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# LOOSING THE CHAINS: IN-HOSPITAL CIVIL LIBERTIES OF MENTAL PATIENTS\*

David Ferleger\*\*

*Pinel immediately led Couthon to the section for the deranged, where the sight of the cells made a painful impression on him. Couthon asked to interrogate all the patients. From most, he received only insults and obscene apostrophes. It was useless to prolong the interview. Turning to Pinel Couthon said: "Now, citizen, are you mad yourself to seek to unchain such beasts?" Pinel replied calmly, "Citizen, I am convinced that these madmen are so intractable only because they have been deprived of air and liberty."<sup>1</sup>*

*Anne M. signed herself into Paris State Hospital as a voluntary patient about five months ago. She had left her husband six months before that and, because he refused to support her, she became a recipient of public assistance. Unable to work as a registered nurse (she had graduated from nursing school with honors) because of physical problems and unable to adjust to a welfare budget (her husband was earning \$22,000 annually), Anne M. was forced to sell the bits of property she had with her, to write checks on an account which had been closed by her husband and, finally, to prostitute herself in order to survive. When she could stand this state of affairs no longer and feared that, in her depression, she might commit suicide, she went to the hospital.*

*On admission, Anne M. was placed in the locked Admissions Unit where, for two weeks, she was forbidden to leave the floor. At the beginning of the third week, her*

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\* Many of the references included herein are either on file with the author or may be located at his direction and the LAWYER has not been able to substantiate the accuracy of such citations. Notation of such references has been made where appropriate and further information may be received by contacting the author at the following address: Mental Patient Civil Liberties Project, 121 South 18th St., Philadelphia, Pa. 19103.

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1. S. PINEL, TRAITÉ COMPLET DU RÉGIME SANITAIRE DES ALIÉNÉS 56 (1836), quoted in N. KITTIRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY 51 (1971).

psychiatrist told her that she could make telephone calls from a pay telephone and that she could leave the floor and go to various activities if accompanied by an aide or a group of other patients. A week later, a nurse told Anne that she had "grounds privileges"—she could go out onto the hospital grounds unescorted.

Three times every day Anne, standing in line with the other patients at the nursing station, awaited her turn to be handed a tiny paper cup containing two or three pills. Not long after her admission, Anne's hands began to tremble, her vision became blurred, her mouth and throat seemed to dry up and her thinking became muddled. Recognizing these symptoms as possible side-effects of her medication, she asked a nurse, "What medication are you giving me? Because of what's happening to me, I just can't keep taking these pills." The nurse refused to reply except to say, "This is what the doctor ordered; it will make you feel better."

One morning, Anne refused medication. That afternoon, the nurse and two aides told her that, unless she cooperated, she would be placed in the seclusion room. Anne repeated her complaints about the medicine and demanded that she be allowed to consult an attorney. Her requests received no response; the aides began to lead Anne toward the locked door of the seclusion room. When she went limp, they carried her down the hall and, a few seconds later, dropped her onto the concrete floor in "seclusion." Anne began to scream and the nurse entered with a hypodermic needle in her hand. With the aides holding her down, Anne received an intramuscular injection in her buttocks. She quickly fell asleep.

When she awoke, Anne began pounding on the door asking to be released and to see an attorney, her doctor and the head of the hospital. She began to tear at the only furniture in the room—a one inch thick mat about six feet long and two and a half feet wide. After an hour, four aides wheeled a metal bed into the small room, placed Anne on it and tied her arms and legs to the four corners. After two days, Anne agreed to take her medicine and she was released from seclusion.

Anne's work assignment in the admissions unit was to wet mop the dayroom every afternoon. Her roommate's job was to clean and scour the bathroom which was used communally by the twenty-five women on the ward. When Anne was granted grounds privileges, she was given an Industrial Therapy assignment in addition to her housekeeping duties; she typed institutional purchase order forms and answered the telephone when the Industrial Therapy secretary was out to lunch. Anne was not paid for this work although, since

*her husband continued to refuse to support her, she had no spending money to use in the hospital canteen.*

*After a month in the Admission Unit, Anne was transferred to another building—one in which the ward was unlocked. Her medication was reduced and she enjoyed greater freedom and more respect from the staff. Anne began to write angry letters to her husband demanding that he support her and accusing him of infidelity. She gave these to the ward clerk for mailing. When her husband did not respond, Anne's letters became angrier and more accusatory. Her psychiatrist told her that her husband had called the hospital complaining about Anne's communications; the doctor (who then told Anne that he had been shown each of the letters by the ward clerk before mailing) said that he agreed with her husband that it would be best if Anne stopped writing.*

*Anne continued to write letters home but would ask her fellow patients to mail them in town when they were out on a day pass. After further protests from her husband, Anne's psychiatrist ordered Anne transferred back to the locked ward and ordered that her "group" and "grounds" privileges be taken away. Not until three weeks later was Anne permitted to return to the open building. [A month ago, Anne was again sent "up the hill" when a fellow patient with whom she had had an argument falsely told the doctor that Anne was again secretly writing letters.]*

*Anne M. is now in seclusion, having refused to wet mop the dayroom and having thrown a bucket of water at the nurse in charge of the unit.<sup>2</sup>*

### INTRODUCTION

The factual details of patient life in a mental hospital are not very pleasing; unfortunately, however, they are not totally unexpected by those familiar with mental hospital administration. Although the description above of Anne M.'s hospital lifestyle might seem unduly exaggerated or excessively melodramatic to the outsider, it is the daily routine<sup>3</sup> for hundreds of thousands of our fellow citizens.<sup>4</sup>

Conditions inside mental hospitals have been largely ignored by the legal community.<sup>5</sup> Only recently, as the analogies between

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2. A composite portrait of a patient at Paris State Hospital.

3. See E. GOFFMAN, *ASYLUMS* (1961) [hereinafter cited as GOFFMAN].

4. In 1969, there were 767,000 persons in or admitted to state and county inpatient services for the mentally ill. An additional 124,000 were private psychiatric inpatients. *STATISTICAL ABSTRACT OF THE UNITED STATES 1972*, Table No. 112.

5. With the exception of the right to treatment, most attention has been

prisons and mental hospitals become more apparent, are those inmates like Anne M. beginning to receive even the most rudimentary constitutional protections. Consumers of psychiatric services have recognized the need to organize<sup>6</sup> and bring to public and legal attention objectionable policies and practices; both the bench and the bar are gradually becoming aware of the fact that mental patients have been systematically deprived of those civil liberties deemed basic to a free society.

This article is intended to be an exploratory examination of various aspects of the "patient phase"<sup>7</sup> or "in-hospital" rights of mental patients. In order to provide the most enlightening perspective of hospital environment, those areas of hospital life that most seriously effect the mental patient's civil liberties will be discussed and analyzed.<sup>8</sup> Recommendations designed to effectuate adequate safeguards of patient rights while minimizing disruption of hospital administration will follow each section.

The setting for the analysis discussed above will be an actual mental hospital. Paris State Hospital,<sup>9</sup> the subject of the "case study," is a relatively new facility, about twelve years old, and sprawls across the hilly country suburbs of a large city in the northeastern United States. Paris has a patient population of just under six hundred, a psychiatric medical staff of twenty-five physicians (fifteen full-time), and a nursing staff of fifty registered nurses, seventeen licensed practical nurses and one hundred ninety aides. I believe that Paris is sufficiently typical to make

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devoted to the commitment process—how one gets in—rather than to what happens once one is in. See, e.g., Schneider, *Civil Commitment of the Mentally Ill*, 58 A.B.A.J. 1059 (1972); Comment, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 YALE L.J. 87 (1967).

A notable recent exception is *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), which sets forth minimal constitutional and medical standards for mental institutions. Even this landmark case, however, did not deal significantly with many of the issues discussed below.

6. As of March, 1973, there existed in the United States more than sixteen groups of patients, ex-patients and sympathizers known to this author. Some of their names illustrate the range of their ideological and political perspectives: Mental Patients Liberation Project, Insane Liberation Front, Patient Advocacy Legal Service, Mental Patients Political Action Committee, Center for the Study of Legal Authority and Mental Patient Status, and Mental Patients Resistance.

7. The term "patient phase" is from GOFFMAN, *supra* note 3.

8. A wide range of constitutional rights are involved in every area of hospital life. In the pages that follow one will immediately recognize such basic constitutional provisions as due process, religious freedom, right to privacy, and freedom from unreasonable search and seizure. Additionally, less traditional concepts such as an individual's freedom of thought and sensation and a patient's right to receive or refuse certain types of medicinal treatment will be discussed.

9. For obvious reasons a fictitious name is being used.

my analysis pertinent to a general inquiry into the restrictions of civil liberties which mental hospitalization presently entails.<sup>10</sup> In fact, because Paris is a hospital with fairly high standards and a good professional reputation, the restrictions of rights found there are probably a representative understatement of the situation at other state and private institutions.

The first, and major, obstacle in appraising the rights of mental patients involves physician expertise and the resultant control over the patient. The mental patient, frequently uninformed, confused, or scared, is particularly susceptible to an almost unimpeachable reliance upon the doctor's professional prerogatives and the associated de-emphasis of the traditional medical-legal doctrine of informed consent.<sup>11</sup> Physicians' expertise often serves as a rationalization for an "I know best" attitude toward the patient that results in a subordination of patient rights to medical paternalism. When faced with a conflict between recognition or possible extension of patient rights on the one hand, and medically indicated treatment on the other, most doctors will not hesitate to choose the latter without even paying lip service to the former. Stemming directly from this professional control of the doctor over his patient is the all too easy assumption that since a person has been diagnosed<sup>12</sup> as "schizophrenic" or "paranoid,"<sup>13</sup> he or she is incompetent to provide decisive guidance and control regarding the ranges or alternatives for treatment. It should be clearly understood that a mental patient retains all the rights ac-

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10. Although the degree of deprivation may vary, patients' experiences in private mental hospitals are generally similar to those in state mental hospitals with respect to most of the issues discussed below. Private patients' difficulties are alleviated somewhat by the frequent personal attention they receive from their psychiatrists. An extremely useful and exhaustive summary of all the states' statutory patient rights provisions may be found in S. BRAKEL & R. ROCK, *THE MENTALLY DISABLED AND THE LAW* (1971) [hereinafter cited as BRAKEL AND ROCK].

11. Under most circumstances, a physician may not impose treatment upon a person without first disclosing the probable risks and consequences involved and then obtaining an "informed consent." The doctor's advice and professional judgment are held subordinate to the patient's right to control what happens to his or her body. See, e.g., *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960), *rehearing denied*, 187 Kan. 186, 354 P.2d 670 (1960). Unfortunately, a "best interest theory" exception has been carved into the above doctrine. The doctor is given a privilege, on alleged therapeutic grounds, to withhold information the disclosure of which would jeopardize the recovery of an unstable or depressed patient.

12. It is significant that psychiatrists in private practice rarely resort to such formal designations. The legal, administrative and political (see n.13, *infra*) aspects of hospitalization seem to encourage such categorization.

13. With reference to the meaning and effect of such diagnostic labeling, see generally the work of Thomas S. Szasz, M.D., including *THE MYTH OF MENTAL ILLNESS* (1961), *LAW LIBERTY AND PSYCHIATRY* (1963) and *THE MANUFACTURE OF MADNESS* (1970).

cruing to individuals outside the hospital unless specific legal proceedings have been completed.

Much of the research involved in preparing this article is necessarily of a largely personal nature. The observations and conclusions herein are based upon my study of a state mental hospital,<sup>14</sup> my involvement in providing direct legal services to mental patients,<sup>15</sup> and my experiences at other mental institutions. The presentation is, inevitably, selective and reflects my biases and a "legal consumer-oriented" perspective.<sup>16</sup> Doctors tend to treat diseases, not persons. The mental patient becomes a "case" rather than a personality with unique and complex problems set against a background of constitutionally protected rights. This article is not meant, of course, as an attack on the motives of psychiatrists in general or those at Paris State Hospital. It has been my experience that hospital doctors sincerely believe that their actions are for the benefit and welfare of the patient.<sup>17</sup> Sincerity, however, is the test of neither legality nor morality.

#### POLICY AND DISCRETION

Two major elements which constantly appear in the hospital context involve the extent to which hospital policy is inaccessible, unknown, ignored, violated or forgotten by personnel in their dealings with patients and the ease of abuse of the wide discretion possessed by the staff in routine decisionmaking. Each of these requires some comment as they may cause or encourage denial of patient rights.

##### *Policy*

"Hospital policy" is not the unified body of authority that the words imply; it<sup>18</sup> is found in many sources and is difficult to

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14. D. Ferleger, *In-Hospital Civil Liberties of Mental Patients, Part I 1972* (unpublished, on file with the author).

15. The Mental Patient Civil Liberties Project, of which the author is Director, has a contract with a state mental hospital which guarantees access for the provision of independent services to patients.

16. For an enlightening and knowledgeable exposition of this contrast see Sparer, *On the Matter of "Community Relations": The Consumer Movement and The Albert Einstein Medical Center (1971)*, 2 MATERIALS ON HEALTH LAW 591 (1972).

17. Recall the remarks of Mr. Justice Brandeis, dissenting in *Olmstead v. United States*, 277 U.S. 438, 479 (1928):

Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding

18. This discussion of "hospital policy" is limited to those aspects of it

locate or understand. At Paris State Hospital, policy may be located in the *Physicians' Handbook*, the *Nursing Manual*, the *Patient and Relative Manual*, the state mental health statute, regulations promulgated pursuant to that statute, directives and memoranda from the various offices of the state Department of Public Welfare, and directives and memoranda issued by the Hospital Director and subordinate hospital administrators. The semi-autonomous physician also makes decisions which are properly treated as contributing to overall policy. Additionally, the nursing staff contributes to the relevant hospital policy as it determines the rules which govern each unit, ward and building. Finally, various meetings and other interactions, both formal and informal, among administrators, staff and doctors are factors shaping hospital policy.

The diversity of hospital policy confuses its creators and participants as much as it does the outside observer. I have spent many hours attempting to unravel the contradictory threads of policy provided by staff and patients.<sup>19</sup> It was not unusual to be told one thing by a nurse on the north ward of a floor and the opposite by a south ward nurse a minute later. On occasion, as when two aides responded to the question "Are mechanical restraints used when a patient is locked in seclusion?" one with a "yes," the other with a "no," the contradictions came simultaneously. The very first day of observation at the hospital, I was told there was absolutely no censorship of mail; a manual for patients and their relatives stated that there was censorship; a nurse told me she didn't know "if there's a policy on it."

A related issue is the lack of uniformity in applied policy. While the staff must retain a certain degree of flexibility to work out its own modes of operation, certain variations, unjustifiable on legal or rational grounds, are needlessly confusing or inappropriate, and frequently contrary to superceding statutory or hospital policy. For example, if one refuses oral medication, he may get "a needle in the ass," be secluded, lose a day's grounds privileges<sup>20</sup> or just be left alone. The sanction applied may depend upon one's location within the hospital, the decision of the nursing staff, or one's doctor. On some wards, a patient can take a nap in his or her room; on other wards, this is impossible. Depending

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which refer to or affect in-hospital liberties. I am not including in the term such things as budgetary, staffing, dietary or maintenance policy.

19. At Paris and other institutions, I have interviewed persons at all levels—administrators, doctors, nursing staff, social workers, volunteers and patients.

