Postcommitment: An Analysis and Reevaluation of the Right to Treatment

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NOTES

POSTCOMMITMENT: AN ANALYSIS AND REEVALUATION OF THE RIGHT TO TREATMENT

I. Introduction

During the nineteenth century, bizarre or unusual behavior subsequently labelled mental illness was thought to be caused by disease. The disease theory stemmed partially from the fact that at that time a significant number of behavioral disorders were organic in nature—the result of syphilis. Terminology commonly associated with physical infirmities such as "patient," "illness," "hospital," "diagnosis," "therapy," and "cure" were similarly in relation to mental disorders. The idea soon developed that people suffering from the "sickness" could best be "treated" within mental "hospitals." In essence a treatment paradigm had been created.

While there undoubtedly still exist numerous organic causes for behavioral problems, the recent trend has been developing away from the solitary disease concept. It is increasingly being recognized that mental illness is a very broad and ambiguous label, generally referring to a wide range of social behavior. Behavioral and sociocultural theories defining mental illness as essentially problems in living have gained wide acceptance. As a consequence of the diversity of sources from which deviant behavior can stem, any single approach to defining and alleviating mental illness is ineffectual. Yet, this is precisely what society has done. The conceptualization of mental illness as a "sickness" has led to development and perpetuation of state mental hospitals. While the trend has been away from the overly simplistic medical approach, society has failed to respond and has not created nonmedical alternatives with which to remedy the problems. Perhaps the reluctance to do so is due in part to the pervasiveness of the treatment paradigm itself coupled with the fact that mental hospitals are a relatively inexpensive device for removing social undesirables from

2 Id. at 3.
3 Id. at 5.
4 See generally A. Deutsch, The Mentally Ill in America (2d ed. 1949). The medical approach to mental illness is illustrated by the following excerpt:

The remarkable achievements of medicine had been based on the conception of disease as a state of affairs or a process which had a specific etiology, a predictable course, manifestations describable in signs and symptoms, and a predictable outcome modifiable by certain describable maneuvers. Mental illness became described according to the same basic notions. The discovery of knowledge of some etiological agents like the [syphilis] spirochete provided justifiable basis for the expectation that the problem about the etiology of mental illness could be solved along similar lines as in medicine. . . . In this framework psychopathology is viewed as an in-dwelling property of the patient, as something the patient has.

5 See Milton, supra note 1.
7 See generally Milton, supra note 1.
the mainstream of society. Whatever the reasons, the lack of realistic alternatives for the nonmedically mentally ill poses serious legal problems as to the states' power to involuntarily confine such individuals in these restrictive mental facilities.

Traditionally, the legal rights of mentally handicapped individuals confined to institutions have rested with administrative agencies and only given cursory treatment by state legislatures. As a result, the mental patient has suffered great deprivation of individual liberties and is subjected to a dehumanizing environment. While the courts have considered who shall be committed and for what duration, the issue of postcommitment responsibilities has only recently caused judicial concern. The ambiguous nature of mental illness and a perceived lack of expertise on the part of judges have largely accounted for this dearth of judicial intervention.

In recent years increasing attention has justifiably been given the rights of mental patients in the postcommitment environment. As Judge Bazelon noted in Covington v. Harris, "it makes little sense to guard zealously against the possibility of unwarranted deprivations prior to hospitalization, only to abandon the watch once the patient disappears behind the hospital doors." Because of social concern over the disarray and deplorable conditions found in certain mental institutions, the courts have been receptive to legal challenges

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8 The cost of community-based programs is generally regarded as more expensive than the institutional approach. See generally R. Moos, Evaluating Treatment Environments: A Social Ecological Approach (1974).


12 See note 96 & accompanying text infra. See also Bazelon, Foreword to a Symposium on the Right to Treatment, 57 Geo. L.J. 676 (1969).


For example, in Wyatt, Alabama's principal facility for the mentally retarded had been evaluated by the A.A.M.D. [American Association for Mental Deficiency] several years before commencement of the Wyatt litigation. The evaluation identified numerous conditions that were incompatible with even the most primitive notions of human decency. For example, evaluators found that in a ward of ambulatory severely retarded young boys: "Ground food was brought to the day room in a very large aluminum bowl along with nine metal plates and nine metal spoons. Nine working residents were sent in to feed these 54 young boys from this one bowl of food and nine plates and nine spoons. The feeding was accomplished in a total state of confusion. Since there were no accommodations to even sit down to eat, it was impossible to tell which residents had been fed and which had not been fed with this system."
made by confined mental patients. The primary vehicle for implementing the legal rights of these patients has been the right to treatment concept. While it cannot be denied that mental patients do have legal rights, the treatment concept and its development require critical analysis. The concept appears to be an extension of the treatment paradigm in that it attempts to rectify inadequate conditions within mental hospitals instead of addressing mental illness in a broader context. Even if the right to treatment concept were fully implemented there would still remain numerous, needlessly involuntarily confined individuals suffering from nonmedical problems for whom the best of state hospitals and treatment provide no relief. The liberty and fundamental rights of these individuals must be considered before the judiciary acquiesces in society's blunder of incarcerating social deviates under the guise of their need for treatment or the mental illness label. The position taken herein is that the right to treatment concept and its corresponding standards represent an inadequate approach.

