INAPPROPRIATE PATIENT CONFINEMENT AND APPROPRIATE STATE ADVOCACY

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I
INTRODUCTION

The appropriate role of mental health lawyers representing patient interests has been the subject of vigorous commentary and debate for some time.[1] Some authors have chastised lawyers opposing commitment proceedings for being too lax,[2] while others have asserted that those lawyers are too aggressive and mechanically adversary.[3] The role of mental health lawyers in law reform litigation has also been seriously scrutinized.[4]

Curiously, however, discussions of advocacy in mental health law have rarely touched on the appropriate role of attorneys representing commitment petitioners or state hospitals.[5] This necessarily brief article attempts a modest redress of the imbalance by sketching some concerns regarding the appropriate role of state advocacy not in commitment hearings themselves, but in the limited yet important context of post-commitment litigation involving arguably inappropriate patient confinement.

"Arguably inappropriate patient confinement" is a rather imprecise designation. Included within it are cases in which, because of a possibly invalid court order or a possibly unconstitutional statutory provision, it may be argued that the specified nature or duration of a patient's confinement is not legally required or permitted. The notion can perhaps best be captured by a series of representative illustrations:

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1. D. WEXLER, MENTAL HEALTH LAW: MAJOR ISSUES 95-101 (1981); Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal,* 45 MISS. L.J. 43 (1974); Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill,* 44 TEX. L. REV. 424 (1966); Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems,* 62 CALIF. L. REV. 816 (1974); Poythress, *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony,* 2 LAW & HUM. BEHAV. 1 (1978); Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework,* 84 YALE L.J. 1540 (1975).

2. *E.g.,* D. WEXLER, *supra* note 1, at 95-101; Andalman & Chambers, *supra* note 1; Cohen, *supra* note 1.

3. Reinert, *A Living Will for a Commitment Hearing,* 31 HOSP. & COMMUNITY PSYCHIATRY 857 (1980).

4. Stone, *The Myth of Advocacy,* 30 HOSP. & COMMUNITY PSYCHIATRY 819 (1979).

5. Sometimes, agencies petitioning for commitment are not even represented by counsel. 1 PRESIDENT'S COMMISSION ON MENTAL HEALTH, REPORT TO THE PRESIDENT 42, 69 (1978).

1. A relevant commitment statute does not specifically authorize a committing court to designate a specific location where a committed patient is to be housed. Arguably exceeding its authority, a court orders the state hospital to "treat [the patient] in a maximum security setting."[6]

2. In arguable violation of the relevant commitment statute and of the patient's due process right to liberty, a committing court orders that a committed patient be confined for "no less than 30 days."[7]

3. Without explicit statutory authority, a committing court orders that a civilly committed patient be retained at a mental health facility "until further order of the court."[8]

4. An ambiguous state statute seems to authorize a juvenile court to dispense with the stringent substantive and procedural requirements of the ordinary civil commitment statute after an adjudication of delinquency. The court apparently may apply far more flexible standards and procedures to hospitalize a juvenile in the "disposition" phase of the juvenile proceeding. The juvenile court invokes the more flexible route to commit an *unadjudicated* juvenile to the state hospital for evaluation and treatment.[9]

5. A challenged state law authorizes civilly committed patients to be released as soon as the hospital deems release to be clinically warranted, but seems to require, in arguable violation of due process and equal protection, that persons committed after an insanity acquittal for a crime of violence spend at least ninety days in confinement before becoming eligible even for conditional release.[10]

6. A statute requires that persons committed following an insanity acquittal may be released, either unconditionally or conditionally, only with the concurrence of the court. Nonetheless, the court, believing it lacks the authority to grant conditional release, denies a hospital's application for the conditional release of a patient.[11]

7. A statute, challenged on equal protection grounds, places authority for the conditional or unconditional release of civilly committed patients solely in the hands of the hospital, but requires the additional step of court approval for the release of patients committed following an insanity acquittal.[12]

This article raises some questions and provides some suggestions regarding the proper posture of state advocacy in the types of cases enumerated above. It is first necessary, however, to describe some instances of state advocacy in that context.

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6. *In re* Maricopa County Juvenile Action, 123 Ariz. 298, 599 P.2d 254 (Ct. App. 1979).

7. State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980).

8. *In re* Guzan, 45 Pa. Commw. 525, 527-28, 405 A.2d 1036, 1037 (1979).

9. State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980).

10. People v. DeAnda, 114 Cal. App. 3d 480, 170 Cal. Rptr. 830 (1980); People v. Hurt, 90 Cal. App. 3d 974, 153 Cal. Rptr. 755 (1979). *See also* Harris v. Ballone, 681 F.2d 225, 228-29 (4th Cir. 1982); Benham v. Edwards, 501 F. Supp. 1050, 1073 (N.D.Ga. 1980) (holding unconstitutional a statute restricting the frequency of hospital-initiated requests for a patient's release).

11. Shuler v. United States, 422 A.2d 996 (D.C. 1980); *see also* Hough v. United States, 271 F.2d 458 (D.C. Cir. 1959).

12. United States v. Ecker, 543 F.2d 178 (D.C. Cir. 1976), *cert. denied,* 429 U.S. 1063 (1977); United States v. Ecker, 479 F.2d 1206 (D.C. Cir. 1973).

II
ILLUSTRATIONS OF STATE ADVOCACY

Of the seven examples provided above, only the last three—all involving persons committed following an insanity acquittal—were patient-initiated challenges to the commitment order or underlying statute.[13] In each case, the state assumed the traditional position adversary to the patient's release. Those three examples warrant discussion.

