Tort Liability of the Mentally Ill in Negligence Actions

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Courts have generally held the mentally ill defendant to the same objective standard of tort liability as an average defendant. In contrast, courts have often relied on a subjective standard to find mentally ill plaintiffs incapable of contributory negligence. In the past two decades, critics have argued that in light of dramatic changes in society’s conceptualization and treatment of the mentally ill, the objective standard is no longer appropriate and courts should apply a subjective standard to both mentally ill defendants and mentally ill plaintiffs. The consensus of recent opinion

1. Tort liability for negligence is determined by employing a “reasonable person” standard. Negligence is generally defined as the failure “to do something which a reasonable man, guided by those ordinary considerations which ordinarily regulate human affairs, would do, or the doing of something which a reasonable and prudent man would not do.” Black's Law Dictionary 930 (5th ed. 1979). An objective standard makes no allowances for a particular individual’s capacities or idiosyncrasies. Under an objective standard, a mentally ill person is liable for any tort for which a “normal” person would be held liable. Under a subjective standard, however, a person’s conduct is judged in light of that particular individual’s qualities and abilities rather than those possessed by the “reasonable person.” A subjective standard would take into account a person’s mental illness and hold the person to a less stringent standard of tort liability than that for a normal person. If a person's mental illness were sufficiently severe to prevent him from exercising “reasonable care,” then he would not be found liable for negligence in cases where the average person would be held liable. Thus, the subjective standard may be said to afford, in practice, a defense or type of immunity to tort liability. See generally Seavey, Negligence—Subjective or Objective?, 41 Harv. L. Rev. 1 (1927) (discussing merits of objective versus subjective standards of negligence).

2. The reforms in mental health law over the past two decades have generated substantial litigation and legislation governing the rights of the mentally ill. The use of involuntary commitment has been of particular concern. See, e.g., O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) (no constitutional basis for involuntary confinement of the mentally ill if they are not dangerous and can live safely in the community); Jackson v. Indiana, 406 U.S. 715 (1972) (defining constitutional limits on involuntary civil commitment of persons found incompetent to stand trial). See generally Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190 (1974) (review of case law and statutory developments); Note, Procedural Safeguards for Periodic Review: A New Commitment to Mental Patients’ Rights, 88 Yale L.J. 850 (1979) (discussing procedural protections for limiting the duration of involuntary hospitalization).

3. See Curran, Tort Liability of the Mentally Ill and Mentally Deficient, 21 Ohio St. L.J. 52, 74 (1960) (critique of tort law based on “analysis of modern psychiatric classifications of mental illness,” asserting need to base tort liability on factors related to specific mental illnesses); Ellis, Tort Responsibility of Mentally Disabled Persons, 4 Am. B. Found. Research J. 1079, 1107-09 (1981) (asserting need to adopt either subjective standard or new defense of objective standard since policy rationales supporting current tort standards for mentally ill have become questionable in light of recent scientific and legal developments); Seidelson, Reasonable Expectations and Subjective Standards in Negligence Law: The Minor, the Mentally Impaired, and the Mentally Incompetent, 50 Geo. Wash. L. Rev. 17, 38-44 (1981) (concluding that tort standard for mentally ill is “almost facially unfathomable” and arguing for adoption of subjective standard); Comment, The Tort Liability of Insane Persons for Negligence: A Critique, 39 Tenn. L. Rev. 705, 723 (1972) (common law position should be rejected because of unsound policy grounds and replaced with “disorientation” rule). But see Alexander & Szasz, Mental Illness as an Excuse for Civil Wrongs, 43 Notre Dame Law. 24 (1967) (objective standard appropriate since mental illness a “myth”).
appears to support this proposed adoption of a subjective standard in "primary" negligence cases.\(^4\)

In contrast, this Note will argue that current mental health policy, treatment, and research indicate that an objective standard is more appropriate for the mentally ill.\(^5\) This objective standard should be used for both mentally ill plaintiffs and defendants to obtain consistency in the law and fairness in policy.

I. THE TORT LAW ON NEGLIGENCE AND THE MENTALLY ILL

There has been continuing controversy and uncertainty regarding the appropriate standards of tort liability for the mentally ill. At common law, mentally ill defendants are held to an objective standard to determine liability, whereas mentally ill plaintiffs are held to a subjective standard to determine contributory negligence.

A. Primary Negligence

The issue of the tort liability of the mentally ill was still unresolved in the United States in the early 1900's.\(^6\) Existing English cases presented conflicting authority, and contemporary commentators had adopted divergent opinions on the state of the law.\(^7\) Only one American case, *Williams v. Hays*,\(^8\) had considered the issue, and held that a mentally ill person was liable for negligence. Unfortunately, both the reasoning and principle of *Hays* were obscured by numerous appeals, reversals, and retrials.\(^9\)

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\(^4\) "Primary" negligence occurs when the mentally ill person is the tortfeasor. "Contributory" negligence occurs when the mentally ill plaintiff negligently contributes to his own injuries.

\(^5\) This Note addresses only the tort liability of the mentally ill, focusing on the chronically mentally ill—those persons who may live in the community but who throughout their lives will require intermittent or continual medication, psychotherapy, or brief hospitalization. The Note does not examine cases involving the mentally retarded or persons suffering from organic brain dysfunctions.

The case law concerning tort liability of the mentally ill often makes no distinction between intentional and negligent torts. In some cases, however, the mentally ill have not been held liable for torts requiring malicious intent, such as defamation, and courts generally disallow punitive damages against mentally ill defendants. For a thorough review of the case law broken down by type of tort, see *Curran*, *supra* note 3, at 54-63.

\(^6\) For an historical review of case authority and statements of the law by early textwriters, see *Bohlen, Liability in Tort of Infants and Insane Persons*, 23 Mich. L. Rev. 9 (1924); *Hornblower, In insanity and the Law of Negligence*, 5 Colum. L. Rev. 278, 278 (1905) ("It is a singular fact and one not altogether creditable to our jurisprudence, . . . that in this Twentieth Century, the question of the liability of an insane person for tortious conduct . . . should remain to a large extent an open question.").


