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# Notes and Comments

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## GUARANTEEING TREATMENT FOR THE COMMITTED MENTAL PATIENT: THE TROUBLED ENFORCEMENT OF AN ELUSIVE RIGHT

Americans have been locking up the mentally ill for more than a century. During the past several decades they have held hearings before throwing away the keys to the institutions. American society in the late 1960's turned from the traditional concern for the procedural aspects of commitment of mentally ill persons to the quality of treatment received by those confined to public mental hospitals.

The courts followed public opinion behind the institutional walls. In 1966, the Court of Appeals for the District of Columbia Circuit held, in *Rouse v. Cameron*,<sup>1</sup> that a patient committed to a public mental hospital had a right, protected by statute and possibly constitutionally compelled, to receive adequate treatment for his illness. This landmark decision touched only the broad principles involved in the right to treatment, relegating to future cases the intractable problems of everyday implementation. In the aftermath of *Rouse v. Cameron*, a few state and federal courts have struggled, often without success, not only to formulate workable standards of what constitutes adequate treatment but also to fashion remedies that will effectively implement the right to such treatment.<sup>2</sup> The judiciary's initial reluctance to enter the traditional preserve of psychiatrists<sup>3</sup> appeared to be based on inarticulate description of the genesis of the right, the absence of easily applied standards for evaluating treatment, and the difficulty of framing remedies.<sup>4</sup> Confronted with the grim reality of modern mental hospital life, however, some courts assumed responsibility for trying to move the right to treatment forward to reality. Five types of commitment to mental institutions raise questions concerning the right to adequate

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1. 373 F.2d 451 (D.C. Cir. 1966).

2. The difficulties inherent in developing standards and formulating remedies have caused many courts to practice a "hands-off" policy. See Comment, *Due Process for All — Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633, 642 (1967).

3. *Rouse v. Cameron* itself illustrates the traditional hands-off approach to treatment of mental hospital patients. When the district court initially denied Rouse's habeas corpus petition, Judge Holtzoff stated: "My jurisdiction is limited to determining whether he has recovered his sanity. I don't think I have a right to consider whether he is getting enough treatment. \* \* \*" 373 F.2d at 452 (quoting unpublished district court opinion).

4. Birnbaum, *A Rationale for the Right*, 57 GEO. L.J. 77 n.3 (1969).

treatment: (1) involuntary commitment under a civil commitment statute;<sup>5</sup> (2) voluntary admission commenced by the patient himself or by someone acting on his behalf;<sup>6</sup> (3) mandatory commitment following an acquittal by reason of insanity;<sup>7</sup> (4) mandatory hospitalization following conviction of a crime;<sup>8</sup> and (5) commitment under defective delinquent,<sup>9</sup> sexual psychopath<sup>10</sup> and narcotics addiction statutes.<sup>11</sup> The quality of treatment that must be afforded and the power of the courts to guarantee it are the most important issues still to be developed in implementing the right to treatment.

## I. THE RIGHT TO TREATMENT

### A. Genesis of the Right

In *Rouse v. Cameron*,<sup>12</sup> a patient involuntarily committed to Saint Elizabeth's Hospital under a District of Columbia statute filed a habeas corpus petition claiming that he was being denied adequate treatment in contravention of his constitutional rights and that he had recovered his mental health. The committing statute provided that a person acquitted of a crime by reason of insanity must be confined to a mental hospital<sup>13</sup> until the superintendent certified that the patient had recovered his sanity and was no longer dangerous to others; at such time, the patient would be entitled to unconditional release.<sup>14</sup> The United States Court of Appeals for the District of Columbia Circuit held that a patient committed under these circumstances had a statutory right to receive adequate therapeutic treatment, and remanded the case for a determination of whether the petitioner had received adequate treatment.<sup>15</sup> Judge Bazelon, writing for the majority,

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5. The statutory criteria for civil commitment vary among states; commitment may be solely on the grounds of dangerousness or the need for treatment or both. F. LINDMAN & D. MCINTYRE, *THE MENTALLY DISABLED AND THE LAW* 17 (1961).

6. "Voluntary" admission admittedly is not always truly voluntary since patients are not free to leave at any time and voluntary admission can lead to civil commitment. *Id.* at 107. See T. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY* 40 (1963).

7. See, e.g., D.C. CODE ANN. § 24-301(d)(1) (Supp. IV 1971).

8. See, e.g., N.Y. CORREC. LAW § 408 (McKinney Supp. 1971).

9. See, e.g., MD. ANN. CODE art. 31B, § 1 *et seq.* (1971), *as amended*, (Supp. 1971).

10. See, e.g., D.C. CODE ANN. § 22-3508 (1967); MASS. ANN. LAWS ch. 123A, § 6 (1965).

11. See, e.g., N.Y. MENTAL HYGIENE LAW § 208 (McKinney 1971).

12. 373 F.2d 451 (D.C. Cir. 1966).

13. Act of Aug. 9, 1955, ch. 673, § 927(d), 69 Stat. 610 (now D.C. CODE ANN. § 24-301(d)(1) (Supp. IV 1971)).

14. D.C. CODE ANN. § 24-301(e) (Supp. IV 1971).

15. On the question of whether petitioner had recovered his sanity, the court held that on remand the district court could reconsider its finding that petitioner had not

reached this result by holding that the 1964 Hospitalization of the Mentally Ill Act,<sup>16</sup> which requires that a person hospitalized because of mental illness receive psychiatric care and treatment,<sup>17</sup> includes persons involuntarily committed as a result of criminal proceedings.<sup>18</sup> Even absent such a statute, however, Judge Bazelon said that forced confinement in a public mental hospital without treatment might violate either the due process clause, the equal protection clause or the eighth amendment to the Constitution.<sup>19</sup>

In the six years since the *Rouse* opinion was written, only one court has held that confinement for mental illness unaccompanied by treatment to ameliorate the condition constitutes a denial of due process.<sup>20</sup> Several other courts have suggested that confinement under these circumstances may constitute cruel and unusual punishment.<sup>21</sup> The cases discussing a constitutional right to treatment have relied on dicta in cases which upheld both the commitment statutes and the particular detentions in question.<sup>22</sup> This analytical weakness does not, how-

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recovered his mental health. The court of appeals suggested that the district court judge may have relied on the nature of the offense with which the petitioner had originally been charged — carrying a dangerous weapon — and not on the patient's dangerous propensities arising out of an abnormal mental condition. 373 F.2d at 459. See also *Overholser v. O'Beirne*, 302 F.2d 852 (D.C. Cir. 1961).

16. D.C. CODE ANN. § 21-562 (1967).

17. D.C. CODE ANN. § 21-562 (1967), provides: "A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment." 373 F.2d at 454.

18. This interpretation of the statute has been criticized in 80 HARV. L. REV. 898, 899 (1967).

19. 373 F.2d at 453. The *Rouse* court declared that: "[i]ndefinite confinement without treatment of one who has been found not criminally responsible may be so inhumane as to be 'cruel and unusual punishment.'" *Id.*

20. *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971). Subsequent cases have suggested that inadequate treatment may violate the due process clause. *E.g.*, *Nason v. Bridgewater State Hosp.*, 353 Mass. 474, 233 N.E.2d 908 (1968).

21. The few cases that have contended that the eighth amendment may prohibit confinement without adequate treatment do so on the theory that merely to confine such an individual is to punish for the status of being afflicted with a mental disorder. See *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964). Cf. *Robinson v. California*, 370 U.S. 660 (1962); *Easter v. District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966).

22. See *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) (citing dictum in *Rouse v. Cameron* as holding); *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966) (relying on dictum in *Sas v. Maryland*); *Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964) (which relied on dictum in *Minnesota ex rel. Pearson v. Probate Court*, 309 U.S. 270 (1940)). The type of casual analysis demonstrated by this interdependent chain of dicta is exemplified by the Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967), which stated: "In *Sas*, the Fourth Circuit suggested that Maryland's defective delinquent law discriminated against mentally disturbed defendants . . ." *Id.* at 104. On the contrary, the court held that the statute did not discriminate against that class of individuals. The concern

ever, indicate that in no case will the Constitution require treatment for an individual committed to a mental institution. Proper determination of the constitutional status of the right depends upon the purpose and length of the confinement and on the amenability of the patient to treatment.

Commitment that serves as a substitute for imprisonment on conviction of a crime becomes constitutionally suspect when it exceeds the length of the prison sentence that could have been imposed. If the commitment is merely conceived as confinement for the protection of society from one who could commit such crimes, it is possible that the right to treatment would not exist. However, it would appear to be a denial of equal protection to confine for differing periods of time legally sane criminals incapable of controlling their " 'propensity toward criminal activity,' " <sup>23</sup> legally insane criminals and criminals on whom no psychiatrist has passed judgment. <sup>24</sup> If the commitment is designed to correct the mental or personality deformities that produce the criminal act, it would be a denial of due process to withhold the very treatment that provided the impetus for the confinement.