II. The Right to Treatment Concept

The impetus for the concept of the “right to treatment” originated with a 1960 article by Morton Birnbaum, an attorney and physician. Birnbaum's basic thesis argued that if society sought to deprive an individual of his liberty in order to provide care and treatment, courts should ensure that such treatment is in fact provided.

Rouse v. Cameron first recognized this right to treatment. Charles Rouse had been committed to a state mental institution after being found not guilty by reason of insanity for carrying a dangerous weapon, a misdemeanor having a maximum one year sentence. Four years after being involuntarily committed, Rouse sought release on a habeas corpus petition contending that he was not receiving adequate treatment and was no longer insane. Judge Bazelon, writing for the court of appeals, held that Rouse possessed a statutory right to treat-
the case was remanded for a hearing on whether the petitioner had in fact received adequate psychiatric treatment.

Rouse was a landmark decision because it was the first case to hold that society has a legal duty to provide adequate treatment and to ensure that confinement for purposes of treatment does not degenerate into punishment. Although Rouse was premised on statutory grounds, dicta in the opinion suggested that failure to provide treatment could raise serious constitutional questions of due process, equal protection, and cruel and unusual punishment.

A constitutional basis for the right to treatment for involuntarily committed mental patients was in fact established in Wyatt v. Stickney. The dismissal of 99 employees at Alabama's Bryce Hospital triggered a class action suit which challenged the quality of care and treatment received at the hospital. The plaintiffs, guardians of those involuntarily committed patients, contended that the failure to provide adequate psychiatric treatment had deprived the patients of their liberty without due process of law. The district court agreed, noting that when mental patients are committed involuntarily through noncriminal proceedings without constitutional protections that are afforded criminal defendants, "they unquestionably have a constitutional right to receive such individual treatment as will give them a realistic opportunity to be cured or to improve his or her mental condition." The court reasoned that adequate and effective treatment was constitutionally mandated because, absent treatment, the hospital was transformed into a penitentiary where one could be held indefinitely for no convicted offense. . . . To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.

Although Wyatt was a significant judicial breakthrough for the right to treatment, it was not until Donaldson v. O'Connor that the underpinnings of the new right were articulated in detail. In 1957 Kenneth Donaldson was com-

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21 D.C. CODE ANN. § 21-562 (Supp. V, 1966) provides:
A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment. The administrator of each public hospital shall keep records detailing all medical and psychiatric care and treatment received by a person hospitalized for a mental illness and the records shall be made available, upon the person's written authorization, to his attorney or personal physician.

22 373 F.2d at 461.
23 Since this difference rests only on the need for treatment, a failure to supply treatment may raise a question of due process of law. It has also been suggested that a failure to supply treatment may violate the equal protection clause. Indefinite confinement without treatment of one who has been found not criminally responsible may be so inhumane as to be "cruel and unusual punishment."

Id. at 453. For a discussion of the constitutional arguments in favor of a right to treatment suggested in Rouse, see Note, The Nascent Right to Treatment, 59 VA. L. REV. 1134, 1137-47 (1973); Note, Civil Restraint, Mental Illness, and the Right to Treatment, 77 YALE L.J. 87 (1967).
25 325 F. Supp. at 784.
26 Id. at 784-85.
27 493 F.2d 507 (5th Cir. 1974), vacated on other grounds, 95 S. Ct. 2486 (1975).
mitted to the Florida State Mental Hospital. Fourteen years later he secured his release through a habeas corpus proceeding by claiming that even if he were mentally ill, he had not received adequate treatment. Recognizing that civil commitment entailed a massive curtailment of liberty, the court of appeals sought to identify the governmental interests which could justify such deprivations. The court concluded that only where the individual was dangerous to himself, dangerous to others, or in need of psychiatric treatment could the state constitutionally civilly commit a person against his will. The court reasoned that in parens patriae commitment, the only justification for confinement was treatment of the individual and that fundamental due process required that treatment be rendered. Where justification for commitment was danger to self or others, the state was found to have a duty to extend treatment as the quid pro quo for its right to deprive individuals of their liberty in exchange for the safety of society.

