Twenty-Five Years of Law and Psychiatry

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Dr. Appelbaum reviews the past 25 years of the Law & Psychiatry column, of which he has been the editor since the column's initiation by John Talbott, M.D. The column has included contributions from Dr. Appelbaum as well as from various other mental health professionals and lawyers with various specializations. Citation of the column in other articles suggests that it is meeting a need for timely description and analysis of major legal developments that affect the field of psychiatry and psychiatric patients. Dr. Appelbaum notes that the 104 columns published thus far reflect the evolution of legal concerns in psychiatry as well as the presence of core issues that have remained unchanged. He raises the question of what the next quarter century will hold, positing that mental health law will continue to reflect a tension between the interests of persons with mental illness and the public's fear of such individuals. (*Psychiatric Services* 57:18–20, 2006)

Twenty-five years ago this month, the first of these Law & Psychiatry columns appeared in this journal, then called *Hospital and Community Psychiatry.* Although I have not taken note of previous anniversaries, I hope readers will pardon some reminiscence here. A quarter century seems like a reasonable vantage point from which to reflect on both this column and the field that it covers.

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In the fall of 1980, I was fresh out of residency, having taken my first faculty position at the Western Psychiatric Institute and Clinic of the University of Pittsburgh with Loren Roth, M.D., in his law and psychiatry program. One afternoon Loren came to my office to say that he had received a call from John Talbott, M.D., the newly appointed editor of *Hospital and Community Psychiatry,* who was interested in strengthening and diversifying the topically oriented columns in the journal. John Talbott asked whether Loren would be willing to write a bimonthly column on law and psychiatry.

Loren responded that although he did not have the time to undertake a column, he had a young faculty member in his program who might be interested. John Talbott spoke with me, read a sample piece, and—in what now seems a breathtaking leap of faith in a very junior scholar—asked me to assume responsibility for the column. For the first two years, the Law & Psychiatry column appeared every other month. When that seemed too hectic a pace to sustain, we switched to a quarterly schedule, which has remained in place ever since.

Although I have written the vast majority of the columns, a number of them have been contributed by others, particularly during the years leading up to and including my presidency of the American Psychiatric Association (APA), when time for more academic pursuits was often wanting. The column has been strengthened by these reports from lawyers and mental health professionals with expertise in areas that are less familiar to me, and I thank these authors for their contributions. Many of the early columns were republished by APA in a separate collection (1). And given the frequency of citation of the columns, and the number of people over the years who have told me that they have found one or another of them useful, they appear to have met a need in the field for timely description, interpretation, and analysis of major legal developments affecting psychiatry and our patients.

Looking back

Pausing to look back over the 104 Law & Psychiatry columns that have preceded this one, I am struck by how they reflect the evolution of legal concerns in psychiatry. When the column began in 1981, the mental health field was still experiencing the intense legal focus on patients' rights that had begun in the late 1960s (2). The wave of reform of commitment laws, with new statutes that focused on dangerousness instead of need for treatment as the key criterion for involuntary hospitalization, was largely complete. However, the right to refuse treatment was being actively litigated (3), the existence of a right to treatment was still being debated (4), and psychiatrists feared finding themselves the target of suits alleging deprivation of the rights of their patients (5).

At the same time, public concern with acts of violence by persons with mental illness, a perennial and usually exaggerated fear, was being expressed in the rapid development of case law—and subsequently statutes—on the duty of mental health professionals to protect potential victims of their patients' violence (6). Public concern was also evident in the retention of civil commitment for persons who were likely to be dangerous, notwithstanding the arguments of civil libertarians that this constituted impermissible preventive detention (2).

Another domain in which the continuing concern with mental illness

and its link to violence could be seen was the widespread reform of insanity defense laws that followed the 1982 acquittal by reason of insanity of John Hinckley, Jr., on charges related to his attempted assassination of President Reagan (7). A majority of states and the federal government changed their statutes in the years immediately after the Hinckley trial to make it harder for defendants to win insanity pleas and for those found not guilty by reason of insanity to be released to the community.