20. "Grounds" is the opportunity to leave a locked ward and go outside or visit other areas of the hospital unescorted.



on the local rules, a patient may or may not keep a lock on a private locker. Some units have spot searches of patient rooms and others have regular weekly searches while another has none at all. On some wards, no outgoing mail is examined; elsewhere, nurses and aides examine *all* such mail despite an express statutory prescription that certain mail shall be sent "sealed," that is, free from any inspection whatsoever.<sup>21</sup>

Other "uniform" policies are ignored or violated, occasionally with the acquiescence of the policy-makers. Seclusion orders, for example, are routinely given "p.r.n."<sup>22</sup> although the rule is to the contrary. Rather than being given the choice between cooperative medication and leaving the hospital (as is official policy), the voluntary patient may be forcibly tranquilized. Particularly flagrant is the discrepancy between the hospital's mechanical restraint order form and actual restraint practices. The form indicates that only certain apparatus may be used, namely, camisoles, sheets and towels; however, a box which I saw labelled "Restraints" contained many items (e.g., leather straps and a gag) forbidden by the order form.

Patients are uninformed about hospital policy. Their interests in it range in intensity from mild curiosity to ravenous hunger but, at present, nearly all patients are unsatisfied. Paris has a *Patient and Relative Manual* which, for the most part, deals with such matters as visiting hours, the location of the barber shop and automobile parking regulations; there is a small section relating *some* of the statutory rights in a misleading manner.<sup>23</sup> The *Patient and Relative Manual* is outdated (it is four and a half years old), sometimes inaccurate and not very comprehensive. At any rate, despite official policy to the contrary, patients fail to receive the manual at all.

Whether or not they are concerned with "policy," patients' concern about what is being done to them and under what authority is very real. They have a right to know these things and to be aware of the options available to them and to the hospital. Patients would certainly benefit if they were able to cite chapter and verse on their own behalf, and abuse or avoidance of hos-

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21. The Pennsylvania Mental Health and Mental Retardation Act of 1969 [hereinafter cited as the "Pennsylvania Act"], PA. STAT. tit. 50, §§ 4101, *et seq.* (1969), guarantees the patient "sealed communications to the director [of the institution], any member of his family, the department [of public welfare], the court, if any, which committed him, and the Governor." PA. STAT. tit. 50, § 4123(1) (1969).

22. Abbreviation for the Latin *pro re nata* (according as circumstances may require). DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (24th ed. 1965).

23. For example, the word "sealed" is omitted from this manual's reference to the statutory provision on mailed communications. See note 21, *supra*, for text of statute.

pital policy (whether intentional or unintentional) by hospital staff would be deterred.<sup>24</sup>

### *Recommendations*

1. A short but comprehensive description of hospital rules and policy regarding patient-phase civil liberties should be prepared. This should include relevant materials from such sources as the local equivalent of Paris' *Physicians' Handbook* and *Nursing Manual*, and the state mental health statute and its regulations. Ruling case law should also be incorporated. All physicians, staff and patients should receive a copy of the summary.<sup>25</sup>

2. Those policy areas within which wards or buildings may vary their rules should be clearly defined and all such variations should be clearly posted within view of patients in the unit and inserted as an addendum to the summary rules description suggested above.

3. The *Physicians' Handbook*, the *Nursing Manual*, the statute and the regulations issued pursuant thereto, and all memoranda and directives from the central state authority and the hospital administration should be available in an open hospital area (perhaps the library, chapel or recreation area) to patients, their relatives and staff. Theoretically, most, if not all, of this material is already public information available in a law library, the hospital director's office or the state capitol. Presently, the people most affected by the material, the patients, have the least access to it.<sup>26</sup> There is no justification for this situation.<sup>27</sup>

4. Assuming the rise of "asylum-lawyers" with abilities and functions similar to those of jailhouse lawyers,<sup>28</sup> mental hospitals

24. If they were familiar with all the rules, nurses and aides could more easily decline to carry out doctor's orders which are contrary to hospital policy. As a collective solution to this problem, unionized hospital workers might argue that they may not properly be directed to violate patient rights and that, therefore, some codification of patient rights is required.

25. With reference to the analogous prison situation, it has been stated: Without a set of written rules and regulations, enforcement of discipline in the prison will, by definition, always be arbitrary and capricious, for a most fundamental notion of the rule of law is prior notice of what in fact is deemed by the authorities to be illegal.

RUDOVSKY, *THE RIGHTS OF PRISONERS* 24 (1973).

26. As an interim advocate's approach to this problem, the Mental Patient Civil Liberties Project has begun to distribute a *Patient Rights Manual*, 3-4 *ROUGH TIMES* 12 (1972), at a local mental hospital. See also, B. ENNIS & L. SIEGAL, *THE RIGHTS OF MENTAL PATIENTS* (1973), a useful handbook for patients, laypersons and newly-interested attorneys.

27. Concern over the limited content of prison libraries has been expressed. Compare, e.g., *In re Harrell*, 2 Cal. 3d 675, 470 P.2d 640, 87 Cal. Rptr. 504 (1970) with *Hatfield v. Bailleaux*, 290 F.2d 632 (9th Cir. 1961).

28. *Johnson v. Avery*, 393 U.S. 483 (1969) held unconstitutional blanket prohibitions on prison inmate assistance.

should also make available relevant legal materials to facilitate mutual inmate assistance.<sup>29</sup>

### *Discretion*

The discretionary power of the nursing and aide staff is immense. Neither the hospital administration nor the medical staff is in a position to review the thousands of decisions made daily at that level. Yet that is the level at which nearly all patient-hospital contact occurs. That is the level at which patients' rights and liberties may be most severely threatened. And, from the medical-therapeutic point of view, that is the level which has the most impact on cure and recovery.<sup>30</sup>

A few examples of the areas in which discretion is exercised will illustrate the potential for abuse. When a doctor orders that seclusion or mechanical restraints be used "p.r.n.," as is necessary, it is the aide or nurse on the floor who decides what sorts of behaviors necessitate such action. I have heard an aide threaten a patient (who was sitting quietly watching television and refused to rise at the request of the aide) with the exercise of his "discretion": "I've got a room for you . . . !"

Unlike the open unlocked wards, the locked units do not have pay telephones within ready access of patients; an aide must accompany the patient out through the locked door to the phone booth. Of course, the opportunity, frequency and duration of patient telephone communications thus becomes dependent upon decisions made by the lower-level staff.

If a patient is deemed incapable of overseeing his or her spending money, the money is held for the patient in the nursing station and released only upon request. A nurse indicates that such capability is ascertained in this free-wheeling manner: "By his actions, you can tell." Of course, this conclusion is reached without regard to formal guardianship or incompetency proceedings. The staff at Paris State Hospital often takes advantage of the

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29. Although *Johnson v. Avery* did not directly touch that point, it is difficult to escape the logic that if an inmate has the right to the assistance of *another inmate* in the preparation of legal material, he cannot be absolutely restrained from acquiring the requisite knowledge to *assist himself* in the preparation of his petitions and applications. To reason otherwise would be effectively to grant writ-writers an in-prison monopoly on legal knowledge to which indigent or illiterate inmates must resort for the effective presentation of their complaints.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS, *THE EMERGING RIGHTS OF THE CONFINED* 49 (1972).

30. A major treatment modality in mental hospitals is called "milieu therapy" in which the therapeutic agents are the human and physical environments—the hospital itself. E. ROSEN & I. GREGORY, *ABNORMAL PSYCHOLOGY* 220-21 (1965); A. STANTON & M. SCHWARTZ, *THE MENTAL HOSPITAL: A STUDY OF INSTITUTIONAL PARTICIPATION IN PSYCHIATRIC ILLNESS AND TREATMENT* (1954).

leverage offered by the fact that the patient's cigarettes or money is inaccessibly stored within the nursing station on the locked wards. A young adolescent patient knocked on the station door. This conversation ensued:

Patient: "May I have a cigarette?"

Nurse: "That depends on how you did in school today."  
(The nurse then looked at the patient and noticed that he was sad and upset. In a concerned voice, she asked:) "How do you feel? What's the matter?"

Patient: (mumbles inaudibly)

Nurse: (back to original voice) "How did you do in school? Did you pay attention? Did you learn any new words?"

The young man walked away and never received his cigarette.

There are no easily implemented actions to counter abuse of discretion. It is fundamentally a problem of educating staff and raising individual consciousness to a higher level of empathy and compassion. The nurses' and aides' perceptions of the administrators' expectations are also crucial. If the staff knows that a four or five day seclusion period for a minor infraction is "O.K." with the hospital director and the state capitol, then their self-imposed restrictions on such discretionary decisions will remain loose and casual. On the other hand, if the staff knows that the policy-makers are concerned with providing a more free atmosphere with minimal restrictions on liberty, routine determinations will undoubtedly be affected.<sup>31</sup>

### *Recommendations*

1. Penalties for violation of hospital rules should be clearly determined and posted.
2. Staff training on the use of discretion should be emphasized.<sup>32</sup>

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31. *Pennsylvania ex rel. Rafferty v. Philadelphia Psychiatric Center*, Civil No. 72-2521 (E.D. Pa., filed Jan. 16, 1973), is a case in which the state has joined with a nurse in filing suit against a private mental hospital which fired the nurse after she publicly criticized her former employer, a state mental hospital. The suit seeks to guarantee hospital employees' first amendment right to criticize institutions and seeks to make clear the state's interest in deterring improper practices at the staff level.

32. Again, the analogy between prisons and mental hospitals seems appropriate; the following statement regarding prison guards is equally applicable to the staff in mental hospitals:

In fact, prison guards may be more vulnerable to the corrupting influence of unchecked authority than most people. It is well known that prisons are operated on minimum budgets and that poor salaries and working conditions make it difficult to attract high-calibre personnel. Moreover, the "training" of the officers in dealing with obstreperous prisoners is but a euphemism in most states. *Landman v. Peyton*, 370 F.2d 135, 140 (4th Cir. 1966).

3. Staff should plainly indicate their actions and their reasons therefor within the patient's hospital record.<sup>33</sup>

4. Proper medical standards<sup>34</sup> should be closely followed; that is, reports of incidents and complaints should include the patient's description and explanation. It's suggested that a form be used so the patient may write or dictate his or her version of the incident and that this form be attached to the staff report. Both reports, of course, would become part of the medical record.<sup>35</sup>

5. An effective grievance consideration mechanism should be established. Such mechanisms may take a number of forms depending upon the resources available to the hospital. One simple and inexpensive method is to provide "Suggestion and Complaint" forms to patients with guaranteed intramural delivery to the hospital director's office or mail delivery to the state capitol. Another possibility is a grievance committee composed of staff and patients which would investigate and take action on complaints. However, the most effective method of assuring that low level discretionary decisions will be subject to potential review is to provide a non-hospital "ally/advocate" (with the resources to institute litigation) to represent the patient to the administration.

Whatever method is selected, a grievance consideration mechanism would have an effect far beyond settlement of an individual case. Enforced accountability to the consumers of their services would force nurses and aides to learn and abide by hospital policies.

### THE PRIVILEGE SYSTEM

#### *Description*

There is no aspect of patient behavior which escapes the machinations of the privilege system. All actions or omissions carry the potential of influencing the acquisition, retention or loss of privileges. Patients devote much of their thought and energy

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33. See JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, STANDARDS FOR PSYCHIATRIC FACILITIES (1972).

34. Paris State Hospital standards require that "the complaint of others regarding the patient is included [in the medical records] as well as the patient's comments." Medical Records (for Paris State Hospital), in accordance with the requirements of the Joint Commission on Accreditation of Hospitals and the Department of Welfare, paragraph (a)(3) (on file with the author).

35. See, e.g., *Williams v. Robinson*, 432 F.2d 637, 642-43 (D.C. Cir. 1970), where the court stated:

On their face, the records must be adequate to demonstrate the propriety . . . of the challenged decision. If the records are not adequate on their face, they may not be rehabilitated by a subsequent demonstration in court.

to the procurement of privileges and the fear and avoidance of their restriction. The big stick wielded by hospital staff is the withdrawal of privileges—in hospital terminology, “restriction.”<sup>36</sup>

At Paris State Hospital, after an initial period of total restriction (lasting one to two weeks), the new patient is given “group” or “grounds” privileges. Usually, group privileges are granted first and grounds follow at a later date. “Group privileges permit the patient to attend activities with groups of other patients under the supervision of an employee, volunteer or relative.”<sup>37</sup> Referring to grounds privileges, the *Patient and Relative Manual* states:

Patients accepting *ground privileges* agree to the following:

- (1) that they will not permit these privileges to interfere with their treatment program and will attend all activities as scheduled;
- (2) not to leave the hospital grounds;
- (3) that they will restrict their movement on the grounds to the regular paved roads and observe the north boundary of the green benches on First Avenue before Darby Road, and the south boundary of the employees’ cafeteria building.

(4) not to loiter in front of or to enter Building #3 unless they have a specific assignment there;

(5) to return to their own ward when the street lights go on in the evening, except to attend planned activities in the Recreation Building and then return directly to their ward.

Patients are requested not to enter the South Hall of the first floor of Building #4 or any physician’s office unless he has an appointment, and not to enter any other ward areas. Patients may visit on the patios or in the lobbies of other buildings.

Patients having ground privileges are requested to sign out in a designated book in each ward so that they may be located at any time.<sup>38</sup>

Another sort of privilege provides the opportunity to leave the hospital property for the day, the weekend or, occasionally, for longer periods.

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36. That the privilege system has infiltrated into the most trivial aspects of daily existence, with a depth that exceeds its justification, may be illustrated by the following two signs posted in the Recreation Building, the first by the four bowling lanes and the second sign in front of vending machines just within the building’s entrance:

DO NOT ROLL BALLS DOWN THE ALLEY IF YOU ARE NOT  
BOWLING. RESTRICTION WILL FOLLO.  
PLEASE DISPOSE OF ALL TRASH IN THE WASTE BASKETS.  
if not disposed properly—new restrictions will follow.

37. Paris State Hospital, *Patient and Relative Manual* 11 (1967) (on file with the author) [hereinafter cited as *Patient and Relative Manual*].

38. *Id.* at 12-13.

According to hospital policy, decisions to grant privileges, and later decisions to revoke or regrant them, are made by the patient's psychiatrist and entered by that person on the patient's medical record. Actually, my observations indicate that the nursing and aide staff possesses the effective decisionmaking power with reference to everything following the routine initial lifting of restrictions.

Privileges may be revoked for a myriad of reasons. Two patients note that revocation will result from "getting in any kind of trouble" or "if you don't do what you're 'sposed to." Privileges are routinely withdrawn by the staff as punishment, for example, for refusal of medication or a refusal to clean up one's room or to perform one's work assignment. The above "offenses" usually call for a one day confinement to the ward. Less well-defined behavior, however, may result in the same sanctions. To illustrate: One day, while lunching in the snack bar, I met Gloria, a patient whom everyone seemed to know. She was wiping tables, singing and swaying to juke box music, being friendly and exchanging comments with people. A week later, I learned that Gloria had been restricted to her "open" building for "carrying on." Asked for a clarification of this term, a nurse could state only that Gloria had been "singing and dancing in the canteen and hanging on to people."

The curious coexistence of punishment and therapeutic motives are evidence in these not wholly logical comments by a nurse:

They would not get grounds while they are refusing medicine because then you're defeating your whole purpose. You're rewarding them with grounds when they're not really taking their medicine. You wouldn't give them grounds if they were still refusing their medicine. That doesn't make sense. If they're well enough to have grounds, they're well enough to take their medicine.

