Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release

The states and the federal government annually commit thousands of persons to various institutions for the treatment of insanity, retardation, narcotics addiction, alcoholism, juvenile delinquency, defective delinquency and sexual psychopathy.¹ State activity in these fields has increased dramatically since the Supreme Court validated a Minnesota statute for the commitment of psychopathic personalities.² Misgivings about the general reduction of procedural protections resulting from the widespread use of commitment processes, given new impetus by recent developments in constitutional criminal procedure cases, has

¹ The number of patients in public mental hospitals in 1965 was 476,000. This is a decrease of 83,000 from 1955, despite a population increase of 17%. However, during this same period, 1955-1965, the number of admissions to public mental hospitals increased 77%. The number of admissions in 1965 was 314,500, of which 115,000 had previously undergone one or more periods of hospitalization in the same state system and 55,000 had been hospitalized in some other psychiatric facility. The number of discharges also increased in 1965 as compared with 1955. In 1965 there were 287,000 discharges, while in 1955 there were 126,500. This clearly indicates that periods of institutionalization are shorter now than in 1955. A large part of this change may be attributable to the use of tranquilizers and other drugs, rather than to increases in the size and quality of public institutions. See Kanno & Glasscote, Fifteen Indices 7 (1966). The above figures indicate only part of the mammoth size of civil commitment schemes in this country. The FBI Reports for 1961 indicated that there were 586,682 arrests of persons under eighteen years of age. In 1962 there were 39,000 inmates in juvenile institutions, but the training schools serve between 80,000 and 90,000 juveniles per year. These figures only represent state institutions. Figures for private and local training schools make the totals much larger. For a wide variety of statistics on juveniles, see Lundén, Statistics on Delinquents and Delinquency (1964). See also 2 U.S. DEPT. OF COMMERCE, BUREAU OF CENSUS, INSTITUTIONAL INMATES, 1960 CENSUS OF POPULATION, pt. 8-A, at 12-13, 47-48.

² Minnesota ex rel. Pearson v. Probate Court of Ramsey Cty, 309 U.S. 270 (1940). The fact that the ability of the states to legislate in the field of involuntary commitments has gone virtually unchallenged since 1940 does not mean that a reappraisal of the present limitations (or lack of limitations) on the state's police power is not needed. The tragic results of sexual psychopathic statutes like that approved in Pearson raise grave doubts about the correctness of the present willingness of courts to approve such legislation. Allen, Criminal Justice, Legal Values and the Rehabilitative Ideal, 50 J. CRIM. L., C. & P.S. 226, 230-31 (1959) and authorities cited therein; Morris, Impediments to Penal Reform, 33 U. Chi. L. Rev. 627, 643 (1966); Ross, Commitment of the Mentally Ill: Problems of Law and Policy, 57 Mich. L. Rev. 945, 955-60 (1959); Comment, The Plight of the Sexual Psycopath: A Legislative Blunder and Judicial Acquiescence, 41 Notre Dame Law. 527 (1966). The Supreme Court has also upheld provisions for the commitment of persons who have been accused or convicted of federal crimes. Greenwood v. United States, 350 U.S. 366 (1956); see 18 U.S.C. §§ 4244-48 (1964).
led to some significant changes in commitment procedures. Despite the importance of these reforms, commitment procedures cover only a part of the problem, since the procedural method by which a person is placed in an institution has no effect upon his status after commitment. Too frequently, it is overlooked that the interests of the involuntarily committed patient are seriously endangered without some method to assure that he may obtain both treatment and timely release.

The present lack of proper treatment facilities and the extreme

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3 A recent example is New York ex rel. Glenn E. Rogers, Jr. v. Stanley, 17 N.Y.2d 255, 217 N.E.2d 636, 270 N.Y.S.2d 573 (1966), which held that an indigent mental patient is entitled to the assignment of counsel as a matter of constitutional rights in a habeas corpus proceeding. The imposition of greater procedural requirements upon juvenile court proceedings is occurring. In re Gault, 35 U.S.L. Week 4399 (U.S. May 15, 1967); Kent v. United States, 383 U.S. 541 (1966); United States v. Morales, 233 F. Supp. 160 (D. Mont. 1964). Traditionally the courts have avoided the imposition of criminal procedural requirements upon involuntary commitment proceedings by calling the latter "civil" rather than "criminal." E.g., In re De La O, 59 Cal. 2d 128, 378 P.2d 793, 28 Cal. Rptr. 489 (1963). Proceedings under commitment statutes supposedly do not involve conviction for a crime, do not result in imprisonment, and are therefore not in violation of the due process clause of the Constitution. Recently, in United States ex rel. Gerchman v. Maroney, 355 F.2d 302 (3d Cir. 1966), the civil-criminal distinction was broken down decisively when Pennsylvania's Batt-Walker Act for the commitment of persons convicted of certain sex crimes, Pa. Stat. tit. 19, §§ 1164-74 (1964), was held criminal in nature. As a result, certain criminal procedural safeguards were found to be required in the commitment hearing. See also Kent v. United States, 383 U.S. 541 (1966); Baxstrom v. Herold, 383 U.S. 107 (1966).

4 While the growth of procedural reform is an important development, the existence of procedural guarantees does not necessarily mean they are being properly enforced. See Katz, Goldstein & Dershowitz, Psychoanalysis, Psychiatry and Law, 422-752 (1967); Szasz, Law, Liberty and Psychiatry 159-81 (1963); Szasz, Psychiatric Justice 85-248 (1965); Cohen, The Function of the Attorney and the Commitment of the Mentally Ill, 44 Texas L. Rev. 424 (1966); Kutner, The Illusion of Due Process in Commitment Proceedings, 87 Nw. U.L. Rev. 383 (1962).


burden of proof placed upon a person for obtaining his own release suggest that an exploration of the constitutional duty of a state to provide treatment for its involuntarily committed citizens and the burden of proof that is properly required for a state to maintain control over its confined patients is timely.

The breadth of such an inquiry requires that broad categories, rather than specific state or federal statutory schemes, be used in an effort to classify involuntarily committed persons. The Public Health Service Draft Act for the Commitment of the Mentally Ill provides that a person may be committed if he "(1) is mentally ill, and (2) because of illness is likely to injure himself or others if allowed to remain at liberty, or (3) is in need of custody, care or treatment in a mental hospital, and because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization. . . ."8 The classification of mentally ill persons as dangerous to others, dangerous to self, or in need of treatment provides a structure within which further analysis of commitment, treatment, and release procedures may be made.9

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8 National Institute of Mental Health, A Draft Act Governing Hospitalization of the Mentally Ill § 9(g) (Pub. Health Serv. Pub. No. 51, 1951) [hereinafter cited as DRAFT ACT]. The Draft Act has been used by a substantial number of states as a basis for their commitment statutes. See Holm v. State, 404 P.2d 740 (Wyo. 1965). The Draft Act itself does not provide for any differences in importance among the various categorizations. This comment uses the categories as a base for more general theories.

9 The classification of committed persons into those dangerous to others, those dangerous to self, and those in need of treatment connotes some ability to describe differences between the categories. Goldstein & Katz, supra note 7, at 225, suggest that criteria for these categorizations have not been precisely articulated. In analyzing commitments after successful insanity pleas, the authors suggest that: "dangerous behavior might be construed to include: (1) only the crime for which the insanity defense was successfully raised; (2) all crimes; (3) only felonious crimes (as opposed to misdemeanors); (4) only crimes for which a given maximum sentence or more is authorized; (5) only crimes categorized as violent; (6) only crimes categorized as harmful, physical or psychological, reparable or irreparable, to the victim; (7) any conduct, even if not labelled criminal, categorized as violent, harmful, or threatening; (8) any conduct which may provoke violent retaliatory acts; (9) any physical violence towards one-self; (10) any combination of these." These various types of behavior may provide a starting point for analysis of commitments in
I. RIGHT TO TREATMENT

A. The Constitutional Mandate

Theoretically, the state, in committing one of its citizens, confers a benefit upon both the general public and the confined individual. This theory has been applied to justify confinements of criminals who have been institutionalized rather than imprisoned, of persons committed after "successful" insanity pleas, of persons hospitalized as incompetent to stand trial, and of persons committed in a variety of other proceedings. Although these confinements are held to be justified under the state's police power for the protection and welfare of the general society, commitment proceedings are circumscribed by some limitations. Notions of due process have concrete applicability, rather than simply of commitments after insanity pleas. The third classification, those in need of treatment, brings us back to the definition of mental illness, specifically, that mental illness which impairs choice-making mechanisms. This is a definitional problem faced daily in criminal law and in guardianship proceedings. The literature is voluminous. See generally Katz, Goldstein & Dershowitz, op. cit. supra note 4.

