BOOK REVIEW

Mental Health Law: Major Issues. By David B. Wexler. Plenum Press, New York, 1981. Pp. 270.

> We are told a judicial proceeding of some kind should be had to determine the fact of insanity, and have the proper legal sanction for the confinement of the individual in some hospital. . . . [W]hat good purpose is gained by taking the decision of such questions out of the hands of medical men and placing them in the hands of judges and a jury of twelve men? None whatsoever, as far as we are able to see, but much harm. . .by confirming in the minds of the insane the impression, too often held, that they are criminals, and thus giving countenance to the idea, which all right-minded people have for years been endeavoring to efface, that the insane were to be treated as criminals, and not as those who were afflicted with the severest form of disorder to which flesh is subject.[1]

The debate over the degree of legal control that best comports with proper treatment of the mentally ill is not new. Even the Committee on Admission of Patients into Insane Asylums of the Medical Society of Pennsylvania, which offered the above opinion in 1869, was struck by the seeming incongruity of applying standards and procedures devised for the adjudication of criminals to institute treatment of those afflicted with mental disease. Nevertheless, even the statute proposed by the committee and later enacted into law provided a number of procedural protections usually associated only with the criminal system.[2]

More than a century later, we continue to struggle with the same dilemma. Notions of fairness toward those subject to involuntary deprivation of liberty and the fear of abuse of unlimited discretion by physicians and family members appear to us to require procedural and substantive protections that sometimes interfere with optimal treatment for the mentally ill. As a society, we have vacillated repeatedly in our attempts to reach some equitable compromise between these two im-

1. *Report of the Committee on the Admission of Patients into Insane Asylums*, 5 TRANSACTIONS OF THE MED. SOC'Y OF PA. 318 (1869).

2. Act of April 8, 1869, 1869 Pa. Laws, Pub. L. No. 78.

portant considerations. During the first half of the nineteenth century, the Progressive era (roughly 1900-1920), the 1950's, and the early 1960's, a balance was struck in favor of more informal commitment procedures and broader substantive standards that expedited commitment and promised a greater chance of cure. In contrast, the latter part of the nineteenth century, the 1920's, 1930's, and the late 1960's to the present, were all periods in which our legal system tended to give greater weight to individual liberties and less to societal interests in treating mental illness. This emphasis on protection of individual liberties is reflected in more rigid procedural and substantive standards.

David Wexler's *Mental Health Law: Major Issues* is a collection of essays, each originally published in a somewhat different form during the last decade. The book is both a reflection of the latest period of concern for individual liberties and a documentary history of some of the major writings that gave impetus to that concern. Its publication now—when the mood of the public seems to have shifted away from the involvement with civil liberties that has characterized the last twenty-five years, and when the Supreme Court is poised to rule on some of the major issues addressed in the book[3]—provides us with an opportunity to reflect on the last fifteen years of activity by the mental health bar.

At the outset, a few words must be said about the structural aspects of *Mental Health Law*. The book's chapters are condensed and mildly reworked versions of papers that Wexler has published over the last decade. But unless one were already familiar with Wexler's work or read the "acknowledgements" at the start of the book very carefully, one might easily miss this fact. The title, the "blurbs" on the book's jacket, and above all the introduction give the impression that this is a work that comprehensively addresses the current issues in mental health law.

In fact, the coverage is uneven, since only those issues that Wexler chanced to address over the years are included. Behavior modification receives two chapters, and psychosurgery, which is rarely performed, one, although the more compelling issue of the right to refuse psychotropic medications is covered only cursorily. The introductory chapter labors hard to convince us that the book is a coherent whole, but aside from some transitional paragraphs at the beginning and end of each

3. Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980), *cert. granted*, 49 U.S.L.W. 3851 (May 18, 1981) (the constitution guarantees involuntarily committed mentally retarded persons a right to treatment consistent with the standard of care of the treating professions); Rogers v. Okin, 478 F.Supp. 1342 (D.Mass. 1979), *aff'd in part*, 634 F.2d 650 (1st Cir. 1980), *cert. granted*, 49 U.S.L.W. 3779 (April 20, 1981) (involuntarily committed mental patients have a constitutionally guaranteed right to refuse treatment with psychotropic medications).

chapter, it is clear that this represents not a text, but a collection of independent essays.