In *People v. Hurt,*[14] the defendant was charged with aggravated assault. Following his acquittal on grounds of insanity, Hurt was committed to a state hospital for a statutorily prescribed minimum stay of ninety days. The trial court believed that the defendant, although not fully recovered, could have been treated successfully as an outpatient. The court read the statute, however, as precluding it from ordering anything other than a ninety-day minimum institutional commitment.[15] Hurt, who had apparently been free on bail during his trial, obtained a stay of execution of the commitment order pending his appeal from that order.[16]

In the appellate court, Hurt urged a permissive rather than a mandatory interpretation of the ninety-day institutional confinement provision.[17] In addition, his counsel argued that "[t]o place appellant in a state hospital now, after he has remained safely in the community during most of the pendency of his case at the trial level and all of the pendency of his case at the appellate level, obviously would not serve any legitimate or intended purpose of the law, nor would it meet the constitutional mandate"[18] of *Jackson v. Indiana*[19] that the nature and duration of confinement must bear some reasonable relation to the purpose of commitment.[20]

Assuming an adversarial role, the state opposed both of Hurt's contentions. Tracing the legislative history of the ninety-day commitment provision, the State argued for a mandatory interpretation of the minimum confinement period.[21] The state emphasized the "public's safety"[22] and the "uncertainty of psychiatric

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13. Illustration 1 did not involve any court challenge concerning the issue posed in the text. Illustrations 2-4 involved *state*-initiated challenges to the commitment orders, a procedure which will be discussed *infra*. Not surprisingly, the *patient*-initiated challenges, Illustrations 5-7, involved persons who entered the mental health system by way of the criminal justice system. Unlike their civilly committed counterparts, such criminally committed patients often receive vigorous representation by appointed counsel even in the appellate and post-commitment stages.

14. 90 Cal. App. 3d 974, 153 Cal. Rptr. 755 (1979).

15. *Id.* at 976, 153 Cal. Rptr. at 756. The statute, repealed in 1980, provided that defendants acquitted by reason of insanity "shall" be confined unless fully recovered, and that defendants guilty of a felony involving "death, great bodily injury," or an act presenting a "serious threat" to others must be confined for 90 days. *Id.*

16. *See id.* at 977, 153 Cal. Rptr. at 757.

17. *Id.* at 976, 153 Cal. Rptr. at 756.

18. *Id.* at 977, 153 Cal. Rptr. at 757.

19. 406 U.S. 715 (1972).

20. *Id.* at 738.

21. *See* Brief for Respondent at 5-19, People v. Hurt, 90 Cal. App. 3d 974, 153 Cal. Rptr. 755 (1979). This brief was prepared by the Criminal Division of the California Office of the Attorney General. The legislative history indicated that discretion was intentionally given to the court only in cases involving nonviolent crimes; confinement was intended to be mandatory where violent crimes were involved. 90 Cal. App. 3d at 977, 153 Cal. Rptr. at 757.

22. Brief for Respondent, *supra* note 21, at 22.

prognosis"[23] in arguing that a mandatory minimum inpatient evaluation period did serve a legitimate purpose.[24] The *Hurt* court, agreeing with the State,[25] affirmed the order of commitment.

People v. DeAnda[26] is very similar to *Hurt,* although its legal nuances are somewhat more complex, and it is factually more favorable to the defendant patient. The defendant, accused of assaulting his wife with a deadly weapon, suffered from schizophrenia and perhaps from psychotic depression. After being acquitted by reason of insanity, DeAnda was stabilized, as an outpatient, on antipsychotic medication. In February 1980, more than a year after the assault, the California trial court concluded a sanity hearing to determine whether DeAnda had "fully recovered" his sanity or whether he had to undergo a ninety-day institutional evaluation.[27]

By then, the court had received psychiatric input from a number of experts. Almost without exception, the psychiatrists agreed that the defendant did not need "to be hospitalized but that he should continue his [outpatient] treatment with the Mental Health Department,"[28] that his psychosis was "in remission with appropriate medication,"[29] that he was "not now psychotic"[30] or dangerous,[31] that hospitalization would be "very deleterious"[32] and that confinement would "halt the progress that [was] being made."[33]

The court believed that a defendant could not legally be considered "fully recovered" if continued medication was necessary to maintain the defendant in a state of remission. It felt statutorily obliged to order the unrecovered defendant institutionalized for a ninety-day minimum evaluation period. The trial court believed:

> [that] it had no discretion to do otherwise; that it did not see "any useful purpose" in so doing and was inclined to think such hospitalization would be "counter-productive;" and that if the Legislature had granted the court discretion in the matter, it would have ordered defendant to continue his treatment on an outpatient basis.[34]

Like Hurt, DeAnda obtained a stay of the commitment order and perfected an appeal. On appeal, DeAnda argued that psychopharmaceutical restoration to sanity should be deemed full recovery (thus obviating the necessity for inpatient confinement); that he was statutorily eligible for outpatient treatment without first

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23. *Id.* at 21.

24. Contrary to appellant's contention, until the medical director has had a minimum opportunity for *institutional* observation and examination of appellant in order to intelligently form an opinion as to whether he is a danger to the health and safety of others, the reasons for confining appellant have not been satisfied.

Id. at 21-22.

25. 90 Cal. App. 3d at 977, 153 Cal. Rptr. at 757. The court made specific reference to arguments in respondent's brief. *Id.*

26. 114 Cal. App. 3d 480, 170 Cal. Rptr. 830 (1980).

27. *Id.* at 487, 170 Cal. Rptr. at 833.

28. *Id.* at 486, 170 Cal. Rptr. at 832.

29. *Id.*

30. *Id.*

31. *Id.* at 487, 170 Cal. Rptr. at 833.

32. *Id.*

33. *Id.*

34. *Id.* at 488, 170 Cal. Rptr. at 833 (appellate court reporting facts in proceeding below).

undergoing a mandatory ninety-day institutional evaluation; and that a ninety-day mandatory confinement period would violate his right to due process and equal protection of the law.[35]

As in *Hurt*, the State argued forcibly against each of DeAnda's contentions. The State's argument headings, as they appear in the table of contents of its brief, capture the State's position:

> I Appellant had not fully recovered his sanity within the meaning of Penal Code section 1026
> II The trial court had no discretion to place appellant on outpatient status even though the doctors thought outpatient treatment was preferable
> III The order committing appellant to the state hospital for 90 days did not deprive appellant of his right to due process of law
> IV Due process of law is not violated by a mandatory hospital commitment even when there is substantial evidence that outpatient treatment would be more appropriate
> V The mandatory 90 day commitment for defendants acquitted of violent acts by reason of insanity does not violate equal protection of the law
> VI Principles of statutory construction require appellant to be committed for 90 days prior to undergoing outpatient treatment[36]

The appellate court in *DeAnda,* agreeing with each argument of the state, affirmed the trial court's reluctant order of commitment in December 1980, some two years after the then-psychotic defendant assaulted his wife.

Another example of state advocacy in operation is *Shuler v. United States*.[37] In *Shuler,* the appellant was charged in the District of Columbia with unarmed robbery. He was found not guilty by reason of insanity and was committed to St. Elizabeth's Hospital, a public mental health facility in Washington, D.C. Later, the hospital superintendent asked the court for Schuler's conditional release so that the patient might spend the Thanksgiving and Christmas holidays with his family. The trial court denied the request as being beyond its authority and the patient appealed.

