"Make Promises by the Hour": Sex, Drugs, the ADA, and Psychiatric Hospitalization

Michael L. Perlin
"MAKE PROMISES BY THE HOUR*": SEX, DRUGS, THE ADA, AND PSYCHIATRIC HOSPITALIZATION

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I. INTRODUCTION

A. The Act ¹

The Americans with Disabilities Act has been hailed by advocates for persons with disabilities as "a breathtaking promise,"² "the most important civil rights act passed since 1964,"³ and as the "Emancipation Proclamation for those with disabilities."⁴ It is, without question, "Congress' most innovative attempt to address the pervasive problem of discrimination against physically and mentally handicapped citizens"⁵ by providing, in the words of a congressional committee, "a clear and comprehensive national mandate to end discrimination against individuals with disabilities."⁶ The ADA provides basically the same bundle of protections for persons with disabilities as the

* BOB DYLAN, Love Minus Zero/No Limits on Bringing It All Back Home (1965).

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4. Id. at 1183 n.2 (quoting statement by the bill's sponsors); see also Sandra K. Law, Comment, The Americans with Disabilities Act of 1990: Burden on Business or Dignity for the Disabled?, 30 DUQ. L. REV. 99, 114 (1991) (calling the ADA a "solid and positive step toward making this country a better nation").


Civil Rights Acts of the 1960s did for citizens of color with clear, strong, and enforceable standards. The language that Congress chose to use in its introductory fact-findings is of extraordinary importance. Its specific finding that individuals with disabilities are a "discrete and insular minority... subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness," is not just precatory flag-and-apple-pie rhetoric. This language—interpreted as granting "the force of law"—was carefully chosen; it comes from the heralded "footnote 4" of United States v. Carolene Products that has served as the springboard for nearly a half century of challenges to state and municipal laws that have operated in discriminatory ways against other minorities. It reflects a congressional commitment to provide

8. See id. at 43-48, 63-64, 93-95, 101-02 (discussing enforcement provisions under titles I, II, and III of the ADA); cf. Pamela Karlen & George Rutherglen, Disabilities, Discrimination, and Reasonable Accommodation, 46 Duke L.J. 1 (1996) (reading the ADA as providing more protections than other civil rights acts).
11. Cf. Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 11 (1981) (stating that rights language in Developmentally Disabled Assistance and Bill of Rights Act simply created a federal-state granting statute and did not vest developmentally disabled individuals with a legally enforceable cause of action). This conclusion was criticized as "absurd" and "objectionable" in an article co-authored by plaintiffs' lead counsel in the Pennhurst case. See David Ferleger & Patrice M. Scott, Rights and Dignity: Congress, the Supreme Court, and People with Disabilities After Pennhurst, 5 W. New Eng. L. Rev. 327, 350 (1983). For a survey of all commentary, see 2 PERLIN, supra note 5, § 7.13, at 617-23. On the question of whether key sections of the ADA will be seen as little more than hortatory language, see infra text accompanying notes 64-75.

A number of authors have noted the significance of the Carolene Products language to the ADA. See, e.g., Leonard Rubenstein, Ending Discrimination Against Mental Health Treatment in Publicly Financed Health Care, 40 St. Louis U. L.J. 315, 339 (1996) (stating that ADA's invocation of Carolene Products footnote demonstrates justification for employing "heightened judicial scrutiny" test); see also Susan Lee, Heller v. Doe: Involuntary Civil Commitment and the "Objective" Language of Probability, 20 Am. J.L. & Med. 457, 468 n.90 (1994) (comparing language of the ADA to Supreme Court language in Carolene Products which the author interprets as congressional intent to identify disabled persons as group "deserving heightened scrutiny"); Robert E. Rains, A Pre-History of the Americans with Disabilities Act and Some Initial Thoughts As to Its Constitutional Implications, 11 St. Louis U. Pub. L. Rev. 185, 200-01 (1992) ("There can be little question that in adopting its findings in the A.D.A., Congress was attempting to
"protected class" categorization for disabled persons. This language, in turn, forces courts to employ a "compelling state interest" or "strict scrutiny" test in considering statutory and regulatory challenges to allegedly discriminatory treatment. The law's invocation of the "sweep of congressional authority, including the power to enforce the fourteenth amendment," simply means that any violation of the ADA must be read in the same light as a violation of the Equal Protection Clause of the Constitution. This guarantees—for the first time—that this core constitutional protection will finally be made available to disabled persons.

utilize the Carolene Products formulation to mandate a heightened level of judicial scrutiny inada cases); Lisa A. Montanaro, Comment, The Americans with Disabilities Act: Will the Court Get the Hint? Congress' Attempt to Raise the Status of Persons with Disabilities in Equal Protection Cases, 15 Pace L. Rev. 621, 663 (1995) (arguing that by adopting the ADA, Congress attempted to utilize Carolene Products theory to imply that a "heightened level of scrutiny" should be used in ADA cases).

15. See, e.g., Phyllis Coleman & Ronald A. Shellow, Ask About Conduct, Not Mental Illness: A Proposal for Bar Examiners and Medical Boards To Comply with the ADA and Constitution, 20 J. Legis. 147, 151 n.23 (1994) (stating that "[t]he ADA treats disabled persons as a suspect class"); Lowndes, supra note 9, at 446 (stating that "Congress clearly intended to create a new protected class—the disabled"); Miller, supra note 12, at 412 (stating that Congress applied "suspect class" test in ADA statutory language); Montanaro, supra note 14, at 663-64 (concluding that "Congress' intent was to transform the disabled into a suspect class for purposes of constitutional and statutory interpretation").

16. On the relationship between this language and the heightened scrutiny requirement, see Crowder v. Kitagawa, 842 F. Supp. 1257, 1264 (D. Haw. 1994) (assuming application of strict scrutiny level for purposes of evaluating blind plaintiffs' fourteenth amendment claims against the state officials and agency); Lee, supra note 14, at 477 n.90 (noting ADA language identical to that which the Supreme Court uses to identify groups deserving heightened scrutiny); Heidi A. Boyd, Comment, Heller v. Doe: Denying Equal Protection to the Mentally Retarded, 21 New. Eng. J. on Crim. & Civ. Confinement 437, 461 (1995) (stating that it was "clear" from the language of Congress' findings that Congress was mandating heightened scrutiny); William Christian, Note, Normalization as a Goal: The Americans with Disabilities Act and Individuals with Mental Retardation, 73 Tex. L. Rev. 409, 424 (1994) (arguing that in light of the ADA, laws treating persons with disabilities differently should be subject to heightened scrutiny).

In City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 441-42 (1985), the Supreme Court had ruled that mental retardation was neither a suspect class nor a quasi-suspect class for purposes of equal protection analysis. In supporting its conclusion, the Court noted that a contrary decision would have made it difficult to distinguish other groups such as the mentally ill "who have perhaps immutable disabilities setting them off from others, who cannot themselves mandate the desired legislative responses, and who can claim some degree of prejudice from at least part of the public at large." Id. at 445; see also Schweiker v. Wilson, 450 U.S. 221, 231-34 (1981) (employing rational basis test in challenge to statute reducing SSI benefits to certain individuals in institutions for mental illness); Adoption of Kay C., 278 Cal. Rptr. 907, 914-15 (Ct. App. 1991) (reaching conclusion similar to Cleburne on state constitutional law grounds). Cleburne is discussed in this context in 2 Perlin, supra note 5, § 7.22 at 662-63 n.350. At least one commentator has argued that the ADA legislatively overrules the "rational basis" standard of Cleburne. See Miller, supra note 12, at 409-15.


18. See, e.g., Timothy M. Cook, The Americans with Disabilities Act: The Move to Integration, 64 Temp. L. Rev. 393, 434 (1991) ("[Congressional] findings indicate unambiguously that Con-
This Article will focus on a fairly narrow (but, to my mind, extraordinarily important) question of ADA law: its application to individuals in inpatient psychiatric hospitals. This is a population that is classically voiceless, friendless, and with few contacts in the "free world." It is a population whose disenfranchisement starkly mirrors the sort of powerlessness and marginalization spoken to by the Supreme Court in the *Carolene Products* case and spoken to by Congress in the ADA's initial findings section.\(^{19}\)

By its terms, the entire ADA applies to persons with mental disabilities, including persons with mental illness. Yet, very little of the final statute, the legislative history, or floor debate focused on the "grotesque" history of discrimination and mistreatment suffered by such individuals;\(^{20}\) the crushing economic, social, and psychological burdens borne by such persons in their day-to-day lives; the conditions faced by such persons when institutionalized in public facilities or when discharged from such facilities to lives of misery on our cities' streets without adequate transitional mental health, medical, or social services; and the pernicious legal effects that flow from the badge of mental disability.

The phrase "mental impairment" or "mental disability" is mentioned only a handful of times in the final act. In the initial findings section, disability is defined to include a "physical or mental impairment."\(^{21}\) Congress notes further that forty-three million Americans "have one or more physical or mental disabilities";\(^{22}\) discrimination includes failure to make "reasonable accommodation" to an otherwise-qualified person's "known physical or mental limitations,"\(^{23}\) and

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\(^{19}\) See Rubenstein, *supra* note 14, at 339, 350.

\(^{20}\) *City of Cleburne*, 473 U.S. at 454 (1985) (Stevens, J., concurring); *id.* at 461 (Marshall, J., concurring in part and dissenting in part); *see* Cook, *supra* note 18, at 399-407.


