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Lawyers and Psychiatrists in the Court: Afterword

LAWYERS AND PSYCHIATRISTS IN THE COURT: AFTERWORD

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"No, no!" said the Queen
"Sentence first — verdict afterwards."[1]

The process by which people are involuntarily committed to mental institutions has been the subject of increased attention by both lawyers and doctors.[2] And rightfully so, for no other area of the law permits, as does civil commitment, the summary detention of persons for an indefinite period of time.

"Due process" is satisfied by notifying the detainee-patient that he may subsequently receive a judicial hearing if he requests one.[3] The study of interaction between lawyers and psychiatrists in such judicial hearings was part of a comprehensive study of the effect of New York's Mental Hygiene Law, and is the subject of the article reviewed here.[4]

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1. L. CARROLL, ALICE'S ADVENTURES IN WONDERLAND 161 (ann. ed. 1960).

2. The following cases are among the most recent challenging state civil commitment laws: United States *ex rel.* Schuster v. Herold, 410 F.2d 1071 (2d Cir. 1969); Logan v. Arafeh, Civil No. 14386 (D. Conn., filed May, 1971); Dixon v. Attorney General, 325 F. Supp. 966 (M.D. Pa. 1971); Anderson v. Solomon, 315 F. Supp. 1192 (D. Md. 1970); Fhagen v. Miller, 29 N.Y.2d 348, 278 N.E.2d 615 (1972).

On civil rights and civil commitment, *see generally* J. KATZ, J. GOLDSTEIN & A. DERSHOWITZ, PSYCHOANALYSIS, PSYCHIATRY & LAW (1967); R. ROCK, *et al.*, HOSPITALIZATION & DISCHARGE OF THE MENTALLY ILL (1968); *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st & 2d Sess. (1969 & 1970); Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101 (1971).

3. MD. ANN. CODE art. 59, § 13 (1972). For categorical listings of statutes from other states see S. BRAKEL & R. ROCK, THE MENTALLY DISABLED & THE LAW (rev. ed. 1971).

4. The complete work is Kumasaka, Gupta, Stokes & Sharma, Final Report: Evaluation of Mentally Ill — Civil Commitment Problems, May, 1971 (unpublished report under National Institute of Mental Health Grant MH 16485).

Besides the article discussed herein, other portions of the study have been published: Gupta, *New York's Mental Health Information Service: An Experiment in Due Process*, 25 RUTGERS L. REV. 405 (1971); Zitrin, Herman, & Kumasaka, *New York's Mental Hygiene Law — A Preliminary Evaluation*, 54 MENTAL HYGIENE 28 (1970); Kumasaka, Stokes & Gupta, *Criteria of Involuntary Hospitalization*, 26 ARCHIVES OF GENERAL PSYCHIATRY 399 (1972). Several others have been accepted for publication: Kumasaka, *Lawyer's Role in Involuntary Commitment — New York's Experiment*, MENTAL HYGIENE; Kumasaka & Stokes, *Involuntary Hospitaliza-*

I. METHODOLOGY

Before reaching the findings and conclusions of the authors, it might be useful to explore the methodology employed in this study, not only to examine its validity, but more importantly, to shed light on the difficulties of achieving an analytically objective approach to the subject matter. While the complete case files (hearing transcript, physician certificates, and MHIS report) were examined, it is clear that the attitudinal approaches of the doctors and lawyers involved was determined by the professional analysts primarily from the form and content of the questions asked during the hearings and the responses given. The problem in this approach is alluded to by the authors in their examination of part of the testimony in Case 27.[5]

There, as in most of the cases examined, the analysts disagreed whether the doctor and lawyer were in agreement on the issue involved (in this case, "dangerousness"). The explanation of the disagreement by the authors is certainly plausible, if not necessarily correct. But is it not also plausible that the lawyer conducting the cross-examination in the case seriously doubted that dangerousness existed? It is not clear whether any further cross-examination was conducted which would have given any additional clues. But if we assume that the cross-examination ended with the transcript excerpt, can we not also assume that the lawyer prudently ended the examination after planting the seed of doubt regarding the patient's dangerousness?

That the lawyer-analyst concluded (or "guessed") otherwise not only suggests problems in this approach, but also raises questions as to whether an analyst could be objective in a study of this sort. We are furnished with the identity and credentials of the analysts involved, who appear to be eminently well qualified as experts in the

tion: Attitudes and Opinions of Lawyers and Psychiatrists, COMPREHENSIVE PSYCHIATRY.