Commitment that is grounded on the well-being of the patient and that is to continue until the patient recovers becomes imprisonment for mental illness if no "humane therapeutic treatment" is provided. <sup>25</sup> Casting the deprivation of liberty in terms of "civil" confinement becomes an exercise in semantics; <sup>26</sup> in truth, the "patient" is imprisoned

of the court's dictum was over the application of the statutory scheme. *Sas v. Maryland*, 334 F.2d 506, 514, 516 (4th Cir. 1964).

23. *Sas v. Maryland*, 334 F.2d 506, 516 (4th Cir. 1964).

24. The Supreme Court suggested in a recent case that the equal protection clause would forbid the application of different procedural rubrics to commitment under two different Wisconsin statutes: the Mental Health Act, WIS. STAT. ANN. ch. 51 (1957), and the sex crimes act, WIS. STAT. ANN. § 959.15 (1958), *as amended*, ch. 975 (1971). *Humphrey v. Cady*, 40 U.S.L.W. 4324, 4326 (U.S. Mar. 22, 1972). *See Baxstrom v. Herold*, 383 U.S. 107 (1966). *Cf. Skinner v. Oklahoma*, 316 U.S. 535 (1942).

25. *Ragsdale v. Overholser*, 281 F.2d 943, 949 (D.C. Cir. 1960) (Fahy, J., concurring). The case upheld summary commitment under D.C. CODE ANN. § 24-301(a) (Supp. VIII 1960), which in effect allowed commitment on the basis of a jury verdict that a criminal act had been committed and that there was more than a reasonable doubt that the person charged was sane at the time of the act.

26. *Cf. Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964) (dictum).

[A]rguments as to whether the Act is civil or penal in nature are futile exercises in semantics. An Act which deprives sane men of their liberty by confining them under severe discipline with or without treatment requires a basic fairness of procedure and substance — "implicit in the concept of ordered liberty" — to comport with the guarantees of our National Constitution.

*Id.* at 516 n.5. The Supreme Court in *Minnesota ex rel. Pearson v. Probate Court*, 309 U.S. 270 (1940), also read a requirement of "basic fairness of procedure and sub-

for his madness. Such confinement would seem, per se, to constitute a denial of due process under the standard of *Robinson v. California*.<sup>27</sup> Illustrative of this point is *Wyatt v. Stickney*.<sup>28</sup> In that case, guardians of patients involuntarily committed to Bryce Hospital in Alabama sought an Order of Reference to a panel of experts under the Federal Rules of Civil Procedure for the purpose of obtaining a factual determination of the adequacy of treatment actually received at that institution.<sup>29</sup> The plaintiffs alleged that the patients were being denied their constitutional right to treatment because the hospital was severely understaffed and therapeutic treatment programs were nonexistent.<sup>30</sup>

Judge Johnson concluded that the existing treatment programs were "scientifically and medically inadequate"<sup>31</sup> and "failed to conform to any known minimums established for providing treatment for the mentally ill."<sup>32</sup> Noting that the plaintiffs had been involuntarily committed for the purpose of treatment and had been committed through civil proceedings which lacked the constitutional safeguards characteristic of criminal trials, the court held that the patients had a right to treatment. In the court's view, the only constitutional justification for detaining a person in a hospital under those procedures was treatment; to deprive a patient of such treatment "violates the very fundamentals of due process."<sup>33</sup> The reasoning of this case would apply with equal force to the situation of the voluntarily committed patient, whose confinement is not necessarily purely voluntary and may lack the fundamental procedural safeguards of due process.<sup>34</sup>

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stance" into a Minnesota statute containing provisions analogous to the Defective Delinquent Act in Maryland.

27. 370 U.S. 660 (1962).

28. 325 F. Supp. 781 (M.D. Ala. 1971). Judge Johnson placed the authority for his conclusions solely on *Rouse v. Cameron*. This analysis is criticized in note 22 *supra*.

29. Fed. R. Civ. P. 53(b) allows a district court to refer particular issues to a court-appointed master for a report on factual issues. Initially, former employees of Bryce Hospital joined the suit requesting that they be reinstated but subsequently withdrew their request.

30. Pre-trial brief for Plaintiffs at 7-8, *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971). Neither the plaintiffs' brief nor their pre-trial brief raised the issue of inadequate facilities although the opinion in *Wyatt* seems to conclude that the facilities at Bryce were inadequate.

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

32. *Id.*

33. *Id.* at 785.

34. See note 6 *supra* and accompanying text. Procedural safeguards may have to be elevated to the rigor of a criminal trial for these "patients." An advocate of the right to treatment cautions that without stringent safeguards mental hospitals in the United States could be used as similar institutions in the Soviet Union are now being used, as political prisons. Dershowitz, *A Question of Madness by Zhores A. & Ray A. Medvedev*, N.Y. Times, Nov. 28, 1971, § 7 (Book Review), at 4, col. 2.

### B. Standards for Determining Adequacy of Treatment

*Rouse v. Cameron* set forth vague and perhaps unworkable standards for determining adequacy of treatment. According to that decision, the hospital is required "to provide treatment which is adequate in light of present knowledge."<sup>35</sup> The treatment prescribed for a particular patient need not be the best possible, and it need not improve the patient's condition. To satisfy the requirement of adequate treatment, the hospital must show a "bona fide effort" to cure and improve; it must show that it has conducted preliminary and periodic examinations of the individual patient's condition and provided a therapeutic program suited to the patient's particular mental disability.<sup>36</sup> While the *Rouse* court acknowledged that psychiatrists, with their highly divergent schools of thought, may not agree on the standards for adequate treatment, it declared that lack of consensus did not exonerate a court from its duty to uphold the rights of a committed patient.<sup>37</sup> A trial court in reaching a decision could consult independent experts as well as pertinent data indicating minimum standards of treatment published by several governmental agencies and such private associations as the American Psychiatric Association.<sup>38</sup>

When reviewing the hospital's program of treatment — or lack thereof — for an individual, the court's role is similar to that when reviewing agency action; it must decide whether the hospital authorities have made a "permissible and reasonable decision in view of the relevant information and within a broad range of discretion."<sup>39</sup> As pointed out in *Covington v. Harris*,<sup>40</sup> the purpose of this limited standard of judicial review is to insure that the decision-makers have made a reasonable decision using the proper criteria and taking account of everything of substantial relevance.<sup>41</sup> Under this standard the hospital administration is acting as an administrative agency exercising considerable discretion in making its findings of fact. The reviewing court is essentially restricted to its function in administrative law — determining whether the decision is supported by substantial evidence,

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35. 373 F.2d at 456.

36. *Id.*

37. *Id.* at 457.

38. See AMERICAN PSYCHIATRIC ASS'N, STANDARDS FOR PSYCHIATRIC FACILITIES (1969). Other sources of pertinent data suggested by *Rouse* include the National Institute of Mental Health, the National Association of State Mental Health Program Directors and the Group for Advancement of Psychiatry.

39. *Tribby v. Cameron*, 379 F.2d 104, 105 (D.C. Cir. 1967). See *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

40. 419 F.2d 617 (D.C. Cir. 1969).

41. *Id.* at 621.

that is, "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."<sup>42</sup>

The approach adopted in *Rouse* has encountered considerable criticism; many authorities have questioned the judiciary's qualification for choosing among multifarious therapies, none of which have been conclusively shown to be effective.<sup>43</sup> If a case before the court involves a choice among numerous psychotherapies, the standards suggested by *Rouse* may not provide sufficient guidelines for determining adequacy.<sup>44</sup> In addition, the reliability of some of the standards recommended by *Rouse* has been attacked. For example, one authority has asserted that the minimum standards established by the American Psychiatric Association in 1958 "represent a compromise between what was thought to be adequate and what was thought had some possibility of being realized."<sup>45</sup>

One acceptable solution to the problem of the formulation of standards is the legislative enactment of standards defining the right to treatment. Pennsylvania is the only state to have ever attempted enactment of such legislation. The Pennsylvania Right to Treatment Law of 1968, which was rejected by the legislature in 1968 and again in 1969, would have resulted in the creation of minimal treatment stand-

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42. Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938). For a discussion of judicial review of questions of fact in administrative law, see L. JAFFE, JUDICIAL CONTROL OF ADMINISTRATIVE ACTION 595 (1965). Judge Bazelon has suggested a specific standard of reasonableness that reviewing courts could apply: is the patient receiving therapy which recognized psychiatric opinion generally regards as falling within the range of acceptable alternatives. Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 745 (1969) [hereinafter cited as Bazelon].

43. Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 104-14 (1967); 80 HARV. L. REV. 898 (1967). As Judge Burger wrote in a concurring opinion in *Dobson v. Cameron*, 383 F.2d 519 (D.C. Cir. 1967): "I have grave doubts that we are qualified to oversee mental hospitals in cases of civil commitment . . ." *Id.* at 523.

The American Psychiatric Association has contended that "[t]he definition of treatment and the appraisal of its adequacy are matters for medical determination." American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIATRY 1458 (1967).