Despite precedent indicating that the trial court had misconstrued its authority to approve a conditional release[38] and despite authority that construction of the applicable conditional release statute "is not precluded by mootness,"[39] the U.S. attorney nonetheless raised mootness as its central argument in the appellate court.[40] Given existing case law, however, the *Shuler* court reached the merits of appellant's claim and held that the lower court did have the authority to grant the requested conditional release. Accordingly, the order denying release was vacated.[41]

United States v. Ecker,[42] one of the most complex instances of government advocacy in cases of arguably inappropriate patient confinement, also arose in the Dis-

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35. *Id.* at 484, 170 Cal. Rptr. at 831.
36. Brief for Respondent at i, People v. DeAnda, 114 Cal. App. 3d 480, 170 Cal. Rptr. 830 (1980). As in *Hurt,* the state's brief was prepared by the Criminal Division of the California Attorney General's office.
37. 422 A.2d 996 (D.C. 1980).
38. Hough v. United States, 271 F.2d 458 (D.C. Cir. 1959).
39. Friend v. United States, 388 F.2d 579, 581 (D.C. Cir. 1967).
40. *Shuler,* 422 A.2d at 997.
41. *Id.*
42. 543 F.2d 178 (D.C. Cir. 1976), *cert. denied,* 429 U.S. 1063 (1977).

trict of Columbia.[43] In 1968, Ecker was found not guilty by reason of insanity on counts of rape and felony murder and was committed to St. Elizabeth's Hospital. Five years later, the hospital sought court approval for Ecker's conditional release in order to implement an optimal treatment plan for its patient. Under the plan, Ecker would continue to live at the hospital but would have increased access to the community to allow him to participate in a vocational training program.[44] Pursuant to standard procedure, the Office of the United States Attorney, which had prosecuted Ecker, was notified of the hospital's conditional release request.[45] Because the Government objected to the proposed release, a court hearing was held on the propriety of conditional discharge.[46]

At the hearing, four mental health experts were called as witnesses. Although each of them supported the hospital's proposed plan for conditional release, the lower court denied the release application. Ecker appealed, contending that the Government should bear the burden of proof when it opposes release and that a conditional release scheme that is more onerous for insanity acquittees than for civilly committed patients runs afoul of equal protection guarantees. The Government argued against Ecker's release, voicing concern about public protection. In fact, the Government asserted that Ecker did not satisfy the conditional release requirement that he not be dangerous to himself or others[47] and that, "contrary to Ecker's argument, the Government does not bear the burden of proof on the dangerousness issue when it opposes release, despite the hospital's certification."[48] The District of Columbia Circuit, with one dissent, affirmed the lower court's denial of the hospital's request for the patient's conditional release.[49]

III
THE PROBLEM WITH STATE ADVOCACY IN INAPPROPRIATE CONFINEMENT CASES

The illustrations discussed above provide an appropriate background for assessing the state advocacy problem in cases of arguably inappropriate patient confinement. The problem is a rather obvious one: in such cases, the state has various, often inconsistent, interests at stake. There is a strong public protection interest involved, which may be represented by the attorney general or department of justice acting as the prosecutive arm of the state. Yet, the attorney general is also counsel for the state department of health or its equivalent; and that department and the state hospital may have a very different interest in these and related cases.

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43. For a discussion of state advocacy problems unique to the District of Columbia, see *infra* note 53.

44. An earlier hospital application for Ecker's conditional release had been denied by the trial court and that decision affirmed on appeal. United States v. Ecker, 479 F.2d 1206 (D.C. Cir. 1973).

45. 24 D.C. CODE § 301(e) (1973) (current version in 5 D.C. CODE ANN. § 24-301(e) (1981)), set forth in full in *Ecker*, 543 F.2d at 183 n.12.

46. 543 F.2d at 182.

47. 543 F.2d at 202 (Wright, J., dissenting); 5 D.C. CODE ANN. § 24-301(e) (1981).

48. 543 F.2d at 202 (Wright, J., dissenting).

49. On the burden of proof question, each of the three judges expressed separate views, and there was accordingly no opinion of the court on that issue.

Justice in its prosecutive role actively oppose the release in court. The apparent conflict of interest did not escape the attention of Judge Wright, dissenting in *Ecker*, who noted that "this puts the United States Attorney's office in the anomalous position . . . of potentially being called upon to represent both sides—choosing on its own to oppose the release, but being called upon to serve as lawyer for the government hospital."[53]

It is not always the case, however, that hospital interests in therapeutic flexibility are submerged in litigation in favor of public protection interests. In fact, research has uncovered a small number of cases where the *state* has challenged a statute or court order on the grounds that the legislation or judicial order obliged the hospital to confine a patient inappropriately.[54]

Suppose, for example,[55] that the state challenges the legitimacy of a court order requiring it a) to "treat the patient in the maximum security unit,"[56] or b) to confine a patient for "no less than 30 days," or c) to hospitalize a civilly committed patient "until further order of the court," or d) to accept an unadjudicated

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53. 543 F.2d at 203 (Wright, J. dissenting). I have noted a similar problem in Hawaii:

> Interesting problems [may] seemingly arise in instances where a state properly initiates a release application and presses it . . . despite a mixed reaction from the Sanity Commission, so that a court hearing will eventuate . . . . Since . . . the state has the right to apply for the patient's release, but . . . the state has the burden in a court hearing to establish that the patient is not safe for release, the "state" is put in a peculiar position.

Wexler, *supra* note 51, at 16.

The representation problem may be particularly pronounced in the District of Columbia, where the United States Department of Justice serves as a local prosecutor as well as the lawyer for federal agencies, including St. Elizabeth's Hospital, which is a unit within the Department of Health and Human Services. Outside the District of Columbia, the state attorney general may represent the state hospital, and the district attorney may serve as the local prosecutor. *See* Matter of Torsney, 47 N.Y.2d 667, 394 N.E.2d 262, 420 N.Y.S.2d 192 (1979). Nonetheless, since in most jurisdictions the attorney general, rather than the district attorney, handles all appeals growing out of criminal cases, NAT'L ASS'N OF ATTORNEYS GENERAL, POWERS, DUTIES AND OPERATIONS OF STATE ATTORNEYS GENERAL 156 (1977), the problem may resurface at the appellate level.

