1981

Concurrence in Quotes: A Critical Assessment of Chief Justice Burger's Objections to a Right to Treatment for the Involuntarily Confined Mentally Ill

Richard Delgado
University of Alabama - School of Law, rdelgado@law.ua.edu

Michael N. Alexander

Peggy Bernardy

Fran Bremer

U.C. DAVIS LAW REVIEW

University of California Davis

VOLUME 15 SPRING, 1982 NUMBER 3

"Concurrence" in Quotes: A Critical Assessment of Chief Justice Burger's Objections to a Right to Treatment for the Involuntarily Confined Mentally Ill

RICHARD DELGADO,* MICHAEL N. ALEXANDER,†
PEGGY BERNARDY,††† FRAN BREMER,†††
HOLLY C. CHANG,††† JAKE DEAR,††
DENNIS T. IMAI,††† SUSAN JAWOROWSKI,†††
AND DEBRA MARGOLIS†††

Table of Contents

* Professor of Law, U.C.L.A. Law School; Visiting Professor, U.C. Davis School of Law.
† Executive Editor, U.C. Davis Law Review.
†† Editor, U.C. Davis Law Review.
††† Second year student, U.C. Davis School of Law.

INTRODUCTION

More than twenty years ago, Morton Birnbaum proposed a right to treatment on behalf of the institutionalized mentally ill.[1] His argument was simple and elegant: The state, in exercising its power to commit, deprives mental inmates of a variety of procedural and substantive rights.[2] The *quid pro quo* that justifies this deprivation is treatment. Thus, mental commitment without treatment violates inmates' constitutional rights.[3] In *Rouse v. Cameron*,[4] Judge David Bazelon elaborated on the right to treatment, and a number of states[5] and federal circuits[6]

---

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

[2] *Id.* at 502-03.

[3] *Id.* Unjustified incarceration obviously violates a patient's right to liberty, *id.* at 503, but a failure to provide treatment can also subvert custodial protection, the principal competing goal of confinement for mental illness. *See* O'Connor v. Donaldson, 422 U.S. 563, 582 (1975) (Burger, C.J., concurring); notes 150-202 and accompanying text *infra*. Without an adequate staff of psychologists, psychiatrists, and other mental health workers, and without the spur of regularly scheduled treatments and meetings with the patient, the quality of care afforded at public institutions may decline to shocking levels. Consider the conditions in Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); and Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *rev'd in part, remanded in part sub. nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). In *Romeo*, the petitioner suffered over 70 bodily injuries, some of which became infected either from inadequate medical attention or from contact with human excrement that the institution's staff failed to remove. 644 F.2d at 155. In *Rockefeller*, the court found over 1,300 reported incidents of injury, assaults on patients, or fights during one eight-month period. The court noted that there were only half the number of doctors needed, and all other staff were in similarly short supply. Generally, the conditions were "hazardous to the health, safety, and sanity of the residents." 357 F. Supp. at 755-57. *See* notes 153-158 and accompanying text *infra*. In *Wyatt*, the Court found overcrowding, fire and other emergency hazards, poorly trained staff, inadequate numbers of staff, and failure to provide a humane psychological and physical environment. 325 F. Supp. at 782-84.

[4] 373 F.2d 451 (D.C. Cir. 1966) (right to treatment for a criminal defendant acquitted of an offense by reason of insanity and subsequently committed to a mental hospital).

[5] States that recognize a right to treatment by statute or case law include: Alabama, ALA. CODE tit. 22, §§ 189-230 (1975); Alaska, ALASKA STAT. §

subsequently adopted some form of the right.

The right to treatment for the confined mentally ill has come before the United States Supreme Court on two occasions. In *O'Connor v. Donaldson,*[7] the Court considered a damages suit brought by a mental inmate who charged that the institution in which he had been confined improperly denied him release or treatment.[8] Finding that the inmate could live outside the institution with the help of friends, the Court ordered his release.[9]

47.30.130 (1971); Arizona, ARIZ. REV. STAT. ANN. § 31-224 (right to treatment for criminals); Arkansas, ARK. STAT. ANN. § 59-1409 (1979); California, CAL. WELF. & INST. CODE §§ 5152, 5172, 5250(c), 5260(c), 5307 (West Cum. Supp. 1981); Colorado, COLO. REV. STAT. § 27-10-101 (1975); Connecticut, CONN. GEN. STAT. § 17-206(c) (1973); Delaware, DEL. CODE tit. 16, §§ 5121-5135 (1970 and Cum. Supp. 1980); District of Columbia, D.C. CODE § 21-562 (1973); Georgia, GEORGIA CODE § 88-502.2 (1978); Illinois, ILL. REV. STAT. ch. 91 ½ (1973), Indiana, IND. CODE § 16-14-1-2 (1971); Kansas, KAN. STAT. § 59-2927 (1973); Kentucky, KY. REV. STAT. ANN. § 202.267 (Baldwin 1972); Louisiana, LA. REV. STAT. ANN. § 28:182 (West 1969); Maine, ME. REV. STAT. tit. 34, § 2252 (1965); Maryland, MD. ANN. CODE art. 59, § 2 (1972); Massachusetts, MASS. GEN. LAWS ANN. ch. 123, § 2 (West 1972); Michigan, Silvers v. People, 22 Mich. App. 1, 176 N.W.2d 702 (1970); Mississippi, MISS. CODE ANN. § 41-17-5 (1972); Missouri, MO. REV. STAT. § 630.115 (1980); Montana, MONT. REV. CODES ANN. § 38-1309 (1975); Nebraska, NEB. REV. STAT. §§ 83-307, -356 (1971); New Hampshire, N.H. REV. STAT. ANN. §§ 135-B:42-44 (1973); New Jersey, Application of D.D., 118 N.J. Super. 1, 6, 285 A.2d 283, 286 (1971); New York, N.Y. MENTAL HYG. LAW § 7.05 (McKinney 1973); North Carolina, N.C. GEN. STAT. §§ 122-55.1, 122-55.5-.6 (1974); Oklahoma, OKLA. STAT. tit. 43A, § 91 (1971); Pennsylvania, 50 PA. CONS. STAT. § 4201 (1969); Tennessee, TENN. CODE ANN. § 33-306(b) (1973); Texas, TEX. REV. CIV. STAT. ANN. art. 5547-70 (Vernon 1958); Utah, UTAH CODE § 64-7-6 (1968); Vermont, VT. STAT. ANN. tit. 18, § 7703 (1977); Washington, WASH. REV. CODE § 71.05.360(2) (1974); West Virginia, W. VA. CODE §§ 27-5-9 (1974).

[6] Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977) (right to treatment for a prison inmate); Welsch v. Likins, 550 F.2d 1122 (8th Cir. 1977) (leaving open right to treatment for state mental hospital patients); Scott v. Plante, 532 F.2d 939 (3d Cir. 1976) (right to treatment for state mental hospital patient); Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) (right to treatment for state mental hospital inmates). Federal district courts in other circuits have also recognized the right to treatment. *See, e.g.,* Flakes v. Percy, 511 F. Supp. 1325 (W.D. Wis. 1981) (inmates have a right to minimum level of treatment adequate to cure); Eckerhart v. Hensley, 475 F. Supp. 908 (W.D. Mo. 1979) (right to treatment for those involuntarily confined); Davis v. Watkins, 384 F. Supp. 1196 (N.D. Ohio 1974) (articulating standards for mental patient's right to treatment).

[7] 422 U.S. 563 (1975).

[8] *Id.* at 565-73.

[9] *Id.* at 568, 577.

Although the case was decided on right to liberty rather than on right to treatment grounds, Justice Burger wrote an impassioned concurrence[10] in which he argued that a right to treatment does not and should not exist.[11]

Late in the 1981 term, the Supreme Court decided a second case presenting right to treatment issues, again declining to confront the right squarely. *Pennhurst State School & Hospital v. Halderman*[12] presented the question of whether a federal statute[13] created a substantive right and cause of action for an institution's failure to provide appropriate treatment. The Supreme Court held that the statute expressed only a congressional "nudge"[14] and remanded the case to determine whether state law supplied a concrete right.[15]

Youngberg v. Romeo,[16] a case currently before the Court on writ of *certiorari*, also presents right to treatment issues. In *Romeo*, the Third Circuit found that the involuntarily committed mentally retarded have a right to treatment based on the fourteenth amendment.[17] This right implicates "mixed questions of law and medical judgment,"[18] requiring flexible judicial review and a degree of deference to medical expertise.[19] The right arises regardless of the basis of commitment—danger to self, danger to others, or need for treatment.[20]

Romeo presents a number of issues other than the right to treatment, including a right against shackling and a right to pro-

---

[10] For a fascinating account of the maneuverings surrounding the Chief Justice's concurring opinion and the majority decision, see B. WOODWARD & S. ARMSTRONG, THE BRETHREN 437-54 (1979).

[11] O'Connor v. Donaldson, 422 U.S. 563, 578 (Burger, C.J., concurring).

[12] 101 S. Ct. 1531 (1981).

[13] 42 U.S.C. §§ 6000-6081 (1978) (the Developmental Disabilities Assistance and Bill of Rights Act).

[14] Pennhurst State School & Hosp. v. Halderman, 101 S. Ct. 1531, 1541 (1981). *But see id.* at 1547-48 (Blackmun, J., concurring).

[15] *Id.* at 1546-47.

[16] 644 F.2d 147 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term).

[17] Romeo v. Youngberg, 644 F.2d 147, 158-59, 165-66, 168-69 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term).

[18] Romeo v. Youngberg, 644 F.2d 147, 159 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term).

[19] Romeo v. Youngberg, 644 F.2d 147, 158-59, 165 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term).

[20] Romeo v. Youngberg, 644 F.2d 147, 165 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term).

tection from harm.[21] It is therefore possible that, as it did in *O'Connor* and *Pennhurst*, the Court will decide *Romeo* on nontreatment grounds. Still, the frequency with which right to treatment cases have arisen,[22] the intense public interest they generate,[23] and the lack of unanimity among the circuits[24] suggest that the Supreme Court will soon confront the "right" and decide whether it actually exists.

When the Court does confront the right, Chief Justice Burger's concurring opinion in *O'Connor v. Donaldson* will likely assume major significance. It is the only existing opinion by a Supreme Court Justice on the question.[25] Moreover, it is unequivocal: Chief Justice Burger opposes such a right and will vote against it when the issue comes before the Court. Unless the Chief Justice has changed his position—and there is no indication that he has—the objections he raised in *O'Connor* remain of continuing importance.

This article identifies and evaluates Chief Justice Burger's objections to a right to treatment. Some of the Chief Justice's objections are aimed only at a constitutionally based right; others focus on any type of right to treatment.[26] His first objection is that a right to treatment is inconsistent with society's tradi-

---

[21] Romeo v. Youngberg, 644 F.2d 147, 159-62 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term).

[22] *See* cases cited in notes 5-6 *supra*.

[23] In *Romeo*, for example, at least 23 *amicus curiae* briefs were filed, including briefs submitted by every major psychological and psychiatric association and many state attorneys general. Telephone interview with Edmond Tiryak, attorney for respondent Nicholas Romeo, in Philadelphia (December 8, 1981). *But see* Eisenberg & Yeazell, *The Ordinary and the Extraordinary in Institutional Litigation*, 93 HARV. L. REV. 465 (1980) (arguing that the "extraordinary" concern and attention that center around such "institutional" cases are unwarranted).

[24] Courts that have adopted a right to treatment are cited in note 6 *supra*. Cases that have refused to recognize the right include: Morales v. Turman, 562 F.2d 993 (5th Cir. 1977); Marshall v. Parker, 470 F.2d 34 (9th Cir. 1972) (drug addict has no constitutional right to rehabilitation program), *aff'd sub nom.* Marshall v. United States, 414 U.S. 417 (1973).

[25] The majority opinion in *O'Connor* rested on "right to liberty" grounds, and did not reach the issue of a mental patient's right to treatment. O'Connor v. Donaldson, 422 U.S. 563, 577 n.12 (1975).

[26] For example, the Chief Justice's "historical" and "medical" criticisms argue equally against statutory and constitutionally based right to treatment. His doctrinal objections seem mainly aimed at a constitutional *quid pro quo* argument. *See* notes 108-148 and accompanying text *infra*.

tional views of mental illness.[27] Another group of objections are "medical," based on the notion that mental illness cannot or should not be approached with treatment as an objective.[28] After addressing these, the article evaluates several objections based on doctrinal or institutional considerations, and the possibility of abuse of the right to treatment.[29] The final section discusses four recently developed theories supporting a right to treatment and evaluates the extent to which each survives the Chief Justice's criticisms.[30] The article does not decide whether a right to treatment is constitutionally compelled or even wise. Rather, it concludes only that a right to treatment is maintainable in the face of Chief Justice Burger's objections.

I. Analysis of the Chief Justice's Arguments

A. The Historical Argument

To support his conclusion that no constitutional right to treatment now exists, the Chief Justice asserts that custodial care, not treatment, has historically been the major goal of state mental institutions.[31] The suggestion that treatment has been only a secondary goal of confinement for mental illness does not, however, withstand critical scrutiny.[32]

---

[27] *See* notes 31-76 and accompanying text *infra*.

[28] *See* notes 77-107 and accompanying text *infra*.

[29] *See* notes 108-148 and accompanying text *infra*.

[30] *See* notes 149-284 and accompanying text *infra*.