44. One authority lists thirty-five methods of psychotherapy. Szasz, *supra* note 6, at 215.

45. Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. PSYCHIATRY 1 (1958). This statement may not be accurate today as the American Psychiatric Association has established general standards and has discontinued its previous reliance on staffing ratios. Compare AMERICAN PSYCHIATRIC ASS'N, STANDARDS FOR PSYCHIATRIC FACILITIES (1969), with AMERICAN PSYCHIATRIC ASS'N, STANDARDS FOR HOSPITALS AND CLINICS (rev. ed. 1958).



ards establishing minimum numbers of professional and nonprofessional staff and a legal right to minimum standards of treatment.<sup>46</sup>

Despite criticism,<sup>47</sup> the *Rouse* standard or a variation of it has been applied in other jurisdictions. The Supreme Judicial Court of Massachusetts, for example, in *Nason v. Bridgewater State Hospital*,<sup>48</sup> declared that the requirements of adequate treatment were fulfilled when the hospital delivered and "followed diligently"<sup>49</sup> the appropriate therapy "determined by competent doctors in their best judgment within the limits of permissible medical practice."<sup>50</sup> In *Wyatt v. Stickney*, the federal district court employed a standard of treatment that would afford the individual "a realistic opportunity to be cured or to improve his or her mental condition."<sup>51</sup>

One of the most far reaching aspects of *Rouse v. Cameron* was its denial of the defense of inadequate staff and facilities. This defense was disallowed because the 1964 Hospitalization of the Mentally Ill Act did not delimit the treatment due each patient according to the availability of facilities.<sup>52</sup> The District of Columbia Circuit decided this omission was significant since the Draft Act enacted by many states provides that every patient is entitled to treatment only "to the extent that facilities, equipment, and personnel are available . . ."<sup>53</sup>

46. S.B. 1274, Pa. Gen. Assembly, 1968 Sess.; S.B. 158, Pa. Gen. Assembly, 1969 Sess. This bill would have created a Mental Treatment Standards Committee to formulate the minimum standards and review them periodically plus a Patient Treatment Review Board to hear and investigate petitions filed on behalf of patients who allege that they are not receiving treatment meeting the minimum standards.

47. In response to these criticisms Judge Bazelon has argued that courts frequently adjudicate controversies in areas in which they have no expertise, supervising such matters as railroad rates and power plant construction. Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742 (1969).

48. 353 Mass. 474, 233 N.E.2d 908 (1968). For a further discussion of *Nason* see note 122 *infra* and accompanying text.

49. 233 N.E.2d at 914.

50. *Id.*

51. 325 F. Supp. 781, 784 (M.D. Ala. 1971). The *Wyatt* standard ignores the patient who refuses treatment or is not amenable to treatment. For a discussion of the dilemma presented by the mental patient who either refuses treatment or is unamenable to treatment, see note 82 *infra* and accompanying text.

52. The provisions of the 1964 Hospitalization of the Mentally Ill Act are codified in D.C. CODE ANN. § 21-501 *et seq.* (1967).

53. NATIONAL INSTITUTE OF MENTAL HEALTH & OFFICE OF GEN. COUNSEL, PUB. HEALTH SERV. PUB. NO. 51, DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL 14-15 (rev. Sept. 1952). See, e.g., IDAHO CODE § 66-344 (Supp. 1969); MO. ANN. STAT. § 202.840 (1959); N.M. STAT. ANN. § 34-2-13 (Supp. 1971); OHIO REV. CODE ANN. § 5122.27 (Page 1970); VT. STAT. ANN. tit. 18, § 7703 (1968).

The American Psychiatric Association prefers the Draft Act approach because "in the perspective of the over-all mental health manpower shortage in our country, one must settle for something less until personnel shortages can be overcome." *Position Statement*, *supra* note 43, at 1460.

*Rouse* implied that the denial of this defense could be justified even in the absence of such a statute. While recognizing that no public mental hospital was considered adequately staffed,<sup>54</sup> the court declared that this fact could not be relied upon to delay indefinitely adequate treatment.<sup>55</sup> Citing *Watson v. City of Memphis*,<sup>56</sup> Judge Bazelon contended that, "[t]he rights here asserted are \* \* \* present rights \* \* \* and, unless there is an overwhelmingly compelling reason, they are to be promptly fulfilled."<sup>57</sup>

Other courts have similarly disregarded the budgetary limitations of mental hospitals.<sup>58</sup> In *Sas v. Maryland*,<sup>59</sup> the Court of Appeals for the Fourth Circuit held the Maryland Defective Delinquent Act<sup>60</sup> facially constitutional. However, the court declared "deficiencies in staff, facilities and finances"<sup>61</sup> could undermine the constitutional application of that act, since release is not predicated on the termination of the prison sentence, but rather on mental rehabilitation.<sup>62</sup> The case was then remanded for inquiries into possible deficiencies in staff, facilities and finances.<sup>63</sup> Ultimately, the Fourth Circuit concluded, in *Tippett v. Maryland*,<sup>64</sup> that the purposes of the act were being carried out in a constitutional fashion. This conclusion, which the court indi-

54. 373 F.2d at 458. As authority for this proposition the *Rouse* court cited the U.S. SURGEON GENERAL'S AD HOC COMMITTEE ON PLANNING FOR MENTAL HEALTH FACILITIES, PLANNING OF FACILITIES FOR MENTAL HEALTH SERVICES 38 (1961); Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. PSYCHIATRY 1, 7 (1958).

55. 373 F.2d at 458.

56. 373 U.S. 526 (1963).

57. 373 F.2d at 458, quoting *Watson v. City of Memphis*, 373 U.S. 526, 533 (1963).

58. See, e.g., *Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964).

59. 334 F.2d 506 (4th Cir. 1964).

60. MD. ANN. CODE art. 31B (1971), as amended, (Supp. 1971). The Defective Delinquent Act provides for the commitment and treatment of "an individual who, by the demonstration of persistent aggravated anti-social or criminal behavior, evidences a propensity toward criminal activity, and who is found to have either such intellectual deficiency or emotional unbalance, or both, as to clearly demonstrate an actual danger to society . . ." *Id.* § 5 (1971). This statute consequently serves to protect society from dangerous persons and simultaneously substitutes psychiatric treatment for conventional punishment. However, only persons convicted and sentenced for specified crimes are subject to the Defective Delinquent Act. *Id.* § 6.

61. *Sas v. Maryland*, 334 F.2d 506, 516-17 (4th Cir. 1964).

62. MD. ANN. CODE art. 31B, § 5 (1971), permits release when the inmate has been sufficiently cured to make it reasonably safe to release him.

63. The trial court was also instructed to consider whether the statutory definition of defective delinquent as applied was sufficiently definitive and whether the statutory procedures as applied afforded due process within the confrontation requirement of the sixth amendment. 334 F.2d at 509.

64. 436 F.2d 1153 (4th Cir. 1971) (the appeal of the dismissal on remand of *Sas v. Maryland*).

cated was subject to re-evaluation at any time, was based on increased appropriations for the institution and its low recidivism rate.<sup>65</sup>

The rule disallowing the defense of lack of staff and facilities is an essential element of the right to treatment, since a patient's mental condition may be aggravated if he is confined without treatment in an ill-equipped, poorly staffed mental hospital.<sup>66</sup> The Second Circuit declared in a recent case: "[T]here is considerable evidence that a prolonged commitment in an institution providing only custodial confinement for the 'mentally sick' and nothing more may itself cause serious psychological harm or exacerbate any pre-existing condition."<sup>67</sup> This rule is significant considering the general inadequacies of public mental hospitals. A recent study of twenty-nine inmates committed to a Michigan hospital showed shortages of facilities and staff, neglect of patients, numerous treatment failures and retention of patients ready for discharge.<sup>68</sup> As reasonably can be anticipated, there is a direct correlation between low budgetary appropriations, lack of facilities and staff, and inadequate treatment.<sup>69</sup> It has been demonstrated that understaffing and lack of physical facilities result in custodial care, which means that the least-trained hospital employee exercises the greatest control over a patient's treatment.<sup>70</sup>

### C. *Application of Standards*

In applying standards, the courts have focused on three factors: (1) the hospital facilities and resources as a whole, including physician-patient ratios, staff-patient ratios and cost-per-patient statistics;<sup>71</sup> (2) the treatment received by patients in general<sup>72</sup> and (3) the type of treatment received by the individual patient.<sup>73</sup>

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65. *Id.* at 1158 n.18. *But see* McCray v. Maryland, Misc. Pet. No. 4363 (Howard County Cir. Ct. Nov. 11, 1971), wherein the court stated that the Patuxent Institution where defective delinquents are committed was not offering total rehabilitative treatment. *Id.* at 41.

66. "The milieu of the hospital, if properly structured, is . . . a constructive force in getting well; if improperly constructed it is a force for remaining sick." *Hearings on a Bill to Protect the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 88th Cong., 1st Sess. 12 (1963) (remarks of Dr. D. Cameron, Superintendent, St. Elizabeth's Hosp.).

67. *United States ex rel. Schuster v. Herold*, 410 F.2d 1071, 1079 (2d Cir. 1969).

68. Lewin, *Disposition of the Irresponsible: Protection Following Commitment*, 66 MICH. L. REV. 721 (1968).

69. *Position Statement*, *supra* note 43, at 1460.

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

71. *Nason v. Bridgewater State Hosp.*, 353 Mass. 474, 233 N.E.2d 908, 911 n.6 (1968).

72. *Director of Patuxent Institution v. Daniels*, 243 Md. 16, 221 A.2d 397 (1966).