54. Cases discovered were State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980); *In re* Guzan, 45 Pa. Commw. 525, 405 A.2d 1036 (1979); Matter of Torsney, 47 N.Y.2d 667, 394 N.E.2d 262, 420 N.Y.S.2d 192 (1979).

55. These examples track Illustrations 1-4 noted in the Introduction and are suggested by the cases cited in notes 6-9 *supra*. Factually and procedurally, the actual cases are to a large extent idiosyncratic and untidy, and are accordingly employed here only to suggest the types of issues that might be raised in a state-initiated challenge.

56. Although such orders are rarely challenged, an empirical study suggests just how troublesome such orders can be to the administration of mental health services:

> The [Arizona State Hospital's Special Classification Committee] is sometimes baffled by civil commitment orders containing language to the effect that the patient is "to be held in the Maximum Security Ward." A problem arises when the SCC is faced with a patient's request to transfer out of Maximum Security and at the same time with a commitment order containing the above language. In such a case the SCC does not know whether it is bound to follow the order—in which case it is easier to discharge the patient than to change his ward—or whether the committing court has exceeded its authority. . . . In any case, committing courts should refrain from attempting to tie the hospital's hands with respect to the appropriate ward of confinement. This is particularly so in view of the fact that few judges are sufficiently acquainted with the facilities of the hospital to recognize, for example, that tight security is available not only in the Maximum Security Unit (Encanto Hall), but also in a slightly less restrictive ward (Hermosa Hall), and that even the general population wards do not grant grounds privileges to all patients.

Wexler & Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona,* 13 ARIZ. L. REV. 1, 219 n.30 (1971).

juvenile for the purpose of evaluation and treatment. Surely, in each of those instances, the state's desire to preserve its hospital's scarce resources and therapeutic flexibility might lead it to initiate a challenge. In one case involving a commitment order to confine a juvenile charged with delinquency for a specified period of time, a petition filed by the state included as an exhibit an affidavit of a staff psychiatrist which made explicit the state's interest in being able to discharge the juvenile promptly. Among other things, the sworn statement specified:

> 1. That [the juvenile] is not suffering from a substantial disorder of emotional processes, thought, cognition or memory; she is not mentally ill.
>
> 2. That [the juvenile] is not in need of inpatient psychiatric hospitalization and should be discharged from the Arizona State Hospital.
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> 3. That the Child/Adolescent Unit of ASH is presently filled to its 23-bed capacity and that there are approximately five mentally ill children awaiting placement on said unit by the Department of Economic Security, their parents and/or the Superior Courts of the State of Arizona.
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> 4. That [the juvenile's] continued placement at ASH will not benefit her current problems and needs and may in fact have a serious detrimental affect [sic] upon her mental health.
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> 5. That [the juvenile] is occupying a bed which could presently be used by at least five children needing mental health care.
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> 6. That [the juvenile's] presence at the ASH is taking professional staff time away from the other.patients on the Child/Adolescent Unit, to their detriment.[57]

Why is it that the state sometimes argues forcefully against the propriety of such matters as mandatory minimum confinement periods[58] and the requirement of court approval for release,[59] and at other times, as in *Hurt, DeAnda, Shuler,* and *Ecker,* actively supports such requirements? In general, it seems that the state is far more likely to assert its public protection interest when a patient has been channelled into the mental health system through a criminal charge, especially when the charge was a serious one. That may explain the state's stance in *Hurt, DeAnda, Shuler,* and *Ecker*. Yet, even among criminal cases resulting in mental health commitment, there are some notable exceptions. In *Matter of Torsney,*[60] for example, a police officer charged with murdering a fifteen-year old youth was committed after successfully interposing an insanity defense based on psychomotor epilepsy. Shortly thereafter, the state commissioner of mental hygiene, claiming Torsney was neither dangerous nor mentally ill, applied for a court order authorizing Torsney's release, and successfully pursued the case through the appellate level.[61]

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57. The affidavit was included in a petition filed originally in the intermediate appellate court and ultimately transmitted to the Supreme Court of Arizona in connection with State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980). In the text, pertinent paragraphs from different portions of the affidavit have, for the sake of convenience and readability, been brought together and renumbered.

58. *See* State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980).

59. *See In re* Guzan, 45 Pa. Commw: 525, 405 A.2d 1036 (1979).

60. 47 N.Y.2d 667, 394 N.E.2d 262, 420 N.Y.S.2d 192 (1979).

61. In *Torsney,* however, the prosecutive interest was vigorously pressed by the District Attorney's office, which opposed the release. *Id.* at 671, 394 N.E.2d at 264, 420 N.Y.S.2d at 194. For an example of a state-initiated action opposing hospitalization of a juvenile charged with three acts of delinquency, see State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980). *Dandoy* was a special action brought by the State, on relation of the Director of the Department of Health, against the committing court. The Attorney General represented the Director and the County Attorney represented the respondent court. Since hospitalization was ordered upon a request for psychiatric examination made by the juvenile's counsel, the juvenile real party in interest—represented by the Public Defender—opposed the

Moreover, even if a state distinguished sharply between criminal commitments[62] and civil commitments, taking a prosecutive posture with the former category and a more therapeutic posture with the latter category, such a policy decision would be far from satisfactory. Should a state adhere to a purely prosecutive perspective even after a criminally committed patient has been confined for many years? Is a pure public protection rationale justified even for criminally committed patients involved in nonviolent criminal activity?[63] What reason, other than habit or tradition, can be given for advancing a greater public protection interest in a nonviolent criminal commitment case than in the modern variety civil commitment case?

Civil commitment cases are increasingly being tried by public prosecutors[64] and typically allege not only a patient's mental illness, but also the patient's dangerousness as evidenced by a recent overt act, attempt, or threat.[65] If a court in a civil commitment case orders that a patient be confined in a maximum security unit, or that the patient be confined for a specified minimum period or until further order of the court, the court's order may well reflect a judicial concern about the patient's dangerousness and the public's protection. That concern, moreover, may have originated with the prosecuting attorney who tried the case.

In short, it does not appear that the state's public protection and therapeutic interests are being advanced under a scheme defendable as a coherent policy of appropriate advocacy in mental health cases. It would not be surprising to learn that any given state advocacy stance is determined in practice largely by procedural factors and happenstance—such as whether a particular case falls administratively within the purview of the criminal division of the attorney general's office. Mental health law has always been plagued by confusion between police power and therapeutic interests,[66] and it is evident that the confusion has not escaped the realm of state advocacy.

