OF THE SHARED RESPONSIBILITY FOR CIVIL COMMITMENT

Stephen Rachlin, M.D.

Procedures and standards for civil commitment of the mentally ill have undergone significant changes in recent years. A part of the reason for this phenomenon has been legal activism, and its challenges to psychiatry. This article examines the vicissitudes of the relationships between mental health professionals and attorneys, with particular reference to the impact on involuntary hospitalization. It is the author's position that active collaboration between disciplines with varying perspectives is both necessary and desirable, but that lawyers should develop a method of sharing accountability for the outcome of their interventions.

Relationships between the mental health field and the law have evolved so rapidly as to make it rather difficult to conceptualize that, less than a generation ago, civil commitment routinely required judicial authorization. With the recognition that hospitalization of the mentally ill was perhaps more a medical issue, laws were changed throughout the country in order to make the commitment process a physician's task. From this arose the now rather ubiquitous medical certification of mental illness.

Mental health professionals were more than moderately surprised when we subsequently became accused of being jailers, of thoughtlessly admitting the mentally ill to hospitals and keeping them there without adequate justification. Part of this arose from the early, and ill conceived, overenthusiasm of some in the community mental health movement, who held that our "institutions" were inherently bad. Another contributing factor was the civil rights crusade, with its hard-won successes. Attorneys turned their efforts to the deprivation of constitutional entitlements experienced by our patients and actively pushed for reform. Unfortunately, this sometimes went so far as to equate hospitalization only with its attendant loss of liberty. The result of all of this has been a partial recriminalization of civil commitment.

Dr. Rachlin is Chairman, Department of Psychiatry and Psychology, Nassau County Medical Center, 2201 Hempstead Turnpike, East Meadow, New York 11554, Associate Professor of Clinical Psychiatry, State University of New York at Stony Brook School of Medicine, and a member of the Executive Committee, Board of Editors, Psychiatric Quarterly. This paper was presented at the 58th Annual Meeting of the American Orthopsychiatric Association, New York, N.Y., March 28—April 1, 1981.
HOW DID THIS STATE OF AFFAIRS COME ABOUT?

There are, first and foremost, marked differences in training and philosophical outlooks between law and psychiatry. For example, although attorneys may well consider counseling of clients a primary function, the legal profession nonetheless places high value on zealous advocacy and the adversary system. Medicine is, among other things, paternalistic. It is virtually axiomatic that the law subscribes the tenet that it is better to let the guilty go free in order to protect the innocent. When this criminal justice illustration is broadly applied to something clinicians generally consider therapeutic, that is, involuntary hospitalization of the seriously ill, many of us and, admittedly, progressive members of the mental health bar as well, would respond that little is lost by several days’ confinement for observation. Class action litigation, which attorneys view as an important means of making changes, is anathema to physicians and others, who see their prime concern as the individual, one at a time.

As Stone points out, it cannot be claimed that providing lawyers for our patients has reduced mental illness any more than counsel for criminals have lowered the incidence of antisocial acts. Attorneys do not have a primary treatment capacity and so, if they want to be or are to be considered mental health professionals, they must be given a different role on the team. But herein lies the rub. Psychiatrists, when serving as part of an interdisciplinary group, strongly prefer the leadership position. Legal activism challenges this assumption of authority and is thus viewed as a threat to the autonomy traditionally expected by medical personnel.

There are several different potential responses to this onslaught, all of which I have observed in staff with whom I have worked. The classically passive-aggressive posture abdicates the making of treatment decisions, with the contention that one or another legal right is being violated no matter which way you turn. A direct expression of the hostility engendered when territory is violated would be to fight each and every incursion, with little realization of potentially beneficial outcomes. When, of course, the reaction to perceived interference is intense ambivalence, paralysis of action results. All of the foregoing is rather maladaptive, since patient care inevitably suffers when judgment is compromised or clouded by other than clinical considerations.

The reasons for interprofessional alliance go beyond the old, “If you can’t beat them join them” cliche. Early research by Kumasaka showed that the presence of lawyers, employing their own judgment, was the key to out-of-court settlements in cases of involuntary commitment. Indeed, although patients requesting hearings were discharged at a much higher rate than those who did not object to further hospitalization, this was the result of a psychiatric, rather than judicial, decision. The attorneys functioned as mediators, exerting pressures on patients as well as physicians, perhaps in part because of the observation that judges tended to follow medical recommendations in those cases that reached the court. A somewhat disconcerting finding was that those lawyers least directly involved with hospitalization procedures were, attitudinally, more like psychiatrists than their brethren who actually represented the patients.