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Involuntary Civil Commitment and the Right to Treatment in Pennsylvania

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INVOLUNTARY CIVIL COMMITMENT AND THE RIGHT TO TREATMENT IN PENNSYLVANIA

I. INTRODUCTION

Historically the development of community attitudes towards mental illness was determined by the belief that this condition was due to the will of God and was therefore, incurable.[1] This attitude was reflected in the early colonial period when the primary concern was custodial confinement of the insane with no attempt at care or treatment.[2] In Pennsylvania, the legislature authorized the establishment of a mental hospital in 1751[3] but it was not until 1869 that any detailed rules for civil commitment were enacted.[4] Even under these new rules, however, custody was emphasized since the rules required only "the certification of two or more reputable physicians"[5] for hospitalization with no mention of care or treatment. With the exception of a few minor amendments, Pennsylvania retained this statute until the passage of the Mental Health Act of 1951[6] which collected and codified existing law. Although there was some mention of treatment in the 1951 Act, its main thrust was still the exercise of custody of the mentally ill for protection of the community.[7]

The growing awareness of the plight of the insane and the development of new concepts in the mental health field emphasized the glaring inadequacy of this statutory scheme. Recognizing this deficiency, the General Assembly promulgated the "Mental Health and Mental Retardation Act of 1966"[8] which was intended to redress the previous statute's failure to acknowledge psychiatric advancements. Although the 1966 Act is couched in therapeutic terms and justifies commitment only when a person is mentally ill and "in need of care," the custodial rather than the therapeutic aspects of civil commitment are still predominant in Pennsyl-

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1. J. POLIER, THE RULE OF LAW AND THE ROLE OF PSYCHIATRY 141 (1968).

2. Kittrie, *Compulsory Mental Treatment and the Requirement of "Due Process,"* 21 OHIO ST. L.J. 28 (1960).

3. For an excellent analysis of the historical developments of mental health legislation in the United States, *see* A. DEUTSCH, THE MENTALLY ILL IN AMERICA (2d ed. 1949).

4. Pa. Laws 1869, No. 78.

5. Pa. Laws 1869, No. 78, § 1. The procedure outlined by this statute has remained significantly unchanged over the century which elapsed since its enactment.

6. No. 141, [1951] Laws of Pa. 533 (repealed 1966).

7. An empirical analysis of the lack of treatment under this Act may be found in Note, *Hospitalization of Mentally Ill Criminals in Pennsylvania and New Jersey,* 110 U. PA. L. REV. 78 (1961).

8. PA. STAT. tit. 50, §§ 4101–704 (1969). For an excellent comparative analysis of the new Mental Health and Mental Retardation Act of 1966 with the Mental Health Act of 1951, *see* Comment, *Hospitalization of the Mentally Disabled in Pennsylvania: The Mental Health — Mental Retardation Act of 1966,* 71 DICK. L. REV. 300 (1967). *See also* Comment, *Involuntary Commitment of the Mentally Ill in Pennsylvania,* 5 DUQ. L. REV. 487 (1967); Comment, *Release Procedure Under the Pennsylvania Mental Health and Mental Retardation Act of 1966,* 5 DUQ. L. REV. 496 (1967).

vania in the absence of a statutory right to treatment.[9] The purpose of this Comment is to explore the development of a right to treatment and analyze the effect that its recognition would have on Pennsylvania law and practice in the field of mental health. This Comment will be divided into three sections: (1) the present statutory and case law in Pennsylvania and its performance in terms of available facilities and resources; (2) the theoretical and practical basis for a right to treatment; and (3) the proposed Pennsylvania statute dealing with a right to treatment.

II. INVOLUNTARY CIVIL COMMITMENT IN PENNSYLVANIA

A. Present Pennsylvania Law

The primary legal justification for involuntary civil commitments[10] in Pennsylvania, as in many other states, is the doctrine of *parens patriae*.[11] This doctrine refers "to the sovereign power of guardianship over persons under disability . . . such as . . . insane and incompetent persons. . . ."[12] The underlying rationale for *parens patriae* is that these people are unable to care for themselves and the state has a "right, if not [a] duty, to care for those persons. . . ."[13] The necessary inference to be drawn from this rationale is that since the prospective patient is "in need of care," hospitalization will be beneficial and, therefore, confinement is justified.[14] Although this may be an accurate representation in some cases, it will be seen later that hospitalization is frequently not beneficial and that to some individuals it may actually be detrimental.[15]

9. The phrase "right to treatment" has acquired a number of meanings depending in part upon whether it is viewed as a constitutional, statutory or administrative right. Since these differences will be discussed fully in Part II of this Comment, it will suffice at this time to define right to treatment as the duty of the state to provide the treatment upon which it justified involuntary hospitalization of the individual. *See* Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 748 (1969).

10. This Comment will deal only with those three sections [PA. STAT. tit. 50, §§ 4404–406 (1969)] which are directed at compulsory hospitalization of objecting non-criminals. No attempt will be made to view the rights of voluntary patients [PA. STAT. tit. 50, §§ 4402–403 (1969)] or those of persons either charged with or found guilty of a crime [PA. STAT. tit. 50, §§ 4407–417 (1969)]. Many aspects of the latter, however, are discussed elsewhere. *See* Comment, *Commitment to Fairview: Incompetency to Stand Trial in Pennsylvania*, 117 U. PA. L. REV. 1164 (1969); *see also* Comment, *Equal Protection and Prison-To-Hospital Transfers: United States ex rel. Schuster v. Herold*, 118 U. PA. L. REV. 410 (1970).

11. *See, e.g.*, United States *ex rel.* Grove v. Jackson, 16 F. Supp. 126 (M.D. Pa. 1936) (the state is *parens patriae* of the insane); Commonwealth *ex rel.* Tate v. Shovlin, 205 Pa. Super. 370, 208 A.2d 924 (1965) (the court is *parens patriae* for the insane petitioner).

12. BLACK'S LAW DICTIONARY 1269 (4th ed. 1951).

13. Comment, *Compulsory Commitment: The Rights of the Incarcerated Mentally Ill*, 1969 DUKE L. REV. 677, 683.

14. *But see* Kaplan, *Civil Commitment "As You Like It,"* 49 B.U.L. REV. 14 (1969), where the author states that the threat of a "therapeutic state" is upon us due to the vague notions of *parens patriae* used to deprive a person of his liberty, "for his own good," against his will.

Some authors have also viewed non-judicial commitments on the basis of *parens patriae* as being on highly questionable constitutional grounds. *See, e.g.*, Tao, *Some Problems Relating to Compulsory Hospitalization of the Mentally Ill*, 44 J. URBAN LAW 459 (1967); Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288 (1966).

15. See note 93 infra and accompanying text.

Parens patriae in Pennsylvania is incorporated into the Mental Health and Mental Retardation Act of 1966 through the phrase "mentally disabled and in need of care" found in many of its sections. Only three of these sections, however, deal with the involuntary civil commitment of a person found to be mentally disabled.[16] The first is Section 404 which is entitled "Commitment on Application . . ."[17] and is commonly referred to as an *ex parte* commitment "because the process is initiated by persons other than the prospective patient, with no notice to him and no opportunity for him to protest."[18] The statute simply requires that any of the designated groups or individuals may make written application "in the interest of any person who *appears* to be mentally disabled and in need of care."[19] This application must also be accompanied by certificates of two examining physicians stating that "in their opinion, such person is mentally disabled and in need of care."[20] These two requirements suffice to authorize the director of the institution to detain this individual until he may be discharged in accordance with the provisions of the Act.[21]

Although serious doubts have arisen concerning the lack of due process safeguards inherent in this procedure, a number of courts and scholars have found it to be justified.[22] The usual argument is that formal due process requirements would be harmful to the mentally ill person sought to be committed[23] and that the procedural standards need not be

16. *See* note 10 *supra.*

17. PA. STAT. tit. 50, § 4404 (1969).

18. Comment, *Hospitalization of the Mentally Disabled in Pennsylvania: The Mental Health — Mental Retardation Act of 1966,* 71 DICK. L. REV. 300, 317 (1967).