\(^9\) An insurer's subrogee sued the captain of a ship that went down in a storm. The plaintiff charged the captain with negligence in failing to acknowledge obvious damage to the ship's rudder post and in declining two offers of help from passing ships. The captain pleaded in response that he
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The confusion over the proper standard of tort liability for the mentally ill was reflected in the American Law Institute's Restatements. The first Restatement of Torts, published in 1934, stated that a "reasonable person" standard should be employed unless the actor is an "insane person." The Restatement expressed no opinion as to whether insane persons should be held to the objective reasonable person standard. The 1948 Supplement deleted this exception, explaining that while there had been insufficient authority in 1934 on which to base a definitive rule, enough authority existed by 1948 to hold the insane to an objective standard. The Restatement (Second) of Torts, published in 1965, unequivocally stated that the mentally ill were to be held liable for their torts. With only a few modern exceptions, the courts have consistently adhered to this common law rule. A few states have incorporated it into their

had remained continually on the bridge for 48 hours during the storm and that upon finally retiring he had taken quinine for his malaria. He claimed that exhaustion and quinine impaired his faculties and he could not be held responsible for his actions when called back to the bridge after problems with the rudder post developed. At the first trial, the jury was instructed that the captain, if found insane, was not guilty of negligence. The jury found for the captain. The court of appeals reversed, stating that the captain would not be negligent only if his insanity were solely the result of his efforts to save the ship. A new trial resulted in a directed verdict for the plaintiff. The court of appeals again reversed, holding that it was error for the trial court to find the captain liable regardless of whether his actions were the result of exhaustion. After this reversal the plaintiffs dropped the case. For a thorough discussion of the case, including extensive quotations, see Hornblower, supra note 6, at 294-95. See also Wilkinson, Mental Incompetency as a Defense to Tort Liability, 17 Rocky Mt. L. Rev. 38, 43 (1944) ("Williams v. Hayes is filled with the drama of the sea, but it is not very enlightening as to the law of the land.").

10. Restatement of Torts § 283 (1934).

11. A caveat stated: "The Institute expresses no opinion as to whether insane persons are required to conform to the standard of behaviour which society demands of sane persons for the protection of the interests of others." Id. at 744.

12. Restatement of Torts § 283 (Supp. 1948).

13. See id. at 658. The additional cases decided between 1934 and 1948 were relatively few and dealt primarily with intentional torts. See, e.g., McGuire v. Almy, 297 Mass. 323, 8 N.E.2d 760 (1937) (battery); Van Voren v. Cook, 273 A.D. 88, 75 N.Y.S.2d 362 (1947) (same). The Restatement cites only one additional case where a mentally ill person was held liable for negligence. Restatement of Torts § 283, at 654 (Supp. 1948) (citing Sforza v. Green Bus Lines, Inc., 150 Misc. 180, 268 N.Y.S. 446 (Mun. Ct. 1934) (bus driver became suddenly insane and collided with plaintiff)). The reporters, however, state that the language in the opinions holding the mentally ill liable for intentional torts is phrased broadly enough to include liability for negligence. Id.

14. "Unless the actor is a child, his insanity or other mental deficiency does not relieve the actor from liability for conduct which does not conform to the standard of a reasonable man under like circumstances." Restatement (Second) of Torts § 283B (1965).

15. See infra p. 160.

Courts have traditionally given four rationales for holding the mentally ill to an objective standard of tort liability. The most common is that the mentally ill should be required to compensate the victims of any damage they cause. A second frequently cited rationale is that a defense of mental illness raises evidentiary problems because of the difficulty of determining the existence and degree of mental illness and because of the possibility of a person's feigning mental illness. The two remaining rationales are less persuasive and have been given decreasing attention by the courts. One, cited mostly in early cases, is that holding the mentally ill liable will encourage their caretakers to exercise greater diligence in preventing them from committing torts. The other is that the difficulty
of distinguishing between mental illness and other variations in emotional, intellectual, or physical make-up would ultimately result in a complete erosion of the objective standard.\(^2\)

B. Contributory Negligence

In contrast to the use of the objective standard in primary negligence cases, the overwhelming majority of courts have held that a completely insane person is incapable of contributory negligence and that lesser degrees of mental impairment, not amounting to complete insanity, may be considered by the jury in determining whether the plaintiff is guilty of contributory negligence.\(^2\) A minority of courts have held that although completely insane persons cannot be held contributorily negligent, no lesser degrees of mental impairment may be considered.\(^2\)

No policy reasons for this distinction between primary and contributory negligence standards have ever been clearly articulated. Several factors, however, have been suggested. First, there is a vague supposition that the policy rationales supporting an objective standard in primary negligence cases have less force in cases of contributory negligence.\(^2\) Second, there seems to be less equitable discomfort in allowing mentally ill plaintiffs to recover since the mentally ill victim appears less threatening and more deserving of sympathy than a mentally ill tortfeasor who causes an injury.\(^2\) Third, the doctrine of contributory negligence is widely considered

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\(^2\) See, e.g., Jolley, 299 So. 2d at 648; \textit{Restatement (Second) of Torts} § 283B comment b(1) (1965).


\(^2\) See \textit{Restatement (Second) of Torts} § 464 comment g (1965). This may be true with regard to the compensation rationale; holding the mentally ill incapable of contributory negligence does not have the undesirable result of denying compensation to innocent victims. The evidentiary problems of determining the existence of mental illness, however, remain. \textit{See Ellis, supra} note 3, at 1091. \textit{See also Restatement (Second) of Torts} § 464 comment f (standard of care required for protection of oneself may differ from standard of care required for protection of others).

\(^2\) See Ellis, \textit{supra} note 3, at 1091-92.

\(^2\) \textit{See id.} at 1092.
to be too harsh; this approach thus provides a means of avoiding some harsh results.\textsuperscript{27}

No court appears to have formulated a new standard of care for mentally ill plaintiffs in states which have abandoned the doctrine of contributory negligence in favor of comparative negligence.\textsuperscript{28} In comparative fault states, the courts have been willing merely to carry over their approach under contributory negligence.\textsuperscript{29}

C. Criticisms of the Law

Legal commentators have criticized the common law doctrine of holding the mentally ill liable for their torts since its inception.\textsuperscript{30} The first criticisms appeared in the early 1900's, apparently in response to the case of \textit{Williams v. Hays}\textsuperscript{31} and to various commentators who declared the doctrine a settled principle of law.\textsuperscript{32} These early critics claimed that it was

