

BEYOND MEDICAL LEGAL PARTNERSHIPS: ADDRESSING RECOVERY-HARMING SOCIAL CONDITIONS THROUGH CLUBHOUSE-LEGAL PARTNERSHIPS

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ABSTRACT

Because people with mental illnesses are particularly vulnerable to income, housing, educational, and familial instability, Medical-Legal Partnerships (“MLPs”) can be a helpful resource for them and their doctors. However, they can also harm clients and lawyer-client relationships. MLPs affirm the medical model, are entangled in harms perpetuated by hospitals and other providers—including forced treatment—and do not account for the traumatic history between people with mental illnesses and the medical profession. This Article proposes that in order to take advantage of MLPs’ proven strengths and serve people with mental illnesses in an autonomy-respecting way that builds power for them and their communities, the MLP model must be adapted. The best way to do that is by incorporating the tenets of community lawyering and partnering with non-medical, recovery-centered community centers called clubhouses to form “Clubhouse-Legal Partnerships.”

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I.

INTRODUCTION

Medical-Legal Partnerships (“MLPs”) are a model of legal services delivery where a legal organization partners with a medical organization to provide patients with the legal aid necessary to improve their health.¹ For example, an MLP lawyer may assist a patient in restoring electricity to their home so they can refrigerate vital medications.² MLPs allow lawyers to reach people in acute need of legal aid in a setting where they are already seeking help, and tie their work to the overarching goal of guaranteeing quality health care for all.³ People with mental illnesses are particularly vulnerable to income, housing, educational, and familial instability;⁴ as a result, the MLP model has served as a valuable resource for the doctors and therapists who treat them.⁵ In fact, a special type of MLP called Behavioral Health-Legal Partnerships (“BHLPs”) has evolved to encourage lawyers to partner with clinical mental health providers.⁶

While this is a positive trend, the MLP (and consequently the BHLP)⁷ model does not account for the painful and often traumatic history between people with mental illnesses and the medical profession,⁸ and fails to distinguish between voluntary and involuntary treatment.⁹ By its very nature, it affirms the medical model,

1. See *FAQs*, NAT’L CTR. FOR MED.-LEGAL P’SHIP, <http://medical-legalpartnership.org/faq/> [<https://perma.cc/BUB5-E6NA>].

2. See *MLP IN ACTION: A UTILITIES CASE STUDY*, NAT’L CTR. FOR MED.-LEGAL P’SHIP, <https://medical-legalpartnership.org/response/utilities-case-study/> [<https://perma.cc/SB3D-KGR5>].

3. See *FAQs*, *supra* note 1.

4. *Infra* notes 57–63. See also *infra* Part II.E.

5. See *infra* Part II.E.

6. *Id.*

7. The BHLP is merely a specific kind of MLP. BHLPs and non-mental health MLPs are identical in every way other than the specialization of the medical partner. This Article uses “MLP model” and “BHLP model” interchangeably when referring to the overall model.

8. See *infra* Part III.D.

9. See *infra* Part III.C.

which views the doctor rather than the person with the mental illness as the care expert.¹⁰ These characteristics make MLPs incompatible with the mental health recovery movement¹¹ and with autonomy-focused lawyer-client relationships.

To take advantage of the MLP model's proven strengths and serve people with mental illnesses in an autonomy-respecting way that builds power for them and their communities, the MLP model must be adapted. This Article proposes that the best way to do that is for legal service providers to partner with non-medical, recovery-centered community centers called clubhouses to form "Clubhouse-Legal Partnerships."

Part II of this Article describes the existing MLP model and its strengths. It also discusses how it has been implemented in mental health settings (BHLPs) and the challenges of working with clients who have a mental illness. The question is then whether and how MLPs can overcome these challenges. Part III answers this question. It introduces the recovery model and discusses how BHLPs perpetuate contemporary and historical harms against people with mental illnesses, making BHLPs incompatible with the recovery model. It concludes that an adaptation to the model is needed to best serve people with mental illnesses. Part IV introduces the Clubhouse-Legal Partnership ("CLP") model as an adaptation of the MLP model that respects and affirms mental health recovery. It explains how CLPs could function and the need to incorporate the tenets of community lawyering, and it explores next steps.

II.

THE EXISTING MODEL

A. History

The first Medical-Legal Partnership was established in 1993 when the Boston Medical Center ("BMC") realized that moldy apartments were causing asthmatic pediatric patients to become unresponsive to medication and need repeated hospital visits.¹² At the request of BMC, lawyers at Greater Boston Legal Services stepped in to help patients enforce the sanitary codes their landlords had been violating.¹³ Eight years later an article about the partnership was published in *The New York Times*, inciting other institutions to replicate the program.¹⁴ By 2006,

10. *See infra* Part III.B.

11. The term "recovery" will be defined in depth in Part III of this Article. *Infra* notes 88–92 and accompanying text. *See infra* Part III.A.

12. Ellen Lawton, *A History of the Medical Legal Partnership Movement*, CMTY. HEALTH FORUM, Fall/Winter 2014, at 12, <http://medical-legalpartnership.org/wp-content/uploads/2015/01/NACHC-Magazine-A-History-of-the-Medical-Legal-Partnership-Movement.pdf> [<https://perma.cc/8V8L-S9AN>].

13. *Id.*

14. *Id.*; see also Carey Goldberg, *Boston Medical Center Turns to Lawyers for a Cure*, N.Y. TIMES (May 16, 2001), <http://www.nytimes.com/2001/05/16/us/boston-medical-center-turns-to-lawyers-for-a-cure.html?mtref=query.nytimes.com&gwh=B5AA8FE077AAD86150234D0406EE>

almost 75 other MLPs had been established, and the National Center for Medical-Legal Partnerships (“National Center”) was created to provide resources and best practices to existing and emerging MLPs.¹⁵ Today, MLPs have been established at 333 health care institutions in 46 states.¹⁶

B. Combatting Health-Harming Social Conditions

The main goal of MLPs is to “combat health-harming social needs.”¹⁷ Health-harming social needs refers to the social factors—such as income, access to health care, job stability, education, and immigration status—that can negatively influence a person’s health.¹⁸ Another term for this is “social determinants of health.”¹⁹ The intent of MLPs is to provide “legal care”—in conjunction with medical care—to meet those “civil legal needs that profoundly affect health.”²⁰ MLPs aim to halt the social conditions that, if left untreated, can debilitate personal and population health, and lead to increased health care utilization and costs.²¹

Every low-income individual in the United States, on average, has two to three health-harming civil legal needs.²² This means there are 50 million people for whom medical care will not be enough to attain and maintain health.²³ The table in Figure 1 below, produced by the National Center, demonstrates how each

91D6&gwt=pay [https://perma.cc/DY8P-6K2Q], the *New York Times* article that promoted the growth of the MLP movement.

15. Lawton, *supra* note 12, at 12.

16. *Home*, NAT’L CTR. FOR MED.-LEGAL P’SHP, <https://medical-legalpartnership.org/> [https://perma.cc/SXW9-E8G3].

17. *Id.*

18. *See The Need*, NAT’L CTR. FOR MED.-LEGAL P’SHP, <https://medical-legalpartnership.org/need/> [https://perma.cc/ALL8-C2LC]. As evidence of the impact social factors have on health, the National Center points to research showing that the U.S. spends \$0.90 on social services for every \$1 it spends on health care, while other developed countries with better health outcomes spend \$2 on social services for every \$1 spent on health care. *Id.*

19. *See Social Determinants of Health*, WORLD HEALTH ORG., http://www.who.int/social_determinants/sdh_definition/en/ [https://perma.cc/8VH2-WMAS] (explaining that social determinants of health “are the conditions in which people are born, grow, live, work and age[,] . . . shaped by the distribution of money, power and resources[, and] mostly responsible for health inequities”).

20. *The Need for Medical-Legal Partnership: Legal Problems are Health Problems*, NAT’L CTR. FOR MED.-LEGAL P’SHP, <https://web.archive.org/web/20161029094403/http://medical-legalpartnership.org/need/> [https://perma.cc/DK47-Q75K]; *see also* THE NAT’L CTR. FOR MED.-LEGAL P’SHP, THE STATE OF THE MEDICAL LEGAL PARTNERSHIP FIELD 4 (Aug. 2016) [hereinafter THE STATE OF MLPs], <https://medical-legalpartnership.org/wp-content/uploads/2017/11/2015-MLP-Site-Survey-Report.pdf> [https://perma.cc/NG38-WWVT].

21. *Id.*

22. *The Need for Medical-Legal Partnership: 50 Million People from Kids to Vets*, NAT’L CTR. FOR MED.-LEGAL P’SHP, <https://web.archive.org/web/20161029094403/http://medical-legalpartnership.org/need/> [https://perma.cc/HH7A-D9DB] (citing LEGAL SERVS. CORP., DOCUMENTING THE JUSTICE GAP IN AMERICA: THE CURRENT UNMET CIVIL NEEDS OF LOW-INCOME AMERICANS 13–17 (Sept. 2009), http://www.lsc.gov/sites/default/files/LSC/pdfs/documenting_the_justice_gap_in_america_2009.pdf [https://perma.cc/ZT3W-ARMZ]).

23. *Id.*

social determinant of health can be addressed through legal interventions, and how that legal intervention can improve the person's health.²⁴






Common Social Determinant of Health	How Legal Services Can Help	Impact of Legal Services on Health / Health Care
<p>INCOME Resources to meet daily basic needs</p> 	<ul style="list-style-type: none"> • Appeal denials of food stamps, health insurance, cash benefits, and disability benefits 	<ol style="list-style-type: none"> 1. Increasing someone's income means s/he makes fewer trade-offs between affording food and health care, including medications. 2. Being able to afford enough healthy food helps people manage chronic diseases and helps children grow and develop.
<p>HOUSING & UTILITIES A healthy physical environment</p> 	<ul style="list-style-type: none"> • Secure housing subsidies • Improve substandard conditions • Prevent evictions • Protect against utility shut-off 	<ol style="list-style-type: none"> 1. A stable, decent, affordable home helps a person avoid costly emergency room visits related to homelessness. 2. Consistent housing, heat and electricity helps people follow their medical treatment plans.
<p>EDUCATION & EMPLOYMENT Quality educational and job opportunities</p> 	<ul style="list-style-type: none"> • Secure specialized education services • Prevent and remedy employment discrimination • Enforce workplace rights 	<ol style="list-style-type: none"> 1. A quality education is the single greatest predictor of a person's adult health. 2. Consistent employment helps provide money for food and safe housing, which also helps avoid costly emergency health care services. 3. Access to health insurance is often linked to employment.
<p>LEGAL STATUS Access to jobs</p> 	<ul style="list-style-type: none"> • Resolve veteran discharge status • Clear criminal / credit histories • Assist with asylum applications 	<ol style="list-style-type: none"> 1. Clearing a person's criminal history or helping a veteran change their discharge status helps make consistent employment and access to public benefits possible. 2. Consistent employment provides money for food and safe housing, which helps people avoid costly emergency health care services.
<p>PERSONAL & FAMILY STABILITY Safe homes and social support</p> 	<ul style="list-style-type: none"> • Secure restraining orders for domestic violence • Secure adoption, custody and guardianship for children 	<ol style="list-style-type: none"> 1. Less violence at home means less need for costly emergency health care services. 2. Stable family relationships significantly reduce stress and allow for better decision-making, including decisions related to health care.

Fig. 1. KATE MARPLE, NAT'L CTR. FOR MED.-LEGAL P'SHIP, FRAMING LEGAL CARE AS HEALTH CARE 3 (Jan. 2015) <https://medical-legalpartnership.org/wp-content/uploads/2015/01/Framing-Legal-Care-as-Health-Care-Messaging-Guide.pdf> [<https://perma.cc/D92Z-KZMQ>].

24. See *infra* Fig. 1.

C. The MLP's Proven Benefits

One in six Americans needs legal care in order to be healthy.²⁵ A number of studies have begun to prove the effectiveness of the MLP model, showing that those who are served by MLPs are much more likely to see improved health outcomes than those who receive only medical treatment.²⁶ Though the data is still limited, it is both promising and growing.²⁷ Examples include:

- After attorneys became involved through MLPs to help asthmatic patients fix mold, cockroach, rodent, and dust contamination in their homes, these patients saw a 91% decrease in emergency hospital visits, with 91% dropping two or more classes in asthma severity.²⁸
- After an MLP for cancer patients was implemented, 75% of patients saw a reduction in stress, 30% of patients reported better treatment adherence, and 25% of patients experienced a greater ease in keeping appointments.²⁹
- Patients referred to an MLP within a family medicine clinic reported their concerns regarding legal issues lessened, resulting in a decrease in perceived stress and an increase in perceived well-being.³⁰

25. DAYNA BOWEN MATTHEW, CTR. FOR HEALTH POL'Y AT BROOKINGS, *THE LAW AS HEALER: HOW PAYING FOR MEDICAL-LEGAL PARTNERSHIPS SAVES LIVES AND MONEY* 3 (Jan. 2017), https://www.brookings.edu/wp-content/uploads/2017/01/es_20170130_medicallegal.pdf [<https://perma.cc/EU39-U7LZ>].

26. *See Impact*, THE NATL. CTR. FOR MED-LEGAL P'SHIP, <https://medical-legalpartnership.org/impact/> [<https://perma.cc/KN69-5FSU>].

27. On August 11, 2016, the National Center announced that it received a \$2 million grant to study the benefits of legal interventions on patients and health care organizations. Press Release, Nat'l Ctr. for Med.-Legal P'ship, *National Center Receives \$2 Million Grant to Study Impact of Legal Interventions on Health Care* (Aug. 11, 2016), <http://medical-legalpartnership.org/grant-study-legal-interventions/> [<https://perma.cc/R6X5-H3GV>].

28. Mary M. O'Sullivan, Julie Brandfield, Sumdeh S. Hoskote, Shiri N. Segal, Luis Chug, Ariel Modrykamien & Edward Eden, *Environmental Improvements Brought by the Legal Interventions in the Homes of Poorly Controlled Inner-City Adult Asthmatic Patients: A Proof-of-Concept Study*, 49 J. OF ASTHMA 911, 913 (2012), <https://pdfs.semanticscholar.org/47f0/08d9acac1632d144991d61b50e20ef06f5b1.pdf> [<https://perma.cc/M9TS-5D4R>].

29. TISHRA BEESON, BRITTANY DAWN MCALLISTER & MARSHA REGENSTEIN, THE NAT'L CTR. FOR MED.-LEGAL P'SHIP, *MAKING THE CASE FOR MEDICAL-LEGAL PARTNERSHIPS: A REVIEW OF THE EVIDENCE* 6 (Feb. 2013), <https://medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf> [<https://perma.cc/SZR6-ZU9Y>] (citing Stewart B. Fleishman, Randy Retkin, Julie Brandfield & Victoria Braun, *The Attorney as the Newest Member of the Cancer Treatment Team*, 24 J. CLIN. ONCOL. 2123, 2124 (May 2006), <http://ascopubs.org/doi/pdf/10.1200/JCO.2006.04.2788> [<https://perma.cc/BDQ4-AM4Q>]).

30. Anne M. Ryan, Randa M. Kutob, Emily Suther, Mark Hansen & Megan Sandel, *Pilot Study of Impact of Medical-Legal Partnership Services on Patients' Perceived Stress and Wellbeing*, 23 J. OF HEALTH CARE FOR THE POOR & UNDERSERVED 1536 (Nov. 2012), <https://muse.jhu.edu/arti->

- A pilot MLP program for high-need, high-risk patients resulted in a decrease in 30-day and seven-day readmission rates, a reduction in health care use and costs, an over 50% reduction in inpatient and Emergency Department use, and a 45% decrease in overall costs.³¹
- A study documenting the health outcomes of veterans who accessed legal services at four MLP sites in Connecticut and New York found that a subsample of 148 veterans who were followed for one year saw significant improvements in housing, income, and mental health—including significant reductions in symptoms of hostility, paranoia, and generalized anxiety disorder. Veterans who received more MLP services showed greater improvements in housing and mental health than those who received fewer. These improvements included reduced spending on abused substances and reduced symptoms of psychosis and posttraumatic stress disorder. Lastly, veterans who achieved their predefined legal goals showed greater improvements in housing status and community integration than those who did not.³²

D. The Key Elements

MLPs do more than serve clients. In fact, according to the National Center, partnerships that transform health care delivery: (1) provide legal aid to patients onsite at the medical setting, as part of the patient's health care; (2) train health workers to screen for legal issues and work collaboratively with lawyers; (3) make recommendations and changes to improve the medical partner's institutional policies; and (4) prevent legal issues by identifying patterns of need and engaging in systemic work.³³

cle/488862/pdf?casa_token=v0zBQRFgVWkAAAAA:bEw-yiu6D0nIxQCRpplzIIAd-sWbZWGJ2iKX5mttE33k-GoAv8cBx6p9zRenTgPD60eto5wOG [https://perma.cc/4URX-RDUC] (finding that the mean Perceived Stress Score (SS-10) decreased 8.1 points and wellbeing scores increased by 1.8 points).

31. Jeffrey Martin, Audrey Martin, Catherine Schultz & Megan Sandel, *Embedding Civil Legal Aid Services in Care for High-Utilizing Patients Using Medical-Legal Partnerships*, HEALTH AFFAIRS BLOG (April 22, 2015), <http://healthaffairs.org/blog/2015/04/22/embedding-civil-legal-aid-services-in-care-for-high-utilizing-patients-using-medical-legal-partnership/> [https://perma.cc/UA7T-3ZQS].

32. Jack Tsai, Margaret Middleton, Jennifer Villegas, Cindy Johnson, Randye Retkin, Alison Seidman, Scott Sherman & Robert A. Rosenheck, *Medical-Legal Partnerships at Veterans Affairs Medical Centers Improved Housing and Psychosocial Outcomes for Vets*, 36 HEALTH AFFAIRS 2195, 2200-2202 (Dec. 1, 2017), <https://www.nhchc.org/wp-content/uploads/2018/11/health-affairs-jack-tsai.pdf> [https://perma.cc/8SPU-HEZJ].

33. See *The MLP Response*, NAT'L CTR. FOR MED.-LEGAL P'SHIP, <https://web.archive.org/web/20160319085319/http://medical-legalpartnership.org/mlp-response/> [https://perma.cc/CLB2-XJX8]; see also THE STATE OF MLPs, *supra* note 20, at 7, 18, 19.

