES 147-69 (Harold Schwartz ed., 1994); Harold Schwartz, *The Impact of Cost-Containment Measures on Somatic Psychiatry*, in PSYCHIATRIC PRACTICE UNDER FIRE: THE INFLUENCE OF GOVERNMENT, THE MEDIA AND SPECIAL INTERESTS ON SOMATIC THERAPIES 135-46 (Harold Schwartz ed., 1994).



ment caps, capitation, prospective drug use review, restricted formularies, preferred pharmacy networks, copayment plans, "economic credentialing," and the use of nonmedical professionals to screen mentally disordered patients.<sup>216</sup> Although comprehensive data are not yet available, Dr. Schwartz presents data from a number of studies that suggest that these practices limit the appropriate use of psychiatrists and psychiatric somatic treatments on nonclinical bases.<sup>217</sup> Psychiatrists who have actively opposed such practices are certainly motivated in part by their own economic self interests, but they chose their professions in larger part to provide service to mentally disordered persons, and are systematically being prevented from doing so by purely economic factors. But psychiatrists often find themselves in the dilemma of obeying their masters on possible penalty of losing their jobs, while simultaneously risking malpractice suits for delivering care that they themselves know is inadequate.<sup>218</sup>

A number of cases have addressed the responsibility of managed care organizations to provide adequate medical care. In *Wickline v. State*,<sup>219</sup> the California Court of Appeals held that Medi-Cal was not liable when a physician discharged a patient too soon and post-operative complications ensued,<sup>220</sup> but it did observe that "[t]hird party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms." In *Hughes v. Blue Cross of Northern California*,<sup>221</sup> Blue Cross retrospectively denied payment for several hospitalizations, arguing that the hospital had not provided adequate records to justify the hospitalizations.<sup>222</sup> The California Court of Appeals affirmed the trial court's verdict for the plaintiff, including punitive damages, holding that Blue Cross failed to make reasonable efforts to obtain adequate information.<sup>223</sup> In *Harrell v. Total Health Care, Inc.*,<sup>224</sup> the Missouri Court of Appeals found that a state statute exempting a managed care entity from liability for negligence was constitutional, and that the legislature could distinguish between hospitals, which are liable for negligence in selecting and supervising staff, and managed care entities, which are not.<sup>225</sup>

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216. *Id.*

217. Schwartz, *supra* note 215.

218. *Id.*; see also Paul Appelbaum, *Legal Liability and Managed Care*, 48 AM. PSYCHOLOGIST 251 (1993).

219. 228 Cal. Rptr. 661 (1986).

220. *Wickline*, 228 Cal. Rptr. at 672. The court stated:

This court appreciates that what is at issue here is the effect of cost containment programs upon the professional judgment of physicians to prescribe hospital treatment for patients requiring the same. While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment. We have concluded, from the facts in issue here, that in this case it did not.

*Id.*

221. 245 Cal. Rptr. 273 (1988).

222. *Hughes*, 245 Cal. Rptr. at 276-77.

223. *Id.* at 279.

224. 781 S.W.2d 58 (Mo. Ct. App. 1989).

225. *Harrell*, 781 S.W.2d at 62-64.

#### D. *Internal Moral Coercion on Clinicians*

The legal concept of rights under which legal activists operate is a relatively recent historical phenomenon, but it has become so dominant in the United States that it is taken for granted. Although individual rights have lost some of their preeminent status recently, attempts to utilize different concepts of rights have met with rejection by the prevailing culture. Under the Greek theory of natural rights,<sup>226</sup> which established the original basis for the practice of medicine, the "wise man," a category which included the physician, had the duty to restore patients to physical and mental health so that they could fulfill their obligations as citizens. Those afflicted with mental or physical illnesses had a concomitant responsibility to cooperate with their physicians by following their orders.