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release. For a somewhat similar situation involving a commitment order for a mentally retarded juvenile and a successful opposition to that order by the Attorney General on behalf of the State Department of Mental Retardation, see *In re* Maricopa County Appeal, 15 Ariz. App. 536, 489 P.2d 1238 (1971).

62. The term "criminal commitment" is a rough one, used to describe cases in the mental health system that have some connection to the criminal justice system (e.g., insanity acquittees, persons found incompetent to stand trial, and sexual psychopaths). *See* D. WEXLER, *supra* note 1, at 117-33.

63. A recent report drew a distinction between violent and nonviolent insanity acquittees, and suggested that court approval be required as a condition for release only with respect to the former category. ASS'N OF THE BAR OF THE CITY OF NEW YORK, MENTAL ILLNESS, DUE PROCESS AND THE ACQUITTED DEFENDANT 37 (1979). Evidently, the Association thought public protection interests warranted judicial scrutiny of release only in certain criminal commitment settings. For a discussion of the view that a requirement of judicial release approval may, in the aggregate, hasten rather than retard the release of criminally committed and dangerous civilly committed patients, see D. WEXLER, *supra* note 1, at 122-27.

64. For a discussion of public prosecutors in civil commitment cases, see *In re* Kossow, 292 A.2d 97 (D.C. 1978); Wexler, *Victimology and Mental Health Law: An Agenda,* 66 VA. L. REV. 681, 707-11 (1980). *See also* THE PRESIDENT'S COMMISSION ON MENTAL HEALTH, *supra* note 5, at 69 (discussing need for counsel to represent the state in commitment cases).

65. D. WEXLER, *supra* note 1, at 37.

66. Since these commitment procedures include actions premised on remedial and care-giving (i.e., parens patriae) functions of the State, as well as those concerned essentially and primarily with protection of the community (viz, police power functions), a number of critical public policy, legal, and programmatic issues continue to be rather thoroughly confounded.
Shah, *Foreword* to D. WEXLER, CRIMINAL COMMITMENTS AND DANGEROUS MENTAL PATIENTS: LEGAL ISSUES OF CONFINEMENT, TREATMENT, AND RELEASE at vi (1976).

IV
SOME SUGGESTIONS

The primary purpose of this article is to expose the state advocacy problem, not to solve it. Once the problem is laid bare and the legal and mental health actors in the system are forced to direct their attention to it, their reformative suggestions, grounded in experience and knowledge of local nuances and intricacies, will be as valuable as the ones made here. Moreover, given the wide variation among jurisdictions in such basic matters as the processing of commitment cases,[67] the structure of state legal services,[68] and the role of the state attorney general's office[69] and its relationship to agency counsel and to local prosecutors, an action that may constitute workable reform in one state may violate another state's constitution. The suggestions made here are often cast in somewhat general terms and must be viewed within the constraints of the caveats just noted. They often take the form of structural frameworks and procedural options rather than resolutions on substantive matters.

A. Communication

The first step in formulating a sensible advocacy position is to insure that the attorney general is aware of the various state interests at stake. Constant communication between the attorney general's office and the state department of mental health (and its state hospitals) is thus essential. Where the department has its own house counsel,[70] counsel is in the best position to coordinate communication. In the absence of house counsel, the attorney general should periodically send a deputy into the field to consult with department and hospital administrators and staff in order to learn of frustrations and concerns. In turn, state administrators must utilize increased opportunities for communication to express concerns over legal mandates which lead to arguably inappropriate confinement, rather than suffering silently over such rulings. In short, they should express the state's interest in treating only those persons who truly require confinement. Until effort is expended to establish this two-way communication, there is little hope of altering the course of state advocacy.[71] Once the attorney general has been notified of particular concerns, various means for legal expression exist. The posture of real or potential litigation will help determine the expression in any given case.

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67. Variation even exists, for example, on whether a commitment petitioner is represented by counsel in commitment cases and, if so, whether the case for commitment may be pressed by private counsel or only by a public prosecutor. *See* sources cited *supra* note 64.

68. NAT'L ASS'N OF ATTORNEYS GENERAL, THE STRUCTURE OF STATE LEGAL SERVICES (1979).

69. NAT'L ASS'N OF ATTORNEYS GENERAL, COMMON LAW POWERS OF STATE ATTORNEYS GENERAL (1977); NAT'L ASS'N OF ATTORNEYS GENERAL *supra* note 53.

70. Whether departments or agencies may employ their own counsel is a matter of wide variation among the states. NAT'L ASS'N OF ATTORNEYS GENERAL, *supra* note 68, at 20-38. In states which do employ agency counsel, there is a wide range of possible relationships between agency counsel and the attorney general. *Id.* at 51-56.

71. A good example of expressed concerns that did alter the course of state advocacy is State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980).

B. Response to Patient-Initiated Petition

Consider cases in which a patient is pressing an argument of inappropriate confinement. The attorney general might, in a case like *DeAnda,* soften its stance regarding the statutory availability of outpatient treatment or the question of whether a patient might be deemed legally recovered if the patient's mental functioning is restored by psychopharmacological means.[72] In a case like *Shuler,* involving the ability of a commitment court to authorize passes and conditional releases, the government might simply confess error, given the hospital's interests and the precedents on point.[73] Even if the attorney general does not wish to present the hospital's view for public protection reasons, he should consider authorizing the hospital to seek participation in the litigation through its house counsel or through the appointment of special counsel,[74] perhaps in an amicus capacity.[75]

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72. Compare the actual position taken by the State in *DeAnda*; *see supra* text accompanying note 36.

73. Although confessions of error are typically resorted to in the context of criminal cases, Sibron v. New York, 392 U.S. 40 (1968); Young v. United States, 315 U.S. 257 (1942), they are also available in civil litigation. Swarb v. Lennox, 405 U.S. 191 (1972); Cates v. Haderlein, 342 U.S. 804 (1951) (per curiam); Chadha v. Immigration and Naturalization Serv., 634 F.2d 408 (9th Cir. 1980); Atkins v. United States, 556 F.2d 1028 (Ct. Cl. 1977), *cert. denied,* 434 U.S. 1009 (1978). The confession of error doctrine is also recognized by state courts. *In re* D.P., 556 P.2d 1256 (Alaska 1976) (per curiam) (juvenile proceeding); Whitty v. State, 34 Wis. 2d 278, 149 N.W.2d 557 (1967), *cert. denied,* 390 U.S. 959 (1968) (sexual psychopath commitment).

