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A NEW EMANCIPATION: TOWARD AN END TO INVOLUNTARY CIVIL COMMITMENTS

I. Introduction

Recent constitutional developments make timely the reassessment of policies involving involuntary civil commitment of the mentally ill on the part of the states and the federal government. Involuntary civil commitment procedures in most states presently provide poorly for the interests of committed parties. Psychiatric and medical appraisals of those suspected to be ill are frequently unreliable in determining either the mental health or the dangerousness of the examinees. The care afforded the committed is often paltry, and the legal protections against both active and passive abuses of patients are practically nonexistent. Consequently, decisions may be forthcoming which hold that commitment for the "care" ordinarily provided mental patients is violative of constitutional due process rights.

Anticipating this possibility, Congress and state legislatures should pointedly examine the propriety of involuntary civil confinement of the mentally ill. It is the contention of this note that such examination can and should conclude that the abolition of involuntary civil commitment is the best legislative response to current constitutional developments from both legal and policy standpoints. This note encompasses a discussion of the definition and disposition of the mentally ill, of constitutional and policy issues involved in their commitment, and of the case to be made for their freedom.

II. Civil Commitment Procedures

Civil confinement under the police power of persons considered mentally ill is based upon two premises. The first is the concept of *parens patriae*,¹ a theory under which the state is the ultimate guardian of each person's welfare and claims the right to commit people for therapeutic treatment. The second is that of preventive detention, whereby "patients" are confined for the safety of themselves or others.² The states traditionally have exercised broad power to commit the mentally ill. Substantive limitations upon this exercise and the methods for invoking those limitations vary dramatically among the states.³ Since treatment is a more soothing notion than preventive detention, it is treatment that has long been stressed in statutes providing for civil commitment and in judicial interpretations of such statutes.⁴

1 *Parens patriae* refers to the right and duty of the sovereign to protect any person who is under a disability.

2 T. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY*, 45 (1963).

Schneider, *Civil Commitment of the Mentally Ill*, 58 A.B.A.J. 1059, 1060 (1972);

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

3 See *Jackson v. Indiana*, 406 U.S. 715, 736-37 (1972).

4 77 YALE L.J., *supra* note 2, at 87-88. As a step towards a more appealing terminology, the term "commitment" is replaced in nineteen states and in the District of Columbia by the less offensive term "hospitalization." S. BRAKEL & R. ROCK, *THE MENTALLY DISABLED AND THE LAW*, 34 (American Bar Foundation Study, rev. ed., 1971).

In 1972, the Supreme Court noted an American Bar Foundation study of the premises for involuntary confinement showing:

that in nine States the sole criterion for involuntary confinement is dangerousness to self or others; in 18 other States the patient's need for care or treatment was an alternative basis; the latter was the sole basis in six additional States; a few States had no statutory criteria at all, presumably leaving the determination to judicial discretion.⁵

The weight of opinion and observation is that involuntary admission is overutilized.⁶ Civil commitment proceedings are frequently such that the legal trappings of due process are mostly ceremonial and not genuinely protective.⁷ No state requires a jury trial in every hospitalization case.⁸ Most jurisdictions fail to provide counsel in hospitalization cases in which the party alleged to be mentally ill has none.⁹ The period of commitment may be either determinate or indeterminate, although the latter constitutes the more widespread practice in this country.¹⁰ Courts have routinely rejected constitutional attacks upon these proceedings by asserting that the commitment statutes are not penal, but are civil and rehabilitative.¹¹

The minimal requirements of notice and an opportunity to be heard, although adhered to in judicial proceedings, often appear to be of little substance in effect.¹² Those involuntarily committed can have their constitutional right

5 Jackson v. Indiana, 406 U.S. 715, 737 n.19 (1972).

6 BRAKEL & ROCK, *supra* note 4, at 63.

7 Schneider, *supra* note 2; Inadequate procedural safeguards for "defective delinquents" (whose legal status resembles that of the mentally ill) have been assailed by Justice Douglas:

When a State moves to deprive an individual of his liberty, to incarcerate him indefinitely, or to place him behind bars for what may be the rest of his life, the Federal Constitution requires that it meet a more rigorous burden of proof than that employed by Maryland to commit defective delinquents . . . the Maryland Court of Appeals has determined that the State need only prove its case by the "fair preponderance of the evidence" [citations omitted]. Petitioners have thus been taken from their families and deprived of their constitutionally protected liberty under the same standard of proof applicable to run-of-the-mill automobile negligence actions.

Murel v. Baltimore City Criminal Court, 407 U.S. 355, 359 (1972) (Douglas, J., dissenting); *But see* Lessard v. Schmidt, Civil No. 71-C-602 (E.D. Wis. Oct. 19, 1972) a three-judge federal court holding that for civil commitment the state must prove its contentions beyond a reasonable doubt. For this and many other significant procedural dictates, *Lessard* is a valuable step in the right direction. *See infra* note 80.

8 BRAKEL & ROCK, *supra* note 4, at 54.

9 *Id.*

10 *Id.* at 35; there is no disagreement on this point. HEARINGS ON CONSTITUTIONAL RIGHTS OF THE MENTALLY ILL BEFORE THE SUBCOMMITTEE ON CONSTITUTIONAL RIGHTS OF THE SENATE COMM. ON THE JUDICIARY, 91st Cong., 1st & 2nd Sess., [hereinafter cited as 1969-1970 HEARINGS] at 37: "Commitment, unlike a prison sentence, usually is for an indefinite period."

11 77 YALE L. J., *supra* note 2, at 93; 1C. ANTIEAU, MODERN CONSTITUTIONAL LAW 507 (1969); *Cf.* an opinion of Judge (now Chief Justice) Burger regarding a habeas corpus suit brought by a person confined to a mental institution after being acquitted of a criminal charge on grounds of insanity:

In *Overholser v. Leach*, [citation omitted] we held that the burden of proof to establish eligibility for release under § 24-301 is on the petitioner. This violates no Constitutional guarantee for it has no relationship to the presumption of innocence since neither "guilt" nor "innocence" is involved in this proceeding and the statutory objectives are not punishment but protection and rehabilitation.

Ragsdale v. Overholser, 281 F.2d 943, 949 (D.C. Cir. 1960).

12 BRAKEL & ROCK, *supra* note 4, at 60.

to notice of proceedings against them voided when the judge concludes this would be antitherapeutic.¹³ Psychiatrists do not inform patients of the right to object to involuntary institutionalization, and in some varieties of civil commitments the patient is never brought before a judge.¹⁴ As late as 1961 only five states made it mandatory for the judge to appoint counsel when a person so requested.¹⁵ While state constitutional clauses guarantee the right to trial by jury in most states, a majority of the courts rule that these clauses do not require jury trial in involuntary commitment proceedings.¹⁶

In 1972 Justice Blackmun observed: "Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power [to commit the mentally ill] have not been more frequently litigated."¹⁷ Infrequent litigation is less surprising in light of the fact that court-imposed mental treatment is rarely visited upon the middle or upper classes.¹⁸ The allegedly mentally ill usually possess neither funds, expertise, nor initiative to successfully contest an involuntary hospitalization.¹⁹

The inmate effectively commands little choice of either his doctor or his manner of therapy within the state-imposed treatment context.²⁰ Even inmates who voluntarily enter an open hospital can often be legally handled like escaped criminals should they depart shortly after admission contrary to administrative wishes.²¹ And in the private voluntary hospitals the inmate is usually confined within a locked ward from which he cannot leave without formal consent.²²

In New York, which is typical of many [in fact most] states, a "voluntary" patient is not free to leave the hospital. He can be held under "voluntary" status for at least 15 days, or until 10 days after he requests release, whichever is longer. Furthermore, he can be converted to involuntary status under a "two physician" certificate, and not released at all. When he signs in as a voluntary patient, he is not notified that he can be converted to involun-

13 ANTIEAU, *supra* note 11, at 513-15.

14 SZASZ, *supra* note 2, at 175.

15 ANTIEAU, *supra* note 11, at 512.

16 *Id.* at 519.