I heard another nurse justify the use of seclusion for a patient on the grounds that, for the particular patient, revocation of privileges was "not enough punishment." Two additional staff motives are prevention of unauthorized leaves and a concern with "appearances," that is, publicly appropriate behavior; both motives are illustrated by the following reply of a nurse to my request for reasons for removal of privileges:

Like I have a patient, Sandra Myers. Sometimes she packs her clothes and says, "I'm going home. I'm going home." Then I hold her grounds. That's one instance.

Another instance is someone who is very upset like Jano Ganzer. She would scream at the top of her lungs, "You murder-

ers, you torture me. You're making my nose big." Very delusional in her talk. Not only delusional but screaming at the top of her lungs and offending other people. We'll hold her grounds for that afternoon. She quiets down. She will keep on doing it for about ten minutes but she knows she has to quiet down because she can't go down to the lobby and act like that. I pointed out to her that if she's not able to act appropriately, then she's not able to go down.

No review of privilege decisions is practically available to patients. Despite hospital policy, the nurses' notes and doctors' orders in the medical record most often include (though not as a rule) only the staff's version of the incident which precipitated the decision. Patients confirmed that they were rarely asked for their side of the story and complained that they were frequently left in the dark as to the reasons for their restriction.

### *Discussion*

From the hospital's point of view, the privilege system provides incentive for positive behavioral change as it performs its therapeutic function in the ward's milieu.<sup>39</sup> A commentator is under great pressure to tread lightly in this area because of the fundamental importance of the privilege system to the hospital organization. Mail censorship or room searches, for example, could be abandoned with a minimum of pain and suffering; however, weakening or eliminating the privilege system might be so threatening to the power of the staff as to preclude serious consideration of its desirability.

While patients are manipulated by staff into desired behavior, they also learn to use the privilege system for personal advantage. Alert patients, if they want to leave the hospital or maximize their freedom within it, quickly learn how to be a "good" patient; that is, they learn which *overt* behaviors and verbalisms will elicit rewards and which will result in punishment. Though hallucinations, anxiety or paranoia may remain, they are hidden from the staff by the "good" patient. One possible professional response to this adaptation is to applaud the patient for learning the skills of lying and pretense which pervade life "outside." Another reaction is concern for the masking of some of the very human problems in living which might have prompted the patient's hospitalization—problems which, since unresolved, are likely to continue to create difficulty after release. The entire constellation of issues which arise from this "good patient" syndrome illustrates a basic shortcoming in the privilege system.

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39. See generally GOFFMAN, *supra* note 3.



Another troublesome aspect of the privilege system is the subjection of people who are already deprived of their liberty, to further restriction on the basis of unreasonable, minor, often trivial justifications. "Carrying on" or "upsetting people" outside the hospital earn one a bit of social ostracism and possibly the loss of an acquaintance or two; such behavior would not result, as it does in the hospital, in losing the "privilege" of walking in the sun or using the telephone.<sup>40</sup>

Procedural due process would require, at the least, accurate and full hospital records as to staff actions and the reasons therefor to assure that all relevant information (including the patient's explanation) has been taken into account and that a permissible decision has been made.<sup>41</sup>

A potential legal restriction on the privilege system is the set of absolute in-hospital rights established by *Wyatt v. Stickney*,<sup>42</sup> the landmark right to treatment case. Although the *Wyatt* court carefully permitted the limitation of some "privileges" by hospital professionals (*e.g.*, the right to visitation and telephone communications),<sup>43</sup> there are some rights which were recognized with no qualifications whatsoever. For example, "[p]atients have a right to be outdoors at regular and frequent intervals, in the absence of medical considerations,"<sup>44</sup> the right to regular exercise periods and facilities,<sup>45</sup> the right to religious worship,<sup>46</sup> the right to interaction with the opposite sex,<sup>47</sup> and the right to a television in the dayroom.<sup>48</sup> Following other decisions in the mental health law field, the *Wyatt* court held that "patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment."<sup>49</sup> This right would include the right to privileges if the person's mental condition were such that privileges could

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40. The attempt to distinguish the hospitalized patient from the psychiatric outpatient or physically ill person on the basis that the mental patient must be controlled (by drugs, locked doors or restraints) to prevent physical injury is not persuasive. Mental illness is not necessarily equatable with danger. . . .

GAY, DEFICIENCIES OF COMMUNITY BASED FACILITIES IN RELATION TO ST. ELIZABETH'S PATIENTS 2 (1972).

41. On judicial review of hospital decisions regarding internal administration, the issue is whether the hospital "has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion." *Tribby v. Cameron*, 379 F.2d 104 (D.C. Cir. 1967). See also *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

42. 344 F. Supp. 373 (M.D. Ala. 1972).

43. *Id.* at 379.

44. *Id.* at 381.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.* at 382.

49. *Id.* at 379. The doctrine of "least restrictive alternative" was first

be taken advantage of without adverse consequences; use of the privilege system as punishment or for manipulation of behavior would, under this reasoning, be prohibited.<sup>50</sup>

### *Recommendations*

The privilege system is punishment therapy. It could be otherwise. It could be a system of enforceable community rules accepted as legitimate by all concerned while recognizing the absolute rights described above. To effect this suggested transformation, the following recommendations are made:

1. Offenses and punishments should be clearly defined in a published and distributed "schedule."
2. Patients should have a significant part in formulating the community rules.
3. The rules should govern *all* members of the hospital community. In addition to sanctions for patient offenses, there should be sanctions against a nurse or aide who, for example, secludes without a doctor's order, and against a physician who revokes a patient's privileges without sufficient cause.
4. An uncomplicated "judicial" system should be established for minor restrictions to resolve disputed questions of fact.<sup>51</sup> Administrative review should be available.

## ROOM SEARCHES

### *Description*

One assigned duty of the nursing and aide staff at Paris State Hospital is to make regular searches of patients' rooms. According to the institution's assistant superintendent, decisions as

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applied in the mental health commitment area in *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966). See also Wexler, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1 (1971). This concept was extended to the in-hospital situation by *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

50. For an excellent examination of the status of "absolute" rights within the mental hospital see Wexler, *Token and Taboo: Behavior Modification, Token Economics and the Law*, 61 CAL. L. REV. 81, 93-95 (1973).

51. A number of prisoners' rights cases have articulated procedures for use in disciplinary actions for minor violations. These would be appropriate for use in the mental hospital privilege revocation context. *Bundy v. Cannon*, 328 F. Supp. 165 (D. Mo. 1971) required (1) representation by another inmate or staff member, and (2) a written decision with a reasoned basis for findings and recommendations. For minor inmate offenses within the Virginia penal system, a federal district court compelled (1) verbal notice, (2) an impartial tribunal, and (3) a chance to cross-examine the complaining officer, and to present testimony in defense. *Landman v. Royster*, 333 F. Supp. 621 (E.D. Va. 1971).

to the extent and scheduling of searches are made by the nurses on the ward.

Actual practice appears to vary widely. One nurse told me that spot checks are made once a week. Other units make regular thorough searches of bedside cabinets in all patient rooms and dormitories. Often, patients do not know that these searches are made because they are accomplished while the patients are at meals or about on the grounds.

Policies are often embodied in notices posted inside the nursing station (beyond the view of patients). For example:

June 28, 1971

THE AIDES ARE INSTRUCTED TO MAKE A THOROUGH SEARCH OF BEDSIDE CABINETS ONCE A WEEK (UNLESS OTHERWISE NOTIFIED). THIS IS TO CONFISCATE MATCHES AND/OR OTHER CONTRABAND. THE AIDES ARE TO SELECT THE DAY & TIME AND FOLLOW THROUGH.

/s/ Miss Random

"Contraband" apparently includes, in addition to matches, such articles as sharp or pointed instruments, drugs, alcoholic beverages, any glass articles, spiked heels, umbrellas and razor blades. These items are listed in the *Patient and Relative Manual*<sup>52</sup> as items which "[v]isitors are not permitted to bring."<sup>53</sup> I have not been able to locate any list of officially-designated contraband, nor are patients given any such list.

Occasional specific searches are conducted in addition to the routine ones. For example, if a safety razor was found missing after the "sharp count,"<sup>54</sup> every room on the locked ward would be searched. In an unlocked ward or building, "the whole building is given a shakedown," as one nurse told me, if a particular patient were suspected of possessing contraband or if there were a belief on the part of the staff (based either on an informant's tip<sup>55</sup> or unsubstantiated feelings) that some patient might have violated the rules. This is the general policy as confirmed by the hospital psychiatrists and administrators.

The major justification for this stringent policy is, of course, hospital security. The hospital administration seeks to deter or

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52. See *Patient and Relative Manual*, *supra* note 37 at 11.

53. *Id.*

54. "Sharp count" is the regular check and count of sharp and pointed objects (e.g., safety razors, scissors) which are kept on the ward for limited patient use and are locked in a nursing station cabinet.

55. When acting pursuant to an informant's disclosures, the hospital staff does not limit the search to the location or person described by the informant because, I was told, "he's probably lying."

prevent suicide attempts, assaults and other untoward events. The factual basis for this concern may be indicated by an analysis of Paris State Hospital's official records of all incidents for February, 1972; during this month, 16,646 patient/days of service were provided.

There were a total of four relatively trivial self-inflicted injuries during that month, all occurring in the unlocked wards. These were described as follows: (1) drank soap and bleach solution, (2) abrasion of head, (3) attempted strangulation, and (4) punched door—injured hand. Seven patients were attacked by other patients, three others were bitten and one was sexually assaulted. There was one case of illicit use of drugs and a similar case involving alcohol. These seventeen incidents yield a rate of only one per 979 patient/days.

### Discussion

The extremely low rate of incidents at Paris indicates that there is little problem with disruptive or dangerous patient behavior. Although it may be argued that this is due simply to the effectiveness of the contraband policy, other evidence suggests that this is not the case. The fact is that the overwhelming majority of mental patients in the United States are not dangerous to themselves or others.<sup>56</sup> Most patients could, without adverse effect, leave the hospital for outplacement in the community—in nursing homes, foster homes, halfway houses, the patients' own homes or special personal care facilities.<sup>57</sup> Thus, although the mental hospital may legitimately be concerned with the potential for danger created by the presence of items which would facilitate

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56. See note 40, *supra*.

57. One major study of 4,000 patients at St. Elizabeth's Hospital in Washington, D.C., found that "68% of the patient population has no behavior problem which could limit outplacement. Thus, none of these patients could be considered 'dangerous to themselves or others' by any definitions of the terms." Abraham & Bucker, Preliminary Findings from the Psychiatric Inventory 3 (1971) (on file with the author). Those with problems were described as "assaultive" (10% of the total population), "destructive" (5%), "suicidal" (3%), "sexual" (3%), "alcoholic" (7%) and "other" (4%). *Id.* at Table I. Another commentator concluded that:

there is a large proportion of the patient population, 43 per cent, whose presence in the hospital cannot readily be explained in terms of their psychiatric condition. Their presence suggests the putative character of the societal reaction to deviance, and that for at least a near majority of the patients, their status is largely ascribed rather than achieved.

T. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY 168 (1966). See also Mendel, *Brief Hospitalization Techniques*, 6 CURRENT PSYCHIATRIC THERAPIES 310 (1966) which discusses a study in which 75% of almost 3,000 patients with a diagnosis of schizophrenia were found to be suitable for discharge to the community.

a self-inflicted injury or assault, the need for security is, at best, a minimal one; tight security measures should have, as their target population, only that minority of patients who are identified as "dangerous."<sup>58</sup>

All patients have a vital and constitutionally protected interest in maintaining their own bit of private space and property in the otherwise impersonal institution;<sup>59</sup> during searches for allegedly dangerous contraband, the nurse or aide may peruse and handle private papers, diaries, books, secreted foods, contraceptives or other items. The patient has the right to keep these and other personal effects from the eyes and hands of others. The authors of the Constitution "sought to protect Americans in their beliefs, their thoughts, their emotions, and their sensations. They conferred, as against the Government, the right to be left alone—the most comprehensive of rights and the right most valued by civilized men."<sup>60</sup> Surely, each and every mental hospital patient cannot be thought to have abandoned in all respects their right to be left alone. Treatment of a person for "mental illness" is no justification for denial of the constitutional and human right to privacy.<sup>61</sup>

Furthermore, the fourth amendment prohibits both wholesale shakedowns of wards and buildings on tips from often anonymous or untrustworthy informants, and routine checks of personal property in bedside cabinets and elsewhere.

*Lankford v. Gelston*<sup>62</sup> was an action to enjoin mass police investigation of more than 300 locations, mostly private homes and most involving searches, in an unsuccessful effort to locate "armed and dangerous" robbers. At the hearing, police officers "testified that in serious cases it was routine to make searches of homes on the basis of anonymous calls."<sup>63</sup> The court ordered such searches without probable cause enjoined; its discussion included the following paragraph which applies as well to both the serious and routine situations facing the mental hospital worker:

In ordering the issuance of an injunction we have not blotted from our consideration the serious problems faced by the

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58. There are doubtless some patients who want the protection from reduced self-control which is offered by the search-and-find hospital policy. Especially for truly voluntary patients who hospitalized themselves in order to work through their destructive feelings and, in effect, contracted with Paris for a "safe" environment, this motive must be respected.

59. Cf. *Stanley v. Georgia*, 394 U.S. 557 (1969); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

60. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

61. *Wyatt v. Stickney*, 344 F. Supp. 313, 379 (M.D. Ala. 1972) explicitly holds that mental "[p]atients have a right to privacy and dignity."

62. 364 F.2d 197 (4th Cir. 1966).

63. *Id.* at 200.

law enforcement officer in his daily work. His training stresses the techniques of the prevention of crime and the apprehension of criminals, and what seems to him to be the logical and practical means to solve a crime or to arrest a suspect may turn out to be a deprivation of another's constitutional rights. . . . While fully appreciating the exceedingly difficult task of the policeman, a court must not be deterred from protecting rights secured to all by the Constitution.<sup>64</sup>

Simply because the mental health professional sees the shakedown as the "logical and practical" means to locate offending patients does not justify depriving them of their constitutional rights. This is especially so in the hospital situation where dozens of innocent persons will suffer the inconvenience and indignity of a vain search so that the authorities *may* locate the one person who *may* have in his or her possession an item which *may*, at some indeterminate future time, cause an unspecifiable harm, which *may or may not* be serious.

The United States Supreme Court, in *Camara v. Municipal Court*,<sup>65</sup> held that an inspector attempting to enforce a local housing code could not make a general area inspection without a warrant. The Court declared that the Fourth Amendment applied to routine periodic inspections conducted under regulatory laws. It said:

It is surely anomalous to say that the individual and his private property are fully protected by the Fourth Amendment only when the individual is suspected of criminal behavior. . . . The practical effect of this system is to leave the occupant subject to the discretion of the official in the field. This is precisely the discretion to invade private property which we have consistently circumscribed by a requirement that a disinterested party warrant the need to search.<sup>66</sup>

Similarly, although the nurses and aides are not law enforcement authorities and routine searches may arguably be a proper interest on the part of the hospital, the institution must meet the constitutional test of reasonableness to justify intrusions into a patient's effects without consent.<sup>67</sup> It is highly unlikely, because of their condition,<sup>68</sup> that most patients would come into posses-

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64. *Id.* at 204.

65. 387 U.S. 523 (1967).

66. *Id.* at 530-32.

67. It would be impermissible to distinguish between the mental hospital situation and that in *Lankford* and *Camara* on the grounds that those cases involved searches of persons' residences. "[T]he fourth amendment protects people, not places." *Katz v. United States*, 389 U.S. 347, 351 (1967). In any case, the mental hospital is, at least for a temporary time, the home of the subject of the search.

