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### Constitutional Law—Due Process—Civil Commitment—Absent Treatment, a Nondangerous Mentally Ill Person Able to Survive Safely in Society Has a Constitutional Right to Release—*O'Connor v. Donaldson*, 422 U.S. 563 (1975)

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CONSTITUTIONAL LAW—DUE PROCESS—CIVIL COMMITMENT—ABSENT TREATMENT, A NONDANGEROUS MENTALLY ILL PERSON ABLE TO SURVIVE SAFELY IN SOCIETY HAS A CONSTITUTIONAL RIGHT TO RELEASE—*O'Connor v. Donaldson*, 422 U.S. 563 (1975).

Plaintiff Kenneth Donaldson, a former state mental patient, brought an action for damages under 42 U.S.C. § 1983<sup>1</sup> in federal district court against five state hospital officials alleged to have intentionally and maliciously deprived him of his constitutional right to liberty. Despite repeated efforts to secure his release,<sup>2</sup> the plaintiff was

1. 42 U.S.C. § 1983 (1970) provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

*See generally* Note, *Civil Rights: The Federal Courts and the "Right to Treatment" Under 42 U.S.C. § 1983 (1970)*, 27 OKLA. L. REV. 238 (1974). *See also* Note, *A New Emancipation: Toward an End to Involuntary Civil Commitment*, 48 NOTRE DAME LAWYER 1334, 1342-43 (1973).

While still a patient at the Florida State Hospital at Chattahoochee, Donaldson filed the original complaint as a class action on behalf of himself and fellow patients in his department of the hospital. The plaintiffs petitioned for habeas corpus relief ordering their release, compensatory and punitive damages, and declaratory and injunctive relief requiring the hospital to provide adequate treatment. This class action was dismissed following Donaldson's release, and he submitted an amended complaint on his own behalf which was the basis for the present suit. 422 U.S. at 565 n.1.

2. Prior to the commencement of the present suit, the plaintiff had unsuccessfully petitioned state and federal courts for a writ of habeas corpus. The petitions contained substantially similar allegations: (1) plaintiff's initial commitment was procedurally defective; (2) court-appointed counsel had been denied by the state even though plaintiff was indigent and adjudged incompetent; (3) plaintiff was unable to obtain review of the hospital's decision to detain him based on his presumed need for treatment; and (4) plaintiff was being denied his constitutional right to treatment. *See* Birnbaum, *Some Remarks on the "Right to Treatment,"* 23 ALA. L. REV. 623, 635-36 in n.26 (1971) (criticizing the role of the judiciary in Donaldson's struggle to obtain legal redress). On four separate occasions over a 10-year span the United States Supreme Court denied plaintiff's petitions. *Donaldson v. O'Connor*, 400 U.S. 869 (1970) (writ of certiorari); *Donaldson v. O'Connor*, 390 U.S. 971 (1968) (writ of certiorari); *Donaldson v. Florida*, 371 U.S. 806 (1962) (habeas corpus); *In re Donaldson*, 364 U.S. 808 (1960) (leave to file petition for writ of habeas corpus).

In addition to his endeavors to procure a court-ordered discharge, the plaintiff also requested release through the normal hospital channels. These applications were supported by persons and organizations willing to assume responsibility for Donaldson's supervision outside the institution. Helping Hands, a halfway house for mental patients, expressed willingness to accept Donaldson into a rehabilitation program that was endorsed by the Minneapolis Clinic of Psychiatry and Neurology. A similar offer to care for Donaldson was made a number of times by a longtime family friend. In response to these overtures, the hospital superintendent, Dr. J.B. O'Connor, stated that a hospital "rule" (apparently of O'Connor's own making) precluded Donaldson's release to persons other than the patient's parents. Since the patient's parents were too elderly

confined in a Florida state mental hospital for nearly fifteen years following his civil commitment in 1957 for care, maintenance, and treatment.<sup>3</sup> Although the plaintiff was provided with routine custodial care during his hospital stay, he received no psychiatric treatment<sup>4</sup> for his presumed mental illness.<sup>5</sup> Contending that the defendants were aware of the institution's inadequate treatment program, plaintiff argued that his continued detention in the state facility without treatment violated his right to due process of law guaranteed by the fourteenth amendment.

At trial, the jury assessed \$28,500 compensatory and \$10,000 punitive damages against Dr. J.B. O'Connor, the hospital superintendent, and a codefendant, plaintiff's attending physician. The Court of Appeals for the Fifth Circuit affirmed, adopting the view that a person who is involuntarily civilly committed to a mental hospital has a constitutional right to receive such individual treatment as will give him a realistic opportunity to be cured or to improve his mental condition.<sup>6</sup> On certiorari, the United States Supreme Court affirmed with respect to the violation of plaintiff's right to liberty in the absence of treatment, but remanded to the court of appeals for evaluation of the jury instructions concerning the qualified immunity from liability afforded

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and infirm to take responsibility for their son, the practical effect of this rule was to foreclose the possibility of Donaldson's discharge. *O'Connor v. Donaldson*, 422 U.S. 563, 568-69 (1975); See Brief for Respondent at 24-30.

3. Although the plaintiff challenged only the propriety of his post-commitment detention by the hospital, his commitment was apparently invalid *ab initio*. According to one commentator, Donaldson had been in Florida for only four months when he was involuntarily hospitalized pursuant to state statutes limiting civil commitment jurisdiction to persons who had been resident in the state for at least one year. See Schwartz, *In the Name of Treatment: Autonomy, Civil Commitment, and Right to Refuse Treatment*, 50 NOTRE DAME LAWYER 808 (1975).

4. 422 U.S. at 573. In addition to the lack of psychiatric treatment, plaintiff was denied privileges allowed other patients at the institution. The staff repeatedly refused Donaldson's requests for ground privileges, occupational therapy, and an opportunity to consult with hospital authorities. 422 U.S. at 569. For Donaldson's personal account of his experiences written while within the mental hospital, see Patient No. A-25738, *Right to Treatment Inside Out*, 57 GEO. L.J. 886 (1969), in which he asks that the "legal treatment" necessary to remedy his situation replace the state's pretense of medical treatment. Although defendant O'Connor characterized the plaintiff's treatment as milieu therapy, that description was expressly rejected by the Court as a euphemism for mere custodial care. 422 U.S. at 569. See also discussion at note 55 *infra*. In fact, the hospital's own records of Donaldson's stay (ironically denominated "progress notes") contain numerous staff directions to "continue custodial care." Brief for Respondent at 6, *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

5. Plaintiff was initially diagnosed paranoid schizophrenic and civilly committed pursuant to the Florida State Public Health Code then in effect. 422 U.S. at 565, 566 n.2.

6. *Donaldson v. O'Connor*, 493 F.2d 507, 520 (5th Cir. 1974).

to state officials.<sup>7</sup> *Held*: A nondangerous individual who is capable of surviving safely in society by himself or with the aid of willing and responsible family members or friends cannot constitutionally be confined in a mental hospital that provides no treatment beyond mere custodial care. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

*O'Connor* is notable as the first decision of the United States Supreme Court to extend substantive due process protections to the involuntarily<sup>8</sup> civilly committed.<sup>9</sup> This note will examine the traditional

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7. 422 U.S. at 576-77. See also note 59 and accompanying text *infra*.

8. Although this note deals only with the due process issues raised by involuntary confinement, the voluntary-involuntary commitment dichotomy may well be an illusory one in practice. As suggested by its name, voluntary admission is presumed to be an individual decision made entirely free from state coercion. This conception is undermined, however, by evidence that voluntary admission is often a method to hospitalize persons already under some form of official custody. Such individuals may be threatened with involuntary commitment or criminal prosecution in order to induce them to seek "voluntary" admission. Thus, "[v]oluntary admission occurs in approximately 35% of the cases which come to court for involuntary commitment hearings." Gilboay & Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 Nw. U.L. REV. 429, 444 (1971).

Voluntary admission nullifies the procedural safeguards of the civil commitment process that are designed to protect individuals from the dangers of arbitrary state action. The state, by manipulating voluntary admissions, avoids the procedural due process and statutory requirements connected with civil commitment. *Id.* at 453.

The notion that voluntary hospital admittees do not need due process protections may be discredited for another reason. Voluntary patients are often unaware that release on demand is not automatic in some jurisdictions. See, e.g., ILL. ANN. STAT. ch. 91½, § 5-2 (Smith-Hurd Supp. 1976). See also Gilboay & Schmidt, *supra* at 431. Often several days' notice of the patient's desire to be released is required by hospital rules or state statutes in order to give the state an opportunity to petition for a judicial commitment hearing. See ILL. ANN. STAT. ch. 91½, § 5-3 (Smith-Hurd Supp. 1976) (five days written notice required). Pending the final court order the patient may be forced to remain within the institution. *Id.* But see WASH. REV. CODE § 71.05.050 (Supp. 1975) which states that a voluntarily admitted patient "shall be released immediately upon his request." If the patient is considered dangerous or is "gravely disabled," then he may be further detained for a "sufficient time" to notify the county mental health professional so such county official can take legal steps to detain the patient for further evaluation and treatment if necessary. *Id.* See also *id.* § 71.05.380 (1974) (voluntary patients have all rights secured to involuntary patients).

9. The *O'Connor* case affects the legal rights of a substantial number of persons designated mentally ill and hospitalized pursuant to civil commitment statutes. Although precise data regarding the incidence of mental illness in the general population is unavailable, it is considered to rank among the four leading health problems confronting the nation. Statistical projections indicate that one out of every ten Americans will be subjected to institutionalized psychiatric care at some point in his or her life. See AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW xv (rev. ed. S. Brakel & R. Rock eds. 1971) [hereinafter cited as ABF STUDY]. The National Institute of Mental Health has estimated the cost of mental illness in the United States for 1974 to be at least \$36.786 billion. See NATIONAL INSTITUTE OF MENTAL HEALTH, STATISTICAL NOTE 125, THE COST OF MENTAL ILLNESS I (DHEW Pub. No. (ADM) 76-158, 1976).

