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THE CIVILLY-COMMITTED PUBLIC MENTAL PATIENT AND THE RIGHT TO AFTERCARE

RICHARD B. SAPHIRE*

I. INTRODUCTION

Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.¹

The history of American social policy regarding the mentally ill² has, in many respects, been less than a proud one. Until the mid-nineteenth century, public attitudes toward the mentally ill were primarily characterized by fear and suspicion. These attitudes were reflected in governmental policies which, although frequently cloaked behind the rubric of concern for the treatment and welfare of the mentally disabled, were evidenced by total neglect and abdication of public responsibility. Perhaps because of the predominant political and economic helplessness of most public mental patients,³ a long-overdue reexamination of the actual conditions and effects of mental institutionalization, and a reevaluation of the role of the institution itself in mental health system, have only recently been initiated.

¹. Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting) (footnote omitted).
². For purposes of this article, "mental illness" will be used, in the generic sense, to include a handicap in mental functioning, either psychological or physiological in origin, which impairs the ability to function in society according to socially prescribed norms. For examples of statutory definitions of mental illness, see S. BRAKEL & R. ROCK, THE MENTALLY DISABLED AND THE LAW 66-71 (rev. ed. 1971) [hereinafter cited as BRAKEL & ROCK].
³. See, e.g., A. HOLLINGSHEAD & F. REDLICH, SOCIAL CLASS AND MENTAL ILLNESS (1958). See also note 46 and accompanying text infra.

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The above definition would include persons diagnosed as mentally retarded. For a very informative discussion of basic facts about the traditional clinical and theoretical types of mental illness and retardation, see I LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 35-75 (B. Ennis & P. Friedman eds. 1974).

It should be noted that there is some opinion in the psychiatric community that mental illness does not exist objectively, but is rather a fiction created by psychiatry. For an intriguing discussion of this idea, see T. SZASZ, THE MYTH OF MENTAL ILLNESS (1961).

Much has been said concerning the need to guard against arbitrariness and abuse in the methods by which an individual comes to find himself in a public mental institution—whether by choice or by the exercise of coercive governmental action.\(^4\) And yet, it was not until the beginning of the last decade that serious discussion was initiated in the legal and medical communities concerning the plight of the public mental patient once commitment has been effected.\(^5\) The controversy and concern generated by these discussions, coupled with developments in psychiatry and a greater appreciation of the need to protect individual civil rights, have created a favorable climate for further examination of the traditional governmental approach to the delivery of mental health services. In this climate, efforts can now turn to a more critical attempt to define the appropriate scope of the states' powers vis-a-vis the mentally handicapped, and, just as importantly, the special responsibilities created by the exercise of those powers.

This article will explore a new frontier in the area of the states' obligations towards the involuntarily committed public mental patient\(^6\)—a frontier emerging as a result of recent developments in constitutional law and contemporary perceptions of the public mental institution. The impact of institutionalization on the mentally handicapped will be assessed, and arguments developed for the creation of an obligation of the states to provide aftercare services for discharged mental patients. It has been noted that there is "little sense in guarding zealously against the possibilities of unwarranted deprivations prior to hospitalization, only to abandon the watch once the patient disappears behind mental [hospital] doors."\(^7\) This article will proceed from the premise that it makes just as little sense, in terms of both public policy and constitutional law, to abandon the watch once the patient leaves the institution, especially where the nature

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5. See Donaldson v. O'Connor, 493 F.2d 507, 519 n.12 (5th Cir. 1974), and articles cited therein.
6. For purposes of this discussion, involuntary civil commitment can be defined as the process by which, pursuant to statutorily created procedures, a person judged to be mentally ill is removed, without his consent or acquiescence, from his normal surroundings to a hospital or other institution authorized to detain him. See BRAKEL & ROCK, supra note 2, at 35.
of the institutional experience has created new mental and physical handicaps.

II. DISTINGUISHING THE VOLUNTARY PATIENT

The article will deal primarily with the characteristics and problems of mental institutionalization as they are brought to bear upon the public mental patient. Although the arguments for the right to aftercare developed herein are in large part premised in the coercive or non-consensual aspects of involuntary civil commitment, they are equally applicable, in many respects, to the voluntarily admitted patient. In general, it is the exercise of the states' mandatory processes against the individual that has traditionally been held to create a concomitant obligation for the development of formal protections, whether in the form of procedural safeguards or publicly-funded services. Traditionally, the states' obligations to provide resources and services to the individual, and the underlying determination of the allocation of public funds, have generally been considered a matter of legislative prerogative, not of constitutional command. But where a state exercises its coercive powers in such a manner that unconstitutional conditions and practices result, it will be compelled by the courts to eliminate the unconstitutionalities, even where to do so would compel it to take steps that would not otherwise have been required. In this respect, the obligation to provide aftercare services as a necessary corollary to the operation of public mental institutions may be viewed as closely linked to the coercive nature of the civil commitment process.

Voluntary admissions to public mental hospitals have been viewed by many mental health professionals as preferable to involuntary civil commitment. It has been suggested that a patient who recognizes his

own mental disabilities and who seeks professional help on his own volition is much more likely to participate actively in his own treatment, and is thus better able to benefit from his experiences in a mental institution.\textsuperscript{13} Consequently, advocates of a voluntary approach to mental institutionalization have argued that long-term confinement to mental hospitals, even where progressive treatment programs have been initiated, has severe therapeutic limitations where the patient is maintained on an involuntary status.\textsuperscript{14} Moreover, voluntary admissions have been viewed as minimizing the stigmatization traditionally associated with the involuntary commitment process.\textsuperscript{15} The technical distinctions between the two processes, however, must be viewed cautiously since their utilization in actual practice frequently results in an obfuscation of their formal differences.

For purposes of analysis, voluntary hospitalization can be defined as a process by which one becomes a patient at a mental hospital, either by self-initiated personal application or through acquiescence in the application of another in one's behalf.\textsuperscript{16} Virtually every state makes statutory provision for the voluntary admission of the mentally ill and the procedure generally requires a formal application.\textsuperscript{17} Unlike the involuntary commitment process, which generally requires a judicial determination of mental illness, voluntary admission is customarily a matter left to the direction of the chief administrative officer of the mental institution.\textsuperscript{18} Some typical characteristics of the voluntary admission procedure tend to indicate that it is not always as "voluntary" as its formal designation implies.

In this regard, it must be noted that statutory constraints are frequently imposed on voluntary public mental patients which act to

\begin{thebibliography}{18}
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\bibitem{13} Brakel & Rock, \textit{supra} note 2, at 17.

Although increasing numbers of public hospital mental patients are voluntary, the overwhelming majority of patients are involuntarily committed. N. Kittrie, \textit{The Right to Be Different 71} (1971).

\bibitem{14} See, \textit{e.g.}, Katz, \textit{The Right to Treatment—An Enchanting Legal Fiction?}, 36 U. CHI. L. Rev. 755, 773 n.56 (1969).

\bibitem{15} The stigmatization associated with commitment is discussed at Note, \textit{The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill}, 67 COLUM. L. Rev. 672, 673 n.9 (1967).

\bibitem{16} For a comprehensive discussion of voluntary admission to public mental hospitals, see Brakel & Rock, \textit{supra} note 2, at 17-33.

\bibitem{17} Id. at 19.

\bibitem{18} See R. Rock, M. Jacobson & R. Janopaul, \textit{Hospitalization and Discharge of the Mentally Ill 34} (1968). The authors note the existence of a third form of admission, frequently called a "non-protested admission." This procedure has many characteristics of a purely voluntary one, but depends on a lack of protest on the part of the patient at the time of admission rather than an affirmative act indicating the exercise of free choice. \textit{Id.} at 38. See also B. Ennis & L. Siegel, \textit{The Rights of Mental Patients 36} (1973).
\end{thebibliography}
abridge their liberty to leave the hospital and frequently result in substantially increased risk of involuntary commitment.\textsuperscript{19} Typically, the statutory scheme will require the voluntary patient to give written notice of his desire to leave within periods ranging from 48 hours to 15 days of the desired date,\textsuperscript{20} during which period the superintendent of the institution or other interested parties can initiate involuntary commitment procedures. Thus, in a very real sense, a voluntary patient can be transformed into an involuntary one by his mere presence in the institution. Moreover, the voluntary patient, although complying with procedural prerequisites for the achievement of that status, quite often does not enter the mental institution under conditions that are in fact voluntary. It has been noted that there is a large-scale inducement to many persons already in some form of official custody, or persons threatened with such a prospect, to "voluntarily" commit themselves to a public mental institution.\textsuperscript{21} Many voluntarily-admitted patients are brought to the hospital by the police and are "persuaded" that their signing of the appropriate applications will ensure their receiving the kind of attention and treatment that they could not receive in a local jail. Still others are brought to the hospital by friends, relatives or even the family physician and are similarly "persuaded" that voluntary admission will be for their own good, or are threatened with the alternative prospect of the initiation of involuntary commitment or criminal procedures against them.\textsuperscript{22} In these circumstances, the legal distinctions concerning voluntary and involuntary admission are significantly blurred.

The advantages of voluntary admission to public mental institutions are further minimized where a minor or incompetent is admitted pursuant to the initiative of a parent or guardian. Although the parent or guardian may have the legal power or right to effectuate such an admission, it is clear that the interests of the two parties may frequently conflict. It has been observed that families seeking commitment of allegedly mentally-handicapped children often exhibit severe stress, dislocation and disharmony.\textsuperscript{23} The children are often not mentally ill at all, but rather are disagreeable or difficult to handle within the

\textsuperscript{22} See discussion and authorities, \textit{id}. at 433 n.18.
family unit.\textsuperscript{24} For them, little solace can be found in the knowledge that prolonged mental hospitalization was initiated pursuant to a procedure that the law deems voluntary.

One final consideration should be entertained before a formal distinction between voluntary and involuntary mental hospitalization is accepted at face value. One view of voluntary admission envisions the relationship between the patient and the hospital as essentially contractual.\textsuperscript{25} In exchange for the patient giving up his freedom of movement and accepting certain other restrictions, the state agrees to provide the patient with certain services and therapeutic benefits. It is extremely doubtful, however, that the exact terms and conditions of institutional confinement are ever objectively and comprehensively explained to the voluntary applicant.\textsuperscript{26} It has been suggested that, in most states, the voluntary patient is not told at the time of his request for admission that he will not be absolutely free to leave at his own discretion.\textsuperscript{27} Furthermore, it is quite likely that the reality of life in the institution, including the sometimes pervasive dehumanization and neglect inherent therein,\textsuperscript{28} is not adequately disclosed. In short, the voluntary patient is frequently unaware of exactly what he is getting himself into.

In light of these considerations, a distinction between the rights of voluntarily-admitted and involuntarily-committed mental patients must be cautiously drawn. Insofar as a patient is admitted to a public mental institution under circumstances that are truly voluntary, the constitutional arguments for aftercare that will be developed in this article may be conceptually diminished. But regardless of the legal status of the patient, there is little question that a person who voluntarily admits himself for institutionalized treatment makes a sacrifice in personal liberty comparable to that of the patient who is compelled by the state to submit to such treatment. Moreover, there is little significant difference between the rights of different categories of mental patients in terms of formal or informal restrictions upon the exercise of civil rights.\textsuperscript{29} The potentially destructive and antithera-


\textsuperscript{25} See, e.g., Gilboy & Schmidt, supra note 21, at 440.

\textsuperscript{26} In this respect, the validity of the contract of confinement is subject to question. \textit{Cf.} L. Simpson, \textit{Handbook of the Law of Contracts} 67 (2d ed. 1965).

\textsuperscript{27} B. Ennis & L. Siegel, supra note 18, at 37. \textit{But see} Roberts v. Paine, 199 A. 112 (Conn. 1938) (hospital held to have no obligation to inform voluntary patient of his right to leave the hospital).

\textsuperscript{28} See section IV infra.

\textsuperscript{29} Brakel & Rock, supra note 2, at 20–21.
peutic conditions of mental institutionalization, to be discussed below, apply equally to them all.

III. THE EVOLUTION OF THE MENTAL INSTITUTION

The public mental institution is a relatively recent phenomenon in the development of organized society's approach to mental illness. At common law, there was little concern with questions relating to confinement of the mentally ill because public institutions for custody or care of the mentally abnormal were nonexistent. Societal attitudes toward mental illness have ranged from the brutal tortures of the Middle Ages, designed to exorcise the demons thought to be possessing the mentally deviant, to an enlightened, humanistic view that has begun to be manifested in contemporary medical-legal circles. Perhaps the only common thread woven into the history of formal governmental policies vis-a-vis mental illness has been fear of the violence and destructiveness that have been thought inherent in the lunatic or the "madman."

The English concern for the mentally ill was characterized by policies designed primarily to protect the property and estate of the afflicted during periods of incapacitation. Sometime between 1255 and 1290, the statute De Praerogativa Regis was enacted, dividing the mentally disabled into two classes, the idiot and the lunatic. The idiot was considered a person whose mental abnormality was traceable from birth, while the lunatic was viewed as having lost his "use of reason" sometime after birth. The king was given custody and control of the idiot's property and provided necessaries to him while retaining profits from his land. The lunatic's estate was entrusted to the king during periods of incapacity. The king applied profits from the estate to the maintenance of the lawful owner, and the surplus was returned during lucid intervals when the afflicted person was thought to have regained his competency. No formal institutions were

30. See W. BLACKSTONE, COMMENTARIES 131-33 (Gavit ed. 1941). For general discussion of the evolution of social policy concerning mental illness from Roman times, see BRAKEL & ROCK, supra note 2, at 1–13.

See generally A. DEUTSCH, THE MENTALLY ILL IN AMERICA (2d ed. 1949) [hereinafter cited as DEUTSCH].

31. Shryock, The Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association, One Hundred Years of American Psychiatry 1 (J. Hall, G. Zilboorg & H. Bunher eds. 1944). See also Kitthie, supra note 13, at 56.

32. 17 Edw. 2, c. 9, 10. See 1 F. POLLOCK & F. MAITLAND, THE HISTORY OF ENGLISH LAW 480–81 (2d ed. 1898).

33. BRAKEL & ROCK, supra note 2, at 2.

34. For one of the earliest English cases expounding the law of insanity, see Beverley's Case, 76 Eng. Rep. 1118 (K.B. 1603).
created to house and care for the mentally ill, this responsibility generally having been entrusted to relatives or heirs.

In colonial America, the family, or others personally interested in the welfare of the mentally-handicapped individual, remained the primary institution responsible for the care and maintenance of the mentally ill. Only where family or friends were unable to provide for the ill person's welfare did the local or colonial government offer material assistance. Moreover, public concern was generally focused on the dangers and disruptions to community safety and welfare that were perceived as inherent in mental illness. No formal social policy existed to deal with the indigent mentally ill who had no family or friends able or willing to look after them. Consequently, during the seventeenth and eighteenth centuries, mental illness became, in large part, an incidental element of the operation of the poor laws. Mental illness and dependency were frequently viewed as mutually inclusive conditions. The indigent mentally ill, ostracized from their communities, often banded together with other derelicts and paupers and roamed the countryside living as best they could off the land. Prior to the mid-eighteenth century, the great majority of the insane were confined in local almshouses and jails and treated as common criminals or paupers.

In the mid-eighteenth century, social pressures inherent in the industrialization and urbanization of much of America created a movement towards more formal institutions for the mentally ill. Rapid population growth and the accelerated interpersonal contact brought about by urban migration greatly increased the general visibility of social deviancy and brought into sharper focus the need to develop a broader and more organized approach to the mentally ill. It became evident that local almshouses and jails could no longer accommodate the increasing numbers of mentally-handicapped persons brought to the attention of the community. The problem was exacerbated by a large influx of lower-class immigrants who were often unable to adjust culturally or economically to the largely impersonal life of industrialized cities. Coupled with the increased financial and administrative inability of local facilities to adequately provide for the mentally ill was a philosophical awakening leading to the conviction that human social problems were manageable and susceptible of

rational and benevolent solution. Moreover, a new concept of morality, influenced by the French Revolution, slowly began to affect popular attitudes concerning public responsibility for the socially and culturally deprived.

In response to these trends, states began to establish large mental institutions to house and provide for the mentally ill. By 1870, most states had at least one public mental hospital. But from the outset these institutions and their patients were faced with enormous problems. Albert Deutsch, a noted historian and critic of American mental institutions, has noted:

Hardly were hospitals opened than their capacities became overtaxed by the never-ceasing flow of patients. Overcrowding soon forced upon authorities the problem of selection. Faced with the necessity of admitting a certain number of applicants and excluding others, authorities naturally favored the admission of recent cases over chronic and incurable cases. Gradually, then, there developed the custom—in some states amounting to an “unwritten law,” in others explicitly stated in statutes—of sending only acute cases to institutions for the insane, while the chronics (sometimes euphemistically called the “surplus insane”) were confined in poorhouses and jails or else supported in the homes of friends or relatives. Generally, if a dependent patient in a hospital was not discharged recovered within a stipulated period (say, twelve months), he was returned from the hospital to his place of settlement as incurable and was thenceforth maintained at a local institution, usually the poorhouse or jail.

The unexpectedly high population growth and the discovery that “cure rates” were significantly lower than anticipated resulted in

39. In many respects, the mid-nineteenth century witnessed a growth in optimism concerning the curability of mental illness generally, and the movement toward the establishment of large mental institutions can be viewed as having been partially stimulated by the belief that they would provide an optimal setting for proper treatment. D. Rothman, The Discovery of the Asylum 130-37 (1971). See also Deutsch, supra note 30, at 153.


