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THE NEW OHIO MENTAL HEALTH ACT

INTRODUCTION

ON AUGUST 26, 1976, the new Ohio Mental Health Act¹ became effective. The Act makes sweeping changes, both procedural and substantive, in the law concerning the treatment of the mentally ill in Ohio. The new law affects every aspect of treatment and defines and limits the ability of the state to insist upon treatment. In addition, the law establishes guidelines for the process of commitment, manner of treatment, mode of confinement and rights of the mentally restored.

The revision of the statute appears to be a product of several sources of criticism that had been aimed at the prior statute. The Citizens Task Force Report on Mental Health and Mental Retardation,² which was prepared in 1971 by a special commission appointed by former Governor Gilligan, sharply criticized the level of care and treatment existing in the state institutions:

Further criticism is found in the opinion of *In re Fisher*,³ decided by the Supreme Court of Ohio in 1974. In that case, indigent patients had been involuntarily committed to Hawthornden State Hospital and sought to secure their release through a writ of habeas corpus, alleging that the state's failure to appoint counsel at their commitment hearings was a denial of due process under the fourteenth amendment of the United States Constitution. The Court decided in favor of the petitioners and, in a rather lengthy opinion, also found fault with other aspects of the Ohio civil commitment procedure. The court noted that:

- (1) the state did not require that the individual sought to be committed receive personal notice of any commitment hearings;
- (2) the presence of the individual at the hearings was discretionary;
- (3) the statute failed to require that an adequate record be maintained for purposes of judicial review;
- (4) there was no standard of proof required to justify commitment;
- (5) the court was not required to explore less restrictive treatment alternatives;
- (6) the proceedings were subject to a number of evidentiary abuses.⁴

¹ Act of May 27, 1976, H.B. 244, 111th General Assembly (1975-1976).

² CITIZENS TASK FORCE ON MENTAL HEALTH AND RETARDATION, FINDINGS AND RECOMMENDATIONS: DESIGN FOR A COORDINATED SYSTEM FOR THE MENTALLY ILL AND MENTALLY RETARDED IN OHIO (1971) [hereinafter cited as TASK FORCE].

³ 39 Ohio St. 2d 71, 313 N.E.2d 851 (1974).

⁴ *Id.* at 79, 313 N.E.2d at 857.

The third influence appears to have been a general nationwide disenchantment⁵ with the "medical model"⁶ of civil commitment statutes, which tends to emphasize the doctor's role in prescribing and administering treatment. The problem with this model is not that medical practitioners are called upon to diagnose and treat mental illness—for no one could rationally argue that courts are equipped or competent to perform this task—but that the decision of whether to provide treatment is left solely in the hands of the doctors. In contrast to this approach, the new statute is patterned after the "legal model." This model seeks to give mentally ill individuals more choice in determining the course of their own treatment by making the procedures that lead to involuntary hospitalization more adversarial in character and by permitting commitment only after a judicial determination that it is necessary.⁷

The purpose of this comment is to highlight the new procedural and substantive rights that are now guaranteed to the person sought to be committed for mental illness. The writers seek to evaluate it against a background of social and medical desirability, as well as constitutional mandates. One should keep in mind that our current method of dealing with the mentally ill is by no means either universal or necessary. Other societies have used different methods; some have been less compassionate, while others have been more so.⁸ In order to attempt to place Ohio's law in this broad perspective, the writers have drawn upon the writings of commentators as well as judicial opinions and statutory law from other jurisdictions.

⁵ See, e.g., *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Hawaii 1976), where the court notes that the medical model had been in effect in Hawaii a scant six years before it came under persistent attack by civil libertarian groups and added:

While mistreatment of some patients is alleged, the impetus for the attack is probably more properly ascribed to a growing disillusionment with the medical model in all fields of behavioral control of human beings, the impact of recent decisions of the federal courts, and the ongoing skepticism of civil libertarians with all forms of enforced assistance.

⁶ This label is somewhat of a misnomer. In case of physical illness it is the medical practitioners who practice medicine, but—absent an emergency—it is the patient who determines whether or not to accept treatment. Thus, a pure "medical model" type of legislation would leave the decision of treatment solely to the patient and would permit no compulsory treatment or confinement. However, when the term is applied to commitment statutes, it appears to mean that the question of whether or not to force treatment on a person is left with doctors rather than with judges, juries and lawyers.

⁷ See *Involuntary Treatment of the Mentally Ill in Iowa: The 1975 Legislation*, 61 *Iowa L. Rev.* 261, 266 (1975). The need for safeguards exists only when the question of involuntary commitment arises, for it is only then that there is a question of forcible treatment. When a person seeks treatment on his own, there is no state interference and the traditional doctor-patient relationship—what amounts to the pure "medical model"—exists.

⁸ During the colonial period, for instance, the mentally ill were expelled from towns along with paupers generally, and . . . wandered about in bands, subject to the whims and, sometimes, cruelties of a society that equated both mental illness and idleness with moral turpitude . . . For these persons, it was un-

I. WHO IS SUBJECT TO THE NEW ACT

The Ohio Revised Code, prior to the amendments discussed herein, defined both a "mentally ill individual"⁹ and a "mentally ill individual subject to hospitalization by court order,"¹⁰ and incorporated the first term into the latter definition. A person who was, or who believed himself to be, mentally ill could be eligible for voluntary hospitalization.¹¹ If, in addition, he was likely to injure himself or others, or was unable to make a responsible decision in regard to treatment, and either of these conditions existed because of his illness, the person was subject to coerced confinement.¹² The new legislation replaces the definition of "mentally ill individual" with a definition for "mental illness"¹³ and redefines "mentally ill individual subject to hospitalization by court order,"¹⁴ but it retains the two-tiered standard that existed under the old law. Thus, each of the two new definitions must be examined in order to determine which persons are subject to the statute.

A. Definition of "Mental Illness"

If the concept of mental illness as statutorily defined were solely a standard by which to base eligibility for voluntary treatment, any vagueness, ambiguity, or possible overbreadth in its applicability would be of little concern; in fact, giving a broad scope to the term could be beneficial in that the greatest possible number of people who desired treatment would

doubtedly more merciful to erect institutions, and to confine the mentally incapacitated for their own safety. They were helpless to survive for long outside of an institutional environment.

Lessard v. Schmidt, 349 F. Supp. 1078, 1086 (E.D. Wis. 1972), *vacated and remanded on other grounds*, 414 U.S. 473 (1974).

In contrast to such inhumane treatment, the mentally ill in rural Ghana are rarely confined to mental hospitals, although such care is available. Instead, those afflicted with mental illness are cared for by their relatives and physically restrained only during episodes of violent behavior. D. BLACK, *THE BEHAVIOR OF LAW* 120 (1976).

⁹ OHIO REV. CODE ANN. § 5122.01 (A) (Page 1970) (amended 1976) defined a "mentally ill individual" as

an individual having an illness which substantially impairs the capacity of the person to use self-control, judgment, and discretion in the conduct of his affairs and social relations, and includes "lunacy", "unsoundness of mind", "insanity", and also cases in which such lessening of capacity for control is caused by such addiction to narcotics, sedatives, alcohol, or stimulants as to make it necessary for such person to be under treatment, care, guidance, or control.

¹⁰ *Id.* § 5122.01 (B) defined a "mentally ill individual subject to hospitalization by court order" as

a mentally ill individual who, because of his illness, is likely to injure himself or others if allowed to remain at liberty, or is in need of care or treatment in a mental hospital, and because of his illness lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization.

¹¹ *Id.* § 5122.02 (A).

¹² *Id.* § 5122.01 (B).

¹³ OHIO REV. CODE ANN. § 5122.01 (A) (Page Supp. 1976).

¹⁴ *Id.* § 5122.01 (B).

be covered by the Act. However, the import of the term is greatly magnified when it is recalled that the presence of mental illness is an integral part of the criteria for compulsory hospitalization. Even if a person were found to represent a substantial risk of harm either to himself or to the community, he could not be adjudicated a "mentally ill person subject to hospitalization by court order" and subsequently confined without the initial finding of mental illness as the causal factor.¹⁵

"Mental illness," as defined in the new statute, means "a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life."¹⁶ Although the similarities between this definition and the prior definition of a "mentally ill individual" are apparent,¹⁷ the new definition appears to be more precise and more psychologically oriented. The non-medical terms such as "lunacy," "unsoundness of mind," and "insanity" are excluded, as is the reference to lessening of capacity for one's control caused by addiction to alcohol or drugs, which necessitates treatment or guidance.¹⁸

The present definition, however, contains words that leave room for much interpretation. For example, how substantial must "substantial" be; and what is the criterion for "grossly" impaired judgment or behavior? Is the standard one's own previous judgment and behavior or does an objective standard exist against which one is to be measured? Also, what are the "ordinary demands of life" that one is to meet? Unless these demands include only the basic necessities of life, they may be construed differently depending upon one's lifestyle. However, these terms may not be less precise than the "reasonable man" standard found in tort law or the "substantial evidence" test that is used as a standard to review administrative decisions, terms to which the courts ultimately give content. While undoubtedly grey areas will exist where it will be difficult to determine if a person is indeed mentally ill, extremes at either end of the spectrum can be recognized and identified more easily.

Another definitional problem is that "mental illness" is stated to mean a disorder of the mind—thought, mood, perception, orientation, or memory—which affects behavior. Many psychologists argue, however, that mental illness is in fact a condition which is diagnosed from behavior that deviates

¹⁵ See statutory definition set out in text accompanying note 10 *supra*.

¹⁶ OHIO REV. CODE ANN. § 5122.01 (A) (Page Supp. 1976).

¹⁷ See note 9 *supra*.

¹⁸ OHIO REV. CODE ANN. § 5122.041 (A) (Page Supp. 1976) provides for the establishment of "special facilities which shall be reserved for the study, care, treatment, counseling, rehabilitation, and aftercare of drug dependent persons or persons in danger of becoming drug dependent."

from the norm, rather than a separate condition of the mind that can be isolated from behavior.¹⁹

Since mental illness is deemed inseparable from behavior, and behavior is evaluated against that which is normal, critics have argued that the concept is far too subjective to be used as the basis for the massive curtailment of liberty that results from civil commitment.²⁰ The diagnostician measures symptomatic behavior against his own ideas of normality; thus a clinician with a different set of standards may well find no mental illness, or may find a different disease.²¹ Such variations become intolerable in light of the possible consequences involved.

In order to objectify the standard, one writer has suggested that "a commission of experts [be] appointed to establish and regularly update criteria for diagnosis of presence of mental illness derived from such precise factors as psychiatric examination, psychological examination, and biochemical testing."²² Desirable as this may be in the abstract, its accomplishment may be impossible. Mental illness is so complex that, with the exception of the relatively few cases that can be traced to organic sources, the experts themselves have not yet settled on any firm criteria for diagnoses.²³

Until such objective criteria are developed, the use of the adversary system to enlighten the judgment of the court must suffice. However, since the statute entitles the person who is allegedly mentally ill to both counsel and independent expert evaluation,²⁴ he has an effective opportunity to challenge the evidence presented against him. Independent evaluation should result in more careful and less biased assessment of the person's medical

¹⁹ See *In re Ballay*, 482 F.2d 648, 665 (D.C. Cir. 1973) (most mental illness defined and measured in terms of behavioral deviance); R. LAING, *THE POLITICS OF THE FAMILY AND OTHER ESSAYS* 43-45 (1967) [hereinafter cited as LAING]; J. ROBITSCHER, *PURSUIT OF AGREEMENT: PSYCHIATRY AND THE LAW* 133 (1966) ("psychiatric commitment is a form of social control"); T. SZASZ, *THE MANUFACTURE OF MADNESS* 34-35 (1970); Hardisty, *Mental Illness: A Legal Fiction*, 48 WASH. L. REV. 735, 737 (1973) (psychiatrists use the phrase "mental illness" to achieve social purposes rather than to describe a medical condition); Livermore, Malmquist & Meehl, *On the Justification for Civil Commitment*, 117 U. PA. L. REV. 75, 80 (1968) ("[T]he definition of mental illness is left largely to the user and is dependent upon the norms of adjustment that he employs"); Roth, Dayley & Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 SANTA CLARA LAW. 400, 407-11 (1973) (application of the term "mental illness" is dependent on such factors as age, sex, financial position and lifestyle); Comment, *Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1255 (1974) [hereinafter cited as *Civil Commitment*].

²⁰ *Civil Commitment*, *supra* note 19, at 1256.

²¹ *Id.* at 1255.

²² Comment, *Reforming the Mental Health Law of Ohio*, 7 AKRON L. REV. 475, 489 (1974).

²³ The problem is further complicated by the fact that probably everyone is a bit schizoid; the difference between sickness and health is a matter of degree. In fact, the persons called upon to judge the presence of insanity may not be of entirely sound mind themselves. *In re Pickles*, 170 So. 2d 603, 614 (1965).

²⁴ OHIO REV. CODE ANN. § 5122.05 (C) (2) (Page Supp. 1976).

condition.²⁵ It is also usually the most effective rebuttal to the committing physician's description of the person's mental condition.²⁶ Furthermore, it has been documented that fewer people are committed in cases in which an attorney actively represents his client's best interests²⁷ since such representation forces the court to consider the matter more carefully.²⁸

B. Definition of "Mentally Ill Person Subject to Hospitalization by Court Order"

In *O'Connor v. Donaldson*,²⁹ the Supreme Court of the United States determined that a bare finding of "mental illness" does not justify civil commitment. The Court said:

A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that the term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining

²⁵ In a non-adversarial system, medical examiners often spend little time examining the person who is alleged to be mentally ill; one study showed that interviews last from five to seventeen minutes, with the mean time being 10.2 minutes. T. SCHEFF, *BEING MENTALLY ILL: A SOCIOLOGICAL THEORY* 144 (1966). The physicians tended to assume that there was mental illness present. One said, "If the patient's own family wants to get rid of him, you know there is something wrong." *Id.* at 149. Most examinations result in a finding of mental illness, regardless of the behavior exhibited during the interview. *Id.* at 128-68; LAING, *supra* note 19, at 33; de Grazia, *The Distinction of Being Mad*, 22 U. CHI. L. REV. 339, 343 (1955). In less than a third of the cases that resulted in commitment were the statutory criteria fully met. SCHEFF, *supra*, at 143.

²⁶ S. SCHWARTZ & D. STERN, *A TRIAL MANUAL FOR CIVIL COMMITMENT* (1977), *excerpted in* 1 MENTAL DISABILITY L. REP. 380, 385 (1977). Counsel for the respondent may also attempt to discredit the adverse testimony by bringing out on cross-examination the fact that the diagnosis and predictions of psychiatrists are unreliable. For an example of this technique, see Dixon & Blondis, *Cross-Examination of Psychiatric Witnesses in Civil Commitment Proceedings*, 1 MENTAL DISABILITY L. REP. 164, 168-69 (1976).

²⁷ *Civil Commitment*, *supra* note 19, at 1285.

²⁸ Usually the court has rubber-stamped the finding of the medical examiner. When the Ohio statute required only an affidavit containing a statement that the patient was "mentally ill" and needed "immediate hospital treatment," many courts relied on a bare allegation of mental illness to order involuntary hospitalization. In fact, when a hospital in Cleveland began submitting fuller reports in order to give the court a broader range of information upon which to make a finding, one court requested that the hospital return to the old method of reporting, evidently because the court believed that it would be a waste of time to review information that it was unqualified to analyze. Strand, *Legal Aid for Patients in State Mental Institutions: The Cleveland Experience*, 6 CLEARINGHOUSE REV. 483, 485 (1972) [hereinafter cited as Strand].

The court may justify such cavalier disposal of the cases by the widely-held idea that the person before the court would benefit, or at least not be harmed, by commitment. See SCHEFF, *supra* note 25, at 147, 151. The unfortunate part of this justification is that the idea is erroneous. See the discussion on the consequences of commitment at text accompanying notes 331-49, *infra*. The court is more likely to see conflict of interest between "responsible relatives" and "irresponsible patients," and thus less likely to order commitment if both sides of the picture are presented. Szasz, *Civil Liberties and the Mentally Ill*, 9 CLEV.-MAR. L. REV. 399, 404 (1960) [hereinafter cited as *Civil Liberties*].

²⁹ 422 U.S. 563 (1975).

such persons involuntarily if they are dangerous to no one and can live safely in freedom.³⁰

This statement suggests that a finding of mental illness in addition to something else may be sufficient justification for custodial confinement. The two grounds most frequently advanced in defense of involuntary commitment statutes are the exercise of the state police power to protect other members of the community from harm and the use of the state's *parens patriae* authority to shield the individual from possible harm to himself.³¹

Judged in these terms, the prior statutory definition³² may have been able to survive constitutional attack. The likelihood of the person causing injury to others if allowed to remain at liberty was considered sufficient justification for use of the police power, and the likelihood of injury to himself, or his inability to seek needed treatment, was seen as a proper object of the *parens patriae* authority.³³ Both theories, however, have been subject to virulent attack, and the new legislation may well represent an attempt to lessen such criticisms.

One of the most vocal critics has been psychiatrist Thomas Szasz, who believes that involuntary confinement for mental illness is *never* justified. Szasz believes that petitions for involuntary commitment are usually instigated when the mentally ill person has failed to fulfill family obligations.³⁴ For example, when a woman is suffering from serious postpartum depression and consequently neglects her household duties, it is her husband who is faced with the dilemma of a disintegrating household and an incoherent wife and who calls in a physician. Ostensibly, he is requesting help for his wife, but it is actually the husband who perceives the need for help in remedying

³⁰ *Id.* at 575.

³¹ For a full discussion of both grounds, see *Civil Commitment*, *supra* note 19, at 1207-40.

³² See note 9, *supra*, for the text of the statute. The Florida statute which permits commitment when a mentally ill person has been found "in need of care or treatment and lacking sufficient capacity to make a responsible application on his own behalf" was recently held precise enough to withstand a constitutional attack on vagueness grounds. *In re Beverly*, 342 So. 2d 481 (Fla. 1977).

³³ Society is entitled to protect itself against predatory acts on the part of anti-social people, regardless of the cause of their anti-social actions. Therefore, if the State can prove that an individual is likely to injure others if left at liberty, it may hospitalize him. The State is also entitled to prevent a person from injuring himself in the very specific sense of doing physical damage to himself, either actively or passively. Therefore, when it can be demonstrated that an individual has a self-destructive urge and will be violent towards himself, or alternatively that he is so . . . mentally ill that by sheer inactivity he will permit himself to die either of starvation or lack of care, then the State is entitled to hospitalize him.

State ex rel. Hawks v. Lazaro, 202 S.E.2d 109, 123 (W. Va. 1974).

³⁴ *Civil Liberties*, *supra* note 28, at 413. Szasz points out that when a person has failed to fulfill obligations outside of the home, other sanctions are available. If a person fails to perform on his job, chances are high that he will be fired; if he fails to perform a legal duty, such as paying taxes, he will be prosecuted.

his situation.³⁵ Since he is the one who wants to change the situation, he should take action on his own behalf, that is, to sever the relationship with his failing partner.³⁶

Szasz explains that involuntary commitment for the wife cannot be justified by the state's police power. Although she is not living up to society's expectation of fulfilling her role as "wife," she has violated no legal rule. Any rules that she has broken fall into the realm of social customs or mores, and these types of violations are usually penalized outside of the legal system, by social ostracism, loss of employment or alienation of a spouse.³⁷ To say that she *might*, someday, perform a criminal act is insufficient justification for commitment. A democratic government must take some chances with respect to what its citizens might do; some safety and security must be sacrificed in the name of personal liberty and dignity.³⁸ This argument is strengthened by the fact that it is difficult to justify such preventive detention on an empirical basis.³⁹ The presence of mental illness has not proven to be an accurate predictor of dangerous behavior,⁴⁰ and studies have generally shown that those classified as mentally ill are not as a group more dangerous than others.⁴¹

While Szasz does not favor involuntary commitment under the police power doctrine, neither does he favor involuntary commitment under the *parens patriae* doctrine. Szasz argues that treatment imposed ostensibly for the patient's benefit is too readily converted into a means of social control

³⁵ *Id.* at 401.

³⁶ To simply detach oneself from the annoying person is not so easy in a family situation, for one is likely to have guilt feelings when abandoning a relative. Some people find it easier to have the troublesome family member committed to a mental institution—or even to kill him—than to leave him. *Id.* at 414 n.23.

³⁷ *Id.* at 407.

³⁸ *Id.* at 411.

³⁹ See Dershowitz, *The Law of Dangerousness: Some Fictions About Predictions*, 23 J. LEGAL EDUC. 24, 33 (1970); Hardisty, *supra* note 19, at 761; Shah, *Dangerousness and Civil Commitment of the Mentally Ill: Some Public Policy Considerations*, 132 AM. J. PSYCH. 501, 502 (1975).

⁴⁰ See Dershowitz, *supra* note 39, at 33 (mental illness "not an accurate predictor of dangerous conduct"); Livermore, *supra* note 19, at 83 (although mental illness is not very useful in determining potentially dangerous individuals, the probability of dangerous conduct would increase if only those mentally ill individuals who had previously engaged in dangerous behavior were used in the computations). Yet in spite of this low reliability, approximately 50,000 mentally ill persons are committed on the ground of dangerousness every year. Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCHIVES GEN. PSYCH. 397, 400 (1972).

⁴¹ See *In re Ballay*, 482 F.2d at 666 (little reason to suspect that persons classified as "mentally ill" tend to be more dangerous to society than others); Albers, Pasework & Mayer, *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 CAP. U. L. REV. 11, 24 (1976) (citing studies which support "the view that persons labelled 'mentally ill' are not necessarily more dangerous than persons within the general population"); Rubin, *supra* note 40, at 400.

and that instead of forcing psychiatric treatment on unwilling patients, the state should create "economic, moral, and political circumstances favorable to a plentiful supply of competent physicians and effective drugs"⁴² so that each person is able to pursue and obtain adequate medical care if he so desires. Such a desire may spring from a realization that his personal relationships are not as satisfactory as they might be, or it may be a result of a fear of loss of employment or possible criminal prosecution. The goal would be to make medical intervention in the area of mental illness similar to that involving physical illness; the individual would have access to treatment but would not be compelled to accept it.⁴³

At least one court has seen fit to limit the state's *parens patriae* authority in the mental health field. The West Virginia Supreme Court of Appeals struck down a statute,⁴⁴ similar to Ohio's, that permitted commitment on the basis of a finding that the person involved was mentally ill, but unable to make his own decisions in regard to treatment. The court stated that the standard was so subjective that opportunities for abuse were created and the committing authority's determination could not be challenged in a meaningful appeal.⁴⁵ The court noted that consideration for the person's health could not override the foregoing due process concerns, because "[s]ociety abounds with persons who should be hospitalized, either for gall bladder surgery, back operations, corrective orthopedic surgery, or other reasons; yet in these areas society would not contemplate involuntary hospitalization for treatment."⁴⁶ The court found mere general concerns about the person's welfare insufficient to overrule his capacity for self-determination since "[m]odern welfare programs, community mental health facilities and private social service agencies have eliminated the problems of actual starvation and persecution of the mentally disturbed."⁴⁷

⁴² Szasz, *The Right to Health*, 57 GEO. L.J. 734, 751 (1969).

⁴³ *Id.* at 744. Szasz points out that many mental patients are tricked into entering the hospital. *Civil Liberties*, *supra* note 28, at 410. That this is at least sometimes true was illustrated in *Geddes v. Daughters of Charity of St. Vincent de Paul, Inc.*, 348 F.2d 144 (5th Cir. 1965). In that case, the brother of a 59 year-old woman gave her the impression that she was going to the hospital to receive medical treatment for abdominal adhesions that had resulted from a ruptured appendix many years ago. She admitted herself voluntarily with this idea in mind, but discovered later that she was in a mental hospital for the purpose of receiving psychiatric treatment.

⁴⁴ W. VA. CODE § 27-5-4 (2) (1971) (repealed 1975) permitted involuntary hospitalization if the individual "[i]s in need of custody, care or treatment in a hospital and because of his illness or retardation lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization."

⁴⁵ *State ex rel. Hawks v. Lazaro*, 202 S.E.2d 109, 123 (W. Va. 1974). *But see In re Beverly*, 342 So. 2d 481 (Fla. 1977), discussed in note 32, *supra*.

⁴⁶ 202 S.E.2d at 123.

⁴⁷ *Id.* For a historical description of society's treatment of the mentally ill, see *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084-86 (E.D. Wis. 1972). In the early American colonies mental illness was equated with moral turpitude, and indigent incompetents were often expelled from the towns and left to wander about the countryside. *Id.* at 1086.

Although these arguments against involuntary commitment are very forceful, a few problems will remain. For example, if freedom of choice is at issue, the person who is so ill that he is unable to make a responsible decision concerning his own welfare must be considered. When unconscious forces have overwhelmed any conscious choice, it is ludicrous to speak of freedom of choice.⁴⁸ For instance, to leave a catatonic schizophrenic to his own fate is to deny him any choice at all;⁴⁹ it is comparable to leaving a person who is brought to the hospital in a diabetic coma untreated because he does not voluntarily assent to treatment.⁵⁰ Limited treatment could thus be justified on the ground that it will give the person greater intrapsychic freedom to make a meaningful choice as to what treatment, if any, he wishes to pursue.⁵¹

Problems also arise when the behavior of the mentally ill person seriously endangers his own or others' safety, either actively or passively. Though married persons can relieve themselves by seeking divorce, other relationships cannot be dissolved as easily. For example, a person cannot divorce his elderly parent who makes life intolerable for the people around him. Even if the parent is told to live elsewhere, the problem does not disappear because other people are going to find the anti-social behavior equally objectionable. Unfortunately, our society has not yet made humane provisions for the unwanted who are unable to care for themselves.

