COMMENTS AND NOTES

COMPULSORY COMMITMENT: THE RIGHTS OF THE INCARCERATED MENTALLY ILL

The passage of the District of Columbia Hospitalization of the Mentally Ill Act in 1965 and more recent legislative re-evaluations of state mental health laws manifest a developing concern over the plight of the mentally ill. However, though much attention has been focused on the commitment process, it has been noted that legislative and public concern often has stopped at the asylum door and has left the incarcerated mentally ill at the mercy of inadequate facilities, deficient treatment, and at times antiquated philosophies about mental illness. In addition to reviewing the commitment process as it now exists, this comment examines the "inner system" of mental health, isolates some of its major inadequacies, and evaluates current judicial and legislative attempts to improve the mental health picture inside the institution.

The current American attitude toward the phenomenon of mental illness is in many ways a reflection of the economic and social conditions of the latter eighteenth and nineteenth centuries. Indeed, it is an unfortunate commentary on our lack of medical and legal sophistication to note that current commitment procedures and institutional conditions manifest in great measure the "outworn popular misconceptions of the mentally sick or insane or either raving maniacs, dangerous lunatics, or gibbering idiots." Though often medically and legally unreasonable, contemporary approaches to mental health problems are understandable when viewed in the light of historical antecedents.


3 Green, Public Policies Underlying the Law of Mental Incompetency, 38 Mich. L. Rev. 1189 (1940), suggests that the harsh treatment of insane persons which occurs is due in part to
It has been noted that the attitudes and modes of treatment prevalent in early America were not peculiar to the colonies, but rather grew out of conditions in the old world. Nevertheless, a study of the care and treatment accorded the mentally ill during the colonial period reveals the hopeless confusion then prevailing, for certainly neither the nature nor proper treatment of mental disease was understood. Although the first American asylum exclusively for the mentally ill was opened in 1773 at Williamsburg, Virginia, an actual therapeutic approach to mental illness was many years away, and mere custodial confinement, much like that afforded to indigents and petty criminals, marked the extent of society's benevolence. It was not until the beginning of the nineteenth century that mentally ill persons first came to be seen as sick rather than cursed and as susceptible to aid through proper treatment. By 1830 eight states had established special institutions for the insane.

However, despite such advances these few institutions could accommodate but a small fraction of the total number of persons suffering from mental diseases, and the cheap design of the physical plants often disregarded essential details of construction and equipment. Perhaps the most serious problems concerned the anachronistic conception of the dualism of mind and body embraced by "psychiatrists" of earlier periods and which unfortunately in many ways "rules us from the grave." See generally Deutsch, supra note 1.

1 It has been noted that "[d]uring the witchcraft delusions in Salem and elsewhere, the mentally ill were hanged, imprisoned, tortured, and otherwise persecuted as agents of Satan. Regarded as sub-human beings, they were chained in specially devised kennels and cages like wild beasts, and thrown into prisons, bridewells and jails like criminals. They were incarcerated in workhouse dungeons, or made to slave as able-bodied paupers, unclassified from the rest. They were left to wander about stark naked, driven from place to place like mad dogs, subjected to whippings as vagrants and rogues. Even the well-to-do were not spared confinement in strong rooms and celler dungeons, while legislation usually concerned itself more with their property than their persons." Deutsch, supra note 1, at 53.

2 "Treatment" offered the mentally ill during colonial America was limited. "The violent mentally ill were . . . accorded the treatment applicable to criminals generally, which consisted of detention in jails. The non-violent and indigent insane, on the other hand, were treated in the same fashion as were all other paupers, by being provided with food and shelter. . . . [T]hese practices took notice of the distinctive character of the mentally ill as a class, and it was only after mental institutions became prevalent that commitment to them finally introduced a system designed especially for the mentally ill." Kittrie, Compulsory Mental Treatment and the Requirements of "Due Process," 21 Ohio St. L.J. 28, 31 (1960) [hereinafter cited as Kittrie].

3 Deutsch, supra note 1, at 112.

4 A poor institution for the insane, it was believed, was better than none at all. Consequently, hell-holes and "Bedlams" were tolerated as providing at least a modicum of care for the mentally ill, while serving to protect society. Id. at 141-42.
informal commitment procedures which then existed and the abuses which developed from them.\textsuperscript{8} Under such statutes arose the most famous of the nineteenth century “railroading” cases, that of Mrs. E.P.W. Packard, who was committed in 1860 by her minister husband to the Illinois State Hospital as “insane and distracted.”\textsuperscript{9} Detained there for three years, she finally procured her own release through habeas corpus proceedings and immediately began a vigorous campaign for increased legal protection against wrongful commitment.\textsuperscript{10}

Unfortunately, legislative attempts to cure these deficiencies, particularly the problem of improper commitments, manifested themselves in statutory enactments which demonstrated some degree of overreaction.\textsuperscript{11} Highly technical procedures, which for the first time included judicial supervision and control, replaced the previous informality. The Illinois “personal liberty” bill of 1867, for example, provided that no person should be committed without a jury trial and that all persons then in state hospitals be given a jury trial to ascertain their mental condition.\textsuperscript{12} This emphasis on

\textsuperscript{8} The informality of commitment procedures during this period led to numerous cases of wrongful commitments. When the early asylums were first established commitment was achieved with great ease, with little concern for the personal rights of the individual. For some time, lack of legislative supervision and absence of public recognition permitted such inequities to continue. See Curran, Hospitalization of the Mentally Ill, 31 N.C.L. Rev. 274, 277 (1952).

\textsuperscript{9} Mrs. Packard was committed under the 1851 Illinois commitment statute, which provided that “married women and infants who, in the judgment of the medical superintendents of the state asylum at Jacksonville are evidently insane or distracted, may be entered or detained at the request of the husband or the guardian of the infant, without the evidence required in other cases.” Ill. Laws 1851, § 10, at p. 96, 98. See Kittrie, supra note 5, at 33.

\textsuperscript{10} Mrs. Packard, in both books and lectures, sought the introduction of many of the formal legal safeguards of criminal due process into the field of mental health, including the right to a hearing and a jury trial in determining the question of insanity. See Kittrie, supra note 5, at 34.

\textsuperscript{11} The reasons for such overreaction are clear when the journalism and public opinion of the 1860's are considered. For example, one Charles Reade, “a sensationalist writer of the time . . . published a book called Hard Cash which made its appearance in America in 1860. It told the lurid tale of a rich young man who was committed to an insane asylum by his business associate who had designs on his fortune. . . . The law under which the young man was committed gave him little protection. The novel was highly successful and a public clamor for safeguards in the law against wrongful commitment was raised throughout this country and England.” Curran, supra note 8, at 275.

\textsuperscript{12} The Illinois “personal liberty” bill of 1867, enacted primarily as a result of the efforts of Mrs. Packard, replaced the very lax act of 1851. See note 9 supra and accompanying text. See DEURSCH, supra note 1, at 426.
the judicial process and the borrowing of procedural safeguards from the criminal law, which continued into the first half of this century, in many respects served a valuable function. Much-needed legislative attention was finally directed toward some of the more glaring inequities of the mental health system, and public concern was newly aroused. However, despite the changing judicial and legislative climate, deficiencies persisted, and even in Illinois, where Mrs. Packard's campaigns were most successful, the jury trial procedure resulted in more commitments of sane persons than under previous procedures. Furthermore, these statutes, though much concerned with the commitment process, failed to devote sufficient attention to the rights of the individual while in the asylum with legislative concern often stopping at the hospital door.

Recent years have witnessed a growing disenchantment with the judicially-enforced, criminal law oriented procedures for mental commitment, and some states have abandoned the jury trial altogether. In addition, statutes more attuned to the unique needs

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13 See Kadish, A Case Study in the Signification of Procedural Due Process—Institutionalizing the Mentally Ill, 9 W. POLITICAL Q., 93, 103-06, 112-15 (1956). For an eloquent statement see In re Lugo's Guardianship, 172 N.Y.S.2d 104 (Ct. Cl. 1958). "The history of past misdeeds towards and mishandlings of person and property of alleged incompetents has too often been so offensive to the conscience of man that today we revolt against any thing or occasion that could even resemble the past. We readily suspect that were this not the case, many feeble- or weak-minded persons could be incarcerated in a mental institution and be prevented from the exercise of their own free will over their own possessions . . . ." Id. at 108.

14 Curran, supra note 8, at 276. The judicial attitude which often led to the abuse of the commitment process is exemplified in Martin v. Beuter, 79 W. Va. 604, 91 S.E. 452 (1917), in which the Supreme Court of Appeals of West Virginia, addressing itself to a statute which permitted guardianship as an alternative to commitment, stated that such a provision was not to be considered a mere means of regaining liberty, for insane persons "have no constitutional or statutory right of liberty in the ordinary sense of the term." 79 W. Va. at 607, 91 S.E. at 453-54; accord, Maxwell v. Maxwell, 189 Iowa 7, 177 N.W. 541 (1920) (the right to restrain an insane person is not governed by the general law which provides that no person shall be deprived of life, liberty or property without due process of law). See generally Weihofen, Commitment of Mental Patients—Proposals to Eliminate Some Unhappy Features of Our Legal Procedure, 13 ROCKY MT. LAW REV. 99, 105-06 (1941). An unfortunate aspect of borrowing procedural devices from the criminal process is that it has often "resulted in statutes that do more to prevent witch hunts than to aid the mentally ill, that handcuff psychiatrists, and that brand the patient with the stigma attendant upon public trial employing terminology common to criminal prosecution." Project, Civil Commitment of the Mentally Ill, 14 U.C.L.A.L. REV. 822, 824-25 (1967).

15 1961 Hearings, supra note 2, at 1, 2.

16 See, e.g., In re Fehl, 159 Ore. 545, 81 P.2d 130 (1938) (in lunacy inquisition, the
of the specific patient have been developed, thus evidencing a legislative sensitivity for the traumatic effect which formal proceedings may have on the person. However, this trend toward more informal, administrative proceedings has not had the prophylactic effect hoped for, and commitment in most states remains “unsound, archaic, and even vicious in . . . operation.”

The combination of police, jail and court has been recognized as capable of inflicting incalculable harm on the patient and gravely impeding his chances of recovery.

Once inside the institution the patient’s plight often worsens, due in part to the overcrowding of existing facilities created by the annual admission of more than 500,000 people—approximately ninety percent of whom are committed through the compulsory process. Furthermore, in spite of varying approaches taken by the individual states, no state mental health system today meets the defendant is not entitled to a jury trial as a matter of law). See generally Curran, supra note 8. Most jurisdictions, however, have chosen not to eliminate the use of jury trials during commitment proceedings, but rather have made its availability dependent upon the request of the patient or his counsel. See ILL. REV. STAT. ch. 91 1/2, § 9-2 (1967) (patient, his spouse, any relative or friend, or an attorney appearing for any of them may demand a jury trial on the question of need for mental treatment); TEX. REV. CIV. STAT. art. 5547-48 (1957) (jury trial if not waived, or on demand by proposed patient or his attorney). See also Swinford v. Logue, 313 S.W.2d 547 (Tex. Civ. App. 1958) (denial of jury trial upon original commitment for mental illness or in restoration hearing is unconstitutional).

In Illinois, ILL. REV. STAT. ch. 91 1/2; § 9-4 (1967), and Texas, TEX. REV. CIV. STAT. art. 5547-49, presence at the commitment hearing is made discretionary with the patient. Other jurisdictions permit the holding of the hearing in a place other than a courtroom, a provision which tempers the inquisitorial nature of the proceeding and makes it a less traumatic experience for the patient. Presently twenty-five states allow the hearing to be held at any place selected by the court. 14 U.C.L.A.L. REV. 822, supra note 14, at 852, 874-75.

1961 Hearings, supra note 2, at 43. Some writers, adhering to the familiar “due process” arguments, have contended that a few legislatures have gone too far in “liberalizing” admission procedures to mental institutions. One such critique was leveled at the 1960 amendments to section 73(a) of the New York State Mental Hygiene Law. This legislation permitted commitment without a court order without requiring verified petitions. The critic called for a re-examination of the trend away from judicial-like safeguards. DeCain, Commitment Procedures and the Non-Mentally Ill, 33 N.Y.S.B.J. 151 (1961).

1961 Hearings, supra note 2, at 43.

“Recent studies . . . attest to the continuance of the stripping of the patient, loss of his individuality, and dignity, depersonalization, and demoralization. The chronically acute shortage of physicians in most wards makes the term ‘psychotherapy’ a hideous mockery for most patients.” Id.

LINDMAN & McINTYRE, supra note 1, reviewed, Curran, 75 HARV. L. REV. 1252, 1253 (1962). Each year, more than one million patients are treated in mental institutions, which is more than five times the prison population. As a result, more than half of all available hospital beds are presently occupied by mental patients. 1961 Hearings, supra note 2, at 329.
minimum staffing and facility requirements set by the American Psychiatric Association.22

Finally, in addition to the physical deficiencies of present systems, public opinion concerning mental illness, replete with beliefs reminiscent of the colonial experience, presents further difficulties. The inefficacy of statutory relabeling in the past few years should be sufficient indication that a mere reconstruction of psychiatric or statutory nosology will not eradicate the stigma which has attached to mental illness and institutionalization.23

Greater advances can be made if emphasis is placed on the creation of humane hospitalization laws24 which would not only provide the requisite protection for society, but would also accord with the limited resources presently available and be sensitive to the unique needs of the individual. Through an analysis of the existing inadequacies of the American mental health system, this comment, in addition to assessing the present stature of the commitment process, will critically review the current legislative-and judicial thought surrounding the rights of the mentally ill during incarceration.

THE COMPULSORY COMMITMENT PROCESS

Philosophical Bases

Although an individual is not subject to imprisonment until his criminal transgression is proved beyond a reasonable doubt,25 sovereign power has been exercised for centuries to confine the mentally ill through procedures which demonstrate a negligible

22 As of 1958, it was noted that only 15 states had more than 50% of the total number of physicians needed to staff the public mental hospitals according to APA standards. On the national average registered nurses are calculated to be only 19.4% adequate, social workers 36.4%, and psychologists 65%. Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 Am. J. Psychiatry 1, 7 (1958). In the ten years since that report the number of patients in mental institutions has increased by 187%, without an equivalent increase in physician staffing. Curran, *Community Mental Health and the Commitment Laws: A Radical New Approach is Needed*, 57 AM. J. PUBLIC HEALTH AND THE NATION'S HEALTH 1565 (1967). An enlightening treatment of current manpower needs and possible sources for the future is presented in Kubic, *The Overall Manpower Problem in Mental Health Personnel*, 144 J. OF NERVOUS AND MENTAL DISEASE 466 (1967). The author suggests "middle-older" people as an untapped source.