19. PA. STAT. tit. 50, § 4404(a) (1969) (emphasis added). Those persons who may file an application include:

> a relative, guardian, friend, individual standing in loco parentis to the person to be committed, or by the executive officer or an authorized agent of a governmental or recognized non-profit health or welfare organization or agency or any responsible person.

20. PA. STAT. ANN. tit. 50, § 4404(b) (1969).

21. *Id.* 4404(c). The Mental Health and Mental Retardation Act of 1966 lists three sections dealing with release. The first is Section 4418 which provides for release when "care or treatment is no longer necessary." This determination is made in accordance with Section 4404(d), which requires at least an annual review of the patients' status by the staff of the detaining facility. For discususion of "staff" conferences, *see* Comment, *Commitment to Fairview: Incompetency to Stand Trial in Pennsylvania,* 117 U. PA. L. REV. 1164, 1188 nn.144–47 (1969).

The second release provision is Section 4420 which authorizes review of any commitment under this Act by the Director of the Department of Public Welfare and further provides that the Director may release any person who was civilly committed and is no longer in need of care.

The third release provision is Section 4426 which allows any person committed or detained under the Act or anyone acting in his behalf to petition for a writ of Habeas Corpus. The petition may be based upon (1) the insufficiency or illegality of the proceeding leading to commitment or (2) although the proceedings were proper, continued detention is no longer warranted. An extensive discussion of release procedures under this Act may be found in Comment, *supra* note 18, at 333–43. *See also* Morris, *Habeas Corpus and the Confinement of the Mentally Disordered in New York: The Right to the Writ,* 6 HARV. J. LEGIS. 27 (1968).

22. *E.g.,* Ryman's Case, 139 Pa. Super. 212, 11 A.2d 677 (1940) (where the court stated that the alleged insane person need not receive notice of hearing if it would further endanger his mental health); *but see* State *ex rel.* Fuller v. Mullinax, 364 Mo. 858, 269 S.W.2d 72 (1954) (where the court found that due process was violated if notice was not given prior to admission).

23. *See* Kittrie, *supra* note 2, at 46.

as stringent for civil commitment as for criminal prosecutions since the former requires incarceration only as an incident of treatment. Many other scholars have found this reasoning unconvincing,[24] but there nevertheless seems to be a general trend among the states "toward more relaxed and less technical quasi-judicial and administrative procedures."[25] Pennsylvania has always been dependent on a type of quasi-judicial procedure which, in the past, took the form of *ex parte* commitments that generally accounted for more than two-thirds of all voluntary and involuntary commitments.[26] There is a case currently pending in the District Court for the Western District of Pennsylvania, however, which may drastically restrict the use of that section.[27] *Dixon v. Attorney General* is a class action brought by certain inmates of Fairview Hospital to test the constitutionality of Section 404 as applied to that class.[28] Should the plaintiffs be successful, the validity of that section as applied to all other persons will come under close judicial scrutiny. The effect of such a holding would also tend to increase the number of commitments under Section 406 of the new statute.

The second most widely used method for involuntary incarceration in Pennsylvania is that employed under Section 406 which is entitled "Civil Court Commitment."[29] Under this provision the same broad category of individuals or institutions that initiate the *ex parte* commitment of Section 404[30] initiate this commitment procedure by petitioning the Court that the named person "is believed to be mentally disabled, and in need of care or treatment by reason of such mental disability."[31] Once this is accomplished the court will: (1) issue a warrant requiring the person to be brought before the court; (2) fix a date for a hearing which will be as soon as the warrant is executed; and (3) notify interested parties.[32] After the hearing, the court may order either an immediate examination by two physicians or commitment for a period up to ten days for the purpose of examination.[33] In either situation, a finding that the person is "in need of care" authorizes the court to order hospitalization, partial hospitalization or outpatient treatment for the designated individual.[34] The desirability of providing the court with options to full-time hospitalization is unquestionably a significant improvement over the

24. *E.g.*, Harris, *Mental Illness, Due Process and Lawyers*, 55 A.B.A.J. 65 (1969); Kutner, *The Illusion of Due Process in Commitment Procedures*, 57 NW. U.L. REV. 383 (1962); Slovenko, *The Psychiatric Patient, Liberty and the Law*, 13 KAN. L. REV. 59 (1964); Comment, *Due Process for All — Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633 (1967); Comment, *Liberty and Required Mental Health Treatment*, 114 U. PA. L. REV. 1067 (1966).
25. *See* Comment, *supra* note 13, at 690.
26. *See* Comment, *supra* note 18, at 321 n.118.
27. *Dixon v. Attorney General*, Civil No. 69293 (W.D. Pa. 1970).
28. *Id.*
29. PA. STAT. tit. 50, § 4406 (supp. 1969).
30. *See* note 19 *supra*.
31. PA. STAT. tit. 50, § 4406(a) (supp. 1969).
32. *Id.* § 4406(a)(3).
33. *Id.* § 4406(a)(4).
34. *Id.* § 4406(b).

Mental Health Act of 1951,[35] however, the omission of the requirement that a person be found mentally disabled is a notable shortcoming. Under Section 404 there must be a finding of both mental disability *and* "need of care" whereas Section 406 requires only the latter.[36] Since the court is theoretically choosing hospitalization for the person sought to be committed because he is unable to make that choice, it is submitted that a finding that he cannot in fact make this rational choice should be a minimal prerequisite for commitment.[37]

Although the due process safeguards are more stringent under Section 406 than under Section 404, the former still lacks certain basic safeguards. First, the hearing under this section is given at the wrong point in the procedure. Instead of holding a hearing *after* the prospective patient has been examined, it is held prior to any inquiry into his mental condition.[38] Second, the person sought to be committed has no right to have an examination by the physician of his choice. This denies him a potentially valuable witness for his defense.[39] Third, the statute does not specify a right to counsel nor have Pennsylvania courts recognized such a right because "an insanity hearing is not a criminal or an adversary proceeding to determine appellant's guilt or innocence, but is a collateral proceeding . . .

35. PA. STAT. tit. 50, § 1203(c) (1954), provided only for committing the person to an institution without mention of intermediate alternatives.

36. The Mental Health Act of 1951 also required a finding "that the person in question is mentally ill *and* . . . is a proper subject for care." *Id.* § 1203(c).

37. A great deal has been written on the subject of what standards will suffice to: define the circumstances under which public authority — whether exercised through medical or judicial agencies or some combination of them — may justifiably intervene, notwithstanding the patient's disinclination.