A problem also exists where the person who has previously engaged in violent behavior is very likely to do so again. To ignore him is to put innocent bystanders in jeopardy. It appears that when this threat of harm exceeds the potential harm caused by involuntary commitment, confinement is justified.⁵²

Perhaps because these problems are not easily resolved, Ohio's new Mental Health Act has taken a middle ground. While involuntary commitment has not been abolished, the new statute attempts to delineate more clearly the criteria for its use. After a finding of mental illness has been made, the statute permits hospitalization by court order in the following four circumstances.

⁴⁸ Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 770 (1969) [hereinafter cited as Katz].

⁴⁹ *Id.* at 771.

⁵⁰ Even Szasz has agreed that extreme cases such as this should be treated without the patient's consent. But once the diabetic or schizophrenic, whichever the case may be, has regained consciousness, Szasz would say that consent is required for any further treatment. Even if treatment is then incomplete, a conscious patient has the right to leave the hospital whenever he pleases. *Civil Liberties*, *supra* note 28, at 408.

⁵¹ Katz, *supra* note 48, at 771.

⁵² *Civil Commitment*, *supra* note 19, at 1236. The quantum of "dangerousness" to be weighed against harm to the individual can be defined as "the product of the magnitude of the harm he is predicted to cause and the probability that he will cause it." *Id.*

(1) The mentally ill person "represents a substantial risk of physical harm to himself as manifested by evidence of threats of, or attempts at, suicide or self-inflicted bodily harm."⁵³ The state is still asserting an interest in the protection of its citizens, even from themselves, but the basis of intervention is more limited than it was under the prior statute in at least three respects. First, the injury must be *physical*; intervention on the basis of mismanagement of social relations, for example, is no longer justified. Second, the necessity of some concrete evidence means that allegations and proof must be clearly focused, thus enabling the allegedly mentally ill person to present some sort of rebuttal.⁵⁴ Third, the fact that there must be evidence of past destructive behavior provides less room for speculation about future possibilities.

(2) The mentally ill person "represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior or evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm."⁵⁵ Again, the harm contemplated must be physical rather than social or psychological, and fear of the harm must be evidenced by specific past behavior, which greatly enhances the reliability of any predictions of dangerousness.⁵⁶

(3) The mentally ill person "represents a substantial and immediate risk of serious physical impairment or injury to himself as manifested by evidence that he is unable to provide for and is not providing for his basic physical needs because of his mental illness and . . . appropriate provision for such needs cannot be made immediately available in the community."⁵⁷ The state is again concerned with protection of the individual from himself,

⁵³ OHIO REV. CODE ANN. § 5122.05 (C) (1) (Page Supp. 1976).

⁵⁴ One of Szasz's main criticisms of the commitment procedure has been the lack of precise "charges" against the respondent. In contrasting commitment with criminal procedure he points out that:

Once the psychiatrist has made a "diagnosis," the patient is considered "sick." The psychiatrist does not have to prove his allegation (in court or outside of it). But the patient must now prove, as it were, that he is "not sick." And how can he do this, especially when he is ignorant of the criteria used to establish that he was "sick" in the first place?

Civil Liberties, *supra* note 28, at 407-08 (emphasis in original).

⁵⁵ OHIO REV. CODE ANN. § 5122.01 (B) (2) (Page Supp. 1976).

⁵⁶ Livermore, *supra* note 19, at 83. Preventive detention has been judicially recognized as acceptable in such a case.

Although attempts to predict future conduct are always difficult, and confinement based upon a prediction of dangerousness must always be viewed with suspicion, civil commitment can be justified in some cases if the proper burden of proof is satisfied and dangerousness is based upon a finding of a recent overt act, attempt or threat to do substantial harm to oneself or another.

Lessard v. Schmidt, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1974), *on remand* 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), *on remand* 413 F. Supp. (E.D. Wis. 1976).

⁵⁷ OHIO REV. CODE ANN. § 5122.01 (B) (3) (Page Supp. 1976).

but the harm contemplated is not violent self-harm. This section permits commitment in cases where only custodial care is contemplated or possible, the senile elderly parent being the most obvious candidate for involuntary hospitalization. Concrete evidence of past behavior must be available which would point to the inability of the person to care for himself and the inadequacy of care elsewhere in the community must be shown. This is in accord with the "least restrictive alternative" concept which is also part of the new Act.⁵⁸

(4) The mentally ill person "would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself."⁵⁹ This is the least precise section of the new statute. Here no prediction of future physical harm to the individual or anyone else is required; instead, the statute refers to the need of and benefit from treatment and to the "risk of substantial rights," which terms are not defined. Presumably this section would cover the situation in which the individual is in a state of mind which renders him unable to make any meaningful decisions regarding his own welfare. Such a situation is not directly covered by the other statutory criteria.⁶⁰ Presently, however, this section is open to interpretation and may be construed to cover the deteriorating social relations that were part of the definition of mental illness under the prior statute.⁶¹ "Substantial rights" might be extended to include the right of a husband to be free from excessive expenditures made by his wife, the right of a wife to have her husband support the household instead of spending his paycheck elsewhere, and the right of children to be free from mental distress from an abusive and insulting parent. Thus, the scope of this section will remain in doubt until it has been interpreted by the courts.

Concern about the vagueness of this section, however, may be lessened by certain built-in constraints. For example, the person urging commitment must show a need for treatment as manifested by concrete evidence of past behavior and must also show that the "sick" person would benefit from

⁵⁸ See text accompanying notes 409-13 *infra*.

⁵⁹ OHIO REV. CODE ANN. § 5122.01 (B) (4) (Page Supp. 1976).

⁶⁰ Under the old law, such a situation would have been covered under § 5122.01 (B) (Page 1970), which provided for involuntary hospitalization in the case where a person was found to need treatment but lacked capacity to make responsible decisions regarding hospitalization. See note 9 *supra*. If this section of the statute would be held not to dispose of this situation, it may be possible to accomplish the same result by applying for appointment of a guardian and having the person admitted to the hospital by the guardian under the section governing voluntary hospitalization. See OHIO REV. CODE ANN. § 5122.02 (B) (Page Supp. 1976). In some cases it may also be possible to argue that the person is unable to take care of his physical needs because of his mental illness and so is covered by the third criterion. See *id.* § 5122.01 (B) (3).

⁶¹ See note 9 *supra*, for the text of the old statute.

treatment. Thus, the mentally ill person at least is made aware of the accusations against him and has the opportunity to present contrary evidence.⁶² Additional protection is provided in that the person has a right to a judicial hearing, with counsel,⁶³ and all elements of the case must be shown by clear and convincing evidence.⁶⁴

One should observe that all four criteria meet the *Donaldson* standard of constitutionality, *i.e.*, in no case is a person kept in indefinite custodial confinement upon a bare finding of "mental illness." The first three criteria are justified on the ground that the mentally ill person is likely to cause physical harm to himself or others;⁶⁵ the rationale of the fourth criterion is that the mentally ill person will benefit from treatment.⁶⁶

⁶² Both results are important to the person accused of mental illness. See notes 33 and 59 *supra*.

⁶³ OHIO REV. CODE ANN. § 5122.15 (C) (Page Supp. 1976). One court has required proof beyond a reasonable doubt because of the significant deprivation of liberty that results from commitment. *Lessard v. Schmidt*, 349 F. Supp. at 1095. If that standard of proof were required, the process of commitment would be significantly more difficult. See *Civil Commitment*, *supra* note 19 at 1296-1300. However, such a standard would not be totally impracticable. *Id.* at 1301-03.

⁶⁴ OHIO REV. CODE ANN. § 5122.15 (C) (Page Supp. 1976).

⁶⁵ These grounds for involuntary commitment have been legally accepted elsewhere. See note 33 *supra*.

⁶⁶ The Supreme Court of Appeals of West Virginia upheld a similar statutory provision, but in a conclusory fashion:

The State would also be permitted, under the Constitution, to hospitalize a person who suffers from a mental illness or retardation which is likely to produce some form of injury other than direct physical injury, if the type of injury were definitely ascertainable, and if the State had a treatment program which it could be demonstrated offered a reasonable likelihood of ameliorating the illness or condition.

State *ex rel. Hawks v. Lazaro*, 202 S.E.2d at 123-24. However, problems could arise if the patient refused treatment, not an unlikely situation when he has been involuntarily committed. Then he would be kept in simple custodial confinement, which would seem to be constitutionally prohibited under *Donaldson*. See text accompanying note 30 *supra*. Alternatively, if the person were treated in spite of the fact that he did not wish to be, other problems arise. Absent an emergency, such unauthorized treatment would constitute a tort in any other context. See, *e.g.*, *Scott v. Plante*, 532 F.2d 939 (3d Cir. 1976); *Parker v. St. Paul Fire & Marine Ins. Co.*, 335 So. 2d 725 (La. App. 1976); *Sard v. Hardy*, 367 A.2d 525 (Md. App. 1976); *Gray v. Grunnagle*, 423 Pa. 144, 155, 223 A.2d 663, 668-69 (1966); *Small v. Gifford Memorial Hosp.*, 133 Vt. 552, 349 A.2d 703 (1975). When the state participates in such conduct, it could constitute a violation of the eighth amendment, *Scott v. Plante*, 532 F.2d 939, 946 (3d Cir. 1976); *Souder v. McGuire*, 423 F. Supp. 830 (M.D. Pa. 1976) (memorandum opinion denying defendant's motion to dismiss); the first amendment, *Scott v. Plante*, 532 F.2d at 946; the Equal Protection Clause of the fourteenth amendment (the classification of those persons subject to compulsory treatment is under-inclusive in that it does not include those persons suffering from physical illnesses); or the Due Process Clause of the fourteenth amendment (forcing an ill person to submit to treatment infringes on the fundamental liberties guaranteed to every citizen in a free state). The natural law arguments behind a substantive due process claim become even stronger when looked at in light of the Ohio Constitution, which begins by stating, "All men are, by nature, free and independent, and have certain inalienable rights, among which are those of enjoying and defending life . . . and seeking and obtaining happiness and safety."¹³ OHIO CONST. art. I § 1.

II. PROCEDURE

A. Hearings Required for Involuntary Commitment

Under the new Mental Health Act, Ohio's procedures relating to judicial hospitalization are an attempt to comply with those minimal due process standards suggested by the Ohio Supreme Court in *In re Fisher*. The proceedings are still commenced by the filing of an affidavit by "any person or persons"⁶⁷ with the appropriate court, however, much has been added by the legislature in an effort to curtail abusive use of this process. The judge or referee reviewing the affidavit must make an initial *ex parte* determination as to whether probable cause exists to believe that the individual is subject to detention prior to a full hearing on the merits.⁶⁸ Provision is also made for investigation by the court of the allegations contained in the affidavit⁶⁹ and medical examination of the individual sought to be hospitalized to consider whether care and treatment are necessary.⁷⁰

Newly enacted is a provision for a probable cause hearing, if requested, which unlike the *ex parte* determination upon receipt of the affidavit, affords all the attributes of an adversary hearing.⁷¹ Hence the new Act provides the individual sought to be committed with two opportunities to test the allegations of the affidavit. The last step in the commitment procedure is the full hearing, expanded to provide a full range of procedural safeguards.⁷² Moreover, after judicial commitment, the new Act provides that mandatory hearings be held at specified intervals to consider the necessity of continued commitment,⁷³ and with respect to all hearings, the court is under an affirmative duty to provide adequate notice to the individual sought to be hospitalized.⁷⁴

1. Initial Filing

In order to obtain a court order to hospitalize a person who is allegedly mentally ill, one must file an affidavit with the probate division of the court of common pleas.⁷⁵ "Any person or persons" having "reliable information or actual knowledge" of "facts sufficient to indicate probable cause to believe that the person [sought to be hospitalized] is a mentally ill person

⁶⁷ OHIO REV. CODE ANN. § 5122.11 (Page Supp. 1976).

⁶⁸ *Id.*

⁶⁹ *Id.* § 5122.13.

⁷⁰ *Id.* § 5122.14.

⁷¹ *Id.* § 5122.141.

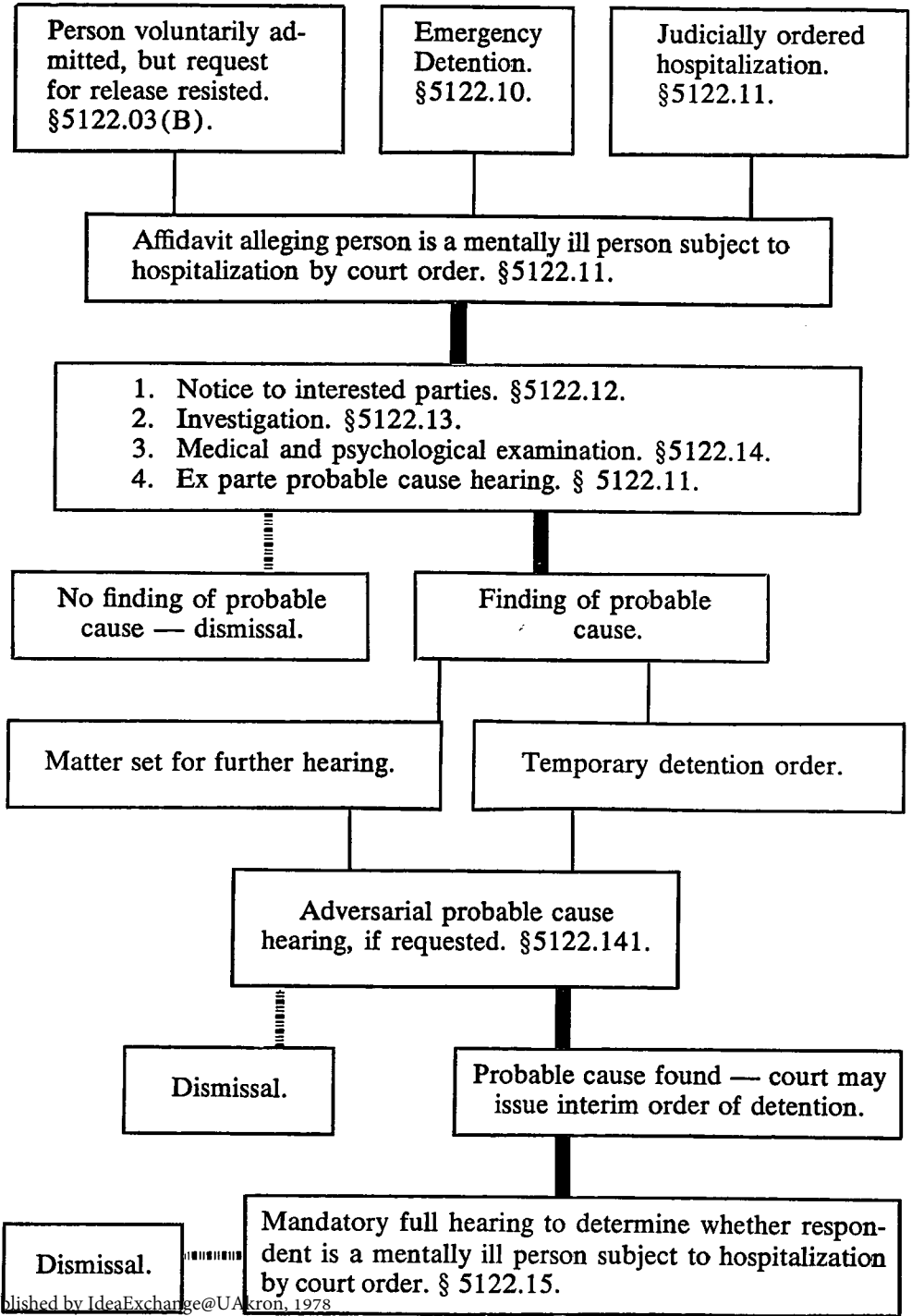
⁷² *Id.* § 5122.15.

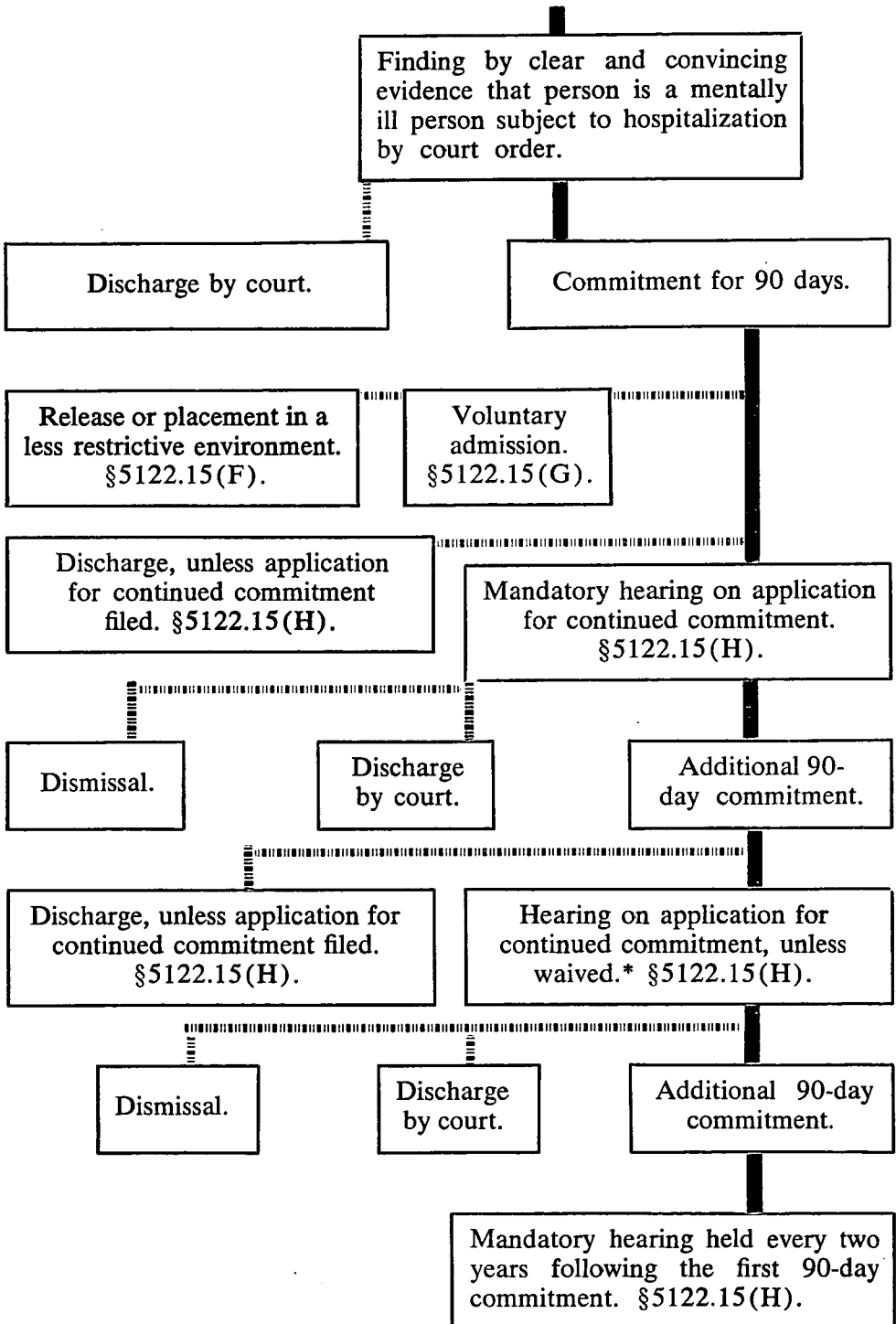
⁷³ *Id.*

⁷⁴ *Id.* § 5122.12.

⁷⁵ *Id.* § 5122.11. All references to court in the Act mean "the probate division of the court of common pleas." *Id.* § 5122.01 (Q).

HEARINGS





*Under the proposed amendments this hearing would not be held unless requested.

subject to hospitalization by court order" can file such an affidavit.⁷⁶ Previously the law required only that there exist "reason to believe that the individual . . . is likely to injure himself or others if allowed to remain at liberty, or needs immediate hospital treatment."⁷⁷

Prior law had permitted the affidavit to be based merely on "information or actual knowledge,"⁷⁸ which had the effect of allowing hearsay to support the affidavit, a practice which the Ohio Supreme Court has disapproved.⁷⁹ Although the new requirements do not act as an absolute bar to the use of hearsay in the affidavit, insofar as the information must have some indicia of reliability, one may presume that only hearsay which would qualify for admission under the rules of evidence should be acceptable in the affidavit.⁸⁰

Upon receipt of the affidavit, the court may further require either a certificate from a psychiatrist⁸¹ stating that he has examined the individual sought to be hospitalized and is of the opinion that the individual is mentally ill and ought to be subject to hospitalization by court order, or may require signed certificates of both a licensed clinical psychologist⁸² and a licensed physician⁸³ stating conclusions to the same effect.⁸⁴ Prior law did not require certification, but accepted the statement of a licensed physician that he had examined the individual and was of the opinion that the individual was "mentally ill and should be hospitalized."⁸⁵ In lieu of either of these classes of certification, the applicant may be required to submit a written statement under oath that the person sought to be hospitalized has refused to consent to an examination.⁸⁶

In addition, the court or an attorney appointed by the court to act

⁷⁶ *Id.* § 5122.11.

⁷⁷ OHIO REV. CODE ANN. § 5122.11 (Page 1970) (amended 1976).

⁷⁸ *Id.*

⁷⁹ *In re Fisher*, 39 Ohio St. 2d 71, 79-80, 313 N.E.2d 851, 857 (1974) ("many petitions for commitment are based upon hearsay evidence and subject to the same abuses in civil commitment hearings which render such evidence inadmissible in any other civil or criminal proceeding"). See also *Lynch v. Baxley*, 386 F. Supp. 378, 394 (M.D. Ala. 1974) ("At the very least, due process requires that the rules of evidence applicable to other judicial proceedings be followed in involuntary commitment proceedings In particular, if hearsay evidence would be excluded from other proceedings, it should be excluded from commitment hearings as well").

⁸⁰ A further effort to restrict the type of evidence acceptable in commitment procedures is found in OHIO REV. CODE ANN. § 5122.15 (A) (9) (Page Supp. 1976) where the court or appointed referee is constrained to accept only "reliable, competent, and material evidence."

⁸¹ As defined at OHIO REV. CODE ANN. § 5122.01 (E) (Page Supp. 1976).

⁸² *Id.* § 5122.01 (I).

⁸³ *Id.* § 5122.01 (D).

⁸⁴ *Id.* § 5122.11.

⁸⁵ OHIO REV. CODE ANN. § 5122.11 (Page 1970) (amended 1976).

⁸⁶ OHIO REV. CODE ANN. § 5122.11 (Page Supp. 1976).

as referee must make an initial *ex parte* determination of whether there is probable cause to believe that the "person named in the affidavit is a mentally ill person subject to hospitalization by court order."⁸⁷ Upon such a determination, the court or referee may issue a temporary order of detention which empowers any health or police officer or sheriff to take the individual into custody and transport him to a hospital or other facility approved by the statute.⁸⁸ Thus, the Act still provides for issuance of an *ex parte* order of detention, a practice which had been the subject of criticism.⁸⁹ However, the statute does indicate that wherever possible, the probable cause hearing should be held prior to taking custody of the respondent.⁹⁰ If this is impossible and the individual is first taken into custody, he may be treated and observed until a probable cause hearing is held, and if such a hearing is not held, until the full hearing is conducted.⁹¹

2. Notice of Hearings

After filing the affidavit, written notice of any judicial hearing, *e.g.*, the probable cause hearing or the mandatory full hearing, must be sent to a number of persons specifically designated by the statute.⁹² Among these persons are the respondent,⁹³ the affiant, respondent's counsel, or any other person that the respondent may designate.⁹⁴ Absent from the new law is the former provision which allowed the court to dispense with notice to the individual sought to be hospitalized where notice would be "injurious to the individual."⁹⁵ Apparently in response to several recent cases criticizing this practice,⁹⁶ the new Act declares that notice to the individual sought to be committed may not be waived.⁹⁷ In addition, "[a] copy of the affidavit

⁸⁷ *Id.*

⁸⁸ *Id.* The other facilities are described at OHIO REV. CODE ANN. § 5122.17 (Page Supp. 1976) and include the individuals "home, a licensed rest or nursing home, a licensed or unlicensed hospital, a mental health clinical facility, or a county home . . ." Jails are excluded "unless the court finds that a less restrictive alternative cannot be made available." In no event may the individual be detained for more than forty-eight hours in any of these facilities pending removal to a hospital.

⁸⁹ See, *e.g.*, Dewey, *Imprisonment of the Mentally Ill: An Inquiry Into the Deprivation of Civil Liberties Under Ohio Laws and Procedures*, 1 CAP. L. REV. 1, 11-14 (1972).

⁹⁰ OHIO REV. CODE ANN. § 5122.141 (Page Supp. 1976).

⁹¹ *Id.* § 5122.11. If no probable cause hearing is held, observation and treatment are permitted until the full hearing provided for in § 5122.15.

⁹² *Id.* § 5122.12.

⁹³ Respondent, as used throughout the Act "means the person whose detention, commitment, hospitalization, or continued hospitalization or discharge is being sought in any proceeding under this chapter." *Id.* § 5122.01 (N).

⁹⁴ *Id.* § 5122.12.

⁹⁵ OHIO REV. CODE ANN. § 5122.12 (Page 1970).

⁹⁶ *E.g.*, *Lessard v. Schmidt*, 349 F. Supp. 1078, 1090 (1972); *In re Fisher*, 39 Ohio St. 2d 71, 79, 313 N.E.2d 851, 857 (1974).