[31] O'Connor v. Donaldson, 422 U.S. 563, 582 (1975) (Burger, C.J., concurring). *But see* Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971) (the purpose of involuntary hospitalization is treatment, not mere custodial care or punishment), *rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

[32] The following analysis addresses only the *accuracy* of the Chief Justice's historical argument. It does not address the broader question of the wisdom of judicial reliance on historical or social science research. Such research has been used and abused by advocates and jurists alike. For a discussion of the role of social science literature in the early segregation cases, see Craven, *The Impact of Social Science Evidence on the Judge: A Personal Comment*, 39 Law & Contemp. Probs. 150 (Winter 1975). *See also* Yudof, *School Desegregation: Legal Realism, Reasoned Elaboration, and Social Science Research in the Supreme Court*, 42 Law & Contemp. Probs. 57 (Autumn 1978). Particularly in the jury trial cases, the Court has contorted and misused social science research. In Ballew v. Georgia, 435 U.S. 223 (1978), the Court used empirical research to conclude that five-member criminal juries failed to provide the minimum constitutional protection demanded by the sixth amendment. Ear-

1. Treatment in Ancient Times and the Middle Ages

In ancient Roman, Greek, Israeli, and Byzantine societies, treatment and rehabilitation of the mentally ill were recognized concerns.[33] Ancient therapies included songs, shrines, milieu therapy, bleedings, special diets, physical restraint, calm, and drugs.[34] Methods suggested in a 15th century textbook included hospitalization, music therapy, environmental stimulus, and soothing activities.[35] Arab healers developed an impressive milieu therapy that emphasized open buildings with courtyards where patients participated in and watched plays, heard stories

---

lier, in Williams v. Florida, 399 U.S. 78 (1970), the Court had held six-member juries to be constitutionally adequate in criminal trials. *See id.* at 100-02. *Williams* generated much scholarly work on jury size, which, the *Ballew* Court noted, dramatically demonstrated that six-member juries failed to provide the constitutional protection of twelve-member panels. 435 U.S. at 231-39. The *Ballew* Court further reasoned that, if six-member panels were constitutionally inferior to twelve-member panels, then five-member panels must be worse. But despite acknowledging data that clearly showed six-member panels to be inadequate, the *Ballew* judgment reaffirmed the constitutionality of six-member juries in criminal cases. *Id.* at 243-45. Chief Justice Burger, in concurrence with Justice Powell, questioned the efficacy of using social science data to support the desired results. *Id.* at 246 (Powell, J., Burger, C.J., and Rehnquist, J., concurring). The Chief Justice has further observed that "[t]he commands of the Constitution cannot fluctuate with the shifting tides of scientific opinion." Eisenstadt v. Baird, 405 U.S. 438, 470 (1972) (Burger, C.J., dissenting).

One may question whether a conclusion that history does not support a right to treatment implies anything significant about recognizing such a right today. Legal doctrine is ever-changing. The Court's great strides in past decades in support of individual rights refute any static concept of American jurisprudence. *See, e.g.*, Zablocki v. Redhail, 434 U.S. 374 (1978); Moore v. City of East Cleveland, 431 U.S. 494 (1977); Roe v. Wade, 410 U.S. 113 (1973); Goldberg v. Kelly, 397 U.S. 254 (1970); Benton v. Maryland, 395 U.S. 784 (1969); Washington v. Texas, 388 U.S. 14 (1967); *In re* Gault, 387 U.S. 1 (1967); Klopfer v. North Carolina, 386 U.S. 213 (1967); Harper v. Virginia Bd. of Elections, 383 U.S. 663 (1966); Griswold v. Connecticut, 381 U.S. 479 (1965); Pointer v. Texas, 380 U.S. 400 (1965); Malloy v. Hogan, 378 U.S. 1 (1964); Reynolds v. Sims, 377 U.S. 533 (1964); Gideon v. Wainwright, 372 U.S. 335 (1963); Mapp v. Ohio, 367 U.S. 643 (1961); Cole v. Arkansas, 333 U.S. 196 (1948).

[33] J. NEAMAN, SUGGESTION OF THE DEVIL, INSANITY IN THE MIDDLE AGES AND THE TWENTIETH CENTURY 5, 24-26 (1978); G. ROSEN, MADNESS IN SOCIETY, 21-136 (1968).

[34] J. NEAMAN, *supra* note 33, at 24-26.

[35] T. GRAHAM, MEDIEVAL MINDS 64-65 (1967). Caelius Aurelianus, for example, urged treatment with warm sponges, woolen pads, plays, and general comfort. Alexander of Tralles suggested violent "cures" by bleeding and deceptions, and Paul of Aegina urged hydrotherapy and recreation. *Id.* at 31-34.

and discussions, and read books.[36] These approaches anticipated modern projective doll-play and psychodrama therapy.[37] Roman therapists even used primitive electroshock treatment.[38] Thus, in ancient times treatment was indeed a "major goal" in dealing with mental illness.

2. Treatment in American Colonial Society

Although some early New England towns enacted ordinances recognizing the community's responsibility as guardian of the mentally ill,[39] others did not. Unprotected, mentally ill persons were often sold as slaves.[40] Institutional care began in America in 1773 with the opening of the Eastern Lunatic Asylum in Williamsburg, Virginia.[41] Similar hospitals were soon operating in Italy, England,[42] and most of the American colonies.[43] Prevailing theories of that time attributed mental illness to the pressures of modern society.[44] Mental illness was therefore considered susceptible to cure:[45] Patients needed only isolation from the world's fast pace and humane, nonphysical treatment combined with activity therapy.[46] Fantastic cure rates of 90 to 100% were

---

[36] *Id.* at 56-58.

[37] *Id.* at 58; J. NEAMAN, *supra* note 33, at 11.

[38] J. NEAMAN, *supra* note 33, at 12.

[39] L. BELL, TREATING THE MENTALLY ILL FROM COLONIAL TIMES TO THE PRESENT 3 (1980).

[40] *Id.*

[41] *Id.* at 5; G. ROSEN, *supra* note 33, at 275-76.

[42] G. ROSEN, *supra* note 33, at 275-76.

[43] *Id.* at 276.

[44] L. BELL, *supra* note 39, at 25 *et seq.*

[45] *Id.* at 15; R. CAPLAN, PSYCHIATRY AND THE COMMUNITY IN NINETEENTH CENTURY AMERICA, THE RECURRING CONCERN WITH THE ENVIRONMENT IN THE PREVENTION AND TREATMENT OF MENTAL ILLNESS 9 (1969); G. ROSEN, *supra* note 33, at 276.

[46] L. BELL, *supra* note 39, at 25; M. GREENBLATT, R. YORK & E. BROWN, FROM CUSTODIAL TO THERAPEUTIC PATIENT CARE IN MENTAL HOSPITALS 407 (1955). The theory was explained in J. CONOLLY, TREATMENT OF THE INSANE WITHOUT MECHANICAL RESTRAINTS (reprint ed. 1973):

> We seek a mild air for the consumptive, and place the asthmatic in an atmosphere which does not irritate him, and keep a patient with heart disease on level ground; and on the same prophylatic and curative principles, we must study to remove from an insane person every influence that can further excite his brain, and to surround him with such as, acting soothingly on both body and mind, may favour the brain's rest, and promote the recovery of its normal

reported,[47] and by mid-century, asylums were considered the proper and progressive solution to mental illness.[48] The "major goal" at that time, given the grand projection of curability, was clearly treatment rather than custodial care.[49]

3. The Emergence of Custodial Care

In the late 19th century, asylums began to de-emphasize treatment in favor of custodial care. This shift resulted not so much from changes in social thinking regarding the efficacy of treatment as from changes in political views, economic events, and professional perceptions.

a. Political Factors

At least three political factors worked to undermine the concept of treatment. First, after the Civil War, states became actively concerned with operating and regulating mental hospitals.[50] Superintendent positions were often given to the

---

action.

Id. at 55.

[47] L. BELL, *supra* note 39, at 15, 26; R. CAPLAN, *supra* note 45, at 90; R. HUNTER & I. MACALPINE, THREE HUNDRED YEARS OF PSYCHIATRY, 1535-1860, at 988 (1963) ("cure rates" of up to 68%). *See* M. GREENBLATT, R. YORK & E. BROWN, *supra* note 46, at 411 ("cure" rates of over 50%).

[48] *See* D. ROTHMAN, THE DISCOVERY OF THE ASYLUM 130-54 (1971); D. DIX, ON BEHALF OF THE INSANE POOR (reprint ed. 1971).

[49] *See* O'Connor v. Donaldson, 422 U.S. 563, 582 (1975) (Burger, C.J., concurring) (custodial care historically the prime goal of confinement for mental illness). To support his assertion, the Chief Justice cites A. DEUTSCH, THE MENTALLY ILL IN AMERICA 98-113 (2d ed. 1949). 422 U.S. at 582. But our reading of Deutsch's work does not yield this interpretation. The cited pages in Mr. Deutsch's work support, in our view, the opposite proposition. *See* notes 50-53, 59-62 and accompanying text *infra* (custodial care only a fall-back position when therapeutic treatment became politically or financially unfeasible; custodial care never a primary goal).

[50] L. BELL, *supra* note 39, at 36; A. DEUTSCH, *supra* note 49, at 249-52. Some advisory boards sought to discontinue the prevailing practice of treating both the "chronic" and "temporarily" insane. *Id.* at 257-59. This led, of course, to custodial care for those patients found to be "chronically insane." *Id.* at 263. These state-sponsored movements from treatment to custodial care were initiated, not because of a change in the belief regarding the efficacy of treatment, but because of institutional responses to overcrowding. *Id.* at 263. Even under the dual treatment plan, all patients were given the opportunity to respond to treatment; only those who showed no benefit were sent to custodial institutions. *Id.* at 266.

inexperienced as political favors.[51] Second, increasing numbers of civil and criminal commitments led to overcrowded facilities, destroying the peaceful therapeutic milieu.[52] Finally, public support for mental hospitals waned when it became clear that authorities were committing immigrants to institutions at the expense of the fee-paying middle class.[53]

b. Economic Factors

Economic conditions also contributed to the decline of mental treatment. The typical treatment hospital was a rather lavish building with expansive grounds.[54] By the 1850s, inflation, bank failures, and massive public work programs required drastic reductions in appropriations for asylums.[55] By the next decade, many asylums stood in disrepair.[56] The public, already suspicious of increased costs and unwilling to support immigrants, began to turn against state-supported mental institutions.[57] Inade-

---

[51] L. BELL, *supra* note 39, at 54; D. ROTHMAN, *supra* note 48, at 270.

[52] L. BELL, *supra* note 39, at 29-30; R. CAPLAN, *supra* note 45, at 58-69.

[53] R. CAPLAN, *supra* note 45, at 72, 80. Because hospital administrators were unable to deal with immigrants' seemingly violent and uncivilized rejection of Protestant norms, they reverted to force and regimentation to control patients. *Id.* at 48. Moral treatment, which had been created to serve the Protestant work ethic, was seen as inappropriate for treating persons who did not fit those cultural patterns. *Id.* at 73. *See also* L. BELL, *supra* note 39, at 33, 58-73; N. DAIN, CONCEPTS OF INSANITY IN THE UNITED STATES, 1789-1865, at 129 (1964); M. GREENBLATT, R. YORK & E. BROWN, *supra* note 46, at 412-13; D. ROTHMAN, *supra* note 48, at 273, 283-85.

[54] D. ROTHMAN, *supra* note 48, at 130-54.

[55] R. CAPLAN, *supra* note 45, at 81-82; D. ROTHMAN, *supra* note 48, at 270.

[56] R. CAPLAN, *supra* note 45, at 82.

[57] *Id.* at 79. Caplan explains further that:

> The financial difficulties of asylums strained relationships between doctors and patients and between practitioners and community. In the former case, superintendents were obliged to subordinate therapeutics to administration, to spend a large amount of time on hospital accounts, on plotting economies, and in lobbying for more funds. The liberality of earlier, smaller, well-endowed institutions was necessarily curtailed. In the community, meanwhile, [mental health therapists] and laymen had contact more and more on money matters rather than on other issues. The legislator was the source of public monies, the private citizen of donations and bequests. This inevitably affected relations between the hospital and the extramural world, in which professionals were suppliants for their own salaries, as well as for hospital funds.

Id. at 86.

quate funding eventually led to severe overcrowding that paralyzed the therapeutic programs, transforming hospitals into custodial facilities.[58]

c. *Medical and Professional Factors*

Perhaps the final blow to the therapeutic ideal of the 18th century came when proponents of treatment realized that early predictions of curability were grossly exaggerated.[59] Cure rates had fallen dramatically by the 1870s, with a corresponding drop in public and professional confidence in treatment.[60] The public could not be persuaded to contribute money for treating patients doomed forever to insanity.[61] The profession reacted by questioning the efficacy of its own treatment. By overselling itself, the movement had contributed to its own demise.[62]

Moreover, by the late 19th century, most of the original proponents of treatment had been replaced with younger superintendents, who did not share the founders' goals.[63] These administrators were often political appointees who cared more about efficiency than therapy.[64] Efficiency was a goal more consistent with custodial care than with therapy.

With the demise of curability came a new theory of insanity: causation based on heredity. Social Darwinism justified and, in fact, required custodial care in lieu of treatment for those mem-

---

[58] N. DAIN, *supra* note 53, at 129-30; M. GREENBLATT, R. YORK & E. BROWN, *supra* note 46, at 412; D. ROTHMAN, *supra* note 48; at 270.

[59] *See* D. ROTHMAN, *supra* note 48, at 266-68; note 47 *supra*.

[60] R. CAPLAN, *supra* note 45, at 49. The earlier cure rates were based on discharges; thus, patients admitted many times were counted as multiple cures. Such accounting practices inflated and misrepresented the actual situation. *Id.* at 91. *See also* N. DAIN, *supra* note 53, at 131-33; A. DEUTSCH, *supra* note 49, at 232-51; G. ROSEN, *supra* note 33, at 278. *See generally* P. EARLE, THE CURABILITY OF INSANITY (reprint ed. 1972).

[61] L. BELL, *supra* note 39, at 43; R. CAPLAN, *supra* note 45, at 49, 88-96.

[62] L. BELL, *supra* note 39, at 43.

[63] R. CAPLAN, *supra* note 45, at 98-103.

