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STANLEY S. HERR, STEPHEN ARONS, AND RICHARD E. WALLACE, JR.: LEGAL RIGHTS AND MENTAL HEALTH CARE

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BOOK REVIEWS

LEGAL RIGHTS AND MENTAL HEALTH CARE. By Stanley S. Herr, Stephen Arons, and Richard E. Wallace, Jr. Lexington, Ma.: Lexington Books 1983.

*Reviewed by Robert D. Fleischner**

In recent years there has been both a growing recognition that people with mental disabilities have legal rights¹ and an almost exponential growth of their rights. But, as one court has recognized, "[w]ith no mechanism for assisting mentally disabled persons in enforcing them, these rights might as well not exist."²

A critical issue, then, is how to transform the promise of new rights into reality. Perhaps the most obvious way is to insure that the professionals and paraprofessionals, the primary providers of services to mentally disabled people, are aware of their clients' rights and are in a position to act to procure or protect those rights or to find someone who can. It is apparently to that end that Stanley S. Herr, Stephen Arons and Richard E. Wallace, Jr. have written their new book, *Legal Rights and Mental Health Care*.³ The book is important, however, because it is something more than just a helpful desk manual for mental health workers. It is an attempt to make those workers more comfortable with the very idea of legal rights for their

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1. We have, after all, recently completed, with remarkably little fanfare, the National Year of Disabled Persons (1982).

2. *Brewster v. Dukakis*, 520 F. Supp. 882, 889 (D. Mass. 1981), *rev'd and remanded on other grounds*, 687 F.2d 495 (1st Cir. 1982).

3. S. HERR, S. ARONS & R. WALLACE, *LEGAL RIGHTS AND MENTAL HEALTH CARE* (expected publication Spring 1983). Stanley Herr is a noted advocate and commentator on the rights of people with mental handicaps. Professor Arons and Attorney Wallace were once associated with the Mental Patients Advocacy Project, an independent law office on the grounds of the Northampton State Hospital, Northampton, Massachusetts.

clients and with the role and place of advocates in the mental health system.

Although "advocacy" is widely believed to be among the most powerful weapons in the limited arsenal available to people with handicapping conditions,⁴ the very concept of "advocacy" is the subject of some broad disagreement⁵ and fundamental misunderstanding. The word "advocacy" itself often seems to mean all things to all people. For instance, in some residential programs and group homes, the staff are called "advocates"; there is a growing "self-advocacy" movement in which groups of formerly institutionalized people come together to assert their rights from a position of strength; Associations for Retarded Citizens, in particular, promote programs of "citizen advocacy" which encourage friend relationships between an unpaid citizen and a person with retardation; professional and parent groups hold themselves out as "advocates" for various disabled people; individual service providers, professional or otherwise, define their role, in whole or part, as that of "client advocates";⁶ many human rights committees view their work as "client advocacy"; and even a state agency may have its mission defined as that of an "advocate."⁷ Consequently, it is not unusual, although it can be disconcerting, to attend a meeting concerning services for a person with handicaps at which all the participants announce themselves to be that person's advocate but promptly proceed to espouse diametrically opposite views about the person and his or her needs and desires.⁸

The confusion this causes is not necessarily the result of any-

4. See, e.g., S. HERR, *THE NEW CLIENTS: LEGAL SERVICES FOR MENTALLY RETARDED PERSONS* (1979); *Legal Advocacy for Persons Confined in Mental Hospitals*, 5 MENTAL DISABILITY L. REP. 274 (1981) ("point-counterpoint" exchange between Samuel J. Brakel, research attorney with the American Bar Foundation and Steven J. Schwartz and Robert D. Fleischner, attorneys with the Mental Patients Advocacy Project, Northampton, Massachusetts).

5. E.g., *Legal Advocacy for Persons Confined in Mental Hospitals*, *supra* note 4.

6. For instance, the Massachusetts Department of Mental Health has argued that its program of providing its clients with "service coordinators" or "case managers" fully satisfies the client's advocacy needs. *Brewster v. Dukakis*, 520 F. Supp. 882, 891 (D. Mass. 1981), *rev'd and remanded on other grounds*, 687 F.2d 495 (1st Cir. 1982); see also J. WESTMAN, *CHILD ADVOCACY: NEW PROFESSIONAL RULES FOR HELPING FAMILIES* (1979) (arguing that advocacy should be added to the job descriptions of all planners and providers of services).