17 Jackson v. Indiana, 406 U.S. 715, 737 (1972).

18 Schneider, *supra* note 2, at 1061; SZASZ, *supra* note 2, at 47; Cf. J. MYERS & L. BEAN, A DECADE LATER 207 (1968).

19 Schneider, *supra* note 2, at 1062-63; Mental hospitals prove to be dumping grounds for the helpless poor:

The role of mental hospitals in caring for the aged, the senile, and others for whom some states provide no special facilities continues to be a source of great concern.

BRAKEL & ROCK, *supra* note 4, at 38-39;

It is also a demonstrable fact that slum areas of our metropolitan cities have several times as many hospitalized schizophrenic patients in relation to population as have the better residential areas.

United States v. Baldi, 192 F.2d 540, 566 (3rd Cir. 1951).

20 Katz, *The Right to Treatment—An Enchanting Legal Fiction?* 36 U. CHI. L. REV. 755, 778 (1969); the state-claimed right to impose involuntary therapy has even been seen to override religious liberty:

A federal court has held in the case of a Christian Scientist [Winters v. Miller, 306 F. Supp. 1158 (E.D.N.Y. 1969)] that freedom of religion does not give a right to be free from medical treatment, at least where no "drastic treatment" was administered and such treatment was limited to medication.

ANTIEAU, *supra* note 11, at 67 (Supp. 1972).

21 SZASZ, *supra* note 2, at 181.

22 1969-1970 HEARINGS, *supra* note 10, at 126.

tary status. A statute giving voluntary patients the absolute right to release on demand would do much to encourage voluntary admission. The State's interest in detaining those few voluntary patients who, if released, might be dangerous, is less than the state's [sic] interest in promoting widespread use of voluntary admission.²³

III. Professional Uncertainties

A. *Mental Health and Treatment*

Any precise definition of mental illness, as grounds for confinement and appropriate remedies, is difficult if not impossible to obtain. For example, most patients in state hospitals have been deemed "schizophrenic"²⁴ even though "schizophrenia" is a word that fails to describe how people behave; and it carries no clear indication of what should be done for them. It has no meaning except as a rationale for confinement or for seeing a psychiatrist.²⁵

In 1956 Justice Frankfurter delivered an opinion of the Supreme Court concerning a defendant found incompetent to stand criminal trial in which he noted:

While the District Court did not accept the [court appointed psychiatrists'] conclusion, their testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgement. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgement. . . .²⁶

Justice Frankfurter might well have hearkened back to a dissent he had authored four years previously in *Leland v. Oregon*²⁷ in which he discussed criminal pleas of not guilty due to insanity: "Sanity and insanity are concepts of incertitude. They are given varying and conflicting content at the same time and from time to time by specialists in the field."²⁸

Consistent with such thinking, Chief Justice Burger has even suggested

²³ *Id.* at 271.

²⁴ Szasz, *supra* note 2, at 175.

²⁵ Thomas L. Shaffer, *A Lawyer's Plea: Open Mental Hospital Doors* THE NATIONAL OBSERVER (December 9, 1972), at 26; *See also* Szasz, *Psychiatry, Ethics, and the Criminal Law*, 58 COLUM. L. REV. 183, 191 (1958). Myths attached to victims branded with the word "schizophrenic" are tragically widespread:

We wish only to discuss briefly the common belief that schizophrenics are dangerous. They are, indeed, somewhat more dangerous to themselves than they would be if they were not schizophrenic, but they are not more dangerous to other people.

The risk of homicide among schizophrenics is no greater than it is for non-schizophrenics. Nevertheless, this belief is so well engrained it has until recently been an article of faith for mental hospital architects, society and even for nursing staffs. This is one reason mental hospitals have been built like fortresses and jails. The best evidence that this is false is the fact that one or two rather small female nurses can herd as many as forty to sixty or more chronic schizophrenics.

A. HOFFER, *HOW TO LIVE WITH SCHIZOPHRENIA* 44-45 (1966).

²⁶ *Greenwood v. United States*, 350 U.S. 366, 375 (1956).

²⁷ 343 U.S. 790 (1952).

²⁸ *Id.* at 803 (Frankfurter, J., dissenting); *See also* *Jackson v. Indiana*, 406 U.S. 715, 720 n.2 (1972).

that the defense of insanity be altogether abandoned²⁹ in criminal proceedings. "The whole problem of psychiatric testimony," he has frankly contended, "is not fitted to the adversary procedure."³⁰

Uncertainty as to the effective meanings of phrases like "mental health" provides a broad choice of options for the psychiatrist willing to interpret terms in a manner implementing his own value judgments. (For instance, the overwhelming majority of abortions in 1970 were approved on psychiatric bases. But both abortion proponents and foes agreed that psychiatric indications could not justify so great a number.)³¹ There exists very little agreement among psychiatrists on the definition of "mentally ill person."³² In fact it has been found that psychiatrists are influenced by the social class of the patient in determining both the nature and extent of his illness.³³

Past court experience with psychiatric testimony in other contexts provides a pessimistic outlook as to psychiatrists' capacity to concisely prescribe and

29 1969-1970 HEARINGS, *supra* note 10, Appendix at 562.

30 *Id.*

31 116 CONG. REC. 37377 (1970) (remarks of Representative Dingell); Dr. Thomas Szasz has repeatedly called attention to the impact of subjective factors upon professional decisions: Difficulties in human relations can be analyzed, interpreted, and given meaning only within specific social and ethical contexts. Accordingly, the psychiatrist's socioethical orientations will influence his ideas on what is wrong with the patient, on what deserves comment or interpretation, in what directions change might be desirable, and so forth. Even in medicine proper, these factors play a role, as illustrated by the divergent orientations which physicians, depending on their religious affiliations, have toward such things as birth control and therapeutic abortion. Can anyone really believe that a psychotherapist's ideas on religion, politics, and related issues play no role in his practical work?

SZASZ, *supra* note 2, at 15.

No less a figure than Sigmund Freud himself warned of the inevitable connection between the personal attitudes of psychiatric examiners and their consequent appraisals of examinees:

Illusions need not necessarily be false—that is to say, unrealizable or in contradiction to reality. For instance, a middle-class girl may have the illusion that a prince will come and marry her. This is possible; and a few such cases have occurred. That the Messiah will come and found a golden age is much less likely. Whether one classifies this belief as an illusion or as something analogous to a delusion will depend on one's personal attitude.

S. FREUD, THE FUTURE OF AN ILLUSION 49 (1964).

32 1969-1970 HEARINGS, *supra* note 10, at 69. The gross failure of specialists to distinguish the "ill" from the "healthy" was highlighted in 1973:

The plight of the normal person who finds himself committed to a mental institution and unable to convince anyone he is not insane is a standard plot for horror fiction. But in a remarkable study . . . Dr. David L. Rosenhan, professor of psychology and law at Stanford University, and seven associates reported just such a nightmare in real life. To find out how well psychiatric professionals can distinguish the normal from the sick, they had themselves committed to mental institutions. Their experiment, reported in the *Journal of Science*, clearly showed that once inside the hospital walls, everyone is judged insane.

