International Journal of Law and Psychiatry 38 (2015) 100–113

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage:

Outpatient commitment and procedural due process

Candice Teri-Lowe Player *

Assistant Professor of Law, Northwestern University Law School, Philadelphia, PA, USA 19104

ARTICLE INFO

Available online 4 March 2015

Keywords:
Kendra's Law
Outpatient commitment
Procedural due process

ABSTRACT

A large empirical literature on Kendra's Law has assessed the impact of court ordered outpatient treatment on outcomes such as treatment adherence, psychiatric hospitalization, quality of life, and treatment costs. Missing from the empirical literature, however, is a better understanding of procedural due process under Kendra's Law. Procedural due process concerns the safeguards that must be in place when governments deprive persons of their liberties, for example – notice, the right to a hearing and the right to appeal. This article reports the findings from a qualitative study of procedural due process and assisted outpatient treatment hearings under Kendra's Law. Attorneys reported significant barriers to effective advocacy on behalf of their clients. Further, despite the shift from a medical model of civil commitment to a judicial model in the 1970s, by and large judges continue to accord great deference to clinical testimony.

© 2015 Published by Elsevier Ltd.

In 1999 the New York State Legislature enacted Kendra's Law, in memory of Kendra Webdale, a young woman who was pushed to her death in front of an oncoming train by a man with untreated schizophrenia. Under Kendra's Law, a court can order a person with a mental illness to participate in an "assisted outpatient treatment" (AOT) program. A typical AOT order includes a host of interventions designed to improve medication compliance in the community, among them – periodic blood tests or urinalysis to determine compliance with prescribed medications; counseling and toxicology screens for patients with a history of substance abuse and day or partial day programming.[1] For those who are not under a supervised housing requirement, courts will sometimes order an "ACT" or assertive community treatment team to visit the patient's home.

A large empirical literature on Kendra's Law has assessed the impact of court ordered outpatient treatment on outcomes such as treatment adherence, psychiatric hospitalization, quality of life, and treatment costs (Link, Epperson, Perron, Castille, & Yang, 2011; Phelan et al., 2010; Steadman et al., 2001; Swanson et al., 2013; Swartz, Swanson, Steadman, Robbins, & Monahan, 2009). A recent study by Jeffery Swanson and colleagues found that people who participated in the AOT program were less likely to be hospitalized and less likely to be arrested than they were before participating in the AOT program (Swanson et al., 2013). The same study found that Medicaid costs dropped by more than half, while medication refills and assertive community treatment services went up, for an overall net savings. A smaller number of studies have also examined recipient perceptions of coercion and procedural justice in the AOT program. In a 2009 study of the AOT program, AOT recipients reported mostly positive attitudes about medication and favorable perceptions of procedural justice (Swartz et al., 2009).

Missing from the empirical literature, however, is a better understanding of procedural due process under Kendra's Law. Procedural justice concerns perceptions of justice, dignity, participation and trustworthiness held by respondents (i.e. patients) who participate in commitment hearings. Procedural due process, on the other hand, concerns the procedural safeguards that must be in place when governments deprive persons of their liberty, for example – notice, the right to a hearing and the right to appeal. Like most outpatient commitment statutes, Kendra's Law includes a number of due process protections including the right to a hearing and the requirement that petitioners prove their case by "clear and convincing evidence."[2] Still critics argue that people with mental illnesses are routinely ordered to participate in the assisted outpatient treatment program based on no more than "a bare recital of the statutory criteria" or the "vaguest allegation of a serious violent act" (Feld & Darrow, 2013).

Indeed we know very little about procedural due process in inpatient or outpatient settings. Scholars who observed inpatient civil commitment hearings in the late 1960s and 70s commonly described

* Tel.: +1 215 746 8773.
E-mail address: player@post.harvard.edu.

[1] N.Y. Mental Hyg. Law §9.60 (2006).

[2] N.Y. Mental Hyg. Law § 9.60 (j)(2006).

http://dx.doi.org/10.1016/j.ijlp.2015.01.013
0160-2527/© 2015 Published by Elsevier Ltd.

the proceedings as "perfunctory" or "a legal charade" in which judges abdicated their role as neutral factfinders to clinicians (Shah, 1974). Studies on procedural due process and inpatient civil commitment conducted during that period also reported that attorneys rarely cross-examined clinicians, raised objections, argued for less restrictive alternatives to hospitalization, or investigated the facts alleged to justify civil commitment (Andalman & Chambers, 1974; Lelos, 1981; Steir & Stoebe, 1979; Warren, 1977; Zander, 1976; Turkheimer & Parry, 1992). As one observer remarked, "[m]any hearings give the impression of being merely a 'rubber stamp' of the psychiatrist's decision, and not a true adversary process" (Hart, 1974). More recently, Michael Perlin has written extensively on the corrosive effects of "sanism" and "pretextuality" in civil commitment hearings (Perlin, 1991). As Perlin writes, "sanism is an irrational prejudice" based on myths and stereotypes regarding people with mental illnesses, sustained by our reliance on heuristic reasoning, or simply put, alleged "ordinary commonsense" (Perlin, 1999: 4). Moreover the pretext of careful consideration "demeans participants," and promotes "blasé judging" (Perlin, 2010: 874).

This article reports the findings from a study of procedural due process and assisted outpatient treatment hearings under Kendra's Law. The primary objective of this study was to understand how courts determine whether someone meets the criteria for AOT and how much they rely on clinical recommendations. This study also aimed to understand how judges define the term "clear and convincing evidence" and what constitutes clear and convincing evidence that someone meets the criteria for AOT as required by law. Moreover, how do defense attorneys understand their role in AOT hearings? How do they understand their professional obligations to their clients?