R. ROCK, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 8 (1968). According to a recent compilation and analysis of the mental health statutes in every state, the predominant standards for commitment are a finding of (1) mental illness, (2) need of care, or (3) dangerousness. AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW (F. Lindman & D. McIntyre eds. 1961). The difficulty in using these concepts is that they are relative and not easily translated into legal standards. One author expresses the dilemma in this manner:

> Mental illness in short is . . . a conclusionary term. . . . This is not to deny that certain individual psychic states exist which are not in the range of the experimental spectrum of the majority. These "medical" states may be subject to a certain amount of classification for treatment purposes by appropriate therapists. Even by the use of labels, however, nosological categories are arbitrary, overlapping and descriptive.

Kaplan, *supra* note 14, at 29. The problem becomes, therefore, one of determining what *degree* of mental illness, need of care or dangerousness is necessary before an individual may be involuntarily committed. Unfortunately, no state statute speaks of degree and the determination is left solely to the discretion of the court, psychiatrist or both in accordance with the state statute in question. Some commentators go beyond these arguments and state that the construct of mental illness is mythical. *E.g.*, Szasz, *Hospital Refusal to Release Mental Patient,* 9 CLEV.-MAR. L. REV. 220 (1960). *But see* Slovenko, *supra* note 24, at 77, where the author states:

> Critics say that psychiatry is depriving people of their liberty and dignity. But what is psychiatry depriving them of? Their "right" to waste life, to commit suicide, to kill others? It is appealing to say, "let everyone do as he pleases," but that attitude wrongfully absolves us from our social responsibilities.

38. It appears that two hearings would be ideal; one prior to the examination to determine whether this examination is necessary and another after a finding of mental disability to allow the prospective patient an opportunity to question the medical findings and, if necessary, the type of treatment he is to receive.

39. The availability of the prospective patient's own expert witness is an absolute necessity for a fair hearing.

to inform the conscience of the Court. . . ."[40] Furthermore, the Pennsylvania Supreme Court has stated that counsel is not necessary because the insanity proceeding is "for [the prospective patient's] benefit or for the benefit of the public or both."[41] These arguments seem to beg the question however, since the protesting person does not admit to his mental disability nor does he feel that compulsory treatment will be beneficial (or necessary) yet these are the central issues which are being adjudicated.

Section 405, which is entitled "Commitment for Emergency Detention" is the third and final method authorizing involuntary civil commitments in Pennsylvania.[42] The purpose of this procedure is to enable a specified class of persons to take into custody individuals who are believed to be: (1) mentally ill; (2) pose a danger to themselves or others; and (3) are in need of immediate care. Section 405 not only fulfills this stated objective but also protects the civil rights of the individual while so doing. It provides that the specified class of persons may take into custody a person believed to be mentally ill but only if a written application has been approved by the director of the institution or his delegate and:

> [t]he acts or threats which give cause to believe the person to be mentally disabled *and* in need of immediate care are overt, *demonstrate a clear and present danger to self or others* and are set forth in the application.[43]

Immediately after being taken into custody, the person must be taken to a physician or designated facility for examination. If the person is found to be in immediate need of care at a particular facility, he will be transported to such facility where he will be examined again to determine if his detention is necessary in accordance with the statute.[44] If the latter is answered affirmatively, he may be detained for a maximum of ten days unless application is made under other provisions of the Act or the patient volunteers for admission.[45] Should the physicians find, however, that the person in custody is not in need of immediate care — assuming he has not committed a criminal act — he is to be *returned to the place where he was taken into custody and released.*[46] The fact that the due process safeguards offered by this procedure are eminently more satisfactory than those of Sections 404 and 406 may be due in part to the additional requirement of "danger to self or others" as a prerequisite to commitment.

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40. Commonwealth v. Bechtel, 384 Pa. 184, 190–91, 120 A.2d 295 (1956).
41. *Id.* at 190, 120 A.2d 295. *But see* Commonwealth *ex rel.* McGurrin v. Shovlin, 435 Pa. 474, 257 A.2d 902 (1969), where the court ruled, under its supervisory power, that legal counsel should be present at a hearing before a court-appointed commission when the prospective patient has been convicted or charged with a crime and his sanity is at issue. The Pennsylvania Supreme Court, however, has not extended this ruling to civil commitments. *See also* Comment, *The Right to Counsel at Civil Competency Proceedings,* 40 TEMP. L.Q. 381 (1967).
42. PA. STAT. tit. 50, § 4405 (supp. 1969).
43. *Id.* § 4405(a)(1)–(2) (emphasis added).
44. *Id.* § 4405(b).
45. *Id.* § 4405(f).
46. *Id.* § 4405(d).

The phrase "danger to self or others" is an expression of *dangerousness* which is a derivative of the state's police power rather than the doctrine of *parens patriae*.[47] The police power differs from the latter in that it is "based on a theory of preventive detention — that some persons, though innocent of any criminal act, are considered so dangerous that they must be restrained to protect society or themselves."[48] There is little or no emphasis upon treatment under this theory and without the assumption of benevolent intent, commitment tends to be viewed in a more realistic light as just another form of incarceration which necessitates greater concern over definitional standards and procedural safeguards.[49]

Some states have chosen to utilize their police power as the sole justification for involuntary civil commitment whereas most states rely on various combinations of the police power and *parens patriae*.[50] Of the three sections dealing with involuntary civil commitments in Pennsylvania, only Section 405 specifically mentions dangerousness as a prerequisite.[51] Since Section 405 commitments are for a maximum of ten days, however, it is logical to conclude that *parens patriae* accounts for virtually all of Pennsylvania's involuntary civil commitments. As noted earlier, the Pennsylvania statute embodies the doctrine of *parens patriae* by use of the disjunctive phrase "need of care or treatment." This phrase serves the practical purpose of recognizing that some individuals may require care even though they do not need treatment. The term care is not defined anywhere in the statute, but it would seem that it refers to a person who is either unwilling or unable to provide for his bodily needs, thereby endangering his life or health. Included in this category would be persons who are aged and/or senile and persons for whom there is no known cure but who still require care. It is also conceivable that certain of those persons who are considered dangerous may fall under this general classificatory scheme. There are, however, some dangerous individuals who are neither in need of care nor treatment but who are nevertheless being preventively detained under *parens patriae* because the Pennsylvania statute does not have a police power section appropriate for such cases.

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47. *See generally* Goldstein & Katz, *Dangerousness and Mental Illness: Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity*, 70 YALE L.J. 225 (1960); Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288 (1966).

48. *See* Comment, *supra* note 13, at 683–84.

49. Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967).

50. *See* AMERICAN BAR FOUNDATION, *supra* note 37, at 7–8.

51. PA. STAT. tit. 50, § 4405 (supp. 1969). Although Sections 404 and 406 make no reference to the police power, the phrase "in need of care or treatment" is sufficiently broad to include individuals who are primarily dangerous and yet would not benefit from treatment even if it were available. Such an approach may be regarded as a practical necessity but it hardly justifies committing an individual on the grounds that he is "in need of care or treatment" when, in fact, neither care nor treatment is necessary in many instances. Sections 404 and 406 should be amended to include "dangerousness" as a ground for commitment and thereby remedy this inconsistency between theory and practice.