[64] *Id.* at 102-03, 174.

> All these factors conspired to bring into the practice of psychiatry a heterogeneous collection of individuals, many of whom lacked the originality, charisma, enthusiasm and dedication of the founders of the profession. It was these men who influenced the further development of American psychiatry during the second half of the [nineteenth] century.

Id. at 104.

bers of society thought to be genetically inferior.[65] The new theory of genetic causation thus rationalized custodial treatment of "helpless," chronic patients,[66] while the mental institution served the important custodial function of protecting society from genetic undersirables.[67]

This review of the antecedents of current societal views of treatment casts doubt on the Chief Justice's assertion that "providing places for custodial confinement of the so-called 'dependent insane' . . . emerged as the major goal of the States' programs. . . ."[68] Characterizing the move to custodial care as a "goal" suggests a change in society's belief in the desirability of treatment. The historical literature does not suggest such an advertent policy change. The change in emphasis from treatment to custodial care resulted instead from political, economic, and professional medical factors in the late 19th century. Treatment was never rejected as a proper goal; it was de-emphasized because it had become unpopular and expensive.

4. Treatment in the Twentieth Century

Treatment began to regain respect at the turn of the century. The ensuing decades saw the rise and fall of various therapeutic approaches: clinical treatment,[69] mental health centers,[70] occupational therapy,[71] shock therapy,[72] psychopharmacotherapy,[73] and community alternatives.[74] As one observer noted, "institutional psychiatry has supported a bewildering array of therapeutics that have followed a roller coaster pattern of fashion-

---

[65] Some voiced the fear that if "weaker" individuals were "saved," they would intermarry and spread their inferior genes. This was, of course, a handy justification for custodial care of blacks and the Irish. *Id.* at 147.

[66] *Id.* at 149.

[67] L. BELL, *supra* note 39, at 36-37, 39, 58-73; N. DAIN, *supra* note 53, at 134; M. GREENBLATT, R. YORK & E. BROWN, *supra* note 46, at 414; D. ROTHMAN, *supra* note 48, at 274-75.

[68] O'Connor v. Donaldson, 422 U.S. 563, 582 (1975) (Burger, C.J., concurring).

[69] L. BELL, *supra* note 39, at x-xi.

[70] *Id.* at 74-88.

[71] *Id.* at 120-23.

[72] *Id.* at 135-40.

[73] *Id.* at 150-60.

[74] *Id.* at 164-80.

ability."[75] While critics have noted the propensity of many institutions to emphasize custodial care,[76] it would be inappropriate to infer that custodial care has been the goal of institutionalization. Custodial care evolved only as a *response* to the apparent failure of therapy. To characterize it as a policy goal of state institutions is therefore misleading. Custodial care has never been a goal, although it has been a necessity in chronic cases. The goals of mental health institutions have been and remain treatment and cure.

Of course, if treatment and cure are the goals of commitment, medicine must be able to achieve them. Chief Justice Burger's next criticism is that a right to treatment is medically infeasible.

B. The "Medical" Objections

In his concurrence, the Chief Justice made several objections that are related to modern medicine's ability to treat the mentally ill. He posited that there are many forms of untreatable mental illness,[77] many types where the cure rate is low,[78] that

---

[75] *Id.* at 181. The author continues:

> A new therapy is introduced with great excitement and enthusiasm. Sophisticated, detailed reports verify its effectiveness and show remarkable cure and improvement ratios. This excitement and interest soon fade. Follow-up studies and additional research challenge the initial reports and reveal that the therapy has limited applications, that it should be given only a modest place in psychiatry's armamentarium. Even the most dramatic therapeutics have followed this cycle of hope and disillusionment.

Id.

[76] By 1950, many state hospitals remained custodial. *Id.* at 103, 150. By 1961, as many as 80% of public institutions were custodial. *Id.* at 169.

[77] O'Connor v. Donaldson; 422 U.S. 563, 578 n.2 (1975) (Burger, C.J., concurring). Of course, if mental illness does not exist, there is no need for a right to treatment. *See* Szasz, *The Right to Health*, 57 GEO. L.J. 734 (1969) (arguing that mental illness might not actually exist). Psychiatrist Thomas Szasz theorizes that mental disease indeed does not exist; rather, patients simply suffer "problems in living." T. SZASZ, THE MYTH OF MENTAL ILLNESS 262 (1974). Szasz assumes that the study of medicine is firmly grounded on changes in "the physiochemical integrity of the body," *id.* at 12, and concludes that, because mental illness has no corresponding physical manifestations, it does not exist. In Szasz's view, any attempt at involuntary treatment is thus a "crime against humanity." *Id.* at 268.

Szasz's views are being rejected, as it becomes increasingly apparent that physical changes cause many mental disorders. *See, e.g.*, T. HARRISON, HARRISON'S PRINCIPLES OF INTERNAL MEDICINE (9th ed. 1980):

psychiatric diagnoses are uncertain,[79] and that a large proportion of mentally ill persons do not wish to be treated.[80]

1. Guaranteed Successful Treatment

Chief Justice Burger's principal "medical" objection—that involuntarily committed patients need not be treated because successful treatment cannot be guaranteed—distorts what the pro-

---

> In recent years attention has been focused largely on biological factors, particularly chemical derangement of certain structures in the limbic portion of the brain. . . . In several cases . . . the norepinephrine levels in these regions have been significantly increased. This finding, if verified, would incriminate a disorder in neurotransmitter dynamics as the chemical pathology. . . .

Id. at 151. In the mentally ill, these neurotransmitters receive or dampen an abnormal number of these messages. Berger, *Biochemistry and the Schizophrenias*, 169 J. NERVOUS & MENTAL DISORDERS 90 (1981). *See also* K. HAAS, ABNORMAL PSYCHOLOGY 148-49 (1980). Drug therapy can control this abnormality and alleviate the disorder.

It might be objected that this physical connection does not reveal the primary cause of mental illness: that which makes the neurotransmitters develop abnormalities in the first place. In most medical illnesses, the physician can point to a virus or bacterium as the cause of the illness. But indefiniteness does not invalidate the existence of a disorder, whether physical or mental. Cancer is a disease whose primary origin is unknown; there are many others. *See, e.g.*, T. HARRISON, *supra* this note, at 1584. Most physicians agree that a change in the cell's genetic structure is responsible for cancerous growth, yet no general consensus exists as to the cause of the structural change. *Id.* Several physical illnesses with psychological components fit this pattern. *Id.* at 1683. *See, e.g.*, Cushing's disease, *id.* at 1730, Addison's disease, *id.*, and Grave's disease, *id.* at 1704. *See also* 1 A. FREEMAN, H. KAPLAN & B. SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1056-61 (3d ed. 1980). With some illnesses, both the physical cause and the mechanism of causation are known with relative certainty. *See, e.g.*, Gattaz, Ewald & Beckmann, *The HLA System and Schizophrenia*, 228 ARCHIV. PSYCHIATRIC AND NERVENKRANKHEITEN 205 (1980) (genetic linkages in schizophrenia); Wertkamp, Stancer, Persad, Flood & Guttormsen, *Depressive Disorders and HLA: A Gene on Chromosome 6 That Can Affect Behavior*, 305 NEW ENG. J. MED. 1301 (1981) (genes at a locus on chromosome 6 a major contribution to susceptibility to depressive illness); Wyatt, Potkin & Murphy, *Platelet Monoamine Oxidase Activity in Schizophrenia: A Review of the Data*, 136 AM. J. PSYCHIATRY 377 (1979) (enzyme dysfunction is a likely source of schizophrenia). The charge that mental illness is a myth should thus be laid to rest.

[78] O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring).

[79] *Id.* at 579 (Burger, C.J., concurring).

[80] *Id.* at 584 (Burger, C.J., concurring).

ponents of treatment demand. At issue is not a right to cure, but a right to treatment. It may be impossible for treatment to cure every mental illness. Many patients, however, can be treated so that their symptoms subside, enabling them to be discharged and with continued therapy lead functional lives.[81] Thus, the question should not be whether treatment will enable a patient to recover with no chance of relapse. Rather, the question should be whether with maintenance therapy the person can lead a healthy life. Many forms of therapy are effective in this limited sense.[82] The permanent cure rate should thus have little bearing on the decision whether to recognize a right to treatment.

The next question is whether a treatment must benefit all patients to be justifiable. Surely a therapy that is safe, not prohibitively expensive, and beneficial to some patients should be made available. Recent studies have shown that modern drugs effectively relieve the symptoms of schizophrenia,[83] manic depression,[84] and other illnesses.[85] Chief Justice Burger ignored these developments in concluding that many patients are un-

---

[81] *See, e.g.*, notes 77 *supra*, 83-85 *infra*.

[82] *Id.*

[83] *See, e.g.*, Alexander, Van Kammen & Bunney, *Antipsychotic Effects of Lithium in Schizophrenia*, 136 AM. J. PSYCHIATRY 283 (1979) (lithium may serve as an alternative to neuroleptics in treating schizophrenics); Wyatt, *Biochemistry and Schizophrenia (Part IV) The Neuroleptics—Their Mechanism of Action: A Review of the Biochemical Literature*, 12 PSYCHOPHARMACOL. BULL. 5 (July 1976) (neuroleptic drugs clearly have positive effects in the treatment of schizophrenia). Schizophrenia appears to be more easily treatable than in the past. "About 60 percent of [patients hospitalized for an attack of acute schizophrenia] will be socially recovered five years later." 2 A. FREEMAN, H. KAPLAN & B. SADOCK, *supra* note 77, at 1189.

[84] *See, e.g.*, Amsterdam, Brunswick & Mendels, *The Clinical Application of Tricyclic Antidepressant Pharmacokinetics and Plasma Levels*, 137 AM. J. PSYCHIATRY 653 (1980) (tricyclic antidepressants have become the preferred treatment for most types of depressive illnesses, and have been found to be about 70% effective); Davis, *Overview: Maintenance Therapy in Psychiatry: II. Affective Disorders*, 133 AM. J. PSYCHIATRY 1 (1976) (empirical data consistently show that lithium has a substantial prophylactic effect). *See also* Mendels, *Lithium in the Treatment of Depression*, 133 AM. J. PSYCHIATRY 373 (1976); Weissman, Prusoff, DiMascio, Neu, Goklaney, & Klerman, *The Efficacy of Drugs and Psychotherapy in the Treatment of Acute Depressive Episodes*, 136 AM. J. PSYCHIATRY 555 (1979) (combination treatment was most effective).

[85] Anxiety has been relieved by use of a benzodiazepine derivative. McCurdy, *Lorazepam, A New Benzodiazepine Derivative in the Treatment of Anxiety: A Double-Blind Clinical Evaluation*, 136 AM. J. PSYCHIATRY 187 (1979).

treatable. Instead, the Chief Justice relied on Professor Schwitzgebel's *The Right to Effective Treatment*,[86] which indicated that modern treatment methods are substantially ineffective. Schwitzgebel's observation, however, concerned conventional "talking" therapy,[87] no longer the preferred treatment for many illnesses.[88] The Chief Justice's statement that treatment is not effective is thus untenable in light of current research.

2. Uncertain Psychiatric Diagnoses

Another of the Chief Justice's objections to a right to treatment concerned "uncertainties of psychiatric diagnosis . . . [and] a divergence of medical opinion. . . ."[89] There is some truth to the statement that psychiatrists do not always concur.[90] The situation is not as haphazard and inaccurate as Chief Justice Burger believes, however. A brief history of psychiatry demonstrates the scope of the problem.

Before the invention of the microscope, medical doctors could not delve into cells and microorganisms to find a biological basis for illness. They were forced to base their diagnoses on personal observation.[91] When psychiatry developed, it used the same process of diagnosis.[92] In the mid-19th century, however, medical scientists discovered the underlying biological causes of symptoms and were no longer limited to less accurate observation methods.[93] Modern psychiatry has not yet made a comparable leap, but it appears to be on the verge of doing so.[94]

Psychiatrists have worked to hone their diagnostic categories, to make their science as objective as possible. Their first step was to promulgate the Diagnostic and Statistical Manual of

---

[86] O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring) (citing Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936 (1974).

[87] Schwitzgebel, *supra* note 86, at 941-48.

[88] *See* notes 77, 83-85 *supra*.

[89] O'Connor v. Donaldson, 422 U.S. 563, 579 (1975) (Burger, C.J., concurring).

[90] 1 A. FREEMAN, H. KAPLAN & B. SADOCK, *supra* note 77, at 1041-42.

[91] *See, e.g.*, C. SINGER & E. UNDERWOOD, A SHORT HISTORY OF MEDICINE (2d ed. 1962).

[92] *See, e.g.*, F. ALEXANDER & S. SELESNICK, THE HISTORY OF PSYCHIATRY (1966).

[93] *See, e.g.*, A CASTIGLIONI, A HISTORY OF MEDICINE 667-742 (1941).

[94] *See generally* notes 77-83 *supra*, 98-100 and accompanying text *infra*.

Mental Disorders (DSM I),[95] a nationwide system for classifying mental disorders. A revised system, DSM II, was published in 1967.[96] Studies showed that the accuracy of these initial systems proved high in some areas, but only fair or low in others.[97] Thus, in 1975, Chief Justice Burger's statement that psychiatric diagnosis was uncertain contained an element of truth.

Five years after Chief Justice Burger wrote his concurrence in *O'Connor*, however, DSM III was published.[98] Its improved format included narrower definitions, provided diagnostic criteria, and used a multi-axial framework. A reliability study by its authors concluded that in "most of the diagnostic classes the reliability was quite good, and in general it was much higher than previously. . . ."[99] Several other studies have confirmed the greatly increased accuracy of DSM III.[100]

Moreover, disagreement over diagnosis of a particular patient's condition does not necessarily render treatment impossible. Some treatments benefit more than one condition;[101] some

---

[95] TASK FORCE ON NOMENCLATURE AND STATISTICS, AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS I (1952). *See 1* A. FREEMAN, H. KAPLAN & B. SADOCK, *supra* note 77, at 1071.