A further difficulty arises because the category "socially dangerous," for example, does not exist in psychiatric terminology. Problems then arise in the use of the statute by psychiatrists. In dealing with a sexual offenders statute, one group of doctors construed the term "sexually dangerous" in a parsimonious way. Kozol, Cohen & Garofalo, The Criminally Dangerous Sex Offender, 275 New England J. Medicine 79, 80 (1966). It was construed to include "principally those persons who are likely to rape or otherwise to assault sexually a child or woman," but to exclude both nuisance offenders, such as voyeurs, exhibitionists, transvestites, fetishists, and consenting adult homosexuals.


12 E.g., Overholser v. O'Beirne, 302 F.2d 852, 853-54 (D.C. Cir. 1962); Foller v. Overholser, 292 F.2d 732, 733 (D.C. Cir. 1961); Ragsdale v. Overholser, 281 F.2d 943, 946 (D.C. Cir. 1960). In Overholser v. O'Beirne it is said: "The twofold purpose of the mandatory hospital confinement must never be overlooked, first, recovery of the patient and second, protection of society and the patient. To ignore the need for both protections or to equate this 'protective' hospitalization with punishment confuses the issue and does a grave disservice to the social purposes of the statute..." 302 F.2d at 854 (emphasis in original).

13 E.g., Sutton v. Settle, 302 F.2d 286, 287 (8th Cir. 1962); Higgins v. United States, 205 F.2d 650, 653 (9th Cir. 1953).


15 E.g., Higgins v. United States, 205 F.2d 650, 653 (9th Cir. 1953), where it was said: "The several states in their character as parens patriae have general power and are under the general duty of caring for insane persons. The prerogative is a segment of police power. In the exercise of such power, insane persons may be restrained and confined both for the welfare of themselves and for the protection of the public."
cations in the field of commitments, even though the more specific provisions of the Bill of Rights may not be applicable.\(^{16}\)

In order to evaluate the application of the due process clause to institutional care, several competing policies must be examined. Consistent with the theories used to justify commitment statutes, the need for public protection and the desire to help the committed individual are most frequently mentioned as bases for commitment schemes. The need for public protection is most evident with respect to those persons found to be socially dangerous. The professed desire to aid committed individuals in their personal efforts to regain their well being necessarily includes a desire to return committed individuals to society as productive citizens.\(^{17}\) The cost to society for failing to implement these goals can be expressed in terms of the harmful actions of dangerous persons, the loss of services to the general society that would normally be conferred by confined persons, and the loss to the committed individual of benefits that he would usually confer upon himself or his family.

The traditional justifications for judicial enforcement of commitment statutes—benefit to both the public and to the committed individual—must be evaluated in light of the detrimental effect any commitment, to either a satisfactory or an unsatisfactory institution, may have upon an individual. Involuntary confinement often causes the patient to demean himself and the society to stigmatize the patient.\(^{18}\) The very nature of an involuntary commitment can produce disastrous effects upon a patient.\(^{19}\) The degrading effects of institutional existence may

\(^{16}\) E.g., Kent v. United States, 383 U.S. 541 (1966); United States ex rel. Gerchman v. Maroney, 355 F.2d 302 (3d Cir. 1966); Holm v. State, 404 P.2d 740 (Wyo. 1965). Mr. Justice Fortas, in In re Gault, 35 U.S.L. WEEK 4399, at 4402, noted that as to juvenile delinquency proceedings, "there appears to be little current dissent from the proposition that the Due Process Clause has a role to play."

\(^{17}\) Because of low state effort these policy goals are not often carried through successfully. See authorities cited notes 2, 4-7 supra. It is also true that inability to "cure" certain types of disabilities would prevent complete attainment of rehabilitative goals. See notes 50-103 infra and accompanying text.

\(^{18}\) GOFFMAN, ASYLUMS 354-56 (1961); GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY 5, 41-104 (1963); SCHUR, CRIMES WITHOUT VICTIMS 1-10, 141-45, 175-76 (1965).

\(^{19}\) "In response to his stigmatization and to the sensed deprivation that occurs when he enters the hospital, the inmate frequently develops some alienation from civil society, sometimes expressed by an unwillingness to leave the hospital. This alienation can develop regardless of the type of disorder for which the patient was committed, constituting a side effect of hospitalization that frequently has more significance for the patient and his personal circle than does his original difficulties." GOFFMAN, ASYLUMS 355-56 (1961).
be heightened by a combination of other factors: arrest, institutional entry procedures, control by a department of corrections rather than by a department of mental hygiene, and loss of personal legal rights. The effects of commitment are not limited to loss of self-esteem. It is also true that society somehow sets the mental patient apart. There is a general feeling that institutional confinement is not the same as normal hospitalization, which is usually both voluntary and short in duration.

Further evaluation of the traditional bases of commitment should also take into account the prognosticative features of any commitment or release decision. The commitment of a person for the protection of either society or the individual is based upon the assumption that future human behavior is, to a sufficient extent, predictable. However, because the degree of predictability is unknown, caution should be exercised in the use of psychiatry as a tool for depriving persons of their liberty; to approve commitments without careful scrutiny places too great a reliance upon the predictive accuracy of psychiatric testimony.

The combination of the possible adverse effects of involuntary commitment and the difficulties of predicting human behavior would appear to require substantial justification for any mandatory confinement. Benefit to both the public and the committed individual, while legiti-

20 Even if no crime is involved, the defendant may be subject to arrest by the police. See, e.g., § 8 of the recently enacted New York narcotics addict commitment statute, N.Y. Sess. Law: 1966, ch. 192; Draft Act §§ 6-8.

21 "We very generally find staff employing what are called admission procedures, such as taking a life history, photographing, weighing, fingerprinting, assigning numbers, searching, listing personal possessions for storage, undressing, bathing, disinfecting, hair cutting, issuing institutional clothing, instructing as to rules, and assigning to quarters." Goffman, Asylums 16 (1961).

22 See, e.g., In re De La O, 59 Cal. 2d 128, 378 P.2d 793, 28 Cal. Rptr. 489 (1963); United States ex rel. Gerchman v. Maroney, 355 F.2d 302 (3d Cir. 1966). See also Morris, supra note 2, at 643, criticizing the general confusion and overlap between the state's correctional and social welfare functions.

23 Szasz, Psychiatric Justice 137 (1965): "You asked how is it different to be called mentally ill than from having pneumonia. A person who has pneumonia loses none of his civil rights. But a person who is said to be mentally ill to the extent of being hospitalized loses his civil rights—he can't walk around as a free man." The loss of civil rights by a mental patient is usually substantial. Rights to contract, vote, and generally to handle one's affairs are sharply, if not totally, curtailed. For an exhaustive survey, see Rankin & Dallmayr, Rights of Patients in Mental Hospitals, in 1961 Senate Hearings 329-70. See also Ross, supra note 2 at 980-98; Draft Act § 21.


25 Goldstein & Katz, supra note 7.

26 The same is true of the criminal law, but the motives are different than in commitment. General deterrence and retribution are not, or at least should not be, major purposes of civil commitment. Compare Andenaes, General Preventive Effects of Punishment, 114 U. Pa. L. Rev. 949 (1966), with Morris, supra note 2.