NEWSWEEK, Jan. 29, 1973, at 46, col. 2.

33 A. HOLLINGSHEAD & F. REDLICH, SOCIAL CLASS AND MENTAL ILLNESS 360 (1958).

Definitions of mental illness that are so broad as to be almost free-floating allow enormous proportions of society to be found psychologically diseased:

Some 15 to 30 percent of the world's population suffers from one form or another of serious mental or emotional disorder. According to the World Health Organization, over 1,000 people kill themselves every day. Schizophrenia, paranoia, and a host of other psychotic afflictions are on the increase everywhere. According to one study, every other adult in New York City is in need of psychiatric help. Another study found that only 12 per cent of the children in that city were what could be found as mentally healthy.

W. Whitehart, *Why No "Peace on Earth"?* PLAIN TRUTH (Dec., 1972,) at 11.

analyze any particular regimen for involuntary patients.³⁴ "Psychiatric treatment" per se simply does not exist.³⁵ Examination of the literature of psychotherapy reveals a bewildering array of schools of thought concerning therapeutic techniques, few with sufficient empirical support to justify conclusive assertions as to their effectiveness.³⁶ The various types of mental illness are medically classified without uniformity or unanimity.³⁷ Even when an agreement is reached among the medical professionals as to mere descriptive classifications, their conclusions as to treatment are decidedly different.³⁸ Many of the treatments enjoying a great vogue today will be looked upon as strange ten, fifteen or twenty years hence.³⁹

B. *Professional Uncertainty and Dangerousness*

Dangerousness, like mental health or illness, is a concept that has proven to be impossible to manage equitably. Studies indicate that psychiatrists err in the prediction of dangerousness.⁴⁰ The statutes relying upon the concept of dangerousness as a justification for confinement are vague in significant aspects. In application, this standard becomes as broad as the ingenuity of the person who must apply it.⁴¹

Fear of the supposedly dangerous mental inmates is usually baseless. Preventive detention of people who are thought to be both dangerous and mentally ill may appear to be more plausible than preventive detention of the "sane," but it is not.⁴² Even professional warnings are not always well founded. Those permanently employed at hospitals for the mentally ill definitely develop a sense of overcaution relative to patients.⁴³ Predictions of future dangerous behavior are not very accurate, and psychiatrists tend to overpredict. The psychiatrist's rule of thumb is: when in doubt, commit.⁴⁴ Even regarding those few inmates whom he himself considers potentially dangerous, Morton Birnbaum, M.D. (member of the New York Bar and "Father of the Right to Treatment") favors liberty, at least if they are not being afforded genuine care.⁴⁵

Probably very few of our mental inmates are a menace to society, since the crime rate of former mental inmates—including patients with prior arrests—is only about 50 per cent that of the general populace.⁴⁶ The "treatment" which former inmates endured was probably not the determinative factor in accounting for this lower crime rate.

34 Comment, 80 HARV. L. REV. 898, 900 (1967).

35 Schimideberg, *The Promise of Psychiatry: Hopes and Disillusionment*, 57 N.W. U.L. REV. 19, 22 (1962).

36 77 YALE L. J., *supra* note 2, at 105.

37 Bassiouni, *The Right of the Mentally Ill to Cure and Treatment: Medical Due Process*, 15 DEPAUL L. REV. 291, 293 (1965).

38 *Id.*

39 1969-1970 HEARINGS, *supra* note 10, at 30.

40 Schneider, *supra* note 2.

41 BRAKEL & ROCK, *supra* note 4, at 39.

42 1969-1970 HEARINGS, *supra* note 10, at 264.

43 *Id.* at 154.

44 *Id.* at 271.

45 *Id.* at 64.

46 Shaffer, *supra* note 25.

IV. Disposition of Involuntary Patients

A. Care Afforded

In 1972 care afforded to the civilly committed was either inadequate or nonexistent.⁴⁷ Approximately a decade ago fully 80 per cent of the mental institutions were wholly custodial, and many of the rest only provided adequate treatment for those private patients who paid well.⁴⁸ As recently as 1967 Pennsylvania burdened the average staff physician in state-operated mental hospitals with some 170 patients at any given time.⁴⁹ And in data published by the National Institute of Mental Health a great disparity between public mental institution death rates and general population death rates is revealed.⁵⁰

The term "psychiatric treatment" simply covers anything that can be inflicted upon a person under medical auspices. For example, mere custodial care has sometimes been fancied as "environmental (or milieu) therapy," whereby hospital confinement itself is defended as beneficial.⁵¹ This imaginative contention was judicially rejected in 1967 by the United States Court of Appeals for the District of Columbia.⁵² Nevertheless, the confining institution was required to provide only bona fide efforts at treatment rather than demonstrably effective techniques.⁵³ This leaves environmental therapy—wherever performed—a vital concept even if disguised under new names.

The limited facilities that may be afforded in mental hospitals are sometimes inferior to those in ordinary prisons. In the mid-1960's at least one of New York's mental hospitals had a physician-patient ratio worse than that in Sing Sing. The regular federal penitentiaries generally have medical and psychiatric opportunities superior to those of many state-administered mental facilities.⁵⁴ It has

47 Schneider, *supra* note 2, at 1061.

48 Schmideberg, *supra* note 35.

49 Comment, *Involuntary Civil Commitment and the Right to Treatment in Pennsylvania*, 15 VILL. L. REV. 951, 958 (1970).

50 1969-1970 HEARINGS, *supra* note 10, at 532; This discrepancy between the institutional population death rates and general population death rates was highlighted in this Senate hearing exchange:

[Senator Ervin.] "You have stated figures which indicate that the number of fatal illnesses among patients in hospitals, when you exclude the old age group, are really vastly higher than those in the outside world."

Dr. Bartlett. "Yes; they are substantially higher. The death rates are at least three to five times higher than those outside."

Id. at 204.

51 Morris, "Criminality" and the Right to Treatment 36 U. CHI. L. REV. 774, 784 n.58.

52 Rouse v. Cameron, 373 F.2d 451, 456 (D.C. Cir. 1967).

53 *Id.*

54 Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134, 1146 n.45.

Staggering physician-patient ratios imply offhand diagnoses. These may not be rare even in voluntary contexts:

In a community mental health clinic I once interviewed a young woman who impressed me as a hysterical or dissociating character. (After a little experience in clinical psychiatry, you get so that you can recognize people of this kind very quickly, by their general manner and way of speaking, even though you cannot put your finger on what it is about them that gives that impression. Since this way of dealing with people is a normal defense mechanism and not restricted to patients, a psychiatrist or clinical psychologist quickly learns to identify the chief normal defenses used by his friends and acquaintances, and you can often identify the typical defenses and life style of a stranger in a few minutes' conversation.)