In addition, although an attempt at updating has been made, some anachronisms remain. I doubt if it was true even in 1973 and 1974, when the original papers on behavior modification were published, that "almost all chronic psychotics are still hospitalized."[4] Now, in the midst of a debate on *re*institutionalization, such a statement is decidedly out of place. In addition, it is certainly no longer true that all commitments are of determinate length in only a "small number of states."[5]

I stress this because the field of mental health law is being bombarded with new books and periodicals each year, many of them touted as definitive and up-to-date overviews of the subject. Confused practitioners, both lawyers and mental health clinicians, are left with little guidance as to which book might be of most use to them. Those who follow Wexler's work closely will find little new in this volume; those who are new to the field deserve a more straightforward account of its origins.

As one would expect from a work that reflects a period of recriminalization of the mental health system,[6] Wexler's book opens with a review of criminologic theory, particularly what he calls "therapeutic justice."[7] The first chapter mingles discussion of therapeutic approaches to criminality with the approach to involuntary treatment of the mentally ill as if these actions by the state represented two sides of the same coin. Of course, that is precisely Wexler's argument: State intervention designed to "alter behavior" without a person's consent rests on the same justifications and poses the same problems regardless of the source—mental illness or criminality—of the person's "deviance."

Wexler supports his argument by attempting to provide evidence of the abuses that occur in the "decriminalized" system. He offers a summary of one of the most famous studies of the mental health commitment system in action, his 1970-1971 examination of civil commitment in Arizona.[8] Wexler tells us that "[s]ince at the time of the study that justice system was very much under the control of physicians and psychiatrists, the study was in essence one of 'psychiatric justice,' and

4. D. WEXLER, MENTAL HEALTH LAW: MAJOR ISSUES 214-15 (1981).

5. *Id.* at 149; *State Laws Covering Civil Commitment*, 3 MENTAL DISABILITY L. REP. 206 (1979).

6. Recriminalization refers to the renewed tendency to superimpose upon the mental health system the protections provided the individual by the policies and rationales of the criminal law.

7. D. WEXLER, *supra* note 4, at 11.

8. *Id.* at 71.

will be referred to as such."[9] "Psychiatric justice," as contrasted to "real justice," is the kind of pejorative label that the Pennsylvania Medical Society committee was responding to in 1869, and implies that allowing discretion to reside in the hands of physicians inevitably results in abuses of individual rights.

When viewed in retrospect, what is remarkable about Wexler's study is how little its findings support such a conclusion. The system he examined allowed relatively little discretion to psychiatrists[10] and such abuses as he found originated elsewhere. Emergency petitions, providing entry into the involuntary system, were often filed by friends or family members and screened by a county agency before they reached a judge who could order an individual's detention for examination. Wexler's team found that the petitions were frequently inadequate or presented information in a conclusory manner, although county screeners often accepted them and judges frequently ordered detention anyway.[11] The facilities for detention varied from adequate, in one of the counties studied intensively, to utterly inadequate in other parts of the state where mentally ill detainees were often housed in jails.[12]

The formal commitment hearings that followed the detention period were even more problematic. Attorneys were often appointed immediately prior to the hearing and had no chance to prepare their cases. Cross-examination was perfunctory, hearings were brief, and conclusory psychiatric testimony often unchallenged, all despite the presence of strict substantive standards for commitment that required a showing of dangerousness. Attorneys were reluctant to argue vigorously against commitment when they believed that their clients were mentally ill.[13] Judges often made their decisions based solely on psychiatrists' conclusory recommendations, and psychiatrists were often grossly ignorant of the applicable legal standards.

Wexler's study clearly demonstrated two points. First, procedural protections for those allegedly in need of commitment were widely ignored by the county screening agencies, the patients' attorneys, and the judges themselves. Second, beyond offering conclusory testimony, which the experienced psychiatrist knows is often solicited by both counsel and fact-finder, psychiatrists had little to do with the deprivation of rights involved. Far from demonstrating the failure of "psychiatric justice," Wexler has shown how administrators, lawyers, and judges involved in the mental health system can subvert even a sub-

9. *Id.*
10. *Id.* at 72-75, 78.
11. *Id.* at 75-77.
12. *Id.* at 80-84.
13. *Id.* at 95-101.

stantially "criminalized" process. Nor is this the only study that makes these points. Almost every study of actual commitment practices, both those designed to show the evils of the old, "liberal" statutes of the 1960's[14] and those designed to evaluate the new, "civil libertarian" statutes of the 1970's,[15] reached similar conclusions. Confirming these findings are experimental interventions designed to train attorneys to be more aggressive in their representation of clients facing possible commitment.[16] Despite these studies, the lesson that Wexler and others draw from these data is that even more procedural safeguards are needed.[17]

