Civil Restraint, Mental Illness, and the Right to Treatment

Follow this and additional works at: http://digitalcommons.law.yale.edu/ylj

Recommended Citation
Civil Restraint, Mental Illness, and the Right to Treatment, 77 Yale L.J. (1967).
Available at: http://digitalcommons.law.yale.edu/ylj/vol77/iss1/4
Civil Restraint, Mental Illness, and
the Right to Treatment

The state normally cannot imprison an individual until it has shown beyond reasonable doubt that he has committed a specific illegal act; the criminal process is further hedged round by strict procedural limitations. The scarcely less awesome power to incarcerate for reasons other than conviction has not been subjected to similarly rigorous scrutiny, either substantive or procedural. Yet today thousands of people are restrained under a variety of statutes for reasons other than conviction for crime. The rise of the rehabilitative ideal in this country has meant a strong trend toward the use of civil restraint systems as an alternative to the ordinary criminal process. Two grounds, seldom clearly distinguished from one another in statutes and judicial opinions, support this civil confinement. The most frequently asserted ground is society's right, if not duty, to commit for treatment people so mentally disordered as to be unable to decide whether to seek treatment themselves. The second rationale is preventive detention: some persons are adjudged so dangerous that they must be restrained to protect society or themselves, even though they have not committed any criminal act with the traditionally required mens rea.

Prevention detention sounds bad; it conflicts with our traditions and seems constitutionally dubious. Our natural reaction is that if we are to allow such restraint at all the occasions for it must be carefully defined—as the elements of a crime usually are—and it must be implemented under procedures which assure careful protection for the rights of the person affected.

Treatment, on the other hand, sounds good; when we restrain a man to treat him, we act for his own benefit; we decide for him as we assume he would decide for himself if he were of sound mind. With benevolent intent assumed, definition of standards and procedural protections seem less important.

1. Usually because that process is denominated civil instead of penal. See pp. 92-93 infra.
2. The venerable notion of parens patriae.
For these reasons, statutes providing for civil confinement, and judicial decisions interpreting them, have long stressed the treatment aspect of such detention. Unfortunately, the reality of the treatment afforded those confined as insane persons, sexual psychopaths, and defective delinquents does not always reflect the asserted benevolent intentions.

Much of the care received today in our gigantic state mental institutions is merely custodial. Most of these institutions are woefully overcrowded and include within their walls many senile patients and others who could be more effectively cared for elsewhere if society wanted to provide for them. Complicating the situation still further is a severe and continuing manpower shortage, which includes both psychiatrists and other personnel such as psychologists, nurses, social workers, and attendants. Our state mental hospitals have not attracted a sufficient number of trained psychiatrists, who often feel greater professional satisfaction and earn higher incomes in private practice.

3. See p. 92 infra.


There is little doubt that, for many mentally disturbed individuals, institutionalization without real treatment can actually result in a worsening of their mental disease. See generally J. Cumming & E. Cumming, Ego and Milieu 83-105 (1963); E. Goffman, Asylums (1961). One commentator has even characterized the effects of institutionalization as so severe that if the patient is not released within two years of his admission, the chances are good that he will die in the hospital. Bloomberg, A Proposal for a Community-based Hospital as a Branch of a State Hospital, 116 Am. J. of Psychiatry 814 (1960).

5. Approximately 30 per cent of state patients are 65 or over. Action for Mental Health 175. See J. Katz, J. Goldstein & A. Dershowitz, Psychoanalysis, Psychiatry and Law 554 (1967) [hereinafter cited as Psychoanalysis, Psychiatry and Law]. Officials at a large state hospital in New York City estimated that between 40 and 60 per cent of their patients could be cared for with something less than full-day institutionalization, but that the necessary community facilities are not yet available. Interviews at Bronx State Hospital, April 1967. See also note 114 infra.

It should be noted in fairness that many state hospital systems are today in a period of rapid and far-reaching change, most of it for the better. This includes in-hospital developments, Action for Mental Health 109, and those relating to other facilities. The trend toward use of community mental health centers has been accelerated by the Community Mental Health Centers Act of 1963, 42 U.S.C. §§ 2661-87 (1964). These centers provide treatment of mental disease without formal institutionalization, with a maximum of program flexibility, and close to the patient's normal environment. Increased emphasis is also being given to outpatient care coordinated with state hospitals, day-care, and after-care programs to ease the often difficult transition back into the community. Halfway houses are also being experimented with. On day-care, see Zwerling & Wilder, Day Hospital Treatment for Psychotic Patients, in 2 Current Psychiatric Therapies 200 (J. Masserman ed., 1962).

A community attitude of fear and rejection of the mentally ill complicates this recruitment problem. A recent District of Columbia case suggests that when society confines a man on the asserted ground that he needs treatment, its lofty purpose cannot then be forgotten—treatment must be provided. Charles Rouse was committed to St. Elizabeth's Hospital under a District statute providing that a person found not guilty of a crime by reason of insanity shall be summarily committed to a mental hospital. Three years later he sought his release on a petition for habeas corpus, alleging that he was not receiving adequate treatment. The court of appeals held that he had stated a legally sufficient claim and remanded for a hearing on the adequacy of treatment. The decision depended upon a statute providing that any person committed to a mental hospital "shall . . . be entitled to medical and psychiatric care and treat-

7. See Action for Mental Health 56-85; G. Gurin, Americans View Their Mental Health (1960).
8. Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966). The history of the case has become somewhat complex. The 1966 decision remanded the case for another hearing in the district court, which was held in January, 1967, with the district court determining that Rouse was receiving treatment. Rouse appealed that decision, but also in April, 1967, brought another habeas corpus petition, alleging that he had not voluntarily pleaded insanity at his initial trial, and that the mandatory commitment section was unconstitutional. The court of appeals held for Rouse on the first ground, citing Lynch v. Overholser, 369 U.S. 709 (1962), and avoided the constitutional challenge. Rouse v. Cameron, No. 29,962 (D.C. Cir., Sept. 1, 1967) (en banc). The court filed a separate opinion on the appeal from the district court's action, declaring the treatment issue moot in view of its disposition of the second petition. Rouse v. Cameron, No. 29,881 (D.C. Cir., Sept. 1, 1967) (en banc) (per curiam).

Though the court of appeals may now not be anxious to expand the first Rouse opinion, the decision still seems to be good law. Along with its action on Rouse's second petition, the court in September, 1967, remanded two habeas corpus petitions for consideration of the adequacy of treatment. Dobson v. Cameron, No. 20,563 (D.C. Cir., Sept. 1, 1967) (en banc) (per curiam); Stultz v. Cameron, No. 20,576 (D.C. Cir., Sept. 1, 1967) (en banc) (per curiam). Those cases concerned civil commitment, not mandatory commitment following the insanity defense, but there is no reason to believe the court's attitude would be different for the latter route.

9. If any person tried upon an indictment or information for an offense, or tried in the juvenile court of the District of Columbia for an offense, is acquitted solely on the ground that he was insane at the time of his commission, the court shall order such person to be confined in a hospital for the mentally ill. D.C. CODE ANN. § 24-301(d) (1961).

10. The court also remanded a companion case for findings on treatment, holding that the right applied to those committed under the District's sexual psychopath statute. Millard v. Cameron, 373 F.2d 468 (D.C. Cir. 1966).

Rouse had also contended that he was not mentally ill. The opinion expressed concern with the extent to which the offense for which Rouse was arrested, carrying a dangerous weapon, influenced the judge's decision on dangerousness, 373 F.2d at 459-60, and remanded for clarification of that issue as well. Judge Danaher dissented on the ground that the treatment issue was not before the court, because Rouse's major contention was that he was sane and needed no care. Judge Danaher did not discuss the constitutional arguments for a right to treatment in detail, but his opposition to court supervision of treatment has become clear. 373 F.2d at 462-67 (dissenting opinion); Rouse v. Cameron, No. 29,962 (D.C. Cir., Sept. 1, 1967) at 9-11. Judge Fahy concurred, but wrote a separate opinion directed at Danaher's arguments concerning Rouse's assertion of his sanity. 373 F.2d at 461-62.
ment."\textsuperscript{11} But, more significantly, the court ranged beyond the statute to hint at the possible constitutional infirmities of confinement without treatment.\textsuperscript{12}

First, Judge Bazelon noted the lack of procedural safeguards attendant upon Rouse's commitment. Such informalism was permissible because of the "humane therapeutic goals" of commitment for treat-

\textsuperscript{11} D.C. CODE ANN. § 21-562 (Supp. V, 1966). [The provision appears as section 9(b) of the 1964 District of Columbia Hospitalization of the Mentally Ill Act, reprinted in pertinent part in PSYCHOANALYSIS, PSYCHIATRY AND LAW 488-93.] The court's statutory interpretation seems at best doubtful. The opinion seems finally to rest upon the argument that while many of the provisions are specifically restricted to "mentally ill persons," a category which excludes those committed by courts in criminal proceedings, D.C. CODE ANN. § 21-501 (Supp. V, 1965), the treatment provision is not. Though there is much in the debates over the Act to indicate that Congress wished to provide a right to treatment, there are also indications that it meant the concept to apply only to non-criminal cases. See, e.g., 110 CONG. REC. 1845 (1964) (remarks of Senator Ervin). The whole section of the Act of which § 21-562 is a part was specifically limited to such cases.