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\item \textit{Seidelson, supra note 3, at 1091; Comment, supra note 3, at 722. The doctrine of contributory negligence is considered overly harsh because any negligence on the plaintiff's part bars recovery even though the defendant's negligence may have substantially caused the injury. See W. Prosser, \textit{Handbook of the Law of Torts} § 67, at 433 (4th ed. 1971).
\item There are two forms of comparative negligence. Under "pure" comparative negligence, no matter how great the plaintiff's contributory negligence is in comparison with the defendant's negligence, the plaintiff is not barred from recovery. Under "modified" comparative negligence, the plaintiff will be permitted partial recovery (fault is apportioned) so long as the plaintiff's contributory negligence was "not as great as" or "no greater than" the defendant's negligence. See M. Franklin, \textit{Injuries and Remedies: Cases and Materials on Tort Law and Alternatives} § 4, at 324 (1979); W. Prosser, \textit{supra} note 27, § 67, at 436-37.
\item Very little has been written on the contributory negligence of the mentally ill. See Note, \textit{supra} note 22. The one commentary which does discuss the issues of contributory and comparative negligence suggests the doctrinal basis for the objective standard is further weakened in comparative negligence states. Ellis, \textit{supra} note 3, at 1098. The author argues that: (1) under comparative negligence, cost is apportioned on the basis of fault, and the standard is thus incompatible with holding the mentally ill liable since they are faultless; and (2) comparative negligence makes the incongruity of treating mentally ill plaintiffs and defendants differently more visible and more difficult to justify, and presents awkward problems for juries trying to allocate responsibility. Ellis, \textit{supra} note 3, at 1096-98.
\item Almost every decade since 1900, one or two commentaries have been published criticizing the law. See, e.g., Hornblower, \textit{supra} note 6 (1905); Ames, \textit{Law and Morals}, 22 \textit{Harv. L. Rev.} 97 (1908); Cook, \textit{Mental Deficiency in Relation to Tort}, 21 \textit{Colum. L. Rev.} 333 (1921); Bohlen, \textit{supra} note 7 (1924); Wilkinson, \textit{supra} note 9 (1944); Note, \textit{Torts: Liability of an Insane Defendant}, 34 \textit{Cornell L. Rev.} 274 (1948); Ague, \textit{supra} note 8 (1956); Curran, \textit{supra} note 3 (1960); Comment, \textit{supra} note 3 (1972). For the two most recent critiques, both of which appeared in 1981, see Ellis, \textit{supra} note 3; Seidelson, \textit{supra} note 3.
\item Only one article unequivocally supports holding the mentally ill to an objective standard of tort liability. See Alexander & Szasz, \textit{supra} note 3. The authors conclude that the mentally ill should be held liable for their torts on the grounds that there is no such thing as mental illness and that giving the mentally ill tort immunity would facilitate the exercise of social control over the mentally ill. \textit{But cf.} Seidelson, \textit{supra} note 3, at 45-46 (vulnerability of mentally ill to formal adjudications of incompetency or commitment supports affording a subjective standard).
\item 143 N.Y. 442, 38 N.E. 449 (1894), \textit{later appealed}, 157 N.Y. 541, 52 N.E. 589 (1899).
\item Bohlen, \textit{supra} note 7; Cook, \textit{supra} note 30; Hornblower, \textit{supra} note 6. These three early commentators cited the ambiguities of the holding in \textit{Williams v. Hays}, the lack of other authority, and the conflicting opinions of various textwriters as evidence that the issue of the tort liability of the mentally ill had not been definitively settled. They argued that it was inappropriate to hold the mentally ill liable for their torts. These early critiques helped keep the ALI from taking a position on the
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inconsistent with justice and reason to hold the mentally ill liable for their torts. Such liability purportedly violated the fault principle since the mentally ill could not control their actions and thus were morally blameless.\textsuperscript{88}

As society’s views of the mentally ill changed, calls for reform of the common law tort doctrine became more squarely grounded in social policy arguments. Critics assert that, given psychiatric and legal advances, it is no longer justifiable for society to hold the mentally ill to a tort standard impossible for them to meet.\textsuperscript{84} Since the mentally ill are in this view incapable of conforming to a “reasonable person” standard, these commentators argue that holding the mentally ill liable for their torts violates the fault principle and imposes strict liability upon them without sound justification.\textsuperscript{88}

Critics have faulted each of the traditional rationales for the objective standard. They contend that psychiatry and psychology can now provide reasonably reliable diagnoses, thus minimizing evidentiary problems.\textsuperscript{88} Critics attack the law’s denying a defense of mental illness simply because a few “normal” persons may attempt to feign mental illness as unnecessar-ily harsh toward the mentally ill,\textsuperscript{7} especially since “normal persons” would be unlikely to feign such a defense because of the stigma associated

tort liability of the mentally ill in its first draft of the Restatement of Torts. See Comment, supra note 3, at 710–11.

As of the mid-1900’s, critics were still asserting that the doctrine of holding the mentally ill liable for their torts rested on weak and inconsistent case authority. See Ague, supra note 8, at 224–28 (recommending that a “perpetual lunacy commission” of mental health professionals in each court district determine whether a person was sane enough to be held liable in tort); Wilkinson, supra note 9, at 57 (suggesting courts deduce general principles of law and use advances in modern psychology and psychiatry to articulate the types of mental deficiencies which can or cannot be considered in particular tort cases).

33. See Bohlen, supra note 7, at 31–34; Cook, supra note 30, at 349–50.

34. See Curran, supra note 3, at 66–74 (urging development of theories of liability that incorporate modern psychiatric knowledge of the relationship between various mental disorders and conduct); Comment, supra note 3, at 723 (psychiatry now sufficiently advanced to develop a M’Naughten-type rule “separating the gravely insane from those with mental illness not clearly indicating inability to use due care”). A recent commentator suggests that application of the objective standard to mentally ill defendants is a remnant of the era when society sought to confine all mentally ill persons, and that adoption of a subjective standard would represent a “modest step” toward the equitable treatment of the mentally ill consistent with other advances in their legal status. Ellis, supra note 3, at 1108–09.

35. Curran, supra note 3, at 65; Ellis, supra note 3, at 1081–84; Seidelson, supra note 3, at 38 n.85. Some critics contend that if the law is primarily or exclusively concerned with compensating victims, then negligence should be eliminated in favor of strict liability in all cases. See Comment, supra note 3, at 716. The rebirth of strict liability in tort law, based on efficient allocation of losses to those who can best bear the cost, id. at 716–17, does not support strict liability for the mentally ill since they are rarely better able to bear the cost or to redistribute their loss on the public.

36. See Ellis, supra note 3, at 1086–90, 1107 (while evidentiary problems have not been eliminated, diagnoses are reliable in some cases, and evidentiary problems would be no greater than those encountered in other types of proceedings involving mental competency); Comment, supra note 3, at 715 (diagnoses are reliable at least in cases of severe mental illness); see also supra note 19 (studies of diagnostic reliability).

37. See Ague, supra note 8, at 221–22; Comment, supra note 3, at 714–15.
with mental illness. Moreover, critics respond to the potential erosion of the objective standard by noting that exceptions to the objective standard of liability have already been created with respect to children and the physically disabled. Finally, a few courts have reconsidered or rejected the common law doctrine.

