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ADEQUATE PSYCHIATRIC TREATMENT—A CONSTITUTIONAL RIGHT?*

"The purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions. . . ."

INTRODUCTION

For one out of every ten Americans now alive involuntary psychiatric confinement is a very real and threatening possibility. In fact, admissions to mental institutions have doubled over the last 15 years. Mental patients outnumber prisoners by approximately three to one and occupy more hospital beds than all other kinds of patients. While approximately 350,000 mental patients are cared for by private hospitals, veteran's hospitals, and psychiatric wards of general hospitals, nearly 400,000 of the three-quarter of a million mental patients in this country are confined in state or county mental facilities. However, even more terrifying than the statistical odds relating to psychiatric confinement is the fact that a majority of those committed are simply forgotten, receiving custodial care with little or no attempt made at rehabilitation. Legal and medical help is needed for this invisible segment of society.

This pattern of neglect flows from the mistaken premise that there is

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* The St. Thomas More Institute for Legal Research.
2 B. Ennis, PRISONERS OF PSYCHIATRY at vii (1972) [hereinafter cited as Ennis].
3 These statistics were compiled in 1972. At that time it was predicted that the number of patients in mental hospitals would increase to one and a half million within the next year. Ennis, supra note 2, at vii.
This paper deals primarily with the right of involuntary mental patients to receive treatment. On the basis of the recent statement of the New York Court of Appeals in In re Buttonow, 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968), that the equal protection clause of the fourteenth amendment requires that voluntary patients be given all the rights that involuntary patients are accorded by statute, it might well be argued that the rights espoused here for involuntary patients are also applicable to voluntary patients.
4 Florida State Hospital in Florida and Bryce State Hospital in Alabama have been referred to as human warehouses where treatment is nonexistent. These institutions are far from being exceptional; "[h]undreds like [them] can be found all over the country." Ennis, supra note 2, at 99.
no alternative to involuntary hospitalization and from the belief that the rights of those hospitalized have been satisfactorily safeguarded during the commitment process. Any attempt to formulate remedial programs must begin with an analysis of the theoretical basis for committing persons to mental institutions. Two well established principles often relied on as justification for involuntary commitment of the mentally ill are the role of the state as parens patriae, and the power and duty of the state to preserve the safety of its citizens. The concept of parens patriae suggests that the state as guardian over the disabled is allowed and even required to institutionalize mentally ill people who are in need of treatment. It is hypothesized that these people are infirm and cannot recognize their need for treatment. The idea of the guardian protecting the weak individual is buttressed by the argument that the state must exercise its police power to protect society. This analysis justifies the institutionalization of those mentally ill persons who are deemed to be potentially dangerous to themselves or to others.

6 Mental illness is defined as “an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care and treatment.” N.Y. MENT. HYG. L. § 1.05(17) (McKinney Supp. 1972).

This paper will not discuss the right to treatment of geriatric patients and mentally retarded patients. These two classes suffer from mental disorders that stem from physiological imbalances. Treatment could at best teach these patients to cope with their disorders while a total cure is presently beyond hope. One court has stated:

The evidence is without dispute that these patients are not properly confined [in an institution geared to rehabilitate the mentally ill] since these . . . patients cannot benefit from any psychiatric treatment or are not mentally ill.

This paper deals with the plight of those patients who suffer from “curable” mental disorders. Their treatment is hopefully directed toward an eventual release from the institution in which they are confined. Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971).


7 A determination as to whether or not a person is “dangerous” is often more a function of the examining psychiatrist’s analysis or, in some cases, whim, than of a well defined statutory term:

The statutes authorize preventive incarceration of mentally ill persons who are likely to injure themselves or others. Generally, ‘injure’ is not further defined in the statutes or in the case law, and the critical decision whether a predicted pattern of behavior is sufficiently injurious to warrant incarceration—is relegated to the psychiatrist’s unarticulated judgments. . . . One psychiatrist recently told a meeting of the American Psychiatric Association that “you”—the psychiatrists—“have to define for yourself the word danger, and then having decided that in your mind . . . look for it with every conceivable means. . . .”

Dershowitz, The Psychiatrist’s Power in Civil Commitment: A Knife Cuts Both Ways, PSYCHOLOGY TODAY, February 1969, at 44-46 [hereinafter cited as Dershowitz]. New York State has, however, taken affirmative steps to alter this situation by providing some valuable standards in its revised Mental Hygiene Law. Dangerousness of a prospective patient is equated with “likelihood of serious harm” which is defined as:
The persuasiveness of these principles and the legitimacy of involuntary hospitalization has been seriously questioned on both philosophical and practical grounds. The role of the state as parens patriae in helping those who are in need of treatment has been attacked as contrary to an essential premise of liberty:

The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental or spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves than by compelling each to live as seems good to the rest.

Society grants token recognition to this principle by permitting people to smoke although it is medically agreed that smoking shortens lives. By allowing a patient in a general hospital to refuse surgery although it may save his life the state explicitly recognizes that he is the "proper guardian of his own health." However, once a person is adjudged mentally ill, he is no longer permitted to make the decisions that affect his life. The individual's self direction is sacrificed to the paternalistic assumption that a mentally ill person, if he were sane, would choose for himself precisely what the committing physicians say he should choose, i.e., treatment and care in a state mental institution.

This assumption is possibly erroneous. Even if it is hypothesized that a prospective patient would receive treatment to improve his mental condition, he might realistically fear the stigma attached to confinement in an institution, a stigma which has, in fact, cost many patients valuable employment and educational opportunities. Furthermore, the prospective patient might justifiedly fear the anti-therapeutic affects of prolonged involuntary hospitalization. One intensive study has concluded:

The depressing surroundings, the idleness, the loss of ordinary privileges, the isolation from family, friends and developments in the outside world—these and many other aspects of institutional life, which are almost inherent characteristics of state hospitals, lead to a loss of motivation, to withdrawal and regression, and to apathy, submissiveness and an inability to make decisions. In short, hospitalization itself produces a distinct functional pathology, appropriately dubbed 'institutional neurosis.'

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1. substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or
2. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear or serious physical harm.


† J.S. MILL, ON LIBERTY 18 (1859).