[96] TASK FORCE ON NOMENCLATURE AND STATISTICS, AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS II (1967).

[97] *See* note 90 *supra*.

[98] TASK FORCE ON NOMENCLATURE AND STATISTICS, AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS III (1980).

[99] Spitzer, Williams & Skodol, *DSM III: The Major Achievements and an Overview*, 137 AM. J. PSYCHIATRY 151, 154 (1980) (describing the reliability study as the largest ever conducted). *See generally* R. SPITZER, A. SKODAL, M. GIBBON & J. WILLIAMS, DSM-III CASE BOOK (1981) (a collection of cases to illustrate application of DSM III).

[100] *See, e.g.*, Helzer, Brockington & Kendell, *Predictive Validity of DSM III and Feighner's Definitions of Schizophrenia*, 38 ARCHIVES GEN. PSYCHIATRY 971 (1981) (DSM III very specific in prediction of outcome); Stangler & Printz, *DSM-III: Psychiatric Diagnosis in a University Population*, 137 AM. J. PSYCHIATRY 937 (1980) (DSM III "holds promise for increasingly discrete, uniform, and reliable identification of clinical entities"); Webb, Gold, Johnstone & DiClemente, *Accuracy of DSM III Diagnoses Following a Training Program*, 138 AM. J. PSYCHIATRY 376 (1981) (DSM III was 74.2% accurate, with 11% near-misses; overall accuracy is relatively high and very encouraging). *See also* Morey, *The Differences Between Psychologists and Psychiatrists in the Use of DSM-III*, 137 AM. J. PSYCHIATRY 1123 (1980) (no significant difference was found in the two professions' "perception of DSM-III symptom importance").

[101] *E.g.*, Post & Bunney, *Progress in Psychopharmacology*, 19 CURRENT PSYCHIATRIC THERAPIES 69, 77, 79 (1980) (lithium primarily used to treat manic-depressive disorders, but may sometimes be used in schizophrenia).

illnesses are "mixed," *requiring* more than one form of treatment.[102] Chief Justice Burger's uncertainty-of-diagnosis argument has therefore lost much of its original force.

3. Patient Cooperation

The Chief Justice's third reason for not recognizing the right to treatment is that "it is universally acknowledged as fundamental to effective therapy that the patient acknowledge his illness and cooperate with those attempting to give treatment. [A] large portion of mentally ill persons . . ." do not do so.[103] Chief Justice Burger derived support for this contention from Professor Katz' *The Right to Treatment—An Enchanting Legal Fiction?*,[104] in which Katz stated that in psychotherapy a patient's consent is necessary.[105] Yet, Katz also stated that "organic therapies . . . can bring about changes . . . in a patient's behavior without his cooperation."[106] Today drug therapy is the preferred treatment for most mental illnesses, including schizophrenia and manic-depression.[107] Thus, Chief Justice Burger's statement regarding the necessity of cooperation was not completely accurate at the time of the *O'Connor* decision and is even less so today.

C. Institutional and Doctrinal Arguments, and the Possibility of Abuse

A third group of objections concerns the doctrinal standing of a right to treatment, the danger that government will abuse a treatment requirement, and the institutional ability of courts to

---

[102] For a discussion of treatment of "mixed" illnesses, see A. LUDWIG, PRINCIPLES OF CLINICAL PSYCHIATRY 367 (1980). Of course, overmedication must be avoided. *See id.* at 362.

[103] O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring).

[104] 36 U. CHI. L. REV. 755 (1969).

[105] *Id.* at 777.

[106] *Id. But see* A. LUDWIG, *supra* note 102, at 358 (optimal therapeutic management requires the full cooperation of the patient).

[107] *See* notes 77, 83-85 and accompanying text *supra*. *See also* L. KOLB, MODERN CLINICAL PSYCHIATRY 428-29 (9th ed. 1977) (drugs were the "primary therapeutic agents" for treating serious disturbances of personality); 2 A. FREEMAN, H. KAPLAN & B. SADOCK, *supra* note 77, at 1922 (drugs more effective than psychotherapy alone in treatment of schizophrenia); A. LUDWIG, *supra* note 102, at 368, 380 (electroshock or drug treatment for major disorders).

enforce such a right.

1. Doctrinal Objections

Chief Justice Burger argues that proponents of a right to treatment, particularly those who proceed on a *quid pro quo* theory,[108] are guilty of legal alchemy.[109] That alchemy consists of transforming what are essentially procedural guarantees, those of substantive and procedural due process, into a substantive right to treatment.[110] The Chief Justice further argues that, even if this transformation were possible, it would not yield a right to treatment. Due process is a flexible requirement, varying from context to context; it cannot generate a uniform substantive requirement such as treatment.[111]

a. Procedure-into-Substance

Right to treatment proponents have emphasized the reduced level of due process protections afforded in mental commitment proceedings.[112] Proponents have also concluded by urging a con-

---

[108] *See, e.g.,* Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), *vacated and remanded,* 422 U.S. 563 (1975); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); Gary W. v. Louisiana, 437 F. Supp. 1209, 1216-18 (E.D. La. 1976); Morgan v. Sproat, 432 F. Supp. 1130, 1135-36 (S.D. Miss. 1977); Martarella v. Kelley, 349 F. Supp. 575, 599-600 (S.D.N.Y. 1972); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) (cases discussing *quid pro quo* theory of right to treatment).

[109] O'Connor v. Donaldson, 422 U.S. 563, 586-87 (1975) (Burger, C.J., concurring).

[110] *Id.* at 587.

[111] It is too well established to require extended discussion that due process is not an inflexible concept. . . . The *quid pro quo* theory is a sharp departure from, and cannot coexist with, due process principles . . . [T]he theory presupposes that essentially the same interests are involved in every situation where a State seeks to confine an individual; that assumption, however, is incorrect. . . . [Further, the theory] would elevate a concern for essentially procedural safeguards into a new substantive constitutional right.

Id. at 585-87 (footnotes omitted).

[112] Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971), *rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Comment, *Civil Restraint, Mental Illness, and the Right to Treatment,* 77 YALE L.J. 87, 87 n.1 (1967) [hereinafter cited as *Civil Restraint*]. *But see* Ferlegger & Boyd, *Anti-Institutionalization: The Promise of the* Pennhurst *Case,* 31 STAN. L. REV. 717, 734 (1979).

stitutional right to treatment. They reason as follows:

> 1. Society does not wish to treat the mentally ill as convicted criminals, *i.e.*, by simply confining them;[113]
> 2. Treatment is the principal way by which the confinement of the mentally ill is distinguished from penal confinement;[114]
> 3. The treatment of the involuntarily committed mentally ill is what legitimates commitment without the usual due process protections accompanying criminal incarceration;[115]
> 4. Therefore, unless treatment is provided, civil commitment violates due process.[116]

This reasoning does not result in "converting" procedure into substance. It does presuppose that due process protections may be adjusted in light of the substantive right at stake.[117] The reduced procedural protections accompanying civil commitment are permissible *because* of a past undertaking—to treat civil commitment differently from criminal incarceration. The changed procedural requirements are thus only a reflection, not the source, of the right to treatment.

Moreover, both are aimed at the same goal—the protection of liberty, or opportunity for freedom.[118] They are conceptually related through a common objective; their "equivalence," if any is needed, may be judged by their relative effectiveness in promoting the common goal. Thus, if the Chief Justice is concerned with a *quid pro quo* rationale that relies on an exchange of procedural rights, where the difficulty in assessing equivalence is greatest, his objection is overstated.

b. Varying quid, *uniform* quo.

Chief Justice Burger also takes issue with the *quid pro quo* theory[119] for deriving a uniform right to treatment from a flex-

---

[113] Rouse v. Cameron, 373 F.2d 451, 452-53 (D.C. Cir. 1966); D. WEXLER, MENTAL HEALTH LAW 23, 33-34 (1981) (procedural protection during commitment process); *Civil Restraint, supra* note 112, at 87 n.2.

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

[115] *Id*; Civil Restraint, supra note 112, at 87.

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

[117] O'Connor v. Donaldson, 422 U.S. 563, 585 (1975) (Burger, C.J., concurring); L. TRIBE, AMERICAN CONSTITUTIONAL LAW §§ 10-13 to -15 (1978).

[118] *See* notes 176-187, 246-253 and accompanying text *infra*.

[119] This theory was first used in connection with the right to treatment in Donaldson v. O'Connor, 493 F.2d 507, 522 (5th Cir. 1974), *vacated and remanded*, 422 U.S. 563, 577 (1975) (right to treatment arises in mental commitment because the "three central limitations" on government's power to detain

ible due process standard.[120] Due process protection varies from context to context, depending on the right at stake, the type of proceeding, the characteristics of the parties, and other factors.[121] According to Chief Justice Burger, to derive a substantive remedy for all contexts from a source that differs from one context to another cannot be correct; the *quid pro quo* theory converts due process into an inflexible concept,[122] a "variable" into a "constant."

The right to treatment theory, however, does not *derive* the right from the procedural protections that accompany commitment.[123] The substantive right to treatment derives from basic intuitions about what constitutes civilized treatment of the mentally ill.[124] Moreover, the treatment afforded mental patients under a right to treatment is not unvarying. Some will receive drug therapy, others behavioral therapy; still others will receive group therapy or individual analysis, or be relocated outside the institution.[125] The Chief Justice errs, then, both in characterizing the source of the right to treatment and in asserting that the right is incommensurable with the mistakenly identified source.

2. Possibility of Abuse

Chief Justice Burger's next objection suggests that the *quid pro quo* theory creates the potential for governmental abuse because it would allow a state to confine any individual so long as

---

are absent, calling for rehabilitation as a substitute).

[120] O'Connor v. Donaldson, 422 U.S. 563, 586 (1975) (Burger, C.J., concurring).

[121] L. TRIBE, *supra* note 117, §§ 10-13 to -15.

[122] O'Connor v. Donaldson, 422 U.S. 563, 586 (1975) (Burger, C.J., concurring).

[123] *See* text accompanying notes 112-113 *supra*.

[124] Rouse v. Cameron, 373 F.2d 451, 455 (D.C. Cir. 1966) (confinement without treatment is "shocking"); Wyatt v. Stickney, 325 F. Supp. 781, 785 (M.D. Ala. 1971) (to deprive any citizen of his liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then to fail to provide adequate treatment violates the very fundamentals of due process), *rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). *See also Civil Restraint, supra* note 112, at 87.

[125] *See* Wyatt v. Stickney, 325 F. Supp. 781, 785 (M.D. Ala. 1971) (mental inmates have a right to individualized treatment that will give them a realistic opportunity to become cured), *rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

the state provided treatment.[126] This concern is again based on a misreading of the right to treatment. The right would not make anyone committable simply on a showing that treatment would be provided. Indeed, recognizing the right would not require *any* change in the standards of mental commitment. These standards, which generally require grave disability or danger to oneself or others,[127] would remain intact. As the majority opinion specifically indicated, "[m]ere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty. . . . [A] state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom. . . ."[128] Thus, the Chief Justice's fear that a sane, though troublesome, person could be put away is groundless. As always, the state must show that the confinement of an individual serves a legitimate state interest. The right to treatment would merely require that persons committed after a proceeding determining the state's interest be afforded treatment.

If the Chief Justice's concern is that procedural safeguards will *deteriorate* upon recognition of a right to treatment, that concern seems groundless in the light of experience. States and circuits that have imposed a right to treatment have not succumbed to any temptation to relax procedural safeguards at the time of commitment.[129]

3. Institutional Capacity

Chief Justice Burger's final objection is that courts are ill-suited to enforce and administer a right to treatment.[130] Such a

---

[126] "[The *quid pro quo*] theory may be read to permit a State to confine an individual simply because it is willing to provide treatment, regardless of the subject's ability to function in society. . . ." O'Connor v. Donaldson, 422 U.S. 563, 585 (1975) (Burger, C.J., concurring).

[127] *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1203-05 (1974) [hereinafter cited as *Developments in the Law*].

[128] O'Connor v. Donaldson, 422 U.S. 563, 575-76 (1975) (Burger, C.J., concurring).

[129] Indeed, the trend is toward expanding procedural protections in civil commitment cases. A comprehensive review of state and federal statutory schemes and case law discloses no such relationship. *See* B. ENNIS & R. EMERY, THE RIGHTS OF MENTAL PATIENTS (3d ed. 1978).

[130] O'Connor v. Donaldson, 422 U.S. 563, 587 (1975) (Burger, C.J., con-

right will inevitably require some degree of judicial intervention in matters of institutional administration.[131] Judges may be required to choose among available therapies and to decide which patient receives which type of treatment. Because of the "wide divergence of medical opinions regarding . . . diagnosis . . . and therapy,"[132] the Chief Justice argues that such decisions are best left to institutional administrators and psychiatrists, or to the legislature.[133] This is particularly true, he maintains, because judges can adjudicate a right to treatment only as a trade-off for lost procedural protections. Judges should be slow to sacrifice the essential protection of due process in favor of the uncertain benefit of treatment.

The Chief Justice's argument for deference to psychiatric expertise is in tension, however, with his view that psychiatric knowledge is too rudimentary to support a right to treatment.[134] An argument for judicial deference is strongest in connection with a highly technical field of knowledge about which courts cannot be expected to make intelligent decisions.[135] If psychiatric expertise is not highly advanced, as Chief Justice Burger maintains, then the argument for deference weakens. Any alternative decisionmaker would be just as hampered as the courts in deciding the appropriate level of treatment.

Courts should weigh a number of factors when deciding to adjudicate in a given area. These include the importance of the interest at stake,[136] the availability of nonjudicial remedies,[137] the likelihood that erroneous decisions will be corrected in the democratic marketplace,[138] and any alternative decisionmaker's impartiality, legitimacy, and ability to discern relevant facts.[139]

---

curring).