27 See generally Katz, Goldstein & Derhowitz, op. cit. supra note 4.
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mate objectives, do not outweigh the deprivation of liberty inherent in an involuntary confinement unless they are actually implemented through appropriate state action. Lack of treatment reduces a commitment to virtual imprisonment, a situation which severely impairs the justification for a state's commitment structure. The general society, while it may be protected from socially dangerous persons, loses the potential benefit untreated individuals may be able to confer upon society as healthy individuals.

The courts have generally been hesitant to inquire into the treatment of inmates in mental institutions. The appropriately named "hands off doctrine," often used to justify the refusal to review prisoners' complaints, has been applied with equal force to the inmates of non-penal institutions. However, just as the "hands off doctrine" seems to be breaking down under numerous complaints from prisoners, the courts are also beginning to inquire into the status of individuals confined in commitment institutions.

28 Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); Ragsdale v. Overholser, 281 F.2d 943 (D.C. Cir. 1960); see authorities cited notes 2, 4-7 supra.

29 This loss arises in two ways. First, patients released from non-treating institutions are presumably less able to operate in society than those released after periods of successful treatment. Second, persons confined without treatment are prevented from conferring any benefit upon society during their confinement. This loss is also present in confinements to treating institutions. However, a drop in recidivism would probably result if there were treatment.


31 See Haynes v. Harris, 344 F.2d 463 (8th Cir. 1965); Overholser v. O'Beirne, 302 F.2d 852 (D.C. Cir. 1962); Sutton v. Settle, 302 F.2d 286 (8th Cir. 1961).

In some cases terse statements to the effect that treatment is being given to the petitioner are made without apparent reason. Feller v. Overholser, 292 F.2d 782 (D.C. Cir. 1961); Barnes v. Director of the Patuxent Institution, 175 A.2d 20 (Md. 1961).

In one interesting sequence a petitioner was told to seek habeas corpus for inquiry into the treatment he was being given. In re Kemmerer, 309 Mich. 313, 15 N.W.2d 652 (1944). Later proceedings resulted only in the court's replying that such matters were "for consideration of the State Hospital Commissioner." Kemmerer v. Benson, 165 F.2d 702, 703 (6th Cir. 1948).

In another sequence a federal court ordered Maryland courts to inquire into the operation of a defective delinquent statute. Sas v. Maryland, 334 F.2d 506 (4th Cir. 1964). The Maryland Court of Appeals, while obeying the federal courts, noted that it much preferred to leave the whole issue to the executive and legislative branches. Director of the Patuxent Institution v. Daniels, 243 Md. 16, 42, 221 A.2d 397, 411 (1966).

The first cautious court inquiries arose in the "commitment to prison" cases. In *In re Maddox*, appellant, originally committed as a sexual psychopath, was transferred from Ionia State Hospital to the State Prison of Southern Michigan at Jackson. In granting his writ of habeas corpus for release from the prison, the court wrote:

Clearly then, in design and purpose and interpretation, we have a statute which purports to represent civil commitment for treatment due to a mental state or condition. And our courts have upheld the civil and noncriminal procedures of the statute in direct relationship to its stated purpose and to the treatment contemplated.

The hard fact posed by our current case is that we are faced by a record which shows that a person committed under this remedial and corrective legislation for hospitalization and treatment is, in fact, serving potentially a life sentence in our biggest State prison, treated in all respects similarly to other criminals therein confined.

The prison cases emphasize the traditional theory that a person is committed not only for the benefit of the society, but also for the benefit of the individual. The nature of imprisonment conflicts with both justifications for commitment statutes. An imprisoned individual often receives little except stigmatization from his confinement, and the society loses the possible benefits which a rehabilitation program may confer upon the general public. The result of the prison cases would seem to suggest that the police power of the state is judicially limited to the extent that a state fails to give support to the beneficent goals of

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35 The basis of the transfer, curiously enough, was that Maddox refused to admit that he had committed the sex offenses with which he was charged. Because of this he was felt to be uncooperative. *Id.* at 477. The state tried to justify the lack of treatment by referring to "milieu therapy."

36 *Id.* at 475.

37 In order for a commitment statute to be sustained as non-penal, "it is necessary that the remedial aspect of confinement thereunder have foundation in fact. It is not sufficient that the Legislature announce a remedial purpose if the consequences to the individual are penal." Commonwealth v. Page, 339 Mass. 313, 317, 159 N.E.2d 82, 85 (1959).
its commitment legislation. However, the state courts have not taken full advantage of the implications of the commitment to prison cases.\textsuperscript{38} Despite the fact that a patient may force the state to transfer him from a prison to a hospital, he has generally not been able to force the state to provide treatment in the hospital.

The federal courts, however, are beginning to take bolder steps toward reviewing the great variety of institutional care programs.\textsuperscript{39} To some extent this progress is based upon the existence of statutes requiring that treatment be given to confined persons.\textsuperscript{40} In \textit{Sas v. Maryland},\textsuperscript{41} Maryland’s Defective Delinquent Act was found to be “facially constitutional.”\textsuperscript{42} However, the court remanded for consideration of “whether the proposed objectives of the act are sufficiently implemented in its actual administration to support its categorization as a civil procedure and justify the elimination of conventional proce-


\textsuperscript{40} Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); Millard v. Cameron, 373 F.2d 468 (D.C. Cir. 1966). \textit{Rouse}, 373 F.2d at 455 n.21, indicates that there are at least eleven jurisdictions with statutory provisions—California, District of Columbia, Idaho, Illinois, Iowa, Missouri, New Mexico, New York, Oklahoma, Texas, and Utah. The strongest statute is in the District of Columbia. D.C. CODE ANN. § 21-562 (Supp. V, 1966). It reads: “Any person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment. The administrator of each public hospital shall keep records detailing all such care and treatment received by any such person and such records shall be made available, upon that person’s written authorization, to his attorney or personal physician. Such records shall be preserved by the administrator until such person has been discharged from the hospital.” See generally \textit{Hearings on a Bill to Protect the Constitutional Rights of the Mentally Ill Before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary, 88th Cong., 1st Sess.} (1963). The Draft Act provides only that: “Every patient shall be entitled to humane care and treatment and, to the extent that facilities, equipment, and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice.” DRAFT Act § 9. The later discussion on the development of standards for the enforcement of the right to treatment would apply to the statutory right to treatment as well as to the constitutional. See notes 50-104 infra and accompanying text.

\textsuperscript{41} MD. ANN. CODE art. 31B, §§ 1-19 (1967). The concept of the facial constitutionality of commitment statutes seems to have arisen first in Minnesota ex \textit{rel.} Pearson v. Probate Court of Ramsey Cty., 309 U.S. 270, 275 (1940), where it was said that to support a challenge of a proceeding \textit{in limine}, “the statute in its procedural aspect must be found to be invalid on its face and not by reason of some particular application inconsistent with due process.”
dural safeguards." Among inquiries to be made upon remand were the possibilities of deficiencies in staff, facilities, and finances. The decision in *Darnell v. Cameron,* while remanding for a hearing previously denied the petitioner, noted the lack of treatment being given to the petitioner, and granted him the right to raise the issue in subsequent habeas corpus petitions. In *Rouse v. Cameron,* the court discussed the constitutional infirmities which led to the passage of the District of Columbia's right to treatment statute and held that lack of treatment is an issue cognizable in habeas corpus proceedings. The opinion noted that the difference between civil and criminal proceedings arose because of a need for treatment in certain cases: "Since this difference rests only on need for treatment, a failure to supply treatment may raise a question of due process of law."

The recent judicial statements leave many issues unresolved. No court has made a serious attempt to discuss the extent of the right to treatment and no detailed discussion of the various forms of relief available to the patient has occurred. Recognition of the right to treatment necessitates the development of standards for its proper application.