\(^{22}\) *Id.* § 12101(a)(1) (emphasis added).

\(^{23}\) *Id.* § 12112(b)(5)(A) (emphasis added).
a section on paratransit and special transportation services requires that public entities provide such services to any individual who is unable, “as a result of a physical or mental impairment” to use other public transportation vehicles.24 And that is all.

Although the entire ADA recognizes that much of the discrimination faced by persons with disabilities flows from “unfounded, outmoded stereotypes and perceptions, and deeply imbedded prejudices,”25 the legislative history in no way illuminates the specific prejudices and biases faced by mentally disabled persons, especially those who have been institutionalized because of mental illness.26 It is a failure that screams out for attention.

The ADA is not the first federal statute that has purported to provide legal rights for persons with mental disabilities. Section 504 of the Rehabilitation Act of 1973,27 the Mental Health Systems Act,28 the Protection and Advocacy for Mentally Ill Individuals Act (“PAMI Act”),29 the Developmental Disabilities Assistance and Bill of Rights Act30 ("DD Act") all, on their face, provide such individuals with a broad range of constitutional and civil rights. Yet, each of these has been found wanting. Section 504 of the Rehabilitation Act, by its own terms, applies only to discrimination “under any program or activity receiving Federal financial assistance”;31 its shortcomings have been noted by both courts and commentators.32 The title of the Mental Health Systems Act of 1980 that urged states to revise their laws to

24. Id. § 12143(c)(1)(A)(i) (emphasis added). The only other section of the Act that looks specifically to mental disability is an exclusion section that states that the Act is inapplicable to, inter alia, certain sexual disorders (for example, transvestism, transsexualism, and other “gender identity disorders”), id. § 12211(b)(1), and to compulsive gambling, id. § 12211(b)(2).
30. Id. § 6000.
“ensure that mental health patients receive the protection and services they require” was repealed less than a month after its enactment as part of the Omnibus Budget Reconciliation Act of 1981. Although the Protection and Advocacy systems established under the PAMI Act have certainly resulted in the provision of much “needed rights enforcement services for certain institutionalized mentally disabled persons,” the legislation is not a panacea or a total palliative for the underlying problems facing institutionalized persons. Additionally, courts have generally held that the PAMI Act does not provide a private cause of action to individual litigants. The Supreme Court has made it clear that the DD Act is to be construed merely as a voluntary “federal-state grant program” conferring no rights on mentally disabled individuals enforceable by private civil litigation.

In short, none of these federal laws has had an impact remotely approaching a transformative effect on the lives of persons institutionalized because of mental disability. We still do not know whether the ADA will ultimately have such a transformative effect, or whether it will be simply another “paper tiger,” filled with promise but bereft of substance. It is this question that I wish to address here.

To consider this question, it is also necessary to consider the question of timing. The euphoria of the 1970s—when litigators representing persons with mental disabilities eagerly awaited the latest federal court decision, knowing instinctively that there would be new rights created, new causes of actions found—crashed some fifteen years ago with the ascension of a new, conservative federal judiciary and a Rehnquist-driven Supreme Court. Decisions such as Youngberg v. Romeo (establishing a pallid “substantial professional judgment” test

34. See 2 Perlin, supra note 5, § 8.15, at 797 (discussing repeal).
39. Id. at 12.
40. See generally Michael L. Perlin, Ten Years After: Evolving Mental Health Advocacy and Judicial Trends, 15 FORDHAM URB. L.J. 335 (1986-87) (discussing this period of euphoria).
41. See, e.g., Michael L. Perlin, The Voluntary Delivery of Mental Health Services in the Community, in LAW, MENTAL HEALTH AND MENTAL DISORDER 150 (Bruce Sales & Daniel W. Shuman eds., 1996).
in assessing liability in institutional cases),\textsuperscript{42} Pennhurst State School \& Hospital v. Halderman II (expanding the scope of the Eleventh Amendment's sovereign immunity theory far beyond any prior court decision),\textsuperscript{43} and even Mills v. Rogers (sidestepping the issue of a federal constitutional basis of a right to refuse antipsychotic drug treatment)\textsuperscript{44} all seemed to clarify that the federal courts were no longer going to be the forum of choice for litigants representing persons with mental disabilities. Indeed, as I will discuss below, Mills (and then later, the Fourth Circuit's en banc decision in United States v. Charters (a case severely limiting the right of a criminal pretrial detainee to refuse such treatment))\textsuperscript{45} seemed to augur an exodus from federal to state courts in a whole range of disability cases, an exodus spurred on by the rise of Justice Scalia as the Rehnquist Court's intellectual leader and by the appointment of Justice Thomas.

At the same time, the public—originally somewhat sympathetic to the cause of persons with mental disabilities—turned hostile.\textsuperscript{46} The day has long passed when advocates seeking to abolish involuntary civil commitment appeared to be amassing support for their efforts.\textsuperscript{47} The familiar "pendulum swing"\textsuperscript{48} has resulted in a call for expanded commitment powers in many jurisdictions;\textsuperscript{49} the perceived linkages between involuntary civil commitment requirements and homelessness make it likely that the time of the abolition movement has come and gone.\textsuperscript{50} The public is indignant when it appears—in a few idiosyncratic, yet widely publicized cases—that a "clearly crazy" person is to

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  \item \textsuperscript{42} 457 U.S. 307 (1982).
  \item \textsuperscript{44} 457 U.S. 291 (1982).
  \item \textsuperscript{45} 863 F.2d 302 (4th Cir. 1988).
  \item \textsuperscript{46} See generally Michael L. Perlin, Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization, 28 Hous. L. Rev. 63 (1991) (describing society's unsympathetic view of homelessness and deinstitutionalization).
  \item \textsuperscript{47} 1 PERLIN, supra note 5, § 2.24, at 168. In 1978, President Carter's Commission on Mental Health's Task Force Panel on Legal and Ethical Issues recommended a "modified abolition" position. See id. at 172-75.
  \item \textsuperscript{49} See, e.g., 1 PERLIN, supra note 5, § 2.27A, at 48 (Supp. 1996); Durham & LaFond, supra note 48, at 398.
\end{itemize}
be released from a psychiatric hospital because of some purported technical deficiency in the court papers or because judges allegedly and unthinkingly accept abstract civil libertarian arguments from young, naive lawyers.  

It appeared, in short, as if the mental disability law movement was in danger of becoming the public interest law equivalent of pop music's "one hit wonders."

As a result of these factors—coupled with budget shortfalls, increased cynicism about the role of the government in even ameliorating social conditions, and a growing mean-spiritedness in public life—it appeared that the time that persons institutionalized for reasons of mental disability could rely on federal courts to craft broad prophylactic remedies in institutional reform litigation was long past. The passage of the ADA, however, has made us rethink this conventional wisdom. For if the ADA does what some commentators say it does and what Congress seems to have said it should do, then the time may be right for a counter-counter-revolution in this area of the law.

What impact, if any, has the ADA yet had on these trends and on this population? A simple ALLFEDS computer search on Westlaw of "AMERICANS WITH DISABILITIES ACT" & MENTAL +2 (ILLNESS DISABILITY) (performed on April 24, 1997) reveals a universe of 212 decisions. However, a reading of those cases suggests that the vast majority of those with substantive holdings deal with two issues largely unrelated to the problems faced by inpatients: the impact of the ADA on professional licensure decision making (both regarding special accommodations for examinations and the questions that may be asked in the application process as to past or present psychiatric treatment) and the extent to which employers have made reasonable accommodations to persons with mental disabilities in job

51. Several years ago, in reviewing a book about deinstitutionalization, I characterized the public's "take" on this issue in this manner:

[N]urtured by radical psychiatrists (such as Thomas Szasz and R.D. Laing), spurred on by politically-activist organizations pushing egalitarian social agendas (such as the ACLU), a cadre of brilliant but diabolical patients' rights lawyers dazzled sympathetic and out-of-touch judges with their legal legerdemain—abetted by wooly-headed social theories, inapposite constitutional arguments, some oh-my-god worst-case anecdotes about institutional conditions, and a smattering of "heartwarming, successful [deinstitutionalization] cases"—as a result of which courts entered orders "emptying out the mental institutions" so that patients could "die with their rights on." When cynical bureaucrats read the judicial handwriting on the hospital walls, they then joined the stampede, and the hospitals were thus emptied. Ergo deinstitutionalization. Ergo homelessness. Endgame.


52. See generally Perlin, supra note 46 (discussing the myths of deinstitutionalization).

settings. Only a handful of cases even touch on the issues that are of daily significance to individuals who reside in large, public psychiatric institutions. The Supreme Court has acknowledged the potential connection only once in its decision in *Heller v. Doe*, where it upheld a Kentucky statutory scheme that established a heightened standard of review for involuntary civil commitment based on mental illness but a lesser standard for commitment based on mental retardation. The Supreme Court, however, refused to consider the question on the merits, finding that it had not been properly presented. Similarly, there has been an explosion of law review articles and articles in the "trade" press and legal newspapers on all aspects of the ADA (a simple "AMERICANS WITH DISABILITIES ACT" search on the LRI database of Westlaw done on April 24, 1997, revealed 1,051 separate listings). Yet, of all of these, only a few—most notably, the late Timothy Cook's brilliant *The Americans with Disabilities Act: The Move to Integration* piece—are remotely relevant to questions involving inpatient hospitalization.