Talcott Parsons, in his discussion of the "sick role,"<sup>227</sup> followed the Greek concept by arguing that there are four aspects of the social expectation system relative to the sick role: 1) an exemption from normal social role responsibilities, with such exemption requiring legitimization, ultimately by physicians, and imposing obligations on the patient; 2) no expectation that the sick person can get well by an act of decision or will; 3) definition of the illness as an undesirable state, and desire by the patient to get well; and 4) a requirement that the patient seek technically competent help and cooperate with the helper in trying to get well. Because of "secondary gain," a patient may be motivated to continue the privileges and exemptions of the sick role.<sup>228</sup> Just as it is the patient's obligation to cooperate in getting well, it is the physician's obligation to "do his part" in helping the patient to get well. Parsons did not explicitly consider the societal obligations of the physician to restore his patients to health, so that they may (in Parsons' words) become "functional" again.<sup>229</sup>

Physicians, including psychiatrists, continue to be socialized in their training to be responsible for the health of their patients, although the sense of responsibility is usually so covert as to be almost subliminal. When they accept patients—particularly patients that are legally committed to their care—who refuse the prescribed treatment—especially if they do so because they deny the very disorder for which treatment is being recommended—it places physicians in a considerable, if usually unexamined, ethical and professional bind.

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226. See Leonard Kaplan & Robert D. Miller, *Law, Psychiatry and Rights*, presented at the 15th International Congress on Law and Mental Health, Jerusalem, Israel (June 26, 1989) (on file with author).

227. TALCOTT PARSONS, *THE SOCIAL SYSTEM* 428-79 (1951).

228. Goffman first discussed impression management by apparently mentally disordered persons. See generally ERVING GOFFMAN, *THE PRESENTATION OF SELF IN EVERYDAY LIFE* (1959). Subsequent controlled research studies verify that patients diagnosed with schizophrenia are quite capable of varying their behavior and reported thinking, depending on their goals in the situation. See Benjamin Braginski & Dorothea Braginski, *Schizophrenic Patients in the Psychiatric Interview: An Experimental Study of Their Effectiveness at Manipulation*, 31 *J. CONSULTING PSYCHOL.* 543 (1967); Mark Sherman et al., *Impression Management in the Psychiatric Interview: Quality, Style, and Individual Differences*, 43 *J. CONSULTING & CLINICAL PSYCHOL.* 867 (1975).

229. PARSONS, *supra* note 227.

Nonmedical mental health professionals are socialized in different ways and are, as a result, demonstrably less authoritarian in their relationships with their clients.<sup>230</sup> Nonpsychiatric physicians are subject to the same professional pressures as are psychiatrists; but they have several escape clauses not available to psychiatrists. Most important, with rare exceptions, patients are not legally committed to nonpsychiatric physicians. Those doctors, therefore, have the option of terminating the physician-patient relationship with patients that refuse to accept their recommendations. Nonpsychiatric physicians also frequently will not treat mentally disordered patients even for their nonpsychiatric illnesses, referring them instead to psychiatrists.

## VII. DISCUSSION

We live in a society in which coercion—governmental and private, overt and covert, subtle and dramatic—impacts on everyone in some way or another, but mentally disordered persons are perhaps subject to more coercion than most other groups. In order to utilize the benefits of coercion while minimizing the negative, socially unproductive effects, it is essential that *all* types of coercion be considered. It is not sufficient to examine part of the elephant and conclude that the problems are understood, much less solved. Legal rights are certainly important, but they remain only one small part of the picture. Single-minded attention to legal rights has led to increases in other types of coercion of mentally disordered persons that are at times arguably worse than the abolished or modified coercion.<sup>231</sup>

Before the civil rights litigation of the 1960s and '70s, psychiatrists largely called the shots in dealing with mentally disordered persons. They resisted intrusion by the courts into what they considered areas of clinical expertise. They resented restrictive civil commitment statutes, the recognition of a right to refuse treatment, and various reporting duties.<sup>232</sup> By staking out a narrow

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230. See Frank Baker & Herbert Schulberg, *The Development of a Community Mental Health Ideology Scale*, 3 COMMUNITY MENTAL HEALTH J. 216 (1967); Robert Langston, *Community Mental Health Centers and Community Mental Health Ideology*, 6 COMMUNITY MENTAL HEALTH J. 387 (1970). Even the terms by which different mental health professionals refer to the mentally disordered persons whom they treat demonstrate significant conceptual differences: medically-trained clinicians (psychiatrists and nurses) use the term "patient," while nonmedical clinicians (psychologists, social workers, and other therapists) prefer "client."