74. All attorneys general have the authority to appoint special counsel, and often do so in cases involving a conflict of representation. NAT'L ASS'N OF ATTORNEYS GENERAL, *supra* note 68, at 42. In some instances of inter-agency conflict, the attorney general, acting through two assistants operating independently, will represent both of the parties to a lawsuit. State *ex rel.* Conway v. Hunt, 59 Ariz. 256, 126 P.2d 303, *vacated on rehearing on other grounds,* 59 Ariz. 312, 127 P.2d 130 (1942). On somewhat related matters, see Stern, *"Inconsistency" in Government Litigation,* 64 HARV. L. REV. 759 (1951); Note, *Judicial Resolution of Inter-Agency Legal Disputes,* 89 YALE L.J. 1595 (1980).

Depending largely upon whether the attorney general is regarded as retaining his common law powers, jurisdictions differ substantially in the extent to which they view the attorney general as being primarily a lawyer for state agencies or as being primarily responsible for representing the public interest. *Compare* Santa Rita Mining Co. v. Department of Property Valuation, 111 Ariz. 368, 371, 530 P.2d 360, 363 (1975) ("The Attorney General is the attorney for the Agency, no more. In the instant case the Attorney General did not have the power to appeal against the wishes of his client.") and Arizona State Land Dep't. v. McFate, 87 Ariz. 139, 143, 348 P.2d 912, 915 (1960) ("[T]he fundamental obligation of the Attorney General is to act as legal advisor to the official agencies of the State. The legal services of his Department must be furnished whenever required by a department of the State even in situations where the Attorney General may not agree with the policies pursued by the particular department.") *with* Secretary of Admin. and Fin. v. Attorney Gen., 367 Mass. 154, 163, 326 N.E.2d 334, 338 (1975) ("The Attorney General represents the Commonwealth as well as the Secretary, agency or department head who requests his appearance. . . . He also has a common law duty to represent the public interest. . . . Thus, when an agency head recommends a course of action, the Attorney General must consider the ramifications of that action on the interests of the Commonwealth and the public generally, as well as on the official himself and his agency.") and Feeney v. Commonwealth, 373 Mass. 359, 366 N.E.2d 1262 (1977) (where appeal, in the attorney general's judgment, would further interests of the state and public, he may present appeal over express objections of state office he represented in court below). *See also* D'Amico v. Board of Medical Examiners, 11 Cal. 3d 1, 520 P.2d 10, 112 Cal. Rptr. 786 (1974).

75. Whether one is permitted to appear as an amicus is within the discretion of the court, Matthews v. Ingleside Hosp., Inc., 21 Ohio Misc. 116, 254 N.E.2d 923 (1969), and in cases involving issues of public interest, amicus assistance is often needed and the request of an amicus to appear is generally granted. *Id.* The attorney general and interested state agencies have been permitted to appear as amicus curiae. Carden v. Johnson, 282 Or. 169, 577 P.2d 513 (1978). The principal restriction on the role of an amicus is that it may not raise questions not raised by the parties. Mears v. Little Rock School Dist., 593 S.W.2d 42 (Ark. 1980); State *ex rel.* Dept. of Health and Environ. Sciences v. Lasorte, 596 P.2d 477 (Mont. 1979). It

C. State Initiated Challenges

If a case alleging inappropriate patient confinement is not ongoing as a result of a patient-initiated petition, a state hospital administrator or house counsel may persuade the attorney general to initiate a suit on behalf of the state. Such a suit may allege, for example, the invalidity of a court order requiring the hospital to confine a patient in a certain location or for a certain minimum stay. Such state-initiated suits, although possible,[76] have been infrequent, perhaps because hospital interests have not been effectively communicated to the attorney general.

Structures can be devised to insure that state-initiated suits challenging court orders that restrict a hospital's therapeutic flexibility can be brought without concealing or sacrificing possible interests in public protection. If, for example, the challenge is brought against the committing court as a special action or extraordinary writ in the nature of mandamus or prohibition,[77] the court should have an interest in its order sufficient to request the county or district attorney to argue in support of the order.[78] The district attorney's interest and incentive in upholding the order will be especially strong in jurisdictions in which commitment cases are themselves brought by public prosecutors.[79]

In many instances, a state-initiated suit may seek simply to obtain an interpretation of a state statute and the resulting obligations of a hospital. Illustrative issues are as follows: Under an applicable statute, does the committing court have the right to require a hospital to house a patient in the maximum security unit?[80] Does the statute give the court a right to require that a patient be held for a minimum time period?[81] Does the statute authorize a hospital to release a patient on the hospital's own initiative, or may a court require court approval before a patient may be released?[82] Is the court authorized by statute to grant passes or conditional releases?[83]

Sometimes, however, a challenge may involve more than simply a question of statutory interpretation. In cases like *Hurt, DeAnda,* and *Ecker,* constitutional questions were also presented. If a statute does in fact require a hospital to confine

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may, however, be permitted to argue existing issues according to its own theories. Keating v. State, 157 So. 2d 567 (Fla. Dist. Ct. App. 1963).

In cases of arguably inappropriate patient confinement, it might also be helpful to have organizations of mental health professionals, or of state hospital administrators, such as the American Association of State Mental Health Program Directors, appear in an amicus capacity.

76. State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980); *In re* Guzan, 45 Pa. Commw. 525, 405 A.2d 1036 (1979).

77. State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980); 17A ARIZ. REV. STAT. ANN. RULES OF PROC. FOR SPECIAL ACTIONS, 1(a) (1973 & Supp. 1981); 7A COLO. REV. STAT. R. CIV. PROC. 106 (1973 & Supp. 1981); 7B N.Y. CIV. PRAC. LAW § 7801 (McKinney 1980). *See* Lesher, *Extraordinary Writs in the Appellate Courts of Arizona,* 7 ARIZ. L. REV. 34 (1965).

78. Fenton v. Howard, 118 Ariz. 119, 121, 575 P.2d 318, 320 (1978). *Fenton,* however, holds only that a county attorney may represent a respondent judge, not that he must do so. *Id.*

79. *See* sources cited *supra* note 64. In State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980), the county attorney, who represents petitioning agencies in commitment cases, appeared in the appellate courts in support of the commitment court's order. *Id.* at 185, 619 P.2d at 13.

80. *In re* Maricopa County Juvenile Action, 123 Ariz. 298, 599 P.2d 254 (Ct. App. 1979).