J. FINNEY, CULTURAL CHANGE, MENTAL HEALTH, AND POVERTY 244 (1970).

been said with respect to a committed juvenile that the educational, psychological and social consequences of a mental institution "are, as a rule, worse than those of the reformatory—*yet his stay is claimed not to be punishment.*"⁵⁵

B. Brutality

There are a number of reported cases of brutality inflicted upon involuntarily institutionalized persons⁵⁶ although that brutality is not calculated hospital policy. Even the superintendent of a large state hospital may be ignorant of the maltreatment of patients.⁵⁷ The widespread instances of patients being killed have been appalling.⁵⁸

"Treatment" itself can be cruel:

The fact is that a person can be locked up because a physician says he should be. He can be kept locked up as long as a physician says he should be. And the only "treatment" he will be given may be at best a locked door, and at worst a horrifying routine of humiliation and torture and curious surgery.⁵⁹

Indeed, it has been argued that "the primary concern of any mental hygiene law is to empower physicians to imprison innocent citizens, under the rubric of 'civil commitment,' and to justify torturing them by means of a variety of violent acts called 'psychiatric treatments'."⁶⁰

In California mentally ill criminals and "noncriminal" criminals (*i.e.*, those acquitted by reason of insanity)⁶¹ have been subjected to drug experimentation.⁶² It is clear that this particular experimentation is likely to leave a harmful impression or effect on the subjects: "*For a period of one and one-half to two minutes of muscle paralysis, the patients, though fully conscious, were not able to breathe.*"⁶³ The grim reality of such handling of "patients" receiving "care" in the aforementioned context suggests the worst for the civilly committed as well.

55 Schmideberg, *supra* note 35, at 22 (emphasis in the original).

56 Alexander, *Torts*, 21 SYRACUSE L. REV. 677, 683 (1969); 1969-1970 HEARINGS, *supra* note 10, at 263.

57 Daniel Walker, Position Paper, *Dan Walker Speaks Out on a Mental Health Program for the People of Illinois* (1972).

58 1969-1970 HEARINGS, *supra* note 10, at 201.

A 1969 state's attorney investigation of widespread unpunished crime in Illinois' Tinley Park and Chicago State mental hospitals found numerous instances of murder, rape, prostitution, torture, narcotics traffic and aggravated battery. . . .

Patients have been killed by fire, scalding, beating, and motor vehicles. One was burned to death by two patients and a former patient when she refused to submit to sexual intercourse, the investigators found.

Id. at 202.

59 Shaffer, *supra* note 25.

60 Szasz, *The Right to Health*, 57 GEO. L. J. 734, 742 (1969).

61 Morris, *supra* note 51, at 788.

62 *Id.* at 798.

63 *Id.* at 799 (emphasis in the original).

V. Inadequacy of Habeas Corpus

The safeguard par excellence for citizens stripped of their liberties is habeas corpus. "It is well settled that habeas corpus challenges the place as well as the fact of confinement, even if the challenged place is a particular hospital ward. . . ."⁶⁴ Comparatively few actions for illegal detention have been brought by mental inmates,⁶⁵ generally far fewer than those brought by convicts.⁶⁶ It is possible that the crucial variable causing this difference is the freer access of penitentiary inmates to legal advice. This has been suggested by at least one comparison of mental patients committed by the criminal route (all of whom had some legal counsel) with civilly committed inmates.⁶⁷ Of course, more profound differences also incur. Once a patient is committed, he is immediately subject to "treatment" such as electroshock therapy and massive doses of tranquilizers, which has the undisputed affect of robbing the patient of any initiative and the will to resist.⁶⁸

In 1966, in Bellvue, less than 10% of the "two-physician" [civilly committed] patients requested judicial review (531 out of 4,496). More important, however, is that over one-third of the "two-physician" patients who did request judicial review were determined not to be in need of treatment for mental illness, and were discharged. Not all of the 531 patients had to appear in court. Approximately 25% (141) were administratively released when the hospital determined it would be futile to oppose release. Of the 390 patients whose release was actively opposed, 37 (or nearly 10%) were found by the court not to be mentally ill. It seems reasonable to conclude that, had they received a *prior* judicial hearing, those persons would not have been committed at all.⁶⁹

The mental inmate ordinarily is unaware of his rights⁷⁰ and "psychiatrists usually consider it 'good therapy' to keep from the involuntarily hospitalized patient information about his legal rights and recourses, lest he thereby deprive himself of needed 'treatment.'"⁷¹ A habeas corpus hearing can itself be viewed as having an antitherapeutic impact.⁷² Civilly committed patients are frequently

64 *Covington v. Harris*, 419 F.2d 617, 620 (D.C. Cir. 1969); *See also Lake v. Cameron*, 364 F.2d 657, 659 (D.C. Cir. 1966).

65 53 VA. L. REV., *supra* note 54, at 1148.

66 80 HARV. L. REV., *supra* note 34, at 903.

67 SZASZ, *supra* note 2, at 68.

There is a fundamental lesson to be learned from the contrast between the appeals for judicial intervention by prison inmates and by mental institution inmates:

The ratio of patients to prisoners is 3 to 1. For every public defender we should have three mental health lawyers. That we do not is but one more indication of society's incredible neglect of the constitutional rights of the mentally ill. 1969-1970 HEARINGS, *supra* note 10, at 271.

68 1969-1970 HEARINGS, *supra* note 10, at 267.

Physical methods that erode the inmate's will are commonplace: "A survey recently carried out in Massachusetts disclosed that EST [electro-shock therapy] is, in many instances, being used indiscriminately in hospitals and doctor's offices." NEWSWEEK, Jan. 8, 1973, at 54.

69 1969-1970 HEARINGS, *supra* note 10, at 280-81 (emphasis in the original).

70 53 VA. L. REV., *supra* note 54, at 1148.

There is no dispute on this point: "In general, patients do not know their rights." 1969-1970 HEARINGS, *supra* note 10, at 171.

71 SZASZ, *supra* note 2, at 67.

72 Birnbaum, *A Rationale for the Right*, 57 GEO. L. J. 752, 761 (1969).

told by psychiatrists that if they remain quiet and docile they will be freed within sixty days, but if they request review, they will be restrained for six months.⁷³

The habeas corpus demand brands an otherwise helpless patient as an adversary of the institutional staff.⁷⁴ Conveniently for institutional administrators, suits for damages for false imprisonment are interpreted as themselves symptomatic of mental illness.⁷⁵ If staff members tell inmates that habeas corpus suits are felt to be similar symptoms, inmates could be intimidated. If an inmate nevertheless seeks redress, he may be hindered by restrictions on his correspondence.⁷⁶ Yet another explanation of the dearth of prolonged hearings is expense, although it has been intelligently argued that in light of *Gideon*,⁷⁷ *Miranda*⁷⁸ and *Gault*⁷⁹ the inmate may be constitutionally entitled to court-appointed attorneys and expert witnesses.⁸⁰

Unfortunately, some courts refuse to allow habeas corpus to test the evidence under which the applicant was committed. These courts further decline to consider testimony to demonstrate that the petitioner was not insane at the time of the commitment proceeding.⁸¹ Clearly, the "availability of habeas corpus in the abstract"⁸² is no panacea. The majority of patients are too unsophisticated and do not have sufficient resources to initiate habeas corpus proceedings or petitions for discharge.⁸³ And some authorities assert that even the habeas corpus right plus legal representation can nevertheless leave a patient nearly impotent.⁸⁴

VI. The Due Process Imperative

A. *The Juvenile Parallel*

It is contended that commitment proceedings are civil and not criminal, and that the due process standard to be applied is that which is appropriate to civil cases. The contention that commitment statutes are not penal, but are civil and rehabilitative is similar to that made for many years by state courts in dealing with juveniles:

The right of the state, as *parens patriae*, to deny to the child procedural rights available to his elders was elaborated by the assertion that a child, unlike an adult, has a right "not to liberty but to custody." . . . If his parents default in effectively performing their custodial functions—that is, if the child is "delinquent"—the state may intervene. In doing so, it does not

73 1969-1970 HEARINGS, *supra* note 10, at 280.