⁹⁷ OHIO REV. CODE ANN. § 5122.12 (F) (Page Supp. 1976).

and temporary order of detention [if issued] shall be served with such notice to the parties and to respondent's counsel, if counsel has been appointed or retained."⁹⁸

3. Investigation

Upon receipt of the affidavit, the court must order an investigation concerning the allegations contained in the affidavit⁹⁹ and any "other information relating to whether or not the person named in the affidavit or statement is a mentally ill person subject to hospitalization by court order."¹⁰⁰ The investigation must be conducted by a social worker or other investigator as the court may appoint.¹⁰¹ Prior to the full hearing, the individual's counsel, if known, must be sent a copy of the report of this investigation, and the person conducting the investigation must submit a written report to the court which will become a part of the official court record.¹⁰² Insofar as the probable cause hearing is conducted in accordance with the same procedures as the full hearing,¹⁰³ including the requirement that with the consent of the respondent all relevant documents, information, and evidence in the custody or control of the state shall be made available to counsel for the respondent,¹⁰⁴ one could argue that this investigative report should be made available to counsel prior to the probable cause hearing as well. Considering the adversary nature of the probable cause hearing, such a report could be very helpful in the preparation of an adequate defense of the allegations.

4. Pre-hearing Medical Examination

In the event the court requires certification of examination by a psychiatrist, or by a psychologist and physician to accompany the affidavit, the court may order an examination of the individual sought to be hospitalized; if no certificate has been submitted, the court must order an examination.¹⁰⁵ The ex-

⁹⁸ *Id.*

⁹⁹ *Id.* § 5122.13. It should be noted that this section is currently being reconsidered in H.B. 725, 112th General Assembly (1977-78) which is currently in committee. Under the new proposals, the investigation would be discretionary rather than mandatory. The scope of the investigation is broadened to include an inquiry into the availability of appropriate treatment alternatives. Additionally, the investigative report will not be admissible as evidence on the question of whether a person is mentally ill and subject to court ordered hospitalization, but it shall be used to aid the court in selecting an appropriate placement for such an individual.

¹⁰⁰ OHIO REV. CODE ANN. § 5122.13 (Page Supp. 1976).

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Section 5122.141 provides in part that the "probable cause hearing shall be conducted in a manner consistent with the procedures set forth in divisions (A) (1) to (15) of section 5122.15" relating to the full hearing.

¹⁰⁴ OHIO REV. CODE ANN. § 5122.15 (A) (1) (a) (Page Supp. 1976).

amination is to be carried out, if possible, in a place least likely to have a harmful effect on the respondent's health, and the individual's home is specifically suggested.¹⁰⁶ At the first hearing, the examiner shall report to the court his findings as to the mental condition of the respondent, and his need for custody, care, or treatment in a mental hospital.¹⁰⁷ Prior to the full hearing, a copy of this report must be sent to the individual's counsel, if known,¹⁰⁸ and it also should be noted that at the probable cause hearing and the full hearing, the individual sought to be hospitalized must be informed that he may have independent expert evaluation, if necessary, at state expense.¹⁰⁹

5. Probable Cause Hearing

The new Act provides for two possible occasions when a probable cause determination must be made on the question of whether an individual sought to be judicially committed to a mental health facility is indeed a mentally ill individual subject to court ordered hospitalization. First, an *ex parte* determination must be made by the court or referee upon receipt of the affidavit.¹¹⁰ Second, the court must make the same determination after an adversary proceeding if the provisions of Ohio Revised Code § 5122.141 requiring a probable cause hearing are invoked.

This process may prove to be administratively cumbersome; however, from the point of view of the individual involved in the judicial hospitalization procedure, it affords an extra measure of protection against unjustified commitment. To illustrate this, one need only juxtapose similar procedures of the old and new acts. The earlier provision allowed the court to issue a temporary detention order upon receipt of the affidavit where there was reason to believe that the individual needed treatment or was likely to injure himself or others if allowed to remain at large.¹¹¹ Thereafter, the individual was granted a hearing, but the court could order the individual involuntarily hospitalized for a period of ninety days, solely upon the court's finding that there was probable cause to believe that the individual was mentally ill and needed treatment.¹¹² In contrast, the present Act provides that the referee still may issue a temporary order of detention based on the affidavit, but only upon a probable cause determination that the person is a mentally ill individual subject to hospitalization by court order,¹¹³ a

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* §§ 5122.141 and 5122.15 (A) (4).

¹¹⁰ See notes 68 and 76 and accompanying text *supra*.

¹¹¹ OHIO REV. CODE ANN. § 5122.11 (Page 1970) (amended 1976).

¹¹² *Id.* § 5122.15.

¹¹³ OHIO REV. CODE ANN., § 5122.11 (Page Supp. 1976). See text accompanying notes 53-58 *supra*.

highly particularized definition of precisely who is subject to involuntary commitment. After this determination the individual is afforded another opportunity to test the allegations of the affidavit at a probable cause hearing. Again, this may result in involuntary detention, but generally only for such time as would be necessary to arrange a full hearing on the same question, and in no event later than forty-five days after the original involuntary detention.¹¹⁴

However, one should note that the probable cause hearing is not a necessary consequence of the judicial hospitalization procedure. Unless the court orders such a hearing on its own motion, it must be requested by an individual who has already been detained involuntarily or against whom judicial hospitalization proceedings have been initiated, or his guardian, his counsel, or the head of the hospital.¹¹⁵ Because the probable cause hearing must be conducted in accordance with the procedural rights of the full hearing, it may be inconvenient for some of the parties to seek actively such a hearing especially when one considers that the hearing must be held within three court days from the request.¹¹⁶ Provision is made for continuance for good cause, but in no event may the probable cause hearing be held later than ten days from the request, and failure to do so results in immediate discharge of the individual and expungement of the record.¹¹⁷ Many circumstances could interfere with the initiation of a probable cause hearing. The court may not meaningfully implement this right in light of a crowded docket. Moreover, the head of the hospital may have the medical equivalent of a crowded docket, and it is therefore reasonable to assume that at times he will be less than eager to request another hearing. Where the guardian is the person seeking hospitalization,¹¹⁸ his interest is likely to lie with an expeditious determination; clearly another hearing, from his point of view, would be an unnecessary hurdle. Hence, it appears that the burden of invoking this procedural tool will fall on the individual sought to be committed or his counsel.

This, in turn, assumes that the individual is given adequate notice of the availability of the hearing. The Act requires that an individual who has been involuntarily detained be apprised of this opportunity as soon as he

¹¹⁴ OHIO REV. CODE ANN. § 5122.141 (Page Supp. 1976).

¹¹⁵ *Id.* Note also that a patient who voluntarily admits himself may request release and if such release is not effected within three days, such request for release serves as a request for a probable cause hearing. *Id.* § 5122.03 (B).

¹¹⁶ *Id.* § 5122.141.

¹¹⁷ *Id.*

¹¹⁸ Recall that proceedings leading to judicial hospitalization are commenced by the filing of an affidavit by "any person" *Id.* § 5122.11.

is taken into custody.¹¹⁹ However, nowhere is it explicitly stated that an individual who is named in an affidavit seeking judicial hospitalization, and who is not taken into custody, must be given such notice. However, as noted earlier, the court or referee must give written notice to the individual of any hearing which the court directs, after receipt of the affidavit.¹²⁰ In order to avoid discriminating between those individuals who are presently involuntarily detained and those who are named in the affidavit, yet presently not in custody, it would seem that this notice requirement should be mandatory for apprising both classes of individuals of the availability of this hearing.

By incorporating the procedures of a full hearing into the probable cause hearing,¹²¹ the legislature establishes that it too must be conducted in a manner consistent with *due process of law*.¹²² Because this requirement introduces the procedures of both the probable cause and the full hearings, it perhaps has more significance than the drafters intended. The due process requirement is one which is continually subject to judicial interpretation, and thus develops in accordance with contemporary social values.¹²³ By requiring the courts to conduct these hearings in accordance with due process standards, the mentally ill person is granted further protection of his substantive rights. Judges, in enforcing due process requirements, can go beyond the standards of fairness set out in the statute. Moreover, adherence to due process standards, which are constantly changing, provides the Act with built-in flexibility.

Further protection of substantive rights is provided by the section which mandates that the individual sought to be committed has a right to attend the hearing.¹²⁴ Although this provision is an improvement on the prior section which permitted the court to prevent the individual from attending the hear-

¹¹⁹ *Id.* § 5122.05 (C) (3).

¹²⁰ See notes 92-98 and accompanying text *supra*.

¹²¹ This section is also subject to change if H.B. 725, now pending before the Ohio House of Representatives, is enacted in its present form. That bill would eliminate the need to apply the rules of Civil Procedure, which are presently mandated to the extent not inconsistent with the remainder of the mental health chapter. See note 137 *infra*. The present Act limits evidence admissible at the probable cause hearing to that which is reliable, competent and material. See note 135 *infra*. However, the proposed changes would allow certificates and written reports prepared pursuant to § 5122.11, *supra* notes 81-86, and § 5122.14, *supra* notes 105-07 to be accepted into evidence without direct testimony of the proponent, who would be excused from testifying at the hearing. Hence, the respondent would also lose the right he presently has to subpoena and cross-examine those witnesses. See note 126 *infra*.

¹²² OHIO REV. CODE ANN. § 5122.15 (A) (Page Supp. 1976).

¹²³ Consider in this regard the recent rise of the right to counsel, and the societal pressures which required extension of this right to state criminal proceedings as illustrated in A. LEWIS, *GIDEON'S TRUMPET* 102-17 (1967).

¹²⁴ OHIO REV. CODE ANN. § 5122.15 (A) (2) (Page Supp. 1976).

ing if it found that his presence would be injurious to him,¹²⁵ the new law is deficient of any restriction on the administration of personality altering drugs immediately preceding the hearings. This omission or oversight is perhaps more significant when one considers that under the new law "[t]he respondent has the right to testify and the respondent or his counsel has the right to subpoena witnesses and documents and to examine and cross-examine witnesses."¹²⁶ Allowing the individual to be present and to participate actively in his own defense is a right seriously limited when the individual is likely to be in a drugged state. The courts may interpret such a practice as a deprivation of due process,¹²⁷ and if so, such judicial condemnation of these practices could supplant the need for statutory amendment.

Perhaps the most significant procedural requirement of the probable cause hearing is that "[t]he respondent shall be informed that he may retain counsel . . . and, if unable to obtain an attorney, shall be represented by court-appointed counsel"¹²⁸ This is in apparent compliance with the mandate of the Ohio Supreme Court which has held that the

right to be represented by counsel must be made available at the earliest stage of the proceedings commensurate with the individual's need for a timely preparation of a defense or advancement of an argument for alternative modes of treatment, preferably upon the filing of an affidavit in Probate Court under R.C. 5122.11.¹²⁹

This holding entails more than just availability of counsel; it requires counsel who is prepared to defend the individual. Seemingly in answer to this, the legislature engrafts what might be deemed a requirement of effective assistance of counsel, by mandating that he be provided (if the respondent permits) with all relevant documents in the control of any of the parties to the hearing.¹³⁰ However, one cannot reasonably expect a court-appointed

¹²⁵ OHIO REV. CODE ANN. § 5122.15 (Page 1970) (amended 1976). A provision similar to this was held unconstitutional in *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974).

¹²⁶ OHIO REV. CODE ANN. § 5122.15 (A) (11) (Page Supp. 1976).

¹²⁷ See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078, 1092 (1972) for criticism of such practices and *Lynch v. Baxley*, 386 F. Supp. 378, 389 (M.D. Ala. 1974) holding that "Due process is not accorded by a hearing in which the individual, though physically present, has no meaningful opportunity to participate because of incapacity caused by excessive or inappropriate medication."

¹²⁸ OHIO REV. CODE ANN. § 5122.15 (A) (4) (Page Supp. 1976). Section 5122.15 (A) (3) provides that if the individual is not present at the hearing and has not validly waived his right to counsel, the court must immediately appoint counsel. In such a case the court must continue the case, presumably to provide counsel time to familiarize himself with the case.

¹²⁹ *In re Fisher*, 39 Ohio St. 2d 71, 82, 313 N.E.2d 851, 852 (1974).

¹³⁰ OHIO REV. CODE ANN. § 5122.15 (A) (1) (a)-(c) (Page Supp. 1976). Query however whether most practicing attorneys would know how to utilize all this material to the benefit of his client? In this regard, see Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEXAS L. REV. 424 (1966) and *Civil Commitment*, *supra* note 19

counsel to have fully ingested all this material if in fact he is not appointed until the probable cause hearing. Hence, Ohio Revised Code § 5122.05 (C) (2) provides in part:

(C) Any person who is involuntarily detained in a hospital or is otherwise in custody under this chapter shall, immediately upon being taken into custody, be informed of and provided with a written statement that he may:

(2) Retain counsel and . . . if he is unable to obtain an attorney, be represented by court-appointed counsel

Thus, the individual should be apprised of this right, and ideally, exercise it, as soon as his liberty is impaired.

But what would be the result if an individual has been named in an affidavit seeking judicial hospitalization under Ohio Revised Code § 5122.11 where the court or referee has found probable cause to believe that the individual is subject to hospitalization, yet does not issue a temporary detention order and merely sets the matter for further hearing?¹³¹ The individual is not in custody and therefore the provision calling for written notice of the right to counsel¹³² is not invoked. Yet, Ohio Revised Code § 5122.12¹³³ requires that after receipt of the affidavit, notice of any hearing be sent to respondent's counsel, if retained. If this section is to have any meaningful application, it must envision counsel who has already been appointed, arguably upon receipt of the affidavit, which would comport fully with the suggestion of the Ohio Supreme Court in *In re Fisher*.

At the probable cause hearing the court is to examine the sufficiency of all documents filed and inform the respondent, if present, and his counsel of the nature and content of the documents and the reason for which he is being detained, or for which his placement is being sought.¹³⁴ Further, the court is directed to receive only reliable, competent, and material evidence,¹³⁵ and the individual must be advised that he may not be compelled to testify against himself.¹³⁶

The Ohio Rules of Civil Procedure are to be followed at the probable cause hearing insofar as they are consistent with the chapter,¹³⁷ and a complete transcript and record of the proceeding must be maintained and provided to indigent respondents upon request, free of charge.¹³⁸

¹³¹ This procedure is fully analyzed at notes 75-91 and accompanying text *supra*.

¹³² OHIO REV. CODE ANN. § 5122.05 (C) (2) (Page Supp. 1976).

¹³³ See text accompanying notes 92-98 *supra*.

¹³⁴ OHIO REV. CODE ANN. § 5122.15 (A) (8) (Page Supp. 1976).

¹³⁵ *Id.* § 5122.15 (A) (9).

¹³⁶ *Id.* § 5122.15 (A) (12).

¹³⁷ *Id.* § 5122.15 (A) (15).

¹³⁸ *Id.* § 5122.15 (A) (14).

In short, the new Act provides for a genuine adversary hearing on the question of whether there is probable cause to believe that the individual is mentally ill and therefore subject to judicial hospitalization. If after the hearing, the court does not find probable cause to believe that the individual is subject to hospitalization, he must be released immediately and all record of the proceeding expunged.¹³⁹ On a finding of probable cause, the court may issue an interim order of detention.¹⁴⁰ If the individual is the subject of judicial hospitalization proceedings under Ohio Revised Code § 5122.11, the court must order a full hearing on the same question.¹⁴¹ Counsel at that time may request, and if so requested, the court shall schedule the hearing within ten days of the probable cause hearing.¹⁴² Unless discharged, it is mandatory that a full hearing be held within thirty to forty-five days after the original involuntary detention of any respondent who has had no probable cause hearing, or who failed to request a full hearing under this section, or whose full hearing was not held because a continuance was granted.¹⁴³

6. Full Hearing and Mandatory Hearing on Continued Commitment

The procedures of the full hearing have been set out in the discussion of the probable cause hearing.¹⁴⁴ However, final disposition on the question of whether an individual is a mentally ill person subject to judicial hospitalization must be determined by clear and convincing evidence.¹⁴⁵ Although argument has been advanced that commitment of an individual should be based on proof of mental illness beyond a reasonable doubt, the better view seems to invoke a clear and convincing evidence standard.¹⁴⁶ In any event, a clear and convincing standard affords much greater protection against unjustified commitment than the probable cause standard, discussed in the preceding section.¹⁴⁷

¹³⁹ *Id.* § 5122.141.

¹⁴⁰ *Id.* See note 88 and accompanying text *supra*.

¹⁴¹ OHIO REV. CODE ANN. § 5122.141 (Page Supp. 1976).

¹⁴² *Id.*

¹⁴³ *Id.* See § 5122.15 (A) (13) which provides that "On motion of the respondent or his counsel for good cause shown or on the court's own motion the court may order a continuance of the hearing."

¹⁴⁴ *Id.* § 5122.15 (A) (1)-(15). See text accompanying note 121 *supra*.

¹⁴⁵ OHIO REV. CODE ANN. § 5122.15 (C) (Page Supp. 1976). The prior section allowed commitment for up to ninety days on a finding by the court that there was probable cause to believe that the individual was mentally ill and needed treatment. OHIO REV. CODE ANN. § 5122.15 (Page 1970) (amended 1976).

¹⁴⁶ See, e.g., *In re Ballay*, 482 F.2d 648 (1973) and *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), both holding that proof of mental illness such as would warrant civil commitment must be beyond a reasonable doubt. *But see Lynch v. Baxley* 386 F. Supp. 378 (M.D. Ala. 1974), invoking a clear and convincing standard.

¹⁴⁷ *Supra*, notes 112 and 145.

This determination is to be made by the trier of fact,¹⁴⁸ which term generally refers to the court, when it makes determinations of fact, or a jury. The prior statute stipulated that the commitment hearing was to be conducted without a jury.¹⁴⁹ It might be argued that the intent of the legislature was to allow for a trial by jury. Presently, no section explicitly provides for notice to the individual that such a trial is available and such ambiguity may require further clarification by the legislature.¹⁵⁰

Unless the trier of fact determines by clear and convincing evidence that the individual is mentally ill and subject to judicially enforced hospitalization, he must be released immediately.¹⁵¹ Upon a finding of clear and convincing evidence that the individual is mentally ill and subject to hospitalization, the court may order the individual to be placed in a mental health facility, any other suitable facility, or under a suitable person's care for a period of up to ninety days.¹⁵² That, however, is not the sole alternative open to the court; it may in fact "*order the respondent's discharge.*"¹⁵³ This provision perhaps symbolizes the essence of the entire Act, that is, that the state, when dealing with a mentally ill individual, must seek out those treatment alternatives that will be the least restrictive avenue which will restore the individual to lucidity. The Act directs the courts and mental health officials to explore these options, and goes so far as to suggest that the environment of one's own home is an available alternative to commitment. Consider in this regard the words of Justice Stewart in *O'Connor v. Donaldson*:

There is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom [T]he mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution.¹⁵⁴
(Emphasis added)

However, provision is made for commitment of the individual; and for those persons who are not discharged under this section, the Court may order the respondent, for a period not to exceed ninety days, to:

- (1) A hospital operated by the Department of Mental Health and Mental Retardation;

¹⁴⁸ OHIO REV. CODE ANN. § 5122.15 (B)-(C) (Page Supp. 1976).

¹⁴⁹ OHIO REV. CODE ANN. § 5122.15 (Page 1970).

¹⁵⁰ H.B. 725, 112th General Assembly (1977-78), currently in committee, deletes "trier of fact" and substitutes "court", thus resolving the ambiguity, if enacted, in favor of a trial without jury.

¹⁵¹ OHIO REV. CODE ANN. § 5122.15 (B) (Page Supp. 1976).

¹⁵² *Id.* § 5122.15 (C) (1)-(6).

¹⁵³ *Id.* § 5122.15 (C) (emphasis added).

¹⁵⁴ *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

- (2) A private hospital;
- (3) The veterans' administration or other agency of the United States Government;
- (4) A community mental health clinical facility;
- (5) Receive private psychiatric or psychological care and treatment;
- (6) Any other suitable facility or person consistent with the diagnosis, prognosis, and treatment needs of the respondent.¹⁵⁵

From this range of options the court must select the "least restrictive alternative available," consistent with the individual's diagnosis and treatment goals.¹⁵⁶

If at any time during the ninety day commitment period the person or institution in charge of the individual determines that the individual's treatment needs could be met in "an available and appropriate less restrictive environment," the individual must be released and referred to the court. At this point, the court must either dismiss the case or order placement in a less restrictive environment upon consideration of recommendations by the hospital, facility, or person.¹⁵⁷

During the ninety day commitment period, the individual may apply for voluntary admission to the hospital, facility, or person to which he was committed.¹⁵⁸ If the individual is accepted as a voluntary patient, the court must dismiss the case upon written notification of the same.¹⁵⁹ Such application may also be made at any time following the filing of the affidavit initiating judicial hospitalization proceedings.¹⁶⁰ However, if after such voluntary admission the individual requests release, it would appear that the entire judicial hospitalization procedure would have to be commenced anew.¹⁶¹

If the individual remains involuntarily detained at the end of the ninety day period of commitment, he must be discharged unless an "application for continued commitment" has been filed at least ten days prior to the termination of that period.¹⁶² If an application has been filed, a mandatory hearing must be held upon expiration of the ninety day commitment period. If the court finds clear and convincing evidence that the individual is a

¹⁵⁵ OHIO REV. CODE ANN. § 5122.15 (C) (Page Supp. 1976). This is essentially the same as the prior section with the addition of the provision in subsection (6). See OHIO REV. CODE ANN. § 5122.15 (A)-(E) (Page 1970). The addition broadens the scope of possible treatment alternatives, consistent with the general philosophy of the Act.

¹⁵⁶ OHIO REV. CODE ANN. § 5122.15 (E) (Page Supp. 1976).

¹⁵⁷ *Id.* § 5122.15 (F) (1)-(3).

¹⁵⁸ *Id.* § 5122.15 (G).

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ See note 115 and accompanying text *supra*.

¹⁶² OHIO REV. CODE ANN. § 5122.15 (H) (Page Supp. 1976).

mentally ill individual subject to hospitalization by court order, it may discharge him or continue commitment for a second ninety day period.¹⁶³

A hearing on continued commitment must be held in this manner at the termination of each subsequent ninety day period, unless such hearings are waived.¹⁶⁴ Further, there must be a mandatory hearing held every two years after the termination of the first ninety day commitment period.¹⁶⁵

If the individual has been committed to a hospital or a mental health clinical facility by judicial order, he must be examined within twenty-four hours after admission.¹⁶⁶ Based upon this examination, the head of the hospital must certify that the individual is a mentally ill person subject to hospitalization by court order.¹⁶⁷ If such certification is not made, the individual must be discharged immediately.¹⁶⁸ Also, the head of the hospital retains broad powers to subsequently discharge any person who has been found to be a mentally ill individual subject to court ordered hospitalization. Unless the individual has been indicted or convicted of a crime, the head of the hospital, after a determination that "the conditions justifying involuntary hospitalization no longer obtain" can grant a discharge without the consent or authorization of any court.¹⁶⁹ If the court orders hospitalization, such treatment must be the least restrictive alternative available commensurate with the individual's need. Presumably if another alternative arises that is less restrictive and still meets the individual's treatment needs, the head of the hospital should exercise this prerogative under the above authority.

7. The Question of Waiver

It has been noted that various procedural aspects of the Act are mandatory and therefore non-waivable.¹⁷⁰ A waiver has been defined as "an intentional relinquishment of a known right."¹⁷¹ If one emphasizes the requirement of intent and knowledge, it is readily apparent that a person laboring under a mental disability may indeed be incapable of making such a waiver.¹⁷² Hence, the possibility of an invalid waiver of fundamental rights may be

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.* § 5122.19. Previously this section commanded that the examination be carried out within five working days of admission. OHIO REV. CODE ANN. § 5122.19 (Page 1970).

¹⁶⁷ OHIO REV. CODE ANN. § 5122.19 (Page Supp. 1976).

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* § 5122.21.

¹⁷⁰ For example, notice of and presence at all hearings are deemed non-waivable.

¹⁷¹ *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938).

¹⁷² *See, e.g., Heryford v. Parker* 396 F.2d 393, 396 (10th Cir. 1968) ("special problems may arise with respect to the effective waiver of rights by minors and mentally deficient persons").

mitigated by a clear determination by the trial court, on the record, that the individual has exercised the waiver knowingly and intelligently.¹⁷³ Also, several cases have allowed counsel to exercise the right for the individual who has been deemed incompetent.¹⁷⁴ However, it appears that this practice should be permitted only where counsel is actually playing an adversarial role and acting in the best interests of the patient.¹⁷⁵

8. Summary

It has been previously noted¹⁷⁶ that the Ohio Supreme Court in the case of *In re Fisher*¹⁷⁷ found a number of problems with the then-existing mental health statutes. Although its finding of unconstitutionality was based on that part of the statute concerning the lack of any guarantee of counsel during the course of commitment proceedings, the court also disapproved of the notice provisions, the failure to require the presence of the individual sought to be committed at the hearings, the general absence of any formalities in the commitment hearings, and the failure to explore less restrictive treatment alternatives.

The new Mental Health Act appears to answer these criticisms; counsel is mandated by the statute,¹⁷⁸ notice to the individual is no longer discretionary,¹⁷⁹ hearings are expanded under the new Act to provide for a probable cause hearing, if requested, and a full hearing, both of which have extensive procedural requirements which should, in theory, render the hearings adversarial.¹⁸⁰ And finally, the Court is under an affirmative duty to seek out less restrictive treatment modes.¹⁸¹ Beyond this, the Act narrows the available procedures for involuntary detention,¹⁸² and provides for periodic mandatory hearings on continued commitment.¹⁸³

Hence, from a procedural point of view, it is clear that *In re Fisher* provided the Ohio legislature with what it felt were minimum due process

¹⁷³ This approach is suggested in *Doremus v. Farrell*, 407 F. Supp. 509, 517 (D. Neb. 1975) and *Lynch v. Baxley*, 386 F. Supp. 378, 389 (M.D. Ala. 1974).