B. Pennsylvania Practice

The Mental Health and Mental Retardation Act of 1966 states that the Department of Public Welfare has the power and the duty to "assure within the state the availability and equitable provision of adequate mental health . . . services for all persons who need them. . . ."[52] As seen earlier, the 1966 Act also provides that the state may commit anyone against his will who is mentally ill if he is "in need of care or treatment."[53] Reading these provisions together, it seems conclusive that the state is responsible for providing adequate treatment to all persons committed under the provisions of this Act and who can benefit from it since need of treatment is the sole justification for detention. If the state does have such a duty, the question arises as to whether it is being performed. The necessary components of that question include: (1) availability of treatment; (2) adequacy of treatment; and (3) objective standards by which to measure Pennsylvania's performance against other states.

The State of Pennsylvania, through the auspices of the Office of Mental Health, administers eighteen hospitals for the mentally ill, as well as a number of out-patient and halfway house facilities.[54] During the fiscal year 1967-68, these facilities served nearly 62,000 persons and of these, more than 51,000 were listed as patients in the eighteen state hospitals.[55] During this same period of time, discharges from these institutions were approximately equal to admissions so that no significant increase or decrease was registered.[56] Based on these figures, a recent study estimates that the average staff physician in Pennsylvania state-operated hospitals was assigned 170 patients at any given time.[57] This simple division of total number of staff physicians into total number of patients, however, does not accurately depict the situation. Actually:

> [The] number of doctors includes those in the clinics and in intensive care sections whose patient load does not exceed 50 or 60 and frequently does not exceed 20 to 30.
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> . . . .
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> In effect the result is that there are relatively few doctors to take care of the psychiatric needs of the hundreds and sometimes thousands of patients in the back wards who constitute the overwhelming number of patients.[58]

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52. *Id.* § 4405(f).

53. *See* Part I A *infra.*

54. PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE, PUBLIC WELFARE REPORT 73 (1968).

55. *Id.* at 73, 76.

56. *Id.* at 74.

57. *See* Reibman, *Rights of Mental Patients To Treatment and Remuneration for Institutional Work,* 39 PA. B. ASS'N Q. 538 (1968).

58. *Id.* at 538. The author also states that as few as 20 to 30 patients represents a heavy caseload if the doctor is actually providing psychiatric treatment.

The term *back ward* is generally used to denote "a ward where mentally ill patients whose prognosis is poor are housed and where patients typically receive only custodial care." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 160 (1965).

These statistics disclose the availability of adequate mental health services in Pennsylvania state institutions but reveal very little about the adequacy of treatment since the only presently available standards with which to measure adequacy of treatment are themselves misleading. These standards, which were promulgated by the American Psychiatric Association, merely set out manpower requirements and express no preference concerning different therapies or quality of treatment.[59] Although they are far from comprehensive, the APA standards do provide, however, one measure of adequacy of treatment — availability.

When viewed against these minimum standards, the manpower resources available in Pennsylvania's public mental hospitals are grossly inadequate and in the patient-load category specifically, these institutions are 25% below minimum standards.[60] This figure, when combined with the previously mentioned discrepancy in averaging techniques, is rather conclusive that the majority of patients in Pennsylvania mental hospitals rarely see a physician and many back ward patients almost never see a physician.[61] This finding may not suffice to rule the treatment received in these institutions as inadequate, but it does indicate that it is not readily available to all who need it (unless custody is considered therapeutic), nor is it commensurate with national standards.[62]

The Mental Health and Mental Retardation Act of 1966 places great stress on "need of care" and other therapeutic aspects of involuntary commitment but in practice the custodial rather than the therapeutic elements are far more apparent. There are two avenues of approach open to remedy this inconsistency. The first is to abandon any pretext of treatment by amending the statute along the lines of preventive detention for dangerousness rather than the present *parens patriae* rationale. By

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59. AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS (1958).

60. The American Psychiatric Association, in conjunction with the Pennsylvania Mental Health Survey Committee, calculate yearly personnel quotas based on APA Standards for Pennsylvania's Mental Health Hospitals. The quotas are expressed as a percentage of the optimum APA standard for each employee classification and as of June 30, 1966:

Classification	*Percentage of Quota*
Physicians	74
Psychologists	79
Social Workers	37
Registered Nurses	40
Attendants	94
Occupational Therapists	37
Industrial Therapists	58
Therapeutic Recreators	35

DEP'T OF PUBLIC WELFARE, COM. OF PA., REPORT ON PERSONNEL OF STATE MENTAL INSTITUTIONS: 1966 (Oct. 4, 1966).

61. Because the hospitals are so terribly understaffed not only in terms of doctors, but nurses, psychiatric social workers, psychologists, therapists and aids, many patients become virtually permanent residents of the institution. . . . what it all boils down to is that the choice is made *not to treat* these large numbers of chronically ill patients in the mental institutions of this state. Reibman, *supra* note 57, at 539.

62. *Id.* at 538, where the author states that in 1966 Pennsylvania ranked forty-fifth among all states in terms of the ratio of doctors to patients.

defining "dangerousness" with sufficient breadth, the police power of the state could then replace *parens patriae* power thus making the statutory theory consistent with practice. This, however, would be a regression from the declared desire to rehabilitate to the merely protective consideration of custodial detention.[63] Notwithstanding humanitarian objections, this approach also suffers from significant practical shortcomings. Preventive detention of dangerous persons for an indeterminate period of time is ultimately based upon a prediction of future behavior (or misbehavior). The problem then becomes one of predicting how "likely" or "probable" it is that the person will endanger himself or others.[64] If it seems "likely" that he will injure himself or others, certain pivotal considerations arise. Of what significance, for example, is the extent of probable injury; or that the predicted injury is to property rather than person? These and other similar questions suggest the type of information necessary before a person may be involuntarily committed for "dangerousness." Such information, however, can be accumulated only by the use of presently available clinical tools and methods for predicting future behavior, and their reliability is doubtful. Another consideration related to the question of commitment for dangerousness was raised by the District of Columbia circuit in *Rouse v. Cameron*[65] when the court suggested that confinement for dangerousness would be constitutionally permissible only if the individual is afforded procedural safeguards similar to those in the criminal process. Although the *Rouse* approach has not yet received general acceptance, in the absence of the benevolent intent found in *parens patriae,* the procedural safeguards under the police power rationale are necessarily more stringent in most jurisdictions.[66]

A second approach to solving the conflict between the statutory justification for deprivation of liberty and the conditions actually prevalent in mental institutions is the recognition of a right to treatment.

III. THE RIGHT TO TREATMENT

Psychiatrists and lawyers have recently become cognizant of the fact that overcrowding and understaffing in our public mental institutions results in inadequate treatment for the average patient. One proposal suggested that a remedy to this problem was recognition of a so-called "right to treatment."[67] As originally envisioned, the right would apply where

> a person is involuntarily institutionalized in a mental institution because he is sufficiently mentally ill to require institutionalization for

63. *See* Deutch, *supra* note 3.

64. For an excellent discussion of the difficulties encountered in attempting to predict future behavior, *see* Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment,* 117 U. PA. L. REV. 75 (1968). *See also* Tao, *Some Problems Relating to Compulsory Hospitalization of the Mentally Ill,* 44 J. URB. L. 459, 478–82 (1967).

65. 373 F.2d 451 (D.C. Cir. 1966).

66. *See* AMERICAN BAR FOUNDATION, *supra* note 37, at 44–51. For a general discussion of statutory basis, *see* Livermore, *supra* note 64.

67. *See* Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499 (1960).