III. Evaluation of the “Treatment” Theory

As in Wyatt, other courts have approached the right to treatment concept by analyzing the nature of commitment itself. It is generally recognized that a state can commit an individual through either its power as parens patriae or its police powers. The common law did not address involuntary civil commitment and related problems for the simple reason that mental institutions were virtually non-existent. However, under English law at the time of the American colonial period, the King had the authority to act as “the general guardian of all infants, idiots, and lunatics.” In acting as parens patriae, the King or his representative was required to promote the interests and welfare of his wards but was not empowered to sacrifice the ward’s welfare for the welfare of others. During “lucid

28 Donaldson had been diagnosed as a paranoid schizophrenic.
29 The action was filed pursuant to 42 U.S.C. § 1983 (1970).
30 The original complaint was filed as a class action on behalf of all patients on Donaldson’s ward. It sought damages for plaintiff and the class, habeas corpus relief for the entire class, and declaratory and injunctive relief requiring the hospital to provide adequate treatment. 31 493 F.2d at 520.
32 Id. At the district court, instructions to the jury suggested that treatment is constitutionally required only if mental illness alone, rather than danger to self or others, is the reason for confinement. See O’Connor v. Donaldson, 95 S. Ct. 2486, 2491 n.6 (1975).
33 493 F.2d at 520-27. The use of the parens patriae power to confine the mentally ill in order to facilitate their rehabilitation is commonly traced to In re Oakes, 8 L. Rep. 122 (Mass. 1845). Chief Judge Shaw held that “the great law of humanity” justified depriving an insane person of his liberty whenever his “own safety or that of others require[d] that he should be restrained for a certain time, and [when] restraint [was] necessary for his restoration, or [would] be conducive thereto.” Id. at 125. See Note, Civil Commitment of the Mentally Ill., 87 Harv. L. Rev. 1209 (1974) [hereinafter cited as Developments—Civil Commitment].
34 493 F.2d at 522-25.
35 See note 32 & accompanying text supra.
36 For an extensive discussion of these powers and civil commitment in general see Developments—Civil Commitment, supra note 33.
38 Hawaii v. Standard Oil Co., 405 U.S. 251, 257 (1972), quoting 3 Blackstone, Commentaries *47. The statute De Praerogativa Regis was enacted between 1255 and 1290 to regulate the Crown’s actions in caring for the estates and persons of idiots and lunatics. See Developments—Civil Commitment, supra note 33, at 1207.
moments" the lunatic, or incompetent, was permitted to manage his own property, and to generally exercise his civil rights. He was also entitled to an accounting from the King. It appears that the development of the *parens patriae* doctrine in this country originated from the earlier English statute. The Supreme Court has suggested that like the police power, *parens patriae* power is vested in the very nature of the state.

The due process basis for the right to treatment contemplates the state acting in the role of *parens patriae*. Justice Wisdom has summarized this approach: “where the rationale for confinement is the ‘parens patriae’ rationale that the patient is in need of treatment, the due process clause requires that minimally adequate treatment be in fact provided.” Nevertheless, the state functioning as *parens patriae* should not necessarily have as its only goal the treatment of the individual. The focus on institutional treatment distorts and shortchanges the basic doctrine of *parens patriae*. The state as *parens patriae* is obligated to promote the total interests and welfare of the individual. English precedent clearly demonstrates this point. Treatment within an institution is only one possible means of protecting or promoting the welfare of a significant proportion of individuals found in mental institutions. Community-based residential facilities and other semicustodial or noncustodial programs are preferable alternatives. The institutionalization approach is an outgrowth of the antiquated treatment paradigm predicated on the assumption that those labeled as mentally ill can be best helped by being placed in a “hospital” for their “sickness” and then “treated.” In reality, the state, instead of assisting and protecting the individual, has acted in a police power capacity, protecting society by sweeping social deviates off the streets and into institutions for “treatment.”

Since treatment is not the purpose for confinement in the police power commitments, the quid pro quo rationale was developed as a means of extending the right to treatment to individuals who were confined under this label. The courts developed the idea that since civil commitment proceedings under the states’ police powers lacked the same procedural safeguards accorded in criminal proceedings, a constitutional right to treatment would serve as the quid pro quo for the relaxation of criminal due process standards. Chief Justice Burger and

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40 Id. See note 33 *supra*. See generally Developments—Civil Commitment, *supra* note 33.
41 Mormon Church v. United States, 136 U.S. 1 (1890).
42 Donaldson v. O’Connor, 493 F.2d 503, 521 (5th Cir. 1974).
43 See notes 38-41 & accompanying text *supra*.
44 See generally Moos, *supra* note 8.
46 *Parens patriae* commitments are ostensibly for the benefit of the individual while police power commitments serve the state interest in protecting public safety. See generally Developments—Civil Commitment, *supra* note 33.
48 See *supra* note 47.
49 See e.g., Donaldson v. O’Connor, 493 F.2d 503 (5th Cir. 1974).
50 *See generally Note, Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967).
51 The requirements of due process are not static; they vary depending upon the importance of the interests involved and the nature of subsequent proceedings. Lessard v. Schmidt,
others have been quick to point out the inadequacy of this approach. The theory assumes that treatment is required whenever a state seeks to confine an individual through the use of its police powers. As Chief Justice Burger points out, this assumption is easily refuted, for it is impractical and naive to assume a duty of treatment exists when the state imposes a quarantine to protect the public from communicable diseases.