24 Curran, supra note 8, at 289.

degree of rigor. Much like criminal imprisonment, commitment entails the restriction or loss of basic civil liberties and subjection to the regimens of custody and control. Unlike imprisonment, commitment primarily serves medically therapeutic, non-punitive purposes, and theoretically physical control is utilized only when necessary to further treatment. Thus, some of the justifications for commitment for mental illness necessarily differ from the reasons which support imprisonment. Today, two grounds, often indistinguishable in statutes and judicial construction, are most often cited to support state-imposed civil confinement. The first rationale, the notion of *parens patriae*, is based on society’s right, if not its duty, to care for those persons who because of their mental disorders are incapable of caring for themselves. The second ground, that of police power, is based on a theory of preventive detention—that some persons, though innocent of any criminal act, are considered so dangerous that they must be

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26 Definitions, "commitment" in the context of this comment refers to compulsory or involuntary detention in an institution designated as a mental hospital. See Szasz, supra note 23, at 39. Such commitments are typically of the judicial variety, and can be further broken down into two classes: "immediate, issuing out of a magistrate's court, and formal, arising in ... the general court of original jurisdiction." S. Pearlstein, Psychiatry, The Law and Mental Health 62-64 (1967).

Although possessing punitive elements, it should be remembered that imprisonment theoretically serves rehabilitative purposes as well. See generally Weihofen, Treatment of Insane Prisoners, 1960 ILL. L.F. 524.

27 Comment, Civil Restraint, Mental Illness, and the Right to Treatment, 77 Yale L.J. 87 (1967).

28 E.g., Hook v. Simes, 98 N.H. 280, 98 A.2d 165 (1953) (inquiry into the competency of a person and the appointment of a guardian is a proceeding by the state in its character of *parens patriae*, based on its interest in the welfare of the alleged incompetent); United States ex rel. Grove v. Jackson, 16 F. Supp. 126 (M.D. Pa. 1936) (it is fundamental that the state is *parens patriae* of the insane).

29 The necessity for distinguishing between psychologically-based mental disorders and those of a physiological origin has been ably dealt with by Thomas Szasz. T. Szasz, The Myth of Mental Illness: Foundations of a Theory of Personal Conduct (1961). Szasz has noted elsewhere that "the expression 'mental illness' is a metaphor which we have come to mistake for a fact. We call people physically ill when their body-functioning violates certain anatomical and physiological norms; similarly, we call people mentally ill when their personal conduct violates certain ethical, political, and social norms." T. Szasz, Law, Liberty and Psychiatry 17 (1963).

30 E.g., Porter v. Ritch, 70 Conn. 235, 39 A. 169 (1898) (insanity proceedings are an exercise of the police powers of the state). See generally Ross, Commitment of the Mentally Ill: Problems of Law and Policy, 57 Mich. L. Rev. 945, 954-60 (1960); Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 79 Harv. L. Rev. 1288 (1966); 77 Yale L.J. 87, supra note 27.
Confinement is thereby utilized to protect society against a probability of prospective harm, a restraint which seems constitutionally justified only so long as the danger exists.\(^{32}\)

From these sources of state power to commit and confine, the courts and legislatures have developed three standard criteria for involuntary commitment. Dangerousness, a direct derivative of police power, is a legal basis for commitment in fourteen states.\(^{33}\) Perhaps the greatest difficulty under this criterion lies in determining what degree or type of behavior should make a person's freedom unacceptable and therefore statutorily "dangerous."\(^{34}\) While recidivism and repeated acts of violence present viable measures, such standards, legislatively designed to facilitate uniform application, thus far have not been forthcoming.\(^{35}\) Furthermore, if the ideas of preventive detention fostered under these "dangerousness" criteria are to be logically consistent, some means for determining a person's potential for antisocial acts must be developed. Once harm has been inflicted, it would appear that much of the justification for the use of such civil commitment statutes has disappeared.\(^{36}\) Thus, subtle, before-the-fact criteria will

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\(^{31}\) See 77 Yale L.J. 87, supra note 27.

\(^{32}\) See Ross, supra note 30, at 956. The connotative differences between the \textit{pars pro toto} and the police power bases for commitment have been recently explored. "Preventive detention sounds bad; it conflicts with our traditions and seems constitutionally dubious. Our natural reaction is that if we are to allow such restraint at all the occasions for it must be carefully defined—as the elements of a crime usually are—and it must be implemented under procedures which assure careful protection for the rights of the person affected."

"Treatment, on the other hand, sounds good; when we restrain a man to treat him, we act for his own benefit; we decide for him as we assume he would decide for himself if he were of sound mind. With benevolent intent assumed, definition of standards and procedural protections seem less important." 77 Yale L.J. 87, supra note 27.

\(^{33}\) See 14 U.C.L.A. Rev. 822, supra note 14, at 822, 872-73 (1967) (the fourteen states which have statutes based on dangerousness are Arizona, California, Connecticut, Florida, Idaho, Kansas, Maine, Massachusetts, Missouri, Montana, Rhode Island, South Carolina, Utah and Washington).

\(^{34}\) See 79 Harv. L. Rev. 1288, supra note 30, at 1291.

\(^{35}\) As to the use of "recidivism" as a guide see Dodd v. Hughes, 81 Nev. 43, 398 P.2d 540 (1965), in which the court declared its doubts "that the legislature ever intended medical classifications to be the sole guide for judicial commitment . . . . Recidivism, repeated acts of violence, the failure to respond to conventional penal and rehabilitative measures, and public safety, are additional and relevant considerations for the court in deciding whether a person is mentally ill." 81 Nev. at 46, 398 P.2d at 542. On the question of statutory standards see Livermore, Malmquist & Mehl, \textit{On the Justifications for Civil Commitment}, 117 U. Pa. L. Rev. 75 (1968).

\(^{36}\) Following the occurrence of a substantial antisocial act such as a crime, society may
have to be developed before these statutes can fulfill their intended purpose. Neither a post-hoc nor "gut-reaction" approach should be accepted. Following a similar line of reasoning one commentator has suggested that a rigorous test of potential dangerousness combined with a "clear and convincing" standard of proof might be the most valuable approach. Thus, antisocial tendencies of psychological origin would have to be heavily documented and medically supported to indicate such a Weltanschauung that commitment would become a statutory necessity.

The Supreme Judicial Court of Massachusetts in 1845 suggested a second criterion for involuntary hospitalization—the patient's need for care and treatment. The increasing popularity of this standard is no doubt due to its idealistic connotations. From the very best of motives, society desires to alter an aberrant person's behavior and bring him closer to the "norm." Unfortunately, involuntary commitment achieved under such a standard may unwittingly be reduced to an almost summary process because of such good intentions. Therefore, to protect against wrongful commitments, exacting definitions of what constitutes a "need for treatment" are necessary. Presently, a number of statutes which prescribe commitment on this basis are poorly and ambiguously worded, and courts have been forced to rely heavily on inaccurate
psychiatric classificatory schemes. Further problems develop when
states that hospitalization may follow if a physician's report demonstrates that the person is
such broad statutory language, commitment may often depend on the particular school-orientation of the examining physician. As a result, different consequences may follow, not
due to statutory variation, but rather due to the philosophical variations among physicians.
Thus, it has been suggested that because "[p]sychiatry is primarily an art rather than a
science, [and] [i]n order to emphasize to the participants in the decision making process that
the questions are essentially social, the statutes defining mental illness should be phrased in
non-psychiatric terms and the expert witnesses should be required to testify in terms of social
facts and predictions rather than in psychiatric terms." Ross, supra note 30, at 961, 963.
Furthermore, mere conclusory statements of an individual's condition, though phrased in
statutorily-prescribed terms, should not be permitted to obscure the necessity for a
substantial basis for institutionalization. Inquiry into the probability of successful treatment,
the probable duration of confinement, and the specific examples of indicative symptoms and
behavior should be made before the otherwise meaningless statutory criterion of "need for
treatment" is invoked. In addition, the individual should be accorded ample opportunity to
rebut "state expert witnesses" by being provided with medical representation of his own. See
notes 91-97 infra and accompanying text. In an area as undefined as this, the "patient"
should be able to effectively challenge those who rely on statutorily-provided conclusions
such as a "need for treatment."

42 To understand the complexities facing any court which receives psychiatric testimony in
the professional "parlance" one need only refer to HINSHIE & CAMPBELL'S PSYCHIATRIC
DICTIONARY (3d ed. 1960) in which literally scores of supposed mental maladies are given
such nomenclature as confabulation (the act of replacing memory loss by phantasy or by
reality that is not true for the occasion); hysteria (characteristic features of which are a
physical manifestation without structural lesion and dissociation of mental and bodily func-
tions); schizophrenia (commonly known as the split-personality syndrome); and the more com-
mon terms of id, ego, superego, neurosis, psychosis, functional psychosis, complexes and so on.
The artificiality of such conceptual nosology becomes abundantly clear when one considers the
differing import given these conditions by classical psychoanalysis, the interpersonal school,
the cultural school, individual psychology, analytical psychology, the behaviorists, and the
group therapists. For example, whereas the typical classical Freudian views aberrant behavior
as merely symptomatic, and indicative of an underlying disorder, the behaviorist would view the
symptoms themselves as the disorder and believe that alleviation of the behavioral "aberrancy"
will eliminate the disorder itself, and that no underlying disorder in fact exists. See S. Pearl-
"One need only glance at the diagnostic manual of the American Psychiatric Association
to learn what an elastic concept mental illness is. It ranges from the massive functional
inhibition characteristic of one form of catatonic schizophrenia to those seemingly slight
aberrances associated with an emotionally unstable personality, but which are so close to
conduct in which we all engage as to define the entire continuum involved. Obviously, the
definition of mental illness is left largely to the user and is dependent upon the norms of
adjustment that he employs. Usually the use of the phrase 'mental illness' effectively masks the
actual norms being applied. And, because of the unavoidably ambiguous generalities in
which the American Psychiatric Association describes its diagnostic categories, the
diagnostician has the ability to shoehorn into the mentally diseased class almost any person
he wishes, for whatever reason, to put there." Livermore, Malmquist & Meehl, supra note
35, at 80. See also Dershowitz, Psychiatry in the Legal Process: A Knife that Cuts Both
the propriety of commitment for purposes of treatment is considered in the context of present institutional conditions. Arguably, if the theory of curative commitment is to be constitutionally valid, the validity of any particular commitment must depend on whether the person will receive proper and substantial care and treatment while hospitalized. Modern experience indicates that this requisite is seldom fulfilled.

A third criterion for commitment, though the least prevalent, is that of welfare of self or others, and ranks as the most ambiguous and difficult standard to apply. Whereas statutes which adopt the dangerousness criterion are often complemented by the inclusion of the need for treatment standard, welfare is sufficiently broad to absorb both standards and more. Obviously, such a broad rubric can accommodate both police power and parens patriae bases. But such language, due to its ambiguity, may be unusually susceptible to abuses, such as the attempted commitment of persons by unscrupulous relatives or business associates for personal gain or benefit and the aggravation of institutional deficiencies due to increased numbers of commitments.

In light of these considerations, it is not surprising that the law

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\(^{a}\) See Kubic, supra note 22.

\(^{b}\) See Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960). "The principal barriers to effective treatment are inadequate financing, an acute shortage of hospital beds and equipment, in some states a poorly designed administrative structure for the state hospital system, and most of all, lack of trained personnel." Ross, supra note 30, at 1001-02.

\(^{c}\) As of 1967, eight states had statutes which made provision for the issuance of a hospitalization order if it was found that such commitment was necessary for the welfare of the person himself or others. See, e.g., Ala. Code tit. 45, § 205 (1959): "A person shall be adjudged insane who has been found by a proper court sufficiently deficient or defective mentally to require that, for his own or others' welfare, he be moved to the insane hospital for restraint, care and treatment." [Emphasis added.]

\(^{d}\) See notes 38-44 supra and accompanying text.

\(^{e}\) For example, those persons suffering from a disease of the aged—such as a cerebrovascular disease and accompanying cerebral impairment (senility)—may well be candidates for incarceration for their "own welfare" while being neither dangerous nor treatable. It would seem that if the state wishes to intervene in such cases it should do so in a manner which does not involve a total loss of freedom. The desire to "help" ought not to take the form of simple jailing. See Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966), for one court's opinion as to remedial alternatives to jailing in such a case.

\(^{f}\) See, e.g., In re Lugo's Guardianship, 172 N.Y.S.2d 104 (Ct. Cl. 1958).

\(^{g}\) The District of Columbia Hospitalization of the Mentally Ill Act, see notes 98-100 & 113 infra and accompanying text, indirectly decreased institution population by restricting commitment to "dangerous" mentally ill. See Note, The District of Columbia Hospitalization of the Mentally Ill Act, 65 COLUM. L. REV. 1062, 1069 (1965).
of involuntary commitment is confused and contradictory when the desire to obtain treatment for sick persons conflicts with the need to prevent unjust deprivations of liberty. However, only through a weighing of such conflicting policy considerations will valid definitional and functional criteria for commitment be developed. These goals, though incompatible in many respects, are not mutually exclusive. Idealistic connotations should not be permitted to obscure the difficult constitutional and other legal problems confronted when state action seeks to deprive an individual of his liberty.

Procedural Devices

Developments in commitment legislation since 1860 have borrowed heavily from the criminal law as a procedural model: The older commitment statutes demand sworn complaints, jury trials, open court hearings, and the recitation of formal charges. Under these laws, "the walls around the mental hospitals were built high." Although formidable obstacles were created to prevent improper admissions, little notice was taken that such statutes also made it difficult to get out, and thus, institutions often became custodial warehouses, especially for psychotics from the lower socio-

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20 It has been noted that commitment, as a form of social control, necessarily involves certain policy considerations which must be considered with respect to the constitutional and statutory bases for compulsory hospitalization. Some of the principal policy questions have been isolated: (1) the degree or type of social-adaptive failure which should be required to justify hospitalization against the wishes of the individual; (2) how this standard should be incorporated in legal procedures so that the policy reasons behind the standard will be effectuated and the individual still protected against unwarranted deprivation of his liberty; and (3) the effect, if any, that compulsory hospitalization should have on the legal rights of the individual, other than his loss of personal liberty. Ross, supra note 30, at 955.