41. The first general hospital to receive mental patients was established in Philadelphia, Pennsylvania in 1751. Deutsch, supra note 30, at 58-59. In 1773, a privately-funded hospital which was exclusively devoted to care of the mentally disabled was erected in Williamsburg, Virginia. Id. at 66. The Eastern Kentucky Lunatic Asylum, established in 1822, was the first mental hospital constructed and operated exclusively with state funds. Id. at 106.


43. Deutsch, supra note 30, at 231.
unmanageable overcrowding, expense, and reduction in the quantity and quality of care that could be accorded each patient. Moreover, prior to 1860 there were few statutory provisions relative to conditions for, and limitations upon, admission to mental institutions. The decision to admit rested wholly within the discretion of the hospital administrator, who would often be under great pressure to admit especially indigent persons in view of the lack of alternatives for support and care in the community.

The movement towards the creation of state mental institutions was stimulated by the crusading of individuals such as Dorothea Lynde Dix. From 1840 to 1880, Mrs. Dix carried on a private crusade to expose the conditions existing in poorhouses and local jails and effectively lobbied in many states for the creation of public institutions and for rational and fair admission procedures. But despite the progressive, humanitarian work of such mental health reformers, the institutions themselves, in terms of the pervasive substandard and dehumanizing aspects of patient-life, continued to deteriorate. In many respects, the people who became state mental patients were doomed to despair and deprivation once the asylum doors closed behind them. They were, by definition, the rejects of society—the old, the poor, the helpless, and the unwanted. The public mental institution's history has been pervaded by the neglect and apathy of a society which, in other areas, became increasingly sensitized to and concerned with the despair and frustration of its people; yet this despair and frustration permeated the lives of many of the same people who became the mental institution's primary constituency.

Even today, the social characteristics of most public mental patients can be perceived as a pivotal factor in society's general lack of enthusiasm and commitment to reforming and improving public mental institutions. Admissions to state mental hospitals have primarily come from what has been referred to as the "residual" population. Numerous studies have shown striking correlations between social class and mental illness, with overwhelming evidence proving that most public mental patients come from deprived social and economic backgrounds. Moreover, a majority of those admitted to

44. BRAKEL & ROCK, supra note 2, at 8.
45. I. BELKNAP, HUMAN PROBLEMS OF A STATE MENTAL HOSPITAL 32 (1956).

One writer has gone so far as to say that the primary criteria for distinguishing
state institutions have achieved a relatively low level of formal education. Similarly, the overall political and economic powerlessness of state mental patients can be inferred from the disproportionate numbers of elderly citizens who are civilly committed. In a very real sense, these institutions have become the “dumping grounds” for the aged and senile, whose common bond can perhaps be more accurately perceived as poverty and rejection rather than mental illness.

IV. INSIDE THE MENTAL INSTITUTION

A. An Overview of Institutional Life

Some physicians I interviewed frankly admitted that the animals of nearby piggeries were better housed, fed, and treated than many of the patients on their wards. I saw hundreds of sick people shackled, strapped, straightjacketed, and bound to their beds. I saw mental patients forced to eat meals with their hands because there were not enough spoons and other tableware to go around—not because they couldn’t be trusted to eat like humans. I saw them crawl into beds jammed together, in dormitories filled to twice or three times their normal capacity. I saw them incarcerated in “seclusion rooms”—solitary isolation cells, really—for weeks and months at a time. I saw signs of medical neglect, with curable patients sinking into hopeless chronicity. I found evidence of physical brutality, but these paled into insignificance when compared with the excruciating suffering stemming from prolonged, enforced idleness, herdlike crowding, lack of privacy, depersonalization, and the overall atmosphere of neglect. The fault lay not with individual physicians, nurses or attendants—underpaid, undervalued, and overworked as they were—but with the general community that not only tolerated but enforced these subhuman conditions through financial penury, ignorance, fear and indifference.

47. Biometry Branch, National Institute of Mental Health, Statistical Note 104 (1974). Other surveys have also shown that the utilization of state and county mental hospitals is inversely related to level of education. E.g., Biometry Branch, National Institute of Mental Health, Statistical Note 34, at 1, 2 (1970), which showed that during 1969, about 20% of total admissions had not completed grade school, about 16% had completed grade school only, about 27% had attended high school but did not graduate, and an additional 27% completed high school only.


49. Hearings Before the Subcomm. on Constitutional Rights of the Senate Comm.
This observation by one of the most noted historians and observers of American public mental institutions vividly describes the life that awaits the public mental patient once the institutional doors close behind him. Prior to attempting the effort of exploring potential legal arguments for the states' obligations to provide aftercare services for the involuntarily-committed mental patient, it is essential to understand the nature and scope of the physical and mental deprivations that have been an inevitable part of the institutional environment.

In this context, the process of institutionalization creates certain inherent problems for the public mental patient. In one of the earliest and most important attempts to describe the experience of the committed mental patient, Erving Goffman graphically illustrated the immense depersonalization and dehumanization associated with the introduction to institutional life. Upon entrance, the patient is stripped of self-conceptions that were made possible by social relationships on the outside. He loses his possessions, his privacy, and any developed concept of personal responsibility; “he begins a series of abasements, degradations, humiliations, and profanations of self.” The mental institution, described by Goffman as a “total institution,” can be viewed as disrupting precisely those behavioral and normative patterns that are necessary for a person to acquire and develop self-determination, autonomy, and responsibility. Moreover, for the involuntary patient, the shock of the often strict regimentation of the institution follows closely on the heels of the trauma and confusion that usually accompany the commitment process, which in turn is generally precipitated by emotionally and psychologically disruptive events. For many, the first few days of confinement in a public


52. Goffman, supra note 50, at 43. See also Kaimowitz v. Michigan Dep't of Mental Health, Civil No. 73-19434-AW (Cir. Ct., Wayne County, Mich., July 10, 1973) where a three-judge state court, in holding that an involuntarily-committed mental patient may not give constitutionally sufficient consent to experimental psychosurgery, noted that institutionalization, per se, tends to strip the mental patient of the support which would permit him to maintain his sense of self-worth and the value of his own physical and mental integrity. See also Action Against Mental Disability 34 (1970). (The Report of the President's Task Force on the Mentally Handicapped) (concluding that state institutions for the mentally retarded are “a national disgrace”).

53. See 1961 Senate Hearings, supra note 49, at 185-86 (testimony of Hugh A. Ross); id. at 132 (testimony of Hon. John Biggs, Jr.).
mental institution establish a foundation for the self-fulfillment of the mental illness prophecy.\(^{54}\)

The picture of the public mental institution painted by Goffman and others\(^ {55}\) has, in the last three decades, helped focus attention on the general failure of the institution as the cornerstone of formal American social policy toward the mentally ill. Perhaps one of the most striking indicia of the general bankruptcy of mental institutional life can be found in data indicating that there is a shocking disparity between public mental institution death rates and death rates for the general population. Several studies have shown that mortality rates among the hospitalized mentally ill are considerably in excess of those of corresponding age groups in the general population.\(^ {56}\) For example, in 1966 death rates for mental patients ranged from 1.3 times that of the general population in New Mexico to 16.6 times that of the general population in Arizona. The average national mortality rate for mental patients in that year was greater than 7.5 times that for the general population, and only two states showed a lower rate for their mental patients.\(^ {57}\) While the incredibly high institutional death rates may not prove conclusively that mental institutions inevitably hasten their patients' deaths, they certainly present unavoidable evidence of the fact that confinement in such institutions tends to cause deprivations which create a substantial risk of premature death to which the general population is not subjected.\(^ {58}\) It is possible, of course, that these statistics may reflect the fact that people of advanced age constitute a substantial proportion of involuntarily-
committed patients. But it is likely that these figures can be more closely correlated with the fact that many public mental institutions are overcrowded, unsafe, and unsanitary, and that the ratio of physicians to patients generally has been much lower in the mental hospital than in the general population. In a very real sense, confinement in most state mental institutions increases the patient's risk of death or serious illness by combining a dangerous and destructive physical environment with significantly reduced access to adequate medical attention.

B. The Public Mental Institution: Therapy or Anti-Therapy?

In recent years, the increased publicization of the inhumane psychological and physical environment prevailing in many public mental institutions has substantially affected public attitudes toward the American mental health system and the medical and mental

59. At the time of the filing of suit in Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), aff'd sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974), the district court found that Alabama's Bryce Hospital had approximately 5,000 inmates, 1,500 to 1,600 of whom were geriatrics. 325 F. Supp. at 782, 784.

60. For a description of conditions prevailing in several mental institutions, see A. DEUTSCH, THE SHAME OF THE STATES (1948). See also H.R. REP. No. 694, 88th Cong., 1st Sess. 9, 11 (1963), where, in reference to the Mental Retardation Facilities and Community Health Centers Act of 1963, 77 Stat. 290 (1963), as amended, 42 U.S.C. §§ 2681-87 (1970), it was noted that almost 20% of the then existing state mental institutions were fire and health hazards by the standards of their own states, and that most residential facilities for the mentally retarded were obsolete and overcrowded.

61. Lessard v. Schmidt, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972). Here, the court noted that Wisconsin, in 1965, had one physician for each 175 public mental patients, placing that state 46th among the 50 states in patient-physician ratios. These figures compare with the minimum standards for staff-patient ratios set by the American Psychiatric Association, which recommended a minimum of one physician for every 30 inmates requiring admission or intensive treatment services, and one physician for every 150 inmates on continued treatment services. AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS (1956). Even these recommended physician-patient ratios are probably very conservative, representing a "compromise between what was thought to be adequate and what it was thought had some possibility of being realized." Solomon, The American Psychiatric Association in Relation to American Psychiatry, 115 AM. J. PSYCHIATRY 1, 7 (1958). See also Wyatt v. Aderholt, 503 F.2d 1305, 1311 (5th Cir. 1974), where, in affirming that part of the district court's decision finding a constitutional right to treatment for the involuntarily-committed mental patient, the court approved the district court's findings concerning the woeful inadequacy of medical treatment, noting that at the time of initiation of the suit, there were ratios of only one medical doctor with some psychiatric training for 5,000 patients in Partlow State Hospital.


It should also be noted that the large, open wards of many institutions frequently are not segregated in terms of the potential or actual violence of patients commingled therein. Consequently, patients who are passive and non-aggressive may find themselves exposed to physical intimidation or injury from more violent patients.
health establishment. Sociologists, psychiatrists, and psychologists who have been involved in the mental institutional system are fast reaching a consensus that confinement in the traditional public mental hospital is antitherapeutic, especially in the case of long-term and indefinite commitment. The writings of Deutsch and others graphically portray the public mental institution as a cold, isolated, dangerous place which fosters depersonalization, dependency, isolation, dehumanization and misery, and which inevitably causes the breakdown of many socially-valued behavioral characteristics and patterns acquired prior to the patients' admission. The existence of this degenerative or regressive aspect of the public mental institution has been implicitly recognized by the United States Supreme Court in *Jackson v. Indiana* where the rationale for commitment to a mental institution in the pretrial criminal setting was questioned in view of available empirical data concerning the state of most American mental institutions.

The anti-therapeutic effect of long-term hospitalization has been

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64. It should be noted that freedom itself has been regarded as a therapeutic tool. As Deutsch noted in 1961, after describing the miserable conditions existing in a typical mental hospital ward:

This is in spite of the overwhelming evidence, not only abroad but now in this country, that loss of liberty harms the mental patient and is unnecessary for public safety. Indeed, it has been amply demonstrated that freedom is a therapeutic tool [and] that it speeds recovery . . . .


In this context, testimony of Dr. Gunnar Dybawd, Professor of Human Development at the Graduate School for Advanced Studies in Social Welfare at Brandeis University, in the case of *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), aff'd sub nom. *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974), is informative. In describing the profoundly dehumanizing effects of confinement of residents at Partlow hospital, Dr. Dybawd stated:

"I think if you walk through Partlow, you can see it; you can see the effect—the people who begin to become involved in eccentric mannerisms, the rocking back and forth, peculiar behavior mechanisms, the people who sit in a semi-stupor in a place, without any activity, the people who slowly deteriorate and turn to the simple elements of human behavior. . . . In other words, it is a deterioration. I would further now add to this from my own observations, but not at Partlow that we have ample documentation in this country that individuals who come to institutions and can walk stop walking, who come to institutions and can talk will stop talking, and can feed themselves will stop feeding themselves; in other words, in many other ways, a steady process of deterioration."

66. As of the end of 1962, the median length of stay for all public mental hospital residents was 8.4 years, while the median length of stay for schizophrenics, the largest single group of mental patients, was 12.8 years. Kramer, *et al.*, *supra* note 56, at 27. Kramer, *et al.*, attribute the accumulation of these patients, particularly the schizophrenics, to a combination of the severity of their illness and the depersonalizing
the subject of many studies. One such study concluded that the social processes and structures of a typical "chronic" ward worked in opposition to the goal of treatment.\textsuperscript{67} The debilitating effects of prolonged institutionalization have been recognized as potentially insurmountable obstacles to the stabilization or improvement of schizophrenics.\textsuperscript{68} Common utilization of such techniques as the privilege system, whereby every action or omission of the patient carries the potential of sanction or reward, although usually designed to achieve positive behavior modification, frequently results in the suppression of the very problems that led to commitment.\textsuperscript{69} Consequently, even the most ambitious forms of therapy may have little positive effect. Research evidence and clinical experience, using relatively objective measurements and independent criteria of functioning have persuasively demonstrated that the negative, anti-therapeutic effects of institutionalization often counteract processes of natural or induced remission in mental dysfunction, thus producing more psychologic harm than good.\textsuperscript{70} Moreover,

effects of long-term institutionalization, per se. They cite such factors as inadequate treatment and rehabilitation programs, lack of psychological stimulation, insufficient staff, and insufficient community resources to bridge the gap between hospital and community. \textit{Id.} at 28-29.

Retention figures have changed drastically in the last 10 years. In 1971, only slightly over 10\% of patients admitted during that year to state and county mental hospitals were retained continuously for over 6 months. Biometry Branch, National Institute of Mental Health, Statistical Note 74, at 2 (1973). This sharp decrease in long-term commitment has generally been attributed to increased use of chemotherapy in treatment, increased recognition of the damaging effects of long-term confinement, increased public and professional pressure for the "communitization" of mental health services, and the increased administrative pressure to reduce inpatient cases for financial reasons.

\textsuperscript{67} Kantor & Gelineau, \textit{Making Chronic Schizophrenics}, 53 \textit{Mental Hygiene} 54 (1969). \textit{See also} Pittman, Langsley, Kaplan, Flomenhaft, & DeYoung, \textit{Family Therapy as an Alternative to Psychiatric Hospitalization}, \textit{American Psychiatric Ass'n, Psychiatric Report} No. 20, at 188 (1966).

\textsuperscript{68} A. FRAZIER \& S. CARR, \textit{Introduction to Psychopathology} 124 (1964). \textit{See generally} Dunham \& Weinberg, supra note 51, at 244 ("prolonged hospitalization . . . operates adversely on patients with a functional disorder."); Bloomberg, \textit{A Proposal for a Community-Based Hospital as a Branch of a State Hospital}, 116 \textit{Am. J. Psychiatry} 814 (1960) ("There is repetitive evidence that once a patient has remained in a large mental hospital for two years or more, he is quite unlikely to leave except by death."); Klerman, \textit{Current Evaluation Research on Mental Health Services}, 131 \textit{Am. J. Psychiatry} 783, 784 (1974) ("Within the mental health professions, there is a general awareness that large mental hospitals too easily become professionally and therapeutically bankrupt.").


the psychologically degenerative characteristics of mental institutionalization become evident in even the short-term patient,\(^7\) although the degree of institutionalization, dependency, and deterioration is probably closely related to the amount of time spent in confinement.\(^7\)

The anti-therapeutic effect of confinement in public mental hospitals becomes even more apparent when consideration is accorded the fact that many past and present patients are untreatable, and that many others cannot benefit from any further treatment that can be offered by the hospital.\(^7\) In this regard, one study has noted that out of some 200,000 schizophrenic patients hospitalized for longer than 1 year in public mental hospitals, estimates of those

71. The mere diagnosis of mental illness prerequisite to indefinite, involuntary commitment, can have a harmful effect on the mental patient, encouraging him to enter into a "sick role." T. Scheff, Being Mentally Ill 117-21 (1966). See also Goffman, supra note 50, at 355-56; D. Mechanic, Mental Health and Social Policy 63 (1969).


72. Several studies have shown that the longer a mental patient is confined, the less likely are his chances for release. See, e.g., Duran & Errion, Perpetuation of Chronicity in Mental Illness, 70 Am. J. Nurs. 1707 (1970); Kramer, et al., supra note 56, at 27-28. See also Biometry Branch, National Institute of Mental Health, Statistical Note 66 (1972).

Although there appear to be few studies relative to the maximum period of institutionalization that can be expected to be constructive before the point of "psychologic diminishing returns" is reached, one study claimed that between 75% and 85% of newly admitted and readmitted patients should be released within 3 months, with the optimum average length of stay being 28 to 32 days. The consequences of failing to meet these goals were said to be:

Unless units come close to reaching those figures, staff attitudes and programs should well become suspect.

Close confinement is anti-biologic and unhuman [sic]. The person confined has a choice of two responses—to vigorously attack or to passively withdraw.