B. Development of Standards

The development of standards for the implementation of the right to treatment is obviously a complex task. It is possible that this complexity was a significant factor in the development of the "hands off doctrine." However, the difficulty of a problem is not a satisfactory basis upon which to measure the propriety of judicial action. This is especially true where the possibilities of unfairness are multiplied by the inactivity of the courts. There is an obligation upon society in general, and the courts in particular, not only to sanction the use of tools which are beneficial to society, but also to guarantee that these tools are used in an enlightened rather than an oppressive way.

In analyzing an individual's right to treatment, several different factors must be reviewed. First, the type of treatment which a person is receiving or will receive in the institution to which he is going to be sent may vary from minimal treatment to no treatment, and perhaps,

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43 334 F.2d at 509.
44 348 F.2d 64 (D.C. Cir. 1965).
45 373 F.2d 451 (D.C. Cir. 1966).
47 373 F.2d at 453. See also Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966).
48 For the best effort, see Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966).
50 See generally Katz, Goldstein & Dershowitz, op. cit. supra note 4.
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for persons already committed, to outright mistreatment or abuse. Second, the possibility of successful treatment varies from patient to patient. Third, the types of disabilities faced by each patient are different. Some patients are confined because they are dangerous to society; some because they are dangerous to themselves; some because they are simply in need of treatment. Fourth, a broad range of remedies are available to a patient. These may range from release, through some form of probation, to the ordering of changes within a hospital.

Habeas corpus provides a patient with a flexible judicial procedure by which to challenge mis- or non-treatment. The federal act provides that courts are to "dispose of the matter as law and justice require," making available a wide range of possible case solutions. Among them are release, transfer to another institution, and substitution of an "alternative course of treatment," including outpatient care, day hospitals, foster homes, and other nonconfining arrangements. Other remedies which may be of use include mandamus and injunction. Both provide for the correction of faults due to the actions of a hospital administrator or his subordinates, rather than to the lack of funds, staff, or facilities.

The complex nature of the medical and policy problems which courts will have to face in any right to treatment case necessitate the imposition of some limitations upon repeated applications for habeas corpus or other remedies. Sanders v. United States provides that:

Controlling weight may be given to denial of a prior application for habeas corpus... only if (1) the same ground presented in the subsequent application was determined adversely to the applicant on the prior application, (2) the prior determination was on the merits, and (3) the ends of justice would not be served by reaching the merits of the subsequent application.

A hearing on the application may be denied only if the record shows that the application is conclusively without merit. The standards of

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57 Id. at 15.
58 The allegation and burden of proof problems are considered infra, notes 104-26 and accompanying text.
Sanders would certainly make it difficult for a patient to continually file applications for habeas corpus after a finding has been made that he is receiving satisfactory treatment. Problems would arise only when an allegation is made that treatment has been halted or curtailed. If such an allegation is false, it can easily be met by the production of hospital records showing a continual program of treatment. If the records are inconclusive, or if an allegation is made that the records have been falsified, a hearing on the single question of whether treatment has been maintained at a level consistent with that previously found satisfactory would be in order. A thorough review of all treatment questions with respect to a repeated habeas corpus applicant would be in order only after a finding has been made that the treatment level has actually been diminished. Presumably, similar standards could be applied to repeated applications for mandamus, injunction, or recommitment hearings.  

Turning to specific abuses, perhaps the easiest cases to deal with are those involving outright mistreatment or abuse of committed persons. Just as there are certain types of punishment that cannot be used against prisoners, there are certain types of “treatment” that cannot be used against committed persons; the prohibition against cruel and unusual punishments is certainly applicable to committed persons. Although confinement via commitment proceedings is not by itself a cruel and unusual punishment, beatings, starvation diets, or the like cannot be used in the “treatment” of committed persons.  

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59 The limitations upon recommitment hearings may also be prescribed by the particular commitment statute involved in a case. Some statutes provide for mandatory review of a patient’s status after a certain length of time. E.g., CAL. WELFARE & INSTITUTIONS CODE § 3151. Other statutes are less limiting on the state in providing only that a patient may request a hearing after a certain period of time. E.g., D.C. CODE ANN. § 24-609(b) (1961).


63 This is true even in criminal proceedings. E.g., Harper v. Wall, 85 F. Supp. 783 (N.J. 1949).
Shock treatment, restraint, or the continual use of drugs cause more difficult problems. Notwithstanding the fact that these methods of treatment are thought by many psychiatrists to be valuable tools for the treatment of some patients, they may be used in an abusive manner. Shock treatment provides a perfect illustration. This treatment should not be used as a method of punishment, or as an example to other patients. However, such use is apparently not uncommon, despite the harshness of the treatment. In some cases, the refusal of an institution to obtain the consent of all concerned persons, including the patient if at all possible, would be an indication of institutional laxity in the use of shock treatment.

The use of bodily restraints and isolation cells has had a stormy career. The acceptance of open wards in most British hospitals, and in some hospitals in this country, has been a very successful venture, at least in comparison with prior methods. While there is no suggestion here that open wards are constitutionally required in all cases, the contrast between open wards and unnecessary restraint is illuminating. In some cases, it could be argued that the very use of restraint as a steady method of treatment negates the effectiveness of the treatment efforts of an institution. An allegation that unnecessary restraint is being used should lead to court inquiry into the reasons for the use of restraint, the length of the treatment, the severity of the restraint,

64 The prevalence of these methods of treatment is demonstrated by their wide use in general hospital psychiatric wards. See Glasscote & Kanno, General Hospital Psychiatric Units 16-21 (1965), published by The Joint Information Service of the American Psychiatric Association and the National Association for Mental Health.

65 Shock treatment is most effective in cases of depression: "Where immediate results are the most important consideration, as in the suicidal patient, there is no substitute for ECT [shock treatment] which is both the most effective and rapid treatment for depression. This method of therapy though, is much more difficult to administer than drugs, causes a particularly unpleasant side effect—impairment of memory—and does not lend itself well to maintenance therapy [outpatient care]. Wherever possible, therefore, endeavor to use pharmacotherapy [drugs] in treating depression." Lehmann, The Psychotropic Drugs: Their Actions and Applications, 2 Hospital Practice 74, 76 (1967).


67 It is clear that familial and patient consent is not possible in all cases. Some persons have no family, and others are unable to give consent because of their mental state. Parties uneducated in psychiatric technique may know nothing about shock treatment. This is especially true of the indigent. However, institutional refusal or failure to seek out cooperation of both family and patient, when it is possible, would seem to indicate a callousness inconsistent with proper methods of care.

68 There is "overwhelming evidence, not only abroad, but now in his [sic] country, that loss of liberty harms the mental patient and is unnecessary for the public safety. Indeed, it has been amply demonstrated that freedom is a therapeutic tool, that it speeds recovery and that it therefore is conducive to economy." Testimony of Albert Deutsch, 1961 Senate Hearings 45.
the type of patient involved, the seriousness of the circumstances which led to the restraint, the possible use of the restraint as punishment, and the possible use of restraint as an example to other patients.

Similar problems arise with respect to the overuse of tranquilizers and other drugs. The advent of tranquilizers has led to a reduction in the use of physical restraints in many institutions. While medicines may be used in a salutory fashion, continual mental stupor is not very different from continual physical restraint. Since the overuse of drugs cannot be said to be beneficial treatment, doubtful use of drugs could lead to the same sort of inquiry as in the case of doubtful use of physical restraints.

Judicial relief for situations of mistreatment or abuse can be obtained by the use of injunction, mandamus, or habeas corpus. These remedies all embrace solutions short of release. The structure of any remedy certainly may vary from case to case, since the use of restraint, drugs, or shock treatment may be necessary in certain cases. The ability to remedy situations of mistreatment or abuse without release avoids the necessity of considering the possible cost to society involved in the release of dangerous personalities. The question of amenability to treatment is also not relevant here; regardless of whether a person is amenable to treatment, it is apparent that mistreatment should not be condoned.