One example of the key role all four elements play in an MLP's strategy is the Community Advocacy Project's integration of lawyer-drafted, special education request letters into MetroHealth Medical Center's electronic record system.³⁴ The Community Advocacy Program ("CAP") is a Medical-Legal Partnership between the Legal Aid Society of Cleveland and MetroHealth Medical Center started by Mallory Curran as a Skadden Fellowship project in 2002.³⁵

In 2013, a large piece of CAP's work was ensuring children with chronic health needs or disabilities received special education services.³⁶ As part of this effort, CAP noticed that many parents were having difficulty getting their children evaluated for special education services in spite of repeated verbal requests to the schools.³⁷ Knowing that parents needed evidence but CAP had limited capacity, the lawyers began searching for a way to help parents make properly documented written requests without increasing the lawyers' caseload.³⁸ Request letters needed to be written by doctors, but doctors had little time to dedicate to this task and lacked the legal knowledge to write persuasive letters with all the necessary elements to assert and protect a patient's rights.³⁹ Meanwhile, the lawyers did not have the bandwidth to draft a letter for each doctor whose patient needed one.⁴⁰ After learning that some doctors used the electronic medical record system to store templates they had prepared themselves, CAP came up with the idea of having attorneys draft templates, upload them to the electronic medical record system, and make them available to all doctors at MetroHealth.⁴¹ As a result, a doctor with a patient in need of a letter could simply download a template and fill it in, easily providing the patient with written documentation of their evaluation requests.⁴² This would increase the patient's access to education and create a paper trail between the patient and the school that would be useful if litigation or advocacy became necessary down the road.⁴³

This electronic medical records project involved all four of the MLP elements. First, patients received legal care in conjunction with their health care.⁴⁴

34. Mallory Curran, Supervising Attorney at MFY Legal Services, Inc., Keynote Address at the Review of Law and Social Change Alumni Reception, *Preventive Law: Interdisciplinary Lessons from Medical-Legal Partnership* (April 17, 2013), in 38 N.Y.U. REV. L. & SOC. CHANGE 595 (2015), https://socialchangenyu.files.wordpress.com/2015/07/curran_7-16-15_cleaned_an.pdf [<https://perma.cc/5MHZ-BNVY>].

35. *Id.* at 598.

36. *Id.* at 599.

37. *Id.*

38. *Id.*

39. *See id.*

40. *See id.*

41. *Id.*

42. *Id.* at 599–600.

43. *See id.* at 600. Recognizing the potential of such a streamlined process in other settings, additional electronic medical advocacy letters were created by CAP. *Id.*

44. *See id.* at 599–600.

an advocacy letter was provided along with a prescription or a checkup.⁴⁵ Second, doctors were trained to screen for special education issues and identify patients in need of an advocacy letter.⁴⁶ Doctors also needed to buy into the idea that it was their role to inquire about a patient's education, and to commit to working with lawyers.⁴⁷ Third, the initiative was clearly born from doctors and lawyers communicating and collaborating to see how each of their skills, resources, practices, and routines could be leveraged to find solutions to patients' social determinants of health.⁴⁸ Here, the legal partner changed the medical provider's institutional policy by scaling up a strategy that a few individual doctors were already using.⁴⁹ Suddenly, medical records were institutionally being used to store not only medical information, but also downloadable legal advocacy templates.⁵⁰ Not only were the records tracking what medications each patient took, their height, and their weight, but also what legal aid they were receiving.⁵¹ Fourth, the initiative is a perfect example of work with individual clients that led to identifying a pattern of need and addressing it systemically.⁵² The lawyers went from writing individual letters to creating a template every patient's doctor could access.

E. Behavioral Health-Legal Partnerships and Serving Clients with Mental Illnesses

MLPs between legal organizations and behavioral and mental health providers, such as psychiatric hospitals and mental health clinics, are often called Behavioral Health Legal Partnerships.⁵³ BHLPs do not operate under a different model; they follow all of the guidelines and values of the MLP model.⁵⁴ In fact, BHLPs might be more accurately described as a useful category to group mental health provider-based MLPs. Given the relatively modest amount of research available on MLPs generally, it is not surprising that there is little research published on BHLPs specifically.⁵⁵ Instead, most of the information available on how

45. *See id.*

46. *See id.*

47. *See id.*

48. *See id.*

49. *See id.*

50. *See id.*

51. *See id.*

52. *See id.*

53. *See Resources for Behavioral Health Settings*, NAT'L CTR. FOR MED.-LEGAL P'SHIP, <http://web.archive.org/web/20170322012633/http://medical-legalpartnership.org/behavioral-health/> [<https://perma.cc/NUC5-STZL>] [Hereinafter *Resources for Behavioral Health Settings*].

54. *See id.*

55. Existing articles mostly describe programs, without engaging in an empirical analysis of the program's success or impact. *See, e.g.,* Jeanette Zelhof & Sara J. Fulton, *MFY Legal Services' Mental Health-Legal Partnership*, 44 CLEARINGHOUSE REV. 535 (2011), <http://www.mfy.org/wp-content/uploads/MFY-Legal-Services-Mental-Health-Legal-Partnership.pdf> [<https://perma.cc/RC7S-TGG7>]; Aleah Gathings, *MFY Legal Services Inc.'s Medical Legal Partnership with Bellevue Hospital Center: Providing Legal Care to Children with Psychiatric Disabilities*, 18

MLPs operate in mental health settings is a result of efforts made by the National Center for Medical-Legal Partnership to train legal and medical practitioners involved in BHLs.⁵⁶

The most obvious distinction between non-mental health MLPs and BHLs are the needs of the clients themselves. Because BHLs serve people with mental illnesses, lawyers involved in them must: (1) be sensitive to clients' heightened vulnerability; (2) have knowledge of mental health and be competent to address clients' symptoms and experiences; and (3) be prepared to address capacity and competency issues, including by challenging their own values and biases.

People with mental illnesses are at increased risk for poverty⁵⁷ and homelessness.⁵⁸ They are discriminated against in housing,⁵⁹ employment,⁶⁰ education,⁶¹

CUNY L. REV. 1 (2014), <http://www.cunylawreview.org/wp-content/uploads/2015/05/MFY-LEGAL-SERVICES.pdf> [<https://perma.cc/6TJJ-SX6C>]; Catherine F. Wong, Jack Tsai, Anne Klee, Howard R. Udell, Laurie Harkness & Margaret Middleton, *Helping Veterans with Mental Illness Overcome Civil Legal Issues: Collaboration Between a Veterans Affairs Psychosocial Rehabilitation Center and a Nonprofit Legal Center*, 10 PSYCH. SERVS. 73 (2013), <https://www.ncbi.nlm.nih.gov/pub-med?term=22984876> [<https://perma.cc/FMH7-CT95>].

56. See *Resources for Behavioral Health Settings*, *supra* note 53.

57. See Brandon C. Vick, Kristine Jones & Sophie Mitra, *Poverty and Severe Psychiatric Disorder in the U.S.: Evidence from the Medical Expenditure Panel Survey*, 15 J. MENTAL HEALTH POLICY ECON. 83–96 (2012) (“In multivariate regressions, the presence of a household member with severe psychiatric disorder predicts a 52-percentage point increase in poverty depth and 3.10 times the odds of being poor.”), <http://www.ncbi.nlm.nih.gov/pubmed/22813941> [<https://perma.cc/8YF2-9VMS>]; see also Esther Entin, *Poverty and Mental Health: Can the Two-Way Connection Be Broken?*, THE ATLANTIC (Oct. 26, 2011), <http://www.theatlantic.com/health/archive/2011/10/poverty-and-mental-health-can-the-2-way-connection-be-broken/247275/> [<https://perma.cc/3YUN-K4GD>].

58. See *Homelessness and Housing*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/homelessness-housing> [<https://perma.cc/3KTY-6XTS>] (“People with mental and/or substance use disorders can be particularly vulnerable to becoming homeless or being precariously housed. . . . In January 2016, one in five people experiencing homelessness had a serious mental illness”) (citing DEPT. OF HOUS. & URBAN DEV., 2016 ANNUAL HOMELESSNESS ASSESSMENT REPORT (2016), <https://www.hudexchange.info/resources/documents/2016-AHAR-Part-1.pdf> [<https://perma.cc/T3S3-X2TE>]); NAT’L COALITION FOR THE HOMELESS, MENTAL ILLNESS & HOMELESSNESS (July 2009), http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf [<https://perma.cc/7WE3-D6WN>].

59. Though substance abuse and mental illness contribute to homelessness, studies have found that the primary cause is the lack of low-income housing. People with substance abuse issues and other mental illnesses “experience even greater barriers to accessible housing than their counterparts: income deficits, stigma, and need for community wraparound services.” *Health & Homelessness*, AM. PSYCH. ASS’N, <http://www.apa.org/pi/ses/resources/publications/homelessness-health.aspx> [<https://perma.cc/F8TQ-9LBK>]. This makes finding a home even harder, all else equal.

60. See Teresa Scheid, *Employment of Individuals with Mental Disabilities: Business Response to the ADA’s Challenge*, 17 BEHAV. SCI. L. 73 (1999) (describing a survey conducted among employers on attitudes toward the ADA) (finding employers viewed those with mental disabilities with more discomfort than other types of employees); See generally Heather Stuart, *Mental Illness and Employment Discrimination*, 19 CURR. OPIN. PSYCH. 522 (Sept. 19, 2006) (summarizing evidence on employment-related stigma); *Employment*, BAZELON CTR. FOR MENTAL HEALTH LAW, <http://www.bazelon.org/our-work/employment/> [<https://perma.cc/N7BQ-WFRU>] (describing their work combatting employment discrimination against people with mental illnesses).

61. See *Education*, BAZELON CTR. FOR MENTAL HEALTH LAW, <http://www.bazelon.org/our-work/education/> [<https://perma.cc/RMJ7-LLN3>] [hereinafter *Education*] (describing their work

and health care.⁶² Their risk of losing custody of their children is as high as 80 percent⁶³ and they are at high risk of being killed by the police.⁶⁴ In addition, people with mental illnesses are much more likely to be misunderstood and discriminated against than those with physical illnesses, resulting in an unwillingness to seek services.⁶⁵ Stigma—including the belief that people with mental illnesses are dangerous and unpredictable, to blame for their illness, and incompetent to achieve most life goals—leads people with mental illnesses to believe that they will never recover, they are undeserving of care, they are dangerous, or they are responsible for their illness.⁶⁶ This in turn can make them feel shame, low self-esteem, and low self-efficacy, resulting in the “why try” effect or a refusal to ask for help and seek treatment to avoid being labeled in the first place.⁶⁷

combatting discrimination against people with mental illnesses in K-12 and higher education); see also Katie J.M. Baker, *How Colleges Flunk Mental Health*, NEWSWEEK (Feb. 11, 2014, 11:13 AM), <http://www.newsweek.com/2014/02/14/how-colleges-flunk-mental-health-245492.html> [<https://perma.cc/N5H8-GDV4>] (reporting on universities that force students with mental illnesses to withdraw or take an involuntary leave of absence after a medical incident, or that initiate disciplinary action); HealthCentral Editorial Team, *Discrimination Against Students with Mental Health Issues on the Rise*, HEALTHCENTRAL (Apr. 4, 2008), <https://www.healthcentral.com/article/discrimination-against-students-with-mental-health-issues-on-the-rise> [<https://perma.cc/3UQE-BFWD>].

62. Medicare and Medicaid policies discriminate against people with mental illnesses by not offering full coverage for the treatments they need. See Liz Szabo, *Cost of Not Caring: Stigma Set in Stone*, USA TODAY (June 25, 2014), <http://www.usatoday.com/story/news/nation/2014/06/25/stigma-of-mental-illness/9875351/> [<https://perma.cc/7HFB-Y32J>]. Researchers have also found that people with mental illnesses often have their pain untreated or misdiagnosed by doctors who believe their physical pain stems from their mental illness, and experience negative attitudes and mistreatment by health care staff. Graham Thornicroft, Diana Rose & Aliya Kassam, *Discrimination in Health Care Against People with Mental Illness*, 19 INTL. REV. OF PSYCH. 113, 116–19 (2007), <https://meded.duke.edu/practice/wp-content/uploads/2012/05/ainstPeoplewith-MentalHealthIllness-IntlReviewofPsych2007.pdf> [<https://perma.cc/8D2L-R8EX>].

63. See JOANNE NICHOLSON, KATHLEEN BIEBEL, BETSY HINDEN, ALEXIS HENRY & LAWRENCE STIER, UNIV. OF MASS. MED. SCHOOL, CRITICAL ISSUES FOR PARENTS WITH MENTAL ILLNESS AND THEIR FAMILIES 10 (July 30, 2001), https://escholarship.umassmed.edu/cgi/viewcontent.cgi?article=1142&context=psych_pp [<https://perma.cc/8G6S-BVRS>] (“The literature suggests parents with mental illnesses are quite vulnerable to losing custody of their children, with custody loss rates in some studies as high as 70% to 80%.”); see also NAT’L COUNCIL ON DISABILITY, ROCKING THE CRADLE: ENSURING THE RIGHTS OF PARENTS WITH DISABILITIES AND THEIR CHILDREN 1 (Sept. 27, 2012), https://www.ncd.gov/rawmedia_repository/89591c1f_384e_4003_a7ee_0a14ed3e11aa.pdf [<https://perma.cc/GP26-CBZN>] (“Removal rates where parents have a psychiatric disability have been found to be as high as 70 percent to 80 percent”).

64. See Wesley Lowery, Kimberly Kindy, Keith L. Alexander, Julie Tate, Jennifer Jenkins & Steven Rich, *Distraught People, Deadly Results*, WASH. POST (June 30, 2015), <http://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/> [<https://perma.cc/4FMX-BZVK>].

65. Patrick W. Corrigan, Benjamin G. Druss & Deborah A. Perlick, *The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care*, 15 PSYCHOL. SCI. IN THE PUB. INT. 37, 42–45 (Oct. 2014), <https://www.ncbi.nlm.nih.gov/pubmed/26171956> [<https://perma.cc/5XQK-Q5KG>] [(discussing how stigma impacts help-seeking behaviors).

66. *Id.* at 42–43.

67. *Id.* at 43–44.

Thus, it is unsurprising that people with mental illnesses often face many more and recurring legal issues that can become intertwined in a complex web. During a webinar hosted by the National Center titled “Behavioral Health and MLP: Nuts and Bolts,” attorney presenters Erin Planalp and Jay Chaudhary stated that their BHLPL clients usually face many legal issues at once, while their non-mental health MLP clients often have just one.⁶⁸ This means attorneys working with this population must be prepared to practice as generalists and may require the ongoing support of social workers and other non-legal partners. These attorneys must be familiar with antidiscrimination laws and sensitive to the ways in which their clients may have already experienced harm from the various systems with which they interact.

Another challenge for BHLPLs is that clients may experience symptoms or challenges in their mental health recovery while the lawyer-client relationship is ongoing. In a society that frowns upon talking openly about these issues, a client’s mental health needs may not always be obvious. Attorneys must be prepared to ask their clients: about their ongoing health and recovery; how they would like to be supported; and what strategies they believe the lawyer can use to ensure representation is centered on the client’s own goals.

Lastly, though it is important for attorneys to prepare for instances where their client is unable to make decisions, it is also important that they recognize implicit biases that could lead them to mistakenly rush to that conclusion. Our society routinely infantilizes people with disabilities.⁶⁹ They are treated as if they are children unable to understand complex issues, decide what is right for themselves, and have adult desires and interests.⁷⁰ People with mental illnesses in particular are perceived to be erratic, unstable, and unable to decide what is best for themselves.⁷¹

68. Erin Planalp & Jay Chaudhary, Behavioral Health and MLP: Nuts and Bolts, Webinar, for the Natl. Ctr. for Med.-Legal Partnership (notes on file with author).

69. See Kenneth L. Robey, Linda Beckley & Matthew Kirschner, *Implicit Infantilizing Attitudes About Disability*, 18 J. DEV. & PHYSICAL DISABILITIES 441, 451 (Dec. 2006), <http://link.springer.com/article/10.1007%2Fs10882-006-9027-3> [<https://perma.cc/8VJG-459X>] (finding support for the suggestion that individuals tend to implicitly associate disability-related words with child-like features).

70. See, e.g., Creigh Farina & Caley Farinas, *Don’t Call My Sister Cute—6 Good Reasons to Stop Infantilizing Disabled People*, EVERYDAY FEMINISM (Dec. 5, 2015), <http://everydayfeminism.com/2015/12/infantalizing-disabled-people/> [<https://perma.cc/L5PC-9UUR>] (detailing how infantilization is perpetuated through actions such as: calling a person with a disability “cute,” speaking to them as if they were a child or a pet, over-simplifying vocabulary or over-explaining concepts, denying them the right to have adult speech patterns, habits or desires—such as swearing and sexual attraction—addressing another adult or caregiver instead of them, not taking their opinions, beliefs, or desires seriously, and not allowing them to be independent).

71. See Corrigan, Druss & Perlick, *supra* note 65, at 42–43.

As a result, many in our society have determined that denying them their autonomy is justified in the name of the community's safety and the person's own protection.⁷²

All people are entitled to make their own choices and to have their bodily integrity respected. The principle of autonomy rests on this basic premise. People are autonomous when they make choices that are free from coercion and result from the consideration of available, meaningful alternatives. The United Nations Convention on the Rights of Persons with Disabilities,⁷³ the Americans with Disabilities Act,⁷⁴ and the U.S. Constitution⁷⁵ all protect a person's ability to assert their individual autonomy.

Often, discussions about the autonomy of people with mental illnesses are focused on the most extreme situations where people are experiencing significant psychosis.⁷⁶ It is precisely when describing these situations that adults with mental

72. See, e.g., Amitai Etzioni, *The Limits of Autonomy: Should the Mentally Ill Be Forced into Treatment?*, THE HUFFINGTON POST (May 31, 2011, 3:25PM), http://www.huffingtonpost.com/amitai-etzioni/the-limits-of-autonomy_b_869278.html [<https://perma.cc/R6UG-5WLX>] (“As I see it, mental patients are like children who are not fully competent to make decisions. Adults, who are charged with their care, owe it to the community—and above all to the children—to second-guess and amend their decisions, if need be by use of force. . . . The same goes for mental patients.”).