A number of interesting conclusions are reached in the *Preliminary Evaluation, supra,* and should be noted, notwithstanding the risks involved in a major oversimplification. Most patients were released administratively by the doctors prior to the actual hearing. At each step of the process leading to judicial hearing, clinical variables become less important factors in considering the patient for release. At the hearing level, personal expressions of the patient and his socio-demographic characteristics are of paramount importance. Patients who request hearings stand a much better chance of being released sooner than others, and the chance for release increases further with the pressure exerted by the patient. This results in the detention of "less sick" patients who do not actively voice their opposition to commitment and release of the "sicker" vocal patients.

The number of patients administratively released has increased significantly since the formation of the Mental Health Information Service.

5. *See* pp. 14–15 *supra.*

field. But this is not enough. The analysts' conceptions of "dangerousness," "functioning," "abnormal behavior," and so forth, as well as their views on involuntary civil commitment must have been the yardstick they employed to identify the issues in the cases examined. That experts do not agree is clear,[6] and we are not furnished with the analysts' views or conceptions.[7]

Furthermore, if, as the authors suggest, it is not clear whether the differences between the lawyers and the psychiatrists are due to the nature of the court procedure or to their preconceived opinions regarding the need for civil commitment, we are faced with the situation in which the attitudes and conceptions of doctors and lawyers which may be based on unknown preconceived opinions are being measured by another doctor and lawyer who have their own preconceived opinions which are similarly unknown to the readers.[8]

Despite the flawed methodology, one must generally agree with the conclusions reached for several reasons. Solid evidence leading directly to certain conclusions is simply not available in this type of study and a relatively high level of objectivity is not attainable. Also one is forced to conclude, from a reading of the transcript excerpts and the analysts' evaluations, that a communication problem does, in fact, exist. Finally, these conclusions accord with those reached by most practitioners who have, at one time or another, examined a psychiatrist on the witness stand. It remains to be seen whether the communications problem is merely attitudinal in nature or is a reflection of other factors.

II. THE AUTHORS' CONCLUSIONS

Concluding that lawyers and doctors would not be in complete agreement even if they understood each other, the authors seek to isolate and examine points of disagreement to determine if its nature is more apparent than real. This examination is important, they contend, for the patient is the one who is ultimately burned by the heat. In fact, a number of definitional differences are revealed, and a clearer understanding of what was meant in the doctor-lawyer

6. *Compare, e.g., 1969 Hearings, supra,* note 2, at 304 (remarks of Dr. H. Kaufman), *with 1969 Hearings, supra* note 2, at 12 (remarks of Dr. Z. Lebensohn).

7. The views of the author of this *Afterword* are less relevant but, anticipating like criticisms from the reader, the writer would state that he finds the arguments advanced by Dr. Thomas Szasz most convincing.

8. A gnawing question remains: why weren't the doctors and lawyers involved in the studied cases asked what *they* thought the issues were?

exchanges in the judicial hearings would have decreased the conflict and, perhaps, shed additional light.

But the argument is not convincing. Conceptual disagreements regarding the issues involved appear in a substantial number of the cases that are analyzed in the article. In addition, where the differences between the lawyers and the doctors can clearly be labeled as semantical or definitional, we are not shown the possibilities of a different disposition of the case if those differences had been nonexistent.

Case 51[9] is an excellent example of a conceptual difference (in that case, between the judge and the doctor) which may more fully reveal the source of disagreement between the legal and medical professions. In their discussion of that case, the authors expose the problem of varying threshholds of tolerance. The perception of what constitutes a significant mental disorder and how much potential danger can be anticipated from that disorder depends largely on the degree of abnormal behavior which one feels should be tolerated by society. The authors readily state that the threshhold of tolerance for lawyers is generally much higher than that for doctors. In Case 14,[10] the doctor was insisting on in-patient medical care for the patient's own good while the lawyer and judge were inclined to allow the patient to seek medical help voluntarily. It is submitted here that the tolerance threshhold is a central consideration in the major issues involved in the article, including "dangerousness," "functioning" and "abnormal behavior."[11]

The advocacy role of the lawyer, with his or her legal and civil libertarian orientation is recognized by the authors as a major factor in his or her tolerant stance toward behavior.[12] Lawyers look for proof, hard evidence and detailed facts. Doctors offer their expert opinions based on whatever contact they have had with the patient.

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9. *See* pp. 32–34 *supra.*

10. *See* pp. 19–23, 29–30 *supra.*

11. For an excellent examination of societal tolerance and community mental health, see Shah, *Community Mental Health and the Criminal Justice System: Some Issues and Problems,* 54 MENTAL HYGIENE 1 (1970).

Should the hippie be tolerated? The court said yes in *In re* Sealy, 218 So. 2d 765 (Fla. Dist. Ct. App. 1969).