If civil liberties and patients' rights largely dominated mental health law in the 1980s, with protection from violence only a secondary theme, those positions largely reversed in the 1990s and the early years of the 21st century. The shift was reflected in progressive tinkering with commitment statutes in many states, almost always in the direction of making it easier to hospitalize persons with mental illness. Criteria for involuntary hospitalization have been expanded gradually in many jurisdictions, and procedural rigor has been somewhat relaxed (8).

More significant has been the new generation of outpatient commitment statutes adopted in roughly one-quarter of the states, often stimulated by a high-profile crime of violence perpetrated by someone with a mental illness (9). With these statutes, states seek leverage over mentally ill persons in the community, hoping that requirements for supervision and treatment will prevent the emergence of symptoms that precipitate violence. Mental health courts represent another manifestation of ascendant concerns with protecting society. As these much-heralded mechanisms for mandating treatment for persons who come under the authority of the criminal justice system have grown in geographic coverage, their jurisdiction often has been extended from misdemeanants to persons who have committed felonies (10).

It could be argued, and with some justice, that a desire to see treatment rendered to persons with mental illness who once would have been committed to state hospitals for care—and not merely a quest for public safety—motivated many of these changes. In contrast, the trend toward adoption of "sexually violent offender" (or similarly named) statutes in many states appears to derive solely from concerns with the public peril. The new sex offender statutes, their constitutionality twice upheld by the U.S. Supreme Court, typically allow commitment of prisoners after their sentence has been served, ostensibly for the purpose of treatment. But the failure to render treatment during the preceding years of incarceration—and the almost negligible rate of discharge of offenders in some states—appears to belie this rationale (11).

Some issues, of course, have been present throughout the quarter century, and, although the particular foci of debate and literature have shifted over time, the core dilemmas they present remain unchanged. Death penalty proceedings have constituted one of these perennial issues (12). The focus of concern has ranged from whether psychiatrists and other mental health professionals should participate at sentencing hearings and how their testimony should be framed to whether adolescents, persons with mental retardation, and persons with severe mental illnesses should be eligible at all for the death penalty.

Confidentiality of information communicated in the course of mental health treatment has been another enduring concern. In the 1980s mental health professionals worried about the impact of a duty to protect endangered third parties on patients' willingness to speak openly in treatment (13). As those concerns have grown familiar and been accommodated, clinicians' fears have centered instead on the implications of the coming changeover to electronic medical records and the pressure to link record systems into regional or even national networks (14). With the regulations derived from the 1996 Health Insurance Portability and Accountability Act (HIPAA) providing only limited protections—and many supporters of a national "health information infrastructure" advocating federal preemption of stricter state laws—fears that medical privacy may soon be only of historical interest have been compounded. Nonetheless, there have been some victories for confidentiality along the way, including the U.S. Supreme Court's support for a psychotherapist-patient privilege (15) and tighter protections for psychotherapy notes than for other health records in the HIPAA regulations.

The needs of people with severe mental illness—and their limited affirmative rights under American law—have been another recurring trope. A deliberate attempt by the Reagan Administration in the early 1980s to strip thousands of people with mental disabilities from the Social Security Disability rolls was stifled by the courts (16). But the law has afforded little leverage for those seeking to mandate better community-based treatment, housing, rehabilitation, and other services. An exception to this trend came with the U.S. Supreme Court's recognition that the Americans With Disabilities Act created some right to receive care in the least restrictive setting (17). But although the ruling may be helpful for persons who might otherwise face long-term hospitalization, it hardly represents recognition of a thoroughgoing right to treatment of the sort that advocates have urged since the 1960s.

And then there were the issues of the moment in psychiatry, such as whether psychotherapists could be held liable for inducing "recovered memories" among their patients (18) and the impact of managed care on liability for poor patient outcomes (19). The column examined whether psychiatric patients have the right to smoke in hospitals (20) and whether persons with mental disorders have the right to attend medical school (21). Rules governing expert testimony in the courts were a repeated focus, a product of the growth in demand for accountability of expert witnesses (22).

Looking forward

What is the next quarter century likely to bring? Predicting the future is a more hazardous task than reconstructing the past. But it seems safe to suggest that mental health law will continue to reflect a tension between the desire to see people with mental illnesses fully integrated into the community and an entrenched public fear of people with mental illness.