74 SZASZ, *supra* note 2, at 67.

75 1969-1970 HEARINGS, *supra* note 10, at 139; *See also id.* at 227.

76 53 VA. L. REV., *supra* note 54, at 1148.

77 *Gideon v. Wainwright*, 372 U.S. 335 (1963).

78 *Miranda v. Arizona*, 384 U.S. 436 (1966).

79 *In re Gault*, 387 U.S. 1 (1967).

80 Birnbaum, *supra* note 72, at 760-61; *See Lessard v. Schmidt*, Civil No. 71-C-602 (E.D. Wis., Oct. 19, 1972), finding there to be little doubt that parties detained on grounds of mental illness enjoy the right to counsel, including appointed counsel in case of indigence.

81 ANTIEAU, *supra* note 11, at 523-24.

82 *Ragsdale v. Overholser*, 281 F.2d 943, 950 (D.C. Cir. 1960).

83 1969-1970 HEARINGS, *supra* note 10, at 298.

84 SZASZ, *supra* note 2 at 173.

deprive the child of any rights, because he has none. It merely provides the "custody" to which the child is entitled.⁸⁵

Judges and legislators also shrank from calling juvenile court laws "criminal" and preferred to call them "civil." This was done in part to circumvent comprehensive application of Bill of Rights safeguards to juveniles.⁸⁶

The Supreme Court in 1967 held in *In re Gault*⁸⁷ that the constitutional right of juveniles to due process necessitates that courts go beyond the labels "civil" and "criminal" and look "instead at the interests involved and the actual nature of the proceedings."⁸⁸ As a result juveniles are now entitled to many of the safeguards available to adult criminals. A similar examination of the actual interests regarding the civilly committed is needed. This is because the civilly committed are now subordinated to the state as are children. The expansion of due process rights for committed adults so as to put them at least on an equal footing with children is called for as a matter of consistency and equity.

B. *The Right to Treatment*

The loss of the due process rights of those committed is a long-perceived peril. The Supreme Court asserted in 1940:

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.⁸⁹

Commentators had reasoned as early as 1960 that if anyone were restrained of his liberty because of a mental ailment the state was bound to provide reasonable medical attention. If attention reasonably well adapted to his needs were withheld, the victim would be not a patient but "virtually a prisoner."⁹⁰ Eight years later the Supreme Court of Massachusetts edged toward agreement. "Confinement of mentally ill persons, not found guilty of crime, without affording them reasonable treatment" it reasoned, "also raises serious questions of deprivation of liberty without due process of law."⁹¹ And in 1970 the Supreme Court of Nevada conceded that, "Due process may forbid the confinement of a mentally ill person, not found guilty of a crime, without affording reasonable treatment."⁹²

It appears that the law is developing the substantive right to adequate treat-

85 *In re Gault*, 387 U.S. 1, 17 (1967).

86 *Id.* at 59 (Black, J., concurring).

87 *In re Gault*, 387 U.S. 1 (1967).

88 *Murel v. Baltimore City Criminal Court*, 407 U.S. 355, 364 (1972) (Douglas, J., dissenting).

89 *Minnesota v. Probate Court*, 309 U.S. 270, 276-77 (1940).

90 Editorial, *A New Right*, 46 A.B.A.J., 516, 517 (1960).

91 *Nason v. Superintendent of Bridgwater State Hosp.*, 353 Mass. 604, 233 N.E.2d 908, 913 (1968).

92 *Maatallah v. Warden, Nevada State Prison*, 470 P.2d 122, 123 (Nev. 1970).

ment.⁹³ In the 1966 landmark case⁹⁴ rendered by the United States Court of Appeals for the District of Columbia, *Rouse v. Cameron*,⁹⁵ it was held that an involuntarily committed person acquitted of a criminal charge in the District of Columbia by reasons of insanity had a federal statutory right to meaningful treatment during incarceration. The *Rouse* court said: "Regardless of the statutory authority, involuntary confinement without treatment is 'shocking'" and accordingly it discerned that constitutional issues were involved.⁹⁶ Three years later in *Covington v. Harris*⁹⁷ the same circuit alluded to the logic of *Rouse*: "Under present law, the principal justification for involuntary hospitalization is the prospect of treatment, and a failure to provide treatment would present 'serious constitutional questions.'"⁹⁸

In 1971 the thrust toward a due process-founded right to treatment was illustrated in *Wyatt v. Stickney*⁹⁹ which asserted:

When patients are so committed for treatment purposes they unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition.¹⁰⁰

The *Wyatt* holding concerning the involuntarily civilly committed is straightforward: "The purpose of involuntary hospitalization for treatment purposes is *treatment* and not mere custodial care or punishment."¹⁰¹

The *Wyatt* decision was the logical climax of the due-process argument for a right to treatment. In finding that civilly committed inmates in an Alabama state facility had treatment rights under the fifth and fourteenth amendments *Wyatt* clarified the status of involuntary civil patients. The *Wyatt* principle holds that these parties are genuine patients. They cannot be deemed less by institutional staffs.

It was feared, subsequent to *Rouse*, that the right to treatment as a necessary adjunct of involuntary commitment, although resting on both constitutional and statutory grounds, might be established only with difficulty.¹⁰² Indeed, at least

93 Schneider, *supra* note 2, at 1062.

94 1969-1970 HEARINGS, *supra* note 10, at 53.

The potential of *Rouse* is widely admitted: Birnbaum, *Some Remarks on "The Right to Treatment,"* 23 ALA. L. REV. 623, 624 (1971).

95 373 F.2d 451 (D.C. Cir. 1966); see also *Darnell v. Cameron*, 348 F.2d 64, 68 (D.C. Cir. 1965), and *Sas v. State of Maryland*, 334 F.2d 506, 516-17 (4th Cir. 1964) for pre-*Rouse* allusions to a potential constitutional right to treatment.

96 *Rouse v. Cameron*, 373 F.2d 451, 455 (D.C. Cir. 1966).

97 419 F.2d 617 (D.C. Cir. 1969).

98 *Id.* at 625. State courts have thought similarly: "The confinement of one who is mentally ill is primarily for the purpose of treatment. . . ." *Maattallah v. Warden, Nevada State Prison*, 470 P.2d 122, 123 (Nev. 1970).

99 325 F. Supp. 781 (M.D. Ala. 1971).

100 *Id.* at 784. When *Lessard v. Schmidt*, Civil No. 71-G-602 (E.D. Wis. Oct. 19, 1972), was appealed before the Fifth Circuit in December, 1972—

Robert Johnson, Justice Department attorney, argued that detaining a mental patient without adequate treatment "would be like taking him to a desert and saying, 'We're going to leave you here until you build a house.' If you do that, we must provide him a hammer and nails."

The New York Times, Dec. 18, 1972, at 34.

101 *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971) (emphasis in the original).