It is paradoxical that the concept of *parens patriae* should be used to justify the permanent neglect of the mentally ill. The sweeping use of the state's police power against the mentally ill on the grounds that they are dangerous to themselves or to others, has also been attacked. One critic has noted that most mental patients are unable to organize their lives and assert themselves. Such a characteristic, he argues, makes them "less dangerous than the 'average' citizen." As proof of his assertion, he points out "the New York study showing that over a five-year period the arrest rate of 5,000 former patients, all adult males, was less than one-twelfth the rate for the community at large; the rate for serious crimes was even lower." However, it must be conceded that a small minority of the mentally ill are, in fact, dangerous individuals. Despite this fact, society must ask itself why it chooses preventive detention only for these persons while it jealously protects the liberty of a criminal who has finished his prison term without any showing of rehabilitation. It would shock our sense of justice to assume without proof that an ex-convict will necessarily commit a further criminal act and should therefore be protectively detained. However, our sensitivities are not confronted with this disturbing comparison because it is further argued that a mentally ill person (i.e., one who, in the uncertain opinion of medical experts, is dangerous to himself or others) is confined not merely to protect society but also to help him adjust to reality through therapy and treatment. Such a rationalization is weakened if not destroyed by the hard fact that prolonged stay in a state mental hospital often causes psychiatric deterioration. *Parens patriae* is most persuasively used to support the logical necessity for confining those who are unable to attend to their own basic needs.

It is a virtual certainty that our courts will not question the per se legitimacy of involuntary institutional commitment. However, some state legislatures have instituted fundamental reforms limiting the scope of such commitments. The California experience, in particular, serves as a model for the future. Legislation has been enacted directing that only persons who are presently demonstrably dangerous to themselves or others are subject to involuntary commitment. Presumptive time limits placed

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1 See, e.g., Dershowitz, *supra* note 7, at 43.
2 Ennis, *supra* note 2, at 225.
3 Even those courts that have elected to inquire into the validity of individual confinements have not challenged the per se validity of involuntary commitment. See, e.g., Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966), which held that involuntary commitment should be ordered only if no suitable but less drastic alternatives could be found. See also, Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 Mich. L. Rev. 1107 (1972). Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969), and Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), have applied a similar rationale to the examination of living conditions after a patient is committed. In *Wyatt*, Judge Johnson recognized that "patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment." 344 F. Supp. at 379.
upon involuntary hospitalizations—14 days for persons who are suicidal and 90 days for those who are homicidal or assaultive—ensures that patients will be quickly returned to their communities. The non-dangerous mentally ill are treated in neighborhood clinics.

The results of these reforms are encouraging. The average period of hospitalization has been reduced, as has the rehospitalization rate and the incidence of suicide or anti-social behavior by discharged patients. Other legislatures should carefully study California’s reforms with a view toward reconstructing their own outmoded mental health laws.

While no court has or is likely to challenge the state’s power to confine the mentally ill, a landmark federal decision, Wyatt v. Stickney, has ameliorated some of the consequences of confinement in a mental institution. The Alabama district court declared that a mental patient has a constitutional right to treatment and set forth minimum standards for the creation of a humane psychological and physical environment. The Wyatt decision declared that patients have a right to have visitors, to attend religious services, to wear their own clothes, to exercise physically several times weekly, to be outdoors regularly, to interact with members of the opposite sex, to receive nutritionally adequate meals, to receive minimum compensation for work performed, and to have a residence unit with screens or curtains to insure privacy. This article will trace the development of the right to treatment, consider various means for its enforcement in light of Wyatt and discuss the emerging concept of the right to refuse treatment.

HISTORICAL DEVELOPMENT OF THE RIGHT TO TREATMENT

In 1960, Morton Birnbaum, a lawyer and a psychiatrist, was the first to suggest that an involuntary mental patient had a right to receive proper psychiatric treatment. Birnbaum reasoned that since most mental patients are committed in civil proceedings under statutes promising treatment, if a patient is not in fact given adequate treatment, his confine-
ment becomes equivalent to penal incarceration. Therefore, Birnbaum argued, adequate psychiatric treatment must be provided to justify the commitment under substantive due process guidelines. While a number of cases preceding Birnbaum's formulation also sought to protect the rights of mental patients, his commentary was the first to set forth a rationale for requiring treatment.

Although not mentioned by name, Birnbaum's theory was given judicial support in Ragsdale v. Overholser. Ragsdale had been acquitted of robbery charges on grounds of insanity and confined to a mental institution. His petition for habeas corpus was dismissed in federal district court, and the dismissal was affirmed by the Court of Appeals for the District of Columbia. The majority opinion declared that Ragsdale's case history was sufficient to support a finding that he was dangerous and not suitable for release. However, Judge Fahy's concurring opinion interpreted a District of Columbia statute requiring mandatory commitment following a plea of not guilty as presupposing "that treatment will be accorded." This opinion was the first judicial support given to the Birnbaum theory.

Six years later in Rouse v. Cameron, Judge Bazelon wrote the majority opinion recognizing the right to treatment. Like Ragsdale, Rouse had been acquitted on a criminal charge on a finding of insanity and subsequently involuntarily committed. The federal district court, arguing that it only had jurisdiction to inquire into whether or not Rouse had regained his sanity, refused to consider his contention that he had not received treatment following his confinement. However, the Court of Appeals acknowledged that the statute created a right to treatment and thereby

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22 Such confinement is not supported by the traditional justification for the lack of a definitely stipulated time period in psychiatric costs cases. The justification has been explained as follows: "Hospitalization . . . bears no relation to a jail sentence. A jail sentence is punitive and is to be imposed by the judge within the limits set by the legislature. Hospitalization is remedial and its limits are determined by the condition to be treated." Overholser v. Lynch, 288 F.2d 388, 394 (D.C. Cir. 1961), rev'd on other grounds, 369 U.S. 705 (1962).

23 Birnbaum, supra note 20, at 503.

24 See, e.g., Commonwealth v. Page, 330 Mass. 313, 159 N.E.2d 82 (1959), wherein the court, interpreting a state statute requiring the custody and treatment of the mentally ill, ruled that absent such treatment mere custodial care would be an unconstitutional application of the statute. For a discussion of other pre-Birnbaum cases dealing with the right to treatment, see Drake, Enforcing the Right to Treatment: Wyatt v. Stickney, 10 AM. CRIM. L. REV. 587, 588 (1972) [hereinafter cited as Drake].

25 281 F.2d 945 (D.C. Cir. 1960).

26 Id. at 945-46.

27 D.C. CODE ENCYCLOPEDIA § 24-301 (West 1967).

28 281 F.2d at 950.

29 373 F.2d 451 (D.C. Cir. 1966).