73. *Convention on the Rights of Persons with Disabilities*, G.A. Res. 61/106, U.N. Doc. A/RES/61/106, (Jan. 24, 2007), <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-3-general-principles.html>. The first principle of the United Nations Convention on the Rights of Persons with Disabilities, of which the United States is a signatory, is “[r]espect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons.” *Id.* Many of the declaration’s articles seek to guarantee this right by requiring that people with disabilities be given meaningful choices for employment, housing, mobility, and the sharing of private information, among others. See *id.* at art. 20, 22, 26, 27.

74. Americans with Disabilities Act, 42 U.S.C. §§ 12101–12213. The Americans with Disabilities Act (ADA) is the most important civil rights legislation for people with disabilities. Though the ADA makes no mention of an affirmative right to autonomy, its antidiscrimination protections seek to ensure people with mental illnesses are treated equally under the law, have meaningful choices in areas such as employment and education, and are able to participate equally in society. See *id.* Each is essential to achieving autonomy.

75. U.S. Const. amend. XIV. Two of the U.S. Constitution’s most important guarantees are the rights to liberty and privacy, which enable people to self-determine what happens to their bodies. See generally *Griswold v. Connecticut*, 381 U.S. 479 (1965) (establishing right to privacy for the first time in the context of marriage); *Roe v. Wade*, 410 U.S. 113 (1973) (establishing right to an abortion); *Lawrence v. Texas*, 539 U.S. 558 (2003) (establishing right to consensual sex for same sex couples).

76. See generally Emma E. McGinty, Alene Kennedy-Hendricks, Seema Choksy & Colleen L. Barry, *Trends in News Media Coverage of Mental Illness in the United States: 1995-2014*, 35 HEALTH AFFAIRS 1121 (June 2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4921198/> [<https://perma.cc/EQ6U-Y4W2>] (finding media coverage from 1995-2014 was disproportionately focused on violence, with mental health treatments being the second most common type of content); see also, e.g., Etzioni, *supra* note 72. According to the National Institute for Mental Health:

The word psychosis is used to describe conditions that affect the mind, where there has been some loss of contact with reality. When someone becomes ill in this way it is called a psychotic episode. During a period of psychosis, a person’s thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what

illnesses are likened to helpless children who need someone to act in their best interest.⁷⁷ Also invoked is the interest of the state in protecting its citizens from these supposedly volatile people.⁷⁸ These skewed narratives are used to strip even those who are in recovery of their autonomy rights.⁷⁹ In reality, for people with mental illnesses, psychosis is not a constant experience.⁸⁰ And even during those moments, tools such as psychiatric advance directives⁸¹ can allow a person to detail the kinds of treatments they do and do not want, and who may act as their proxy if needed. Those who work with and serve people with mental illnesses should not opt for the quick fix of assuming a lack of capacity and should instead invest time in de-escalation and engaging the person in recovery planning.

is not. Symptoms of psychosis include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear). Other symptoms include incoherent or nonsense speech, and behavior that is inappropriate for the situation. A person in a psychotic episode may also experience depression, anxiety, sleep problems, social withdrawal, lack of motivation, and difficulty functioning overall.

What is Psychosis?, NAT'L INST. OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-psychosis.shtml> [<https://perma.cc/G96B-KS89>].

77. See, e.g., Etzioni, *supra* note 72.

78. Mental Illness Policy Org., a pro-forced treatment website that uses fear mongering as a tactic, has used this argument to advance its position that involuntary commitment should be easier to impose on a person. DJ Jaffe, *Involuntary Treatment and Involuntary Commitment Laws: Basis in Law and History*, MENTAL ILLNESS POLICY ORG., <https://mentalillnesspolicy.org/ivc/involuntary-commitment-concepts.html> [<https://perma.cc/DZC9-A87T>] (arguing that eliminating the requirement that someone be dangerous in order to be involuntarily committed would “offer[] greater protection to both society and the individual.”); see also Etzioni, *supra* note 72.

79. Mental Illness Policy Org. is a prime example of an entity that relies on this skewed narrative and misrepresented data to promote its own agenda. See *generally Home*, MENTAL ILLNESS POLICY ORG., <https://mentalillnesspolicy.org/> [<https://perma.cc/WGV8-L9N2>].

80. *RAISE Questions and Answers*, NAT'L INST. OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/raise-questions-and-answers.shtml> [<https://perma.cc/PKY4-SMGU>] (clarifying that “[m]any people who receive early treatment never have another psychotic episode. For other people, recovery means the ability to live a fulfilling and productive life, even if psychotic symptoms return sometimes.”).

81. A psychiatric advance directive is a legal document where a person can specify what their treatment preferences are in the event that they should be found incompetent to make their own choices. See *Psychiatric Advance Directives*, BAZELON CTR. FOR MENTAL HEALTH LAW, <http://www.bazelon.org/our-work/mental-health-systems/advance-directives/> [<https://perma.cc/SQN6-9GSV>]; NATL. RES. CTR. ON PSYCH. ADVANCE DIRECTIVES, *What Are Psychiatric Advance Directives? Where Did They Come From?*, in Swanson, Swartz, Hannon, Elbogen, Wagner, McCauley, Butterfield, *Psychiatric Advance Directives: A Survey of Persons with Schizophrenia, Family Members, and Treatment Providers*, 2 INT'L J. OF FORENSIC MENTAL HEALTH 73, <http://www.nrc-pad.org/images/stories/PDFs/pads%20background.pdf> [<https://perma.cc/9VF4-BPSH>]. See also *About PADs*, NATL. RES. CTR. ON PSYCH. ADVANCE DIRECTIVES, <http://www.nrc-pad.org/> [<https://perma.cc/82YF-7K97>]. Though it is unclear whether they are legally binding (state laws vary, and the courts have not unanimously ruled on the question), they can increase the likelihood that doctors and family members will honor the person's choices. *FAQs: Frequently Asked Questions About Psychiatric Advance Directives*, NATL. RESOURCE CTR. ON PSYCH. ADVANCE DIRECTIVES, <https://www.nrc-pad.org/faqs/> [<https://perma.cc/2Y5U-G48Y>]. Advance directives can help provide doctors with helpful information, including whether the person has experienced side effects to particular medications. *Id.* As part of the directive, the person can also appoint an agent to make decisions for them, and, in fact, in some states appointing an agent is required for the directive to be valid. *Id.*

The mental health community is extremely diverse. Within it are people who view their diagnosis as an identity and refuse all treatments outright,⁸² those who prefer drug therapy, those who rely on alternative recovery tools,⁸³ and those who are experiencing psychosis for the first time, among others. All deserve to have their autonomy respected, but all will need varying kinds of support to be able to exercise it. A system where the assumption is that people with mental illnesses are like children in need of someone to act on their behalf does not honor this reality. On the contrary, this assumption systemizes gross human rights violations. Replacing it with the premise that respect for autonomy is necessary *in all situations* does not mean that we will abandon those who in extreme and rare cases cannot make their own choices; it means that we will not assume that this is *always* (or often) the case for *everyone*.

Lawyers working with people with mental illnesses must not give in to this fear-fueled myth.⁸⁴ They must be continuously vigilant in fighting these misconceptions and biases to avoid harming their clients by perpetuating these attitudes and actions. Instead, lawyers should learn about the most common serious mental illnesses, how to identify symptoms and psychosis, and crisis response strategies. This will allow them to better support their clients in an autonomy-respecting way. When decision-making ability is in question, lawyers must be prepared to make use of established, non-infantilizing, non-coercive, and autonomy-respecting strategies to aid clients in making their own choices. Such strategies include: supported decision-making, where a person with a disability signs an agreement detailing who will support them in making decisions, how, and in what areas of their life (e.g. finances, health care, etc.);⁸⁵ psychiatric advance directives;⁸⁶ and, even postponing legal decisions, when possible, until the client has recovered from a loss of decision-making ability.

82. See, e.g., Ia Robinson & Astrid Rodrigues, 'Mad Pride' Activists Say They're Unique, Not Sick, ABC NEWS (Aug. 24, 2009), <http://abcnews.go.com/Health/story?id=8382903> [<https://perma.cc/7QVC-WVFX>].

83. See, e.g., Bridget M. Kuehn, *Yoga Promotes Mindful Recovery for Veterans Experiencing PTSD*, SAMHSA, <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/yoga-promotes-mindful-recovery> [<https://perma.cc/K4EA-6LHJ>].

84. See Carrie Kaufman, *Resisting Infantilization, Building Change*, AREA CHI. (Nov. 3, 2018), <http://areachicago.org/resisting-infantilization-building-change/> [<https://perma.cc/C4PE-SWDG>] (explaining infantilization as the product of fear, and the need to keep people with mental illnesses "separate, away, 'safe,' and dependent").

85. See *EVERYONE Has the Right to Make Choices*, NATL. RESOURCE CTR FOR SUPPORTED DECISION-MAKING, http://supporteddecisionmaking.org/choices_brochure [<https://perma.cc/D6DE-KKUZ>]; Jonathan Martinis, *Supported Decision-Making: EVERYONE has the Right to Make Choices*, Webinar for Natl. Res. Ctr. for Supported Decision-Making, <https://www.youtube.com/watch?v=Db8N0093lo8> [<https://perma.cc/H9ZM-R4PY>]. Supported Decision-Making (SDM) is most commonly used as an alternative to guardianship, a legal status that strips a person of part or all of their civil rights—to contract, vote, marry, work, consent to treatment, sue and defend lawsuits, choose living arrangements, and manage money and property—and lets another exercise them on their behalf. *Id.* SDM mirrors the decision-making process most people, with and without disabilities, use. *Id.*

86. See *supra* note 81.

Understanding the various challenges attorneys face when working with people with mental illnesses, the relevant question is whether BHLPS are the ideal way to serve this population. Certainly all three of the recommendations for working with people with mental illnesses discussed above—(1) being sensitive to clients’ heightened vulnerability; (2) having knowledge of mental health and being competent to address clients’ symptoms and experiences; and (3) being prepared to address capacity and competency issues, including by challenging their own values and biases—can be implemented by BHLPS lawyers.⁸⁷ But this Article argues that the model itself must be adapted to fully promote clients’ autonomy and recovery. Part III will demonstrate that because of its implicit approval of outdated treatment methods, the BHLPS model impedes lawyer-client relationships, and the goal of supporting the clients’ recovery altogether.

III.

THE NEED FOR A NEW MODEL BASED ON RECOVERY

A. The Recovery Model

The Recovery Model can be described as a health delivery model, a set of tenets, or a philosophy that emphasizes people’s autonomy in improving their mental health and wellness.⁸⁸ It is based on the recognition that, though people with mental illnesses may experience symptoms throughout their life, they can recover.⁸⁹ For most, recovery is a journey full of both successes and setbacks, rather than a fixed destination.⁹⁰ According to the Substance Abuse and Mental Health Services Administration (“SAMHSA”), four major dimensions that support life in recovery are:

- Health—overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.
- Home—having a stable and safe place to live.
- Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors,

87. Indeed, the National Center has encouraged the adoption of a few of these recommendations. See *Resources for Behavioral Health Settings*, *supra* note 53.

88. See *Recovery and Recovery Support*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/recovery> [<https://perma.cc/Y4RZ-8CTG>] [hereinafter *Recovery and Recovery Support*].

89. See *id.*

90. See Patricia Deegan, *Recovery is a Journey of the Heart*, 19 PSYCH. REHAB. J. 91, 96–97 (1996), <http://toronto.cmha.ca/files/2012/11/Deegan1996-Recovery-Journey-of-the-Heart1.pdf> [<https://perma.cc/7MAG-5K2E>].

and [having] the independence, income, and resources to participate in society.

- Community—having relationships and social networks that provide support, friendship, love, and hope.⁹¹

In order to achieve recovery, people with mental illnesses must decide for themselves what it looks like to manage and cope with their symptoms. For one person, recovery may include psychiatric drugs, journaling, support from their faith leader, and volunteering at a local animal shelter. For another, it may be psychotherapy. The key is that (1) the individual, not their doctor, is the care expert and decision-maker, and (2) the goal is not full symptom resolution or finding a cure, but resilience and control.⁹²

The Recovery Model has gained acceptance in recent years among U.S. states,⁹³ the U.S. federal government,⁹⁴ other national governments,⁹⁵ health providers,⁹⁶

91. *Recovery and Recovery Support*, *supra* note 88 (emphasis in original).

92. See K. S. Jacob, *Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care*, 37 INDIAN J. PSYCHOL. MED. 117, 117–118 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418239/> [<https://perma.cc/4ET3-CPC6>].

93. See Nora Jacobson & Laurie Curtis, *Recovery as Policy in Mental Health Services: Strategies Emerging from the States*, PSYCH. REHABILITATION J., at 3–4 (2000), http://im.sut.ac.th/Articles/02_Recovery%20as%20Policy%20in%20Mental%20Health%20Services.pdf [<https://perma.cc/NS6S-JNXF>].

94. See *Recovery and Recovery Support*, *supra* note 88 (recognizing recovery and detailing establishment of the Recovery Support Strategic Initiative).

95. See, e.g., AUSTRALIAN GOVERNMENT, NAT'L STANDARDS FOR MENTAL HEALTH SERVS. 2, 42–44 (2010), [http://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/\\$File/servst10v2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf) [<https://perma.cc/45VT-QJ5S>] (Australia) (recognizing principles of recovery as essential to mental health care delivery and providing definitions and recommendations); Mary O'Hagan, *Recovery in New Zealand: Lessons for Australia?*, 3 AUSTRALIAN E-JOURNAL FOR THE ADVANCEMENT OF MENTAL HEALTH 1, 1–2 (2004), https://www.researchgate.net/publication/274777869_Guest_Editorial_Recovery_in_New_Zealand_Lessons_for_Australia [<https://perma.cc/JV4W-C8YL>] (New Zealand) (detailing the history of the Mental Health Commission's adoption of the recovery model and its attempt to adapt it by shifting the focus from individual to social responsibility, challenge the biomedical model of mental illness, and reflect the values of the survivor movement); *Where We Came From*, SCOTTISH RECOVERY NETWORK, <https://www.scottishrecovery.net/where-we-came-from/> [<https://perma.cc/8LWE-WFKK>] (Scotland) (detailing how the network was created in response to a report by the Scottish Executive's National Plan for Improving Mental Health & Well-Being: Action Plan 2003-2006).

96. The American Psychological Association and the American Psychiatric Association have jointly launched “Recovery to Practice,” an initiative to promote recovery-based principles among their members. See *Recovery to Practice (RTP)*, AM. PSYCH. ASS'N, <http://www.apa.org/pi/mfp/psychology/recovery-to-practice/> [<https://perma.cc/H9B3-XDQT>]; *Recovery-Oriented Care in Psychiatry Curriculum*, AM. PSYCHIATRIC ASS'N, <https://www.psychiatry.org/psychiatrists/practice/professional-interests/recovery-oriented-care> [<https://perma.cc/EW29-KY9U>]. The National Association of Social Workers and the American Psychiatric Nurses Association also support the model. See *NASW Practice Snapshot: The Mental Health Recovery Model*, NAT'L ASS'N. OF SOC. WORKERS, https://www.socialworkers.org/practice/behavioral_health/0206snapshot.asp; *Recovery to Practice Pledge*, AM. PSYCHIATRIC NURSES ASS'N, <http://www.apna.org/i4a/pages/index.cfm?pageID=4606> [<https://perma.cc/5WZE-E2JD>] (“We are committed to shifting the paradigm of our professions to

and consumer and family-led community organizations.⁹⁷ Notably, SAMHSA and the World Health Organization recommend it as a best practice.⁹⁸

Admittedly, BHLs can, and often do, attempt to integrate the recovery model. The National Center hosted a webinar led by Dr. Marianne Farkas of the Center for Psychiatric Rehabilitation on the basics of the recovery model.⁹⁹ The webinar was part of a series intended as a resource for BHLs. Dr. Farkas emphasized that rights protection should be just one part of the client's recovery, and that each case should be entirely guided by them: "It's important to believe in the person no matter what."¹⁰⁰ Dr. Farkas also explained the four recovery values for the provision of services: (1) *Person Orientation*: focusing on the person's strengths, talents, and interests instead of their diagnosis; (2) *Choice*: the person has agency and the individual power to make decisions without coercion; (3) *Partnership*: including people with mental illnesses in the designing and delivery of services; and, (4) *Hope*.¹⁰¹ Dr. Farkas' specific recommendations included developing decision-making aids for common issues—such as eviction—that explain the client's options, and role-playing with clients before appearances in court to prepare them for active participation.¹⁰²

While these are helpful recommendations, they demonstrate that the most BHLs can aspire to achieve with regards to adhering to the recovery model is an individual, attorney-by-attorney adoption of recovery-based practices, and perhaps the encouragement of health providers to do the same. But this is not enough. What is needed is a legal services delivery model that not only adopts as much of the recovery model as possible, but is structured according to, and guided by, the recovery model.

The main associations of psychiatrists, psychologists, and psychiatric nurses all support the recovery model and provide resources for their members to learn how to play a role within it.¹⁰³ But that role must be as a resource for people with

ensure the realization of a recovery oriented system of care that will stand as a new beacon of hope for persons with, or at risk for, behavioral health conditions and their families.").

97. See, e.g., *What is Recovery?*, NAT'L ALL. ON MENTAL ILLNESS OF SOUTHWEST OHIO, <http://namiswoh.org/about-recovery/what-is-recovery/> [<https://perma.cc/4RFY-H4EP>] (representing people with mental illnesses and their families and providing a working definition of recovery); *Recovery*, NAT'L COAL. FOR MENTAL HEALTH RECOVERY, <http://www.ncmhr.org/recovery.htm> [<https://perma.cc/Y22Q-9UJB>] (advocating for consumers and providing information on recovery).

98. See WORLD HEALTH ORG., MENTAL HEALTH ACTION PLAN 2013-2020, at 14 (2013), http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf [<https://perma.cc/88ET-UL4B>] (defining recovery and stating as an objective that community-based services be delivered using a recovery-based approach); *Recovery and Recovery Support*, *supra* note 88.