102 53 VA. L. REV., *supra* note 54, at 1147.

seven times during the 1960's the Supreme Court denied certiorari regarding the right to treatment.¹⁰³ However, the prospect for a universally recognized right to treatment is not necessarily remote in light of *Rouse* and *Robinson v. California*.¹⁰⁴ This latter case saw the Supreme Court strike down a state statute making narcotics addiction a crime and its dictum "contains, albeit implicitly, the important limitation that permissible civil confinement is the confinement required for *treatment*."¹⁰⁵

Sooner or later the right of each mental institution inmate to adequate treatment may be expressly determined to be within the fourteenth amendment due process and equal protection requirements by the United States Supreme Court.¹⁰⁶ The emerging consciousness of inmate rights is such that in a 1972 Supreme Court concurring opinion Justice Douglas compared the continued holding of an ex-convict for mental observation after the expiration of sentence with the practices of Communist China.¹⁰⁷

C. *The Right to Least Restrictive Alternative*

The involuntarily civilly committed have already been promised security under the principle of *least restrictive alternative*, which requires incarcerating authorities to impose the minimum restraints requisite to each particular inmate's care. Least restrictive alternative is a theory founded upon the due process clause, which mandates that no person shall be deprived of liberty without substantial cause. A patient's liberty is unduly circumscribed to the extent that he is overly restricted in light of his particular needs. This due process theory, if seriously put into practice, might well have a measurable impact upon our state hospitals. At New York City's Bronx State Hospital in 1967, for example, officials "estimated that between 40 and 60 per cent of their patients could be cared for with something less than full-day institutionalization"¹⁰⁸ granted the necessary facilities. It was charged in 1972 that in Illinois "readmissions are due, in the main, to the lack of after-care facilities in many communities."¹⁰⁹ Alertness to the need for genuine implementation of a least restrictive alternative-like approach has led to the cautioning that a person should not be forced to remain in a public psychiatric institution for observation if an adequate examination could

103 Birnbaum, *supra* note 94, at 635 n.26.

104 370 U.S. 660 (1962).

105 77 YALE L.J., *supra* note 2, at 97-98 (emphasis in original); *Robinson v. California* 370 U.S. 660, 666 (1962).

106 1969-1970 HEARINGS, *supra* note 10, Appendix at 529; *Lessard v. Schmidt*, Civil No. 71-C-602 (E.D. Wis. Oct. 19, 1972), is founded upon due process grounds. Jurisdiction in both *Lessard* and in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), was pursuant to 42 U.S.C. § 1983, which 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.

107 *McNeil v. Director, Patuxent Institution*, 407 U.S. 245, 254 n.3 (Douglas, J., concurring) (1972).

108 77 YALE L.J., *supra* note 2, at 88 n.5.

109 Daniel Walker, *supra* note 57.

be performed without depriving him of his liberty.¹¹⁰ Yet, even if enforced, the theory would not necessarily be of profound import. Chief Justice Burger reminds us that "a person's freedom is no less arrested, nor is the effect on him significantly different, if he is confined in a rest home with a euphemistic name rather than at St. Elizabeths [District of Columbia mental] Hospital."¹¹¹

The least restrictive alternative approach was held a due process right by the United States Court of Appeals for the District of Columbia in *Covington v. Harris*¹¹² which decided that the principle of the least restrictive alternative, consistent with the legitimate purposes of a commitment, inheres in the very nature of civil commitment.¹¹³ This safeguard is not exhausted at the hospital door:

The principle of the least restrictive alternative is equally applicable to alternative dispositions *within* a mental hospital. It makes little sense to guard zealously against the possibility of unwarranted deprivations prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. The range of possible dispositions of a mentally ill person within a hospital, from maximum security to outpatient status, is almost as wide as that of dispositions without.¹¹⁴

Covington further held that the confining hospital bore the burden of justifying a maximum security incarceration,¹¹⁵ and that such justification must be reasonably related to treatment.¹¹⁶

In *Lake v. Cameron*,¹¹⁷ a case preceding *Covington*, Chief Justice Burger (while a judge on the United States Court of Appeals for the District of Columbia) vigorously dissented to the majority's response to a habeas corpus proceeding. The majority in *Lake* instructed the district court to determine the relevance of institutional restraints upon the appellant, taking a tack consistent with the principle of least restrictive alternative. The dissent insisted that, "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."¹¹⁸

110 SZASZ, *supra* note 2, at 188-89.

111 *Lake v. Cameron*, 364 F.2d 657, 664 (D.C. Cir. 1966) (Burger, J., dissenting); That euphemisms are widely invoked was suggested when it was charged during 1972 that in Illinois the highly touted program for moving patients out of the State hospitals has simply moved people from warehousing in large State institutions to warehousing in smaller, wholly inadequate nursing homes and rest homes.

Daniel Walker, *supra* note 57.

112 419 F.2d 617 (D.C. Cir. 1969).

113 419 F.2d at 623; *accord*, *Lessard v. Schmidt*, Civil No. 71-G-602 (E.D. Wis. Oct. 19, 1972).

114 *Id.* at 623-24 (emphasis in the original).

115 *Id.* at 626.

116 *Id.* at 625, 626-27.

117 364 F.2d 657 (D.C. Cir. 1966).

118 *Id.* at 663 (Burger, J., dissenting); Chief Justice Burger is not alone in drawing attention to this matter:

The questions currently asked in commitment proceedings only rarely raise the issue whether the patient, who may need treatment, could benefit as much or more from ambulatory treatment in a local center or regular visits at home by a trained nurse.

Comment, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1298 (1966).

The *Lake* dissent dwells upon the inadequacies of judicial appraisal of appropriate alternatives. Justice Burger's objection is reconcilable with the least restrictive alternative principle, however, once granted the presupposition that the burden is on the institution to establish the legality of its disposition. Judicial inability to weigh the legitimacy of each confinement disappears when the authorities are bound to present a comprehensible case.

It will be seen that funding for the right to treatment is likely to be inadequate. Hence, the treatment right would override the significance of the least restrictive alternative right to the inmates. Once given that institutions lack funding for virtually any treatment, litigation as to exactly what care is appropriate becomes irrelevant. It is the invocation of the right to treatment which is the more important for inmates of the 1970's.

VII. Obstacles to the Treatment Right

A. Expense

Even if the *Wyatt* rationale of a right to treatment is eventually upheld by the Supreme Court, a cooperative reaction from those responsible for the involuntarily civilly committed may not be forthcoming. *Wyatt* itself presented on its facts a greater financial than constitutional dilemma.¹¹⁹ This kind of difficulty was perceived immediately after *Rouse* with this simple recognition: "There is no reason to believe that mental hospitals will be adequately financed or staffed, at least for a long time to come, to provide adequate treatment."¹²⁰

No cost-reductive treatment breakthroughs seem imminent. An impressive decline in the number of public mental hospital resident patients up to the 1970's was attributable to the increased utilization of drugs.¹²¹ Whether such drug usage constitutes curative treatment is debateable. "As one doctor put it, 'What we offer the patient here is control and the drugs are just another form of control—a chemical strait jacket.'¹²²

Even massive new funding might be insufficient to meet *Wyatt* standards of fundamental medical treatment. Already the District of Columbia spends at least twice as much for mental health care per capita as any state or metropolitan area in the United States.¹²³ Yet at the District's St. Elizabeths Hospital roughly 50 per cent of the inmates have been receiving no treatment at all:¹²⁴

[M]inimal custodial, security "care" actually costs the U.S. taxpayer and the citizens of the District of Columbia \$31.11/day. That's over \$900/month. Over \$10,800/year. Think about it. For that money a person in SEH could afford a nice house or apartment, a car, and live very com-

119 Comment, 23 ALA. L. REV. 642, 654 (1971).

120 Katz, *supra* note 20, at 781.

121 1969-1970 HEARINGS, *supra* note 10, at 19.