30 Schneider, Civil Commitment of the Mentally Ill, 58 A.B.A.J. 1059, 1061 (1972).

31 373 F.2d at 452.
raised the question whether habeas corpus was the proper remedy to enforce this right. Judge Bazelon recognized the need to insure that treatment be adequate for those persons whose commitment is without procedural due process safeguards. He went on to assert: "One who is in custody 'in violation of the Constitution and laws' of the United States is entitled to relief in habeas corpus, and the court is required to ‘dispose of the matter as law and justice requires’." However, the decision avoided the question of a constitutional right to treatment, noting, "[b]ecause we hold that the statutory right to treatment provision applies to appellant, we need not resolve the serious constitutional questions. . . ."

Rouse and numerous subsequent decisions enforced a statutory right to treatment where one existed, but the courts avoided deciding whether a mental patient's right to treatment was constitutionally mandated in the absence of state statutes.

Wyatt v. Stickney found such a mandate. A class action commenced in federal district court by the guardians of all mental patients confined to Bryce Hospital in Tuscaloosa, Alabama, sought to enjoin the State Department of Mental Health from reducing the number of professional personnel and from instituting an experimental treatment program. Although an injunction was not issued, the court ordered that proper standards for adequate treatment be both promulgated and implemented within six months time. Since there was no state statute at issue the court

Many of those detained in institutions today were put away with little ceremony or under standards grossly vague in meaning. Lengthy civil commitment often results from a brief and informal hearing before one or more psychiatrists. Rouse's commitment, for example, was automatic after the judge concluded there was reasonable doubt of his sanity at the time he had committed the criminal acts charged; there was no hearing on the issues of his continued dangerousness or treatability.

Note, Civil Restraint, Mental Illness, and the Right to Treatment, 77 YALE L.J. 87, 100 (1967).

When a case is presented to a court by writ of habeas corpus, the court is limited to protecting the right to treatment of one or only a handful of patients. The Wyatt plaintiffs, by virtue of a class action seeking an injunction against the Department of Mental Health of the State of Alabama, brought an entire mental hospital under judicial inspection. The use of this type of action served to protect the constitutional rights of over 500 patients. In addition to habeas corpus relief and class action suits, other remedies commonly sought to protect or enforce the rights of mental patients are: money damages for a failure to provide statutorily and constitutionally required treatment; money damages for false imprisonment; and writs of mandamus to require treatment. See Drake, supra note 24, at 598-600.


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Based its order on the patients' constitutional right to treatment. The court's reasoning seemed to echo Birnbaum's theory formulated more than a decade earlier: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process."  

Understanding of the protection afforded by a constitutional right to treatment may be furthered if the following questions are answered: What is the theoretical basis for declaring the existence of such a right? If treatment is denied due to inadequate funding of mental health facilities, does the Constitution empower the courts to compel legislatures to provide for satisfactory treatment. Finally, granting that there is a constitutional right to such treatment is there a correlative duty to submit to such treatment?

The Constitutional Foundation of the Right to Adequate Treatment

The Wyatt court, the first to determine that mental patients have a constitutional right to adequate treatment, stated without explanation that due process was the basis for this right. The Rouse court, although basing the decision on statutory rights, suggested, in dicta, numerous constitutional grounds to support the right to treatment, i.e., equal protection of the laws, substantive due process, and the prohibition against cruel and unusual punishment. These cases, when read together, begin to crystallize the reasoning behind a claim of constitutional right. However, it is necessary to explore further to determine which constitutional foundation best supports the right to treatment.

Substantive Due Process

Substantive due process of law, guaranteed by the fifth and fourteenth amendments, has traditionally required only that a rational basis exist for a given legislative enactment. The courts have recently adopted a functional due process approach which frames the issue in these terms: Does a statute having a proper legislative purpose provide real and substantial means for achieving that end?

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37 F.2d at 453:

[A] failure to supply treatment may raise a question of due process of law. It has been suggested that a failure to supply treatment may violate the equal protection clause. Indefinite confinement without treatment of one who has been found not criminally responsible may be so inhumane as to be a 'cruel and unusual punishment.'


See Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966). The case holds that involuntary civil
Mentally ill people are involuntarily hospitalized, under state statutes, for therapeutic reasons. Compulsory hospitalization for rehabilitation purposes is deemed a proper goal of state legislation. If, however, treatment is then denied, the statutory means, compulsory hospitalization, neither achieves nor is justified by the purported purpose of rehabilitation. Chief Judge Johnson stated in Wyatt: "When patients are . . . committed for treatment purposes they unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition."

Birnbaum's theoretical proposition that there is a right to treatment and the Wyatt court's articulation of its constitutional basis were framed in terms of substantive due process. The argument is relatively simple: if a statute commits mentally ill people under promise of treatment, then such treatment must be forthcoming or the statute cannot be upheld. If there is no longer legal basis for holding him, the confined individual who has been denied treatment can be released for just such a denial. Judge Bazelon, commented, "unconditional or conditional release may be in order if it appears that the opportunity for treatment has been exhausted." He went on to formulate four criteria that should be considered when such a release is contemplated: the amount of time during which the patient has been denied treatment; the length of time the patient has been confined; the nature of the patient's mental condition; and the degree of danger that would be imposed on society if the patient were released. Therefore, under a combination of conditions meeting these criteria, a patient denied his substantive due process rights should win release.

Cruel and Unusual Punishment

Perhaps the most compelling articulation of a constitutional right to treatment is found in terms of the eighth amendment's prohibition against cruel and unusual punishment. Society is constantly defining and redefining the meaning and purpose of punishment for criminal activities.
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ishment is generally sanctioned for four reasons: retribution, deterrence, protection of society, and rehabilitation. Certainly, the threat of confinement will not deter mental illness. It follows that, if a person has not committed a crime, his confinement cannot be justified as a retributory measure. If a person is not considered dangerous, his confinement cannot be approved for the protection of society. And if a person is adjudged to be in need of treatment and is then denied it, it is highly questionable whether his incarceration can be deemed rehabilitative. In short, absent a need or provision for retribution, deterrence, protection of society, or rehabilitation, any confinement is cruel and unusual punishment. It can well be argued that this is precisely the situation of most mental patients whose confinement denies them treatment.

The Supreme Court's decision in Robinson v. California provides a basis for applying the prohibition against cruel and unusual punishment to mental patients confined without treatment. The Court struck down a statute that made narcotics addiction a misdemeanor punishable by imprisonment. It held that imprisoning a person who has not engaged in criminal activity but who is merely "guilty" of belonging to a class—such as drug addicts—is cruel and unusual punishment. The mental patient denied rehabilitative therapy is being treated even more unjustly than Robinson. A drug addict who is imprisoned solely because he is an addict is being subjected to punishment for his status. The addict, however, has in all probability caused his addiction by his voluntary and criminal acts. Mental illness, unlike addiction, lacks the elements of either voluntary initiation or criminality. Confinement of a mentally ill person under these circumstances is equivalent to punishment, and any punishment in the absence of criminal activities must be deemed cruel and unusual.