¹⁷⁴ See *Kendall v. True*, 391 F. Supp. 413 (W.D. Ky. 1975); *Doremus v. Farrell*, 407 F. Supp. 509 (D. Nev. 1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974).

¹⁷⁵ See *Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968) (questioning but not deciding whether the "mother as natural guardian, having set in motion the commitment machinery, represented such conflicting interest that she could not effectively waive the son's right to counsel").

¹⁷⁶ See text accompanying notes 3-4 *supra*.

¹⁷⁷ 39 Ohio St. 2d 71, 313 N.E.2d 851 (1974).

¹⁷⁸ See notes 128-29 and 144 and accompanying text *supra*.

¹⁷⁹ See notes 92-98 and accompanying text *supra*.

¹⁸⁰ See notes 110-61 and accompanying text *supra*.

¹⁸¹ See note 156 and accompanying text *supra*.

¹⁸² See notes 222-23 and accompanying text *infra*.

¹⁸³ See notes 162-65 *supra*.

guarantees. The legislature appears to have incorporated these into the new Act, however it is also apparent that some innovative features which go far beyond the dictates of *In re Fisher* have been added, making the present Ohio procedural scheme perhaps the most progressive of its type extant.

B. *Non-judicial Hospitalization*

The standards for commitment under the voluntary and involuntary admission procedures of Ohio's civil commitment act have been revised to provide more effective due process protections. Designated individuals may now request a court determination as to whether hospitalization is in the best interest of one who has been "voluntarily" committed by a parent or guardian. A person involuntarily committed is to be informed of his right to retain counsel and, if unable to obtain such, to be represented by court appointed counsel and to have a probable cause hearing upon request to determine whether he falls within the commitment criteria necessary for judicial hospitalization. In addition, definite time limits have been imposed for which a person may be hospitalized subsequent to a request for release and prior to a probable cause hearing.

C. *Voluntary Hospitalization*

1. Admission of Voluntary Patients

Ohio's Mental Health Act, as amended, continues to distinguish between a truly voluntary patient¹⁸⁴ who is 18 years of age or older and applies for his own hospitalization, and the voluntary patient who is either under 18 years of age or an adult incompetent¹⁸⁵ for whom voluntary admission has been requested by the parent or guardian.¹⁸⁶ Any person 18 years of age or over who is, appears to be, or believes himself to be mentally ill may apply to the head¹⁸⁷ of a hospital¹⁸⁸ for voluntary admission.¹⁸⁹ Application

¹⁸⁴ OHIO REV. CODE ANN. § 5122.01 (C) (Page Supp. 1976) defines patient to mean "a person admitted either voluntarily or involuntarily to a hospital or other place" pursuant to the Act "who is under observation or receiving treatment in such place."

¹⁸⁵ OHIO REV. CODE ANN. § 2111.01 (D) (Page 1976) defines incompetent to mean "any person who by reason of advanced age, improvidence, or mental or physical disability or infirmity, chronic alcoholism, mental retardation, or mental illness, is incapable of taking proper care of himself or his property or fails to provide for his family or other persons for whom he is charged by law to provide, or any person confined to a penal institution within this state."

¹⁸⁶ *Id.* § 2111.01 (A) defines a guardian.

¹⁸⁷ OHIO REV. CODE ANN. § 5122.01 (K) (Page Supp. 1976).

¹⁸⁸ Hospital is defined as "a hospital or part thereof licensed by the division of mental health of the Department of Mental Health and Mental Retardation . . . and any institution, hospital, or other place established, controlled, or supervised by the department" OHIO REV. CODE ANN. § 5122.01 (F) (Page Supp. 1976).

¹⁸⁹ *Id.* § 5122.02 (A). The provision in this section which allowed any person at least sixteen years of age who believed he was mentally ill due to drug abuse and in danger of becoming drug dependent to apply for voluntary admission has been deleted. 133 Ohio 30

for admission for one under 18 years of age may be made on his behalf by a parent or guardian or by the one having custody, and for an adult incompetent person by his guardian or the one having custody.¹⁹⁰ Subject to suitable accommodations, the head of the hospital was formerly under a statutory duty to admit voluntary patients for diagnosis, care, or treatment; now, however, such patients may be admitted unless the head of the hospital finds that hospitalization is inappropriate.¹⁹¹ The requirement that residents of the state who are applicants for voluntary admission to a public hospital¹⁹² must be residents of the hospital district has also been eliminated.¹⁹³

A newly enacted portion of Section 5122.02¹⁹⁴ provides that, if application for admission has been made on behalf of a minor or one adjudicated incompetent because of mental illness, the court shall determine upon petition by the legal rights service,¹⁹⁵ private or appointed counsel, a relative, or one acting as next friend, whether the admission or continued hospitalization is in the minor or incompetent's best interest.¹⁹⁶ This safeguard is in addition to the retained statutory obligation of the head of the hospital to discharge any voluntary patient who has recovered or whose hospitalization he determines to be no longer advisable.¹⁹⁷

2. Right to Release of Voluntary Patients

The new section providing for court determination upon request as to whether the admission or continued hospitalization of a minor or incompetent is in his best interest appears to recognize several potential inadequacies in the applicability of existing provisions relating to the release of voluntary patients. A voluntary patient shall be released if he requests his release in writing or if his counsel, legal guardian, parent, spouse, or adult next of kin

Laws 2745 (1970). OHIO REV. CODE ANN. § 5122.041 (A) (Page Supp. 1976) provides for the establishment of special facilities for the care and treatment of drug dependent persons.

¹⁹⁰ OHIO REV. CODE ANN. § 5122.02 (B) (Page Supp. 1976).

¹⁹¹ *Id.*

¹⁹² A public hospital is "a facility which is tax-supported and under the jurisdiction of the Department of Mental Health and Mental Retardation." *Id.* § 5122.01 (G).

¹⁹³ OHIO REV. CODE ANN. § 5122.02 (Page 1970) (amended 1976).

¹⁹⁴ OHIO REV. CODE ANN. § 5122.02 (C) (Page Supp. 1976).

¹⁹⁵ A legal rights service is established under § 5123.94 of the Ohio Revised Code (Page Supp. 1976).

¹⁹⁶ See *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975) (requiring that children, before being committed to a mental hospital, be afforded due process rights including a probable cause hearing, written notice, and the right to counsel). For a critique on the *Bartley* decision, see Rolfe and MacClintock, *The Due Process Rights of Minors "Voluntarily Admitted" to Mental Institutions*, 4 J. PSYCH. & L. 333 (1976).

¹⁹⁷ OHIO REV. CODE ANN. § 5122.02 (C) (Page Supp. 1976). The provision of this section which gave the head of the hospital discretion as to the discharge of a voluntary patient if such discharge contributed to the effective use of the hospital has been eliminated. OHIO REV. CODE ANN. § 5122.02 (Page 1970) (amended 1976).

requests it,¹⁹⁸ except when the head of the hospital files an affidavit¹⁹⁹ for his detention pursuant to Section 5122.11.²⁰⁰ A limitation, however, upon the release of a patient who admitted himself is that such release, when written application is made by another, is conditioned upon the patient's approval.²⁰¹ Moreover, the requirement that a minor's release may be conditioned upon the consent of his parent or guardian has been deleted.²⁰²

Although the head of the hospital is legally required to provide reasonable means and arrangements for informing voluntary patients of their rights to release and to assist them in presenting such requests,²⁰³ a minor may be too young to comprehend his right to request release or unwilling or unable to withstand the possible emotional conflict of opposing the parent's or guardian's decision for hospitalization.²⁰⁴ An adult incompetent may also lack the capacity to sufficiently understand his right to request his release in writing or the ability to do so.²⁰⁵

Even if admission to the hospital or continued hospitalization is no longer in the best interest of a minor or incompetent, those authorized under Section 5122.03²⁰⁶ to request his release in writing may not agree or may be unaware that hospitalization is not in his best interest. That the legal rights service or one acting as next friend are included in those authorized to petition the court for a determination of whether the admission or continued hospitalization is in the minor or incompetent's best interest²⁰⁷ gives further potential protection to persons whose "voluntary" admission has been sought by a parent or guardian.²⁰⁸

The right of any voluntary patient to be released upon written request

¹⁹⁸ OHIO REV. CODE ANN. § 5122.03 (Page Supp. 1976).

¹⁹⁹ The affidavit is to allege facts sufficient to indicate probable cause that such person is a mentally ill person subject to hospitalization by court order. *See* text accompanying notes 76-79 *supra*. Under the prior law, the affidavit was to state that in the opinion of the head of the hospital, the patient was mentally ill and release would be unsafe for the patient or others. OHIO REV. CODE ANN. § 5122.03 (A) (3) (Page 1970) (amended 1976).

²⁰⁰ OHIO REV. CODE ANN. § 5122.03 (B) (Page Supp. 1976).

²⁰¹ *Id.* § 5122.03 (A).

²⁰² OHIO REV. CODE ANN. § 5122.03 (A) (2) (Page 1970) (amended 1976).

²⁰³ OHIO REV. CODE ANN. § 5122.03 (B) (Page Supp. 1976). The right to assistance in preparing requests includes those for a probable cause hearing.

²⁰⁴ *See* Rolfe and MacClintock, *The Due Process Right of Minors "Voluntarily Admitted" to Mental Institutions*, 4 J. PSYCH. & L. 333, 340, 351 (1976).

²⁰⁵ *See* Dewey, *Imprisonment of the Mentally Ill: An Inquiry into the Deprivation of Civil Liberties Under Ohio Laws and Procedures*, 1 CAP. U. L. REV. 1, 3-4 (1972).

²⁰⁶ The patient's counsel, legal guardian, parent, spouse, or adult next of kin.

²⁰⁷ OHIO REV. CODE ANN. § 5122.02 (C) (Page Supp. 1976).

²⁰⁸ Dewey, *supra* note 89, at 3-4, discusses the senile person and the person against whom involuntary commitment proceedings have been initiated, both of whom may be persuaded to "voluntarily" admit themselves. These two categories of "voluntary" patients do not appear to be covered under Section 5122.02 (C) (Page Supp. 1976).

is qualified by the provision allowing the head of the hospital to commence court proceedings by filing an affidavit with the court within three days from the receipt of the request.²⁰⁹ Release may then be postponed until either a probable cause²¹⁰ or full hearing²¹¹ is held.²¹² Unless the person is released within three days from the receipt of the request by the head of the hospital, such request shall also serve as a request for a probable cause hearing under Section 5122.141.²¹³ Since the period of time which may elapse before judicial proceedings must be initiated has been shortened from ten days to three days,²¹⁴ thus giving a patient less time to become acclimated to the hospital surroundings and conditions, it seems likely that more requests for release will be made. Therefore, if continued detention is desired, additional proceedings for involuntary hospitalization will have to be commenced, a requirement not within the prior law. Yet, if a patient is not mentally ill to the extent that he represents a substantial risk of harm to himself or others, he should not have to spend one day longer than necessary in the hospital. Moreover, if his condition does meet the criteria for one who is mentally ill and subject to involuntary hospitalization,²¹⁵ the few additional days in the hospital would probably not be sufficient to alter measurably his condition prior to a judicial hearing and subsequent determination concerning his status.

If the court finds probable cause to believe that the voluntary patient is a "mentally ill person subject to hospitalization by court order," all provisions of Chapter 5122 of the Ohio Revised Code relating to involuntary hospitalization are applicable to him.²¹⁶ Since judicial proceedings for hospitalization of voluntary patients shall not be instituted except pursuant to the provisions for requests for release,²¹⁷ there is some assurance to a person considering voluntary admittance or to one already admitted that he has a certain amount of control over his status in the hospital. Yet, the potential "threat" of court proceedings still may operate to a degree as a

²⁰⁹ OHIO REV. CODE ANN. § 5122.03 (B) (Page Supp. 1976). A telephone call from the head of the hospital within three court days from the receipt of the request for release, notifying the court that the affidavit has been mailed, sufficiently complies with the time limitation for such filing. *Id.* See note 199 *supra*.

²¹⁰ See text, Part II. § (A) (5) *supra*.

²¹¹ *Id.* § (A) (6).

²¹² Under the prior law, release could be postponed for as long as the court deemed to be necessary for commencement of proceedings under Section 5122.11-.15, but not for more than ten days. OHIO REV. CODE ANN. § 5122.03 (A) (3) (Page 1970) (amended 1976).

²¹³ OHIO REV. CODE ANN. § 5122.03 (B) (Page Supp. 1976). As noted earlier, the head of the hospital is to provide information and assistance in this regard. See note 203 *supra*.

²¹⁴ OHIO REV. CODE ANN. § 5122.03 (A) (3) (Page 1970) (amended 1976).

²¹⁵ See text accompanying notes 53-57 *supra*.

²¹⁶ OHIO REV. CODE ANN. § 5122.03 (B) (Page Supp. 1976).

deterrent to voluntary admissions since one can be completely sure of remaining *voluntarily* hospitalized only until he attempts to leave.

D. Involuntary Hospitalization

1. Admission of Involuntary Patients

The involuntary hospitalization procedures of the new Ohio civil commitment act have eliminated two of the four previous methods of involuntary hospitalization and, in addition, provide substantive and procedural due process rights for those taken into custody pursuant to the Act.²¹⁸ The two procedures now available for the compulsory hospitalization of persons alleged to be mentally ill and to represent a substantial risk of harm are the "emergency"²¹⁹ and the "judicial."²²⁰ If admission is applied for under one of these procedures, any person whose behavior and condition is believed to necessitate psychiatric medical emergency treatment must be received by the head of a public hospital²²¹ for observation, diagnosis, care, and treatment. No longer available for the involuntary hospitalization of a person under this Act are the non-protest form of admission entitled "non-judicial hospitalization"²²² and the procedure entitled "emergency hospitalization with medical certificate."²²³

Section 5122.05 has been amended to provide specifically for exclusion from compulsory hospitalization any person who is being treated by spiritual means through prayer alone according to a recognized religious method of healing, unless the court has determined that such person "represents a substantial risk of impairment or injury to himself or others."²²⁴ Apparently,

²¹⁸ See text accompanying notes 231-34 *infra*.

²¹⁹ OHIO REV. CODE ANN. § 5122.05 (A) (1) (Page Supp. 1976).

²²⁰ *Id.* § 5122.05 (A) (2).

²²¹ *Id.* § 5122.05 (A). In addition, the head of a hospital, other than a public hospital, has discretion to receive such person.

²²² This permitted an individual who did not object in writing to be confined in a hospital for a period as long as ninety days. The procedure could be instituted by a friend, relative, spouse, guardian, health or public welfare officer, or the head of any institution in which he might be. Two physicians had to certify that they examined the person and believed he was a "mentally ill individual subject to hospitalization by court order". OHIO REV. CODE ANN. § 5122.06 (Page 1970) (repealed 1976). Also applicable to this procedure was § 5122.18 (Page 1970) (amended 1976), requiring notice to be given to the patient's guardian, spouse or next of kin if one of such persons did not admit the patient, and § 5122.24 (Page 1970) (repealed 1976) requiring the patient's release upon written request unless judicial proceedings were commenced within ten days.

²²³ An individual could be confined in a hospital for up to sixty days upon application by any person stating the belief that he is likely to cause injury to himself or others if not immediately restrained and upon certification by one physician that he examined the person and believed him to be mentally ill and therefore likely to injure himself or others if not immediately restrained. Notice and request for release provisions were applicable here also. OHIO REV. CODE ANN. § 5122.08 (Page 1970) (repealed 1976).

²²⁴ OHIO REV. CODE ANN. § 5122.05 (B) (Page Supp. 1976).

a person to whom this provision is applicable is not subject to being involuntarily hospitalized through the use of the emergency procedure,²²⁵ but is subject only to judicial hospitalization which requires a court determination that there is probable cause to believe that the person is a "mentally ill person subject to hospitalization by court order"²²⁶ preceding detention.

An individual must be considered to represent "a substantial risk of physical harm to himself or others if allowed to remain at liberty pending examination"²²⁷ before he may be taken into custody pursuant to the emergency detention provision. Thus, to effectuate the legislative intent that such allegedly dangerous persons be removed at least temporarily to surroundings²²⁸ where the potential harm may be prevented, judicial proceedings could be initiated immediately by the filing of an affidavit pursuant to Section 5122.11 and an order issued without delay for the person's detention.²²⁹ The question might be raised as to why this procedure requiring a preliminary hearing to indicate probable cause prior to confinement is not equally applicable with respect to those not being treated according to a recognized religious method of healing who are detained under the emergency provision.²³⁰

Section 5122.05 (C), as amended, affords further substantive and procedural rights to any person involuntarily hospitalized or taken into custody under the Act. Immediately upon being detained, such person shall be informed and provided with a written statement that he may:

- (1) Immediately telephone or use other reasonable means to contact an attorney, a physician, a licensed clinical psychologist²³¹ or other persons for the purpose of securing counsel or obtaining medical or psychological assistance, and be provided assistance in making the calls if needed and requested;
- (2) Retain counsel²³² and have independent expert evaluation²³³ of

²²⁵ *Id.* § 5122.10.

²²⁶ *Id.* § 5122.141.

²²⁷ *Id.* § 5122.10.

²²⁸ Section 5122.17 of the Ohio Revised Code (Page Supp. 1976) provides in part that, pending removal to a hospital, a person taken into custody or ordered hospitalized under the Act may be detained for not more than forty-eight hours in his home, a licensed rest or nursing home, a licensed or unlicensed hospital, a mental health clinical facility, or a county home.

²²⁹ This situation might, however, present a problem if the behavior which is considered to warrant detention occurs at night, on a holiday or on a weekend.

²³⁰ See generally arguments opposed to emergency commitments in Roth, Dayley, and Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 SANTA CLARA LAW. 400 (1973).

²³¹ OHIO REV. CODE ANN. § 5122.01 (I) (Page Supp. 1976).

²³² See text accompanying notes 128-30 *supra*.

²³³ OHIO REV. CODE ANN. § 5122.01 (P) (Page Supp. 1976).

his mental condition; if unable to obtain an attorney, he may be represented by court appointed counsel and have the independent evaluation at public expense;

- (3) Be granted a hearing, upon request, to determine whether there is probable cause to believe he is a mentally ill person subject to hospitalization by court order.²³⁴

However, as with the voluntary hospitalization "right to release" provision,²³⁵ a person who has been involuntarily taken into custody might be incapable of understanding these rights, especially if they are not adequately presented or if the required assistance is not offered to him.²³⁶

Section 5122.06, as newly enacted, provides that an attorney shall be designated by either the director of the Department of Mental Health and Mental Retardation or the head of the hospital (if the patient is not in a hospital operated by the Department). The attorney shall present the case demonstrating that the respondent²³⁷ is a "mentally ill person subject to hospitalization by court order" on behalf of the state or the hospital at the probable cause and full hearings²³⁸ held pursuant to this Act.

2. Emergency Hospitalization

Any psychiatrist,²³⁹ licensed clinical psychologist, licensed physician,²⁴⁰ health or police officer, or sheriff,²⁴¹ who has reason to believe that an individual is "a mentally ill person subject to hospitalization by court order" and represents a substantial risk of physical harm to himself or others if allowed to remain at liberty pending examination, may take the person into custody²⁴² and immediately transport him to a hospital.²⁴³ The transporting person must give to the receiving hospital a written statement presenting the circumstances and reasons for which the individual has been taken into custody. This statement must be made available to the respondent or his attorney upon the request of either.²⁴⁴ Relevant to this provision, Section

²³⁴ See text accompanying notes 53-57 *supra*.

²³⁵ OHIO REV. CODE ANN. § 5122.03 (Page Supp. 1976). See text accompanying notes 198-200 *supra*.

²³⁶ See Dewey, *supra* note 89, at 3-4; Roth, Dayley, Lerner, *supra* note 19, at 416-22.

²³⁷ Respondent is defined by § 5122.01 (N) (Page Supp. 1976).

²³⁸ See notes 210-11 *supra*.

²³⁹ Psychiatrist is defined by § 5122.01 (E) (Page Supp. 1976).

²⁴⁰ Licensed physician is defined by § 5122.01 (D) (Page Supp. 1976).

²⁴¹ The prior law did not specify psychiatrist, licensed clinical psychologist, or licensed physician. OHIO REV. CODE ANN. § 5122.10 (Page 1970) (amended 1976).

²⁴² See text accompanying notes 231-34 *supra*.

²⁴³ This section further provides that "every reasonable and appropriate effort shall be made to take persons into custody in the least conspicuous manner possible."

²⁴⁴ Prior to amendment, the statement was required to be given only to the hospital and need not be in writing. In addition, the head of the hospital had ten working days to make

5122.34 provides that persons acting reasonably and in good faith, who assisted in the hospitalization procedure, are released from any criminal or civil liability.

If the person taken into custody is transported to a general hospital, that hospital may provide treatment, but within 24 hours after admission the person must be transferred to a hospital²⁴⁵ as defined under this Act. After the person has been transported to a proper hospital or mental health facility,²⁴⁶ he must be examined by the staff within 24 hours.²⁴⁷ Then, unless the head of the hospital believes that the person is a "mentally ill person subject to hospitalization by court order" or a court has issued a temporary detention order pursuant to judicial hospitalization, he shall discharge the person immediately.²⁴⁸ If the head of the hospital does believe the person is "mentally ill subject to hospitalization by court order," he may detain him for not more than three court days following the examination. During this period, he must either arrange for the voluntary admission of the patient pursuant to Section 5122.02²⁴⁹ or file an affidavit pursuant to Section 5122.11. If he does neither and a temporary detention order has not been issued by the court, the patient must be discharged at the end of the three-day period.²⁵⁰ In addition, upon his own, his guardian's or his counsel's request, the patient must be given a probable cause hearing. Such hearing shall be held within three court days from the date of the request, unless continued for good cause shown, which continuance may not be extended for more than ten days after the request.²⁵¹

Prior to the present amendment, a person hospitalized under this section could be held up to five days.²⁵² Although the emergency procedure now provides for a three-day detention period, a person who has first been transported to a general hospital and then to a hospital authorized under this Act will still have been confined lawfully for a five-day period before the affidavit must be filed or before his release takes place. However, as Section 5122.05 (C) states that a person involuntarily detained is to be immediately informed of his right to request a probable cause hearing which must be held within three days after the request, utilization of this procedure by a

a report of the admission to the Division of Mental Hygiene. OHIO REV. CODE ANN. § 5122.10 (B) (Page 1970) (amended 1976).

²⁴⁵ OHIO REV. CODE ANN. § 5122.01 (F) (Page Supp. 1976).

²⁴⁶ *Id.* § 5122.01 (H).

²⁴⁷ *Id.* § 5122.10.

²⁴⁸ *Id.*

²⁴⁹ See text accompanying notes 209-13 *supra* on voluntary admission; Dewey, *supra* note 89, at 4.

²⁵⁰ OHIO REV. CODE ANN. § 5122.10 (Page Supp. 1976).

²⁵¹ *Id.* § 5122.141.

²⁵² OHIO REV. CODE ANN. § 5122.10 (Page 1970) (amended 1976).

patient before being transported might effectively limit his time in custody to three days.²⁵³

E. Summary

The safeguards which have been enacted in Ohio's new civil commitment act to protect the rights of those coming within its purview provide a substantial improvement over the former commitment procedures for the hospitalization of the mentally ill. A person may no longer be committed for indefinite periods of time without any assurance of having a formal hearing to determine not only whether he is mentally ill but also whether, because of his illness, he is a substantial risk of harm to himself or others, a necessary finding for involuntary hospitalization.

While voluntary commitment would seem to be a preferable procedure for treatment of the mentally ill, the Act could have gone further in encouraging its use. For, although the legal rights service and one acting as next friend are now included in those who may help oversee the legal rights of persons "voluntarily" committed by parents or guardians, any voluntary patient who requests his release may become subject to involuntary hospitalization if the head of the hospital files an affidavit for a probable cause hearing and such hearing results in the court's finding that such patient meets the criteria for commitment. The uncertainty that one will be able to remain a truly "voluntary" patient after he requests to leave the hospital may discourage wide use of the voluntary admission procedure.

III. NEW SUBSTANTIVE RIGHTS FOR OHIO'S MENTALLY ILL

The new Mental Health Act marks a major effort to improve the status and care of mental patients in Ohio. It provides a comprehensive list of rights, most of which were not contained in the prior law. These rights can be grouped into four general categories: the right to treatment, the right to a humane environment, the right to maximum freedom, and the right to refuse unwanted treatment.

A. The Right to Treatment

1. The Impetus Behind the Adoption of a Right to Treatment

Since Dr. Birnbaum wrote his article, *The Right to Treatment*²⁵⁴ in 1960, the subject has received much attention by both courts and legal commentators.²⁵⁵ Dr. Birnbaum proposed that

²⁵³ See *Lessard v. Schmidt*, 349 F. Supp. 1078, 1091 (E.D. Wis. 1972) stating that "[E]ven a short detention in a mental facility may have long lasting effects on the individual's ability to function in the outside world due to the stigma attached to mental illness."