68. See notes 56 and 57 *supra*.

sion of contraband. Thus, it is difficult to discern any legitimate reason for discretionary routine searches of all rooms and dormitories.<sup>69</sup>

### *Recommendations*

A policy which would be constitutional and cognizant of human dignity would be to ban mass periodic and shakedown searches entirely and to allow searches only where there is probable cause to believe that the contraband rules have been violated and that the subject of the search is the violator.<sup>70</sup>

A Maryland court has defined procedures which must be followed in searches conducted at the Patuxent Institution for adult "defective delinquents,"<sup>71</sup> a special facility whose specific responsibility is to provide psychiatric treatment for offenders committed there. The following suggestions are based upon that court's determinations.

1. Searches must be conducted with maximum respect and minimum discomfort to the patients.
2. Only items prohibited by explicit rules may be confiscated.
3. All items removed in searches of rooms and dormitories must be replaced without damage.

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69. Fourth amendment law as developed in the prison and school contexts is not directly applicable to the mental hospital situation despite the similarities of all three institutions as "total institutions." See GOFFMAN, *supra* note 3.

The security requirements of prisons are much greater than those of hospitals; the need to prevent the introduction of weapons, tools and other contraband is recognized by the courts. Compare *United States v. Marin*, 378 F.2d 472 (2d Cir. 1967) (search of inmates returned from escape); *Cline v. United States*, 116 F.2d 275 (5th Cir. 1940) (search of inmate about to be transferred); *People v. Frazier*, 262 Cal. App. 2d 630, 64 Cal. Rptr. 447 (1968) (search of cell revealing homosexual activity) with *People v. Vasques*, 275 N.Y.S.2d 14, 9 N.E.2d 758 (1966), in which the opening and search of two envelopes which had been taken from an inmate were held to be unreasonable; although the taking was a proper protection of security interests, the search of the envelopes' contents went beyond that which was necessary to secure those interests.

In school locker search cases, the private areas of students are not invaded as the mental patients' rooms are. Dormitory, as well as locker, searches have typically involved criminal behavior, frequently with the police participating in or initiating the search, often pursuant to a warrant. See, e.g., *People v. Overton*, 24 N.Y.2d 522, 249 N.E.2d 366, 301 N.Y.S.2d 479 (1969); *State v. Stein*, 203 Kan. 638, 456 P.2d 1 (1968), *cert. den.* 397 U.S. 947 (1970); *In re Donaldson*, 269 Cal. App. 2d 599, 75 Cal. Rptr. 220 (1969); *Piazzola v. Watkins*, 316 F. Supp. 624 (M.D. Ala. 1970); *Moore v. Student Affairs Committee of Troy State University*, 284 F. Supp. 725 (M.D. Ala. 1968). The searches in these cases are quite different from the hospital's administrative searches for items the possession of which is non-criminal. None of the cited school cases even take note of *Camara*.

70. One psychiatrist at Paris State Hospital already follows this policy in his unit with apparent success.

71. *McCray v. Maryland*, 10 CRIM. L. RPTR. 2132 (Cir. Ct. Montgomery Co. Md. Nov. 11, 1971).

4. Patients have a right to be present during any search.
5. Patients must be given a written list of all items confiscated.

#### REFUSAL OF TREATMENT

##### *Description*

Paris State Hospital official policy (although unwritten), according to the assistant superintendent, is that medication is not forcibly administered to (1) short-term civil court commitments for evaluation prior to final court commitment for treatment, (2) voluntary patients, and (3) persons whose religious beliefs preclude medication. In explaining these classifications, the administrator indicated that a voluntary patient would be given a choice between cooperative medication and leaving the institution; however, he claims, this situation "hasn't arisen." Also, religious expressions would be ignored if they were part of the "ideation" of the patient's illness. The assistant superintendent expressed his support for the general practice of enforced medication in these terms: "We can't just sit by and let them be sick."

A patient describes the policy this way. If medication is refused, "the goon squad forces you—a needle in the ass—and then they put you in the seclusion room." Most of the staff acknowledges that a patient's group or grounds privileges will be withheld while medication is being refused, whether or not the medication is actually received by intramuscular injection ("I.M."). There seems, however, to be some difference in practice among the various wards regarding the use of seclusion in such cases. One nurse denied that seclusion is *ever* used when medication is refused while an aide in another unit freely discussed with me the techniques for forced medication and subsequent seclusion.

A psychiatrist at Paris suggested that a nurse will often decide *sua sponte* to medicate a patient involuntarily even in cases where the doctor would forego the medication if presented with the opportunity to choose. Confronted with medical records ordering medication, the nurse's perceived obligation is to enforce the "sacred" word of the doctor and the patient's willingness to receive such medication is simply ignored.

A nurse on one ward uses an approach more thoughtful than summary coercion. She first attempts to discuss the refusal with the patient:

I point out the benefits. "You're here for a reason and if you don't take your medicine you won't get well. This is one of the reasons you're here." Most of the time they do take it. Now if they absolutely refuse and there's no way they will take it, I have to point out to them that if they don't take



their medicine by mouth, then I'll have to get an order for an injectable medicine. And then, 80% of the time, they take it orally and maybe 20% have to be given injections. It's usually once or twice [in their hospitalization that] they refuse.

It is probably a fear of the "goon squad" and other sanctions rather than any recognition of the medical benefit which limits medication refusals to "once or twice" in a patient's hospital career. Another factor might be the effect of the medication itself; as one doctor, drawing on the catchwords of his trade, pointed out to me, some medications are "miracles" and some are simply "chemical restraints."

The assistant superintendent was able to state that the situation in which a voluntary patient refused medication and was offered an opportunity to leave "hasn't arisen" because this purported policy just doesn't exist at the staff-patient interface. None of the nurses, aides or treating psychiatrists made any distinction between voluntary and involuntary patients in terms of decisions to invoke sanctions for refusal of medication.

In one open ward individual choice is recognized, apparently without interfering with institutional efficiency. The psychiatrist in charge permits his patients to choose their medication and to determine when they go "on" or "off" it. If a patient refuses, this doctor explains, "I don't give it to them. And then, when they get unhappy, I say, 'Let's try it my way.'"

### *Discussion*

Patients often complain that the direct or side effects of most of the commonly used psychopharmaceuticals leave them in a daze, slow their thought processes, create confusion and engender apathy.<sup>72</sup> Unpleasant or unexpected physical disturbances also may accompany certain medications.<sup>73</sup> These problems are compounded by the fact that patients are told little, if anything, about the effect of the drugs they take (except that it will make them "feel better") and often the drug's name is kept secret from them.

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72. See generally, GOODMAN & GILLMAN, *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* (4th ed. 1970). The general effects of the commonly used phenothiazine drug Thorazine have been summarized as follows:

In short, the patient is no longer interested in himself, others, or the situation in which he finds himself; he becomes quite calm and easy to manage. With repeated administration, the patient slowly begins to appear less drugged but remains generally unconcerned, unquestioning and much easier to manage.

Mental Patient Civil Liberties Project, *Patients' Drug Manual 3* (unpublished working draft, 1972) (on file with the author).

73. See generally authorities cited note 72 *supra*.

For many reasons, therefore, patients may justifiably decide that they prefer not to receive prescribed medication.

The right to refuse treatment is based upon both the traditional legal concept of informed consent and upon fundamental constitutional protections.

### *Informed Consent*

An individual's right to physical and psychical integrity is a well-defined legal<sup>74</sup> and philosophical<sup>75</sup> concept. More than eighty years ago, the United States Supreme Court declared:

No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by Judge Cooley, "The right to one's person may be said to be a right of complete immunity: to be let alone."<sup>76</sup>

In general, there is no legal obstacle to a person's decision to live with great pain or shorten his or her life or even to die<sup>77</sup> rather than to submit to a physician's recommendations for proper medical treatment.<sup>78</sup> The law has consistently recognized the control

74. See, e.g., *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960) *Stack v. New York, N.H. & H.R.R.*, 177 Mass. 155, 157, 58 N.E. 686, 687 (1900) ("The common law was very slow to sanction any violation of or interference with the person of a free citizen."); *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914); Note, *Experimentation on Human Beings*, 20 STAN. L. REV. 99 (1967).

75. I. BERLIN, *TWO CONCEPTS OF LIBERTY* (1958):

[T]here ought to exist a certain minimum area of personal freedom which must on no account be violated, for if it is overstepped, the individual will find himself in an area too narrow even that minimum development of his natural faculties which alone makes it possible to pursue, and even to conceive, the various ends which men hold good or right or sacred. It follows that a frontier must be drawn between the area of private life and that of public authority. Where it is to be drawn is a matter of argument, indeed of haggling.

76. *Union Pacific Ry. v. Botsford*, 141 U.S. 250, 251 (1891).

77. See, e.g., *In re Estate of Brooks*, 32 Ill. 2d 361 (1965). There are some cases in which non-consensual life-saving medical treatment has been permitted. In one of the most significant, Georgetown College was authorized to perform a blood transfusion in its hospital on an objecting Jehovah's Witness. The patient was "in extremis and hardly compos mentis" and those two factors (together with the non-protesting attitude of the patient's husband) justified the decision of the court to intervene. *Application of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964), *rehearing denied*, 331 F.2d 1010 (D.C. Cir. 1964), *cert. den. sub. nom.*, *Jones v. Georgetown College*, 377 U.S. 978 (1964). In the mental hospital, it is rarely, if ever, a matter of such life-or-death urgency that medication be consumed. Even in the rare case, there may be less restrictive and oppressive alternatives available. See note 49, *supra*.

78. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception. *Natanson v. Kline*, 186 Kan. at 404, 350 P.2d at 1104.

of a patient over his or her body; indeed, doctors have long been held liable for the least touching without "informed consent."<sup>79</sup>

Aside from asserted concerns for the "best interests" of the patient<sup>80</sup> and for administrative quietude, the hospitals' justifications for forced medication are that (1) patients, unless medicated, may be dangerous to themselves or others and (2) hospitalized mental patients are incompetent to refuse consent. As discussed earlier,<sup>81</sup> most patients are *not* suicidal or assaultive and, for those few who are, a less restrictive alternative than forced medication should be sought. With reference to incompetency, even "from a medical viewpoint, there is no necessary relationship between committability and incompetency."<sup>82</sup> The trend in recent years among legislatures has been toward complete separation of hospitalization and incompetency; it has been recognized that their merger may needlessly deprive persons of essential personal rights.<sup>83</sup>

There have been a number of cases in which the doctrine of informed consent has explicitly been applied to the mental hospital situation. *Mitchell v. Robinson*<sup>84</sup> concerned a malpractice action for convulsive fractures suffered while under insulin therapy. The plaintiff was a diagnosed schizophrenic who, on recommendation of his physicians, underwent "combined electroshock and insulin subcoma therapy."<sup>85</sup> The issue in the case, as stated by the court, was "whether in the circumstances of this record the doctors were under a duty to inform their patient of the hazards of the treatment, leaving to the patient the option of living with his illness or of taking the treatment and accepting its hazards."<sup>86</sup> The court held there was a duty to inform the mental patient.<sup>87</sup>

*Lester v. Aetna Casualty & Surety Co.*<sup>88</sup> upheld the validity of a wife's consent to electroshock therapy administered to her husband. Although the husband agreed to the treatment, there was apparently some fear on the part of the hospital and the wife that if he were told of the hazards in great detail the result might

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79. See note 74, *supra*. See also W. PROSSER, HANDBOOK OF THE LAW OF TORTS, § 18 (4th ed., 1971).

80. See notes 11 and 16, *supra*.

81. See notes 56 and 57, *supra*.

82. DAVIDSON, FORENSIC PSYCHIATRY 196 (1952).

83. BRAKEL & ROCK, note 10, *supra* at 250-265.

84. 334 S.W.2d 11 (Mo. 1960).

85. *Id.* at 12.

86. *Id.* at 15.

87. See *Wilson v. Lehman*, 379 S.W.2d 478 (Ky. 1964) (trial court properly presumed that the mental patient had consented to treatments to which she voluntarily submitted).

88. 240 F.2d 676 (5th Cir. 1957).

be catastrophic to his personality. The court made it quite clear that the psychiatrist is not exempt from the

well settled principles that a physician must, except in real and serious emergencies, acquaint the patient, or, when the circumstances require it, some one properly acting for him, of the diagnosis and the treatment proposed, and obtain consent thereto, express or implied, and, consent obtained must proceed in accordance with proper reasonable medical standards and in the exercise of due care.<sup>89</sup>

The informed consent cases, both in the general medical field and in the mental health law area, support the principle that mental patients must be given the opportunity to consider and make a knowledgeable decision before psychiatric treatment is administered.<sup>90</sup> Without such opportunity and subsequent consent, the patient has a right to refuse treatment.

### *Constitutional Rights*

A mental patient involuntarily subjected to treatment has been denied his or her constitutional right to be free from invasion of privacy and from interference with freedom of thought and sensation.<sup>91</sup>

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89. *Id.* at 679.

90. This principle applies primarily to the so-called "organic therapies" which can change the patient's behavior without his or her cooperation. Such therapies include medication, electroshock therapy, brain surgery and aversive conditioning. For an analysis of these therapies see Note, *Conditioning and Other Techniques Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616 (1972). See also Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 776-77 (1969) [hereinafter cited as Katz]:

Within these therapeutic approaches two models of therapy can be distinguished: the psychotherapeutic and the organic. While both models share the possibility of being employed in the service of social control and subversion of a patient's way of life, the patient can resist the impact of such applications in psychotherapy to a considerable extent, or even completely, especially if he wishes to do so. If, in addition, any psychotherapy that includes covert but deliberate manipulations of human behavior is proscribed, the opportunity for unilateral attempts at social control or uninvited subversion is further reduced. Psychotherapeutic techniques, to be successful, require the cooperation of the patient though the nature and quality of this cooperation is not precisely known. The organic therapies, on the other hand, can bring about changes, even radical changes, in a patient's behavior without his cooperation. They can make him docile and agreeable to subsequent interventions that are at least in part the result of the effects by chemical or physical agents. They can cause alterations in behavior that are reversible and irreversible. However, the crucial distinction between the two models is that "therapeutic benefits" or "therapeutic harm" can be conferred in the psychotherapeutic model only with the collaboration of the patient and, in the organic model, even in its absence (Footnotes omitted).

91. For a discussion of this approach in another context see Bowers, *Prisoners' Rights in Prison Medical Experimentation Programs*, 6 CLEARINGHOUSE REVIEW 319 (1972) [hereinafter cited as Bowers]. See also A. Taylor, *The*

These rights were the basis for the decision in *Stanley v. Georgia*,<sup>92</sup> which held that private possession of obscene material cannot constitutionally be made a crime. In that case, the individual asserted "the right to read or observe what he pleases—the right to satisfy his intellectual and emotional needs in the privacy of his own home."<sup>93</sup> The Supreme Court held this personal sphere inviolable: "Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds."<sup>94</sup> Just as the Court rejected Georgia's assertion of a right to "control the moral content of a person's thoughts,"<sup>95</sup> so ought the asserted right to control the "saneness" of a person's thoughts be rejected.<sup>96</sup>

*Huguez v. United States*<sup>97</sup> involved a border search for narcotics. The "intrusive body cavity invasion," as the court described it, (the drugs were hidden in the man's rectum) necessitated a forcible medical examination with government agents keeping the subject against the examination table. This "force process" caused, as might be expected, "considerable discomfort and pain."<sup>98</sup> The Ninth Circuit weighed the problems of law enforcement against the "individual's right to human dignity and privacy as protected by the Fourth Amendment"<sup>99</sup> and found that the Government had gone too far. The court observed:<sup>100</sup>

Nor are the intimate internal areas of the physical habitation of mind and soul any less deserving of precious preservation from unwarranted and forcible intrusions than are the intimate internal areas of the wife and family. Is not the

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Right of Mental Patients to Refuse Treatment (unpublished 1973) (on file with the author).