Different considerations are present when commitment is not based on the need to treat. If one is committed as dangerous, or as a nuisance, or as unable to care for oneself, and treatment can cure this condition, then it is easier to strike the balance between deprivation of liberty and the right to refuse treatment in favor of compulsory treatment. If told that this is the price of freedom, the patient may accede; if he prefers confinement to treatment, perhaps the state ought not to override his wishes. But at least in this situation the question is ethically a close one.

"The difficulty with present commitment procedures is that they tend to justify all commitments in terms that are appropriate only to some, and to prescribe forms of treatment that are necessary in only some cases." Livermore, Malmquist, & Meehl, supra note 35, at 95.

22 Id. at 1566.
economic classes. Following this period of custody rather than cure, attention was directed away from criminalistic terminology and jury trials, and reforms permitting easier access to mental hospitals became increasingly popular. This newly focused concern resulted in 1950 in a "Draft Act" composed under the auspices of the National Advisory Mental Health Council and submitted to the state governors. More recently, legislation has developed which recognizes the difficulty of gaining freedom from the mental hospital.

Yet, despite this continuing evolution of commitment law, none of the existing statutes make a radical break with the basic structure of the "Packard Laws." All prescribe rigid procedures for commitment and sacrifice even a limited flexibility to meet individual needs in order to codify precise methods of handling all patients. The variations in methodology which apparently distinguish between states' procedural approaches are often superficial and are more realistically seen as idiosyncracies in a few basic commitment schemes. Moreover, since few problems in this

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23 Id. (Curran notes that the deficiencies under the early systems were especially harsh on the poor, and "the larger the hospital, the worse the conditions.")


The Draft Act eliminated criminalistic terminology and jury trials, and advocated voluntary admission and adoption of a nonjudicial procedure under which a patient could be confined without notice or a chance to protest before a court or other tribunal. Constitutional rights were ostensibly protected by the right to protest after confinement. Curran, supra note 22, at 1566.

25 In several states judicial commitment may be challenged through appeal, e.g., CONN. GEN. STAT. ANN. § 17-202 (1958), GA. CODE ANN. § 88-1606(j) (1963), IOWA CODE ANN. § 229.17 (Supp. 1968), MINN. STAT. ANN. § 246.55 (Supp. 1968); or through a special form of judicial review, e.g., N.D. REV. CODE § 25-03-17 (1959), OKLA. STAT. ANN. tit. 43A, § 75 (Supp. 1968), TEX. REV. CIV. STAT. art. 5547-53 to -54 (1958); or at least through an enlarged habeas corpus hearing with opportunity to review the patient's mental condition at the time of hospitalization or at any subsequent occasion, e.g., S.D. CODE § 30.0111 (1939).

26 See note 9 supra and accompanying text.

27 See Curran, supra note 51, at 1567.

28 Despite the apparent uniformity which exists among the state statutes, procedures for compulsory hospitalization are divisible into three basic patterns. The distinguishing feature is the agency that has final responsibility for the determination of the need for commitment and the making of the commitment order. Thirty-four states require a judicial hearing and the issuance of an order before commitment may be made. While not departing from the
field are projected beyond state boundaries, uniform legislation, often a cure for the statutory inadequacies of a federal system, is not necessarily a proper solution for the deficiencies of mental health laws. However, it has been noted that the impact of commitment on legal capacity to contract, and the increased number of Veterans Administration patients, most of whom are committed under state statutes, indicate a need for some degree of uniformity.

The Due Process Consideration. Historically, arguments have been offered that the introduction of strict formalities has made treatment less accessible and retarded the development of the mental health system. However, much has been written in recent years on the effectiveness of various procedural methodologies in preserving due process. Although the present trend is toward more relaxed and less technical quasi-judicial and administrative procedures, several authorities have persisted in arguing that the incorporation of legal principles into this area is of great importance and that legal guarantees are necessary whenever society sets out to deprive its members of their liberty or property, whether in criminal or commitment cases.

As to the desirability of uniform legislation among the states in respect to the hospitalization of the mentally ill, the American Bar Association's special committee on the rights of the mentally ill has concluded that the subject of commitment does not advantageously lend itself to a uniform state law. See Ross, supra note 30, at 947.

The most frequently stated objections to the present structure and operation of compulsory hospitalization laws are: (1) present commitment procedures resemble criminal proceedings and have a traumatic effect on the patient; (2) the taint of criminality is at least partially responsible for adverse public attitude toward mental illness; (3) the medical question of hospitalization has been improperly delegated to judicial officers; and (4) present admission procedures are cumbersome and discourage early and speedy treatment. See Kittrie, supra note 5, at 46. See also Kutner, The Illusion of Due Process in Commitment Proceedings, 57 Nw. U. L. Rev. 383 (1963).

The basis of the due process argument is the fourteenth amendment's due process clause. Despite the variety which exists among commitment procedures, most state statutes, through devices such as notice, hearings and jury trials, provide a degree of due process for the mentally ill analogous to that safeguarding the criminal defendant. This near-unanimity among the statutes is surprising when one considers that many of the constitutional questions in this area have never been decided. For example, although several courts have held that the requirements of due process are generally satisfied only if commitment is made after notice and hearing, it is still undetermined whether the giving of notice to the alleged mentally ill of the initiation of commitment proceedings is a constitutional requisite. It would appear, however, that so long as a judicial methodology is retained in commitment law, logical consistency requires the giving of sufficient notice to enable the individual to benefit fully from other safeguards in the system.

Though statutorily defined, modes of notice presently provided for are of dubious efficacy. A number of state statutes provide that if medical examiners certify that notice to the patient would be harmful, the court may in its discretion omit such notice altogether. Other jurisdictions, though requiring personal notice to

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\[1\] The doctrine that substantial rights could not be impaired without an opportunity being given the person to present his case was adopted by the Supreme Court in Simon v. Craft, 182 U.S. 427 (1901), and became generally accepted as a procedural necessity. See Kittrie, supra note 5, at 44.


\[3\] It is apparent that the denial of one right can have the effect of reducing related statutory or constitutional rights to a nullity. For example, the right to counsel, though constitutionally derived under the sixth and fourteenth amendment, will be relatively worthless as a procedural safeguard if the defendant is not notified of the charge and his right to procure counsel within sufficient time to permit the adequate preparation of his case. Thus, in Miranda v. Arizona, 384 U.S. 436 (1966), the Supreme Court held that "[t]he suspect must be warned prior to any questioning, that he . . . has the right to the presence of an attorney . . . ." Id. at 479.

\[4\] The states include Arizona, Hawaii, Idaho, Maine, Michigan, New Mexico, Ohio, South Carolina, Utah, Washington and Wisconsin. See 14 U.C.L.A.L. Rev. 822, supra note 14, at 872-73. See also Weihofen & Overholser, Commitment of the Mentally Ill, 24 Tex. L. Rev. 307, 340 (1946).
be served on the person or his guardian, permit service to be made
only a day or two before the date of hearings, thus converting the
notice requirement into a hollow guarantee.68

Similarly, hearings designed to determine whether involuntary
commitment is justified vary in efficacy and formality among the
jurisdictions. A major cause of the existing variation is the number
of concessions which have been made in response to medical
opinion. These have tended to dilute the procedural formalism
customarily attendant to legal proceedings.69 For example, under
the District of Columbia Hospitalization of the Mentally Ill Act,70
the subject's presence at the hearing is not required.71 Other states
authorize the holding of the hearing at any place selected by the
court or commission,72 while attempting to draw away from the
adversary nature of the proceeding. In California, for example,
relatives and friends of the individual are encouraged to accompany
him to the hearing and to reassure him during the course of
proceedings, and no "prosecuting attorney" is present during the
hearing.73 In this manner the "opportunity to be heard" permits a
more objective investigation by the court itself, while lessening the
possible traumatic impact on the individual.

As indicated above, the status of jury trials in the commitment
scheme is insecure at best.74 Nevertheless, a number of state
constitutions make provision for a jury trial in commitment
proceedings if the patient requests, even though "there is no
federally guaranteed right to jury trial in civil cases in state
courts."75 Despite these provisions the use of such tribunals is of

68 See, e.g., ILL. REV. STAT. ch. 91 1/2, § 8-3 (1965) (at least one day before the time for
examination as set by the court, a copy of the petition for admission must be "personally
delivered to the person" and to the nearest relatives).
69 See 1961 Hearings, supra note 2, at 330.
71 Id. § 21-542(a).
72 See, e.g., ILL. REV. STAT. ch. 91 1/2, § 9-1 (1967); TEX. REV. CIV. STAT. art. 5547-49
(Supp. 1968).
note 14, at 852.
74 Because a hearing for compulsory hospitalization is not a criminal proceeding, the
sixth amendment [apparently] does not . . . require a jury trial . . . State and federal
courts, in construing provisions of their own constitutions [similar to that of the seventh
amendment's jury trial guarantee], have arrived at differing conclusions." 61 NW. U.L. REV.,
supra note 62, at 977, 1000-01.
doubtful value, particularly when the possible traumatic effects of the proceeding are considered.\textsuperscript{26} In addition, the lay jury seems "peculiarly unsuited for evaluating psychiatric testimony and is more likely to commit unjustly than judges sitting alone."\textsuperscript{27} Finally, the retention of criminal-like proceedings is of little aid to efforts to remove the stigma attached to mental illness by the patient and society.\textsuperscript{28} These factors, coupled with the adverse view which the medical profession takes toward the judicial commitment process in general and juries in particular,\textsuperscript{29} outweigh any due process value which a jury might lend to the commitment process. It has been suggested that the best system would be to permit a jury trial where a patient, informed by civil authorities of his rights and advised by counsel or his guardian ad litem, specifically requests it, but to require a special verdict.\textsuperscript{30} However, the worthy objective of lessening the impact of the proceeding on the individual could be advanced more completely by eliminating the use of jury trials altogether. The most obvious suggestion would be to replace the judge and jury by a medical-legal board with power of commitment, which would conduct the hearing but would not necessarily be vested with "all-or-nothing" powers. Rather, statutory provision could be made to enable the board to prescribe some form of temporary, limited or out-patient treatment in addition to indefinite commitment. This determination would be made after hearing the respective arguments of the proponents of commitment and the patient's counsel. Thus, greater attention would be paid to the medical needs of the individual with little or no sacrifice of effective legal safeguards.

\textsuperscript{26} U.S. 261, 288 (1947); Barry v. Hall, 98 F.2d 222 (D.C. Cir. 1938) (insanity not a crime and therefore constitutional guarantee of jury trial not applicable).
\textsuperscript{27} See T. Szasz, supra note 23, at 159-68; Kutner, supra note 61; 1961 Hearings, supra note 2, at 74-79 (statement of Dr. Jack Ewalt, Representative, American Psychiatric Association).
\textsuperscript{28} Id. U.C.L.A. L. Rev. 822, supra note 14, at 858. See generally Weihofen, supra note 14.
\textsuperscript{29} See note 76 supra (statement of Dr. Ewalt).
\textsuperscript{30} It has been observed that "[m]ost medical authorities state that the optional jury trial is unnecessary to protect the sane and is undesirable because a jury can be fooled by a paranoiac who can be lucid and convincing during the trial." Ross, supra note 30, at 970.
\textsuperscript{32} The creation of a medical-legal board is provided for under the District of Columbia Hospitalization of the Mentally Ill Act, Act of Sept. 15. 1964, Pub. L. No. 88-597, 78 Stat. 944, D.C. Code § 21-502 (1967). However, power of commitment is in the court.
An additional consideration in the preservation of due process is the adequacy of representation offered by existing statutes. Throughout the history of judicial commitment, courts and legislatures have been adamant in asserting that "an adjudication of insanity is not an adversary proceeding." Nevertheless, the machinery of the commitment process is set in motion only when an individual is "accused" of suffering from mental illness. Therefore, this analogy between criminal law and civil commitment would seem to require that a person threatened with involuntary psychiatric hospitalization be accorded much the same protection as would be his if accused of a crime, including the assistance of counsel. As of 1967 thirty states statutorily provided for a right to counsel in commitment cases, and fifteen of these made appointment of counsel mandatory in the case of an indigent person. Yet glaring inadequacies exist, the most fundamental of which are ineffective notification of the right to counsel, inadequate compensation for appointed counsel, and the very limited time allowed for case preparation under several of the acts. Much like the deficiencies in many of the notice statutes, the effectiveness of legal representation as a protective device may be reduced to a nullity if these limitations are permitted to exist.

Despite the recognition of the value of legal counsel, a problem equally important, though legislatively less well-considered, is that of medical advocacy. Two difficulties arise with respect to psychiatric testimony. The initial problem is that the psychiatrist is recognized not as an advocate, but as a neutral intermediary between state and patient whose function is to advise civil authorities as to the

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83 See generally Szasz, Hospital Refusal to Release Mental Patient, 9 CLEV.-MAR. L. REV. 220 (1960).

84 Id. at 223.


86 Many commitment statutes are deficient with respect to the time permitted for case preparation. For example, "[i]n many states notice is served only two or three days prior to the hearing. This short period is not adequate for a contested hearing . . . ." Ross, supra note 30, at 968.

87 See note 65 supra and accompanying text.
individual's mental condition. Secondly, once the psychiatrist for
the state or municipality has made his diagnosis and recommended
commitment, the person is considered "sick." Often the
psychiatrist does not have to prove his allegation either inside or
outside of the court. But the patient, in order to avoid imminent
incarceration, must prove that he is not "sick," a burden of
considerable weight when the person is ignorant of the criteria
utilized by the physician to establish the fact of mental illness. Thus
when no provision is made for medical representation, the patient is
without a counter-diagnostician, a situation comparable to the lack
of defense counsel. The judge, having heard only state-introduced
testimony, cannot be presumed to be completely impartial,
especially if he views the proceeding as in the "best interests" of
the "accused." Thus, the person's liberty is jeopardized without
his being accorded the opportunity to adequately challenge his
accusors.