73. *Whitree v. State*, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968).

By suggesting that courts determine adequacy of treatment given plaintiffs in light of data which reflect the minimum objective standards of treatment as determined by certain agencies, *Rouse* encouraged judicial inquiries into the treatment administered to the overall patient populace at the institution in question. Maryland adopted this approach in *Director of Patuxent Institution v. Daniels*,<sup>74</sup> in which two inmates committed to a mental institution under the Maryland Defective Delinquent Act challenged their confinement as unconstitutional. Although the major thrust of the suit was the unconstitutionality of the Act, one petitioner also alleged that Patuxent was not furnishing him adequate treatment, and as a result he was being denied equal protection of the laws.<sup>75</sup> After examining the physical plant and the treatment furnished to all inmates of Patuxent, the court concluded that the milieu therapy<sup>76</sup> afforded all patients treatment.<sup>77</sup> The court held that Daniels had not been denied equal protection since he "has received or had had available to him . . . all of the treatment techniques available to other inmates at Patuxent, and also as generally recognized and utilized in the field of psychiatry . . ." <sup>78</sup>

The approach taken in *Daniels* has been criticized for neglecting totally the most crucial aspect of the right to treatment — the duty imposed on the institution to afford *each* patient appropriate therapy. By concentrating examination on the operation of the entire hospital, the court could find compliance with acceptable standards on that level ignoring the fact that an individual patient may not be receiving adequate treatment.<sup>79</sup>

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74. 243 Md. 16, 221 A.2d 397 (1966).

75. In this respect, the *Daniels* court held that the indeterminate confinement, treatment and rehabilitation provisions of the Defective Delinquent Act are reasonably calculated to effect the purpose of the Act. 243 Md. at 42-43, 221 A.2d at 412-13.

76. The *Daniels* court discussed at length the "therapeutic milieu" offered at Patuxent. 243 Md. at 58-64, 221 A.2d at 421-26. Milieu treatment or therapy refers to the organization of the hospital ward so that all its parts are designed to have a particular impact on the patient. See *Position Statement*, *supra* note 43, at 1460; Goocher, *The Milieu Therapy Approach on a Maximum Security Ward: Development, Results, and Implications*, PSYCHIATRIC STUDIES & PROJECTS, Oct., 1964, at 2.

77. The court in its findings of fact, nevertheless, did note "lapses in the treatment program and the efficient operation of the Institution" but did not conclude that these lapses were sufficiently flagrant to have a bearing on the constitutional questions. 243 Md. at 65, 221 A.2d at 426.

78. 243 Md. at 50, 221 A.2d at 417. This approach which focuses on the treatment given the patient populace in general was initially suggested in *Sas v. Maryland*, 334 F.2d 506, 517 (4th Cir. 1964).

79. See Address by David L. Bazelon, Chief Judge, United States Court of Appeals for the District of Columbia Circuit, 20th Mental Hospital Institute, Oct. 3,

Of course, when the treatment received by all the patients committed to the hospital is at issue, the *Daniels* approach is appropriate. In *Wyatt v. Stickney*,<sup>80</sup> a class action initiated on behalf of all patients confined in Alabama's Bryce Hospital, the district court rightfully made an extensive inquiry into the staffing of the hospital, the function of the hospital regarding the mental condition of patients committed and the hospital budget.<sup>81</sup>

The internal logic supporting the right to treatment breaks down when applied to the untreatable patient or the patient who refuses treatment. In both instances the patient cannot receive treatment calculated to improve his mental condition, turning his confinement into mere detention. The *Rouse* standard requiring a "bona fide effort" to cure is irrelevant to the problem patient who is found unamenable to treatment; indeed, *Rouse v. Cameron* deliberately chose to ignore this dilemma.<sup>82</sup> According to the *Rouse* rationale a hospital must continue its efforts to cure and improve the patient, a course of action that could lead to an indeterminate confinement.<sup>83</sup> Likewise, the *Rouse* standard cannot be applied to a patient who refuses treatment, unless such refusal is viewed as an affirmative defense to the obligation placed upon the defendant institution.<sup>84</sup> These considerations raise the question of whether the right to treatment imposes a corresponding duty to accept treatment. Such a contention runs the risk of constituting

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1968. See generally Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 107, 116 (1969).

Judge Sobeloff, in his concurring opinion in *Tippett v. Maryland*, 436 F.2d 1153, 1159 (4th Cir. 1971), urged Maryland courts to look not only to the general treatment program but also to the treatment the individual is receiving.

80. 325 F. Supp. 781 (M.D. Ala. 1971).

81. *Id.* The *Wyatt* court suggested that the commitment of non-psychiatric geriatric patients was not proper since they were not mentally ill and therefore could not benefit from psychiatric treatment.

82. *Rouse v. Cameron* relegated discussion of the untreatable patient to a footnote in which the court declared: "We need not now resolve the implications of 'the right to treatment' for a patient who is demonstrated by the hospital to be 'untreatable' in the present state of psychiatric knowledge, if such a patient exists." 373 F.2d at 457 n.28.

83. This standard was applied in *Eidinoff v. Connolly*, 281 F. Supp. 191 (N.D. Tex. 1968), in which expert testimony indicated that the patient, a true paranoid, was not amenable to treatment.

84. One practical basis for such a defense may lie in the fact that the success of many treatment plans, particularly group therapy and psychotherapy, depend on the patient's cooperation. Szasz, *supra* note 6, at 314. The argument has also been advanced that untreatable patients receive adequate treatment even though they are receiving purely custodial care since nothing more can be provided for them. 80 HARV. L. REV. 898, 900 (1967).

For an excellent critique of the legal problem raised by the patient who refuses to accept treatment, see Katz, *The Right to Treatment — An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755 (1969).

an invalid infringement on an area of personal privacy similar to freedom from forced medical treatment for a non-contagious disease.<sup>85</sup>

The recent case of *McCray v. Maryland*<sup>86</sup> represents one of the rare attempts by a court to deal with the problems surrounding the refusal of treatment. There, several patients confined to Patuxent Institution as defective delinquents<sup>87</sup> filed habeas corpus petitions alleging that the institution's disciplinary procedures violated their constitutional rights. Responding to the practice of deliberately withholding rehabilitative efforts to "recalcitrant prisoners," the court declared that patients could not be confined indefinitely for purposes of treatment and then be deprived of all therapy unless the authorities first endeavored to discover the basis for refusal.<sup>88</sup> Implicit in the obligation placed on the administrators to provide treatment was the necessity of distinguishing between the patient who is "so emotionally unstable that he refuses help" and the patient who is consciously hostile to treatment attempts.<sup>89</sup> The court did not, however, indicate what the administrator was to do once he had decided in which category a patient belonged.

## II. REMEDIES FOR THE INDIVIDUAL PATIENT

Judicial determination that a right to treatment does exist and has been denied to a particular individual is academic absent enforcement mechanisms capable of ensuring a patient the treatment due him. Obviously, the responsibility for understaffed and poorly equipped hospitals must rest with state legislatures and with a society which has not yet deemed treatment of the mentally ill a goal worthy of

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85. Cf. *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914) (removal of tumor by surgeon without patient's consent held an assault). *Accord*, *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905). For a discussion of this problem see Katz, *The Right to Treatment — An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 756 (1969).

86. Misc. Pet. No. 4363 (Howard County Cir. Ct. Nov. 11, 1971). Patients confined in isolation cells at Patuxent brought this class action on behalf of all those similarly confined in segregation sections of that institution.

87. See note 60 *supra* and accompanying text.

88. Misc. Pet. No. 4363, at 42 (Howard County Cir. Ct. Nov. 11, 1971).

89. *Id.*

The *McCray* court ordered that the administrators of Patuxent revise the rules and regulations to comply with the dictates of procedural due process and eliminate vestiges of cruel and unusual punishment as well as mail censorship.

The State of Maryland has accepted the *McCray* order with the exception of five rules, including that which requires intensified treatment for those patients in segregated tiers. The Attorney General, accordingly, requested a stay pending an appeal of the order as it relates to the five disputed areas. The stay was denied and the order modified in June. See *The Sun* (Baltimore), June 3, 1972, § B, at 11, cols. 1-3, and June 6, 1972, § A, at 1, col. 7. One week later, the Maryland Court of Appeals overruled the Circuit Court and granted the stay. *The Sun* (Baltimore), June 10, 1972, § A, at 12, col. 1.

substantial tax revenues. Four remedies — release of a patient denied adequate treatment, confinement in a manner less restrictive than total deprivation of liberty, award of damages to a patient deprived of treatment and a court order compelling the initiation of therapeutic programs — should be analyzed both in the context of their effectiveness in assuring treatment to those committed to public mental hospitals and in terms of the factual circumstances in which each remedy is appropriate.

