

**THE CHRONICLES OF PSYCHIATRY: LANDMARK CASES THAT  
SHAPED THE CIVIL RIGHTS OF PSYCHIATRIC PATIENTS**

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## ABSTRACT

A thoughtful survey of the history of psychiatry sheds light on a rich and intricate story of our evolving understanding, experience, and treatment of mental illness through time. These chronicles are at once a show of human curiosity for the mind-body connection, and an experiment in cruel and unusual treatment of illnesses that have proven difficult to quantify through both ancient and modern scientific means. It is the latter that makes an ethical study of the past so vital in a concerted effort to write a more just future for all patients. This paper provides a survey of the history of mental health and psychiatry from ancient Egypt to modern-day America, highlighting the injustices suffered by patients with mental illness throughout all times with a particular focus on the burden shouldered by vulnerable and underprivileged persons, minorities, and urban populations. Through an analysis of landmark American cases, it examines the establishment of civil rights for psychiatric patients in the areas of: the right to treatment, right to refuse treatment, and civil commitment. Drawing upon these precedents and historical contexts, this paper explores how the principles of bioethics can be applied to the future of psychiatry with respect to emerging trends like the use of social media, telehealth, gene editing, and AI/VR in medicine. By thoughtfully reflecting on the past and applying the lessons we have gleaned to the future, this thesis aims to promote a more ethical and equitable approach to mental healthcare, one that protects and actively fosters the empowerment of all patients, regardless of background, mental status, or socioeconomic status.

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## CHAPTER 1: INTRODUCTION

The field of psychiatry has come a long way since it earned its official name and place as a medical specialty in the early 1800s. But for centuries, the understanding and treatment of mental health and illness has been a perplexing and elusive pursuit for historians, philosophers, and scientists alike. From the earliest appearances of mental illness in ancient civilizations, where the mentally ill were thought to be possessed by deities, to the more recent use of telehealth and psychotropic drugs in modern psychiatry, the history of mental healthcare is a checkered one. The field has been plagued by bioethical dilemmas and indiscretions, particularly with regard to its treatment of the most marginalized and vulnerable members of society.

As the relationship between provider and patient is the foundation of all medical practice, it is imperative that this sacred bond is built on mutual trust, respect, and the oath to safeguard all patients' rights. This is especially true in the field of mental healthcare, where the duty to protect is of the highest order. Unfortunately, even within the modern age of medicine, the history of psychiatry in America is marred by a number of cases where this oath has been blatantly disregarded.

Looking at these injustices through the critical lens of urban bioethics entails a survey of the ways in which the principles of social justice, agency and autonomy, solidarity, and beneficence and non-maleficence were violated and then righted by the American judicial system. In a three-part review of the law, this paper will address those landmark cases throughout history that have helped establish and shape the civil rights of

psychiatric patients with respect to the areas of: right to treatment, right to refuse treatment, and civil commitment.

It is by examining these historical transgressions and ethical abuses that we can move forward as a profession and society. While society continues to evolve, there are new opportunities and challenges facing the field of psychiatry. Novelties like artificial intelligence, virtual reality, and telehealth are slowly becoming facets of everyday life. But the long-term impact of these technologies on medicine and psychiatry remains to be seen. We must ask ourselves regularly how these changes align with the principles of bioethics. Are new methodologies for mental healthcare delivery being used in a manner that is fair, transparent, and above the influence of bias or discrimination? Are patients' civil rights and privacy being meaningfully protected? Is there parity in access to high-quality mental healthcare for all people?

The final chapter of this paper will explore some of these questions and discuss how an urban bioethics framework and an understanding of the past can be used to navigate the novelty currently facing the field of psychiatry as we look towards a more patient-centered and ethical future for mental health care delivery.

## CHAPTER 2: MENTAL HEALTH THROUGH THE AGES

The history, perceptions, and experience of mental illness can be traced back to ancient civilizations, where the treatment and understanding of mental health issues varied widely. In ancient Egypt, for instance, one of the earliest and most important medical documents known as the Ebers papyrus made special mention of clinical depression and dementia, an indication that ancient Egyptians had their own conceptualization of mental illness. At the time in the 1500s BCE, this form of pathology was thought to be a result of malevolent spirits and was treated by priests by way of exorcisms and incantations.

In 4<sup>th</sup> century Ancient Greece, Hippocrates and his disciples employed the term *phrenitis* to refer to an acute inflammation of the humoral components of the body, medically causing a disturbed mental state. His humoral theory stated that the imbalance was occurring somewhere in the body's fluids – black bile, yellow bile, phlegm, or blood (Bos, 2009). Though they could not localize the inflammation they thought to be causing disturbed mental states - anatomically or otherwise - they treated people with a combination of therapy and medication.

In Baghdad in the 9<sup>th</sup> century, the Arab world saw the rise of the first known hospital, called a *bimaristan*, that contained a designated ward for the mentally ill. These were the early forms of asylums that housed patients who exhibited particularly violent or bizarre behaviors. At the same time, the Middle Ages brought with it a dark period in the history of mental illness in the Western world. People suffering from mental health

conditions were commonly persecuted, tortured, and even executed. They were looked on with suspicion as societal fear of witchcraft and demonic possession abounded.

In the 11<sup>th</sup> century, Persian polymath, Ibn Sina, known in the west as *Avicenna*, came to prominence. He is regarded as one of the most influential physicians, philosophers, and astronomers of the Islamic Golden age and has been called the father of early modern medicine. One of Avicenna's most notable contributions to psychiatry and medicine was his book, *Canon of Medicine*, the most significant medical encyclopedia for six centuries afterwards that was widely used in Asia and Europe. In this book, he uncovered the mind-body connection in ways that no one had previously (Namazi, 2001). He described different types of mental disorders and their symptoms, providing detailed explanations of their causes and treatments. He also discussed the importance of the doctor-patient alliance and the therapeutic role of the physician in treating mental illness. He recognized that emotional factors like stress and grief had the power to significantly affect mental illness and emphasized psychological interventions such as music therapy and counseling, in addition to medical treatments. Avicenna's work and conceptualization of mental illness as a result of medical and psychosocial factors became the standard for the field of psychiatry for the next six centuries and remains the foundation upon which modern psychiatry is built.