Judge Danaher pointed out some of the difficulties of statutory interpretation in his dissent, 373 F.2d at 466 n.12. Doubts about the correctness of its reading of section 21-562 apparently prompted the court to add a supplementary footnote to its opinion, Id. at 461 n.15, which argued in effect that the plain language of the statute took precedence over the doubtful legislative history. It also hinted that any differences in treatment between criminally and civilly committed persons, if found on the face of the statute, might render it unconstitutional under Baxstrom v. Herold, 383 U.S. 107 (1966). This Comment argues that as long as sufficient safeguards are provided, d\textit{angerousness} provides a rational basis for different disposition, though the simple label "criminal" does not. See pp. 98-100 infra.

The \textit{Rouse} opinion also noted that ten states recognize a right to treatment in some form by statute, 373 F.2d at 455 & n.21. Examination of these provisions, however, indicates that none has established a separate right to treatment ascertainable on habeas corpus. Like the D.C. provisions, they are typically not a part of any particular commitment procedure, but rather express the overall aim or hope of the statute. The most frequently used section is that found in the Draft Act, providing that a patient is entitled to treatment "to the extent that facilities, equipment, and personnel are available." NATIONAL INSTITUTE OF MENTAL HEALTH, DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL § 9 (Public Health Service Pub. No. 51, rev'd ed. 1952) reprinted in AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW, app. A, at 404 (F. Lindman & D. McIntyre eds. 1961) [hereinafter cited as \textit{LINDMAN \\& MCINTYRE}]. The quoted language was omitted in the D.C. Act; section 21-562 otherwise closely resembles the Draft Act section.

12. Though constitutional grounds had not been previously spelled out, the D.C. Court of Appeals had spoken of a possible right to treatment in earlier cases. Judge Faby had perhaps been the first to mention it in his concurrence in Ragsdale v. Overholser, 251 F.2d 943 (D.C. Cir. 1966). While concurring on the question of the constitutionality of the mandatory commitment law, he said:

\textsuperscript{12} This mandatory commitment provision rests upon a supposition, namely, the necessity for treatment of the mental condition which led to the acquittal by reason of insanity. And this necessity for treatment presupposes in turn that treatment will be accorded. \textit{Id.} at 950. In Darnell v. Cameron, 348 F.2d 64 (D.C. Cir. 1965), the court made it clear that it would consider right to treatment arguments:

We are constrained to note this question here because the District Court did not recognize that the alleged absence of treatment might draw into question "the constitutionality of the mandatory commitment section" as applied to appellant. This question may be explored if raised in subsequent proceedings. \textit{Id.} at 657 (footnote omitted). In Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) (en banc), the court considered treatment alternatives for an aged patient, remanding for an inquiry into the possibility of more appropriate treatment than confinement at St. Elizabeth's hospital. For the events following the first \textit{Rouse} decision in the court of appeals, see note 8 supra and 97 infra. There are presently a number of cases pending in the District of Columbia courts examining the implications of the right to treatment.
ment; but if treatment was not in fact provided, Bazelon suggested that "a full range of procedural safeguards might be constitutionally required."13 Second, he pointed out that Rouse could have been sentenced to no more than one year in prison if found guilty of the crime for which he was charged.14 Having been found not guilty by reason of insanity, he was committed to St. Elizabeth's for an indefinite term. The disparity of disposition if not justified by actual treatment raised equal protection questions. Finally, Judge Bazelon toyed with the possibility 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.’ "15

The Rouse dicta have signal importance in suggesting new constitutional grounds for challenge of institutional confinement when adequate treatment is not provided.16 They may force a re-evaluation of the trend toward "civil" forms of restraint. Moreover, to the extent that adequate treatment may become a constitutional touchstone for confinement, the decision raises the difficult problems courts will face in administering a right to treatment.

I. Commitment Laws and Their Bases

Judge Bazelon's constitutional suggestions—that confinement without treatment either is wholly invalid or requires quasi-criminal safeguards—demand firm distinctions between the two bases of civil confinement which are not made by existing legislation. Legislative and judicial formulations often muddle the two justifications for con-

13. 573 F.2d at 453 n.9. It is not completely clear that Bazelon would approve an interpretation of his opinion which would allow restraint for dangerousness without the promise of treatment, as advocated in this Comment. The quoted portion seems to indicate that he would, if procedures were stricter. Footnote 18a, added later, as we have seen, hints at equal protection problems if the right is not extended to all committed persons. The latter may, however, be a result of his defensive position on the statutory interpretation question. See note 11 supra.

14. 573 F.2d at 453.

15. Id. (footnote omitted).

16. The notion of a specific right to adequate treatment first gained notice in the 1960's. See, e.g., Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960); M. Bassiouni, The Right of the Mentally Ill to Cure and Treatment: Medical Due Process, 15 DePaul L. Rev. 291 (1966). Both authors seem to base the right on substantive due process, and do not discuss the differing bases for commitment. See also S. Rubin, PSYCHIATRY AND CRIMINAL LAW: ILLUSIONS, FICTION AND MYTHS, ch. 7 (1965); Birnbaum, Some Comments on the Right to Treatment, 13 Arch. of Gen. Psychiatry 24 (1966).

finement into a confused melange, adopting “treatment” language to approve procedural informality and turning to the rationale of preventive detention when treatment is impossible or unavailable.

A. Civil Commitment

The most important method of involuntary restraint for mental disorder is civil commitment under the various state laws, descended from the centuries-old lunacy law common to almost all countries. These laws reflect a welter of historically superimposed purposes, rarely distinguished from each other in practice.17

An American Bar Foundation study of these statutes in 1961 found that in five states involuntary commitment of a mentally ill person was based on dangerousness to himself or others; in twelve the need for care and treatment could be an alternative ground; in seven the need for care and treatment was the only basis; and in seven hospitalization could occur only where the welfare of the individual or of others justified it. Six states furnished no statutory criteria, and Massachusetts permitted confinement in cases of “social nonconformity.”18

These criteria, presumably reflecting the purposes of confinement, are often treated as though there were no differences among them. Civil commitment acts themselves never suggest that procedural requirements might depend on the reason for commitment.19 Similarly, judicial discussion of the purpose of civil commitment, usually in re-

17. In its earliest development, confinement was primarily for the protection of society, but as medical knowledge increased and rehabilitation therapy developed more and more emphasis has been placed on the restoration of the subject to normal life free from the stigma of a criminal record. Overholser v. O'Beirne, 302 F.2d 852, 853 (D.C. Cir. 1961).

18. Since mental hospitals, in some places at least, have come to be therapeutic as well as custodial institutions, many jurisdictions have extended coverage of commitment statutes to those who need care and treatment for their own welfare whether or not there is any danger in permitting them to be at liberty. Leavy, Hospitalization of the Mentally Ill Under Connecticut Law 44 (1966). See generally A. Deutsch, The Mentally Ill in America (2d ed. 1949); Note, Civil Commitment of Narcotic Addicts, 76 Yale L.J. 1160, 1164-68 (1967).

19. On commitment procedures, see Lindman & McIntyre 17-18. State provisions vary from judicialized procedures like those of D.C. to the medical certification used in New York. Many psychiatrists, concerned because of the supposed traumatic effects of hearings and jury trials on a mentally disturbed person, favor freer medical certification, while many lawyers and civil liberties groups favor safeguards close to those of the criminal process. See generally Association of the Bar of the City of New York, Special Committee to Study Commitment Procedures; Mental Illness and Due Process (1962); Kittrie, Compulsory Mental Treatment and the Requirements of “Due Process,” 21 Ohio Sr. L.J. 23 (1960); Ross, Commitment of the Mentally Ill: Problems of Law and Policy, 57 Mich. L. Rev. 945 (1959); Note, Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release, 34 U. Chi. L. Rev. 633 (1967).
Right to Treatment

buttal to attacks on a lack of procedural safeguards, rarely reflects any sense that confinement based on the need for care might imply different rights from confinement based on the individual's dangerousness. Instead, courts have routinely repulsed all constitutional attack on the uncritical reasoning that such laws are civil and rehabilitative rather than penal.