7. See, e.g., MASS. GEN. LAWS ANN. ch. 28A, §§ 3-4 (West 1981 & Supp. 1982), which created the Office for Children, a state agency charged with acting as an "advocate" for children in Massachusetts.

8. It is all too seldom that the disabled person is allowed to attend and thereby straighten out the confusion. To its credit, the Massachusetts Department of Mental

thing evil. In fact, it is probably the product of a growing recognition across the various professional disciplines and, indeed, throughout our society, that human dignity and legal rights are at least as important to people with handicapping conditions as they are to the rest of us. But the benevolent motivations of this broadly defined community of advocates are not enough, in themselves, to relieve the confusion, lessen the inevitable professional tensions, or necessarily to result in anything meaningful for the client. The most obvious problem caused by all of this is that far too much energy and time are wasted in arguments about who speaks for whom, from what professional, moral, or ethical perspective, and with what grant of authority.⁹

Of course, "advocates" are people who work within the mental health care delivery system itself. But ironically, as Herr, Arons, and Wallace recognize, the most serious threat to patients' human rights lies in the highly bureaucratized settings in which mental health care is often organized. Since nearly every important decision about a mentally disabled person's life will be made from within the context of that bureaucracy, there can be palpable discord when an "outside" advocate intrudes and demands either something more than the bureaucracy is willing to grant or something the bureaucracy believes not to be in its client's "best interest." Consequently, the "advocates" are often at each other's throats.

The situation just described need not be so. With the publication of their book, Herr and his colleagues have taken a sizeable step toward the reduction, though hardly the elimination, of these potentially destructive misunderstandings. *Legal Rights and Mental Health Care* is an up-to-date, comprehensive, readable, and copiously documented work which explains the authors' views of the role of "outside" primarily legal, advocates and the tools—their client's legal rights—with which they labor. Since the book's intended audience is mental health professionals, it is written without the legalese which that audience can find so troubling. Nevertheless, the material will be of value to lawyers, clients, and interested citizens as well.

For the greater part of the book, the authors have carefully surveyed and explained most of the important legal rights which affect the lives of people labeled as mentally ill. In this regard, it is partic-

Health has promulgated regulations mandating client attendance at so-called "Individual Service Planning" meetings. MASS. ADMIN. CODE tit. 104, §§ 16.05(2), 21.46 (1980).

9. Such internecine struggles, of course, are nothing new. See Wald & Freidman, *The Politics of Mental Health Advocacy in the United States*, 1 INT'L J.L. & PSYCHIATRY 137 (1978).

ularly encouraging and somewhat innovative that the rights of clients of community programs are given space and treatment equal to that of their institutionalized counterparts. The chapters on the right to treatment,¹⁰ the right to refuse treatment,¹¹ the special problems and rights of children, the principle of the least restrictive alternative,¹² issues of privacy, confidentiality and access to records, anti-discrimination laws, and guardianship and other protective services are quite excellent. The chapters are filled with information that should be of great value to clinician and lawyer alike.¹³ But aside from the usefulness of these informative chapters, the book's more deeply obvious value lies in the authors' efforts to interpret the nature of advocacy, to illuminate the difficult concepts of competency and consent, and to explain why it is that mental patients' rights should be taken seriously.

In what may be their most provocative chapter, the authors describe what they believe to be fundamental principles which must be maintained if advocacy is to be true to its own ethics and useful to its clients. For the authors, the cardinal principle is that the advocate's sole loyalty is to his or her client. In practice, this largely inflexible rule is often the one which troubles mental health professionals because they must often "balance their loyalty to their clients with bureaucratic demands, programmatic responsibilities and professional

10. The Supreme Court's recent and discouragingly narrow decision in *Youngberg v. Romeo*, 102 S. Ct. 2452 (1982), is fully analyzed in this chapter.

11. The chapter on the right to refuse treatment compares the decision in *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) with *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom.*, *Mills v. Rogers*, 102 S. Ct. 2442 (1982).