92. 394 U.S. 557 (1969).

93. *Id.* at 565.

94. *Id.* See *Griswold v. Connecticut*, 381 U.S. 479 (1965) for a fuller exposition of the right to privacy. See also *Roe v. Wade*, 93 S. Ct. 705 (1973).

95. 394 U.S. at 565.

96. See generally N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY* (1971). Equally important to the patient is the right to observe, feel and think without the deadening interference of mind-affecting medication.

This right to refuse treatment would probably not extend to medication for brief periods in emergency situations where actual dangerousness is established. Cf. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wisc. 1972) (civil commitment standard of "dangerousness" required); *In re Williams*, 157 F. Supp. 871 (D.D.C. 1958), *aff'd*, 252 F.2d 629 (D.C. Cir. 1958) (mere showing of potential dangerousness doesn't warrant involuntary commitment). But even in the emergency situation, there are grounds for "conscientious objection" to treatment. See notes 106 and 107 *infra*.

97. 406 F.2d 366 (9th Cir. 1968).

98. *Id.* at 373.

99. *Id.* at 376, quoting with approval *Henderson v. United States*, 390 F.2d 805, 808 (9th Cir. 1957).

100. 406 F.2d at 382, n.84.

sanctity of the body even more important, and therefore, more to be honored in its protection than the sanctity of the home . . . ?

This reasoning applies with equal or greater force in the mental hospital where the patient has committed no crime and where the forcible intrusion of treatment is a continuous, rather than a one-time, occurrence.

An earlier Ninth Circuit case, *York v. Story*,<sup>101</sup> held that the actions of state officers in photographing the nude body of a female complainant constituted "an arbitrary invasion upon the security of one's privacy in this Due Process sense."<sup>102</sup> The court said that "we cannot conceive of a more basic subject of privacy than the naked body."<sup>103</sup> There is no reasonable alternative but to support the conclusion of one commentator on these cases that "it would be inconsistent and illogical to find that photographing and viewing the naked body constitutes an unconstitutional invasion of privacy, but that the far greater intrusion of injecting a potent chemical agent does not."<sup>104</sup>

A right to refuse medication on first amendment religious grounds was upheld in *Winters v. Miller*,<sup>105</sup> in which a New York state mental institution administered treatment to a Christian Scientist against her religious beliefs. It was held that absent a finding of special incompetence (a finding of "mental illness" did not raise even a presumption of incompetency or inability to manage one's affairs), the mental patient retains the right to sue or defend in his or her own name, to sell or dispose of property, to marry, draft a will, in general to manage his or her own affairs, and, in the case at bar, to refuse medication on first amendment grounds. Based on the decision of the Supreme Court in *United States v. Seeger*<sup>106</sup> that it was unconstitutional to restrict recognition of conscientious objection to military service to persons professing only traditional religious beliefs, the *Winters* case may properly be extended to those mental patients who are in a very real sense "conscientious objectors," and whose opposition to medication is as sincerely and deeply felt as that of Ms. Winters.<sup>107</sup>

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101. 324 F.2d 450 (9th Cir. 1963).

102. *Id.* at 455.

103. *Id.*

104. Bowers, *supra* note 91 at 329.

105. 446 F.2d 65 (2d Cir. 1971).

106. 380 U.S. 163 (1965). The Court declared that "[t]he test [for conscientious objection] might be stated in these words: A sincere and meaningful belief which occupies in the life of its possessor a place parallel to that filled by the God of those admittedly qualifying for the exemption comes within the statutory definition." *Id.* at 176. "In such a personal area, of course," the Court explained, "the claim of the registrant that his belief is an essential part of a religious faith must be given great weight." *Id.* at 184.

107. Conscientious objection was extended to persons with purely moral

As implied by the court in *Winters v. Miller*, there may be a procedural due process requirement which must be met before a mental hospital can impose medication even on an *incompetent* patient:

While it may be true that the state would validly undertake to treat Miss Winters if it did stand in a *parens patriae* relationship to her and such a relationship might be created if and when a person is found legally incompetent, there was never any effort on the part of the appellees to secure such a judicial determination of incompetency before proceeding to treat Miss Winters in the way they thought would be "best" for her . . . . Under our Constitution there is no procedural right more fundamental than the right of the citizen, except in exceptional circumstances, to tell his side of the story to an impartial tribunal.<sup>108</sup>

In cases involving medical or mental treatment the United States Supreme Court has required procedural protection<sup>109</sup> against the "grievous loss"<sup>110</sup> similar to that of imposed institutional psychiatric therapy.

A recent commentator supports my conclusion that there must be some limits imposed on the broad authority now exercised by the psychiatric profession in treating persons who are mental patients:

In the context of a right or duty to be treated, the presently unrestricted option to impose any treatment, particularly experimental procedures, therapeutic techniques with uncertain predictive consequences, and treatments which aim for social control, can no longer be left to the sole discretion of the mental health profession.<sup>111</sup>

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and ethical convictions in *Welsh v. United States*, 398 U.S. 333 (1970). The reasoning of *Welsh* and *Seeger* suggests that it would be unconstitutional to discriminate in favor of persons such as Ms. Winters whose objection to treatment was based on a traditional religious belief; patients with moral or ethical scruples against organic therapies may not be compelled to violate their consciences. See L. Curry, *The Right to Refuse Psychiatric Treatment in Prison*, 1972 (unpublished work) (on file with the author).

108. 446 F.2d at 71.

109. *Specht v. Patterson*, 386 U.S. 605 (1967); *Skinner v. Oklahoma*, 326 U.S. 535, 543 (1942) (Stone, J. concurring opinion). This procedural protection is required when "a new finding of fact," 386 U.S. at 608, is involved. In the mental hospital, the new findings of fact involved (whether for a patient involuntarily committed as "mentally ill" or for a voluntary patient) is whether that person is incompetent to refuse to consent to treatment.

110. *Joint Anti-Fascist Refugee Committee v. McGrath*, 341 U.S. 123, 168 (1951):

The Court is not alone in recognizing that the right to be heard before being condemned to suffer grievous loss of any kind even though it may not involve the stigma and hardship of a criminal conviction, is a principle basic to our society.

111. *Katz*, *supra* note 90, at 778.

### *Recommendations*

1. Patients must always be informed on their diagnosis and treatment plans, as well as the nature of their medication and the hazards involved.
2. If there are alternative modes of treatment available, the patient, after consultation with the psychiatrist, must make the ultimate choice.
3. In general, the mental hospital may not force treatment upon an objecting patient. The only exceptions to this are the emergency situation where there is no less restrictive alternative and the case where a court has ordered a particular mode of treatment.
4. "Conscientious objection" to psychiatric treatment should be recognized.
5. For appropriate cases, a due process procedural mechanism must be utilized to determine incompetence to refuse in those jurisdictions which decline to recognize the absolute right to refuse treatment.

### FORCED LABOR

#### *Description*

Many state hospitals in the United States have farms, dairies, laundries or industries which employ (typically without pay) their patients.<sup>112</sup> Paris State Hospital does not have such facilities and thus patient labor is confined largely to personal and ward house-keeping tasks, and to work through the Vocational Adjustment Service, the hospital department which is the equivalent of "industrial therapy."

Patients are referred to the Vocational Adjustment Service (V.A.S.) by their doctors not long after admission; the V.A.S. staff make the particular work assignment within its program. No patient receives regular payment for his or her work although some receive compensation for particular bits of work at irregular rates and intervals. A majority of Paris patients work at least five hours per day at their V.A.S. assignments performing such functions as dishwashing, sewing, furniture repair and refinishing, delivery of mail and messages, canteen food sales, grounds maintenance and landscaping, car washing, secretarial duties and general janitorial work. If work is performed for the benefit of the

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112. For a general discussion of mental patient labor see F.L. Bartlett, *Exploitative Work Programs in American State Hospitals 1971* (unpublished paper); Bartlett, *Present Day Requirements For State Hospitals Joining the Community*, 276 NEW ENGLAND JOURNAL OF MEDICINE 90 (1967); Bartlett, *Institutional Peonage: Our Exploitation of Mental Patients*, ATLANTIC, vol. 214, no. 1 (1964).



hospital (for example, repair of outdoor wooden benches), the patient will receive nothing; if, on the other hand, a staff member or a private citizen brings an article to be repaired to V.A.S., the patient theoretically receives 75% of any donation, the remaining 25% being placed in a general fund for patient activities. Not surprisingly, most patients interviewed at Paris State Hospital have never received a penny for such repair work and were unaware of the 75-25 policy.

Patients must keep their own living area clean and neat. A sign posted on one ward directs:

ALL PATIENTS WILL SWEEP THEIR ROOMS OUT AND  
PUT THEIR CLOTHES AWAY EVERY MORNING

In addition, patients perform what are called "ward assignments" on their particular unit. A large permanent chart is typically displayed behind the nursing station window with every patient's name affixed to movable stickers and assigned to an item of work. The jobs are rotated periodically. The following excerpt is a *partial* list of the chart (including verbatim job descriptions) on one locked ward:

#### WARD ASSIGNMENTS

- Dayroom—wet cloth, furniture and clear ashtrays. Sweep and dry mop.
- Luxury and Linen Closet—straighten up and wet mop.
- Shower room—clean tub and shower and wet mop.
- Kitchen—dry mop, sweep, clean cabinet.
- Nurses' Station—empty waste cans, clean windows.
- Janitor's room—straighten up pails and dry mop.
- Bathroom—toilets, floor and walls.
- Laundry room—clean sink and wet mop.
- Main halls—dry mop and sweep.
- Piano room—wet mop, clean furniture.
- Cross halls—dry mop, sweep.

The work is done after breakfast and, on the closed wards, before the unit's door is unlocked for those with grounds privileges. Failure or refusal to perform will usually result in loss of privileges for the day. A nurse explains, "If we have a lazy patient that can do it, then there's some action to be taken. If a patient is usually sloppy, then no action is taken."

The hospital staff places great emphasis on patient attitudes and performance of assigned labor. A nurse noted on a patient's hospital record, "Does ward assignments well under strict supervision." In staff discussions about release from seclusion or trans-

fer to an open building, a patient's work record (both on the ward and at his or her V.A.S. assignment) is usually one of the bases for decision. One patient was told that she would not be transferred out of a locked ward unless she agreed to become an institutional mail carrier.

The general staff acceptance of the propriety of patient labor is epitomized in the comment of one aide that "they know it's their job and they do it." However, one hospital worker I spoke with disagrees, at least in part; concerning the ward assignment system, he said:

Institutional housekeeping should be a job. To the extent patients do it, someone is not getting paid to do it—employees or patients.

Organized resistance to forced labor in mental hospitals is, as might be expected in such total institutions,<sup>113</sup> quite rare. On occasion, though, the collective energy for such a demonstration is mobilized. One February morning, all the women on one of the locked wards at Paris State Hospital sat down after breakfast and refused to work. In characteristic response, the staff revoked everyone's grounds privileges for that day and a doctor was called in to "speak" to the patients.

### Discussion

The Thirteenth Amendment to the United States Constitution broadly prohibits involuntary servitude with only one exception:

Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.<sup>114</sup>

When forced labor is exacted from patients in mental hospitals, it seems most appropriate to call upon this historic amendment for its protections. As the President's Committee on Civil Rights stated in 1947,

Slavery was abolished in this country nearly a century ago, and in its traditional form has disappeared. But the temptation to force poor and defenseless persons, by one device or another, into a condition of virtual slavery still exists. . . . Where large numbers of people are frightened, uneducated,

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113. See GOFFMAN, *supra* note 3.

114. On the thirteenth amendment generally, see tenBroek, *Thirteenth Amendment to the Constitution of the United States*, 39 CALIF. L. REV. 171 (1951). Congress has exercised its implementing power under Section 2 of the amendment by enacting civil and criminal sanctions. 18 U.S.C. § 1584 (1964) provides a fine and imprisonment for anyone holding another in involuntary servitude; any law, regulation or usage which maintains a system of peonage is declared void by 42 U.S.C. § 1994 (1964).

and under privileged, the dangers of involuntary servitude remain.<sup>115</sup>

Whether the system is denominated "slavery," "peonage," or "involuntary servitude,"<sup>116</sup> the courts have affirmed the absolute nature of the right to be free from involuntary servitude. For example, in *Pollock v. Williams*,<sup>117</sup> the United States Supreme Court declared that the "undoubted aim of the thirteenth amendment . . . was not merely to end slavery but to maintain a system of completely free and voluntary labor throughout the United States."<sup>118</sup> Compulsion of work by threats, fears or coercion may, in particular circumstances, be violative of the amendment's command.<sup>119</sup>

An early case involving forced labor of mental patients is *Stone v. City of Paducah*,<sup>120</sup> decided in 1905. There, the court held that a city ordinance which attempted to require labor of "idiots, insane persons, and inebriates" during confinement in city jails, enroute to asylums, was unconstitutional:

115. PRESIDENT'S COMMITTEE ON CIVIL RIGHTS, TO SECURE THESE RIGHTS 29-30 (1947).

116. Slavery has been described as "the state of entire subjection of one person to the will of another," while involuntary servitude encompasses forced service of one person to another. *Hodges v. United States*, 203 U.S. 1, 16-17 (1905). Peonage requires an element of indebtedness. See *Bailey v. Alabama*, 219 U.S. 219 (1911); *Clyatt v. United States*, 197 U.S. 207 (1905).

117. 322 U.S. 4 (1944).

118. *Id.* at 17. See also *Anderson v. Ellington*, 300 F. Supp. 789 (M.D. Tenn. 1969) (three-judge court held unconstitutional statute authorizing imprisonment as a means of recovering costs against criminal defendants); *Wright v. Matthews*, 209 Va. 246, 163 S.E.2d 158 (1968).

119. In *United States v. Shackney*, 333 F.2d 475 (2d Cir. 1964), a Connecticut chicken farmer had imported a Mexican family to work on his farm. The government charged that 18 U.S.C. § 1584 (1964) (involuntary servitude) had been violated in that the defendant had used force by psychological and economic intimidation and coercion. The appellate court reversed the conviction because it found, after a review of the evidence, no basis for deciding that the statute was "satisfied by a threat to have the employee sent back to the country of his origin, at least absent circumstances which would make such deportation equivalent to imprisonment or worse." *Id.* at 486. The court defined involuntary servitude as "action by the master causing the servant to have, or to believe he has, no way to avoid continued service or confinement." *Id.* at 486. See also *Bernal v. United States*, 241 F. 339 (5th Cir. 1917) (threats to turn victim over to immigration authorities unless debt was worked off); *In re Peonage Charge*, 138 F. 686 (N.D. Fla. 1905) (physical force and capture); *Davis v. United States*, 12 F.2d 253 (5th Cir. 1926), *cert. den.*, 271 U.S. 688 (1926) (employee physically restrained by guards); *Pierce v. United States*, 146 F.2d 84 (5th Cir. 1944), *cert. den.*, 324 U.S. 873 (1945) (fear of return to prison and physical violence). Because of the nature of mental hospitalization, psychological coercion to work involuntarily is ever-present; in addition to fearing withdrawal of precious privileges, patients justifiably believe that cooperative work habits will convince hospital personnel that the patient is a "good patient" and may properly be released. Noncooperation with work means prolonged confinement in the hospital.