IV. Inadequacies of the Existing “Treatment” Concept

While the right to treatment concept grew out of and developed as response to the unsatisfactory conditions existing in public mental institutions, it has not yet achieved its founders’ goals. Inadequate conditions still exist in state facilities and individuals remain incarcerated, often receiving only custodial care. The concept has not been adequately developed, nor applied so as to recognize the constitutional rights of mental patients in the postcommitment setting. The theoretical development of the concept has been unsatisfactory both in terms of scope and result.

The doctrine was first advocated as “the recognition and enforcement of the legal right of a mentally ill inmate of a public institution to adequate medical treatment for illness.” While subsequent legal theory has developed out of this treatment paradigm, the emphasis on securing mandatory treatment for the involuntarily confined has diverted attention from more fundamental problems of commitment.

Instead of shaping legal theory to remedy an inequitable situation, scholars and courts alike have focused only on developing situations where the state is required to provide medical and psychiatric care for involuntarily committed mental patients. This judicial emphasis is insufficient, since it continues to ignore the nonmedical aspects of mental illness resulting from the states’ failure to deal comprehensively with the problem.

Additionally, application of the right to treatment concept is unsatisfactory because it requires treatment only for the involuntarily committed patient. Patients voluntarily committed are denied similar constitutional protections, and therefore terminology again creates artificial legal distinctions that lack substance and remedy.


54 Id. at 2499.

55 See notes 13-17 & accompanying text supra.

56 See note 15 supra.


58 See supra.

59 See notes 1-8 & accompanying text supra.

60 Both courts and commentators have focused on the civilly or criminally committed patient’s right to treatment. See generally Hoffman & Dunn, Beyond Rouse and Wyatt: An Administrative-Law Model for Expanding and Implementing the Mental Patient’s Right to Treatment, 61 Va. L. Rev. 297 (1975).

61 Existing legal theories were developed around the involuntarily committed mental patient.

62 See notes 1-8 & accompanying text supra.
are often not permitted to voluntarily leave the facility.\textsuperscript{63} Most states statutorily provide that the “voluntary” patient will be permitted to leave—five or 10 (or in some cases 30) days after he notifies the hospital unless during that time the hospital initiates involuntary commitment proceedings.\textsuperscript{64} Whenever “voluntary” patients are not permitted to leave the institution at will,\textsuperscript{65} they should be afforded the full constitutional safeguards granted involuntarily committed patients, since in terms of actual freedom they are equally deprived, regardless of any label used to describe their commitment.

The strongest argument for discarding past right to treatment rationales and replacing them with constitutionally grounded theories which would protect against encroachment of fundamental rights is the benefit of eliminating the treatment paradigm itself. Right to treatment cases have progressed on the assumption that treatment is an adequate remedy to postcommitment deprivation of civil rights. In turn, remedies have centered on the implementation of medical and psychiatric care.\textsuperscript{66} The logic being employed is the same that led to the development of mental institutions—namely that mental illness is a “sickness” susceptible to treatment.

The right to treatment is both naive and dangerous. It is naive because it considers the problem of the publicly hospitalized mental patient as a medical one, ignoring its educational, economic, moral, religious, and social aspects. It is dangerous because its proposed remedy created another problem—compulsory mental treatment . . . in a context of involuntary confinement.\textsuperscript{67}

If treatment were defined broadly enough to include both medical and non-medical approaches, then past treatment theories might have been of value. However, this has not been done.\textsuperscript{68} Courts typically have attempted to ensure that adequate medical and psychiatric treatment is provided only within the institution, instead of looking at legal alternatives to confinement.\textsuperscript{69} The implementation of a limited medical solution to what may be basically a social problem is neither legally nor morally satisfactory.

V. An “Alternative” Approach

Efforts to secure postcommitment rights have failed for the most part to develop a more basic underlying issue involving the deprivation of fundamental liberties.\textsuperscript{70} It is undeniable that civil commitment involves a critical loss of liberty

\begin{itemize}
\item \textsuperscript{63} See B. Ennis & L. Siegel, The Rights of Mental Patients 36-40 (1973).
\item \textsuperscript{64} Id. at 37.
\item \textsuperscript{65} The patient should be permitted to exit at will or within a reasonable period of time thereafter.
\item \textsuperscript{66} See Hoffman, supra note 60.
\item \textsuperscript{68} The current impetus of the right to treatment concept has focused on the improvement of conditions within the institutions themselves.
\item \textsuperscript{69} See Developments—Civil Commitment, supra note 33. In Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974), the court ordered imposition of the least restrictive conditions necessary to achieve the purposes of commitment, but relied on the existing scope of community alternatives.
\end{itemize}
in the constitutional sense. Accordingly, confinement must rest on a consideration that society has a compelling interest in such deprivation. When a state exercises its power and infringes upon fundamental rights, the public interests advanced must be "compelling" and the action taken must be the least restrictive alternative which will serve those interests. The least restrictive alternative doctrine, first alluded to by the Supreme Court in Shelton v. Tucker, has been applied to civil commitment.