#### A. Release

*Rouse v. Cameron* suggested that release would be a sufficient remedy if “the opportunity for treatment has been exhausted or treatment is otherwise inappropriate.”<sup>90</sup> If the reason for confinement is treatment, then the internal logic of the syllogism requires that a patient be released if treatment is denied. Similarly, if a hospital denies adequate treatment on a mass basis, the same internal logic might require all the patients to be transferred to another facility capable of providing therapy. Simple logic, however, is not necessarily efficacious. Release of a patient dangerous to himself or society is an extreme action. Never has a court ordered the release of a patient denied treatment, or ordered the closing of a public mental hospital. Even were such a remedy contemplated, hospital administrators would surely be granted a period of grace to develop a treatment program.<sup>91</sup> Moreover, release of one patient does not insure that the hospital will institute adequate treatment programs for the remaining patients who are being denied treatment.<sup>92</sup>

Release might be inappropriate for the untreatable patient,<sup>93</sup> but the courts that have had to deal with that issue have chosen to sidestep it. For example, in *People ex rel. Blunt v. Narcotics Addiction Control*

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90. 373 F.2d at 459.

91. See, e.g., *Rouse v. Cameron*, 373 F.2d 451, 458 (D.C. Cir. 1966); *Nason v. Bridgewater State Hosp.*, 353 Mass. 474, 233 N.E.2d 908, 914 (1968).

92. Judge Bazelon believes that “the fact that courts will release committed patients unless treatment can be provided seems a compelling argument for a larger appropriation from the legislature.” Address by David L. Bazelon, *supra* note 79. However, as Judge Bazelon points out, the legislature might “retaliate” by committing persons solely on the basis of dangerousness. *Id.*

93. *Barnes v. Director of Patuxent Institution*, 240 Md. 32, 212 A.2d 465 (1965) (held constitutional to confine an individual considered untreatable due to his dangerous characteristics); *People v. Rancier*, 240 Cal. App. 2d 579, 49 Cal. Rptr. 876 (1966) (held not cruel and unusual punishment to confine indefinitely a sexual psychopath unamenable to treatment on ground that court could not conclude that he “has been or in the future will be denied treatment.” 49 Cal. Rptr. at 879).

*Board*,<sup>94</sup> a narcotics addict whose sentence to a New York prison was predicated on his receiving treatment for addiction sought release on the ground that he was receiving no treatment.<sup>95</sup> The court found that the only therapy offered was a group therapy session conducted two or three times a week which Blunt refused to attend. Although the court strongly suggested that the drug addiction program was inadequate and lacked competent professional personnel, it dismissed the habeas corpus petition on the theory that the court could not interfere with "[t]he experimental nature of the program."<sup>96</sup> In light of the undisputed evidence that Blunt in fact received treatment no different from non-addict prisoners, the New York court's decision seems unduly restrained.<sup>97</sup> The right to treatment theory could be seen to dictate that persons committed under statutes similar to the New York Drug Addiction Law or the Maryland Defective Delinquent Act, who refuse treatment or demonstrate themselves to be untreatable, should be returned to the custody of prison officials in order to serve the remainder of the statutory sentence of the crimes for which they had previously been convicted. Such statutes substitute treatment for conventional punishment of those persons convicted and sentenced for

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94. 58 Misc. 2d 57, 295 N.Y.S.2d 276 (Sup. Ct.), *aff'd mem.*, 31 App. Div. 2d 718, 296 N.Y.S.2d 533 (1968).

95. Blunt was given a maximum sentence of thirty-six months under a New York drug addiction statute. N.Y. MENTAL HYGIENE LAW § 208 (McKinney 1971). This statute certifies any misdemeanant or person convicted of prostitution who is found to be a narcotics addict to the custody of the Narcotic Addiction Control Commission. Such persons remain in the Commission's custody until rehabilitation or until the expiration of thirty-six months.

No provision of the New York drug addiction law guarantees a right to treatment although the provisions implicitly seem to envision treatment of addicts.

96. 295 N.Y.S.2d at 282. For another example of failure to deal with a patient's refusal to accept treatment, see *In re Newton*, 353 Mass. 474, 259 N.E.2d 190 (1970), in which the court held that petitioner sentenced to Bridgewater Treatment Center for an indefinite period as a sexually dangerous person could not complain of inadequate treatment if he refused treatment.

97. Other courts have likewise exhibited reluctance to interfere with the operation of experimental programs. See *Tippett v. Maryland*, 436 F.2d 1153, 1157 (4th Cir. 1971); *Director of Patuxent Institution v. Daniels*, 243 Md. 16, 42, 221 A.2d 397, 411 (1966).

A New York court recently in *People ex rel. Stutz v. Conboy*, 59 Misc. 2d 791, 300 N.Y.S.2d 453 (Sup. Ct. 1969), upheld confinement in state prisons of persons committed pursuant to the provisions of the drug addiction law. The court justified the confinement of these misdemeanants (who would have spent no more than one year in prison) for a three-year program of treatment even though the program itself was conducted in a prison rather than a hospital. Noting that the prisoners could have been released in less than three years if "properly motivated" the court rationalized that "[u]nder the circumstances, they [had to] take the bad with the good." 300 N.Y.S.2d at 458.



specified crimes whose mental condition is deemed to necessitate treatment. Though convicted initially by criminal standards these persons are committed under civil procedures to confinement longer than that of the original statutory sentence.<sup>98</sup> The release compelled by the logic of the *Rouse* test discussed earlier could at least be accommodated by "releasing" the dangerous patient unamenable to treatment to his former prison sentence.

In contrast to dangerous criminals, many mental patients pose no threat to society.<sup>99</sup> Consequently, when these patients receive only custodial care and are denied the therapy which forms the basis for their continued confinement, release might be proper.<sup>100</sup> Judge Skelly Wright, in his concurring opinion in *Lake v. Cameron*,<sup>101</sup> contended that the mere fact that an individual's mental condition demands custodial care does not also entitle the government to compel acceptance of care at the price of freedom.<sup>102</sup> In that case, a harmless but senile sixty-year-old woman who frequently could not care for herself sought unconditional release. During her four-year confinement at Saint Elizabeth's she had received only custodial care. The majority of the District of Columbia Circuit, however, was not as inclined toward release as was Judge Skelly Wright and sought instead a less restrictive alternative to her confinement.<sup>103</sup>

Unconditional release is a remedy of last resort; should circumstances occasion its use, the dangerousness of the patient must be taken into account. The harmless patient may in some cases appropriately be released, or in others at least provided a less restrictive incarceration. Release of the dangerous patient is not practicable; even so, several authorities rightly assert that the procedures for committing this type

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98. In contrast to the New York law under which the maximum period of incarceration is thirty-six months, the Defective Delinquent Act allows for indefinite confinement.

99. A recent unpublished survey taken at Saint Elizabeth's Hospital in Washington, D.C., showed that a substantial majority of patients were not dangerous. The *Evening Star* (Washington), Aug. 9, 1971, § A, at 1, col. 1. The newspaper article indicated that the statistics were recorded in a confidential preliminary report of patient inventory prepared by the hospital staff in 1970.

For an excellent discussion of the difficulties inherent in determining whether a patient will be harmful to himself or others upon release, see Goldstein & Katz, *Dangerousness and Mental Illness: Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity*, 70 *YALE L.J.* 225 (1960).

100. Comment, *Compulsory Commitment: The Rights of the Incarcerated Mentally Ill*, *DUKE L.J.* 677, 725 (1969).

101. 364 F.2d 657, 662 (D.C. Cir. 1966). For a further discussion of *Lake v. Cameron*, see note 111 *infra* and accompanying text.

102. 364 F.2d at 663.

103. For some of the alternatives suggested by the *Lake* court, see note 113 *infra*.

of patient should include the constitutional safeguards characteristic of a criminal trial.<sup>104</sup>

*B. The "Less Restrictive Alternative"*

The American Psychiatric Association estimates that in 1967, ninety percent of all patients in mental hospitals, both public and private, were harmless.<sup>105</sup> At Washington, D.C.'s Saint Elizabeth's Hospital sixty-eight percent of the patients "had 'no behavior problem'" and "could [not] be considered dangerous to themselves or others by any definition of the term."<sup>106</sup> Physicians at Saint Elizabeth's concluded that only thirty-two percent of the patients required inpatient care, recommending that thirty-five percent be provided with foster care, twenty-one percent be placed in nursing homes, and twelve percent be cared for in other places, such as their own homes.<sup>107</sup> The thrust of these and other reports is that a number of patients presently confined could be cared for on an outpatient basis.<sup>108</sup> Instead, more than half the patients at Saint Elizabeth's were confined in wards with no building, ground or city privileges.<sup>109</sup>

One solution to the problem of undue long-term hospitalization, of course, lies in legislation. The California legislature recently enacted a statute designed to eliminate "inappropriate, indefinite, and involuntary commitment of mentally disordered persons."<sup>110</sup> The District of Columbia Circuit in *Lake v. Cameron*<sup>111</sup> presented another solution when it recognized that the 1964 Hospitalization of the Mentally Ill Act allows a court to order "'any other alternative course of treatment which the court believes will be in the best interests of the person or of the public.'"<sup>112</sup> Although the evidence showed that Mrs. Lake,

104. See Bazelon, *supra* note 47, at 749; Comment, *Due Process for All — Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633, 649 (1967).