II. AN OBJECTIVE STANDARD IS CONSISTENT WITH CURRENT MENTAL HEALTH TREATMENT POLICY

Commentators have argued that recent changes in the medical and legal treatment of the mentally ill indicate that a subjective standard should be adopted. The shift from institutionalization to community treatment, however, suggests the appropriateness of the objective standard.

A. Deinstitutionalization and Community Mental Health Treatment

The most dramatic change in the mental health field in the past two decades has been the move from institutionalization to community treatment. Deinstitutionalization attempts to reintegrate the mentally ill as

38. See Ellis, supra note 3, at 1087; Seidelson, supra note 3, at 39.

39. The most complete discussion of the analogies between the mentally ill and the physically disabled or children is Ellis, supra note 3, at 1098-1106.

The standard of care for a physically disabled person is generally that of a reasonable person "under like disability." RESTATEMENT (SECOND) OF TORTS § 283C (1965). The major rationales for applying a subjective standard to the physically disabled are the greater public familiarity with and acceptance of the physically disabled, and the ease and certainty with which physical disabilities may be proven. Id. comment b.

Generally, children are held to a standard of conduct reasonable for a child "of like age, intelligence, and experience." Id. § 283A. This standard is justified by a greater public interest and sympathy towards the welfare of children, and the wide basis of community experience for determining what can be expected of them. Id. comment b.

It has been suggested that the mentally ill have not been similarly afforded the benefit of a subjective standard due to outdated ideas of the "grave threat" the mentally ill pose to society. See Ellis, supra note 3, at 1086.

40. FitzGerald v. Lawhorn, 29 Conn. Supp. 511, 513, 294 A.2d 338, 339 (C.P. 1972) ("This court is not willing to accept the majority point of view. It appears to be an outdated point of view."). Although FitzGerald involved an intentional tort, the language in the opinion may be construed as allowing mental illness as a viable defense to negligent torts, as recognized in Turner v. Caldwell, 36 Conn. Supp. 350, 350, 421 A.2d 876, 876 (Super. Ct. 1980). The Turner court, however, declined to follow the dicta in FitzGerald. Id. at 351, 421 A.2d at 877.

The doctrine has also been reconsidered in cases where a defense of mental illness has been allowed at the trial level but then overturned on appeal by the plaintiff. Vosnos v. Perry, 43 Ill. App. 3d 834, 837, 357 N.E.2d 614, 615 (1976) (affirmative defense of insanity overturned by appellate court holding that even if it was "incongruous" to hold insane persons liable, such liability provided compensation to innocent victims and prevented defendants from feigning mental illness); Kuhn v. Zabotsky, 9 Ohio St. 2d 129, 134, 224 N.E.2d 137, 141 (1967) (trial court erred in allowing defense of sudden insanity); see also Breunig v. American Family Ins. Co., 45 Wis. 2d 536, 173 N.W. 2d 619 (1970) (no liability for torts committed as result of sudden and unforeseeable onset of insanity). It remains to be seen whether Breunig represents a turning point in the common law or merely an exception for sudden insanity.

41. Support for a move from institutional to community treatment of the mentally ill first appeared in the mid-1950's, grew during the 1960's, and remains widespread today. See Morissev,
self-sufficient members of the community, by establishing community mental health centers and community programs. Community treatment is thought to reduce the time patients spend hospitalized; to reduce readmission rates by providing alternate services in the community; and to allow chronic patients to return to the community, where they are likely to be happier and better adjusted.

Although deinstitutionalization was the result of a confluence of several forces, its initial impetus came from works published during the 1950's and 1960's describing the harmful effects of institutionalization. These commentators suggested that hospitalization was actually detrimental to patients, serving to decrease rather than increase their capacities to function in the outside world. The most frequently cited problems were stigma, dependency, isolation, and degeneration. Commentators ar-

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Although the general population of the nation has increased, the inpatient population of mental institutions has decreased from a peak of 558,922 in 1955 to 137,810 in 1979. Division of Biometry and Epidemiology, National Institute of Mental Health, Provisional Patient Movement and Administrative Data on State and County Mental Hospitals: 1950-1979 (1981).


44. Only a brief overview is presented here. For more extensive coverage, see B. Bloom, Community Mental Health (1975); R. Leifer, In the Name of Mental Health (1969); Klerman, Better But Not Well: Social and Ethical Issues in Deinstitutionalization of the Mentally Ill, 3 Schizophrenia Bull. 617 (1977); Williams, Bellis & Wellington, supra note 41. But see A. Scull, Decarceration: Community Treatment and the Deviant: A Radical View (1977) (questioning traditional reasons for deinstitutionalization movement).

45. See R. Barton, Institutional Neurosis (2d ed. 1966) (suggesting institutionalization itself causes a type of psychiatric disorder); I. Belknap, Human Problems of a State Mental Hospital (1956) (generally describing negative effects of conditions in state mental hospitals); A. Deutsch, The Mentally Ill in America (1939) (historical review of treatment methods concluding that contemporary institutional treatment is national disgrace); E. Goffman, Asylums (1961) (leading work discussing sociological characteristics and effects on patients of “total institutions”).

46. The term “institutional neurosis” refers to a disorder which often results from long-term institutionalization. The neurosis is characterized by apathy, loss of initiative, lack of ability to plan for the future, deterioration in personal habits, loss of individuality, and resigned acceptance. See R. Barton, Institutional Neurosis 2–3 (3d ed. 1976); see also Kantor & Gelineau, Making Chronic Schizophrenics, 53 Mental Hygiene 54 (1969) (empirical evidence that institutional treatment of chronic schizophrenics was antiatherapeutic and reinforced their deviant adaptation).

47. See E. Goffman, supra note 45, at 355.

48. See id. at 358–61, 380–81. Goffman suggests that the regimentation and freedom from daily
gued that the long-term, isolated hospital patient tended to forget how to interact normally with others. The patient also became dependent on the routine, structured environment and services provided by the institution. Discharged long-term patients were often unable to perform simple but necessary daily routines, such as handling money, shopping for groceries, cooking meals, and getting dressed. Institutional care, rather than preparing people to return to a place in the outside world, was teaching them to become chronic patients. Moreover, as criticisms of institutional care escalated, newly introduced psychotropic medications facilitated non-institutional care by reducing the incidence of florid psychotic symptoms among patients. Finally, some observers suggest, the move toward deinstitutionalization was also aided by the economic growth, political liberalism, and interest in civil rights that began during the early 1960's.

Although there has been some discrepancy between promise and performance, the consensus of opinion appears to be that community treatment and generally concluding that drug treatment may prevent relapses).