231. In a classic paper, Penrose argued that the distribution of "socially undesirable" persons in prisons or mental hospitals depends on the availability of hospitals and the thoroughness of the psychiatric evaluations. See generally L.S. Penrose, *Mental Disease and Crime: Outline of a Comparative Study of European Statistics*, 18 BRIT. J. MED. PSYCHOL. 1 (1939). His observations have come to be called the "hydraulic theory," which holds that societal tolerance for deviant behavior is limited, and that if one repository for such persons is reduced (e.g., limiting involuntary psychiatric hospitalization,) another (e.g., incarceration in the criminal justice system) will expand to respond to the social need. While the situation he described is certainly unfortunate, it is also the reality that must be fully considered in analyzing coercion.

232. In the Council of the American Psychiatric Association, *Position Statement on the Adequacy of Treatment*, 123 AM. J. PSYCHIATRY 1458 (1967), the Council rebuffed judicial efforts to establish a right to treatment, stating, "The definition of treatment and the appraisal of its adequacy are matters for medical determination. Final authority with respect to interpreting the law on the subject rests with the courts." The American Psychiatric Association for years steadfastly opposed court inquiry into such matters, and in fact refused to submit a brief to the court in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), recommending clinical standards when requested to

territory, attorneys and advocates wrested hegemony over those aspects of mental health care that impinged on civil rights. Activist patient groups have rejected the goals of both clinicians and advocates in favor of just being left alone.<sup>233</sup> Groups representing families of mentally disordered persons, such as the National Alliance for the Mentally Ill, have supported easier access to treatment, and have generally sided with the psychiatrists. The National Mental Health Association has supported legal rights in some situations and clinical rights in others.

Addressing unproductive coercion effectively will require collaboration among all the groups concerned with mentally disordered persons. The extremists in each camp must moderate their positions and be willing to compromise or they remain a major part of the problem, rather than the solution. Adversarial roles will continue to be important in individual cases, but as they, by definition, ignore the larger systemic issues, they do not contribute to system solutions.<sup>234</sup> Litigation will still be necessary in individual situations in which the legislative and executive branches of government are unwilling to provide adequate resources. It is not, however, sufficient to deal with multisystem problems, especially with the "hands off" policies currently in vogue in federal courts. Legislative action will be essential, and legislators are more responsive when all the interest groups concerned are in accord.<sup>235</sup>

There must be some common ground among those groups for progress to be made. One axiom that must be accepted is that mental illness is not a myth, and that at least some mental disorders are biological diseases that respond to

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do so. Fortunately, the APA has changed its position significantly since those days, and now regularly submits amicus briefs to the Supreme Court on issues involving mentally disordered persons, and assists local chapters of the Association in state and lower federal court cases.

233. The problem, of course, is that if "left alone" by the mental health system, their behavior will not allow the mentally disordered to be left alone by the many other systems of social control, such as the police, social services, etc. If they choose the latter course competently, then that choice should certainly be respected. The conflict arises when the mentally disordered make self-destructive choices based on treatable mental disorders. The issue is not merely an individual's right to privacy, because most mentally disordered persons who are not committed to psychiatric treatment, or who are committed but not required to take medication, consume governmental resources that would not be required if they were to be treated effectively, even against their stated wishes.