The *Rogers* case is currently pending before the Supreme Judicial Court of Massachusetts upon certification of questions from the Court of Appeals for the First Circuit. The certified questions involve, *inter alia*, the status of Massachusetts law regarding institutionalized mental patients in light of a Supreme Judicial Court decision establishing that mentally ill people living in the community have a right to refuse psychotropic medication. *In re Guardianship of Roe*, 1981 Mass. Adv. Sh. 981, 421 N.E.2d 40 (1981). See 5 W. NEW ENG. L. REV. 565 (1983). Therefore, through no fault of the authors, this chapter may well be out of date not long after it is published.

12. This chapter is a useful and accurate description of the lengthy litigation in *Brewster v. Dukakis*, No. 76-4423-F, (D. Mass. Dec. 7, 1978) (Consent Decree), 544 F. Supp. 1069 (D. Mass. 1982) (describing decree and awarding fees).

13. Many mental health professionals may be disappointed that the book gives such brief coverage to questions of professional liability. The only issue addressed in this regard is that of confidentiality and the dangerous client. Many clinicians are concerned about whether they are likely to be sued for what they do or fail to do. Nevertheless, this book is about the rights of the client; "clinicians' rights" should be, and are, addressed elsewhere. See, e.g., A. VAN BIERVLIET & I. SHELDON-WILGEN, *LIABILITY ISSUES IN COMMUNITY BASED PROGRAMS* (1981).

judgments that what the client wants may not be what the client needs."¹⁴ Yet without the rule, both advocate and client are lost. The authors carefully and clearly explain the overriding need for confidentiality and trust in the advocate-client relationship and show that to maintain that trust, the advocate cannot serve two masters. Since probably few clinicians would want to define their rule in very different terms, this account is a helpful point of departure for a deeper understanding of the advocate's role.

Similarly, the authors believe that the advocate can function effectively only if he or she works from a presumption of client autonomy. This presumption means that the advocate should follow the expressed wishes of the client and must regard the client as a person possessed of all of the legal rights of any other citizen.¹⁵ Since most clinicians are trained to look behind the expressed wishes of their clients to find the "true" or "deeper" meaning of what is being said, this presumption is for them a particularly difficult one to fathom. The advocate's emphasis on "rights" and "autonomy" may be maintained, from the clinician's view at least, at the expense of the client's health, sanity, safety, or best interest. The resulting conflict between the lawyer-advocate and the clinician-advocate can be spirited. The authors are honest with their readers and recognize that there is probably no way to eliminate this tension, short of one side or the other either fundamentally altering its professional ethic or getting out of the business altogether. Probably the best result would be a deeper mutual understanding of the differences in professional orientation and a more quiet debate in an atmosphere that recognizes the full extent of shared goals; one that ultimately leads to something of value to the client.¹⁶

14. Nor is the most conscientious advocate necessarily free from countervailing pressures. For instance, some advocacy offices may choose not to represent clients involved in a particular kind of case, (e.g. medication refusals), so as not to rock the institutional boat. Brakel, *Legal Aid in Mental Hospitals*, 1981 AM. B. FOUND. RESEARCH J. 23, 63. Even those advocates who avoid such obvious co-optation cannot help but have their efforts subtly affected by their own values, their need to preserve their own mental health and their desire to assure the future of their project. Thus, it is well worth striving for the authors' overriding goal of "sole loyalty" as a criteria for choosing among cases.

15. The authors of *Legal Rights and Mental Health Care* recognize, as they must, that these presumptions are overcome by a legal declaration of incompetency, such as the appointment of a guardian.

16. The other fundamental principles of advocacy discussed by the authors are: confidentiality of communication between client and advocate; an attitude of professionalism toward mental health staff and systems; regular and dependable physical access to clients; and the ability and willingness to pursue the full range of remedies for a client's complaint.

Legal Rights and Mental Health Care is a positive step forward in that process. The book's essential morality, that mental patients have a right to dignity and to be treated like human beings, cannot be denied. The essential ideal, that mentally handicapped people can benefit from assertive advocacy, is likewise beyond dispute. Yet its essential hope, that all the professionals, including advocates, who have such inordinate power over the lives of handicapped people will be able to labor for the client in an atmosphere of compassion, mutual trust and understanding, remains unfulfilled.