INTRODUCTION

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George Bernard Shaw once wrote that "the worst sin towards our fellow creatures is not to hate them, but to be indifferent to them: that's the essence of inhumanity."[1] This symposium on mental health and the law, focusing primarily on developments in the civil law context, provides a welcome occasion to reflect on society's progress in moving away from the sinful indifference it has historically manifested toward the mentally ill. Because the symposium is aimed at the two professions—law and medicine—that have the most responsibility in dealing with the mentally ill, I hope it will provoke serious criticism and debate. At the very least, those who read it must take a harder look at the distance that remains to be traveled.

The eight articles that follow cut across a broad range of current controversies. Several of the pieces address recent trends in substantive legal doctrine. In *The Rights of the Mentaly Ill Under State Constitutions*, Alan Meisel argues that the federal judiciary, after years of bold initiatives to remedy abuses in the mental health system, is showing signs of a more reluctant, restrained approach. He urges advocates for the mentally ill to pursue "a virtually untapped source of rights"— state constitutional law. Meisel's piece should prove to be a useful litigation primer, both as a survey of substantive state doctrine and as a roadmap of procedural pitfalls that the lawyer must anticipate. The Note, *From Wanderers to Workers: A Survey of Federal and State Employment Rights of the Mentally Ill*, provides a similarly valuable review of legislative and administrative efforts to secure meaningful employment opportunities for the mentally handicapped. And in *Foreseeing is Believing: Community Imposition of Liability for the Acts of "Dangerous" Former Mental Patients*, Bruce Ledewitz offers a provocative analysis of the clash between two developments in mental health law: the increasing judicial tendency to impose liability on psychiatrists for the acts of "dangerous" former mental patients, and growing legislative efforts to deinstitutionalize the mentally ill by bringing them out of the back wards and into the mainstream of society. Ledewitz argues that recent trends in psychiatrists' liability represent an "unjustifiable judicial infringement of legislative prerogatives," and he urges judges to "fine-tune" this spectrum of tort law to respect legislative balancing of the benefits and risks of deinstitutionalization.

Two pieces in this symposium address the murky decisional process that is employed in determining whether to channel problem individuals into the criminal justice system or the mental health system. George Huber, Loren Roth, Paul

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1. G. SHAW, THE DEVIL'S DISCIPLE, act II (1901).

Appelbaum, and Timothy Ore, in their fascinating piece *Hospitalization, Arrest, or Discharge: Important Legal and Clinical Issues in the Emergency Evaluation of Persons Believed Dangerous to Others*, examine this process from the standpoint of psychiatric emergency room personnel, the individuals whose initial classifications often determine the fate of those they diagnose. The authors' contentions are sure to provoke much debate. They argue that because the ethical and legal duties of emergency personnel are often at odds with their diagnostic responsibilities, and because of the many "disincentives" to cooperation between the mental health and criminal justice systems, a significant number of classifications are wholly unreliable. "Mental hospitalization is the easiest option for clinicians to pursue," the authors contend, "even when the clinician finds it personally and professionally distasteful to admit the person to the hospital." One need not agree with the authors' goal—"a greater societal consensus that potentially dangerous persons should not be brought to the mental hospital for evaluation in the first place"—to welcome their forthright analysis.

Vitek and Beyond: The Empirical Context of Prison-to-Hospital Transfers, authored by Eliot Hartstone, Henry J. Steadman, and John Monahan, continues this exploration of the relationship between prisons and mental hospitals. In *Vitek v. Jones*,[2] the Supreme Court held that prisoners transferred to mental hospitals must be accorded due process hearing rights. The authors undertake an empirical analysis of transfer practices in six states, concluding that, if *Vitek* is to have meaningful impact, the decision must be read broadly to apply to transfers of prisoners to mental health facilities *inside* as well as outside the prison system. Their empirical findings also identify a serious problem that has received scant attention: the significant number of "underidentified" prisoners in need of clinical assistance who are permitted to languish in the prison system.

Several of the pieces I have discussed illustrate a problem that has long been of particular concern to me—the excessive reliance in the mental health field on "labeling." I am nearly convinced that no formulation of words will produce the information necessary for a proper consideration of such issues as responsibility, dangerousness, and the meaning of mental illness itself. That is why I expressed the fear some years ago that "while the generals are designing an inspiring new insignia for the standard, the battle is being lost in the trenches."[3] The dangers of labeling within the psychiatric profession have long been evident. At Washington's St. Elizabeth's Hospital some years ago, for example, sociopathy was transferred from the category of "mental illness" to that of "no disorder" by a simple vote of the doctors one weekend! The change did not reflect new insight, let alone new scientific knowledge.

I am concerned that too many reformers also place excessive faith in labeling. Over the years, in test cases and by legislative lobbying, they have won significant rights for the mentally ill. The criteria for civil commitment, for example, have been narrowed: individuals may be committed only if they are "dangerous" or

2. 445 U.S. 480 (1980).