²⁵⁴ Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

²⁵⁵ E.g., *A Symposium on the Right to Treatment*, 57 Geo. L.J. 673 (1969); Birnbaum, *Some*

the courts under their traditional powers to protect the constitutional rights of our citizens begin to consider the problem of whether or not a person who has been institutionalized solely because he is sufficiently mentally ill to require institutionalization for care and treatment actually does receive adequate medical treatment so that he may regain his health, and therefore his liberty, as soon as possible.²⁵⁶

Birnbaum adopted what in essence amounts to a substantive due process approach,²⁵⁷ with his legal argument as follows: the mentally ill, involuntarily committed only because they need care and treatment, become no more than prisoners if that care and treatment is not provided. Since, without treatment, there is no motive for the confinement, the hospitalization amounts to a deprivation of liberty without due process of law.²⁵⁸

Since that time several courts have recognized a constitutionally based right to treatment. Judicial acceptance of this right has been based on various theories, including a violation of due process,²⁵⁹ deprivation of equal protection of the law,²⁶⁰ and avoidance of cruel and unusual punishment.²⁶¹

Remarks on "The Right to Treatment," 23 ALA. L. REV. 623 (1971); Katz, *supra* note 48; Szasz, *supra* note 42; Note, *Persons in Need of Supervision: Is There a Constitutional Right to Treatment?* 39 BROOKLYN L. REV. 624 (1973); Note, *Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right*, 32 MD. L. REV. 42 (1972); Note, *Reflections on the Right to Treatment*, 8 NEW ENGLAND L. REV. 231 (1973); Note, *Involuntary Civil Commitment—A Constitutional Right to Treatment*, 23 SYRACUSE L. REV. 125 (1972); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967).

²⁵⁶ Birnbaum, *supra* note 254, at 503.

²⁵⁷ *Id.*

²⁵⁸ *Id.*

²⁵⁹ Donaldson v. O'Connor, 493 F.2d 507, 519-27 (5th Cir. 1974), *vacated*, 422 U.S. 563, *reh. denied sub nom.*, Gumanis v. Donaldson, 423 U.S. 885 (1975); Rouse v. Cameron, 373 F.2d 451, 453 (D.C. Cir. 1966); Wyatt v. Stickney, 325 F. Supp. 781, *on submission of proposed standards by defendants* 334 F. Supp. 1341 (M.D. Ala. 1971) *enforced* 344 F. Supp. 373 (1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). The Wyatt court reasoned that since the purpose of confinement was to rehabilitate, commitment could not be justified unless the patient was in fact given a realistic opportunity to cure or improve his condition. 325 F. Supp. at 784.

²⁶⁰ Rouse v. Cameron, 373 F.2d at 453 (dictum); *In re Anonymous*, 69 Misc. 2d 181, 329 N.Y.S.2d 542 (Sup. Ct. 1972). The basis for this argument is that if the state interest served by commitment is the protection of society, commitment statutes are both over-inclusive (since most mentally ill people are not dangerous) and underinclusive (since dangerous individuals who are not mentally ill are not subject to preventive detention). The statutes authorizing commitment can then be justified only by the prospect of treatment; if treatment is not in fact provided, there is no constitutional basis for the confinement. *Civil Commitment*, *supra* note 19, at 1329-30.

²⁶¹ Rouse v. Cameron, 373 F.2d at 453 (dictum); Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972); *People ex rel. Kaganovitch v. Wilkins*, 23 App. Div. 2d 178, 259 N.Y.S.2d 462 (1965).

The cases which rely on the eighth amendment as the basis for a right to treatment commonly refer to *Robinson v. California*, 370 U.S. 660 (1962), where the Supreme Court struck down a statute which made it a crime to be a heroin addict. The Court reasoned that in that case punishment was directed at status alone without the presence of anti-social

The fundamental idea in these cases is that there must be a good reason to confine a person against his will. If the reason asserted is that confinement will be good for him—and perhaps also for society—because he can receive treatment, it should be a certainty that such treatment will be forthcoming. Moreover, if the person is not treated, his condition is likely to worsen,²⁶² and he thus suffers a double penalty. Though this issue has yet to be decided by the United States Supreme Court, the question was presented in *Donaldson v. O'Connor*.²⁶³ There the Fifth Circuit had ruled in favor of the right, but the Supreme Court did not discuss the right to treatment issue except to vacate the Fifth Circuit's decision on the ground that the ruling in regard to treatment was unnecessary. The Supreme Court held that the petitioner was entitled to the release which he had requested because he was not dangerous to himself or others and had also shown ability to take care of himself by securing a responsible job.²⁶⁴

Although the issue is far from being settled on the federal level, the trend towards recognition of a constitutional right to treatment may well have influenced the Ohio legislature to provide a detailed and comprehensive statutory plan setting forth a right to treatment.²⁶⁵ In addition, there

conduct. In the course of its opinion the Court analogized punishment for drug addiction to punishment for mental illness in the following way:

It is unlikely that any State . . . would attempt to make it a criminal offense for a person to be mentally ill [A] law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the eighth and fourteenth amendments.

Id. at 666.

However, it must be recalled that this strong sounding statement was only dictum and not at all necessary to the Court's conclusion in the *Robinson* case. More importantly, civil commitment statutes do not in fact make it a crime to be mentally ill; on the contrary, such legislation usually purports to have a beneficent purpose rather than a penal one. The fact that confinement results does not mean that a constitutional violation has necessarily occurred. As discussed earlier, commitment statutes have been justified on the ground that they are a valid exercise of the police power or of the *parens patriae* authority. See note 31 and accompanying text *supra*.

²⁶² See, e.g., *Renelli v. Commissioner of Mental Hygiene*, 73 Misc. 2d 261, 340 N.Y.S.2d 498 (Sup. Ct. 1973), where a retarded girl was confined for twelve years in an institution where there was no attempt made to treat her. Her mother testified that, prior to her admission, she was "a cheerful, gentle child and had no tendency to inflict physical harm on herself." *Id.* at 264, 340 N.Y.S.2d at 502. Even five years later she was described as "affectionate, content, played well with others and could dress herself." *Id.* However, after being institutionalized for twelve years for her own good, she was "cranky, anti-social, withdrawn, belligerent, unable to dress herself, and having a pronounced tendency to do herself and others physical damage." *Id.* Such deterioration is usually directly traceable to the lack of an adequate environment and insufficient stimulation. *Examination of Expert Psychiatric Witness in MR Treatment Case*, 1 MENTAL DISABILITY L. REP. 299, 303-04 (1977).

²⁶³ 493 F.2d 507

²⁶⁴ *O'Connor v. Donaldson*, 422 U.S. at 573.

²⁶⁵ Other jurisdictions have also created statutory rights to treatment. E.g., D.C. CODE § 21-562 (1973); IDAHO CODE § 66-344 (Supp. 1977); IOWA CODE § 225.15 (Supp. 1977-78) ("treatment . . . as in the physician's judgment [is] necessary"); MO. ANN. STAT. § 202.840

is Ohio law which may have been influential. The Ohio Constitution provides that "[i]nstitutions for the benefit of the insane . . . shall always be fostered and supported by the state; and be subject to such regulations as may be prescribed by the general assembly."²⁶⁶ The courts of Ohio have interpreted this provision to mean that the state is obligated to provide proper care for the mentally ill.²⁶⁷ The exact manner in which this care is to be provided has, in the past, been ruled to be the legislature's concern,²⁶⁸ however, the old statute did provide that the hospital "shall examine and treat"²⁶⁹ the patient and that "[e]very patient shall be entitled to humane care and treatment and, to the extent that facilities, equipment, and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice."²⁷⁰

Nevertheless, the state constitutional and statutory provisions have not enabled Ohio citizens who are mentally ill to receive adequate treatment. Because the institutions are located in rural areas, comfortably remote from the public eye, and because the Department of Mental Hygiene and Corrections was not accessible to inspection or consultation on a regular basis by professional groups, the courts, or the news media, Ohio's mental patients were provided with shockingly substandard care.²⁷¹ When friends and relatives of the mental patients began publicizing the degrading conditions at the state institutions, state officials began to investigate.²⁷² The legislators were surprised to learn that members of the department itself described the "patient care as essentially custodial and of extremely low quality and the Department as under-funded, under-staffed, and poorly supported."²⁷³ They set up a task force to investigate the situation in a comprehensive way. Its investigation found that the institutions were providing "little more than the

(Vernon 1972) ("to the extent that facilities, equipment and personnel are available"); N.M. STAT. ANN. § 34-2-13 (Supp. 1975) ("to the extent that facilities, equipment and personnel are available"); N.Y. MENTAL HYG. LAW § 15.03 (a) (McKinney 1976) ("treatment that is suited to [the patient's] needs and skillfully, safely and humanely administered with full respect for his dignity and personal integrity"); OKLA. STAT. ANN. tit. 43 A, §§ 2, 91 (West 1954); TEX. STAT. ANN. art. 5547-70 (Vernon 1958) ("adequate medical and psychiatric care and treatment . . . in accordance with the highest standards accepted in medical practice"); UTAH CODE ANN. § 64-7-46 (1968) ("to the extent that facilities, equipment, and personnel are available").

²⁶⁶ OHIO CONST. art. VII, § 1.

²⁶⁷ *State ex rel. Goebel v. Brown*, 4 Ohio L. Abs. 333 (Ct. App. Hamilton County 1926); *Gollwitzer v. Gorman*, 3 Ohio Op. 426, 428 (C.P. Cuyahoga County 1935).

²⁶⁸ *State v. Kieseewetter*, 37 Ohio St. 546, 549 (1882); *Doren v. Fleming*, 6 Ohio C.C. (n.s.) 81, 85, (1905).

²⁶⁹ OHIO REV. CODE ANN. § 5122.15 (Page 1970) (amended 1976) (emphasis added).

²⁷⁰ *Id.* § 5122.27 (emphasis added).

²⁷¹ TASK FORCE, *supra* note 2 at 5-20.

²⁷² See, e.g., *Anger Made Her an Activist*, Akron Beacon J., Jan. 23, 1977, at F5.

²⁷³ TASK FORCE, *supra* note 2 at 5-20.

most primitive form of custodial, institutional care,"²⁷⁴ and that there were "insufficient personnel to provide programs of rehabilitation and resocialization."²⁷⁵ Also, the personnel were inadequately trained,²⁷⁶ and problems existed in "availability of service, coordination of services, the physical plant in which the service is rendered, in funding, . . . in the inadequacy of standards and the lack of support from the citizen sector."²⁷⁷

Litigation attacking the inadequacy of conditions and treatment programs existing inside the institutions also put pressure on the legislature. In *Sidles v. Delaney*,²⁷⁸ parents of residents at Apple Creek State Institute for the Mentally Retarded filed a massive federal civil rights suit against the state in order to force improvements at the institution. A consent decree was entered in which the state agreed to a staged program focusing on staffing, programmatic development, deinstitutionalization, and compliance with professional accreditation requirements. In *Rone v. Fireman*,²⁷⁹ patients at a state mental institution alleged that the hospital administrators failed to provide adequate treatment programs; that facilities, staff and supplies did not meet constitutional standards; that patients were unnecessarily and inappropriately medicated, denied personal privacy, and subjected to a degrading and inhumane environment of continual violence and abuse from both staff and other patients. The patients claimed to have deteriorated physically, emotionally and mentally as a result of their confinement in the institution. The suit was postponed pending passage of the new Mental Health Act,²⁸⁰ but is now scheduled for trial on January 3, 1978.²⁸¹

2. Ohio's Statutory Right to Treatment

The new statute provides for an upgrading of mental health services offered to the citizens of Ohio. By April 1, 1977,²⁸² the Department of Mental Health and Mental Retardation was supposed to have set standards for treatment "consistent wherever possible with standards set by the Joint Commission on Accreditation of Hospitals."²⁸³ In addition, by July 1, 1978, the director of the Department is to enter into agreements with medical

²⁷⁴ *Id.* at 5-63.

²⁷⁵ *Id.*

²⁷⁶ *Id.* at 5-90.

²⁷⁷ *Id.* at 5-64.

²⁷⁸ No. C75-300A (N.D. Ohio, Apr. 26, 1976), summarized in 1 MENTAL DISABILITY L. REP. 19 (1976).

²⁷⁹ No. C75-355A (N.D. Ohio). The allegations in the complaint are summarized in 1 MENTAL DISABILITY L. REP. 34 (1976).

²⁸⁰ 1 MENTAL DISABILITY L. REP. 34 (1976).

²⁸¹ *Judge Contie Faces Heart Surgery*, Akron Beacon J., Sept. 4, 1977, at D1.

²⁸² 136 Ohio Laws 4-268 (1976).

²⁸³ OHIO REV. CODE ANN. § 5122.27 (C) 1 (Page Supp. 1976).

schools "to establish, manage, and conduct residency medical training programs."²⁸⁴ A Residency Training Committee is to conduct residency training at one or more state mental institutions; it is also to assist the department "by advising about medical research, and training programs that will improve treatment, secure and maintain academic, professional, and institutional accreditation and enhance the reputation of the institutions."²⁸⁵ By July 1, 1979, the Department and any institutions under its supervision or jurisdiction are *compelled* to "meet or exceed standards set forth for psychiatric and mental retardation facilities by the Joint Commission."²⁸⁶ The Joint Mental Health and Mental Retardation Advisory and Review Commission is to act as a watchdog over the quality of care provided. Among its other duties, it is to "[s]tudy the effectiveness of patient care and treatment and the availability of services for mentally ill . . . at state mental health . . . facilities."²⁸⁷

The new Act provides for the individual patient's right to treatment.²⁸⁸ More significantly, in light of the manner in which the right to treatment was regarded under the prior statute, the new statute provides rules for implementation of the right to treatment, effective April 1, 1977. The statute provides that

The head of the hospital or his designee shall assure that all patients hospitalized pursuant to Chapter 5122. of the Revised Code shall:

- (A) Receive, within twenty days of their admission sufficient professional care to assure that an evaluation of current status, differential diagnosis, probable prognosis, and description of the current treatment plan is stated on the official chart;
- (B) Have a written treatment plan consistent with the evaluation, diagnosis, prognosis, and goals . . . ;
- (C) Receive treatment consistent with the treatment plan . . . ;

²⁸⁴ *Id.* § 5119.492 (A).

²⁸⁵ *Id.* § 5119.492 (C) (7).

²⁸⁶ *Id.* § 5119.10.

²⁸⁷ *Id.* § 5119.801 (C).

²⁸⁸ All patients hospitalized pursuant to Chapter 5122. of the Revised Code shall:

- (F) receive humane care and treatment, including without limitation, the following:
 - (1) The least restrictive environment consistent with the treatment plan;
 - (2) The necessary facilities and personnel required by the treatment plan;
 - (3) A humane psychological and physical environment within the hospital facilities;
 - (4) The right to obtain current information concerning his treatment program and expectations in terms that he can reasonably understand;
 - (5) Participation in programs designed to afford him substantial opportunity to acquire skills to facilitate his return to the community;
 - (6) The right to be free from unnecessary or excessive medication;
 - (7) Freedom from restraints or isolation unless it is stated in a written order by the head of the hospital or his designee, or the patient's individual physician or psychologist in a private or general hospital.

- (D) Receive periodic reevaluations of the treatment plan by the professional staff of the hospital at intervals not to exceed ninety days²⁸⁹

Thus, individualized treatment plans which must be drawn up for each patient provide evidence that the hospital has focused on the individual's unique problems.²⁹⁰ Adequate treatment requires more than proper facilities, staff and advanced programs; each person requires individualized attention and a plan for treatment, and that is now required by statute. And the fact that the plan must be updated periodically helps to insure that the promise of treatment is actually being carried out.²⁹¹ The recordkeeping ought not to be unduly burdensome, as the required system is similar to the "medical audit" widely used in general medical hospitals.²⁹²

Moreover, the treatment plan is not a secret document to be kept solely for viewing by the hospital staff, but is to be made available "upon request of the patient or patient's counsel, to the patient's counsel and to any private physician or licensed clinical psychologist designated by the patient or his counsel or to the legal rights service."²⁹³ Thus, independent evaluation and judicial review are facilitated should a question arise concerning the adequacy of treatment.

3. Judicial Review

When judicial review is contemplated, the question arises as to what constitutes adequate treatment and who decides what this treatment entails. The establishment of a right to treatment has been criticized on the ground that courts are not competent to judge the adequacy of treatment.²⁹⁴ Many types of therapy are available, many of which are new, and some of which produce drastic effects. It would appear that the situation is further complicated by factors unique to the individual which must be considered in weighing the merits and risks of these therapies.²⁹⁵ Considering these factors, one court has held that adequacy of treatment is non-judicable.²⁹⁶ However,

²⁸⁹ *Id.*

²⁹⁰ This consideration for the individual is essential to any meaningful right to treatment. Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 746 (1969) [hereinafter cited as Bazelon].

²⁹¹ *Id.*

²⁹² Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936, 939 (1974).

²⁹³ OHIO REV. CODE ANN. § 5122.27 (B) (Page Supp. 1976).

²⁹⁴ Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616, 650 (1972) [hereinafter cited as *Prisoners and Mental Patients*].

²⁹⁵ *Id.*

²⁹⁶ *Burnham v. Department of Public Health*, 349 F. Supp. 1335, 1341-42 (N.D. Ga. 1972),

other courts have circumvented these problems by the use of one of two methods that have been developed whereby they are able to enforce a right to treatment without assuming the role of a practicing physician.²⁹⁷

The first method sets standards for the institutions themselves on the theory that certain physical conditions must exist in order for effective therapy to occur.²⁹⁸ For example, in *Wyatt v. Stickney*,²⁹⁹ the court, which recognized a right to treatment, set forth a detailed list of requirements to be met in an effort to enforce that right. The plan was composed of three general categories: "(1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment, and (3) individualized treatment plans."³⁰⁰ This task has been accomplished in Ohio by the enactment of the new Mental Health Act; institutional standards similar to those ordered by the *Wyatt* court exist in the statute.³⁰¹ Presumably, any deviations from the statutory requirements can be corrected by court order.

The second method focuses on the individual and the precise treatment that the patient has received. In addition to ruling on the adequacy of tangible attributes of the institution, Judge Bazelon, who made the first judicial formulation of the right to treatment,³⁰² believes that lack of psychiatric expertise should not hinder courts from ruling on the adequacy of treatment in regard to a specific case. He points out that courts often decide questions depending on specialized knowledge; they make complicated decisions involving such diverse subjects as economics, aeronautical engineering, atomic energy and, it might be noted, the adequacy of treatment in cases involving physical illness—not from any special expertise of their own, but with the

²⁹⁷ *Civil Commitment*, *supra* note 19, at 1337.

²⁹⁸ *Id.*

²⁹⁹ 334 F. Supp. at 1343.

³⁰⁰ The *Wyatt* court found that humane conditions must exist for any therapy to be effective and directed the hospitals to make provision for patients' privacy and dignity, freedom from all but a minimal amount of physical restraint and isolation, use of personal clothing and possessions, religious worship, social contact with the opposite sex and regular outdoor activity. 344 F. Supp. at 379-81. Specific staff-to-patient ratios were delineated as the minimum necessary to provide adequate treatment. *Id.* at 383-84. Treatment plans were required so that the hospitals would be forced to consider the individualized needs of each patient. *Id.* at 384-85.

³⁰¹ The new statute also recognizes personal rights of patients similar to those set forth by the *Wyatt* court. See OHIO REV. CODE ANN. § 5122.29 (Page Supp. 1976). The setting of institutional standards was delegated to the Department of Mental Health and Mental Retardation. OHIO REV. CODE ANN. § 5122.27 (C) (Page Supp. 1976). These standards have not yet been promulgated, probably because legislation designed to amend the current statute is currently pending before the House (but the right to treatment will not be affected). See Sub. H.B. No. 725 (1977). The provision for individualized treatment plans is set out at OHIO REV. CODE ANN. § 5122.27 (B) (Page Supp. 1976).

³⁰² *House v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966).

help of expert evidence presented to them.³⁰³ Moreover, he sees the judge's role as a limited one, similar to that in a case of administrative review. In *Tribby v. Cameron*,³⁰⁴ he stated:

We do not suggest that the court should or can decide what particular treatment this patient requires. The court's function here resembles ours when we review agency action. We do not decide whether the agency has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion.

The court can examine whether "the hospital's expertise was actually brought into play"³⁰⁵ in arriving at a decision concerning the prescribed course of treatment and whether the therapy is one "which respectable professional opinion regards as within the range of appropriate treatment alternatives."³⁰⁶ Thus, treatment need be only appropriate, not necessarily the best possible.³⁰⁷ This standard is institutionally useful in that it relieves the court from attempting to ascertain the "best" treatment which may be impossible and allows doctors professional leeway in treating their patients. At the same time, it protects the patient against gross psychiatric abuses,³⁰⁸ which in this regard the Council of the American Psychiatric Association has promulgated guidelines that may be helpful.³⁰⁹

Under Ohio law the statute itself contemplates that some guidance will be available to the court. The statute provides that the Department of Mental

³⁰³ Bazelon, *supra* note 290, at 743, 745.

³⁰⁴ 379 F.2d 104, 105 (D.C. Cir. 1967).

³⁰⁵ *Williams v. Robinson*, 432 F.2d 637, 641 (D.C. Cir. 1970).

³⁰⁶ Bazelon, *supra* note 290, at 745.

³⁰⁷ [Under this standard] what would a judge do if presented with a patient suffering from endogenous depression who had been treated with tricyclic antidepressants . . . but who now complains in court that he should have been given ECT [electro-convulsive therapy]? ECT is approximately 80 percent effective in controlling the symptoms of endogenous depression and it usually works within less than two weeks, while tricyclic compounds are estimated to be from 32 to 80 percent effective and usually take from two to three weeks to work Since "the possibility of better treatment does not necessarily prove that the one provided is unsuitable or inadequate," . . . [t]he court could probably . . . justify the use of tricyclic antidepressants. Such a finding could be buttressed by pointing out that: (1) ECT is more expensive than drugs; (2) ECT engenders pain while the antidepressant drugs do not; and (3) ECT is often accompanied by side effects that are more severe than those accompanying drug therapy. *Prisoners and Mental Patients*, *supra* note 294, at 652.

³⁰⁸ For example, suppose that the depressed patient [in the above footnote] were simply provided psychotherapy. Since either ECT or drug therapy is the treatment of choice for severe endogenous depression, this would seem to be a gross departure from sound psychiatric techniques which the court would have little difficulty in ascertaining, and would, therefore, breach the . . . standard.

Id.

³⁰⁹ *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCH.

Health and Mental Retardation shall set standards for treatment,³¹⁰ and to test whether these standards have been implemented or whether they are adequate, the statute provides for an adversary hearing with expert testimony.³¹¹ Since the patient's counsel, the legal rights service, and an independent medical expert of the patient's choice have access to the written treatment plan,³¹² both sides of the question should be fully developed, and any gross departure from accepted standards should come to light.

The opportunity for judicial review of the adequacy of treatment arises automatically at periodic intervals. At the end of the first ninety day commitment period, a hearing must be held to justify further confinement if the person has not already been discharged or has not admitted himself voluntarily.³¹³ Further hearings are held at the end of each subsequent ninety day period, unless waived,³¹⁴ and must be held at least every two years.³¹⁵ At each hearing the patient has a right to counsel and independent expert evaluation³¹⁶ so that his interests will be fully represented. The patient's "diagnosis, prognosis, past treatment, [and] a list of alternative settings and plans" are reviewed at each hearing.³¹⁷ Thus, the patient may ask any questions he has concerning the appropriateness of his treatment. Even if the patient does not question his treatment, the certainty of review should be prophylactic in that medical personnel will be encouraged to pay attention to their long-term patients "rather than [to allow] them to exist indefinitely, with minimal custodial care, virtually forgotten in the hospital's back wards."³¹⁸

The patient, however, need not wait until his next hearing date to assert his right to treatment. Each patient is entitled to a "written list of all rights enumerated in [the] chapter."³¹⁹ He also has "[t]he right to communicate freely with and be visited at reasonable times by his private counsel or personnel of the legal rights service."³²⁰ The legal rights service was created "to assure that all persons detained, hospitalized, discharged, or

³¹⁰ OHIO REV. CODE ANN. § 5122.27 (C) (Page Supp. 1976).

³¹¹ See text accompanying notes 110-43 *supra*.

³¹² OHIO REV. CODE ANN. § 5122.27 (B) (Page Supp. 1976).

³¹³ *Id.* § 5122.15 (H). If the person has become a voluntary patient, he must be released upon his own request unless the head of the hospital instigates a probable cause hearing or a commitment hearing. *Id.* § 5122.03 (B).

³¹⁴ *Id.* § 5122.15 (H). This section of the statute may be amended to provide that subsequent ninety-day hearings be held only upon the request of the patient. See Sub. H.B. No. 725 (1977).

³¹⁵ OHIO REV. CODE ANN. § 5122.15 (H) (Page Supp. 1976).

³¹⁶ *Id.* § 5122.15 (A) (4).

³¹⁷ *Id.* § 5122.15 (H).

³¹⁸ Strand, *supra* note 28, at 486.

³¹⁹ OHIO REV. CODE ANN. § 5122.29 (A) (Page Supp. 1976).

institutionalized . . . are fully informed of their rights and adequately represented by counsel . . . in any proceedings to secure the rights of such persons."³²¹

4. Remedies

In the event that the patient does not receive adequate treatment, several remedies are available. First, if the head of the hospital determines that treatment consistent with the treatment plan cannot be provided in that facility and he is unable to effect transfer to a facility that can provide such treatment, any involuntary commitment order is automatically terminated unless he has received an order of the court to the contrary.³²² Second, the patient has the right to petition for a writ of habeas corpus.³²³ Although the statute does not specifically state that lack of adequate treatment is a sufficient ground for the writ, it might be inferred from the statute's guarantee of treatment. Courts in other jurisdictions which recognize the right to treatment have indicated that the writ should issue when treatment has not been forthcoming, at least where there is no other justification for confining the person, such as dangerousness to himself or the community.³²⁴ Yet both of these remedies may be unsatisfactory in that while they may effect the patient's freedom, they do not secure him treatment. Moreover, the person who has exhibited dangerous behavior or who is unable to care for himself probably will not be released.