As the conditions in which a patient is found move away from mistreatment or abuse toward a state of inactivity or minimal treatment, the courts will be faced with different and still more complex issues.

69 Id. at 42. See also GLASSCOTE & KANNO, GENERAL HOSPITAL PSYCHIATRIC UNITS 16-21 (1965).

70 Drugs are generally divided into three classes. The major tranquilizers deal with psychotic patients, the minor tranquilizers with various neuroses, and the antidepressants with cases of depression. Abuse arises when drugs are used in ways other than as tools to aid a psychiatrist in his work with patients. For a short survey of medical theory about drug usage, see Lehmann, supra note 65.

71 Mis-treatment less severe than that discussed above is involved in the withdrawal of what are commonly called institutional "privileges." For a recent critique of the privilege doctrine, see Reich, The New Property, 73 YALE L.J. 733 (1964). Courts have been especially fearful of becoming involved in inquiries into such matters as letter mailing, visitation rights, library use, or other institutional amenities. See, e.g., Sutton v. Settle, 302 F.2d 286 (8th Cir. 1962); Haynes v. Harris, 344 F.2d 463 (8th Cir. 1965). Given the possibility of constitutional deprivations, such hesitancy seems unjustifiable. Allegations of unnecessary withdrawal of institutional amenities could lead to inquiry into the reasons for the withdrawal and the severity of the curtailments. The curtailment of "normal" living activities should be investigated to see if the withdrawal is harmful to the possibility of effective treatment, or if the withdrawal hinders a patient in his efforts to perfect an appeal of his commitment. See Johnson v. Avery, 252 F. Supp. 783 (M.D. Tenn. 1966); Note, Habeas Corpus: Right of Prisoners to Assistance of "Jail-House Lawyers," 66 COLUM. L. REV. 1542 (1966).
The institutional problems may not be solved by the use of injunctions or mandamus for correcting deficiencies. The courts will have to consider the possibilities of transfer or conditional or outright release. The necessity for considering the "treatability" of the patient and the patient's "dangerousness" to others then arises. No longer concerned with mistreatment or abuse, the courts will move towards inquiries into the character of a patient's treatment or proposed treatment. These inquiries involve standards applicable to institutions in general and treatment methods applicable to particular forms of disability.

Quantitative measures may be used by the courts in an effort to bring general standards into the evaluation of state and federal institutions. Patient to staff ratios, figures on the size of hospital budgets, cost per patient statistics, and sociological, physiological, and psychological data on general treatment methods are all available in varying degrees for various kinds of institutional problems. Although these quantitative measures are only partial indicators of an institution's quality, they may demonstrate inadequacies inconsistent with the duty to provide treatment. The quantitative indices may thus be used as background material in efforts to define the character and extent of an individual patient's right to treatment. A finding that an institution does not meet the minimum general standards as established by the court should make it much more difficult for a state or federal institution to demonstrate that it is making reasonable treatment efforts for a particular patient. The average of the fifty states in areas such as state expenditures cannot be used as a proper standard, since the general level of state effort appears so low. Instead, standards of the American Psychiatric Association might be used as a base. The factor of accreditation by the Association or a similar group should certainly be considered in the evaluation of any institution.

Beyond general standards, it is also necessary to consider the method of treatment best suited for the patient's particular form of disability. The method of treatment is the issue most closely associated with the discretion of the hospital administrator. It is at best difficult and prob-

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73 Kanno & Glassco, Fifteen Indices (1966).

74 See American Psychiatric Association, Emerging Patterns of Administration in Psychiatric Facilities (1964); American Psychiatric Association, Standards for Hospitals and Clinics (1958); Glassco & Kanno, General Hospital Psychiatric Units (1965). Rouse v. Cameron, 373 F.2d 451, 467, n.34 (D.C. Cir. 1966), suggests that other sources for standards might include the National Institute of Mental Health, The National Association of State Mental Health Program Directors, The Group for the Advancement of Psychiatry, and experts from various universities.
ably unwise for courts to prescribe a course of treatment. However, some inquiry may be necessary. The objectivity of testimony by institutional psychiatrists has been seriously questioned, since the psychiatrist must play a dual role as both psychiatrist and prosecutor. Independent psychiatric testimony may be used in order to evaluate more fully the quality of an institution’s program. The court’s inquiry will vary depending upon whether the proceeding is an original commitment or a habeas corpus proceeding. Only in the latter is a specific course of treatment, or lack thereof, open for review. In a case of original commitment, the inquiry must involve treatment methods now being used with patients similar to the proposed inmate.

The treatability of the patient is intimately connected with any proposed treatment method. In some cases of serious mental illness or addiction, it is difficult to predict whether a certain person can be effectively treated. Other types of conditions are presently seen as entirely untreatable. The problem of the person not amenable to treatment was presented, but not effectively dealt with, in People v. Rancier. The court simply said that the patient was diagnosed as untreatable but would be given more treatment. The court, in allowing the confinement to continue, relied heavily upon the alleged social dangerousness of the petitioner. No effort was made to fully investigate the treatability of the patient, and no inquiry was made into the type of treatment being given him. Rancier should be contrasted with Lake v. Cameron, which involved the commitment of an allegedly senile woman. The court ordered that possible alternatives to total confinement, including various semicustodial arrangements, be investigated. Only in the last resort would the court allow total confinement.

Rancier, while an ineffective opinion, is a good illustration of the relationship between the amenability to treatment and the social dangerousness of a patient. The degree to which a patient is a threat to the general society or to himself must play an important part in any


77 Among these untreatable conditions are some congenital mental defects and some forms of senility.


rates for similar patients, if such figures were available or could be fairly easily collected.

80 364 F.2d 657 (D.C. Cir. 1966).

Such an investigation could have been made by studying release and recidivist
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Commitment as to the possible release of the patient. However, because unsusceptibility to treatment, without a change in our state of knowledge, may lead to confinement for the life of the patient, it should be substantially more difficult to commit or maintain the commitment of an untreatable person than a treatable person subject to release upon improvement; the required degree of dangerousness should be substantially higher in the case of a person not amenable to treatment. Proper hesitancy to invoke the full measure of confinement is well demonstrated in Lake v. Cameron, most notably in the concurring opinion of Judge Skelly Wright. Noting that the evidence only demonstrated that Mrs. Lake was somewhat senile and "unable to care for herself at all times," Judge Wright refused to "accept the proposition that this showing automatically entitles the government to compel Mrs. Lake to accept its help at the price of her freedom." Accordingly, it would seem to be totally unjustifiable to commit a relatively harmless but untreatable individual; the lack of danger to the society or to the individual should preclude such state activity.

The applicability of commitment statutes to treatable persons who are not being mistreated or abused involves the great bulk of cases which would be brought to request the enforcement of a patient's right to treatment. The Public Health Service Draft Act, while providing a basis for a discussion of these cases, does not explain the impact of the differences between persons dangerous to others, persons dangerous to themselves, and persons in need of treatment, upon substantive issues of commitment, treatment, and release. For the purposes of evaluating the various remedies of a patient whose right to treatment is being or may be violated, it is necessary to investigate, in this respect, the relative merits of the several categories.

Persons dangerous to others may include the criminally insane, violent juveniles, and aggressive psychotic personalities. Commitments

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81 Indeterminate commitments are usually the result of involuntary commitments. The new narcotics commitment statutes are generally an exception, in that a maximum period of confinement is defined in the statutes. E.g., CAL. WELFARE & INST'NS CODE § 3201 provides for a maximum commitment of seven years. However, the same section provides that the court may extend the commitment if it finds reasonable grounds, and that a patient may be recommitted without regard to past time spent in an institution for addicts. Ibid.

82 364 F.2d at 662.

83 364 F.2d at 663-63.

84 Note that this would limit the scope of the Draft Act substantially in cases of unsusceptibility to treatment. The third category would be eliminated, and the use of the first two would require higher than normal thresholds of proof.