Psychotropic medications are drugs that alter a person's mood, thought, or behavior. The three major types of psychotropic medications are tranquilizers, antidepressants, and stimulants. See Balter & Levine, The Nature and Extent of Psychotropic Drug Usage in the United States, 5 Psychopharmacological Bull. 3 (1969) (listing types of drugs, their purposes and effects, and extent of usage). Psychotropic medications make it possible to control and limit patients' overt manifestations of deviant symptoms and behavior, thus reducing or eliminating the need for hospitalization. See Crane, Clinical Psychopharmacology in Its 20th Year, 181 Science 124 (1973) (community treatment would be impossible without psychotropic medications but drugs' negative side effects deserve more attention); Engelhardt, Rosen, Freedman & Margolis, Phenothiazines in Prevention of Psychiatric Hospitalization, 16 Archives Gen. Psychiatry 98 (1967) (empirical evidence from an eight-year study of hospitalization rates demonstrating that drug treatment significantly prevents hospitalization); Gittelman, Klein & Pollack, Effects of Psychotropic Drugs on Long-Term Adjustment: A Review, 5 Psychopharmacologia 317 (1964) (reviewing empirical studies on effectiveness of drug treatment and generally concluding that drug treatment may prevent relapses). See generally S. Iversen & L. Iversen, Behavioral Pharmacology (2d ed. 1981) (describing how specific drugs affect specific types of behavior); A. Mason & R. Granacher, Clinical Handbook of Antipsychotic Drug Therapy (1980) (describing principles of antipsychotic drug therapy and its application to specific types of disorders).


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ment is likely to continue. There remain, however, a number of barriers to effective community treatment.

B. Relation Between the Law and Current Mental Health Policy

As a result of deinstitutionalization and community treatment, most mentally ill persons in the United States spend the majority of their time in the community. The substantial increase in the number of mentally ill persons now living in the community increases the importance of holding them to an appropriate standard of care. This determination should be guided by the dominant mental health treatment policies which have been adopted—deinstitutionalization and community treatment.

1. An Objective Standard is Appropriate in Determining Primary Negligence

The mentally ill must be held to a uniform objective standard of tort liability in order to meet the present requirements and aims of community treatment. The objective standard helps minimize the burden on the community from deinstitutionalization, helps foster community acceptance of

56. Braun, Kochansky, Shapiro, Greenberg, Gudeman, Johnsen & Shore, supra note 55, at 748 ("qualified affirmative response" has been given to the feasibility of community treatment); Purvis & Miskimins, Effects of Community Follow-Up on Post-hospital Adjustment of Psychiatric Patients, 6 COMMUNITY MENTAL HEALTH J. 374 (1970) (community treatment essential in increasing community adjustment; even brief rehospitalization engenders dependency and inhibits rehabilitation); Test & Stein, supra note 55, at 360 (community treatment represents most effective treatment currently available).


58. Out of an estimated 1,100,000 schizophrenics in the United States, only about 180,000 are hospitalized, leaving almost a million in the community. While 750,000 psychotic elderly reside in state hospitals and nursing homes, another one million psychotic elderly live in the community. Finally, of the total number of severely mentally ill persons in the United States, 1.1 million are institutionalized while 3.1 million are living in the community. See Talbott, supra note 57, at 44; see also Ozarín, Redick & Taube, A Quarter Century of Psychiatric Care, 1950-1974: A Statistical Review, 27 HOSP. & COMMUNITY PSYCHIATRY 515 (1976) (reporting statistical data reflecting pattern of change from hospital to community treatment). These figures only represent the most severely disabled and therefore underestimate the total number of mentally ill persons in the community.

While many of those discharged are at some point readmitted to the hospital, on the average they are institutionalized only four weeks a year. See Minkoff, A Map of the Chronic Mental Patient, in THE CHRONIC MENTAL PATIENT: PROBLEMS, SOLUTIONS AND RECOMMENDATIONS FOR A PUBLIC POLICY (J. Talbott ed. 1978). Currently only 25% of discharged patients return to their own homes. See Talbott, supra note 57, at 45.
the mentally ill, and encourages the mentally ill to become self-sufficient, responsible members of the community.

a. Community Perspective

Community treatment attempts to reintegrate the mentally ill into the community as relatively self-sufficient, normal citizens. Discharged mental patients must therefore be able to obtain follow-up mental health care, adequate housing, job training, and opportunities to associate with “normal” persons. Local communities, however, have not yet provided such support services. They have sought instead to isolate the mentally ill through city ordinances, zoning restrictions, and discriminatory employment practices. Since the ultimate success of community treatment depends upon community acceptance and support, mental health profes-

59. See L. Bachrach, supra note 57, at 11-13; Talbott, supra note 57, at 49-52; Test, supra note 57, at 72-77.


61. One of the major obstacles to community treatment has been a growing community resistance to integration. See Aviram & Segal, Exclusion of the Mentally Ill, 29 Archives Gen. Psychiatry 126, 128-30 (1973) (describing new formal and informal mechanisms of exclusion that communities have developed to prevent integration of the mentally ill); Kirk & Therrien, Community Mental Health Myths and the Fate of Former Hospitalized Patients, 38 Psychiatry 209, 212-14 (Aug. 1975) (discussing “myth of reintegration”); Klerman, supra note 44, at 627 (discussing community pressure to sequester discharged mental patients in special neighborhoods). See generally Sarbin & Mancuso, Failure of a Moral Enterprise: Attitudes of the Public Toward Mental Illness, 35 J. Consulting & Clinical Psychology 159 (1970) (public still wants to segregate mentally ill).

In many cities, “deviant ghettos” have emerged which foster degeneration and interpersonal isolation in much the same way as institutions. See A. Scull, supra note 44, at 153; Estoff, supra note 57, at 116-17; Reich & Seigel, The Emergence of the Bowery as a Psychiatric dumping Ground, 50 Psychiatric Q. 191 (1978); The Discharged Chronic Mental Patient: A Medical Issue Becomes a Political One, World News, Apr. 12, 1974, at 47. Many of today’s “homeless” are deinstitutionalized mental patients who wander the streets. See Morganthau, Michael, Camper & Donosky, Down and Out in America, Newsweek, Mar. 15, 1982, at 28-29; Tempest, Millions Hit Bottom in the Streets, L.A. Times, Dec. 26, 1982, at 24, cols. 2-3 (estimate that the mentally ill make up as much as 40% of Los Angeles County’s estimated 30,000 homeless people).