In Lake v. Cameron, the court maintained that the commitment statute required judicial inquiry into less drastic alternatives than involuntary commitment to a state mental institution. That same court later noted that due process likewise required an examination of less restrictive alternatives to hospitalization. Further, in Lessard v. Schmidt, a three-judge federal district court held that the party recommending involuntary civil commitment must bear the burden of proving what alternatives are available, what alternatives were investigated, and why the investigated alternatives were not deemed suitable. The search for alternatives is based on the idea that "the most basic and fundamental right to be free from unwanted restraint.... and therefore persons] cannot be totally deprived of their liberty if there are less drastic means for achieving the same basic goal."

Application of the least restrictive alternative doctrine to the postcommitment setting has gained limited recognition. The Wyatt court applied the principle that the state is required to investigate alternatives and select the least restrictive in reference to the state's providing treatment. Similarly, a federal district court in Minnesota has ruled that the doctrine of least restrictive alternative should apply to the services provided at the Minnesota State Hospital for mentally retarded persons.

Specifically, the final decree in Welsch v. Likins ordered that no mentally retarded person could be committed to a state hospital if the necessary services and programs were available in the community. It further directed that persons suffering from retardation could not be committed to state institutions unless they were additionally suffering from psychiatric or emotional disorders and treatment at such a facility would be appropriate. While neither of the above cases have

72 See, e.g., Developments in the Law--Equal Protection, 82 Harv. L. Rev. 1065, 1087-1132 (1969); Developments--Civil Commitment, supra note 33.
73 364 U.S. 479 (1960).
75 364 F.2d at 659-60.
76 Covington v. Harris, 419 F.2d 617, 623 (D.C. Cir. 1969).
78 349 F. Supp. at 1096.
79 Id. Possible alternatives to civil commitment were suggested by the Lessard court. They included voluntary or court-ordered out-patient treatment, day treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services.
80 The Wyatt court, however, did not order the creation of alternatives outside of already existing facilities in the community.
82 See Nat'l Center for Law and the Handicapped Inc., Welsch Court Orders Implementation of Least Restrictive Programs, 11 Newsline 3 (1974).
ordered the creation of alternatives, it is clear that the least restrictive alternative doctrine is viable in the postcommitment setting. Furthermore, Likins, by prohibiting the admission of mentally retarded individuals to state hospitals, can be seen as an expansion of the applicability of the least restrictive alternative concept—requiring that it be extended to the initial commitment phase itself. Most recently, in Donaldson the Supreme Court recognized the possible applicability of the least restrictive alternative doctrine by citing the Shelton case and by stating:

that the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends.\textsuperscript{84}

Incorporation of the least restrictive alternative doctrine to the postcommitment setting could alleviate many of the shortcomings of existing right to treatment theories. First, the idea that postcommitment rights should be contingent on, or stem from, the initial mode of commitment is unfounded.\textsuperscript{85} As a preliminary point, clear distinctions between police power and parens patriae commitments are not always specified nor may they be distinct from one another.\textsuperscript{86} The state, through the use of labels applied in the commitment process, should not be able to avoid its constitutional responsibilities. Whether an individual is going to be civilly incarcerated in an institution for his own or society's benefit is irrelevant when considering the loss of liberty.

More importantly, fundamental liberties are at stake in any type of civil confinement.\textsuperscript{87} The ongoing deprivation of liberty itself compels the imposition of the less drastic alternative doctrine. The burden should be on the state to justify the total deprivation of liberty characteristic of institutions. Secondly, when the state restricts a person's liberty for the declared purpose of providing a service, then it is constitutionally obligated to provide that service by the due process clause.\textsuperscript{88} The state should not be allowed to indefinitely confine individuals who are labeled mentally ill under the guise of "treatment," when a realistic appraisal of mental illness and the inadequacy of institutions as a treatment method reveals a dramatic need for alternatives.\textsuperscript{89}

The argument exists that if less drastic alternatives to institutionalization are lacking, the doctrine has no practical significance, and the loss of liberty will