A suit for damages may be a more effective remedy since the hospital administrators will then suffer some penalty for neglecting a patient and presumably will be more careful in the future. Limitations do exist, however, on the personal liability of hospital personnel. Ohio law shields them from liability when they act "reasonably and in good faith, either upon actual knowledge or information thought by them to be reliable."³²⁵ The hospital

³²¹ *Id.* § 5123.94 (A).

³²² *Id.* § 5122.27 (G). Upon the determination by the head of the hospital that treatment cannot be provided, he must immediately notify the patient, the court, the legal rights service, the chief of the Division of Mental Health, and the patient's counsel and legal guardian. If the court is going to order continued confinement, despite the patient's inability to secure adequate treatment, it must do so within ten days of the time the chief of the Division of Mental Health receives such notification from the head of the hospital. *Id.*

³²³ *Id.* § 5122.30. This was true under the old statute also, as the only change made in this section was the use of the word "person" rather than "individual." See OHIO REV. CODE ANN. § 5122.30 (Page 1970).

³²⁴ *E.g.*, *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *Nason v. Superintendent of Bridgewater State Hospital*, 353 Mass. 604, 233 N.E.2d 908 (1968); *Application of D.D.*, 118 N.J. Super. 1, 285 A.2d 283 (1971).

³²⁵ OHIO REV. CODE ANN. § 5122.34 (Page Supp. 1976). *Cf.* *Wood v. Strickland*, 420 U.S. 308, 322 (1975), where the Supreme Court held that a school official is not immune from liability under 42 U.S.C. § 1983 (1970) only if

he knew or reasonably should have known that the action he took within his sphere of official responsibility would violate the constitutional rights of the student affected,

corporation or the state itself,³²⁶ when a state institution is involved, may be a more appropriate party to sue. In construing the New York mental health statute,³²⁷ which also proclaims a right to treatment, a New York court held that a man who had been involuntarily confined in a New York state hospital for thirty-seven years had a valid claim for damages against the State of New York upon a showing that he had been detained amidst indifference and neglect as to his treatment.³²⁸

Most satisfactory may be a writ of mandamus to compel the hospital administrator to provide the required treatment. The Ohio Revised Code specifically provides that it is his duty to assure each patient treatment consistent with the treatment plan,³²⁹ and the administrator of the legal rights service has the authority to initiate actions in mandamus "when attempts at administrative resolution prove unsatisfactory."³³⁰

B. *A "Bill of Rights" for Mental Patients*

Horror stories of abuse, degradation and regimentation in mental institutions are not uncommon. Most people who are afraid of mental hospitals believe that if one is not crazy before being confined, he certainly would be afterwards. Such fear is not completely unfounded since deterioration may result simply from confinement at an institution.

The mental patient exists within a completely controlled situation, in which he loses all individual ability to make any decisions regarding his own life. He is told when and where to sleep, eat, shower, defecate, and he is forced to follow directives from all staff members

The usual result of hospital treatment of long-term patients is sometimes referred to as "institutionalization," that process by which individuals

or if he took the action with the malicious intention to cause a deprivation of constitutional rights or other injury to the student.

This standard was subsequently applied to the mental health field. *O'Connor v. Donaldson*, 422 U.S. at 577.

³²⁶ After such recent decisions as *Corbean v. Xenia City Bd. of Educ.*, 366 F.2d 480 (6th Cir. 1966), *cert. denied*, 385 U.S. 1041 (1967) (the federal Civil Rights Act has not abrogated Ohio's doctrine of sovereign immunity) and *Lehew v. Rhodes*, 23 Ohio App. 2d 102, 261 N.E.2d 280 (1970) (doctrine of sovereign immunity still applied by Ohio courts), the Ohio legislature finally enacted legislation whereby the state granted consent to be sued "in accordance with the same rules of law applicable to suits between private parties." OHIO REV. CODE ANN. § 2743.02 (A) (Page Supp. 1976). The statute specifically "waives the immunity from liability of all hospitals owned or operated by one or more political subdivisions." *Id.* § 2743.02 (B).

³²⁷N.Y. MENTAL HYG. LAW § 15.03 (McKinney 1976).

³²⁸ *Bartlett v. State*, 52 App. Div. 2d 318, 383 N.Y.S.2d 763 (1976).

³²⁹ OHIO REV. CODE ANN. § 5122.27 (C) (Page Supp. 1976).

³³⁰ *Id.* § 5123.94 (G). This statutory right is important because at least one court has held that mandamus could not be issued to the superintendent of a hospital to compel him to provide adequate treatment. *Nason v. Commissioner of Mental Health*, 351 Mass. 94, 98, 217 N.E.2d 733, 736 (1966).

lose their ability to think or act for themselves, and become completely dependent upon the institution Rather than providing treatment enabling the disturbed patient to return and function in the world outside the hospital, the hospital has the opposite effect.³³¹

This process is exacerbated when the patient is confined not only to the hospital but is further restricted with handcuffs, straitjackets, isolation or excessive medication.³³²

The legal consequences of commitment under prior law further limited the ability of the person to act for himself. For example, an adjudication of involuntary commitment carried with it an automatic determination of incompetency.³³³ Since an incompetent cannot legally conduct his own business affairs, his capacity to contract, devise, and otherwise convey property and enter into agreements was also affected.³³⁴ In addition, the patient could be denied the right to write and receive uncensored mail and to receive visitors if the hospital administrator deemed it "necessary for the medical welfare of the patient,"³³⁵ and the administrator could also take possession of the patient's money and valuables.³³⁶ Other consequences have been that the involuntarily committed person could lose his driver's license,³³⁷ have his professional license suspended by the body having statutory authority to regulate the profession,³³⁸ deprived of the right to marry,³³⁹ to vote,³⁴⁰ to hold elective office,³⁴¹ and to serve on a jury.³⁴² An even more devastating consequence was that his children could be put up for adoption without his consent.³⁴³

Besides having lost significant civil rights, the mental patient in a state hospital was often asked to perform menial labor for little or no pay in order

³³¹ Strand, *supra* note 28, at 484.

³³² ROBITSCHER, *supra* note 19, at 135.

³³³ OHIO REV. CODE ANN. § 2111.01 (D) (Page 1970) (amended 1976).

³³⁴ *In re Fisher*, 39 Ohio St. 2d at 80, 313 N.E.2d at 857.

³³⁵ OHIO REV. CODE ANN. § 5122.29 (Page 1970) (amended 1976).

³³⁶ *Id.* § 5123.42.

³³⁷ OHIO REV. CODE ANN. § 4507.08 (B) (Page 1973).

³³⁸ *In re Fisher*, 39 Ohio St. 2d at 80, 313 N.E.2d at 857. See OHIO REV. CODE ANN. §§ 4723.28 (nurses), 4730.05 (C) (physician's assistants), 4731.22 (B) (16) (practice of medicine), 4731.70 (F) (physical therapists), 4732.17 (I) (psychologists), 4734.11 (chiropractors), 4735.18 (GG) (realtors), 4739.06 (steam boiler operators), 4741.22 (P) (veterinarians), 4749.03 (A) (1) (private investigators) (Page 1977). Sub. H.B. No. 725 (1977) would amend these sections to provide that suspension cannot occur unless the licensee has been adjudicated incompetent for the purpose of practicing the profession.

³³⁹ OHIO REV. CODE ANN. § 3101.06 (Page 1972).

³⁴⁰ *Id.* § 3503.18 (Page 1972).

³⁴¹ OHIO CONST. art. XV, § 4.

³⁴² OHIO REV. CODE ANN. § 2313.06 (Page 1954).

³⁴³ OHIO REV. CODE ANN. § 9107.06 (B) (1) (Page 1972) (amended 1976).

to contribute to the upkeep of the hospital.³⁴⁴ While many patients may have performed their tasks willingly, because of lack of anything better to do,³⁴⁵ there was, nevertheless, an element of coercion behind such a request. Privileges could be withdrawn for failure to perform the requested task.³⁴⁶ Also, nonperformance could be interpreted as a lack of desire to become well, which would mean longer confinement.³⁴⁷ However, if the patient did his assigned work well, the hospital might be tempted to keep him longer than necessary, for he then helped "to solve the employment problem."³⁴⁸ Other than the obvious problems which a forced labor situation creates, the use of patient labor created the further problem of increasing rather than diminishing the patient's dependency on the hospital, so that rather than getting well, he learned only how to become a "good patient."³⁴⁹

Such dehumanizing conditions, which are horrifying on the moral level, seem to be sufficient reason for the Ohio legislature to enact legislation to correct them. Yet, there is a more pragmatic reason why the legislature should have concerned itself with these conditions existing at state mental institutions. Each restriction on human freedom and autonomy increases patient dependency on the hospital and therefore hinders recovery.³⁵⁰ A recognition of increased patient liberties is an intrinsic part of enlightened treatment programs that seek to restore dignity in patients, not just to enable them to live more comfortably at the hospitals, but to prepare them for responsible living *outside* the institution. To accomplish this the hospital must seek to recreate the kind of living conditions found in the everyday life of people at large.³⁵¹

In order to ensure the best possible treatment, medical authorities have advocated that each patient have specified rights and privileges. Among these include the right to be addressed and regarded in the same respectful

³⁴⁴ Hospitals have needed this lowly paid patient labor in order to keep their expenses within their budgetary limits. *Civil Commitment*, *supra* note 19, at 1372. Private hospitals employ outside labor to perform the institutional chores that are done by the patients in state hospitals. ROBITSCHER, *supra* note 19, at 148.

³⁴⁵ See Wexler, *Token and Taboo: Behavior Modification, Token Economies and the Law*, 61 CALIF. L. REV. 81, 85 (1973).

³⁴⁶ Ferleger, *Loosing the Chains: In-Hospital Civil Liberties of Mental Patients*, 13 SANTA CLARA LAW. 447, 449, 478-79 (1973); Friedman, *The Mentally Handicapped Citizen and Institutional Labor*, 87 HARV. L. REV. 567, 580-81 (1974).

³⁴⁷ ROBITSCHER, *supra* note 19, at 148.

³⁴⁸ Dewey, *Civil Incompetency in Ohio: Determination and Effect*, 34 U. CIN. L. REV. 419, 433 n.51 (1965).

³⁴⁹ Bartlett, *Institutional Peonage: Our Exploitation of Mental Patients*, ATLANTIC MONTHLY, July 1964 at 116.

³⁵⁰ Recall that the *Wyatt* court recognized that a humane psychological and physical environment was essential to adequate treatment. See note 300 and accompanying text *supra*.

³⁵¹ Morris, *Institutionalizing the Rights of Mental Patients: Committing the Legislature*, 62 CALIF. L. REV. 959, 965-66 (1974).

manner as his healthy peers and to be clothed and groomed in such a way as not to cause embarrassment to him. He should have the right to some privacy for himself, to certain of his possessions, and to the time necessary to develop and exercise his capacity for independent and responsible behavior. Finally, he should be allowed to maintain and nurture useful contacts between himself and the other patients and members of the community so that he can receive from these individuals sufficient reaction to his behavior, thinking and feelings to enable him to have that information which is necessary to develop a realistic self-appraisal.³⁵²

A patient should also have the right to be free from excessive medication. One cannot adapt to life in the outside world or to any kind of autonomous life if he is constantly in a drugged state. One example of drug abuse that occurred in Ohio concerned the leader of a group of patients who were protesting their transfer from an open to a closed ward. He was treated with increased dosages of a tranquilizing medication, which caused him to become so thick-tongued and fuzzy-minded that he was unable to continue in his petitioning efforts.³⁵³ In addition, excessive medication can often render patients unable to conduct a rational defense at their commitment hearings.³⁵⁴

If a person is expected eventually to resume responsible citizenship in the community, he must have some practice in managing his own affairs. The impaired judgment that accompanies commitment does not necessarily prevent a person from properly managing his property or business affairs. Moreover, any impairment that existed prior to hospitalization may be alleviated in a short time by proper medical treatment.³⁵⁵

Another reason, less idealistic, for the Ohio legislature to accord mental patients more rights and better living conditions is to qualify the state for federal funding. When the Task Force appointed by Governor Gilligan investigated conditions in the state institutions, it found that one of the prime reasons for the then-prevailing low standard of care was underfunding.³⁵⁶ Since Ohioans appear to be generally resistant to the idea of spending tax dollars for personal services,³⁵⁷ an attractive way to acquire extra money is the receipt of federal money. In line with this idea, the legislature created

³⁵² Cameron, *Nonmedical Judgment of Medical Matters*, 57 GEO. L.J. 716, 732 (1969).

³⁵³ Strand, *supra* note 28, at 484.

³⁵⁴ "Often it is the drugs themselves which are responsible for 'crazy' behavior. Tranquilizers often give people a blank starey look and make them slow in responding to questions." Lessard v. Schmidt, 349 F. Supp. at 1092 n.19, quoting *Hearings on H.R. 12854 and S. 2869 Before the Senate Subcomm. on Constitutional Rights*, 91st Cong., 1st. & 2d Sess. 426 (1969-1970).

³⁵⁵ Dewey, *supra* note 348, at 425.

³⁵⁶ TASK FORCE, *supra* note 2, at 5-4.

³⁵⁷ Ohio ranks 30th in per capita expenditures for personal services. *Id.* at 5-61.

the Joint Mental Health and Mental Retardation Advisory and Review Commission, one of the functions of the Commission being to "study federally funded programs that could benefit mentally ill . . . persons, and report to the department and the general assembly any executive or legislative actions necessary to obtain federal support of state or local programs related to mental health."³⁵⁸ As many patients in state mental hospitals are aged or poor, a large financial gain to the state could be possible if at least part of the expenses incurred by hospitalization were paid through Medicare.³⁵⁹ To be eligible for Medicare and Medicaid payments, the providers of health services must comply with certain standards;³⁶⁰ many of the patients' rights in the new Act probably reflect a desire to comply with these requirements.

³⁵⁸ OHIO REV. CODE ANN. § 5119.80 (D) (1) (Page Supp. 1976).

³⁵⁹ In 1972 three Ohio institutions had already lost medicare funds, and three more were in danger of losing certification. Decertification would mean a loss of six to seven million dollars annually to the state of Ohio. TASK FORCE, *supra* note 2, at 5-64.

³⁶⁰ One set of conditions for participation includes patients' rights.

The governing body of the facility [must establish] written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for development of, and adherence to, procedures implementing such policies These patients' rights policies and procedures [must] ensure that, at least, each patient admitted to the facility:

- (1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;

- (3) Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

- (5) Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient and as a citizen;
- (6) May manage his personal financial affairs;
- (7) Is free from mental and physical abuse, and free from chemical and [except in emergencies] physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or others;

- (9) Is treated with consideration, respect, and full recognition of his dignity and individuality;
- (10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;
- (11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated [as documented by his physician in his medical record];

- (13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated [as documented by his physician in his medical record]; and
- (14) If married, is assured privacy for visits by his/her spouse; . . .

In accordance with the ideas discussed above, the Ohio legislature has enacted legislation that marks a significant step forward for the rights of the mentally ill to human dignity, privacy and liberty. Section 5122.27 provides that all mental patients shall:

(F) Receive humane care and treatment including without limitation the following:

(1) The least restrictive environment consistent with the treatment plan;

...

(3) A humane psychological and physical environment within the hospital facilities;

(4) The right to obtain current information concerning his treatment program and expectations in terms that he can reasonably understand;

(5) Participation in programs designed to afford him substantial opportunity to acquire skills to facilitate his return to the community;

(6) The right to be free from unnecessary or excessive medication;

(7) Freedom from restraints or isolation unless it is stated in a written order by the head of the hospital or his designee, or the patient's individual physician or psychologist in a private or general hospital.

Further rights are set out in Section 5122.29:

(B) The right at all times to be treated with consideration and respect for his privacy and dignity, including without limitation, the following:

(1) At the time a person is taken into custody for diagnosis, detention, or treatment . . . the person taking him into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by that person;

(2) A person who is committed, voluntarily or involuntarily, shall be given reasonable protection from assault or battery by any other person.

(C) The right to communicate freely with and be visited at reasonable times by his private counsel or personnel of the legal rights service and unless prior restriction has been obtained, to communicate freely with and be visited at reasonable times by his physician or psychologist.

(D) The right to communicate freely with others, unless specifically restricted in the patient's treatment plan for clear treatment reasons, including without limitation the following:

(1) To receive visitors at reasonable times;

(2) To have reasonable access to telephones to make and receive con-

fidential calls, including a reasonable number of free calls if unable to pay for them and assistance in calling if requested and needed;

(E) The right to have ready access to letter writing materials, including a reasonable number of stamps without cost if unable to pay for them, and to mail and receive unopened correspondence and assistance in writing if requested and needed.

(F) The right to the following personal privileges consistent with health and safety:

- (1) To wear his own clothes and maintain his own personal effects;
- (2) To be provided an adequate allowance for or allotment of neat, clean, and seasonable clothing if unable to provide his own;
- (3) To maintain his personal appearance according to his own personal taste, including head and body hair;
- (4) To keep and use personal possessions, including toilet articles;
- (5) To have access to individual storage space for his private use;
- (6) To keep and spend a reasonable sum of his own money for expenses and small purchases;
- (7) To receive and possess reading materials without censorship, except when the materials create a clear and present danger to the safety of persons in the institutions.

(G) The right to reasonable privacy, including both periods of privacy and places of privacy.

(H) The right to exercise all civil rights, including but not limited to the rights to contract, hold professional, or occupational or vehicle operator's licenses, marry, obtain a divorce, register, vote, make a will, and sue and be sued, unless he has been adjudicated incompetent for that purpose in a separate judicial proceeding.

(I) The right to free exercise of religious worship within the institution, including a right to services and sacred texts that are within the reasonable capacity of the institution to supply, provided that no patient shall be coerced into engaging in any religious activities.

(J) The right to social interaction with members of either sex, subject to adequate supervision, unless such social interaction is specifically withheld under a patient's written treatment plan.

The statute also provides that "no patient . . . shall be compelled to perform labor which involves the operation, support, or maintenance of the hospital."³⁶¹ If a patient volunteers to perform such labor, he is to be compensated according to the value of the work that he has performed.³⁶² A patient

³⁶¹ OHIO REV. CODE ANN. § 5122.28 (Page Supp. 1976).

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³⁶² *Id.* "Value" is to be determined by "the prevailing wage rate for comparable work or

may, however, be required to perform other tasks if such tasks are therapeutic in nature,³⁶³ or he may "be required to perform tasks of a personal house-keeping nature."³⁶⁴

Protection is also extended to mental patients after they have received treatment and have been discharged into the community by providing that "[n]o person shall be deprived of any civil right or public or private employment solely by reason of his having received services, voluntarily or involuntarily, for a mental disability."³⁶⁵ The legislature here has presumably recognized the social stigma that is still associated with the commitment of the mentally ill.³⁶⁶ However, a mere proclamation of non-discrimination may not be sufficient to extend protection to the rights of the formerly mentally ill.³⁶⁷ Discrimination in fact may be easy to cover up and difficult to prove. Yet the statute at least prohibits such adverse decisions as *Spencer v. Toussaint*³⁶⁸ where a United States District Court held that the City of Detroit could deny a prospective employee a position as a city bus driver on the basis of the applicant's history of mental illness.

It is noteworthy that the rights created are not later limited by making them dependent on the judgment of the hospital personnel. The few restrictions that exist are subject to standards of "reasonableness" or "health and safety,"³⁶⁹ terms which the courts are experienced in interpreting. The

by the wage rates established under Section 4111.06 of the Revised Code." *Id.* Section 4111.06 (Page 1973) (amended 1976) permits the director of industrial relations to issue regulations providing for a lower wage scale to be applied to people "whose earning capacity is impaired by physical or mental deficiencies or injuries."

³⁶³ *Id.* Some tasks may be assigned simply to avoid the boredom that accompanies life in an institution. Wexler, *supra* note 345.

³⁶⁴ OHIO REV. CODE ANN. § 5122.28 (Page Supp. 1976).

³⁶⁵ *Id.* § 5122.301 (Page Supp. 1976).

³⁶⁶ Recall that Thomas Eagleton resigned under pressure as the Democratic nominee for the Vice-Presidency when it was discovered that he had received electro-convulsive therapy for treatment of depression many years earlier. A University of Kentucky researcher discovered that mental illness ranks 21st in the social acceptability of various handicaps, behind such disabilities as amputation, paralysis, epilepsy, alcoholism, and even prior criminal conviction. Interestingly enough, an ulcer, which may represent a somatic reaction to stress and tension, was the *most* socially acceptable. *Is Mental Illness Acceptable?* Mental Health Association of Stark County Bellringer, Feb. 1977, at 2. And in *Hearings before the Senate Subcomm. on Constitutional Rights*, 91st Cong., 1st & 2d Sess. (1969-1970) (testimony of Bruce Ennis) it was related that "in the job market, it is better to be an ex-felon than ex-patient."

³⁶⁷ Ennis suggests that those who were mentally ill in the past will be sufficiently protected only if employers are forbidden by statute to ask a job applicant if he has ever been hospitalized or treated for mental illness. Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101, 123-24 (1971).

³⁶⁸ 408 F. Supp. 1067 (E.D. Mich. 1976).

³⁶⁹ Under the prior statute patients held rights—which included only the rights to communicate by sealed letter and to receive visitors—subject to the determination of the head of the

most discretionary standard appears in Section 5122.29 (D), where the right to communicate freely with others may be abridged "for clear treatment reasons." Even here, however, there are curbs on arbitrariness. The restrictions and the reasons therefor are to be delineated in the treatment plan, which means they are subject to periodic judicial review. Moreover, the patient still has the right to write and receive uncensored mail;³⁷⁰ he also has the unrestricted right to communicate freely with his private counsel or personnel of the legal rights service.³⁷¹ He therefore may be expected to complain if he believes that his right to communicate freely has been unduly restricted.

Other rights may be restricted by court order, including the right "to communicate freely with and be visited at reasonable times by his personal physician or psychologist"³⁷² and "the right to exercise . . . civil rights" when "adjudicated incompetent for that purpose."³⁷³ "Incompetency" means the "inability [to take] proper care of himself or his property or [failure] to provide for his family or other persons for whom he is charged by law to provide."³⁷⁴ The person alleging incompetency must show that the patient has a mental disorder which causes bad judgment so that he squanders his money, is easily victimized by those who would take advantage of him, or so hoards his assets as to deprive himself or his family of necessities.³⁷⁵ Although the bad judgment must be caused by a mental disorder rather than by ignorance or inexperience,³⁷⁶ a simple finding of mental illness is insufficient.³⁷⁷ Incompetency is a pragmatic concept; a person may be competent to handle a small monthly income, yet incompetent to manage a large

hospital that it is necessary to impose restrictions." OHIO REV. CODE ANN. § 5122.29 (Page 1970) (amended 1976). Thus, the rights under the new statute are not only more numerous, they are also more secure. The Ohio legislature is to be commended for its strong stance on patients' rights. Compare CAL. WELF. & INST. CODE § 5326 (West Supp. 1977) ("The professional person in charge of the facility or his designee may, for good cause, deny a person any of the rights under the previous section To ensure that these rights are denied only for good cause, the Director of Health shall adopt regulations specifying the conditions under which they may be denied."); MASS. GEN. LAWS ANN. ch. 123 § 23 (West Supp. 1976-77) ("any of these rights may be denied for good cause by the superintendent or his designee and a statement of the reasons for any such denial entered in the treatment record of such person").

³⁷⁰ OHIO REV. CODE ANN. § 5122.29 (E) (Page Supp. 1976).

³⁷¹ *Id.* § 5122.29 (C).

³⁷² *Id.*

³⁷³ *Id.* § 5122.29 (H). It is noteworthy that a determination of incompetency does not follow automatically upon civil commitment, as it did under the old statute. See text accompanying notes 333 and 334 *supra*.

³⁷⁴ OHIO REV. CODE ANN. § 2111.01 (D) (Page 1970) (amended 1976).

³⁷⁵ Davidson, *An Appraisal of Competency*, 9 CLEV.-MAR. L. REV. 441 (1960).

³⁷⁶ *Id.*

inheritance or the proceeds from the sale of his home.³⁷⁸ Moreover, a determination of incompetency applies only to the particular type of transaction adjudicated, so that a person who has been found incapable of assenting to a contract may still be found capable of making a will.³⁷⁹ Since an adjudication of incompetency is a partial deprivation of liberty, borderline cases should be given the benefit of the doubt.³⁸⁰

Much potential for abuse also exists in a proceeding to determine incompetency. The statutes do not specify any particular procedure to be followed at the hearing,³⁸¹ it is *ex parte* in nature,³⁸² and there is no requirement that the alleged incompetent be present at the hearing or that someone be appointed to represent him.³⁸³ Unless these defects are remedied by a revision of the law concerning guardianship,³⁸⁴ it can only be hoped that the legal rights service, which is supposed to insure that patients are at least represented by counsel in any proceedings to secure the rights of patients,³⁸⁵ will help to curb unnecessary deprivation of legal capacity.

The statute makes provision for enforcement of the rights guaranteed to mental patients. The Joint Mental Health and Mental Retardation Advisory and Review Commission is to "receive and evaluate reports of alleged

³⁷⁸ Davidson, *supra* note 375, at 442. Medically speaking, incompetency does not depend on how much money can be squandered or hoarded. It is just as "crazy" to believe erroneously that you have one dollar in your pocket as it is to believe you have a million dollars. But legally it makes sense to base a judgment on the amount of money involved. It requires more expertise to handle a large sum of money than it does a small sum; moreover, incompetency proceedings cost money, and so may be impracticable when the stakes are small. *Id.*

³⁷⁹ *E.g.*, to be legally competent to make a deed or enter a contract, one must be capable of assent, which requires a "sound mind possessed of memory, will, and understanding." *Lore v. Truman*, 1 Dec. Rep. 510, 514 (1852), *rev'd on other grounds*, 10 Ohio St. 45 (1859) and 14 Ohio St. 144 (1862). But capacity to marry depends on cognizance of the nature and obligations of the marriage contract at the time it is entered into. *Fisher v. Adams*, 151 Neb. 512, 38 N.W.2d 337 (1949). And "[a] testator with mind enough to understand the ordinary affairs of life, the kind and extent of his property, who are the natural objects of his bounty, and that he is giving his property to the persons mentioned in his will, in the manner therein stated, is capable of making a will." *Hardy v. Barbour*, 304 S.W.2d 21, 34 (Mo. 1957).