[131] *See, e.g.*, Wyatt v. Stickney, 325 F. Supp. 781, 785-86 (M.D. Ala. 1971) (setting out a detailed order and requirements for treatment), *rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). *See also* Wyatt v. Stickney, 344 F. Supp. 373, 379-86 (M.D. Ala. 1972) (Appendix A).

[132] O'Connor v. Donaldson, 422 U.S. 563, 587 (1975) (Burger, C.J., concurring).

[133] *Id.*

[134] *See* notes 77-88 and accompanying text *supra*.

[135] *See* notes 138, 143-148 and accompanying text *infra*.

[136] P. BREST, PROCESSES OF CONSTITUTIONAL DECISIONMAKING 982 (1975).

[137] *Id.* at 981-82.

[138] *Id.* at 981.

[139] *Id.* at 982-83.

With the possible exception of the last, none of these factors requires deference to institutional authority. The decisions of hospital and asylum administrators regarding treatment are not readily reviewable by the courts. Further, because of the low visibility and relative helplessness of mental patients, these decisions are not easily corrected by legislatures. The interest at stake is very important; treatment or its absence may have a grave impact on an individual's comfort, health, well-being, and liberty.[140] Although many hospital administrators are conscientious physicians who make treatment decisions humanely and impartially, abuses have occurred.[141] Moreover, because administrators are less accountable than judges and are selected in a less visible manner, their institutional legitimacy is not as high.[142]

Institutional administrators and psychiatrists are, however, in a better position than courts to ascertain facts about particular patients and their treatment needs. They have more immediate access to the patients' records and greater familiarity with developments in psychiatric theory and practice than do courts. They are also better able to monitor the effectiveness of treatment. On the other hand, hospital personnel may be under economic pressures not to treat patients. For instance, successful treatment might require the release of an inmate who is performing useful institutional labor.[143]

Yet, courts are not without some resources for ascertaining relevant facts. Courts may periodically assess patients' pro-

---

[140] Lack of treatment may prevent an individual from living a productive or self-fulfilling life, and may instead cause him to further isolate himself from society, resulting perhaps eventually in a chronic and helpless state of mental dysfunction.

[141] Romeo v. Youngberg, 644 F.2d 147, 155 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term) (patient was severely injured in many fights, suffered from inadequate medical attention, inadequate sanitation, and had been shackled to a bed or chair for long periods daily); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973) (over 1300 reported injuries, assaults, and fights in one year), *see* notes 155-158 and accompanying text *infra;* Wyatt v. Stickney, 325 F. Supp. 781, 782-84 (M.D. Ala. 1971) (improper categorization of patients, understaffed conditions), *rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

[142] This is particularly true when judges are elected to the bench. *See* P. DUBOIS, FROM BALLOT TO BENCH (1980).

[143] *See generally* B. ENNIS & R. EMERY, THE RIGHTS OF MENTAL PATIENTS 159-60 (3d ed. 1978).

gress.[144] Courts may call expert psychiatric witnesses,[145] or consult with appointed panels of expert psychiatrists and psychologists.[146] They may also appoint a fact-finding master or referee.[147] The ascertainment-of-facts problem, then, seems neither theoretically nor practically insuperable. This seems particularly true given that under most theories of right to treatment, courts need not decide whether the patient receives the "best . . . possible treatment," but only whether he obtains "carefully chosen therapy . . . [falling] within the range of . . . treatment alternatives."[148]

In conclusion, Chief Justice Burger's "medical objections," while having some support in 1975 when he concurred in *O'Connor v. Donaldson,* are no longer valid. Treatment and cure, the primary goals of confinement, are at least partially attainable. Psychiatric diagnosis is more accurate. In addition, Chief Justice Burger bases his institutional and doctrinal arguments on a misreading of the arguments advanced by proponents of the right to treatment. Therefore, the Chief Justice's objections in *O'Connor* should not prevent the Supreme Court from establishing a right to treatment for the institutionalized. The Court's remaining problem is deciding how to derive such a right from existing principles.

II. Theoretical Bases of a Right to Treatment

When Chief Justice Burger wrote his concurrence in *O'Connor*

---

[144] Rouse v. Cameron, 373 F.2d 451, 456 (D.C. Cir. 1966); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 769 (E.D.N.Y. 1973).

[145] Fed. R. Evid. 706(a) (Court's power to appoint experts).

[146] Wyatt v. Stickney, 325 F. Supp. 781, 785 (M.D. Ala. 1971), *rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

[147] *See, e.g.,* Fed. R. Civ. P. 53 (courts' power to appoint masters).

[148] Bazelon, *Implementing the Right to Treatment,* 36 U. Chi. L. Rev. 742, 745 (1969). *See also Developments in the Law, supra* note 127. Under this "administrative model" of review, courts only "determine whether the professionals . . . have made responsible decisions based on a thorough consideration of all the evidence relevant to the individual case." Bazelon, *supra,* at 748. This narrower model of review permits judges to scrutinize treatment decisions without taking on the role of expert psychiatric diagnostician. The concern about judicial usurpation is further mitigated by the circumstance that many right-to-treatment cases will arise in settings where the failure to treat is blatant and institution-wide, calling for little, if any, individualized review of the needs of particular patients. *See, e.g.,* cases cited in note 3 *supra.*

v. Donaldson, right to treatment proponents principally relied on the *quid pro quo* theory.[149] Recent decisions and commentary have developed three additional theoretical grounds: Protection from harm, equal protection, and the least restrictive alternative doctrine. This section outlines these three theories and evaluates the extent to which they are vulnerable to Chief Justice Burger's objections. In addition, it proposes a fourth theory, a "theoretical maximum duration of confinement."

A. Protection from Harm

New York State Ass'n for Retarded Children v. Rockefeller,[150] and its related consent judgment, *New York State Ass'n for Retarded Children v. Carey,*[151] developed protection from harm as a basis for a right to treatment for involuntary committees. Under this theory, an inmate in a state institution has a right to protection from physical assaults and inhumane living conditions. By extension, this right requires treatment to maintain an inmate's physical integrity.

The *New York State Ass'n for Retarded Children*[152] litigation arose out of allegations of substandard living conditions at the Willowbrook State School for the Mentally Retarded.[153] Seventy-three percent of the inmates at the school were there on court order; over three quarters were severely retarded.[154] Reports dating back to 1964 had complained of overcrowding and inadequate staffing, and by the time litigation commenced in 1972, the conditions at Willowbrook had deteriorated dramatically.[155] The testimony of parents and officials revealed extensive physical danger to the inmates, with over 1300 reported incidents of injury, assaults, and fights in 1972 alone.[156] On these facts, the *Rockefeller* court found no constitutional basis for a right to treatment.[157] The court did find, however, that the re-

---

[149] *See* Spece, *Preserving the Right to Treatment,* 20 ARIZ. L. REV. 1, 4 (1978) [hereinafter cited as *Spece I*].

[150] 357 F. Supp. 752 (E.D.N.Y. 1973).

[151] 393 F. Supp. 715 (E.D.N.Y. 1975).

[152] New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 758-68 (E.D.N.Y. 1973).

[153] *Id.* at 755-56.

[154] *Id.* at 756.

[155] *Id.*

[156] *Id.*

[157] *Id.* at 764.

sidents had a right to be protected from harm. "One of the basic rights of a person in confinement is protection from assaults by fellow inmates or by staff. . . . Another is the correction of the conditions which 'violate basic standards of human decency.' "[158] Thus, the right to protection from harm incorporated protection from physical assaults and inhumane living conditions.

The relief granted, however, resulted from the court's narrow reading of the right to protection from harm. It included a prohibition against seclusion, an order to hire additional staff, and an order to contract with a hospital for medical services. The order did not include medical screening, a basic treatment element, because it related "to the right to treatment rather than to the right to protection from harm."[159]

In *New York State Ass'n for Retarded Children v. Carey*,[160] the parties to the Willowbrook litigation agreed to a consent judgment that expanded the *Rockefeller* reading of the right to protection from harm. The judgment recognized that "protection from harm requires relief more extensive than this court originally contemplated, because harm can result not only from neglect but from conditions which cause regression or which prevent development of an individual's capabilities."[161] Thus, "a certain level of affirmative intervention and programming is necessary if that capacity for growth is to be preserved, and regression prevented."[162] The court concluded that the effects of the right to protection from harm were similar to those of a right to treatment: "The relief the parties agreed to will advance the very rights enunciated in the [right to treatment] case law since this court's 1973 ruling."[163] Thus, protection from harm requires treatment that will at least maintain the patient's condition.

1. Constitutional Basis of the Right to Protection from Harm

The *Rockefeller* court did not identify a single constitutional basis for finding the right to protection from harm. Rather, it stated that the right could rest on the eighth amendment, the due process clause, or the equal protection clause of the four-

---

[158] *Id.* at 764-65.
[159] *Id.* at 769.
[160] 393 F. Supp. 715 (E.D.N.Y. 1975).
[161] *Id.* at 718.
[162] *Id.* at 717 (quoting from Appendix to Proposed Consent Judgment).
[163] *Id.* at 719.

teenth amendment.[164] Of these, the eighth amendment fails in civil commitment cases because it protects only those convicted of a crime. Under a due process analysis, which may require a right to treatment, there are no clear guidelines for establishing minimum standards of protection.

a. The Eighth Amendment

The eighth amendment guarantees that government will not inflict cruel and unusual punishment.[165] Failure to protect mental inmates from physical injury or disease might be considered a violation of this constitutional prohibition. Cases citing *New York State Ass'n for Retarded Children* have generally interpreted that decision as basing the right to protection from harm on this ground.[166]

Robinson v. California[167] has also provided an eighth amendment basis for the right to treatment. In *Robinson*, the United States Supreme Court held that a statute declaring drug addiction to be a crime constituted cruel and unusual punishment in the absence of treatment, because the punishment was for a status, and not a crime.[168] Commentators have argued by analogy that civil commitment without treatment is cruel and unusual punishment, applied because of an individual's status as mentally ill.[169]

It is clear, however, that the eighth amendment does not apply to the mentally ill. The Supreme Court recently indicated that the amendment applies only to persons convicted of a crime.[170] Thus, although *Rockefeller* and *Robinson* have sug-

---

[164] New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 764 (E.D.N.Y. 1973).

[165] U.S. CONST. amend. VIII.

[166] New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 764 (1973). Language in *Rockefeller* suggests parallels to criminal cases: "The cases dealing with prison conditions reflect a balance between the requirements of humane treatment and the necessary loss of rights . . . follows incarceration for a criminal offense. . . . [Willowbrook residents] must be entitled to at least the same living conditions as prisoners." *Id.* at 764. "Prisoners may not be denied medical care. . . ." *Id.* at 765.

[167] 370 U.S. 660 (1962).

[168] *Id.* at 666-67.

[169] *Spece I, supra* note 149, at 17 n.59 (listing authorities for assertion that eighth amendment-based right to treatment exists).

[170] Bell v. Wolfish, 441 U.S. 520 (1978). *See also* Romeo v. Youngberg, 644

gested parallels to the criminal context,[171] the Supreme Court has effectively removed the foundation for those suggestions.

b. Due Process

Although the eighth amendment fails as a basis for a right to protection from harm, the deprivation of life[172] or liberty clause[173] of the fourteenth amendment might guarantee this right.

(i) Deprivation of Life

The deprivation of life clause might apply in several situations. For example, the lives of persons confined in mental institutions and surrounded by dangerous patients may be threatened in the absence of proper security measures. Lack of medical care and indecent living conditions may also endanger a patient's life. Furthermore, improperly supervised suicidal patients could take their own lives.[174]

If the state commits an individual, precipitating these dangers, the state must protect the patient.[175] Failure to do so would violate the due process clause, in that the state's action would endanger life without due process. Even when the state commits a mentally ill person who is very dangerous to society, it is difficult to justify confining him and then denying him the right to protection and medical care. Thus, one basis for the right to protection from harm is the fourteenth amendment's proscription

---

F.2d 147, 156 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term); Philipp v. Carey, 517 F. Supp. 513, 517 (N.D.N.Y. 1981) (because of *Bell*, the eighth amendment cannot apply to civil committees). *But see* Flakes v. Percy, 511 F. Supp. 1325 (W.D. Wis. 1981).

[171] *See* note 166 *supra*.

[172] *See* Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977).

[173] *See* Romeo v. Youngberg, 644 F.2d 147, 156 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term).

[174] Harper v. Cserr, 544 F.2d 1121 (1st Cir. 1976) (after long history of suicide attempts, patient hung herself).

[175] *Cf.* New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 765 (E.D.N.Y. 1973) (patients have right to basic hygiene, adequate heat, and medical attention). The theory was referred to with approval in Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295, 1321 (E.D. Pa. 1977) and in Woe v. Mathews, 408 F. Supp. 419, 428-29 (E.D.N.Y. 1976). The theory also has been relied upon in the prison context. *See Spece I, supra* note 149, at 29 n.96.

against deprivation of life without due process.

(ii) Deprivation of Liberty

The liberty clause of the fourteenth amendment provides two due process bases for the right to protection from harm. The first is the right to maintain physical and mental health, and to prevent regression of disease or injury.[176] The second is the right to be free to protect oneself from assault or punishment and to live in a secure environment.[177]

Institutionalized mental patients lack many fundamental freedoms. They are confined in institutions, often involuntarily, and must comply with institutional restrictions.[178] Typically, committed patients are required to give up rights to come and go as they please, to live where they choose, to enjoy privacy, and to exercise a host of other freedoms that nonconfined people take for granted.[179] "A valid involuntary commitment *ex necessitate* extinguishes a retarded person's right to freedom from confinement. Nevertheless, a residuum of liberty remains that is entitled to due process protection."[180]

It would be difficult to justify the state's taking away from the involuntarily committed the right to obtain medical help, to live in a clean and secure environment, and to avoid assaults. If this were, in fact, justified, the evidentiary standard in commitment proceedings would have to be much higher.[181] Since confinement may preclude the patient's exercise of these residual rights, the state has a duty to protect them. The state, in confining a patient, should make all reasonable efforts to maintain for the patient any freedom possible.[182] To this end, the patient should be

---

[176] New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 765 (E.D.N.Y. 1973).