Traditionally, the courts have upheld civil commitment procedures that gave no notice or hearing until the patient was hospitalized. *E.g.*, *Sporza v. German Sav. Bank*, 192 N.Y. 8, 84 N.E. 406 (1908). Recently, several courts have suggested that committing procedures should be the same for civil and criminal commitment; patients should have the right to notice, a hearing, counsel, an independent psychiatric examination and cross-examination. See *Dixon v. Attorney General*, 325 F. Supp. 966 (M.D. Pa. 1971); *Anderson v. Solomon*, 315 F. Supp. 1192 (D. Md. 1970).

105. *Position Statement*, *supra* note 43, at 1459.

106. *The Evening Star* (Washington), Aug. 9, 1971, § A, at 1, col. 1.

107. *Id.* at 6, col. 8.

108. *1963 Hearings*, *supra* note 66, at 25 (remarks of Dr. W. Overholser, Superintendent, St. Elizabeth's Hosp.).

109. *The Evening Star* (Washington), Aug. 9, 1971, § A, at 6, col. 7.

110. CAL. WELF. & INST'NS CODE § 5001(a) (West Supp. 1971).

111. 364 F.2d 657 (D.C. Cir. 1966).

112. *Id.* at 659, quoting D.C. CODE ANN. § 21-545(b) (Supp. V 1966).

who could not care for herself, needed care, the majority declared that deprivation of liberty solely based on danger to the patient herself should not exceed what is necessary to protect the patient. Thus, the *Lake* court mandated the hospital and the trial judge to explore alternatives that would allow Mrs. Lake a degree of liberty consonant with the degree of care required.<sup>113</sup> The principle of the "least restrictive alternative" was extended to alternate dispositions within the hospital in *Covington v. Harris*,<sup>114</sup> primarily on the basis of the 1964 Act and, secondarily, on the rationale underlying the right to treatment. In that case, petitioner, who had been civilly committed to Saint Elizabeth's ten years earlier, after the dismissal of a murder charge, sought transfer to a less restrictive ward.<sup>115</sup> Confinement in a maximum security ward was reasonable, the majority ruled, only when the hospital had found inadequate all alternative dispositions. The opinion noted in this connection that confinement in a maximum security ward may not be "beneficial 'environmental therapy'" for all and, therefore, the hospital must substantiate the considerations behind such confinement.<sup>116</sup>

From these decisions it can be shown that if a patient demonstrates that he is not dangerous and that his mental condition does not require full-time hospitalization, conditional release with out-patient treatment, or placement in a halfway house or foster or rest home might be the most appropriate remedy. Similarly, if confinement within the institution is mandatory the patient should be confined in the least restrictive atmosphere, keeping the confinement consonant with its legal justification.

### C. Damages

Sometimes institutional neglect reaches tortious proportions. In 1947, a middle-aged man was committed to New York's notorious Matteawan State Hospital upon a finding that he was incompetent to

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113. The *Lake* court suggested that on remand the lower court consider public health nursing care, community health and day care services, foster care, home health aide services and private care. 364 F.2d at 661. The court also held that plaintiff did not bear the burden of showing the availability of alternatives since proceedings involving care and treatment are not adversary.

114. 419 F.2d 617 (D.C. Cir. 1969).

115. Covington was confined in the maximum security ward, the John Howard Pavilion, which has the characteristics of a prison. See AD HOC COMMITTEE FOR THE EVALUATION OF SECURITY PROGRAMS AND FACILITIES AT SAINT ELIZABETH'S HOSPITAL, THE EVALUATION OF SECURITY PROGRAMS AND FACILITIES AT SAINT ELIZABETH'S HOSPITAL (Nov. 1, 1968) (excerpts reprinted in 419 F.2d 617, 631 (D.C. Cir. 1969)).

116. 419 F.2d at 625, quoting *Rouse v. Cameron*, 373 F.2d 451, 456 (D.C. Cir. 1966).

stand trial for a violation of probation.<sup>117</sup> In the fourteen and one-half year nightmare that followed, this patient received only three in depth psychiatric examinations, all of which were in the first four months of his confinement.<sup>118</sup> Following his release, the now aging victim of delinquent inactivity brought suit against New York seeking money damages for false imprisonment, negligent psychiatric treatment and assault on his person. The court in *Whitree v. State* found that had he received proper care, plaintiff would have been released some twelve years earlier than he was.<sup>119</sup> Applying common law principles the court held that he had not received psychiatric and medical treatment conforming to the standards of the community. Negligence was determined to be the causative factor of the inordinate length of a confinement constituting false imprisonment. The award to Whitree totaled \$300,000, a sum compensating him for the decade of negligent treatment and for the severe physical injuries inflicted on him by the hospital staff and his fellow patients.

Since few causes of action for damages have been brought, only speculative evaluations of their effectiveness in implementing the right to treatment can be made. Certainly, only a few awards of the proportions of *Whitree* need be affirmed in a state before the legislature will appropriate funds to improve public mental hospitals. On the other hand, an award of damages affects only one individual directly and then only after he has suffered great abuse. Other patients are affected only in an indirect fashion; an award of damages only assists them if the legislature increases appropriations.

### III. CURING AN ENTIRE HOSPITAL: THE REMEDY OF *Wyatt v. Stickney*

#### A. *The Order to the Hospital*

A court order compelling a hospital to institute adequate treatment may be the most viable method of enforcing the right to treatment.

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117. *Whitree v. State*, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968). Whitree had been placed on probation a year earlier after a conviction for assault in the third degree. For an analysis of the application of a common law tort standard to a public mental hospital and a complete discussion of the case itself, see 82 HARV. L. REV. 1771 (1969).

118. The abusive treatment of Whitree was blatant. The court found that the petitioner not only received improper psychiatric care but inadequate medical care as well. Whitree was placed in maximum security for over four years; the psychiatric notes taken during this period were all closely related in time to applications for writs of habeas corpus. In addition, Whitree was never exposed to psychotherapy or psychological testing. He was beaten by patients as well as by attendants. The court also found that had Whitree been given proper psychiatric care he would have been discharged no later than May 19, 1949. 290 N.Y.S.2d at 501.

119. *Id.*

Characteristically, *Rouse v. Cameron* first recommended that the hospital be granted "a reasonable opportunity to initiate treatment"<sup>120</sup> as an alternative to release should a court find a mandatorily committed patient was being denied adequate treatment. The opinion also suggested criteria for determining the latitude that might be given to a hospital in developing a program: the length of time the patient has been denied adequate treatment, the length of his total confinement, the mental condition that led to confinement and any dangerous tendencies of the patient that would be manifested if he were released could be considered.<sup>121</sup>

*Nason v. Bridgewater State Hospital*<sup>122</sup> also considered applying the remedy of compelled treatment to a single petitioner seeking a writ of habeas corpus. The *Nason* court found that the standards of treatment provided at Bridgewater were inconsistent with good practice and failed to conform to the accreditation requirements of the American Psychiatric Hospital Association or the licensing requirements of Massachusetts.<sup>123</sup> However, Bridgewater was permitted a reasonable opportunity to institute adequate therapeutic programs for Nason and the patient population in general before the court would contemplate other remedies.

The pragmatic approach of the district court in shaping the remedy in *Wyatt v. Stickney*<sup>124</sup> contrasts with the uncertain enforcement of the right to treatment in *Rouse* and *Nason*.<sup>125</sup> The generally deplorable conditions prevalent at Bryce Hospital in Alabama may well have caused the court to abandon the earlier period of adjustment. Evidence introduced at trial, for example, indicated that a patient population of 5,200 was being "cared for" by only three medical doctors with psychiatric training, none of whom had been certified by the Medical Board of Examiners. In addition, recent staff dismissals precipitated by a budgetary crisis affecting Alabama's mental health program left Bryce with but two clinical psychologists,<sup>126</sup> ten to twelve patient activity workers and ten social workers, two of whom had master's degrees.<sup>127</sup> The Bryce staff seems to have been so minimal that patients did not receive adequate custodial care, not to mention therapeutic treatment.

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120. 373 F.2d 451, 458 (D.C. Cir. 1966).

121. *Id.*

122. 353 Mass. 474, 233 N.E.2d 908 (1968).

123. 233 N.E.2d at 912 n.7.

124. 325 F. Supp. 781 (M.D. Ala. 1971).

125. See text accompanying notes 36-42, 122-23 *supra*.

126. One clinical psychologist had a Ph.D while the other had a master's degree. Pre-trial brief for Plaintiff at 4, *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971).