85 See text accompanying note 8 supra.

of these persons generally result from the desire to protect the community, as well as to aid the patient,\(^87\) and the hesitancy of courts to become involved in treatment issues in such cases may well result from the understandable fear of releasing dangerous persons from public wardship. However, such a fear is unjustifiable if less drastic remedies than release can be tailored to meet the situation of a socially dangerous person confined, or about to be confined, in an institution not equipped to offer treatment.

To the extent that lack of treatment is traceable to the actions of hospital administrators, a remedy will lie to correct the faults.\(^88\) The effect of any remedy upon a particular hospital administration may be small because of the lack of funds, staff, and facilities.\(^89\) However, the effect might be broadened if a patient is transferred to a better hospital. The difficulty lies, of course, in locating a more palatable institution. *Nason v. Commissioner of Mental Health*\(^90\) represents the all too frequent case in which the picture at the petitioner’s hospital may not have been as gloomy as at other Massachusetts institutions to which he might have been transferred.\(^91\) However, such a dismal situation should not preclude a search for what may only be a minimal improvement in the patient’s environment; the court should be concerned with finding the institution which will best aid the patient. The factor of social dangerousness may be a basis upon which an institution is chosen, but it should have no effect upon the duty of a state to find the best institution for the particular patient. This duty is also present with respect to persons about to be committed. While a prospective patient obviously cannot

\(^{87}\) E.g., Sas v. Maryland, 334 F.2d 506 (4th Cir. 1964).


\(^{89}\) See authorities cited notes 2, 4-7 supra.

\(^{90}\) 217 N.E.2d 733 (Mass. 1966).

\(^{91}\) *Id.* at 735 n.3 reads: “This testimony [of several physicians] showed that in 1963 Bridgewater was ‘markedly understaffed.’ It did not then have the six physicians allocated as its ‘quota in the budget,’ but in addition to the director of clinical psychiatry had only two other physicians, neither of whom was able to give psychotherapy. The director’s time was largely taken with court appearances, administrative work, and three staff meetings a week. Most of the State’s mental hospitals were undermanned; even with a staff of six Bridgewater would have been at marginal level. At that time Bridgewater did not give treatment unless ‘it’s an emergency.’ An effort was made to give treatment as much as possible. Nason was not receiving treatment. Medication had been prescribed and he had refused it. Nason would in the opinion of the physicians benefit from electric shock treatment or insulin therapy which was not provided. At the close of a hearing on December 13, 1963, the judge in Superior Court said, ‘On Dr. Allen’s testimony, Bridgewater isn’t fit for anybody.’ The assistant district attorney representing the Commonwealth said, ‘I agree with you, Your Honor. It’s a deplorable condition. I believe it should be remedied.’”
be transferred, the investigation of various confinement choices would seem to be required for all patients.92

Inability to alter an existing hospital environment by administrative change or transfer should not mean that a socially dangerous person is precluded from seeking further relief. Because it is clear that some persons are not as dangerous as others, the balance between public safety and an individual's well being will not be the same in every case. In both pre- and post-commitment cases, the use of outpatient care, custody awards to private institutions or foster parents, "work-out, sleep-in" arrangements, or other semicustodial schemes should be considered. The use of drugs and tranquilizers, now common in mental institutions,93 may provide a means of continuing care on an outpatient basis.

Furthermore, it may be appropriate in some cases to issue a moratorium order providing that failure to institute treatment within a certain period would result in the release of the patient.94 The fashioning of the moratorium period, like the fashioning of probationary arrangements, should turn upon the degree of the patient's social dangerousness, the treatment being given, the possibility of successful treatment, and the length of the patient's previous confinement, if any.95 Finally, if it is felt that the lack of treatment outweighs other considerations of public policy, the remedy of outright release or refusal to commit would be in order.

92 Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966). Also note that if and when more funds become available to various institutions, the range of transfer choices will increase.93 See authorities cited note 64 supra.
94 A well known precedent is provided by Brown v. Board of Education, 349 U.S. 294 (1955).
95 Another factor may be introduced by a suggestion that "power over a criminal's life should not be taken in excess of that which would be taken were his reform not considered as one of our purposes." Morris & Howard, Studies in Criminal Law 175 (1964). The implication of this idea is that a criminal would not be committed on any grounds for a period longer than the maximum possible prison term allowed for his crime. Note that indeterminate terms of commitment have been upheld as an intimate part of the commitment power. E.g., Director of Patuxent Institution v. Daniels, 243 Md. 16, 221 A.2d 387 (1966). This principle is severely limited by its inapplicability to non-criminal proceedings. Robinson v. California, 370 U.S. 660 (1962), takes a certain group of persons out of the "criminal" category. As a corollary to the Morris & Howard standard, it would be possible to prohibit the commitment of these persons for periods longer than the maximum prison term for their "ancestor crimes," i.e., ninety days in the case of Robinson. If there is no criminal or quasi-criminal act as the precipitating circumstance for the commitment, definitive moratorium standards cannot readily be found. The general use of the Morris & Howard standard in situations where "criminal" patients are receiving treatment may be unwise. The general fear of releasing dangerous persons may be a justifiable basis upon which to object to the general use of the standard.
The second broad category of persons that the Draft Act would commit is persons dangerous to themselves. A typical example is a commitment after an attempted suicide. The purpose of this confinement is not only to treat the patient, but also to protect the patient from himself. As in other confinements, a balancing of interests must take place before the commitment of any person supposedly dangerous to himself may be initiated or continued. The institution to be provided for the benefit of the proposed patient must guarantee greater safety for the person than he would be guaranteed by living according to his own tastes. In fact, it would seem that the difference between the patient's institutional and community levels of safety should be very substantial in order to justify the deprivation of liberty and possible harm to the patient involved in a commitment. Because of the lack of danger to the general society, the interest of the state in the commitment of persons dangerous to themselves is not as substantial as in the commitment of socially dangerous persons; there ought not to be as much need for caution in the release of persons dangerous to themselves in comparison with persons dangerous to society.

Efforts to gain administrative changes or transfer to a better institution are possible first approaches to the problem of a person dangerous to himself confined in a non-treating institution. However, if neither administrative changes in the hospital nor transfer to a different institution would alleviate the violation of a patient's right to treatment, the remedy of release should be seriously considered. Similarly, for patients about to be committed, a refusal to commit becomes a definite possibility when a suitable hospital cannot be found for the defendant. The release or refusal to commit could be either absolute or limited, depending upon the patient and the type of violation or possible violation of the person's right to treatment. The possibility of outpatient care through the use of drugs must again be considered. Because of the difference in a state's interest in the commitment of persons dangerous to society and dangerous to self, a violation of the right to treatment not correctable in a short period of time may often overcome a state's interest in the continued total confinement of persons dangerous to

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96 Ross, supra note 75, at 954-60; Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 79 HARV. L. REV. 1288 (1966). This analysis presumes that suicide is not as serious as assault or other socially dangerous activities. That suicide is a crime in some states does not seem to detract from the argument. Ross, supra note 75, at 957, posits the case of an old man, living alone on a farm, subject to fits of severe depression. The man desires to remain on the farm, despite the fact that the odds of suicide are high. Should he be committed despite the lack of danger to the general community? The problem's force may be seen if two facts are changed. Shift the man to a city apartment building, and suppose his cycles of depression endanger the safety of the little girl across the hall.
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themselves. The use of moratorium periods would seem to be necessary in only the most serious cases.

The third group of persons committable under the Draft Act involves those in need of treatment, but lacking sufficient rationality to make a proper choice as to hospitalization. Persons committed within this or a similar category often are passive homosexuals, narcotics addicts, and alcoholics. The extension of involuntary commitment into this area has been something less than gratifying and successful. Since commitments of persons in need of treatment do not involve consideration of substantial danger either to society or to self, the traditional bases of commitment, yet still entail unfortunate debasing and stigmatizing effects, the interest of the state in the forceful commitment of non-dangerous persons would seem to be small. The only possible basis for the commitment of these types of persons is treatment, with the goal of returning the persons to society to fill more productive roles than before commitment. Even this goal is somewhat ambivalent, since the validity of the assumption that all narcotics addicts and homosexuals are now unproductive members of society is questionable. Generally, when the stigmatizing effects and involuntary nature of commitment are joined with lack of treatment, it appears difficult to justify the actions of the states in the confinement of persons in need of treatment.