B. Sexual Psychopath Laws

A relative newcomer among commitment laws is the so-called sexual psychopath statute, singling out for special disposition and indeterminate custody a particular class of offenders, those who commit sex crimes or engage in habitual sexual misconduct. The usual pattern is for the court, either before or after a conviction, to require a psychiatric examination of the person and to order indeterminate confinement at a mental hospital if a finding of psychopathy is made. Some laws do not require either an actual conviction or even a criminal charge.²⁰

Sexual psychopath laws vary in their definitions of to whom they apply, but all the formulations are marked by a striking looseness of terms.²¹ Like civil commitment laws, they are usually viewed as civil when constitutionally attacked.²² And, again like civil commitment,
they are indiscriminately rationalized by a stated need for societal protection or individual treatment, or both.

The protection interest is often mentioned. The District of Columbia law, for example, has been interpreted as constituting “an extension of established law which relates to the commitment to hospitals of persons who by reason of insanity or inability to control impulses are dangerous to other persons.”23 The Michigan Supreme Court has said that its act deals with those “who require confinement, treatment, and care, both for their own protection and for the protection of the public.”24 The California courts have stated that the primary purpose is to protect society, with a secondary aim of rehabilitation,25 and more recently that “... the statutory scheme was not designed for the benefit of the criminal defendant, but for the protection of society ...”26

The need for treatment has also been stressed. Thus, the Missouri Supreme Court emphasized the “future well-being and return to normal living of a person so charged,”27 though it also recognized the protective function.28 Similar emphasis on treatment has been made by Michigan29 and New Hampshire courts.30

C. Defective Delinquent Laws

Closely related to the sexual psychopath laws are the defective delinquent statutes in force in some ten states.31 They do not require a finding of insanity, but are based upon a finding of mental deficiency or personality disorder which results in repeated criminal conduct. Like the sexual psychopath laws, they have been vigorously but unsuccessfully attacked as simple preventive detention based on vague psy-

the bodily safety of the public, or was mentally ill and a habitual offender. The court held that this procedure did not satisfy due process:

The effort of enlightened penology to alleviate the condition of a convicted defendant by providing some elements of advanced, modern methods of cure and rehabilitation and possible ultimate release on parole cannot be turned about so as to deprive a defendant of the procedures which the due process clause guarantees in a criminal proceeding.

Id. at 310. In Specht v. Patterson, 386 U.S. 605 (1967), the Supreme Court came to the same conclusion, noting that the situation was akin to the requirement of a hearing under habitual offender acts, and not comparable to that in Pearson, supra, where there was a full hearing on the psychiatric issues.

28. Id. at 1256, 232 S.W.2d at 902.
Right to Treatment

chiatric analysis. Here too the aims are confused, but with protection occupying a pre-eminent place. The Fourth Circuit upheld Maryland's recently-enacted law on its face, reserving the question whether it could infringe basic rights as applied. The court explained that the law was not strictly based on the need to treat the disordered person, but rather on the desire to protect society and the individual concerned.

D. Commitment Following Acquittal by Reason of Insanity

Twenty-nine states have laws requiring mandatory commitment following an acquittal by reason of insanity similar to the one at issue in the Rouse case. Many other laws allow such commitment at the discretion of the trial court. Judges have repeatedly upheld these statutes as long as habeas corpus is available to challenge later the key issues of continuing insanity and legality of commitment. But here too a dual objective emerges—treatment of the individual, and protection of society and the accused from his actions.

This interest in protection is strikingly evident in the congressional reaction to Durham v. United States. That decision, significantly broadening the legal definition of insanity in the District of Columbia,

33. Sas v. Maryland, 334 F.2d 506 (4th Cir. 1964). Deficiencies in staff, facilities, and finances would undermine the efficacy of the Institution and the justification for the law, and ultimately the constitutionality of its application.
Id. at 516-17. In response to the Fourth Circuit's mandate, the Maryland courts then made an extensive study of the statute in operation, upholding its constitutionality in all respects, including the reasonableness of the basic definition of defective delinquency. Director of Patuxent Institution v. Daniels, 243 Md. 16, 221 A.2d 397 (1966).
34. 334 F.2d at 513.
35. LINNMAN & McINTYRE 353, chart at 378-85. Some states allow relaxation of the rule and consequent release upon a specific finding of present sanity. Id. For a criticism of mandatory commitment, see Halleck, The Insanity Defense in the District of Columbia—A Legal Lorelei, 49 Geo. L.J. 294 (1960).
An important recent case in this field is People v. Lally, 19 N.Y.2d 27, 277 N.Y.S.2d 654, 224 N.E.2d 87 (1966). The New York Court of Appeals upheld its mandatory commitment statute, stating that it was reasonable to hold one who successfully pleads insanity in a criminal trial. Surprisingly, however, the court sent the case back for a jury trial on the dangerousness issue, as required in its view by the Equal Protection Clause. Thus in New York there is little difference between civil commitment and commitment following a successful insanity defense, the major one being that in the latter case the acquitted accused can be held in the interim (another may be burden of proof, upon which the Lally opinion is unclear). The D.C. Court of Appeals rejected an opportunity to demand a similar hearing under its mandatory commitment statute in cases discussed supra note 8.
37. 214 F.2d 882 (D.C. Cir. 1954).
was swiftly followed by a mandatory commitment law,\footnote{D.C. CODE ANN. § 24-301(d) (1961).} the legislative history of which makes it clear that Congress was concerned primarily with the protection of society from those persons whose mental state made them dangerous although not criminally responsible.\footnote{The enactment of § 24-301(d) in 1955 was the direct result of the change in the standard of criminal responsibility in the District of Columbia wrought by Durham v. United States . . . . That decision provoked a Congressional re-examination of the laws governing commitment of the criminally insane. Lynch v. Overholser, 369 U.S. 705, 715 (1962). A Committee on Mental Disorder as a Criminal Defense had been organized and in its report had recommended a mandatory commitment scheme: [T]he public is entitled to know that, in every case where a person has committed a crime as a result of mental disease or defect, such person shall be given a period of hospitalization and treatment to guard against imminent recurrence of some criminal act by that person.


1. It is both wrong and foolish to punish where there is no blame and punishment cannot correct. (2) The community's security may be better protected by hospitalization under . . . [the mandatory commitment section] than by imprisonment.

Williams v. United States, 259 F.2d 19, 22-26 (1957). Quite clearly, the right to treatment and the expansion of the insanity defense are closely related. If the number of those exculpated because of "sickness" is to be increased and the number of blameworthy decreased, society must be able to offer treatment or the commitment will be tantamount to life imprisonment for many. Thus the pressure for more adequate treatment is the cutting edge of the trend toward liberalization of the insanity defense.}

The conceptual confusion involved in all the varieties of civil confinement laws\footnote{It should be noted that there are several other ways one can be involuntarily committed to a mental institution in the United States. Mental retardation, incompetency to stand trial, narcotics addiction, alcoholism, and even epilepsy may in certain states in certain circumstances lead to institutionalization. These other routes are not our primary concern in this Comment, but they can be seen to suffer from the same confusion of statutory purpose as do the types of commitment discussed supra.} arises from a failure to recognize and distinguish between the two distinct needs to which mental illness may give rise. Protection of society and treatment for the individual of course can and do overlap in many instances, but they are in theory different justifications for confinement and respond to different variables. New psychiatric knowledge may, for example, broaden the range of treatable persons without changing society's view of who is dangerous. Since Rouse may eventually compel both courts and legislators to distinguish between these two needs and to set different standards for society's response to each, an analysis of the treatment problem is surely needed which does not abandon each difficult question by abruptly invoking the need to protect society.
II. The Constitutional Arguments for the Right to Treatment

The Rouse opinion suggested two principal and one subsidiary constitutional attacks on confinement without treatment, which differ importantly in principle and effect. First, Judge Bazelon hinted that indefinite civil confinement without treatment—that is, preventative detention—may be so inhumane as to constitute cruel and unusual punishment. Second, a procedural two-step is suggested under the due process clause: confinement for dangerousness is tolerated, but only with rigorous procedural guarantees similar to those required in the criminal process; confinement for treatment is allowed on more summary procedure, but only if treatment is genuinely provided.