81. State *ex rel.* Dandoy v. Superior Court, 127 Ariz. 184, 619 P.2d 12 (1980).

82. *In re* Guzan, 45 Pa. Commw. 525, 405 A.2d 1036 (1979).

83. Shuler v. United States, 422 A.2d 996 (D.C. 1980).

certain patients for a mandatory minimum, ninety-day stay, does that provision violate due process or equal protection? If a statute authorizes civilly committed patients to be released on the hospital's own initiative but requires court approval for the release of criminally committed patients, does the statute deny criminally committed patients equal protection of the law?

Hurt, DeAnda, and *Ecker,* however, dealt with constitutional questions raised by patients themselves. Could the same issues have originated in a state-initiated challenge? That inquiry raises the question whether an attorney general, or a state agency represented by the attorney general, may assert the unconstitutionality of a state statute.

Jurisdictions vary remarkably on the issue; their positions virtually cover the gamut. Some courts have suggested that an attorney general would be "derelict in his duty" if he did not vigorously defend the constitutionality of a state statute.[84] Other courts view an attorney general's challenge to the constitutionality of legislation as curious,[85] while still others see such behavior as perfectly permissible.[86] Finally, one court has stated that the attorney general may even have the "duty" to initiate an action to determine the validity of a law he believes is unconstitutional.[87]

Apart from the question of the powers of the attorney general himself, there is the question of the right of state agencies and public officials, who are represented by the attorney general, to assert the unconstitutionality of state statutes. Even jurisdictions which generally adhere to the principle that public officials charged with administering a law are prohibited from challenging its constitutionality often craft exceptions to the rule when the issue involved is considered to be one of "substantial public interest."[88] Leeway to challenge the constitutionality of state

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84. White House Milk Co. v. Thomson, 275 Wis. 243, 247, 81 N.W.2d 725, 729 (1957); *see* City of Kenosha v. Dosemagen, 54 Wis. 2d 269, 271, 195 N.W.2d 462, 464 (1972).

85. Arizona State Land Dep't v. McFate, 87 Ariz. 139, 145, 348 P.2d 912, 916 (1960); *cf.* Baxley v. Rutland, 409 F. Supp. 1249, 1255, 1257, (M.D. Ala. 1976) (since legislation may require attorney general to defend the very type of case he now seeks to prosecute, action by state attacking the validity of its own statutes in federal court seems "incongruous").

86. State *ex rel.* Meyer v. Peters, 188 Neb. 817, 820, 199 N.W.2d 738, 739 (1972); Commonwealth *ex rel.* Hancock v. Paxton, 516 S.W.2d 865, 868 (Ky. Ct. App. 1974) ("[i]f the Constitution is threatened by an item of legislation, the Attorney General may rise to the defense of the Constitution by bringing a suit . . . .").

87. Hetherington v. McHale, 10 Pa. Commw. 501, 511, 311 A.2d 162, 167 (1973); *see also* NEB. REV. STAT. § 84-215 (1978):

> When the Attorney General issues a written opinion that an act of the Legislature is unconstitutional and any state officer charged with the duty of implementing the act, in reliance on such opinion, refuses to implement the act, the Attorney General shall, within ten working days of the issuance of the opinion, file an action in the appropriate court to determine the validity of the act. In any such action filed under the provisions of this section, the Attorney General may sue as defendant any person having a litigable interest in the matter or in lieu thereof may sue the Secretary of State. If the Secretary of State is named as defendant, it shall be his duty to defend such action and to support the constitutionality of the act of the Legislature and for such purpose is authorized to employ special counsel.

88. Neeland v. Clearwater Memorial Hosp., 257 N.W.2d 366, 369 (Minn. 1977); *see also* Federal Express Corp. v. Skelton, 265 Ark. 187, 193, 578 S.W.2d 1, 5 (1979) (issues involving "public interest"); Thompson v. South Carolina Comm'n on Alcohol and Drug Abuse, 267 S.C. 463, 467, 229 S.E.2d 718, 719 (1976) (per curiam) (issues of "wide concern"); City of Madison v. Ayers, 85 Wis. 2d 540, 545, 271 N.W.2d 101, 103 (1978) (issues of "great public concern").

statutes is often accorded on public interest grounds if a state agency finds itself in a situation of conflicting obligations because of the law.[89] Furthermore, state departments are sometimes allowed to press such suits if it seems unlikely that the issue would otherwise be raised.[90]

Cases involving constitutional issues of inappropriate patient confinement may well fall within the public interest exception. In addition, state hospitals may often find themselves subject to conflicting obligations because of possibly unconstitutional laws. If the arguably unconstitutional statute or order of the committing court is followed, state hospitals may be forced to neglect their obligations to act in the best interests of their patients and to release them when confinement seems no longer warranted.[91] On the other hand, if the hospital discharges a patient on clinical grounds despite a court order requiring it to hold the patient, the hospital places itself in legal jeopardy.[92]

Moreover, inappropriate confinement cases involving constitutional issues may easily be viewed as appropriate ones for state-initiated challenge under the doctrine that, if a state suit is disallowed, the important issue at stake may go unlitigated.[93] In *Johnson v. Avery,*[94] the Supreme Court recognized the importance of insuring that indigent and uneducated prison inmates have access to the courts on constitutional claims. It held that a prison that did not otherwise make provisions to insure inmates access to the courts could not prohibit jailhouse lawyers from rendering legal assistance to fellow inmates. Especially in days of decreasing funding for patient legal assistance programs,[95] *Johnson* should stand as formidable authority for the proposition that, unless a state is permitted to assert unconstitutional patient confinement, a largely indigent, uneducated, and lawyerless population of involuntarily committed mental patients will be denied access to the courts

89. Thompson v. South Carolina Comm'n on Alcohol and Drug Abuse, 167 S.C. 463, 467, 229 S.E.2d 718, 720 (1976) (per curiam); *see also* City of Madison v. Ayers, 85 Wis.2d 540, 545, 271 N.W.2d 101, 103 (1978); *cf.* Brewer v. Hoxie School Dist., 238 F.2d 91, 99 (8th Cir. 1956) (state officials, under constitutional duty to integrate schools, have federal constitutional right to be free from interference with their duty, and may bring injunctive action in federal court to prohibit further obstruction).

