

A Brief History of Patient Rights Nationally and at the South Carolina Department of Mental Health

In early America when the Constitution and Bill of Rights were being formulated as written documents, the primary concern of the law was the protection and security of “society,” not the “individual”. The law required that criminals be incarcerated. Laws were usually repressive toward the poor. The violently insane were treated as criminals, and the indigent were treated as the poor.

Each family was responsible for individuals within their own family. The local community would deal with the mentally ill only if the family could not - but this usually meant the local jail or poorhouse. Generally, commitment statutes did not exist, and any commitments were not for treatment. One of the earliest commitment statutes found was in 1676. The Massachusetts Bay Company statute instructed select men from each town to take care of the mentally ill so that “they did not damnify others.”

A reform movement occurred early in the 19th century. A philosophy of moral treatment advocated treatment within an institution where an individual’s environment could be therapeutically structured. Special institutions with selective admissions achieved success in treatment and care. A humanitarian crusade during the period for better care and treatment led to a network of public institutions. In response to a petition drawn by Benjamin Franklin in May 1751, the Pennsylvania Assembly authorized the establishment of a hospital for the poor and mentally ill. Other early hospitals included one in Williamsburg, Virginia; Eastern Kentucky State Hospital; and South Carolina State Hospital.

With the government assuming responsibility for the care and treatment of people with mental illness, institutions could no longer be selective in their admission procedures. Public hospitals quickly exceeded their capacities. The structured, therapeutic environment envisioned by the reformers could not exist in most of these institutions.

There was concern for the rights and liberty of individuals during this growth period, but the concern was for the sane rather than the mentally ill. Vigorous commitment laws attempted to protect the sane from being committed. The commitment process took on the appearance of a criminal proceeding, often including a jury trial. Unfortunately, jury trials resulted in more commitments than ever before. During World War II and after, with advances in psychiatric knowledge, many commitment statutes were altered to allow commitments based solely on psychiatric certifications by qualified professionals.

In the 1960’s and 1970’s grew an increasing awareness of minority and individual rights. This awareness extended to people with mental illness. The responsibility for the inadequacies of the mental health field was placed on almost every segment of our society: administrators and professionals for their paternalistic attitude; psychiatrists for their inability to accurately predict behavior; legislatures for setting improper priorities; and the public for intentionally ignoring people with mental illness. One southern state was said to have placed a greater priority on Civil War monuments and the protection of bird species. During this period the courts issued several significant decisions addressing commitment and

treatment issues. In response, most states passed comprehensive measures to protect individual rights during the commitment process and throughout hospitalization.

It is involuntary commitment, rather than voluntary hospitalization, that is most closely scrutinized under law because involuntary commitment unwillingly deprives a person of liberty. The US Constitution requires a state to show a compelling interest before any citizen is deprived a fundamental right, including liberty. Involuntary commitment of people with mental illness is normally justified on two grounds. First, the state has a responsibility to those who are incapable of caring for themselves or making a decision that they are in need of treatment. Second, a person's mental illness may make an individual dangerous to himself or society.

To constitutionally deprive an individual of liberty, due process requires that the commitment procedure must include strict safeguards. Prior to January 1975, the South Carolina Mental Health Code did not provide the required strict, procedural safeguards. For instance, there was no right to a hearing in which a judge decided whether a person had mental illness and no right to request a re-examination. As litigation in other states set minimal constitutional standards, mental health officials in South Carolina recognized that, unless changes were made, the courts would intervene. On February 11, 1972, an action (Alexander v. Hall) was filed in federal court in South Carolina challenging the commitment statutes and hospital conditions. In response, the state passed legislation on July 9, 1974, that went into effect January 5, 1975.

The South Carolina law requires the filing of commitment actions in the probate court. The commitment petition must be accompanied by a certification by a licensed physician and the proposed patient must be given appropriate notification. The notice must state the proposed patient's right to have an attorney and specifically state the time, date and place a hearing will take place. At the hearing, a judge must decide whether the individual has a mental illness and whether the mental illness requires treatment or makes the person dangerous to himself or others. This decision must be based on clear and convincing evidence, including examination by two court appointed examiners. The individual also has a right to request an independent examiner. Finally, the individual may appeal the decision of the probate court.

In the past, once committed to a hospital the patient was usually neglected. With no public interest, little financial support and an increasing population, public mental institutions were often without adequate means to provide proper care and treatment. With this greater public awareness of individual rights, there was a growing concern for the conditions of hospital life for patients. At the same time commitment statutes were revised, most state legislatures, including the South Carolina General Assembly, also added laws guaranteeing certain patient rights and privileges while hospitalized.

In 1975 the SC Department of Mental Health (DMH) created an ombudsman type position. This "ombudsman" had responsibility for reviewing patient rights issues within DMH. Thereafter, DMH appointed a task force to develop patient rights standards and a procedure for reviewing patient rights issues. The task force discovered a lack of knowledge nationwide about patient rights issues within

mental health agencies. Consequently in 1978, DMH sponsored one of the first conferences on Patient Rights. Representative from 24 states and many federal agencies attended this conference. The gathering stimulated further development of internal patient rights procedures adopted by DMH in 1980. Enforcement of the procedures depended on existing staff.

In 1980, after hearing extensive testimony about poor institutional conditions across the nation, Congress passed the Civil Rights and Institutionalized Persons Act (CRIPA). CRIPA authorizes the U.S. Justice Department to initiate actions to remedy the violation of rights for people in institutions. It was under CRIPA in 1983 that the Justice Department intervened into conditions at South Carolina State Hospital. During this same period, mental health agencies nationwide were beginning to establish internal patient rights programs. In response to these events, the DMH Commission became interested in establishing an advocacy office which would be separate and independent of any other office at DMH. The advocacy office would have responsibility for patient rights and advocacy matters only. Funding was allocated and an advocacy office was started in late 1985.

Congress passed the Protection & Advocacy for Mentally Ill Individuals Act of 1986 which created a protection and advocacy system for persons with mental illnesses similar to the system already in place for persons with developmental disabilities. The advocacy agencies established under this act are required to be external to (independent from) the service delivery system (DMH and private providers) and are required in each state. SC Protection & Advocacy for People with Disabilities, Inc. is the agency currently operating in this state.

By the late 1980's nearly all state mental health programs considered internal advocacy offices to be a necessary service, as did various licensing, certifying and accreditation organizations. The Joint Commission on Accreditation of Health Care Organizations (JCAHCO) now emphasizes patient rights. JCAHCO mandates a system for addressing patient complaints and informing patients about their rights, as do various federal certifying regulations. The Federal Vocational Rehabilitation's Act of 1983 and the Americans with Disabilities Act also require agencies establish grievance mechanisms to address grievances under these acts. Finally, with amendments to the statute in 1990, the South Carolina law on patient rights was revised, providing more scope and detail to the rights of patients in DMH programs and to require a procedure for addressing patient complaints.

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