Criticisms of the Quasi-Judicial Process. Such inadequacies of
present attempts to preserve a notion of due process for the
mentally ill during the commitment process indicate that severe
drawbacks exist. The basic question of whether insistence on the
traditional criminal law formalities of due process is the most
effective method for the protection of those "charged" with mental
illness remains unresolved. Existing procedures, in attempting to
 placate the divergent views of the medical and legal professions
about mental health, present an unfortunate compromise. In trying
to satisfy both viewpoints, the majority of state legislatures have
thus far developed mental health systems which satisfy neither and
bear most heavily upon the individual subjected to its
inconsistencies.

The insistence of legal scholars that persons threatened with
confinement be given the same procedural safeguards as criminals arises out of the fear that perfectly sane members of society may
otherwise be "railroaded" into mental institutions in a manner
reminiscent of the pre-Packard period. Psychiatrists, however,

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58 T. Szasz, supra note 23, at 408.
59 Id.
60 Id.
61 See Note, Hospitalization of the Mentally Ill: Due Process and Equal Protection, 35
62 See Kutner, supra note 61, at 386.
maintain that excessive formality may do substantial harm to the mental patient. Indeed, certain aspects of formal commitment with which the medical profession strongly disagrees, seem quite susceptible to deletion without the sacrifice of essential due process safeguards. The problem is thus two-fold: The legal profession must be persuaded not to construct commitment procedures which are medically unreasonable and the medical profession must be convinced of the necessity for some procedural rigor. Therefore, if a procedural scheme similar to the judicially-oriented process is retained, the most effective procedure must strike a balance between medical and legal considerations—a synthesis which recent statutory enactments have attempted.

Such a recent statutory reconciliation is the District of Columbia Hospitalization of the Mentally Ill Act which, though enacted by Congress for the District, was intended as a model for the states. Although the Act seeks to establish a number of safeguards for the mentally ill who are committed under court order, considerable emphasis is placed upon the encouragement of voluntary admissions. This philosophy represents a national

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91 Kutner, supra note 61, at 386. The argument of the medical profession that such excessive formality as jury trials and service of process may do traumatic harm to the individual has been challenged by the "legalists" who assert that such a position presupposes the very fact which is sought to be determined by the hearing— the mental illness of the "accused."

92 It is noted previously that juries may be "peculiarly" incompetent to decide questions of sanity. See note 84 supra and accompanying text. Ample proof of this is given by the Illinois experience immediately after the passage of the "Packard Laws," under which more improper commitments occurred than had been the case under any other procedure. See note 14 supra and accompanying text.

93 Kutner, supra note 61, at 388.

94 This synthesis between medical and legal demands has resulted in less formalized proceedings which manifest a response to attacks on antiquated mental health laws which subjected the mentally ill to arrest, public trial, and other unfortunate experiences. One reason for the changed attitude toward mental illness is that it is no longer viewed as a moral failure of the person, but rather as a psychological "problem in living." See T. Szasz, supra note 23, at 13. However, for such a liberalized approach to be fully successful, some regulation must be retained to protect individuals against oppressive and unchecked commitment processes.


96 See 65 COLUM. L. REV. 1062, supra note 49 (1965).

97 The D.C. Act evidences a legislative decision to encourage voluntary admissions by providing that the voluntary patient is entitled to release within forty-eight hours of his filing a written request with the "chief of service." D.C. CODE § 21-353(b) (1967). See 65 COLUM. L. REV. 1062, supra note 49, at 1062-64.
trend, for virtually all states presently make voluntary hospitalization available. Yet, less than twenty percent of those admitted to mental hospitals in the United States enter voluntarily. The reasons for this low figure are public skepticism of the adequacy of treatment and the possibility of release, as well as the stigma appurtenant to mental illness and institutionalization.

As addressed to involuntary commitment, the D.C. Act represents a well-considered attempt to interweave specific requisites of due process with legitimate medical concerns. For example, jury trials and the patient’s presence at the hearing are made discretionary with the patient, and any hearing or trial is conducted in as informal a manner as possible. Furthermore, the location of the hearing is chosen so as to minimize possible harmful effects upon the patient. In addition, the class of persons who by petition may initiate such proceedings is severely restricted, thus limiting the possibility of repeated harassment by “non-interested” parties. The original petition is filed with the mental health commission, not the court, and thus the judicial process is avoided as long as is practicable. The commission is composed of one lawyer and two physicians and, therefore, is able to bring a “composite legal-medical mind” to bear upon each individual case. However, the actual decision to commit is not made by the commission or any other administrative board, but by the court itself.

Another notable aspect of the D.C. Act is the narrow criterion for “commitability” which it establishes. The individual must be mentally ill, and because of such illness must be likely to injure himself or others if allowed to remain at liberty. The effect of

102 1961 Hearings, supra note 2, at 5-6.
103 D.C. CODE § 21-544 (1967).
104 Id. § 21-542(a).
105 Id. § 21-541.
106 Id. § 21-542(a).
107 Id. § 21-541.
109 The mental health commission is statutorily provided for in D.C. Code § 21-302 (1967).
110 Id. The Commission is composed of a chairman, who is a member of the bar and presides at each meeting, and eight physicians who serve two at a time on rotating assignment. Id.
111 Id. § 21-545 (1967).
112 Id. § 21-545(b) (1967) (emphasis added).
this "dangerousness" requirement is both a stricter standard which decreases the likelihood of improper commitments, and a lower overall number of admissions which lightens the burden of overcrowded facilities, since no one merely "in need of treatment" will be admitted. Although the long-range goal remains the provision of treatment for all who require it, the D.C. Act, by recognizing the limitations of presently inadequate staffs and facilities, and by diminishing institution population through decreased admissions, presents at least a realistic approach to the problem.13

RIGHTS OF THE MENTALLY ILL DURING INCARCERATION

Experience demonstrates that too often public and legislative concern for the rights of the mentally ill has ceased at the asylum door.14 Although the past century has witnessed a substantial effort and some achievement in the establishment of more just and "patient-responsive" commitment proceedings, often those who enter the hospital are subsequently deprived of even nominal rights and liberties.15 Near-summary proceedings, which may result in indefinite incarceration, further magnify the post-commitment deficiencies of a number of jurisdictions.

In the New York case of Whitree v. State,16 for example, the claimant had been committed by court order in 1947 after examination and recommendation by two psychiatrists.17 In 1968,

13 It has been suggested that in some areas, such as trial by jury and the form and manner of notice, "legal considerations have received over-zealous attention by the drafters to the detriment of the primary goal sought to be achieved—that of providing the best possible treatment for the mentally ill. While it is desirable to guarantee the patient an opportunity to fairly contest attempted compulsory hospitalization, marginal procedural protections with possibly serious results upon the state of his mental health should be avoided." 65 COLUM. L. REV. 1062, supra note 49, at 1074.
14 1961 Hearings, supra note 2, at 1074.
16 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968).
17 Whitree was first arrested on March 25, 1945, on a stabbing charge. He was given a suspended sentence and placed on probation. There was a violation of probation and he was taken into custody on April 7, 1947. On April 29, 1947 he was ordered to Bellevue Hospital for formal psychiatric examination. The technical diagnosis was paranoid condition in a chronic alcoholic. On May 15, 1947, he was committed to Mattewan State Hospital by order of the General Sessions court. It is to be noted that the maximum period of a sentence for either of the above offenses was three years. Whitree in fact was incarcerated for eleven years more than the criminal term he could have received. Id. at 694-98, 290 N.Y.S.2d at 490-92.
when the claimant’s damage action against the state for wrongful confinement was finally litigated, the court held that Whitree had been wrongly confined in the state hospital for almost twelve years and four months, on the basis of evidence that with proper psychiatric treatment he should have been released no later than 1949.118 During his first six years of incarceration Whitree received a total of three in-depth psychological examinations, all during the first four months.119

One reason for the recurrence of such institutional experiences is that relatively few actions are brought by mental patients for improper treatment or illegal detention, even though habeas corpus120 and, possibly, tort remedies121 are available. The reasons for this are manifest. First, the patient is generally unaware of his rights, and the accessibility of the courts thus goes unrecognized. Although most statutes provide for personal service of notice of commitment proceedings, once the person has entered the institution the availability of counsel in most states is severely restricted, if present at all.122 Without such legal assistance the patient, because of his mental condition or ignorance, will remain unaware of his statutory and constitutional rights. In this respect, contemporary mental health faces a dilemma in the dual role of the institutional psychiatrist, for the psychiatrist, as employee of the state and

118 "On September 25, 1961, after a thorough and complete psychiatric examination at Bellevue Hospital, Whitree was diagnosed as 'Schizoid Personality with Paranoid Features' and further that 'He is not in such a state of idiocy, imbecility or insanity as to be incapable of understanding the charge, indictment, proceedings or of making his defense.' One, of course, must realize that sanity is an area and not a point on a line. The diagnosis was one that fit within socially acceptable behavior, albeit one that most would prefer not to have. . . . [I]f this man had received proper and adequate psychiatric treatment such diagnosis would have been developed much sooner; and Whitree would have been released from Mattewan State Hospital much sooner." Id. at 706, 290 N.Y.S.2d at 500.

119 Id. at 703-05, 290 N.Y.S.2d at 498-99.

120 Habeas corpus is available as a remedy to the incarcerated mental patient in a number of states. See, e.g., ILL. REV. STAT. ch. 91 1/2, § 10-6 (1967); IDAHO CODE ANN. § 66-347 (1951); TEX. REV. CIV. STAT. art. 5347-85 (1965). In some states, however, the availability of habeas corpus is dependent upon the exhaustion of other remedies, see, e.g., NEW YORK MENTAL HYGIENE LAW § 86 (1951) (available only if administrative remedy is exhausted). See People v. LaBurt, 17 N.Y.2d 738, 270 N.Y.S.2d 206 (1966).


122 See 1961 Hearings, supra note 2, at 330-37.
mindful of the therapeutic and “beneficent” role of the hospital, simply cannot be depended upon to inform patients of their right to protest or challenge their hospitalization and treatment.\textsuperscript{123}

Secondly, even if the patient is aware of his rights and does seek redress, he may be substantially hindered by hospital-imposed restrictions on correspondence, by censorship or by the burden of proof he must meet to challenge successfully his confinement. In some states an adjudication of insanity has the effect of “shifting the burden” so that the adjudged person, in later efforts to regain his liberty, must affirmatively establish that his disability no longer exists.\textsuperscript{124} Even in jurisdictions which provide for the appointment of counsel for indigent patients seeking release,\textsuperscript{125} such a burden is likely to prove insurmountable, especially when the expense and difficulty of procuring expert psychiatric testimony on the patient’s behalf is considered.

Judicial and Legislative attention has been increasingly directed toward the definition and protection of the legal and medical rights and status of the committed person. In some mental health codes provisions have been incorporated which preserve certain civil and medical rights for the patient, the originator of such an approach being the federally-constructed Draft Act of 1951.\textsuperscript{126} Similar, but expanded, codifications of patient rights are found in the California Mental Health Act of 1967,\textsuperscript{127} the Idaho Hospitalization of the Mentally Ill Act of 1951,\textsuperscript{128} and the 1967 revision of the Texas Mental Health Code.\textsuperscript{129}

However, because of the national character of the enacting body and the depth of the research involved in its preparation, the most important of the recent mental health codes is the District of

\textsuperscript{123} T. Szasz, \textit{supra} note 23, at 169-70.


\textsuperscript{126} \textit{Draft Act.} \textit{supra} note 54, § 19-26. See note 54 \textit{supra}.

\textsuperscript{127} Cal. Welf. & Inst’ns Code § 5325 (1968-69).


Columbia Hospitalization of the Mentally Ill Act. The D.C. Act specifically provides for the mandatory twice-yearly examination of patients hospitalized under court order. The patient is entitled to have his own physician participate in the examination, and an indigent patient may have the assistance of the Department of Public Health in obtaining a physician to participate in his behalf. If the physicians' reports lead to a determination by the chief of service that the patient is no longer dangerous, his immediate release must be ordered. Moreover, a contrary determination by the chief of service does not preclude release, since the patient is entitled to petition the court for an order of release if one or more of the examining physicians is of the opinion that the statutory conditions for confinement no longer exist. The Act, therefore, not only has taken a significant step to insure the timely release of persons whose hospitalization is no longer legally justifiable, but also has averted the two major difficulties confronting patients seeking release: Release is not completely contingent on the patient’s knowledge of its availability, and outside medical assistance is assured. Nevertheless, it has been noted that the statute provides only two alternatives—continued hospitalization or unconditional release—and a provision permitting conditional release, through which patients could be freed from the institution on the stipulation that they attend out-patient clinics and undergo periodic examination, has been suggested as a desirable addition.

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121 Id. § 21-548.
122 The “chief of service” is the “physician charged with overall responsibility for the professional program of care and treatment in the particular administrative unit of the hospital to which the patient has been admitted or such other member of the medical staff as the chief of service designates . . . .” Id. § 21-501 (1967).
123 Id. § 21-546 (1967).
124 Id.
126 Id. at 1073.
127 Id. It is notable, however, that in certain respects several state statutes go beyond the quite liberal D.C. Act. As suggested, a valid criticism of the D.C. Act may be the lack of provision for conditional release. Under the Idaho Hospitalization of the Mentally Ill Law, IDAHO CODE ANN. § 66-301 to 66-359 (1967), the state board of health may release an improved patient “on the condition that he receive outpatient or non-hospital treatment or on such other reasonable conditions as may be specified by the board of its designee.” IDAHO CODE ANN. § 66-338 (1967). A similar provision is available under the Texas Mental Health Code of 1957, TEX. REV. CIV. STAT. arts. 5547-1 to 5547-104 (1958), which permits “the head of a mental hospital . . . [to] furlough an improved patient,” TEX.
In addition, other rights of the institutionalized person are specifically recognized by the Act, including the right to communicate with a limited class of persons outside the hospital, a right to care and treatment, and the retention of certain civil rights and liberties during hospitalization. While in principle such statutory enumeration of patients’ rights may seem objectionable as impinging upon the executive authority of the hospital, in practice it probably does not interfere with orderly administration, and studies have indicated that it “reflect[s] the . . . standards of care in . . . better-run mental hospitals.” Like provisions under the Draft Act which preceded it, the D.C. Act explicitly provides for many of the individual rights which would seem to be necessarily implied from the function of a mental hospital. The creation of a sympathetic public attitude toward the operation of this Act, and a more general acceptance of its much needed tenets are, however, facilitated by the express guarantees.