> care and treatment, he needs, and is entitled to adequate medical treatment; that being mentally ill is not a crime; that an institution that involuntarily institutionalizes the mentally ill without giving them adequate medical treatment for their mental illness is a mental prison and not a mental hospital; and that *substantive due process of law* does not allow a mentally ill person who has committed no crime to be deprived of his liberty by indefinitely institutionalizing him in a mental prison.[68]

The right to treatment, therefore, was considered to be constitutionally enforceable through the due process clause of the fourteenth amendment but, the author was less emphatic in regard to the standards with which to measure adequacy of treatment.[69] He did state, however, that if a court found that a patient was not receiving "proper medical treatment," the patient should be released in spite of the existence or severity of his mental illness.[70] The broad implications of this novel proposal aroused considerable controversy among legal and medical scholars when it was initially suggested and it has not yet been resolved.[71]

The passage by Congress of the Hospitalization of the Mentally Ill Act[72] for the District of Columbia in 1964 was the first major breakthrough for statutory implementation of the right to treatment. The Act states specifically that: "A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment."[73] Relying on this language, the United States Court of Appeals for the District of Columbia has ruled in a recent group of cases that civilly committed patients,[74] persons confined after an insanity acquittal,[75] and persons committed as sexual psychopaths[76] all have a judicially enforceable right to treatment. Although in these cases the right was found to be statutorily based, Chief Judge Bazelon went beyond the statute to express the view that there existed possible constitutional infirmities in commitments that are absent treatment.[77] He suggested that (1) civil confinement for indefinite duration without treatment may be sufficiently inhumane as to constitute cruel and unusual punishment,

68. *Id.* at 503 (emphasis added).

69. Dr. Birnbaum felt that the courts should establish standards for adequacy of treatment using APA standards as a guide. *Id.* at 504. More recently, however, Dr. Birnbaum has been a strong advocate of a legislative approach and assisted in drafting Pennsylvania's proposed "Right to Treatment Act of 1968" which is discussed at length in Part III of this comment. *See* Birnbaum, *A Rationale for the Right,* 57 GEO. L.J. 752 (1969).

70. Birnbaum, *supra* note 67, at 503.

71. *See, e.g.,* Bassiouni, *The Right of the Mentally Ill to Cure and Treatment: Medical Due Process,* 15 DE PAUL L. REV. 291 (1966); Szasz, *Civil Liberties and the Mentally Ill,* 9 CLEV.-MAR. L. REV. 399 (1960); Note, *The Nascent Right to Treatment,* 53 VA. L. REV. 1134 (1967). *See generally Symposium, The Right to Treatment,* 57 GEO. L.J. 673 (1969).

72. D.C. CODE ANN. § 21-501 to -591 (1967).

73. *Id.* § 21-562 (1967).

74. Dobson v. Cameron, 383 F.2d 519 (D.C. Cir. 1967).

75. Tribby v. Cameron, 379 F.2d 104 (D.C. Cir. 1967); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966).

76. Millard v. Cameron, 373 F.2d 468 (D.C. Cir. 1966).

77. Rouse v. Cameron, 373 F.2d 451, 453 (D.C. Cir. 1966).

and that (2) confinement for dangerousness without treatment will be violative of due process unless rigorous procedural safeguards similar to those in criminal process are utilized.[78] The extent of judicial recognition of a right to treatment based on *constitutional* grounds is found in two cases — *Nason v. Super. of Bridgewater State Hospital*[79] and *Sas v. Maryland*.[80] In *Nason* the Massachusetts Supreme Court ruled that "[i]f such treatment is not available on a reasonable, nondiscriminatory basis, there is substantial risk that the constitutional requirements of equal protection of the laws will not be satisfied. . . ."[81] The court in *Sas* on the other hand, stated that although Maryland's commitment statute was constitutional on its face, it might be unconstitutional as applied if treatment was not made available as required by statute. The cases of these three jurisdictions comprise the extent of judicial recognition of a statutory and/or constitutional right to treatment and will be the focal point of the ongoing discussion concerning the desirability of adopting such a right.[82]

The bulk of the criticism heaped upon the right to treatment as promulgated by the D.C. Circuit, the Fourth Circuit, and the Massachusetts Supreme Court falls primarily within two broad categories. The first is that the courts do not possess the expertise to determine the adequacy of treatment, and that the definitions of treatment and it's adequacy are the responsibility of physicians. However, one response to this criticism might be, as stated by one authority, that:

> [W]henever deprivation of liberty is in issue, it is often not fully realized that the law, and not psychiatry, is the ultimate decision-maker. As long as this is not clear, role confusion will intrude on any delegation of authority.[83]

The courts are not attempting to impinge upon the legitimate role of psychiatrists but rather are requiring that the medical profession establish standards of treatment which will enable the courts to intelligently determine if continued detention is necessary in a given case. Without such guidelines, psychiatrists, and not the courts, are the final authority in determining the personal liberties of mental patients.[84] This abdication of the traditional judicial function can hardly be justified in light of this country's historical concern over the need to guard the civil liberties of its citizens.

The second general criticism is that the courts are not the proper arm of the government to implement such a far-reaching concept as the right

78. *Id.*
79. 353 Mass. 604, 233 N.E.2d 908 (1968).
80. Sas v. Maryland, 334 F.2d 506 (4th Cir. 1964) (where the court examined substance of treatment to determine if confinement met constitutional and statutory requisites).
81. Nason v. Super. of Bridgwater State Hospital, 353 Mass. 604, 612, 233 N.E.2d 908, 913 (1968).
82. *See* note 71 *supra.*
83. Katz, *The Right to Treatment — An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 765 (1969).
84. *Id.* at 764-67.

to treatment. Since the legislature is better equipped to create specific procedures and establish the necessary institutions for full adoption of the right to treatment (if they so desired), it is argued that the courts should recognize the boundaries of their field of competence and thereby cease legislating rights for which there are no remedies.[85] Chief Judge Bazelon, however, responds to this argument by pointing out that although he is fully aware of the legislature's superior resources and expertise in such an area, in the absence of any legislative intent to utilize these admittedly preferable tools, the court must function to protect the rights of persons committed to our public mental institutions.[86] Furthermore, he replies that "[t]he duty of the reviewing court is . . . to study the record . . . to insure that the administrators have performed their task with care and reached a reasonable result."[87] Although related, this refutation does not fully answer the second type of criticism which is directed at the inability of the courts to anticipate and rectify the *effects* of a right to treatment. One of the most troublesome aspects of this right is that under the guidelines set out in *Rouse,* the already understaffed hospitals will be forced to spend extensive periods of time preparing for and participating in hearings to determine the adequacy of therapy.[88] The reason for this is that *Rouse* requires that in habeas corpus proceedings the institutions must show not only adequacy of personal and physical facilities but also that the therapy being given is adequate for "this petitioner."[89] The burden is an extremely heavy one and necessarily relies upon subjective judgments by the court since standards to measure availability and quality of treatment are vague and generally unsatisfactory.[90] It has also been suggested that a habeas corpus hearing at which the adequacy of treatment is being discussed could very well have an anti-therapeutic effect upon the participating patient.[91]

These problems are associated with the failure of the courts to make appropriate distinctions regarding what "duties" and "rights" are implied by the term "right to treatment." If a patient has a right to receive treat-

85. *E.g.,* Birnbaum, *A Rationale for the Right,* 57 GEO. L.J. 752, 760 (1969); Note, *supra* note 49, at 107; Recent Cases, 80 HARV. L. REV. 898 (1967).

86. *See* Bazelon, *Implementing the Right to Treatment,* 36 U. CHI. L. REV. 742 (1969).