In Furman v. Georgia the Supreme Court failed to articulate a simple comprehensive eighth amendment test. Nonetheless, Mr. Justice Brennan, in the most persuasive of the five majority opinions, has indicated there is an ultimate determinate—the basic premise of the eighth amendment is that punishment is cruel and unusual if it is "degrading to human dignity." Confinement of the mentally ill without treatment would by this meaning from the evolving standards of decency that mark the progress of a maturing society."
measure be cruel and unusual punishment.57

Judge Morris E. Lasker, a federal district court judge for the Southern District of New York has, in a series of cases, enumerated three considerations useful in determining whether punishment is cruel and unusual: (1) the reasonableness of the punishment and its effect on the recipient;58 (2) whether the punishment outweighs the offense;59 and (3) whether the punishment conflicts with the “broad and idealistic concepts of dignity, civilized standards, humanity, and decency.”60 Under all three guidelines, confinement of mental patients coupled with a denial of therapy is cruel and unusual punishment. As to the first test, the Second Circuit, in United States ex rel. Schuster v. Herold,61 said, “prolonged commitment in an institution providing only custodial confinement for the ‘mentally sick’ and nothing more may itself cause serious psychological harm or exacerbate any pre-existing conditions.”62 The second test also establishes that punishment of the mentally ill is cruel and unusual for any punishment will necessarily outweigh the “offense” of being mentally ill. Finally, under the third test, the answer to the question whether a “civilized society” would punish its sick appears self-evident.

Equal Protection

The equal protection clause of the fourteenth amendment suggests an alternative though speculative framework for a constitutional right to treatment. Equal protection requires that there be equality of treatment within a class of people.63 It has been argued that one such classification is “ill people”—be they physically or mentally ill.64 Physically ill people certainly cannot be imprisoned for their condition, and, except for rare instances where contagion threatens, cannot be forcibly hospitalized.65

58 Davis v. Lindsay, 321 F. Supp. 1134, 1135 (S.D.N.Y. 1970). This case related to the confinement of a “political prisoner,” Angela Davis, in solitary facilities pending her extradition upon kidnapping and homicide charges.
60 Id., quoting Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968).
61 410 F.2d 1071 (2d Cir. 1969).
62 Id. at 1079.
63 See, e.g., Skinner v. Oklahoma, 316 U.S. 535 (1942). This case stated that a statute requiring habitual criminals to be sterilized must be applicable to all habitual criminals or it will be deemed discriminatory.
65 Benton v. Reid, 291 F.2d 780 (D.C. Cir. 1956). This case denies the states the power to imprison the physically ill. However, Robinson v. California, 370 U.S. 660 (1962), does permit a state to compel hospitalization for such a person.
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Therefore, since there are mentally ill people whose hospitalization without treatment amounts to imprisonment, equal protection is denied within the class of ill people. It is argued that the only possible way to avoid such an allegation of imprisonment is to afford treatment to those mental patients involuntarily confined. A similar argument was unsuccessfully presented to the Supreme Court in Minnesota ex rel. Pearson v. Probate Court in which appellant contended that the Supreme Court of Minnesota had denied him equal protection of the laws by construing a state statute dealing with "psychotic personality" to be limited to persons who like himself could not control their sexual impulses. Commenting on appellant's contention the Court stated that "[t]he argument proceeds on a view that that statute has selected a group which is a part of a 'larger class.'" The Court went on to say that:

The question, however, is whether the legislature could constitutionally make a class of the group it did select. That is, whether there is any rational basis for such a selection. Whether the legislature could have gone further is not the question. The class it did select is identified by the state court in terms which clearly show that the persons within the class constituted a dangerous element in the community which the legislature in its discretion could put under appropriate control. The legislature is free to recognize degrees of harm, and it may confine its restrictions to those classes of cases where the need is deemed to be the clearest. If the law 'presumably' hits the evil where it is most felt, it is not to be overthrown because there are other instances to which it might have been applied.

Under such an analysis alone a right to treatment based on equal protection criteria will not stand. It can be argued that while the class of "ill people" is broader than mere mentally ill people, it is the mentally ill who pose a threat to society as potentially dangerous individuals and who, therefore, are in need of compulsory confinement and treatment.

A stronger equal protection argument, however, can be advanced. Such an argument suggests that a person acquitted of a crime by reason of insanity must not be confined for a period of time longer than the period allowed had he been convicted of the offense charged. A longer term

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46 See note 22 supra.
47 309 U.S. 270 (1940).
48 205 Minn. 545, 287 N.W. 297 (1939).
49 309 U.S. at 274.
70 Id.
71 In Baxstrom v. Herold, 383 U.S. 107 (1966), the court held that both prisoners and non-prisoners have a right to a jury trial and judicial hearing before being committed to a mental hospital.

It has been contended that Baxstrom's mandate for equal protection can:

also be applied to the case of the patient who was committed to the mental hospital for a period of time greater than he would have had to serve in prison had he been convicted of the crime and received the maximum sentence therefore.
would have to be imposed for a stated purpose—i.e., treatment and rehabilitation, if it were to be justified within an equal protection framework. Therefore, equal protection of the law may require that mental patients receive psychiatric treatment, but only to the extent necessary to remedy the disparity in confinement between convicted criminals and unconvicted mental patients charged with identical crimes.

**Court Orders to Provide Treatment**

In this period of inflation and governmental freezing of monies earmarked for domestic spending, one cannot speak of enforcing a constitutional right to treatment without inquiring into how such enforcement is to be financed and whether the courts can or should compel reluctant legislatures to appropriate adequate funds for such treatment. One very important question which must be asked is whether a state can afford not to treat its mental patients or to treat them at an inadequate level. Studies have shown that the longer a patient goes untreated the longer he will remain “hospitalized” and the greater will be the cost to the state. The *Rouse* and *Wyatt* decisions declared that inadequate treatment

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N.Y. CRIM. PROC. LAW § 730.50(3) (McKinney 1973) offers protection to those confined because they lacked capacity to stand trial in that such a person may not be retained for a period in excess of “two-thirds of the authorized maximum term of imprisonment for the highest class felony charged in the indictment or for the highest class felony of which he was convicted.”