Although Avicenna set the scene for a more holistic examination and treatment of mental illness, the early modern era from the 13<sup>th</sup> century to the 18<sup>th</sup> represented a winding path towards just treatment for the mentally ill before it was set straight. Privately owned asylums were erected to house the sick, poor, and *insane*, where the conditions were inhumane and unsightly at best. In facilities like the Bethlem Royal

Hospital in London, people who were deemed dangerous were chained and confined (Allderidge, 1979).

In 1656, Louis XIV of France established a public hospital system for the mentally ill, resembling the private institutions seen in England (Shorter, 1997). But like the English, the asylum systems that proliferated throughout Europe did little but house and imprison mentally ill patients; rather, they were devoid of any meaningful treatments and humanity.

Fortunately, the 18<sup>th</sup> and 19<sup>th</sup> centuries brought with them new social policies and a refreshing movement known as moral treatment. Attitudes towards the mentally ill began to change as criminals, prostitutes, orphans, and the mentally ill ceased to be discarded. While some were still incarcerated, instead of being met with indifference and subhuman living conditions, they were re-educated and rehabilitated in a variety of jails, learning institutions, and asylums. Thus, the ways of the Enlightenment touched even some of the most vulnerable members of society.

By 1758, Bethlem Hospital earned itself significant notoriety from modern thinkers like the English physician Dr. William Battie in his *Treatise on Madness*, regarding the management of mental disorders. Battie showcased how barbaric the hospital's physical conditions and custodial policies were and challenged Bethlem to reconsider a more compassionate treatment approach that involved rehabilitation, cleanliness, nutritious food, and fresh air (Beard, 2007). He dared to posit that patients who spent time in an asylum or other psychiatric institution should derive some form of therapeutic benefit in the treatment of their "madness".



As people began to see mental illness as something that could be appropriately managed rather than a life sentence, moral treatment became the new standard of care. This movement was led by psychiatrists such as Philippe Pinel of France and William Tuke of England, who sought to drastically improve the conditions in asylums across Europe and further propagated the notion that mental illness was a medical condition that required humane treatment in the form of therapy (Elkes, 1967).

Tuke's approach to mental healthcare stood in stark contrast to the brutal practices that were prevalent in the late 1700s. He advocated for a kind and gentle approach that focused on the individual's needs and took into account their physical and emotional well-being. Pinel is famously known for “untying the chains” of the patients at the Parisian asylum of Bicetre. He recognized that in many cases, his asylum patients were not suffering from incurable mental illness perse, but rather from a variety of socioeconomic difficulties in their present environment.

The work of Tuke and Pinel marked a turning point in the treatment of mental illness. Both physicians played a pivotal role in the history of modern psychiatry, particularly when it came to righting the path of justice and treating patients with not only non-maleficence, but purposeful beneficence (Borthwick et al., 2001). In other words, they made it their mission, and by extension psychiatry's, to both do no harm, and actively do right by all patients. Those were the founding principles of the famed York Retreat when it opened its doors in 1796 in England. This hospital served as a guidepost for others around the world, including the still-standing Friends Hospital in Philadelphia, and the current Institute of Living in Connecticut.

Across the ocean, the trajectory of mental healthcare in the US largely paralleled that of its European counterparts. Before America gained its independence, the Pennsylvania Hospital was established in Philadelphia, becoming both the first public hospital in America and the first to include a ward for patients with mental disorders. It was around this time that Dr. Benjamin Rush, now regarded as the Father of American Psychiatry, came to prominence. Born in Pennsylvania and trained in Scotland, Rush returned to the United States to practice mental healthcare and teaching. He was among one of the first American psychiatrists to propose the use of moral therapy in the treatment of mental health conditions. Like Pinel and Tuke, Rush believed that mental illness could be cured through a thoughtful combination of compassion, medicine, and occupation. He called for the creation of stand-alone mental health institutions that were separate in their own right from general hospitals. He played a key role in the establishment of the Pennsylvania Hospital for the Insane – later The Institute of Pennsylvania Hospital – which became the first hospital dedicated to the treatment of mental illness in America.

In addition to his advancements in the field of psychiatry, Rush was also a pioneer in the area of occupational therapy, a field that hadn't yet been established. He encouraged his patients to engage in regular occupations like knitting, gardening, and listening to music in the course of their therapy. But Rush wasn't just a compassionate physician, he was also an engaged civic leader in the American Revolution and a signatory of the Declaration of Independence (Fried, 2019).

Despite Rush's many invaluable contributions to the field of psychiatry and his steadfast advocacy for his patients through several epidemics in Philadelphia at the turn

of the 19<sup>th</sup> century, his legacy is somewhat tarnished by his advocacy of practices that are now considered as barbaric as they were unethical and ill-informed. Rush was a strong proponent of bloodletting, purging, and the use of mechanical restraints, all of which were well accepted conventions to heal the body of many ailments in that time period. His complex legacy in the history of American psychiatry makes him one of the few doctors of his time to recognize that mental illness was diagnosable, classifiable, and treatable with compassionate care.

Consistent with other radical thinkers at the time, a German physician named Johann Reil began publishing a journal in which he argued that the profession he called ‘*psychiaterie*’ deserved to be a discipline in its own right with specially trained practitioners (Binder, 2007). Thus, in 1808, the field of psychiatry was officially born and named. Soon after, Dr. Rush published his *Observations and Inquiries Upon the Diseases of the Mind*, which became the first American textbook on psychiatry (Rush, 1812).

The 1800s continued to see an explosion of interest in the theories of the mind and the subsequent foundation of societies dedicated to the pursuit of psychiatric knowledge. In 1844 the precursor organization of the American Psychiatric Association was established in Philadelphia. By the late 1800s, the first dictionary of psychiatry was published (Corsini, 1999). For the first time, the clinical symptoms of psychosis were defined and later reformulated as schizophrenia. And by the turn of the century, Sigmund Freud’s theories took a stronghold on prevailing psychological theories and therapies in the early 1900s as he went onto publish his postulations on psychopathology, psychoanalysis, the ego, dreams, and influences of early development on the adult experience of sexuality. His hyper focus on sexuality caused some well-known scholars

like Carl Jung, Alfred Alder, and Adolf Meyer to break from Freud, form their own scholarly theories on the mind, and develop other modes of psychotherapy.