Published mental health statistics tend to underestimate the prevalence of mental illness due to the reluctance of many persons to acknowledge mental disabilities. For this same reason it is believed that at least 50% of all visits to internists, pediatricians,

bases for the state's civil commitment power, particularly the *parens patriae* rationale sanctioning involuntary hospitalization of mentally ill individuals in need of treatment. It is under this rationale that some courts have embraced the concept of a right to treatment in a long overdue effort to extend minimal constitutional rights and safeguards to the mentally ill. The right to treatment denotes the affirmative obligation of the state to provide adequate treatment in order to justify the involuntary confinement of mentally ill persons for therapeutic purposes. In this sense, however, the *O'Connor* decision does not create a right to treatment, since the duty imposed on the state is a negative one—that of release in the absence of treatment. *O'Connor* established only that the provision of some treatment is *necessary* to justify confinement of those nondangerous mentally ill persons who are capable of caring for themselves outside an institution.

Although this due process limitation on state power is of unquestionable significance, this note will explore the more far-reaching question of whether adequate treatment is *sufficient* to justify involuntary confinement of nondangerous persons able to provide or obtain care for themselves. Based on an evaluation of the competing state and individual interests inherent in the civil commitment process it concludes that a functional, nondangerous person may not be confined for enforced psychiatric treatment.

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and general practitioners result from psychological and emotional rather than from physical illness. READINGS IN LAW AND PSYCHIATRY 12 (rev. ed. R. Allen, E. Ferster, & J. Rubin eds. 1975).

*O'Connor* most directly affects those patients who receive inpatient care. In 1973, the number of resident patients in state and county mental hospitals in the United States was estimated as 119.4 per 100,000 population. See NATIONAL INSTITUTE OF MENTAL HEALTH, STATISTICAL NOTE 113, STATE TRENDS IN RESIDENT PATIENTS—STATE AND COUNTY MENTAL HOSPITALS 6 (DHEW Pub. No. (ADM) 75-158, 1975). Yet the number of patients under custodial care has decreased by 50% between 1964 and 1973, especially in the 45- to 54-year-old age group. See NATIONAL INSTITUTE OF MENTAL HEALTH, STATISTICAL NOTE 112, CHANGES IN THE AGE, SEX, AND DIAGNOSTIC COMPOSITION OF THE RESIDENT POPULATION OF STATE AND COUNTY MENTAL HOSPITALS UNITED STATES 1964-1973 1 (DHEW Pub. No. (ADM) 75-158, 1975). Inpatients of state and county mental hospitals comprise only a portion of the total number of persons in the United States who receive custodial care.

Data are not generally available on the legal status of patients admitted to community mental health centers, private mental hospitals, psychiatric units of general hospitals, and residential treatment facilities for emotionally disturbed children. See Marker, *How Many Kenneth Donaldsons Are There?*, MENTAL HEALTH L. PROJ. SUMMARY OF ACTIVITIES, Sept., 1975, at 18. Thus it has been surmised that the number of involuntary patients in the United States may be many times larger than that estimated by the National Institute of Mental Health. *Id.*

## I. CIVIL COMMITMENT UNDER THE *PARENS PATRIAE* RATIONALE: EVOLUTION OF THE "RIGHT TO TREATMENT"

Traditionally, two bases have been advanced to justify civil commitment of the mentally ill: state exercise of its police power and state action as *parens patriae*.<sup>10</sup> The police power rationale is invoked whenever a mentally ill person deemed dangerous to others is preventively detained for the protection of society,<sup>11</sup> thereby subordinating individual liberty to state interests. In comparison, involuntary commitment by the state in its role as *parens patriae* is designed to promote the best interests of incompetent persons who fail to seek hospitalization on their own.<sup>12</sup> The state's *parens patriae* commitment power typically extends to those mentally ill adjudged either "in need

10. See *Jackson v. Indiana*, 406 U.S. 715, 737 (1972). See also ABF STUDY 36; Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 MO. L. REV. 215, 220-22 (1975); Schwartz, *supra* note 3, at 817-19. See generally Comment, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288 (1966).

For a comprehensive overview of the statutory mental hygiene provisions of the 50 states and the District of Columbia, see B. ENNIS & L. SIEGEL, *THE RIGHTS OF MENTAL PATIENTS* app. A, at 93-282 (1973) [hereinafter cited as ENNIS & SIEGEL]. See also Comment, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1203-04 (1974) [hereinafter cited as *Developments*].

11. Several courts have relied on the police power rationale. See *In re Ballay*, 482 F.2d 648, 658 (D.C. Cir. 1973); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974). See also ENNIS & SIEGEL 20-23; Livermore, Malmquist, & Meehl, *On the Justifications for Civil Commitment*, 117 PA. L. REV. 73, 81 (1968) [hereinafter cited as Livermore, Malmquist, & Meehl]; Postel, *Civil Commitment: A Functional Analysis*, 38 BROOKLYN L. REV. 1, 28-29 (1971). See generally Schreiber, *Indeterminate Therapeutic Incarceration of Dangerous Criminals: Perspectives and Problems*, 56 VA. L. REV. 602 (1970).

12. The state as *parens patriae* (literally, "father of the country") functions as the guardian of persons unable to act in their own behalf due to various legal disabilities, including infancy and mental incompetency. See *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972). See generally Horstman, *supra* note 10, at 221-22; Postel, *supra* note 11, at 30-37.

The authority of the state to commit individuals based on their need for care or treatment is commonly traced to *In re Oakes*, 8 L. RPTR. 122, 125 (Mass. 1845) in which the court suggested that an insane person could be deprived of his liberty when "restraint [was] necessary for his restoration, or [would] be conducive thereto." For a discussion of the common law history of the state's conduct towards the mentally disabled in its role as *parens patriae*, see *Developments* 1207-22. One commentator has remarked:

The paucity of legal critiques in the *parens patriae* area is well illustrated by the continued reliance upon this lone and ambiguous case [*In re Oakes*] as a landmark decision in the growth of therapeutic commitment powers.

N. KITTRIE, *THE RIGHT TO BE DIFFERENT* 66 n.63 (1971).

## Civil Commitment

of care, maintenance and treatment”<sup>13</sup> or “dangerous to themselves.”<sup>14</sup> Since the underlying motivation for the state’s exercise of its *parens patriae* authority is benevolent concern for the individual, the state’s non-adversarial posture in civil commitment proceedings has served to justify disregard for procedural and substantive constitutional safeguards.<sup>15</sup>

Although the consequences to the individual of involuntary commitment are virtually identical to those of the criminal process—loss of liberty, indeterminate period of detention, and social stigma<sup>16</sup>—

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13. See ENNIS & SIEGEL 23–26; Comment, *Civil Commitment of the Mentally Ill: Theories and Procedures*, *supra* note 10, at 1295–97. See also Livermore, Malmquist, & Meehl 83. Need for treatment as a legitimate basis for civil commitment rarely has been challenged, leading the Supreme Court to observe that “it is . . . remarkable that the substantive constitutional limitations on this power have not been more frequently litigated.” *Jackson v. Indiana*, 406 U.S. 715, 737 (1972).

14. See, e.g., WASH. REV. CODE § 71.05.210 (1974) (likelihood of serious harm to self). See also Comment, *Civil Commitment of the Mentally Ill: Theories and Procedures*, *supra* note 10, at 1293–95; Postel, *supra* note 11, at 57. See generally Livermore, Malmquist, & Meehl 83.

15. The deficiency of civil commitment legislation in this regard has not gone unnoticed by the judiciary. In *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), the court remarked:

State commitment procedures have not, however, traditionally assured the due process safeguards against unjustified deprivation of liberty that are accorded those accused of crime. This has been justified on the premise that the state is acting in the role of *parens patriae*, and thus depriving an individual of liberty not to punish him but to treat him.

There are indications, however, that *parens patriae* reasoning is no longer acceptable as a justification for relaxed procedural protections. See *Kent v. United States*, 383 U.S. 541, 555 (1966) (state’s *parens patriae* authority is not an “invitation to procedural arbitrariness”). For a survey of procedural due process rights in the civil commitment area, see Comment, *Progress in Involuntary Commitment*, 49 WASH. L. REV. 617, 632–40 (1974) (notice and opportunity to be heard, right to counsel, right to jury trial, burden of proof, right to be proceeded against by rules of evidence, and privilege against self-incrimination discussed).

16. See *In re Ballay*, 482 F.2d 648, 649–50 (D.C. Cir. 1973). See also Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 101 (1967). Judicial opinions regarding due process rights may vary depending on how closely the mental health institution under discussion resembles a penal institution. See generally 1 PLI MENTAL HEALTH LAW PROJECT, LEGAL RIGHTS OF THE MENTALLY HANDICAPPED (B. Ennis & P. Friedman eds. 1973).

In many respects the consequences of civil commitment approximate criminal sanctions: denial of written communication, visitation privileges, and compensation for work. See ABF STUDY 155. Further, involuntary hospitalization for mental illness is potentially more onerous than imprisonment due to the intrusive nature of certain treatment practices. In particular, mental hospital rules often authorize electroshock (ECT) treatment, psychosurgery, and chemotherapy. See Schwartz, *supra* note 3, at 812–17. State statutes may fail to impose limits on the hospital’s use of mechanical restraints, insulin coma therapy (ICT), or solitary confinement. See ENNIS & SIEGEL 67–74. *But see* WASH. REV. CODE § 71.05.370 (1974). Worse still, patients may lack the legal right to refuse eugenic sterilization. See generally Comment, *Rights of the Mentally Ill—Involuntary Sterilization—Analysis of Recent Statutes*, 78 W. VA. L. REV. 131 (1975–76). One commentator has contended: “[T]o say that we shall treat

the characterization of the proceedings as civil rather than criminal tends to obscure the fact that the individual's freedom is at stake irrespective of the label attached to the confinement.<sup>17</sup> Such semantic niceties typify prior judicial deference to society's control of its deviant members, often in derogation of the individual's rights. A trend

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him in a 'mental hospital' is to ignore the simple fact that, from the 'patient's' point of view, involuntary 'hospitalization' is imprisonment, and involuntary treatment is torture." Szasz, *The Sane Slave: Social Control and Legal Psychiatry*, 10 AM. CRIM. L. REV. 337, 355 (1972).