What sort of explanation can be offered for the empirical evidence of Wexler and others that it is the legal side of the mental health system that seems to undercut the very procedural guarantees it is charged with enforcing? To answer, we need to examine the mental health system from a more panoramic perspective. An organized criminal justice system existed in this country and in Europe for hundreds of years before widespread state mental health systems came into being. State mental health systems arose in the early nineteenth century not merely to control deviance, since that could be accomplished by processing the mentally ill through the criminal system. Rather, for the first time, in the early nineteenth century when the great state hospital system was born, it was believed that insanity could be consistently cured by institutional care.[18] In contrast to the diverse goals of the criminal system,

14. R. ROCK, M. JACOBSON, & R. JANOPAUL, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL (1968); Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L. J. 43 (1974); Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424 (1966).

15. Andalman & Chambers, *supra* note 14; Hiday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom*, 11 LAW & SOC'Y REV. 651 (1977); Lelos, *Courtroom Observation Study of Civil Commitment*, in CIVIL COMMITMENT AND SOCIAL POLICY: AN EVALUATION OF THE MASSACHUSETTS MENTAL HEALTH REFORM ACT OF 1970 (1981); Lipsett, *Courtroom Observation Study of Civil Commitment* in *id.*; Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 LAW & SOC'Y REV. 629 (1977); Note, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 IOWA L. REV. 1284 (1979); Baxa, Psychiatrists in the Legal Model of Commitment (unpublished paper presented at the Annual Meeting of the American Psychiatric Association, San Francisco, May 3-9, 1980); Knapp, Dirks, & Magee, *Act 143 and the Rate of Involuntary Psychiatric Hospital Admissions* (unpublished manuscript).

16. Poythress, *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUMAN BEHAVIOR 1 (1978).

17. *See, e.g.*, Andalman & Chambers, *supra* note 14, at 75-86; Cohen, *supra* note 14, at 457-59; Luckey & Berman, *Effects of a New Commitment Law on Involuntary Admissions & Service Utilization Patterns*, 3 LAW AND HUMAN BEHAVIOR 149, 160 (1979). Although Wexler's study did not directly address the issue of whether substantive standards were being violated as well, he states his preferences for substantive grounds for commitment elsewhere. Under the state's police powers, patients can be involuntarily committed only when they evidence substantial dangerousness to others by a recent overt threat, attempt, or act. Under the parens patriae doctrine, involuntary commitment can occur only when the patient is incompetent and a reasonable person would consent to the proposed treatment.

18. N. DAIN, CONCEPTS OF INSANITY IN THE UNITED STATES 1789-1865 (1964).

the purpose of mental health commitment historically has been, and continues to be, treatment of the severely mentally ill.

It would be a mistake, however, to suggest that the motives behind this desire to treat were at all times entirely benevolent. Society has always feared the mentally ill and recognized them as potentially socially disruptive. Thus, the factors that Wexler neatly separates into "police power" and "parens patriae" bases for commitment have always been intertwined. We have always been sensitive to intrusions on individual liberty at the same time that we have recognized the need to treat the mentally ill. This tension has resulted in the historical alternations between more and less rigorous standards and procedures for involuntary commitment of the mentally ill.

What those who advocate radical criminalization of mental health law fail to appreciate is the extent of the need for easier means of entry into the involuntary treatment system. While psychiatric, sociological, and legal theorists may question the reality of mental illness, the families and friends of the mentally ill, the lawyers with whom they deal, and the judges who must rule on commitment petitions know better. They not only recognize the presence of illness, but also desire to see it treated if at all possible, and fear the consequences of a failure to do so. Therefore—and this is the key—these crucial actors will consistently subvert any system that erects procedural or substantive barriers to involuntary treatment that contradict their common sense notions of what ought to be done.

Only now do Wexler's empirical results, mirrored in so many other studies,[19] begin to make sense. It is not because involuntary commitment is too easy that patients' procedural rights are violated, but, at least in part, because it is too difficult.[20] Before-and-after studies of new commitment statutes show that despite the implementation of more rigorous procedures and standards, and often after an initial fall-off in the rate of commitments, the system will readjust and return to the previous level.[21] If "need for treatment" commitments are eliminated, as in Pennsylvania, the same individuals will be committed as

19. See the studies cited in notes 14 & 15 *supra*.

20. This is not to suggest that a commitment law that is broad enough to meet real societal needs is a sufficient prerequisite to guarantee that procedural rights are observed. The experience earlier in this century, in the face of relaxed substantive standards, belies that contention. What is suggested here is that an appropriately broad substantive standard is a necessary prerequisite to the observance of procedural rights.