99. Marianne Farkas, *The Human Experience of Recovery: What Can I Do? I'm Not a Mental Health Provider*, Webinar for Natl. Ctr. for Med.-Legal P'ship (Dec. 10, 2015) (notes on file with author).

100. *Id.*

101. *Id.* at 28:30.

102. *Id.* at 51:15.

103. A number of professional organizations have worked with the Substance Abuse and Mental Health Services Administration to develop educational curricula and training materials

mental illnesses, and not as decision-makers. While medical treatment can be an important part of a person's mental health recovery, it is often not the only or the most important component. By situating legal services in a medical setting, BHLPs are inevitably centering medical care as the most important component of a person's recovery. By identifying medical providers, such as hospitals and clinics, as the ideal partners for attorneys, BHLPs are indicating that medical professionals like psychologists, psychiatrists, and psychiatric nurses are in the best position, as opposed to social workers or peer support specialists, to aid people with mental illnesses. These may seem like subtle or symbolic considerations, but they are decisions that perpetuate problematic power dynamics and bolster systems that have historically harmed people with disabilities, as discussed in Parts III.B and III.C.

Lastly, though medical settings like hospitals may seem like the best locations to come in contact with people with mental illnesses, it does not follow that they are the best locations to serve them. Moreover, the assumption that people with mental illnesses will be at hospitals paints an incomplete picture. It can just as well be argued that the people in most need have not yet sought—or been forced to seek—treatment. They may instead be interacting with providers such as shelters, food banks, mental health nonprofits, or support groups.

B. BHLPs Affirm the Medical Model

The medical model of disability is often considered the antithesis of the recovery model.¹⁰⁴ Under the medical model of disability, a person's disability is a problem belonging to the individual rather than to society, which must be cured using clinical and diagnostic means.¹⁰⁵ Medical professionals are seen as experts

that promote recovery principles within their specialty areas. *APNA Recovery to Practice Program*, AM. PSYCHIATRIC NURSES ASS'N, <https://www.apna.org/i4a/pages/index.cfm?pageid=5296> [<https://perma.cc/NBS4-KTMD>]; *Recovery-Oriented Care in Psychiatry Curriculum*, AM. PSYCHIATRIC ASS'N, <https://www.psychiatry.org/psychiatrists/practice/professional-interests/recovery-oriented-care/recovery-oriented-care-in-psychiatry-curriculum> [<https://perma.cc/EW29-KY9U>]; *Recovery to Practice Curriculum Modules*, AM. PSYCHOLOGICAL ASS'N, <http://www.apa.org/pi/mfp/psychology/recovery-to-practice/training.aspx> [<https://perma.cc/JX7Q-55PJ>].

104. *But see* Ken Duckworth, *Science Meets the Human Experience: Integrating the Medical and Recovery Models*, NAT'L ALL. ON MENTAL ILLNESS (Apr. 10, 2015), <https://www.nami.org/Blogs/NAMI-Blog/April-2015/Science-Meets-the-Human-Experience-Integrating-th> [<https://perma.cc/3X8J-EB8N>] (arguing the recovery model and the medical model can and should be integrated); Stephen Seager, *Medical Model? Recovery Model? No Problem*, PSYCHOLOGY TODAY (Apr. 20, 2015), <https://www.psychologytoday.com/blog/braintalk/201504/medical-model-recovery-model-no-problem> [<https://perma.cc/3HTF-CDK7>] (arguing that while both models can work in unison, the recovery model only works for those who have been made well by their medications).

105. *See Models of Disability*, THE ALL. FOR INCLUSIVE EDUC., <http://www.all-ife.org.uk/pages/useful%20info/medical.html> [<https://perma.cc/2BS8-JFMM>]; *The Social and Medical Model of Disability*, UNIV. OF LEICESTER, <http://www2.le.ac.uk/offices/accessibility/staff/accessabilitytutors/information-for-accessability-tutors/the-social-and-medical-model-of-disability> [<https://perma.cc/R5BL-SUYW>].

who are well positioned to decide what the mental health consumer¹⁰⁶ needs and what care they should be provided.¹⁰⁷ This denies the consumer the ability to choose—a key component of recovery. Despite the gains made by the recovery model, the medical model is still entrenched in the health community and society as a whole, producing devastating consequences.

First, as explained by Simon Brisenden, Co-Founder of the Independent Living Centre of Southampton, in his well-known article *Independent Living and the Medical Model of Disability*, the medical model teaches that doctors and medical treatment are the only legitimate response to mental illness:

The medical model of disability is one rooted in an undue emphasis on clinical diagnosis, the very nature of which is destined to lead to a partial and inhibiting view of the disabled individual. In order to understand disability as an experience, as a lived thing, we need much more than the medical ‘facts’ . . . In the past especially, doctors have been too willing to suggest medical treatment and hospitalization, even when this would not necessarily improve the quality of life for the person concerned. Indeed, questions about the quality of life have sometimes been portrayed as something of an intrusion upon the purely medical equation. This has occurred due to a failure of imagination, the result of the medical profession’s participation in the construction of a definition of disability which is partial and limited. This definition has portrayed disability as almost entirely a medical problem, and it has led to a situation where doctors and others are trapped in their responses by a definition of their own making. They cannot respond in ways that go outside the parameters of a view of disabled

106. The term mental health consumer refers to a person who has a mental illness or who has lived experience of mental illness or the symptoms associated with it. *Definitions*, CONSUMERS OF MENTAL HEALTH WA, <http://www.comhwa.org.au/about-us/definitions/> [<https://perma.cc/8K5W-LKDK>].

It is a term preferred by a significant number of advocacy groups both in the United States and abroad, as well as governmental organizations like SAMHSA. *See, e.g., About the Clearinghouse*, THE CLEARINGHOUSE, <https://www.mhselfhelp.org/> [<https://perma.cc/EJ7D-CLGK>]; *Statewide Consumer Network Program*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., at N.1, <https://www.samhsa.gov/grants/grant-announcements/sm-16-002#> [<https://perma.cc/WG98-S7K8>] (last updated Nov. 16, 2015); *Guidelines for Consumer and Family Participation*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/grants/applying/guidelines-consumer-participation> [<https://perma.cc/5TRP-KAWP>] (last updated Sept. 15, 2017) (defining consumer as “mental and/or substance use treatment recipients”); *see also Defining Consumers and Family Members of Mental Health Services*, WORKING WELL TOGETHER, http://www.cibhs.org/sites/main/files/file-attachments/defining_cfms_of_mh_services.pdf [<https://perma.cc/C6U6-9LXK>].

107. *See, e.g.,* Simon Brisenden, *Independent Living and the Medical Model of Disability*, UNIV. OF LEEDS, <https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/brisenden-brisenden.pdf> [<https://perma.cc/CUF6-9APT>] (“Our opinions, as disabled people, on the subject of disability are not generally rewarded with the same validity as the opinions of ‘experts’, particularly medical experts.”) (commenting on the deference given to medical perspectives, published in academic forums).

people which they themselves have created. They are stuck within the medical model of disability.¹⁰⁸

This leads the government and private foundations to limit already scarce funding streams to medical treatment.¹⁰⁹ In reality, even if people with mental illnesses choose medical treatment, they need much more to recover. Studies have shown that psychosocial programs—which tend to align more closely with the recovery model’s goals—are crucial to long-term recovery.¹¹⁰ Psychosocial programs focus on a person’s quality of life and include different types of psychotherapy and social and vocational training, such as programs that provide support for finding housing or developing employment skills.¹¹¹

Second, the medical model encourages the use of forced treatment and restraints. Forced treatment includes being forced to take medication, see a therapist, or remain in a hospital against one’s will. It can be divided into two categories based on the setting: involuntary outpatient treatment¹¹² and involuntary in-

108. *Id.*

109. Specialty providers include[ing] psychiatric units of general hospitals, specialty psychiatric hospitals, psychiatrists, other [mental health] professionals such as psychologists, social workers, and counselors, and specialty [mental health] and [substance use disorders] centers providing mostly outpatient and residential treatment services . . . are projected to account for the majority of MH treatment spending between 2009 and 2020, as they have historically. The share of specialty provider MH treatment spending is expected to decline slightly from 2009 to 2020, from 72 percent to 70 percent.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., PROJECTIONS OF NATIONAL EXPENDITURES FOR TREATMENT OF MENTAL AND SUBSTANCE USE DISORDERS, 2010-2020, 27 (2014), <https://store.samhsa.gov/shim/content/SMA14-4883/SMA14-4883.pdf> [<https://perma.cc/SG4R-G86Y>]; see also, e.g., Stefanie Feldman, *New Funding to Increase Access to Mental Health Services and New Protections Under the Health Care Law*, THE WHITEHOUSE BLOG (Feb. 18, 2014, 7:22 PM), <https://www.whitehouse.gov/blog/2014/02/18/new-funding-increase-access-mental-health-services-and-new-protections-under-health-> [<https://perma.cc/DY3G-UQ42>] (plans for future mental health spending are focused on medical treatment).

110. See *Psychosocial Treatments*, NAMI, <https://www.nami.org/learn-more/treatment/psychosocial-treatments> [<https://perma.cc/CR53-82MM>] (defining psychosocial treatments and providing examples). One important example is supported employment. See Sandra Moll, James Huff & Lisa Detwiler, *Supported Employment: Evidence for a Best Practice Model in Psychosocial Rehabilitation*, 70 CANADIAN J. OF OCCUPATIONAL THERAPY 298, 306–07 (Dec. 2003); Morris D. Bell, Paul H. Lysaker & Robert L. Milstein, *Clinical Benefits of Paid Work in Schizophrenia*, 22 SCHIZOPHRENIA BULLETIN 51, 63–65 (1996); Laura Blankertz & Susan Robinson, *Adding a Vocational Focus to Mental Health Rehabilitation*, 47 PSYCH. SERV. 1216, 1221–22 (1996). Another example is the Clubhouse Model. See *infra* Part IV.B.

111. See *supra* note 110.

112. Involuntary outpatient treatment (IOT) is often euphemistically called “assisted outpatient treatment” and involves a court order that requires a person to visit a clinical provider for treatment while living in their usual setting. See Morgan Shields, *The Murphy Bill: Ethical Considerations for the State of Mental Health Care and Its Consumers*, HARV. PUB. HEALTH REV. (Jan. 29, 2015), <https://medium.com/harvard-public-health-review/the-murphy-bill-ethical-considerations-for-the-state-of-mental-health-care-and-its-consumers-ae08ead77a3f#wok9qkrgh> [<https://perma.cc/ZPJ7-MFK2>]. IOT is often used for those who would otherwise not qualify for an involuntary commitment because they are not a danger to themselves or others, thereby expanding the curtailment of people with mental illnesses’ liberty rights beyond emergency situations. See *Position Statement on Involuntary*

patient treatment.¹¹³ Meanwhile, restraints involve restricting a person's movement.¹¹⁴

There are three methods of restraints typically used in psychiatrist treatment facilities. With mechanical restraints, a device such as a wrist strap or a straitjacket is used to restrain the patient. When using physical restraints, other individuals physically hold down the patient. Using the isolation method, patients are put into a secluded room empty of items that could be potentially used to cause oneself harm.¹¹⁵

Forced treatment and restraints have been described by those who have experienced them as scary, traumatic, and harrowing. One qualitative study examining the experience of involuntarily committed patients who were restrained found that patients felt afraid and rejected, reporting the following statements:

- “Hurt, frightened, made me feel like prey. Feel like somebody is going to cut me into pieces. I don't want to come back.” [Inpatient 31]
- “I didn't like it. Cold. Was like a place you are by yourself and you know they don't care. Scary. Very bad. I hope no one goes there.” [Inpatient 09]
- “Felt like it was torture. Not being able to move at all, very uncomfortable.” [Inpatient 36]
- “It was harmful to my whole being, an assault on my dignity and attack on my soul.” [Inpatient 44]¹¹⁶

Commitment, BAZELON CTR. FOR MENTAL HEALTH LAW, <http://www.bazelon.org/wp-content/uploads/2017/04/Position-Statement-on-Involuntary-Commitment.pdf> [https://perma.cc/67YB-EA73]. Though most IOT statutes do not require a finding of dangerousness, a number of them explicitly allow police to forcibly pick up and detain a person for mental evaluations if they have failed to comply with any provision in the order. *Forced Treatment > Policy Documents*, BAZELON CTR. FOR MENTAL HEALTH LAW, https://web.archive.org/web/20170211201951/http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment/Forced-Treatment-Policy-Documents.aspx#State_Involuntary_Outpatient_Commitment_Laws [https://perma.cc/27LV-3YAD]; *see generally* BAZELON CTR. FOR MENTAL HEALTH LAW, INVOLUNTARY OUTPATIENT COMMITMENT SUMMARY OF STATE STATUTES (April 2000), <https://web.archive.org/web/20170423141129/http://www.bazelon.org/LinkClick.aspx?fileticket=CBmFgyA4i-w%3d&tabid=324> [https://perma.cc/R6L6-5SEH]. The most common consequence for violating an IOT order is re-evaluation for an inpatient involuntary commitment. *Id.*

113. *Infra* Part III.C will discuss the harms of involuntary in-patient treatment, often called “involuntary commitment.”

114. *See* Bronte Lawson Silverstein, *Discussing the Use of Mechanical Restraints*, USC GOULD SCHOOL OF LAW, (Mar. 27, 2012), <http://weblaw.usc.edu/press/article.cfm?newsid=3852> [https://perma.cc/64R4-QWA3].

115. *Id.*

116. Sara Ling, Kristin Cleverley & Athina Perivolaris, *Understanding Mental Health Service User Experiences of Restraint Through Debriefing: A Qualitative Analysis*, 60 CAN. J. PSYCHIATRY 386, 389 (Sept. 2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4574714/> [https://perma.cc/AA4M-U9VT].

Unsurprisingly, researchers concluded that “loss of autonomy as it related to the hospital environment significantly contributed to the anger that precipitated restraint events.”¹¹⁷

Despite evidence of the threat to physical and mental wellbeing posed by restraints, they remain a common experience for people with mental illnesses who are hospitalized.¹¹⁸ Elyn Saks, founder of the Saks Institute for Mental Health Law, Policy, and Ethics at the University of Southern California Gould School of Law and a legal scholar who has schizophrenia, has spoken about her own experiences:

I’ve been mechanically restrained three or four times, for up to 20 hours. . . . It was degrading, dehumanizing and very painful. I’ve had nightmares about it for years.¹¹⁹

Keris Myrick, the director of Project Return Peer Support Network, speaking at an event held by the Saks Institute on the use of restraints, echoed Saks:

The first time I was subdued with mechanical restraints it was a very violent act. . . . Several men came towards me and took me down because I didn’t comply with a nurse’s request. They put me in a four-point restraint, where one hand is held up and the other is held down and you’re tied to a bed. I wanted to end my life, then more than ever.¹²⁰

Saks and Myrick are not alone. Beginning in the late 1960s to early 1970s, a movement of people known as ex-patients, psychiatric inmates, ex-inmates, or psychiatric survivors—among other self-selected terms—led the charge to end the use of force and restraints, among other demands.¹²¹ Decades later, that call has gained traction with governmental organizations and medical professionals who

117. *Id.* at 390.

118. See Ravi Parikh, *Rethinking Hospital Restraints*, THE ATLANTIC (Aug. 18, 2014), <http://www.theatlantic.com/health/archive/2014/08/rethinking-hospital-restraints/375647/> [<https://perma.cc/GW3V-3AG2>] (“As a supposed measure of last resort [] restraints are surprisingly common” with a 2007 study “estimat[ing] that 27,000 patients are restrained every day in U.S. hospitals—an average of five patients per hospital per day”). See, e.g., *Video Shows Struggling Mental Patient Die in Restraints*, DENVER ABC 7 (Nov. 7, 2011, 1:20AM), <https://web.archive.org/web/20160604084031/http://www.thedenverchannel.com/news/video-shows-struggling-mental-patient-die-in-restraint> [<https://perma.cc/73E2-UDXT>] (content warning: video of a man dying due to a physical restraint).

119. Silverstein, *supra* note 114.

120. *Id.*

121. See *Mental Health Advocacy, from Then to Now*, NAT’L ASS’N FOR RIGHTS PROT. AND ADVOCACY, <http://www.narpa.org/reference/mental-health-advocacy-from-then-to-now> [<https://perma.cc/75UX-5E5F>]; Judi Chamberlin, *The Ex-Patients’ Movement: Where We’ve Been and Where We’re Going*, NAT’L EMPOWERMENT CTR. (1990), <http://power2u.org/the-ex-patients-movement-where-weve-been-and-where-were-going/> [<https://perma.cc/ZE47-AJH9>].

are now calling for safer alternatives.¹²² One pilot program to reduce restraints and seclusions during involuntary commitments found that verbal de-escalation takes less time than the process of restraint and involuntary medication, and avoiding coercion not only helps reduce injuries to staff and patients, but also helps establish the trust needed for a successful therapeutic relationship.¹²³ The program also resulted in a decrease in assaults, injuries, and insurance costs, as well as an increase in patient and staff satisfaction, which led to higher staff retention.¹²⁴ But much still remains to be done to end the use of involuntary restraints altogether.

By teaching doctors that they know what is best for their patients, the medical model imposes an implicit duty on doctors to carry out their will even when it is opposed to the patient's.¹²⁵ Adherence to this duty can lead to events such as the ones experienced by Saks, Myrick, and the patients in the study. Moreover, this implicit duty is in stark opposition to the duty of lawyers to honor and zealously advocate for their client's wishes without passing judgment (instead providing legal and strategic advice).¹²⁶

Lastly, because the medical model focuses on treatment and symptom management—which could be interpreted as curing difference—it ties wellness to assimilation. A person with schizophrenia will be rewarded with safety from forced

122. Health professionals are beginning to develop alternatives to the use of force and restraints. See STEPHAN HAIMOWITZ, JENIFER URFF & KEVIN ANN HUCKSHORN, NAT'L ASS'N OF STATE MENTAL HEALTH PLANNING DIRECTORS, RESTRAINT AND SECLUSION—A RISK MANAGEMENT GUIDE 23–28 (Sept. 2006), <http://www.power2u.org/downloads/R-S%20Risk%20Manag%20Guide%20Oct%202006.pdf> [<https://perma.cc/4HME-CBM5>]; *Alternatives to Seclusion and Restraint*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/trauma-violence/seclusion> [<https://perma.cc/APG2-DEMD>] (Last updated Sept. 16, 2015).