\textsuperscript{84} O'Connor v. Donaldson 95 S. Ct. 2486, 2493-94 (1975).
\textsuperscript{85} See note 32 & accompanying text supra.
\textsuperscript{86} See generally Marshall, A Critique of the "Right to Treatment Approach," in THE MENTALLY ILL AND THE RIGHT TO TREATMENT 38 (G. Morris ed. 1970). When civil commitment is used to protect both the individual and society from harm, the state is acting both as parens patriae and under its police power. Such a situation would not be unusual. See note 47 supra.
\textsuperscript{87} See note 71 & accompanying discussion supra.
\textsuperscript{88} See generally Donaldson v. O'Connor, 493 F.2d 507, 521-22 (5th Cir. 1974).
\textsuperscript{89} See notes 1-15 & accompanying text supra.
continue. This viewpoint assumes that inadequate resources can serve as a justification for the deprivation of constitutional rights, and that courts are incapable of ordering the creation of alternatives. Neither contention withstands a comparison to case law. The Wyatt court expressly stated that, “the unavailability of neither funds, nor staff and facilities, will justify a default by defendants in the provision of suitable treatment for the mentally ill.” Although there are no decisions in the postcommitment field ordering the creation of alternatives, courts have done so in other areas on numerous occasions. It is only through the untenable logic characteristic of the old treatment paradigm that implementation of the less drastic alternative doctrine will be forestalled. While the state does have an interest in providing for its unfortunate, this interest and the means utilized must be balanced with the individuals’ constitutional rights. If society is unable to provide satisfactory alternatives, as justice so requires, at the very least the individual deserves the option of having his freedom restored. Release in this situation is the satisfactory alternative, and courts should not hesitate ordering it.

VI. Implementing Postcommitment Rights

Until science advances to the stage where behavioral disorders are more accurately and fully understood, problems and mistakes in commitment itself will continue, and postcommitment rights will require close scrutiny. To date the major obstacle to effective judicial enforcement of a constitutional right to treatment and similar rights has been the lack of ascertainable and enforceable standards for monitoring the postcommitment setting. Commentators as well as critics argue that the ambiguous nature of mental illness itself defies judicial evaluation and precludes the implementation of practical standards. Conflicting theories of psychiatry and a wide array of treatment therapies have led at least one court to hold that the treatment issue does not provide “judicially ascertainable and manageable standards.”

Future judicial acceptance of a constitutional right to treatment and other constitutionally required rights may ultimately hinge on the development of practical standards through which courts can evaluate individual needs and ensure that the least restrictive alternative is being utilized.

90 See Developments—Civil Commitment, supra note 33, at 1245-53.
94 Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).
95 “Treatment” as used herein includes both medical and nonmedical treatment.
Proponents of the right to treatment concept have expressed varying views concerning constitutionally mandated standards of care. Likewise, courts have taken diverse approaches to the type or amount of treatment which should be accorded individual patients. The initial standard applied in Rouse consisted of the following criteria: whether the hospital had made a bona fide effort to cure or improve the patient; whether the treatment administered was adequate in light of present knowledge; and whether the hospital had determined initially, and periodically thereafter, the patient’s individual needs and conditions in order to ensure individualized treatment. The vagueness and generalities of the standards included in Rouse reflect the fact that it was the first judicial inquiry into the components of a right to treatment.

Judge Bazelon acknowledged that the Rouse standards were underdeveloped by stating in a later article “[t]he next criticism that adequate treatment standards are sorely lacking . . . is similarly true beyond cavil.” Yet, he was quick to point out that “the fact that treatment may take many forms, while possibly complicating the implementation of the right to treatment, need not defeat it,” and later in the same article, “[i]t is critical that society and its representatives be made aware of the failure of its promises so that they make an honest choice to take constructive action or withdraw the promises.

The ambiguous and unascertained standards in Rouse were partially clarified in the Wyatt case. Relying on Rouse and other District of Columbia circuit court cases, the first Wyatt opinion held that persons involuntarily committed for purposes of treatment “unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition.” Because Bryce Hospital was undergoing reorganization at the time, the district court reserved judgment on the question of whether or not the patients were receiving adequate treatment.

The second published Wyatt opinion resulted from the state’s failure to implement acceptable standards. There, the district court specified three minimum conditions essential for adequate and effective treatment: a humane psychological and physiological environment; qualified staff in sufficient numbers;
and individualized treatment plans.\textsuperscript{109} As a result of the state’s inability to
develop satisfactory standards, the petitioners and amici were allowed to submit
proposed standards for judicial review. The result was judicial approval of
35 “minimally adequate” standards.\textsuperscript{110} The standards accepted\textsuperscript{111} can be
classified into two categories: (a) those applicable to the institution as a whole,
and (b) those pertaining to the individual patient and his needs. On the insti-
tutional level, standards were designed to ensure a clean and comfortable en-
vironment through regulations governing sanitary facilities, temperature and
living space.\textsuperscript{112} Other standards involved staffing ratios and training and licens-
ing requirements for treatment personnel.\textsuperscript{113}

On the individual level, the court found the following criteria to be con-
titutionally minimum standards for insuring adequate treatment: a statement of
the nature of the specific problems and specific needs of the patient; a statement
of the least restrictive treatment conditions necessary to achieve the purposes of
commitment; a description of intermediate and long-range treatment goals, with
a projected timetable for their attainment; a statement and rationale for the
plan of treatment for achieving these intermediate and long-range goals; a speci-
fication of staff responsibility and a description of proposed staff involvement
with the patient in order to attain these treatment goals; criteria for release to less
restrictive treatment conditions; and criteria for discharge.\textsuperscript{114}

As Rouse was a landmark case in breaking the ice for recognition of a con-
stitutional right to treatment, Wyatt is a landmark in the implementation of
the right. The identification of objective, minimally adequate constitutional
standards should act as an impetus to other courts to carefully scrutinize the post-
commitment rights of mental patients.