21. Luckey & Berman, *supra* note 17; Munetz, Kaufman & Rich, *Modernization of a Mental Health Act: I. Commitment Patterns*, 8 BULL. OF THE AM. ACAD. PSYCH & THE L. 83 (1980). *But see* the contrasting finding in Lelos, *supra* note 15, at 10-13, of a sharp decrease in the number of admissions following implementation of a new Massachusetts statute. This may be explained in part by an increase in the diversion of noncommittable individuals to the criminal system. Geller & Lister, *The Process of Criminal Commitment for Pretrial Psychiatric Examination: An Evaluation*, 135 AM. J. PSYCH. 53 (1978).

gravely disabled.[22] As in California, if the commitment system as a whole is constricted so as to shut the flow to a trickle, patients will be found incompetent under another provision of the mental health act and committed by their guardians.[23] It is almost as if all involved were saying, "We know who needs to be committed, and though it may require ever-increasing legal contortions, we will continue to see that these people receive involuntary inpatient care."

Reformers can respond to this determination in two ways. First, they can denounce those who evade the intent of the restrictive statutes and attempt to tighten their provisions even further. This has been the usual course of action until now.[24] Or, reformers can acknowledge not only the degree of resistance to their efforts, but its realistic basis. The psychiatric literature and the daily newspapers abound with evidence that people who should have been committed were not, to their own detriment and that of others.[25]

What changes ought to be made? Clearly, as far as substantive standards are concerned, the historic grounds for commitment—need for treatment—must come back in some form. Wexler's suggestion that findings of incompetency to make decisions about treatment be coupled with a "best interests" standard as judged by a reasonable man might provide a guide here.[26] Although the determination of competency to consent to treatment is currently a theoretical and practical morass, it may be possible to establish more definitive guidelines.[27] Ideally it might come to replace the problematic "dangerousness standard" entirely. In any event, some measures must be taken to address the widespread perception that those who ought to be receiving treatment are not.

Paradoxically, if this chain of reasoning is accurate, such a relaxation of substantive standards for commitment may ensure that procedural protections are more strictly adhered to. The motivation for evasion removed (and, it is hoped, adequate resources provided for

22. Munetz, Kaufman & Rich, *supra* note 21, at 90-91.

23. Morris, *Conservatorship for the "Gravely Disabled": California's Non-declaration of Nonindependence*, 1 INT'L. J.L. & PSYCH. 395 (1978).

24. *See* B. ENNIS, PRISONERS OF PSYCHIATRY 223-32 (1972).

25. Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCH. 496 (1976); Seigel, *Feeling the Chill*, N.Y. TIMES, March 3, 1981, § A, at 19; Basler, *Assault on Officer and Drifter's Lack of Treatment*, N.Y. TIMES, May 12, 1981, § A, at 1

26. D. WEXLER, *supra* note 4, at 41. This is not unlike the systems, proposed by Stone and Roth, in which only those patients who are incompetent to make treatment decisions and for whom treatment can be effectively provided would be involuntarily committed. A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION (1975); Roth, *A Commitment Law for Patients, Doctors, and Lawyers*, 136 AM. J. PSYCH. 1121 (1979).

27. Appelbaum & Roth, *Competency to Consent to Research: A Psychiatric Overview*, ARCHIVES OF GENERAL PSYCH. (1981) (in press); Appelbaum & Roth, *Clinical Issues in the Assessment of Competency*, AM. J. PSYCH. (1981) (in press).

such things as attorneys' fees for indigents), all concerned may be more willing to observe the formalities usually associated with courtroom procedures. Nonetheless, some procedural changes also may be necessary. For example, rules that prevent the introduction of evidence, such as those banning hearsay, often exclude important data with little corresponding benefit.[28] Experienced fact-finders in mental health hearings are often able to discriminate between grossly unreliable reports of third parties and more credible evidence. Rules formulated to prevent the potentially biasing effects an inexperienced criminal jury might face from hearsay evidence are being applied in this quite different setting to the detriment of accurate fact-finding. In addition, state rules requiring that findings be made beyond a reasonable doubt are of questionable utility.[29] Psychiatry is too inexact an area to cope with such a standard. Wexler, it should be noted, offers an ingenious means of meeting a reasonable doubt standard, although one that would be terribly difficult to apply in practice. He suggests that we identify more precisely what we are being asked to prove. It may be possible, he argues, to prove beyond a reasonable doubt that there is a 20% chance (or some other figure less than 100%) that the patient will be dangerous.[30] Although intriguing, it is hard to imagine hard-pressed lower court judges making distinctions like this in practice.