A. Cruel and Unusual Punishment

The most fundamental assault on civil confinement statutes suggested by Rouse is based on the Eighth Amendment, as interpreted by the Supreme Court in Robinson v. California. The California statute challenged in Robinson made it a crime to “be addicted to the use of narcotics.” The Court reasoned that a law making leprosy a crime would universally be thought to involve cruel and unusual punishment and concluded that “[w]e cannot but consider the statute before us of the same category.” The statute struck down explicitly made addiction a crime, as well as prescribing confinement for it. The Court did not hold that confinement was in itself punishment; indeed it noted that a “state might determine that the general health and welfare require that victims of [mental disease, leprosy, or venereal disease] be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration.” This dictum does not give carte blanche to civil commitment; it contains, albeit implicitly, the important limitation that permissible civil confinement is the confine-

41. 373 F.2d at 453.
42. 370 U.S. 660 (1963). Justice Douglas, in a concurring opinion, alluded to the parallel with psychiatric treatment: If addicts can be punished for their addiction, then the insane can be punished for their insanity. Each has a disease and each must be treated as a sick person. Id. at 674.
43. 370 U.S. at 660.
44. Id. at 667. Prior to Robinson, it had been held that the public health laws relating to communicable diseases could not be construed to permit detaining a tubercular in jail. Benton v. Reid, 231 F.2d 780 (D.C. Cir. 1956). Robinson has since been interpreted to cover the jailing of persons for the status of alcoholism. Easter v. District of Columbia, 361 F.2d 50 (D.C. Cir. 1966); Driver v. Hinnant, 356 F.2d 761 (4th Cir. 1966).
ment required for treatment. It is unlikely that a general locking up of diseased persons could escape the strictures of Robinson by simply being labelled "civil" confinement. In more than one decision, including the recent Gault case, the Court has looked behind the label to find the functional equivalent of imprisonment in nominally "civil" confinement.

On one reading of Robinson, then, the Court could find all confinement for mental disorder to be "cruel and unusual punishment" unless accompanied by treatment. Such a reading has deep attractions, rooted in the hostility of our law and tradition to preventive detention without a criminal conviction and in the peculiarly repellent quality of the notion that sick people can be immured and left to rot. Their sickness may make them dangerous to the rest of us; but if they are to be confined for a condition which they are neither responsible for nor able to combat, there should be a reciprocal obligation for society to attempt to help them.

This interpretation of Robinson is supported by the close resemblance of some civil confinement to imprisonment. Some institutions for "defective delinquents" or the "criminally insane" look like prisons; they have bars, cells, and more burly guards than doctors and therapists. Civil confinement is for an indefinite term and may amount to a life sentence in an institution little different from a prison.

However, practical problems render unlikely a full hardening into constitutional requirements of the radical hints that can be found in Robinson. Some dangerous and mentally disordered people are untreated in our current state of knowledge; any doctrine which compels that they be left free is of dubious viability. Further, although at least ameliorative treatment is known for some kinds of mental disorder, neither enough public money nor sufficient personnel is avail-

46. In re Gault, 387 U.S. 1 (1967), and cases cited notes 56-58 infra.
47. See generally Weihofen, Institutional Treatment of Persons Acquitted by Reason of Insanity, 38 Texas L. Rev. 849 (1960). Psychoanalysis, Psychiatry and Law 706-02 compares in detail a prison and a "secure" mental hospital in Massachusetts, showing the similarity of conditions.
48. Present laws, Robinson aside, seem to recognize this.

Inherent in the statutory scheme, whether we like it or not, is the proposition that one who is "incurably insane" and "incurably dangerous" if there are such—may be hospitalized indefinitely.

Overholser v. O'Beirne, 302 F.2d 852, 854 (1961). Two of the most astute commentators have described the purpose of civil commitment as follows:

that "mentally ill" persons who evidence dangerousness to themselves or others be provided by the state with custody and care even if there is no known effective therapy or therapy is unavailable.

able to provide such treatment for all the dangerously disordered; nor are judicial decrees likely to produce the needed psychiatrists and appropriations. The alternative is release of the palpably dangerous, if treatment is to be a flat prerequisite for confinement.

The "no preventive detention" reading of Robinson could be reconciled with the unwillingness of courts to free the dangerously insane by a simple device—gutting the requirement of treatment. Confinement for treatment could be read to mean confinement with an announced intention to treat, coupled with an asserted willingness to provide actual treatment as the needed knowledge, personnel, and money turns up. This solution would have the comfortable virtue of coupling high constitutional ideals to an almost total absence of inconvenient change in a system of mass preventive detention.

If neither the drastic reading nor the hypocritical rejection of preventive detention commend themselves to the courts, Robinson can also be read to tolerate civil confinement for dangerousness. Civil commitment for mental disorder is distinguishable from imprisonment following conviction. Imprisonment is accompanied by an officially sanctioned and imposed stigma, rooted in the collective moral condemnation of society. While a stigma doubtless attaches to mental illness as well as sexual psychopathy and defective delinquency, at least an enlightened minority within society accepts the official characterization of these statuses as forms of sickness arising from no fault of the persons themselves. And, of course, the official characterization, particularly if adhered to by deed as well as by word, may enlarge the enlightened sector of society. Nor is a blanket indictment of public institutions for civil confinement fair; some superior ones resemble general hospitals in both facilities and atmosphere. Ultimately, whether the distinction between imprisonment and civil commitment for dangerousness is of constitutional magnitude will depend on the quality of public mental institutions.

Meanwhile, the Robinson decision throws no more than a shadow punch at preventive detention. Indeed, Mr. Justice Douglas, who can rarely be accused of lagging behind the Court, actually reaffirmed the validity of confinement for protection of the public in his concurring

49. This stigma is supposed to result from the ceremony of conviction, and not necessarily from confinement itself. Both Robinson and Easter emphasized the importance of convicting the sick person to their conclusion that he had been punished: "Cruel and unusual punishment results not from confinement, but from convicting the addict of a crime." 370 U.S. at 676 (concurring opinion). "It is the fact of criminal conviction that is critical." 361 F.2d at 55. In most civil commitment cases, of course, there is no conviction.
opinion. Moreover, Robinson does not in terms extend to acts caused by illness, as opposed to the illness itself. Yet restraint under insanity defense laws and many psychopath statutes is triggered by anti-social acts, although the condition of illness may be in whole or part the determining factor. At least where the individual has by such actions justified a reaction by society, Robinson loses some or all of its force.

B. Due Process

If the courts reject the Eighth Amendment assault upon civil confinement without treatment, the constitutional issues of definition and procedure mentioned in Rouse remain. Many of those detained in institutions today were put away with little ceremony or under standards grossly vague in meaning. Lengthy civil commitment often results from a brief and informal hearing before one or more psychiatrists. Rouse’s commitment, for example, was automatic after the judge concluded there was reasonable doubt of his sanity at the time he had committed the criminal acts charged; there was no hearing on the issues of his continued dangerousness or treatability. Many would argue that the standards applied in proceedings to commit for “sexual psychopathy” or “defective delinquency” have no clear meaning, either scientific or colloquial. If it were candidly admitted that these proceedings were designed to confine individuals solely because they were dangerous, with no view toward curing or treating them, it is doubtful that such loose standards and procedures could be constitutionally tolerated.

However, civil commitment statutes, sexual psychopath laws and the like are not frankly called preventive detention measures. Rather they are justified under the benevolent rubric of treatment and cure of the sick. Under this rubric, procedural constraints are slackened or dropped; confinement follows, often with few of the indicia of treatment and many of preventive detention. Indeed, many courts have not required even the assertion of an intent to treat, but have been satisfied with a determination that commitment statutes are civil in nature, or have a regulatory rather than a penal purpose.

An occasional court has looked behind the label “civil,” or the assertion of a curative or rehabilitative purpose, to examine what is actually done to the person committed. In Gault, the Supreme Court held that the due process clause required certain procedural safeguards akin to

50. 370 U.S. at 676. 51. See notes 21 and 32 supra. 52. See cases cited notes 22-30 supra.
those traditional in criminal law for juvenile court cases, despite the "civil" nature of the proceeding and the good intentions underlying the juvenile court movement. Juvenile proceedings, found the Court, are often very like criminal trials—they determine that a defendant has committed an illegal act, and order his incarceration. The social stigma surrounding the status "juvenile delinquent," while not officially imposed in theory, is scarcely less damning than that attached to criminals.

Though the Court makes it clear that each civil process will carry its own due process standard, the reasoning in Gault applies with almost equal force to certain forms of confinement for mental disorder. Some sexual psychopath and defective delinquent laws require proof of criminal acts, and in their very names lurks a stigma which is, if anything, worse than that imposed on criminals. Commitment of persons found not guilty by reason of insanity has many of the same characteristics. Even routine civil commitment, though not based upon an adjudication of past misdeeds, carries with it loss of liberty and a damaging stigma.