Although moral treatment and therapy set the undertones for modern psychiatry, many ill-informed, non-science backed treatments for mental illness came to center stage as technology expanded in the 1900s. In 1927, for instance, an Austrian psychiatrist by the name of Manfred Sakel developed insulin shock therapy as a treatment for psychosis (Jones, 2000). This was a form of treatment where patients were repeatedly given supratherapeutic doses of insulin in order to instigate comas on a daily basis over the course of several weeks. In the process of inducing hypoglycemic comas, patients would suffer the side effects typically associated with low blood sugar, the most dangerous of which was seizures. A decade later, Sakel traveled to introduce this form of shock therapy to America, where it remained in popular use for years.

Other forms of shock therapy included the use of epileptic drugs such as Metrazol and electroconvulsive therapy (ECT), both used to induce seizures in patients whose nervous and mental disorders had been refractory to other treatments. The Italian psychiatrist Ugo Cerletti became the first to use ECT to successfully treat a schizophrenic patient with delusions, hallucinations, and confusion. He was also the first to use any form of shock therapy safely in the treatment of schizophrenia, manic-depressive episodes, and major depression (Cerletti, 1956). Although the standards of care and requirements for informed consent have changed significantly since Cerletti's time, ECT remains in use today.

Alongside ECT, in 1948, lithium became the first effective pharmaceutical intervention for mood stabilization in bipolar disorder. Soon after, a Nobel Prize was

given to a Portuguese neurologist, Egas Moniz, for his work on lobotomies as a cure for mental illness. At a time when the lobotomy and insulin-induced comas were viable treatment options for patients who often were not asked for consent, the success of lithium as a non-invasive therapy could not be overstated. From then on, advancements in clinical diagnoses and interventions continued with the first Diagnostic and Statistical Manual of Mental Disorders (DSM) published in 1952, and the subsequent discoveries of the antipsychotic drug chlorpromazine, monoamine oxidase inhibitors (MAOI) for depression, and benzodiazepines in the following decade.

By the 1960s, it became widely recognized that mental health is health. In 1963, US President John F. Kennedy introduced legislation authorizing the National Institute of Mental Health to administer Community Mental Health Centers for those who were discharged from state psychiatric hospitals, providing patients a meaningful bridge back to their everyday lives. Many state-run asylums shut down as part of a larger effort to deinstitutionalize and provide more humane care to the mentally ill.

In the late 1960s, societal attitudes had shifted not only towards mental health, but also towards recreational drugs. During a time that challenged all preexisting sociopolitical norms – from the civil rights movement, to anti-war protests, to environmental protectionism – recreational substances began to spread across college campuses and war veterans, collapsing the notion that drug use is akin to drug abuse, or that drugs were associated with any particular group of people. Simultaneously, crime rates were rampant, rising by over 100 percent within the decade.

In response to these shifts, in 1969, President Richard Nixon announced his intention to address the uptick in narcotic and recreational drug use at the federal level.

His plan was to address both the supply and the demand, a seemingly rational approach to a growing problem. The result was The United States U.S. Controlled Substances Act of 1970, which pulled together all existing federal drug laws and expanded their scope and policing. It put LSD, DMT, Psilocybin, Mescaline, and Marijuana on Schedule I of V drug schedules, in order of decreasing potential for abuse and accepted medical use. At the time, this schedule system left little room to address addiction from an evidence-based medical perspective, or to even adequately conduct research with the drugs.

The law also established the National Commission on Marijuana and Drug Abuse (also known as the Shafer Commission), headed by their own expert and politician, Raymond Shafer to study the use and abuse of cannabis in the US. In 1971, President Nixon declared war on drugs, saying “America's public enemy number one in the United States is drug abuse. In order to fight and defeat this enemy, it is necessary to wage a new, all-out offensive” (Nixon Foundation 2016). Contrary to the way in which marijuana policies have been utilized against impoverished communities since then, the Shafer Commission studied marijuana use for two years and in 1972, officially recommended the decriminalization of marijuana in small amounts at the time. In their report to Congress, Shafer said:

“[T]he criminal law is too harsh a tool to apply to personal possession even in the effort to discourage use. It implies an overwhelming indictment of the behavior which we believe is not appropriate. The actual and potential harm of use of the drug is not great enough to justify intrusion by the criminal law into private behavior, a step which our society takes only with the greatest reluctance” (Childs Esq., 2016).

While the era of drug policing was just beginning, the following decades brought with them great advances in the treatment of mental illness with the introduction of the

first antidepressant SSRI (selective serotonin reuptake inhibitor), fluoxetine in 1988. It became and remains one of the most prescribed psychotropic medications of all time. In 1996, President Bill Clinton signed the Mental Health Parity Act into law, requiring health insurance providers to cover psychiatric conditions as they did any other medical or surgical diagnoses, and preventing them from imposing any disproportionate dollar limits on mental health benefits (Centers for Medicare and Medicaid Services, 2020).

At the turn of the century, a new tech boom changed the way people talk about mental health and wellness once again. Rather than being shrouded in mystery or locked behind closed doors, mental health, therapy, and use of psychotropic medication became normal topics of conversation. Social media altered the landscape and reach of advocacy, education, and social justice permanently. By 2013, the fifth and latest iteration of the DSM was published, destigmatizing gender dysphoria, further elucidating autism spectrum disorder, and revising our understanding of depressive and eating disorders.

Today, one decade later, 2023 is witnessing the short and long-term effects of generations of people living through global crisis after crisis. From the COVID-19 pandemic to international sociopolitical unrest to an ever-looming financial crash, our collective mental health is taking a hit. In June 2022, 33 percent of adults in the US reported symptoms of anxiety or depression, compared with 11 percent before COVID. Yet, a severe dearth of psychiatrists and mental health professionals impacts a significant portion of the American population, with more than half of all counties lacking even a single psychiatrist, without even speaking to the gaps between access and need or the social determinants impacting urban populations (Weiner, 2022).