This Article seeks to shed some light on these issues. If and when cases are brought seeking to apply the ADA to individuals institutionalized in psychiatric hospitals, will federal courts interpret the ADA as it was written (in the light of Congress’s clear statutory intent) or will the key language to which I have already alluded be seen as little more than hortatory shibboleths? Will courts say, "No, Congress really didn’t mean what it said."? Will they say, "Well, Congress may have meant it, but only in an aspirational way, and there’s really nothing for us here."? Or will they say, "Yes, Congress said it, Congress meant it, and, dammit, we’re gonna enforce it!"?

Here, I am looking at two substantive rights issues only: the issue of sex (whether hospitalized patients have a right to voluntary sexual in-

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57. *Id.* at 319-27.

58. *Compare id.* at 319, *with id.* at 336-37 (Souter, J., dissenting) (addressing the applicability of the ADA to the case before the Court).


60. *See, e.g.*, Niece v. Fitzner, 941 F. Supp. 1497, 1508 (E.D. Mich. 1996) (refusing to follow Torcasio v. Murray, 57 F.3d 1340 (4th Cir. 1995), which had declined to apply ADA to state prison cases).
teraction) and the issue of drugs (the extent to which such patients' right to refuse the imposition of antipsychotic medications can be limited by reason of their institutionalization). Both of these are controversial; both "push our buttons" in different, provocative ways, and both force us to think about how we construct the universe of "mental patients" and the extent to which we think such "mental patients" are like or unlike the rest of us. Both are highly contentious, and both are of critical importance to the population in question, in the context of their current status as inpatients and in the context of the likelihood that they can be reintegrated into the community once they are released from an inpatient hospital setting.

Now, resolution of these issues is made even more complex by the fact that it is impossible to understand in a meaningful manner any aspect of mental disability law without an understanding of what I call "sanism" and "pretextuality." "Sanism" is an irrational prejudice of the same quality and character of other irrational prejudices that cause, and are reflected in, prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry.61 "Pretextuality" is the way in which courts often accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (frequently meretricious) decision making, specifically where witnesses, especially expert witnesses, show a high propensity to distort purposely their testimonial ends.62 I will conclude that it is only through these filters that the posed questions can be answered. In addition, I believe that the ADA must also be considered under the lens of therapeutic jurisprudence (a means of studying the law as a therapeutic agent, recognizing that substantive rules, legal procedures, and lawyers' roles may have either therapeutic or antitherapeutic consequences) in order for us to fully understand the problems at hand.63

My thesis here is that the actual application of the ADA to these key areas of patients' civil rights law might result in the total transformation of these areas of the law, and might do so in ways that combat sanism, expose pretextuality, and provide a building block of thera-


peutic jurisprudence. This Article’s title comes from Bob Dylan’s compelling and evocative love ballad, *Love Minus Zero/No Limits*. The protagonist of the song—presumably his then-girlfriend (the song was written in 1965)—“makes promises by the hour.” The ADA, it seems to me, “makes promises by the hour” to persons with mental disabilities—promises of emancipation and redemption. Are these authentic promises or are they empty ones? I believe that an examination of the subject matter areas I have chosen—controversial ones, laden with stereotypes, with stigmas, with taboos—will help illuminate the underlying issues and help answer this difficult and important question.

The paper will proceed in this manner. In Part II, I will look at both the meager ADA case law and the scant scholarly literature that has emerged in this area, with an eye toward determining the extent to which courts see the ADA as merely offering hortatory or aspirational words to this population and the extent to which courts have taken the Act’s findings, its incorporation of the Equal Protection Clause, and its invocation of the *Carolene Products* language seriously. The answers to these questions lead us to the first overarching question that must be addressed: under the ADA, is institutionalization in se enough of a rationale upon which to premise rights deprivation? Put another way, can the state (through hospital authorities) demonstrate a compelling state interest to deprive plaintiffs of otherwise-guaranteed constitutional, civil, and statutory rights? In Part III, I will consider the substantive topics—sex and drugs—by looking at the state of the case law as it stands today and the impact that I believe a taken-seriously and enforced-seriously ADA would have on that case law. In Part IV, I will consider the meanings of sanism, pretextuality, and therapeutic jurisprudence and will assess the impact that a taken-seriously and enforced-seriously ADA would have on these hidden variables in mental disability law jurisprudence. In Part V, I will offer some modest conclusions.

II. ADA AND MENTAL DISABILITY

A. Introduction

How is the ADA to be construed in decisions involving institutionalized psychiatric patients? What does the case law teach us, what can we glean from the scholarly literature, and what sort of tests should courts apply in deciding questions that arise under the Act? Before addressing these questions though, it is necessary to consider a “fore-runner” question that may give us insights into how these questions
will be substantively resolved. That is, what is the likelihood that the ADA will be seen as more than merely hortatory or aspirational in this context? It is to this question that I first turn.

B. Hortatory Language

Little attention has been paid to the ways that disability rights statutes may be read as simply "aspirational" or "hortatory," but I think it is a key concern. For years, environmental law scholars have written critically about the dilemma caused by enactment of "aspirational statutes"—laws with high-sounding, ambitious aims but passed without either meaningful appropriations or workable enforcement powers.64 Put another way, aspirational laws are laws that "express goals that we wish we could achieve, rather than what we can realistically achieve."65 At least one judge has characterized such statutes as "a perfect device for evading the truly hard policy decisions."66

Professor Susan Rose-Ackerman has written more broadly in this area, focusing on the federal courts’ failure to require Congress to either authorize or appropriate funds when it passes prophylactic or remedial legislation (thus allowing Congress to eventually set appropriations at zero without actually repealing such a law).67 Such a result “encourage[s] members of Congress to include language in substantive statutes that appears to promise benefits that legislators have no intention of funding adequately.”68

Here, she points directly to an important mental disability law case: *Pennhurst State School & Hospital v. Halderman*.69 There, as I have already noted, the Supreme Court rejected plaintiffs’ argument that the federal “Bill of Rights for the Developmentally Disabled” (that included findings that persons with developmental disabilities “have a right to appropriate treatment, services, and habilitation” in the setting “that is least restrictive of the individual’s personal liberty”) created substantive, privately enforceable rights.70 In the course of his opinion that characterized this language as nothing more than a "fed-

68. Id.
70. Id. at 8 (quoting 42 U.S.C. §§ 6009 (1)-(2) (1984)).
eral-state grant program," 71 Chief Justice Rehnquist quoted with approval this language from Rosado v. Wyman: "Congress sometimes legislates by innuendo, making declarations of policy and indicating a preference while requiring measures that, though falling short of legislating its goal, serve as a nudge in the preferred directions." 72

Will the Supreme Court read the ADA in the same niggardly way it read the DD Act's Bill of Rights in Pennhurst, thus gutting it of most of its force? In an earlier article, I wondered aloud whether full enforcement of the ADA—full enforcement that could potentially lead to profound "sea changes" in the ways that society treats persons with disabilities—might lead to a congressional repeal effort. 73

There are certainly differences between the two Acts (the ADA is silent on funding questions and the ADA's inclusion of the Carolene Products language and its citation to the Fourteenth Amendment are both absent from the DD Act's legislation). On at least one more recent occasion, the Supreme Court has—in the context of a case interpreting a mandatory federal Medicaid funding law—distinguished Pennhurst on the basis of differences in statutory language. 74 Moreover, the legislative history of the ADA certainly is unequivocal in its commitment to transforming the lives of persons with disabilities. But . . . will the Supreme Court take it seriously?

I concluded my earlier ADA piece with this thought:

Finally, once "Rip Van Winkle" is awakened, how will Congress respond? In speaking against the ADA, Senator Humphrey referred to it as "one of the most radical pieces of legislation" he had encountered in his eleven years in the U.S. Senate. I believe that he was right, but with entirely the wrong spin. If the ADA does force a change in our social attitudes, then it will work a fundamental change in our social fabric. It will force us to reevaluate centuries of discrimination, bigotry and prejudice. Such a change will also force us to acknowledge that persons with disabilities, whether persons with mental disabilities, persons with mental illnesses, or persons who were previously institutionalized for mental illnesses, are full citizens of this country. Only then will it be recognized that they, like all other citizens, deserve to be treated "as human beings." That thought would be radical, indeed. 75

For the purposes of this Article, I will predict—tentatively, to be sure—that the Court will give the ADA, at the least, a construction

71. Id. at 11.
72. Id. at 19 (quoting Rosado v. Wyman, 397 U.S. 397, 413 (1970)).
73. See Perlin, supra note 1, at 43.
75. Perlin, supra note 1, at 45.
approximating congressional intent. I thus now turn to the case law (meager though it may be) and the scholarship in an effort to determine the route that the courts may be taking.