123. See Scott Zeller, Policy Institute: Engagement Instead of Coercion, Presentation to NAMI 2015 Convention (July 9, 2015) (notes on file with author) [hereinafter Zeller Notes]; see also Scott Zeller & Tom Lane, Understanding Agitation, Webinar for Depression and Bipolar Support Alliance (May 20, 2015), <http://www.dbsalliance.org/pdfs/webinars/UnderstandingAgitation.pdf> [<https://perma.cc/7NAZ-GTV9>]; Garland H. Holloman & Scott L. Zeller, *Overview of Project BETA: Best Practices in Evaluation and Treatment of Agitation*, 13 WEST J. EMERG. MED. 1, 2 (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298232/> [<https://perma.cc/BZY4-WCQG>].

124. Zeller Notes, *supra* note 123.

125. The widely cited Hippocratic oath imposes a duty on doctors to exercise their own judgment about what is best and to “[f]ollow the method of treatment, which according to [the doctor’s] ability and judgment, [the doctor] consider[s] for the benefit of [her] patient.” Amy Killelea, *Collaborative Lawyering Meets Collaborative Doctoring: How a Multidisciplinary Partnership for HIV/AIDS Services Can Improve Outcomes for the Marginalized Sick*, 16 GEO. J. ON POVERTY L. & POL’Y 413, 448 (2009) (citing Nancy S. Jecker, *Introduction to the Methods of Bioethics*, in *BIOETHICS: AN INTRODUCTION TO THE HISTORY, METHODS, AND PRACTICE* 113 (2006) (quoting Hippocrates, trans. William H.S. Jones, 1923)).

126. Killelea discusses how the ethical codes of doctors and lawyers seem to conflict. See Killelea, *supra* note 125, at 448. According to her, lawyers owe their clients advocacy and zealous pursuit of the goals they have determined for themselves. *Id.* Meanwhile the Hippocratic Oath taken by doctors, “is focused on the doctor making good faith judgments about what to do for the patient, which seems to be far more paternalistic than the attorney’s duty to give voice to the client.” *Id.*

treatment, restraints, poverty,¹²⁷ police brutality,¹²⁸ the loss of their children,¹²⁹ discrimination,¹³⁰ etc., and be considered a “success story” if they have managed to “cure” and “control” their symptoms, with the help of psychiatrists and medications, to the point where no one knows that they hear voices.

This expectation of assimilation hurts people with mental illnesses who have no interest in hiding their experiences or who do not aspire to society’s definition of “normal.” Wendy Lu, a journalist and disabled advocate, presents the desire to “cure” people with disabilities—not just those with mental illnesses—as a harmful product of ableism:

The idea of needing to “fix” or “cure” disability communities automatically assumes a negative relationship between people and their disabilities. It also perpetuates the misconception that disability is something to be ashamed of. In reality, disability is a complex identity, and disabled people are multifaceted non-monolithic human beings. I am proud, like many people, to be disabled. When people suggest that my life would be better without my disability, it feels like they’re rejecting me as a person. . . . When cure functions as a type of social control or pressure to eradicate disability communities, it becomes the opposite of liberation. Especially for people whose disabilities don’t have cures, this mindset can make them feel trapped or inadequate.¹³¹

In the Mad Pride movement, people who have been diagnosed with serious mental illnesses refuse treatment and take pride in their inability to fit within a neurological binary that presents normal and abnormal as polar opposites.¹³² Within the medical model, the Mad Pride community is seen as sick, and their collective choice to experience what some call an illness as an identity is labelled dangerous.¹³³ This strictly scientific and diagnostic framework leaves out vocal segments of the mental health community, and limits what the community can achieve and desire.

Certainly, for many people with mental illnesses, a diagnosis and medical treatment are a tried and true part of their journey to achieve recovery.¹³⁴ Rejecting

127. See *supra* note 57 and accompanying text.

128. See *supra* note 64 and accompanying text.

129. See *supra* note 63 and accompanying text.

130. See *Health & Homelessness*, *supra* note 59; Scheid, *supra* note 60; *Education*, *supra* note 61; Szabo, *supra* note 62.

131. Wendy Lu, *Disabled People Don’t Need to Be “Fixed”—We Need a Cure for Ableism*, EVERYDAY FEMINISM (May 21, 2018), <https://everydayfeminism.com/2018/05/a-cure-for-ableism/> [<https://perma.cc/5CVH-YNPG>].

132. See Robinson & Rodrigues, *supra* note 82.

133. See *id.*

134. See Kate Bailey, *Prozac Saved My Life, and Other Reasons One Experience with Psychiatric Drugs Does Not Account for Them All*, THOUGHT CATALOG (Oct. 16, 2013), <http://thoughtcat->

the medical model does not disallow this course of action for those who choose it. On the contrary, it expands the possibilities and reimagines the process of medical intervention to be one where the person seeking care rather than the health professional is considered the expert and the decision-maker. Moreover, true autonomy can only be borne of choice. If mental health consumers have nothing but drugs available to them, then their treatment is already coercive.

As explained above,¹³⁵ BHLs are incompatible with the recovery model largely because they affirm the medical model. By partnering with medical providers and existing in the medical setting, BHLs imply that medical treatment is what is best for a client. By presenting partnerships between lawyers and doctors as a best practice, BHLs suggest that medical treatment and legal aid are the two main components of a person's recovery. This can be a dangerous assumption.

C. BHLs Are Entangled in Harms Perpetuated by Hospitals

In *O'Connor v. Donaldson*, the U.S. Supreme Court ruled that:

[a] finding of “mental illness” alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement. . . . a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.¹³⁶

The implication of this ruling, however, is that it is *not* a violation of the constitutional right to liberty to confine a person who *does* pose a danger so long as there is due process.¹³⁷ Though states vary to some degree in their involuntary commitment laws, all must follow the *O'Connor* standard: to involuntarily commit someone, the person must (1) have a mental illness that (2) makes them a danger to themselves or others, and (3) there must not be a less restrictive alternative.¹³⁸

alog.com/kate-bailey/2013/10/prozac-saved-my-life-and-other-reasons-one-experience-with-psychiatric-drugs-does-not-account-for-them-all/ [https://perma.cc/M9ZF-2333]. Between 2002 and 2013, the percentage of adults using prescription medication for mental health reasons increased from 10.5 to 12.5 percent. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: MENTAL HEALTH FINDINGS 2 (2013), <http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf> [https://perma.cc/6DZA-KBRV]. Furthermore, “in 2013, 3.3 million youths aged 12 to 17 (13.6 percent) received treatment or counseling for problems with emotions or behavior in a specialty mental health setting (inpatient or outpatient care) in the past 12 months. The percentage in 2013 was higher than those in 2007 through 2012 (ranging from 12.0 to 12.7 percent).” *Id.*

135. See *supra* Part III.A.

136. *O'Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975).

137. See *id.* at 580.

138. See *id.* at 576; See ROBERT M. LEVY & LEONARD S. RUBENSTEIN, THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES 26–35 (Southern Illinois University Press, 1996) (explaining the involuntary commitment standard); see also Megan Testa and Sara G. West, *Civil Commitment in the*

There have been a number of critiques of the involuntary commitment standard. Cynthia Ward has denounced prong one's emphasis on pathology, which requires reliance on medical interpretation often biased toward commitment,¹³⁹ as well as the courts' treatment of "dangerousness" in prong two as synonymous with "mental illness."¹⁴⁰ She proposes an alternative "purely legal standard" which focuses on the person's capacity.¹⁴¹ As a compromise between autonomy and paternalism, Elyn Saks proposes an alternative standard that would define "danger" more strictly and precisely, but only for those who have been previously committed.¹⁴²

Though not true in every case, opposition or support for involuntary commitment (and other forced treatment programs) can separate the mental health community into directly impacted mental health consumers and legal advocates on one side, and their loved ones, caregivers, and health providers on the other.¹⁴³ But

United States, 7 PSYCHIATRY 30, 31–34 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/pdf/PE_7_10_30.pdf [<https://perma.cc/29EA-63NP>] (detailing the history of involuntary commitment and the standard in the United States).

139. Cynthia V. Ward, *Mental Illness and Danger to Self*, 3 MENTAL HEALTH L. & POL'Y J. 253, 290–95 (2014) <https://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=2740&context=facpubs> [<https://perma.cc/KM3K-NV7N>]. Ward believes the involuntary commitment standard should focus on the mental state and capacity of the person, thereby transforming it into a legal determination that can be made by courts. *Id.* at 305.

140. *Id.* at 274. Ward reached this conclusion based on empirical data of court proceedings post *O'Connor*. She found that at the very least, "dangerousness" was treated as primarily the concern of mental health professionals. *Id.* In fact, the data showed no significant changes in the rate or substantive proceedings of commitments after *O'Connor*. *Id.* at 276.

141. As an alternative to the *O'Connor* standard, Ward proposes:

[A] purely legal standard which contains (1) a dangerousness element; (2) a cognitive capacity element designed to gauge the respondent's ability to exercise autonomous judgment on the question of hospitalization or other psychiatric treatment; and (3) a causal element explicitly linking the legitimacy of state intervention to the respondent's deliberative and reasoning capacities.

Id. at 305.

142. Saks's proposal is two-tiered, with one standard for someone's first psychotic breaks and one for subsequent psychotic breaks. *See* ELYN SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL (2002). The first standard would allow an involuntary commitment for the first *serious psychotic* break, without the need for dangerousness, but only in the absence of a less restrictive alternative. *Id.* at 59–68. Saks defines serious psychosis as: the presence of hallucinations or profound delusions or incoherence, involving documentation of significant disability or distress, and a risk of further detrimental consequences, such as loss of employment. *Id.* at 61. The second standard for subsequent psychotic episodes is stricter: the person must have a 1) *severely impairing* mental illness, 2) that has transformed their character to make them a *serious* danger to themselves or others, or gravely disabled, and 3) be likely to benefit from treatment. *Id.* at 68. Consideration should also be given to whether the person would have authorized the treatment if competent. *Id.* Though seemingly similar to *O'Connor*, "serious danger" in Saks's test means a harm that rises to the level of homicide or aggravated battery, or a near certainty that someone will end their own life. *Id.* at 69–80. This elevated second standard reflects Saks's intent to afford autonomy grave respect once the person has learned their preferences from the initial experience of psychosis and forced treatment. *Id.* at 59.

143. *See, e.g.*, Laura Parker, *Families Lobby to Force Care*, USA TODAY (Feb. 12, 2001, 10:32 AM), <http://usatoday30.usatoday.com/news/health/2001-02-12-mental-health.htm#more> [<https://perma.cc/N3XL-2ES8>]. In fact, one of the biggest divides in the movement is between the

even those who believe forced treatment is a necessary evil cannot deny that it is perhaps the biggest threat to a person's autonomy authorized by civil law. Moreover, forced treatment undermines the therapeutic relationship,¹⁴⁴ deters people from seeking care for fear that their liberty will be restricted,¹⁴⁵ instills fear,¹⁴⁶ creates potentially high costs of enforcement,¹⁴⁷ diverts funds from psychosocial support programs and community-based treatment,¹⁴⁸ and can function as a tool

National Alliance on Mental Illness (NAMI), perceived to be a family-led organization, and consumer-led groups. Consumer-led groups refer to the mothers and families that started NAMI as "NAMI Mommies" and accuse them of ignoring evidence-based alternatives to drug therapy and the medical model. See Ken Braiterman, *Tuesday Dinner with the NAMI Mommies*, MAD IN AMERICA (June 13, 2012), <http://www.madinamerica.com/2012/06/tuesday-dinner-with-the-nami-mommies/> [<https://perma.cc/DP2Z-SVXF>]; NAMI DEAREST: HELPING NAMI PARENTS OVERCOME LAZINESS, <http://www.namidearest.com/> [<https://perma.cc/5LHK-GTFV>].

144. A 2011 study found that "[p]atients who experienced high levels of coercion tended to rate their relationship with the admitting clinician more poorly than those who experienced low levels of coercion. This was true for both voluntarily and involuntarily admitted patients." Kathleen Ann Sheehan & Tom Burns, *Perceived Coercion and the Therapeutic Relationship: A Neglected Association?*, 62 PSYCHIATRIC SERVS. 471, 474 (2011), https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.62.5.pss6205_0471. According to Sheehan and Burns, their "quantitative finding supports recent qualitative studies showing that coercion, as experienced by the patient, consistently had a negative impact on relationships." *Id.* (citing Helen Gilbert, Diana Rose & Mike Slade, *The Importance of Relationships in Mental Health Care: A Qualitative Study of Service Users' Experiences of Psychiatry Hospital Admission in the UK*, 8 BMC HEALTH SERVS. RES. 1 (2008), <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-8-92> [<https://perma.cc/TEA9-JP29>]); see also Marie Høgh Thøgersen, Britt Mørthorst & Merete Norden-toft, *Perceptions of Coercion in the Community*, 81 PSYCHIATRIC QUARTERLY 35 (2010), <https://link.springer.com/article/10.1007/s11126-009-9115-5> [<https://perma.cc/X3SR-ZVQ8>]; Jacinta O.A. Tan, Anne Stewart, Raymond Fitzpatrick & Tony Hope, *Attitudes of Patients with Anorexia Nervosa to Compulsory Treatment and Coercion*, 21 INT. J. OF L. AND PSYCHIATRY 13 (2010), <https://www.sciencedirect.com/science/article/pii/S0160252709001137> [<https://perma.cc/6C4K-U7AW>]). According to the researchers, one of the studies they cited, Gilbert, "concluded that coercion was the main barrier to the formation of a therapeutic relationship." *Id.*

145. See, e.g., Marvin S. Swartz, Jeffrey W. Swanson & Michael J. Hannon, *Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals*, 21 BEHAVIORAL SCI. & THE L. 459, 460 (June 8, 2003), <https://onlinelibrary.wiley.com/doi/abs/10.1002/bsl.539> [<https://perma.cc/QC58-ZHG9>] (qualitative study finding "mandated treatment may serve as a barrier to treatment, but that ongoing informal pressures to adhere to treatment may also be important barriers to treatment.").

146. See *supra* Part III.B.

147. Forced treatments often involve additional efforts to enforce. Those who have been involuntarily committed have a right to a hearing. See *infra* note 176. This means that there will be additional costs associated with legal representation for both the hospital and the person committed. Meanwhile, enforcing involuntary outpatient treatment may include the cost of having the police pick someone up. See *Position Statement on Involuntary Commitment*, *supra* note 112, at 2.

148. See *supra* note 109 and accompanying text.

of racial discrimination.¹⁴⁹ Further, studies show that consumer-led treatment¹⁵⁰ and alternative programs focused on de-escalation¹⁵¹ result in better outcomes.¹⁵²

Many hospitals in the United States have a unit for patients who have been involuntarily committed.¹⁵³ Thus, BHLs that work with mental health hospitals may be serving at least some people who are receiving mental health treatment against their will, mandated and administered by the medical professional partnered with the BHL lawyer. This creates significant challenges for building positive lawyer-client relationships, makes it difficult to implement recovery-based practices, and is fundamentally incompatible with the recovery model. When BHLs work with entities that support forced treatment, they are not just allied with but are part of a system that hurts their clients.

D. BHLs Are Located at the Sites of Personal and Historical Trauma

For many people with mental illnesses, hospitals are traumatic places. Whether the stay is voluntary or involuntary, it can involve some of their darkest and scariest moments. Even if doctors and staff members have the best intentions,

149. A 1984 study found that compared to white men, non-white men are at high risk for involuntary commitment, more likely to experience it, and more likely to be referred to hospitals by law enforcement officials. See Sarah Rosenfield, *Race Differences in Involuntary Hospitalization: Psychiatric vs. Labeling Perspectives*, 25 J. OF HEALTH AND SOC. BEHAVIOR 14, 21 (1984), http://www.jstor.org/stable/2136701?seq=1#page_scan_tab_contents [https://perma.cc/8A6T-WVTK]. A 2003 study confirmed this trend, but only for low-poverty areas, finding that “Blacks and Hispanics were much more likely than Whites to be referred by law enforcement officials in” those areas. Julian Chun-Chung Chow, Kim Jaffee & Lonnie Snowden, *Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas*, 93 AM. J. PUBLIC HEALTH 792, 796 (2003), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447841/#r43> [https://perma.cc/8C85-2RWA].

150. See, e.g., Alexander S. Young, Matthew Chinman, Sandra L. Forquer, Edward L. Knight, Howard Vogel, Anita Miller, Melissa Rowe & Jim Mintz, *Use of a Consumer-Led Intervention to Improve Provider Competencies*, 56 PSYCH. SERV. 967, 973–74 (Aug. 2005), <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.56.8.967> [https://perma.cc/FUL6-VYJU]; Judith H. Hibbard and Jessica Greene, *What Evidence Shows About Patient Activation: Better Health Outcomes and Experiences; Fewer Data on Costs*, 32 HEALTH AFFAIRS 207, 211–12 (Feb. 2013), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.1061> [https://perma.cc/3PNG-63SS].

151. See *supra* notes 123-124 and accompanying text.

152. As an alternative to forced treatment, Leah Harris suggests increasing funding for outreach efforts that attract consumers voluntarily to services that actually work for them. See Leah Harris, *Washington’s Horrible Mental Health Legislation*, HUFFINGTON POST (Nov. 23, 2015, 10:20 AM), http://www.huffingtonpost.com/leah-harris/washingtons-horrible-mental-health-legislation_b_8623226.html [https://perma.cc/44AZ-SEN7]. In cases where a person lacks the capacity to make informed treatment decisions, she suggests investing in programs that focus on getting people with mental illnesses to partner with professionals as part of their care. *Id.* Two of the programs she suggests are supported decision-making and Open Dialogue. *Id.*; See generally Soumitra Pathare and Laura S. Shields, *Supported Decision-Making for Persons with Mental Illness: A Review*, 34 Pub. Health Rev. 1 (2012), <http://supporteddecisionmaking.org/legal-resource/supported-decision-making-persons-mental-illness-review> [https://perma.cc/6955-5LJJ] (highlighting research on the use of supported decision-making for persons with mental illness); *About the Open Dialogue Approach*, THE INST. FOR DIALOGIC PRACTICE, <http://www.dialogicpractice.net/open-dialogue/about-open-dialogue/> [https://perma.cc/23GM-GA9S] (describing Open Dialogue).