90. City of Madison v. Ayers, 85 Wis. 2d 540, 545, 271 N.W.2d 101, 103 (1978).

91. O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) ("[E]ven if [the patient's] involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed."); Parham v. J.R., 422 U.S. 584, 607 (1979) (if medical standards for admission are not met, hospital must have authority to refuse to admit a child volunteered for admission). Furthermore, if the hospital complies with an arguably unconstitutional order, it will be frustrated in its obviously "significant interest in confining the use of its costly mental health facilities to cases of genuine need." *Id.* at 604-05. Finally, such orders arguably interfere with the constitutional rights of mental health professionals to properly engage in their profession. *See* Singleton v. Wulff, 428 U.S. 106, 113 (1976) (leaving open question of infringement of doctor's constitutional right to practice medicine).

92. Semler v. Psychiatric Inst., 538 F.2d 121 (4th Cir. 1976) (civil suit against hospital by mother of victim killed by patient who was released from hospital in violation of court order); Hilton Hilltop, Inc. v. Riviere, 597 S.W.2d 596 (Ark. 1980) (petition for contempt denied).

93. *See supra* text accompanying note 89.

94. 393 U.S. 483 (1969); *accord* Wolff v. McDonnell, 418 U.S. 539 (1974) (*Johnson* holding applies to civil rights claims as well as to habeas corpus actions).

95. On the need for patient advocacy, see Task Panel, President's Commission on Mental Health, *Mental Health and Human Rights: Report of the Task Panel on Legal and Ethical Issues,* 20 ARIZ. L. REV. 49, 54-63 (1978). For a description and analysis of some foundation-funded or university-affiliated programs for bringing legal services to mental hospital patients, see Brakel, *Legal Aid in Mental Hospitals,* 1981 A. B. FOUND. RESEARCH J. 21.

in matters of considerable constitutional concern.[96]

V
CONCLUSION

Questions of patient advocacy in mental health law and questions of public protection and therapeutic justifications for commitment have traditionally interested mental health law scholars and practitioners. Those same questions in the context of state advocacy, however, have gone completely unaddressed. In this article, some problems and inconsistencies in approaches to state advocacy have been identified. Some general suggestions for reform have been made, keeping in mind the severe constraints which often flow from local law and from the structure of state governments and state legal services. Real reform will be possible, how-

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96. Conceptually, the law regarding the capacity of state officials to challenge the federal constitutionality of state statutes seems to be a state court public litigation counterpart to what is known in private federal litigation as the standing of a private litigant to assert constitutional jus tertii, the constitutional rights of third parties. On jus tertii generally, see L. TRIBE, AMERICAN CONSTITUTIONAL LAW 102-09 (1978); Sedler, *Standing to Assert Constitutional Jus Tertii in the Supreme Court,* 71 YALE L.J. 599 (1962); Note, *Standing to Assert Constitutional Jus Tertii,* 88 HARV. L. REV. 423 (1974).

When a state is granted standing to challenge the federal constitutionality of a state statute, as in Thompson v. South Carolina Comm'n on Alcohol and Drug Abuse, 267 S.C. 463, 229 S.E.2d 718 (1976) (per curiam) (equal protection challenge), it is obviously asserting a constitutional violation not of the state's rights, but of the rights of some state citizens. *See also* Neeland v. Clearwater Memorial Hosp., 257 N.W.2d 366, 369 (Minn. 1977) (allowing public official to challenge constitutionality "would in effect permit him to assert private rights of third parties"); *cf.* State *ex rel.* Meyer v. Peters, 188 Neb. 817, 199 N.W.2d 738 (1972) (where jurisdiction views attorney general as representing public interest, he may bring suit in name of state challenging constitutionality of legislation, and general rule prohibiting the assertion of jus tertii would not apply in such suits). *But cf.* Brewer v. Hoxie School Dist., 238 F.2d 91 (8th Cir. 1956) (rather unusual case relying in part on traditional jus tertii cases and holding state officials have federal constitutional right to be free from interference in carrying out their constitutional obligations to others).

The exceptions to the general rule prohibiting the assertion of jus tertii constitutional rights seem to parallel the exceptions to the rule prohibiting public officials from attacking the federal constitutionality of state legislation. Thus, in Craig v. Boren, 429 U.S. 190 (1976), the Court allowed a vendor of 3.2% beer to challenge the constitutionality of a statute prohibiting the sale of the beer to males under 21 and to females under 18. *Id.* at 192-97. The vendor was injured in fact by the statute and was placed in a conflicting position because of it. *Id.* at 194. She could either acquiesce in it and suffer financial loss by not selling to males aged 18-21 or she could disobey the statute and suffer possible sanctions. *Id.* Moreover, if she acquiesced or could not raise the rights of would-be male consumers aged 18-21, the absent 18-21 year old males could suffer a denial of their equal protection rights. *Id.* at 195-97. Accordingly, she was permitted to argue that the statute deprived males aged 18-21 of equal protection of the law. *Id.* at 197. State hospitals, which may be viewed as vendors (albeit sometimes to "compulsory consumers") of mental health services, are placed in a comparable, conflicting position by instances of inappropriate patient confinement. If they violate a court order or statute, they may be subject to sanction. If they acquiesce in it, they will suffer a drain on resources and the constitutional rights of their patients may be diluted.

In jus tertii cases, the courts are very much concerned with the factual ability or inability of third parties to assert their own rights, and are often receptive to jus tertii standing when one in a close professional relationship to third parties raises third party claims that the third parties themselves are unlikely to be able to assert. *See* Singleton v. Wulff, 428 U.S. 106 (1976) (plurality opinion permitting physician plaintiffs to raise the rights of women who sought abortions); Women's Medical Center v. Roberts, 512 F. Supp. 316 (D.R.I. 1981) (medical facility allowed to assert constitutional rights of women seeking abortions). Johnson v. Avery, 393 U.S. 483 (1969), cited in the text for the proposition that prisoners—and a fortiori mental patients—are unlikely to assert their constitutional rights absent assistance, is actually a jus tertii case. There, a jailhouse lawyer, disciplined for violating a prison regulation prohibiting inter-inmate legal assistance, was able to argue that the regulation unconstitutionally impeded *other* inmates in litigating their constitutional claims. The similarity of a mental hospital-patient situation to the situations in *Singleton* and *Johnson* seems apparent.

ever, only if the issues are examined in the context of individual jurisdictions. Perhaps attorneys general, counsel to state departments of health, hospital administrators, and legal scholars will be prompted to explore the questions in the laboratories provided by local law.