Civil confinement laws diverge from juvenile proceedings where they have the express purpose of treatment. "Treatment" is a more definite and hopeful goal than the "rehabilitation" sought under the juvenile laws; it connotes specific diseases and medically prescribed procedures designed to cure them. One of the Court's objections to summary juvenile court procedures in Gault was the unproved and speculative nature of the claims that the process "rehabilitated" its clients.

Rouse suggests that a similar realistic scrutiny may be in the offing for the civil confinement process. Assertion of a benevolent purpose to treat will not be enough; treatment will have to be provided if procedures are to be slighted. In this implication Rouse does not stand alone. A few state courts have also had due process doubts about civil

53. 387 U.S. at 27. In reviewing disposition under juvenile statutes, courts in the District of Columbia asserted an early kind of right to treatment, derived from concepts of due process and the statutes themselves. White v. Reid, 125 F. Supp. 64 (D.D.C. 1954), held that a juvenile not convicted of a crime could not be mingled with criminals in a federal correctional facility. Kautter v. Reid, 183 F. Supp. 352 (D.D.C. 1950), held that a juvenile could not be held in a local jail after violating his parole. The court noted that constitutional safeguards had been disregarded in juvenile proceedings, "and it seems fundamental to this Court, ... that this disregard is warranted only if proper facilities are, in fact furnished." Id. at 354. Gault simply carries this philosophy to its limits. More recently, the D.C. Circuit has in terms extended the right to treatment to juveniles, holding that a juvenile held for trial in juvenile court had a right to receive needed psychiatric care, having been granted "a legal right to a custody that is not inconsistent with the parens patriae premise of the law." Creek v. Stone, 379 F.2d 105, 111 (D.C. Cir. 1967).

54. 387 U.S. at 13-14, 30.

55. 387 U.S. at 21-22.
confinement. They have held that a sexual psychopath, never convicted of a crime, could not be held in prison as part of his "treatment";60 that prisoners near the end of their terms could not be held indefinitely in prison (awaiting establishment of a treatment center) when they were found to be sex offenders;67 and that judges before giving indeterminate sentences to sex offenders should be "reasonably certain that treatment will be given."68

These cases,69 taken with the dicta in Rouse, suggest the following minimum constitutional limitations upon civil confinement for mental disorder. First, if the state is to confine someone because he is dangerous, with no promise of treatment, it must do so under statutes with clearly defined standards and with procedures approaching those of the criminal process in rigor. The permissible standard for "dangerousness" is a separate question, with constitutional dimensions of its own. States should not be allowed, for example, to prove dangerousness solely by showing commission of a minor property crime, or the prediction of one.60 Second, where procedure is slighted, only a finding of treat-

56. In re Maddox, 351 Mich. 358, 88 N.W.2d 470 (1958). Maddox had been under treatment at Ionia State Hospital, and challenged his confinement after being transferred to the state prison. He was confined under nearly the same conditions as were regular prisoners, sending him back to the hospital, the court noted:

57. [It is necessary that the remedial aspect of confinement . . . have foundation in fact. It is not sufficient that the Legislature announce a remedial purpose if the consequences to the individual are penal. While we are not now called upon to state the standards which such a center must observe to fulfill its remedial purpose, we hold that a confinement in a prison which is undifferentiated from the incarceration of convicted criminals is not remedial so as to escape the requirements of due process. Commonwealth v. Page, 339 Mass. 313, 317-18, 159 N.E.2d 82, 85 (1959). The center was later set up, and approved by the court in Commonwealth v. Hogan, 341 Mass. 372, 170 N.E.2d 327 (1960). See pp. 107-08 infra.]


59. However, some courts have rejected the due process arguments. In People ex rel. Anonymous v. La Burt, 14 App. Div. 2d 560, 218 N.Y.S.2d 738 (1961) a New York court refused to consider evidence on inadequate treatment, saying:

60. Precisely what standards and procedures should be required is a question beyond the scope of this Comment. In general, however, several kinds of decisions will have to be made: (1) Whether basic procedural guarantees such as confrontation, notice, counsel, and jury trial should apply. Common sense and Gault demand that they obtain in the dangerousness proceeding. (2) Where the burden of proof is to be placed. Considering the nature of the proceeding, it should certainly be on the state, both on the mental disease and dan-
Right to Treatment

ability and actual adequate treatment of the person committed can justify continued detention. Such a limited right to treatment has certain advantages over the more wholesale assault upon civil confinement implicit in any Eighth Amendment challenge. It does not press courts into the dilemma of either releasing dangerous individuals or so watering down the notion of treatment as to have no effect on current practice. It allows the confinement of the dangerously insane, but under strict standards and procedural safeguards. It allows informal confinement for treatment where treatment is possible and actually available. And it requires the treatment or release of the harmless and neglected.

An equal protection argument for a right to treatment, noticed by Judge Bazelon in Rouse, and adopted by the Fourth Circuit in Sas v. Maryland, seems conceptually only a special case of the due process gerousness questions. (5) What quantum of proof should be required. The usual commitment standard of "weight of the evidence" will not be enough as the dangerousness proceeding is separated and examined. Because of the nature of the judgments involved, "beyond a reasonable doubt" may not be a practical alternative, and a point in-between may be best. See Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 79 Harv. L. Rev. 1288 (1966); Comment, Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release, 34 U. Chi. L. Rev. 652, 654-59 (1967). (4) Finally, and perhaps most importantly, what kinds of acts are to provide the content for the notion of dangerousness. Certain limits may have to be set down in the statute itself, or courts may have to exclude certain types of acts as insufficient in themselves. It would not do, for example, for dangerousness to be made out on the prediction that the subject will commit a misdemeanor if left free; the likelihood of physical harm to persons should predominate. Where the allegation is that the respondent is dangerous to himself, the notion of physical danger also predominates, with the proviso that helplessness raises a presumption of that danger. See Overholser v. Russell, 283 F.2d 195 (D.C. Cir. 1960) (any "criminal act" enough); Overholser v. Leach, 257 F.2d 667 (D.C. Cir. 1958) ("reasonably foreseeable" danger); 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).

This same set of problems applies to the decision to release a person committed under this system. Since treatment here is not the sine qua non of confinement, it is essential that regular review of dangerousness be provided.

61. A detailed treatment plan need not be presented at this point, but the court should require expert opinion that the subject's illness is amenable to treatment, and a showing that a facility capable of providing treatment is available.

62. The scheme advocated here could operate in the context of one commitment statute, but two separate procedures would seem preferable. This would make the dangerousness proceeding, with its criminal-type procedural safeguards, more visible, and leave the treatment route like present medical certification, with the added requirement that both treatability and the availability of facilities must be proved. This is not to suggest that there be no attempt to treat those committed for dangerousness, but rather that lack of treatment does not remove the state's right to confine in their case. Insuring their treatment will have to be done without the weapon of court-ordered release, probably by nonjudicial efforts. See pp. 114-16 infra.

Where the individual is shown to be sufficiently dangerous to be committed, but also treatable, difficult problems are presented. Perhaps courts could be armed with the power to force the state to use the treatment route, or to use treatment orders short of outright release.

63. 334 F.2d 506 (4th Cir. 1964).
The doctrine just outlined. In Sas, the Fourth Circuit suggested that Maryland's defective delinquent law discriminated against mentally disturbed defendants by confining them for indeterminate periods to a state hospital, while "normal" persons convicted of the same crimes received determinate sentences; the distinction could only be justified if actual treatment were provided in the institution for defectives. A due process rationale would require either that actual treatment be provided the defectives, or that they be shown to be dangerous in some way that ordinary criminals are not, under clearly defined standards and with procedural safeguards close to those of the criminal process. Civil commitment for dangerousness, however, does fulfill the primary equal protection requirement of a rational classification. The "sentence" is indeterminate because of a finding that the defendant is dangerous in a sense beyond that implied by his conviction. The dangerousness is presumed to stem from affected behavior controls, which cannot be expected to respond to punishment in any fixed length of time. If the Eighth Amendment argument is rejected, this justifies further preventive detention.

III. Enforcing a Right to Treatment

If either the cruel and unusual punishment or the due process rationale is adopted, courts will face the problem of defining the standard of treatment which justifies continued confinement. The multiplicity of possible treatments and the institutional incompetence of courts to evaluate them in detail require a careful effort to sort out legal issues appropriate for judicial decision and medical issues best left to experts in that profession.