[177] *Id.*

[178] B. Ennis & L. Siegel, The Rights of Mental Patients 36 (1973).

[179] *Id.*

[180] Romeo v. Youngberg, 644 F.2d 147, 159 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981).

[181] *See* Addington v. Texas, 441 U.S. 418 (1979) ("beyond reasonable doubt" standard of evidence used in criminal cases rejected on grounds that civil commitment is not punitive in nature, and committee may benefit from commitment).

[182] Alternatively, this argument could be viewed as another aspect of the least restrictive alternative analysis. *See* text accompanying notes 246-255 *infra*.

afforded the right to protection from harm.

A second aspect of the fourteenth amendment's liberty clause is the right to freedom from punishment.[183] Although the eighth amendment does not protect the institutionalized mentally ill, patients do enjoy the right to freedom from punishment that all persons hold until convicted of a crime.[184] However, courts have so narrowly defined the concept of punishment that the right to freedom from punishment will not encompass a right to treatment for the mentally ill. An institution's action is not deemed punishment if it is not intended to be punishment; it is rationally related to an institutional need, such as security, order, or discipline; it is promulgated by the informed judgment of the institution's administrators; and it is not an exaggerated response to legitimate institutional needs.[185] In addition, courts are reluctant to label an action punishment if it results in little or no discomfort for the inmate.[186] Applying this standard might well proscribe some of the worst conditions in mental institutions,[187] but it would not provide a basis for a right to treatment. Punishment as currently defined is not broad enough to include failure to provide treatment.

c. *Equal Protection in the Protection from Harm Theory*

Equal protection as a basis for the right to protection from harm is usually premised on "irrational discrimination between prisoners and innocent mentally [disabled] persons."[188] Since the criminally confined have the right to protection from harm,[189] mental inmates should have the right as well.[190]

---

[183] *See* Bell v. Wolfish, 441 U.S. 520 (1979).

[184] *Id.*

[185] *See, e.g.*, Beckett v. Powers, 494 F. Supp. 364 (W.D. Wis. 1980).

[186] *See* Flakes v. Percy, 511 F. Supp. 1325 (W.D. Wis. 1981).

[187] *See, e.g., id.* (confinement with inadequate toilet facilities).

[188] New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 764 (E.D.N.Y. 1973).

[189] *See* Estelle v. Gamble, 429 U.S. 97 (1976).

[190] To determine whether two classes are similarly situated, and thus entitled to equal protection of the laws, one must look to the purpose of the state action. J. NOWAK, R. ROTUNDA & J. YOUNG, CONSTITUTIONAL LAW 520 (1978). *See* notes 206-243 and accompanying text *infra*. The applicable standard of review is the rational relationship test. L. TRIBE, *supra* note 117, at 994-97; *Spece I, supra* note 149, at 7 n.25, 10 n.33. Although the judicial trend is to give broad meaning to the rational relationship test, *see, e.g.*, United States

The right to protection from harm has been extended to criminal prisoners because prisons are inherently dangerous and inmates are unable to protect themselves.[191] The right includes reasonable medical and psychological care for injuries suffered while in prison[192] or even before incarceration.[193] The purpose of the right to protection from harm is to protect persons who, because of state action, find themselves in dangerous situations, unable to protect themselves or to obtain medical treatment.

Persons committed to mental institutions may suffer similar injuries and illnesses requiring medical care.[194] Thus, criminal inmates and mental patients are similarly dangerously situated and need protection from harm.

The state might seek to justify the provision of treatment to the criminally confined, but not to those confined for mental disorders, on several grounds. For example, it could be argued that the purpose of affording criminal inmates protection from harm is not to benefit them, but to help maintain prison security.[195] Courts have consistently rejected this construction, however.[196] The state might also argue that physical conditions are worse in prisons than in mental hospitals, so that criminal inmates need a

---

R.R. Retirement Bd. v. Fritz, 449 U.S. 166 (1980); Sterling v. Harris, 478 F. Supp. 1046 (N.D. Ill. 1979), *rev'd sub nom.* Schweiker v. Wilson, 101 S. Ct. 1074 (1981), it is not a "toothless standard." Mathews v. Lucas, 427 U.S. 495, 510 (1976). *See* Barrett, *The Rational Basis Standard for Equal Protection Review of Ordinary Legislative Classifications*, 68 Ky. L.J. 845, 860 (1979). The state's arguments for disparate treatment of mental and criminal inmates are weak. *See* text accompanying notes 197-198 *infra*. Mental inmates should therefore receive the same degree of protection from harm as prisoners.

[191] *See* Hutto v. Finney, 437 U.S. 678 (1978); Madyun v. Thompson, 657 F.2d 868 (7th Cir. 1981); Bowring v. Godwin, 551 F.2d 44, 46-47 (4th Cir. 1977); Woodhous v. Virginia, 487 F.2d 889 (4th Cir. 1973); Holt v. Sarver, 442 F.2d 304 (8th Cir. 1971); Penn v. Oliver, 351 F. Supp. 1292 (E.D. Va. 1972).

[192] *See, e.g.*, Estelle v. Gamble, 429 U.S. 97 (1976); Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977); Newman v. Alabama, 503 F.2d 1320 (5th Cir. 1974), *cert. denied*, 421 U.S. 948 (1975). The right to medical care arises whether the condition arose before or after confinement began. *See* note 206 *infra*.

[193] *See* Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977).

[194] *Id.*

[195] *Id. See also* New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); notes 150-159 and accompanying text *supra*.

[196] *See* Estelle v. Gamble, 429 U.S. 97 (1976); Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977); Newman v. Alabama, 503 F.2d 1320 (5th Cir. 1974), *cert. denied*, 421 U.S. 948 (1975).

right to protection from harm, whereas mental patients do not.[197] This argument fails, however, when one looks at actual hospital conditions, which may be "much more stern and dreary than exist in many medium and light security correctional institutions."[198] The mentally ill and the criminally confined are therefore similarly situated and equally entitled to protection from harm.

2. Protection from Harm as a Source of a Right to Treatment

Under equal protection theory, mental inmates would have a right to treatment equal to that provided prisoners. Prisoners have both a right to protection from harm and a right to obtain treatment for physical or mental diseases or for injuries that are curable and might cause substantial harm.[199] Mental patients should have a similar right.[200] As with prisoners, treatment of mental patients should be "limited to that which may be provided upon a reasonable cost and time basis . . . the essential test [being one] of medical necessity."[201] Treatment would be "only the modicum . . . necessary to maintain the patient's debilitated condition at the moment of confinement."[202]

If the right to protection from harm were based on the deprivation of life clause, treatment would be mandated when failure to provide it would endanger the mental patient's life. The state

---

[197] *See, e.g.*, E. GOFFMAN, ASYLUMS (1961), *quoted in* Wyatt v. Aderholt, 503 F.2d 1305, 1312 n.8 (5th Cir. 1974) (commitment proceedings are for the convenience of relatives, police, and judges). *But see* Foote, *Comments on Preventative Detention*, 23 J. LEGAL EDUC. 48, 51-52 (1970).

[198] Flakes v. Percy, 511 F. Supp. 1325, 1333 (W.D. Wis. 1981). *See also* O'Connor v. Donaldson, 422 U.S. 563 (1975); Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981); Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134, 1146 (1967).

[199] *See* notes 189-193 and accompanying text *supra*.

[200] It might be claimed that prisoners have only a right to treatment for those injuries or diseases suffered while incarcerated, and that the mentally ill should not be afforded the same right because they entered the institution with the ailment. Failure to provide treatment to prisoners injured before incarceration, however, would be cruel and unusual punishment. *See* Hughes v. Noble, 295 F.2d 495 (5th Cir. 1961) (prisoner incarcerated after automobile accident).

[201] Bowring v. Godwin, 551 F.2d 44, 47-48 (4th Cir. 1977).

[202] *Spece I, supra* note 149, at 32.

could avoid providing treatment by protecting a patient's life in other ways, such as increasing the security staff or by removing dangerous objects from the patient's vicinity. A more expansive right results, however, if the right to treatment is derived from liberty considerations. Confinement without treatment precludes any treatment the patient might have obtained had he been outside the institution. To infringe as little as possible on the patient's liberty, the state should provide comparable treatment. The parameters of a right based on the liberty clause are unclear.

B. Equal Protection

Right to treatment cases have generally avoided equal protection analysis. A few cases have mentioned equal protection as a possible basis for the right to treatment;[203] others have raised and dismissed it with little analysis.[204] Equal protection, however, does merit attention because it is a traditional mode of constitutional analysis and avoids some of the doctrinal and practical pitfalls of other approaches.[205]

The fourteenth amendment requires that persons similarly situated be given equal protection of the laws.[206] The normal standard of judicial review for a state's disparate treatment of similarly situated persons is the rational relationship test.[207] If suspect classifications or fundamental interests are present, however, the standard of review is one of heightened scrutiny.[208] Finally, an intermediate standard has been used recently to review quasi-suspect classifications and some protected interests.[209]

Equal protection analysis in the mental health area can focus on several classifications: physical versus mental illness;[210] civilly versus criminally committed persons;[211] or the mentally ill ver-

---

[203] *E.g.*, Philipp v. Carey, 517 F. Supp. 513 (N.D.N.Y. 1981).

[204] *See, e.g.*, New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973).

[205] *See* notes 165-171 and accompanying text *supra* (eighth amendment inapplicable to mental patients); notes 200-202 and accompanying text *supra* (due process leads to uncertain protection of the right to treatment).

[206] J. NOWAK, R. ROTUNDA & T. YOUNG, *supra* note 190, at 517.

[207] *See* Williams v. Lee Optical, 348 U.S. 483 (1955).

[208] *See, e.g.*, L. TRIBE, *supra* note 117, at 1000-19.

[209] J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 192, at 524.

[210] *See, e.g.*, Doe v. Colautti, 592 F.2d 704 (3d Cir. 1979).

[211] *See* text accompanying notes 188-198 *supra*.

sus the general population. The following analysis focuses on the latter classification.

Under the rational relationship test, confinement must bear a rational relationship to a legitimate governmental objective.[212] States commonly give three purposes for involuntary commitment of mentally ill persons: (1) Some are dangerous to society and must be confined to prevent them from harming others; (2) some are dangerous to themselves and unless cared for will harm themselves either actively or passively; and (3) some need treatment.[213] *O'Connor v. Donaldson*[214] left unanswered the question of whether custodial confinement of the mentally ill adequately promotes these or any other "police power" objectives.[215] A principal difficulty is that the classification of mentally ill persons versus the general population is both under- and over-inclusive with respect to these goals.

Many persons who are mentally ill are not dangerous to themselves or others;[216] other individuals are dangerous but not mentally ill. Treatment for mental illness, however, is something from which virtually all mentally ill persons, both dangerous and

---

[212] J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 190, at 524; L. TRIBE, *supra* note 117, at 994-97.

[213] *Spece I, supra* note 149, at 6.

[214] 442 U.S. 563 (1975). The Supreme Court held that the state could not constitutionally confine a nondangerous mentally ill person who had the ability to live safely outside the institution:

> A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that the term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.

Id. at 575.

Justice Stewart's holding was aimed both at the purpose of commitment and the means employed to serve this purpose. He dismissed any argument that commitment was essential to afford the petitioner a superior living standard because 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 and friends." *Id.* Moreover, the Court rejected mere improvement of a person's quality of life as a compelling interest. *Id.*

[215] *Developments in the Law, supra* note 127, at 1207-45 (origins and applications of state's police and *parens patriae* power). *But see* Flakes v. Percy, 511 F. Supp. 1325 (W.D. Wis. 1981).

[216] *See* notes 195-198 *supra*, note 242 and accompanying text *infra*.

non-dangerous, can benefit.[217] Thus, the classification fits only if the state's objective is treatment.[218] Nonetheless, the present classification scheme will probably be upheld, because under the rational relationship test the state need only show a *conceivable* relationship to a legitimate state goal.[219] However, if "mental illness" is a suspect or quasi-suspect classification,[220] or if civil commitment amounts to an unjustified infringement on protected liberty,[221] some form of heightened scrutiny is required.

There is no consistency of judicial opinion on whether mental illness is a suspect classification.[222] The Supreme Court has avoided the issue.[223] There is a strong argument in favor of holding the mental illness classification to be quasi-suspect.[224] A quasi-suspect class is one whose members share some of the indicia of suspectness, and "bear enough resemblance to . . . minorities to warrant more than casual judicial response when they are injured by law."[225] Mentally ill persons do share certain characteristics with persons in traditional suspect classifications.[226] The indicia of suspect classes vary. One is "an immuta-

---

[217] *See generally* notes 81-82 and accompanying text *supra*.

[218] *Developments in the Law, supra* note 127, at 1329-30; Note, Wyatt v. Stickney, 86 HARV. L. REV. 1282, 1293-96 (1973). *See* Simpson, *Mental Illness: A Suspect Classification?*, 83 YALE L.J. 1237 (1974).

[219] J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 190, at 524.

[220] *See* notes 221-238 and accompanying text *infra*.

[221] *See* notes 177-187 and accompanying text *infra*.

[222] *See* Doe v. Colautti, 592 F.2d 704 (3d Cir. 1979); Flakes v. Percy, 511 F. Supp. 1325 (W.D. Wis. 1981); Sterling v. Harris, 478 F. Supp. 1046 (N.D. Ill. 1979), *rev'd sub nom.* Schweiker v. Wilson, 101 S. Ct. 1074 (1981); New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973).