87. *Id.* at 744.

88. *See* Adelstein, *Rights of Mental Patients to Treatment and Remuneration for Institutional Work,* 39 PA. B. ASS'N Q. 548, 549 (1968); Birnbaum, *supra* note 85, at 760.

89. Rouse v. Cameron, 373 F.2d 451, 456 (D.C. Cir. 1966). Habeas corpus proceedings are commonly used in most states to review findings of insanity. *See* 39 C.J.S. *Insane Persons* § 48 (1955).

90. The criteria expressed by the Court include: (1) bona fide effort by the hospital to provide treatment that will improve or cure the patient; (2) effort to provide treatment adequate in light of present knowledge although it does not have to be the best; (3) adequate number of psychiatric personnel; and (4) a periodic review of the adequacy of the patient's treatment program. *Id.* at 456–58. With the sole exception of the third criteria, these requirements are far too vague to provide the courts any guidance in making their findings. *See* Katz, *supra* note 83, at 779.

91. *See* Birnbaum, *supra* note 85, at 761. The author expressed the view that hearings not only delayed the patients receipt of psychiatric services, but that the atmosphere created by adversary litigation could also have an anti-therapeutic effect.

ment and the institution has a corresponding duty to dispense it, what should be the response of an institution if a patient refuses treatment or refuses a particular form of therapy or there is no known treatment to cure a given patient's condition? A number of alternatives would seem to be open to the institution including, but not limited to: (1) retention of the patient until he is ready to accept treatment; (2) coercion of the patient into accepting treatment or administering treatment against his will; (3) releasing the patient; or (4) making some other form of custodial disposition.[92] Such determinations necessarily involve a delicate balancing between the patient's right to freedom and society's well-being. In many instances it may also require a complete re-examination of the state's statutory basis for involuntary commitments. Although, as Chief Judge Bazelon suggested, the courts do have a role to play in this area, the magnanimity of the problem presupposes the need for legislative intervention.

It has been suggested that the first task of law and psychiatry is to limit the right to treatment.[93] The reason for this is that there are a number of patients who are committed to mental hospitals who are incurable or at least for whom there is no known method of effective treatment. The actual rationale for committing such patients is either that they are too dangerous to remain at large or that they are "in need of care" because they cannot or will not supply their own bodily needs. There is serious doubt that mental hospitals are the proper place for such persons but in the absence of other appropriate facilities, these institutions must continue to detain and care for such individuals. To extend a right to treatment to such persons, however, is highly delusional since they cannot benefit from it. There may well be some patients who are "dangerous" or are simply in "need of care," but who might also benefit from treatment. In such cases the right to treatment should apply. The logical limit of the right to treatment, therefore, is that any patient *who can benefit from treatment,* regardless of the reason for his commitment, has a right to receive adequate treatment and the state has a duty to make it available. The need for such a clarification is undisputed but represents only a start at attempting to nullify the negative aspects of this otherwise desirable concept.

By way of recapitulation it has been seen that Pennsylvania relies upon the doctrine of *parens patriae* to justify virtually all of its involuntary civil commitments.[94] Since *parens patriae* deprives a mentally ill person of his liberty because he is in "need of care or treatment," it would seem to follow that the state has a duty to make that treatment available to all who can benefit from it.[95] Pennsylvania and most other states have failed to fulfill this responsibility yet they continiue to hold these persons in custody.[96] The courts of several jurisdictions have attempted to rectify

92. *See* Katz, *supra* note 83, at 756.
93. *Id.* at 775.
94. *See* note 51 *supra* and accompanying text.
95. *See* notes 52–53 *supra* and accompanying text.
96. *See* Part I B *infra.*

this situation by recognizing a judicially enforceable "right to treatment" based on statutory and/or constitutional grounds. While recognizing the obvious merits of such an approach, many scholars are critical of the manner and source by which such a right would be implemented and favor a legislative rather than judicial adoption. The courts, in the face of legislative inaction, reiterate that they can not refuse to protect the fundamental rights of the involuntarily committed mental patient.[97]

At this juncture it seems desirable to examine the options which confront the State of Pennsylvania concerning the right to treatment. It would seem that Pennsylvania can act or be acted upon in either of three ways. The first and most apparent form of action is inaction, or the maintenance of the *status quo*. Such an approach would not only be inconsistent with the paternalistic rationale used to justify the deprivation of liberty of many Pennsylvania citizens, but would also be a gross dereliction of the State's duty not to provide treatment for these people. The inequity of maintaining the *status quo* is so obvious as to not warrant further discussion. The second option is for Pennsylvania courts to recognize and enforce a "right to treatment" based either on statutory or constitutional grounds. The third type of action available is legislative and would encompass a restructuring of the State's Mental Health Act to include, among other things, a right to treatment. These two proposals will be treated separately below.

A review of the statutory language in the Mental Health and Mental Retardation Act of 1966 reveals that phrases such as "need of care" and "need of care *or* treatment" are used repeatedly but that "need of care *and* treatment" is not utilized.[98] The latter, which is a component of the District of Columbia provision,[99] would amount to a guarantee by the State that a patient is entitled to active treatment. There is authority to the effect that use of the disjunctive phrase "care *or* treatment" in the 1966 Act was intended by the legislators because it was felt that the "Commonwealth would be exposing itself to innumerable lawsuits for services that its facilities could not now provide."[100] The disjunctive phrase also recognizes, however, that some patients, although in need of *care,* are not in need of treatment nor could they benefit from receiving such treatment. Whether this expression of legislative intent would preclude a court's finding of a statutory right to treatment is not clear but it does diminish the likelihood of such an occurrence.

An argument might be made that the statutory language is clear on its face and does charge the Department of Public Welfare with the duty to provide adequate mental health services for all who need them.[101] The

97. *See* Part II *infra.*
98. PA. STAT. tit. 50, §§ 4101–704 (supp. 1969) (emphasis added).
99. D.C. CODE ANN. § 21–562 (1967); *see* note 73 *supra.*
100. Comment, *supra* note 18, at 346, citing to an interview with Dr. William P. Camp, Commissioner of Mental Health for the Commonwealth of Pennsylvania, in Harrisburg, October 25, 1966.
101. PA. STAT. tit. 50, § 4201 (supp. 1969).

failure of the Act to define "adequate mental health services," "care" and "treatment"[102] would hardly justify a court's finding that mere custody of a person in need of treatment may be statutorily equated to any or all of these especially in light of the paternalistic tone of the entire Act. Although it would be speculative indeed to assert that such an argument would meet favorable response in the courts, it does indicate that recognition of a statutory right to treatment is not altogether improbable.