Some authors suggest that whereas a period of prosperity and political liberalism in 1960’s initially fostered the development of community treatment, current conditions of economic depression and conservatism may foster retrenchment and calls for reinstitutionalization. See Klerman, supra note 44, at 619, 627; Williams, Bellis & Wellington, supra note 41, at 61-62.


One analyst concluded that “[u]nless [community] opposition is diluted and a balance found between the interests of the community and the interests of the former patients, the movement has gone about as far as it can go.” Armstrong, Society v. the Mentally Ill: Exploring the Roots of Prejudice, 29 Hosp. & Community Psychiatry 602, 602 (1978).

Studies aimed at identifying the obstacles to effective delivery of community treatment have named, in addition to fragmentation in programs and funding, attitudes of communities and community leaders, lack of community support systems, lack of employment opportunities, lack of housing alterna-
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...sionals are trying to increase community acceptance of the mentally ill and to minimize the burden deinstitutionalization places on the community. Holding the mentally ill to an objective standard of tort liability facilitates the achievement of both goals.

Allowing a defense of mental illness to tort liability may increase public resistance to having the mentally ill in the community. The public's attitudes toward the mentally ill vacillate capriciously and it takes only a few well-publicized cases absolving the mentally ill from tort liability to start a public outcry. If the law gives the mentally ill special immunities from liability for causing harm, then society might well restrict their opportunities to create injuries. Opportunities for the mentally ill to obtain licenses, employment, or housing might be substantially circumscribed.

Many of the measures recommended in the studies cited above, such as increasing the availability of mental health services, residential alternatives, and employment opportunities were incorporated in the Mental Health Systems Act, 42 U.S.C. § 9401 (1980). In addition, recent class action suits have been brought on behalf of the mentally ill to try to force states and counties to provide adequate community care alternatives. See, e.g., Brewster v. Dukakis, 675 F.2d 1 (1st Cir. 1982) (affirming lower court order implementing consent degree against state of Massachusetts requiring defendants to make good faith efforts to secure funding for community mental health services); Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975) (holding that federal and city governments had joint responsibility to provide adequate community care and finding statutory right to treatment in least restrictive alternative).

A number of strategies to increase community acceptance have been suggested. See, e.g., Armstrong, supra note 62, at 603-05 (portraying mentally ill favorably in the media); Johannsen, Attitudes Toward Mental Patients: A Review of Empirical Research, 53 MENTAL HYGIENE 218, 224-27 (1969) (increasing personal contact with mentally ill persons and educating public); Talbott, supra note 57, at 50 (developing constituency for mentally ill by educating public about their needs).

There has been a growing recognition of the need to examine the social costs of deinstitutionalization and ways in which the burden on the community can be minimized. See Arnhoff, Social Consequences of Policy Toward Mental Illness, 188 SCIENCE 1277 (1975); Test & Stein, Alternative to Mental Hospital Treatment III: Social Cost, 37 ARCHIVES GEN. PSYCHIATRY 409 (1980); Test & Stein, supra note 55, at 361-62.

Even though two of the reasons most often given for the development of community treatment were the increased community tolerance of deviance and concern for the civil rights of mental patients, community resistance is today one of the major obstacles confronting effective community treatment. See generally Sarbin & Mancuso, supra note 61 (thorough review of empirical studies on public attitudes toward mental illness).


For example, assume the mentally ill were given tort immunity. In automobile collision cases where the defendant is a released mental patient, insurance companies might raise a defense of insanity on the driver's part to avoid having to pay the claim (whether the insured wanted to raise the...
Finally, such immunity would probably exacerbate the problems of social segregation and stigmatization of the mentally ill, since such immunity effectively labels them as a special class of irresponsible, incompetent persons that the general community would wish to avoid.\textsuperscript{67}

An important consideration in minimizing the community burden of deinstitutionalization is the impact of the law on the total number of torts committed. Since deinstitutionalization has significantly increased the number of mentally ill persons in the community, it will also probably increase the number of torts they, as a class, commit.\textsuperscript{68} One of the purposes of tort law is to encourage people to prevent accidents from occurring.\textsuperscript{69} Just as holding average persons liable for their torts may make them behave more conscientiously, holding the mentally ill liable may have a similar effect.\textsuperscript{70} If the mentally ill are not held responsible for their defense or not). See Alexander & Szasz, supra note 3, at 38. The public may respond by advocating for stricter restrictions on the issuance of driver's licenses to discharged mental patients.

The same reasoning can be extended to other areas. Employers might be more reluctant to hire ex-mental patients who could claim immunity for causing injuries to other employees or accidents on the job. Similarly, landlords might be more hesitant to rent to former mental patients. In Samson v. Saginaw Professional Bldg., 393 Mich. 393, 224 N.W.2d 843 (1975), three dissenting justices stated: "In requiring landlords to treat with suspicion persons who formerly suffered mental illness even after mental health officials have certified them ready to resume life in the community, this Court undermines this salutory and humanitarian advance [i.e., community treatment] and perpetuates the isolation of the mentally ill." Id. at 416, 224 N.W.2d at 853.

\textsuperscript{67} See Alexander & Szasz, supra note 3, at 36 ("[M]entally healthy persons may be expected to avoid dealing with mentally sick ones . . . if the mentally sick are held harmless when they injure.").

\textsuperscript{68} There have been no studies or statistics reported regarding whether deinstitutionalization has increased the number of torts committed. Studies of crime and arrests among released mental patients, however, show a possible increased risk of crime committed by released mental patients. See Rakbin, Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research, 86 Psychological Bull. 1 (1979); Sosowsky, Crime and Violence Among Mental Patients Reconsidered in View of the New Legal Relationship Between the State and the Mentally Ill, 135 Am. J. Psychiatry 33 (1978); Steadman, Cocozza & Melick, Explaining the Increased Arrest Rate Among Mental Patients: The Changing Clientele of State Hospitals, 135 Am. J. Psychiatry 816 (1978). Thus it might be suggested that if the discharged mentally ill are more likely to commit crimes, they may also be more likely to commit torts. Attempts to identify accident-prone individuals also suggest that persons exhibiting unstable emotional or mental characteristics may be more likely to be accident prone. See James & Dickinson, Accident Proneness and Accident Law, 63 Harv. L. Rev. 769, 773-75 (1950); Maloney & Rish, The Accident-Prone Driver: The Automotive Age's Biggest Unsolved Problem, 14 U. Fla. L. Rev. 364, 371-74 (1962); Tillmann & Hobbs, The Accident-Prone Automobile Driver: A Study of the Psychiatric and Social Background, 106 Am. J. Psychiatry 321 (1949).

\textsuperscript{69} Originally, this was the principal objective of the tort law, although the law has increasingly tended to focus on the need to compensate victims. See W. Prosser, supra note 27, § 5 at 23, § 83 at 551.