Certain other legal disabilities attend civil commitment, including loss of personal possessions and incompetency to manage property. See ENNIS & SIEGEL 65-66, 74-77. One court stated:

It is certainly true that many people, maybe most, could benefit from some sort of treatment at different periods in their lives. However, it is not difficult to see that the rational choice in many instances would be to forego treatment, particularly if it carries with it the stigma of incarceration in a mental institution, with the difficulties of obtaining release, the curtailment of many rights, the interruption of job and family life, and the difficulties of attempting to obtain a job, drivers license, etc. upon release from the hospital.

*Lessard v. Schmidt*, 349 F. Supp. 1078, 1091 (E.D. Wis. 1972), vacated on other grounds, 414 U.S. 473 (1974). See also *Developments* 1193, 1198-1200.

Besides the greater legal disabilities which attend civil commitment as compared to imprisonment, living conditions in most state prisons are preferable to those in state mental institutions which often fail to provide even the most basic amenities. See Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616, 642 (1972); See also notes 85-87 and accompanying text *infra*.

17. In *Specht v. Patterson*, 386 U.S. 605, 608 (1967), involving the procedural deficiencies of a state sex offender statute, the Supreme Court disregarded the civil-criminal label, ruling that "commitment proceedings whether denominated civil or criminal are subject both to the Equal Protection Clause of the Fourteenth Amendment . . . and to the Due Process Clause" (citation omitted).

In the context of juvenile proceedings the civil-criminal dichotomy has been repudiated as a determinant of procedural due process requirements. In *In re Gault*, 387 U.S. 1, 50 (1967), the Court ruled that alleged delinquents were entitled to many of the same constitutional protections afforded to criminals, since ". . . commitment is a deprivation of liberty. It is incarceration against one's will, whether it is called 'criminal' or 'civil.'" *Accord, In re Winship*, 397 U.S. 358, 365-66 (1970) (requiring proof beyond a reasonable doubt in juvenile delinquency proceedings since civil labels and good intentions do not themselves obviate the need for criminal due process safeguards in juvenile courts). See also *Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968), in which the issue before the court was whether a mentally deficient person has a due process right to counsel when involuntarily committed to a state institution. The court observed:

It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process.

*Accord, Schwitzgebel, Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria*, 8 HARV. CIV. RIGHTS-CIV. LIB. L. REV. 513, 514 (1973) (labeling commitment "civil" should not disguise the severe deprivations of liberty imposed by the state). See generally Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, *supra* note 16, at 100-01.



toward increased judicial activism is emerging, however, in reaction to evidence of the deplorable conditions common in state mental institutions.<sup>18</sup> The judicial demand for governmental accountability underlies the body of case law known under the rubric of the "right to treatment."

### A. Statutory Right to Treatment

The proposition that an involuntarily committed person is entitled to receive treatment at state expense as a necessary concomitant of confinement was first advanced in 1960.<sup>19</sup> Judicial recognition of this so-called right to treatment followed six years later in the landmark

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18. See, e.g., *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *hearing on standards ordered*, 334 F. Supp. 1341 (M.D. Ala. 1971), *enforced*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). The Alabama institution involved conceded its failure to meet the three minimum conditions for adequate treatment established by the court: (1) a humane psychological and physical environment; (2) adequate staffing; and (3) individualized treatment programs. 503 F.2d at 1310-11.

The reality of institutional conditions cannot support confinement premised on the benefits of hospital care. See Comment, *Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633, 659 (1967). In *Jackson v. Indiana*, 406 U.S. 715, 734-35 n.17 (1972), the Court commented that there are "substantial doubts about whether the rationale for pretrial commitment—that care and treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions." See also ABF STUDY 418.

In 1961, no public mental hospital met the minimum staffing standards established by the American Psychiatric Association as "necessary for a public mental hospital to provide even the lowest level of acceptable care." Brief for American Psychiatric Association as Amicus Curiae in Support of the Grant of Certiorari at 4-5, *O'Connor v. Donaldson*, 422 U.S. 563 (1975). Recent data indicate that nationwide staff-to-patient ratios have improved primarily due to right to treatment litigation brought against state mental hospitals. See NATIONAL INSTITUTE OF MENTAL HEALTH, STATISTICAL NOTE 122, STAFFING OF STATE AND COUNTY MENTAL HOSPITALS: UNITED STATES, 1974, at 4 (DHEW Pub. No. (ADM) 76-158, 1975) (statistical study of mental hospital staffing levels in each of the 50 states). One commentator sees dangers with the notion of minimum standards, arguing that hospitals able to satisfy such standards (e.g., minimum staff-to-patient ratios) may still fail to provide an individual patient with adequate treatment. See Twerski, *Debate: The Right to Treatment—Encounter and Synthesis*, 10 DUQUESNE L. REV. 554, 563 (1972).

19. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499, 503 (1960):

It is proposed in this article that 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 . . . 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; that the courts do this by means of recognizing and enforcing the right to treatment; and, that the courts do this, independent of any action by any legislature, as a necessary and overdue development of our present concept of due process of law.

Birnbaum's seminal article was promptly endorsed by the American Bar Association. Editorial, *A New Right*, 46 A.B.A.J. 516 (1960).

case of *Rouse v. Cameron*,<sup>20</sup> in which the Court of Appeals for the District of Columbia premised such a right on statutory<sup>21</sup> prescription. The petitioner in *Rouse* requested habeas corpus relief based upon the District's failure to provide treatment subsequent to his criminal commitment. The court interpreted the statute on which it relied to require release of involuntarily hospitalized patients not receiving adequate treatment.<sup>22</sup> Compliance with this judicially-construed mandate was measured in terms of the hospital's good faith efforts toward effecting a cure, rather than the success of the treatment administered.<sup>23</sup> The significance of *Rouse* rests largely on the court's consider-

20. 373 F.2d 451 (D.C. Cir. 1966). A few cases prior to *Rouse* alluded to the possibility of a constitutional or statutory right to treatment. See cases cited in *Developments* 1322 n.26. The Court of Appeals for the District of Columbia Circuit has been presented with numerous opportunities to reaffirm the statutory basis for the right to treatment, and to outline the contours of the right. See *In re Curry*, 452 F.2d 1360 (D.C. Cir. 1971) (patient civilly committed for emergency observation and diagnosis is entitled to same as an essential preliminary step to providing treatment); *Dobson v. Cameron*, 383 F.2d 519 (D.C. Cir. 1967) (Burger, J., concurring) (review limited to the issue of whether any treatment was provided by the state); *Tribby v. Cameron*, 379 F.2d 104 (D.C. Cir. 1967) (review of hospital's treatment program limited to whether it was reasonable); *Millard v. Cameron*, 373 F.2d 468 (D.C. Cir. 1966) (indefinite commitment under sexual psychopath law is justified only if suitable treatment is provided despite lack of staff or facilities).

21. 373 F.2d at 453-54. The court interpreted the 1964 Hospitalization of the Mentally Ill Act to provide for treatment. The Act provides in pertinent part: "A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment." D.C. CODE ANN. § 21-562 (1973) (patterned after the Draft Act). See NATIONAL INSTITUTE OF MENTAL HEALTH, FEDERAL SECURITY AGENCY, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL (Public Health Service Pub. No. 51, 1952), reprinted in ABF STUDY, app. A, at 454-73. Most state statutes protecting a patient's entitlement to treatment are similar to the Draft Act. See, e.g., WASH. REV. CODE § 71.05.360(2) (1974) which provides: "Each person involuntarily detained or committed pursuant to this chapter shall have the right to adequate care and individualized treatment."

The *Rouse* court's interpretation of the provisions of the 1964 Hospitalization of the Mentally Ill Act is supported by the Act's legislative history. For example, Senator Ervin, the Senate bill's sponsor, stated its purpose in terms of a right to treatment:

Several experts advanced the opinion that to deprive a person of liberty on the basis that he is in need of treatment, without supplying the needed treatment, is tantamount to a denial of due process. [The Senate bill] embodies provisions which will ameliorate this problem whereas existing law makes no provisions for safeguarding this right.

*Hearings on a Bill to Protect the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 88th Cong., 1st Sess., at 12 (1963), cited in *Rouse v. Cameron*, 373 F.2d 451, 455 (D.C. Cir. 1966).

22. 373 F.2d at 457.

23. *Id.* at 456. *Accord*, *In re Jones*, 338 F. Supp. 428, 429 (D.D.C. 1972):

[T]his court may not decide whether the Hospital has made the best possible decision, but only that it has made a permissible decision based on relevant information and within the broad range of discretion given to the Hospital administrator. . . . This court's review of the Hospital's treatment plan is, therefore, of a very

able dicta suggesting alternative constitutional sources of the right to treatment, specifically the eighth amendment's prohibition against cruel and unusual punishment<sup>24</sup> as well as the equal protection<sup>25</sup> and due process<sup>26</sup> clauses of the fourteenth amendment.

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limited nature. This court has neither the expertise nor the inclination to become the administrator of Saint Elizabeths Hospital.  
338 F. Supp. at 429 (citations omitted).

24. 373 F.2d at 453. The eighth amendment's proscription of cruel and unusual punishment has been relied on as an independent doctrinal basis for a constitutional right to treatment. *See Welsch v. Likins*, 373 F. Supp. 487, 496-97 (D. Minn. 1974) (class action on behalf of mentally retarded state patients to enforce a right to treatment under 42 U.S.C. § 1983 (1970)). *See also In re Ballay*, 482 F.2d 648, 659-60 (D.C. Cir. 1973) (dictum). The rationale is derived from *Robinson v. California*, 370 U.S. 660 (1962), in which the Court held that confinement of a person for the crime of being a narcotic addict constitutes punishment for a status in violation of the eighth amendment. The argument has been advanced that the absence of treatment converts a hospital into a prison, resulting in punishment for the status of being mentally ill. Since the mentally ill individual is not guilty of a crime, treatment is the only legitimate purpose for the state's exercise of its commitment power. *Cf. Knecht v. Gillman*, 488 F.2d 1136, 1139 (8th Cir. 1973) ("mere characterization of an act as 'treatment' does not insulate it from eighth amendment scrutiny"). *But cf. Powell v. Texas*, 392 U.S. 514 (1968) (conviction for crime of public drunkenness not held to be punishment for a status in violation of the eighth amendment). *See generally Developments* 1330-33; Comment, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282, 1291-93 (1973) [hereinafter cited as Comment, *Wyatt v. Stickney*]; *Martarella v. Kelley*, 349 F. Supp. 575, 599 (S.D.N.Y. 1972), *enforced*, 359 F. Supp. 478, 481 (S.D.N.Y. 1973); *Commonwealth v. Page*, 339 Mass. 313, 317, 159 N.E.2d 82, 85 (1959) ("It is not sufficient that the Legislature announce a remedial purpose if the consequences to the individual are penal.").