These challenging times have proven to bring silver linings however. As a result of the pandemic pushing healthcare online, more patients who were once hard to reach are receiving the care they need from the comfort of their homes – without losing time and energy commuting across county lines. While telemedicine makes up a slim minority of all care in this country at just 5 percent, the proportion of mental health care that remains available via telehealth is at a whopping 40 percent (Weiner 2022). Many pandemic-era Medicare restrictions on telehealth payment structures have been permanently lifted to enable the safe and necessary delivery of mental healthcare for all people through the means that are most feasible and affordable to them.

According to the Bureau of Labor Statistics (BLS), the increasing demand for mental healthcare will be met with a positive outlook on job growth in the field of psychiatry, which is projected to grow nearly 10 percent from 2021 to 2031, faster than the 4 percent average growth for all occupations (Brachter). Consumers of the \$450 billion wellness industry in the U.S. parallels these trends, growing at a rate of 5 to 10 percent annually (McKinsey & Co., 2022). Consumers and patients alike are driving this trend because they increasingly value services that address them as whole individuals with regard to their wellness across several dimensions – from mental health and mindfulness, to nutrition and fitness. It is incumbent on the mental health and medical profession to meet these growing needs with care, caution, and alignment with the principles of justice, autonomy, beneficence, and non-maleficence, and an understanding of the history that led to this moment in time. The following sections will expand on the disparate impacts of unjust mental health practices, and the landmark cases that shaped our modern understanding of patients’ civil rights.



### CHAPTER 3: DISPARATE IMPACTS

Mental healthcare and medicine in general, have been shaped by social and political factors, which include evolving medical biases and misconceptions. A discussion on the history and bioethics of psychiatry would be remiss to exclude the disparate impact of such biases and ill-informed public policy on various urban, marginalized, and non-white populations.

Beginning with the man regarded as the “father” of American psychiatry, Dr. Benjamin Rush had a complicated relationship with race and slavery. In the 1770s, Rush became one of the first American physicians to openly call for the abolition of slavery. His stance was rooted in the idea that slavery was not only morally reprehensible for a devout Christian, but also harmful to the well-being of all those involved. From an urban bioethics perspective, his approach was one of solidarity, morally binding the heinous act of enslaving others to the inhumanity faced by the enslaved. In his 1773 “Address to the Inhabitants of the British Settlements in America, upon Slave-keeping” he referred to slavery as a “ vice which degrades human nature, and dissolves that universal tie of benevolence which should connect all the children of men together” (Rush, 1773, 28). In terms of ethics, Rush tried to appeal to the public’s sense of benevolence and spirit of solidarity, which he derived from religion. He went on to say:

“Every prohibition of Covetousness—Intemperance—Pride—Uncleanness—Theft—and Murder, which [Christ] delivered,—every lesson of meekness, humility, forbearance, Charity, Self-denial, and brotherly-love, which he taught, are levelled against this evil;—for Slavery, while it includes all the former Vices, necessarily excludes the practice of all the latter Virtues, both from the Master and the Slave” (Rush, 1773, 13-14).

In an attempt to further abolitionist sentiment by way of science and intellectualization, Rush decided that Africans' dark skin was due to the effects of a mild form of leprosy that was exacerbated by the stress of being a slave; he referred to this disease as "*Negritude*" (Perzichilli, 2020; Rush, 1799). By labeling blackness as the symptom of disease, he made the logical argument that a cure to eliminate blackness would lay to rest any argument for slavery based on skin color. With the elimination of blackness, his sociopolitical solution was to erase African people's experiences and worldview by educating them in the way of proper Christian, republican values (Herschthal, 2017).

For many seemingly well-intentioned abolitionists of the time, this became a new means to exert control over the enslaved people they sought to free. In the name of mental health, Christianity, liberty, and education, people like Benjamin Rush subliminally and blatantly endorsed black inferiority to white Europeans, setting a white, Christian education as the prerequisite to freedom. For a population that already had no autonomy in the public sphere, these extra conditions on their freedom further set back their sense of agency, a key component of an urban bioethics worldview.

In bioethics, a person who is autonomous in the traditional sense is rational, informed, un-coerced, and has the right and liberty to exercise their free will (Jones, 2019). But having rights and liberties in theory is very different from having the capacity to see a complete array of available options and carry out a particular choice in a given situation. This more complex dynamic is referred to as agency, which exists within an individual's context, how they carry themselves and are perceived in their world – from gender, orientation, and skin color, to socioeconomic class, religious affiliation, and educational background. In the context of slavery then, enslaved persons lacked both the

freedom and ability to make active choices about their lives and were severely restricted by their enslavers and society at large. When leaders like Dr. Rush placed additional conditions on their potential freedom, such as the requirement for education or religious conversion, they effectively undermined the agency of black Americans. In effect, they leveraged liberty against African Americans' sense of humanity and agency in all facets of life. Yet, to the degree that enslaved individuals remained at the mercy of white abolitionists, this was still a far better bargain than the alternative.

While Rush's beliefs about race and abolition were complicated at best, some other psychiatrists around the same time were far less compassionate towards the plight of the enslaved. Dr. Samuel Cartwright was one such psychiatrist who took advantage of his status as a physician to malevolently spread false beliefs in African Americans' inferior biological makeup and predisposition to mental illness throughout the antebellum South. He held that enslaved people who felt the overwhelming desire to be free suffered from a mental illness he termed "drapetomania" or "the disease causing Negroes to run away". According to Cartwright, this disease came as a result a weakness of the mind that could be treated only with harsh punishment ("whipping the devil out of them") and control (Warner, 2021; Perzichilli, 2020). Drapetomania was only one in a slew of fabricated mental illnesses Cartwright assigned to enslaved people to further violate their freedoms and agency (Perzichilli, 2020). Frighteningly, these beliefs were not uniquely held by just Cartwright. They afflicted the broader medical community and had deleterious effects on the availability of mental and physical healthcare for people of color. In the early 1800s, most asylums were located only in rural areas, where predominantly white people with mental illness were isolated from society. Although the

conditions in these asylums were far from luxurious, this made mental healthcare even more scarce for urban populations, a stark reminder that an ethical critique of the available resources must also include a critique of the complete lack thereof.