\textsuperscript{70} The admonitory objective of tort law is not dependent purely on monetary judgments. The knowledge that one will be confronted with a lawsuit, placed in the position of a defendant, and possibly faced with a judgment of liability is expected to motivate a person to exercise additional care. This may be an even more effective deterrent in the case of the mentally ill since they are often especially fearful of going to court, having generally experienced courtroom proceedings in connection with involuntary commitment. See Splane, Role and Function of the Attorney in Civil Commitment 179 (1981) (unpublished doctoral dissertation) (mentally ill clients are reported to be afraid of court appearance even when told likely result is release from involuntary hospitalization).
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torts, the community might become concerned that such immunity would result in an increased number of torts.

Correspondingly, if the mentally ill were allowed to escape tort liability, there is a risk that the public might become outraged by the perceived injustice of denying compensation to innocent victims.71 This is the compensation rationale most often cited by the courts. And although many mentally ill defendants are likely to be judgment proof,72 victims should not be denied compensation in those cases where there is insurance to cover the judgment or where the defendant has the means to pay.73

Ultimately, the important point is not the mentally ill person's ability to pay, but the symbolic act of holding the person liable regardless of his or her ability to pay. Otherwise society will be treating the mentally ill as a special sub-class of inept citizens who cannot be blamed or held accountable for socially undesirable conduct.74

b. Individual Perspective

Deinstitutionalization assumes that with adequate support services the mentally ill will be able to function competently in the community. It is important not only to the community at large but also to the deinstitutionalized mentally ill that the latter be regarded as fully responsible members of the community rather than as a special class of incompetents.75 Consequently, while the public might warily tolerate the immunity of a small class of tortfeasors, it is likely that public tolerance for the class immunity will decrease as the social cost of accidents rises.76

Current figures indicate that between 30% and 50% of discharged patients return to work. However, 70% of them return to less skilled jobs and only 20% to 30% are still employed after one year. Talbott, supra note 57, at 45. Similar employment statistics are reported in Anthony, Cohen & Vitalo, supra note 51, at 367-68. In any event, a defendant's wealth or ability to pay tort damages is immaterial to legal liability. P. Atiyah, ACCIDENTS, COMPENSATION AND THE LAW 232 (1970). Moreover, it is in general difficult to recover tort damages from individual defendants. Id. at 240.

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73. In general, it has been noted that in the majority of tort cases, tort damages are not paid by the individual tortfeasor but from some other source. P. Atiyah, supra note 72, at 240, 255. Automobile and workplace accidents, which are generally covered by insurance, appear to dominate the tort system. Id. at 25. A survey of automobile accident costs and compensation, for example, found that fewer than 3% of plaintiffs received any payment from individual tortfeasors. A. Conrad, J. Morgan, R. Pratt, C. Voltz & R. Bombaugh, AUTOMOBILE ACCIDENT COSTS AND PAYMENTS 221 (1964).

74. See Alexander & Szasz, supra note 3, at 35 (stating that to deny a person the legal capacity to commit intentional acts denies their status as full-fledged human beings; such persons can neither be blamed nor credited for their actions).

75. There is a growing body of psychological research that the stigma attached to the label of mental illness can affect a person's self-perception and interpersonal relations, as well as the response of society in general. See, e.g., Ennis, Civil Liberties and Mental Illness, 7 CRIM. L. BULL. 101, 123-24 (1971) (ex-convicts find jobs more quickly than ex-mental patients); Farina, Glica, Boudreau, Allen & Sherman, Mental Illness and the Impact of Believing Others Know About It, 77 J. ABNORMAL PSYCHOLOGY 1 (1971) (believing others to be aware of their status as mentally ill caused persons to feel less appreciated, appear more tense, and to find performance tasks more difficult); Farina, Holland & Ring, Role of Stigma and Set in Interpersonal Interaction, 71 J. ABNORMAL PSYCHOLOGY 421 (1966) (mentally ill persons described as less desirable as friends and neighbors than criminals); Johannsen, supra note 63, at 222-23 ("Society's attitudes toward the mentally ill have a demonstrable effect on how patients see themselves and how adequately they adjust."); Sarbin & Mancuso, supra note 61, at 159 ("[T]he public tends to be more tolerant of deviant conduct when
sequently, the law should not adopt a tort standard which tells both the returning mental patient and society that the mentally ill are considered incapable of behaving in a reasonable, responsible manner.\textsuperscript{76}

Critics of the common law tort doctrine contend that the objective standard unjustly imposes a form of strict liability upon the mentally ill. This argument, however, makes the untenable assumption that the mentally ill have no capacity to conform to the law or to control their behavior.\textsuperscript{77} The introduction of psychotropic medications has greatly facilitated the control of psychotic behavior.\textsuperscript{78} Two-thirds of deinstitutionalized patients never become severely symptomatic.\textsuperscript{79} Although severe mental illness does exist, the gravely mentally ill are the most likely to be institutionalized, and the least likely to be in the community committing torts.\textsuperscript{80} With psychotropic medications and outpatient therapy, most mentally ill persons in the community can conduct themselves in accord with minimally acceptable behavioral standards.\textsuperscript{81}

Holding the mentally ill to an objective standard does not work an "extraordinary injustice" upon them, as critics claim. The mentally ill are not by definition incapable of conforming to a reasonable person standard. Moreover, the whole aim of community treatment is to foster and encourage the mentally ill to behave "reasonably" and "normally" in the community.\textsuperscript{82} The objective standard is no more unjust to the mentally ill than it is to numerous other persons whose individual capacities do not quite match up to the capacities of the "ideal prudent person."\textsuperscript{83}

\textsuperscript{76} It has been suggested that the law's treatment of the mentally ill may have a significant effect in determining the public's opinion towards the mentally ill. See Johannsen, \textit{supra} note 63, at 222, 227.

\textsuperscript{77} As the fault principle has evolved, it has become less a concept of moral blame and more an objective societal judgment as to what constitutes adequate or prudent conduct. Mistakes or good intentions are not exculpating factors when negligent conduct harms another. See Alexander & Szasz, \textit{supra} note 3, at 28-35. See generally W. Prosser, \textit{supra} note 27, at 18-19 (liability based on social fault not moral blameworthiness). Therefore, arguing that the mentally ill are somehow morally blameless is not sufficient justification for exculpating them when their negligent conduct has harmed another.

\textsuperscript{78} See \textit{supra} note 53.

\textsuperscript{79} See Talbott, \textit{supra} note 57, at 45.