3. United States v. Brawner, 471 F.2d 969, 1012 (D.C. Cir. 1972) (Bazelon, C.J., concurring in part and dissenting in part)(formulation of standard for the insanity defense).

"unable to care for personal needs." Similarly, the "handicapped" have been accorded long-overdue rights. But what do these terms mean? How are they applied "in the trenches"? In *Major Current Issues Concerning Civil Commitment Criteria*, George Dix marshalls a disturbing array of legal and empirical evidence in support of his argument that "broad and imprecise" civil commitment standards carry "an unacceptable risk of arbitrary application." His review of the empirical literature paints a broad-brushed picture of the astonishing variations in the day-to-day application of commitment criteria. Dix's work provides powerful illustration, I believe, that no reform in the standards applied to gauge mental illness can be taken seriously without adequate attention to the "infrastructure" of the mental health system itself.

The two dominant components of that system are the medical and the legal professions. Although we have sought to encourage cooperation between the two groups for almost thirty years,[4] their relationship continues to be best characterized as one of distrust, ignorance, and protective posturing. Both professions have been riven, moreover, with internally conflicting allegiances.

The continued refusal of the medical profession to welcome the rigors of the adversary process has been unfortunate. In seeking to scrutinize the decisions of mental health professionals, we have merely sought to ensure that clinical expertise submit to the same process by which the shortcomings of all opinion evidence is tested. Let there be no misunderstanding, the fact that psychiatry can be abused does not make psychiatry an abuse. Yet the ethics of the medical model governed by the Hippocratic Oath, are all too often eroded by the situational ethics of public decisionmaking, where extraneous social, political, and economic factors come into play. And every clinician has a permanent emotional bias; an operational identification with an opinion that is used to support one side of a conflict; an inevitable identification with the accuracy of his own findings. The professional is subject to the same prejudices as the rest of us; this reality belies the myth that a medical expert can or should be removed from the adversary system.

Turning to the legal profession, its record has also been less than inspiring. I refer not only to the failure of most of the profession to attend to the critical needs of the mentally ill. All too many lawyers who *do* choose to represent these "silent clients" display a dismaying lack of knowledge and preparation in grappling with the fundamental issues. Too often they tend to defer to the "expertise" and "credibility" of clinical professionals. These problems, I think, are simply manifestations of the pervasive role conflicts that lawyers face in the mental health field: rather than act as zealous advocates for their clients, too many lawyers in this context view themselves instead as "friends of the court," or as guardians of the "family's wishes," or as trustees of their client's "best interests."

Two of the pieces in this symposium analyze these serious role conflicts. Michael Perlin and Robert Sadoff, in *Ethical Issues in the Representation of Individuals in the Commitment Process*, survey the fiduciary challenges that confront advocates for the mentally ill, and pronounce the record of the legal profession in meeting

4. *See, e.g.,* Durham v. United States, 214 F.2d 862 (D.C. Cir. 1954).

these challenges "grossly inadequate." Their article sensitively and sensibly traces the additional, unique obligations of counsel who work on behalf of mentally ill clients. In *Inappropriate Patient Confinement and Appropriate State Advocacy*, David Wexler shifts the focus to government lawyers, arguing that state governments have failed to develop a "coherent theory of appropriate advocacy." Rather, lawyers for the state are called upon to represent two frequently inconsistent interests—the state's role as protector of the public safety, and the state's duty of therapeutic reform of its institutionalized citizens. All too often, the latter interest loses out.

Recent events dramatically demonstrate the tenuous character of judicial and legislative reforms and the continued vulnerability of the mentally ill. The recession and budget cutbacks have had an especially devastating impact on these troubled Americans. The transference of social welfare responsibilities from the Federal Government to the states raises significant dangers that, in competing for funding with other groups, the mentally ill will be shunted to the side. Efforts are underway to eliminate important federal regulations guaranteeing employment and educational rights of the handicapped. And, perhaps most disturbingly, advocacy programs for the mentally ill have been decimated. The budget of the Legal Services Corporation has been slashed, for example, and other advocacy projects have either been repealed or have lost funding.

These crises render the publication of this symposium especially timely. As the articles in this issue recognize, the essential ingredient in the process of sensitizing the public and its legal and medical institutions to the problems of the mentally ill is a core of dedicated and knowledgeable advocates. Future efforts to reform the mental health system—or just to hold the line—can only be made possible through enhanced public awareness and understanding of the needs and hopes of these troubled fellow citizens. The law, after all, is seldom the spearhead of social revolution; it merely conforms to and ratifies changes in society and social perceptions. With this symposium, *Law and Contemporary Problems* has provided a valuable tool to those who would devote themselves to championing the battle against society's sinful indifference to the rights and aspirations of the mentally ill.