[223] Schweiker v. Wilson, 101 S. Ct. 1074 (1981). In one case, the Court granted summary affirmance of a case holding the rational relation test applicable in reviewing a statute that gave benefits to physically ill persons while denying them to the mentally ill. *See* Legion v. Weinberger, 414 U.S. 1058 (1973). The precedential value of the Supreme Court's summary affirmance of *Legion* has been interpreted differently. *See* Doe v. Colautti, 592 F.2d 704 (3d Cir. 1979); Sterling v. Harris, 478 F. Supp. 1046 (N.D. Ill.), *rev'd sub nom.* Schweiker v. Wilson, 101 S. Ct. 1074 (1981).

[224] Simpson, *supra* note 218.

[225] L. TRIBE, *supra* note 117, at 1090 (footnote omitted).

[226] Traditionally, suspect groups include race, religion, alienage, and perhaps illegitimacy. *Id.* at 1012, 1052, 1057.

ble characteristic determined solely by the accident of birth"[227] that "frequently bears no relation to ability to perform or contribute to society."[228] Another concerns classifications affecting "discrete and insular minorities . . . unable to express a potent voice in the political process."[229] A third looks to groups subjected to "a history of purposeful unequal treatment . . . as to command extraordinary protection . . .,"[230] or subjected to a "stigma of inferiority and badge of opprobrium."[231]

Some types of mental illness and mental retardation are certainly "immutable characteristic[s] determined . . . by the accident of birth."[232] Other types may not be determined at birth, but they may well be immutable in the sense of being beyond a person's control; most mental patients do not choose to become ill.[233] The second aspect of this indicium of suspect classifications concerns a person's ability to perform or contribute to society. Mentally ill persons often will not meet this test, because without treatment they are generally unable to function in society.[234]

The mentally ill also meet other indicia of suspect classifications. They have reduced political power. In many states, they are not allowed to vote.[235] Shut away in institutions, they exemplify the "discrete and insular minorities"[236] that the equal pro-

---

[227] Frontiero v. Richardson, 411 U.S. 677, 686 (1973).

[228] *Id.*

[229] United States v. Carolene Prods. Co., 304 U.S. 144, 152-53 n.4 (1938).

[230] San Antonio School Dist. v. Rodriguez, 411 U.S. 1, 28 (1973).

[231] Black, *The Lawfulness of the Segregation Decisions*, 69 YALE L.J. 421, 424 (1960); *Developments in the Law—Equal Protection*, 82 HARV. L. REV. 1065, 1127 (1969).

[232] Frontiero v. Richardson, 411 U.S. 677, 686 (1973).

[233] *See* notes 77, 83-85 and accompanying text *supra*. *But see* T. SZASZ, LAW, LIBERTY, AND PSYCHIATRY 215 (1968). For an excellent sociological perspective, see E. LEMERT, HUMAN DEVIANCE, SOCIAL PROBLEMS, AND SOCIAL CONTROL (2d ed. 1972).

[234] Doe v. Colautti, 592 F.2d 704 (3d Cir. 1979).

> Although the mentally ill have been the victims of stereotypes, the disabilities imposed on them have often reflected that many of them do have reduced ability for personal relations, for economic activity, and for political choice. . . . It is important that the legal disabilities have been related, even if imperfectly, to real inabilities from which many of the mentally ill suffer.

Id. at 711.

[235] *E.g.*, N.Y. ELEC. LAW § 5-106(6) (McKinney 1978).

[236] United States v. Carolene Prods. Co., 304 U.S. 144, 152-53 n.4 (1938). *See*

tection clause should safeguard. Finally, the mentally ill have been subjected to "a history of purposeful unequal treatment."[237] Traditionally, persons with mental disabilities have been stigmatized and have suffered from prejudice and discrimination.[238]

Thus, a classification based on "mental illness" is suspect under most of the indicia of a suspect classification. Although the Supreme Court "has been hesitant to recognize new suspect classifications,"[239] the mentally ill bear enough of the characteristics of suspect classes that they should be accorded at least quasi-suspect status.[240]

If the mentally ill constitute a quasi-suspect class, state actions affecting them will have to withstand an intermediate level of scrutiny. Under intermediate scrutiny, courts should examine the relationship of means and end, and the closeness of classificatory fit.[241] Current civil commitment schemes probably fail these tests because the group burdened is both under- and over-inclusive.[242] However, provision of treatment is an important state objective, and the "mental illness" classification fits that purpose exactly.[243] Thus, under the intermediate level of review, states may confine the mentally ill for the purpose of providing treatment. This is not to say that treatment is given in exchange for the individual's liberty,[244] nor does it elevate "a concern for procedural safeguards into a new, substantial constitutional right."[245] It simply recognizes that treatment is the only acceptable rationale for the restraints on freedom that accompany institutionalization.

---

also San Antonio School Dist. v. Rodriguez, 411 U.S. 1, 28 (1973).

[237] San Antonio School Dist. v. Rodriguez, 411 U.S. 1, 28 (1973) (*obiter dicta*).

[238] *See generally* E. LEMERT, *supra* note 233, at 62-101 (discussing "secondary deviations" and legal commitment); E. LEMERT, SOCIAL PATHOLOGY (1951); Simpson, *supra* note 218.

[239] Sterling v. Harris, 478 F. Supp. 1046, 1049 (N.D. Ill. 1979).

[240] *See* L. TRIBE, *supra* note 117, at 1090.

[241] *Id.* at 1082-91.

[242] Simpson, *supra* note 218.

[243] *See* note 218 *supra*.

[244] *See* O'Connor v. Donaldson, 422 U.S. 563, 585 (1975) (Burger, C.J., concurring).

[245] *Id.* at 587 (Burger, C.J., concurring).

C. The Least Restrictive Alternative Theory

A constitutional right to treatment for the involuntarily committed mentally ill can also be based on least restrictive alternative principles.[246] Under this theory, the state can achieve its commitment goals and concurrently minimize intrusion upon individual liberty. Like the protection from harm and equal pro-

---

[246] This doctrine requires that government action must not intrude upon a constitutionally protected interest to a degree greater than necessary to achieve a legitimate purpose:

> [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 abridgment must be viewed in light of less drastic means for achieving the same basic purposes.

Shelton v. Tucker, 364 U.S. 479, 488 (1960).

The most convincing case in favor of applying the least restrictive alternative theory is O'Connor v. Donaldson, 422 U.S. 563 (1975). Although the Court avoided the issue of a committee's right to treatment, *see id.* at 573, the case supports a compelling state interest test. *See* Grant, Donaldson, *Dangerousness, and the Right to Treatment*, 3 HASTINGS CONST. L.Q. 599, 611-14 (1976). The Court stated that commitment 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. The elements of the least restrictive alternative are shown by the Court's: (1) reliance on Shelton v. Tucker, 364 U.S. 479 (1960) (setting forth the least restrictive alternative test); (2) using least restrictive alternative language, *e.g.*, commitment is "rarely if ever a necessary condition," 422 U.S. at 575; and (3) using least restrictive alternative logic, *i.e.*, reasoning that the state goal of providing care and assistance would be denied if other methods, like help from family or friends, would impinge less on individual rights. Spece, *Justifying Invigorated Scrutiny and the Least Restrictive Alternative as a Superior Form of Intermediate Review: Civil Commitment and the Right to Treatment as a Case Study*, 21 ARIZ. L. REV. 1049, 1084 (1979) [hereinafter cited as *Spece II*].

In State v. Sanchez, 80 N.M. 438, 457 P.2d 370 (1969), the court had stated that the least restrictive alternative had no application to civil commitment. *Id.* at 441, 457 P.2d at 373. The Supreme Court dismissed Sanchez's appeal "for want of a substantial federal question." Sanchez v. New Mexico, 396 U.S. 276 (1970). Lower courts, however, have ignored the Supreme Court's dismissal in *Sanchez*, and have applied the least restrictive alternative to civil commitment. *See, e.g.*, Covington v. Harris, 419 F.2d 617, 623 n.17 (D.C. Cir. 1969); Rone v. Fireman, 473 F. Supp. 92, 125 (N.D. Ohio 1979); Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295, 1319 (E.D. Pa. 1977), *aff'd on other grounds*, 612 F.2d 84 (3d Cir. 1979) (*en banc*), *rev'd on other grounds*, 101 S. Ct. 1531 (1981); Gary W. v. Louisiana, 437 F. Supp. 1209, 1216-17 (E.D. La. 1976); Welsch v. Likins, 373 F. Supp. 487, 501-02 (D. Minn. 1974).

tection theories, this theoretical basis for a right to treatment was not well developed when Chief Justice Burger wrote his concurrence in *O'Connor*.

Professor Roy G. Spece has formulated the clearest exposition of a right to treatment theory under least restrictive alternative analysis.[247] The theory, which postulates that confinement with treatment is less intrusive than confinement *simpliciter*, derives from three assertions: (1) The right to freedom from confinement is a fundamental interest; (2) as a result, invigorated scrutiny is the appropriate standard of review; and (3) under that standard of review, if the state fails to meet its heavy burden of proof, it must provide treatment, because confinement with treatment intrudes less upon the right to freedom from confinement than does simple confinement.[248]

---

[247] *Spece II, supra* note 246, at 1049-50. *See also Spece I, supra* note 149, at 38-39.

[248] The theory assumes that the least restrictive alternative is an independent standard of judicial review, one in which the state bears a heavy burden of proof. While the state need only use equally effective alternative means, it must not draw overly inclusive classifications, and must use alternative means that minimize intrusions. Further, the least restrictive alternative principle is a relatively mild intrusion into the political process, because it does not deny any state goals. *Spece I, supra* note 149, at 35.

Each of these assumptions has support. Tradition and precedent favor the independent use of invigorated scrutiny. It is a well established principle that has been used in every field of constitutional adjudication, and has been applied independently in first amendment and commerce clause cases. *Spece II, supra* note 246, at 1053-56. Policies on placing the burden of proof indicate that the state should bear such a burden. *Id.* at 1057-58. Civil commitment involves a change of the status quo through a massive deprivation of liberty. *Id.* at 1057-58. Also, the state's claim that a person is mentally ill is an assertion of a fact more improbable than not. *Id.* Civil commitment is a great intrusion on a preferred right, the right to freedom from confinement. Finally, because it operates institutions, the state has better access to information; it knows who the patients are, what should be done, and it has access to massive technical resources. *Id.* at 1058.

The state need only use equally effective alternative means, because any alternative would be too burdensome. On the other hand, the state should not use overly broad classifications, because the intrusion on one's rights would be too great. The least restrictive alternative is only a mild intrusion in the political process, because only the means are scrutinized. *Spece I, supra* note 149, at 35. This would merely require the legislature to fashion legislation having a more specific focus. *Spece II, supra* note 246, at 1058-59.

1. The Appropriate Standard of Review

The United States Supreme Court applies a strict standard of review when the individual right infringed is closely related to fundamental constitutional interests.[249] Civil commitment substantially, perhaps irreversibly,[250] intrudes upon an individual's freedom. It affects personal liberty,[251] family privacy,[252] and other rights.[253] Therefore, an invigorated standard of review is appropriate.

2. Recognizing Conflicting Goals

The least restrictive alternative standard provides a means for recognizing the state's goals, the needs of individuals, and the concerns of legislators.[254] The state, as before, may protect its legitimate interest in confining dangerous or gravely disabled

---

[249] L. TRIBE, *supra* note 117, at 1000-19. *See also* Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1108, 1155 (1972).

[250] Irreversible intrusions trigger heightened scrutiny. *See, e.g., Spece II, supra* note 246, at 1074 n.127. Commitment may be irreversible by causing or accelerating a patient's death. *See* notes 173-176 and accompanying text *supra*. It may also be irreversible if an individual is confined indefinitely or until death.

[251] Shapiro v. Thompson, 394 U.S. 618 (1969) (one year residency requirement to obtain welfare benefits violates fundamental right of interstate travel).

[252] Moore v. City of East Cleveland, 431 U.S. 494 (1977) (state cannot impose definition of "family" so as to prohibit certain blood relatives from living together).

[253] *See* U.S. CONST. amend. VI; Moore v. City of East Cleveland, 431 U.S. 494, 500 (1977); *Spece II, supra* note 246. In Griswold v. Connecticut, 381 U.S. 479 (1965), the Court applied an invigorated standard of review and recognized the right to be free from government regulations on contraceptives. *Id.* at 485. Invigorated scrutiny was invoked because the right to use contraceptives is closely related to family privacy and personal liberty. *See id.* at 485-86.

In Roe v. Wade, 410 U.S. 113 (1973), the Court used invigorated scrutiny to decide the issue of prohibition of abortion. The rule of *Roe* is the same as that of *Griswold*, with the addition of two factors: (1) Invigorated scrutiny may require a massive or absolute deprivation; and (2) it does not require the presence of only judicially manageable issues. *Spece II, supra* note 246, at 1092. These factors exist in civil commitment cases because confinement is a massive curtailment of liberty. Moreover, the Supreme Court has rejected the contention that civil commitment cases are not subject to judicially manageable standards. O'Connor v. Donaldson, 422 U.S. 563, 574 n.10 (1975). *See also* Humphrey v. Cady, 405 U.S. 504, 509 (1972).

[254] *Spece II, supra* note 246, at 1058-59. *See also* note 251 *supra*.

persons. The least restrictive alternative theory only requires the state to confine these individuals in the least intrusive manner. Treatment will ordinarily lessen the intrusion of confinement and thus will ordinarily be required. If the state demonstrates that providing treatment would not enhance an individual's freedom or improve his mental condition, then treatment would not be required.[255] Under this standard of review, therefore, the courts would pay close attention to both the state's and the patient's interest.