25. 373 F.2d at 453, 459. There are two lines of argument supporting the equal protection basis for a right to treatment. First, since civil commitment either encroaches on fundamental liberties, or is based on a suspect classification (mental illness), or both, a compelling state interest must be established if the statute as applied is to survive the strict scrutiny of the court. *See Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1161-62 (1972) [hereinafter cited as *Chambers*]; Note, *Mental Illness: A Suspect Classification?*, 83 YALE L.J. 1237, 1239-45 (1974). *See also Developments* 1329 n.53 (although mental illness is not a suspect classification, strict scrutiny is nevertheless appropriate since fundamental liberties are at stake).

The second line of argument is that civil commitment legislation must be reasonably calculated to achieve its purpose of rehabilitation through treatment. *See Sas v. Maryland*, 334 F.2d 506, 514 (4th Cir. 1964), *cert. dismissed as improvidently granted*, 407 U.S. 355 (1972) (the confinement of defective delinquents for indeterminate sentences while persons not so labeled receive determinate sentences for the same crimes is rationally related to a legitimate governmental goal); *Director of Patuxent Institution v. Daniels*, 243 Md. 16, 221 A.2d 397, 411, *cert. denied*, 385 U.S. 940 (1966). *See generally* Comment, *Wyatt v. Stickney* 1293-95.

26. Constitutional due process is rooted in the concept of fundamental fairness: Due process is that which comports with the deepest notions of what is fair and right and just. . . . In applying such a large, untechnical concept as "due process," the Court enforces those permanent and pervasive feelings of our society as to which there is compelling evidence of the kind relevant to judgments on social institutions.

*Solesbee v. Balkcom*, 339 U.S. 9, 16 (1950) (Frankfurter, J., dissenting).

## B. Constitutional Right to Treatment

The first federal court decision<sup>27</sup> to base the right to treatment on constitutional grounds<sup>28</sup> was the 1971 case of *Wyatt v. Stickney*,<sup>29</sup> a class action suit on behalf of all civilly committed Alabama state mental patients.<sup>30</sup> The court relied on the fourteenth amendment for its view that "[t]o deprive any citizen of his or her liberty upon

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At various periods in the Supreme Court's history, substantive due process has been disfavored as a device used by the judiciary to substitute its own social and economic beliefs for legislative ones. *See, e.g.*, *Ferguson v. Skrupa*, 372 U.S. 726, 729-31 (1963). Recently, however, there is evidence of the renewed popularity of substantive due process. *See, e.g.*, *Roe v. Wade*, 410 U.S. 113 (1973), in which the Court limited the permissible scope of state criminal abortion laws.

In *Minnesota ex rel. Pearson v. Probate Court*, 309 U.S. 270, 276-77 (1940), the Court discussed the due process rights of the allegedly mentally ill:

We fully recognize the danger of a deprivation of due process in proceedings dealing with persons charged with insanity . . . and the special importance of maintaining the basic interests of liberty in a class of cases where the law though "fair on its face and impartial in appearance" may be open to serious abuses in administration and courts may be imposed upon if the substantial rights of the persons charged are not adequately safeguarded at every stage of the proceedings. *Accord*, *Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973) (dictum) (civilly committed patients have a constitutional right to treatment since confining a person on the altruistic theory that he must receive treatment and then failing to provide it violates due process); *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 82, 85 (1959) (commitment of sex offenders comports with due process only if the remedial aspects of confinement have foundation in fact).

27. Prior to *Wyatt* some state courts had indicated their willingness to enforce the rehabilitative provisions of state nonpenal statutes by invoking constitutional due process constraints. In *Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 612, 233 N.E.2d 908, 913 (1968), the Supreme Judicial Court of Massachusetts stated that confinement of a person found incompetent to stand trial would raise an issue of deprivation of liberty without due process of law if treatment were not provided. *See also* *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 82, 85 (1959) (dictum) (sexual offender confinement in a penal institution violates his due process right to remedial treatment); *In re Maddox*, 351 Mich. 358, 88 N.W.2d 470, 475, 477-78 (1958) (dictum) (imprisonment of sexual psychopath committed for hospitalization and treatment contravenes the corrective purpose of the statute).

28. Basing the right to treatment on constitutional rather than statutory grounds precludes the legislative response that followed the Washington Supreme Court's decision in *Bresolin v. Morris*, 86 Wn. 2d 241, 543 P.2d 325 (1975). In *Bresolin*, the court construed WASH. REV. CODE § 69.32.090 (1974) to require that the petitioner be provided with prison facilities for treatment of his drug addiction despite the lack of funding for such a rehabilitative program. The Washington State Legislature's reaction was to repeal the statutory provisions at issue in the case, thereby eliminating the basis for an inmate's right to treatment for addiction. Ch. 103, § 3, [1976] Wash. Laws, 2d Ex. Sess.

29. 325 F. Supp. 781 (M.D. Ala.), *hearing on standards ordered*, 334 F. Supp. 1341 (M.D. Ala. 1971), *enforced*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part, modified in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). For more detailed analyses of the implications of *Wyatt* see Drake, *Enforcing the Right to Treatment: Wyatt v. Stickney*, 10 AM. CRIM. L. REV. 587 (1972); Comment, *Wyatt v. Stickney*.

30. Plaintiffs in *Wyatt* also included residents of the state institutions for the mentally retarded.

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the altruistic theory that confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process."<sup>31</sup> Treatment was presumed to be the only constitutional justification for involuntary civil commitment. The *Wyatt* court conceived of adequate treatment in broader terms than those formulated in *Rouse*, however, defining such treatment as that which would give a patient a "realistic opportunity to be cured or to improve his or her mental condition."<sup>32</sup> Aided by the litigants and *amici*, the court specified minimum treatment standards it considered judicially enforceable.<sup>33</sup>

*Wyatt* and other right to treatment decisions<sup>34</sup> generated extensive commentary,<sup>35</sup> largely concerned with uncontroverted evidence of

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31. 325 F. Supp. at 785.

32. *Id.* at 784.

33. 344 F. Supp. at 377. The standards promulgated by the *Wyatt* court encompass such diverse aspects of hospitalization as proper staff/patient ratios, individualized treatment programs, and the right to privacy. See also note 18 *supra*. As in *Wyatt*, the court in New York Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973), on *submission of proposed standards*, New York Ass'n for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975), relied on a review panel to implement the court order in favor of the plaintiffs' right to protection from harm. See also *Davis v. Watkins*, 384 F. Supp. 1196, 1206-12 (N.D. Ohio, 1974) in which the court appointed a special master to enforce a detailed order setting forth the right of patients to individualized treatment plans, protection of their personal possessions, privacy, and improved diet and accommodations.

Although the judiciary should be reluctant to assume the administration of state agencies, especially when such intervention requires the appropriation of funds, judicial interference is often mandated to vindicate constitutional rights. For a discussion of such court action in the areas of public schools, housing, and the political process, see Comment, *Wyatt v. Stickney* 1300. Cf. *Holt v. Sarver*, 442 F.2d 304 (8th Cir. 1971); *Gates v. Collier*, 349 F. Supp. 881 (N.D. Miss. 1972) (setting minimum standards for prisons).

34. The right to treatment has been extended to persons committed under non-penal statutes for purposes of treatment: (a) *juvenile delinquents*: *Nelson v. Heyne*, 355 F. Supp. 451, 459 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352, 360 (7th Cir. 1974); *Morales v. Turman*, 364 F. Supp. 166, 175 (E.D. Tex. 1973); (b) "*persons in need of supervision*": *Martarella v. Kelley*, 349 F. Supp. 575, 585 (S.D.N.Y. 1972), *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1973); (c) *sexual offenders and defective delinquents*: *Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973); *Gomes v. Gaughan*, 471 F.2d 794, 800 (1st Cir. 1973); *Director of Patuxent Institution v. Daniels*, 243 Md. 16, 221 A.2d 397, *cert. denied*, 385 U.S. 940 (1966); (d) *persons incompetent to stand trial*: *United States v. Pardue*, 354 F. Supp. 1377, 1382 (D. Conn. 1973); *United States v. Walker*, 335 F. Supp. 705, 708 (N.D. Cal. 1971); *Maatallah v. Warden*, 86 Nev. 430, 470 P.2d 122 (1970).

A right to treatment for civilly committed patients was rejected in *Burnham v. Department of Public Health*, 349 F. Supp. 1335, 1339 (N.D. Ga. 1972), *rev'd and remanded*, 503 F.2d 1319 (5th Cir. 1974), *cert. denied*, 422 U.S. 1057 (1975). The *Burnham* court stated that it "find[s] no legal precedent for [a right to treatment] and to the contrary finds persuasive authority compelling an opposite conclusion." 349 F. Supp. at 1339 (footnote omitted).

35. See notes 71-73 *infra*.

the gross inadequacies of state institutions. Although generally supportive of increased judicial activism in the civil commitment area, legal scholars anticipated difficulties with implementation of the new right.<sup>36</sup> In particular, court decrees indirectly necessitating additional appropriations to state institutions have been attacked by commentators as judicial usurpation of state legislative functions.<sup>37</sup> Moreover, a recognition of a right to treatment involves defining such terms as mental illness,<sup>38</sup> dangerousness,<sup>39</sup> and adequacy of treatment.<sup>40</sup> The judi-

36. See generally Drake, *supra* note 29; Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755 (1969); Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936 (1974).