C. Case Law

The ADA title most important to institutionalized psychiatric patients is Title II. Under that Title, "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."76 The legislative history stressed that discrimination continued in "such critical areas as . . . institutionalization."77 Although this title has not been the subject of much consideration in institutional cases, courts have held that allegations of restraint, isolation, and segregation could constitute discriminatory treatment under the ADA78 and that the Act requires that a psychiatric patient "be placed in the most integrated setting, . . . which meets the needs of her disability but which give [sic] her the most freedom."79

As I have already noted, most of the ADA/mental disability case law has focused on questions of professional licensure and examinations and on the range of accommodations necessary in employment situations. Several courts have enjoined bar committees from inquiries into applicants' histories of having been treated for mental disorders, but others have declined to do so.80 Yet other courts have considered the application of the ADA to conditions under which professional licensure exams are to be taken.81 On whether accommodations are reasonable in the employment context, courts are split. It appears that most decisions have been fact-based, turning on the individual judge's perception as to whether the plaintiff could perform the

81. See, e.g., Argens v. New York State Bd. of Law Exam'rs, 860 F. Supp. 84 (W.D.N.Y. 1994); In re Rubenstein, 637 A.2d 1131 (Del. 1994); In re Underwood, 3 Am. Disabilities Cas. 573 (Me. 1993).
job tasks satisfactorily, even with the statutorily mandated "reasonable accommodation." 82

There is a smattering of other mental disability cases that focuses on issues somewhat closer to the ones I am discussing in this Article. For instance, a district court in Florida found an ADA violation when a town’s budget cuts eliminated community recreational programs that were solely for persons with disabilities, 83 as did a district court in Massachusetts that considered a state law that required state hospital residents to contribute to the costs of assigned counsel. 84 On the other hand, a District of Columbia district court ruled that mentally disabled residents of a homeless shelter failed to state a claim in their allegations that restrictions on their freedom of expression were in violation of the same Act. 85 The most important of the mini-universe of cases is Helen L. v. DiDario, 86 where the court found that a state welfare department regulation that forced certain patients to receive required care services in the segregated setting of a nursing home (rather than through a community-based attendant care program) violated the ADA.

Helen L. is significant for several reasons. First, the Third Circuit read the Act’s antidiscrimination language broadly and loudly. The court cited congressional findings that “[h]istorically, society has tended to isolate and segregate individuals with disabilities, and . . . such forms of discrimination . . . continue to be a serious and pervasive social problem,” 87 and that “the Nation’s proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.” 88 Next, the court read the ADA as being “intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides . . . and ignores them,” and declared that it would not “eviscerate the ADA by conditioning its protections upon a finding of intentional or overt ‘discrimination,’” 89 focusing specifically

83. Concerned Parents To Save Dreher Park Ctr. v. City of West Palm Beach, 846 F. Supp. 986 (S.D. Fla.).
87. Id. at 332 (alteration in original) (quoting 42 U.S.C. § 12101(a)(2)).
88. Id. at 335 (alteration in original) (quoting 42 U.S.C. § 12101(a)(8)).
89. Id. at 335.
on Congress' finding that "'discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization.'"\(^9\) Finally, it rejected the state's argument that it could not change the plaintiff's regimen of care because the two programs in question were funded on separate budgetary lines. In language that has potential impact on all cases assessing the potentially discriminatory basis of the provision of public hospital service benefits, the court was clear:

[T]he ADA applies to the General Assembly of Pennsylvania, and not just to DPW [the Department of Public Welfare]. DPW can not rely upon a funding mechanism of the General Assembly to justify administering its attendant care program in a manner that discriminates and then argue that it can not comply with the ADA without fundamentally altering its program. . . .

"Because the Commonwealth, including all its branches, is bound by the decree, the argument of inability to comply rings hollow. Even if the executive branch defendants were physically or legally incapable of complying with the decree, those Commonwealth officials sitting in the General Assembly certainly are not incapable of insuring the Commonwealth's compliance." The same applies here: since the Commonwealth has chosen to provide services to [plaintiff] under the ADA, it must do so in a manner which comports with the requirements of that statute.\(^9\)

By applying a discrimination analysis to a case that arose in an institutional setting and by focusing on congressional language that enumerates institutionalization as an area in which discrimination persists, the Third Circuit provides an important building block for subsequent ADA-based challenges to institutional policies. Its rejection of the "separate budgetary line" defense suggests that courts may be willing to "pierce the veil" of administrative or financial explanations for discriminatory actions. In two important ways, then, Helen L. offers strong support to arguments that at least one federal circuit is willing to take the ADA both literally and seriously.

**D. The Literature**\(^9\)

By far the most important analytic piece discussing the ADA and its potential impact here has been Timothy Cook's *The Americans with Disabilities Act: The Move to Integration* article in *Temple Law Review*.\(^9\) Cook argued that the ADA meant an end to what he termed

\(^9\) Id. at 336 (quoting 42 U.S.C. § 12101(3)).
\(^9\) Id. at 338-39 (quoting Delaware Valley Citizen's Council for Clear Air v. Pennsylvania, 678 F.2d 470, 475-76 (3d Cir. 1982)) (citation omitted).
\(^9\) This section is generally adapted from MICHAEL L. PERLIN, LAW AND MENTAL DISABILITY 324-25 (1994).
\(^9\) Cook, supra note 18.
the segregation of institutions for the mentally disabled. He read congressional intent through the legislative history to abolish, in Senator Weicker’s words, the “monoliths of isolated care in institutions and segregated educational settings. . . . Separate is not equal. It was not for blacks; it is not for the disabled.” The House Judiciary Report here was equally explicit: “[I]ntegration is fundamental to the purposes of the ADA. Provision[s] of segregated accommodations and services relegate persons with disabilities to second-class citizen status.” Cook read the Act to bar intentional and unintentional discrimination and quoted researchers who concluded that “institutions and other segregated settings are simply unacceptable.” He concluded that the Act’s invocation of the Fourteenth Amendment effectively overruled the substantial “professional judgment” standard of Youngberg v. Romeo.

Cook was writing primarily about individuals institutionalized in facilities for persons with mental retardation or developmental disabilities. Can these same arguments be made about cases involving persons institutionalized because of mental illness? Are there clear differences? Do police power considerations inherent in the involuntary civil commitment process make a difference? Does the invocation of the Fourteenth Amendment and the use of “discrete and insular minority” language truly significantly alter the Youngberg standard?

I wrote three years ago that “[t]hese are difficult questions for which there are no ready or apparent easy answers,” and little has changed my mind since then. Cook’s article has been cited in a number of trial court decisions in cases—except for two decided by the same judge—involving a variety of ADA topics, ranging from a case brought by a child with a severe respiratory condition who sought to prohibit exceptions to a city’s ban on open burning to employ-

94. Id. at 429.
95. Id. at 423.
97. Id. at 427.
98. Id. at 413.
100. Perlin, supra note 1, at 38.
ment discrimination cases brought by persons suffering from asthma, shoulder injury, carpal tunnel syndrome, and spinal injury. None of these cases, though, involve the sort of "big issue" that Cook's methodology might eventually reach. Yet, that methodology provides litigators with a blueprint for frontal attacks on Youngberg-based case law that limits patients' civil and treatment rights. The unanswered question here, of course, is whether institutional plaintiffs' litigators will take the challenge.

E. Applying a Test

What methodology, then, must be used in cases such as the ones that I discussed in my introduction? The first question must be this: Do defendant's policies discriminate against plaintiffs? If they do, is there a compelling state interest to justify that discrimination? Early cases that struck down overbroad involuntary civil commitment statutes had employed this test in challenges both to the procedural and substantive limitations of the commitment power, and even a few have done so since the Supreme Court declined in City of Cleburne v. Cleburne Living Center, Inc. in 1985 to apply a "heightened scrutiny" test to a zoning case involving group homes for persons with mental retardation. I am convinced, however, that the ADA legislatively overrules this aspect of the Cleburne case and now requires a compelling state interest justification for discrimination.

107. 2 PERLIN, supra note 5, § 4.44, at 19 n.820.1 (Supp. 1996) (citing cases). Another major potentially persuasive scholarly force is Rubenstein, supra note 14, who urges litigators to focus on ADA as source of rights in combating discrimination in health benefits for persons with psychiatric disabilities.
III. Substantive Areas of Civil Rights

A. Sex

The question of the right of institutionalized mentally disabled persons to engage in consensual sexual activity is one of the most threatening to be raised to clinicians, line workers, administrators, advocates, attorneys, or family members (in the words of a story in the Chicago Tribune, "a public policy question as controversial as they get"). The taboo and stigma attached to sexual behavior is inevitably heightened when it is coupled with and conflated with stereotypes of the meaning of mental disability. The question challenges the traditional "liberal" position on questions of institutionalization and civil rights enforcement, and it reflects the massive use of ego defenses (such as denial) in the way we think about hospitalization questions. It is, finally, astonishingly underdiscussed in light of the fundamentality of sexuality as an expressive human experience.

The treatment standards established in Wyatt v. Stickney—the first broad-based law reform case granting a right to treatment to institutionalized psychiatric patients—guaranteed such individuals the right to reasonable interaction with members of the opposite sex. Of the many states that adopted the Wyatt standards as bases of their Patients' Bills of Rights, however, only four adopted this portion of the standards. There has also been no follow-up litigation based upon any of the statutes that do provide for this right, and only a scattering of cases has been litigated anywhere that has sought


112. Rob Karwath, Mental Center Sex Rule Studied, CHI. TRIB., Apr. 9, 1989, § 2, at 1.

113. See Dorfman, supra note 62.


115. See generally 2 PERLIN, supra note 5, §§ 4.07-4.24, at 29-126.


117. See PERLIN, supra note 92, at 190-96 (discussing state statutory and constitutional rights regarding mentally disabled persons).