127. *Id.*

When representatives of the United States Department of Justice visited Bryce subsequent to the decision in *Wyatt v. Stickney*, they reportedly found "human feces caked on toilets, patients who had not been bathed in days, urine on the floor, stopped up plumbing, [and] beds without linen."<sup>128</sup>

Judge Johnson held that inadequate treatment at Bryce was directly attributable to lack of operating funds. There was undisputed evidence that Alabama in 1970 ranked last among the states in per-patient expenditures and that the treatment standards at Bryce were so deficient that the hospital was not eligible for Medicare and Medicaid programs.<sup>129</sup> Judge Johnson also found that the hospital population improperly included 1,500 to 1,600 geriatric patients as well as 1,000 mental retardates who could not benefit from psychiatric treatment. The *Wyatt* court held that "lack of operating funds" could not justify a denial of treatment.<sup>130</sup> Quoting *Rouse v. Cameron*<sup>131</sup> which quoted *Watson v. City of Memphis*,<sup>132</sup> Judge Johnson reasoned that insufficient finances was not an "overwhelmingly compelling reason" for denying "present rights."<sup>133</sup>

Acknowledging that Bryce's transition to the unit-team system<sup>134</sup> was incomplete, Judge Johnson denied the motion for an Order of Reference in order to give the Mental Health Board the opportunity to initiate and implement standards that would provide adequate care and treatment for the patients at Bryce. In contrast with previous orders of this nature, the *Wyatt* decree was comprehensive; it ordered the plaintiffs to submit within ninety days a specific plan for providing adequate treatment, a definition describing Bryce's function and mission, and a report indicating the progress of implementation of the unit-team system.<sup>135</sup> The order required the defendants to institute within

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128. The Tuscaloosa (Ala.) News, Aug. 1, 1971, at 1, col. 2.

129. 325 F. Supp. 781 (M.D. Ala. 1971). See JOINT INFORMATION SERVICE, REVISION FOR FIFTEEN INDICES (1971).

130. 325 F. Supp. at 784.

131. 373 F.2d 451, 458 (D.C. Cir. 1966).

132. 373 U.S. 526, 533 (1963).

133. 325 F. Supp. at 784.

134. Typically, the unit-team system divides a state into geographical county units with all patients from a particular geographic area assigned to the same unit in a hospital. A team consisting of professionals, physicians, psychologists, social workers, aides and nurses, coordinates the treatment program of each unit. See Zubowicz, *The Change to a Unit System*, PSYCHIATRIC STUDIES & PROJECTS, Aug., 1969, at 1.

135. The order also directed that a progress report list the names of patients entitled to receive psychiatric care and the treatment administered. This list was to be made available to the plaintiffs and all parties entering the case as amici curiae 325 F. Supp. at 784.

six months a treatment program that would give every treatable patient "a realistic opportunity to be cured or to improve his or her mental condition."<sup>136</sup> Failure to comply with the decree would result in the appointment of a panel of experts to effectuate the order. Finally, the court invited the United States Departments of Justice and Health, Education and Welfare and the Public Health Service to appear as amici curiae to assist the court in its subsequent evaluation of Bryce Hospital and the defendants in complying with the Departments' standards.

Following that evaluation, Judge Johnson held the treatment program proposed by the Mental Health Board deficient in three fundamental areas because it failed to establish "(1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment, and (3) individualized treatment plans."<sup>137</sup> Formal hearings were consequently ordered to formulate minimum medical and constitutional standards for the operation of Bryce and two other institutions, Searcy Hospital, a mental institution, and Partlow State School and Hospital, an institution for the mentally retarded.<sup>138</sup> In the third *Wyatt* decision, the court made its order applicable to involuntarily confined mental retardates because they also "have a constitutional right to receive such individual habilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society."<sup>139</sup> Judge Johnson reasoned that this conclusion was necessary if society is to justify civil commitment of mentally retarded persons.

As a result of these hearings the court formulated minimum medical and constitutional standards for the two mental hospitals and the institution for the retarded.<sup>140</sup> The minimum standards for Bryce and Searcy Hospitals stipulate *inter alia* that "[p]atients have a right to the least restrictive conditions necessary to achieve the purposes of commitment;"<sup>141</sup> "to send sealed mail;"<sup>142</sup> "to be free from unnecessary or excessive medication;"<sup>143</sup> and not to be subjected to shock

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136. *Id.* at 785.

137. *Wyatt v. Stickney*, 334 F. Supp. 1341, 1343 (M.D. Ala. 1971).

138. Searcy and Bryce were included when the class of plaintiffs was enlarged to encompass the patients confined at those two institutions.

139. *Wyatt v. Stickney*, Civil No. 3195-N, at 3 (Partlow State School and Hospital) (M.D. Ala. Apr. 13, 1972).

140. *Wyatt v. Stickney*, Civil No. 3195-N (M.D. Ala. Apr. 13, 1972).

141. *Wyatt v. Stickney*, Civil No. 3195-N, at 9 (Bryce Hospital and Searcy Hospital) (M.D. Ala. Apr. 13, 1972).

142. *Id.* at 10.

143. *Id.*

therapy without "their express and informed consent after consultation with counsel or [an] interested party of the patient's choice."<sup>144</sup> In addition, the court ordered the Mental Health Board to implement specific staff-patient ratios and to devise individual treatment plans. A human rights committee was also judicially created to review all research proposals and rehabilitative programs and to advise and assist patients alleging infringement of their legal rights.<sup>145</sup> Finally, defendants were ordered to report to the court within six months on the progress of implementation including justifications for incomplete performance. Judge Johnson reserved the right to appoint a master and a professional advisory committee in the event that the State did not satisfactorily comply with the order.

The *Wyatt* remedy, if followed in subsequent decisions, may provide a viable, effective alternative to release of treatable patients who have been denied treatment. This decision indicates that the judiciary has a flexible tool for rectifying those conditions that deprive patients of treatment. In addition, the decision may induce other courts to compel the furnishing of the outpatient services discussed earlier for those patients whose mental condition does not require full-time hospitalization. Indeed, the minimum standards established for Bryce and Searcy hospitals provide that the Mental Health Board is obligated to offer outpatient services to patients upon their release from involuntary confinement.<sup>146</sup> Until now, outpatient treatment has been denied many of these patients on the ground that appropriate facilities did not exist. The reasoning of *Wyatt v. Stickney* and *Rouse v. Cameron* would disallow this defense.<sup>147</sup> Consequently, a court could fashion a decree similar to the one in *Wyatt*, ordering the state to provide effective alternatives within a specific period of time on threat of direct judicial intervention.

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144. *Id.* at 11.

145. A human rights committee with similar functions was also established at Partlow.

146. The *Wyatt* court declared that such services should include "psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, outpatient treatment, and treatment in the psychiatric ward of a general hospital." *Wyatt v. Stickney*, Civil No. 3195-N, at 21 (Bryce Hospital and Searcy Hospital) (M.D. Ala. Apr. 13, 1972).

147. *Cf. Watson v. City of Memphis*, 373 U.S. 526, 537 (1963), in which Justice Goldberg declared: "it is obvious that vindication of conceded constitutional rights cannot be made dependent upon any theory that it is less expensive to deny than to afford them"; *Long v. Robinson*, 316 F. Supp. 22 (D. Md. 1970), and *Holt v. Sarver*, 309 F. Supp. 362 (D. Ark. 1970), in which the need to conserve state finances was held an insufficient justification for continuation of unconstitutional practices.



Fearing such intervention, several states have enacted statutes providing that a patient is entitled to treatment "to the extent that facilities, equipment, and personnel are available."<sup>148</sup> Applying the holding in the first *Wyatt* decision would necessarily render such statutory provisions unconstitutional if the right to treatment is a constitutional right, since according to that decision lack of facilities is not a compelling justification for denying a constitutional right. A recently decided case may be instructive by way of analogy. In *North Carolina State Board of Education v. Swann*,<sup>149</sup> the Supreme Court invalidated a North Carolina statute prohibiting busing and the assignment of students to schools on the basis of race to attain racial balance. Chief Justice Burger, writing for a unanimous Court, asserted that "state policy must give way when it operates to hinder vindication of federal constitutional guarantees."<sup>150</sup> Similarly, the Draft Act statutes, by permitting public mental health authorities to delimit the delivery of treatment on the basis of the availability of facilities, would prevent the realization of the constitutional right to treatment.

### B. *The Order to the Legislature*

The remedy mandated by *Wyatt v. Stickney* raises questions concerning the authority of the judiciary to compel the legislature, however indirectly, to appropriate additional funds for public mental hospitals. The propriety of judicial intervention in matters falling within the jurisdiction of the legislative or executive branch when those branches act in derogation of constitutional rights is generally accepted.<sup>151</sup> For example, the Supreme Court in *Watson v. City of Memphis*,<sup>152</sup> ordered immediate desegregation of public parks maintained by the city on the theory that when constitutional rights are being violated, prompt rectification of the situation is necessary. The judiciary has, however, been hesitant in the past to interfere when dealing with the constitutionality of prison systems and public mental

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148. These statutes are based on the DRAFT ACT, *supra* note 53, § 19. The Act has been adopted in IDAHO CODE § 66-344 (Supp. 1969); MO. ANN. STAT. § 202.840 (1959); N.M. STAT. ANN. § 34-2-13 (Supp. 1971); OHIO REV. CODE ANN. § 5122.27 (Page 1970); VT. STAT. ANN. tit. 18, § 7703 (1968).

149. 402 U.S. 43 (1971).

150. *Id.* at 45.

151. *See, e.g.*, *Brown v. Board of Educ.*, 347 U.S. 483 (1954), and cases implementing it: *e.g.*, *Griffin v. County School Bd.*, 377 U.S. 218 (1964); *Green v. County School Bd.*, 391 U.S. 430 (1968); *United States v. Montgomery County Bd. of Educ.*, 395 U.S. 225 (1969); *Alexander v. Holmes County Bd. of Educ.*, 396 U.S. 19 (1969).