Thus, along with efforts to expand community services, we will witness never-ending battles over zoning of group homes and other facilities. Even with the level of mental health services in most areas well below acceptable standards, there will be pressure to divert funding for basic treatment and support services for the vast majority of persons with mental illness who represent no threat to others to the small minority who may present a risk of violence or other criminal acts.

The cutting-edge areas of mental health law will involve the acceptable limits of coercion in the community—picking up themes that dominated the attention of the courts in the 1970s, when the focus was on institutional treatment—and the extension of rights to participate fully in ordinary activities of life to persons with mental illnesses. Protecting the right of persons with mental illnesses to vote is one such area of current litigation (23), but we can anticipate that the Americans With Disabilities Act and similar statutes will be pushed to their limits in an effort to maximize the participation of mentally ill persons in community life.

How will it all turn out? That, I am afraid, I cannot say quite yet. But if you stay tuned for my 50th anniversary column, I will let you know what happens.

References

1. Appelbaum PS: Paul Appelbaum on Law & Psychiatry: Collected Articles From Hospital and Community Psychiatry. Washington, DC, American Psychiatric Association, 1989
2. Appelbaum PS: Almost a Revolution: Mental Health Law and the Limits of Change. New York, Oxford University Press, 1994
3. Appelbaum PS: A.E. & R.R.: Utah's compromise on the right to refuse treatment. Hospital and Community Psychiatry 32: 167–168, 1981
4. Appelbaum PS: The cautious advance on the right to treatment. Hospital and Community Psychiatry 33:895–896, 1982
5. Appelbaum PS: Civil rights litigation and mental health: section 1983. Hospital and Community Psychiatry 32:305–306, 1981
6. Appelbaum PS: Tarasoff: an update on the duty to warn. Hospital and Community Psychiatry 32:14–15, 1981
7. Appelbaum PS: Insanity defense: new calls for reform. Hospital and Community Psychiatry 33:13–14, 1982
8. Appelbaum PS: The Draft Act Governing Hospitalization of the Mentally Ill: its genesis and its legacy. Psychiatric Services 51:190–194, 2000
9. Appelbaum PS: Ambivalence codified: California's new outpatient commitment statute. Psychiatric Services 54:26–28, 2003
10. Steadman H, Davidson S, Brown C: Mental health courts: their promise and unanswered questions. Psychiatric Services 52:457-458, 2001
11. Appelbaum PS: Confining sex offenders: the Supreme Court takes a dangerous path. Psychiatric Services 48:1265–1267, 1997
12. Appelbaum PS: Death, the expert witness, and the dangers of going barefoot. Hospital and Community Psychiatry 34:1003–1004, 1983
13. Appelbaum PS: The expansion of liability for patients' violent acts. Hospital and Community Psychiatry 35:13–14, 1984
14. Appelbaum PS: A "health information infrastructure" and the threat to the confidentiality of health records. Psychiatric Services 49:27–28,33, 1998
15. Appelbaum PS: Jaffe v Redmond: psychotherapist-patient privilege in the federal courts. Psychiatric Services 47:1033–1034, 1996
16. Appelbaum PS: The disability system in disarray. Hospital and Community Psychiatry 34:783–784, 1983
17. Appelbaum PS: Least restrictive alternative revisited: Olmstead's uncertain mandate for community-based care. Psychiatric Services 50:1271–1272,1280, 1999
18. Appelbaum PS: Third-party suits against therapists in recovered memory cases. Psychiatric Services 52:27–28, 2001
19. Appelbaum PS: Managed care's responsibility for decisions to deny benefits: the ERISA obstacle. Psychiatric Services 49: 461–462, 472, 1998
20. Appelbaum PS: Do hospitalized patients have a right to smoke? Psychiatric Services 46:653–654,660, 1995
21. Appelbaum PS: Do the mentally disabled have the right to be physicians? Hospital and Community Psychiatry 33:351–352, 1982
22. Appelbaum PS: Evaluating the admissibility of expert testimony. Hospital and Community Psychiatry 45:9–10, 1994
23. Appelbaum PS: "I vote. I count": mental disability and the right to vote. Psychiatric Services 51:849–850, 863, 2000