118. See Martha A. Lyon et al., Patients' Bills of Rights: A Survey of State Statutes, 6 MENTAL DISABILITY L. REP. 178, 185-201 (1982) (listing all state statutes). At the time that Lyon and her colleagues conducted this survey, Kansas, Montana, New Jersey, and Ohio had enacted such laws. Since that time, Kansas has repealed its statute, while similar laws have been signed in Colorado (on behalf of developmentally disabled persons) and Louisiana (on behalf of institutionalized minors).
to vindicate this right. In addition, this right is conspicuous by its absence from either piece of complementary federal civil rights legislation.

Most states do not recognize their patients’ right to personal or interpersonal relationships. Often, the right to sexual interaction depends on the whim of line-level staff or on whether such interaction is seen as an aspect of an individual patient’s treatment plan. It has even been suggested that “sexual activities between psychiatric inpatients should be strictly prohibited and when it occurs patients should be isolated, . . . and tranquilized if necessary.” One hospital’s guidelines stated: “If you develop a relationship with another patient, staff will get together with you to help decide whether this relationship is beneficial or detrimental to you . . . .”

Of the few litigated cases, the most important is Foy v. Greenblott. There, an institutionalized patient and her infant child (conceived and born while the mother was a patient in a locked psychiatric ward) sued the mother’s treating doctor for his failure to either maintain proper supervision over her so as to prevent her from having sex or to provide her with contraceptive devices and/or sexual counseling.

The court rejected plaintiffs’ claims of improper supervision, finding that institutionalized patients had a right to engage in voluntary sexual relations as an aspect of either the “least restrictive environment” or “reasonably non-restrictive confinement conditions” and that right included suitable opportunities for the patient’s interactions with members of the opposite sex. On the other hand, the court did characterize defendants’ failure to provide plaintiff with contraceptive devices and counseling as a deprivation of her right to reproductive choice. It also rejected a claim for “wrongful birth” by the infant child, concluding “[o]ur society has repudiated the proposition that


123. 190 Cal. Rptr. 84 (Ct. App. 1983).

124. Id. at 87.

125. Id. at 90 n.2.

126. Id. at 91-92.
mental patients will necessarily beget unhealthy, inferior or otherwise undesirable children if permitted to reproduce.”

While Foy has been applauded as “a model exposition of the reproductive rights of institutionalized women,” it is an isolated case. A reading of the case law reveals that this area simply does not exist as an active area of patients’ rights litigation.

This cannot be attributed to mere oversight or coincidence. One of the United States Supreme Court’s most ominous decisions of the twentieth century came in the infamous forced sterilization case of Buck v. Bell. The handful of recent cases that has been litigated on questions of sexual rights of the institutionalized convey a dominant set of messages: judges—some of whom continue to endorse Justice Holmes’ chilling dictum in Buck (that “three generations of imbeciles are enough”)—are excruciatingly uncomfortable deciding these cases; lawyers are often quick to abandon any allegiance to advocacy roles in litigating such cases, and, frequently, these cases serve as a battlefield in which parents are pitted against their children over the question of the extent to which institutionalized mentally disabled persons can enforce this right. This is, in sum, “an area in which virtually all participants in the judicial system join with a significant number of hospital staff employees in wishing the underlying problem would simply go away.”

What impact will the ADA have on this question? Can hospital procedures—either written or unwritten—that prohibit all patients from meaningful, voluntary sexual interaction survive ADA-based challenges? Congress’ findings specifically acknowledged how “overprotective rules and policies” discriminate invidiously against mentally disabled persons. Certainly, many of the institutional rules banning sexual contact flow from this discriminatory notion of overprotectionism.

127. Id. at 93.
128. Stefan, supra note 120, at 433.
129. 274 U.S. 200 (1927).
130. Id. at 207. For a contemporaneous endorsement by a sitting trial judge, see Judge Ralph B. Robertson, Letters, Dev. Mental Health L., Jan.-June 1991, at 4.
132. Perlin, supra note 111, at 534.
The ADA’s legislative history—as it applied to persons with mental disability—did focus specifically on questions of stereotyping and “reflects Congressional awareness of the pernicious danger of stereotyping behavior.”134 First, the legislative history makes this clear through its heavy reliance on the Supreme Court’s language in School Board of Nassau County v. Arline135 that “society’s accumulated myths and fears about disability and diseases are as handicapping as are the physical limitations that follow from the actual impairment.”136 Congress stressed that its inclusion in the definition of disability an individual who is regarded as being impaired137 acknowledges this teaching about the power of myths.138

Second, the history of a qualifying section that requires that a putatively covered individual “not pose a direct threat to the health or safety of other individuals in the workplace”139—also relying on the Arline case—specifies that, for mentally disabled persons, “the employer must identify the specific behavior on the part of the individual that would pose the anticipated direct threat” and that the determination must be based on such behavior, “not merely on generalizations about the disability.”140 In such a case, there must be “objective evidence . . . that the person has a recent history of committing overt acts or making threats which caused . . . or which directly threatened harm.”141

134. Perlin, supra note 1, at 25; see id. at 25-26 (explaining the legislative history of the ADA).
136. Id. at 284.
139. 42 U.S.C. § 12113(b).
141. H.R. REP. No. 101-485, pt. 3, at 45-46 (1990), reprinted in 1990 U.S.C.C.A.N. 445, at 468-69. This language closely parallels that of the Fair Housing Act Amendments of 1988, under which an otherwise-qualified disabled person can be excluded from the definition of handicap only where a landlord can establish that the individual’s tenancy would be a “direct threat” to others based upon “a history of overt acts or current conduct.” 42 U.S.C. § 3604(f)(9) (1994). To trigger this section, the legislative history of the Fair Housing Act Amendments stressed that “there must be objective evidence from the person’s prior behavior that the person has committed overt acts which caused harm or which directly threatened harm.” H.R. REP. NO. 100-711, pt. 1, at 29 (1988), reprinted in 1988 U.S.C.C.A.N. 2173, at 2190; see Richard Simring, The Impact
In an earlier consideration of hospital sexual policies, I suggested that these policies flowed, in large part, from two contradictory stereotypes: one of infantilization (denying the reality that institutionalized persons with disabilities may retain the same sort of sexual urges, desires, and needs the rest of us have and generally upon which the rest of us act) and, paradoxically, one of demonization (expressing fear of their hypersexuality and the correlative need of protections and limitations to best stop them from acting on these primitive urges). How can these stereotypes be reconciled with the legislative history to which I have just referred?

To what extent is sex seen by the courts as a fundamental right? Although the Supreme Court has never found sexual interaction per se to be a specifically protected right, it has found a fundamental right to privacy in a broad array of cases involving reproductive choice, contraception, marriage, and family relationships and has recognized a fundamental right to be free, "except in very limited circumstances, from unwanted governmental intrusions into one's privacy." In December 1996, the Supreme Court held that a state may not condition the right to appeal from a decision terminating a parent's rights on his or her ability to pay certain filing fees. In the course of its opinion, the Court stressed that "[c]hoices about marriage, family life, and the upbringing of children are among associational rights that it has ranked as 'of basic importance in our society," citing, inter alia, Skinner v. Oklahoma ex rel. Williamson, a 1942 case finding a right to procreation.

There is, in short, no compelling state interest to support a policy banning all voluntary sexual interaction in hospital facilities. Any presumption of incompetence that may be relied upon—either explicitly or implicitly—to support such a blanket proscription also fails to...
pass any sort of heightened scrutiny analysis, especially in light of the fundamentality of sexual experience as a constitutionally protected privacy right.

This is not to suggest, of course, that hospital facilities are not free to impose reasonable restrictions on inpatient sexual activity. For a variety of clinical, administrative, and public safety reasons, carefully drawn limitations will pass ADA muster, as long as these policies are not based on stereotypes, allow for individualized decision making in individual cases, and authentically reflect a compelling state interest.

B. Drugs

The question of the right to refuse antipsychotic medication remains the most important and volatile aspect of the legal regulation of mental health practice. The issues that are raised—the autonomy of institutionalized mentally disabled individuals to refuse the imposition of treatment that is designed (at least in part) to ameliorate their symptomatology, the degree to which individuals subjected to such drugging are in danger of developing irreversible neurological side effects, the evanescence of terms such as “informed consent” or “competency,” the practical and administrative considerations of implementing such a right in an institutional setting, and the range of the philosophical questions raised—mark the litigation that has led to the articulation of the right to refuse treatment as “a turning point in institutional psychiatry” and “the most controversial issue in forensic psychiatry today.” Perhaps the most compelling issues raised by

152. There is a correlative right to be left alone. The Sixth Circuit, for instance, has found a fundamental constitutional right to be free from “forced exposure ... to strangers of the opposite sex” when it is not necessary for a legitimate overriding reason. Kent v. Johnson, 821 F.2d 1220, 1226 (6th Cir. 1987).

153. See Perlin, supra note 111, at 540-45.


the right to refuse antipsychotic medication are the potential infringement of individuals' constitutional rights, including the First Amendment right to privacy and mentation, the Sixth Amendment right to a fair trial, the Eighth Amendment right to freedom from cruel and unusual punishment, and the Fourteenth Amendment's due process guarantee. Given the multiplicity and gravity of the issues involved in these cases, their significance frequently transcends the narrow focus of a "mental disability law" case.