152. 373 U.S. 526 (1963).

hospital administrations, deferring their judgment to "administrative expertise."<sup>153</sup>

The recent Eighth Circuit case of *Holt v. Sarver*,<sup>154</sup> typifies the movement now underway to reject the "hands-off" approach. In *Holt*, prisoners in Arkansas state prisons sought a declaratory judgment that the state's practices, acts and policies in the prison system violated their constitutional rights. The court denied without discussion the state's motion to dismiss on the ground that the suit was nothing more than an attempt to compel the legislature to appropriate more funds for the operation of the prison system. The district court then held that the conditions in the prison system amounted to cruel and unusual punishment and ordered their elimination as soon as possible. To destroy the remnants of this unconstitutional system, the district court declared that if Arkansas intended to maintain a prison system, it had to be operated within the framework of the Constitution.<sup>155</sup> Hence, the obligation placed on the State Board of Corrections to extinguish the unconstitutional aspects of the system exceeded "what the Legislature may do, or . . . what the Governor may do, or, indeed . . . what Respondents may actually be able to accomplish."<sup>156</sup> The third *Wyatt* decision likewise recognized that implementation of the order required the state legislature to appropriate the necessary funds. Here, however, the legislature was put on notice that the court would utilize other methods to raise the requisite funds if the legislature failed to finance the required improvements. The opinion does not explicitly state what methods might be pursued other than the appointment of a master and an advisory panel.<sup>157</sup>

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153. Typical of the traditional "hands-off" approach concerning the administration of prisons is *McCloskey v. Maryland*, 337 F.2d 72 (4th Cir. 1964). See generally Hirschkop & Millemann, *The Unconstitutionality of Prison Life*, 55 VA. L. REV. 795 (1969).

154. 309 F. Supp. 362 (E.D. Ark. 1969), *aff'd*, 442 F.2d 304 (8th Cir. 1971).

155. *Id.* at 368. The constitutional underpinnings of *Griffin v. Illinois*, 351 U.S. 12 (1956), seem to support this conclusion. There the Supreme Court held that if Illinois recognized the right to appellate review, the due process and equal protection clauses would require that stenographic transcripts necessary to obtain review be available to indigents at state expense as readily as they were available to those who could pay for them. It follows in right to treatment analysis that, although the state has no naked obligation to provide treatment, once the legislature appropriates money to construct mental hospitals and establishes procedures that commit people to those institutions against their will, courts can compel the legislature to provide minimum appropriations sufficient to ensure adequate treatment.

156. 309 F. Supp. at 385.

157. The plaintiffs in the third *Wyatt* case had requested that necessary funds be raised by ordering the Mental Health Board to sell its land holdings and by enjoining

The general scheme of desegregation cases taken with *Holt v. Sarver* supports the legitimacy of Judge Johnson's action in *Wyatt v. Stickney*. Nonetheless, there are limits on the extent to which such intervention may properly and realistically extend. In upholding the imposition of a court-created school desegregation plan on the ground that the school authorities had reneged on their affirmative obligation to convert to a unitary school system, the Supreme Court, in *Swann v. Charlotte-Mecklenburg Board of Education*,<sup>158</sup> attempted to define limitations on the court's role by noting:

In seeking to define even in broad and general terms how far this remedial power extends it is important to remember that judicial powers may be exercised only on the basis of a constitutional violation. Remedial judicial authority does not put judges automatically in the shoes of school authorities whose powers are plenary. Judicial authority enters only when local authority defaults.<sup>159</sup>

Similarly, in *Holt* the court's decree admittedly was designed to implement only the "minimum requirements" of a prison system.<sup>160</sup> Analogizing from the accepted role of the judiciary in school desegregation and prison reform to its role in implementing the right to treatment, it appears that if the state authorities desire to maintain mental hospitals at all, the judiciary can compel the authorities to maintain them in a constitutional fashion. The judicial branch can lawfully intervene only to the extent necessary to remedy constitutional violations. Consequently, a court cannot require that the *best* treatment be given; due process requires no more than minimal adequate treatment.

Generally, when the question of judicial intervention arises, an administrative body is given the opportunity to eradicate those conditions that resulted in a denial of constitutional rights. In *Green v. County School Board*,<sup>161</sup> the Supreme Court declared that its decision in the second *Brown v. Board of Education* case<sup>162</sup> placed an affirmative duty on recalcitrant local school boards to provide plans that would disband dual school systems. The district court in *Holt* decided to allow

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the state treasurer and comptroller from expending state funds on nonessential state functions.

158. 402 U.S. 1 (1971).

159. *Id.* at 16.

160. 309 F. Supp. at 383.

161. 391 U.S. 430 (1968). *Accord*, *Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1 (1971).

162. 349 U.S. 294 (1955).

the Commissioner of Corrections an opportunity to come forward with a plan eliminating cruel and unusual punishment in the state prisons prior to its consideration of other remedies. This decision, in contrast to the school desegregation cases, was based on the good faith the state had exhibited in ameliorating prison conditions prior to the *Holt* decision.<sup>163</sup>

Future decrees designed to remedy inadequate treatment being delivered in public hospitals will probably be guided by the equitable principles set out in school desegregation cases. The problems inherent in effectuating a unitary school system are similar to the complex problems of upgrading public mental hospitals. First, as in school desegregation, courts dealing with the right to treatment have no expertise and, therefore, will have to depend on the cooperation of local officials and government agencies such as the Department of Health, Education and Welfare. Second, no one plan can remedy all the inadequacies; each case will have to be "assessed in light of the circumstances present and the options available in each instance."<sup>164</sup> In the language of the second *Brown* decision, the courts will have to be governed by equitable principles characterized by flexibility in the fashioning of remedies and by reconciling "public and private needs."<sup>165</sup> Like the decree in *Wyatt*, an appropriate remedy must necessarily recognize that adequate treatment cannot be provided overnight. Third, judicial scrutiny of plans submitted by local health authorities in response to a decree should follow the guidelines announced in *Green v. County School Board* when deciding whether the proposed program of treatment is adequate: "the availability to the board of other more promising courses of action may indicate a lack of good faith; and at the least it places a heavy burden upon the board to explain its preference for an apparently less effective method."<sup>166</sup> Whether local authorities are given time in addition to that stipulated in the original decree may well depend on good faith implementation. In *Watson v. City of Memphis*,<sup>167</sup> for example, the city was denied the additional time that it argued was necessary to desegregate the public parks partly on the grounds that the city had delayed nine years since the first *Brown v. Board of Education* decision.

In contrast to the Arkansas legislature, the Alabama legislature in the aftermath of *Wyatt v. Stickney* has encountered serious political

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163. The *Holt* court noted that Arkansas had conducted studies investigating the prison system, that new legislation had been proposed for the benefit of the Penitentiary and that the legislature had appropriated increased funds. 309 F. Supp. at 383.

164. *Green v. County School Bd.*, 391 U.S. 430, 439 (1968).

165. 349 U.S. at 300.

166. 391 U.S. at 439.

167. 373 U.S. 526 (1963).

difficulties in attempting to comply with the court's order.<sup>168</sup> As the eighteen-year battle to implement *Brown v. Board of Education* has demonstrated, hostile public officials can do much to frustrate basic and constitutionally required reform, whether it be in public schools or mental hospitals. Formidable as the hurdle may be, political opposition is not a consideration properly before the court, nor is it an excuse for judicial timidity. The Constitution provides no barrier to a court order mandating greater legislative concern, nor do principles of equity.

#### IV. CONCLUSION

*Wyatt v. Stickney* may signal the end of the era of bare recognition of the right to treatment and the inauguration of its effective enforcement. The *Wyatt* court, by framing its decree in the now familiar language of a school desegregation order, may have given the judiciary a viable weapon for compelling public officials to give more than custodial care to individuals committed for treatment purposes. Whether a court would order a remedy fashioned like the one in *Wyatt* if conditions at the hospital in question were less offensive than those at Bryce is uncertain. And, unfortunately, the availability of an effective enforcement mechanism solves only a few of the countless problems delaying widespread realization of the right to treatment. Judges will still have to formulate and apply admittedly awkward standards. In addition, many patients are unaware of their rights — due in part to their mental condition and in part to the fact that hospital officials do not apprise them of their rights. Even when aware, many are unable to obtain counsel.<sup>169</sup> The judiciary still has to face the crucial issues involved with non-dangerous and dangerous persons who either refuse treatment or are untreatable. Finally, without accompanying public concern, the type of decree issued in *Wyatt* will become a futile exercise in legal scholarship, for in the last analysis it falls to the legislatures, prompted by public concern, to ensure that those who are ordered to sacrifice their freedom to obtain therapeutic care in fact receive it.

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168. The state's attempt to provide the additional mental health appropriations required by the court order was characterized by a war of nerves between the Governor and the state legislature; the Governor proposed to divert \$24,000,000 from the teacher retirement fund, but the legislature would only agree to a new tax plan earmarked for mental health financing which the Governor threatened to veto. N.Y. Times, Nov. 14, 1971, § 1, at 55, col. 1.

169. Comment, *Compulsory Commitment: The Rights of the Incarcerated Mentally Ill*, DUKE L.J. 677, 699 (1969).