See *In re Wilson*, 438 Pa. 425, 264 A.2d 614, 617-18 (1970). The case deals with the disparity of treatment as to confinement between juvenile and adult offenders who have been convicted of the same offense. Comparisons between the right to treatment of juvenile offenders and mental patients is justified. One writer sees

[c]lose parallels between juvenile proceedings and psychiatric proceedings. Both involved deprivation of liberty; both were civil rather than criminal; in both, the ostensible purpose was treatment, not punishment; both created stigma; both involved aberrant behavior.

ENNIS, supra note 2, at 186.

An enormous amount of tax money is consumed in building and operating mental hospitals. In the fiscal year 1970-71, New York State spent almost $600 million for its public mental health hospitals and schools for the retarded; the amount was far from adequate. Yet it is not only more money that is needed but also a more sensible allocation of what we have. New York spends about $18 per day for each state hospital patient; Iowa spends about $50 (the national average is about $15). In the long run, however, the taxpayers in Iowa spend a lot less per patient than do the taxpayers in New York. With its higher expenditure, Iowa, unlike New York, is able to hire enough psychiatrists, psychologists, social workers, nurses, and paraprofessionals to give each patient an active treatment program. Consequently, the average period of hospitalization in Iowa is fifteen days, compared to the New York average of sixty days. Fifteen days at $50 per day ($750) is much cheaper than sixty days at $18 per day ($1,080). ENNIS, supra note 2, at 222-23.

373 F.2d at 457.

325 F. Supp. at 784.
cannot be justified by a lack of finances. However, such a "declaration is far different from an order to the state that it must take affirmative action to provide funds. Judicial financing orders have been only rarely entered against government entities." Generally, when a court finds an administrative agency such as a department of mental health neglectful of its duties, the court first gives the agency itself a chance to rectify the situation. However, where there has been a deprivation of constitutional rights, as in the school desegregation cases, courts have acted swiftly to issue financing orders or compel other remedial measures. Until recently, however, courts have been reluctant to intervene in the internal affairs of state mental hospitals and prison systems. Such intervention is necessary if state legislatures are to be moved to action. That is why, prior to the Wyatt decision, Birnbaum had lamented: "unfortunately, it seems a fact of life that few legislatures will take it upon themselves to deal with this problem (of adequately financing mental hospitals) unless the Supreme Court (or any federal court) recognizes a constitutional right to treatment."

It has been suggested that due to a similarity of problems, courts attempting to enforce the right to treatment should look to the school

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77 Although the Wyatt court found that neglect by the Alabama Department of Mental Health had amounted to deprivation of the patient's constitutional rights, nonetheless it granted the state six months to correct conditions in its mental institutions. 325 F. Supp. at 705.

78 See, e.g., Griffin v. County School Bd., 377 U.S. 218 (1964) (the Court compelled Prince Edward County, Virginia, to maintain a desegregated school system by ordering the county to levy a special tax to finance its schools); Watson v. Memphis, 373 U.S. 526 (1963) (the Supreme Court ordered immediate desegregation of city parks). In both cases, the Supreme Court, despite a lack of available funding, took immediate action to protect constitutional rights which otherwise would have been circumvented.

79 As an example of another somewhat "drastic" judicial remedy consider the forced busing of school children to attain racial balance in the schools. Busing could be categorized as an indirect financing order.

80 Wyatt is actually the first case in which an entire mental hospital was opened to judicial inspection. Such a wholesale evaluation of the system can be credited to the use of a class action. See note 38 supra.

81 In Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970), the court ordered the renovation of the entire Arkansas prison system so that it would function within constitutional guidelines.


83 See Note, Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right, 32 Mo. L. Rev. 42, 68 (1972).

84 Courts lack the manpower and expertise to continuously supervise school desegregation and/or mental health plans without aid. They are therefore somewhat dependent on the cooperation of the same agencies who are often defendants in these cases. Also, a court may discover that a master plan for all mental hospitals cannot be formulated, thus making each case dependent on its own facts and circumstances.
desegregation cases for equitable guidelines. The Supreme Court in *Green v. County School Board*,\(^5\) established the test for judicial inspection of proposed school desegregation plans: "The availability . . . of other more promising courses of action may indicate a lack of good faith, and at least it places a heavy burden upon [those submitting plans] to explain [their] preference for an apparently less effective method."\(^6\) This test could readily be adapted to a mental hospital improvement plan. Cooperation may prove difficult to secure, but the courts now seem willing to appoint masters\(^7\) or professional advisory committees where needed to oversee the reformation of mental hospital systems.\(^8\)

What specifics would be included in an order to provide funds or take other affirmative steps? The *Wyatt* decision has given very definite guidelines. These include: (1) a request for legislative cooperation with the threat of court-supervised administration of the facility in case of non-compliance;\(^9\) (2) minimum constitutional standards for the creation of a humane psychological and physical environment;\(^0\) (3) requirement for the employment of a qualified staff in sufficient numbers to administer adequate treatment;\(^1\) and (4) requirement for the introduction of individualized treatment plans.\(^2\) This scheme includes provisions for extended periods of grace for an administrative agency that has shown a good faith attempt to comply with the minimum standards,\(^3\) but has, as of yet, not

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\(^5\) 391 U.S. 430 (1968).
\(^6\) *Id.* at 439.
\(^7\) Federal Rule of Civil Procedure 53(b) permits the appointment of a master to administer an institution such as a mental hospital if an "exceptional condition" exists. It has been contended that the need to devise standards of care that are constitutionally adequate for mental hospitals is such an "exceptional condition." Drake, *supra* note 24, at 598.
\(^8\) While the *Wyatt* court did not take such measures, on rehearing, it did threaten to intervene if court-ordered minimum constitutional standards were not implemented voluntarily. 344 F. Supp. 373 (M.D. Ala. 1972) (dealing with Bryce Hospital); 344 F. Supp. 387 (M.D. Ala. 1972) (dealing with Parlow State School and Hospital for the retarded).
\(^9\) 344 F. Supp. at 378.
\(^0\) The *Wyatt* decision offered detailed descriptions of what constitutes adequate physical facilities (e.g., one toilet per eight patients) and an adequate physical plant (e.g., the temperature in the hospital is not to drop below 68°F nor exceed 83°F.). For a discussion, see note 19 *supra* and accompanying text.
\(^1\) A qualified staff means: each professional employee shall be duly licensed and certified by the state; non-professional staff shall be oriented in clinical techniques; and the hospital must comply with staffing ratios (e.g., four registered physicians, two psychiatrists, twelve nurses (RN), four psychologists (one Ph.D.; one M.A.; and two B.S.'s), and ten patient activity aides per 250 patients). 344 F. Supp. at 383-84.
\(^2\) Some of the requirements of an individualized treatment plan are: a comprehensive mental and physical examination within two days of admission; a formulation of intermediate and long range therapeutic goals; specified staff responsibilities for achieving such goals; criteria for discharge; formulation of a post-hospitalization plan; continuous review of treatment plans; and educational opportunities suitable for each patient. *Id.* at 384-86.
\(^3\) A court can only order an institution to comply with minimum standards. "[D]ue process requires no more than minimal adequate treatment." 32 Md. L. Rev. at 67.
fully conformed.44