The conceptual, social, moral, legal, and medical difficulties inherent in the articulation of a coherent right to refuse treatment doctrine have been made even more complicated by the U.S. Supreme Court's reluctance to confront most of the underlying issues in cases arising in civil settings.\textsuperscript{159} As a result of the Court's decision in \textit{Mills v. Rogers} to "sidestep" the core constitutional questions\textsuperscript{160} and its concomitant articulation of the doctrine that a state is always free to grant more rights under \textit{its} constitution than might be minimally mandated by the U.S. Supreme Court under the \textit{federal constitution},\textsuperscript{161} two parallel sets of cases have emerged.

Both begin with the predicate that institutionalized mentally disabled individuals have a "significant liberty interest" under the Due Process Clause in avoiding the unwanted administration of antipsychotic medications.\textsuperscript{162} The question with which courts regularly grapple is the extent of that right and the type of remedy required to effectuate that right.

In one approach, courts (usually state courts) have generally entered broad decrees in accordance with an "expanded due process" model, in which the right to refuse treatment has been read broadly and elaborately, generally interpreting procedural due process protections liberally on behalf of the complaining patient. These cases have frequently mandated premedication judicial hearings and have relied heavily on social science data focusing on the potential impact of drug side effects, especially tardive dyskinesia.\textsuperscript{163}

\textsuperscript{160} 2 \textit{PERLIN, supra note 5, § 5.33, at 309-12; David Wexler, Seclusion and Restraint: Lessons from Law, Psychiatry, and Psychology, 5 INT'L J.L. & PSYCHIATRY 285, 290 (1982).}
\textsuperscript{162} Harper, 494 U.S. at 221.
In the other approach, courts (usually federal courts) have generally entered more narrow decrees in accordance with a "limited due process model." These provided narrower administrative review and rejected broad readings of the Fourteenth Amendment's substantive and procedural due process protections, relying less on social science data, which was frequently ignored or dismissed as part of an incomprehensible system allegedly beyond the courts' self-professed limited competency. Generally (but not always), the state cases involved civil patients; more frequently, the federal cases dealt with individuals originally institutionalized because of involvement in the criminal trial process.

This division has become somewhat more hazy, however, since the Supreme Court's 1992 decision in Riggins v. Nevada. The Riggins Court reversed a death sentence in the case of a competent insanity defense pleader, who sought to refuse the administration of antipsychotic medications during the pendency of his trial, and found a violation of the defendant's right to a fair trial. In Riggins, although the court did not set down a bright-line test articulating the state's burden in sustaining forced drugging of a detainee at trial, it found that this burden would be met had the state demonstrated medical appropriateness and either (1) considering less intrusive alternatives, that forced drugging was "essential for the sake of Riggins' own safety or the safety of others" or (2) that there was a lack of less intrusive means by which to obtain an adjudication of the defendant's guilt or innocence.

Riggins' use of "less intrusive alternatives" language in this context was especially surprising. Since the Supreme Court chose to bypass this construction in Youngberg v. Romeo and to use in its place the phrase "reasonably nonrestrictive confinement conditions" as part of its articulation of a substantial "professional judgment" test, it had appeared that there was simply no place for this doctrine in mental disability law. Riggins has given this construct new life in the context of a criminal case, and it will thus be necessary for litigators and

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166. See PERLIN, supra note 92, § 2.18, at 258-64.
167. Riggins, 504 U.S. at 135.
judges to rethink the potential reapplication of the “less intrusive means” or “least restrictive alternative” test in subsequent federal constitutional litigation. This becomes especially important in the context of the current inquiry, given the ADA’s “reasonable accommodations” and “direct threat” language, read recently by at least one court to require use of a “least restrictive means” analysis in the context of involuntary hospitalization questions.169

More conceptual light has been shed on this entire murky area of the law by the recent publication of research by the MacArthur Foundation’s Network on Mental Health and the Law (the “Network”). For the past five years, the Network has conducted an extensive study of three areas that are essential to an informed understanding of mental disability law: competence, coercion, and risk.170 The competence aspect of the research has been published171 and reports on the researchers’ attempts to develop a reliable and valid information base upon which to address clinical and policy questions about mentally disabled persons’ ability to provide informed consent to treatment.172

Among the Network’s findings of significance to the question before us are the conclusions that mental patients are not always incompetent to make rational decisions and that mental patients are not inherently more incompetent than nonmentally ill patients.173 In fact, on “any given measure of decisional abilities, the majority of patients with schizophrenia did not perform more poorly than other patients and nonpatients.”174 In short, the presumption in which courts have regularly engaged—that there is both a de facto and de jure presumption of incompetency to be applied to medication decision mak-

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172. Winick, supra note 170, at 3.


ing—appears to be based on an empirical fallacy. In assessing hospital drug policies under the ADA, this should make it more difficult for an institution to justify a regulation that significantly impairs all patients’ ability to exercise autonomy. If the ADA demands that persons with disabilities are treated in the setting “which meets the needs of [their] disabilit[ies] but which gives [them] the most freedom,” most drugging policies, again, need to be reconceptualized.

Consider in this context the relatively obscure New Jersey state case, City of Newark v. J.S. City of Newark was a case in which the city sought to civilly commit a homeless person suffering from tuberculosis. In the course of his opinion reading the tuberculosis involuntary civil commitment statute in light of the ADA, Judge Goldman stressed the need to make an “individualized, fact-specific determination” as a means of satisfying the ADA’s design “to avoid the risk of stereotyping, bigotry and prejudice.” He thus construed the tuberculosis statute “to include those rights necessitated by contemporary standards of due process and the ADA.” Importantly, Judge Goldman found that the patient has the right to refuse prescribed medication “even if this is medically unwise,” citing to a


178. Beyond the scope of this Article is an analysis of how the ADA is to be construed in cases involving individuals with different levels of disability. On the differing interpretations of section 504 of the Rehabilitation Act of 1973 in this context, see, Alicia Apfel, Comment, Cast Adrift: Homeless Mentally Ill, Alcoholic, and Drug-Addicted, 44 CATH. U. L. REV. 551, 597 n.203 (1995).


180. City of Newark, 652 A.2d at 274.

181. Id. at 276.

182. Id. at 277. Judge Goldman further stated:

I believe my conclusions also satisfy the ADA and [School Board of Nassau County v.] Arline, that judicial decisions in this area be based upon, “(a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties), and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.” 480 U.S. at 288.

Id. at 287 (citations omitted).

183. Id. at 278.
New Jersey Supreme Court case that has held that individuals "have the right of self-determination regarding their own bodies."184

*City of Newark* demonstrates how civil commitment law, right to refuse treatment law, and ADA law can be fused. If the ADA is given life in right to refuse cases, that suggests that the "limited due process" universe of cases to which I referred earlier is ripe for a statutory challenge. Although there are, as of yet, no cases frontally attacking policies providing only a limited right to refuse antipsychotic medication, it is likely that the future viability of such policies may now be open to question.

IV. **Sanism, Pretextuality, and Therapeutic Jurisprudence**

A. **Introduction**185

One of the most venerable underpinnings of American jurisprudence is the theory of "neutral principles," most closely associated with the writings of Professor Herbert Wechsler.186 According to Wechsler, legal reasoning had to be "genuinely principled, resting with respect to every step that is involved in reaching judgment on analysis and reasons quite transcending the immediate result that is achieved."187 Judges, this theory suggested, "could impersonally decide cases through the process of 'reasoned elaboration,' i.e., the elaboration of 'principles and policies contained in precedent and legislation [that yielded] a reasoned, if not analytically determined, result in particular cases.'"188

This approach, of course, assumes a fact not in evidence:189 that judges and fact finders are able to approach cases analytically with the sort of "reasoned elaboration" and "neutrality" urged by Wechsler and his adherents. An examination of the development of mental disability law jurisprudence suggests that "neutral principles" are simply not a factor in the case law in this area.190 Rather, the twin themes of

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184. *Id.* at 278-79 (quoting Matter of Farrell, 529 A.2d 404, 408 (N.J. 1987)).
185. This section is adapted from Perlin & Dorfman, *supra* note 173, at 130.
189. On how this sort of assumption infects all of mental disability law, see Perlin, *supra* note 36.
“sanism” and “pretextuality” dominate the mental disability law landscape.191

B. Sanism192

1. Introduction

“Sanism” is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry.193 It infects both our jurisprudence and our lawyering practices.194 Sanism is largely invisible and largely socially acceptable. It is based predominantly upon stereotype, myth, superstition, and deindividuation and is sustained and perpetuated by our use of alleged “ordinary common sense” (“OCS”) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.195

Judges are not immune from sanism. “[E]mbedded in the cultural presuppositions that engulf us all,”196 judges express discomfort with social science197 (or any other system that may appear to challenge law’s hegemony over society) and skepticism about new thinking. This discomfort and skepticism allows them to take deeper refuge in heuristic thinking and flawed, nonreflective OCS, both of which continue the myths and stereotypes of sanism.198

191. See generally Perlin, Morality and Pretextuality, supra note 62.


194. The phrase “sanism” was, to the best of my knowledge, coined by Dr. Morton Birnbaum. See Morton Birnbaum, The Right to Treatment: Some Comments on Its Development, in MEDICAL, MORAL AND LEGAL ISSUES IN HEALTH CARE 97, 106-07 (Frank J. Ayd ed., 1974); Perlin, supra note 46, at 92-93 (discussing Birnbaum’s insights). Dr. Birnbaum is universally regarded as having first developed and articulated the constitutional basis of the right to treatment doctrine for institutionalized mental patients. See Morton Birnbaum, The Right to Treatment, 46 A.B.A. J. 499 (1960); see also Perlin, supra note 5, at 8-13 (discussing Birnbaum).