Adopting the least restrictive alternative standard would likely result in treatment tailored to the needs of the individual. This in turn would likely hasten the recovery and release of patients, thus lessening the infringement on their liberty interests. The least restrictive alternative test would also provide an incentive for legislators to pass laws that do not rest on overbroad classifications. Narrower legislation would more sharply focus on individuals who truly need commitment and treatment. More selective commitment would result.

The greatest disadvantage of the least restrictive alternative theory is that it may generate greater administrative problems and costs. Because judicial inquiry would entail questioning medical judgment, legislative intent, and patients' needs on a case-by-case basis, judicial supervision could become time-consuming and costly. Nonetheless, gains would result. Given treatment tailored to need, discharge of some patients would be possible. Further, the increased administrative costs might spur legislators to devise well-tailored programs to avoid over-commitment of patients and excessive judicial review.

3. The Least Restrictive Alternative Theory in the Lower Courts

Numerous jurisdictions recognize the least restrictive alternative doctrine in statutes applicable to treatment of the involuntarily committed.[256] Moreover, many courts have recognized a

---

[255] *See* text accompanying note 247 *supra*.

[256] *See* Philipp v. Carey, 517 F. Supp. 513, 517 (N.D.N.Y. 1981). *See also* Scott v. Plante, 641 F.2d 117, 131 n.15 (3d Cir. 1981); Romeo v. Youngberg, 644 F.2d 147, 167 n.46 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981) (No. 80-1429, 1981 Term); United States v. Ecker, 543 F.2d 178, 199 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 1063 (1977); Covington v. Harris, 419 F.2d 617, 623 (D.C. Cir. 1969); Rone v. Fireman, 473 F. Supp. 92, 120 (N.D. Ohio 1979); Welsch v.

constitutional right to receive treatment in settings that are least restrictive of personal liberty. These courts have differed, however, in their interpretations of the requirements.[257] One court has held that the Constitution only guarantees involuntarily confined persons treatment that is minimally adequate to furnish a reasonable opportunity to be cured or to improve their mental condition.[258] Another court has declared that a constitutional right to treatment requires a program of treatment that affords an individual a reasonable chance to acquire and maintain those life skills that will enable him to cope as effectively as his own capacities permit.[259] Still another court has stated that the essential elements of minimally adequate treatment include humane physical and psychological treatment environments, sufficient numbers of qualified staff, and an individualized treatment plan for each patient.[260] Finally, one court has held that the state must give thoughtful consideration to the individual's needs, treat him constructively according to his own situation, and carefully tailor the means used to effectuate the state's substantial concerns to minimize infringement of protected interests.[261]

4. The Vulnerability of the Least Restrictive Alternative Right to Treatment Theory

Chief Justice Burger gave at least seven criticisms of a constitutional right to treatment.[262] Some of these criticisms are irrelevant to the least restrictive alternative theory.[263] Assessment of the relevant criticisms indicates that the theory remains intact as a foundation for a right to treatment for the institutionalized patient.

Likins, 373 F. Supp. 487, 502 (D. Minn. 1974). *See also* notes 5-6 *supra.*

[257] Philipp v. Carey, 517 F. Supp. 513, 517-18 (N.D.N.Y. 1981).

[258] Flakes v. Percy, 511 F. Supp. 1325, 1338 (W.D. Wis. 1981).

[259] Johnson v. Solomon, 484 F. Supp. 278, 302 (D. Md. 1979).

[260] Eckerhart v. Hensley, 475 F. Supp. 908, 915 (W.D. Mo. 1979). *See also* Woe v. Mathews, 408 F. Supp. 419, 427-28 (E.D.N.Y. 1976).

[261] Gary W. v. Louisiana, 437 F. Supp. 1209, 1217 (E.D. La. 1976).

[262] *See* notes 26-28 and accompanying text *supra.*

[263] *E.g.,* notes 31-76 and accompanying text *supra* (the "historical" argument). The least restrictive alternative argument derives from doctrines of equal protection and due process. These are, of course, of long standing. Their application to deprivation of liberty is also historically grounded in ample precedent.

Chief Justice Burger's criticism that mental illness is not completely curable has no place in least restrictive alternative analysis.[264] Whether a patient is curable, his right to liberty remains intact.[265] "[A]ppropriate deference to medical expertise does not diminish the judicial duty to safeguard liberty interests implicated in treatment decisions."[266] The least restrictive alternative standard applies even when treatment is only partially effective.

Least restrictive alternative analysis also avoids the Chief Justice's criticism that the psychiatric field lacks unanimity.[267] Under this doctrine, unanimity in psychiatry is of relatively little importance in deciding whether to provide treatment to particular patients. There *is* unanimity that liberty is a protected interest[268] and that mental patients are entitled to assert this interest.[269] In the rare case in which expert psychiatrists disagree completely about the particular form of treatment, an institution should not be relieved of the burden of supplying treatment.[270] Instead, the institution should make an independent evaluation.

Chief Justice Burger also argues that treatment would be ineffective because some patients might not cooperate.[271] A patient's competent refusal of treatment should, of course, be respected and serve as a waiver of the right to treatment. A waiver of the right by some patients, however, should not preclude exercise of that right by all patients.

Chief Justice Burger further asserts that "[t]he *quid pro quo* theory is a sharp departure from . . . due process . . . [because it] presupposes that essentially the same interests are involved in every situation where a State seeks to confine an individual. . . ."[272] The least restrictive alternative right to treatment

---

[264] O'Connor v. Donaldson, 422 U.S. 563, 582 (1975) (Burger, C.J., concurring).

[265] *See* notes 176-187 and accompanying text *supra*.

[266] Romeo v. Youngberg, 644 F.2d 147, 165 (3d Cir. 1980), *cert. granted*, 101 S. Ct. 2313 (1981).

[267] *See, e.g.*, O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring).

[268] U.S. CONST. amend. XIV; L. TRIBE, *supra* note 117, at 564-985.

[269] Notes 179-180 and accompanying text *supra*.

[270] *See* notes 77-85 and accompanying text *supra*.

[271] O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J. concurring).

[272] *Id.* at 586.

theory does not assume that identical interests are at stake in every situation. It requires a case-by-case determination. Under the least restrictive alternative theory, a court inquires into both the state's and the patient's interests, and then examines available alternatives. This allows the state to achieve its goals of confinement, as well as to provide treatment for the individual.

The Chief Justice argues that, "rather than inquiring whether strict standards of proof or periodic redetermination of a patient's condition are required in civil confinement, the [right to treatment] theory accepts the absence of such safeguards but insists that the State provide benefits which, in the view of a court, are adequate 'compensation' for confinement."[273] The least restrictive alternative theory is not, however, based on a *quid pro quo* rationale. The lack of procedural safeguards does not trigger least restrictive alternative analysis. Rather, it is triggered by the infringement of an individual's right to freedom from confinement. Under an invigorated standard of review, the court's focus is just as much on the patient's interest as on the state's. Least restrictive alternative analysis should thus strengthen rather than weaken patients' rights to liberty.

The Chief Justice finally contends that the type of judicial intervention contemplated in right to treatment cases may be beyond the traditional limitations on the scope of judicial review.[274] The type of judicial intervention required to determine or order appropriate treatment is no more extraordinary or expansive than is ordinary litigation.[275] Judicial supervision of default judgments, pre-judgment remedies, probate and trust administration, and bankruptcy[276] is just as elaborate as the judicial intervention required in right to treatment cases. In view of the courts' substantial intervention in ordinary litigation, a court would not be acting outside its customary role in right to treatment cases.

D. Theoretical Maximum Duration of Commitment

Finally, we propose an additional theory supporting treatment for persons who are civilly confined in mental institutions. This theory is based, not on substantive due process or equal protec-

---

[273] *Id.* at 587.
[274] *Id.*
[275] Eisenberg & Yeazell, *supra* note 23, at 474-94.
[276] *Id.* at 482-86.

tion, but on procedural due process. The theory does not call for a *right* to treatment; instead it demands adherence to procedural due process throughout a mental patient's commitment. Confinement beyond the time necessary to enable the patient to return to society may be a deprivation of liberty without due process of law. On the other hand, by providing treatment, the state would effectively be able to insulate itself from *habeas corpus* and other challenges to its power to detain an individual.

1. The Theory

One basic tenet of Anglo-American jurisprudence is that no person should be deprived of liberty without a fair hearing.[277] In civil commitment proceedings, courts relax procedural safeguards, but still require a minimum level of procedural due process to legitimize the deprivation of the patient's liberty.[278] Just as detention of a criminal inmate beyond the date of his sentence constitutes a denial of liberty without due process,[279] the confinement of a mental patient beyond the time authorized for detention effects an identical deprivation.

In criminal cases, a statute or court order usually specifies the duration of confinement.[280] It is more difficult, however, to articulate the duration of commitment authorized by commitment orders. Mental patient inmates are not *sentenced;* rather, they are committed until able to return to society.[281] Nonetheless, the absence of a defined expiration date for civil confinement should not preclude protection of a mental patient's liberty through procedural due process.

2. Theoretical Maximum Duration of Commitment

Obviously, it is impossible to predict accurately the time necessary to enable a mental patient to return to society. Nor is it possible to estimate accurately the date when a currently incar-

---

[277] L. TRIBE, *supra* note 117, § 10-7 (Procedural Due Process: Intrinsic and Instrumental Aspects).

[278] *See* notes 112-118 and accompanying text *supra.*

[279] U.S. CONST. art. I, § 9; 28 U.S.C. §§ 2241-2254 (federal *habeas corpus* remedy for improper detention).

[280] *See generally* B. ENNIS & R. EMERY, *supra* note 129, at 130-31 (3d ed. 1978).

[281] *See generally* F. MILLER, R. DAWSON, G. DIX & R. PARNAS, THE MENTAL HEALTH PROCESS ch. 17 (1971).

cerated person might safely be released. Still, there exists a theoretical maximum duration of commitment that marks the outer limits of the state's license to confine a mental patient.[282] To ascertain this limit, courts should presume that the durational limitations have expired unless treatment has been provided for a substantial part of the confinement period.

3. Application of the Theory

Assume that P, through his guardian, files a writ of *habeas corpus* seeking release from state hospital D. The state obtained authority to confine P at a proper hearing, where the court committed P on the ground, for example, of his danger to others. The state's authority to confine P, however, is not perpetual; rather, it is limited to the time it would take to enable D to return P to society.[283] The court must therefore determine whether this maximum duration of commitment has expired by looking to the facts of the case and applying the following presumption:[284]

> If the patient has been and is being given substantial treatment, and is still confined in an institution, the theoretical maximum duration of commitment has not yet expired, and continued confinement is legitimate. If the patient has *not* been given treatment and is still confined, however, the theoretical maximum duration of commitment has expired, and continued confinement is an unconstitutional deprivation of liberty without due process.

---

[282] In Jackson v. Indiana, 406 U.S. 715 (1972), a unanimous Court wrote that "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual was committed." *Id.* at 738. *See also* D. WEXLER, MENTAL HEALTH LAW 33-34 (1981) (periodic review of status of the confined mentally ill is required).

[283] It is clear, for example, that patients must be discharged as soon as the basis for commitment no longer exists. The *O'Connor* Court recognized this in writing that it was not "enough that Donaldson's original confinement was founded upon a constitutionally adequate basis . . . because even if his involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed." O'Connor v. Donaldson, 422 U.S. 563, 574-75 (1975). *See also* N.Y. MENTAL HYG. LAW § 9.33(d) (McKinney 1978).

[284] This presumption, like most presumptions, is aimed at forwarding certain policy goals at the expense of others. *See generally* Cleary, *Presuming and Pleading: An Essay on Juristic Immaturity*, 12 STAN. L. REV. 5 (1959). It protects the interests of confined mental patients in receiving treatment or discharge. The interest submerged is that of the state in continued and undisturbed confinement of patients without providing treatment.

By presuming that the theoretical maximum duration of commitment has expired, the court protects, at state expense, the patient's liberty interests. If the state's authority to confine has expired, the state has no power to detain P, and P may win his release. Although the state may recommit P, the state will also have an incentive to provide treatment to avoid repeated successful challenges to commitment. As a result, strict compliance with procedural due process may yield treatment for those confined in state mental institutions.

CONCLUSION

For more than twenty years, the theory that treatment is the *quid pro quo* that justifies the state's ability to confine the mentally ill has been the subject of judicial and scholarly debate. In *O'Connor v. Donaldson*,[285] the Supreme Court's most recent analysis of the right to treatment, Chief Justice Burger articulated seven criticisms of the theory. While some of these objections may have appeared valid in 1975, when the Chief Justice made them, they no longer withstand critical scrutiny. As a result, there are no historical, medical, or doctrinal objections to prevent the Court from finding that the involuntarily committed mentally ill have a constitutional right to treatment.

This article has examined and developed three substantive grounds other than the *quid pro quo* rationale for finding a right to treatment. These theories derive from the right to protection from harm, the constitutional mandate of equal protection, and the requirement that states choose the least restrictive alternative available when intruding on fundamental interests. In addition, the article has posited a "theoretical maximum duration of commitment," a procedural due process theory that requires treatment until a patient may be safely released.

When the Supreme Court next addresses the issue,† as it soon

---

[285] 422 U.S. 563 (1975).

† As this article went to press, the Supreme Court decided Youngberg v. Romeo, 50 U.S.L.W. 4681 (U.S. June 18, 1982). The Court held that confined mentally retarded persons have a right to safe conditions, to freedom from unnecessary bodily restraint, and to such training, or "habilitation," as is necessary to effectuate those rights. *Id.* at 4683. The Court did not reach the question of whether a broad, independent, right to treatment exists. *Id.* at 4684. In a concurring opinion, Chief Justice Burger reiterated his earlier position that there is no such constitutional right. *Id.* at 4686 (Burger, C.J., concurring).

must, it will find that Chief Justice Burger's objections to a right to treatment have vanished. Should the Court find it wise or compelling to adopt the right, it may ground its choice on at least four sound theoretical foundations.