The second half of Wexler's book, which deals with the impact of law on therapy, shows much more of the flexibility and recognition of the realistic needs of the mentally ill absent in his discussions of commitment. In his discussion of the psychosurgery decision, *Kaimowitz v. Department of Mental Health*,[31] Wexler recognizes the need for a means whereby prisoners can consent to therapeutic interventions.[32] He sees *Kaimowitz*, correctly I believe, not as a decision that simply applied the elements of informed consent—information, voluntariness, and competency—to the prison setting and found them absent. Rather,

28. The author has observed commitment cases, and heard of others, in which evidence based on a physician's knowledge of a patient's behavior as reported by the nursing staff and recorded in the patient's chart was excluded from consideration because the individual who observed the act was not present to testify. This represents a failure to acknowledge the team-oriented nature of modern psychiatric wards: Information is collected and shared by all involved in the treatment of the patient. If such evidence is to be excluded as hearsay, unless the hospital has every doctor and nurse who ever wrote a note in a patient's chart present at the commitment hearing, the validity of the assessment of the patient's status is seriously impaired.

29. Such rules contrast with Addington v. Texas, 441 U.S. 418, 433 (1979), in which the Court held that a "clear and convincing" standard of proof must be met in order for civil commitment proceedings to comport with the fourteenth amendment.

30. D. WEXLER, *supra* note 4, at 62.

31. No. 73-19434-AW (Cir. Ct., Wayne County, Mich., filed July 10, 1973), *reprinted in* A. BROOKS, LAW, PSYCHIATRY, AND THE MENTAL HEALTH SYSTEM (1974) (consent of prisoner to experimental psychosurgical procedure is inherently defective relative to information, competency, and voluntariness).

32. D. WEXLER, *supra* note 4, at 205.

Wexler views the case as a purely policy oriented decision based in the belief that it would be socially undesirable to permit prisoners to consent to experimental psychosurgical procedures.[33] Such an interpretation avoids the drawbacks of the arguments of those who would hold *Kaimowitz* more broadly and ban any experimental and even any therapeutic interventions with prisoners.

Similarly, in his discussion of legal restrictions on token economies, which are used in behavior modification programs with severely psychotic or retarded patients, Wexler goes beyond the usual analysis of why these programs may infringe on the rights of those enrolled in them.[34] He begins by delineating the difficulties involved: In order to be successful with the most disturbed groups of patients, token economies often have to reward sought-after behavior with items (such as food or toilet paper) or rights (such as privacy) that would otherwise be taken for granted. These programs, therefore, particularly for those in their lowest functional levels, may create statutorily or constitutionally invalid deprivations of basic rights. Nevertheless, Wexler suggests means by which these programs could avoid legal obstacles, as by using rewards ("reinforcers" in psychological parlance) that have a more idiosyncratic meaning for the individual involved, such as offering a choice of foods rather than altering the amount of food. What is perhaps most impressive about his discussion of this issue is his degree of comfort with the psychological literature. He not only can critique current institutional systems, but also can suggest other models that have been developed, but not widely applied, as reasonable alternatives.

Likewise sophisticated is Wexler's analysis of the effects of *Tarasoff v. Regents of the University of California*,[35] which created a duty for psychotherapists to protect third parties who might be intended victims of their patients. He points to what he calls the "victimological virtues" of *Tarasoff*, which could lead to the involvement of potential victims—often relatives or lovers of the patient—in the therapy itself. This broader focus on the patient's social system, Wexler argues, not only makes for more effective therapy, but also protects both parties involved. While one would be hesitant to see the law require that a particular approach to therapy be taken in all cases, Wexler's creative analysis forces the therapeutic professions to rethink the foundations of their work with violent individuals and thereby does an invaluable service.

It is, then, Wexler's ability to see beyond the legal jargon and the

33. *Id.* at 203-04.
34. *Id.* at 219-29.
35. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

knee-jerk civil libertarian responses when dealing with the regulation of therapy that sets him apart from so many other legal critics of the mental health system. Ironically, it is his failure to do this, or to perceive the legitimate individual and societal needs with reference to the civil commitment process that limits the utility of his analysis there. Nonetheless, his book is well worth academic attention. It brings together modestly revised versions of some of the most influential and original papers in mental health law published during the past decade and gives us a chance to reflect on the rapid developments during these years.

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