197. The discomfort that judges often feel in having to decide mental disability law cases is often palpable. See, e.g., Perlin, supra note 164, at 991 (stating that the court’s characterization in United States v. Charters, 863 F.2d 302, 310 (4th Cir. 1988) (en banc), of judicial involvement in right to refuse antipsychotic medication cases as “already perilous . . . reflects the court’s almost palpable discomfort in having to confront the questions before it”).

2. Sanism and the Court Process in Mental Disability Law Cases

Judges reflect and project the conventional morality of the community, and judicial decisions in all areas of civil and criminal mental disability law continue to reflect and perpetuate sanist stereotypes. Their language demonstrates bias against mentally disabled individuals and contempt for the mental health professions. Courts often appear impatient with mentally disabled litigants, ascribing their problems in the legal process to weak character or poor resolve. Thus, a popular sanist myth is that “mentally disabled individuals simply don’t try hard enough. They give in too easily to their basest instincts, and do not exercise appropriate self-restraint.” We assume that mentally ill individuals are presumptively incompetent to participate in ‘normal’ activities, [and] to make autonomous decisions about their lives (especially in the area of medical care).”

Sanist thinking allows judges to avoid difficult choices in mental disability law cases; their reliance on nonreflective, self-referential alleged “ordinary common sense” contributes further to the pretextuality that underlies much of this area of the law. Such reliance is likely to make it even less likely that judicial decisions will

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199. See Perlin, supra note 14, at 400-04.


201. See, e.g., Commonwealth v. Musolino, 467 A.2d 605 (Pa. Super. Ct. 1983) (finding that it was reversible error for trial judge to refer to expert witnesses as “headshrinkers”). Compare State v. Percy, 507 A.2d 955, 956 (Vt. 1986) (conviction reversed where prosecutor, in closing argument, referred to expert testimony as “psycho-babble”), with Commonwealth v. Cosme, 575 N.E.2d 726, 731 (Mass. 1991) (finding it was not error where prosecutor referred to defendant’s expert witnesses as “a little head specialist” and a “wizard”).

202. Perlin, supra note 14, at 396; see J.M. Balkin, The Rhetoric of Responsibility, 76 VA. L. REV. 197, 238 (1990) (noting that the Hinckley prosecutor suggested to jurors, “if Hinckley had emotional problems, they were largely his own fault”); see also State v. Duckworth, 496 So. 2d 624, 635 (La. App. 1986) (juror who felt defendant would be responsible for actions as long as he “wanted to do them” not excused for cause) (no error).

203. Perlin, supra note 14, at 394.

204. Where the fact finder is a nonjudicial officer, the problems discussed here are probably accentuated further. See Donald N. Bersoff, Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law, 46 SMU L. REV. 329, 331-32 (1992) (stating that psychiatrists, as fact finders, are more likely to take paternalistic positions in right to refuse cases).
reflect the sort of "dignity" values essential for a fair hearing in right to refuse treatment cases. Some judges simply "rubber stamp" hospital treatment recommendations in right to refuse cases. Other judges are often punitive in cases involving mentally disabled litigants, and their decisions frequently reflect "textbook" sanist attitudes.

3. Sanism, the ADA, and Psychiatric Inpatients

When I told some otherwise-knowledgeable lawyers that I was going to be presenting a version of this article at the DePaul Law Review Symposium, their response was telling: "Psychiatric patients? The ADA? Wait a minute, Michael . . . isn't that Act about ramps and wheelchairs?" They were surprised to learn that the ADA applied to mental disabilities, that it had an impact on psychiatric patients, and that it might force courts to reconceptualize much of the law that has developed in this area over the past two decades.

Were my friends being overtly or intentionally sanist in their response? I do not think so (and after I told them what my thesis was, their response was kind of, "Gee, that's interesting; I never thought

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205. See generally Perlin, supra note 192. Courts and commentators have regularly discussed "dignity" in a fair trial context both in cases involving mentally disabled criminal defendants and in other settings. See, e.g., Marquez v. Collins, 11 F.3d 1241, 1244 (5th Cir. 1994) ("Solemnity . . . and respect for the dignity of individuals are components of a fair trial."); Hefferman v. Norris, 48 F.3d 331, 337 (8th Cir. 1995) (Bright, J., dissenting) ("[T]he forced ingestion of mind-altering drugs not only jeopardizes an accused's rights to a fair trial, it also tears away another layer of individual dignity . . . ."); Keith D. Nicholson, Would You Like Some More Salt in That Wound? Post-Sentence Victim Allocation in Texas, 26 St. Mary's L.J. 1103, 1128 (1995) (stating that for trial to be fair, "it must be conducted in an atmosphere of respect, order, decorum, and dignity befitting its importance both to the prosecution and the defense"); see also Deborah A. Dorfman, Effectively Implementing Title I of the Americans with Disabilities Act for Mentally Disabled Persons: A Therapeutic Jurisprudence Analysis, 8 J. L. & Health 105, 121 (1993-94) (noting the significance of dignity values in involuntary civil commitment hearings); Tom Tyler, The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings, 46 SMU L. Rev. 433, 444 (1992) (same).

206. See Bruce J. Winick, Competency To Consent to Treatment: The Distinction Between Consent and Objection, 28 Hous. L. Rev. 15, 59 & n.48 (1991) (citing studies).

207. Cf. Perlin, supra note 14, at 401 n.203, which states:

None is perhaps as chilling as the following story: Sometime after the trial court's decision in Rennie . . . , I had occasion to speak to a state court trial judge about the Rennie case. He asked me, "Michael, do you know what I would have done had you brought Rennie before me?" (the Rennie case was litigated by counsel in the N.J. Division of Mental Health Advocacy; I was director of the Division at that time). I replied, "No," and he then answered, "I've taken the son-of-a-bitch behind the courthouse and had him shot."

Id.

about *that* before!). Yet, their responses reflect a kind of unconscious sanism, a kind that ADA supporters—if they are going to make meaningful progress here—must seek to eradicate. Just as the Third Circuit held in *Helen L.* that it would not “[e]viscerate the ADA by conditioning its protections upon a finding of intentional or overt ‘discrimination,’”²⁰⁹ so must we not limit “sanist” inquiries to intentional cases.

It is clear that cases involving persons with mental disabilities are *not* regularly seen as serious “ADA issues,” and it is even clearer that the ADA’s potentially transformative impact on the lives of mentally disabled persons (especially *institutionalized* mentally disabled persons) is not being taken particularly seriously by administrative officials, civil rights litigators, or the courts. This lack of serious attention is to a great extent, I am convinced, sanist at its core.

The ADA, if enforced, forces us to abandon sanist stereotypes in this area of the law. It makes us reject presumptions of incompetence, broadly drawn nonindividualized pictures of mentally disabled persons, and policy rationales that are premised on prejudice and bias. The ADA, if enforced, gives institutional plaintiffs a litigational vehicle to bring some coherence to the state/federal morass in right to refuse treatment law and to seek to force courts to confront issues about personal autonomy and sexuality that judges have been all too happy to avoid for years.²¹⁰

The ADA’s legislative history gives powerful ammunition to advocates who seek to confront the attitudinal biases at the roots of policies that govern patients’ rights to sexual interaction²¹¹ and to refuse antipsychotic medication. It gives advocates an opportunity to articulate the sanist bases of policies that presume that psychiatric patients—by reason of their institutionalization—cannot enter into autonomous decision making in the areas of sexual choice and medication refusal. The MacArthur Network data²¹² tells us that psychiatric patients are not necessarily more incompetent than nonmentally ill persons to engage in independent medication decision making; there is no evidence that study of sexual decision making would yield statistically significant, differing results. In short, the ADA may be a strong tool to combat sanism in these areas of mental disability law.

²¹⁰. See cases cited *supra* note 108 (recent institutional conditions challenges premised partially on ADA theories).
²¹². See *supra* text accompanying notes 170-74.
C. Pretextuality

1. Introduction

The entire relationship between the legal process and mentally disabled litigants is often pretextual. By this, I mean simply that courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (frequently meretricious) decision making, specifically where witnesses, especially expert witnesses, "show a high propensity to purposely distort their testimony in order to achieve desired ends." This pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious and/or corrupt testifying. The reality is well known to frequent consumers of judicial services in this area: mental health advocates and other public defender/legal aid/legal service lawyers assigned to represent patients and mentally disabled criminal defendants, prosecutors and state attorneys assigned to represent hospitals, judges who regularly hear such cases, expert and lay witnesses, and, most importantly, the mentally disabled person involved in the litigation in question.