120. 120 Ky. 322, 86 S.W. 531 (1905).

And as these persons are in jail not because of their conviction of any offense, they cannot be compelled to labor, for such would be involuntary servitude, and in violation of section 25 of the state Constitution and the thirteenth amendment to the Constitution of the United States.<sup>121</sup>

In four federal cases,<sup>122</sup> all brought by inmates of the Medical Center for Federal Prisoners in Missouri, the courts ruled without qualification that the thirteenth amendment prohibited *any* involuntary work by the patients; any possible therapeutic value of the labor was not discussed as constitutionally relevant. Each of the four petitioners had been charged but not convicted of a crime and each, having been found incompetent to stand trial, had been committed for psychiatric treatment. If these persons are protected absolutely by the thirteenth amendment, then, *a fortiori*, mental patients who have not been convicted of a crime may not be forced to labor involuntarily.

Other approaches to the problem—less direct and absolute than the thirteenth amendment argument urged above—have been utilized by the courts. The United States Court of Appeals for the Second Circuit, in *Jobson v. Henne*,<sup>123</sup> held that the plaintiff mental patient had stated a federal cause of action when he alleged that he was required to work in the hospital boiler house and at assigned jobs in a local village. The court “assumed” that the thirteenth amendment does not foreclose the states from requiring that a lawfully committed inmate perform

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121. *Id.* at 323, 86 S.W. at 533.

122. The first case, *Tyler v. Harris*, 226 F. Supp. 852 (W.D. Mo. 1964) was a habeas corpus petition in which the patient claimed that he was required to perform “a non-essential clerical function.” *Id.* at 853. The court held that the claim stated a cause of action under the thirteenth amendment and directed the hospital to file a response.

In *Johnston v. Ciccone*, 260 F. Supp. 553 (W.D. Mo. 1966), the court ruled that “if petitioner is being forced to work at the Medical Center, his constitutional rights are being violated,” and ordered the hospital to show cause why his petition should not be granted. *Id.* at 556.

Two years later, the court reported, in the third case, that the Medical Center “not only acknowledges that it does not have the right to have unconvicted inmates perform work unless the inmate wishes to do so, but also that the Medical Center advises each inmate within a few days of his arrival that if he is an unconvicted person he has the *right not to work*.” *Parks v. Ciccone*, 281 F. Supp. 805, 811 (W.D. Mo. 1968) (emphasis added). The petitioner’s claim was denied since patients who did not work were not “discriminated against” and the petitioner was “free to cease working any time he wishes without being punished for so doing.” *Id.* at 811.

In *Henry v. Ciccone*, 315 F. Supp. 889 (W.D. Mo. 1970), the court denied a forced labor claim after it found that the patient knowingly and freely signed a form which “fully informed him of his right not to work;” the court further found that patients “who do not sign the waiver are permitted all normal privileges and no punitive action is taken against them . . . and that the work assignment form is not . . . binding.” *Id.* at 891.

123. 355 F.2d 129 (2d Cir. 1966).

without compensation certain chores designed to reduce the financial burden placed on a state by its program of treatment for the mentally retarded, if the chores are reasonably related to a therapeutic program, or if not directly so related, chores of a normal housekeeping type and kind.<sup>124</sup>

The *Jobson* court held, however, that some programs might be so "ruthless" in character that the court could properly conclude that the inmate had been subjected to involuntary servitude.<sup>125</sup> *Wyatt v. Stickney*,<sup>126</sup> apparently following the "assumption" in the *Jobson* case, permitted the hospital to require therapeutic labor which does not involve the operation and maintenance of the institution if such activity is part of the patient's treatment plan and is properly supervised. Other labor, therapeutic or not, may be performed only if compensated in accordance with the Fair Labor Standards Act and if the patient engages in such labor voluntarily.<sup>127</sup>

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124. *Id.* at 131.

125. *Id.* at 132.

126. *See* note 5, *supra*.

127. The *Wyatt* standards on patient labor provide:

a. *Institution Maintenance*

(1) No resident shall be required to perform labor which involves the operation and maintenance of the institution or for which the institution is under contract with an outside organization. Privileges or release from the institution shall not be conditioned upon the performance of labor covered by this provision. Residents may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. § 206 as amended, 1966.

(2) No resident shall be involved in the care (feeding, clothing, bathing), training, or supervision of other residents unless he:

- (a) has volunteered;
- (b) has been specifically trained in the necessary skills;
- (c) has the humane judgment required for such activities;
- (d) is adequately supervised; and
- (e) is reimbursed in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. § 206 as amended, 1966.

b. *Training Tasks and Labor*

(1) Residents may be required to perform vocational training tasks which do not involve the operation and maintenance of the institution, subject to a presumption that an assignment of longer than three months to any task is not a training task, provided the specific task or any change in task assignment is:

- (a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;
- (b) Supervised by a staff member to oversee the habilitation aspects of the activity.

(2) Residents may voluntarily engage in habilitative labor at non-program hours for which the institution would otherwise have to pay an employee, provided the specific labor or any change in labor is:

- (a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;

Persons who are patients in mental hospitals require the protection of the thirteenth amendment at least as much as history's slaves and more than persons accepted as healthy. Unless restricted by this constitutional imperative, psychiatrists will be able to continue to ascribe to their patients the modern equivalent of a disease described in 1851 as peculiar to the Negro race, dysaesthesia Aethiopsis—a slave's behavior in neglecting his work.<sup>128</sup>

### *Recommendations*

1. No forced labor of mental patients should be permitted.
2. All labor (with the exception of personal housekeeping tasks) should be voluntary and compensated in accordance with the minimum wage laws of the Fair Labor Standards Act.

## SECLUSION AND RESTRAINTS

### *Seclusion*

On the top floor of the locked building at Paris State Hospital are two seclusion areas each containing five seclusion rooms. Entering the area through the locked door from the ward's hallway, one finds three rooms (behind locked doors) on the left and two locked rooms plus a separate toilet and shower arrangement on the right. There are no doors on the toilet or shower stalls. During my visits to seclusion in the winter, the temperature in the area always seemed cooler than that on the rest of the ward. The seclusion rooms are not large (about four paces by three paces) and contain nothing but a thin mat about thirty inches wide which lies on the tiled floor. The walls are also tiled.

These large seclusion areas are used, one nurse told me, for "problems of agitation which are really management problems." Each ward on the other floors of the locked building has a single seclusion room similar to the ones on the top floor. With reference to this "local" seclusion, an aide said that not only is this room used for "problem" patients but it is "actually a room that can be used to sleep a person" or for a "geriatric patient who's roaming around."

Official, hospital policy for "Nursing Care of the Hyperactive,

(b) Supervised by a staff member to oversee the habilitation aspects of the activity; and

(c) Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. § 206 as amended, 1966.

344 F. Supp. 387, at 402.

128. Szasz, *The Sane Slave: An Historical Note on the Use of Medical Diagnosis as Justificatory Rhetoric*, 25 AM. J. PSYCHOTHERAPY 228 (1971), cited in Wexler, *Therapeutic Justice*, 57 MINN. L. REV. 295 (1972).

Aggressive, Hostile and Assaultive Patient" is contained in a section of the *Nursing Manual* with that title.<sup>129</sup> Two plans are described,<sup>130</sup> the first of which, "Plan I—Communication and Techniques," provides that when a patient's behavior becomes "unacceptable," the staff should first take the patient to an area which provides "less stimuli." This area does *not* have to be the seclusion room but may be, for example, "the music room, visitors' room or patient's bedroom." If Plan I fails, then "Plan II—The Quiet Room" is implemented and the patient is placed in

129. Paris State Hospital, Nursing Manual 32-f32 (no date) (on file with the author).

130. *Id.*

Plan I—Communication Techniques

IMPORTANT STEPS

(Procedure)

I. Observe any precipitating factors involved in patient's unacceptable behavior.

- A. List these factors on the Kardex.
- B. Plan for meeting the patient's needs.

II. Handle the Outburst:

- A. Take the patient to an area that provides less stimuli.

POINT TO REMEMBER:

\* \* \* This area of "less stimuli" does not have to be the seclusion room but can be the music room, visitor's room, or patient's bedroom. \* \* \*

- B. Encourage the patient to act out and provide means to do so. (Proper handling of the patient at this time will often forestall or do away with the need for seclusion for this incident.)

- C. Offer the patient medication if indicated and ordered.

Plan II—The Quiet Room

I. Purpose: To protect the overactive patient from injuring himself, other patients or personnel. The quiet room lessens stimuli, offers control to the patient who has lost control, protects patients from each other, and permits freedom of movement for the overactive individual. Seclusion is justified on therapeutic rational grounds, but only if it is used sparingly, for selected patients, and only for brief periods.

II. Procedure:

1. Explain the reason for the Quiet Room to the patient and reassure him.

POINT TO REMEMBER:

If prompt action is required, the explanation may be given to the patient as you act, but under no condition or circumstance is it ethical or polite to omit it.

2. Escort the patient to the Quiet Room.
3. Select the properly appointed Quiet Room.
4. Allow for appropriate attire of the patient.
5. Notify the physician in charge of the patient immediately. If at night, the night resident is to be notified and must see the patient.

POINT TO REMEMBER:

Any patient in the Quiet Room for more than 8 hours must be seen by the physician.

6. In an acute emergency, the patient may be placed in the Quiet Room and an order from the doctor obtained later.
7. Visit the patient every 15 minutes. . . .
8. Record:
  - a) \* \* \*
  - b) Complete form HSH-32N (Seclusion Order) at the end of every 8-hour tour of duty. . . .
  - c) Chart any known precipitating factors, therapeutic interaction and resulting behavior which necessitated the use of the quiet room as well as the patient's behavior during his stay in the Quiet Room on Nurses Notes. . . .

seclusion. This policy requires that the patient be told the reasons for seclusion because "under no condition or circumstance is it ethical or polite to omit it."

It is clearly intended that, in dealing with the "hyperactive" patient, the procedures of Plan I should be utilized in most situations and that seclusion should be used only in those rare cases where it is necessary to protect the patient or others from actual physical injury. "We use it as a last resort for the protection of self and others" is how one nurse summarized the hospital policy.<sup>131</sup>

Another nurse's conception of proper grounds for seclusion, however, was stated this way:

Just for physical assault or someone who is upsetting the entire unit, like screaming up and down the hallways, banging the doors, really upsetting everybody.

Such seclusion for "upsetting" behavior is but a mild indication of the discretionary stretching of official policy which goes on daily at Paris. Plan II requires a record of "any known precipitating factors, therapeutic interaction and resulting behavior" which necessitates seclusion. Listed below are the *full* nurse's notes recorded verbatim which purport to be these required records. Three separate instances of seclusion are involved:

1. very active, upset last P.M., placed in seclusion. Out at 11:15.
2. hallucinating—became catatonic—seclusion.
3. verbally hostile—seclusion.

The third situation of the "verbally hostile" patient is particularly significant in the light of the protection justification officially invoked by the staff. Either this patient was being punished for mere verbalisms or the staff just wanted some quiet. In all three cases, there is no indication in the record of what aspects, if any, of Plan I were employed or whether any attempt was made to use a less restrictive alternative such as placing the patient in his or her bedroom.

As the above incidents and those noted below indicate, seclusion seems to be the first resort, rather than the last. Some exceptional personnel will take the time to forestall the need for seclusion by following the personal communication policies outlined in the *Manual*,<sup>132</sup> a psychiatrist at Paris State Hospital noted that the policies embodied by Plan I are sound and "many agi-

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131. In addition, a patient, fearful of other patients or feeling a personal need, may request to be secluded. This request would be granted. For example, a nurse noted on the medical record of a patient who had been in seclusion, "since pt was in on request he was released on same."

132. Plan II (II)(8)(c), Nursing Manual, *supra* note 129.



tated patients will settle down if you talk to them." Most staff, unfortunately, are too ready—some are even anxious—to lock the patient up. An experienced professional observer declared that, in many particular cases he has seen, "they practically goad the patient into fucking up."

The hospital's seclusion order dictates that "seclusion is to be employed only on the signed order of a physician. . . ."<sup>133</sup> Paris policy apparently assumes that the physicians are making, or at least, carefully and immediately reviewing, all seclusion decisions. They are not. "Nurses really have more to do with who goes into seclusion" than the doctors, a hospital psychiatrist told me. A nurse said simply, "You don't have to call the doctor all the time." Similarly, nurses often obtain permission to seclude "p.r.n." (as is necessary). Although these p.r.n. orders are contrary to hospital policy, they are given frequently and provide nurses with unfettered latitude regarding the decision to seclude.

Even when the nurse does decide to obtain a doctor's permission to seclude, similar problems arise. Most of the time (4:30 P.M. until 8 A.M. plus all weekend), the patient's own doctor is not at the hospital. The doctor on duty, of course, is not familiar with the patient and more than likely will approve whatever is recommended by the nurse. On one occasion, Dr. Hendrickson, on weekend duty, received a phone call from a nurse who wished to seclude a young patient who was attacking an older man. Assuming the patient would be secluded for a few hours until he quieted down, the doctor gave his verbal assent. The next day, Dr. Hendrickson, curious about the outcome of the night's incident, went to the ward to visit the patient and found written on the medical chart, "Place in seclusion until seen by his doctor" signed by the nurse as a verbal order ("v.o.") from Dr. Hendrickson. The quoted order had not been given; it would have meant seclusion for the patient two or three days although even a *signed* order applies only for a maximum of twenty-four hours.

The combined effect of the discretionary and p.r.n. aspects of seclusion result in interactions such as this: A patient, Joel Marson, about forty years old, had spent the afternoon laughing intermittently; a great part of his amusement, it seemed to me, focused on the spectacle of my walking around the locked ward with my yellow pad taking notes and copying notices from the bulletin board. At one point, writing at the desk in the nursing

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133. Paris State Hospital, Form HSH-32N (1965) (on file with the author). In an emergency, the staff may take immediate action but contact with the doctor must be made as soon as the emergency is over.

station, I looked up and there, three feet away on the other side of the glass, sat Mr. Marson smiling and staring at me. He began to laugh again. An aide soon spoke to the nurse suggesting that before the doctor left the floor, "it might be a good idea to get a p.r.n. to put him in seclusion." The nurse shook her head from side to side and replied, "That's O.K., we can put him in."

As the discussion thus far has implied, grounds for seclusion (as for revocation of privileges) are not prescribed with the clarity that would give a patient notice of the sanctions to be applied for particular misbehavior. Striking a staff member or another patient does not always result in seclusion. Simple "agitation" (for example, over revocation of grounds privileges), including yelling and overturning trash cans, merited seclusion in one case while assaulting a person and cutting his arm went "untreated" in another instance.

Important for the perspective it provides on staff attitudes toward seclusion is this conversation among a psychiatrist, nurse and aide. The nurse and aide were attempting to convince the doctor not to release a patient who was then in seclusion.

Nurse: "I feel very uncomfortable. I don't think he'll jump anyone but I think he should stay in seclusion. I told him he'd be back there for a while, that he knew what he'd done was wrong."

The psychiatrist suggested that the patient be released and told that if he became assaultive in the next few weeks, he would be secluded or have privileges (e.g., the patient was scheduled to return to his outside job) taken away.