Although Wyatt ordered the state legislature to take affirmative steps to improve the treatment and living conditions at state hospitals, the court did not, directly order the legislature to spend a specified sum of money to make the required improvements to its institutions.45 One possible financial remedy, requested by the plaintiffs in Wyatt but on which the court reserved ruling until a future date,46 is an order to the state mental health board to sell or otherwise encumber some of its land holdings (if such exist in excess) so as to raise additional money for treatment programs. This proposal is a desperation measure which could only have short term and short-lived benefits.

A second means of obtaining funds to assist those mental patients most in need of treatment would be to secure a judicial order releasing all patients who are deemed to be "untreatable" and non-violent.47 This technique will alleviate the funding problem only if those released receive either public out-patient or private care. If the patient's release is in fact a transfer to another type of public institution then the cure is specious. For example, it was requested by the Wyatt plaintiffs that the court order the transfer of 1600 geriatric patients, most of whom suffer senility alone, to public or private old age homes. Funds for their care would then be provided not from state mental hospital appropriations but from other public sources such as the Alabama Department of Pensions and Security.48 Unless it can be shown that departments such as Pensions and Security have unused, earmarked funds or that treatment in old age homes would be better, such a proposal is a weak solution to the monetary problem for ultimately it is the same pie, state taxpayer dollars, that is being sliced, only in a slightly different fashion.

A third method for counteracting legislative intransigence would be the implementation of a judicial policy requiring that all patients who are being denied treatment in mental facilities be released49 if compliance with

325 F. Supp. at 785.
45 Traditionally, the courts are reluctant to order relief in an area or manner which would appear to be reserved for state legislative action. However, where fundamental rights are at issue, the courts will mandate either the reallocation or the expenditure de novo of public funds. See Griffin v. County School Bd., 377 U.S. 218, 233 (1964); Hosier v. Evans, 314 F. Supp. 316, 320 (D.V.I. 1970) (fundamental constitutional rights "may be neither denied nor abridged solely because their implementation requires the expenditure of public funds.").
344 F. Supp. at 377.
47 See note 7 supra.
48 Drake, supra note 24, at 598.
49 For the criteria upon which such releases would be based see text accompanying notes 37 & 38 supra. In Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970), the court warned that if Arkansas wanted a prison system, the state must run it within constitutional guidelines. The case seems to imply that if funds are not available to keep the prison system within minimum constitutional standards, the prison system will be closed down. The results of such drastic action are incomprehensible. In all likelihood, funds would be forthcoming before such a step
minimum constitutional standards is not forthcoming by a date certain. Such a threat might be called "judicial blackmail" but it would undoubtedly place great political pressure on state legislatures to finance treatment programs.

Still a fourth avenue of approach is illustrated by recent court decisions awarding monetary damages to mental patients against a state and its mental hospital officials for denying these patients treatment while confining them in state mental facilities. In effect, legislatures would be faced with a choice of appropriating funds for treatment now or paying damages later.

Judge Bazelon of the District of Columbia Court of Appeals believes that court financing orders and other judicial pressure tactics are unworkable and ill-advised. He has suggested the use of "judicial muckraking" to dramatize the plight of mental patients in the eyes of the public:

Courts cannot force legislatures to provide adequate resources for treatment. But neither should they play hand-maiden to the social hypocrisy which rationalizes confinement by a false promise of treatment. Quite the contrary, courts should and must reveal to society the reality that often festers behind the euphemism of 'hospitalization'. Some might call this judicial muckraking. But courts fulfill a necessary function when the drama and publicity attending a concrete case provide the illumination of dark recesses which is essential if society and its legislatures are to make informed judgments.161

A RIGHT TO REFUSE TREATMENT

The Wyatt Court has declared that mental patients have a right to treatment. Does such a right include a right to refuse treatment? Or, does a constitutional right to treatment have attached to it a duty to submit to treatment? The answer to this question is not easily susceptible to generalization since the type of treatment proposed for a given patient may influence one's judgment. Nevertheless, answers to these questions have been phrased in absolute terms by some commentators.

Dr. Thomas Szasz is perhaps the most outspoken advocate of the right to refuse treatment.162 He states that involuntary hospitalization of the mentally ill is a crime against humanity and is comparable in several respects to the institution of slavery.163 In his view, the only way to insure that those who do not wish to submit to treatment can make such a choice

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is to eliminate the system of involuntary commitment in its entirety.\textsuperscript{104} In its place Dr. Szasz at least with respect to the aged mentally ill would seek legislation to compel families to care for their "mentally ill" members much the same as parents are forced by the state to provide care for their children.\textsuperscript{105} Even assuming an abundance of good will, this proposal is quixotic. Most families do not have the money, the expertise, or the time to care for their own mentally ill.\textsuperscript{106}

The opposite extreme is represented by those who see the forced treatment of psychiatric patients as a necessary evil.\textsuperscript{107} Their theory is based on a paternalistic evaluation which credits mental patients with, at best, the intellect of a child in need of schooling: "Since the attitude of distrust which leads a patient to refuse treatment is often a manifestation of the mental infirmity which requires treatment, in most cases the patient could not be considered competent to decide for or against treatment."\textsuperscript{108}

After all, it is argued, a constitutional right, \textit{i.e.}, the right to treatment, can only be waived through intentional relinquishment of a known right.\textsuperscript{109} We must ask may we repose such responsibility in a mental patient? A recent New York case, \textit{Whitree v. State},\textsuperscript{110} persuasively argues that we cannot. In \textit{Whitree} the court denounced a hospital staff for having deferred to the wishes of a mental patient who had refused treatment.\textsuperscript{111}

\textsuperscript{104} Let those who want the state to do all kinds of things for the aged pursue their goal as they see fit. But every hour they spend planning "services" for the aged, let them spend two guaranteeing them the right not to receive but to reject these benefits. The first step in this direction is, of course, clear and simple: the immediate abolition of all involuntary psychiatric intervention imposed . . . by the state.


\textsuperscript{105} \textit{Id.} at 84-85.