Although Donaldson, as a Christian Scientist, on occasion had refused to accept medication, the right to refuse treatment was not at issue in *O'Connor* because damages were not assessed for any period of confinement during which the plaintiff declined treatment. 422 U.S. at 569 n.4.

37. See generally Morris, *Institutionalizing the Rights of Mental Patients: Committing the Legislature*, 62 CALIF. L. REV. 957 (1974) [hereinafter cited as Morris]; Comment, *Enforcement of Judicial Financing Orders: Constitutional Rights in Search of a Remedy*, 59 GEO. L.J. 393 (1970). See also *Developments* 1321 n.18.

38. Although civil commitment legislation commonly employs language of mental illness, the utility of psychiatric terminology for legal purposes is questionable. One commentator has noted:

Many judges and legislators fail to realize that "mental illness" no longer has an accepted psychiatric meaning. Thus courts inadvertently let each testifying psychiatrist listen to his own drummer in defining what the law means by "mental disease." In turn, psychiatric witnesses often assume that "mental disease" is a legal term since they know it has no accepted medical meaning. Since the court does not define it, each such witness assigns his own particular legal meaning to the term. Other psychiatric witnesses attempt to translate "mental disease" into psychiatric jargon, variously assuming that under the law "mental disease" means anything from psychosis to a personality disorder such as antisocial personality. The lack of consensus follows from the absence of accepted psychiatric guidelines.

The result is a random determination of who is legally "mentally ill."

Hardisty, *Mental Illness: A Legal Fiction*, 48 WASH. L. REV. 735, 739 (1973). A study of involuntary mental hospitalization proceedings of the Wayne County Probate Court in Michigan lends further support to the arbitrariness of psychiatric labeling. Statistical analysis of the diagnoses of the court psychiatrists revealed little or no homogeneity in the classifications of symptoms accorded to a diagnosed illness—the average number of diseases inferred from each symptom was 12.9. Comment, *The Language of Involuntary Mental Hospitalization: A Study in Sound and Fury*, 4 MICH. J.L. REF. 195, 204 (1970).

Further, diagnostic designations were found to depend heavily on the predispositions of the particular psychiatrist. Although Dr. A made only 25% of the total diagnoses, he accounted for 56% of the 16 diagnoses of acute schizophrenia, 54% of the 48 diagnoses of paranoid schizophrenia, and 45% of the 20 diagnoses of depressive reaction. *Id.* at 205. The study concluded that medical diagnoses of mental illness relied on to justify involuntary civil commitment are achieved on the basis of invalid and unreliable diagnostic categories and assessments:

[U]nder prevailing circumstances, involuntary mental hospitalization is at least the inevitable temporary outcome of a process which allows the inference of practically any conceivable mental disease on the basis of practically any conceivable symptom-configuration. It should follow, then, that involuntary civil commitment of the mentally ill, premised on diagnostic labels of such questionable reliability and validity, is without sufficient legal justification and should be considered a

ciary would also be forced to determine the extent to which the individual's right to refuse treatment is a correlative of the right to treatment.<sup>41</sup>

Despite the foregoing problems, the Court of Appeals for the Fifth Circuit announced the existence of a constitutional right to treatment

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deprivation of liberty without due process of law in violation of the Fifth and Fourteenth Amendments.

*Id.* at 209-10.

Other commentators have recognized that the definition of mental illness largely reflects the norms of adjustment that the user employs. It has been suggested that "because of the unavoidably ambiguous generalities in which the American Psychiatric Association describes its diagnostic categories, the diagnostician has the ability to shoe-horn into the mentally diseased class almost any person he wishes, for whatever reason, to put there." Livermore, Malmquist, & Meehl 80.

39. By labeling Donaldson "nondangerous" the Supreme Court implicitly recognizes the significance of the term as a statutory criterion for civil commitment. *See, e.g.,* WASH. REV. CODE § 71.05.230 (1974) (defined in terms of presenting a likelihood of serious harm to others). *See also* note 11 *supra*. Legislatures and courts uniformly place great reliance on the ability of psychiatrists or comparable mental health professionals to identify dangerous individuals. This presumption of psychiatric expertise persists despite the consensus of professional literature challenging the reliability and validity of psychiatric evaluations and predictions. *See generally* Dershowitz, *The Law of Dangerousness: Some Fictions About Predictions*, 23 J. LEGAL ED. 24 (1970-71); Rappeport, Lassen, & Hay, *A Review of the Literature on the Dangerousness of the Mentally Ill*, in *THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL* 72-79 (J. Rappeport ed. 1967). Statistical research designed to measure the supposed ability of psychiatrists to predict future dangerousness belies the existence of such expertise. *See* Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972); Rappeport, *Dangerousness and the Mentally Ill Criminal*, 21 S.C.L. REV. 23 (1968). One group of researchers concluded:

[T]here has been no successful attempt to identify [from among known offenders or known violent offenders] a subclass whose members have a greater-than-even chance of engaging again in an assaultive act. The best prediction available today, for even the most refined set of offenders, is that any particular member of that set *will not* become violent. . . .

Wenk, Robison, & Smith, *Can Violence Be Predicted?*, 18 CRIME & DELINQUENCY 393, 394 (1972) (emphasis in original). For an exhaustive survey of this subject see Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974).

In an effort to objectify predictions of dangerousness, some courts have ruled that involuntary civil commitment based on the potential dangerousness of the individual must rest on the commission of a specific act or threat. *See, e.g.,* Lynch v. Baxley, 386 F. Supp. 378, 391 (M.D. Ala. 1974) (confinement justified only upon a showing of overt dangerous acts committed by the individual). Other courts have increased the burden of proof required to establish "dangerousness" for purposes of commitment. *See In re Levias*, 83 Wn. 2d 253, 517 P.2d 588 (1973) ("clear, cogent, and convincing" construed to require proof beyond a reasonable doubt).

40. *Compare* Rouse v. Cameron, 373 F.2d 451, 456 (D.C. Cir. 1966) (adequate treatment requires merely a bona fide effort to effect a cure) with Wyatt v. Stickney, 325 F. Supp. 781, 785 (M.D. Ala.), *hearings on standards ordered*, 334 F. Supp. 1341 (M.D. Ala. 1971), *enforced*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part, modified in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) (adequate treatment defined as such individual treatment as will give each patient a realistic opportunity to be cured or to improve his or her mental condition).

41. *See generally* Schwartz, *supra* note 3; Comment, *Advances in Mental Health: A Case for the Right to Refuse Treatment*, 48 TEMPLE L.Q. 354 (1975).

in *Donaldson v. O'Connor*.<sup>42</sup> In so doing, the court in dictum extended the right to those mentally ill persons committed as dangerous pursuant to the state's police power, as well as to those patients confined pursuant to the state's *parens patriae* authority.<sup>43</sup> The court declared that, although the state has no duty to care for its incompetent citizens, if it voluntarily assumes such an obligation the patient has a right to demand that the state provide adequate treatment.<sup>44</sup> Significantly, the court did not challenge the state's authority to involuntarily commit nondangerous mentally ill persons for enforced therapy. In fact, the court sanctioned the state's exercise of its civil commitment powers so long as it provided the quid pro quo<sup>45</sup> of treatment to compensate the patient for his loss of liberty. The failure of the state to fulfill this hypothetical patient-state bargain led the court to award the plaintiff damages for violation of his right to treatment.

## II. THE REASONING OF THE O'CONNOR COURT

Narrowing the circuit court of appeals' expansive disposition of the case,<sup>46</sup> the Supreme Court stated that *O'Connor* raised "a single, relatively simple, but nonetheless important question concerning every

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42. 493 F.2d 507 (5th Cir. 1974).

43. *Id.* at 521-22.

44. *Id.* at 520.

45. The court of appeals formulated a due process right to treatment based on the principle that the government's power to detain is limited, i.e., detention must be in retribution for a specific offense, limited to a fixed term, and permitted only after proceedings in which procedural safeguards are observed. When these limitations on state power are absent, the court would require the state to furnish rehabilitative treatment as a quid pro quo to justify an individual's confinement. *Id.* at 522. Relying on the quid pro quo theory, the court extended the benefits of a right to treatment to persons committed under police power as well as *parens patriae* rationales. *Id.* at 521. The quid pro quo rationale for civil commitment is subject to criticism on a number of grounds. The analysis allows the state to assert that procedural safeguards are not necessary so long as adequate treatment is in fact provided. See *Developments* 1325-26 n.39. In his concurring opinion in *O'Connor v. Donaldson*, Chief Justice Burger expressly disapproved of the appellate court's quid pro quo theory, criticizing it as a "trade-off" that "would elevate a concern for essentially procedural safeguards into a new substantive right." 422 U.S. at 587.

46. The Supreme Court implicitly disapproved of the Fifth Circuit's extension of its holding to those mentally ill committed as dangerous pursuant to the state's police power, as well as appellate court dictum sanctioning confinement of the harmless mentally ill solely to provide treatment. 422 U.S. at 572-73, 577-78 n.12. See note 45 and accompanying text *supra*. Thus the Supreme Court did not reach many of the issues which were addressed by the Fifth Circuit court:

We have concluded that the difficult issues of constitutional law dealt with by the Court of Appeals are not presented by this case in its present posture. Specifically, there is no reason now to decide whether mentally ill persons dangerous



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man's constitutional right to liberty."<sup>47</sup> Having thus identified the individual interest at stake, the Court next entertained possible state justifications for the plaintiff's confinement.<sup>48</sup> Based on the jury's finding that Donaldson was neither dangerous to himself nor to others, the Court summarily dismissed the defendant's efforts to rely on state police power to justify the plaintiff's continued detention.<sup>49</sup> Similarly, the state's failure to provide treatment nullified its attempts to invoke its *parens patriae* authority. The latter analysis is consistent with the Court's statement in *Jackson v. Indiana*<sup>50</sup> that "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purposes for which the individual was committed."<sup>51</sup>

After determining that treatment sufficient to justify the plaintiff's confinement must be provided by the state, the Court proceeded to evaluate the state's treatment program. Despite the defendant's contention that the issue of adequacy of treatment was nonjusticiable,<sup>52</sup>

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to themselves or to others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment.