Wyatt is not, however, a panacea; standards by themselves are meaningless.
Furthermore, the standards promulgated in Wyatt are directed toward quanti-
tative goals.\textsuperscript{115} Even with well-articulated standards and individual treatment
plans, there is no assurance that the patient is actually being helped or pro-
gressing.\textsuperscript{116}

In Jackson v. Indiana, the Supreme Court noted, “at the least due process
requires that the nature and duration of commitment bear some reasonable

\textsuperscript{109} Id. at 1343. The court held that although the state was deficient in the three areas,
the court would defer appointing a master to oversee the operation of the hospital because
the defendants had demonstrated a desire to obtain minimum medical and constitutional
standards. Id. at 1343-44.

\textsuperscript{110} 344 F. Supp. at 379. According to Dr. Stonewall Stickney, Commissioner of Mental
Health at the time of the original litigation, 90 percent of the standards ultimately set were
stipulated to by the parties in advance of the hearings. The refusal “to defend anything that
was not defensible,” as Stickney put it, led to severe criticism. Dr. Stickney was dismissed
in September 1972, by the Alabama Mental Health Board. Psychiatric News, Oct. 17,

\textsuperscript{111} Not all of the proposed standards were accepted by the court. See 1 Legal Rights

\textsuperscript{112} 344 F. Supp. at 381-82.

\textsuperscript{113} Id.

\textsuperscript{114} Id. at 384.

\textsuperscript{115} For an in-depth analysis of the Wyatt standards, see Hoffman, supra note 60.

\textsuperscript{116} There is no constitutional mandate requiring a state to cure mental patients. Neither
is there a constitutional obligation for the state to provide for its mentally ill. See Welsch v.
Likins, 373 F. Supp. 487, 499 (D. Minn. 1974). However, once the state undertakes to con-
fine the individual, constitutional safeguards must be accorded.
relation to the purposes for which the individual is committed.\textsuperscript{117} Accordingly, the courts instead of merely focusing on the types and quantity of treatment should give more emphasis to its duration and effectiveness. While judicial evaluation of particular therapies is both unsatisfactory and impractical, improvement, or lack thereof, in the particular patient provides a more ascertainable and reliable means for evaluation.\textsuperscript{118} Long-term, involuntary confinement of a patient given only custodial care would require the court to carefully analyze his records and determine if the state could continue the confinement against the patient’s will in that particular setting. Such an approach would decrease the numerous instances, where, as in Kenneth Donaldson’s case,\textsuperscript{119} individuals are removed from the mainstream of society and deposited for life terms in mental institutions. While ambiguity concerning the etiology of an individual’s illness may exist and mistakes made leading to confinement in a mental hospital, the erroneous belief that “treatment” will benefit the individual must be abandoned at least where long-term confinement fails to produce noticeable results. An honest mistake is nevertheless a mistake and should not be perpetuated. The longer the duration of confinement and treatment without reasonably noticeable improvement in the patient’s functioning capabilities—the stronger the inference that the state has failed its obligation to apply the less drastic means.

VII. Enforcement of Postcommitment Rights

Assuming judicial or legislative acceptance of a right to treatment or other theories involving postcommitment rights, there will be a need for the effective enforcement of those rights. Direct judicial review or the implementation of an administrative-type law model are the most practical and workable methods of enforcement.

Legislative proposals which utilize an administrative law approach have been introduced in two states.\textsuperscript{120} In Pennsylvania the proposal\textsuperscript{121} establishes legislative and adjudicative bodies. A three-member board, consisting of an attorney, a psychiatrist, and a physician, would hold hearings and make decisions on patient allegations. The bill limits a patient to one petition per six-month period. A Michigan bill\textsuperscript{122} is patterned after the Pennsylvania model, but differs

\textsuperscript{117} 406 U.S. 715, 738 (1972).

\textsuperscript{118} See generally Schwitzgebel, Implementing a Right to Effective Treatment, \textit{Law & Psych. Rev.}, Spring 1975, at 200.

\textsuperscript{119} Kenneth Donaldson was civilly committed to confinement as a mental patient in the Florida State Hospital at Chattahoochee in January 1957. He was kept in custody there against his will for nearly 15 years. Throughout his confinement Donaldson repeatedly but unsuccessfully demanded his release, claiming that he was neither dangerous nor mentally ill, and that at any rate the hospital was not providing treatment for his supposed illness. Finally, in February 1971, Donaldson successfully brought suit under 42 U.S.C. § 1983 (1970), alleging that the defendants had intentionally and maliciously deprived him of his constitutional right to liberty. See also Rosenberg, Treatment Denied—The Case of Arnold H. Marman, 57 Geo. L.J. 702 (1969).