153. See LEVY & RUBENSTEIN, *supra* note 138, at 63–102.

it can be difficult for someone to feel safe or confident during a hospitalization. This alone can be traumatic. As discussed previously, if the experience is one that involves physical restraints and the use of force, it can be harrowing.

So shared is the trauma of hospital settings that an entire movement emerged in response to it: ex-patients, psychiatric inmates, ex-inmates, and psychiatric survivors, among others.¹⁵⁴ Psychiatric hospitals have a dark history that cannot be ignored. Many hospitals currently operating once served as mental health asylums.¹⁵⁵ Though modern hospitals are undeniably much more humane than the asylums of the 19th and 20th Centuries, it is a failure of the state and a violation of the rights of people with mental illnesses that 54 years after deinstitutionalization¹⁵⁶ began, hundreds of thousands of people with mental illnesses are still living in segregated institutions—including nursing homes—and away from their communities for extended periods of time.¹⁵⁷

154. See *supra* note 121 and accompanying text.

155. See ASYLUM PROJECTS, http://www.asylumprojects.org/index.php?title=Main_Page [<https://perma.cc/L6FP-D84S>] (listing hospitals that were previously asylums).

156. Deinstitutionalization refers to the project of gradually moving people with disabilities, including people with mental illnesses and people with intellectual and developmental disabilities, from large institutions and into the community. *What Is Deinstitutionalization?*, OPEN SOCIETY FOUND. (Apr. 2015), <https://www.opensocietyfoundations.org/explainers/what-deinstitutionalization> [<https://perma.cc/SC9H-LRJW>]; LEVY & RUBENSTEIN, *supra* note 138, at 18–21; see also Deanna Pan, *TIMELINE: Deinstitutionalization and Its Consequences*, MOTHER JONES, (Apr. 29, 2013, 10:00 AM), <https://www.motherjones.com/politics/2013/04/timeline-mental-health-america/> [<https://perma.cc/3M3R-9SDS>]. In the United States, “[l]arge-scale deinstitutionalization of individuals with disabilities began occurring in the 1960’s and 1970’s, in large part in response to a civil rights movement on behalf of individuals with psychiatric and intellectual disabilities confined in massive public institutions. Between 1955 and 1980, the census of public psychiatric institutions decreased from 559,000 to 154,000. By 2000, it had decreased to less than 50,000.” A PLACE OF MY OWN, JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH LAW (Mar. 2014), <http://www.bazelon.org/wp-content/uploads/2017/01/A-Place-of-my-Own.pdf> [<https://perma.cc/8SX9-HNMF>] [hereinafter A PLACE OF MY OWN]. In 1990, Congress passed the Americans with Disabilities Act (ADA) finding 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.’” DEINSTITUTIONALIZATION: UNFINISHED BUSINESS, NAT’L COUNCIL ON DISABILITY 15 (Oct. 13, 2013), https://ncd.gov/rawmedia_repository/NCD_UnfinishedBusiness_Paper_FINAL508.pdf [<https://perma.cc/DD8C-28N3>]. In 1999, the Supreme Court ruled in the case of *Olmstead v. L.C.*, that unnecessary institutionalization of people with disabilities constitutes discrimination under the ADA. 527 U.S. 581, 597 (1999).

157. The community services that were supposed to be developed for individuals leaving institutions, however, did not materialize on the scale initially envisioned, as federal and state dollars for these programs dried up. While the deinstitutionalization of the 1970’s and 1980’s was successful in shutting and downsizing institutions, ‘it was less successful in promoting investments in the kind of community service infrastructure that enables people with psychiatric disabilities to thrive in the community.’ When Congress enacted Medicaid in the 1960’s, it excluded coverage for people in state psychiatric facilities because such care had traditionally been a state responsibility. However, Medicaid does cover nursing home care, providing federal dollars to pay for at least half of such costs. Taking advantage of this coverage, states moved many people from state psychiatric hospitals into nursing homes. By 1980, 750,000 people with serious mental illnesses lived in nursing homes, representing approximately 44% of the nursing home population. Over the years, many

Another less talked about human rights violation committed by and at hospitals was eugenic sterilization. Harmful and ableist beliefs that people with disabilities should not be able to have and raise children originated during the 1920s and 30s when U.S. geneticists hoped to engineer a master society.¹⁵⁸ Beginning with Indiana in 1907, over thirty states enacted laws authorizing involuntary sterilization.¹⁵⁹ In 1927, the Supreme Court upheld the practice in *Buck v. Bell*.¹⁶⁰ In its majority opinion authored by Oliver Wendell Holmes, the Court stated that:

It is better for all the world if, instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles are enough.¹⁶¹

By 1970, more than 65,000 Americans had been sterilized against their will.¹⁶² Even today, almost 29 years after the passage of the Americans with Disabilities

other people who left state psychiatric hospitals went to large board and care homes or other, similar institutional facilities.

A PLACE OF MY OWN, *supra* note 156, at 2–3 (internal citations omitted). *See also Disability Rights—ACLU Position/Briefing Paper*, AM. CIVIL LIBERTIES UNION, <https://www.aclu.org/disability-rights-aclu-positionbriefing-paper> [<https://perma.cc/4VEY-5WKS>] (Last updated 1999) (“Too many disabled people are still institutionalized, despite the fact that the care they need can be provided within their communities.”); Pan, *supra* note 156. The project of deinstitutionalization and enforcing *Olmstead* continues to this day, led by organizations like the Bazelon Center for Mental Health Law. *See e.g. Williams v. Quinn*, 748 F. Supp. 2d 892 (N.D. Ill. 2010) (ongoing settlement enforcement for case challenging Illinois’ segregation of more than 4,000 individuals with mental illnesses in intermediate care nursing facilities in violation of *Olmstead*); *see also Current Litigation: Williams v. Quinn*, JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH LAW (2016), <http://www.bazelon.org/williams-v-quinn/> [<https://perma.cc/7Q8B-TEZ3>].

158. *See* Lisa Ko, *Unwanted Sterilization and Eugenics Programs in the United States*, PBS (Jan. 29, 2016), <http://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/> [<https://perma.cc/H4V5-TRDW>]; Steven A. Farber, *U.S. Scientists’ Role in the Eugenics Movement (1907-1939): A Contemporary Biologists’ Perspective*, 5 ZEBRAFISH 243 (Dec. 2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2757926/> [<https://perma.cc/LN6N-SN5R>].

159. Lutz Kaelber, *Eugenics: Compulsory Sterilization in 50 American States*, UNIV. OF VT., <https://www.uvm.edu/~lkaelber/eugenics/> [<https://perma.cc/QQ22-FMT5>] [hereinafter *Eugenics in 50 States*]; Lutz Kaelber, *Eugenics/Eugenic Sterilizations in Indiana*, UNIVERSITY OF VERMONT, <https://www.uvm.edu/~lkaelber/eugenics/IN/IN.html> [<https://perma.cc/2J8F-CL4G>].

160. *Buck v. Bell*, 274 U.S. 200, 208 (1927); *See generally* PAUL A. LOMBARDO, THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND BUCK V. BELL (2008) (describing the historical context surrounding *Buck v. Bell* and the major players in that case, including correcting misrepresentations made of Plaintiff Carrie Buck); Paul A. Lombardo, *Three Generations, No Imbeciles: New Light on Buck v. Bell*, 60 N.Y.U. L. Rev. 30 (Apr. 1985), <https://pdfs.semanticscholar.org/784b/f1b7cfbbc84b6966f4c3b0f3d554726d551e.pdf> (same); JAMES W. TRENT, INVENTING THE FEEBLE MIND: A HISTORY OF MENTAL RETARDATION IN THE UNITED STATES (1994) (documenting the history of intellectual disabilities in the United States, including forced sterilizations and *Buck v. Bell*); JAMES W. TRENT, INVENTING THE FEEBLE MIND: A HISTORY OF INTELLECTUAL DISABILITY IN THE UNITED STATES (2017) (updated edition).

161. *Buck*, at 207.

162. *Eugenics in 50 States*, *supra* note 159; *see also* LOMBARDO (2008), *supra* note 160, at 293 (appendix listing laws and sterilizations by state); TRENT (2017), *supra* note 160, at 178-216.

Act, several states still preserve some form of involuntary sterilization law, and *Bell*—cited by a federal appeals court as recently as 2001—has yet to be overruled.¹⁶³

A significant number of these sterilizations took place at hospitals, some of which are still operating today.¹⁶⁴ Yet this traumatic history is rarely discussed, and most of the hospitals involved have yet to acknowledge their role in this atrocity.

E. A New Model is Needed

If the historical human rights violations committed at hospitals seem too distant in time to impact the wellbeing of contemporary people with mental illnesses, consider the constant reference to them that still occurs today. Halloween haunted houses are still asylum-themed,¹⁶⁵ strait jackets are popular costumes,¹⁶⁶ and a well-received article was published in *The New York Times* calling for a return to asylums.¹⁶⁷ These occurrences, and the lack of widespread reparations for the harms done,¹⁶⁸ continue to instill fear in the mental health community. And together with the ongoing traumatic experiences of forced treatment, involuntary commitment, physical restraints, general loss of autonomy, and the perpetuation of the medical model, these are systemic instances of violence against people with mental illnesses.

163. *Bell* was cited by a federal appeals court as recently as 2001, in *Vaughn v. Ruoff*, a case involving a mother with an intellectual disability whose social worker told her that getting sterilized would help her regain custody of her children. Her children were not returned. *Vaughn v. Ruoff*, 253 F.3d 1124, 1127–29 (8th Cir. 2001); see also TRENT (1994), *supra* note 160, at 233.

164. The following are just a few examples of hospitals, still operating as psychiatric hospitals today, where eugenic sterilizations of “mentally deficient” people occurred: Bryce State Hospital in Alabama; Napa State Hospital, Metropolitan State Hospital, and Patton State Hospital in California; Connecticut Valley Hospital in Connecticut; Delaware Psychiatric Center and Governor Beacon Health Center in Delaware; Central State Hospital and East Central Regional Hospital Gracewood in Georgia; State Hospital South in Idaho; and Logansport State Hospital in Indiana. *Eugenics in 50 States*, *supra* note 159.

165. See e.g., *The Asylum Haunted House—Denver’s Favorite Haunted House 30 Second*, YOUTUBE (Sept. 13, 2012), <https://www.youtube.com/watch?v=sTWPDhXjNbA> [<https://perma.cc/967T-2VJH>].

166. See e.g., *Adult’s Straight Jacket Halloween Costume*, AMAZON.COM, <https://www.amazon.com/Adults-Straight-Jacket-Halloween-Costume/dp/B000RPOF90> [<https://perma.cc/JS42-SUEK>].

167. See Christine Montross, *The Modern Asylum*, N.Y. TIMES OP. (Feb. 18, 2015), <http://www.nytimes.com/2015/02/18/opinion/the-modern-asylum.html> [<https://perma.cc/YS8S-3STX>]; Letters to the Editor, *Can There Be Good Mental Asylums?*, N.Y. TIMES OP. (Feb. 26, 2015), http://www.nytimes.com/2015/02/26/opinion/can-there-be-good-mental-asylums.html?_r=0 [<https://perma.cc/RTD2-VYNX>].

168. *But see Payments Start for N.C. Eugenics Victims, But Many Won’t Qualify*, NPR (Oct. 31, 2014, 5:04 PM), <https://www.npr.org/sections/health-shots/2014/10/31/360355784/payments-start-for-n-c-eugenics-victims-but-many-wont-qualify> [<https://perma.cc/WW2E-3VC7>]; Nicole Knight, *Thousands Were Sterilized Under California’s Eugenics Law. Now Survivors Could Get Reparations.*, REWIRE.NEWS (Apr. 19, 2018, 11:01 AM), <https://rewire.news/article/2018/04/19/thousands-sterilized-californias-eugenics-law-now-get-reparations/> [<https://perma.cc/T9TD-HXFG>].

Even so, this Article does not deny the benefits of BHLs, nor does it argue that BHLs and/or MLPs generally should cease to exist. Recognizing the merits of a model should not prevent the discussion of its shortcomings. This Article focuses on the MLP model's shortcomings as applied to mental health contexts (BHLs) and how a new model could remedy them. Before discussing the proposed new model, addressing some of the likely counterarguments is essential.

The counterargument that treatment centers, such as hospitals, are the best location for lawyers to connect with people with mental illnesses has already been addressed.¹⁶⁹ An important addition to that discussion is that the proposed adaptation of the MLP model could still reach people with mental illnesses who are at clinical treatment centers through referrals from the treatment center itself. These referrals would encourage people with mental illnesses to seek support, or additional support, for their recovery process from a non-clinical provider who will in turn prove to be a better partner for the lawyer.

A related counterargument might be that BHLs allow lawyers to make change from the inside, by encouraging the doctors and nurses they are in partnership with to adopt recovery values and respect their patients' autonomy. Unfortunately, both medical staff and treatment centers face incentives to adhere to the status quo that are far too great for one patient's lawyer to overcome. First, it is important to re-emphasize that hospitals and doctors believe it is their obligation to serve and take care of people who, in their eyes, are unable to make their own choices. In fact, in this context, involuntary treatment is often framed as increasing access to treatment.¹⁷⁰ Second, treatment centers like hospitals do not want to be liable or responsible for harms caused by someone they did not admit into their care.¹⁷¹ It will take more than the presence of one or a few attorneys to cause the kind of system-wide overhaul that would lead to lowering involuntary commitments or ending the use of restraints, among other reforms.

169. See *supra* Part III.A (final paragraph).

170. See e.g., *Improving Civil Commitment Laws and Standards*, TREATMENT ADVOCACY CENTER, <http://www.treatmentadvocacycenter.org/fixing-the-system/improving-laws-and-standards> [<https://perma.cc/Z7EJ-2KX9>].

171. See, e.g., Steven J. Schwartz, *Annotated List of Damage Cases for Persons with Mental Disabilities*, PSYCHRIGHTS.ORG (May 2002), <http://psychrights.org/research/DAMCASES.htm#FAILURE> [<https://perma.cc/M5PL-VCKR>] (citing *Clark v. N.Y.*, 472 N.Y.S.2d 170 (N.Y. App. Div. 1984) (finding liability for failure to institutionalize person with disability); *Gilchrist v. City of Linonia*, 599 F.Supp. 260 (E.D. Mich. 1984) (finding liability for failure to institutionalize person with disability); *Hamman v. Co. of Maricopa*, 775 P.2d 1122 (Ariz. Sup. Ct. 1989) (holding that psychiatrist has duty to protect public, at least where victim is identifiable or in zone of danger, even in absence of specific threats); *Naidu v. Laird*, 539 A.2d 1064 (Del. Sup. Ct. 1988) (concluding that psychiatrist is liable for \$1.4 million for releasing hospital resident who subsequently kills decedent, based upon violation of duty to protect public and to commit dangerous persons); *Peterson v. State*, 671 P.2d 230 (Wash. Sup. Ct. 1983) (finding liability for failure to petition for involuntary commitment). *But see id.* (citing *Estate of Gilmore v. Buckley*, 608 F. Supp. 554 (D. Mass. 1985), *aff'd*, 787 F.2d 714 (1st Cir. 1986) (holding no duty to hospitalize and no claim under §1983); *Paul v. Plymouth General Hospital*, 408 N.W.2d 492 (Mich. Ct. App. 1987) (holding that emergency room doctor who was not a psychiatrist had no special duty to mentally disabled woman to commit her or to refer her to psychiatric treatment, since she was admitted only for medical care)).

A third argument in favor of lawyers working with hospitals and other clinical settings is that without such a partnership, vulnerable patients experiencing forced treatment will be left without the protection a BHLPL lawyer can offer. This is a misunderstanding of both involuntary commitment laws and the MLP model. In thirty states, people who have been involuntarily committed have a statutory right to counsel.¹⁷² This means that a lawyer—either from an entity specialized in this kind of representation, a public defender’s office for instance, or an appointed attorney—will assist them in challenging the commitment.¹⁷³ In the twenty states that do not provide counsel, it is likely BHLPL lawyers would nevertheless be unable to represent clients in involuntary commitment proceedings. Most MLP (and thus, BHLPL) agreements between hospitals (or other clinical entities) and legal organizations include a promise from the legal organization not to represent clients in complaints against the hospital itself or its doctors.¹⁷⁴ While this is proper due to the inherent conflict of interest that would arise from such representation—likely making it unadvisable even if not a contractual violation¹⁷⁵—it does mean that the lawyer is unable to *fully* ally themselves with their client, and their ability to oppose the doctor’s treatment decisions is limited.

Moreover, concerns about coercive treatment in hospitals and other in-patient treatment settings are not limited to involuntary treatment. In fact, the distinction between involuntary and voluntary admission to a hospital is misleading. Involuntary patients are admitted without their consent and have a constitutional right to a hearing to challenge their admission.¹⁷⁶ Meanwhile, voluntary patients sign a form allowing their admission, either: (1) of their own volition, (2) because they

172. *State Statutes Providing for a Right to Counsel in Civil Cases*, CLEARINGHOUSE REV. J. POVERTY L. & POL’Y 264–268 (2006), http://civilrightstocounsel.org/uploaded_files/21/State_statutes_providing_counsel_Abel_.pdf [<https://perma.cc/UT8Q-3K24>] (Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Montana, Nevada, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Vermont, West Virginia, and Wisconsin).

173. In those states, for attorneys interested in a BHLPL, partnering with these involuntary commitment defense lawyers to have them refer client’s poverty law issues may be an alternative to partnering with the hospital itself.

174. Admittedly, this limitation would also apply to Clubhouse-Legal Partnerships, as lawyers would likely be unable to represent members who have complaints against the clubhouse. *See infra* Part IV. Such a constraint is likely unavoidable with any partnership. However, in clinical settings, given that medical care is being provided—which is more inherently risky than psychosocial support—this limitation on whom a lawyer can sue is more significant. One solution is to ensure that BHLPL/MLP agreements do not prevent lawyers from referring cases they cannot take themselves due to a conflict of interest with the partner entity.