A. Which Right to Treatment?

In Rouse Judge Bazelon tentatively defines the standard for treatment as that adequate "in light of present knowledge." But this standard is not found in the statute upon which the decision is based, nor is it the only plausible one. Why not treatment adequate in the light

64. In Baxstrom v. Herold, 383 U.S. 107 (1966), for example, the denial of equal protection lay in committing the prisoner without the due process hearing received by the ordinary committed person. This is consistent with the theory here advanced.
65. See Judge Bazelon's comment in Williams, quoted supra note 39.
66. If the right to treatment is never put on constitutional grounds, but remains a creature of statute, the following discussion would still be relevant in the process of administering it.
67. 373 F.2d at 456.
of the state's abilities or in the light of the resources allocated by the
state for that purpose? Why not some treatment, with virtually any
colorable treatment satisfying the requirement? Finally, why not the
right to one particular form of treatment as opposed to another?

Judge Bazelon noted in his Rouse opinion that the possibility of
better treatment does not mean that one being provided is inadequate,68
and indeed it would be a serious mistake for courts to undertake to
determine and require the "best" treatment. Judge Bazelon does, how-
ever, seem to envision courts choosing between therapies on the basis of
their relative adequacy and the patient's particular needs.69 But courts
may be ill-suited to choose among competing schools of psychotherapy.
What is needed is a workable definition of responsible treatment which
judges can apply to curb negligent or palpably inappropriate treatment
without unduly encouraging litigation or straitjacketing the medical
profession.

Upon examining the literature of psychotherapy, one is immediately
struck by the bewildering array of schools of thought, theories, and
points of view concerning therapeutic techniques, few with enough
empirical support to justify conclusive assertions about their effective-
ness.70

The most effective form of therapy for many disorders, one-to-one
communication between patient and doctor over an extended period,
is probably impossible for state hospitals to use except with selected
patients. The typical state institution has thousands of patients; individ-
ual therapy would require a staggering number of psychiatrists and
psychologists. Unless massive additional resources are devoted to this
task, psychotherapy will never be available on an individual basis to
more than a minority of state patients.71

Various forms of group therapy are offered in the state hospitals,
though they are necessarily limited in the number of participants ac-
commodated at any one time.72 Occupational therapy is available, but
varies from meaningful job training to little more than hard labor. Its
effectiveness in treating certain types of disorders is advocated by a

68. Id. at 456-57.
69. Id. at 456.
70. For a series of volumes on current practices and new therapeutic ideas see CURRENT
71. Cumming, Cumming, Kennard & Hoffman, Social Structure and Patient Care in the
Large, Public Mental Hospital, in The Patient and The Mental Hospital 36, 38 (M. Green-
balt, D. Levinson & R. Williams eds. 1957). On the difficulties of the large-scale use of
psychoanalysis see ACTION FOR MENTAL HEALTH 79-80.
72. See generally R. White, The ABNORMAL PERSONALITY 343-50 (3d ed. 1954) [herein-
after cited as WHITE], and sources cited.
The responsible segment of the psychiatric community. Recreational therapy is in widespread use, and has been found to be of some value. In some hospitals experimentation is carried out with psychodrama, a form of therapy in which patients prepare and stage scenes for other patients and staff.

Drugs are administered freely in most state hospitals, though generally for quieting patients and making them more amenable to other types of therapy, rather than as a separate form of treatment. Various types of somatic therapies, such as insulin shock and electro-convulsive therapy, also have their adherents, especially in the treatment of psychoses which are acute or of sudden onset. The continuing research into the nature of mental illness, moreover, produces and will continue to produce a constant stream of new therapies—chemical, physical, and psychological. The efficacy of these modes of treatment is often hotly disputed, and the debates reflect the inconclusive evidence advanced by the theorists who tout either the psychological or the physiological origin of mental disease.

As if the problem of deciding which, if any, of these therapies may be adequate for a specific individual were not difficult enough, other ways of dealing with mental disorder are sometimes responsibly advocated as therapies. Some doctors feel that punishment itself is treatment for some anti-social individuals, or that it will at least make them more likely to accept other forms of treatment—a theory which, if carried too far, could render any constitutional right to treatment meaningless. Far more common is the assertion that simple custody of the mental patient, away from society and its stresses and free from day-to-day responsibility, is treatment. Thus it might be possible to argue that the simple custody, herein contrasted with treatment, has itself the same beneficial effect on the individual and thus justifies detention.

Another school of fairly recent origin has transformed many American mental institutions through what is variously called environ-

---

73. See, e.g., Conte, Occupational Therapy in the Psychoses, in 2 CURRENT PSYCHIATRIC THERAPIES 227 (J. Masserman ed. 1962).
74. See generally ACTION FOR MENTAL HEALTH 39-46; WHITE 47, 505-07, and sources cited; Lehman, The Psychotropic Drugs: Their Actions and Applications, 2 Hospital Practice 74 (1967).
75. See generally WHITE 45-47, 504-06, and sources cited.
76. On one important battleground in the continuing dispute—the source of schizophrenia—see N.Y. Times, Nov. 6, 1966, § 6 (Magazine), at 34.
77. The state psychiatrist argued this in the Maddox case. 351 Mich. at 865-66, 88 N.W.2d at 474. It is also suggested by the court's findings in Daniels. 249 Md. at 58-59, 221 A.2d at 422. On the historical notion of punishment as treatment see ACTION FOR MENTAL HEALTH 25-28.
mental or milieu therapy. This approach entails a recognition that the hospital social structure itself can be a powerful force for rehabilitation of the mentally ill. Morris S. Schwartz has summarized the system in these terms:

Descriptive adjectives that are used to designate a “therapeutic” social structure include: Democratic (as compared with authoritarian); treatment-oriented (as contrasted with custodial-oriented); humanitarian (instead of oppressive); flexible (as opposed to rigid).

The movement toward these objectives has meant opening more wards, liberalizing and civilizing the patient's living patterns, and allowing therapeutic roles to be performed by nurses and other staff members. There is some controversy over whether this sort of program is really treatment at all, or merely a precondition or a setting for treatment. The movement nonetheless exerts a powerful influence on contemporary thought. Its characteristics are so flexible and general that it may often be found in bogus form, making the job of determining adequacy of treatment even more difficult.

B. Judicial Supervision of Treatment

How then is a court to decide whether a person has been adequately treated or is receiving treatment now? In this field judges will have but meager standards to guide them if they attempt to supervise the treatment process by choosing one type of treatment over another.

78. The terms are often misused, and perhaps refer more properly to an attitude about treatment than to a specific body of techniques. The notion of milieu therapy can be distorted by simply labelling custodial functions, in fact any contact with the patient, a part of the therapeutic environment, without any real change in the attitude toward treatment.

The literature on milieu therapy is becoming voluminous. For a brief but useful view of the therapeutic program at the Yale Psychiatric Institute, one of the leaders in milieu techniques, see Psychoanalysis, Psychiatry and Law 659-64. See generally J. Cumming & E. Cumming, Ego and Milieu (1953); M. Edelson, Ego Psychology, Group Dynamics and the Therapeutic Milieu (1954); M. Greenblatt, R. York & E. Brown, From Custodial to Therapeutic Care in Mental Hospitals (1955); M. Jones, The Therapeutic Community (1955); The Patient and the Mental Hospital (M. Greenblatt, D. Levinson & R. Williams eds. 1957); A. Stanton & M. Schwartz, The Mental Hospital (1954).


81. Improvement of the patient, of course, is not a reliable index of whether he is being treated, at least within reasonable time limits. Studies have shown that for some disorders there is a spontaneous remission rate as high as 20 per cent without any treatment. Action for Mental Health 52. On the other hand, some patients will not recover no matter what treatment is attempted.

Whether a given patient receives a given treatment is a product of many factors, including the availability of facilities, the patient's age, his intelligence, his social class, and the kinds of treatments being administered to others in the hospital.
If they take a conservative view, experimental techniques may be discouraged; if they view the choice too broadly, few patients will ever be able to prove they are not being treated adequately.

Few courts have plunged into the difficult area of evaluating treatment and treatment facilities. In *Commonwealth v. Hogan*, the Massachusetts Supreme Judicial Court considered the adequacy of the State’s treatment facilities for sex offenders. The defendant was confined in a closed wing of the state hospital for the criminally insane, with some separate staff but occasional mingling with other inmates. The court reiterated an earlier holding that mere incarceration under the statute would violate due process, but found that the treatment center envisioned “had foundation in fact.” The opinion did not inquire deeply into the requirements for treatment, consider psychiatric sources, or examine the specific treatment being given Hogan. It seemed satisfied with the mere fact that a recognizably separate facility had in fact been established. It did note that the center left much to be desired, adding:

> We cannot assume that the necessary action to establish a fully adequate treatment center, already begun, will not be carried to completion. If it should later appear that it has not, a different question will be presented.