\textsuperscript{106} Dr. Szasz' answer is that the problem is moral. We do not involuntarily confine the helpless newborn. Why do we confine the helpless aged? This argument ignores such emotions as the joy in life renewed—the infant—and the fear of life diminished—the aged.

\textsuperscript{107} \textit{See}, e.g., K. MENNINGER, \textit{MAN AGAINST HIMSELF} (1938).

The importance of consent as an element in the overall receptivity of a patient to treatment has been recognized by medical and legal authorities. \textit{See} Gilboy & Schmidt, "\textit{Voluntary}" \textit{Hospitalization of the Mentally Ill}, 66 NW. U.L. REV. 429 (1971). "Making the patient responsible for his own treatment, rather than committing him forcibly to an institution, is said to increase his feelings of self worth and his receptivity to psychiatric treatment."


\textsuperscript{110} 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968).

\textsuperscript{111} We find that [Whitree] was not treated with any of the modern tranquilizing drugs . . . [T]he reason for not using such drugs was that Whitree refused them. We consider such reason to be illogical, unprofessional, and not consonant with prevailing medical standards.

\textit{Id.} at 707, 290 N.Y.S.2d at 501.
The spectrum of treatment offered to this patient had been limited to a choice of drug therapy or no therapy at all. The court found that the operative facts rather than supporting a right to refuse treatment required an award of damages to the patient. Whitree's refusal of therapy had condemned him to 14 years of such substitute tranquilizers as beatings and isolation.

There are those who advance the right to refuse treatment on constitutional grounds. Various arguments are presented: a first amendment right to privacy of the mind; a fourth amendment right to be let alone; and a fourteenth amendment right to substantive due process. However, these rights are no more compelling than the right to liberty, a right that is eviscerated every time a patient is involuntarily committed. The state could argue that just as a mentally ill person does not recognize the danger he poses to himself or others and is therefore confined against his will, so too, he is unable to recognize or consent to his need for treatment.

Another seemingly plausible argument for advancing the right of the state to compel mental patients to accept treatment is based on the power of the state to protect its treasury. If a mentally ill person could be admitted to a state hospital, treated for his infirmity, and released, the state would be in a more favorable economic position than if it were forced to later provide for his indefinite retention and custodial care.

However, in Shapiro v. Thompson, the Supreme Court struck a Connecticut statutory requirement limiting welfare benefits to state residents despite the argument that the statute was for the protection of the state treasury. The Court reasoned that no compelling state interest was served by the status of "state resident" as a criterion for receiving welfare benefits. The restriction served merely to impede the fundamental right of interstate travel.

In light of Shapiro, it seems unlikely that the "right...
to be let alone" could be circumvented by a desire to preserve state monies.

What then is the right of a mental patient deemed in need of treatment? Must he submit to it or has he a right to refuse it? It seems clear that a middle course must be charted. In certain circumstances treatment must be left entirely to the discretion of medical experts. The spectre of the Whitree alternatives presents too recent, and too compelling, an answer to the accusation of paternalism. In cases where the patient’s condition indicates—and this must be both a medical and legal judgment—that he can make an informed decision as to treatment, then at the very least hospitals should be required during the term of confinement to attempt to convince him that treatment will be beneficial. "The constitutional right to treatment would seem to require that . . . attempts at rehabilitative treatment continue for as long as the patient is detained." This approach bases the right to refuse treatment upon a decision as to the competency of a patient and the adequacy of his guidance by counsel. Those patients possessing the ability to consent to, or to waive treatment should be

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119 23 Syracuse L. Rev. at 134.

120 New York State already has a system under which lawyers, as a part of the Mental Health Information Service, are attached to the State’s four judicial departments and made available to mental patients as a means of protecting their rights while they are hospitalized under voluntary or involuntary proceedings. The statutory framework of New York’s system provides in pertinent part that:

The Mental Health Information Service in each judicial department of the state shall perform the following duties subject to directions made and rules and regulations promulgated by the presiding justice of the appellate division of each department:

1. study and review the admission and retention of all patients.
2. inform patients and, in proper cases, others interested in the patients’ welfare concerning procedures for admission and retention and of the patients’ rights to have judicial hearing and review, to be represented by legal counsel, and to seek independent medical opinion.
3. in any case before a court, to assemble and provide the court with all relevant information as to the patient’s case, his hospitalization, his right to discharge, if any, including information from which the court may determine the need, if any, for the appointment of counsel for the patient or the obtaining of additional psychiatric opinion.
4. provide services and assistance to patients and their families and to the courts having duties to perform relating to the mentally disabled, or the allegedly mentally disabled, who are admitted pursuant to articles thirty-one, thirty-three and thirty-five of this chapter, as may be required by a judge or justice thereof and pursuant to the regulations of the presiding justice of the appellate division of each judicial department.

N.Y. MENT. HyG. L. § 29.09(b) (McKinney Supp. 1972) (emphasis added). These lawyers could be used to aid competent mental patients in making an informed consent or waiver of possible therapies.

121 21 C.F.R. § 130.37(h) (F.D.A. Regulation) (1973): ‘Consent’ means that the person involved has legal capacity to give consent, is so situated as to be able to exercise free power of choice, and is provided with a fair explanation of pertinent information concerning the [treatment]. . . .
permitted to do so; those patients unable to make decisions\textsuperscript{122} would have to rely on the judgment of qualified psychiatrists. In both cases legal advice and independent psychiatric examinations should be provided as a further safeguard, in an attempt to ascertain whether or not a patient possesses the ability to make an informed consent or waiver.\textsuperscript{123}

In concluding this section it will be profitable to focus upon particular types of treatment which have recently been challenged in the courts and which put into issue the right to refuse treatment. \textit{Sanders v. Brennan},\textsuperscript{124} a suit brought against the United States Department of Labor, sought to put an end to patient labor in mental facilities. \textit{Doe v. Department of Mental Health}\textsuperscript{125} has challenged the use of certain surgical procedures to correct mental disorders. These cases should be viewed in light of the preceding arguments supporting the right to refuse treatment. \textit{Sanders} was instituted in the United States District Court in Washington, D.C. by the National Association for Mental Health, the American Association on Mental Deficiency, and three mental patients. These plaintiffs alleged that thousand of mental patients in non-federal hospitals are being compelled to perform menial jobs with little or no compensation for their work. Two of the most common defenses for such labor are: first, that the work is therapeutic,\textsuperscript{126} and secondly, that such labor helps defer part of the cost of hospitalization.\textsuperscript{127} The District of Columbia plaintiffs have apparently

\textsuperscript{122} How does one obtain consent from a severely ill catatonic schizophrenic who could not even give the time of day much less consent to treatment or from a paranoid inmate whose refusal of treatment is a product of his illness? How does one obtain informed consent from a inmate placed in the institutional setting because he was not competent to stand trial or from a sociopath who is by his nature generally uncooperative?