122 *Id.*, Appendix at 425.

123 *Id.* at 130.

124 80 HARV. L. REV., *supra* note 34, at 901 n.18.

fortably. An old person could live in a nice private nursing home. Yet at this phenomenal cost these human beings are kept like animals.¹²⁵

The courts do not have the power to legislate adequate appropriations and resources for treatment, but at the same time they cannot condone their unfulfilled promise to the mental patient that he will receive adequate treatment.¹²⁶ *Wyatt* held that "effective treatment is constitutionally required because, absent treatment, the hospital is transformed 'into a penitentiary where one could be held indefinitely for no convicted offense.'"¹²⁷ And *Wyatt* additionally insisted: "The failure to provide suitable and adequate treatment to the mentally ill cannot be justified by lack of staff or facilities."¹²⁸

Even pre-*Wyatt*, state mental health programs followed only education, highways and public welfare for their share of state expenditures, and the "total expenditures of state and county governments constitute over one billion dollars annually for capital and operating costs of mental hospitals."¹²⁹ The result of a *Wyatt*-like Supreme Court holding could be astronomical state expense. The staggering liability that could ensue from damage suits alone would be sobering.¹³⁰ On the other hand, treated patients who returned to the working force would reduce the annual wage loss, estimated over \$2 billion, attributed to mental patients.¹³¹

There are few new resources to be tapped. Institutional peonage is now universal in traditional state hospitals, which accommodate the greatest proportion of the severely mentally ill.¹³² In the large state hospitals, if all the patient laborers stopped working, the institutions would have to close down.¹³³ This is implied by the enormous disparity between the daily expense of private psychiatric

125 1969-1970 HEARINGS, *supra* note 10, at 412.

Note the "treatment" of a patient incarcerated upon a finding of not guilty by reason of insanity and of one incarcerated as a sexual psychopath in 1967 and 1966, respectively:

The Government concedes in its brief that appellant is "receiving little or no treatment; at least this was true at the time of the hearing." During the four months preceding the hearing in the District Court he had seen a psychiatrist "approximately three times" and had not participated in any activities or therapeutic programs other than "environmental therapy." The hospital made no effort to induce him to participate and did not even tell him that any treatment was available. Passivity is a mark of his illness.

Tribby v. Cameron 379 F.2d 104, 105 (D.C. Cir. 1967).

Counsel later made another proffer that appellant would testify that "he receives no treatment whatever; that his time is spent in mopping floors; and eating and sitting around watching television all day long; that he has only the briefest and most casual interviews with the professional staff at St. Elizabeths Hospital. . . ."

The judge responded that he considered the purpose of the hearing to be only to determine whether appellant was still a sexual psychopath. He made no findings of fact on the alleged lack of treatment.

Millard v. Cameron 373 F.2d 468, 472 (D.C. Cir. 1966).

126 *Schneider*, *supra* note 2, at 1062. See, Note, *Problems of Enforcing the Rights of the Mentally Retarded*, 48 NOTRE DAME LAWYER 1314 (1973), (printed herein). This note discusses judicial intervention to obtain proper financing for the treatment of the mentally retarded, a traditionally legislative area.

127 *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971); *see also* *Rouse v. Cameron*, 373 F.2d 451, 458-59 (D.C. Cir. 1966).

128 *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971).

129 1969-1970 HEARINGS, *supra* note 10, Appendix at 532.

130 *Id.*, Appendix at 529.

131 *Id.*, Appendix at 532.

132 1969-1970 HEARINGS, *supra* note 10, at 195.

133 *Id.* at 197-98.

hospitalization and the cost of state hospitalization.¹³⁴ In every one of the large state hospitals, patients who are needed as unpaid laborers are so conscripted. The extent to which patients labor in state mental hospitals would astonish their families and friends.¹³⁵ Every such hospital commands up to 75 per cent of its men and women patients to work.¹³⁶

B. *The Sham Treatment Gambit*

It is certain that attempts will be made to dilute the *Wyatt* right to treatment. Although *Rouse* has already held that milieu therapy was not per se sufficient, there is a danger that a very low level of "treatment" will receive judicial approval as "adequate" treatment, and will thereby cast a legitimizing stamp on the continued custodial confinement of hundreds of thousands of patients.¹³⁷ It was acknowledged in 1969 that some staff physicians at St. Elizabeths still took the position that incarceration in the institutional setting alone was treatment.¹³⁸

Staff professionals like those at St. Elizabeths may prevail even under *Wyatt*, insofar as treatment can be said to exist when a psychiatrist says that it does.¹³⁹ And it is no surprise that a large majority of patients cannot afford to obtain the services of a private psychiatrist to participate in a periodic review, since most of the involuntarily civilly committed are the poor, the helpless, and the unwanted.¹⁴⁰

Farcical "treatment" of the civilly committed is a deeply entrenched reality. It is not atypical for a patient to talk with a psychiatrist once every two or three months for five or ten minutes.¹⁴¹ The Medical Director of the Minnesota Department of Public Welfare announced that he could cite many examples of what one must call the prostitution of the treatment idea: "The most flagrant is our old friend 'industrial therapy' . . . which is often a euphemism for unpaid labor."¹⁴² If the *Wyatt* rationale is not carefully implemented, the constitutional right to treatment of those involuntarily civilly committed could immediately degenerate into the right to indeterminate imprisonment ("environmental therapy") and to uncompensated labor ("industrial therapy").

C. *The "Commitment Lobby"*

It was believed that if the problem of implementing *Wyatt* becomes acute, that the district court could order the patients sent home until the necessary funding is released for the proper administration of the confining institution.¹⁴³ Some authority is sympathetic to such an outcome, arguing that: "Since, according to the American Psychiatric Association, no state provides enough money for ade-

134 *Id.* at 269.

135 *Id.*, Appendix at 339.

136 *Id.*

137 *Id.* at 269-70.

138 *Id.* at 174.

139 *Id.* at 69.

140 *Id.* at 174.

141 *Id.* at 270.

142 *Id.* at 69.

143 23 ALA. L. REV., *supra* note 119, at 654 n.45.

quate staff, the best answer is for healers to get out of the business of forcing people to be normal."¹⁴⁴ As the Supreme Court has held regarding constitutional rights, "the rights here asserted are, like all such rights, *present* rights; they are not merely hopes to some *future* enjoyment of some formalistic constitutional promise."¹⁴⁵

Freedom for the involuntarily civilly committed would antagonize the "mental health lobby" and be politically unpopular. The true constituencies of the mental hospitals are not those within, but those without. Approximately 500 worried lawyers flooded the office of the Clerk of one United States District Court in September, 1965, with phone calls and visits asking for advice when relatives discovered that some patients would be restored to freedom.¹⁴⁶ And little wonder. It is safely said that when a patient is institutionalized the family goes about its life business with enhanced effectiveness and greater comfort.¹⁴⁷ Our mental health system bears the sins of our callous treatment of old people and many others.¹⁴⁸ Mental hospitalization absorbs those people of our society—the destitute elderly, the mentally deficient, and the maladjusted—who are unwanted in any social group or institution.¹⁴⁹

VIII. Freedom Best Response

A. *Expediency and Consistency*

It is important for the courts and legislatures in all jurisdictions to avoid a post-*Wyatt* sham-treatment route. The necessity for more funds to provide constitutionally mandated care for the current number of involuntarily committed can be minimized by outright removal of the involuntarily civilly committed from institutional rolls. This would be an alternative to raising appropriations in order to afford more staff members and more facilities to fulfill the treatment right.¹⁵⁰

The *Wyatt* principle, if upheld, will be a great opportunity for legislators in every jurisdiction if only seen as such, and not seen as a threat. The due process right to treatment can encourage Congress and state legislatures to completely abolish involuntary civil commitment. The responsibility in the eyes of the public for so politically unpopular a move might be placed upon the judiciary, such as politically unpalatable racial integration was attributed to the courts by southern legislators in the 1950's and 1960's, and by northern legislators more recently.