175. *See* MODEL RULES OF PROF’L CONDUCT r. 1.7 (AM. BAR ASS’N 2017), https://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_7_conflict_of_interest_current_clients.html [<https://perma.cc/7GZJ-SABN>].

176. The Supreme Court has yet to rule on whether *preliminary* hearings held promptly after an individual has been committed are constitutionally required, but courts have found a constitutional due process right to a *full* hearing, at which the need for commitment must be proved by clear and convincing evidence. LEVY & RUBINSTEIN, *supra* note 138, at 70–71.

were pressured by a third party, such as the hospital staff or police, or (3) because they are a minor whose parents have authorized it.¹⁷⁷ While voluntary patients enjoy privileges such as the right to refuse treatment, unlocked wards, and increased grounds access, they can be converted to involuntary status if they assert the right to refuse treatment.¹⁷⁸ As a result, voluntary patients may be threatened into compliance out of fear. This demonstrates that regardless of their status as voluntary or involuntary patients, the hospital setting, in itself, is coercive and autonomy-harming. BHLs located in hospitals or in-patient treatment centers, thus, cannot fully untangle themselves from that coercion.

Lawyers who want to stand with and fight alongside the mental health community, who want to adopt the recovery model and engage in work that builds power for people with mental illnesses, cannot resign themselves to partnering with and working within the systems that inflict harm and stifle this progress. A new model is needed.

IV.

A NEW MODEL: THE CLUBHOUSE LEGAL-PARTNERSHIP

A. Addressing Recovery-Harming Social Conditions

As stated in Parts II and III, when it comes to serving people with mental illnesses, the Medical-Legal Partnership has both concerning shortcomings and impressive advantages. Though Part III focused on the ways BHLs (as MLPs in the mental health context) fall short of upholding the recovery model and autonomy principles, it is worth restating the MLP model's strengths. MLPs allow lawyers to: (1) reach people with health needs at a location they already frequent; (2) work with health experts to support their clients; (3) effect health delivery system improvements by suggesting new policies to their health partners; and (4) transform individual client advocacy into systemic change.¹⁷⁹ In short, the MLP's biggest success is in outlining how lawyers can work effectively with health experts to improve health outcomes at both an individual and systemic scale.

As discussed in Part III.A, health—specifically, symptom management—is just one of the four elements of recovery.¹⁸⁰ The failure of BHLs, then, is that their focus on addressing health-harming social conditions leaves out important components of recovery. Recovery requires that health choices be self-directed and well informed, that people have a purpose and community, and that people have control over their lives.¹⁸¹ BHLs provide legal services that address hous-

177. *Id.* at 66–67 (describing the process of voluntary admission), 46–53 (describing the process of voluntary admission for minors).

178. *Id.* at 67.

179. *See supra* Parts II.A to II.D.

180. *Recovery and Recovery Support, supra* note 88. *See also supra* Part III.A.

181. *See Recovery and Recovery Support, supra* note 88.

ing, benefits, education, and employment issues, all of which are essential to recovery. But Part III demonstrated that the BHLP model ignores the ways in which the medical partner itself can be recovery-harming. Shifting the focus from health to recovery would make it necessary for lawyers to move from thinking about the law as a way to secure resources that alleviate their clients' symptoms, to thinking of the law as a set of tools the clients themselves can use to find a home, friendship, meaning, and community.

This section, thus, proposes a model that preserves the MLP's outline of how to work with experts who are already serving the target population, and focuses it on addressing *recovery*-harming social conditions by partnering with non-clinical recovery experts.

B. The Clubhouse Model

The right partner for an MLP adapted to serving people with mental illnesses is one that: (1) believes in, is committed to, and has expertise in the recovery model; (2) respects the autonomy of people with mental illnesses; (3) is non-clinical, respects each person's right to seek or not seek medical care, and helps those who want it, to access it; (4) provides services *only* voluntarily; and, (5) is open to all people with mental illnesses who seek to participate. Clubhouses meet every one of these criteria.

Clubhouses are mental health community centers that are run by people with mental illnesses ("members") themselves with the help of a small number of staff who work side-by-side with them.¹⁸² Fountain House, established in 1948 in New York City, was the first clubhouse.¹⁸³ Today, there are over 300 clubhouses in 30 countries,¹⁸⁴ including 187 in the United States.¹⁸⁵ All clubhouses are overseen and supported by Clubhouse International, an international, non-governmental, non-profit organization located in New York City that is dedicated to creating new and sustaining existing clubhouses around the world.¹⁸⁶

182. See *What Clubhouses Do*, CLUBHOUSE INT'L, <http://clubhouse-intl.org/what-we-do/what-clubhouses-do/> [https://perma.cc/X9XS-YJNJ].

183. *Mission and History*, CLUBHOUSE INT'L, <http://clubhouse-intl.org/about-us/mission-history> [https://perma.cc/4E33-AA9V] [hereinafter *Clubhouse History*].

184. *Clubhouse Directory*, CLUBHOUSE INT'L, <https://clubhouse-intl.org/what-we-do/international-directory/> [https://perma.cc/JRQ8-VVPV].

185. *Clubhouse Directory: USA*, CLUBHOUSE INT'L, <http://clubhouse-intl.org/what-we-do/international-directory/?lt=country&country=USA> [https://perma.cc/E9UN-PBHA].

186. Originally named the International Center for Clubhouse Development, Clubhouse International was established in 1994, just two years after the enactment of the Americans with Disabilities Act. Though Fountain House had long been working to expand its model, Clubhouse International was established in response to the need for an organization that would oversee expansion efforts and devote resources to strengthening and nurturing new clubhouses. It works to teach and implement clubhouse values by revising and implementing the Clubhouse Standards, establishing an accreditation program, and coordinating trainings to start new clubhouses and develop existing ones. See Aaron Levin, *Fountain House Planted Seeds for Global Movement*, PSYCHIATRIC NEWS (Aug. 2012), https://psychnews.psychiatryonline.org/doi/full/10.1176/pn.47.15.psychnews_47_15_5-a [https://perma.cc/3NRQ-85U2]; *Clubhouse History*, *supra* note 183.

Many clubhouses, known as free-standing clubhouses, are structured as independent non-profit organizations. These clubhouses have a Board of Directors charged with fundraising, setting policy, overseeing the budget, and supporting and evaluating the Executive Director, as well as a Clubhouse Director (and staff) in charge of daily operations, including working with and recruiting members and complying with grants and contracts.¹⁸⁷ Others operate as a specific program within a larger organization known as an auspice agency.¹⁸⁸ Each structure has its benefits and challenges.¹⁸⁹ Like other non-profits, clubhouses rely on a variety of funding sources, including traditional fundraising and donations.¹⁹⁰ Clubhouses may lobby to receive state, county, city, or government funding, including funds targeted at improving services for people with mental illnesses.¹⁹¹ Sometimes, federally funded vocational rehabilitation agencies are open to subcontracting out vocational services to Clubhouse Model programs.¹⁹² Many clubhouses also receive private funding, such as foundation grants.¹⁹³

187. See *Starting a Clubhouse*, CLUBHOUSE INT'L, http://www.clubhouse-intl.org/starting_clubhouse.html [<https://perma.cc/QY4F-BPGX>]; Jack Yatsko, Clubhouse Int'l Director of Training, *12th International Clubhouse Seminar, Plenary Presentation: The Role of the Clubhouse Director* (2003), www.iccd.org/newimages/download%20and%20discuss%20-%20Director.doc [<https://perma.cc/DJ9B-2FDF>].

188. See Mike Furches, *The Benefits of a Free-Standing Clubhouse*, CLUBHOUSE INT'L, <http://www.clubhouse-intl.org/06furch.htm> [<https://perma.cc/26MT-KB7F>]; *Clubhouse Relationships with Auspice Agencies: Supporting a Strong, Standards-Based Clubhouse*, CLUBHOUSE INT'L, http://www.clubhouse-intl.org/images/download_discuss_auspice%20agency_clubhouse_relationship.pdf [<https://perma.cc/ZNW8-9Q3D>].

189. According to Mike Furches, who has worked in both free-standing and auspice-sponsored clubhouses, operating as a free-standing clubhouse gives the organization the freedom to direct its own operations and engage in any projects it wants, and enjoys the support of a Board of Directors fully committed to the clubhouse—as opposed to a board that is focused on several different programs, only one of which is the clubhouse. Furches, *supra* note 188. Operating as an auspice agency makes implementing and upholding clubhouse standards more difficult, as the auspice agency may have different priorities, may not understand the model, and may assert inappropriate influence over the clubhouse program. *Id.* However, Furches acknowledges that clubhouses with auspice agencies that provide other mental health services have immediate referral sources. *Id.* Other clubhouses find the auspice structure to be ideal for their communities. See *Clubhouse Relationships with Auspice Agencies*, *supra* note 188. High Hopes Clubhouse is operated as part of the auspice agency Kennebec Behavioral Health in Waterville, Maine. *Id.* The organizations jointly authored a short paper where they discussed how they divide and delineate responsibilities to ensure the clubhouse can be successful. *Id.* In their case, the auspice agency commits to allowing the clubhouse independence while providing global financing, IT, billing, and clinical support, as well as help promote and advocate for them. *Id.* at 2. The clubhouse also has an Advisory Board that works closely with the auspice agency's Board of Directors. *Id.*

190. See *Starting a Clubhouse*, *supra* note 187.

191. *Id.*

192. *Id.*

193. *Id.*

Clubhouses follow what is known as the work-ordered day.¹⁹⁴ Members and staff equally participate in various tasks related to the maintenance of the clubhouse and support members in attaining housing, education, and jobs.¹⁹⁵ This is done through involvement in “units” specialized in areas such as clerical work, cooking, cleaning, education, employment, and reaching out to members who have become less active or are hospitalized.¹⁹⁶ Furthermore, as detailed by Melanie Sennet of Stepping Stone Clubhouse:

The underlying belief of the Work-ordered Day is that regardless of a member’s disability every member has a contribution to make that will assist with achieving the work required of the clubhouse. The belief of members being needed, expected and wanted portrays the message that we need you to be involved to get the work done. This sense of belonging is very powerful and ultimately helps members to increase their self-esteem and confidence.¹⁹⁷

Clubhouses also host social events and celebrate holidays on the day they fall.¹⁹⁸ They are egalitarian: all decisions are made by consensus at open forum meetings,¹⁹⁹ and there are no staff-only areas.²⁰⁰ Membership is voluntary, free, open to anyone with a mental illness, and lifelong.²⁰¹ Clubhouses must be located

194. See Melanie Sennett, *Work Ordered Day How Can Three Simple Words Have So Much Meaning?*, CLUBHOUSE INT’L (Apr. 30, 2014), https://www.clubhouse-intl.org/documents/sennett_eng.pdf [<https://perma.cc/5AUK-29TW>]; Nancy Emory, *Building the Work Ordered Day*, CLUBHOUSE INT’L (May 20, 2015), https://www.clubhouse-intl.org/documents/workday_eng.pdf [<https://perma.cc/88L6-Y2NV>].

195. See Emory, *supra* note 194, at 5; Sennett, *supra* note 194, at 1.

196. See *supra* note 194. Standard 18 of the International Standards for Clubhouse Programs states: “The clubhouse is organized into one or more work units, each of which has sufficient staff, members and meaningful work to sustain a full and engaging Work-ordered Day. Unit meetings are held to foster relationships as well as to organize and plan the work of the day.” *International Standards for Clubhouse Programs*, CLUBHOUSE INT’L (2016), https://www.clubhouse-intl.org/documents/standards_2016_eng.pdf [<https://perma.cc/JX6E-F2U5>] [hereinafter *International Standards*]. In addition, the work-ordered day mimics the typical business hours of the working community where the clubhouse is located. See Sennett, *supra* note 194, at 3-4. Standard 7 states: “The Clubhouse provides an effective reach out system to members who are not attending, becoming isolated in the community or hospitalized” *International Standards, supra*.

197. Sennett, *supra* note 194, at 2.

198. Standard 32 states: “The Clubhouse has recreational and social programs during evenings and on weekends. Holidays are celebrated on the actual day they are observed.” *International Standards, supra* note 196.

199. Standard 37 states: “The Clubhouse holds open forums and has procedures which enable members and staff to actively participate in decision making, generally by consensus, regarding governance, policy making, and the future direction and development of the Clubhouse.” *Id.*

200. Standard 14 states: “All Clubhouse space is member and staff accessible. There are no staff only or member only spaces.” *Id.*

201. Standard 1 states: “Membership is voluntary and without time limits.” *Id.* Standard 2 states: “The Clubhouse has control over its acceptance of new members. Membership is open to anyone with a history of mental illness, unless that person poses a significant and current threat to the general safety of the Clubhouse community.” *Id.* Standard 6 states: “Members have a right to

in areas accessible via public transportation,²⁰² and members can come and go as they please as well as decide how and when to participate in clubhouse activities.²⁰³ In sum, clubhouses seek to build power for people with mental illnesses and aid them in re-entering the workforce, securing safe housing—which is a right of membership—and gaining a sense of autonomy and community.

Research on the Clubhouse Model has found that it is effective,²⁰⁴ and cost-effective when compared to other mental health care approaches.²⁰⁵ In fact, the Clubhouse Model has been recognized as an evidence-based program by SAMHSA.²⁰⁶ Studies have found that hospitalization, incarceration, and involvement with the criminal legal system decrease significantly as a result of membership.²⁰⁷ Improved wellbeing has also been proved when compared to people receiving psychiatric services without clubhouse membership.²⁰⁸ One study found that clubhouse members were much more likely to report that they had close friendships, and someone they could rely on when they needed help.²⁰⁹ Anecdotal evidence shows that many members feel that they have found a home and a place

immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a threat to the Clubhouse community.” *Id.*

202. Standard 26 states: “The Clubhouse is located in an area where access to local transportation can be assured, both in terms of getting to and from the program and accessing [transitional employment] opportunities. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.” *Id.*

203. Standard 3 states: “Members choose the way they utilize the Clubhouse, and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members.” *Id.*

204. *See generally, Clubhouse Outcomes*, CLUBHOUSE INT’L, <http://clubhouse-intl.org/our-impact/clubhouse-outcomes/> [<https://perma.cc/YTP3-FU2P>]; Marsha Carolan, Esther Onaga, Francesca Pernice-Duca & Tiffeny Jimenez, *A Place to Be: The Role of Clubhouses in Facilitating Social Support*, 35 PSYCH. REHABILITATION J. 125, 138–140 (2011).

205. *See* Colleen E. McKay, Brian T. Yates & Matthew Johnsen, *Costs of Clubhouses: An International Perspective*, 34 ADMIN. & POL’Y IN MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 62, 69–71 (2007).

206. The Clubhouse Model was accepted for inclusion on the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence Based Practices and Programs (NREPP) in 2011. *Recent Research*, CLUBHOUSE INT’L, <https://clubhouse-intl.org/recent-research/> [<https://perma.cc/3ZVF-J325>]. The review indicated that “the ICCD Clubhouse Model surpassed the minimum levels of research required for inclusion,” indicating “there is evidence that supports clubhouse outcomes from studies with experimental or quasi-experimental designs.” *Id.* In April 2018, SAMHSA announced it would discontinue the NREPP program. SAMHSA, NAT’L REGISTRY OF EVIDENCE BASED PRACTICES AND PROGRAMS, <https://www.samhsa.gov/nrepp> [<https://perma.cc/2W5D-2DRH>].

207. *See generally* Josphine Di Masso, Tamara Avi-Itzhak & Doris Richard Obler, *The Clubhouse Model: An Outcome Study on Attendance, Work Attainment and Status, and Hospitalization Recidivism*, 17 WORK 22 (2001) (hospitalizations); Jay Johnson & Scott Hickey, *Arrests and Incarcerations After Psychosocial Program Involvement: Clubhouse vs. Jailhouse*, 23 PSYCH REHAB J. 66 (1999), <http://psycnet.apa.org/journals/prj/23/1/66/> (incarceration and criminal legal system involvement).

208. *See* Richard Warner, Peter Huxley & Terry Berg, *An Evaluation of the Impact of Clubhouse Membership on Quality of Life and Treatment Utilization*, 45 INT. J. SOC. PSYCH. 310, 317–19 (1999), <https://www.ncbi.nlm.nih.gov/pubmed/10689615> [<https://perma.cc/8JMV-MEWH>].

209. *Id.* at 318.

where they belong.²¹⁰ For a population that is often abandoned by both loved ones and the systems meant to protect them, the value of this is unquantifiable.

Lastly, clubhouses are ideal partners because they often serve low-income people—many of whom live solely off disability benefits—who have little access to services, live in group homes, and/or who have experienced homelessness.

C. Adopting the Tenets of Community Lawyering

One key component of the proposed model is that the people served must also be partners. Because clubhouse members are experts on their own recovery and recognized as partners in the clubhouse's management, they must also be involved in all elements of the proposed partnership's work. Just as the recovery model asks medical professionals to recognize people with mental illnesses' inherent expertise on their own lives, the lawyer must also recognize the client's expertise in their circumstances and needs. Community lawyering is thus an essential component of the proposed model.

Community lawyering is a model of lawyering that centers community members, organizations, and organizers as the experts on what their community's collective needs are, what strategies they would like to pursue, and when and how they would like to pursue them.²¹¹ The role of lawyers, then, is to offer their services as “tacticians in the struggle for change,” by using litigation, policy advocacy, research, community education, and/or infrastructure-building to support the community's efforts—but only when and as requested by the community.²¹² In the same way that the recovery model calls on medical providers to be supporters and advisors rather than decisionmakers, the community lawyering model calls upon lawyers to be “tacticians” rather than “saviors or gatekeepers.”²¹³

Several authors and practitioners have written extensively about community lawyering.²¹⁴ However, the integration of community lawyering within MLPs has

210. *Member Stories*, CLUBHOUSE INT'L, <http://clubhouse-intl.org/news-stories/member-stories/> [https://perma.cc/SR3F-DPZH].