234. When the author served as director of the admissions unit at a state mental hospital, he organized regular meetings with the chief judge, sheriff, police chief, district attorney's office, public defender's office, community mental health center director, and social services liaison for the hospital's major catchment area, to coordinate plans for a small but very difficult population of mentally disordered persons who bounced back and forth among all the social systems in the area. Before the meetings, no system would accept responsibility for these patients, and there was nothing resembling continuity of care. At the meetings, individual treatment plans were developed for each person. Outpatient and inpatient mental health services, as well as correctional and social service involvement, were apportioned according to the behavior and degree of mental disorder of each person. As a result, the systems were able to work together with these very difficult patients, rather than dumping them back and forth amongst themselves. The severity of mental disorder and the criminal behaviors both decreased significantly, and remained at a low level over time.

235. The parity legislation discussed above in note 151 passed despite significant dissension among the various mental health professional groups. Psychiatrists (who had the most to gain, since the disorders covered are those usually treated with psychotropic medications) supported the legislation, while other clinical organizations either abstained or opposed the legislation. Such guild-based dissension highlights the various mental health professions' economic interests in parity and similar legislation, and thereby significantly weakens the credibility of its advocates.

treatment with medications and other organic methods.<sup>236</sup> Another is that mental disorders vary significantly in their severity and in their effects on individual patients' autonomy. A third is that the goal of treatment must be to restore patients' autonomy, and that patients' wishes must be respected as much as possible, as the more voluntary and collaborative the treatment, the more effective it is likely to prove.<sup>237</sup> It is here that the findings of procedural justice research are particularly important—psychiatrists have not traditionally been trained to listen to their patients' wishes in areas of biological treatment; when they do so, many of the problems disappear.<sup>238</sup>

Planning groups must consider the ripple effects of litigation and legislation, and avoid disasters such as deinstitutionalization which resulted in patients being "involuntarily communitized"<sup>239</sup> before adequate resources in the community were available. One current example of similar problems is the movement to reverse the criminalization of mentally disordered persons through jail diversion programs.<sup>240</sup> As with the deinstitutionalization of civil psychiatric hospitals, there is considerable consensus that many mentally disordered inmates charged with minor crimes do not belong in jail. It is not difficult to remove mentally disordered persons from jails; what *is* difficult is to find a place to send them. Those diversion programs that are effective work because there are community mental health facilities willing to accept the responsibility of treating those diverted.<sup>241</sup>

The placement of mentally disordered prison inmates is even more difficult. Many inmates committed crimes in part because they could or would not

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236. Psychotherapy is not usually as effective as medication under coercive conditions, though Katherine Schneider-Braus would disagree. See Schneider-Braus, *supra* note 201. Dr. Schneider-Braus reported that her patient became more invested in treatment after being committed, because she felt that the therapist was also committed to her under the court order, and thus would not abandon her. *Id.*

237. Medications are effective with noncooperative—but not with non-compliant—patients. Hiday and Scheid-Cook have reported that patients involuntarily committed to outpatient treatment, including court orders for medication, were highly compliant with the medication, but long-term treatment necessitates that patients accept their need for medication and take it because they know that it helps them, not because of a court order. See Hiday & Scheid-Cook, *supra* note 63.

238. A careful reading of *Rennie v. Klein*, 462 F. Supp. 1131 (D. N.J. 1978), indicates that Rennie was not so much refusing *treatment* as he was specific medications that the psychiatrist was prescribing for him. It is possible that had the psychiatrist been more receptive to Rennie's preferences, there might never have been a legal case.

239. Stephen Rachlin, *With Liberty and Psychosis for All*, 48 PSYCHIATRIC Q. 410, 410 (1974).

240. See STEADMAN ET AL., *supra* note 79.

241. See *id.* Steadman and his co-authors make a persuasive case that jails are part of the community, and therefore inmates should receive mental health care from community mental health centers. Where the centers accept the responsibility to provide treatment to persons involved with the criminal justice system, diversion is quite effective. Even when community centers are willing to become involved, however, obstacles remain. For example, many states indemnify local service providers from liability that arises from treatment of such patients; but the Colorado state constitution prohibits such protections:

Neither the state, nor any county, city, town, township or school district shall lend or pledge the credit or faith thereof, directly or indirectly, in any manner to, or in aid of, any person, company or corporation, public or private, for any amount, or for any purpose whatever; or become responsible for any debt, contract or liability of any person, company or corporation, public or private, in or out of the state.