422 U.S. at 573.

47. 422 U.S. at 573. *Accord*, *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) (commitment characterized as a "massive curtailment of liberty"); *In re Ballay*, 482 F.2d 648, 668 (D.C. Cir. 1973) (loss of liberty regarded as an interest of transcending value).

Freedom from physical restraint is inextricably intertwined with a number of other rights deemed fundamental, e.g., the right of privacy, the right to travel, the right to vote, and the right of association. See note 16 *supra*. Traditional due process analysis would require a compelling state interest to justify state action that infringes on fundamental rights. See, e.g., *Roe v. Wade*, 410 U.S. 113, 155 (1973); *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969).

48. 422 U.S. at 573. The Court observed that "even if [the plaintiff's] involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed." *Id.* at 575. The Court's statement suggests that states may have a duty to provide for periodic review of the asserted grounds for civil commitment orders.

49. *Id.* at 568.

50. 406 U.S. 715 (1972) (mentally defective person detained because of incompetency to stand trial could be held without a formal commitment hearing only for a reasonable period necessary to determine if improvement in his condition were possible).

51. *Id.* at 738.

52. 422 U.S. at 574 n.10. *Accord*, *Burnham v. Department of Public Health*, 349 F. Supp. 1335 (N.D. Ga. 1972), *rev'd*, 503 F.2d 1319 (5th Cir. 1974), *cert. denied*, *Department of Human Resources v. Burnham*, 422 U.S. 1057 (1975).

On a number of occasions, Chief Justice Burger has expressed his misgivings regarding judicial oversight of state institutions:

Although proceedings for commitment of mentally ill persons are not strictly adversary, a United States court in our legal system is not set up to initiate inquiries and direct studies of social welfare facilities or other social problems. *Lake v. Cameron*, 364 F.2d 657, 663 (D.C. Cir. 1966) (Burger, J., dissenting). See

the Court defined its responsibility to oversee psychiatric judgments where individuals' civil liberties are involved: "Where 'treatment' is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present."<sup>53</sup> In its discussion of the inadequacy of the treatment provided by the state, the Court evaluated the state's program of milieu therapy in terms of the standard on which the jury was instructed: whether it gave the patient a realistic opportunity to improve or to be cured.<sup>54</sup> The Court characterized the state's

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also *Dobson v. Cameron*, 383 F.2d 519, 523 (D.C. Cir. 1967) (Burger, J., concurring) ("I have grave doubts that we are qualified to oversee mental hospitals in cases of civil commitments . . ."). For a discussion of the problems with judicial supervision of state treatment programs, see Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, *supra* note 16, at 107-14. See also note 33 *supra*.

53. 422 U.S. at 574 n.10. *Accord*, Comment, *Wyatt v. Stickney* 1296-99 (adequacy of treatment is a justiciable issue).

54. 422 U.S. at 569. This definition of adequate treatment is not necessarily one the Court would adopt. See *id.* at 574 n.10. Since neither party objected to the jury instruction that defined treatment, the Court stated: "There is, accordingly, no occasion in this case to decide . . . how much or what kind of treatment would suffice" to justify involuntary confinement. *Id.*

55. Milieu therapy is the process of removing the patient from the community to the supposedly more beneficial setting of a mental hospital. The amorphous nature of milieu therapy makes it the easiest therapeutic claim for an institution to make and the most difficult one for a patient to refute. Consequently, the assertion that the patient has received the benefit of such treatment is frequently employed as a cover for hospital inaction. See Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782, 786-87 n.19 (1969).

In its most defensible form, milieu therapy provides a secure and supportive hospital environment intended to facilitate recovery by insulating the patient from his former living pattern. However, milieu therapy is not generally recognized as a legitimate treatment modality itself. Rather, it is designed to enhance the effectiveness of other therapies. See READINGS IN LAW AND PSYCHIATRY, *supra* note 9, at 806. See also Robitscher, *The Right to Psychiatric Treatment: A Socio-Legal Approach to the Plight of the State Hospital Patient*, 18 VILL. L. REV. 11, 16-17 (1972), stating that the concept of milieu therapy has been debased by apologists for inadequately staffed hospitals who maintain that the hospital setting is itself the treatment. Another commentator has cautioned that psychiatrists rely on medical jargon to create the impression that the hospital regime is of a therapeutic nature:

Regimentation may be defined as a framework of therapeutic regularity designed to allay insecurity; forced social mixing with a multitude of heterogeneous, displeased fellow inmates may be described as an opportunity to learn that there are others who are worse off. Sleeping dormitories are called wards, this being affirmed by some of the physical equipment, notably the beds, which are purchased through hospital suppliers. The punishment of being sent to a worse ward is described as transferring a patient to a ward whose arrangements he can cope with, and the isolation cell or "hole" is described as a place where the patient will be able to feel comfortable with his inability to handle his acting-out impulses. Making a ward quiet at night through the forced taking of drugs, which permits reduced night staffing, is called medication or sedative treatment.

E. GOFFMAN, *ASYLUMS* 380-81 (1961) (footnote omitted).

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purported treatment by milieu therapy<sup>55</sup> as a euphemism for a simple regime of enforced custodial care.<sup>56</sup>

Since the Court resolved the treatment issue against the defendant, the only remaining justification for the plaintiff's involuntary hospitalization was his alleged mental illness. Noting the doubtful validity of the term "mental illness" for legal purposes,<sup>57</sup> the Court observed:<sup>58</sup>

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

Once the Court had determined that mental illness *per se* was constitutionally deficient as a justification for involuntary detention, the finding that the plaintiff's constitutional rights had been violated readily followed. The defendant's personal liability for damages, however, was not finally resolved by the Court because of the possibility that his actions fell within the scope of governmental immunity.<sup>59</sup>

Although joining in the unanimous decision of the Court, Chief Justice Burger's separate concurring opinion indicated his unwillingness to impose substantive limitations on the state's exercise of its

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56. 422 U.S. at 569. Given that the purpose of the plaintiff's confinement was treatment, mere custodial care could not fulfill state commitment objectives. See *Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 233 N.E.2d 908, 910 (1968) (custodial care described as three meals a day and a bed). See also note 55 *infra*. In *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973), the court noted that no amount of custodial care justifies the deprivation of liberty since "[w]ithout some form of treatment the state justification for acting as *parens patriae* becomes a nullity."

57. 422 U.S. at 575. See discussion at note 38 *supra*.

58. 422 U.S. at 575.

59. *Id.* at 576. Although government officials are not afforded absolute immunity, they cannot be held liable for negligent actions performed in good faith within the scope of their official duties. Qualified immunity has been accorded various officials acting under the aegis of the executive branch of government. See, e.g., *Wood v. Strickland*, 420 U.S. 308 (1975) (public school official); *Scheuer v. Rhodes*, 416 U.S. 232 (1974) (national guard); *Pierson v. Ray*, 386 U.S. 547 (1967) (police officers).

On remand, the court of appeals was to consider whether O'Connor:

knew or reasonably should have known that the action he took within his sphere of official responsibility would violate the constitutional rights of [Donaldson], or if he took the action with the malicious intention to cause a deprivation of constitutional rights or other injury to [Donaldson].

422 U.S. at 577, quoting *Wood v. Strickland*, 420 U.S. 308, 322 (1975). In *Wood* the Court described this standard as involving both objective and subjective elements of good faith. 420 U.S. at 321. The Court asserted that the standard did not impose an

*parens patriae* authority.<sup>60</sup> He relied on the historically custodial orientation of state institutions in order to defend the state's authority to confine nondangerous mentally ill persons without providing treatment.<sup>61</sup> The Chief Justice would limit review of the state commitment scheme to its compatibility with the best interests of persons unable to act in their own behalf.<sup>62</sup> The best interest due process standard advanced by Chief Justice Burger would not condition the state's exercise of its *parens patriae* power on the provision of adequate treatment.<sup>63</sup> Rather, the Chief Justice would allow the commitment of persons not amenable to treatment so long as the state purported to do so for their own welfare.<sup>64</sup> Since he did not view the state's *parens patriae* authority as dependent on the likelihood that hospitalization would rehabilitate the patient, the Chief Justice unequivocally rejected the patient's right to treatment.<sup>65</sup>

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unduly harsh burden "in light of the value which civil rights have in our legal system." *Id.* at 322.

The defendant alleged error because of the trial court's refusal to instruct that defendant's actions performed in his capacity as a state agent fell within the scope of official immunity so long as they were made in good faith reliance on state law. 422 U.S. at 576. In light of the jury's finding that defendant intentionally and maliciously deprived the plaintiff of his constitutional rights, it is difficult to understand why the Supreme Court remanded to the circuit court of appeals, since a finding of good faith reliance on state law would be inconsistent with the jury's award of punitive damages.

60. 422 U.S. at 583-85. The Chief Justice advocated judicial deference to legislative judgments regarding the proper purposes of compulsory hospitalization: "I am not persuaded that we should abandon the traditional limitations on the scope of judicial review." *Id.* at 587.

61. *Id.* at 582-83.

62. The Chief Justice expressed his view:

[D]ue process requires that [the state's *parens patriae* power] not be invoked indiscriminately. At a minimum, a particular scheme for protection of the mentally ill must rest upon a legislative determination that it is compatible with the best interests of the affected class and that its members are unable to act for themselves.

*Id.* at 583.

63. The Chief Justice contended that "the existence of some due process limitations on the *parens patriae* power does not justify the further conclusion that it may be exercised to confine a mentally ill person only if the purpose of the confinement is treatment." *Id.* at 583-84.

64. *Id.* at 584. The Chief Justice contends that patient cooperation is "universally recognized as fundamental to effective therapy." *Id.* A formidable school of psychologists, however, would disagree with the inclusion of uncooperative patients within the category of untreatable patients. Behaviorists have conducted numerous empirical studies demonstrating that subjects unconsciously respond to systematic conditioning, modifying their behavior in accordance with programmed positive and negative environmental stimuli. See generally L. ULLMANN & L. KRASNER, CASE STUDIES IN BEHAVIOR MODIFICATION (1965); B.F. SKINNER, BEYOND FREEDOM AND DIGNITY (1971).