Recently the Maryland courts have made a more searching inquiry into the adequacy of treatment. In *Director of Patuxent Institution v. Daniels* the court of appeals adopted a lower court opinion upholding the adequacy of treatment provided in the state institution for defective delinquents. In the course of the trial, eight days of oral testimony was received from eminent experts such as Dr. Karl Menninger, Dr. Manfred Guttmacher, Dr. Philip Roche, and Dr. Jerome Frank; some 64 printed or written exhibits concerning the operation of Patuxent Institution were also introduced. The inquiry was not as specific as that demanded in *Rouse*; the court did not examine Daniels’ particular diagnosis or the treatment he was receiving at the institution. Instead it was content to examine treatment methods generally to determine whether they brought the institution above the level of

---

82. 341 Mass. 372, 170 N.E.2d 327 (1960). After the court’s decision in *Page*, the state set up a facility for sex offenders, and in *Hogan* the court reconsidered its ruling in light of that fact. See note 57 supra.


84. 341 Mass. at 377, 170 N.E.2d at 330.

Right to Treatment

the merely penal. The court also was willing to look more to the legislative ideal than to reality, asking only

whether or not the act is reasonably calculated to achieve its legislative purpose, leaving for the legislative and executive branches of the government a determination of whether in fact it is accomplishing its legislative purpose.86

The Rouse opinion does acknowledge the problem of standards and suggests several ways out of the judicial morass:

Counsel for the patient and the government can be helpful in presenting pertinent data concerning standards for medical care, and . . . the court may appoint independent experts. Assistance might be obtained from such sources as the American Psychiatric Association, which has published standards and is continually engaged in studying the problems of mental care. The court could also consider inviting the psychiatric and legal communities to establish procedures by which expert assistance can be best provided.87

These methods, however, may not be adequate to the purpose. If a patient is simply locked up in a cell and never seen by hospital staff members, the decision will be relatively easy (unless the claim is that he is receiving punishment therapy), but what if the doctors testify at length that a patient is receiving recreational therapy and is living in a therapeutic milieu which is reforming his shattered ego? Judge Bazelon seems to feel that standards or categories can be developed to label milieu therapy adequate for certain types of disorders and not for others, but difficulties are apparent. There will be a significant divergence of expert opinion on the questions of appropriateness and effectiveness,88 and undoubtedly much reluctance on the part of psy-

86. Id. at 41, 221 A.2d at 411.
87. 373 F.2d at 457 (footnotes omitted).
88. Just as there is controversy among psychiatrists over the meaning of mental illness itself, particularly concerning such fringe disorders as psychopathy. See note 21 supra. On the concept of mental illness see B. Wootton, SOCIAL SCIENCE AND SOCIAL PATHOLOGY ch. VII (1959); M. Jahoda, CURRENT CONCEPTS OF POSITIVE MENTAL HEALTH (1958).
Diagnoses of mental disorder often differ widely, as almost any case in which the insanity defense is raised will show. This was true in the Rouse case. Ridgeway, Who's Fit to Be Free?, New Republic, Feb. 4, 1967, at 24-26.
There is also disagreement over whether a given diagnosis constitutes a mental disease or defect, and this problem has contributed to the criticism of the Durham rule. The broadened insanity defense turned the law's attention, rightly or wrongly, toward disease entities, many of which are not clearly enough delineated. The opposition of so many courts and legislatures to such a standard can be traced in part to a recognition of the vagueness of the definition of mental illness and the lack of clear standards for making judgments about it. Insofar as this criticism is well-founded, and it has been widely articulated, it is even more relevant to the determination of adequacy under a right to
chiatrists to confine and narrow the applicability of the various modes of treatment. There are no easy standards, except in the grossest cases of neglect. Even the American Psychiatric Association standards suggested by the court do not compare therapies but merely set out manpower requirements for adequacy; significantly, no state hospital in the country presently meets these requirements.

In response to the call for assistance in the Rouse opinion, and probably in some alarm over its possible consequences, the American Psychiatric Association recently released a position statement on the adequacy of treatment. It contends that "[t]he definition of treatment and the appraisal of its adequacy are matters for medical determination," but sets down seven considerations relevant in determining whether a patient is receiving adequate treatment: (1) The purpose of hospitalization, and differences between, for example, long-term and short-term treatment programs; (2) The degree to which treatment is revised as diagnosis develops during institutionalization; (3) The need to protect the patient from self-inflicted harm; (4) The importance of interrupting the disease process, as in separating the addict from his drugs or the psychotic from his family stress situation; (5) The effective use of physical therapies; (6) Efforts to change the emotional climate around the patient, which seems to mean roughly milieu therapy and related measures; and (7) The availability of conventional psychological therapies. The statement goes on to stress the importance of considering the limitations of the staff and facilities at hand, and the need for cooperation by the patient in his treatment.


For a case graphically illustrating the dilemma of a court faced with two widely divergent expert views on proper treatment, raised in the context of incompetence to stand trial, see United States v. Klein, 325 F.2d 283, 286 (2d Cir. 1963): Mental disorders being what they are, it is not surprising that eminent psychiatrists differ as to methods of treatment. Here, Dr. Shoenfeld believed that Klein would respond to a psychoanalytic form of therapy; Dr. Douglas, by his own testimony, favored a more physiological approach. Courts of law, unschooled in the intricacies of what may be the most perplexing of medical sciences, are ill-equipped to choose among such divergent but responsible views. In a case such as this, where a man’s life may literally hang in the balance, a judge ought not undertake the hazardous venture of changing the course of psychiatric treatment without, at the least, a much fuller hearing and a far greater preponderance of expert testimony than existed here (footnotes omitted).

89. AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS (1958).
90. 373 F.2d at 458.
92. Id.
93. Id. 1458-59.
Right to Treatment

While it certainly provides some guidance, this framework leaves too much discretion to the hospital and too little substance to the right to treatment.

The court in *Rouse* suggests an analogy to malpractice cases to buttress its conclusion that judgments of adequacy of treatment are manageable. The expensive and inconclusive battles of experts, followed by grab-bag jury verdicts, which mark those cases do not make a happy precedent. And in physical medicine there is relative certain compared with psychotherapy, both in diagnosis and in the efficacy of particular treatments. In the psychiatric malpractice field, the courts have exhibited extreme reluctance to examine the issues of treatment and great confusion in trying to decide when negligence has occurred. Most of the cases involve such matters as discharge or failure to prevent escape from an institution, not the superiority of one treatment over another. Moreover, the malpractice field has at least one legal issue with which courts have grappled in other contexts and feel at home, if only to a limited degree—negligence. In the right to treatment cases even this touchstone will be absent, and courts may well feel even further at sea amidst conflicting expert opinion.

Another perplexing problem is whether the court should consider the state’s capabilities and resources. Bazelon says in *Rouse* that “[c]on-
tinuing failure to provide suitable and adequate treatment cannot be justified by lack of staff or facilities."\textsuperscript{98} He recognizes "that shortage of psychiatric personnel is a most serious problem today in the care of the mentally ill,"\textsuperscript{99} but feels that the right is too important to be qualified in this way. His position seems basically sound; the result of a finding that inadequate treatment is available will normally be either release or, for those for whom the state wishes to prove sufficient dangerousness, a full hearing under due process standards. For courts who interpret the right to treatment as requiring only \textit{an accepted treatment}, and not the best one, it is reasonable to ignore the state's abilities. But care must be taken not to define "adequate treatment" so that it will be impossible for any hospital to provide it.\textsuperscript{100}

The meaning of the constitutional command to treat, if such there be, is not that courts must assume the role of forcing the psychiatric profession toward an ideal but unrealizable system, but that bona fide treatment be made available. There is some danger that in insensitive hands this right can backfire by forcing a retreat from the attempt to rehabilitate that has marked much of recent social history. If too high a standard of treatment is imposed, less conscientious states may desire to abandon all pretense of providing public treatment and confine their mental health programs to preventive detention of the dangerous. States would not be free to define "dangerousness" in any way they chose for commitment purposes, however.\textsuperscript{101} Yet another danger is that the states, faced with the prospect of having to release, say, treatable property offenders, might use habitual offender statutes to accomplish the same end.\textsuperscript{102}

Another problem arises if the state claims that the patient's unwillingness to accept treatment, and not hospital shortcomings, prevents adequate treatment.\textsuperscript{103} This was one of the answers given by the hospital in Rouse's case. It will obviously not do to allow the state to avoid its responsibilities indefinitely on these grounds. If the patient

\textsuperscript{98} 373 F.2d at 457.
\textsuperscript{99} Id. at 458.
\textsuperscript{100} Insofar as the profession articulates its current standards of adequacy, they will reflect present limitations of resources, which inevitably influence judgments of how much treatment, or what kind or treatment, is proper.
\textsuperscript{101} See note 60 supra.
\textsuperscript{102} Indeterminate sentencing laws, which are becoming more popular, could also be attacked on the \textit{Rouse} rationale if the rehabilitation upon which release depends is not offered by the state. Like habitual offender statutes, they show the continuity of "civil" and "criminal" detention methods, and may \textit{have} to be controlled if we are to insist upon the reality of the rehabilitative ideal. See \textit{generally} A. GoLESTEIN, \textit{THE INSANITY DEFENSE} (1967).
\textsuperscript{103} As a medical matter, the patient's willingness to cooperate in treatment is often crucial. G. HOLLAND, \textit{FUNDAMENTALS OF PSYCHOTHERAPY} 36 (1965); \textit{White} 313.
Right to Treatment

can successfully reject all treatment, then under our analysis he must either be released or given his fair hearing if dangerousness can be established. Of course, a different problem is presented if the patient profits by treatment despite strenuously opposing it.