73. A common example of the "untreatable" confined at state mental hospitals are the elderly, who suffer from senility or hardening of the arteries. In testimony before a Senate subcommittee, Dr. Cameron, then superintendent of Saint Elizabeths Hospital in Washington, D.C., agreed that, for many of these persons, treatment consists largely of seeing that they have adequate food and that they are assisted in keeping clean, etc. Hearings on S. 935 Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, 88th Cong., 1st Sess., at 151 (1963). See also Twerski, Treating the Untreatable: A Critique of the Proposed Right to Treatment Law, 22 Hosp. & Community Psychiatry 261 (1971).
not requiring care run as high as 40 percent. For these patients especially, pathological behavior developing after a long period of confinement can usually be attributed to the hospital experience rather than to a manifestation of a preexisting mental illness. Moreover, the dependency fostered by institutional life and the severing of ties with family and friends that frequently results from confinement in the usually remote and isolated mental hospital act to reduce prospects for discharge and ultimate return to the community.

A broader perception of the overwhelmingly detrimental impact of commitment to the public mental hospital can be obtained from statistics showing the extremely high rate of rehospitalization of former mental patients. In 1969, for example, 69 percent of all admitted patients diagnosed as schizophrenic had previously received state hospital care. Almost one-half of the total admissions for that year had had previous episodes of care in a state mental hospital, the majority of these episodes having occurred within the previous 12 months. These high readmission rates have not been, and perhaps cannot be, exclusively attributed to any one factor. Conceivably, the increased reliance on psychotropic drugs as a treatment modality may increase readmission as a result of rapid relapse when the drugs are discontinued after the patient's release. Similarly, administrative and medical pressures toward reducing overcrowding may result in

74. Hogarty, The Plight of Schizophrenics in Modern Treatment Programs, 22 Hosp. & Community Psychiatry 197 (1971). This study, and others cited therein, estimate that the number of schizophrenic patients capable of fully independent living ranges from 3.5% to 17%. Id. at 202.

75. See Ozarin, Moral Treatment and the Mental Hospital, 111 Am. J. Psychiatry 371 (1955).


77. Schizophrenia is the most common diagnosis for persons admitted to public mental hospitals. See generally Biometry Branch, National Institute of Mental Health, Statistical Note 39 (1971).

78. Id.

79. Biometry Branch, National Institute of Mental Health, Statistical Note 53 (1971). An episode of inpatient care is defined as treatment in the inpatient service which is begun by admission directly to that service.

80. Chemotherapy, as a treatment modality in the public mental institution, was introduced on a significant scale in the mid-1950’s. During a brief period, four new types of drugs were introduced into therapeutic practice—chlorpromazine, rauwolfia, mebrobamate, and imipramine. Psychotropic drugs, which influence the mind and alter behavior, mood, and mental functioning, effected major changes in the policies of mental hospitals. Cf. Klerman, Psychotropic Drugs as Therapeutic Agents, 9 Lex et Scientia 110 (1972). See generally Brakel & Rock, supra note 2, at 160; Claghorn & Kinross-Wright, Reduction in Hospitalization of Schizophrenics, 128 Am. J. Psychiatry 344 (1971).

81. Claghorn & Kinross-Wright, supra note 80.
release of some patients before they are able to take full advantage of whatever therapeutic services the institution can offer. However, in view of the overwhelming evidence of the detrimental effect of public mental hospital confinement, there would appear to be a substantial causal relationship between the experience of an initial commitment and the likelihood of subsequent hospitalization.

In considering the overall impact of civil commitment on the mental patient, it is essential to understand the pervasive social stigmatization attendant thereto. This stigmatization has the combined effect of altering society's perception of the mental patient, and altering his perception of himself. Although many psychiatrists still approach mental illness from the perspective of the "medical model," most of society does not. And while any formal labeling of "mental illness" frequently leads to public attitudes of suspicion, fear, hostility, and even ostracism, the fact of confinement in an asylum, often referred to as a "nut house," compounds these feelings vis-a-vis the mental

82. With the recent trend toward phasing out the large state hospital, many chronic patients have been transferred to other extended care facilities or have been discharged into communities which too frequently have few, if any, aftercare or transitional services or facilities. As a result, many of these patients are unable to cope with the pressures of unassisted, non-institutional life, and are ultimately driven back to the mental hospital. See generally Klerman, supra note 68.


84. The altering of self-perception frequently plays an integral role in the individual's development of barriers that tend to inhibit his ability to benefit from any therapeutic programs offered by the institution. In this respect, it has been observed that:

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 do his original difficulties. E. Goffman, Asylums 355-56 (1961).


86. In re Ballay, 482 F.2d 648, 668 n.72 (D.C. Cir. 1973), and cases and text cited therein.
patient. By definition, involuntary commitment is an accusation of mental illness which is seen as analogous to being accused of a wrongdoing or a crime, and mental institutions are viewed as places to send "crazy people," where they can be kept with "their own kind."

The stigmatization attached to involuntary commitment of the mentally ill is manifested in many ways. In many jurisdictions, involuntary commitment has the effect of rendering the patient civilly incompetent, either by virtue of explicit statutory mandate, by the exercise of the committing judge's discretion, or by the exercise of a hospital superintendent's discretion. The diagnosis of mental disability and resultant commitment to a mental institution may provide a predicate for judicial termination of parental rights, such as the right of the biological parent to withhold consent in adoption proceedings involving his or her children. Similarly, involuntary commitment can result in placement of the mental patient's children in foster homes or with public agencies, and can affect the committed person's legal capacity to marry. Although a few states specifically provide that commitment to a public mental institution shall not by itself adversely affect the patient's civil rights, many states have provided that commitment to a mental institution—or other formal declaration of insanity—can create civil disabilities ranging from the legal inability to contract, make a will, and vote, to inability to obtain professional, business and drivers' licenses.

87. Szasz, Civil Liberties and the Mentally Ill, 9 CLEV. MAR. L. REV. 399, 401 (1960).
88. See generally Rock, Jacobson & Janopaul, supra note 18, at 242-52.
90. E.g., MICH. COMP. LAWS ANN. § 330.1469 (1975). For general discussion of differing statutory approaches to involuntary commitment and its relationship to competency, see Brakel & Rock, supra note 2, at 250, 273-78.
91. E.g., ALASKA STAT. § 47.30.150(a) (1975); N.M. STAT. ANN. § 34-2-15 A(3) (Supp. 1975).
92. See generally Brakel & Rock, supra note 2, at 234-38; 248-59; Table 7.3.
93. See, e.g., MICH. COMP. LAWS ANN. § 551.6 (1967).
94. E.g., HAWAII REV. STAT. § 334-57 (1968); NEV. REV. STAT. § 433A.460 (1975).
95. For a comprehensive discussion of the civil disabilities attendant to a declaration of insanity and commitment to a mental institution, and for a survey of state statutes affecting the civil rights of the mentally ill, see Brakel & Rock, supra note 2, at 303-40. See also H.L.A. Hart, Punishment and Responsibility 29 (1968); Note, Testamentary Capacity in a Nutshell: A Psychiatric Reevaluation, 18 STAN. L. REV. 1119 (1966).

In a recent case illustrating the discriminatory treatment given by states to former mental patients, a federal district court held constitutional against an equal protection challenge a North Carolina law that requires every licensed driver who has been
Many of the civil disabilities attendant to a declaration of mental illness are directly traceable to the commitment process itself. But this stigmatization is only part of the burden imposed on the life of the mental patient, much of which is not felt until release or discharge from the institution. In many cases, the informal rejection of the discharged mental patient is felt more deeply, making an unassisted adjustment into the community difficult or impossible. Perhaps the most conspicuous of these hardships appears in the area of employment. Of course, the initial involuntary commitment acts in most cases to make it physically impossible for mental patients to continue in their employment, trade or profession. Upon release, however, former mental patients are generally confronted with formidable obstacles to finding jobs, a problem magnified by the relative lack of education and job-marketability generally characteristic of public mental patients.

Aside from employment problems, the former mental patient is frequently faced with physical exclusion from many communities, either through utilization of formal procedures, such as exclusionary zoning, or more informal procedures that result in "ghettoization." This latter phenomenon results from a de facto exclusion of released, indigent, mental patients from specific neighborhoods, largely as a result of the low level of public assistance and meager rental markets involuntarily committed for mental illness, alcoholism, or drug addiction to submit to special scrutiny and possible loss of license because of the special threat they had been deemed to pose by the state to highway safety. Jones v. Penny, 387 F. Supp. 383 (M.D.N.C. 1974).

96. As one noted expert in the area of the rights and problems of the mentally ill has said: "Former mental patients do not get jobs. In the job market, it is better to be an ex-felon than ex-patient." Hearings Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, 91st Cong., 1st & 2d Sess., 284 (1970) (prepared statement of Bruce J. Ennis) [hereinafter cited as 1970 Senate Hearings]. See also In re Ballay, 482 F.2d 648, 668 (D.C. Cir. 1973); Lessard v. Schmidt, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972), vacated and remanded, 421 U.S. 957 (1975); ACTION FOR MENTAL HEALTH (Report of the Joint Commission on Mental Illness and Health) 56 (1961); But see Landy & Griffith, Employer Receptivity Toward Hiring Psychiatric Patients, 42 MENTAL HYGIENE 383 (1958).

97. Cf. Biometry Branch, National Institute of Mental Health, Statistical Note 104, at 2 (1974) (showing inverse relationship between level of education attained and rate of admission, with the age adjusted admission rate of patients with 0-7 years of education being six times greater than that of patients at the college level). See generally MYERS & BEAN, supra note 46.


99. Aviram & Segal, supra note 83.
available to them, and the tendency of many of these people to find
themselves confined to socially and economically marginal neighbor-
hoods. Moreover, the released mental patient is frequently faced
with more subtle, yet equally debilitating manifestations of pervasive
distrust, fear, and general social disapprobation.

The social stigmatization associated with formal declarations of
mental illness and commitment to a public mental hospital can, and
frequently does, place an insurmountable barrier to the unassisted re-
integration of the mental patient into the community, and frequently
leads to rehospitalization. This is especially true where there is inade-
quate preleave planning and where there are inadequate transi-
tional or aftercare services in the community. Ambitious programs
of public education about mental illness and the deinstitutionaliza-
tion of mental health systems might substantially reduce public fear
of mental institutions and mental patients. Until such time, the
stigmatization traditionally attached to the mental patient will con-
tinue to add to the hardship and deprivation occasioned by involuntary
civil commitment.

V. THE RIGHT TO TREATMENT AND THE RIGHT TO AFTERCARE

A. Judicial Development of the Right to Treatment

The plight of the public mental patient went almost unnoticed by
the general public and the courts until comparatively recent years.

Although there has been significant attention focused on the procedures
by which a person is involuntarily committed to a mental hospital,
only in the last 15 years have the courts and the scholarly literature begun to address the rights of mental patients once commitment has been effected. The various in-institution civil rights residing in mental patients have been brought within the general umbrella of the "right to treatment." The first major case dealing with the right to treatment was 

Rouse v. Cameron where the court, in reversing and remanding the district court's denial of an involuntarily-committed mental patient's petition for a writ of habeas corpus, held that right to treatment existed by virtue of the language of the commitment statute. In dicta, however, the court observed that civil commitment without treatment would raise "considerable constitutional problems" under the due process, equal protection, and cruel and unusual punishment clauses of the federal constitution. This reference to a potential constitutional source for the right to treatment formed the starting point for subsequent judicial analysis of the nature and extent of the obligation owed by the states to their involuntarily-committed mental patients. Since the Rouse decision, several courts have extrapolated the right to treatment from the due process clause of the fourteenth amendment.

106. The seminal article in the area of the right to treatment is Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960). Since this article, there has been a flood of literature addressing the rights of mental patients in the institution. See, e.g., Ennis & Siegel, supra note 18; Legal Rights of the Mentally Handicapped (B. Ennis & P. Friedman eds. 1973) (three volume set); Goodman, Right to Treatment: The Responsibility of the Courts, 57 Geo. L.J. 680 (1969); Ferleger, supra note 69. See also works cited in Donaldson v. O'Connor, 493 F.2d 507, 519 n.12 (5th Cir. 1974).

107. See A Symposium: The Right to Treatment, 57 Geo. L.J. 673 (1969). It should be noted that the analogous principle in the area of the institutionalized mentally retarded has been called the "right to habilitation," involving "such individual habilitation as will give each [patient] a realistic opportunity to lead a more useful and meaningful life and to return to society." Wyatt v. Aderholt, 503 F.2d 1305, 1307 (5th Cir. 1974), quoting, Wyatt v. Stickney, 344 F. Supp. 387, 390 (M.D. Ala. 1972).

108. 373 F.2d 451 (D.C. Cir. 1967).

109. Id. at 453.


The right to treatment has also been applied in analogous cases. See, e.g., Martarella
The constitutional right to treatment, implicitly recognized in *Rouse* and almost unanimously recognized in its progeny, is based on an evaluation of the state's interest in confining a mentally ill person vis-a-vis the individual's interests which are adversely affected by mental institutionalization. In assessing the burdens and deprivations associated with civil commitment, the courts have noted that the impositions on personal freedoms created by confinement are substantially equivalent to those of convicted felons incarcerated in penitentiaries. Indeed, the deprivation could prove to be greater in view of the purely custodial approach of many mental hospitals, the possibility of indefinite confinement, and the often greater stigmatization associated with mental hospital confinement. While it is arguable that humane incarceration without affirmative treatment or rehabilitation is justifiable for convicted felons, the civil commitment of the mentally ill has been viewed much differently.

The judicial analysis of the right to treatment has proceeded by closely scrutinizing the state's goals in civil commitment and by questioning whether these goals are weighty enough to justify the massive personal infringements thereby created. In *Donaldson v. O'Connor*, the purpose of civil commitment legislation was perceived as being based in two areas. The first, falling within the state's "police powers," was protection against the mentally ill individual's potential danger to himself or his danger to others. The second area of the state's


111. See Ragsdale v. Overholser, 281 F.2d 943, 950 (D.C. Cir. 1960) (Fahy, J., concurring) (noting that mandatory commitment of one acquitted by reason of a criminal defense of insanity, where not reasonably circumscribed, would "transform the hospital into a penitentiary where one could be held indefinitely for no convicted offense.").


114. 498 F.2d 507 (5th Cir. 1974), vacated on other grounds, 422 U.S. 563 (1975).

concern, falling within the state’s *parens patriae*\textsuperscript{116} power, was the provision of care or treatment to the individual who was perceived as being unable to care for himself.\textsuperscript{117} Pursuant to the “police powers” rationale, the court of appeals in *Donaldson* viewed the state’s power to deprive an individual of his liberty as being generally conditioned on his having committed an act previously defined as a crime, and the individual’s having been provided with the opportunity—in the form of a criminal trial—to contest the allegations made against him.\textsuperscript{118} Similarly, where civil commitment was effected under the *parens patriae* rationale, the due process clause was interpreted as requiring that minimally adequate treatment in fact be provided.\textsuperscript{119}

The court of appeals in *Donaldson* reasoned that traditional due process safeguards had not been applied to the appellee, who had not been committed to the Florida mental hospital for the commission of a criminal act, and who had not been afforded the due process procedural safeguards ordinarily associated with a criminal proceeding.\textsuperscript{120} Accordingly, the court held that the state must provide a *quid pro

For a general discussion of the commitment of the mentally ill pursuant to the state’s police power, see *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1222–45 (1974) [hereinafter cited as *Developments*].


\textsuperscript{117} 493 F.2d 507, 520 (1974).

\textsuperscript{118} *Id.* at 521–22. The court also viewed commitment of a “dangerous” individual under the police powers rationale as being controlled by three limiting factors, including rehabilitation for a specific offense, detention for a fixed term, and commitment pursuant to procedures accompanied by fundamental safeguards. *Id.* at 522. *Cf.* Powell v. Texas, 392 U.S. 514, 529 (1968).

\textsuperscript{119} The court of appeals in *Donaldson* relied heavily upon the language of the Supreme Court in *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), where the Court “established the rule that ‘[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purposes for which the individual is committed.’” 493 F.2d 507, 521. Although *Jackson* involved the pretrial commitment of a criminal defendant found incompetent to stand trial, the Supreme Court’s reasoning would seem to apply equally to a civilly-committed individual who is confined for the purposes of care or treatment. *Cf.* Murel v. Baltimore City Criminal Court, 407 U.S. 355 (1972); McNeil v. Director, Patuxent Institution, 407 U.S. 245 (1972); Humphrey v. Cady, 405 U.S. 504 (1972).

This view is substantially reinforced by language in the most recent Supreme Court case dealing with the rights of public mental patients, where the Court stated in dictum:

Nor is it enough that *Donaldson’s* original confinement was founded upon a constitutionally adequate basis . . . because even if his involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed.


\textsuperscript{120} Indeed, this is true for most states’ civil commitment schemes. See *Brakel & Rock, supra* note 2, at 38–58; Ennis & Litwack, *Psychiatry and the Presumption of Ex-
pro quo, in the form of rehabilitative treatment, to justify con-

fine-

ment. This right was further refined to include "such treatment as will help him to be cured or to improve his mental condition." 

B. O’Connor v. Donaldson: An Exercise in the Passive Virtues?

The United States Supreme Court, in agreeing to review the Fifth Circuit's decision in Donaldson v. O’Connor, was presented with the opportunity to finally resolve the issue of whether due process guaranteed the nondangerous civilly-committed public mental patient a right to treatment. The Court’s opinion, however, does not ex-


121. In this context the quid pro quo requirement found one of its earliest ex-

pressions in footnote 30 of the Supreme Court’s opinion in In re Gault, 387 U.S. 1, 22 (1967), where the Court noted:

While we are concerned only with procedure before the juvenile court in this case, it should be noted that to the extent that the special procedures for juveniles are thought to be justified by the special consideration and treatment afforded them, there is reason to doubt that juveniles always receive the benefits of such a quid pro quo.