Right of Communication

For the most part legislative recognition of specific rights of the mentally ill during hospitalization has been erratic, with some

Rev. Civ. Stat. art. 5547-79 (1958); and much like the Idaho statute, provides for rehospitalization if the patient’s mental condition warrants it.

However, it should be noted that the bases for commitment under Idaho and Texas law are different from that of the District of Columbia. Whereas the District of Columbia Hospitalization of the Mentally Ill Act requires a finding that “the person is mentally ill, and because of the illness is likely to injure himself or others if allowed to remain at liberty” (D.C. Code § 21-541 (1967)), commitment may be achieved under the Idaho and Texas statutes upon a finding of “need of treatment,” Idaho Code § 66-317 (1967), or need of hospitalization for the individual’s “own welfare,” Tex. Rev. Civ. Stat. art. 5547-41 (1958). Since only “dangerous” individuals are subject to commitment under the D.C. Act, the failure to provide for conditional release of patients evidences a congressional reticence to restore to society those persons previously deemed too harmful to be at large. As long as a strictly “dangerousness” criterion is adhered to in the District, it may be the case that conditional release is just not a viable alternative. This would seem especially so since the term conditional indicates a probability, no matter how slight, that the person is not completely “rehabilitated” or “cured”; and thus not eligible for final discharge.

D.C. Code § 21-561 (1967); see note 151 infra and accompanying text.

D.C. Code §§ 21-562 (1967); see notes 212–17 infra and accompanying text.

“A patient hospitalized pursuant to this chapter may not, by reason of the hospitalization, be denied the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, vote, and hold a driver’s license, unless the patient has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.” D.C. Code § 21-564(a) (1967); see notes 192-197 infra and accompanying text.

See Ross, supra note 30, at 979.
states displaying an almost schizophrenic quality in their approach—taking a very progressive and "liberal" course in some provisions while adhering to seemingly archaic thinking in others.\textsuperscript{142} The right to communication is anomalous in this respect as it was "the first right to receive [judicial and legislative] recognition and is the only right which is guaranteed by the statutes of most states,"\textsuperscript{143} possibly due to the experience derived from the analogous imprisonment situation.\textsuperscript{144} For years courts have followed a "hands off" policy with respect to grievances which prisoners may have against prison administrators.\textsuperscript{145} However, two competing factors have recently resulted in a new ambiguity which surrounds this so-called "noninterference doctrine."\textsuperscript{146} The first factor is "an understandable reluctance of the courts to interfere with prison management,"\textsuperscript{147} based on the belief that prison officials should be given a "wide discretion to cope with the peculiar disciplinary problems" which the prison presents.\textsuperscript{148} The second is the increasing recognition by the courts that a prisoner is not completely without rights or remedies, regardless of such notions as "civil death." It is readily apparent that the same dilemma, even perhaps in greater magnitude, faces the courts in the case of the confined mentally ill. Certainly the justifications for judicial noninterference are even greater, for while the prison is conducive to abuses by an intolerant administration, the hospital is by definition a beneficial environment and ideally there should be no reason to fear the possible denial of patient rights. Practically, however, abuse in the mental hospital has a long and unfortunate history, and accordingly, state legislatures have chosen to make specific provisions of varying degrees of rigor for a right to communication.

\textsuperscript{112} For example, Texas, which has one of the most thoughtful and progressive mental health statutes in the United States, although making provision for temporary hospitalization and observation and providing for specific patient rights, still permits the initiation of commitment proceedings on the basis of a petition filed by any adult person. Tex. Rev. Civ. Stat. art. 5547-41 (1958). The possibility of harassment and the vicious use of such petition procedure has been discussed previously. See note 67 supra.

\textsuperscript{113} See Ross, supra note 30, at 995.

\textsuperscript{114} See 110 U. Pa. L. Rev. 985, supra note 120, at 987.

\textsuperscript{115} Id. at 989.

\textsuperscript{116} Id.

\textsuperscript{117} Id. at 986.

\textsuperscript{118} Id.
Since denial of a patient’s right to communicate may impinge upon his capacity to petition for release, there is general agreement that communication with counsel should be unrestricted. There is controversy, however, with respect to other communications, some statutes providing for the censorship of outgoing mail which contains threatening or offensive material. The D.C. Act takes an approach unlike most jurisdictions and the Draft Act and makes no provision for the censorship of outgoing communications, although incoming mail, except from an attorney or physician, may be read and withheld by hospital authorities if necessary for the patient’s medical welfare. The degree to which the right to communication has statutorily evolved is thus evident: The older statutes authorize the patient to designate a correspondent outside of the hospital and require that mail be forwarded to the designee without examination. However, statutory provisions appearing in the late 1950’s extended the privilege of uncensored mail to and from a selected class of persons or public officials. The Draft Act was precursor of this position. The D.C. Act, by permitting all outgoing mail to pass uncensored, represents a significant advancement in the recognition of this variously-interpreted right.

The effectiveness of currently available sanctions to deter or remedy a denial of the patient’s right to communication remains largely speculative. Early cases demonstrate little more than occasional verbal reprimands by the judiciary. Such castigations, though severe when administered, were largely ineffective as a method of control. The Draft Act, in an effort to create an effective deterrent, provided criminal penalties for the violation of patients’ rights. Similarly, the D.C. Act, under its general relief section, provides for fines of not more than $5,000 or imprisonment for not more than three years, or both, for whoever causes the denial of rights accorded to the patient under the Act. Yet, despite the

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121 D.C. CODE § 21-561 (1967).
122 Ross, supra note 30, at 996.
123 See 1961 Hearings, supra note 2, at 342-43.
126 Id. § 21-548 (1967).
apparent feasibility of such remedies under the D.C. Act, a substantial problem of who is to initiate enforcement remains. Congress has provided some assistance to the patient’s quest for release by requiring periodic examinations or examination at the request of certain specified persons, but no provision is made for the policing of the guaranteed rights. Nor is it indicated how a violation or denial of rights, penalized under the Code, is to be detected in the first place. Primary responsibility for regulation would seem to lie with the mental health commission, but this body can hardly be expected to safeguard effectively the rights of several thousand patients. Consequently, for the single indigent patient with no family and without close contact with counsel to whom he might divulge a violation of his rights, the provisions of the Act promise to be little more than rights without remedies. Moreover, this discussion assumes, probably unrealistically, that the patient is aware of his rights under the Act.

An immediate suggestion for some relief in this area is the enlargement of the mental health commission from its present contingent of one permanent attorney and eight rotating physicians, only two of which staff the commission at any one time. An alternative solution, which appears quite feasible in a metropolitan area such as the District of Columbia, is to expand existing, governmentally-funded legal aid programs. Under such a program, legal advice concerning denial of rights and petitions for release could be provided patients, especially the indigent, who otherwise might find it difficult to procure counsel once incarcerated. In addition, the institutions, due to the regular presence of concerned outsiders, would be subject to a form of continuous inspection, and thus, any gross abuses during incarceration would not go unnoticed. Furthermore, such a “fact-finding force” should provide a substantial deterrent to aid in the elimination of many improper practices.

157 Id. § 21-546 (1967). An examination may be requested by the patient, his attorney, legal guardian, spouse, parent or other nearest relative. Id.
158 Id. §§ 21-561 to 21-565 (1967).
159 Id. § 21-502 (1967).
160 See notes 120-23 supra and accompanying text.
161 As indicated, fairly severe sanctions exist under D.C. CODE § 21-591. The difficulty lies in discovering violations, the search for such being unusually hampered by problems of patients’ conditions and the great autonomy which the mental institution possesses. See GOFFMAN. ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961).
162 See 1961 Hearings, supra note 2, at 330-45.
Right to Privacy

As applied to the mentally ill there appear to be two aspects to the right to privacy or, as it has been phrased, "freedom from publicity."1 The first of these, the protection of judicial and hospital records, has been accorded statutory recognition in a few jurisdictions.2 The crux of the argument proffered with respect to such records is that so long as mental illness carries with it a stigma which does not attach to other forms of illness patients should receive legislative protection against the social disgrace resulting from publicity.3 This contention appears equally applicable to the second aspect of the right to privacy—the privacy of one's person while institutionalized. As yet, however, legislative attention has not been directed toward the need for protection in this latter area.

The necessity for the recognition of a "personal" right to privacy is dramatically demonstrated by the pending Massachusetts case of Commonwealth v. Wiseman4 which involves the legality of a film entitled "Titicut Follies" made at the Bridgewater Correctional Institute portraying patients in fully nude postures. A recent case in New York, Cullen v. Grove Press, Inc.5 concerned the rights of the Bridgewater officials to enjoin the showing of this same film on grounds of defamation and invasion of privacy. The court held that in view of the legitimate public interest in state correctional institutions and the fact that expression by means of motion pictures is included within the free speech and free press guarantees of the first and fourteenth amendments, injunctive relief against the showing of the movie could not be granted unless the picture falsely portrayed conditions within the institution and was made with knowledge of its falsity or in reckless disregard of the truth. The court, however, was careful to note that its holding "[d]id not . . . constitute an adjudication of rights of non-parties, such as individual inmates claiming violation of their own personal rights . . . ."6

Patients in mental hospitals would seem to have a right not to

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1 Ross, supra note 30, at 998-1001.
3 Ross, supra note 30, at 998.
6 Id. at 731.
be so depicted, and in the past, courts have enunciated constitutional bases sufficient to support such a right. In *York v. Story*,109 a police officer caused a woman, who had come to the station to complain of an assault, to be photographed in indecent positions and then circulated the photographs throughout the police department. The court held such activities to be a violation of a fundamental right of privacy guaranteed the plaintiff by the due process clause of the fourteenth amendment.110 Furthermore, the dissenting opinion in *York*, attempting to draw a distinction between the plaintiff and those persons "held" by the government, conceded that "prisoners have a constitutional right to protection" from injury while so held,111 an assertion which would appear to be equally applicable to the committed mental patient, who is also confined under state power. The privacy interest asserted here is arguably analogous to the "privacy of the body" or "inviolability of the person" recognized by the Supreme Court in the nineteenth century.112 This interest was clearly alluded to in the doctrine of privacy enunciated in *Griswold v. Connecticut*,113 where the Court invalidated a Connecticut law forbidding the use of contraceptives as a violation of the right to marital privacy.

While there is a tide in constitutional doctrine favoring a broad scope for first amendment guarantees,114 cases such as *York* and *Griswold* represent a strong position favoring protection of individuals against gross intrusions into their privacy.115 First of all,
it has been held that the first amendment is *not* absolute and limits on its exercise do exist. Beyond these as yet ethereal limitations lies a "protective zone," the intrusion into which will constitute an abuse of first amendment license, and apparently, the violation of individual privilege. The recognition of the protective zone is a necessary evolvement from the steady realization by the courts that "freedom of speech" must be tempered by an observance of rights of others and the reasonable requirements of society. The applicability of such an evolving "right to privacy" to the mental patient is manifest. The problem remains, however, of statutorily and judicially defining both the nature and extent of the right, and the development of viable remedies. Criminal penalties, analogous to those prescribed by statute in the District of Columbia for violations of the right to communication, readily suggest themselves. However, due to the personal nature of a transgression of this "right to privacy," provisions for damages seems justifiable and would supplement the deterrent effect of the criminal penalties.

overruled . . . . [Today], it is not one tort, but a complex of four. The law of privacy comprises four distinct kinds of invasion of four different interests of the plaintiff, which are tied together by the common name, but otherwise have almost nothing in common except that each represents an interference with the right of the plaintiff 'to be let alone.' W. PROSSER, LAW OF TORTS 831-32 (3d ed. 1964) (citation omitted) [hereinafter cited as PROSSER].


A recent federal case, Dietemann v. *Time*, Inc., 284 F. Supp. 925 (C.D. Cal. 1968), has indicated that "the right of privacy might be on more solid ground if it were premised on privacy as a part of liberty protected by the [due process clause of the] Fifth and Fourteenth Amendments." Id. at 932. See generally *Beaney, The Constitutional Right to Privacy in the Supreme Court*, 1962 S. CT. REV. 212.

See note 150 *supra* and accompanying text. It has been recognized that the fact of illness itself gives some degree of privilege against unwarranted publicity. Thus, in the case of Barber v. *Time*, Inc., 348 Mo. 1199, 159 S.W.2d 291 (1942), the Supreme Court of Missouri stated that "[t]he basis of the right to privacy is the right to be let alone. It has been suggested that what is actually involved is 'appropriation of an interest in personality.' The right to privacy (or personality) is a part of the right to liberty and pursuit of happiness, which recognizes that the individual does not exist solely for the state or society but has inalienable rights which cannot be lawfully taken from him, so long as he behaves properly." Id. at 1205, 159 S.W.2d at 294. Certainly if there is any right of privacy at all, it should include the right to obtain medical treatment at home or in a hospital for an individual personal condition, . . . without personal publicity." Id. at 1207, 159 S.W.2d at 295. See Simonsen v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920).

See the similar remarks of Warren & Brandeis, *supra* note 176, at 219-220. According
Retention of Civil Rights During Institutionalization

An important consideration under mental health codes is whether commitment necessarily requires that the mental patient be deprived of the power to perform legally effective acts. Most courts and legislatures have failed to recognize that there are several aspects to this problem. The first is one of administrative control over the patient—how far hospital authorities may go in denying the patient his otherwise normal civil rights. In pursuing this question it has been noted that although there is no abundance of case law, those courts which have considered the problem tend to favor the patient. Thus, unless restrictions on patients’ rights to communicate, to seek release by habeas corpus, or to execute wills have received statutory sanction, hospital authorities have been held unable to invoke institutional regulations to deny patients their civil rights. For example, in the New York case of Hoff v. State a hospital superintendent who surreptitiously attempted to aid in the suppression of a patient’s petition for a writ of habeas corpus was held to have committed a tort, and the state was found liable for damages in a suit brought by the patient after gaining his release.