Even where the patient rejects and cannot profit from treatment, there may be cases where the patient's doctors require a certain period of time to interrupt the disease process and change the patient's worldview sufficiently to allow the beginning of therapy. In such situations, the rejection of treatment is part of a larger, and more properly medical judgment—the timing of treatment. As the American Psychiatric Association statement indicates, this interruption and reorientation period can be crucial as a prelude to treatment. In these cases, which will ordinarily be confined to the first stages of institutionalization, courts must scrutinize the appropriateness of the initial period of inactive therapy and limit its duration by allowing a habeas corpus petition to be reinstated after a certain time has elapsed. They must also be alert, of course, for situations in which the supposed delay is nothing more than custodial confinement, with no clear plans for the future; but by the same token they must not prematurely release patients for whom reasonable and adequate treatment plans have been made.

A final argument state authorities may make is that a given patient is not receiving treatment because he is untreatable. Some types of psychotics and many psychopaths are not now susceptible to treatment in the true psychiatric sense. This claim should not suffice either. A precondition of commitment for treatment is a finding of treatability. The untreatable patient must be released or, with the necessary procedural safeguards and strict definitional standards, committed for dangerousness.

104. This is particularly true of individual psychotherapy. On phases of treatment, see THE PATIENT AND THE MENTAL HOSPITAL 174 (M. Greenblatt, D. Levinson & R. Williams eds. 1957).

105. A study of two hospitals in large eastern states indicated that doctors felt only between 10 and 25 per cent of patients could benefit from psychotherapy at any given time, but much of this must be attributed to poverty of facilities. Note, Hospitalization of Mentally Ill Criminals in Pennsylvania and New Jersey, 110 U. Pa. L. Rev. 78, 85-88 (1961).

106. Organic cases represent one such class. As to schizophrenia, see S. Ahearn, INTERPRETATION OF SCHIZOPHRENIA 480 (1955).

107. Since psychopaths typically feel no anxiety about their conduct, motivation for therapy is often missing. Many hospitals do not even like to admit psychopaths because they can be a disrupting influence. For current efforts, see 2 CURRENT PSYCHIATRIC THERAPIES 189-83 (J. Masserman ed. 1962). See also the extended discussion of the efforts and success of Maryland's treatment program in Director of Patuxent Institution v. Daniels, 243 Md. 16, 221 A.2d 397 (1966).
The difficulty of judicially determining adequacy of treatment imposes practical limits on the scope of court review. Courts should concentrate on finding whether an adequate treatment program is present, not on what is the best possible method of therapy.\textsuperscript{108} Using all the expert opinion available, judges should adopt manageable criteria for judging adequacy. Courts or juries should not be called upon to settle genuine disputes between experts as to whether a given course of treatment meets a judicially defined standard of adequacy. Where a substantial body of \textit{independent} opinion exists indicating that a certain form of therapy is sound for the type of patient before the court, the treatment should be found adequate.

The factor of independence should be stressed, however; the word of the state's mental hospital staff should not be taken against the united opinion of the profession. When professional opinion is not united, the task is certainly more difficult, but the court should discount the arguments of "house doctors" by a factor that may well vary with the quality of the house. Forms of "therapy" apparently derived from the institutional pressure to change state hospitals as little as possible should be viewed with particular suspicion.

IV. Conclusion

The difficulties inherent in judicial implementation of a right to treatment suggest that courts should perhaps limit their role in the mental health process to that of strategic intervenor, using constitutional doctrine to spur public adoption of more suitable means of control. As in the area of police practices, constitutional doctrines can be framed as an invitation to legislative reform.\textsuperscript{109}

The job of determining adequacy of treatment could perhaps be

\textsuperscript{108}. In one sense this would be a two-stage process, since it will be necessary to decide whether an adequate type of treatment is being attempted, and whether the attempt is being carried out adequately. There are indications that the D.C. Circuit may be developing its definition of adequacy cautiously:

We do not suggest that the court should or can decide what particular treatment this patient requires. The court's function here resembles ours when we review agency action. We do not decide whether the agency has made the best possible decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion.


\textsuperscript{109}. In \textit{Miranda} the Court made clear its hope that states would explore alternatives:

Our decision in no way creates a constitutional strait jacket which will handicap sound efforts at reform, nor is it intended to have this effect. We encourage Congress and the States to continue their laudable search for increasingly effective ways of protecting the rights of the individual while promoting efficient enforcement of the criminal law.

performed best by an independent administrative agency. In many states today inmates' complaints are heard by a state Mental Health Commission, which itself administers the state's hospital system. What may be needed is an agency composed of legal and psychiatric experts, freed from administrative burdens and independent of hospital administrators, clothed with real power to hear complaints about inadequate treatment and to act upon them.

New York's recently adopted commitment system suggests what an administrative solution might look like. There patients involuntarily committed have automatic renewal hearings, and the state cannot continue to restrain unless it can once again prove mental illness or dangerousness. Review of the treatment process could be provided on such a basis, with courts exercising their normal powers of review over the agency's action.

An administrative solution might make a right to treatment more meaningful for the patient by eliminating some of the burdens attendant upon the judicial method of habeas corpus petitions. In order to assert his right to adequate treatment effectively in court, the often ignorant and indigent patient must know of the availability of the writ, and be able to procure counsel and psychiatric witnesses in his behalf.

Under an administrative system with a requirement of periodic renewal of authority for restraint by the state, the burden of justifying continued detention would be shifted to the state. The cost to society of providing fair representation and expert help to the patient might be lessened by using relatively informal administrative proceedings.

Whether courts or administrative agencies perform the task of reviewing treatment, the problems of fashioning appropriate orders must be faced. Successful prosecution of the writ of habeas corpus has traditionally meant release from illegal custody, but in *Rouse* Judge Bazelon makes it clear that he does not consider the court restricted to that single disposition. He discusses the alternatives to release, and the considerations making each appropriate.

For those persons the state can prove sufficiently dangerous to meet constitutional requirements for preventive detention, confinement may be continued after a full hearing. The agency supervising treatment may, in addition, be clothed with powers to require treat-

110. E.g., *New York Mental Hygiene Law* § 86 & n.6 (McKinney 1951).
111. Id. § 73 (McKinney, Supp. 1967).
112. 373 F.2d at 458-59.
113. See notes 60-61 supra.
ment, even though release is not the alternative for this class of patients. For patients committed solely because of the need for treatment, several kinds of orders might be appropriate. Courts at least should avoid ordering specific types of treatment where one adequate form of therapy is already being employed. On the other hand, where no treatment or palpably mistaken treatment is being administered, the supervising body may want to order specified or unspecified treatment and maintain jurisdiction to insure that its order is carried out. It may order transfer to a different institution where appropriate treatment is available, including the out-patient and clinic facilities now being developed. The power to release if adequate treatment is not forthcoming remains the residual remedy.

114. See Lake v. Cameron, 267 F. Supp. 155 (D.D.C. 1967). The court of appeals, finding that Mrs. Lake was senile and prone to wandering, ordered an inquiry into a disposition other than commitment to St. Elizabeth’s. The district court found that there were no other appropriate facilities in the area:

The requirement of constant supervision necessarily restricts the availability of other alternative courses of treatment. . . . This reality precludes this Court from ordering her to accept community mental health and day care services, from ordering her to accept various family service agency services, or neighborhood supervision, or part-time supervision from social workers in petitioner’s neighborhood.

Id. at 159. Noting that the court of appeals wanted the lower court’s inquiry to uncover the needs for new facilities, the court added:

While the opinion of the majority speaks mainly in terms of facilities, the statute speaks in terms of treatment. To be sure, the facility may be an element of treatment, but the facility as an entity itself, does not appear approachable under the statute.

Id. at 160.