Interestingly, the Court subsequently cited Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1967), and Millard v. Cameron, 373 F.2d 468 (D.C. Cir. 1966), both cases involving civilly-committed mental patients.

122. 493 F.2d at 520-27. Cf. Robinson v. California, 370 U.S. 660, 666 (1962); Com-


123. 493 F.2d at 527. Although the holding of the court of appeals in Donaldson was limited in application to a nondangerous, involuntarily civilly-committed patient, the scope of the court's analysis would logically compel the applicability of the right to treatment where commitment has been effected pursuant to the "police powers" rationale. Cf. Davy v. Sullivan, 354 F. Supp. 1320 (M.D. Ala. 1973) (criminal sexual psychopath). See generally Developments, supra note 115, at 1236-45.

124. The "passive virtues," in Professor Bickel's terms, describe various devices and techniques of "not doing," devices to which he contended the Supreme Court frequently resorts for disposing of a case while avoiding judgment on the constitutional issue the case raises. A. BICKEL, THE LEAST DANGEROUS BRANCH 111-98 (1962). Although a comprehensive analysis of the validity or applicability of Professor Bickel's theory in the context of the Court's approach to the right-to-treatment issue is outside this article's scope, the issues raised by his ideas permeate the Court's opinion in O’Connor v. Donaldson, 422 U.S. 563 (1975).

125. Petitioner O’Connor, at the time suit was filed in the district court, was the superintendent of the Florida State Hospital where Donaldson had been confined from January 1957, until his release in July 1971. In his brief before the United States Supreme Court, O’Connor’s statement of questions presented included “Whether there is a constitutional right to treatment for persons involuntarily committed to a state mental hospital.” Brief for Petitioner at 2, O’Connor v. Donaldson, 422 U.S. 563 (1975).

Similarly, the American Psychiatric Association, as amicus curiae, extensively briefed the fourteenth amendment right to treatment issue. Respondent Donaldson, however, did not phrase the question presented in pure right to treatment terms. Instead, respondent couched the issue in narrower terms, asking the Court to decide whether one “who was involuntarily confined to a mental hospital for the purpose of treatment . . . and
pressly decide the right to treatment issue, although it provides significant indications of the view the Court might adopt in a case in which it sees the issue directly presented. Moreover, the Court provides at least preliminary indications of its thinking on several related issues which have potential for substantial impact on the rights of public mental patients.\textsuperscript{127}

The most direct and fundamental holding in \textit{Donaldson} deals with the right to \textit{liberty} instead of the right to treatment. Mr. Justice Stewart, speaking for a unanimous Court, stated:

We have concluded that the difficult issues of constitutional law dealt with by the Court of Appeals are not presented by this case in its present posture. . . . As we view it, this case raises a single, relatively simple, but nonetheless important question concerning every man's constitutional right to liberty.\textsuperscript{128}

The Court went on to hold:

In short, a State cannot constitutionally confine \textit{without more} a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.\textsuperscript{129}

In so holding, the Court attempted to make explicit what it was \textit{not} deciding. Accordingly, the Court stated:

\begin{quote}
[T]here is no reason now to decide whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a dangerous, mentally ill individual for the purpose of treatment.\textsuperscript{130}
\end{quote}

who was dangerous neither to himself nor to others, [has] a constitutional right to be restored to liberty, either by treatment or release." Brief for Respondent at 1, O'Connor v. Donaldson, 422 U.S. 563 (1975).
\begin{itemize}
\item \textsuperscript{126} O'Connor v. Donaldson, 422 U.S. 563 (1975).
\item \textsuperscript{127} The importance of the Court's opinion is especially significant in view of the fact that the Court has decided only a few cases directly involving mental patients.
\item \textsuperscript{128} 422 U.S. at 573.
\item \textsuperscript{129} \textit{Id.} at 576 (emphasis added).
\item \textsuperscript{130} \textit{Id.} at 573.
\end{itemize}

Moreover, the Court expressly avoided deciding "whether, when, or by what procedures, a mentally ill person may be confined by the State on any grounds which, under contemporary statutes, are generally advanced to justify involuntary confinement of such a person . . . ." \textit{Id.} at 573. For a discussion of the reasons generally advanced for involuntary civil commitment, see section VA \textit{supra}.

In this context, the Court noted that the jury found none of the traditional grounds for continued confinement were present in Donaldson's case, and that neither party
Although the Court appeared to be straining to avoid the issue of the right to treatment, its holding should achieve the effect of the formal construction of such a right. In essence, the Court was telling the states that continued confinement of at least the non-dangerous mentally ill individual, against that person's will, will result in a violation of that person's constitutional right to liberty founded in due process, unless treatment is provided. Although approving the general propriety of a state's interest in providing care and assistance to the unfortunate, the Court noted that the "mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution." Moreover, to legitimize the intrusion upon the harmless mentally ill's liberty, the state must demonstrate more than the prospect that some citizens might be offended by his presence in the community. In short, the state must do more than contend that an involuntarily-committed person will be better off inside a mental institution than in the community, unless being "better off" is defined in terms of state assistance designed to eradicate or ameliorate the characteristic triggering the state's intrusion—i.e., mental illness. Although Chief Justice Burger expressly disagrees, and the opinion of the Court purports to reserve the issue, it seems that the quid pro quo concept of Wyatt v. Aderholt has, at least in principle, been tacitly endorsed by the Court.

The view that the Court, by avoiding the specific right to treatment issue, was not indicating disapproval of such a right seems further strengthened by developments subsequent to its decision in O'Connor. Although the Court indicated in an O'Connor footnote that its decision vacating the judgment of the court of appeals deprived that court's opinion of precedential effect, it refused to exercise the opportunity to review the Fifth Circuit's decision in Burnham v. Department of Public Health of the State of Georgia. In Burnham, the district court refused to follow those courts which had found a

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131. 422 U.S. at 575.
132. Id. at 586 (Burger, C.J., concurring) ("The quid pro quo theory is a sharp departure from, and cannot coexist with, due process principles.").
133. 503 F.2d 1305 (5th Cir. 1974). See generally notes 121-23 and accompanying text supra.
134. In this context, it is important to note that the Court rejected as unpersuasive O'Connor's contention that the sufficiency of any treatment provided is not a justiciable question within the power of the federal courts to determine. 422 U.S. at 574 n.10.
135. Id. at 577 n.12.
constitutional right to treatment in the civilly-committed public mental patient, and the court granted defendants' motion to dismiss on grounds relating to the eleventh amendment and the lack of a justiciable issue.\(^{137}\) The court of appeals, in a per curiam order,\(^{138}\) reversed and remanded on the authority of its decision in *Donaldson v. O’Connor*\(^{139}\) and *Wyatt v. Aderholt*.\(^{140}\) Consequently, the Supreme Court’s action in *O’Connor v. Donaldson*\(^{141}\) left *Wyatt v. Aderholt* as the law of the circuit. As previously discussed,\(^{142}\) both the district court and the court of appeals in *Wyatt* interpreted the fourteenth amendment as imposing a treatment obligation upon the state. Although a denial of certiorari should not be viewed as a decision upon the merits,\(^{143}\) it should be reasonable to assume that had the Court not viewed favorably a constitutionally premised right to treatment, it would have taken the opportunity to so indicate by granting review in *Burnham*. It would be somewhat inconsistent to view the Court’s decision in *O’Connor* as disapproving the right to treatment in view of the Court’s almost contemporaneous bypass of an occasion to indicate its disapproval of *Wyatt*, a landmark right to treatment case upon which much of the reasoning of the court of appeals in *O’Connor* was premised.\(^{144}\)

Viewed in the above context, and with respect to important dicta regarding areas of vital concern to public mental patients,\(^{145}\) the

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138. 503 F.2d 1319 (5th Cir. 1974).

139. 493 F.2d 507 (5th Cir. 1974).

140. 503 F.2d 1805 (5th Cir. 1974).

141. 422 U.S. 563 (1975).

142. *See* section VA *supra*.


144. This view does not ignore the possibility that other factors may have been operating in the Court’s denial of certiorari in *Burnham*. One such factor may have been the Court’s conclusion that the treatment issue is a justiciable one, *O’Connor v. Donaldson*, 422 U.S. 563, 576, n.10 (1975)—a conclusion previously rejected by the district court in *Burnham*. A second factor may have been the Court’s desire to postpone an express ruling on the right-to-treatment issue pending an assessment of the state and lower federal court’s reactions to the *O’Connor* decision. In any event, the more substantive ramification of the disposition of the *Burnham* case, in terms of the court’s thinking on the right to treatment, should not be overlooked. For an illuminating discussion of the diverse factors frequently involved in the Supreme Court’s decisions to grant or deny certiorari, see Maryland v. Baltimore Radio Show, Inc., 338 U.S. 912 (1950) (opinion of Justice Frankfurter). *But see* Brown v. Allen, 344 U.S. 443, 542-43 (1953) (Jackson, J., concurring). *See generally* R. Stern & E. Gressman, *Supreme Court Practice* § 5.5 (4th ed. 1969).

145. In addition to the ancillary holding that the treatment issue is a justiciable one, *see* note 134, *supra*, the Court’s opinion in *O’Connor* clearly indicates that mental
Court's holding in *O'Connor* gains significance beyond its purported limitation to a narrow prohibition against involuntary confinement "without more" of a nondangerous mentally ill individual. It is logical to expect that state mental health officials will view *O'Connor* as requiring them not only to periodically review and reevaluate continued confinement of at least the nondangerous involuntary patient, but also as requiring them to institute meaningful treatment programs as the constitutionally-compelled price for involuntary commitment.\textsuperscript{146} Whether this obligation is defined in terms of a right to liberty or a right to treatment, its ramifications for the scope of patients' rights and states' responsibilities are both similar and wide ranging.

C. Extending the Right to Treatment Outside the Institution

The *quid pro quo* rationale adopted by the court of appeals in *Donaldson*, and by other courts\textsuperscript{147} has been construed and applied to require the creation of a humane psychological and physical environment in the mental institution, and to ensure that the institutional experience, insofar as possible, is a therapeutic rather than a purely custodial one. However, in terms of the current status of the judicially articulated, conceptual framework for the right, there has been no formal effort to extend its scope to a patient's postdischarge adjustment. In fact, many early right-to-treatment cases were framed as habeas corpus actions in which the plaintiffs sought the alternative

\textsuperscript{146} In at least one state, mental health officials have already indicated that they have read *O'Connor* as requiring provision of effective treatment to nondangerous involuntary mental patients or, in the alternative, the patients' release. Cleveland Plain Dealer, July 16, 1975, § B, at 10, col. 1 (dealing with the post-*O'Connor* discharge of 100 mental patients from Ohio's Hawthornden State Hospital).

\textsuperscript{147} See note 110 supra.
remedies of treatment or release. Indeed, the district court in *Wyatt v. Stickney* found that many inmates of the state's institutions did not suffer from mental illness and ordered them released, while further ordering the state to provide appropriate services and assistance to ease their return to the community. The remedy ordered by the district court required, as part of each individual's treatment plan, that adequate transitional treatment for persons released after a period of involuntary confinement be provided. But the original opinion in *Wyatt* dealt only in terms applicable to the status of the mental patient while confined. Similarly, the opinion of the court of appeals is devoid of any explicit reference to a right to treatment whose scope would reach beyond the institution to include the provision of aftercare or transitional services to discharged mental patients. Although the right to treatment fashioned by the district court judge could and should be extended to compel the states to provide and develop post-discharge services, the argument has apparently not yet been articulated by the courts. Such an effort is made below.

It is clear that the right to treatment can have little meaning unless it encompasses an effective catalyst for improving the chances for the patient to return to the community and to lead a more useful and meaningful life. Indefinite or long-term confinement cannot be justified simply because purely custodial care is supplemented with an active in-hospital program of medical and psychological treatment.


150. 344 F. Supp. at 373 (Order of April 13, 1972 to Bryce Hospital and Searcy Hospital); 344 F. Supp. 387 (Order of April 13, 1972 to Partlow State School and Hospital).

The precise reasoning of the court in ordering aftercare treatment for these patients is not apparent in the original opinion at 325 F. Supp. 781.

151. 344 F. Supp. at 379, 384, 386 (specific reference is made to §§ 11(2), IV(26)(b), IV(27) & (28), and IV(34), respectively, in Appendix A of the court's opinion).


153. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

154. Although Judge Johnson's preliminary orders in *Wyatt*, and his ultimate formulation of individualized treatment plans clearly contemplated a right extending into the community, the failure to develop a reasoned basis for such an extra-institutional dimension has left its conceptual basis open to question. It is submitted that the difference between a state's obligation to provide institutional treatment programs and an expanded duty to provide community based aftercare service is a substantial one and, from a legal process perspective, ought not to be constructed without an articulation of the nature of the underlying obligation.
The purpose of the commitment must be defined in terms of assisting the patient to overcome the prior inadequacies that made him unable to conform to expected modes of social behavior, and the requirement of treatment must be directed toward remediating the socio-psychological abnormality necessitating the commitment itself. A treatment program designed to allow the patient to adjust more easily to institutional life—and not to create the basis for a satisfactory and permanent return to the community—would be akin to no treatment at all. Consequently, the treatment contemplated by *Rouse v. Cameron* and its progeny must be measured by its effectiveness in securing an expeditious and successful return to noninstitutional life.

The potential for institutionalized treatment to be truly effective in "curing" mental illness and in providing the patient with the means to return to the community and a permanent, more acceptable adjustment is problematical. One writer concluded that psychotherapy is no more successful in effecting a cure for mental illness

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155. There is a growing awareness that "the goal of treatment is not adaptation to continued confinement, but alleviation" or elimination of the factors leading to hospitalization. See, e.g., Morris, *Institutionalizing the Rights of Mental Patients: Committing the Legislature*, 62 CALIF. L. REV. 957, 965 (1974); Tucker & Maxmen, *The Practice of Hospital Psychiatry: A Formulation*, 130 AM. J. PSYCHIATRY 887, 889 (1973).

Expressed in other terms, an obligation to provide treatment for the public mental patient must be interpreted as requiring treatment which is suitable to ensuring the patient "a realistic opportunity to be cured or to improve his or her mental condition." Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971). In view of the devastating side effects associated with large mental institutions, see, e.g., *In re Ballay*, 482 F.2d 648, 667 (D.C. Cir. 1973). Since a patient's needs may change after initial commitment, suitable treatment may frequently require placement in an alternative facility.

156. 373 F.2d 451 (D.C. Cir. 1967).

157. One observer has noted that although courts and commentators frequently use the term "adequate" in describing the requisite standard of treatment, others have proposed the standards of "permissible," "appropriate," and "responsible." Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936, 937 (1974), and authorities cited therein. While some exception can be taken to the narrow categorization of effective treatment in terms of "change of patient behavior," id. at 938, it is clear that regardless of nomenclature, treatment must produce results compatible with the purpose of its application. Cf. Powell v. Texas, 392 U.S. 514, 529 (1968) (where Justice Marshall, in contrasting penal incarceration to civil commitment, said that "[t]herapeutic civil commitment' lacks this feature [outside statutory limit of confinement]; one is typically committed until one is 'cured'").

158. Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936 (1974). After a review of literature in the area, Mr. Schwitzgebel concludes that "the evidence for the effectiveness of traditional psychotherapeutic methods for the reduction of anti-social behavior is not very persuasive." Id. at 946. He does note, however, that some of the newer forms of therapy have produced demonstrable changes in behavior. Id. at 947.
than ordinary life-experience and nonspecific treatment.\textsuperscript{159} Assuming, however, that some form of active psychiatric treatment can at least serve to ameliorate symptomatic manifestations in both the acute episodic case and the chronic patient,\textsuperscript{160} difficulties inhere in measuring its effectiveness. Some suggested methods of evaluation include examining the structure of the treatment institution,\textsuperscript{161} the process of treatment delivery, and the treatment outcome.\textsuperscript{162} Whatever the particular treatment modality deemed appropriate for the mental patient while confined to the institution, it should be recognized that the legal status of the patient—whether a voluntary or involuntary committee—may have a large role to play in treatment outcome. Several mental health experts have expressed the opinion that involuntary commitment should only be permitted, if at all, for very short periods of time. According to this view, effective treatment is dependent upon the manner in which it is received. If it is continually forced upon the patient, the likelihood is that he will eventually begin to resist the therapist's efforts, thus causing an erosion of the therapeutic atmosphere which is considered to be a \textit{sine qua non} for positive results.\textsuperscript{163} Consequently, regardless of the standard used for measuring treatment effectiveness, it may be essential that the

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Similar conclusions have been reached with respect to the effectiveness of therapeutic programs in the correctional setting. \textit{See} Schwitzgebel, \textit{Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria}, 8 \textit{HARV. CIV. RIGHTS-CIV. LIB. L. REV.} 513 (1973), and articles cited at 522 [hereinafter cited as \textit{Treatment Standards}].

\textsuperscript{160} \textit{See} Ellsworth, \textit{Reinforcement Therapy with Chronic Patients}, 20 \textit{HOSP. \& COMMUNITY PSYCHIATRY} 238 (1969).

\textsuperscript{161} This approach would place particular emphasis on the size of the institution, staff-patient ratios, and per capita costs. Since these factors are particularly visible and easily provable, some courts have focused on them as persuasive indicators of the kind of treatment being provided at mental institutions. \textit{E.g.}, Wyatt \textit{v. Aderholt}, 503 F.2d 1305 (5th Cir. 1974).


It would appear that the treatment-outcome approach of evaluating the effectiveness of in-hospital treatment would provide the most objective standard. This would assume, of course, that a comprehensive postdischarge record is kept for each patient, closely monitoring his community adjustment and discounting the effects of placement in an environment different from that in which the patient found himself prior to admission. In any event, the treatment-outcome approach will be used in this discussion as the primary standard of effectiveness.