A far stronger case can be made for a right to treatment based upon constitutional grounds. Mr. Justice Roberts of the Pennsylvania Supreme Court, writing for a unanimous Court in *Commonwealth v. Williams,*[103] stated that the:

> Relator in *Rouse* was not in a penal institution, he was in a mental hospital whose only justification for confining him was his need for medical treatment. Having been found guilty of no crime, he could not be kept in custody for any reason other than treatment. It follows inexorably therefore that the court in *Rouse* had no choice but to find relator entitled to proper treatment. To hold otherwise would be tantamount to permitting involuntary hospitalization for no reason other than pure confinement, an obvious *due process violation.*[104]

This favorable commentary on the court's holding in *Rouse* would seem to indicate that if Pennsylvania's highest court was presented with an appropriate case, it would rule that involuntary civil commitment without "proper treatment" is violative of "due process." Since Pennsylvania justifies its involuntary civil commitments upon *parens patriae* — need of care or treatment — and frequently treatment is not or cannot be provided for those who need it, a case presenting a fact situation similar to *Rouse* should not be long in appearing before this court. Although the Supreme Court of Pennsylvania may not yet be ready to find a constitutional right to treatment, a ruling that confinement without treatment violates "due process" would in practice have almost the same effect. Whichever approach the court would choose, it will not avoid the necessary difficulty of defining standards of "proper treatment" or the other problems encountered in judicial enforcement of a right to treatment. But the difficulty of enforcing a right to treatment would not suffice to justify a supreme court decision to defer to the General Assembly's judgment when the latter has not acted and the rights of mental patients are being violated.

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102. *Id.* § 4102.

103. 432 Pa. 44, 246 A.2d 356 (1968). This case dealt with the commitment of mental defectives with criminal tendencies in an institution which provided no treatment. One of appellant's arguments was that it was unconstitutional to commit mental defectives without treatment. The court found, however, that Dallas (the institution) was penal and that there was no need for treatment because mental defectives were excluded in the definition of "mental illness" in the Mental Health Act of 1951. *Id.* at 60, 246 A.2d at 368. *See also* Comment, *Post Conviction Problems and the Defective Delinquent,* 12 VILL. L. REV. 545 (1967). The term mental deficiency is included in the definition of "mental disability" of the Mental Health and Mental Retardation Act of 1966. PA. STAT. ANN. tit. 50, § 4102 (supp. 1969).

104. *Id.* at 60, 246 A.2d at 365 (emphasis added).

IV. RIGHT TO TREATMENT LAW OF 1968

A comprehensive legislative attempt to deal with the complex substantive and procedural problems of adequate treatment and care of mental patients is Pennsylvania's proposed "Right to Treatment Law of 1968."[105] Although this bill was left in committee in 1968 and still remains there after being reintroduced during the General Assembly's 1969 session, its unique status warrants an examination of its main provisions.[106]

The purpose of this bill is to establish an administrative procedure under which each mental patient would have a *legal right* to receive at least a minimum standard of treatment.[107] The bill requires the creation of a "Mental Treatment Standards Committee"[108] which is entrusted with promulgating these standards and compiling them into a "Manual of Minimum Standards for Treatment of the Mentally Ill in State Mental Institutions."[109] One of the bill's goals is to establish standards expressed in objective terms, thus avoiding numerous subjective evaluations.[110] In drafting its standards the committee is instructed to include minimum: (1) personnel-patient ratios (at least equal to APA standards); (2) professional personnel qualifications; and (3) number of consultations and physical examinations.[111] One provision, however, specifically states that "[t]he Committee shall not include in its standards any requirements relating to selection and conduct . . . of their treatment methods or procedures, nor the judgment, skill or care used by these practitioners."[112] Essentially this provision excludes *quality* of treatment as a component of adequate treatment; this exclusion, although consistent with the desire for objective standards, seriously weakens the effectiveness of the right to treatment.[113]

The bill also provides for the establishment of a "Patient Treatment Review Board" whose duty would be to receive, hear and investigate petitions filed on behalf of patients who allege that they are not receiving

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105. S.B. 1274 & H.B. 2118, Pa. Gen. Assembly, 1968 Sess.

106. S.B. 158, Pa. Gen. Assembly, 1969 Sess. [hereinafter cited as Pa. Bill]. The 1968 version of the Pa. Bill was reported out of the Joint Committee on Public Health and Welfare and then referred to the Senate Appropriations Committee where it remained for the duration of the 1968 session. The 1969 version is still in the Senate Committee on Health and Welfare. Since the bills are quite similar, this paper will deal exclusively with the 1969 version of the Pa. Bill.

107. Pa. Bill § 5 (a).

108. *Id.* § 3. This Section specifies that the Committee will be composed of seven members and lists the qualifications which each must possess. Those to be included are: a non-administrator psychiatrist, a licensed physician, a psychiatric social worker, a clinical psychologist, an administrator psychiatrist, a registered nurse and the Commissioner of Mental Health of the Department of Public Welfare who is to serve in an advisory capacity.

109. *Id.* § 4.

110. *Id.* § 4(d).

111. *Id.* § 4(b).

112. *Id.* § 4(d).

113. *See* Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782, 806–17 (1969); *see also* notes 116–18 *infra* and accompanying text.

minimum treatment in accordance with the Manual's standards.[114] The Board, which is composed of two psychiatrists, two medical practitioners and one attorney, operates as an administrative agency in that it makes findings of fact and dispositions in accordance with the provisions set out in the Act. Furthermore the mental patient is permitted to seek judicial review if he disagrees with the Board's findings or ruling.[115]

This legislative proposal has generally received favorable response from scholars in the field[116] but certain weaknesses in its basic approach have been noted. First, the exclusion of the quality of treatment as a component of the minimum standards of treatment is a critical shortcoming. As one author states:

> [t]his approach to adequate treatment indicates that the review board would have no responsibility other than assuring that minimum staff ratios and other criteria were met. Such a statistical summary would tell the board nothing about the treatment being received by a patient. It would be a waste of resources to have a body of expert mental health professionals doing something that a trained accountant could accomplish.[117]

Since both the Standards Committee and the Review Board are staffed almost exclusively with expert medical and mental health personnel, there seems to be little doubt that they could promulgate and enforce minimum standards which would be acceptable to the medical profession.[118] Under

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114. Pa. Bill § 6. The Board is empowered to promulgate and issue procedural regulations which will insure that petitioners receive notice, fair procedure and prompt disposition of their petitions.

As envisioned by this bill the Board will serve as an administrative body to make findings and initiate limited action which may not include release. It also appears that this remedy would have to be exhausted prior to seeking judicial relief. The procedure is initiated when a patient or his representative petition the Board stating that he is not receiving minimum treatment in accordance with the Manual. If the Board agrees with the petitioner, the superintendent involved must be given an opportunity to concur in the finding. Should he concur, a probationary period of three months will ensue during which time minimum treatment is to begin. *Id.* § 7.

Judicial relief is available when: (1) the Board initially found that treatment was adequate and petitioner disagrees; (2) the Superintendent fails to concur in the Board's affirmative finding; (3) treatment was not initiated before the end of the three month period or fails to meet minimum standards; or (4) the Board fails to notify petitioner of any finding within one month of filing. Judicial relief includes a writ of mandamus, and order requiring the Commonwealth to permit and pay for private psychiatric care, and the writ of habeas corpus. The latter is modified in that the court does not have to release a patient, even if he is not receiving treatment, when the patient: (1) is demonstrably dangerous to himself or others; (2) has been convicted of a crime and his sentence has not expired; (3) has been acquitted of a crime by reason of insanity; (4) has been charged with a crime and has not yet been tried; or (5) he has been convicted of a crime and committed in lieu of a sentence. In any of the above circumstances, however, the court may order transfer to an institution where treatment will be available. *Id.* § 8.

115. *Id.*

116. *E.g.,* Adelstein, *supra* note 88, at 548; Bazelon, *Rights of Mental Patients to Treatment and Remuneration for Institutional Work,* 39 PA. B. ASS'N Q. 543; Birnbaum, *supra* note 85, at 763–65.