By the late 19<sup>th</sup> century, when cities became more densely populated and a fear of the mentally ill took hold, many states opened up public psychiatric asylums. In many cases, African Americans were denied entry to these asylums, while the majority of their residents came from otherwise poor and underprivileged backgrounds. From a bioethics standpoint, justice typically calls for the equal treatment of all people – for example, the idea that the doors of an asylum should be open for all and all patients should receive equal attention, compassion, and quality of care from their physicians. *Social* justice however, would dictate not just equal care for all, but contextualized and culturally competent care tailored to the present circumstances of each patient, even if that means providing a different level of services for marginalized patients. The delivery of social justice was a far cry from a situation where even justice was not available for the most underprivileged patients.

The wealthy were able to take refuge in privatized institutions and sanctuaries with far better conditions overall. Meanwhile, black Americans were relegated to prisons and other segregated spaces, such as the Colored Home in NYC, the only institution available to African Americans with mental illness (New York City, 2023; Perzichilli, 2020). The disparate treatment between races and socioeconomic classes points to a history entrenched in inequitable access to care and a violation of the principles of justice and beneficence. This malfeasance continued well into the 20<sup>th</sup> century, when the eugenics movement gained popularity. This led to the forced sterilization of those

individuals deemed to be “unfit” for breeding – encompassing people with mental illness or the “feeble-minded” and in particular, those from marginalized communities (Birnbaum, 1961).

While the Civil Rights Movement ultimately led to the desegregation of society and mental health hospitals in the mid-20<sup>th</sup> century, it did little in the way of equalizing standards. Non-white, non-affluent Americans continued to receive lower quality care compared to white patients. In fact, when black Americans became more visible in society as free individuals, they also became the targets of harmful mislabeling by medical professionals.

For example, prior to the civil rights movement, schizophrenia had been described as a harmless condition connected to neurosis, and by extension, attached to primarily white, middle-class housewives (Metzl, 2011). Later, in the 1960s, the scientific community began to shift their assumptions about schizophrenia and the populations it was associated with. While on one hand, they began to recognize it as a disorder of biological brain function, on the other, it took on an entirely new meaning. Far from the benign, suburban condition it once was, schizophrenia developed a reputation as a violent, urban disease when scientists falsely linked it to black activists during the civil rights movement. They characterized the disorder in black males as one leading to rage and aggression; brain dysfunction became the new cause of urban violence that leading neuroscientists claimed they could prevent by way of psychosurgery (Perzichilli, 2020). In 1968, an article was featured in the *Archives of General Psychiatry* describing schizophrenia as a “protest psychosis” where black men exhibited “hostile and aggressive feelings” and “delusional anti-whiteness” as a result of their activism (Metzl, 2011).

When new antipsychotic treatments for schizophrenia came about, their advertisements reflected these newfound prejudices. A 1974 ad for Haloperidol/Haldol pictured an angry black man with clenched fists in a big city with the title: “Assaultive and belligerent? Cooperation often begins with Haldol”.

Though an ad like the aforementioned, and the civil rights movement of the 1970s might seem like a distant past, the harmful impact of these prejudicial practices lingers on. It has been shown that independent of clinical factors, psychiatrists are more likely to prescribe antipsychotics to non-whites (Ryn & Fu, 2003). The same study found that non-whites are more likely to be involuntarily hospitalized and placed in isolation during their hospitalizations. Lastly, and perhaps unsurprisingly, it was found that black and Latino Americans were less likely than white Americans to receive guideline-adherent treatment and follow-up for their mental healthcare, up until the 21<sup>st</sup> century.

History has shown time and again, doctors have knowingly turned people away or provided suboptimal care to patients on account of various sociopolitical, personal, or economic factors that rendered them vulnerable – in direct violation of our duty to our patients. Unfortunately, it took countless injustices such as these to establish the legal precedents, regulations, and ethical guidelines now in place to protect the rights of patients with mental illness. Despite these positive changes, it will take far more than an officially issued apology from the American Psychiatric Association to rebuild trust and restore a meaningful sense of social justice between the medical system and patients from vulnerable backgrounds (APA, 2021). The following section will analyze a select handful of landmark cases that have shaped our modern understanding of the civil rights of psychiatric patients, exploring the stories of injustice that led us here.

## **CHAPTER 4: CASES THAT ESTABLISHED THE CIVIL RIGHTS OF PSYCHIATRIC PATIENTS**

Psychiatry has had a complex history of balancing the interests of the individual patient with those of psychiatry and society at large. In the past, psychiatric patients were subject to abusive and non-science backed treatment practices, experimental and nonconsensual treatment, and a complete disregard of legal protections for their civil rights. It took a series of landmark legal cases to establish the boundaries and responsibilities of physicians to their patients. These cases shaped the ethical, legal, and practical dimensions of psychiatry and continue to influence modern healthcare. The following will explore select cases that resulted in three critical areas of psychiatry and medicine as we now understand them: right to treatment, right to refuse treatment, and civil commitment. By understanding the roots and consequences of these cases, we can appreciate the significance of being deliberate in our delivery of psychiatric patients' civil rights, and the challenges and opportunities for the future of healthcare.

### **Right to Treatment**

The 1960s and 70s were a time of great social change – from the civil rights movement to antiwar protests, and the popularization of recreational drugs on college campuses to a recognition of mental health as a significant part of overall health. Widespread institutionalization and the neglect of the mentally ill led scientists and legal professionals to reconsider the right of psychiatric patients to receive adequate care, irrespective of their confinement status. This line of thinking deviated from the dominant approach prior to this period that promoted long-term confinement of patients in large

state-run institutions where they were often subject to inhumane conditions and neglect. In 1960, Dr. Morton Birnbaum, an attorney and physician, published an article in the highly influential American Bar Association Journal titled, “the Right to Treatment”, where he wrote:

“there does not appear to have been any significant and realistic consideration given, from a legal viewpoint, to the problem of whether or not the institutionalized mentally ill person receives adequate medical treatment so that he may regain his health, and therefore his liberty, as soon as possible” (Birnbaum, 1960, 499-505).