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involuntarily-committed mental patient be discharged into a less coercive or restrictive treatment environment within a short period after admission, or that he at least be converted to voluntary status.

It should be emphasized that the evaluation of treatment suggested here does not necessarily imply that the right to treatment, as promulgated in the case law, must require that the most effective treatment theoretically available be provided to each patient. Notwithstanding some thorny constitutional problems inherent in that suggestion, the ability of the psychiatric profession to develop treatment modalities that can be said, with certainty, to guarantee better results than other approaches is generally questionable. Instead, effective treatment should be defined as the least restrictive method of providing psychiatric and related services to each patient consistent with an assurance of providing the optimum expectation of satisfactory postinstitutional adjustment. If, in a given case, what can be done for the patient in the mental institution itself cannot reasonably provide this assurance, constitutionally adequate treatment must include services and assistance in the community.

In this context, it is quite clear that environmental factors pertaining to the mental patient's preadmission social setting play a large role in determining when and how he is ultimately committed. These same factors can, in large part, be crucial in determining whether the patient can be expected to remain in the community or whether he is likely to become rehospitalized. If the patient is released to a setting that predictably reduces his chances of a successful adjustment, the discharge itself must be viewed as antitherapeutic and antithetical to the right to treatment. Various studies have demonstrated that an unstructured release without referral to community aftercare or transitional services (such as community mental health centers, foster homes, day-or-nightcare centers, halfway houses, group-living homes, etc.) or

164. For a discussion of the application of the least restrictive alternative doctrine to the involuntarily committed mental patient, see section VII infra.

165. The possibility of an equal protection argument addressed to a comparison of different treatment modalities for similar patients is raised in Treatment Standards, supra note 159, at 524 n.73.


167. See, e.g., Simmons, Davis & Spencer, Interpersonal Strains in Release from a Mental Hospital, 4 Social Problems 21, 26 (July, 1956).

168. Several studies have shown that an effective aftercare program substantially increases a discharged patient's chance to adjust satisfactorily in the community. See, e.g., R. Glasscote, J. Guzman & R. E1fors, Halfway Houses for the Mentally Ill (1971); Drieman & Minard, supra note 101. Cf. B. Pasamanick, F. Scarfitti & S. Dinitz, Schizophrenics in the Community (1967); Davis, Dinitz & Pasamanick, The Prevention of Hospitalization in Schizophrenia: Five Years After an Experimental Program, 42 Am. J. Orthopsychiatry 375 (1972).
without involvement in other community supportive agencies, will result in a predictable and substantial increase in rate of rehospitalization. As one study noted:

A significant proportion of readmitted schizophrenic patients have an impulsive and stormy life style which makes it almost impossible to contain them in treatment programs in which either the patient or his family must take responsibility for keeping the patient involved. Thus, treatment of these patients is frequently limited to brief periods of hospitalization which control the patient's acute psychotic episodes; little is accomplished to improve the patient's community adjustment, and unless effective methods of aftercare are evolved for these patients, their relapses and readmissions are inevitable.

For many of these mental patients, institutional treatment programs are limited in their potential to achieve their own goals. If treatment was confined to in-hospital therapy, the most that could be accomplished for many patients would be a more stable adjustment to the institution.

It is no doubt tautological to say that some patients will be rehospitalized regardless of the type of community service they obtain. There will inevitably be chronic patients who, for reasons of prolonged institutional dependency or otherwise, will be unable to function satisfactorily in even the most constructive aftercare environment. But for many of these individuals, former lives of quiet desperation as chronic patients in public mental institutions can be transformed into something better than a new form of community chronicity cultivated by the neglect and antipathy of crowded nursing homes, run-down rooming houses and other marginal residential facilities. If the right to treatment is to have any significant sub-

171. It is also quite probable that some former patients can reside in the community while actively psychotic and socially withdrawn, even without the stabilizing effect of placement in a positive family environment or in the structured or semi-structured atmosphere of aftercare facilities. In this regard, some discharged patients are able to avoid rehospitalization when their interpersonal performance is within the range of behaviors expected by those with whom they interact. See, e.g., Freeman & Simmons, Mental Patients in the Community: Family Settings and Performance Levels, 23 Am. Sociol. Rev. 147 (1958).
172. Cf. Klerman, supra note 80, at 126.
stance for these patients, it must include the preparation of an after-care program that will provide at least the potential for a useful and meaningful existence in the community. If, because of failure to develop postdischarge planning or lack of viable aftercare alternatives, release from the mental hospital merely accomplishes a transfer from a back ward to a back alley, the right to treatment will be an empty promise indeed.\textsuperscript{173}

The importance of predischarge planning and the development of aftercare services as a component of the right to treatment has become increasingly clear in view of the present emphasis on shorter periods of hospitalization for new patients and the trend in some states toward often precipitous release of chronic mental patients. Several recent studies have described a movement by public mental hospitals toward the unstructured dumping of mental patients into communities that are unprepared to offer the services and facilities necessary to assure a reasonable opportunity for continued treatment and satisfactory community adjustment.\textsuperscript{174} This trend can be attributed in part to a growing belief in the need to eliminate the large public mental hospital, and perhaps also to a backlash to the increasing incidence of a statutory and court-mandated right to treatment. It has been marked by the unceremonious discharge of patients without any serious consideration of their need for alternative care. In describing this development in California, one study noted:

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Some of these patients have gone to run-down transient hotels where they pay twelve to fifteen dollars a week for a single room; some have gone to "board and care" homes, located typically in poor, crime-ridden areas. The supervision of former patients in these homes is often minimal, since the only license needed to operate a six-bed board-and-care home in any county in California is a ten-dollar business license. Other patients have gone to premature deaths.\textsuperscript{175}
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It is apparent that the direct result of such discharges will often be an erosion of many of the therapeutic benefits achievable through in-institution treatment.\textsuperscript{176} Consequently, without inclusion of post-

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\textsuperscript{173} See Aviram & Segal, supra note 83; Ozarin, supra note 75.

\textsuperscript{174} See, e.g., Belknap, supra note 45; Klerman, supra note 68, at 786. See also The New York Times, January 7, 1975, at 37, col. 4.

\textsuperscript{175} Chu & Trotter, supra note 48, at 42–43 (footnote omitted).

\textsuperscript{176} It appears that significant numbers of at least nondangerous involuntary public mental patients may be discharged, perhaps precipitously, in wake of the Supreme Court's decision in O'Connor v. Donaldson, 422 U.S. 563 (1975). Many state mental health officials are likely to view O'Connor as presenting them with a choice between
discharge treatment plans involving, where necessary, placement in suitable aftercare facilities, the right to treatment cannot promise to be effective. Similarly, where institutional confinement has been antitherapeutic, causing regression of a preexisting psychiatric condition or inflicting new types of psychological distress, community-based aftercare may be essential if the former patient is to avoid the "revolving door" effect of rehospitalization.\(^{178}\)

VI. THE EIGHTH AMENDMENT AND THE RIGHT TO AFTERCARE

The right to treatment, as promulgated in *Wyatt v. Stickney*\(^ {179}\) and subsequent cases,\(^ {180}\) has recently emerged in a hybrid form. This form, referred to as the "right to be free from harm,"\(^ {181}\) is not premised in the *quid pro quo*, due process rationale, but appears instead to be based on the eighth amendment to the United States Constitution.\(^ {182}\) In *New York State Association for Retarded Children, Inc. v. Rockefeller*,\(^ {183}\) the court rejected the application of Judge Johnson's due process analysis in *Wyatt*\(^ {184}\) to a suit involving allegedly unconstitu-

... providing meaningful treatment to nondangerous involuntary patients or releasing them outright. Furthermore, because mental health personnel face possible personal liability as a result of the O'Connor decision, they may err on the side of outright release. To date, at least one state mental hospital has released over 100 involuntary patients in the wake of O'Connor because of lack of resources to provide treatment, even though no adequate community alternatives were available. See note 146 and accompanying text supra.

177. Predischarge planning, involving placement in after-care facilities, may not be necessary for mental patients with personal resources or community ties sufficient to ensure adequate postdischarge support and treatment. It should be noted, however, that a placement with friends or family can, in some cases, be foreseeably antitherapeutic. Consequently, even where a patient's family indicates a desire or willingness to offer assistance and support, placement in publicly-supported aftercare facilities may be necessary to maximize potential for successful postdischarge adjustment. Cf. Freeman & Simmons, supra note 169; Landy & Griffith, supra note 96.

178. In this respect, a due process argument for aftercare as part of the *quid pro quo* discussed in the *Wyatt* and Donaldson cases is conceptually analogous to the eighth amendment approach developed below. See note 200 and accompanying text infra.


180. See note 110 supra.


182. The eighth amendment has, of course, been incorporated into the due process clause of the fourteenth amendment. Furman v. Georgia, 408 U.S. 238, 241 (1972) (Douglas, J., concurring); Robinson v. California, 370 U.S. 660, 667 (1962).


184. In so doing, the court distinguished Rouse v. Cameron, 379 F.2d 451 (D.C. Cir. 1967), from the facts of the case before it, which involved retarded children committed to New York's Willowbrook State School. The court noted that the summary nature of
tional treatment of retarded children committed to New York’s Willowbrook State School. In recognizing the increased willingness of the federal courts to inquire into the conditions of confinement,\textsuperscript{185} the court noted that institutionalization for any reason involves restrictions, but that persons residing in state institutions cannot be punished inconsistently with eighth amendment principles.\textsuperscript{186}

Aside from the issue of whether involuntary civil commitment without treatment may constitute, by itself, an eighth amendment violation,\textsuperscript{187} it is clear that conditions existing in a public mental institution can be so oppressive and debilitating as to constitute cruel and unusual punishment.\textsuperscript{188} In this regard, the arguments proffered in

the Rouse commitment was not present because there had been no refusal to release any Willowbrook resident, and that the extended period of confinement involved in Rouse and its progeny was not an issue. 357 F. Supp. at 761. The court did note, however, that due process may be an element in the right to protection from harm. Id. at 762. See generally Murdock, \textit{Civil Rights of the Mentally Retarded: Some Critical Issues}, 48 Notre Dame Law. 133, 155-61 (1971).


\textsuperscript{186} The court in Rockefeller did not rest its decision exclusively on the eighth amendment. It noted that:

The rights of Willowbrook residents may rest on the Eighth Amendment, the due process clause of the Fourteenth Amendment or the equal protection clause of the Fourteenth Amendment . . . . It is not necessary now to determine which source of rights is controlling.

357 F. Supp. at 764. However, most of the authorities relied upon dealt with eighth amendment standards for confinement; and the standards against which the court found that harm to the inmate must be tested, such as "civilized standards of humane decency," \textit{id.} at 765, are derived from eighth amendment cases. \textit{Cf.} Trop v. Dulles, 356 U.S. 86, 101 (1958).


\textsuperscript{188} \textit{See} \textit{Buri, Eighth Amendment Rights in Mental Institutions, 2 Legal Rights of the Mentally Handicapped} 735, 737 (B. Ennis & P. Friedman eds. 1973). \textit{But see}
Wyatt v. Stickney would appear to be applicable to most of America’s public mental institutions. There, it was contended that:

“The conditions in the Alabama mental institutions—the physical deprivation, the lack of basic sanitation, the overcrowding, the lack of physical exercise, the inadequate diet, the unchecked violence of inmates against each other and of employees against inmates, the lack of adequate medical care and psychiatric care, the abuse of solitary confinement and restraint—constitute cruel and unusual punishment. Indeed, the conditions bear a close resemblance to conditions which have been held to be unconstitutional in cases involving convicted criminals and persons accused of crime. Haines v. Kerner, 404 U.S. 519 (1972); Wright v. McMann, 387 F.2d 519 (2nd Cir. 1967); Hancock v. Avery, 301 F. Supp. 786 (M.D. Tenn. 1969); Jones v. Wittenberg, 323 F. Supp. 93 (N.D. Ohio 1971).”

The courts have shown a consistent readiness to apply eighth amendment standards to penal institutions. Their application to conditions of confinement for the civilly-committed mental patient who has not committed any criminal act must be equally, if not more, compelling.

A more complex question is presented in the issue of how far the courts may be willing to go in terms of providing a remedy for the damage suffered by the public mental patient as a result of confinement to an institution where the psychological and physical environment is found to be violative of eighth amendment protections. If the eighth amendment confers a right upon the mental

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*Developments, supra note 115, at 1330–33, discussing both the “impact” and “intent” theories of punishment, and concluding that the “invocation of the eighth amendment is an unnecessary analytical step” in finding a right treatment. *Id.* at 1333.


190. Burt, *supra* note 188, at 739, quoting amici’s brief. *See also* discussion of general conditions existing in many modern-day public mental institutions, section VI supra.

191. *See* cases cited at note 185 *supra*.


193. It should be noted that the ultimate applicability of the eighth amendment to the public mental institution—a matter not yet confronted by the Supreme Court—may well depend on the “cumulative effect” of the institutional milieu upon the individual, and the way this effect is perceived by the Court. In the most recent pronouncement of eighth amendment principles in *Furman v. Georgia*, 408 U.S. 238 (1972), five justices concurred in invalidating the death penalty as applied in Georgia. Although there was no opinion for the Court, the common thread in the opinions concurring in the judgment appeared to place varying importance on several factors. These included: the severity of the punishment; the probability of its being inflicted arbitrarily; the acceptability of the punishment by contemporary society; and the issue of whether the punishment serves the state’s [penal] purposes more effectively than some less severe approach. Where these factors coalesce, to a degree and extent not
patient to be free from harm or to be protected from deterioration, as was indicated by the court in *Rockefeller*, the problem arises as to whether elimination of the abuses complained of and the initiation of institutional treatment programs will be sufficient to redress the substantial destruction to the individual that may have been inflicted by prolonged commitment. This issue would have special significance for the individual committed because he presented a danger to himself, where the only real justification for commitment would have been the state's interest in protecting him from harming himself. At least as to him, the state would seem to have a responsibility to do everything possible to protect against regression or deterioration during the course of confinement.

In this context, the effect on retarded persons of confinement at New York's Willowbrook State School, as revealed by evidence presented in the *Rockefeller* case, is instructive. One expert testified that:

"Confinement of mentally retarded persons in depriving institutions tends to have severe, adverse consequences for the resident's mental, emotional and physical functioning. Among these adverse consequences are a decrease in the resident's measurable intelligence, impairment of his adaptive behavior, decrease in his self-sufficiency [sic], increase in his maladaptive and stereotyped [sic] behavior, including rocking, aggression and self abuse, and increase in his emotional distress: in short, a deterioration in the resident's behavior and functioning, including his habits and manners.

In a depriving institution, such as Willowbrook, the resident's measure of intelligence can be expected to show continued decreases through the course of institutionalization."

The evidence further revealed that:

Confinement of the retarded to an impersonal and inadequate institution such as Willowbrook is likely to have substantial adverse
consequences on their [patients'] ability to cope with the societal environment and to maximize their human inequalities.\textsuperscript{195}

In many cases, the effects of this kind of personal deterioration are likely to be long-term. Moreover, it is reasonable to assume that these by-products of confinement in institutions such as Willowbrook are likely to persist after the individual is released from confinement.\textsuperscript{196} In such cases, the release of the patient pursuant to a writ of habeas corpus, or even the initiation of a court or statutorily-mandated treatment program, would quite possibly be insufficient to effect an amelioration of the damage caused by past institutional experience.\textsuperscript{197}

It is in this regard that a meaningful application of the eighth amendment's guarantees should be held to require more than a remedy limited to the release of the patient from confinement or the imposition of a judicially structured program of in-hospital treatment, which might act prospectively only. Where the patient seeks legal redress for the violation of his right to be free from cruel and unusual punishment,\textsuperscript{198} and where he can establish that physical or psychological damage or deterioration has been sustained as a result of the state's failure to protect him against harm, the proper remedy should include the state's provision of a therapeutic program subsequent to discharge from the institution.\textsuperscript{199}

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\item[195.] Id. at 751.
\item[196.] The district court noted that the parents, family or guardians of the Willowbrook patients were not denied the power to effect a patient's release, New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752, 762 (E.D.N.Y. 1973), and that some 27% of the institution's patients were voluntary. Id. at 756. Consequently, it is possible that a parent or guardian could remove the patient from the institution prior to identification and amelioration of institutionally-created disabilities.
\item[197.] Even in state institutions where the decision to discharge rests in the sole discretion of the administrative staff, the application of the least restrictive alternative doctrine might well require the release of the patient before a newly-initiated treatment program could ameliorate the damage done during confinement. See section VII infra for a discussion of the least restrictive alternative doctrine and involuntary commitment.
\item[198.] Although earlier cases challenging conditions in public mental institutions were frequently brought in the form of habeas corpus, see, e.g., cases cited in Donaldson v. O'Connor, 493 F.2d 507, 523 nn.26, 27 (5th Cir. 1974), most recent cases have sought declaratory and injunctive relief pursuant to the Civil Rights Act of 1871, 42 U.S.C. § 1983 (1970), and the Federal Declaratory Judgment Act, 28 U.S.C. § 2201 (1970).
\item[199.] In a consent decree issued in continued litigation involving New York's Willowbrook Hospital subsequent to the opinion of the district court in the Rockefeller case, the defendants agreed, \textit{inter alia}, to establish within a 12-month period 200 new community placements in hostels, halfway homes, group homes, sheltered workshops, and day care training programs to meet the needs of residents who will be transferred there; to request the state legislature to provide at least $2,000,000 for financing, leasing,
In the case of a patient who is able to privately arrange an acceptable and adequate community placement, the state's obligation should include state-subsidized medical and psychiatric treatment. Where the patient is unable to arrange an adequate placement because of indigency or lack of community ties, the state should be required to provide aftercare treatment and facilities. Such services and facilities, including foster homes, halfway houses, day-or-night care programs, sheltered workshops, and community mental health centers, would provide the discharged patient lodging, medical care, employment training, and other supportive services until he or she has overcome institutionally-created disabilities, or until the best available professional judgment indicates that such services can no longer be useful in helping the patient reintegrate into the community.