12. The complete study [*supra* note 4] found some revealing attitudes among lawyers in the Mental Health Information Service and psychiatrists. Only lawyers of the MHIS in the First Judicial Department take part and represent the patient in the hearing procedure. Lawyers in the Second Judicial Department assume a neutral role, advising patients of their rights and helping patients obtain counsel, but do not interact with the psychiatrists. First Department lawyers are much more inclined to view involuntary commitment as dispensable and "dangerousness" as a meaningless concept or one which can be substantiated only in an historical context. On the other hand, psychiatrists and Second Department lawyers generally agree that involuntary

The essence of the hearing is the probable future behavior of the patient, and on this score, the medical profession has fared poorly.[13] Doctors exhibit a pronounced patronizing approach,[14] appearing to believe that civil liberties, while important, must be tailored to the "best interest" of the patient. They sense a continuing responsibility for the welfare of the patient as opposed to the lawyer's "one shot" involvement. That lawyers are also patronizing, albeit to a lesser extent, is revealed in their "silent defense."[15]

The lawyer, as the patient's advocate, acts in furtherance of his client's expressed interest (that is, to obtain the patient's release), but doubts whether the patient has the mental capability to express his "own best interest." When the lawyer's doubts are strong enough, the "silent defense" or acquiescence results. The question of how much patronizing is appropriate by both lawyers and doctors in civil commitment hearings is raised but left unanswered.

The underlying assumption of that question is that involuntary commitment is a valid method of selecting persons for treatment. As indicated,[16] this assumption no longer remains unquestioned. For the legal practitioner who does not make this assumption the course is clear, and he or she approaches a civil commitment case in the same fashion as a criminal matter. A practitioner who does not rule out involuntary commitment as invalid must wrestle with his or her own position as well as the interests of the client and of the physician. This article provides no guidance in this regard.[17]

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commitment is indispensable and that the concept of dangerousness is a meaningful diagnosis which depends upon the results of a medical examination.

A personal conversation with Dr. Thomas Szasz revealed that while the movement to abolish involuntary civil commitment (led by the American Association for the Abolition of Involuntary Mental Hospitalization, Inc.) was gaining strength in his own profession, it is generally lawyers who have been much more willing to add their support to the effort.

13. Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment,* 117 U. PA. L. REV. 75 (1968).

14. *See* Case 31 discussed *supra* p. 27.

15. *See* N.Y. MENTAL HYGIENE LAW § 88(c), (e) (McKinney 1971). Lawyers in the Mental Health Information Service perform different functions in the First and Second Judicial Departments. *See* note 12 *supra.* The lawyer-advocates in the First Department are nevertheless considered neutral and must report information which may be harmful to the patient's interest. *See 1969 Hearings, supra* note 2, at 287 (remarks of B. Ennis).

16. Note 12 *supra.*

17. There is guidance in Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill,* 44 TEXAS L. REV. 424 (1966).

III. THE LARGER ISSUES IN INVOLUNTARY COMMITMENT

The need to suggest a normative approach for the lawyer-practitioner is critical. Now that we know that lawyers and doctors frequently differ markedly in their approach, and that the courts tend to place great weight on expert testimony in civil commitment cases, how can the patient's interests be best protected? A few suggestions are in order. Expert witnesses should be limited to dealing with the question of mental disorder *vel non* and precluded from drawing conclusions on the issue of dangerousness, where the experts are simply not expert. The patient should be free, at state expense if necessary, to hire a doctor of his own choice. Not only would this establish a sense of fundamental fairness in the use of medical expertise, but could eliminate somewhat the "silent defense." The adoption of the "least restrictive alternative" standard first enunciated in *Lake v. Cameron*[18] could be significant in fostering community mental health centers. The state would have the burden of exploring and presenting acceptable alternatives to absolute commitment. Finally, more research must be done.

The lack or minimal amount of material on the therapeutic effects *vel non* of long-term hospitalization cries out for correction. Similarly, while charges are made that the process of a hearing is detrimental to the patient's mental health and future treatment, these have been refuted by others who feel that the hearing process is, in fact, beneficial therapy for the patient. Neither side has proven its case through any scientific study. The effect of the availability of independent medical expertise on behalf of the patient at the hearing requires exploration.[19] These issues are currently being litigated[20] and the dearth of research is appalling.

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18. 364 F.2d 657 (D.C. Cir. 1966).

19. The authors state that two independent psychiatrists were employed in connection with the fifty-five cases studied. The number is so small as to be insignificant, but a larger sample might have provided an interesting comparison in terms of percentage of judicial releases granted in cases which did not have independent medical expertise present. Further comparisons might be made between MHIS lawyers and private or legal aid lawyers, and between court trials and jury trials, when the latter are available.

20. Logan v. Arafeh, Civil No. 14386 (D. Conn., filed May, 1971); Anderson v. Solomon, 315 F. Supp. 1192 (D. Md. 1970); Fhagen v. Miller, 29 N.Y.2d 348, 278 N.E.2d 615 (1972).