Aide: "I don't think it's fair (to let him out). I spent so much time with him yesterday. I talked to him. Miss Miller talked to him for an hour. I don't think he should be allowed to do what he did."

The doctor listed all the privileges which could be withdrawn and said: "That would disturb him."

Nurse: "I don't think taking away his privileges is any punishment for him . . . ."

Aide: "Miss Gentowsky was walking him down the hall to take him back into seclusion. He thought at first she was taking him down the hall to talk with him about what he had done and when he realized he was being put into seclusion again, he struck her."

### *Restraints*

The state mental health statute forbids the use of mechanical restraints with the hospital except when it is "determined that such are required by the medical needs of such person admitted or committed." Paris' restraint order form requires the signature

of a physician and defines mechanical restraints as "the use of camisoles, or the use of sheets or towels for restricting the patient to his chair or bed." It continues, "In applying apparatus for restraint none other than those mentioned are permitted."<sup>134</sup>

Restraints are used infrequently at Paris State Hospital. There are only two sets of them for the entire locked building. It is rare, I was told by an aide, that they would be used upon a patient in seclusion; usually they are applied in the open area near the nursing station where the patient can be watched. When would a patient be restrained? "If a patient is unsteady on his feet, the doctor might write a restraint order." How is restraint accomplished? "With a little sheet, just a little sheet, tied around the arms of the chair." These are the responses of a veteran staff person.

Further observations cast considerable doubt on the implementation of the restraint order form and on the "little sheet" characterization of the devices actually employed. The only time I was restricted in my research at the hospital was the day when I first asked to see the fifth floor seclusion area on the male side. The nurse hesitated for a moment, said that there was a patient in one of the rooms and that she had to call his doctor for permission for me to enter the area. An hour or so later I reminded the nurse of my earlier request and was told that the doctor had said that the sound of the main door opening might bother the patient who, the nurse indicated, was very upset. The nurse took me over to the female side of the building and showed me the seclusion area there which also had a patient locked in one of the rooms. For this visit, no doctor was consulted. A short time after our return to the male side, an attendant came into the nursing station, his arms full of items he began placing into a box. The box was about twenty-five inches long, a foot and a half wide and five inches deep.

The box was labelled "restraints." Those I saw included a white cotton or gauze gag about four inches wide and eight inches long which ties behind the head, an apron-like garment which holds one's arms at the sides, elbows pressed against one's waist, leather straps about two feet long and an inch wide with buckles at the end, shorter leather straps and objects which looked like cuffs or collars with buckles. The conclusion to which I immediately jumped was that these had been used on the patient for whose sake I had not been permitted to enter the seclusion area. I said to a female aide with whom I had been talking and to the male who had, by then, finished packing the box, "I suppose

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134. Paris State Hospital, Form HSH-32N (1965) (on file with the author).

they're the restraints for the man who was in seclusion." They both replied simultaneously. She said, "No." He said, "Yes."

*Due Process*<sup>135</sup>

Probably because confinement in seclusion or with restraints is usually for relatively short periods of time, unlike confinement in maximum security wards, there are no court decisions on this aspect of mental health law. There are, however, a number of cases involving the solitary confinement of prisoners which are closely analogous to the situation of mental patients.

The courts regard the solitary confinement of prisoners as a much more serious sanction than confinement in maximum security units. Thus, even the rare court which did not require any kind of hearing before a prisoner was transferred to a more secure penal institution did require a hearing before an inmate could be subjected to a protracted segregated confinement.<sup>136</sup> That court held that minimal due process required notice of the charges and a hearing before a relatively objective and impartial tribunal.<sup>137</sup> While the conditions in seclusion in some mental hospitals may not be as barbaric as those in prisons, such solitary confinement is as great a deprivation of liberty as confinement in a maximum security ward, a disposition which requires, *inter alia*, the due process protections of an impartial decisionmaker, notice, the opportunity to confront witnesses and a reviewable record.

It should make absolutely no difference whether a patient is placed in seclusion for violation of a hospital rule or for purported medical treatment; the deprivation in either case is identical.<sup>138</sup> In *Davis v. Lindsay*,<sup>139</sup> the court held that confinement in a solitary cell was unconstitutional even though the prisoner was accorded "all the privileges granted to the remainder of the population and, indeed, in some respects such as the size of her room and the availability of a radio, the present arrangements are favorable to her."<sup>140</sup> The *Davis* court found that there was a "factual, if not legal, penalty of solitude."<sup>141</sup>

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135. I am indebted to Leslie Price, Esq. for her assistance with this section and the discussion below of transfers to maximum security.

136. *Bundy v. Cannon*, 328 F. Supp. 165 (D. Md. 1971).

137. *Id.* at 171. *Landman v. Royster*, 333 F. Supp. 621 (E.D. Va. 1971) required the same due process standard to be applied to solitary confinement as to transfers to maximum security.

138. In *Smoake v. Fritz*, 320 F. Supp. 609 (S.D.N.Y. 1970), the court refused to draw a distinction between prisoners placed in punitive segregation and those placed in administrative segregation. *Accord*, *Urbano v. McCorkle*, 334 F. Supp. 161 (D. N.J. 1971).

139. 321 F. Supp. 1134 (S.D.N.Y. 1970).

140. *Id.* at 1136.

141. *Id.* at 1138.

There are numerous prisoners' rights cases in which courts have defined the due process requirements for solitary confinement. For example, in *Sinclair v. Henderson*,<sup>142</sup> the court required that the "prisoner must be given official written notice of the specific charge against him" and that, before a serious punishment such as punitive segregation can be imposed, "the prisoner must be given a hearing at which he shall have an opportunity to be heard. The determination to impose the punishment should be made by one other than the accusing guard."

### *Eighth Amendment*

No matter what process is used, under some conditions, solitary confinement or use of restraints in the mental hospital may violate the cruel and unusual punishment clause of the eighth amendment to the United States Constitution. This would be so despite the hospital's argument that the sanctions applied are not intended to be punitive.<sup>143</sup>

While no court has yet held that solitary confinement of prisoners is *per se* a violation of the eighth amendment, there have been numerous cases holding that certain conditions accompanying solitary confinement are cruel and unusual punishment.<sup>144</sup>

142. 331 F. Supp. 1123, 1139 (E.D. La. 1970). Compare *Sostre v. McGinnis*, 442 F.2d 178 (2d Cir. 1971); *Carothers v. Follette*, 314 F. Supp. 1014 (S.D.N.Y. 1970); *Smoake v. Fritz*, 320 F. Supp. 609 (S.D.N.Y. 1970); *Carter v. McGinnis*, 320 F. Supp. 1092 (W.D.N.Y. 1970) with *Courtney v. Bishop*, 409 F.2d 1185 (8th Cir. 1969) which, in a case involving a prison stabbing, upheld solitary confinement.

143. See *Davis v. Lindsay*, 321 F. Supp. 1134 (S.D.N.Y. 1970), and *Urbano v. McCorkle*, 334 F. Supp. 161 (D. N.J. 1971) (requirement for hearing can't be circumvented by labelling segregation "administrative" or stating that it is in the interests of order).

144. See, e.g., *Dearman v. Woodson*, 429 F.2d 1288 (10th Cir. 1970) (overruling lower court dismissal of complaint alleging denial of food for more than 50 hours); *Wright v. McMann*, 387 F.2d 519 (2d Cir. 1967) (prisoner forced to remain nude and exposed to winter cold; deprivation of soap and toilet paper; cell covered with human excrement; no bed; prisoner forced to stand at attention when guard was passing); *Sinclair v. Henderson*, 331 F. Supp. 1123 (E.D. La. 1971) (confinement for long periods without regular outdoor exercise); *Knuckles v. Prasse*, 302 F. Supp. 1036 (E.D. Pa. 1969) (no light; one bed for two prisoners; malfunctioning toilet creating dampness and stench; no soap or toilet paper); *Hancock v. Avery*, 301 F. Supp. 786 (M.D. Tenn. 1969) (no light; no means of personal hygiene; cell toilet flushable from outside; no bed or bedding; forced nudity; cell not cleaned); *Jordan v. Fitzharris*, 257 F. Supp. 674 (N.D. Cal. 1966) (facts similar to *Hancock v. Avery*, *supra*); *Fulwood v. Clemmer*, 206 F. Supp. 370 (D.C. 1962) (confinement in cell with no bed or wash basin, a toilet flushable only from outside cell; no reading matter, exercise, visitors or mail and confinement later in Special Treatment Unit not reasonably related to prison breach of the peace). But see, e.g., *Novak v. Beto*, 453 F.2d 661 (5th Cir. 1971) (no light; little food); *Adams v. Pate*, 445 F.2d 105 (7th Cir. 1971) (inadequate ventilation; no light except at mealtimes; water faucet inches above commode); *Ford v. Board of Managers*, 407 F.2d 937 (3d Cir. 1969) (no sink or shower; filthy cell with old mattress for bedding; little food).

It is quite clear, however, that what is constitutional in the prison situation may be absolutely unacceptable in the mental hospital; this was the position taken by the court in *Lollis v. New York State Department of Social Services*<sup>145</sup> which reviewed the prison case of *Sostre v. McGinnis* and found it "replete with indications that treatment not approvable in other circumstances is permissible in penal institutions."<sup>146</sup>

*Lollis* involved a fourteen year old girl who was confined in a juvenile home. She was in a position similar to that of many youths in juvenile homes, unconvicted and unaccused—a status identical to that of nearly all patients in civil mental hospitals. *Lollis* had been confined in isolation for two weeks in a small room for twenty-four hours a day with nothing to do. She was provided with access to a bath and shower and with a wooden bench and blanket; she wore pajamas the entire period of time.

After granting a preliminary injunction enjoining the solitary confinement of the plaintiff in *Lollis* pending the promulgation of new regulations,<sup>147</sup> the court, after a final hearing, rejected the state's provisions as inadequate. New regulations had provided for a maximum of seven consecutive days (four days in some facilities) in isolation with reading matter, recreational activities and ordinary clothing to be available. The court was unconvinced by the charges; it declared:

. . . [I]f a finding were to be made as to the maximum period of isolation permitted under the Eighth Amendment in the case of adolescent persons in need of supervision, that period might well be limited, on the basis of the evidence presented, to twenty-four hours, and under conditions including reasonable facilities and furnishings *in the place of isolation*.<sup>148</sup>

In a companion case to *Lollis*,<sup>149</sup> a sixteen year old had been placed in similar conditions of isolation. In addition, he was

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145. 328 F. Supp. 1115 (S.D.N.Y. 1971).

146. *Id.* at 1118. The Constitutional standard is a flexible one. "The basic concept underlying the Eighth Amendment is nothing less than the dignity of man. . . . The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958). See also *Robinson v. California*, 370 U.S. 660 (1962) and *Weems v. United States*, 217 U.S. 349 (1910). Because the mental hospital exists for the treatment of persons alleged to be mentally ill and because punishment for illness and the incidents of illness is inappropriate within such institutions, *cf. Robinson v. California, supra*, hospital seclusion may not meet the constitutional test.

147. *Lollis v. New York State Department of Social Services*, 322 F. Supp. 473 (S.D.N.Y. 1970).

148. 328 F. Supp. at 1118 (emphasis added).

149. *Pena v. New York State Department of Social Services*, 322 F. Supp. 43 (S.D.N.Y. 1970).

handcuffed and bound. There was a dispute over whether the mechanical restraint was for a period of forty minutes or two to three hours but the court declined to make a factual determination in the light of its resolution of the case. The court held that "a minimal period of handcuffing or binding, where the reasonable necessity for such action is demonstrated, would not violate constitutional rights while, at the other end of the spectrum, unnecessary or prolonged handcuffing or binding might well do so."<sup>150</sup>

### *Recommendations*

The use of seclusion and restraints in the mental hospital is, as currently practiced, so arbitrary and oppressive as to be unconstitutional from both a due process and an eighth amendment viewpoint. It is conceivable that seclusion might be enjoined altogether and that restraints might be limited to use in strictly emergency situations.<sup>151</sup> I would fully endorse such a result. It is more likely, however, that procedural and substantive protections such as the following would be acceptable by the courts.<sup>152</sup>

1. In general, patients have the right to be free from mechanical restraints and seclusion.
2. In an emergency situation, where by reason of physical assaultiveness it is likely that patients will harm themselves or others and where no less restrictive means of restraint are feasible, a nurse may order restraint or seclusion for up to one hour or until a psychiatrist can examine the patient, whichever is sooner. The nurse's order must be in writing and must explain the rationale for the action.
3. A psychiatrist may enter an appropriate written order for seclusion or restraints and such order must include a description of the physically assaultive behavior of the patient and an explanation of why no less restrictive disposition may be utilized.

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150. *Id.* at 484.

151. The Wyatt v. Stickney standards for the institution for the retarded provide:

Seclusion, defined as the placement of a resident alone in a locked room, shall not be employed. . . . Physical restraint shall be employed only when absolutely necessary to protect the resident from injury to himself or others. Restraint shall not be employed as punishment, for the convenience of staff, or as a substitute for a habilitation program. Restraint shall be applied only if alternative techniques have failed and only if such restraint imposes the least possible restriction consistent with its purposes. 344 F. Supp. at 387.

152. See Wyatt v. Stickney, 344 F. Supp. at 387, for provisions regarding physical restraints and seclusion in the mental hospital. It is unclear why these provisions do not reach as far as those for the retarded.

The patient shall have an opportunity to review this order and to present his witnesses, suggestions or arguments to an impartial decisionmaker not familiar with the particular case; the patient's presentation shall be made part of the medical record. If the psychiatrist's order is approved by the decisionmaker, such order shall be effective for no more than twenty-four hours and must be renewed if restraint and isolation are to be continued.

4. Patients must be clearly advised of the standards and procedures used for seclusion and restraint.

5. Seclusion or restraint shall never be employed as a punishment, for the convenience of staff or as a substitute for treatment.

#### TRANSFERS TO MAXIMUM SECURITY

##### *Description*

This section focuses on the function of the only building with locked wards for patients at Paris State Hospital. This "maximum security" installation is a five-story orange brick structure, the top three floors of which contain the living quarters of nearly 200 patients. Most of the patients in this building are there temporarily as new admissions—after two to four weeks, transfer to the unlocked "open" buildings is typically arranged. A large number of the patients (nearly all of them on the top floor, the wards with the five-room seclusion areas) are the "trouble-makers," the "management problems," and others whose actions are unacceptable in the open buildings.<sup>153</sup>

In maximum security, patients sleep in crowded dormitories or multi-bed rooms; these are usually locked during the day and the patients' personal possessions made inaccessible. Meals are served in small dining rooms adjacent to the wards. Unless a person has grounds privileges (and the typical fifth floor patient does not), the entire day must be spent in the appropriately-denominated "dayroom" or pacing the halls. Access to or interaction with the opposite sex or with other patients in the hospital is almost non-existent; homosexual activity is common. Access to a pay telephone for out-going calls is limited to those granted "telephone" privileges or "grounds" by the doctor.

The open buildings are a striking contrast. They are each one story high with individual patient rooms arranged around semi-private alcoves. Rooms are left unlocked. Patients here have access to the entire hospital grounds, including the library,

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153. Unlike Paris State Hospital, many mental hospitals have separate buildings for maximum security and admissions. Because the fifth floor of this building functions as the "maximum security" unit at Paris, it will be referred to as such.



snack bar, recreation building and the surrounding wooded areas. Meals are taken in a separate dining hall and every open building has two pay telephones at which patients can make and receive calls. It is not surprising that the major sanction against patients in the open units is "being sent up the hill" to maximum security.