65. The Chief Justice stated:

In sum, I cannot accept the reasoning of the Court of Appeals and can discern no basis for equating an involuntarily committed mental patient's unquestioned

### III. INVOLUNTARY CONFINEMENT OF PERSONS "IN NEED OF TREATMENT": RESTRAINING STATE PATERNALISM

Due to the constitutional deficiency of Donaldson's confinement, the Court did not address the broader issue of whether the state may constitutionally confine a nondangerous person for treatment. Assuming *arguendo* that treatment is a legitimate state end, *O'Connor* requires the state to provide more than custodial care to satisfy the statutory basis for civil commitment. The holding in *O'Connor* suggests that the importance attached to individual autonomy significantly constrains state authority to commit persons who pose no danger to society. Relying on the analytic framework provided by the *O'Connor* Court, it is submitted that involuntary confinement of nondangerous, self-sufficient persons for therapeutic purposes is impermissible.

#### A. *Reassessing State Goals: In the "Best Interests" of the State or the Individual?*

As previously mentioned, compulsory hospitalization of the mentally ill has been defended on the ground that such individuals would thereby receive the benefit of treatment at state expense,<sup>66</sup> for under the *parens patriae* rationale, the state is only acting in the best interests of the individual by requiring commitment. Although civil commitment for the best interests of the individual has superficial appeal, its use in practice is often in derogation of the rights of the presumably protected party.<sup>67</sup> This abuse of the state's authority is primarily

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constitutional right not to be confined without due process of law with a constitutional right to *treatment*. Given the present state of medical knowledge regarding abnormal human behavior and its treatment, few things would be more fraught with peril than to irrevocably condition a State's power to protect the mentally ill upon the providing of "such treatment as will give [them] a realistic opportunity to be cured."

422 U.S. at 587-89 (emphasis in original).

66. See notes 11-15 and accompanying text *supra*.

67. See *Morris* 959; N. KITTRIE, *supra* note 12, at 394-400. See also note 16 *supra*. See generally Comment, *supra* note 18, at 659 (theoretical basis for involuntary commitment often conflicts with the actual practices of institutional treatment).

The dangers of state paternalism have not gone unnoticed by the courts. In *Olstead v. United States*, 277 U.S. 438 (1928), the Court cautioned:

Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty

attributable to the conflict of the interests of society with the interests of the deviant individual.<sup>68</sup> Not surprisingly, these societal interests carry considerable weight and find expression in the implementation of civil commitment legislation.<sup>69</sup> One unstated aim of such legislation was identified by the *O'Connor* Court:<sup>70</sup>

May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.

Although the Court disapproves of the use of involuntary hospitalization for the state's own purposes, there is abundant evidence that society systematically insulates itself from its aberrant but harmless members by means of compulsory isolation, *i.e.*, civil commitment.<sup>71</sup> In this capacity, hospitals serve as a repository for social derelicts or persons exhibiting inappropriate behavior,<sup>72</sup> often removing the

lurk in insidious encroachment by men of zeal, well-meaning but without understanding.

*Id.* at 479.

68. See Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, *supra* note 16, at 88-89. Cf. Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 NOTRE DAME LAWYER 133, 155-56 (1972). See also Note, *supra* note 16, at 681.

69. Since the legislature is primarily responsive to majoritarian interests, it is a rather unpromising forum for the low-profile (and often disenfranchised) mentally ill. Whenever civil liberties are at stake the judiciary's role as a catalyst for reform is a proper one. See generally Comment, *The Right to Treatment: Judicial Realism—Judicial Initiative*, 10 DUQUESNE L. REV. 609, 611-13 (1972).

70. 422 U.S. at 575. See also *Davy v. Sullivan*, 354 F. Supp. 1320, 1329-30 (M.D. Ala. 1973) (conduct merely repulsive or repugnant is not a sufficient basis for commitment).

71. See Chambers 1120; Comment, *supra* note 18, at 659; Comment, *Civil Commitment of the Mentally Ill: Theories and Procedures*, *supra* note 10, at 1289. See also N. KITTRIE, *supra* note 12, at 3-5, 354; Morris 964 (present priority of mental institutions is servicing society as the primary client, not the mental patient). One commentator argues that involuntary civil commitment is used, not as a means of according treatment to persons in need of it, but rather as a mechanism for socially isolating those members of society whose presence is upsetting although not criminal. T. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY* 40, 47 (1963).

72. See ABF STUDY 38 (hospitalization as a refuge for certain elements of society—the destitute aged, the mentally deficient, and the maladjusted—who are unwelcome in society); Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and a Proposal*, 45 Miss. L.J. 43, 48-49 (1974). One commentator has recommended:

An initially crucial step toward decreasing the number of innocuous but unwanted persons committed would be to require that an alleged mentally ill person be proven "dangerous to himself or others" as a condition precedent to involuntary

burden that such individuals represent to their friends or relatives.<sup>73</sup>

Compulsory confinement may occur because of the misconception that mentally ill persons are more dangerous than other residents of the community;<sup>74</sup> the term, mental illness *per se* connotes dangerousness and occasions a social response of fear. Seen in this manner, *parens patriae* commitment, as with police power commitment, becomes an exercise in societal self-protection, far removed from its ostensible defense of the individual rights of the mentally ill.

This abridgement of individual autonomy in the interest of social conformity is allowed because enforced hospitalization has traditionally been denominated therapeutic, despite overwhelming evidence that state institutions simply warehouse social undesirables without attempting to provide effective treatment.<sup>75</sup> Therefore, the involuntary confinement of the nondangerous mentally ill furthers social interests under the guise of furthering the best interests of the individual.

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commitment. . . . Such a requirement would presumably impose a greater evidentiary burden upon the petitioning party which would provide an additional safeguard against the possibility of institutionalizing persons who are not sufficiently disturbed to warrant involuntary commitment.

A statutory dangerousness requirement and an increased evidentiary burden would be empty, however, without the full panoply of procedural guarantees. . . . Hopefully, such guarantees would do much to prevent civil commitment on the basis of conduct whose only wrong is that it is bizarre, unsettling, inconvenient, frightening, or unpopular.

Comment, *The Language of Involuntary Mental Hospitalization: A Study in Sound and Fury*, *supra* note 38, at 212–14 (footnote omitted). *But see* note 39 *supra* for problems with dangerousness as a standard for commitment.

73. *See* Livermore, Malmquist, & Meehl 86, 90; Robitscher, *supra* note 55, at 12. *See also* ABF STUDY 38; Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 1004 (1959) (“[T]he government’s primary consideration is the patient’s welfare, ‘not what the patient or his relatives believe to be in his interest.’”).

74. *See* Birnbaum, *A Rationale for the Right*, 57 GEO. L. REV. 752, 767 (1969). *See also* Postel, *supra* note 11, at 12. *Accord*, Comment, *Wyatt v. Stickney* 1289–90 n.43, 1295 (mental illness is a poor indicator of future dangerous conduct); *Developments* 1329–31. *See* Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101, 107 (1971):

Probably fifty to eighty per cent of all ex-felons will commit future crimes, but we do not confine them. . . . Of all the identifiably dangerous groups in society, only the “mentally ill” are singled out for preventive detention, and . . . they are probably the least dangerous, as a group, of the groups here mentioned.

(footnotes omitted). *Accord*, Chambers 1124.

75. In *Sas v. Maryland*, 334 F.2d 506, 516 (4th Cir. 1964), *cert. denied*, 407 U.S. 355 (1972), the court warned that:

[A] statute though “fair on its face and impartial in appearance” may be fraught with the possibility of abuse in that if not administered in the spirit in which it is conceived it can become a mere device for warehousing the obnoxious elements of society.

(footnote omitted). *See generally* Szasz, *supra* note 16, at 353–56.

The capacity of the state to function properly as *parens patriae* is extremely doubtful in view of the conflict of interests inherent in this role. *O'Connor* offers an alternative to the traditional *parens patriae* concern with the best interests of the individual that is less susceptible to state abuse. The Court emphasizes the individual's ability to care for himself outside an institution, rather than the presumed but unsubstantiated debilitating effects of his purported illness. The test is whether the person is "capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."<sup>76</sup> Thus, it is arguably beyond the permissible scope of state power to institutionalize a functional person for his own welfare. Focusing on a person's ability to care for himself provides a more objective criterion governing the state's commitment authority and portends an end to the arbitrary best interests standard of *parens patriae* civil commitment.<sup>77</sup>

*B. Reassessing State Means: Requirement of the "Least Restrictive Alternative"*

Even if treatment of the mentally ill were conceded to be a legitimate state interest, the state's choice of means is likewise subject to constitutional attack. It is incumbent on the state to employ means

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76. 422 U.S. at 576.

77. The Washington civil commitment statute appears to be consistent with the rationale of the *O'Connor* Court. A person may be detained for treatment if, as a result of a mental disorder, he or she presents a likelihood of serious harm to self or others, or is gravely disabled. WASH. REV. CODE § 71.05.150 (Supp. 1975). Gravely disabled is defined as: "[A] condition in which a person, as a result of a mental disorder is in danger of serious physical harm resulting from a failure to provide for his essential human needs." *Id.* § 71.05.020 (1974). The statutory provision for treatment of gravely disabled persons parallels the *O'Connor* Court's concern with an individual's ability to "ensure his own survival or safety. . . ." 422 U.S. at 573-74. Although Washington establishes a separate category for persons unable to survive safely in the community (*i.e.*, gravely disabled), the Court included such persons in a comprehensive definition of dangerous to self. The Court observed:

[E]ven if there is no foreseeable risk of self-injury or suicide, a person is literally "dangerous to himself" if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.

*Id.* at 574 n.9.

The Washington statutory provision for civil commitment of persons designated gravely disabled is apparently being narrowly construed by the lower state courts; it is being interpreted to mean persons unable to take care of their basic needs of food, clothing, and shelter. *See, e.g.*, Seattle Times, Nov. 9, 1975, § B, at 15, col. 2. As a result of community dissatisfaction with this judicial construction of the term, an alternative construction has been proposed which would include "persons who have no



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which burden the individual rights at stake least.<sup>78</sup> The constitutional doctrine of the "least restrictive alternative"<sup>79</sup> was adopted by the *O'Connor* Court in its examination of the enforced confinement associated with commitment.<sup>80</sup> The Court refused to consider incarceration

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insights into their own mental illness and who, in the judgment of a mental-health professional, will deteriorate if they do not get treatment." *Id.* at col. 7. The latter recommendation is probably constitutionally deficient. See note 81 and accompanying text *infra*.