Dr. Birnbaum raised a serious ethical and legal concern that highlighted how flawed and unjust the system had been for people with mental illness until then. Their treatment had not only been immoral, but completely out of alignment with the founding principles of the United States. He argued that in the absence of adequate treatment conditions, the confinement of individuals in state-run hospitals constituted a violation of their liberty without due process, an inalienable right for all others. This set the stage for the court rulings that would come to enshrine patients’ constitutional right to treatment.

In 1966, a young man named Charles Rouse was found not guilty by reason of insanity for carrying a weapon without a license, a misdemeanor carrying a maximum imprisonment of one year (Global Health and Human Rights, 2023). At the age of eighteen, he was involuntarily committed to St. Elizabeth’s Hospital in Washington, D.C. without a hearing (Rouse v. Cameron, 1966; Ferleger, Esq., 2023). Several years into confinement, Rouse filed a petition for habeas corpus (a legal protection that allows detained people to argue they are being held illegally) to challenge his captivity without adequate mental healthcare at the state hospital. The court held that a person hospitalized for mental illness in a public hospital is entitled to medical and psychiatry care and that a



hospital must always attempt to provide treatment “in light of present knowledge” and that a lack of staff or resources could not justify a “continuing failure to provide suitable and adequate treatment” (Rouse v. Cameron, 1966). The judge in the case became the first to recognize that an involuntarily and civilly committed psychiatric patient has a right to treatment and that the government holding that individual has an obligation to provide proper care. Rouse’s case represented a turning point in patients’ fight for their civil rights that showed a respect for patient autonomy and a sense of equity in access to psychiatric care when civilly committed.

Shortly after Rouse’s case was decided, a class action suit in Alabama challenged the horrific conditions of the state’s institutions for people with mental illness and intellectual disabilities. The unlikely precipitating factor for this litigation was a 1970 cut in Alabama’s cigarette tax, a tax that had long been earmarked for mental healthcare. The cut set layoffs in motion within the mental health system, including hundreds of staff members across the state’s hospitals. Seeking reinstatement of their jobs, many of the former staffers filed a class action lawsuit on the grounds that patients would receive inadequate treatment without appropriate staffing. To strengthen their position, they included Ricky Wyatt, a fifteen-year-old patient placed in the hospital by the court system, as a plaintiff (Disability Justice, 2023). The focus of the case shifted from the rights of the laid off staffers to those of the patients.

In 1972, *Wyatt v. Stickney*, 344 F.Supp. 387 (1972), led the federal court to rule in favor of involuntarily committed patients who suffered undue harm during their confinement due to mismanaged resources, understaffing, lack of therapeutic treatment, poor physical conditions and lack of general upkeep of the facilities. The court held that

involuntarily committed patients “unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition” (Wyatt v. Stickney, 1972).

Taking it further, Judge Frank Johnson determined it was necessary to set out explicit standards for state institutions to implement in order to effectively deliver both care and civil rights to all patients, regardless of disability or mental status. These standards became known as the Wyatt Standards, which stressed the right of all inhabitants to reside in the “least restrictive conditions necessary to achieve the purposes of habilitation,” and addressed the three principles of: individualized treatment plans, qualified staffing at objectively adequate ratios, and humane psychological and least restrictive environments (Disability Justice, 2023). Although the case circled around appeals courts for three decades – the longest running mental health lawsuit in US history – it led to sweeping reforms in American mental healthcare. From an unlikely beginning to a landmark decision, the Wyatt Standards remain a far-reaching legacy of this case because it created a set of minimum standards of care and rehabilitation for patients with mental and developmental conditions that is grounded in equitable access to adequate care, harm reduction with respect to appropriate staffing, and care that is benevolent and “least restrictive” at its core.

### Right to Refuse Treatment

Just as vital to patient autonomy as the right to treatment, is a patient’s right to refuse treatment. The right to refuse care is particularly important in the context of psychiatry and mental health care, where a patient’s autonomy and decision-making capacity may already be limited due to their mental status. In the course of history, this is

not a right that has been delivered openly to mentally ill patients. Yet, it remains true that this right is founded particularly on a respect for autonomy, beneficence, non-maleficence, and justice. When a patient's autonomy is taken under consideration, their right to refuse treatment promotes their empowerment and ownership of their own healthcare. When it comes to weighing the potential benefits of a given treatment against the promise of doing no harm, this shared decision-making power is invaluable to the therapeutic process. Finally, the principle of justice requires that patients with mental illness, whether involuntarily committed not, have the same rights and access to mental healthcare as other people. These principles were at the epicenter of several landmark cases that helped to establish the legal precedent that individuals with mental illness have the right to make decisions about their own care, and that healthcare providers must consider alternative treatments that may be less invasive and less harmful.

In the case *Rennie v. Klein*, 720 F.2d 266 (1983), a New Jersey court determined that an involuntarily committed patient who has not been deemed incompetent (barring emergencies) has a constitutional right to refuse psychiatric medication. In keeping with respect for patient autonomy, this is especially true in situations where forced medication violates the patient's First Amendment right to freedom of speech and religion, and Eighth Amendment right to be free of cruel and unusual punishment. In the case of forcible medication within emergency situations, due process must be followed to ensure that treatment is only administered if the medication is necessary to prevent serious harm to the patient or others.

In 1990, the case of *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028 (1990) addressed the issue of involuntary medication of criminal defendants deemed

incompetent to stand trial. In this case, a prisoner with bipolar disorder claimed that his forcible administration of antipsychotic medication violated his rights to due process, equal protection, and free speech. The court ultimately held that a state could administer medication to a nonconsenting but competent inmate given that due process by way of a court hearing, determined that administration was absolutely necessary.

More recently, in the 2003 *Sell v. U.S.*, 539 U.S. 166, 123 S.Ct. 2174 (2003), a court held that involuntary medication of criminal defendants is allowed only under certain circumstances, given that certain criteria are met to protect the defendant's constitutional rights. In this case, a dentist convicted of healthcare fraud was diagnosed with delusional disorder, without being a danger to himself or others. The court found however, he was not competent to stand trial in the absence of antipsychotic medication. The question of whether he could be forcibly medicated to become competent to stand trial was central to this case. In a 6-3 ruling, the U.S. Supreme Court held that the government could in fact, involuntarily administer antipsychotics to a criminal defendant with mental illness in order to make him competent to stand trial,

“but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests” (*Sell v. U.S.*, 2003).