Staff and doctors transfer "difficult" or "bothersome" patients to maximum security automatically with scant attention to solving the alleged behavior problem through less restrictive means. A psychiatrist described this situation to the clinical director of maximum security in this way:

With the open buildings, you know, what they do is when they have a little problem, very little, Dr. Smith—the patient is a little upset or so—they don't ask anybody, they just send those things here. We have the best example, O'Connor, the patient asked to be discharged, so they transferred him here. I've found that most transfers are for one reason—the medication is too low.

Dr. Smith is disturbed by this situation and has asked the other hospital physicians to more carefully evaluate all potential transfers and to cease disciplinary transfers altogether; he says, "I don't want to think this building should be used as a punishment building."

Another use of maximum security is made by those in charge of drug experimentation in the research building at Paris. This was explained to a small ward staff meeting as follows:

They have, and this is with the approval of the hospital director, if someone doesn't work out, if they've been on the research program for a while and they're not making any improvement, then they can unload them. Unfortunately, the only place is [maximum security].

One patient, Roger Dawson, was transferred to maximum security on his own request. When I met him, Mr. Dawson wanted to return to his open building but, despite his repeated requests, he was denied permission to do so. Mr. Dawson doesn't know why. Aaron Chalmers was transferred to the security unit on the decision, he indicates, of an attendant; he was given no reason for the transfer. I met a young man, Jim Strock, the day after he arrived in maximum security from an open building. He and a friend had been found drinking in Strock's room; there was a staff meeting (from which Mr. Strock was excluded) after which the patient was told he would be "sent up the hill." Strock was not asked to explain his behavior until after the decision. Three adolescent women in an open building "broke restriction" by ordering out for pizza and eating in their rooms; they were all summarily sent to maximum security.

This sampling of incidents indicates the variety of mechanisms by which patients become residents of the security unit. Factual investigation must be limited to interviewing participants because the medical records are uniformly silent as to the reasons for transfer or precipitating actions. Usually the only reference is something in the nature of "Transfer to maximum security" or "Cancel transfer."

Worry, anger or discomfort on the part of the nurses or aides can result in a patient's transfer out of an open building. This can happen even though such decisions are supposed to be made by the psychiatrist in charge of the unit. On one occasion, an adolescent female who had been involved with drugs was admitted into the hospital and placed directly in an open building. Despite the fact that the patient displayed no violent or threatening behavior, the nursing staff shifted the patient into seclusion in the maximum security building just forty-five minutes before her doctor was to arrive at the open building.

In the incident above, the psychiatrist immediately retrieved his patient. However, other "dumped" patients remain in maximum security for an unjustifiably long time. A nurse mentioned a man who was "caught drinking behind the open building so they sent him up. He's still waiting to go back." Another patient, who had been placed in maximum security for setting a fire in a wastebasket, had been declared ready to return to the open building by the locked unit's staff but, I was told, "They won't discuss it. They're not going to take him back."

### *Discussion*

Increasingly during the last few years, the courts have been willing to use the due process clause of the fourteenth amendment to control the use of maximum security in institutions. Most cases in this area have involved prison inmates but the District of Columbia Circuit Court of Appeals has developed a standard for transfers to maximum security units in mental hospitals.

An essential element of due process is prior knowledge of the society's rules. In society at large and in the smaller societies of prisons and schools, it has been held that a person cannot be punished for violation of a rule of which he could not be aware. In *Sinclair v. Henderson*,<sup>154</sup> the court said that "[t]here must be rules and regulations officially promulgated by prison authorities

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154. 331 F. Supp. 1123, 1129 (E.D. La. 1971). See also *Landman v. Royster*, 333 F. Supp. 621 (E.D. Va. 1971), requiring that a reasonable definite set of rules be distributed to the prisoners before anyone could be disciplined for a violation thereof.

and communicated to the prisoner apprising him of what conduct can subject him to serious discipline, what penalty he can expect and the procedure by which such a determination will be made . . . ." A rule prohibiting "misconduct" by students has been held to be too vague to meet the constitutional requirements.<sup>155</sup>

A second essential aspect of due process is a hearing which affords the person involved a chance to hear the case against him or her and to make an opposing presentation. *Goldberg v. Kelly*,<sup>156</sup> a case concerned with the termination of public assistance without a hearing, is the landmark case defining what minimal due process requires. The Court held that due process for welfare recipients required a hearing at a meaningful time, with adequate advance notice, and with an effective opportunity to defend by confronting any adverse witnesses and by presenting one's own arguments and evidence orally. "In almost every setting where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses," the Supreme Court explained.<sup>157</sup> In addition, the welfare recipient may be represented by counsel. An impartial decisionmaker must be provided whose findings must rest solely upon the law and the evidence adduced at the hearing and who must state reasons for his or her decision and cite the evidence relied upon.

Recently, several cases—*Covington v. Harris*,<sup>158</sup> *Williams v. Robinson*,<sup>159</sup> and *Jones v. Robinson*<sup>160</sup>—have raised the question of what would satisfy due process when a patient in a mental hospital is to be transferred to a maximum security ward. In each case, the court refused to permit a summary transfer that lacked basic procedural protections.

The most recent decision, *Jones v. Robinson*, used *Goldberg v. Kelly* as a guide. The Circuit Court of Appeals held that one impartial person must interview all the witnesses, including the patient and others suggested by him. The patient must be informed of the evidence gathered from the interviews and, in addition, to the extent that it will not have an adverse effect on the

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155. *Soglin v. Kauffman*, 418 F.2d 163 (7th Cir. 1969). The court in that case declared that "[t]he doctrine of vagueness and overbreadth, already applied in academic contexts, presupposes the existence of rules whose coherence and boundaries may be questioned. . . . These same considerations also dictate that the rules embodying standards of discipline be contained in properly promulgated regulations." *Id.* at 167.

156. 397 U.S. 254 (1970).

157. *Id.* at 269.

158. 419 F.2d 617 (D.C. Cir. 1969).

159. 432 F.2d 637 (D.C. Cir. 1970).

160. 440 F.2d 249 (D.C. Cir. 1971).

patients involved, the "accused" must be given the opportunity to confront and cross-examine adverse witnesses. The *Jones* court held that assistance of counsel was not required but that the authorities could assign a lay representative to assist the patient. While no court reporter or transcript was necessary, the court insisted that written records should be made at each stage of the process to facilitate possible judicial review.<sup>161</sup> The inquiring officer must make findings of fact and give reasons for his or her decision; an order to transfer must be affirmed by the hospital superintendent.

Courts' willingness to review decisions to transfer depends, to a certain extent, upon the hospital's reasons for the action. In the three cases, transfers to maximum security were ordered by staff after they had decided that the patient had violated hospital rules—by robbing an employee in *Williams*, by raping a girlfriend in *Jones* and by having contraband money and pills in *Covington*. It is significant that the transfers revolved around *factual* determinations which courts and quasi-judicial bodies are quite accustomed to making and reviewing.<sup>162</sup> These are not the sort of internal administrative problems for which the medical staff has special expertise; a court cannot avoid its responsibility to protect the constitutional rights of mental patients by swallowing wholesale *ex parte* decisions by hospital authorities.

Underlying the requirement of procedural due process before a patient can be transferred to maximum security is a determination that confinement on such a ward is a deprivation of liberty within the meaning of the fourteenth amendment. The conditions which trigger the constitutional protection include the locked nature of the ward, the lack of grounds privileges, the use of a limited area for exercise, more restricted visitor privileges and the denial of access to recreational and educational facilities.<sup>163</sup> Once it has been decided that a patient has been de-

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161. Upon judicial review of the hospital authorities' decision, "[t]he question is 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.'" *Jones v. Robinson*, 440 F.2d at 250-51, quoting from *Tribby v. Cameron*, 379 F.2d at 105.

162. In *Williams*, the court explicitly stated that a due process hearing was required when actions by the hospital rest upon a determination of a disputed issue of fact. *Williams v. Robinson*, 432 F.2d at 641-42. The question in *Jones* was framed in terms of "what type of fact-finding procedure is required before St. Elizabeth's can transfer a patient accused of crime to the maximum security sections of the hospital." *Jones v. Robinson*, 440 F.2d at 250. *Covington* also involved factual questions including a desire by the court for a reliable determination by the hospital staff that the patient was "likely to injure himself or other persons" if allowed to remain outside maximum security. *Covington v. Harris*, 419 F.2d at 623.

163. *Covington v. Harris*, 419 F.2d at 622.

prived of liberty, the court must ascertain whether the decision was reached by due process of law. The courts in prison cases have recognized that due process is required whenever an inmate is transferred to maximum security, no matter what the reason.<sup>164</sup> Thus, the courts have refused to draw a distinction between punitive and administrative segregation:

This court is of the opinion that prisoners who are confined to administrative segregation for the good of the institution should be entitled to the same minimal due process that is already afforded prisoners who are confined to segregation for disciplinary infractions . . . . [B]efore a prisoner is removed from the general population of an institution and placed in segregation, he should be notified in writing of the charges and the nature of the evidence against him and be given a reasonable opportunity to explain away the accusation. We are also of the opinion that in emergency situations, such process may be postponed and emergency action taken. But the prisoners affected should thereafter be afforded within a reasonable time the minimal due process that is stated above.<sup>165</sup>

Considering the paucity of cases involving transfers of mental patients to maximum security wards, the prisoners' rights suits in this area deserve consideration. As early as 1938, a federal appellate court recognized the similarities between the situation of a patient and a prison inmate.<sup>166</sup> The major difference between the two is that one is confined (voluntarily or involuntarily) for care and treatment and the other is confined involuntarily for punishment and deterrence as well as for rehabilitation; this, however, is no justification for shortchanging those persons who are patients in mental hospitals. The prison cases<sup>167</sup> and other authorities<sup>168</sup> have generally supported due process pro-

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164. See notes 138-143, *supra*.

165. *Urbano v. McCorkle*, 334 F. Supp. 161, 168 (D. N.J. 1971). The suggested need for emergency transfers without a prior hearing, with due process provided as soon thereafter as possible, has been recognized in the mental hospital transfer context. *Williams v. Robinson*, 432 F.2d at 644.

166. *Barry v. Hall*, 98 F.2d 222 (D.C. Cir. 1938). A detailed comparison of the conditions at a treatment center and a state prison is provided in "brief of Donald McEwan, Pro Se" in J. KATZ, J. GOLDSTEIN AND A. DERSHOWITZ, *PSYCHOANALYSIS, PSYCHIATRY AND LAW* 700-02 (1967).

167. See, e.g., *Landman v. Royster*, 333 F. Supp. 621 (E.D. Va. 1971); *Beisher v. Swenson*, 331 F. Supp. 1227 (W.D. Mo. 1971); but see *Burns v. Swenson*, 430 F.2d 771 (8th Cir. 1970).

168. School children have been guaranteed protection of their constitutional rights within the school social system. The courts have consistently held that a student cannot be expelled from high school or college without a hearing. See *Wasson v. Trowbridge*, 382 F.2d 807 (2d Cir. 1967); *Dixon v. Alabama State Board of Education*, 294 F.2d 150 (5th Cir. 1961); *Hobson v. Bailey*, 309 F. Supp. 1393 (W.D. Tenn. 1970); *Jones v. Fitchburg*, 211 Mass. 66, 97 N.E. 612

cedures prior to imposition of sanctions which constitute a "grievous loss"<sup>169</sup> to the person affected.

Our society has taken upon itself to provide treatment for a class of persons considered to be mentally ill and to afford special constitutional protection through commitment hearings. It would certainly be ironic if we are willing to protect mental patients solely at the point of entry into the hospital but withdraw that protection when greater deprivations of liberty are inflicted.

### *Recommendations*

1. The hospital must promulgate and communicate to patients rules and regulations which will disclose what conduct may result in transfer to maximum security and by what procedure a determination will be made.
2. The patient must be informed in writing of charges or accusations. An impartial person must interview all parties and witnesses, including those suggested by the patient. The patient must be informed of the information gathered in the interviews and must be given the opportunity to confront and cross-examine any adverse witnesses. Lay advocates should be provided for those unable to represent themselves; the patient must also have the right to obtain counsel, attorney or non-attorney. Written records must be kept at every stage of the proceedings (a tape recording could be made of interviews and hearings) and the inquiring officer must make written findings of fact and must explain the bases for decision. A transfer order should be reviewed by the institution superintendent.

### CONCLUSION

After exploring the environment of Paris State Hospital it becomes apparent that the unfortunate analogy between mental institutions and prisons is quite appropriate. The analogy seems to deteriorate only when one realizes that prisoners are incarcer-

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(1912); *Morrison v. Lawrence*, 72 N.E. 91 (Mass. 1904); *Geiger v. Milford School District*, 51 Pa. D. & C. 647 (C.P. 1944). The courts' decisions requiring due process also extend to in-school civil rights issues. The court in *Stricklin v. Regents of University of Wisconsin*, 297 F. Supp. 416 (W.D. Wisc. 1968), held that students could not be suspended from school for thirteen days without a hearing consistent with due process of law. While a temporary absence from school might have some detrimental effect on a student's education, it is certainly not as injurious to a person as is the loss of freedom and activity accompanying confinement in a maximum security ward. When the courts are so careful to safeguard the rights of students to obtain an education, they should be even more careful to safeguard the personal freedom of patients in mental hospitals.

169. See *Goldberg v. Kelly*, 397 U.S. at 262.

ated after exhaustion of complex and extensive procedures designed to insure due process of law. Even after commitment, a prisoner is entitled to recognition of certain basic constitutional rights. An inmate of a mental institution is generally accorded none of these protections. Although he has usually committed no offense, a mental patient is systematically deprived of those rights so jealously applied in the field of criminal law and deemed basic to the proper functioning of the Constitution. The analogy is misleading, then, not because of any essential dissimilarity between the two forms of institution, but due to the greater degree of oppression that ironically accompanies commitment to a mental hospital.

The approach I have utilized in this article has been a personal one. My observations and investigations at Paris State Hospital are characterized by a concern for the patient as an individual. I believe this type of approach to be necessary because the problem itself is essentially a personal one; those constitutional rights denied the inmate of the mental hospital are individual rights affecting the very essence of human dignity. I have attempted to convey a conceptual framework which may help the reader to share my concern. The recommendations following each section, if adopted, will do much to alleviate the deprivation of inmate civil rights. Perhaps, however, the most important objective of this article is simply to provide insight into life within a mental hospital; only when the legal community realizes the personal vulnerability of the mental patient will sufficient attention be devoted to his and her legal dilemma. Only when the attention of the legal community is directed to the mental patient will the chains which bind him to the archaic oppression of the past be loosened. Once such attention is channelled in the direction of the mental inmate, I have no doubt that those energies expended by courts and attorneys in expanding constitutional protections in the area of criminal law will be applied with equal fervor and success to the plight of the mental patient.





## PART II: THE LEGAL RESPONSE

*Mental illness can never by itself be a justifiable reason for depriving a person of liberty against his objection. Even when such deprivations are accompanied by fair procedures, they are unjustified except on a basis—for example, a violation of the criminal law—that would be equally applicable in the absence of mental illness.*

—Statement of Policy,  
New York Civil Liberties  
Union, adopted December 9, 1968

*Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. . . .  
The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding . . .*

—Mr. Justice Brandeis,  
*Olmstead v. United States*,  
277 U.S. 438, 479 (1929) (dissent)