78. The state's obligation to search for less onerous methods of achieving legislative aims has been recognized in contexts outside the civil commitment area. See, e.g., *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 267 (1974) (state must demonstrate that it has chosen means that do not unnecessarily impinge on constitutionally protected interests) (right to travel); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (right of privacy); *Shelton v. Tucker*, 364 U.S. 479, 488-90 (1960) (right of association).

Prior to *O'Connor*, the application of the least restrictive alternative doctrine to civil commitment was in doubt. In *Sanchez v. State*, 80 N.M. 438, 441, 457 P.2d 370, 373 (1968), *appeal dismissed*, 396 U.S. 276 (1969), the New Mexico state court rejected the least restrictive alternative principle as a limitation on state civil commitment power. The United States Supreme Court's dismissal of the appeal for want of a substantial federal question technically constituted a decision on the merits, i.e., approval of the state's holding. *But see* *Chambers* 1151-54 (arguing that the Supreme Court may have dismissed the *Sanchez* appeal without appreciating its significance due to the Court's heavy workload).

79. The principle of the least restrictive alternative compels the state to canvas the range of possible dispositions other than institutionalization. See *Lake v. Cameron*, 364 F.2d 657, 659 (D.C. Cir. 1966) (nursing home, day care, foster care, and home services were among the possible alternatives suggested by the court); *Dixon v. Weinberger*, 405 F. Supp. 974, 979-80 (D.D.C. 1975) (affirmative duty of hospital to develop suitable treatment settings for persons determined to need such outpatient placement); *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974) (since state has means of knowing the available treatment options, it must bear the burden of showing why none of the alternatives investigated are suitable); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1095-96 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974) (state required to investigate alternatives including community clinics and home services).

In addition, the state must explore the possibility of substantially less restrictive confinement within the hospital itself. See *Covington v. Harris*, 419 F.2d 617, 623-25 (D.C. Cir. 1969). See also *Davis v. Watkins*, 384 F. Supp. 1196, 1206-07 (N.D. Ohio 1974) (mentally retarded patients entitled to least restrictive conditions necessary in accordance with their individual treatment plans); *Kesselbrenner v. Anonymous*, 33 N.Y.2d 161, 165, 305 N.E.2d 903, 905, 350 N.Y.S.2d 889, 892 (1973) (incarceration without treatment of a dangerous mentally ill person in a correctional facility constitutes a greater deprivation of personal liberty than necessary to achieve the purpose for the confinement). See generally *Chambers*.

80. 422 U.S. at 575. The *O'Connor* Court relied on *Shelton v. Tucker*, 364 U.S. 479, 488-90 (1960), often cited for its formulation of the least restrictive alternative doctrine:

[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 more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.

*Id.* at 488 (footnotes omitted).

tion essential to effective therapy even in instances where it might improve the patient's standard of living.<sup>81</sup>

Far from being the least drastic therapeutic measure available to the state, inpatient hospitalization clearly entails a severe curtailment of personal freedom.<sup>82</sup> Indeed, it would be difficult to imagine a more restrictive treatment alternative. The patient is involuntarily removed to unfamiliar surroundings for an indeterminate period and subjected to enforced treatment, while familial and business relations are curtailed—all by virtue of behavior which judicially has been labeled nondangerous. For this reason most present state mental health systems, by their failure to develop less intrusive treatment alternatives (such as outpatient community clinics), unduly constrain civil liberties in a manner inconsistent with constitutional limitations on the government's choice of means.<sup>83</sup>

Apart from the failure of institutionalization as the least restrictive treatment setting, it is questionable whether hospitalization is a viable

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81. Mr. Justice Stewart stated for the Court:

May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a *necessary* condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends.

422 U.S. at 575 (emphasis added).

82. See discussion in note 16 *supra* of the various legal disabilities which attend civil commitment.

83. In *Lessard v. Schmidt*, 349 F. Supp. 1078, 1092 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), the court stated that full-time involuntary hospitalization should be ordered only as a last resort. In addition, the court offered possible alternatives to institutional isolation of the mentally ill:

We believe that the person recommending full-time involuntary hospitalization 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. These alternatives include voluntary or court-ordered 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 aide services.

349 F. Supp. at 1096.

In *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966), the court held that an elderly plaintiff prone to periods of temporary memory loss did not require the complete deprivation of liberty that civil commitment as a person of "unsound mind" represented. *Id.* at 661. On remand, the lower court was to consider other alternatives to inpatient care, including:

whether the appellant and the public would be sufficiently protected if she were required to carry an identification card on her person so that the police or others could take her home if she should wander, or whether she should be required to accept public health nursing care, community mental health and day care services.

alternative at all. In light of well-documented neglect of its state's mental hospitals,<sup>84</sup> a responsible court may be justifiably reluctant to acquiesce in the state's pretense of treatment.<sup>85</sup> Moreover, even given the best hospital facility, there is ample evidence that institutionalization itself is antitherapeutic. Patients isolated from the community for prolonged periods often have difficulty adjusting to life outside the hospital environment.<sup>86</sup> The highly regulated hospital routine fosters socially dysfunctional patient characteristics such as passivity, depend-

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foster care, home health aide services, or whether available welfare payments might finance adequate private care. Every effort should be made to find a course of treatment which appellant might be willing to accept.

*Id.* at 661 (footnotes omitted). *Accord*, *Dixon v. Weinberger*, 405 F. Supp. 974, 977-78 (D.D.C. 1975) (least restrictive alternative principle relied on to require development of more suitable treatment settings for patients determined to need such placement) (class action suit in behalf of all persons confined as mentally ill in District of Columbia hospitals).

In 1973, Washington incorporated the doctrine of the least restrictive alternative as a part of the state's extensive revision of its civil commitment laws. *See, e.g.*, WASH. REV. CODE § 71.05.320 (Supp. 1975) (court or jury may rule on whether treatment less restrictive than detention is in the best interests of the person or others). Recent statutory amendments to *id.* ch. 71.05 require additional consideration of less drastic treatment settings for mental patients. *See id.* § 71.05.210 (outpatient treatment); *id.* § 71.05.300 (court, if requested, may appoint a professional person to seek less restrictive alternative courses of treatment). The Washington statutory scheme is an admirable exception to the typical state mental health system.

84. *See* Schwartz, *supra* note 3, at 817. Based on average state expenditures, state institutions are neglected to such an extent that even the possibility of treatment is precluded. *See* Comment, *supra* note 18, at 647. *Contra*, L. Kubie, *Commitment*, in READINGS IN LAW AND PSYCHIATRY 326-27 (R. Allen, E. Ferster, & J. Rubin eds. 1975). *See also* Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134, 1159 n.94 (1967):

Because circumstances of inadequate treatment are often compounded by lack of privacy, overcrowding, lack of nutrition, sanitation, and recreational facilities, the patient may well suffer not only an unwarranted deprivation of liberty, but also physical harm and aggravation of his mental condition.

One rather striking result of inadequate state funding of Maryland mental hospitals is that pellagra—a vitamin deficiency that itself can cause severe mental illness—is found among patients in all six state institutions. *See* Birnbaum, *The Right to Treatment—Some Comments on Implementation*, 10 DUQUESNE L. REV. 579, 581-82 (1972).

85. *See, e.g.*, *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala.), *hearing on standards ordered*, 334 F. Supp. 1341 (M.D. Ala. 1971), *enforced*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom.*, *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

86. *See* Morris 959. Even if the patient improves while in the institution, his adjustment to the artificial hospital regime is not likely to prepare him to adapt to the pressures of the outside environment. The detrimental effect of prolonged hospitalization is best reflected in the high recidivism rates of mental institutions. In 1972 there were 263,111 patients who had experienced prior inpatient care readmitted to state and county mental hospitals out of a total of 403,924 admissions. *See* NATIONAL INSTITUTE OF MENTAL HEALTH, STATISTICAL NOTE 110, READMISSIONS TO INPATIENT SERVICES OF STATE AND COUNTY MENTAL HOSPITALS 1972 1 (DHEW Pub. No. 75-158, Nov. 1974). *See generally* R. BARTON, *INSTITUTIONAL NEUROSIS* (2d ed. 1966).

ence, and loss of motivation.<sup>87</sup> In sum, compulsory confinement itself contributes to, rather than ameliorates, the patient's social maladjustment. Therefore, the harmful impact of enforced hospitalization on the nondangerous individual cannot be reconciled with the constitutional requirement of the least restrictive alternative.

#### IV. CONCLUSION

The concept of a right to treatment was advanced by the judiciary in an effort to rectify state neglect of the mentally ill. This endeavor, although commendable, tends to focus attention on post-commitment reform rather than questioning the basis for the state's initial exercise of its civil commitment power. To the extent that the state in its role as *parens patriae* purports to act in the best interests of mentally ill persons adjudged in need of treatment, its authority is suspect. Even assuming the ability of the state to furnish adequate treatment, the Court's holding suggests that a nondangerous person able to function safely in society may be beyond the reach of the state's paternal powers.

*Sheila M. Burnstin*

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87. See Chambers 1127 & n.83 (long term hospital patients exhibit withdrawal, flatness of response, muteness, and loss of motivation). For an exhaustive account of the deleterious effects of confinement in a mental institution, see E. GOFFMAN, *ASYLUMS* (1961). See also Morris 959 (civil commitment undermines individual self-esteem); Rosenhan, *On Being Sane in Insane Places*, 13 *SANTA CLARA LAWYER* 379, 394-98 (1973).

#### ERRATUM

1. The second sentence in the last paragraph on page 319 of *Professional Responsibility: Education and Enforcement*, 51 *WASH. L. REV.* 273 (1976), by Robert H. Aronson, should read: "It may be necessary or desirable to adopt a truth-oriented system in the civil area and an adversary or innocence-oriented model in the criminal justice system."