\textsuperscript{120} The states are Pennsylvania and Michigan. See notes 121-22 infra.


\textsuperscript{122} This bill is described in Morris, Legal Problems Involved in Implementing the Right to Treatment, 1 Bull. Am. Academy of Psychiatry & the Law 1 (1973). See also Hoffman, \textit{supra} note 60, at 313-15.
significantly in that it does not provide for an adjudicative agency. Like its Pennsylvania counterpart, the bill calls for the establishment of a committee to promulgate quantitative standards. Commentators have suggested that the absence of provisions for qualitative standards may be due to resistance from the community of mental health professionals. A third proposal urging an administrative law model includes provisions for a rulemaking body, case deciding personnel, legal aid service, and a panel of mental health judges.

The advantages of using an administrative model for the enforcement of postcommitment rights are numerous. Generally they include speed, expertise, and flexibility. Adjudicatory boards relieve congested court dockets and provide expertise in evaluation. Nonjudicial intervention also allows mental health professionals to avoid court proceedings and focus on treatment. Furthermore, it is argued that this type of approach preserves the therapeutic relationship between patient and psychiatrist during the proceedings.

Unfortunately, the above approaches also contain many deficiencies. The proposals preclude or limit the patient's access to the courts and place a restriction on the frequency and number of petitions a patient may file for relief. Adjudicatory boards or committees act as a buffer zone between the courts and the patients. This could very easily lead to the traditional deference by the judiciary and perpetuation of inadequate facilities and treatment. The economic feasibility of creating more bureaucratic positions would divert resources which could be allocated for improvement in physical facilities and treatment programs themselves.

Finally, and perhaps most importantly, the administrative approach may be an outgrowth of the treatment paradigm which has led to many of the problems alluded to previously. By simply labeling all social deviates as being mentally ill, it makes it easier for society to shift, and hide, its responsibilities. Furthermore, each of the above proposals was developed in whole or part by mental health professionals. This fact may represent a conscious or unconscious effort on their part to protect their domain by making provisions for mental health professionals to create the standards involved, and in some cases, also enforce them.

It is submitted that enforcement of statutory and constitutional postcommitment rights should be directly controlled by the courts. Self-regulation by hospital professionals

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123 Hoffman, a professor of psychiatry, recently made the following statement on this subject:

The reluctance of the draftsmen of these bills to allow qualitative rulemaking may be due to resistance from the medical community seeking to preserve the privacy of the physician-patient relationship and the physician's prerogative to prescribe that treatment which he deems most suitable for his patient.

Hoffman, supra note 60, at 314. Professional reluctance to allow qualitative rules may additionally be attributable to the profession's quest for self-regulation.

124 Id. at 315-18.
125 Id. at 312-39.
126 Id. at 339.
127 See notes 1-8 & accompanying discussion supra.
128 The American Psychiatric Association responded to the Rouse decision by stating "the definition of treatment and the appraisal of its adequacy are matters for medical determination." American Psychiatric Ass'n, A Position Statement on the Question of Adequacy of Treatment, 123 AM. J. PSYCHIATRY 458 (1967).
and staff is not effectual as the past clearly demonstrates. The judiciary is in a more neutral position from which it can act as an impartial evaluator, and prevent the deprivation of legal rights. Judicial review of appropriate standards respects the doctor-patient relationship and would not impose on the psychiatrists in diagnosing and selecting treatment methods. As Chief Judge Bazelon has suggested, the function of the judge would be to scrutinize the record and make sure a qualified professional has made a responsible exercise of judgment and that the patient's constitutional and statutory rights have not been infringed upon. Direct judicial review is also consistent with the least restrictive alternative doctrine. It does not take a psychiatrist or medical expert to review the patient's record and to ascertain whether or not the minimum quantitative constitutional standards have been met, and to look at the duration of confinement against the results realized.

VIII. Conclusion

The right to treatment theory originated as a means to improve the conditions of mental hospitals. While the concept has generated considerable legal and medical commentary, the reality remains that mental institutions, and conditions therein, have not been significantly improved. States have not increased the allocation of resources to such facilities, nor have patients been ordered released in any significant numbers because of the lack of treatment.

Like the development of institutions themselves, right to treatment theories have been premised on the erroneous assumption that mental illness is a medical malady capable of being eradicated through medical or psychiatrical treatment within mental hospitals. The emphasis has been placed on improving the conditions in mental facilities instead of addressing the more fundamental problems posed by involuntary civil confinement itself. Because the right to liberty and other fundamental rights are involved, less drastic alternatives to institutionalization should be explored and ordered. Realistic standards accordingly, must be implemented; qualitative standards in addition to quantitative standards must be applied. The states' failure to provide such alternatives should not allow the perpetuation of existing conditions. In the absence of legislative action the judiciary must provide the constitutional protections required and not delegate its authority to others.

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129 See note 15 supra.
131 See generally B. ENNIS, PRISONERS OF PSYCHIATRY (1972).
132 Id.