Even more difficult is the problem of prospective mental illness or addiction. In People v. Victor, the confinement of persons "in imminent danger of becoming addicted" was held to be within the police power of the states. This decision has been sharply criticized. The use


98 The traditional bases of commitment were the police power for those dangerous to society and parens patriae for those dangerous to themselves. The two concepts have now become intertwined and virtually lost as involuntary commitment schemes have grown in scope.

99 See authorities cited supra note 97. It has been suggested that confinement of those in need of treatment is hardly justifiable regardless of the existence or non-existence of treatment. Whitmore, Comments on a Draft Act for the Hospitalization of the Mentally Ill, 19 Geo. Wash. L. Rev. 512, 522 (1951); Note, 79 Harv. L. Rev. 1288 (1966). But see Ross, supra note 97, at 959. Ross also suggests that the justifications for commitment under this third category are about the same as for the institution of guardianship. May not guardianship provide a viable alternative to commitment in some cases?

100 Schur, op. cit. supra note 97, at 102-04, 128-29, 138-41.


of involuntary commitments to deter addiction would seem to reflect a serious confusion as to the proper role of psychiatric and hospital care. It has been suggested that:

[T]here is a clear difference between the medical, social welfare, psychiatric and child care functions of the state and its police and correctional functions. There is too much confusion of purposes and too frequently a sacrifice of justice when we combine the several justifications the state may have for taking power over a citizen's life and in so doing expunge or attenuate the existing limitations and controls of power that each has developed. This confusion, productive of injustice, is frequently to be observed.\textsuperscript{103}

Given the doubtful status of commitment of non-dangerous persons, a violation of the right to treatment should lead to immediate release, unless it can be shown that administrative change or transfer to another institution will alleviate all violations of the patient's right to treatment. Unlike commitments because of dangerousness, there are no state interests to balance against the right of the patient to receive treatment. The only state function must be to restore the committed person to a normal societal role; and if the state does not conscientiously pursue that goal, the patient should be entitled to his release.

II. BURDEN OF PROOF

At original commitment proceedings the state must demonstrate that the patient qualifies for commitment pursuant to the terms of a relevant statute.\textsuperscript{104} However, the courts usually reverse the rule at habeas corpus or recommitment proceedings:\textsuperscript{105} "The presumption of fact is that the condition of insanity continues to the present time, with the result that the burden of proving sanity is upon the person seeking release."\textsuperscript{106} In Overholser v. O'Beirne,\textsuperscript{107} it was held that the patient must demon-

\begin{footnotes}
\textsuperscript{104} This burden is usually based upon the "weight of the evidence" in regular commitment proceedings. People v. Covey, 34 Ill. 2d 195, 215 N.E.2d 220 (1966); People v. Pearson, 65 Ill. App. 2d 264, 212 N.E.2d 715 (1965). However, if the commitment occurs after an insanity defense in a criminal trial the evidentiary rules of the criminal law apply to the defense. If the defendant can create a reasonable doubt as to his sanity, the defense will succeed. It has been suggested that because of the harmful effects of commitment statutes, the general "weight of the evidence" rule should be changed to something closer to "beyond a reasonable doubt." Such a standard may be "by clear and convincing evidence" or "highly likely to commit a dangerous act." 79 Harv. L. Rev. 1288 (1966).
\textsuperscript{105} See authorities cited supra note 7.
\textsuperscript{107} 302 F.2d 852 (D.C. Cir. 1962).
\end{footnotes}
strate that "recovery has reached the point where he has no abnormal mental condition which in the reasonably foreseeable future would give rise to danger to the petitioner or to the public in the event of his release."\textsuperscript{108}

Presumably, the high threshold for release results from a fear of "unfortunate incidents" after premature releases.\textsuperscript{109} While prevention of premature release from a treatment situation may be a laudable goal, there are difficulties with the present burden of proof rules which suggest a need for reappraisal. The patient is faced with several problems in seeking to gain his release. He has a difficult time obtaining beneficial evidence; he is confronted with an unreasonably high burden in order to gain his release; he finds the institutional forces which are supposed to be aiding him arrayed in opposition to his release.

The state has available a great deal of evidence that can be used against a patient; psychiatric reports and institutional doctors are readily obtainable.\textsuperscript{110} By contrast, the patient has a very difficult time obtaining information for his own case. A patient’s ability to talk with "outside people" is often sharply limited.\textsuperscript{111} If the patient is indigent, as is often the case, access to counsel and psychiatric help is further limited.\textsuperscript{112} The practical result is that the state has most of the evidence and the patient has the burden of proof, a situation which would appear to contradict the general rule that the burden of proof should not be placed upon that party which has a significantly inferior access to evidence.\textsuperscript{113}

Not only is the burden misplaced, but the extent of the burden placed upon the patient is unreasonable. The most severe rules require proof that recovery has reached the point where no dangerous mental

\textsuperscript{108} Id. at 854.

\textsuperscript{109} Note that release rates are up along with commitment rates. See note 1 supra. It could be that the reason the release issue has not been raised often is that the states have been forced to release patients because of lack of space.

\textsuperscript{110} It is distressing to note that the psychiatrist must use as evidence a patient’s own statements. Because the procedure is said to be civil there is no violation of the fifth amendment. If the patient refused to cooperate, the psychiatrist may use this against the patient as well. Compare In re Maddex, 351 Mich. 358, 88 N.W.2d 470 (1958), with People v. Bruckman, 33 Ill. 2d 150, 210 N.E.2d 537 (1965).

\textsuperscript{111} See authorities cited supra note 23.

\textsuperscript{112} It is not at all outrageous that the state should furnish medical assistance to its patients, just as some states require counsel to be appointed in commitment proceedings. Presently, it is virtually impossible for an indigent patient to get such assistance. Testimony of Mr. McGee in Hearings on a Bill to Protect the Constitutional Rights of the Mentally Ill Before The Subcommittee on Constitutional Rights of the Senate Subcommittee on the Judiciary, 88th Cong., 1st Sess. 225 (1963). See also Szasz, Hospital Refusal to Release Mental Patient, 9 CLEV.-MAR. L. REV. 220 (1960).

\textsuperscript{113} E.g., Erving Paper Mills v. Hudson-Sharp Mach. Co., 332 F.2d 674 (7th Cir. 1964).
condition exists. To require such absolute proof about the mental health of a committed individual is prohibitive. Absolute behavioral predictions cannot be made about any human being. While such an extreme burden is not always required, even a requirement of probability, rather than certainty, as to one’s future behavior unreasonably places a heavier burden upon the patient to obtain his release than is cast upon the state to obtain an original commitment. Regardless of the degree of the burden, the state must produce evidence that a man is mentally ill and either socially dangerous, dangerous to himself, or in need of treatment in order to obtain a commitment. The patient must demonstrate that he is not mentally ill, not socially dangerous, not dangerous to himself, and not in need of treatment in order to obtain release. The patient’s burden is clearly the more difficult, especially since he already finds himself confined in an institution.