An alternative remedy potentially available to the mental patient for harm sustained as a result of institutional confinement would be a civil damage action. The viability of this approach has been recognized in Donaldson, which was the first major right-to-treatment

and operating the 200 new community placements; to request the legislature to provide additional funds to develop and operate community facilities and programs for the ensuing 5 years; and to develop an individual plan of care, education, and training for each of Willowbrook's 3,000 residents to prepare them for life in the community. New York State Ass'n for Retarded Children v. Carey, No. 72-C-356 (E.D.N.Y., May 5, 1975); 9 CLEARINGHOUSE REVIEW 209 (1975).

A similar argument would be applicable where the patient has suffered physical or mental deterioration not attributable to the ordinary progression of his mental illness, under the more widely adopted due process, quid pro quo right to treatment rationale adopted by the court of appeals in Donaldson and by the district court in Wyatt. In that context, the provision of aftercare services would be an integral part of the "quid" due the patient in exchange for the "quo" of the patient's having surrendered his freedom to the state as a result of his commitment. See note 121 and accompanying text supra.

In preliminary orders in Wyatt the district court found that many inmates in the institutions involved did not suffer from mental illness. The court ordered these patients released, and further ordered the state to provide "appropriate" transitional service and assistance to help repair the damage done to them by incarceration.

Theoretically, where the damage sustained by the patient as a result of the destructive aspects of institutional life is so massive as to be unremediable, the state's obligation of support and care, either in the institutional or community setting, would continue as long as the patient lives. In this situation, a common law tort action might be invoked as an additional remedial device. For a discussion of potential tort liability for failure to provide treatment, see Treatment Standards, supra note 159, at 530.

The eleventh amendment, of course, would preclude a damage award against a state, see, e.g., Edelman v. Jordan, 415 U.S. 651, 663 (1974), but not against the superintendent of a mental institution or other person acting under color of state law. See, e.g., Monroe v. Pape, 365 U.S. 167 (1961).
case pursued as an action to recover damages against hospital physicians for deprivation of a mental patient’s right to receive treatment. Where the deprivations of the patient’s eighth and fourteenth amendment rights have resulted in physical or mental deterioration, the patient’s prayer for relief in a civil rights action brought pursuant to section 1983 of the Civil Rights Act of 1871, could request damages for the deprivation itself plus the amount necessary to provide care and treatment in the community once the state’s obligation to discharge him becomes operative.

VII. LEAST RESTRICTIVE ALTERNATIVE: A POTENTIAL SOURCE FOR THE AFTERCARE OBLIGATION

A. Development of the Least Restrictive Alternative Doctrine in Constitutional Law

In recent years, a new conceptual tool has emerged in both prison and mental health litigation which cuts across the framework of the eighth amendment and the due process clause of the fourteenth amendment in identifying the states’ obligations to their prisoners and institutionalized mental patients. This concept, sometimes referred to as the “least restrictive alternative,” embodies very general principles concerning the relationship between the state and the in-

203. The plaintiff in Donaldson successfully contended in the district court and the court of appeals that the attending physician, having failed to provide treatment, was constitutionally obligated to release him. Consequently, the United States Court of Appeals for the Fifth Circuit, in agreeing with the lower court’s conclusions and jury instructions concerning the nature and scope of the right to treatment, affirmed a jury verdict of $28,500 in compensatory damages and $10,000 in punitive damages.

The Supreme Court, however, vacated the judgment of the court of appeals and remanded the case to enable that court to consider the damages issue in light of Wood v. Strickland, 420 U.S. 308 (1975), which is the Court’s most recent decision on the scope of the qualified immunity possessed by state officials under 42 U.S.C. § 1983. Under that decision, the relevant question in a damage action against state officials is whether the official “knew or reasonably should have known that the action he took within his sphere of official responsibility” would violate the patient’s foreseeable constitutional rights, or “if he took the action with the malicious intention to cause a deprivation of constitutional rights or other injury” to the patient. Id. at 322.

204. This concept has also been referred to as the “least drastic alternative,” Singer, Sending Men to Prison: Constitutional Aspects of the Burden of Proof and the Doctrine of the Least Drastic Alternative as Applied to Sentencing Determinations, 58 CORNELL L. REV. 51 (1972), and as the doctrine of the “reasonable alternative,” Wormuth & Mirkin, The Doctrine of the Reasonable Alternative, 9 UTAH L. REV. 254 (1964). It appears to have been derived from antitrust law, where the availability of less restrictive means of competition militates against acceptance of economic justifications for anticompetitive practice. Struve, The Less-Restrictive-Alternative Principle and Economic Due Process, 80 HARV. L. REV. 1463 (1967).
Broadly stated, the concept requires the state, when pursuing a legitimate goal, to choose a means to achieve that goal by measures which either totally avoid invasion of private interests in liberty or property or which invade those interests as minimally as possible. In short, government is required to pursue the least restrictive course available to accomplish its desired purpose.

One of the earliest applications of the least restrictive alternative doctrine arose in the commerce clause setting. In Dean Milk Co. v. City of Madison, the Supreme Court struck down an ordinance of Madison, Wisconsin, which forbade the sale of pasteurized milk in the city unless it had been pasteurized and bottled at an approved pasteurization plant within 5 miles of the center of the city. The Court, in holding that the ordinance unjustifiably discriminated against interstate commerce, said:

In thus erecting an economic barrier protecting a major local industry against competition from without the State, Madison plainly discriminates against interstate commerce. This it cannot do, even in the exercise of its unquestioned power to protect the health and safety of its people, if reasonable nondiscriminatory alternatives, adequate to conserve legitimate local interests, are available.

The Court, in finding that reasonable and adequate alternatives to the statutory scheme were available, manifested an overriding concern that the exercise of the state's police power be minimally intrusive in terms of applicable constitutional guarantees.

The least restrictive alternative doctrine has more recently emerged in the context of cases involving first amendment issues. Where state statutes regulating expression, belief, or association have been challenged on grounds of vagueness or overbreadth, the Supreme Court has frequently found the regulations invalid where they swept

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205. One writer has, in the due process context, described the concept as requiring that:
If government should restrict human activity only to implement a socially useful purpose, government should restrict human activity no more than necessary to implement that purpose. The intrusion should be minimal. A greater restriction is not socially useful when a lesser one will do the job.

206. Cf. Wormuth & Mirkin, supra note 204. For a general discussion of the least restrictive alternative doctrine in the context of involuntary commitment standards, see Developments, supra note 115, at 1245-53.


208. Id. at 354 (emphasis added) (footnote omitted).

too broadly; i.e., imposed greater restrictions on the exercise of first amendment rights than were essential to vindicate the state's interests.\textsuperscript{210} Essentially, the state must carefully discriminate between protected and unprotected expression, and may be obligated to opt for a less restrictive method of regulation where the distinction between the two is delicate.\textsuperscript{211}

In \textit{Shelton v. Tucker},\textsuperscript{212} the Supreme Court struck down an Arkansas statute requiring, as a condition of employment in a state-supported school, that every teacher annually file an affidavit listing every organization to which he or she had belonged or regularly contributed within the preceding 5 years. While recognizing the state's legitimate interest in the general qualifications of its teachers, the Court said:

\begin{quote}
In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, the purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of \textit{less drastic means} for achieving the same basic purpose.\textsuperscript{213}
\end{quote}

Although the Court failed to suggest what alternatives were available to the state to accomplish its desired objectives,\textsuperscript{214} the state was put on notice that, in deciding which form of regulation to adopt, if


\textsuperscript{211} For a general discussion of the application of the least restrictive alternative doctrine in the first amendment area, see Note, \textit{Less Drastic Means and the First Amendment}, 78 \textit{Yale L.J.} 464 (1969).

\textsuperscript{212} 364 U.S. 479 (1960).

\textsuperscript{213} \textit{Id.} at 488 (emphasis added) (footnote omitted). Justice Frankfurter, in dissent, disagreed with the Court's view of the extent to which the statute constrained fourteenth amendment rights. He agreed, however, that when the reasonableness or fairness of a measure is at issue in the due process context, the availability \textit{vel non} of alternative methods of proceeding was germane, and that the relevant issue was "whether, in light of the particular kind of restriction upon individual liberty which a regulation entails, it is reasonable for a legislature to choose that form of regulation rather than others less restrictive." \textit{Id.} at 494.

\textsuperscript{214} Possible explanations for the Court's failure to specify permissible alternatives to legislation found too restrictive are discussed in Note, \textit{Less Drastic Means and the First Amendment}, 78 \textit{Yale L.J.} 464, 471-72 (1969). One further explanation may be the Court's general reluctance, even when protecting preferred freedoms or fundamental rights, to transgress into a traditionally legislative domain. This reluctance may bode ill for the more specific approach taken by several lower federal courts in identifying, although not compelling, those less restrictive alternatives that might pass constitutional muster in the involuntary civil commitment area. \textit{Lessard v. Schmidt}, 349 F. Supp. 1078 (E.D. Wis. 1972), \textit{vacated on other grounds}, 414 U.S. 473 (1974), \textit{modified}, 379 F. Supp. 1376 (E.D. Wis. 1974).
any, it would be best advised to be more cautious of the impositions placed on its teachers' associational interests.215

Similarly, the Court, in *United States v. Robel*,216 struck down a federal statute on grounds of overbreadth because it abridged appellee's first amendment right of association. Although the Court stated as axiomatic that "'[p]recision of regulation must be the touchstone in an area so closely touching our most precious freedoms,'"217 it provided no specific guidelines to the government concerning what standards of precision must be applied. The Court was unpersuaded by the government's argument that it had considered one possible alternative in passing the challenged statute, but had rejected the alternative as inadequate. Instead, the Court defined the government's general obligation, when drafting a statute which imposes a substantial burden on protected first amendment activities, in terms of using means which have a "less drastic" impact on first amendment freedoms.218

The parameters of the Supreme Court's willingness to utilize a least restrictive alternative concept in fourteenth amendment jurisprudence seem to be coterminous with the Court's inclination to apply an unusually high level of scrutiny to the legislative action in question. In the due process area, the Court has continuously expressed its special sensitivity to legislative action which restricts the "political processes" or which discriminates against "discrete and insular minorities."219 Clearly, the Court's use of less restrictive alternative language

215. For examples of state court decisions applying the least restrictive alternative doctrine in accommodating state legislative interests with state or federal constitutional provisions, see *City of Carmel-by-the-Sea v. Young*, 466 P.2d 225 (Cal. 1970), and other cases cited in Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1149-50 (1972).


218. Other first amendment cases relevant in this context include *Talley v. California*, 362 U.S. 60 (1960); *Lovell v. City of Griffin*, 303 U.S. 444 (1938). It should be noted that the phrase "least restrictive alternative" may, in one sense, be misleading. Because the courts have generally failed to specify which alternatives would be permissible, see note 214 supra, there has often been no clear guidance to the state legislatures in terms of how they must weigh their options. In finding that a regulation is too broad or intrusive, the courts have not expressly required that the least restrictive alternative which is theoretically possible must be adopted. In this respect it has been noted that "invocation of the phrase 'less drastic means' does not so much explain the result (of first amendment cases) as announce it." Note, *Less Drastic Means and the First Amendment*, 78 YALE L.J. 464 (1969).

219. *United States v. Carolene Products Co.*, 304 U.S. 144, 152-53 (1938). In the famous footnote 4 of the opinion, Justice Stone presaged the Court's willingness to apply a more exacting judicial scrutiny to legislation, allegedly directed toward minorities, which infringed upon freedom of speech, association, or expression. For a thorough
manifests the more sensitive view it takes of the burdens imposed upon the individual where "preferred freedoms" are involved. 220 On the other hand, in areas where the state can legitimately act, and where preferred interests or suspect classifications are not involved, the standard for testing the legitimacy of that action has invariably been one of "rationality." 221 Inherent in this approach is the broad discretion permitted the states in acting legislatively, and the presumption of validity attached to such legislation even if its effect is to burden a group or interest more restrictively than absolutely necessary.

The close association between the least restrictive alternative concept and the importance the Supreme Court ascribes to the individual interest adversely affected by legislation is further demonstrated by recent developments in fourteenth amendment equal protection principles. 222 During the past 15 years, and especially under the guidance of the late Chief Justice Warren, the Court has developed a new equal protection standard to be applied where state legislative actions have been found to infringe upon certain "fundamental values" 223 or have discriminated against "suspect classes." 224 Under this test, mere rationality will not sustain the legislative classification under

discussion of this footnote from the Carolene Products case, see Wechsler, Stone and the Constitution, 46 Colum. L. Rev. 764, 795-800 (1946).


For the most part, the Court has refused to apply the least restrictive alternative doctrine to economic regulations. See generally Struve, supra note 204.


222. For general discussion of the evolution, application, and direction of the more activist equal protection theory, see Note, The Evolution of Equal Protection—Education, Municipal Services and Wealth, 7 Harv. Civ. Rights-Civ. Lib. L. Rev. 105 (1972) [herein-after cited as Note, Equal Protection]. In many respects, the "compelling state interest" equal protection standard may be viewed as inherently involving a search for the least restrictive alternative.


224. McLaughlin v. Florida, 379 U.S. 184 (1964) (race held to be suspect classification); Korematsu v. United States, 323 U.S. 214 (1944) (classification according to alienage found "suspect").
equal protection challenge. Instead, the state must show that such laws are "necessary to promote a compelling governmental interest." Moreover, in satisfying this test, it is not sufficient for the state to show that the classification chosen to accomplish its objective furthers a very substantial state interest. In pursuing its important interest, the state cannot choose means that unnecessarily burden or restrict constitutionally protected activity. Statutes affecting constitutional rights must be drawn with "precision," . . . and must be "tailored" to serve their legitimate objectives. . . . And if there are other, reasonable ways to achieve those goals with a lesser burden on constitutionally protected activity, a State may not choose the way of greater interference. If it acts at all, it must choose "less drastic means." In this context, perhaps the clearest approval and articulation of the least restrictive alternative doctrine by the Supreme Court came in a recent case in which the Court rejected an equal protection challenge to Texas' system for financing public elementary and secondary schools. After holding that education was not a "fundamental interest," the Court discarded appellees' argument that local control over Texas schools (one of the state's proffered justifications for its financing system) could be preserved and promoted under other financing systems that resulted in more equality in educational expenditures. To this contention, the Court responded:

Nor must the financing system fail because, as appellees suggest, other methods of satisfying the State's interest, which occasion "less drastic" disparities in expenditures, might be conceived. Only where state action impinges on the exercise of fundamental constitutional rights or liberties must it be found to have chosen the least restrictive alternative."

228. Id. at 51 (emphasis added).

A more recent application of the least restrictive alternative doctrine has created some ambiguity with reference to the Court's willingness to require the states to show that other, less intrusive forms of regulation are not available. In Marston v. Lewis, 410 U.S. 679 (1973), the Court, in a per curiam opinion, held that Arizona's 50-day durational voter residency requirement and its 50-day voter registration requirement were constitutional. The Court accepted the state's claim that the residence requirements were necessary to achieve the state's legitimate goals, without examining the prospect that those same goals could be achieved by an increase in expenditures to improve the administration of the deputy registrar system, which would reduce the
B. The Least Restrictive Alternative Doctrine and the Mental Patient

The increasing awareness of the substantial deprivations created by commitment to the traditional public mental institution, coupled with the recognition that even short-term hospitalization can be anti-therapeutic, has created a framework for application of the least restrictive alternative doctrine to the public mental patient. Such an application would encompass the recognition of an affirmative state obligation to require a search for alternatives to institutional commitment ab initio.

A concomitant duty would exist to limit confinement to the least restrictive institutional setting and to discharge the committed patient outright, or to less restrictive community treatment alternatives, once continued institutionalization could no longer be

restriction on the fundamental individual interest in voting. Cf. Dunn v. Blumstein, 405 U.S. 330 (1972). Justice Marshall, writing for Justices Douglas and Brennan in dissent in Marston, reasoned that a total bar to participation in voting by new Arizona residents could only be justified by the state's showing that "administrative problems of the highest order" would be created by a lower durational residency requirement. 410 U.S. at 685.

In this respect, the Marston decision indicates a growing reluctance by a majority of the Court to apply the least restrictive alternative doctrine in a more literal sense, and further indicates that once a threshold determination is made concerning the invalidity of an outside limit of restrictiveness (i.e., the 1-year residency requirement struck down in Dunn), the Court may refuse to impose additional burdens upon the state. In the context of a state obligation to provide aftercare services to involuntarily committed mental patients, the threshold issue of maximum restrictiveness has not yet been confronted by the Court. But the general statement of the least restrictive alternative doctrine in Dunn remains viable, and its application to the massive deprivations suffered by the mental patient should still be consistent with the arguments developed below. Cf. Note, The First Amendment Overbreadth Doctrine, 83 Harv. L. Rev. 844, 911-18 (1970).