A second problem is that of evidence, and whether the fact of hospitalization should be given any evidentiary weight in
determining an individual's capacity to effectuate contracts, wills, transfers of property, and similar matters. Although it has been held that in the absence of clear-cut statutory direction commitment is conclusive proof of incompetency, the trend of the past decade has been toward the inclusion of provisions in mental health laws which specifically distinguish hospitalization from a ruling of incompetency and provide for separate proceedings for a determination of incompetency, regardless of whether the individual is actually committed. The District of Columbia Act explicitly separates the determination of incompetency from that of hospitalization, and provision is made for the retention of certain legal rights, including the right to dispose of property, the right to make contracts, and the right to vote. In a somewhat less explicit manner, the Draft Act attempted to give recognition to the difference between hospitalization and the status of legal incompetency, a fundamental principle of the Act being that "a patient who needs hospitalization is not necessarily legally incompetent, and a person who is legally incompetent does not necessarily require hospitalization." Thus, while hospitalization under the Draft Act did not result in complete loss of legal capacity, it is clear that the act did not guarantee the patient the full exercise of his normal legal rights, the commentary to the

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108 For the effect of hospitalization on the legal capacity of mental patients in 49 states see Ross, supra note 30, appendix 1. Tables 2 and 4, at 1012-14, 1016. See generally Green, *The Operative Effect of Mental Incompetency on Agreements and Wills*, 21 *Tex. L. Rev.* 554, at 576-80 (1943).

109 "A minority of states hold, even in the absence of clear-cut statutory directions, that commitment is conclusive evidence of incompetency. These decisions are generally characterized by rigid and mechanistic application of principles without any real understanding of the policy problems involved. The courts tend to reason that insanity means commitment and insanity also means incompetency, so that commitment automatically results in total legal incompetency. Typical of this inflexible failure to differentiate between the policy issues bearing on hospitalization and those bearing on competency is the case of *Rohrer v. Darrow*, 66 Colo. 463, 182 P. 13 (1919)." Ross, supra note 30, at 985. See also *Turpin's Adm'r v. Stringer*, 228 Ky. 32, 14 S.W.2d 189 (1929); *Reeves v. Hunter*, 185 Iowa 958, 171 N.W. 567 (1919); *Walton v. Malcolm*, 264 Ill. 389, 106 N.E. 211 (1914); *Topeka Water Supply Co. v. Root*, 56 Kan. 187, 42 P. 715 (1895).


112 See Ross, supra note 30, at 990.

113 Id. at 991.
act's contrary conclusion notwithstanding. Under the D.C. Act, however, a patient's rights may be limited only by adherence to a statutorily prescribed procedure, and wrongful denial of such rights will result in criminal liability.

The Doctrine of Consent and the Right to Decline Treatment

It is manifest that modern hospital practice, with its wide range of available care and treatment, requires some controls and sanctions to deter intentional interference with the person or property. Accordingly legal rules have evolved that a physician may not operate on an individual without his consent, except in cases of extreme emergency. If the patient is known to be incapable of giving consent because of infancy, intoxication or mental incompetence, his failure to object or even his active manifestation of consent will not protect the physician. The mere desirability of treatment does not justify surgery without the consent of the patient or a near relative. Moreover, the surgeon must not abuse the consent privilege by committing acts of a substantially different nature than those agreed upon.

However, the special characteristics of the mental hospital and its patients present special and serious problems. First of all, most patients in state institutions are public charges, many of whom do not have guardians. Secondly, it is quite natural for hospital administrators to proceed on the assumption that the factor of consent is not relevant in the circumstance since a court would probably hold that the patient is mentally incapable of giving consent. Also, under the parens patriae function of the state, broadly worded statutes which give the hospital authority to care for the patient could be liberally construed to allow the hospital to treat without patient consent. Thus, the "ward of the state"

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195 Draft Act, supra note 54, § 35. The Act does not guarantee the patient the full enjoyment of his rights simply because a hospital may ignore them.
197 Id. § 21-591.
199 Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).
200 Prosser, supra note 175, at 105-06.
201 See 1961 Hearings, supra note 2, at 340.
202 The broad language of many commitment statutes and judicial decisions has encouraged the view that mental hospitals, which exercise the governmental function of
status of the mentally ill, if literally adhered to by a court, could be used to justify nonconsensual, and therefore improper, treatment by a hospital.

To best alleviate the problems associated with the consent doctrine and to provide for restriction on the types of treatment dispensed in mental hospitals, it would appear that a two-pronged approach is necessary. Initially, there is a definite need for the control of potentially dangerous treatment such as electro-shock, pre-frontal lobotomy and insulin-induced convulsive therapy, all of which are capable of inflicting severe injuries. Regulation of such techniques, however, has received little or no attention from the courts and legislatures, although a few states, in a half-hearted attempt to exercise some control over such methods, require all forms of treatment to be recorded in the patient’s file. Although such recordation requirements do have the virtue of imposing some burden of “justification” upon the hospital dispensing “treatment,” these after-the-fact attempts at regulation may come too late for the patient if harm already has been inflicted.

California adopts a different approach by permitting the patient himself to refuse both shock treatment and lobotomy. Unfortunately, the effectiveness of this provision in protecting the patient is almost entirely vitiated by the immediately succeeding section, which permits the denial of such rights for “good cause” by the person in charge of the institutional facility or his designee. Several other states provide that except in emergency cases, the hospital may not perform a major operation until notification is given the guardian or relative of the patient, if information concerning such persons is in the patient’s records. However, no provision is made for the control of...
such equally dangerous methodologies as electro-shock, lobotomy, or drug therapy.\textsuperscript{208}

A rationalization of the consent doctrine and the position of the state as \textit{parens patriae}, with respect to potentially dangerous treatment, can come through the development of a classification system for types and varieties of treatment. Under such a scheme, medical attention usually administered as a matter of routine—periodic examinations, the dispensing of ordinary medicines for minor illness, and emergency treatment within specified limits—could be left to the discretion of hospital physicians. On the other hand, more extensive treatment such as surgery, and potentially dangerous therapy by insulin, electro-shock and drugs, should be subject to the consent of either a guardian, the patient’s attorney, or a legal-medical board established for the specific purpose of reviewing the advisability of certain forms of treatment.\textsuperscript{209}

Hopefully it would not be necessary to surround the functioning of such a board with an adversary procedure. Since treatment is often a matter of urgency, avoiding advocacy would eliminate a great potential for delay and be in the best interests of the patient. Thus, the real adversaries under this procedure, if there were any at all, would be the hospital and the legal-medical board. The hospital would argue its diagnosis to the board, but that body would make the final determination upon its own consideration and informed opinion.\textsuperscript{210} Theoretically the board would be acting with the

\textsuperscript{208} Few, if any, statutory provisions seem to have been enacted with a direct view to modern shock and drug therapies. However, at least two attorneys general have endorsed the theory that state hospitals, on the basis of the state’s police power and the principle of \textit{parens patriae}, are entitled to help the medical welfare of the patient by any type of recognized treatment, including such therapies as electro-shock or lobotomy, without the requirement of consent. 1948 PA. Ops. Att’y Gen. 120; 1948 Wis. Ops. Att’y Gen. 502. See 1961 \textit{Hearings, supra} note 2, at 340-41. It is noteworthy that the D.C. Act, although providing for a right to treatment, D.C. Code § 21-562 (1967), does not deal with the problem of consent to surgery or other dangerous treatment.

\textsuperscript{209} It is obvious that in many cases it would be of little value to provide for notice to the patient himself, especially if the individual is severely ill or demonstrates dangerous tendencies. Furthermore, the capacity of the patient to make a meaningful protest to the proposed treatment is limited simply because of the fact of his incarceration. Therefore, in order to challenge more effectively such treatment, provision should be made for notification of other concerned parties, such as guardians, counsel, or the suggested review board. \textit{See also} Dawidoff, \textit{supra} note 203, at 699-700.

\textsuperscript{210} The board should be permitted to engage upon its own research into the area by calling upon “outside” experts to supplement the information received from hospital staff personnel. Such a capacity would add to the objectivity of the board’s decision.
patient's interest in mind and should challenge any treatment which does not seem proper. Of course, the functions of the board in reviewing treatment programs after the person is institutionalized would in no way encroach upon the position of the court in determining whether the person should be hospitalized in the first place. Instead such a review process would ensure the proper effectuation of the state's duty to care for its wards, while tempering the judgments of hospital personnel and subjecting decisions concerning extensive treatment to a more objective scrutiny.

The various statutes are more definitive with respect to the second aspect of the control of treatment—regulation of the use of restraints—and provisions for such control have appeared in the majority of statutes. The District of Columbia Act specifically provides that a mechanical restraint may not be applied to a mental patient unless its use is prescribed by a physician, and that the restraint must be removed when the condition justifying its use no longer exists. Furthermore, the use of the restraint must be made part of the patient's record, together with reasons for its use. Nevertheless, the statute has at least three deficiencies. First, no penalties for the wrongful application of mechanical restraints are clearly provided. The general offense and penalty section of the code makes reference only to wrongful commitment, false certificates of physicians or the "denial... of a right accorded to [the patient] by this chapter." Thus, the restraint proscription would have to be considered to have created a "right to be free from mechanical restraints" before that section could fall within the language of the Act's penalty provision. A second deficiency is less easily remedied; no provision is made for chemical restraints, a substantial inadequacy considering that depressant drugs may be more incapacitating than a straitjacket! Finally, due to the grave psychological effects which mechanical or chemical restraints would bring to bear on an already mentally ill patient, a review board similar to that suggested for the control of potentially dangerous treatment would be an advisable

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211 See, e.g., IDAHO CODE ANN. § 66-345 (1967); TEX. REV. CIV. STAT, art. 5547-71 (1958).
212 Mechanical restraints, such as straitjackets, are no longer considered by psychiatric experts as "ideal" methods of therapy. See 1961 Hearings, supra note 2, at 339.
214 Id.
215 Id. § 21-591.
216 See DEUTSCH, supra note 1, ch. 11.
addition here. Of course in considering the validity of various forms of treatment, the standard of tort law that the technique be one recognized by an established school of medical thought should be the starting point in determinations undertaken by any legal-medical review board.217

The Recognition of a Right to Treatment

Perhaps the most controversial issue to arise out of the current mental health problems of overcrowding and understaffing is that of the so-called "right to treatment."218 The fact that the average inmate of a public mental hospital receives inadequate treatment is becoming ever more apparent to psychiatrists and lawyers.219 The situation is such that "in many of our hospitals about the best that can be done is to give a physical examination and make a mental note on each patient once a year, and often there is not enough staff to do this much."220 The effects of such conditions on mental rehabilitation were vividly presented in a 1957 study, in which it was noted that understaffing and lack of physical facilities caused a "social organization" that resulted in custodial rather than therapeutic care that hindered both the providing of proper treatment and the planning for improvements, and in the least-trained member of the staff, the ward attendant, having the greatest control over the care and treatment of patients.221 The consequences of such an environment can be extreme, for it is well-established that a developing mental disturbance, present at the time of commitment and not properly cared for, will become increasingly

217 "Where there are different schools of medical thought, it is held that the dispute cannot be settled by the law and the doctor is entitled to be judged according to the tenets of the school he professes to follow. . . . A 'school' must be a recognized one with definite principles, and it must be the line of thought of at least a respectable minority of the profession." PROSSER, supra note 175, at 166.


219 See, e.g., Bassiouni, The Right of the Mentally Ill to Cure and Treatment: Medical Due Process, 15 De Paul L. Rev. 291 (1966); Szasz, Commitment of the Mentally Ill: "Treatment" or Social Restraint, 125 J. of Nervous and Mental Disorders 293 (1957); Editor's Forum, Commitment Reform, 55 Cal. L. Rev. 1 (1967); 14 U.C.L.A. L. Rev. 822, supra note 14; 77 Yale L.J. 87, supra note 27.

220 Solomon, supra note 22, at 7.

221 See Birnbaum, supra note 44.
serious under inadequate institutional conditions. Unfortunately, it is a simple fact of legislative and medical logistics that these deficiencies cannot be alleviated immediately, since neither the requisite funds nor personnel are presently available to alter the situation significantly.

With this background, it is not difficult to comprehend the reasons for the emergence of the "right to treatment." The constitutional argument most frequently urged to support this right maintains that to commit someone to a mental institution because of his need for care and treatment and then to fail to provide such treatment is a violation of due process. Indeed, some writers have gone so far as to state that if medical attention reasonably well-adapted to the patient's needs is not given, the victim is not a patient but is virtually a prisoner. Additional constitutional bases for the recognition of the right to treatment have been drawn from several recent cases. For example, even absent any due process objections to commitment without treatment, a comparison between the non-treating hospital and a jail may present such a similarity as to warrant the conclusion that the commitment is virtually punishment for an illness, and thus within the "cruel and unusual" prohibition of the eighth amendment. An arguably analogous application of the eighth amendment occurred in Robinson v. California, where the Supreme Court indicated that to punish a person for narcotics addiction was to punish him for an

\[222\] See Note, Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill, 56 YALE L.J. 1178 (1947).
\[223\] Birnbaum, supra note 44, at 500-02.
\[224\] See 77 YALE L.J. 87, supra note 27.
\[226\] 53 VA. L. REV. 1134, supra note 218, at 1144.
\[227\] U.S. CONST. amend. VIII.
\[228\] 370 U.S. 660 (1962). Traditionally, the eighth amendment's "cruel and unusual punishment" clause has been interpreted as relating only to the method and degree of the punishment inflicted by the state. See Trop v. Dulles, 356 U.S. 86 (1958); Louisiana ex rel. Francis v. Resweber, 339 U.S. 459 (1947); Weems v. United States, 217 U.S. 349 (1910); Note, The Cruel and Unusual Punishment Clause and the Substantive Criminal Law, 79 HARV. L. REV. 635, 636-45 (1966). However, this clause received new interpretation by the Supreme Court in Robinson, where it was determined that the eighth amendment precluded the punishment of a narcotics addict for his addiction, thus holding for the first time that there are some situations in which the eighth amendment denies the state power to impose criminal sanctions of any sort, regardless of the method or degree. 370 U.S. at 662-63; see Starrs, The Disease Concept of Alcoholism and Traditional Criminal Law Theory, 19 S.C.L. REV. 349 (1967).
illness and thus "cruel and unusual." The more recent case of 
Powell v. Texas,\(^2\) although apparently restricting the application 
of a Robinson-type approach, at least as to chronic alcoholism,\(^2\)
would not appear to lessen the applicability of the eighth 
 amendment to mental illness for two reasons. First, the primary 
basis of the Court's decision in Powell seemed to be that it is not 
evident that chronic alcoholics have such an involuntary, irresistible 
compulsion to get drunk that they cannot control their acts and 
thus should not be punished under state public drunkenness 
statutes. Such a view would be patently inapplicable to mental 
illness where the individual, by definition, is unable to "properly" 
constrict his behavior in the societal setting. In addition, a probable 
secondary reason for the Court's holding in Powell was the apparent 
desire to prevent a further extension of the Robinson doctrine into 
the area of criminal responsibility. The majority expressed fear that 
the minority's approach to Robinson would create a constitutional 
doctrine of mens rea which would force the states to refrain from 
punishing anyone whose acts were in any way "involuntary."\(^3\)
The difficulties suggested by such considerations of criminal 
responsibility do not exist in the question of the constitutional 
implications of nontreatment as applied to the mentally ill. Thus, 
to incarcerate the mentally ill and withhold the medical attention 
which might precipitate their release would seem to be as cruel a 
punishment for a person's "status" as jailing him for narcotics 
addiction.