Finally, the burden of proof alignment contradicts the supposed beneficence of state commitment schemes. To forcefully institutionalize a person without providing access to treatment while enforcing a high threshold for the patient to gain his release is a distressing anomaly. Just as the inequities involved in a commitment—stigmatization, the inexact nature of psychiatry—should require caution in originally depriving a person of his liberty, the same inequities should lead to careful scrutiny of any effort to maintain a commitment. If inability to obtain treatment creates gross inequities in commitment systems, inability to obtain release creates similar inequities. The foundation factors of the

114 Overholser v. O'Beirne, 302 F.2d 852 (D.C. Cir. 1962); People v. Misevic, 32 Ill. 2d 11, 203 N.E.2d 393 (1964).
115 In Chicago a man, originally held for a misdemeanor, was committed. After twelve years in an institution (the institution was a psychiatric ward of the state prison, in itself a possible violation of the patient's right to treatment), psychiatrists were ready to release him. However, the criminal court judge refused to release the man "unless there is some assurance he will never commit another dangerous sexual act." Chicago Sun-Times, Oct. 20, 1966, pp. 4, 42. The psychiatrists refused to give such absolute testimony. Only after much adverse publicity did the judge relent. However, the general rule remains. People v. Misevic, 32 Ill. 2d 11, 203 N.E.2d 393 (1964). In Misevic, the patient was asked to show that he was entirely and permanently cured, despite the fact that he was not entirely treatable. The court simply noted its sympathy for the patient and went on to cite the parens patriae power of the state. It is inconceivable that the court could miss the contradiction between the harshness of its decision and the supposed benevolence of the parens patriae theory.
117 The court in Overholser v. O'Beirne, 302 F.2d 852 (D.C. Cir. 1962), was not at all disturbed by its harsh decision: "[S]ociety is discharging an obligation to O'Beirne in the procedure established by Congress to assure him psychiatric care at public expense." Id. at 859.
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right to treatment lead to the conclusion that the patient should not be forced to carry the entire burden of gaining his own release. The most equitable method of preventing premature release would seem to lie in a fair method of eliciting pertinent evidence, and not in the automatic placement of an unreasonably high burden of proof upon one party.

Similarly, the burden of proof as to treatment sufficiency should not be placed entirely upon the patient. The close relationship between the type of disability and the type of treatment needed to deal with the disability renders the possibility of different treatment of the two evidentiary burdens unattractive. The threefold difficulty outlined with respect to the present burden of proof rules as to mental illness applies with equal force to the proof of treatment sufficiency. The District of Columbia Court of Appeals, in remanding a case for consideration of alternate courses of treatment of an allegedly senile woman,\textsuperscript{118} recognized the problems:

Appellant may not be required to carry the burden of showing the availability of alternatives. Proceedings involving the care and treatment of the mentally ill are not strictly adversary proceedings. Moreover, appellant plainly does not know and lacks the means to ascertain what alternatives, if any, are available, but the government knows or has means of knowing and should therefore assist the court in acquiring such information.\textsuperscript{119}

Casting a burden upon the state to "assist" the patient in the gathering and presentation of evidence necessitates the answering of three questions. First, what initiative should be required of a petitioner before the state must actively take part in a case? Second, what should be the nature of the assistance required of the state? And third, what findings should be required for the maintenance of a commitment?

The habeas corpus standards of \textit{Sanders v. United States}\textsuperscript{120} enable a court to dismiss a petition if it is conclusively without merit. This clearly requires that a patient come forth with allegations sufficient to cast doubt upon some state activity.\textsuperscript{121} Allegations that the patient is no longer susceptible to original commitment, that the patient is not

\textsuperscript{118} Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966).
\textsuperscript{119} Id. at 661.
\textsuperscript{120} 373 U.S. 1 (1963). See notes 56-59 \textit{supra} and accompanying text.
\textsuperscript{121} It could be argued that patients should be required to take little if any initiative. Mental disabilities may prevent some persons from pursuing their remedies. If there are no relatives or friends willing to help, these persons vegetate. Perhaps automatic re-hearings should be required in all cases. Such a requirement certainly seems justified in cases of patients with no ability to pursue relief.
receiving treatment or is being mistreated, or that the patient is untreatable and therefore subject to indeterminant confinement should each be sufficient to create substantial issues for judicial determination. Patient petitions should certainly be treated with the same "permissiveness" with which in forma pauperis petitions of prison inmates are now considered. In light of the inability of patients to obtain either information or "outside" help, exacting pleading requirements would defeat many patients' cases at the outset.

Once such allegations are made, the state should be obliged to assist in the handling of a case whenever the court finds such help to be necessary. Petitioners able and willing to present complete cases should certainly be allowed and encouraged to do so. However, the court must be quick to seek help where patients are unable to competently present their own cases. The state should be asked to present evidence not easily obtainable by the patient. Assistance must also come from the court itself. The appointment of counsel and the summoning of independent psychiatrists may be advisable. Judges must realize that "typical" adversary proceedings are not successful in commitment proceedings. The court should plunge into the questioning process rather than sit back in "judge-like splendor." Psychiatric testimony should be especially subject to close and exacting examination. Statements as to the social dangerousness of the patient should lead to further questions as to the reasons for the medical judgment.

Finally, it must be asked what standard should be required for the maintenance of a commitment. The standard of regained sanity is inexact even in comparison with original commitment standards. Total recovery or a threshold close-to-total recovery is unrealistic in the light of human unpredictability. The Draft Act provides that the hospital administrator shall order the release of a patient when "the conditions justifying original hospitalization no longer obtain." The application of such a standard to court, as well as administrative, action should be encouraged. The threshold at which the state may take action should also be the threshold at which the state ceases its activity. The result would be a general rule that the state cannot maintain a confinement unless the patient is susceptible to original commitment.

122 See authorities cited supra note 3.
124 Differences arise in the types of proceedings which can lead to an original commitment. The most pronounced differences appear when a regular commitment hearing is compared with a criminal trial. In the latter, an insanity defense may lead to commitment rather than incarceration. In insanity defense commitments regular civil commitment standards may be used by the judge in his commitment decision unless commit-
Under the Draft Act an original commitment can be made if a person is shown by the weight of the evidence to be mentally ill and to be dangerous to society, dangerous to himself, or in need of treatment. The policy considerations involved in these various types of commitments imply that the type of proofs required for each type of commitment must vary. For example, as a person becomes more or less socially dangerous, the policy of public protection becomes more or less important. The courts must be extremely careful in sifting through the concepts of dangerousness and amenability to treatment when maintaining a commitment for reasons different than those which led to the original commitment.\(^{125}\)

While the primary concern of this discussion has been with recommittment and habeas corpus proceedings, original commitment issues of proof should also be carefully reconsidered. Issues of dangerousness, amenability to treatment, and treatment sufficiency cannot, for reasons similar to those previously outlined, be arbitrarily assigned as affirmative defenses. Once again, the state and the court should assist in the development of the issues. The mental state of a proposed patient should be carefully reviewed to insure that state activity is justified in the particular case. Although the sufficiency of the treatment of a proposed patient cannot be reviewed for lack of a hospital history,\(^{126}\) a review of the state of affairs at the institution to which he is going to be sent is certainly proper.

### III. Conclusion

The judicial approval of involuntary commitment rests upon the assumption that the state is pursuing beneficent purposes for the general society and for the person committed. In many cases the facts of institutional confinement belie the judicial theories used to uphold involuntary commitment schemes. The resulting violations of rights protected by the due process clause should make remedies available to the patient in order to gain treatment, and in some cases, to gain release. The issues of treatability and social dangerousness should be

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\(^{125}\) See ibid.

\(^{126}\) This may not be completely true if the proposed patient is a recidivist recently released. In such a case, the lack of treatment during the previous commitment may cast doubts on the ability of the state to treat the patient.
carefully considered in each case in order to construct remedies best suited to the individual patient. The present burden that a patient must carry in order to gain his own release is inequitable, unreasonable, and contrary to the assumed beneficence of the state's commitment schemes. The complex of obligations properly placed upon a state to maintain or initiate its control over involuntarily committed persons holds promise of remedying some of the abuses presently existing in the use of mandatory commitments.

"Mostly, I'd just like to look over the country around the gorge again, just to bring some of it clear in my mind again. I been away a long time."127

127 KESEY, ONE FLEW OVER THE CUCKOO'S NEST 311 (1962).