Part I traces the evolution of procedural due process and civil commitment. During the first half of the twentieth century, civil commitment decisions were predicated on the "best interests" of the patient and left in the hands of physicians or family members. By the mid-1970s, courts began to prescribe greater procedural due process protections for civil commitment hearings. Since that time the primary site of mental health care in the United States has shifted from large public hospitals to the community, with a particular focus on mandatory outpatient treatment for patients with severe and persistent mental illnesses. However, the fundamental elements of procedural due process have remained the same across inpatient and outpatient settings. Part I discusses *Lessard v. Schmidt* where a Wisconsin district court issued a seminal decision on procedural due process, and *Addington v. Texas*, where the Supreme Court discussed the standard of proof required for civil commitment proceedings. Part I concludes with a review of empirical research on procedural due process and civil commitment. Much of the available case law and empirical research on procedural due process concerns inpatient civil commitment. Nonetheless, Part I will review this literature in detail. The fundamental elements of procedural due process in outpatient commitment settings – e.g. the right to a hearing and the right to counsel – derive from the law of inpatient civil commitment and these rights have been incorporated into the assisted outpatient treatment program by statute.

Part II turns to the mechanics of Kendra's Law and empirical research on the assisted outpatient treatment program. Part III outlines the methods used in this study. Much of the research for this study comes from observing AOT hearings in New York City, as well as candid on-the-record conversations with judges and attorneys, who are involved in Kendra's Law cases. Part IV describes the results. In contrast to early studies on procedural due process and inpatient civil commitment, findings from this study suggest that assisted outpatient treatment hearings in New York City adhere to the black letter requirements of procedural due process. At the same time AOT hearings are not without their problems. Attorneys reported significant barriers to effective advocacy on behalf of their clients. Further, despite the shift from a medical model of civil commitment to a judicial model in the 1970s, by and large judges continue to accord great deference to clinical testimony. As one judge put it, most judges are not "competent" to overrule clinical recommendations. Nor do judges want to be known in the press as the judge who denied a request for supervised treatment, only to have that person injure or kill a member of the general public. Part V discusses the implications of these findings for the assisted outpatient treatment program.

1. Procedural due process

1.1. Case law

Until the late 1960s, the most common form of civil commitment was the two physician certificate, whereby patients were hospitalized on the statement of one or two physicians that they were suffering from a mental disorder and in need of treatment (Appelbaum, 1982; Dwyer, 1989; Miller & Fiddleman, 1983).[3] In most states, commitment could be achieved without a hearing, without counsel and without legal recourse, save for a writ of habeas corpus (Miller & Fiddleman, 1983:43). Whenever possible, commitment decisions were left in the hands of family members or physicians (Appelbaum, 1994:20). By the late 1950s, attitudes toward institutional psychiatry began to change, and in the years following World War II, a series of exposés called attention to deplorable conditions in state hospitals (Appelbaum, 1994:4–7, 27–8).

A further critique of psychiatry arose from the civil rights movement. After an initial focus on racial inequality, the postwar civil rights movement gradually expanded to include a concern for the rights of women, the poor and eventually, the civil liberties of people with mental illnesses (Grob, 1994). Civil rights organizations argued that inpatient commitment standards were vague, overbroad and void for failure to consider less restrictive alternatives to involuntary hospitalization.[4] The actual practice of civil commitment was also under fire. In the late 1960s a small number of states revised their civil commitment statues to provide for the right to a hearing and the right to counsel. Nonetheless, a widely cited study conducted by students at the University of Arizona Law School documented problems at each stage of the civil commitment process, including the cursory nature of most civil commitment hearings averaging no more than five minutes and the tendency by both judges and attorneys to accept conclusory statements from psychiatrists at face value without exploring the facts (Wexler, 1971).

1.1.1. The right to a hearing

In 1972, the Federal District Court for the Eastern District of Wisconsin issued a landmark opinion on procedural due process and civil commitment in *Lessard v. Schmidt*.[5] *Lessard* began when Alberta Lessard was picked up by two police officers in front of her home in West Allis, Wisconsin and taken to a mental health center where she was detained on an emergency basis. Lessard filed a class action in the Federal District Court for the Eastern District of Wisconsin, alleging that the Wisconsin civil commitment statute violated her Fourteenth Amendment right to due process of law. The district court held that the Wisconsin statute was constitutionally defective insofar as it permitted civil commitment without a hearing and failed to afford persons alleged to be mentally ill with timely and effective notice of their right to a hearing.

As Paul Appelbaum writes, "Lessard reflects the ethos of its era" (Appelbaum, 1994:28). In a series of decisions beginning with *Kent v. the United States* in 1966 and *In re Gault* in 1967, the United States Supreme Court addressed the use of civil commitment in delinquency proceedings.[6] In both cases the Supreme Court considered and flatly rejected the state's contention that the therapeutic goals of the juvenile justice system were sufficient to justify civil commitment without the procedural safeguards found in criminal proceedings. Nor was the

[3] *See also* N.Y. Mental Hyg. Law § 31.27, 31.37, 31.39 (McKinney 1973).
[4] Lessard v Schmidt, 349 F.Supp. 1078, 1093 (E.D. Wis. 1972).
[5] 349 F.Supp. 1078, 1093 (E.D. Wis. 1972).
[6] Kent v. United States, 383 U.S. 541 (1966); In re Gault, 387 U.S. 1 (1967).

Download English Version:

https://daneshyari.com/en/article/6554683

Download Persian Version:

https://daneshyari.com/article/6554683

Daneshyari.com