\textsuperscript{80} State hospitals still function to confine and treat the most severely disturbed and troublesome of the mentally ill. See Morrissey, \textit{supra} note 41, at 163-64.

\textsuperscript{81} Released mental patients may have to be periodically readmitted to the hospital for short periods. They spend the majority of their time, however, in the community. See \textit{supra} note 58.

\textsuperscript{82} Critics had faulted institutional treatment for creating an environment in which the patient had no responsibilities and thereby fostering dependency and degeneration. See \textit{supra} pp. 161-62.

\textsuperscript{83} Exceptions have been made to the general rule of applying an objective standard for the physically disabled and children. Such persons, however, can be distinguished from the mentally ill. First, they are clearly recognizable and thus provide notice to potential victims. Second, there exists a wider basis of experience and knowledge upon which to determine what can be reasonably expected from children and the physically disabled, thus making the problems of proof far less substantial than in the case of mental illness. See generally Seidelson, \textit{supra} note 3 (discussing relation between notice
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A final practical consideration should be noted. A defense of mental illness to a tort action could have undesirable, collateral effects for the released mental patient.84 If a person's mental illness were considered sufficient to excuse him or her from tort liability, then society might consider it sufficient to warrant commitment to a mental institution.85 Even if commitment were not deemed warranted, the person might still be vulnerable to having a guardian or conservator appointed, thus hampering the development of personal independence and self-reliance.86

2. An Objective Standard is Appropriate in Determining Contributory Negligence

The arguments favoring an objective standard for the mentally ill in primary negligence cases equally support an objective standard in determining contributory negligence. There are no clearly articulated policy rationales for using a subjective standard in cases involving mentally ill plaintiffs,87 although one rationale is that mentally ill plaintiffs are less threatening to the public and evoke more sympathy than mentally ill defendants. The validity of this assertion is open to serious doubt. The increased number of mentally ill in the community is likely to lead to an increase in the number of mentally ill persons involved in accidents. The public is likely to be dismayed if it becomes apparent through tort cases that they are expected to keep a "special eye" out for the safety of the mentally ill. If mentally ill persons, who have contributed significantly to causing their own injuries, are allowed to recover total damages, then the

and reasonable expectations and use of the subjective standard in tort law). Finally, children are held to the adult reasonable person standard when they engage in adult activities. See, e.g., Dellwo v. Pearson, 259 Minn. 452, 197 N.W.2d 859 (1961) (12-year-old driving a motor boat); Reiszel v. Fontana, 35 A.D.2d 74, 312 N.Y.S.2d 988 (1970) (17-year-old driver held to adult standard while 11-year-old bicyclist held to standard of care of a reasonable 11-year-old); RESTATEMENT (SECOND) OF TORTS § 283A comment c, at 14 (1965) (stating that standard of conduct for a child is that of "a reasonable person of like age, intelligence, and experience under similar circumstances").

84. Critics assert the stigma would prevent normal persons from feigning mental illness. It is unclear why they feel a defense of mental illness would be any more attractive to the discharged mental patient, who may suffer even greater negative social consequences from such a defense.

85. It has been pointed out that the defense of insanity is generally only used in cases of serious crimes because acquittees often draw longer "sentences" in mental hospitals than if they had been convicted. See Burt, Of Mad Dogs and Scientists: The Perils of the "Criminal-Insane," 123 U. Pa. L. Rev. 258, 261 (1974). Alexander and Szasz suggest a similar fate might befall persons accused of civil wrongs and that such an outcome "is perhaps the main deterrent to extending the 'logic' of mental irresponsibility from the sphere of crimes to that of torts." Alexander & Szasz, supra note 3, at 38.

86. A person may lose numerous rights as a result of having a guardian or conservator appointed. See, e.g., CAL. WELF. & INST. CODE §§ 5357–58 (West Supp. 1977) (conservatee may be denied right to drive, enter contracts, consent to medical treatment, and conservator may place conservatee in a psychiatric or medical facility); N.Y. MENTAL HYG. LAW §§ 77.19, 77.25 (McKinney 1979) (giving conservator power to control conservatee's property and assets and to void contracts, but not to deny any civil right solely because of conservatorship). See generally Pickering, Limitations on Individual Rights in California Incompetency Proceedings, 7 U.C.D. L. Rev. 457 (1974).

87. See supra p. 157.
public is in effect being charged for not exercising greater care for their safety than for the average person. This could result in especially negative consequences in such areas as housing or employment. Employers would have an added justification not to hire discharged mental patients, and landlords not to rent to them, if the mentally ill could contribute to causing their own injuries and then recover complete damages. 88

It has also been suggested that allowing a subjective standard for mentally ill plaintiffs provides a means of mitigating the generally harsh results of the contributory negligence doctrine. Such a standard, however, singles out the mentally ill as a distinct class of incompetents requiring heightened protection. The mentally ill living in the community are expected to take care of their own basic needs including the need to look out for their own safety. It is no more unfair or inequitable to require them to exercise due care for their own safety than it is for the average person.

CONCLUSION

The aim of community treatment is to integrate discharged mental patients into the community as responsible and independent functioning members. Attainment of this goal requires that the mentally ill be treated as ordinary citizens. Hence, they should be held to the same standards of tort liability which apply to the rest of society. This Note has sought to demonstrate that the use of a subjective standard in primary negligence cases, rather than being a humanitarian reform, would actually run counter to current mental health policy and would work to the decided disadvantage of the mentally ill. Similarly, the current use of the subjective standard in determining contributory negligence is inappropriate and should be replaced by the objective standard.

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88. As noted, a large number of accidents occur at the place of work or at home. See supra note 73. Employers and landlords, however, may opt out of any potential liability simply by refusing to hire or rent to the mentally ill. In cases where the employee is covered by workmen’s compensation, which is generally based on strict liability, an employer can raise a form of contributory negligence defense in about half the states, i.e. unreasonable failure to observe safety rules or to use safety devices. 1A A. LARSON, LAW OF WORKMEN’S COMPENSATION § 33 (1952 & Supp. 1982). It does not seem to have been decided how this applies against mentally ill employees. However, it would seem that if it was determined that the mentally ill should be given the benefit of a subjective standard across the board that employers would be barred from this defense. See generally Hanson Buick, Inc. v. Chatham, 292 S.E.2d 428 (Ga. Ct. App. 1982) (workmen’s compensation not allowed for psychic trauma precipitated by psychic stimulus because allowing compensation would encourage employers, afraid of having to pay out disability benefits, not to hire “persons of delicate psychic constitution”); Johannsen, supra note 63, at 221 (employers express practical concerns over hiring ex-patients, including belief that insurance carriers might raise rates or refuse coverage for employers of former patients).