In recognition of this principle of selective incompetency the Ohio statute provides that the right to exercise all civil rights continues unless the person "has been adjudicated incompetent for that purpose in a separate judicial proceeding." OHIO REV. CODE ANN. § 5122.29 (H) (Page Supp. 1976) (emphasis added).

³⁸⁰ *In re Pickles*, 170 So. 2d at 614.

³⁸¹ See Dewey, *supra* note 89, at 434.

³⁸² *State ex rel. Davey v. Owen*, 133 Ohio St. 96, 103, 12 N.E.2d 144, 148 (1937).

³⁸³ See Dewey, *supra* note 89, at 434.

³⁸⁴ The Ohio Judicial Conference has indicated that it will be discussing the issue of guardianship as a separate matter and will be making recommendations to the General Assembly at a later time. Memorandum on Ohio Judicial Conference meeting relative to H.B. No. 244, from Nancy Daniels to Senator Tim McCormack and Representative Paul Leonard (Dec. 16, 1976) at 2.

dehumanizing practices and violations of individual or other legal rights."³⁸⁶ If attempts at resolution of complaints through administrative channels prove unsatisfactory, the administrator of the legal rights service may "initiate actions in mandamus and such other legal and equitable remedies as may be necessary to accomplish the purposes of [the Mental Health Act]."³⁸⁷

C. *Treatment in the Least Restrictive Environment*

The Ohio legislature may have been prompted to enact the "least restrictive alternative" provisions of the Mental Health Act for at least three reasons. The first is that it may be constitutionally required. The concept, previously invoked to restrict state attempts to regulate commerce³⁸⁸ and free speech,³⁸⁹ requires government, in its attempts to restrict undesirable conduct, to use those means which are least likely to inhibit protected behavior.³⁹⁰ One of the more articulate statements of the concept appears in *Shelton v. Tucker*,³⁹¹ where the Supreme Court of the United States said that:

[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be narrowly achieved. The breadth of the . . . abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.³⁹²

The Court of Appeals for the District of Columbia was the first to apply the doctrine to a modern case involving civil commitment.³⁹³ In *Lake v. Cameron*,³⁹⁴ the court used the doctrine to construe the "least restrictive alternative" provision in the District of Columbia Code and held that a court must satisfy itself that the deprivation of liberty does not exceed what is necessary for a patient's protection.³⁹⁵ If other less restrictive means of treatment are available which would provide the mentally ill person with sufficient care, they should be used instead of committing the person to an institution.³⁹⁶ This court also has applied this theory to a case involving

³⁸⁶ *Id.* § 5119.801 (G).

³⁸⁷ *Id.* § 5123.94 (G).

³⁸⁸ See *Dean Milk Co. v. City of Madison*, 340 U.S. 349 (1951).

³⁸⁹ See *Soia v. New York*, 334 U.S. 558 (1948); *Martin v. Struthers*, 319 U.S. 141 (1943).

³⁹⁰ *Wormuth & Mirkin, The Doctrine of the Reasonable Alternative*, 9 UTAH L.J. 254, 256 (1964); see 7 CRIM. L. BULL. 101, 112-13 (1971).

³⁹¹ 364 U.S. 479 (1960).

³⁹² *Id.* at 488 (footnote omitted).

³⁹³ See *In re Oakes*, 8 Law Rep. 123 (Mass. 1845).

³⁹⁴ 364 F.2d 657 (D.C. Cir. 1967).

³⁹⁵ *Id.* at 660.

³⁹⁶ *Id.* In examining the choice of environment, the reviewing court is not to determine if the best possible choice was made. Instead, the court is to determine whether the decision made, in view of all relevant information, constituted a reasonable and permissible one. *Covington v. Harris*, 419 F.2d 617, 621 (D.C. Cir. 1969). Hospital personnel are to be given broad discretion in making such decisions. *Id.*

confinement in a maximum security ward after commitment.³⁹⁷

In *Lessard v. Schmidt*,³⁹⁸ a similar case, the court, independent of any statute as in *Lake*, said that those advocating commitment "must bear the burden of proving (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable."³⁹⁹ Possible "alternatives include . . . out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aid services."⁴⁰⁰ Commitment should result only when these alternatives are not feasible. The *Lessard* opinion may well have been very influential to the Ohio legislature because the Ohio Supreme Court has given its general approval to the decision.⁴⁰¹

The second factor which may have prompted the Ohio legislature to enact this particular part of the statute is that minimal restriction serves the purpose of creating a more pleasant environment and increases the effectiveness of treatment programs. For instance, conditions at a Pennsylvania state hospital changed rapidly after operating for two years as a completely open hospital.

The discharge rate of patients had doubled, and thanks to the zooming discharge rate, the hospital population had been reduced in the face of a doubled monthly admission rate. The relapse rate was cut almost in half. There was a sharp drop in violence. Patients got along better with themselves and the staff. Staff morale was raised tremendously. Property damage by patients was reduced by 75 percent.

There had not been a single serious incident in the surrounding community involving a patient. There were no more escapes than before the doors were opened. Patients were expected to act like human beings, and acted like human beings.⁴⁰²

³⁹⁷ *Id.* In *Covington* the court stated that, "[I]n reviewing . . . a . . . committed patient's confinement . . . the court should satisfy itself that no less onerous disposition would serve the purpose of commitment." *Id.* at 623. The court justified its review of in-house operations on the ground that "[i]t makes little sense to guard zealously against the unwarranted deprivations [of liberty] prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors." *Id.* at 623-24.

³⁹⁸ 349 F. Supp. 1078. The Court reached this result without the aid of a helpful statute requiring treatment to be accomplished in the least restrictive manner. It did note, however, that the Wisconsin statutes, which provided that "the court 'may . . . (c) Order him committed if satisfied that he is mentally ill . . . and that he is a proper subject for custody and treatment . . . ' and shall commit the person to a hospital 'if the court or jury finds that the patient is mentally ill or infirm and should be sent to a hospital for the mentally ill or infirm,'" did not conflict with its mandate. *Id.* at 1096.

³⁹⁹ *Id.* at 1096.

⁴⁰⁰ *Id.*

⁴⁰¹ *In re Fisher*, 39 Ohio St. 2d at 71, 313 N.E.2d at 851, 856.

⁴⁰² *Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Con-* 60

A third consideration which also may have motivated the legislature to stress treatment in less restrictive environments is the availability of potential federal funds to further lessen the cost of treatment. The Community Mental Health Centers Act⁴⁰³ is specifically directed at the provision of local community services in the mental health field. To be eligible for federal funding, states must adopt an approved plan whereby comprehensive services are provided.⁴⁰⁴ Such services are to include:

(A) inpatient services, outpatient services, day care and other partial hospitalization services, and emergency services;

. . .

(F) provision of followup care for residents of its catchment area who have been discharged from a mental health facility;

(G) a program of transitional half-way house services for mentally ill individuals . . . who have been discharged from a mental health facility or would without such services require inpatient care in such a facility; . . .⁴⁰⁵

The plan is to "emphasize the provision of outpatient services by community mental health centers as a preferable alternative to inpatient hospital services."⁴⁰⁶ That the Ohio legislature may have contemplated obtaining federal funding is evidenced by the fact that the statute requires the Mental Health Commission to study federally funded programs that could benefit the mentally ill⁴⁰⁷ and to "review and assess the administration and availability of mental health . . . programs and facilities in the state."⁴⁰⁸

The Ohio statute creates a right to receive treatment in "the least restrictive environment consistent with the treatment plan."⁴⁰⁹ Determination of the least restrictive environment is not left solely to the discretion of hospital personnel. At the original commitment hearing, the designee of the director or of the head of the hospital is to present "the diagnosis, prognosis, record of treatment, if any, and less restrictive treatment plans, if any"⁴¹⁰ to the court. "In determining the place to which or the person with

stitutional Rights, Senate Comm. on the Judiciary, 87th Cong., 1st Sess., Part I at 40 (1961) (testimony of Albert Deutsch).

⁴⁰³ 42 U.S.C. §§ 2689-2689aa (Supp V 1975).

⁴⁰⁴ *Id.* § 2689t (a) (2).

⁴⁰⁵ *Id.* § 2689 (b) (1).

⁴⁰⁶ *Id.* § 2689t (a) (2) (D).

⁴⁰⁷ OHIO REV. CODE ANN. § 5119.801 (D) (1) (Page Supp. 1976).

⁴⁰⁸ *Id.* § 5119.801 (D) (2).

⁴⁰⁹ *Id.* § 5122.27 (F) (1). Restraint, of course, may be accomplished without the use of a physical apparatus, but the statute also provides that the patient has "[t]he right to be free from unnecessary or excessive medication." *Id.* § 5122.27 (F) (6).

whom, the [mentally ill person] is to be committed, the court shall consider the diagnosis, prognosis and projected treatment plan . . . and order the implementation of the least restrictive alternative available and consistent with treatment goals."⁴¹¹ At subsequent hearings on continued commitment, "a list of alternative treatment settings and plans, and identification of the treatment setting that is the least restrictive consistent with treatment needs"⁴¹² is to be presented for consideration. The doctrine probably also applies during the treatment intervals.⁴¹³

However, substantial consideration of least restrictive settings will not benefit the mental patient if no less confining facilities are available. For example, in *Lake v. Cameron*,⁴¹⁴ the District of Columbia Circuit Court of Appeals ordered the district court to inquire into the possibility of alternative courses of treatment for a senile woman who had been placed in a locked ward because she had a propensity to wander around on the streets alone at night. On remand, the district court found that the woman was in need of constant supervision for her own safety and that the only facility in the area which could provide for her needs was the closed ward at St. Elizabeth's Hospital.⁴¹⁵ Yet, where there is a statutory right to less restrictive appropriate facilities, the responsible authorities may be obligated to create such facilities if they do not presently exist.⁴¹⁶

Accordingly, the Mental Health Act created a Joint Mental Health and Mental Retardation Advisory and Review Commission⁴¹⁷ whose duties include, *inter alia*, the development of programs with "provisions for community-based alternatives to institutional care, for the availability of services in the least restrictive environment consistent with the individual's needs, and for comprehensive community services for the mentally ill, mentally retarded, and developmentally disabled."⁴¹⁸ The Commission also is to submit

⁴¹¹ *Id.* § 5122.15 (E).

⁴¹² *Id.* § 5122.15 (H).

⁴¹³ *See, e.g.,* *Dixon v. Weinberger*, 405 F. Supp. 974, 980 (D.D.C. 1975).

⁴¹⁴ 364 F.2d 657 (D.C. Cir. 1966).

⁴¹⁵ 267 F. Supp. 155, 159 (D.D.C. 1967).

⁴¹⁶ *Dixon v. Weinberger*, 405 F. Supp. 974, 979 (D.D.C. 1975). Litigation on the right to placement in a facility close to other family members as part of a right to habilitation in the least restrictive environment is currently being conducted in Ohio. *Bettencourt v. Rhodes*, No. C77-12 (N.D. Ohio, filed Jan. 12, 1977). For a summary of the complaint, see 1 MENTAL DISABILITY L. REP. 343 (1977).

⁴¹⁷ OHIO REV. CODE ANN. § 5119.80 (Page Supp. 1976). The Commission consists of thirteen members and three ex officio members. It is interesting to note that at least seven of the members must be nonproviders of mental health or mental retardation services. Two of the members are to come from the legislature, one from the Senate and one from the House of Representatives. The director of the legal rights service is to be one of the ex officio members. The broad spectrum of viewpoints to be represented is in accord with the idea that mental health care involves moral and legal problems as well as medical judgments.

⁴¹⁸ OHIO REV. CODE ANN. § 5119.80 (B) (Page Supp. 1976).

a plan to the General Assembly "for phasing out as many long-term residential institutions and facilities as is possible."⁴¹⁹

The medical and legal concern for treatment in the least restrictive environment has made a difference. Ohio communities are in fact developing a wide array of services which enable many of the mentally ill to live safely outside of an institution. Stark County is presented here as an example—not because that county is necessarily representative of all other counties in the state, but because this illustration indicates that it is desirable to discover what is available in a particular client's locality so that hospitalization may be avoided. In Stark County, outpatient programs include several groups devoted to the rehabilitation of alcoholics and those addicted to narcotics. The Developmental Disabilities Advocacy Program assigns the disabled a personal "advocate" to help integrate the person into the community via socialization and friendship. Also available are numerous counseling services such as Recovery, Inc., which provides training in techniques for self-help for former mental patients to help prevent relapses, the Crisis Intervention Center which operates a 24-hour telephone service to provide early intervention in crisis situations, and the Bureau of Vocational Rehabilitation which seeks to enable those with a physical or mental disability to enter or re-enter employment suitable to their abilities and limitations.⁴²⁰

Stark County also has three mental health centers designed to rehabilitate or to continue a rehabilitation program for those clients who have been referred to them or voluntarily come to the centers. The centers are staffed by consulting psychiatrists, social workers, psychologists, and psychiatric nurses.⁴²¹ The clinics are under-staffed, however, which is evidenced by the fact that they are a few months behind schedule in appointments and the psychiatrists have little time to administer anything but chemotherapy.⁴²²

The Director of Mental Health for Stark County believes that the most innovative program in Stark County is a new district services agency called Transitional Services. The agency primarily serves people who have been previously hospitalized at Massillon State Hospital. Its purpose is to prevent discharged patients "from returning to the hospital out of frustration experienced within the community because of inadequate services and case management."⁴²³ Transitional Services provides assistance to persons "with

⁴¹⁹ *Id.* § 5119.801 (I).

⁴²⁰ Stark County Human Services Directory (1976), *passim*.

⁴²¹ Letter from Charles W. Harris, Executive Director of the Mental Health Association of Stark County, to Janice Gui (Feb. 23, 1977) [hereinafter cited as Harris].

⁴²² *Id.*

⁴²³ *Transitional Services*, Mental Health Association of Stark County Bellringer, Oct. 1976,

a diagnosed or, at least, suspected mental disorder, who need assistance with various needs such as housing, clothing, food, employment, governmental assistance programs or other such related needs which will contribute to their successful coping with community existence."⁴²⁴ One case history provides an example of the comprehensive service that Transitional Services offers. When a 32-year-old divorced female was referred to the agency upon her release from the hospital, it was learned that

[The woman] had no income, no relatives with whom she could live, no funds to pay for medication prescribed for her, no transportation and was in need of counseling as well as psychiatric care. The Transitional Services worker, with her approval, secured a room in a boarding home for her, assisted her file for Adult Emergency Assistance, food stamps and general relief, got her prescriptions filled, made the appropriate referrals to a mental health center where she would be seen by a counselor and psychiatrist and be placed in the adult day care center program. The Transitional Services worker also transported her from the hospital to her new residence as well as . . . to her weekly physicians [sic] appointments for the next two months.

Later the Transitional Services worker also arranged for legal aid representation, and assisted her to find employment in order to go off welfare and to be able to support herself.

Furthermore, since [she] was an excellent student in high school, the Transitional Services worker referred her to the Bureau of Vocational Rehabilitation whereupon they tested her and agreed to send her to college.

. . . Transitional Services has [also] worked with her providing close follow-up and crisis intervention in the early hours of the morning [when she has had an 'inexplicable urge' to commit suicide].⁴²⁵

The main need in Stark County at the present time is the establishment of halfway houses to provide a mixture of guidance and freedom for discharged mental patients. Such homes can enable the mentally rehabilitated to "begin to 'normalize' their lives after perhaps many years of institutionalization."⁴²⁶

⁴²⁴ Agreement between the Mental Health Association of Stark County and the Eastern Stark County Mental Health Foundation. The Eastern Stark County Mental Health Foundation is one of the six agencies in Stark County that contracted with the Mental Health Association to provide Transitional Services.

⁴²⁵ *A Case History*, Mental Health Association of Stark County Bellringer, Feb. 1977, at 3-4.

⁴²⁶ Harris, *supra* note 421. One problem that may arise with the establishment of such homes is that they may run afoul of local zoning ordinances. Because such facilities are usually inhabited by unrelated individuals, they may violate single-family use restrictions. This presents a problem in that absorption of the mentally restored into the community requires that they be placed within ordinary neighborhoods rather than into business districts or rurally isolated areas. *Id.*

It is important for the practicing lawyer to be aware of facilities that the community has to offer. Perhaps a court may be persuaded to release a patient if a reasonable alternative plan for treatment is presented. In some cases a residential change or even marital separation may be an effective way to deal with psychological problems,⁴²⁷ but in many cases some outside help for the disturbed person is desirable.

It should not be overlooked that treatment in a less confining environment poses risks, both to the public and to the patient himself. Various studies concerning the risk to the public lead to conflicting conclusions.⁴²⁸ Those who favor less restriction resolve the conflict by giving the value of human freedom greater weight than the safety of the public. They point to the fact that in a democratic social organization the government must "take chances with respect to what its citizens might do. Such a government cannot strive for the maximum safety in order to maintain the values of liberty and dignity."⁴²⁹ The government does in fact take such chances with those

override any local zoning ordinances that would bar the homes from residential neighborhoods. *See Berger v. State*, 71 N.J. 206, 218-19, 364 A.2d 993, 999-1000 (1976); *Group House of Port Washington, Inc. v. Board of Zoning and Appeals*, 82 Misc. 2d 634, 370 N.Y.S.2d 433 (1976). Some states have enacted legislation that provides that such homes are to be single-family residences for zoning purposes, thus eliminating the need for judicial law on the subject. For example, MINN. STAT. ANN. § 462.357, subdiv. 7-8 (West Supp. 1977) provides that a state licensed group for six or fewer mentally retarded or physically handicapped individuals is to be considered a single-family residence for zoning purposes; group homes for seven to sixteen mentally retarded or physically handicapped people are to be considered multi-family residences. MONT. REV. CODES ANN. §§ 11-2702.1, 11-2702.2 (Supp. 1975) exempts community residential facilities for the developmentally disabled serving eight or fewer residents from local single-family zoning requirements; the statute was upheld by the Supreme Court of Montana. *State ex rel. Thelen v. City of Missoula*, 543 P.2d 173 (Mont. 1975).

In the absence of such legislation, a court may rule that such a group of protected individuals constitutes a "family" for zoning purposes. *Kline v. Dep't of Mental Hygiene*, No. 76-C-661 (E.D.N.Y. May 11, 1976), summarized in 1 MENTAL DISABILITY L. REP. 127 (1976) (a state may not deny aftercare services to residents of a particular community on the basis of local objections to the presence of former mental patients in the area); *Berger v. State*, 71 N.J. at 224, 364 A.2d at 1002 (definition of family which "so narrowly delimits the persons who may occupy a single family dwelling as to prohibit numerous potential occupants who pose no threat to the style of family living sought to be preserved" held to be unreasonable) (alternative holding); *Little Neck Community Ass'n v. Working Org'n for Retarded Children*, 52 App. Div. 2d 90, 383 N.Y.S.2d 364, 367 (1976) (group home established pursuant to statute is designed to resemble reasonably sized biological family).

⁴²⁷ Strand, *supra* note 28, at 485.

⁴²⁸ Compare Overholser, *The Present Status of the Problems of Release of Patients From Mental Hospitals*, excerpted in R. ALLEN, E. FERSTER & J. RUBIN, READINGS IN LAW AND PSYCHIATRY 218, 219 (1968) ("popular fears of violence or other serious antisocial behavior on the part of persons who have been in a state hospital are generally unfounded") with Rappeport & Lassen, *Dangerousness: Arrest Rate Comparisons of Discharged Patients and the General Population*, *id.* at 221 ("for some offenses such as robbery and also probably rape, [former] patients were more frequently arrested than the general population").

⁴²⁹ *Civil Liberties*, *supra* note 28, at 411.

citizens who have criminal tendencies; even "if a sociologist predicted that a person was eighty percent likely to commit a felonious act, no law would permit his confinement."⁴³⁰ There appears to be no rational basis for treating the mentally ill any differently.⁴³¹

Insofar as the patient himself is concerned, it is known that some suicidal patients do harm themselves even while undergoing treatment. One example involves a man who was admitted to an open ward, despite his wife's warnings of suicidal tendencies. Four days after he had been admitted, he jumped into a window well thirteen feet deep. Although he survived, he suffered such severe injuries that eight months later he was confined to a nursing home, "completely disabled both mentally and physically and required constant nursing attendance."⁴³² That the "least restrictive alternative" theory resulted in tragedy both to this patient and his family cannot be denied. Such tragedy can be justified only by a superseding value—the desirability of giving all mental patients the most effective treatment, which will hopefully lead to cure and release.

Calculated risks of necessity must be taken if the modern and enlightened treatment of the mentally ill is to be pursued intelligently and rationally⁴³³

Treatment requires the restoration of confidence in the patient. This in turn requires that restrictions be kept at a minimum. Risks must be taken or the case left as hopeless The standard of care which stresses close observation, restriction and restraint has fallen in disrepute in modern hospitals and this policy is being reversed with excellent results.⁴³⁴

Even if risks to the patient and the public are carefully evaluated, and it is found that a less restrictive environment would probably provide more benefits than risks of harm, the enthusiasm for less restrictive care in community centers must be tempered with a realistic appraisal of the facilities involved. It is essential to insure that alternative treatment facilities do in fact provide adequate care. No benefits are gained by transferring patients to a "community home" where they receive inadequate nutrition, insufficient protection from violence, no attention to medicinal or treatment needs, and physical restrictions as severe as those that would be encountered in a state institution. There is no virtue in moving patients to an environment that

⁴³⁰ Comment, *Civil Commitment of the Mentally Ill*, 79 HARV. L. REV. 1288, 1290 (1966).

⁴³¹ *Civil Liberties*, *supra* note 28, at 411.

⁴³² *Baker v. United States*, 226 F. Supp. 129, 131 (S.D. Iowa 1964).

⁴³³ *Id.* at 134-35.

does not provide an improvement in living conditions nor foster a better psychological attitude in patients.⁴³⁵

D. *The Right to Refuse Treatment*

Although a right to psychiatric treatment, at least for those involuntarily committed, has generally been favored as a humanitarian ideal in both medical and legal circles, it may be a mixed blessing. Thomas Szasz, a psychiatrist who is opposed to any form of involuntary commitment, says:

The idea of a "right to mental treatment" is both naive and dangerous. It is naive because it accepts the problem of the publicly hospitalized mental patient as medical rather than educational, economic, religious and social. It is dangerous because the remedy creates another problem: compulsory medical treatment. For in a context of involuntary confinement, the treatment too shall have to be compulsory.⁴³⁶

Under the *Donaldson* standard, confinement on the ground of mental illness alone is unconstitutional.⁴³⁷ If a patient is not dangerous, and the asserted reason for his confinement is the benefit that he is expected to receive from therapy, any justification for the confinement vanishes if he is in fact not treated. This result would seem to follow regardless of whether the reason for non-treatment is the state's refusal to provide such treatment or the patient's refusal to accept it.⁴³⁸

Forced treatment has occurred in cases involving physical illness. For example, in *Application of President and Directors of Georgetown College, Inc.*,⁴³⁹ a critically ill woman and her husband refused to give consent to a blood transfusion necessary to preserve the woman's life. As a result, the court issued an order requiring the transfusion, its rationale being that in a case where a citizen appears to be in extreme danger, the state may intercede

⁴³⁵ D. MARTINDALE & E. MARTINDALE, *PSYCHIATRY AND THE LAW: THE CRUSADE AGAINST INVOLUNTARY HOSPITALIZATION* 152-53 (1973); *Civil Commitment*, *supra* note 19, at 1404.

⁴³⁶ T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* 215 (1963).

⁴³⁷ 422 U.S. at 573. The problem vanishes when there is voluntary commitment. Then, of course, the patient is free to leave when he pleases so there is no confinement and hence no need to justify it. A voluntarily committed patient may, however, be released if he refuses treatment. *Ortega v. Rasor*, 291 F. Supp. 748 (S.D. Fla. 1968). Sub. H.B. No. 725 would amend OHIO REV. CODE ANN. § 5122.02 (C) (Page Supp. 1976) to provide that the head of the hospital "may discharge any voluntary patient who refused to accept treatment consistent with the written treatment plan required by section 5122.27 of the Revised Code." Ohio judges and hospital personnel have complained that "some voluntary patients refuse treatment and just take up space." Memorandum, *supra* note 127, at 2.

⁴³⁸ *But see* *Robinson v. California*, 370 U.S. at 666, where the Supreme Court said, in dicta, that "[a] State might determine that the general health and welfare require that the victims of [mental illness] be dealt with by compulsory treatment, involving . . . confinement or sequestration."

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⁴³⁹ 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

and act in a manner contrary to the individual's desires or beliefs.⁴⁴⁰ The court noted also that the state has a strong interest in preserving the life of a mother.⁴⁴¹ Cases such as this, however, do not state the general rule; they rest on the emergency exception to the tort doctrine that unauthorized medical treatment is a battery which gives rise to damages.⁴⁴²

The question of a right to refuse mental treatment first was faced squarely by a court in *Winters v. Miller*.⁴⁴³ In *Winters*, the trial court found that the state has both a duty to treat and the power to enforce the duty to treat. Also, the court found a substantial state interest in treating the mentally ill.