229. See 1970 Senate Hearings, supra note 96, at 278.

230. Numerous federal courts have applied the least restrictive alternative doctrine to state correctional institutions, especially in the context of eighth amendment and equal protection arguments involving confinement of pretrial detainees. For example, in Hamilton v. Love, 328 F. Supp. 1182, 1192 (E.D. Ark. 1971), the court said: "it is manifestly obvious that the conditions of incarceration for detainees must, cumulatively, add up to the least restrictive means of achieving the purpose requiring and justifying the deprivation of liberty." Accord, Inmates of Suffolk County Jail v. Eisenstadt, 360 F. Supp. 676 (D. Mass. 1973); Collins v. Schoonfield, 344 F. Supp. 257 (D. Md. 1972); Brenneman v. Madigan, 343 F. Supp. 128 (N.D. Cal. 1972); Jones v. Wittenberg, 323 F. Supp. 93 (N.D. Ohio 1971), aff'd sub nom. Jones v. Metzger, 456 F.2d 854 (6th Cir. 1972). The courts, in viewing the states' purpose in confining the pretrial detainee as exclusively to ensure his appearance at trial, have held that his constitutional rights can only be restricted to the extent necessary to restrain him from endangering or disrupting institutional security. See generally Note, Constitutional Limitations on the Conditions of Pretrial Detention, 79 Yale L.J. 941 (1970).

231. For a discussion of the least restrictive alternative doctrine in the context of the states' duty to create new alternatives in lieu of civil commitment, see Developments, supra note 115, at 1250-53.
therapeutic. Developing case law in this area is recognizing that the
states must provide less restrictive treatment facilities and services as
a condition precedent to involuntarily confining an individual to the
public mental institution.

The first express application of the least restrictive alternative
document to the mental institutional setting appears to have been in
Lake v. Cameron,232 where the court interpreted the relevant civil
commitment statute as requiring a finding by the committing court
that no less onerous disposition than institutional confinement would
serve the purpose of commitment, and thus ordered the committing
court to consider alternatives to hospitalization. Subsequently, in
Covington v. Harris,233 the same court stated that regardless of the
provisions of the applicable statute, "the principle of the least restric-
tive alternative consistent with the legitimate purposes of a commit-
ment inheres in the very nature of civil commitment, which entails
an extraordinary deprivation of liberty . . . ."234 The court then held
that the principle was "equally applicable to alternate dispositions
within a mental hospital."235

The application of the least restrictive alternative, as promulgated
in Covington, was subsequently relied upon by the district court in
Wyatt v. Stickney.236 In Wyatt, the court held that involuntarily
committed mental patients had a constitutional right to such treatment
or habilitation as would help each of them to be cured or to improve
his or her mental condition.237 Although the court's original opinion
did not independently deal with the right of public mental patients
to confinement to or in the least restrictive setting,238 the court's
ultimate remedial order incorporated the doctrine as an integral part
of the state's treatment obligation. In terms of the mentally ill civilly
confined in state institutions, the court established minimum consti-
tutional standards for adequate treatment. The standards include the
recognition that "patients have a right to the least restrictive condi-
tions necessary to achieve the purposes of commitment."239 Moreover,
the State of Alabama was required to establish individualized treat-

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233. 419 F.2d 617 (D.C. Cir. 1969).
234. Id. at 623.
235. Id.
236. 325 F. Supp. 781 (M.D. Ala. 1971), on submission of proposed standards by
defendants, 334 F. Supp. 1341, enforced, 344 F. Supp. 373, 377 (1972), aff'd in part, rem-
anded on other grounds sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).
237. For discussion of the Wyatt case in the right to treatment context, see sec-
tion V supra.
ment plans for all patients, which were to include criteria for release to less restrictive treatment conditions and for discharge;\textsuperscript{240} an individualized posthospitalization plan;\textsuperscript{241} and a requirement that a designated hospital staff member would be responsible for assuring that each patient is released, where appropriate, into a less restrictive form of treatment.\textsuperscript{242} In a separate order, similar requirements were held applicable to mentally retarded persons confined in state institutions,\textsuperscript{243} with the additional requirement that no person should be admitted to an institution without a prior determination having been made that confinement in the institution per se was the least restrictive habilitative setting feasible.\textsuperscript{244}

Although the \textit{Wyatt} court cited \textit{Covington} as authority for the right to treatment,\textsuperscript{245} the remedial order went far beyond the \textit{Covington} court’s application of the least restrictive alternative. In this respect, Judge Johnson, although not stating his underlying rationale, fashioned a remedy which not only required the state to provide \textit{institutional} treatment in the least restrictive setting, but also required the state to act affirmatively to fulfill its duty to “provide adequate \\textit{transitional} treatment and care for all patients released after a period of involuntary confinement,”\textsuperscript{246} which included “psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, out-patient treatment, and treatment in the psychiatric ward of a general hospital.”\textsuperscript{247}

The remedy promulgated by the court in \textit{Wyatt} appears to have gone beyond the conceptual framework for the right to treatment established in the court’s original opinion. In this context, a view of the right to treatment as including treatment in the least restrictive institutional setting is consistent with the due process rationale developed by Judge Johnson. However, an extension of the state’s treatment obligation into the community should generally create a larger drain on the state’s resources than an obligation that only extends to institutional treatment. Since there is no way to determine from the \textit{Wyatt} record precisely what aftercare resources already existed in Alabama, it is difficult to determine what impact the decision will have on that state in terms of the development of alternative mental

\begin{itemize}
\item \textsuperscript{240} \textit{Id.} at 384.
\item \textsuperscript{241} \textit{Id.}
\item \textsuperscript{242} \textit{Id.}
\item \textsuperscript{243} 344 F. Supp. 387 (M.D. Ala. 1972).
\item \textsuperscript{244} \textit{Id.} at 396.
\item \textsuperscript{245} 325 F. Supp. at 784.
\item \textsuperscript{246} 344 F. Supp. at 386 (emphasis added).
\item \textsuperscript{247} \textit{Id.} \textit{See also} 344 F. Supp. at 407, ¶47 (applicable to mentally retarded patients).
\end{itemize}
health placement services. Conceivably, however, the state would have to develop transitional care modalities, even if this evolved into a much costlier proposition than institutional treatment itself. In terms of future commitments, Alabama would presumably have to choose between ensuring the existence of sufficient aftercare services for each patient requiring them for truly meaningful treatment, or discontinuing its entire civil commitment program. Subsequent to Wyatt, several other cases in the mental health field have endorsed the application of the least restrictive alternative doctrine to involuntary commitment. In sustaining a constitutional challenge to Wisconsin's civil commitment procedures, a three-judge federal court held that persons suffering from the condition of mental illness, who had not been accused of criminal conduct, could not be institutionalized if there were less drastic means available for achieving the basic goals of such commitment. The court did not, however, address the issue of whether the state had an obligation to actually provide alternatives to commitment where none were otherwise available. The issue was raised in Welsch v. Likins, where Minnesota's

248. It should be noted that the district court in Wyatt specifically prohibited the admission of any person to any publicly supported residential institution caring for mentally retarded persons unless such institution meets the standards set out in the court's order. 344 F. Supp. at 407.

Also noteworthy is the State of Alabama's argument in the court of appeals that the district court's order was improper because it would require heavy expenditures and reallocations of state resources. This contention was rejected by the court of appeals. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). Cf. Jones v. Metzger, 456 F.2d 854 (6th Cir. 1972); Watson v. City of Memphis, 541 U.S. 526, 537 (1963).


It should be noted that in Sanchez v. New Mexico, 396 U.S. 276 (1969), dismissing for want of substantial federal question 457 P.2d 370 (N.M. 1969), the Supreme Court did not recognize a substantial constitutional issue in the contention that a state must explore less restrictive alternatives as a condition precedent to involuntary civil commitment. However, as noted by the district court in Welsch v. Likins, 373 F. Supp. 487, 501 (D. Minn. 1974), the Sanchez case came to the Court prior to the rapid doctrinal developments in the judicial definition of the rights of mental patients that has taken place in the last several years. Moreover, the Court has frequently dismissed cases for failure to present substantial federal questions only to accept and decide the same issue in subsequent appeals. Compare McGowan v. Maryland, 366 U.S. 420, 425-28 (1961), with Commonwealth v. Grochowiak, 136 A.2d 145, 148 (Pa. 1957), appeal dismissed for want of substantial federal question, 358 U.S. 47 (1958).

For a more recent discussion of the proper weight of a dismissal for want of substantial federal question, see Hicks v. Miranda, 422 U.S. 332, 344 (1975), where the Court cited with approval Port Authority Bondholders Protective Comm'n v. Port of New York Authority, 387 F.2d 259, 263 n.3 (2d Cir. 1967) ("unless and until the Supreme Court should instruct otherwise, inferior federal courts had best adhere to the view that if the Court has branded a question as unsubstantial, it remains so except when doctrinal developments indicate otherwise.").
failure to provide institutional treatment and alternatives to institutionalization was challenged on due process grounds. After holding that due process required that civil commitment for reasons of mental retardation be accompanied by adequate treatment, the court noted the "widespread acceptance by the courts of a constitutional duty on the part of State officials to explore and provide the least stringent practicable alternatives to confinement of noncriminals." The court failed, however, to address itself to the scope of the state's obligation.

A more recent application of the least restrictive alternative doctrine to the civil commitment area has occurred in Davis v. Watkins, where plaintiffs are seeking to establish a right to treatment at Ohio's Lima State Hospital, a maximum security public mental institution. In an interim order, the court has endorsed and adopted the reasoning and remedy promulgated by Judge Johnson in the Wyatt case. Individualized treatment plans required by the court provide for the least restrictive setting while in confinement, and require extensive prerelease planning for each patient. Additionally, the court has required the State of Ohio to implement a mandatory periodic review of each treatment plan for the purpose of evaluating a patient's continued need, and the State's continued justification, for placement in a maximum security facility. Moreover, the court has ordered the Ohio Department of Mental Health and Mental Retardation to provide adequate transitional treatment and care for all patients released from the hospital.

251. Id. at 502. The court viewed due process as requiring that the appropriate officials make good faith efforts to place civilly-committed persons in "settings that will be suitable and appropriate to their mental and physical conditions while least restrictive of their liberties." Id.


253. Id. at 1197.

254. In a telephone conversation of March 14, 1975, with C. Thomas McCarter, Esq., co-counsel for plaintiffs, the writer was advised that the issue of providing aftercare services and facilities to patients discharged from Lima Hospital to the community has not been vigorously pursued, and a clear definition of the scope of the state's obligation in this regard has not yet been given by the court. The percentage of plaintiffs who have been involuntarily committed directly to Lima, pursuant to Ohio Rev. Code § 5122.15 (Page Supp. 1975), is relatively small. Most of the institution's patients have been transferred to Lima from other state institutions or have been confined at Lima after either having been found incompetent to stand trial for criminal charges or having been acquitted for reasons of insanity pursuant to Ohio Rev. Code § 2945.39 (Page 1970). Mr. McCarter indicated that most Lima Hospital patients leave the institution pursuant to administrative transfers to the correctional or lesser-security mental institutions from which they were received. Many others are remitted back to the custody of the committing court when found able to stand trial. Counsel for plaintiffs, however, have interpreted the court's interim order as requiring the State of Ohio to
The remedial requirements in the *Wyatt* and *Davis* cases establish the involuntarily-committed mental patient's right to confinement in, and release to, the least restrictive alternative setting as an element of a due process right to treatment. Neither the original opinion in *Wyatt* nor the interim order in *Davis* expressly deals with the least restrictive alternative doctrine as an independent element of the due process guaranty. However, the conclusions and remedies reached by both courts can be viewed as consistent with the least restrictive alternative doctrine as developed in the first amendment and equal protection cases discussed above.

In this regard, most states have defined their objectives in the establishment of involuntary civil commitment procedures in terms of treatment for those mentally-ill persons incapable of caring for themselves, or providing treatment for those who, because of mental illness, represent a danger to themselves or others. Once this state provide suitable aftercare facilities and services for all Lima patients who are ultimately discharged from the state's custody and jurisdiction.

255. *See also* Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975). In that case, plaintiffs sought to compel creation of least restrictive alternative facilities for more than 1,000 patients involuntarily confined in St. Elizabeths Hospital in Washington, D.C. The patient-plaintiffs proceeded upon two separate theories. First, they claimed that the District of Columbia's 1964 Hospitalization of the Mentally Ill Act, 21 D.C. CODE § 501 (1973), L. No. 88-597 (1964), imposes a duty on the defendants—who include the Secretary of Health, Education and Welfare, and various District of Columbia officers responsible for the care of the mentally ill in the District—to place the patient-plaintiffs in suitable least restrictive alternative facilities. Second, the patient-plaintiffs contended that they have a federal constitutional right to be placed in suitable alternative facilities and thereby to be provided with suitable care and treatment under the least restrictive setting. The constitutional claims were premised upon a right to care and treatment guaranteed by the due process clause of the fifth amendment, and upon a separate constitutional principle of the least restrictive alternative.

The court found it unnecessary to reach the patient-plaintiffs' constitutional argument, finding the statutory grounds sufficient for resolution of the matter. However, in construing the Act, the court acknowledged the doctrine of the least restrictive alternative and held the Act mandated the doctrine's application at the treatment stage as well as the commitment stage. The court ordered that the 1964 Hospitalization of the Mentally Ill Act requires that patients confined in St. Elizabeths Hospital pursuant to the 1964 Act receive suitable care and treatment under the least restrictive conditions as such conditions are required in an individual case consistent with the purposes of the Act; . . . that both defendants have violated the 1964 Act by failing to place plaintiffs and members of their class, who are inpatients at St. Elizabeths Hospital and who have been determined suitable for placement in alternative facilities in proper facilities that are less restrictive alternatives to the Hospital, as it is presently constituted, such alternatives including but not being limited to nursing homes, foster homes, personal care homes and half-way houses . . . .

405 F. Supp. at 979.
purpose has been defined, it follows that the term of hospitalization must be measured by its actual and potential results.\textsuperscript{256} Where it is determined that a given patient is not treatable, or where further efforts directed to in-confinement treatment are predictably anti-therapeutic,\textsuperscript{257} further confinement must be deemed to effect a continuing violation of due process. This conclusion is compelled by the substantial deprivations of liberty imposed by institutional confinement, both in terms of freedom of movement and the restraints imposed on the patients' rights to privacy, free association and speech, and travel.\textsuperscript{258} Where the manifest burdens imposed on the exercise of rights as important as these\textsuperscript{259} are completely unnecessary or unrelated to the achievement of the state's interest in treatment, the state becomes obliged, as a matter of due process, to choose a less restrictive form of regulation.\textsuperscript{260}

The application of the least restrictive alternative doctrine in this

\begin{itemize}
\item \textsuperscript{256} Cf. Jackson v. Indiana, 406 U.S. 715, 738 (1972), where the Court stated: "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."
\item \textsuperscript{257} A review of available mental health research indicates a near-consensus that commitment to public mental institutions, at least for the longer periods of time, invariably becomes anti-therapeutic. See, e.g., Honigfeld & Gillis, \textit{The Role of Institutionalization in the Natural History of Schizophrenia}, 28 \textit{Diseases of the Nervous System} 660-63 (1967); Mendel, \textit{On the Abolition of the Psychiatric Hospital}, \textit{Comprehensive Mental Health} 237-47 (1968).
\item \textsuperscript{258} For a general discussion of the adverse effect of confinement on the mental patient, outside of the obvious restraints on the freedom to come and go, see Chambers, \textit{supra}, note 215 at 1155-68. See also Kaimowitz v. Michigan Dep't of Mental Health, Civil No. 73-19434-AW (Cir. Ct., Wayne County, Mich., July 10, 1973), and note 228 and accompanying text \textit{supra}.
\item \textsuperscript{259} The Supreme Court has recognized that many of these individual interests, which are curtailed by institutional confinement in varying degrees, are fundamental. Roe v. Wade, 410 U.S. 113 (1973) (privacy); Shapiro v. Thompson, 394 U.S. 618 (1969) (travel); N.A.A.C.P. v. Alabama, 357 U.S. 449 (1958) (association).
\end{itemize}
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context would make ongoing hospitalization of the involuntary mental patient—at least as generally known and practiced in America today—dependent upon the state's demonstration that institutional confinement will improve the patient's mental condition and that it will enhance the patient's ability to adjust satisfactorily in the community.

Although a state cannot be expected to review each patient on a daily basis to determine when further institutional care reaches the point of diminishing therapeutic return, it must be obliged to adopt reasonable procedures toward that end. When a determination is made that further confinement would no longer be conducive to further treatment, the least restrictive alternative doctrine would require that the hospital either discharge the patient unconditionally, or release him to some less restrictive setting for future care. It is in this respect that the Wyatt court's requirement that the state act affirmatively to provide adequate transitional treatment and care for all patients can be deemed compatible with the court's due process analysis.

VIII. EQUAL PROTECTION AND THE DISCHARGE PROCESS

One further argument in support of the obligation of the states to provide aftercare services deserves brief attention. This argument, apparently not yet tested in the courts nor generally dealt with by legal commentators, centers around the traditional criteria applied to the administrative discharge process in public mental institutions.

The prevailing procedures for both conditional release and absolute discharge from public mental institutions generally vest substantial discretion in hospital authorities. Primarily, this can be attributed to traditional legislative reliance on the professional judgment of hospital staff concerning the determination of a patient's ongoing mental status and, especially in the case of the involuntary,

261. For a discussion of the potential of the mental hospital to be genuinely therapeutic and minimally intrusive on patients' civil and constitutional rights, see Yolles, Mental Health's Homeostatic State: A New Territory, 7 INT'L J. PSYCHIATRY 327-28 (1969).