\(^2\) 392 U.S. 514 (1968). The majority in Powell based its decision on the grounds that the 
appellant simply had not presented sufficient evidence to show that he and other chronic 
alcoholics are unable to control their drinking or refrain from being in public while drunk. 
In an opinion in which three of his brothers joined, Justice Marshall reasoned that because 
the medical profession is apparently uncertain as to the exact nature and meaning of 
"alcoholism," the Court should hesitate to base constitutional decisions upon medical 
findings in this area. Justice Marshall also distinguished Robinson, saying that in that case 
the defendant had been convicted for being an addict, while Powell was convicted, not for 
being an alcoholic, but for being in public while drunk. Thus, the state had not attempted to 
punish a "status," but rather had imposed penalties for certain proscribed public behavior. 
392 U.S. at 521-37.

\(^3\) However, the authoritativeness of Powell would seem to be diminished in light of the 
fact that the fifth vote of the Court, Mr. Justice White's, was on much narrower grounds 
than that of the other four members of the majority. Mr. Justice White, although indicating 
his belief that Robinson v. California could not continue to stand if Powell represented an 
attempt to distinguish between various forms of addiction, preferred to concur in the 
judgment because Powell "did not show that his conviction offended the Constitution." 392 
U.S. at 554.
Furthermore, where commitment originates as a result of a criminal proceeding, and the civil commitment statute of that jurisdiction provides for a right to treatment, an equal protection question may arise unless the civil standards of commitment are extended to one committed under criminal process. Presently in fifteen states, acquittal of a defendant on grounds of insanity requires that he be committed for an indefinite period. A series of recent decisions, however, has indicated that abbreviated procedures for the commitment of those acquitted by reason of insanity may be unconstitutional as violative of the equal protection clause. In Baxstrom v. Herold, the Supreme Court unanimously declared unconstitutional a New York statute under which prisoners who had become mentally ill during imprisonment were subject to summary commitment without jury review. The decision whether to continue institutional care in a state hospital for the criminally insane or in a civil hospital had rested with administrators. The Court held that the fact that petitioner was nearing the end of his sentence was not relevant to the matter of determining either his sanity or the appropriate institution for confinement. He was entitled under the equal protection clause to the same procedural safeguards as persons civilly committed.

Two recent cases in the Court of Appeals for the District of Columbia Circuit have further expanded the scope of this equal protection approach. In Cameron v. Mullen, the court reviewed the D.C. Code provision for mandatory commitment upon acquittal by reason of insanity and noted that the procedural inequity between that section and the civil commitment statute was more severe than the differences attacked by the court in Baxstrom. More recently, the court of appeals in Bolton v. Harris broke with the myopic commitment-centered concern of previous cases and premised a thorough re-evaluation of the acquittal-commitment process on the basis of the equal protection doctrine, holding that in many respects commitment and release

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224 383 U.S. at 115.
225 387 F.2d 193 (D.C. Cir. 1967).
226 Id. at 200.
227 395 F.2d 642 (D.C. Cir. 1968).
standards should be the same for persons acquitted by reason of insanity as for those civilly committed. In addition, the court specifically remarked that periodic examination and other rights to release, expressly provided for under the "civil" Hospitalization of the Mentally Ill Act, were equally applicable to persons committed through the criminal route.\footnote{238 The court expressly noted that "under civil commitment procedures, a patient is entitled to periodic examinations by the hospital staff and has the right to be examined by an outside psychiatrist... Because we find no rational justification for withholding these safeguards from a... [patient committed after criminal acquittal] we construe... [the statute in question] to require them." \textit{Id.} at 652.}

Proper interpretation of the foregoing cases would indicate that the right to treatment, as statutorily defined under the District of Columbia Hospitalization of the Mentally Ill Act, is capable of analogous application to the patient committed following acquittal. Judicial consideration of such an application of the right to treatment was presented in \textit{Rouse v. Cameron},\footnote{239 373 F.2d 451 (D.C. Cir. 1966).} which arose as a proceeding on petition for habeas corpus. The court, however, merely suggested the possibility that a failure to supply treatment may violate the equal protection clause and based its holding on the grounds that the Hospitalization of the Mentally Ill Act's provision concerning the right to treatment was intended to cover persons hospitalized under statutory authorization.\footnote{240 \textit{Id.} at 454-55.} Thus, Rouse, who had been committed following his acquittal by reason of insanity was held to have a \textit{statutorily} provided right to treatment that was cognizable on habeas corpus, and the constitutional difficulties engendered by an equal protection approach were thus avoided. \textit{Bolton v. Harris} and related cases, however, have taken a more direct, constitutional orientation. The thrust of the \textit{Bolton} case was directed not only at a disparity in commitment procedures, but attacked release procedures as well.\footnote{241 395 F.2d at 653.} Furthermore, a denial of the right to treatment, while not a direct concern of \textit{Bolton}, would appear to be intimately involved with a patient's ultimate release and thus within the ambit of equal protection as applied by the D.C. Circuit. Certainly in many instances the withholding of treatment will increase the duration of an individual's institutionalization and consequently postpone his release. Because the right to treatment, like periodic examination, is provided for in
the same D.C. statute, the source of that right is no different than that of periodic examination, and the Bolton rationale would appear equally applicable.

As the Court noted in Baxstrom, capriciousness of classification employed by the state is subject to attack as violative of the equal protection clause.\footnote{383 U.S. at 115.} Therefore, if legislation is not "reasonable" in defining the group to be treated differently, or if it is not reasonable in the method or extent to which the differentiated group is deprived of something which others have by right, such legislation must fall.\footnote{See Matthews v. Hardy, --- F.2d --- (D.C. Cir. 1969). See generally Tusman & tenBroek, The Equal Protection of the Laws, 37 CAL. L. REV. 341, 343-65 (1949).} To attempt to distinguish the civilly committed from the "acquitted" patient, promising the former a right to treatment and the latter only confinement, appears to be the type of arbitrary classification proscribed by the equal protection clause. The strongest justification for maintaining disparate commitment and release procedures—the proven dangerousness of the person acquitted by reason of insanity—does not warrant a different proceeding for two reasons. First, the determination that a person was "insane" at the time of the crime does not bear a direct correlation to his mental state at the time of trial, and thus acquittal should not result in summary commitment. In addition, the characterization of the acquitted person as dangerous does not permit the arbitrary exclusion of the right to treatment since the criterion for civil commitment under the D.C. Act is one of "dangerousness" as well. Therefore, any attempted classification on this basis seems equally improper.

The states, however, have not emulated the right to treatment approach taken by the District of Columbia. Only eleven states have adopted or considered the promulgation of such a right.\footnote{Illinois has adopted such a provision since the decision in Rouse, see ILL. REV. STAT. ch. 91 1/2, § 12-1 (Supp. 1969). New York and Pennsylvania have undertaken legislative consideration; see Special Study, supra note 36; Rehman, Rights of Mental Patients to Treatment and Remuneration for Institutional Work: Pending Mental Health Legislation, 39 PA. B.A.Q. 538 (1968). See also CAL. WELF. & INST'NS CODE § 5325 (1968); IDAHO CODE ANN. § 66-344 (Supp. 1967); IOWA CODE § 225.15 (1949); MO. ANN. STAT. § 202.840 (1962); N.M. STAT. ANN. § 34-2-13 (1967); OKLA. STAT. tit. 43A, §§ 2, 91 (1954); TEX. REV. CIV. STAT. ANN. art. 5547-70 (1958); UTAH CODE ANN. § 64-7-46 (1961).} However, several state courts have provided guidelines for future development of the right to treatment in their jurisdictions. New
York, for example, has no statute which expressly grants to a mental patient a right to treatment, but by drawing upon selected portions of the Mental Hygiene Law, New York courts have recognized the right to a substantial extent. Two cases, People ex rel. Anonymous v. La Burt and Whitree v. State, have utilized statutory provisions which entrust the state mental health commissioner with the supervision of a patient's course of treatment to formulate several principles arising under the traditional notions of police power and parens patriae. First of all, it is the duty of the State to protect the community and the mentally ill from their own acts, and secondly, it is a policy of the State to care for and protect mentally ill persons and, if possible, to cure them of disease. These principles, however, have not been held to confer on the mentally ill person a right to release in the event of claimed inadequate treatment, and therefore, if a patient who claims inadequate treatment is actually mentally ill, his remedy must lie in the administrative procedures of the New York Mental Hygiene Law.

Although other jurisdictions have attempted to set outer limits on what can be done in the name of adequate treatment, the results of such investigations often have turned on semantic rather than substantive inquiry. For this reason, the case of Sas v. Maryland is an important achievement in the evolution of a non-statutory right to treatment, since it is the first case to suggest that a court must look beneath labels and examine the substance of the treatment program in order to determine whether confinement meets constitutional and statutory requisites.
Unfortunately, a case-by-case emergence of a right to treatment is a costly and time-consuming process, primarily because of the relatively few actions brought by mental patients—a factor attributable to patients' general unawareness of their rights and to fears that an assertion of the right to treatment will contradict a later claim of sanity. Furthermore, such an "ad hoc" approach is hampered by an understandable judicial reticence to undertake, without statutory guidance, the determination and enforcement of what the court considers to be the "best" treatment. To be sure, any attempt to delineate a right to treatment would require the development of a workable definition of responsible treatment which judges could apply against negligent or palpably inappropriate treatment without encouraging litigation or straitjacketing medical procedures. The difficulties inherent in an attempt to enforce such a "right" without standardized nosology becomes apparent upon considering that one school of psychiatric thought asserts that simply custody itself, resulting in the removal of social stresses, constitutes "treatment." Other psychiatrists, however, contend that psychotherapy and maximum security are to a great extent incompatible in theory and implementation. Consequently, some practitioners might recommend hospitalization in a specific case whereas equally noted colleagues would vehemently oppose any such confinement.

This illustrates that in order to develop and enforce effectively a right to treatment, the concerted effort of courts and legislatures is required. Legislatures must statutorily designate and define the right, thereby arming courts with remedies to correct the effects of violations and to assure that they do not recur. Those who advocate judicial recognition and enforcement of the right of the mentally disabled to medical treatment recognize, however, that eventually legislatures will be forced to appropriate larger sums for mental hospitals. Ideally, with greater hospital resources and

231 See notes 125 & 126 supra and accompanying text.
232 See 53 Va. L. Rev. 1134, supra note 218, at 1148.
233 The "definitional" problems involved in the "right to treatment" are analogous to those encountered in defining criteria for original commitment. See notes 33-35 supra and accompanying text.
234 See 1961 Hearings, supra note 2, at 81 (statement of Jack R. Ewalt, M.D.); 77 Yale L.J. 87, supra note 27, at 106.
236 See Birnbaum, supra note 44, at 500.
facilities, all who required mental treatment could be hospitalized and adequately treated—rendering moot the need for enforcement of the right to treatment.

The Search for Viable Remedial Alternatives

As a practical matter, however, under the present mental health system with its limited resources and facilities, treatment for all who require it is simply impossible. Furthermore, it is doubtful that the situation will improve greatly in the near future because the deficiencies of both personnel and physical facilities, the need for which will only increase, are not being sufficiently corrected at the present time. Consequently, due to the present limitations of the system, the development of viable remedies to be administered when a violation of the right to treatment occurs has assumed substantial importance.

Any investigation of such remedies must look to the specific statutory criteria under which the individual was originally committed. To illustrate, where a person has been admitted under one of the numerous statutes which adopt the "police power" criterion of dangerousness, outright release may not always be a practical remedy. However, as indicated in Rouse v. Cameron, alternatives to unconditional release are available, and a form of conditional release may be in order if continued in-hospital treatment is inappropriate. Thus, if the court should find that a compulsorily committed patient is in custody in violation of the Constitution or statutes, it may either allow the hospital a reasonable opportunity to initiate treatment or make arrangements for the patient's supervised release. In determining whether the hospital will be given an opportunity to develop an adequate treatment program, some of the important considerations suggested in Rouse are the length of time the patient has lacked adequate treatment, the length of time he has been in custody, the nature of his mental illness, and the degree of danger resulting from the mental condition that the patient would present if released. It is

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25b But see Millard v. Harris, 406 F.2d 964 (D.C. Cir. 1968).
25c 373 F.2d 451 (D.C. Cir. 1966).
26a See id. at 458-59.
26b See id.
26c Id. at 458.
noteworthy that Chief Judge Bazelon, in the Rouse opinion, saw fit to include conditional release as an alternative to continued confinement without treatment. The District of Columbia Act, under which Rouse was decided, makes no provision for conditional release; Judge Bazelon’s suggestion must rank, therefore, as a well-considered modification and extension of the Act.