[A] mental patient, because of the nature of the illness, may be unable either to seek appropriate treatment or to determine what treatment to allow [W]here the mental patient is not properly treated, the condition may progressively worsen, and the patient may become a public burden and expense Where the proposed treatment is conducive or necessary for the cure or amelioration of mental illness, the failure to provide it would be a step backward in the history of mental hygiene.⁴⁴⁴

The Court of Appeals took a different view of the issues raised in *Winters*.⁴⁴⁵ The court held that the patient's religious convictions which had led to her refusal to accept treatment outweighed the state's interest in compelling treatment for one committed on an emergency basis. The holding was limited though, in that no attempt at civil commitment had been made, so that the state was not fully in the *parens patriae* relationship; the question was left open as to whether a person who had been committed could be treated against his will.

Since *Winters*, the issue has arisen in two federal cases, both involving coerced treatment of the criminally insane. Both courts reached the conclusion that the plaintiffs had alleged sufficient facts to state a claim under the Civil Rights Act. In *Souder v. McGuire* the court stated that the involuntary administration of psychotropic drugs could amount to cruel and unusual punishment and could also be an "unwarranted governmental intrusion into the patient's thought processes in violation of his constitutional right to privacy."⁴⁴⁶ The Third Circuit Court of Appeals recognized these

⁴⁴⁰ *Id.* at 1008.

⁴⁴¹ *Id.*

⁴⁴² See note 59, part I, *supra*.

⁴⁴³ 306 F. Supp. 1158 (E.D.N.Y. 1969).

⁴⁴⁴ *Id.* at 1167.

⁴⁴⁵ 446 F.2d 65 (2d Cir. 1971).

⁴⁴⁶ 423 F. Supp. 830, 832 (M.D. Pa. 1976).

grounds for relief and indicated that a claim could also be grounded on a violation of due process⁴⁴⁷ or an invasion of bodily privacy.⁴⁴⁸

There are good reasons to recognize a right to refuse unwanted mental treatment. First of all, any treatment carries risks of undesirable side effects.⁴⁴⁹ When the treatment is performed to alleviate symptoms of mental, rather than physical, illness, the problem becomes even more acute; not only are there risks of physical disabilities,⁴⁵⁰ but there is also interference with human autonomy. Even the administration of drugs, one of the least intrusive and least controversial forms of therapy, interferes with actions that a person would take "of his own free will." For instance, when a person attempts to organize patients to petition for transfer into an open ward is drugged to an extent which renders him unable to carry out his intentions, an act that he would normally have performed has been prevented. Stronger and longer lasting interference with natural behavior occurs when more radical treatment is used, such as the use of aversive stimuli and psycho-surgery.⁴⁵¹

Even if the interference with human autonomy can be justified on the ground that the treatment elicits conforming behavior from the patient, it is questionable whether the patient has been "cured." The use of aversive

⁴⁴⁷ *Scott v. Plante*, 532 F.2d 939, 946 (3d Cir. 1976).

⁴⁴⁸ *Id.* at 946 n.9. For a full discussion of the possible constitutional bases underlying a right to refuse treatment, see Schwartz, *In the Name of Treatment: Autonomy, Civil Commitment and the Right to Refuse Treatment*, 50 NOTRE DAME LAW. 808 (1975); Comment, *Advances in Mental Health: A Case for the Right to Refuse Treatment*, 48 TEMP. L.Q. 354 (1975).

⁴⁴⁹ See, e.g., *Kaiser v. Suburban Transportation System*, 65 Wash. 2d 461, 398 P.2d 14 (1965). There, a doctor had prescribed an anti-histamine for a bus driver who had a nasal condition. The first day that he took the pills he fell asleep or blacked out while he was driving the bus. When sued by an injured passenger, the bus company defended on the ground that the doctor had failed to warn him that drowsiness was a possible side-effect. The court held that there was enough evidence for the jury to find that the physician's negligence was the proximate cause of the passenger's injuries.

⁴⁵⁰ For example, commonly prescribed tranquilizers can cause photosensitivity and skin eruptions, Parkinson-like symptoms, corneal opacities, and agranulocytosis [an acute disease characterized by an abnormally low white blood corpuscle count and ulcerative lesions in the throat, other mucous membranes, the gastro-intestinal tract, and the skin]. ROBITSCHER, *supra* note 19, at 78. And approximately 20% of the patients put on a program of carefully administered insulin shock therapy sustain bone fractures because of unintended convulsions that occur later. *Mitchell v. Robinson*, 334 S.W.2d 11, 13 (Mo. 1960).

In addition, the therapies are often unpleasant. Anetine (drug) treatments cause "considerable tension and apprehension, soreness of body muscles, prolonged respiratory arrest . . . and a state of total body paralysis often likened to death or drowning." *Prisoners and Mental Patients*, *supra* note 294, at 671. Electro-shock therapy induces convulsions which have been described as "terrifying in the extreme." The initial stage is likened to the experience of 'being electrocuted' or 'roasted in a white-hot furnace,' after which the shock apparently rises 'to an acme of indescribable fear and terror.' de Grazia, *supra* note 25, at 351. And the use of aversive stimuli, which eliminates undesirable behavior by making the activity so distasteful for the subject that he no longer wishes to indulge in it, is by definition unpleasant.

stimuli, for instance, may result in the trading of one mental illness for another. A woman who was a kleptomaniac was successfully cured of her shoplifting tendencies by repeatedly showing her a film where by-standers registered expressions of horror and disgust as they watched such a theft taking place; the patient was also given an electric shock when the shoplifting occurred in the movie. Although she stopped stealing after this treatment, she later reported feelings of intense uneasiness and nervousness whenever she entered a store.⁴⁵² While many may prefer her new affliction, it is debatable whether the woman herself is any more comfortable with it.

The trade of one disability for another becomes more acute when psycho-surgery is performed. For instance, prefrontal lobotomy—a technique which was widely used some years ago, but has since fallen into disrepute—⁴⁵³ has the desirable effect of reducing aggressive drives which may be responsible for criminal behavior. However, while the problem of violence is eliminated, the patient may be reduced to a vegetative state and just as unlikely to do anything useful as he is to do something destructive.⁴⁵⁴ Newer methods of psycho-surgery, which destroy only small, selective areas of the brain, moderate this extreme result,⁴⁵⁵ nevertheless, because treatment is irreversible, any alteration of personality becomes extremely significant and warrants careful consideration before permitting a form of therapy that produces it.

If consent prior to all mental treatment were required, a person would have a “right” to treatment only if he willingly submitted himself to such treatment with a full awareness of the consequences, which is standard procedure when physical illnesses are involved.⁴⁵⁶ Moreover, since treatment for mental illness can interfere with one’s choice of destiny in a way that treatment for physical illness does not, the argument in favor of informed consent before treatment is even more compelling in the former case. Such an approach could invalidate any ground for civil commitment other than dangerousness.⁴⁵⁷

The problem with this analysis is that consent, which implies capacity to consent, may be impossible in the case of mental illness since the disease itself may prevent such capacity. For example, it may be impossible to obtain consent from a severely ill catatonic schizophrenic who is extremely dis-

⁴⁵² Singer, *Psychological Studies of Punishment*, 58 CALIF. L. REV. 405, 433 (1970).

⁴⁵³ Culliton, *Psychosurgery: National Commission Issues Surprisingly Favorable Report*, 194 SCIENCE 299 (1976).

⁴⁵⁴ H. PACKER, *THE LIMITS OF THE CRIMINAL SANCTION* 56-57 (1968).

⁴⁵⁵ See Culliton, *supra* note 453, at 300; Mitchell-Heggs, Kelly & Richardson, *Stereotactic Limbic Leucotomy: A Follow-Up at 16 Months*, 128 BRITISH J. PSYCH. 226 (1976).

⁴⁵⁶ A. MORITZ & C. STETLER, *HANDBOOK OF LEGAL MEDICINE* 129 (1964).

⁴⁵⁷ See text accompanying note 437 *supra*.

oriented or from a paranoid patient whose refusal of treatment is a product of his illness.⁴⁵⁸ To allow a person to deteriorate, disregarding distortions in his inner and outer world, may be as destructive of human life and dignity as to treat him "against his will."⁴⁵⁹ A solution might be to allow coerced treatment on therapeutic grounds where a clinical determination shows that the patient is in a state analogous to "unconsciousness"⁴⁶⁰ so that consent is impossible. Such coercive treatment is similar to that given to one in a diabetic coma, for instance, and can be analogized to the emergency exception to unauthorized treatment for physical illnesses. It can be justified on the ground that initial resistance to treatment was not a "free" choice.⁴⁶¹

In this scheme a duty to be treated would exist only for a limited period of time during which the patient would be given the opportunity to acquire the capacity to decide for or against treatment. Treatment during this time would be restricted to "an exploration of resistance to treatment and thus would extend only to an opportunity to learn to appreciate the value of treatment and those who offer it."⁴⁶² Once "consciousness" is regained, the mental patient would be free to reject further medical care.

Judged by the standards of commentators and the recent federal decisions, the new Ohio statute does provide some protection against unwanted therapeutic intervention, but does not go far enough. The statute provides that

[T]he chief medical officer shall provide all information, including expected physical and medical consequences, necessary to enable any patient of a hospital for the mentally ill to give a fully informed, intelligent and knowing consent, the opportunity to consult with independent specialists and counsel and the right to refuse consent for any of the following:

- (1) surgery;
- (2) convulsive therapy;
- (3) programs involving aversive stimulae;
- (4) sterilization;
- (5) any unusually hazardous treatment procedures;
- (6) psycho-surgery.⁴⁶³

Both informed consent and court approval are required for sterilization,

⁴⁵⁸ *Prisoners and Mental Patients*, *supra* note 294, at 673.

⁴⁵⁹ Katz, *supra* note 48, at 770-71.

⁴⁶⁰ *Id.* at 770.

⁴⁶¹ *Prisoners and Mental Patients*, *supra* note 294, at 675.

⁴⁶² Katz, *supra* note 48, at 773.

⁴⁶³ OHIO REV. CODE ANN. § 5122.271 (A) (Page Supp. 1976).

and unusually hazardous treatment procedures and psychosurgery, unless the patient is legally competent and has voluntarily entered a nonpublic hospital.⁴⁶⁴ Thus, certain forms of therapy can *never* be performed unless the patient consents.

Ordinarily surgery and convulsive therapy may be performed without the patient's consent if he is physically unable to receive and comprehend the information required or has been adjudicated incompetent.⁴⁶⁵ That this part of the statute permits certain types of nonconsensual medical intervention may be justified on the ground that these types of treatment usually interfere less with the patient's autonomy.⁴⁶⁶ Such treatment may make the patient amenable to therapeutic intervention, resulting in greater intrapsychic freedom so that he can exercise his free choice at a future date.⁴⁶⁷ However, the judgment is not left to the sole discretion of the medical personnel involved. If the patient does not have legal capacity to consent, the relevant information may be provided to his guardian, who may consent knowingly and intelligently to the proposed treatment.⁴⁶⁸ To guard against bad faith judgments or over-zealous judgments made in good faith, the statute provides that "[i]n no case shall the guardianship of a mentally ill person be assigned to the head of a hospital or any staff member of a hospital in which the person is hospitalized."⁴⁶⁹

More latitude for discretion is permitted in the case of a medical emergency in which either surgery or convulsive therapy may be administered without the consent of either the patient or his guardian.⁴⁷⁰ However, the physician must obtain informed, knowing, and intelligent consent from the patient's spouse or next of kin, if possible; otherwise the chief medical officer must authorize the treatment.⁴⁷¹

⁴⁶⁴ *Id.* § 5122.271 (B). The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research has recommended some additional requirements. It has proposed that each hospital performing psycho-surgery have an institutional review board, composed of people with diverse backgrounds, which would ensure that the surgeon who performs the operation is competent and that the patient is carefully evaluated, is undergoing psycho-surgery for medically indicated reasons and has consented to the proposed treatment. Culliton, *supra* note 453, at 301. It would have all HEW funding withdrawn from any institution that violates any of the proposed regulations. *Id.* If these recommendations are accepted and enacted into law, such review boards may become part of Ohio institutions, with or without state statutory compulsion. See text accompanying note 358 *supra*.

⁴⁶⁵ OHIO REV. CODE ANN. § 5122.271 (C) (Page Supp. 1976).

⁴⁶⁶ But the Supreme Court of Minnesota has found electroshock therapy to be "intrusive" and therefore subject to judicial approval if the patient does not consent. *Price v. Sheppard*, 239 N.W.2d 905 (Minn. 1976).

⁴⁶⁷ Katz, *supra* note 48, at 771.

⁴⁶⁸ OHIO REV. CODE ANN. § 5122.271 (C) (Page Supp. 1976).

⁴⁶⁹ *Id.* § 5122.39 (B).

⁴⁷⁰ *Id.* § 5122.271 (D).

Protection against the use of aversive stimuli falls somewhere between that accorded psycho-surgery and that accorded convulsive therapy and ordinary surgery. Aversive stimuli "may not be used unless a patient continues to engage in seriously self-destructive behavior after other forms of therapy have been attempted, and informed, knowing and intelligent written consent has been obtained from a guardian."⁴⁷² This amount of protection is justifiable because aversive therapy intrudes more into the patient's individuality and is longer lasting than convulsive therapy; but it does not interfere with the human personality as much as do more radical forms of treatment such as lobotomy.⁴⁷³

The statute does, though, unduly limit the use of aversive stimuli which can be valuable and effective therapy, and which a legally competent person should be able to choose if he so desires. Since a person may prefer to suffer feelings of uneasiness when entering stores, for instance, than to be subject to the social and perhaps criminal consequences of kleptomania, there is no moral reason for the state to deny him that choice.

A major weakness in the present statute is the lack of protection against the coercive use of chemo-therapy.⁴⁷⁴ There is no doubt that drugs are very useful in the treatment of the mentally ill as they can eliminate the need for the physical restraint of a violent patient and can also make an uncooperative patient docile and receptive to psycho-therapeutic techniques. Yet it is also true that chemicals can interfere with human autonomy by producing radical changes in the patient's behavior,⁴⁷⁵ changes which may be long-lasting or even irreversible.⁴⁷⁶ Moreover, all drugs have risks

⁴⁷² *Id.* § 5122.271 (E).

⁴⁷³ See *Prisoners and Mental Patients*, *supra* note 294, at 619-33. The Supreme Court of Minnesota has held that the more intrusive forms of therapy require the consent of the patient if not otherwise judicially found to be reasonable and necessary. *Price v. Sheppard*, 239 N.W.2d 905 (Minn. 1976).

⁴⁷⁴ An exception lies in the case where the patient is receiving spiritual treatment.

Unless there is substantial risk of physical harm to himself or others, or [unless there is a medical emergency], this chapter does not authorize *any* form of compulsory medical, psychological, or psychiatric treatment of any patient who is being treated by spiritual means through prayer alone in accordance with a recognized religious method of healing without specific court authorization.

OHIO REV. CODE ANN. § 5122.271 (F) (Page Supp. 1976) (emphasis added).

⁴⁷⁵ Katz, *supra* note 48, at 777.

⁴⁷⁶ For that reason electroshock therapy may be preferable to the administration of drugs in cases where there is a choice of therapy. Some writers have urged that electro-convulsive therapy is safe when carefully administered and cheaper and more effective than chemo-therapy when used to treat endogenous depression; furthermore, "the misgivings which one must have about the long-term use of psychopharmacologic agents are eliminated." Hesse & Roeder, *Electroconvulsive Therapy in Denmark*, 128 BRITISH J. PSYCH. 241, 245 (1976). Considering this type of controversy within the profession, it makes little sense to impose restrictions on shock therapy but leave involuntary medication virtually unrestrained.

of serious physical side effects.⁴⁷⁷ Thus, the statute should permit legally competent people to refuse unwanted medication.

A second defect in the statute is that it sets no limit on the length of time a person may be compelled to submit to treatment. Lack of any time limit means that the issues concerning the constitutionality of confinement and the psychiatric uncertainties about treatability may be postponed indefinitely.⁴⁷⁸

A third major weakness is that the statute does not define the requirements for informed consent. Presumably, the informed consent necessary for non-tortious medical treatment will suffice. Elsewhere in the Code it is provided that written consent shall be presumed to be valid and effective when—

- (A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks, if any, of death, brain damage, quadriplegia [paralysis of all arms and legs], paraplegia [paralysis of two legs], loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, with the probability of each such risk if reasonably determinable;
- (B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner;
- (C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient . . . lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances.⁴⁷⁹

⁴⁷⁷ *Id.* In *In re Lundquist*, No. 140151 (Probate Ct., Ramsey County, Minn., April 30, 1976), the court permitted a woman who had voiced a fear that her family was trying to control her life with medication to refuse to take Proloxin, a widely used form of drug treatment, if not otherwise found to be reasonable and necessary. The court held the drug to be an "intrusive therapy" because it may produce changes in the patient's mental process lasting from four to eight weeks, and there is no known way to counteract the effects of the drug. Because of this effect, a federal district court has held that an allegation of forcible administration of psychotropic drugs was sufficient to maintain a first amendment claim for unwarranted governmental intrusion into a patient's thought processes. *Souder v. McGuire*, No. 74-590 (M.D. Pa., Dec. 9, 1976), summarized in 1 MENTAL DISABILITY L. REP. 264 (1977). *But see In re Fussa*, No. 46912 (Minn. June 14, 1976), summarized in 1 MENTAL DISABILITY L. REP. 332 (1977), where the Supreme Court of Minnesota effectively nullified any precedential value of the *Lundquist* decision; the court found Proloxin therapy to be similar to a penicillin injection and therefore permissible without a hearing to consider changes in behavior patterns, risks of adverse side effects, or the experimental nature of the treatment. Such a hearing would have been required had the drug been found to be "intrusive."

⁴⁷⁸ Katz, *supra* note 48, at 773.

⁴⁷⁹ Ohio Rev. Code Ann. § 2317.54 (Page Supp. 1976).

The statute also permits the patient to waive knowledge of the details of the more unlikely problems after a general discussion of common problems and alternate methods of treatment.⁴⁸⁰

It is indeed questionable whether this standard adequately protects the patient from unknowing or unwilling submission to the risks of treatment. It appears to allow the therapist to disclose only a minimal amount of information. Although the most hideous risks must be revealed, the physician need not tell the patient for instance, that fractured bones may result from convulsive therapy; nor need he indicate that new emotional problems may result from the use of aversive stimuli. Also, to place the burden of asking questions on the patient is unsatisfactory since the patient may be unable to ask the appropriate questions.

A better standard would be to insist that practitioners provide a patient with sufficient information to make a fully rational choice concerning his treatment. This would include a full explanation of the nature, purpose, expected duration and benefits to be expected from the therapy. The method by which the therapy is to be administered and *any* known hazards, together with the likelihood of occurrence, should also be revealed. Rational choice means that benefits and risks of alternative therapies, or no therapy at all, are made known. In discussing the merits of any treatment, the therapist should also reveal how it will affect the quality of the patient's life. Given this information, the patient may decide that he would prefer more radical treatment of short duration to continuous chemo-therapy that would interfere with his mental processes over a long period of time.⁴⁸¹

⁴⁸⁰ *Id.* § 2317.54 (D).

⁴⁸¹ *Prisoners and Mental Patients*, *supra* note 294, at 675-76. Using this standard, the California statute comes much closer to reaching the ideal. It provides that:

To constitute voluntary informed consent, the following information shall be given to the patient in a clear and explicit manner:

- (a) The reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect.
- (b) The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.
- (c) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.
- (d) The nature, degree, duration, and the probability of the side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent they may be controlled, if at all.
- (e) That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works and its commonly known risks and side effects.
- (f) The reasonable alternative treatments, and why the physician is recommending this particular treatment.
- (g) That the patient has the right to accept or refuse the proposed treatment, and that if he or she consents, has the right to revoke his or her consent for any reason, at any time prior to or between treatments.

Some medical practitioners have opposed the doctrine of informed consent on the ground that some patients may be made more apprehensive by knowledge of all possible risks, and their recovery may be retarded by this nervousness.⁴⁸² They fear that some patients may even refuse needed treatment if they were aware of all the things that could go wrong.⁴⁸³ However, this fear would appear to be remote if the therapist takes the time to explain the benefits to be expected from the treatment, the fact that some risks are indeed very remote, the possibilities of other forms of treatment and the advantages and disadvantages of them, as well as the risks of refusing any sort of treatment at all. If done properly, full disclosure could very well increase the patient's confidence in the therapist, which should aid recovery rather than retard it. Most importantly, it is only after full disclosure that the patient can be said to have a voice in the charting of his own destiny.

CONCLUSION

The new Ohio Mental Health Act is a substantial improvement over the old law. The new definition of "mental illness" and the criteria for involuntary confinement are more objective; there must be some manifestation of illness evidenced in the person's past behavior. Commitment itself has been made more of a legal judgment in that only a court can order long-term involuntary hospitalization; emergency hospitalization based on a written statement by a psychiatrist, licensed clinical psychologist, licensed physician, health or police officer or sheriff is permitted only for a period of three court days. The procedures known as non-protest hospitalization and emergency hospitalization with a medical certificate have been abolished. Furthermore, the process of commitment has been made more adversarial in nature; the person alleged to be mentally ill is entitled to representation by counsel, to be present at the hearing, to subpoena witnesses and to examine and cross-examine witnesses. Commitment is prohibited if there is a less restrictive alternative.

If commitment is found necessary, the patient must be treated so that he has a maximum chance of being able to live in the community again.

⁴⁸² See, e.g., *Lester v. Aetna Casualty & Surety Co.*, 240 F.2d 676, 679 (5th Cir.), cert. denied, 354 U.S. 923 (1957) (in judgment of psychiatrist it was unsafe and unwise to require patient to "undergo the strain and shock of discussing and considering the possible, though not probable, hazards" of electroshock treatments); *Salgo v. Leland Stanford Jr. University Board of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957) (disclosing all risks may make a patient unduly apprehensive and actually increase risks "by reason of the physiological results of the apprehension itself"); *Miceikis v. Field*, 37 Ill. App. 3d 763, 767, 347 N.E.2d 320, 323 (1976) (doctor testified that "it is not good medical practice to recount every potential complication in each case as it could be frightening and at odds with the patient's best interests").

⁴⁸³ See, ROBLESCHE, *supra* note 19, at 78.

Perhaps even more significant is the provision for refusal of certain treatment procedures, such as electroshock therapy and psycho-surgery. While confined, the patient is to be treated humanely and respectfully, and he is to retain his civil rights to the fullest extent possible.

However, there still remains room for improvement. In a country which has such great respect for the individual, no one should be confined against his will unless he has committed some act that infringes on the rights of others. Neither can coerced treatment be justified other than in cases where the person is so ill that he is unable to make an intelligent choice. In all other cases the law should provide that a patient be fully informed of the various forms of treatment available and of their likely effects, both on his body and his personality; then, if the treatment is not deemed desirable by the patient, he should have an absolute right to refuse it.

Whether or not the Act will actually bring about better conditions for the mentally ill depends upon its enforcement. For instance, Ohio has had a statutory right to treatment and humane care for many years; yet the deplorable conditions found to exist by the task force were permitted to come into being. Likewise, a right to counsel does not protect a person at a commitment hearing if the representation is inadequate or if the court does not fully enforce all procedural rights.⁴⁸⁴ The root of the problem appears to lie in our attitude toward the mentally ill; unless someone cares enough

⁴⁸⁴ A Milwaukee County Circuit judge recently found that those accused of mental illness had been denied effective assistance of counsel and due process of law, in violation of their constitutional rights. In regard to the quality of legal representation by court-appointed attorneys he found that:

- (1) the full compensation for a typical case was \$25.45;
- (2) only one case had been tried to a jury during a period of over a year in which approximately 1,238 applications had been filed;
- (3) the attorneys had waived the right to file written motions in all the cases filed during the same period;
- (4) the right to appeal by way of habeas corpus had never been explained to any of the persons accused of mental illness;
- (5) the right to file writs of habeas corpus was waived in 99 per cent of 838 cases;
- (6) no lawsuits seeking to invalidate commitments were brought by the appointed attorneys;
- (7) the attorneys typically failed to object to irregularities in the evidence presented by those seeking commitment;
- (8) witnesses were usually not cross examined;
- (9) subpoenas were virtually never sought; and
- (10) preliminary hearing transcripts were virtually never sought.

His conclusion was that

A lawyer who does nothing, or who assists the prosecution, is obviously not the effective assistance of counsel that is envisioned by the Sixth and Fourteenth Amendments to the Constitution. These petitioners would undoubtedly have been better off without any counsel who became part of the prosecution effort to detain or commit them.

State *ex rel.* Memmel v. Mundy, No 441-417 (Milwaukee Co. Cir. Ct., Wis., Aug. 18, 1976), reported in 1 MENTAL DISABILITY L. REP. 183 (1976), *aff'd*, 75 Wis. 2d 276, 249 N.W.2d 373 (1977).

to protest, statutory rights are of no avail. In the past, no one has complained and obtained a successful result. Once the furor caused by litigation and investigation has died down, the conditions that appeared to be remedied by statute may again appear. While it may be too much to expect society to revise its attitude overnight, and thus protect the statutory rights that have been created, the statute provides an additional safeguard to protect the rights of the mentally ill: the legal rights service. The creation of a group whose specific job is to oversee those rights means that there is an entity which is not dependent on public sentiment, on public officials performing their jobs in accordance with the statutory requirements, or on the patients themselves, who are often unable to assert their rights effectively. If the legal rights service performs its duties diligently, its creation may well be the most important part of the new law; it may become the agency by which the newly enacted rights for the mentally ill are made an actuality.

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