COLO. CONST. art. XI, § 1.

receive treatment in the community. As difficult as it is to obtain treatment before a felony conviction, the convicted felon is even less likely to receive treatment, in part because community mental health centers justifiably fear liability if the future parolee commits additional violent acts. As a result of these obstacles, the sad reality is that many mentally disordered persons receive better mental health care in prisons than they do in the community, and the lack of community facilities willing to accept parolees prolongs their incarcerations. Approaches to this problem require cooperation between the local and state correctional systems, the state and community mental health systems, and often the legislature as well. When all elements work together, diversion programs are demonstrably effective.

Areas in which interdisciplinary cooperation can reduce unnecessary coercion of mentally disordered persons include providing relevant information to legislatures and state bureaucracies concerning requirements to report confidential information about patients (such as the duties to protect third persons, and to report child, elder and domestic abuse) and other legislation affecting mentally disordered persons such as sexual predator acts, chemical castration, and changes in civil commitment law. Further, professional licensing boards should be furnished current data in areas such as the medically appropriate use of anti-anxiety, psychostimulant, and narcotic medications.

A combination of the concepts of procedural justice and therapeutic jurisprudence would seem to provide the best hope of stimulating the interdisciplinary and cross-system collaboration which is essential if meaningful answers to the problems of coercion in all its guises are to be successfully addressed.

#### VIII. SUMMARY

Those genuinely concerned with mentally disordered persons can no longer afford to specialize in one part of the problem. The majority of coercion currently experienced by mentally disordered persons does not come from direct state action, and efforts to convince the federal courts to create new legal rights to community-based treatment are not meeting with the success that earlier suits against hospitals did. Thus, the adversarial approach (even when the clinician defendants actually agree with the complaints)<sup>242</sup> is not only divisive, but has lost much of its effectiveness in reducing total coercion. The social and economic problems responsible for most coercion in practice can be dealt with only through interdisciplinary cooperation.

The apparent conflict between legal and clinical rights is more illusory than real; observation of legal rights does not need to interfere with the provision of clinical rights. In fact, the two can work together as long as each side considers the broader systemic issues discussed in this article. It is only when extremists on either side ignore the rest of the elephant that problems occur. *Appropriate* recognition of the civil rights of mentally disordered persons has led to greater autonomy, as well as better treatment, for patients. But when

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242. See *Conference Report*, *supra* note 142, at 124.

ideologues refuse to listen to other viewpoints, and act as if their positions are the only acceptable ones, problems will and do occur. Libertarians cannot continue to use legal methods as covert abolitionist techniques to coerce their ideological opponents (and even their supposed "clients" at times); and clinicians cannot continue to undermine the observation of legitimate patient rights.

This is not a plea by a clinician to return to the "good old days" before the courts began to take an active interest in mental health issues. Judicial oversight is important symbolically as well as practically, even where judges defer to clinical judgments. The major problems with the current due process protections is not that they prevent needed treatment, but that they delay it excessively.<sup>243</sup> As with justice, "treatment delayed"<sup>244</sup> may be better than no treatment at all; but that should not be the choice.

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243. The time period between clinicians' requests for court hearings on involuntary medications vary, but are usually measured in weeks to months. See Miller et al., *supra* note 55.

244. *Pierce County v. Western State Hosp.*, 97 Wash. 2d 264, 270 (1982) (stating that "[t]reatment delayed and inadequate must surely be better than no treatment at all," and ordering Washington State Hospital to cease its moratorium on admissions in spite of severe overcrowding which resulted in patients sleeping on cots in halls).