Each of these cases brought into question similar ideals derived from our Constitution, while addressing unique circumstances and patients across various settings. Put together, these cases helped establish the legal precedent that individuals with mental illness – whether in voluntary or involuntary settings – have the right to refuse treatment,

and that involuntary medication is acceptable only if certain criteria are met to protect the patient's constitutional rights.

### Civil Commitment

Involuntary commitment often sits at the heart of the discussion around psychiatric patients' civil rights and liberties. One form of this is civil commitment, a legal process by which individuals with mental illness, developmental disability, or substance use disorder are involuntarily confined to a psychiatric hospital or institution (Reisner et al., 2009). Civil commitment is one means to ensure that individuals who pose a danger to themselves or others receive the treatment they need to prevent any future harm. However, the involuntary confinement of individuals has not been regulated by way of policy or objective standards throughout most of human history. This raises significant legal and ethical questions, including concerns about civil liberties, due process, and the potential for abuse by the state and other powerful actors. As a result, civil commitment has been the subject of several landmark cases in the United States that have shaped the way we protect patients' civil liberties and enact mental health policy.

Beginning in 1966, a judge in the case *Lake v. Cameron* ruled that a person who meets clinical standards for involuntary civil commitment cannot be confined in a state institution if an alternative treatment that is less restricting of their liberty exists (Lake v. Cameron, 1966). This case set a precedent that put the burden of providing alternatives to restrictive institutionalization on the government calling for the confinement. A subsequent case addressed not only the issue of civil commitment generally, but also set the specific legal parameters that must be satisfied for a patient to be committed. In

*Lessard v. Schmidt*, a federal district court provided patients in the process of civil commitment a broad array of procedural protections, including:

- Notice and opportunity to be heard
- Probable cause hearing within 48 hours of confinement
- Burden of proof beyond a reasonable doubt
- Right to counsel
- Privilege against self-incrimination
- Exclusion of hearsay evidence (*Lessard v. Schmidt*, 1972).

In 1975, *O'Connor v. Donaldson* further parsed out the criteria for involuntary commitment after Kenneth Donaldson was civilly committed at Florida State Hospital against his will for nearly 15 years (*O'Connor v. Donaldson*, 1975). He claimed that he was not dangerous or mentally ill, and that in all his years of involuntary confinement, he was not provided treating for any alleged mental illness. He argued that his treatment at the hospital constituted a malicious violation of his constitutional right to liberty, which the court sided with and an appellate court affirmed. The ruling set the precedent that the broad label of “mental illness” alone does not justify the indefinite involuntary confinement of an individual who is not otherwise a danger to themselves or others.

Similarly, in the 1979 *Addington v. Texas*, the Supreme Court recognized that civil commitment for any reason whatsoever, represents a substantial deprivation of liberty and thus, requires protection by way of due process. In this case, the court held that a “preponderance of the evidence” standard of proof was not a sufficient to satisfy due process in a proceeding for civil commitment. Instead, because involuntary confinement is such a significant violation of the right to liberty, a much higher “beyond

a reasonable doubt” standard of proof should be applied for a state to justify such a sentence (Addington v. Texas, 1979).

#### Putting it all together

In any society, it is important to balance the need for public safety with the protection of individual civil rights. In the case of patients who are mentally ill and significantly more vulnerable than the general population, their rights are constantly placed under a microscope. Because each patient’s case is so different and mental healthcare has changed so drastically from ancient civilizations to the advent of modern medicine, it wasn’t until relatively recently that objective standards for their care were established, taking their autonomy and overall well-being into account. It is a regrettable reality that landmark cases in mental healthcare that establish the proper standards of care and protection of patients’ civil rights must necessarily be preceded by egregious miscarriages of justice. To tip the scales in favor of justice for all patients, it takes a careful analysis of the existing precedents combined with current ethics and a commitment to advocating for and upholding the rights psychiatric patients. Only by continuously evaluating and improving upon the legal and ethical frameworks surrounding mental health care can we ensure that all patients receive the quality of care and respect they deserve.

The aforementioned landmark cases have played a significant role in establishing and protecting patient’s civil rights in mental healthcare, particularly in the areas of the right to treatment, right to refuse treatment, and civil commitment. The right to treatment ensures that patients receive appropriate care and services to help them recover, while the right to refuse treatment recognizes the importance of informed consent and patient

autonomy. Civil commitment laws balance the individual's rights with public safety concerns, allowing for involuntary hospitalization only when absolutely necessary, and the use of the least restrictive measures whenever possible. These cases and the rights they established have greatly impacted the treatment of psychiatric patients and continue to shape the field of mental healthcare in the U.S. today. It is crucial to acknowledge that the establishment of patients' rights on paper is only one step on the path towards delivering justice. The onus of ensuring these rights in practice rests on the collective responsibility of mental healthcare providers and policymakers alike.



## CHAPTER 5: FUTURE DIRECTIONS

In order to chart a course towards a better, more just future, it is imperative that we have a clear understanding of the past to be able to use this knowledge to inform our actions in the present. The evolution of medical practice and ethics is a constant. What may be considered acceptable or even commonplace one day may later be viewed as outdated or bizarre, much like how we now view the practices of bloodletting and lobotomy. It is therefore essential for bioethicists, scientists, and lawmakers to continually anticipate and adapt to the changes that the future will bring to ensure that advancements in medicine continue to uphold and keep pace with the ethical principles of the time. As psychiatry continues to advance, several novel areas of interest are emerging that deserve the attention of bioethicists, legal professionals, and physicians alike, including the following:

### Public mental healthcare policy

With the CDC estimating that a conservative 1 in 5 Americans experience mental illness each year, the need to shape policy that supports better access to mental healthcare for all remains one of the most pressing concerns for the future of psychiatry (CDC, 2021). For example, recently, the National Suicide Prevention Lifeline Improvement Act of 2020 established a three-digit hotline (988) for mental health emergencies. While this was undoubtedly a step in the right direction, from a bioethics standpoint, further efforts are needed to ensure that this new hotline is properly funded, staffed, and integrated with the appropriate mental health resources to ensure equitable access for all (SAMHSA, 2023).