Several other attempts have been undertaken to fashion more suitable relief for the patient denied treatment. In Lake v. Carson, the court held that upon reviewing a civilly committed patient’s petition for habeas corpus, a necessary consideration was whether any less onerous disposition would serve the purpose of commitment. Drawing upon the D.C. Act the court fashioned a principle of the “least restrictive alternative,” and refused to accept the proposition that merely showing the senility of the patient automatically entitled the government to compel her to accept its “help” at the price of her freedom. In recognizing that a patient might be entitled to release from a mental hospital if other facilities were available and appropriate, the court stated:

‘[T]he entire spectrum of services should be made available, including outpatient treatment, foster care, halfway houses, day hospitals, nursing homes, etc.’ The alternative course of treatment or case should be fashioned as the interests of the person and of the public require in the particular case.

Furthermore, in Covington v. Harris, the court indicated that this principle of least restrictive alternative is “equally applicable to alternative dispositions within a hospital” and that the range of alternatives within a hospital, from maximum security to outpatient status, is “almost as wide as that of dispositions without.”

To the extent that lack of treatment is traceable to the actions of hospital administrators, criminal sanctions, such as those available under the D.C. Act, may act as a deterrent and aid in

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261 See id. at 458-59.
263 Id. at 661.
264 Id. See Covington v. Harris, F.2d (D.C. Cir. 1969).
265 364 F.2d at 663.
266 364 F.2d at 659-60.
267 Id. at 661.
268 Id.
correcting the faults. However, to improve directly and immediately the status of a patient’s confinement, judicial review of the hospital’s internal administration seems a necessity. Suggested standards for such review were articulated in Tribby v. Cameron, where the question was posed as not whether the hospital has made the best decision, but only whether “it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion.” Unfortunately, such review of remedial alternatives, though broadening relief by permitting a patient to seek transfer to a “better” hospital, assumes a more suitable and better-equipped institution can be found—an unwarranted assumption in a number of jurisdictions.

With respect to non-dangerous persons committed under a “need for treatment” statutory criterion, the fact of lack of treatment would seem sufficient grounds for immediate release. The only basis for the commitment of those persons is that treatment can return them to society in a more productive capacity. When this purpose for commitment is not fulfilled, the thread of justification for confinement snaps. Given such a tenuous basis for commitment, a violation of the right to treatment should lead to immediate release unless administrative change or transfer to another institution will eliminate all violations of the patient’s rights. It should be remembered that unlike commitments based on dangerousness, where confinement can be justified by the need to protect society, commitment because of a person’s need for treatment presents no comparable competing state interest to balance against the right of the patient to release upon failure to receive treatment. The only state function is the restoration of the committed person to a normal societal role, and if the state does not conscientiously pursue that goal, or is unable to do so, the patient should be released.

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211 But see 77 YALE L.J. 87, supra note 27, at 107-16.
212 379 F.2d 104 (D.C. Cir. 1967).
213 Id. at 105.
214 See 34 U. Chi. L. Rev. 633, supra note 62, at 650.
216 Although it might be argued that the state has an interest in the health of its populace, this interest is hardly vindicated by failing to provide treatment to the mentally ill and thus should not be used to counterbalance a person’s right to release upon failure to receive treatment.
With respect to the untreatable patient, prerequisites for release have received little attention. Certainly the patient’s susceptibility to treatment should be of prime consideration in determining the advisability of therapy, and the degree to which a patient is a threat to society or to himself should be an important factor in any decision as to his possible release. Thus, dangerous persons, though untreatable, may be justifiably confined because countervailing priorities call for the protection of society. However, because unsusceptibility to treatment, without a change in the state of psychiatric knowledge, may lead to confinement for the life of the patient, it should be substantially more difficult to commit and maintain the commitment of an untreatable, nondangerous person than an individual subject to release upon improvement.

The Manner of Challenging Confinement and the Burden of Proof

Equally important as the development of effective remedial alternatives is the availability of means for patients to challenge their confinement. The effectiveness of such challenge further rests on three considerations—what methods are available, how the burden of proof is to be allocated and what assistance is to be extended to the patient in the preparation and presentation of his complaints. The mere fact that a patient seeking release from a hospital is denied his request should be considered at least *prima facie* evidence of a conflict of interests between himself and hospital authorities. Thus, once suit is brought the respective roles of patient and hospital become that of adversaries, and arguments marshalled in favor of legal and medical representation during commitment proceedings are relevant.

Nevertheless, the problem of unequal representation has received much less attention in the patient-seeking-release situation than in the case of original commitment. While the majority of states recognize, by statute, a right to representation by counsel during hospitalization proceedings, virtually no similar provisions are made for release proceedings. Several courts have attempted to


delineate such a right to counsel, the most notable example being the New York Court of Appeals. In \textit{People ex rel. Rogers v. Stanley}^{283}, the court held that indigent mental patients have a constitutional right to assigned counsel in habeas corpus proceedings invoked to establish their sanity. Unfortunately, the court's reliance on \textit{Gideon v. Wainwright}^{284} left it unclear whether the judges joining in the opinion thought the basic issue was the right of counsel or equal protection. Since the sixth amendment relates only to criminal prosecutions, such a constitutional basis would not seem appropriate to a proceeding brought to test a civil commitment. And, it has been suggested that "[i]f the decision is thought to depend primarily on the inequality of one indigent petitioner when compared with one who can afford counsel, it represents a significant extension of the principles of \textit{Griffin v. Illinois}^{285} to the non-criminal area."^{286}

However, regardless of the extent of judicial or statutory assistance provided, the threshold question remains that of the methods and procedures available to challenge the fact of confinement itself. The devices most often suggested in this context are habeas corpus, mandamus, and injunction—habeas corpus being the primary vehicle available to those seeking outright release. The usefulness of habeas corpus has been somewhat in doubt until quite recently. Courts have traditionally drawn a distinction between an illegal detention and a deprivation of rights during detention and have allowed habeas corpus relief only when the detention itself is illegal.\textsuperscript{287} Under this rule, persons in custody have obtained habeas corpus relief when the court that confined them lacked jurisdiction\textsuperscript{288} or when the confinement proceedings violated due process.\textsuperscript{289} Thus, patients committed to mental hospitals have gained release by demonstrating that they were no longer mentally ill or, if commitment was supposedly based on a "dangerousness" criterion, by showing

that their illness did not make them dangerous. However, most courts have denied habeas corpus relief to patients who have alleged physical mistreatment or the denial of essential privileges by custodial officials. Nevertheless, in Rouse v. Cameron, the availability of habeas corpus was assumed to follow from the proposition that a committed patient who is not given adequate treatment is "in custody in violation of the . . . laws of the United States." Also, in Covington v. Harris, it was noted that habeas corpus may be utilized to challenge "the place as well as the fact of confinement, even if the challenged place is a particular hospital ward . . . ." The availability, therefore, of habeas corpus to the civilly committed now appears well-established.

Mandamus and injunctive relief, unlike traditional habeas corpus, are limited to improving the patient's situation while continuing his confinement, and such devices are appropriate for the "dangerous" individual whose outright release may not be a practical alternative. A remedy derived from mandamus might be a judicial decree ordering the hospital administrators to provide treatment for the patient, but the efficacy of such relief would be severely limited by the available resources. Therefore, the availability of outright release as considered in Rouse, and the treatment alternatives considered in Lake, should enter into counsel's decision as whether to pursue relief through mandamus or to utilize some other device to improve his client's position.

See e.g., Miller v. Overholser, 206 F.2d 415 (D.C. Cir. 1953).


373 F.2d 451 (D.C. Cir. 1966).

21 Id. at 458.

21 Id. F.2d ___ (D.C. Cir. 1969).

21 Id. at ___.

22 Such persons include, primarily, the severely dangerous.


Where a patient is in the custody of federal authorities, this provision might be beneficially employed, since it has been construed as contemplating "action affirmative in nature, rather than injunctive relief to prohibit improper action or conduct." Harms v. Fed. Housing Administration, 256 F. Supp. 757, 760 (D. Md. 1966). One obvious limitation, however, on the successful employment of mandamus, in either state or federal court, is that it has traditionally been limited to ministerial, nondiscretionary acts. See e.g., Wilbur v. United States ex rel. Kadrie, 281 U.S. 206, 218 (1930); Prairie Band of the Pottawatomi Tribe of Indians v. Udall, 355 F.2d 364, 367 (10th Cir.), cert. denied, 385 U.S. 831 (1966); Kurio v. United States, 281 F. Supp. 252, 263 (S.D. Tex. 1968).
An additional device for remedying the violations of rights of mental patients is afforded by federal civil rights legislation, which provides that any person who under color of law or custom, deprives any person under the jurisdiction of the United States of his constitutional or legal rights "shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress." Already held applicable to prisoners, section 1983 would seem equally available for courts to redress mistreatment of the hospitalized mentally ill. It should not be difficult to demonstrate that hospital authorities acted under color of state authority since the commitment of the mentally ill is based on the traditional notion of the state's police power, or its power to care for its wards. Still, problems may arise because relief under section 1983—much like habeas corpus—requires a determination by the court of the rights which the plaintiff possesses. However, Rouse v. Cameron, by holding the right to treatment recognizable in a habeas corpus proceeding, should establish sufficient precedent as to the existence of that right. Statutory provision for other rights of the mentally ill should likewise meet this prerequisite.

The final hurdle facing the mentally ill is that of the burden of proof to be borne. To originate confinement, the state must demonstrate that the patient qualifies for commitment pursuant to the terms of the relevant statute. At habeas corpus or recommitment proceedings, it is presumed that the condition of insanity continues and, therefore, the burden of proving sanity rests upon the person seeking release. In Overholser v. O'Beirne, the court held that the patient must demonstrate that he has so recovered that there no longer exists an abnormal mental condition which in the reasonably foreseeable future would endanger the

232 See notes 27-49 supra and accompanying text.
234 302 F.2d 852 (D.C. Cir. 1961) (O'Beirne had instituted a habeas corpus proceeding for release from confinement in mental institution to which he had been committed following acquittal from criminal charges by reason of insanity).
The reasons for this high threshold for obtaining release result from both the fear of unfortunate incidents after premature release and the beneficial role which the hospital is thought to occupy. But since the state usually possesses all of the crucial evidence, legal and medical representation must be provided the patient or his opportunity to present a successful case will be virtually nonexistent.

Consequently, whether the patient seeks outright release as in O’Beirne or merely alternative treatment as in Covington, it appears inequitable to force him to carry such a high burden of proof. Such was the opinion in Lake in which the court indicated that since proceedings involving the care and treatment of the mentally ill are not strictly adversary, the patient should not be required to carry the burden of showing the availability of alternatives. Since the hospital administration should be aware of the full range of available therapy, placing the duty to investigate alternatives here “can hardly be assailed as an intolerable burden . . . ”

Thus, when the appropriateness of confinement has been called into question by a patient’s petition or complaint, its continued validity must depend upon a showing of a mental condition that precludes release, and a demonstration that hospital authorities are pursuing a proper treatment program.

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305 Id. at 856.
307 See note 304 supra.
308 See note 294 supra and accompanying text.
311 See id. The question of what standard should be required for the maintenance of a commitment has been considered by one author, who suggests that “[t]he threshold at which the state may take action should also be the threshold at which the state ceases its activity. The result would be a general rule that the state cannot maintain a confinement unless the patient is susceptible to original commitment.” 34 U. CHI. L. REV. 633, supra note 62, at 658.

Such a suggestion, however, fails to take into consideration several factors. First, those cases in which the person may not be so ill as to enable the court to originally commit are precisely the same cases in which the inexactness of psychiatry is best demonstrated. Thus, in effect, the institutions would be able to treat patients until this point, and no further. Secondly, too early a return to society and its rigors may cause a relapse in the “unsteady” patient which might have been prevented if slightly longer hospitalization had been possible. Finally, it is a mistake to establish general rules for a situation so individual and person-specific as that of mental illness.

However, the State should be obliged to assist the patient in his quest to prove his sanity, for his release would seem to be in the best interests of the person and the public.
Conclusion

Judicially and legislatively, the four years since the enactment of the District of Columbia Hospitalization of the Mentally Ill Act have manifested a renewed and vigorous national concern with the plight of America’s mentally ill. After two hundred years of short-sightedness, mental illness finally has come to be recognized as a delicate medical, social and legal problem not capable of easy or swift conclusion. However, to remedy fully the deficiencies which still exist and to eradicate the view of mental health treatment as a well-intentioned failure, several revisions and much continued effort is necessary.

The problem as it now exists has several aspects, which primarily include the necessity for increasing governmental expenditures and attracting competent personnel into the mental health field. The result of increased financial support should be immediate and twofold. First, the expansion of facilities, raising the quality and variety of care and therapy, together with a concomitant liberalization of admission and discharge policies, will increase the incidence of those seeking voluntary aid. A secondary product of expansion will be the elimination of much of the necessity for the “right to treatment.”

Nevertheless, assuming that such needed expenditures are not immediately forthcoming, much can be done in the interim to further mental health. Initially, a sound statutory and legal basis for the diagnosis and treatment of mental illness at all stages of severity must be developed according to the most modern psychiatric and medical knowledge. To attain such a system, a mere *rapprochement* between the professions can no longer be the goal. Instead, commitment and treatment schemes must be the result of a total synthesis of legal and medical considerations, and a productive, positive approach must replace the appeasement and concessions made in the past to the detriment of the mental patient. Psychiatry must further remove itself from an artificial semantic approach to mental illness and seek to isolate causative factors which can aid an informed judiciary, trained in basic psychiatric and sociological principles.

In addition, judicial and legislative concern must continue beyond the act of commitment, penetrate the asylum’s walls, and assure proper treatment and speedy discharge. Mental health
administrations must be made aware that the judiciary is concerning itself with those persons who are hospitalized against their will. Surely, the work of both the courts and the psychiatric profession must be to respect and protect the rights of a mentally ill person and to provide for his treatment. Although recent court decisions have evidenced such an approach, at the same time they have manifested professional distrust—a situation which detracts from both professions and injures most the patient.

Finally, although this comment has accepted as a basic premise the present judicially-oriented involuntary commitment procedures and has attempted to suggest positive variations on this basic theme, this country's approach toward the improvement of mental health programs must always remain amenable to constructive criticism. The most important step, the acceptance of responsibility, has been taken. Education, publicity, and the general attitudes of an enlightened public must continue to bring new concepts to the legislatures and minds of the people and shatter the tenacious legal and medical anachronisms which so long have shrouded mental health.