263. For cases requiring periodic review of a mental patient's institutional progress, see Davis v. Watkins, 384 F. Supp. 1196 (N.D. Ohio 1974) (interim order) (requiring review of each patient's treatment plan and the justification for continued confinement at least once a week for the first month after admission, once a month for the next 2 months, and at least once every 90 days thereafter); Wyatt v. Stickney, 344 F. Supp. 387, 397 (M.D. Ala. 1972); Wyatt v. Stickney, 344 F. Supp. 373, 384, 386 (M.D. Ala. 1972).

264. For general discussion of the processes of separation from mental hospitals, see BRAKEL & ROCK, supra note 2, at 133-54.
indeterminately-committed patient, his ability to function in the community. Discharge from the institution does not necessarily mean that the patient has been cured of the mental problem that precipitated his commitment. In fact, some statutes expressly permit discharge of unimproved patients where consistent with the welfare of the patient and the community.

The extensive discretion placed in hospital administrators in terms of the discharge decision has resulted in practices that appear constitutionally suspect. As previously noted, most public mental institution patients come from the lower socio-economic segments of the population. Moreover, the process of involuntary, and in many cases indeterminate, confinement inevitably results in loss of job and home, and other economic hardship. When the decision to discharge or to conditionally release a patient is made, its ultimate outcome may depend on an acceptable placement of the released patient in the community. Too frequently, even where the professional judgment of the institutional psychiatrist indicates a patient's medical readiness for separation from the institution, the patient is retained because he has insufficient personal resources to maintain himself in the community, or there is no available publicly or charitably supported community alternative. Consequently, many patients remain in confinement solely because they are too poor to be released.


266. For an incisive analysis of the factors considered in the administrative discharge decision, see Rock, Jacobson, & Janopaul, supra note 18, at 214–41.

267. Compare former Illinois statute, ILL. ANN. STAT. ch. 91 1/2, § 7-7 (Smith-Hurd 1966) with the present provision, ILL. ANN. STAT. ch. 91 1/2, § 10-4 (Smith-Hurd Supp. 1975), which provides that a hospital may temporarily release a patient whose condition is not considered appropriate for absolute discharge, and that if such a temporarily-released patient is not returned to the hospital within 1 year, he shall be considered absolutely discharged. See generally Brakel & Rock, supra note 2, at 137.

268. See Schneiderman, Social Class, Diagnosis and Treatment, 35 Am. J. Orthopsychiatry 99 (1965). See also authorities cited at note 46 and accompanying text supra.


270. See generally Bleicher, Compulsory Community Care for the Mentally Ill, 16 CLEV.-MAR. L. REV. 93 (1967).

This retention phenomenon is particularly applicable to aged mental patients, who have frequently been admitted to a mental institution because friends and relatives who would otherwise be expected to support and care for them refuse to do so, or are financially unable to help. These elderly patients, frequently diagnosed as senile, become the chronic "back-ward" patients who can only look forward to death in confinement. See generally Pollack, Locke & Kramer, Trends in Hospitalization and Patterns of Care
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Whether the discriminatory retention of involuntarily-committed mental patients derives from the operation of the discretion of a state agency or from statutory provision, it results in the creation of two classifications of mentally ill persons. Both classes consist of involuntary mental patients who have achieved a level of mental recuperation or stabilization that would compel the medical conclusion that they can function acceptably outside of the institution. The one class, however, consists of those who, because of their personal or familial financial resources, are in a position to develop their own placement plans, and are therefore discharged. The second class is composed of those who, because of their personal or familial lack of financial resources, are not in a position to develop their own placement plans and are therefore not discharged.

These classifications, based solely on wealth, would appear constitutionally vulnerable. In recent years, the Supreme Court has frequently struck down state classifications based upon wealth, especially where those classifications encroached upon fundamental or preferred constitutional rights. In Griffin v. Illinois, the Court held that a state could not, in effect, deny an indigent criminal defendant access to an


271. See, e.g., ORE. REV. STAT. § 426.130 (1974), which allows the committing court to order the conditional release of a mentally ill person where a legal guardian, relative, or friend requests permission to care for him during the period of commitment, providing such person can show that there are adequate financial resources available for suitable care.

272. The practical implications of this approach are, to say the least, quite complex. Since no two mental patients are identical, and since patients whose initial psychiatric diagnoses are the same will probably not respond identically to even the most sophisticated treatment, substantial difficulties will be presented in terms of establishing an equivalent level of progress promising an equivalent prognosis for extra-institutional adjustment. In this regard, more definite and reviewable standards would have to be created to control the release decision. Cf. ROCK, JACOBSON & JANOPAUL, supra note 18, at 215 (where the authors note that no single criterion of dischargeability applies to all cases).

Moreover, it is highly unlikely that an institutional superintendent or psychiatrist will admit that he has decided to release one patient but retain another solely because of the latter's indigency. The more likely response, especially if solicited at a judicial hearing, would be to distinguish the patients' levels of response to treatment or remission, and to distinguish relative potential for community adjustment. Increased utilization of periodic review procedures coupled with a presumption of adaptability outside of the institution might ameliorate this difficulty.

273. See generally Note, EQUAL PROTECTION, supra note 222, at 130-46.

appeal of his conviction solely because of his inability to pay for a transcript of the trial proceedings. Similarly, the Court has indicated its special sensitivity to, and has strictly scrutinized, classifications based on wealth which infringe upon the right to vote. Moreover, the Court, in *San Antonio Independent School District v. Rodriguez*, reaffirmed the view that classification based upon wealth may be subjected to strict scrutiny. Although the Court rejected appellee's contentions that Texas' school financing system was sufficiently wealth-related as to invoke strict judicial scrutiny, it did indicate its readiness to examine closely such alleged discriminatory classifications in the future where two distinguishing characteristics are found to be present. First, it must be shown that the classification acts to the peculiar disadvantage of a class fairly definable as indigent. Second, it must be demonstrated that the lack of personal finances has occasioned an absolute deprivation of the desired benefit.

It is submitted that both of the characteristics described by the Court in *Rodriguez* as essential to holding a wealth-related classification suspect are present in the discharge classifications under discussion. The classification clearly acts to the peculiar disadvantage of a well-defined group of indigent mental patients—those who cannot afford to pay for their own placement and care in the community. Second, the lack of adequate resources to live outside the institution—which may very well have been caused by the commitment itself—results in an absolute deprivation of the desired benefit, personal liberty. Even if the patient were retained in a less restrictive institutional setting than before, he still would be subject to the massive restraints and deprivations inherent in institutionalization. Moreover, the Court's


277. Id. at 22.

278. Id. at 23. In *Rodriguez*, the Court found that although appellees' relative poverty may have denied them absolute equality of education with students from wealthier school districts, they still were provided by the state with a minimum or adequate level of education. Thus, the deprivation occasioned by the Texas system was not total and no equal protection violation resulted because "at least where wealth is involved, the Equal Protection Clause does not require absolute equality or precisely equal advantages." Id. at 24 (footnote omitted).

279. As has been previously contended, the patient would have this right anyway by virtue of the application of the least restrictive alternative doctrine. See section VII *supra*.

280. See note 112 and accompanying text *supra*. Receiving "some" minimum amount of education would clearly not be equivalent to receiving some greater degree of privileges or freedom of movement within the four walls of a mental hospital. Re-
analysis (in constitutional terms) of the nature of the wealth discrimination in *Rodriguez* must be viewed in the context of the personal interest that has been vitiated or diminished. In *Rodriguez*, education was found not to be a fundamental or specially protected interest in terms of its constitutional significance. But the individual's interest in the personal liberty that has been taken away by involuntary commitment to a mental institution must be considered fundamental—perhaps the most fundamental interest an individual has under our constitutional system. Consequently, the classifications created by the states in releasing those of its involuntarily-committed mental patients who can afford community placement, but retaining those who cannot, is "suspect" as being wealth dependent while infringing upon the fundamental personal interest in liberty.

To justify such a classification, the state would have to show that regardless of the privileges extended, the mental patient is still deprived of his freedom to leave the hospital.

281. Defined elsewhere as the "new double helix of equal protection," see Note, *Equal Protection*, supra note 222, at 148, the nature of the class discriminated against by the legislation and of the personal interest adversely affected have tended to be synergistically related: the more "suspect" the classification, the less "fundamental" the interest required to trigger strict scrutiny.


Another approach to the inequities resulting from the process of discharge from public mental institutions might view the mental illness status itself as being constitutionally suspect for purposes of equal protection analysis. According to this view, the characteristics which have been deemed essential to constitute a class as suspect are, to varying degrees, associated with the mentally ill. Cf. *Frontiero v. Richardson*, 411 U.S. 677, 684-86 (1973) (plurality opinion) (the frequency with which a group has been disadvantaged or stigmatized by legislative classifications); *Brown v. Board of Educ.*, 347 U.S. 483 (1954) (social opprobrium or stigmatization); *Korematsu v. United States*, 323 U.S. 214, 243 (1944) (Jackson, J., dissenting) (the relative permanence of the disadvantageous characteristic).

For a comprehensive analysis of the view that mental illness is a per se suspect classification, see Note, *Mental Illness: A Suspect Classification?*, 83 YALE L.J. 1237 (1974). According to this analysis, a condition precedent for mental illness's eligibility for entry into the circle of classifications entitled to "suspect" status is numerical domination of legislatures (and presumably other official decision makers) by persons not mentally ill. *Id.* at 1258. It would seem, at least theoretically, that most legislators and most mental institution personnel responsible for the discharge decision are not mentally ill.
it was necessary to achieve a compelling state interest. The only conceivable interest the state would have in retaining custody over a mental patient who has recuperated or stabilized sufficiently to indicate no further medical need for confinement, but who cannot afford to live on his own in the community, would be to ensure that the patient receives food, clothing, shelter, and other necessaries sufficient for survival and to provide future medical-psychiatric care that may be needed. But it is clear that continued confinement in a mental institution is not necessary to accomplish this interest. Placement in a fosterhome, halfway house or other semi-structured environment, accompanied by periodic visits from medical personnel, or trips to outpatient facilities at community mental health centers or general hospitals, would do just as well, and in most cases would be more conducive to continued progress. And, more importantly, these community alternatives would maximize the individual's interest in personal liberty.

In the context of this argument, the states would be left with several possible courses of action. One such course would be to completely restructure public mental health systems so as to minimize their co-


Recent scholarly comment has pointed to the development of a new standard of equal protection analysis which demands more than the rational connection between the legislative classification and the legitimate state goal, but less than the precision of legislative classification demanded by the strict judicial scrutiny approach. See Gunther, The Supreme Court, 1971 Term—Forward: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection, 86 Harv. L. Rev. 1, 33 (1972). This new test, described as a "sliding-scale" rationality test, id. at 17–18, has not been sufficiently developed by the Supreme Court to predict its applicability to the wealth classification area. See generally Note, Mental Illness: A Suspect Classification?, 83 Yale L.J. 1237, 1240–41 (1974).

286. One apparent exception to this reasoning might be the untreatable mental patient who can be proven to be extremely dangerous. In this situation, the state's interest in retaining some control over the individual, as a means of preventing violence to himself or others, may be stronger. But substantial questions have been raised concerning the predictability of dangerousness. See, e.g., Livermore, Malmquist & Meehl, On the Justifications for Civil Commitment, 117 U. Pa. L. Rev. 75 (1968); Morris, Psychiatry and the Dangerous Criminal, 41 S. Cal. L. Rev. 514, 532–36 (1968); Rubin, Prediction of Dangerousness in Mentally Ill Criminals, 27 Archives Gen. Psychiatry 397 (1972); Szasz, Some Observations on the Relationship Between Psychiatry and the Law, 75 Archives of Neurology & Psychiatry 297 (1956).

287. In O'Connor v. Donaldson, 422 U.S. 563, 575 (1975), the Court indicated that such continued confinement would be unconstitutional by stating: 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.

288. See Pasamanick, Scarpetti & Dinitz, supra note 168.
A second alternative would be to discontinue utilization of procedures such as the conditional or convalescent release, so that no one, regardless of wealth, could be released until ready for absolute discharge. A third approach might be to restructure the entire discharge system, so that persons with similar preadmission diagnoses would be discharged after substantially similar periods of confinement. But in view of the obvious propositions that no two patients' illnesses are likely to be precisely the same in origin and degree, nor likely to respond identically to even the most sophisticated treatment, this latter approach could easily result in depriving some patients of needed psychiatric attention.

A fourth response to the above discussed deficiency in discharge procedures is perhaps the most reasonable. This approach would entail the states' development and creation of adequate and sufficient aftercare facilities and services in the relevant communities so that an indigent mental patient whose continued institutionalization was no longer medically justified could be released to a reasonable setting at public expense. By pursuing this course, the states would at least theoretically minimize the current effect of indigency upon a patient's prospect for an early discharge and upon the opportunity for a successful community adjustment. Although the establishment of meaningful aftercare resources cannot realistically be expected to equalize the opportunities available to wealthy and poor mental patients, it could well serve to provide the minimum amount necessary to avoid the kind of total deprivation which, by analogy to the reasoning in Rodriguez, would be unconstitutional.

IX. CONCLUSION

Let the doctor beware, who does not now realize the amount of

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289. It is extremely doubtful that our traditional large, isolated, and remote mental institutions could be sufficiently modified to become truly unrestrictive. See, e.g., E. Goffman, Asylums (1961). Perhaps the only conceivable system that would eliminate the restrictiveness of a "total" institution would be one involving completely out-patient oriented facilities, where patients could come and go at will. Of course, such a system would necessitate the abolition of involuntary commitment, and would require truly therapeutic, democratically administered facilities, probably based in the community.

290. The necessary corollary to this proposition would be the total abolition of the public mental hospital, since the considerations of wealth that often permeate the decision to provisionally discharge will inevitably enter into the decision to discharge absolutely. Cf. Myers & Bean, supra note 46, at 80 (citing data showing direct correlation between socio-economic class and prospect for discharge over a 10-year period). See also Hardt & Feinhandler, Social Class and Mental Hospitalization Prognosis, 24 AM. SOCIOL. REV. 815 (1959). Consequently, to the extent that a person's ability to "pay for himself" in the community is related to the ultimate duration of his confinement, the confinement itself becomes unconstitutional.
mental illness he helped either to cause or to intensify by institutionalizing mental patients.\footnote{291}

This statement by Dr. Stanley Yolles, former Director of the National Institute of Mental Health, adequately embodies the common theme permeating the fourteenth and eighth amendment arguments for aftercare discussed above. Despite the fact that governmental policy is tending to show less reliance on the traditional mental institution as the exclusive vehicle for the delivery of mental health care,\footnote{292} the institution continues to represent the core ingredient of existing state programs.\footnote{293} And as long as these institutions continue to serve as breeding grounds for neglect, abuse, and physical and psychological deprivation, we must be cautious to ensure that we do not allow ourselves to destroy lives under the pretense of saving them.

This article has addressed potential sources and rationales for the creation of a right to aftercare treatment for the civilly-committed public mental patient. The ideas developed above have been made in full realization that the aftercare services and facilities now available in the United States are woefully inadequate to provide the assistance necessary to promote an orderly and constructive transition to community life for discharged patients, who would be condemned to rehospitalization or lives of suffering in their absence.\footnote{294} The task of providing the aftercare facilities required to serve even those patients presently confined in public mental hospitals will not be accomplished without substantial costs.\footnote{295} These costs, however, must be paid if we are to fulfill the promise, whether express or implied, which we make

\begin{footnotes}
\footnote{291}{Yolles, \textit{supra} note 261, at 328.}
\footnote{292}{See 1970 Senate Hearings, \textit{supra} note 96, at 345.}
\footnote{293}{For the year ending June 30, 1973, there were 248,562 inpatients in state and county mental hospital inpatient services. During that same year there were 444,777 inpatient additions to these facilities. Moreover, there were 334 state and county institutions as of June 30, 1973, as opposed to the 327 public institutions existing on June 30, 1972. Division of Biometry, National Institute of Mental Health, Statistical Note 106 at 1, 2, 22 (1974).}
\footnote{295}{For an excellent discussion of the costs and other burdens which the states would potentially have to face in providing meaningful aftercare services, see Chambers, \textit{supra} note 215, at 1193–1200. There is evidence, however, that once meaningful aftercare services are made available, the total costs associated with mental health care can be significantly reduced. See, e.g., \textit{R. Glasscote, J. Gudeman & R. Elpers, Halfway Houses for the Mentally Ill} 24 (1971); Cassell, Smith, Grunberg, Boan & Thomas, \textit{Comparing Costs of Hospital and Community Care}, 23 Hosp. \& Community Psychiatry 197 (1972); Sheehan & Atkinson, \textit{Comparative Costs of State Hospital and Community-Based Inpatient Care in Texas: Who Benefits Most?}, 25 Hosp. \& Community Psychiatry 242 (1974).}
\end{footnotes}
to our mentally ill citizens when we forcibly subject them to the realities of present-day institutional life: the promise that the mental institutional experience will be one which will help them overcome their psychological problems and better enable them to live fuller and more useful lives in free society.

Whether a state’s obligation to provide aftercare to the discharged public mental patient is found in due process, equal protection, or the eighth amendment, its genesis is the intolerable conditions and practices that have been the hallmark of the public mental institution. If and when the concept of the right to institutional treatment becomes fully developed, uniformly recognized, and adequately enforced, the need for aftercare services may be substantially diminished. But until we can confidently assure ourselves that the burdens imposed upon the mental patient are minimal, and that the institutional experience will in fact be beneficial in terms of improving his capacity to achieve the full measure of his potential as a free individual, the provision of aftercare must be viewed as constitutionally and morally mandated.