## Social media and telepsychiatry

Social media platforms such as Twitter, Facebook, Instagram, and TikTok have been used by patient advocates and mental health professionals alike to raise awareness of mental health issues and connect patients with much-needed resources and support. The pandemic famously expedited the expansion of telehealth services, which have emerged as a critical tool for providing mental healthcare to patients who may not have access to traditional in-person care due to location or disability status. However, when it comes to the adoption of telepsychiatry, there are still significant barriers to care, such as limited access to technology and reimbursement policies that are not yet fully developed. In effect, social justice and equity in care cannot be served to its fullest extent when the underlying technological, economic, and education barriers to telehealth go unaddressed. Future efforts must focus on overcoming these barriers and expanding the use of telehealth and social media to enhance mental health advocacy and care delivery.

## Precision Medicine

Personalized medicine is a major budding field in medicine that represents an invaluable opportunity to tailor treatment to an individual's unique genetic and biological characteristics. For the future of psychiatry, the ability to utilize genetic testing, brain imaging and other technologies will make it possible to identify subgroups of patients who may respond better to specifically tailored treatments. Although psychiatry has never been amenable to a one-size-fits-all approach, incorporating precision medicine into clinical mental health could lead to more effective and efficient treatment options, while also upholding patient individuality, autonomy, and agency to make the most informed decisions about their own health with all the relevant data at their hands. Conversely, the

cost of personalized medicine is yet to be seen. If history is any indication, it is likely to be prohibitively costly, and has the potential to exacerbate existing social inequalities if certain classes of people are excluded from access to this new technology. Advancements in technology must not be divorced from social conscience or the desire to benefit all. While the technology of precision medicine itself is a significant leap in the advancement of medicine, it is vital that as technology advances, so too should social policy and equitable access to care.

### Use of AI & VR

The incorporation of artificial intelligence and virtual reality in mental healthcare is an area of rapidly expanding research. The use of AI lies in its power to analyze large sets of data rapidly, predict treatment outcomes, diagnostic accuracy, develop personalized treatment plans, and help identify patterns in speech, facial expressions, and behavior. But the fact remains that trust in AI will be a challenge to foster as its utility must be balanced with the real-life clinical judgement of practitioners who have been in the field for years. The use of VR in exposure therapy for anxiety disorders, phobias, and PTSD has already shown promise (Abramowitz et al., 2019). However, the use of AI and VR in medicine also raises important and valid ethical concerns.

When it comes to algorithms designed by people, there is the potential for technology to perpetuate the biases of their creators or exacerbate existing health disparities and social determinants of health if they are not properly implemented. This risk arises from the notion that algorithm creators might unintentionally embed their own biases into the technical design of the algorithm. Moreover, as with any new AI algorithm, the first sample population that will partake in the machine's learning process

may not be fully representative of the larger population, leading to a skewed view of the pathologies and general population. It may come back down to stereotypically diagnosing all women with anxiety without considering medical causes or prescribing more black patients with antipsychotics, except instead of doctors showcasing their biases, it will be machines. In effect, machine learning algorithms that are not fully tested and refined before public release could place their users and patients at risk of misdiagnosis or other negative health outcomes. For people with mental illness and other comorbidities, this will serve to make them more vulnerable to widening health gaps.

There are also significant concerns around data privacy, security, and surveillance when it comes to machine learning, particularly when it involves sensitive personal health information (PHI). PHI is highly sensitive, especially when it comes to confidential psychiatric and mental health records, and must be handled with the utmost care to avoid data breaches and security issues. Currently, as evidenced by questions around data privacy with respect to Meta, Twitter, TikTok and other social media platforms domestic and international, the United States does not have strong policies in place to protect citizens' privacy from data harvesting and exploitation. When it comes to PHI, the question of security is even more pressing as a JAMA study found that between 2016-2021, cases of ransomware attacks on US hospitals and clinics more than doubled, exposing the PHI of nearly 42 million Americans (Neprash, 2022). Questions around modern data privacy policy implementation continue to linger, as it remains unclear who owns the data used to train machine learning algorithms, and whether individuals have given their consent for their data to be used in this way.

Health disparities and the delivery of social justice will also hinge on the cost of AI. Presumably, AI-guided healthcare should make care more accessible and affordable when it is first released to the public – much like ChatGPT was initially equally open to all. Later, as the algorithm becomes more intelligent and establishes patterns based on its sample population, like ChatGPT, we might expect to see a tiered subscription model where premium service that combines AI with live providers is reserved for the wealthy, while those who may not be able to afford premium care might be more inclined to access AI health services only for their illnesses. In effect, their data and healthcare will be subject to the whims of a manmade algorithm and the government’s lack of expediency towards establishing appropriate data privacy policies, furthering health inequity, social injustice, and limits on patients’ agency.

At this time, the world of AI is shrouded in unknowns. As we learn more about these technologies and how they can be applied in the healthcare setting, careful attention must be given to the ethical implications around patients’ information, their agency and autonomy, healthcare costs, and the best available course for their treatment that balances human expertise with new tech.

### Looking Ahead

As we move forward in the field of psychiatry, it is imperative that we take a critical look at the historical injustices and ethical violations that have impacted countless vulnerable patients at the hands of medical professionals. But simply weaving and understanding an urban bioethics framework into the history of mental healthcare is not enough. It is incumbent on us to ensure that the principles of bioethics are at the forefront of the way in which we enact and effect policies going forward, and that these principles

inform our everyday medical practice. Legal precedents that came about as a reaction to injustice are there to guide us away from the same pitfalls again and to set the standards of care we must now uphold. From an overwhelming history rife with injustice, it is on us to build a future in which we not only protect, but actively deliver our patients' civil liberties, and uphold their rights to obtain or refuse treatment, even within the context of civil commitment. It is our responsibility as care providers to ensure that in our interactions with patients, we respect their autonomy and personhood; we act with not only benevolent intentions but also non-malevolence; and we provide access to mental healthcare in a manner that is fair and equal for all people, from all walks of life. The future of psychiatry holds great promise, and it is up to us to shape it in a way that is compassionate, ethical, and just.

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