117. Halpern, *supra* note 113, at 809.

118. There is no doubt that there exists considerable controversy among the various schools of thought in psychiatry concerning what is adequate treatment; but it would seem that sufficient accord could be had to promulgate *minimum* standards of treatment. The former Superintendent of Saint Elizabeth Hospital in Washington,

these circumstances, including quality of treatment in the standards would create little conflict while serving as a desirable adjunct to the present provisions.

A second major shortcoming of the proposed bill is that the initiative for raising contentions that treatment is inadequate must come from the patient.[119] There have been some suggestions that the bill should provide for periodic and automatic review of the treatment received by the patient every six months or perhaps every year.[120] Under this approach every patient would be insured a minimum standard of treatment regardless of the reason for which he might have failed to raise the issue himself. Another suggestion is that the concept of indeterminate detention be abandoned and that time limits be placed upon the length of detention because:

> [They] will facilitate the establishment of a therapeutic atmosphere which psychiatrists should welcome. No therapeutic community can function optimally with persons who are indefinitely condemned to treatment they do not want or from which they cannot benefit.[121]

This approach attempts to redress the balance between patient and physician in their psycho-therapeutic relationship. Since this relationship is based upon cooperation, removing the threat (actual or implied) of indefinite commitment for refusal to accept treatment would tend to make the relationship more voluntary and thereby more beneficial.[122] This time limit proposal would also obviate the need for periodic review of treatment since patients would be released after relatively short intervals.[123]

The proposed right to treatment law has also raised some doubts concerning its practicality because of the extremely high cost of fully implementing its provisions. One authority estimated that raising personnel levels up to the staffing standard set by the APA alone would require an additional $26 million a year.[124] There is little doubt that the bill's provisions would increase costs but if the right to treatment were limited to those who can benefit from it, the increase in costs would not

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D.C., where most of the right to treatment cases originated, has recently written an excellent article related to this subject. *See* Cameron, *Nonmedical Judgment of Medical Matters,* 57 GEO. L.J. 716 (1969).

119. Pa. Bill § 7(a). *See also* Bazelon, *supra* note 116, at 546.

120. *See* Bazelon, *supra* note 116, at 546; *see also In re* Buttonow, 23 N.Y.2d 385, 297 N.Y.S.2d 97 (1968), where the court noted that a procedure which relied upon a patient's affirmative action to initiate a statutory scheme was inadequate to protect the patient's rights.

121. Katz, *supra* note 83, at 773 n.56. Implementing such a scheme would obviously necessitate an adjustment of the time limit to reflect circumstances such as danger to self or others.

122. *Id.* at 772–75.

123. The LANTERMAN-PETRIS SHORT ACT of California which became effective in July of 1969 has completely abandoned the concept of indefinite involuntary commitments. It establishes an elaborate procedure which determines standards for 72 hour evaluations and 14 day (with a maximum of 90 days) commitment for intensive psychiatric treatment. The time limits vary according to the severity of the mental disorder and degree of dangerousness to self or others. CAL. WELF. & INST. CODE § 5000 *et seq.* (supp. 1970).

124. *See* Adelstein, *supra* note 88, at 548.

be this dramatic. This approach reflects what is already being done in practice — applying resources where they will be most beneficial — but, it will *also require that non-treatment be justified* to an outside authority — the Review Board.[125]

The utility of the "right to treatment" concept is not restricted to the area of making therapeutic facilities available to the mentally ill individual; it also provides an opportunity for reflection upon the entire philosophical basis for involuntary civil commitments. "The law is concerned with control of antisocial or prohibited conduct, and the prevention of such conduct."[126] In fulfilling this function the law must determine what type of conduct justifies the denial of liberty to one of its citizens and establish procedures to insure that the individual's rights are not unduly constricted. As seen earlier, Pennsylvania has determined that it will exercise its sovereign power when an individual is mentally ill and "in need of care or treatment." Since this state action is imposed upon the individual for his own benefit it has been suggested that due process safeguards need not be extensive. This lowering of due process safeguards, however, can be justified only if the state does in fact provide adequate treatment to those individuals who can benefit from it thus enabling them to regain their freedom as soon as possible. In this respect, the right to treatment would guarantee that the condition upon which commitment is based — treatment — is being received.[127] In those cases in which the individual cannot benefit from treatment, or is dangerous and cannot benefit from treatment, his tenure in a state mental institution becomes one of preventive detention. This detention must be checked by procedural safeguards which will adequately protect this individual from indefinite imprisonment. Pennsylvania does not statutorily recognize those who are dangerous and incurable and assumes that *all* mentally ill patients can and will benefit from either care or treatment. This assumption is unfounded and implicitly denies those persons who are dangerous and/or cannot respond

125. If and when the right to treatment is limited, great care should be taken to insure that those who cannot benefit from or will not accept treatment are fully protected. A periodic review of such persons should be required to determine if any change in condition or circumstances has occurred. This procedure should be instituted in addition to the availability of review by the Review Board and the courts.

126. J. POLIER, THE RULE OF LAW AND THE ROLE OF PSYCHIATRY 156 (1968).

127. One authority has suggested that: [those] who feel that the mentally ill have a right to treatment possibly represent less an attempt to get recognition for a new legal principle than a desire to focus the attention of the public and the legislatures on the lack of personnel and the inadequacy of the therapeutic approach in most state hospitals.

J. ROBITSCHER, PURSUIT OF AGREEMENT — PSYCHIATRY AND THE LAW 146 (1966). Although there can be no doubt that the above represents one of the key motivations of those who espouse the "right to treatment" concept, it would seem that disenchantment with the entire scheme of commitment laws is also a strong motivational force. Perhaps the strongest expression of this position is that:

> Mental hospitals and prisons are the waste depositories of our cybernetic society. We must empty the excrement back into society for a renewed fertilization, not because those put back will regenerate . . . but to force the society to see . . . its product and to understand what it is constantly producing.

Kaplan, *supra* note 14, at 33.

to care or treatment the due process safeguards given to criminals who are receiving a similar type of incarceration.

The recognition of a "right to treatment," will not remedy all of the difficulties in the mental health field. It is, however, a step toward assuring that more resources and better treatment will be afforded to mental patients who can benefit from such treatment. A legislative measure of the type proposed in Pennsylvania (with certain modifications) would provide an excellent model for all states and could be of substantial assistance to the courts. It is undisputed that this kind of legislative proposal is far superior to any action that the courts might implement, but if the legislature fails to act, it is the court's duty to insure that mentally ill persons are not denied constitutional rights.

V. CONCLUSION

This Comment has attempted to delineate some of the major shortcomings found in those sections of the Pennsylvania Mental Health and Mental Retardation Act of 1966 dealing with involuntary civil commitments. In so doing, special emphasis was paid to the need to recognize a limited right to treatment for all mental patients who could benefit from such a right. The proposed Pennsylvania statute which would recognize and enforce a right to treatment provides an excellent opportunity for a sound and progressive mental health program in that state. The passage of this legislation, as modified herein, should be a top priority on the General Assembly's agenda.

It is also submitted that the 1966 Act be amended to include a section dealing specifically with the preventive detention of individuals who are dangerous and for whom there is no known cure or treatment available. The doctrine of *parens patriae* presently utilized to commit these persons is inappropriate and inconsistent with the fact that many of them are neither in need of care nor treatment. This proposed section should also incorporate stringent due process safeguards commensurate with the type of detention being imposed.

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