211. See Charles Elsesser, *Community Lawyering—The Role of Lawyers in the Social Justice Movement*, 14 LOY. J. PUB. INT. L. 45, 46–47 (2013), <https://static1.squarespace.com/static/57f66423440243a162891041/t/584829852e69cf464f49bab4/1481124229659/Community+Lawyering+Elsesser.pdf> [https://perma.cc/3VAE-58RD]; William P. Quigley, *Reflections of Community Organizers: Lawyering for Empowerment of Community Organizations*, 21 OHIO N. U. L. REV. 455, 455–56 (1995) http://people.loyno.edu/~quigley/Reflections_Community_Org_Ohio_Northern_LRev_1994.pdf [https://perma.cc/GA99-VMRN]; Scott L. Cummings, *Movement Lawyering*, 2017 U. ILL. L. REV. 1645, 1654 (2017), <https://illinoislawreview.org/wp-content/uploads/2017/10/Cummings.pdf> [https://perma.cc/GL27-MPVJ]; see generally GERALD P. LOPEZ, *REBELLIOUS LAWYERING: ONE CHICANO'S VISION OF PROGRESSIVE LAW PRACTICE* (1992).

212. *Purvi & Chuck: Community Lawyering*, ORGANIZING UPGRADE (June 1, 2010, 07:20), <http://www.organizingupgrade.com/index.php/modules-menu/community-organizing/item/71-purvi-amp-chuck-community-lawyering> [https://perma.cc/U2RY-VQDD].

213. *Id.*

214. See generally *Social Justice Lawyering Reading List*, BILL QUIGLEY SOC. JUSTICE ADVOCACY, <https://billquigley.wordpress.com/2013/08/13/social-justice-lawyering-reading-list/>

not been sufficiently explored.²¹⁵ Clinical Professors and MLP practitioners Amy Killelea and Dina Shek’s writings are among the few exceptions. Killelea has written on how Gerald Lopez’s “rebellious lawyering”²¹⁶ values can strengthen MLPs.²¹⁷ Shek has written on the need for a racial justice and community lawyering lens in MLP practice.²¹⁸ Lawyers working under the proposed model should become familiar with this scholarship and prepare to apply its tenets. Ultimately, as Charles Elsesser notes, the goal of lawyers must be to use their skills “not only to gain benefits for those communities but also to consciously build organizational power and community leadership” so as to promote interdependence among strong communities rather than dependence on lawyers.²¹⁹

D. The Clubhouse-Legal Partnership

The goal of the proposed Clubhouse-Legal Partnership is to address recovery-harming social conditions, prevent and de-escalate health crises, and promote the ability of people with mental illnesses to live independently by providing holistic and collaborative legal advocacy. This would be accomplished through a partnership between a legal services organization and a clubhouse.²²⁰ As part of the partnership, lawyers would offer onsite direct representation, facilitate systemic action, and provide community education. Clubhouse staff and members would take part in and steer systemic action and community education, support direct repre-

[<https://perma.cc/EV96-VR4G>]; Loretta Price & Melinda Davis, *Seeds of Change: A Bibliographic Introduction to Law and Organizing*, 26 N.Y.U. REV. L. & SOC. CHANGE 615 (2002), <http://dev.utlawlabs.com/wp-content/uploads/2015/05/Price.pdf> [<https://perma.cc/K8DR-C34E>].

215. Dina Shek, *Centering Race at the Medical-Legal Partnership in Hawai’i*, U. MIAMI RACE & SOC. JUST. L. REV. (forthcoming) (manuscript at 10–12) (on file with author).

216. Lopez, *supra* note 211.

217. Killelea applies Lopez’s values in the context of MLPs and argues that Lopez’s vision of “rebellious lawyering” can teach lawyers in MLPs to work with non-lawyers and communities, increase trust between lawyers, doctors, and clients, thereby producing better health outcomes, and creating legal and medical partners who speak with, rather than for, affected communities. Amy Killelea, *Collaborative Lawyering Meets Collaborative Doctoring: How a Multidisciplinary Partnership for HIV/AIDS Services Can Improve Outcomes for the Marginalized Sick*, 16 GEO. J. ON POVERTY L. & POL’Y 413 (2009).

218. Shek, *supra* note 215.

219. Elsesser, *supra* note 211, at 47.

220. Though neither an MLP nor a CLP, there is at least one instance where clubhouses have worked with lawyers. See Stephanie Hartwell and Laura Watts, *The Clubhouse Legal Support Project: A Framework for Replication and Development*, 15 INTL. J. OF PSYCHOSOCIAL REHAB. 19 (2010), http://www.psychosocial.com/IJPR_15/Clubhouse_Family_Support_Project_Hartwell.html [<https://perma.cc/4AHT-5MGR>]. The Clubhouse Family Legal Support Project in Boston, Massachusetts, is a statewide program that provides legal representation, support, and advice to low-income parents with psychiatric disabilities at risk of losing custody and/or all contact with their children. *Id.* It is a partnership between Options Clubhouse and the Mental Health Legal Advisory Committee. *Id.* Services include direct representation and monthly community education programs and onsite intakes. *Id.*

sentation by providing complementary psychosocial support to members receiving legal aid, and recruit new members (thereby expanding the lawyers' and the clubhouse's reach).

Just as in the MLP model, CLP lawyers would work onsite at the clubhouse, train staff and members to screen for legal issues, educate members to understand their individual cases as all stemming from the same systemic shortcomings, and address recurring issues through systemic action. The following figure shows the similarities and differences between MLPs/BHLPs and the proposed CLP model.

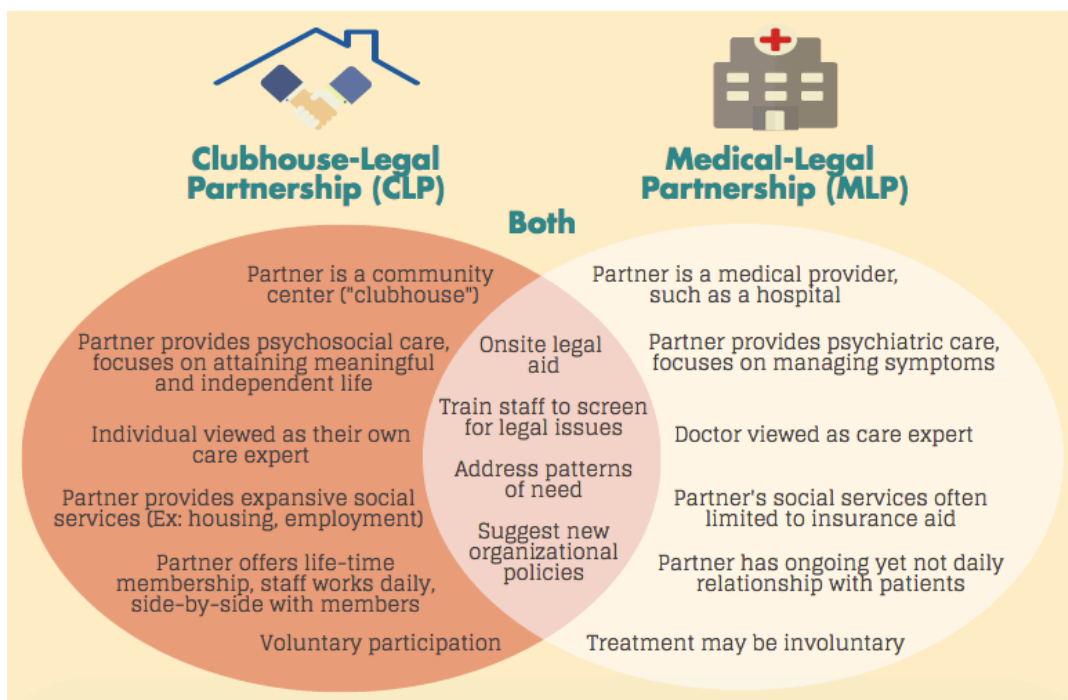


Fig. 2. Viviana Bonilla López, Comparing Clubhouse-Legal Partnerships and Medical-Legal Partnerships (2016).

CLPs would use at least three strategies: direct representation, community education, and system action. Following community lawyering tenets, the use and implementation of all three strategies should originate from and be guided by clubhouse members' own determinations of their community's needs. When approaching a clubhouse to start a CLP, initial conversations should focus on identifying the legal needs and determining the legal organization's capacity to meet them. Does the legal organization have legal expertise in the area? How long do the types of representation needed usually take? Like BHLPs, CLPs will likely focus on the

following legal issue areas: income and insurance; housing and utilities; education and employment; legal status; and personal or family stability.²²¹ That said, as stated in Part II.E, lawyers working with people with mental illnesses must be willing to be generalists. This mirrors the generalist nature of staff positions within clubhouses.²²²

For example, if a clubhouse identified a need for housing, public benefits, and removing legal barriers to a successful reentry after incarceration—three areas critical to recovery and independence—the legal organization should prepare to provide *direct representation* in: landlord-tenant disputes, including eviction defense; denial, reduction, or overpayment of Supplemental Security Income and Social Security Disability Insurance benefits; criminal debt; criminal record expungement; and civil rights restoration.²²³ *Community education* for that same clubhouse might include “Know Your Rights” trainings and workshops on issues such as Medicaid eligibility and how to return to work without losing your disability benefits. Lastly, *systemic action* could include engaging members to collectively draft policy proposals, bringing impact litigation claims, and creating a coalition of mental health advocacy organizations in the city where the clubhouse is located.

As a hypothetical example (to demonstrate how a CLP would work on an individual scale), the clubhouse might identify one of its members, Kevin, as someone who could benefit from the newly-implemented CLP. Suppose Kevin’s situation were as follows:

Last year, clubhouse member Kevin was arrested for drug possession. Charges were dismissed after completion of a jail diversion program but he still owes \$358 in court fees. His driver’s license was suspended for failure to pay. As a result, he is having trouble making it to his weekly therapy sessions. Kevin has also applied for SSI but was denied because the Social Security Administration did not find him sufficiently “disabled.” Because of these stressors, Kevin had a noisy psychotic episode that alarmed his neighbors. His landlord filed for eviction alleging he violated the lease. Kevin is afraid his criminal record could keep him from finding a new apartment if he is evicted, and eventually, from obtaining a job.²²⁴

221. See *supra* Fig. 1.

222. Standard 10 of the International Standards for Clubhouse Programs states: “Clubhouse staff have generalist roles. All staff share employment, housing, evening and weekend, holiday and unit responsibilities. Clubhouse staff do not divide their time between Clubhouse and other major work responsibilities that conflict with the unique nature of member/staff relationships.” *International Standards*, *supra* note 196.

223. Any issue areas that the lawyer is unable to handle would be referred to other legal organizations willing to take the case, with the appropriate follow up.

224. Kevin’s story is a hypothetical based on common scenarios seen by direct civil legal services attorneys who regularly serve people with mental illnesses.

The CLP lawyer might evaluate Kevin's criminal debt issue and personally refer him to a trusted, specialized bankruptcy lawyer. Meanwhile, the clubhouse could help Kevin learn to use public transportation, so he can get around until he is able to obtain a new driver's license. The CLP lawyer might also appeal Kevin's SSI denial by arguing that the proper analysis for a person with both schizophrenia and substance abuse was not conducted. To help Kevin with his housing, the CLP lawyer could file a response to the eviction notice, raising the landlord's obligation to offer reasonable accommodations under the Fair Housing Act as an affirmative defense. The CLP lawyer might also talk to Kevin about applying for a criminal record expungement so that Kevin does not have to worry about it being a hindrance to finding an apartment or a job. As a result of this advocacy, Kevin's mental health might improve. Soon, he might even feel ready to participate in the clubhouse's supported employment program.

Furthering this hypothetical, we could see that the benefits of Kevin's case would not just be individual. Because members in clubhouses work together side-by-side every day, Kevin has likely shared his experiences with at least some of his peers. Other clubhouse members who have talked to Kevin about his worries and who share similar concerns might get together and decide that they would like to canvass the neighborhood where their clubhouse is located to garner support for an amendment that is up for a vote in the upcoming elections that would restore the voting rights of people with certain felonies. The lawyer could support them by arranging a training on canvassing to be conducted by local organizers and by providing education on the collateral consequences of criminal arrests.

This hypothetical is just a glimpse of how a CLP could work. It highlights three major benefits of the CLP model. First, the CLP model allows for recovery-focused and autonomy-respecting legal care. In the hypothetical, Kevin's CLP services were not just focused on addressing personal emergencies, but also on building a better future for him. Each challenge was accompanied by an effort, both legal and psychosocial, that allowed Kevin to grow and gain new skills as he took on his social needs. For example, as a referral attorney was helping him file for bankruptcy, he was learning to take public transportation. Because CLP lawyers will reach clients in a non-clinical setting where the focus is not on their illness, the client's own goals and progress will be at the forefront as they work with the attorney. Lawyers will be able to provide services in partnership with a team of staff that is working toward the client's independence.

Second, CLP lawyers can build long-term relationships with clients and have the security of knowing that their clients will always be supported. One of the most difficult challenges faced by direct services attorneys is the sheer volume of cases and the inability to follow up with every client after the legal representation ends.²²⁵ What happens to the client afterwards? What happens after, in particular,

225. See LEGAL SERVS CORP., JUSTICE GAP REPORT 6 (2017), <https://www.lsc.gov/sites/default/files/images/TheJusticeGap-FullReport.pdf> [<https://perma.cc/9TPT-RJ93>] (finding that, in 2017: (1) 86% of the civil legal problems reported by low-income Americans received inadequate

to a client whose social needs are likely to recur?²²⁶ Because CLP lawyers will regularly work onsite at the clubhouse that their clients visit daily, long term relationships and follow-up will be facilitated. This builds trust and lays the groundwork for law and organizing, as clients gain the confidence to ask the lawyer for support for their own or their community's needs. It also creates opportunities for lawyers to support the leadership development of clients who can become organizers and agitators in their communities. Lastly, it will be a relief for attorneys to know that staff who interact with their client daily will always be on-hand to provide the psychosocial support that the attorneys themselves may not have expertise in.

The third major benefit of this model is that it is ripe for campaign and movement-building. At clubhouses, members meet and work together daily.²²⁷ As part of this process, they are already practicing community organizing values such as asset-based thinking and engagement²²⁸ and making decisions by consensus.²²⁹ Members' skills are constantly being developed and they are given growth and leadership opportunities. Some clubhouses in the United States actively participate in policy-making and advocacy on key mental health efforts.²³⁰ Others may not be accustomed to taking overt political stances. Clubhouse staff and Board Members may need to be agitated into supporting such an idea. Whatever the case may be, clubhouses have people power—they are organized communities whose members can be agitated toward a goal. Many of the ingredients needed to run a successful campaign—such as strong community ties, the expertise and leadership of directly impacted people, and dedicated volunteers—are in place. A CLP attorney could tap into these strengths through agitational interviewing and litigation.²³¹

or no legal help; (2) 71% of low-income households experienced at least one civil legal problem in the last year, including problems with health care, housing conditions, disability access, veterans' benefits, and domestic violence; and (3) it was estimated that low-income Americans would approach legal services corporation-funded legal aid organizations for support with an estimated 1.7 million problems but were expected to receive only limited or no legal help for more than half of these problems due to a lack of resources).

226. See *supra* Part II.E (describing the increased risks and recurring social needs of clients with mental illnesses).

227. See *supra* notes 194–197 and accompanying text.

228. See *Engaged Scholarship: Module 4—Asset-Based Community Engagement*, UNIV. OF MEMPHIS, <https://www.memphis.edu/ess/module4/> [<https://perma.cc/2BTC-NRPJ>].

229. See *Consensus Decision Making*, SEEDS FOR CHANGE, <https://www.seedsforchange.org.uk/shortconsensus> [<https://perma.cc/EF96-DVXB>].

230. See, e.g., *Mental Health Advocacy*, CLUBHOUSE INT'L, <https://clubhouse-intl.org/what-we-do/mental-health-advocacy/> [<https://perma.cc/MV8C-HKBS>] (Jan. 1, 2019) (highlighting advocacy efforts including Indiana, Maine, and Michigan clubhouses' successful years-long efforts to make Accredited Clubhouses eligible for Medicaid reimbursement in their states).

231. See *COMMUNITY ORGANIZING HANDBOOK 3RD EDITION*, UNIV. OF DENVER CTR. FOR CMTY. ENGAGEMENT & SERV. LEARNING 16-17 (2014), https://www.du.edu/ccesl/media/documents/ccesl_handbook_third_edition_print_protected.pdf [<https://perma.cc/X38C-UNDM>] (defining agitation as the art of challenging someone to be true to their self and to act on their self-interest, in a safe space and in the context of a relationship, and avoiding power dynamics or assumptions

Another possibility would be for the CLP lawyer to work with the clubhouse to create a political advocacy unit that carries out organizing work as part of the work-ordered day.²³²

In sum, the possibilities for the day-to-day work of a Clubhouse-Legal Partnership are extensive and capable of significant individual and community-wide impact. Thanks to its solid grounding in recovery and autonomy values, the CLP model has the potential to be a powerful tool in a larger movement for the rights, dignity, and inclusion of people with mental illnesses.

V.

NEXT STEPS & CONCLUSION

The success of the CLP model rests on a few assumptions, including that clubhouse members have unmet legal needs and that clubhouses are interested in providing their members with onsite legal aid and engaging in political action. Only in practice can it be determined whether these assumptions are true: what is needed next is to try this model.

Eventually, studies can be done to compare outcomes between traditional BHLPS and CLPs. Metrics might include: number of clients reached; number and types of cases handled; overall client health attainment; overall recovery attainment; number of hospital visits and criminal legal interventions of clients served before and after the CLP; self-reported happiness, sense of self-efficacy, and sense of community before and after; and satisfaction of clients and the clubhouse/institutional medical partner.

People with mental illnesses have a great need for legal services that support their recovery.²³³ While the MLP model, through the development of BHLPS, has shown promising results, it has serious drawbacks as well. Clubhouse-Legal Partnerships offer a new way to support people with mental illnesses and their communities through direct legal representation, community education, and systemic action that respect their autonomy and build power for their communities.

that the person agitating knows what is best for the other person). When incorporated into the attorney's intake with clients, agitational interviewing can help attorneys understand their client's motivations and uncover and encourage potential areas of collective action.

232. See *supra* Part IV.B (discussing the work-ordered day and the "unit" system of dividing tasks); *supra* notes 194–197 and accompanying text.

233. See *supra* Part II.E.