So libertarian an approach would facilitate jurisprudential consistency. Inasmuch as the *parens patriae* power cannot justify commitment of the physically ill, it should not justify commitment of the mentally ill.¹⁵¹ It would also foster policy consistency:

144 Shaffer, *supra* note 25.

145 *Watson v. City of Memphis*, 373 U.S. 526, 533 (1963) (emphasis in the original) (racial discrimination).

146 1969-1970 HEARINGS, *supra* note 10, Appendix at 507.

147 Birnbaum, *supra* note 72, at 772 n.57.

148 Shaffer, *supra* note 25.

149 BRAKEL & ROGK, *supra* note 4, at 38.

150 1969-1970 HEARINGS, *supra* note 10, Appendix at 641.

151 *Id.* at 273.

Except as applied to mental patients, preventive detention is still an ugly phrase. Our society is remarkably, though properly, reluctant to confine persons solely because of what they might do in the future. Probably 50 to 80 percent of all ex-felons will commit future crimes, but we do not confine them. Ghetto residents and teenage males are also much more likely to commit dangerous acts than the "average" member of the population, but we do not confine them . . . 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.¹⁵²

B. Confidence in Professionals

The discontinuation of involuntary civil commitment would not only provide financial relief to the public, promote consistency, and recognize due process rights, but would also provide an additional benefit. It would diminish the legitimate fear that social pressures are entailed in a patient's institutionalization. The United States Senate has been warned that this can be the case:

[T]he actions of student activists, black nationalists, Mexican-American grape pickers can be viewed as mentally ill by those who would rather throw out these ingredients than to work with or at least tolerate this dissent Why, they might say, these kids and these minorities are acting out; they're paranoid; they're hooked on marihuana and other drugs; they're sex maniacs; they're conducting themselves in a bizarre and disorderly manner by holding protest demonstrations. . . . These kids and these minorities, or at least their leaders, are seen as mentally ill and in need of treatment.¹⁵³

Mental health professionals are not drawn from a cross section of society. In 1970 approximately 90 per cent of all psychiatrists in America were male, as were some 85 per cent of clinical psychologists.¹⁵⁴ Ratios so unbalanced as compared to the society at large must be kept in mind when one speculates as to cultural biases influencing a commitment. "Psychiatrists have a great deal of power over their patients. In the case of a person confined to an institution, this power is virtually unlimited."¹⁵⁵ This itself may provide unease in a free society. "All professions (including the legal profession) contain unscrupulous individuals who use their position to injure others."¹⁵⁶

C. Recognition of Realities

The abolition of involuntary civil confinement would recognize that mental illness and incompetence are not synonymous, and that many persons who are

152 *Id.* at 263; It is an ironic example of our legal double standard that:

If a sociologist predicted that a person was eighty percent likely to commit a felonious act, no law would permit his confinement. On the other hand if a psychiatrist testified that a person was mentally ill and eighty percent likely to commit a dangerous act, the patient would be committed.

Comment, *Civil Commitment of the Mentally Ill*, 79 HARV. L. REV., *supra* note 118, at 1290.
153 1969-1970 HEARINGS, *supra* note 10, at 225.

154 Chesler, *Women & Madness*, Ms., July, 1972, at 111.

155 *Stowers v. Wolodzko*, 386 Mich. 119, 135, 191 N.W.2d 355, 363 (1971).

156 *Id.* at 135, 191 N.W.2d at 363.

mentally ill are entirely capable of making rational and important decisions, including the decision to seek or reject hospital treatment.¹⁵⁷ Nor does mental disorder equal dangerousness, contrary to the widely accepted proposition. "It is a proposition that contradicts common observation."¹⁵⁸ Even a propensity to impassioned moods alone should not justify involuntary commitment:

Many sane persons, under the influence of strong excitements, are subject to serious and perhaps dangerous fits of passion; but another could not be allowed, on this ground alone, to seize and imprison them, in anticipation that possibly the occasion for excitement might arise and the passion be manifested.¹⁵⁹

Liberty for those now civilly committed against their will would not only be well-founded upon constitutional grounds but amount to a safe social policy. The public fears the dreaded sequels of the right to treatment—that the severely mentally ill who need further hospital care and treatment may remain in, or return to, their own communities.¹⁶⁰ But just such a procedure is, and has been, the case in many communities with no significant effects on the murder, non-negligent manslaughter, and suicide rates in those communities.¹⁶¹

The public's fear of the mentally ill is unjustified insofar as it is popularly equated with dangerousness. Whether the mentally ill are allowed to remain in the community or are institutionalized apparently results in no significant difference in the overall rates of violent crime or suicide.¹⁶² A five-and-a-half-year study of 5,000 patients discharged from New York State mental hospitals showed that:

[P]atients with no record of prior arrest have a strikingly low rate of arrest after release. Their overall rate of arrest is less than one-twelfth that of the general population and the rate for each separate offense is also far lower, especially for more serious charges.¹⁶³

IX. Conclusion

One psychiatric authority, Dr. Thomas S. Szasz of the State University of New York, has long called for the virtually total abolition of involuntary commitment.¹⁶⁴ In the present, post-*Wyatt* period, the need for this fundamental improvement in policy is now more pressing than ever. Law has played "Big Brother is watching you" with the mentally ill for a century. Less law rather than more may be the answer henceforth.¹⁶⁵

It has been demonstrated that civil commitment is procedurally a threat to

157 1969-1970 HEARINGS, *supra* note 10, at 262.

158 *Van Deusen v. Newcomer*, 40 Mich. 90, 129 (1879).

159 *Id.* at 129-30.

160 1969-1970 HEARINGS, *supra* note 10, at 44.

161 *Id.*

162 Birnbaum, *supra* note 72, at 757; *see also* 1969-1970 HEARINGS, *supra* note 10, at 156.

163 1969-1970 HEARINGS, *supra* note 10, at 265.

164 *Id.*, Appendix at 473.

165 *Id.* at 26.

civil liberties, and is based upon grossly vague concepts of mental illness and dangerousness. Disposition of mental inmates has been shown to be poor or brutal, with few avenues of relief open to inmates. The due process right to treatment, with the expense that it must entail, makes freedom the best response to recognition of patient rights. Such response, despite the "commitment lobby," would be a consistent and realistic policy.

In the final analysis, however, appeals to authorities in the fields of medicine, psychiatry, or judicial administration do not constitute the heart of the case against involuntary civil commitment. "The real issue is not whether this practice is effective, but whether, in a free society, it is morally tolerable."¹⁶⁶ The actual procedure of involuntary civil commitment and disposition of the committed is an apparent violation of the due process of law to be afforded every American. The theory of involuntary civil commitment, even pursuant to treatment, has Americans so subordinated to the sovereign as children traditionally were kept subordinate to their fathers. There is no room for such arrogance in a democracy.

George S. Swan

¹⁶⁶ SZASZ, *supra* note 2, at 173.