\textsuperscript{123} The argument can be raised that the cost of such a procedure would be prohibitory. However, the right to treatment is fundamental and cannot be justified by a lack of funds. "There can be no legal (or moral) justification for . . . failing to afford treatment. . . ." \textit{Wyatt v. Stickney}, 325 F. Supp. 781, 785 (M.D. Ala. 1971).


\textsuperscript{125} Habeas Corpus \# 19434 (Circuit Courts for the County of Wayne, Mich.).

\textsuperscript{126} The term used to describe an institutional system wherein patients perform various labors and are compensated for such work with money or other mediums of exchange is "token economy." It is a behavioral therapy technique whereby good behavior of a patient (such as helping to maintain the cleanliness of the ward he or she resides in) is rewarded and, therefore, encouraged by giving the patient a "token" which can be used as a medium of exchange for purchasing meals and cigarettes, or can be cashed in for real money. See T. AVILIN & N. ARGIN, \textit{THE TOKEN ECONOMY: A MOTIVATIONAL SYSTEM FOR THERAPY AND REHABILITATION} (1968).

In Patton State Hospital, California, such a "token economy" has proven effective as a therapeutic device. The readmission rate of Patton patients who took part in the experiment is approximately sixteen percent while the national readmission rate is somewhere between 35 and 40\%+. H. SCHAEPFER & P. MARTIN, \textit{BEHAVIORAL THERAPY} 216 (1969). For an in-depth discussion of the legal consequences of a "token economy" see Wexler, \textit{Token and Taboo: Behavior Modification, Token Economies, and the Law}, 61 \textit{CALIF. L. REV.} 81 (1973).

\textsuperscript{127} N.Y. Times, Mar. 14, 1973, at 21, cols. 4-5.
challenged the first defense on the grounds that minimally compensated or uncompensated labor is not therapeutic and is, in fact, harmful. However, a resolution of the issues raised in the case may be reached without passing upon the validity of the claimed therapeutic value of work. Assuming, arguendo, that the labor involved is therapeutic, it would seem from earlier arguments that competent patients under the guidance of counsel should nevertheless, be allowed to choose whether or not to participate in such therapeutic labors. In fact, Judge Johnson in *Wyatt* specifically addressed himself to the question of patient labor and categorically declared that, even absent the concept of informed waiver, “[n]o patient shall be required to perform labor which involves the operation and maintenance of the hospital. . . .” Such work, is permissible, however, if patients volunteer to participate provided their salaries are not applied toward financing their stays in the hospital. In addition such labor is to be compensated in accordance with the minimum wage laws. In light of *Wyatt*, it would appear that plaintiffs' cause of action against the Department of Labor has judicial support.

*Doe v. Department of Mental Health,* brought in the Wayne County Circuit Court of Michigan, was commenced by a civil liberties lawyer on behalf of the patients of Ionia State Hospital to either strictly control or totally ban the class of treatment known as “psychosurgery” which is used to “cure” mental patients. It is feared by civil libertarians—that doctors and lawyers—that “psychosurgery” may be used as an “easy way out” instead of applying “conservative psychotherapy” techniques. “Psychosurgery’s proponents argue that this procedure might be the only hope for a ‘cure’ for some mental patients.” The case presents a conflict of rights situation. A patient identified only as John Doe has requested that such therapy be used on him; if the plaintiffs win their suit John Doe might be denied the treatment he has requested.

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129 See text accompanying notes 115-17 supra.
130 344 F. Supp. at 381.
131 Id.
133 Habeas Corpus #19434 (Cir. Court for the County of Wayne, Mich.).
134 “Psychosurgery” is defined as a:

Technique by which tiny portions of tissue deep in the brain are destroyed through surgery, electricity, radiation or ultrasound . . . to treat such conditions as uncontrollable epilepsy, violent behavior, schizophrenia, severe depression and destructive hyperactivity.

N.Y. Times, March 12, 1973 at 1, col. 7.
135 Id. at 25, col. 1.
136 Id.
137 More recent reports in the *New York Times* have indicated that the three-judge Wayne County Circuit Court panel has ruled that John Doe was being unconstitutionally held in that the statute under which he was convicted was itself declared unconstitutional (N.Y. Times,
It would appear that John Doe's constitutional right to treatment would, granting that his consent was informed,3 give him the right to choose "psychosurgery" unless it be established that such treatment is medically unsound.

The Wyatt decision supports arguments for "psychosurgery" by permitting lobotomies and other unusual therapy techniques when the patient has given his informed consent.3 It is doubtful that "psychosurgery" could be constitutionally administered against a patient's wishes. Such action would violate a patient's "right to be let alone."3 However, it is also doubtful that "psychosurgery" can be denied when requested by a patient capable of giving informed consent.

CONCLUSION

It is now established that mental patients have a constitutional right to treatment. Moreover, the courts can take affirmative steps to bring the care provided by state hospitals up, to at the very least, minimum constitutional standards when the institutions themselves are slow or reluctant to provide care for the mentally ill. However, more must be done if the right to treatment is to become enforceable.

Many state legislatures have yet to codify the right to treatment. Without such codification, plaintiffs must rely solely on constitutional arguments in an attempt to obtain that to which they have a right and yet have been denied. When state statutes are not silent on the right to treatment, treatment is more likely to be forthcoming. And, as has been seen, a statutory right to treatment affords the courts an easier handle to grasp in awarding damages and/or ordering treatment than the yet weakly defined constitutional grounds on which to base such decisions. But, without accompanying public concern, legislatures will remain inert, continuing to ignore the shackling of mental patients who are in quest of treatment and eventual release.

Until such time as legislatures, motivated by public prodding, put the right to treatment into law, the courts will have to continue to push deeper into this constitutional frontier. "The drama and publicity attending a concrete case"14 will define the right to treatment in a usable framework. Case law must establish the "who," "what," "when," "where," and
“why,” of a patient’s right to treatment—and of his right to refuse treatment. Hopefully, as the courts define and enforce these rights on a case by case basis, “judicial muckraking” will pierce the public conscience and stimulate debate and change on a statewide basis. For, if the one out of ten Americans now alive who will someday be mental patients are to be given a decent chance to return to society, it must be the other nine who are moved to demand that help be forthcoming.