The pretexts of the forensic mental health system are reflected both in the testimony of forensic experts and in the decisions of legislators and fact finders. Experts frequently testify in accordance with their own self-referential concepts of "morality" and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment or that articulate functional standards as prerequisites for an incompetency to stand trial finding. Often this testimony is further warped by a heuristic bias. Expert wit-

213. This section is adapted from Perlin, supra note 192, at 77-78.
216. See, e.g., Cassia Spohn & Julia Horney, "The Law's the Law, But Fair Is Fair": Rape Shield Laws and Officials' Assessments of Sexual History Evidence, 29 CRIMINOLOGY 137, 139 (1991) (a legal reform that contradicts deeply held beliefs may result either in open defiance of the law or in a surreptitious attempt to modify the law).
217. See, e.g., Perlin, Morality and Pretextuality, supra note 62, at 135-36.
218. See, e.g., People v. Doan, 366 N.W.2d 593, 598 (Mich. Ct. App. 1985) (expert testified that defendant was "out in left field" and went "bananas").
nesses—like the rest of us—succumb to the seductive allure of simplifying cognitive devices in their thinking and employ such heuristic gambits as the vividness effect or attribution theory in their testimony.\textsuperscript{219}

This testimony is then weighed and evaluated by frequently sanist fact finders.\textsuperscript{220} Judges and jurors, both consciously and unconsciously, frequently rely on reductionist, prejudice-driven stereotypes in their decision making, thus subordinating statutory and case law standards as well as the legitimate interests of the mentally disabled persons who are the subject of the litigation. Judges' predispositions to employ the same sorts of heuristics as expert witnesses employ further contaminate the process.\textsuperscript{221}

2. \textit{Pretextuality and the ADA}

First, nothing in the law is more pretextual than a hortatory/aspirational statute.\textsuperscript{222} To enact legislation and then say, in effect, "Just kidding!", is pretextuality at its most pernicious. If the ADA is ultimately given a reading as cramped as that given the Bill of Rights for the Developmentally Disabled in the first \textit{Pennhurst} case,\textsuperscript{223} then ADA law will be simply another area of legal pretextuality.

Even if we assume that the courts will read the ADA relatively expansively, other potential pretextuality pitfalls are present. Much of the law that has developed in the area of sexual autonomy and medication decision making is pretextual. In other articles, I have looked closely at important medication cases, such as \textit{United States v. Charters},\textsuperscript{224} the Fourth Circuit en banc decision sharply limiting the right of pretrial detainees to refuse medication,\textsuperscript{225} and Justice Thomas' dissent in \textit{Riggins v. Nevada},\textsuperscript{226} and at sexual policy decision making\textsuperscript{227} and have determined that pretextuality lies at the core of the jurisprudence in both of these areas of the law. If the ADA is read broadly and expansively by the courts, it is possible (though certainly not guar-

\begin{itemize}
\item \textsuperscript{219} See generally Perlin, \textit{Psychodynamics}, supra note 198.
\item \textsuperscript{220} See generally Perlin, supra note 14; Perlin & Dorfman, supra note 61.
\item \textsuperscript{221} See generally Perlin, \textit{Pretexts}, supra note 62.
\item \textsuperscript{222} See supra text accompanying notes 64-75.
\item \textsuperscript{223} See supra text accompanying notes 70-72.
\item \textsuperscript{224} 863 F.2d 302 (4th Cir. 1988) (en banc).
\item \textsuperscript{225} See Perlin, supra note 164, at 986-92, 996, 999; Perlin, \textit{Decoding}, supra note 155, at 172-74.
\item \textsuperscript{226} 504 U.S. 127, 148-49 (1992); see 2 Perlin, supra note 5, § 5.65A, at 98-100 (Supp. 1996); Perlin, Decoding, supra note 155, at 174; Perlin & Dorfman, supra note 61, at 58.
\item \textsuperscript{227} See Perlin, supra note 111, at 537-39.
\end{itemize}
anteed) that some of this pretextuality will be exposed and, perhaps, acknowledged and neutralized.

The ADA demands individualized fact-sensitive determinations in cases involving institutionalized persons with mental disabilities.\(^{228}\) If courts are willing to enforce its constitutionally premised provisions, the likelihood will be far less that experts will be able to thwart legislative ends. The memorable (though nonrepresentative), vivid case will lose its allure, and decision making in this area will finally reflect some semblance of rationality.

D. Therapeutic Jurisprudence

One potential solution is to turn to therapeutic jurisprudence ("TJ") for some answers. TJ studies the role of the law as a therapeutic agent, recognizing that substantive rules, legal procedures, and lawyers' roles may have either therapeutic or antitherapeutic consequences and questioning whether such rules, procedures, and roles can or should be reshaped so as to enhance their therapeutic potential, while not subordinating due process principles.\(^{229}\) Therapeutic jurisprudence looks at a variety of mental disability law issues in an effort to both shed new light on past developments and to offer new insights for future developments. Recent articles and essays have thus considered such matters as the insanity acquittee conditional release hearing, juror decision making in malpractice and negligent release litigation, competency to consent to treatment, competency to seek voluntary treatment, standards of psychotherapeutic tort liability, the effect of guilty pleas in sex offender cases, the impact of scientific discovery on substantive criminal law doctrine, and the competency to be executed.\(^{230}\)

Authors have begun to look at ADA sections through the TJ lens (for example, the reasonable accommodations provision of Title III)\(^ {231}\)

\(^{228}\) See City of Newark v. J.S., 652 A.2d 265, 274 (N.J. Super. Ct. Law Div. 1993); supra notes 177-84 and accompanying text (discussing City of Newark).


\(^{230}\) See, e.g., 1 Perlin, supra note 5, § 1.05A, at 8-12 nn.156.6-156.24A (Supp. 1996) (citing recent articles). Recent articles are collected in LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce Winick eds., 1996) [hereinafter THERAPEUTIC KEY].

and the confidentiality provision\textsuperscript{232}) and have begun to consider how the ADA might apply to a range of cutting-edge legal issues (for example, the military’s “don’t ask, don’t tell” policy on disclosure of sexual orientation\textsuperscript{233} and courtroom accessibility for persons with disabilities\textsuperscript{234}).

Deborah Dorfman—a public interest lawyer who represents persons with disabilities—has written thoughtfully about how implementation of Title I of the ADA would be therapeutic for persons with disabilities.\textsuperscript{235} Dorfman writes:

For those with mental disabilities, the stakes are high when it comes to effective implementation of Title I of the ADA. If Title I is carried out as it was intended, the mentally disabled have a great deal to gain beyond just employment. They have the opportunity to become substantially more integrated and accepted into society, the ability to support themselves financially, and thus become better equipped to live independently and enhance the quality of their lives.

If, however, Title I is not adequately enforced, mentally disabled individuals risk losing one of the most significant opportunities to overcome traditional barriers to employment and social integration. With so much riding on Title I for persons with mental disabilities, it is imperative that lawyers, advocates, disabled persons, and employers examine the different implementation and enforcement mechanisms of litigation and . . . [alternative dispute resolution]. In doing so, it is useful to assess the options through a therapeutic jurisprudence filter to determine which means is the most beneficial in carrying out the provisions of Title I.\textsuperscript{236}

I agree with Dorfman that the ADA is a therapeutic law. It gives persons with disabilities autonomy, allows them to engage in individ-


\textsuperscript{235} See Dorfman, supra note 205 (when Dorfman wrote this article, she was co-coordinator of the PAIMI Program at the Legal Center for People with Disabilities in Salt Lake City, Utah; she is currently a staff attorney at the Washington Protection and Advocacy Service in Seattle, Washington).

\textsuperscript{236} Id. at 120-21.
ual decision making in areas of life which we each hold dear, forces others to "get beyond" the label of "psychiatric patient," and—optimally—serves as the best tool in our arsenal to combat the sanism and pretextuality that dominate mental disability law jurisprudence.237

V. CONCLUSION

The words of the ADA offer persons with disabilities hope and the right to dream. The Act tells forty-three million Americans that they cannot be the target of discrimination in employment in the provision of services and in accommodations. It says this in clear, unambiguous language that is supported by explicit findings buttressed by constitutional citations.

The question, as I have already stated, is this: Will the Court give these words life, or will they be reduced to mere hortatory aspirations? Will Congress, in short, simply find itself in the shoes of the protagonist of the Bob Dylan song that provided the beginning of my title—doing no more than making "promises by the hour"? I believe—though I admit that this belief is fueled as much by wishful thinking as it is by constitutional analysis—that the Courts will take seriously the findings, the mandatory language, the invocation of the Fourteenth Amendment, and the Carolene Products language.

But not totally seriously. I do not believe—for a variety of policy, analytical and prudential reasons—that the Court is about to jettison the "substantial professional judgment" standard of the Youngberg case, a jettisoning that Timothy Cook argued six years ago was mandated by the ADA's terms and legislative history.238 But I do believe that courts will begin to scrutinize state hospital policies affecting psychiatric inpatients far more carefully than they have in the years since the Youngberg decision.

Thus I believe that policies that flow from presumptions that psychiatric inpatients are incompetent to engage in certain decision making—as to whether to have sex or as to whether to take certain medications—violate the ADA. Although hospitals may impose reasonable restrictions on the sexual activities of inpatients239 and may override the wishes of certain dangerous and/or incompetent patients to refuse medication,240 administrators may no longer rely on stereo-

238. See Cook, supra note 18, at 465-66.
239. See, e.g., Mossman et al., supra note 154.
types about persons with mental disabilities in crafting hospital policies in these areas. The ADA forces them to confront sanism and to reject pretextuality. It also gives life to an authentically therapeutic jurisprudence. The "promises made by the hour" to psychiatric patients will thus be redeemed.

One of Love Minus Zero/No Limits' more ambiguous couplets serves as my conclusion here. "She knows there's no success like failure/and failure's no success at all," sings Dylan at the end of the second verse.²⁴¹ If the ADA is seen as merely hortatory aspirations, it will be a failure. And failure here is no success at all.
