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Foreword

Mental Health Law and the Movement Toward Voluntary Treatment

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I

In recent years, scholarship in the field of mental health law has centered largely on three areas: criminal responsibility, civil commitment, and, somewhat more recently, the rights of institutionalized patients. This emphasis is reflected in the articles in the present Symposium; in fact, with only one exception—the interesting piece on tort liability and the psychotherapeutic relationship by Professor John Fleming and Bruce Maximov¹—the fit into this three-part format is a perfect one. Yet the articles are by no means content to echo traditional wisdom. Indeed, in each of the three areas of inquiry, the Symposium authors, drawn from a variety of disciplines, break new ground and provide significant insights into the theory and practice of mental health law.

A key question in each of these areas involves the proper deference to be given the judgments of psychiatric practitioners in applying the law's coercive powers to the mentally disabled. The article by Bruce Ennis, a mental health reform lawyer, and Thomas Litwack, a clinical psychologist and lawyer, questions the usefulness of these judgments in courtroom proceedings.² Ennis and Litwack canvass the

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1. Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025 (1974).

2. Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974).

entire body of medical and psychiatric literature relating to the reliability and validity of psychiatric diagnoses, and conclude that psychiatrists are remarkably inaccurate at predicting violent behavior and are often unable to agree even among themselves whether particular persons are mentally ill. The authors suggest that the role of psychiatrists in civil commitment processes should be drastically curtailed. Ennis and Litwack's findings will undoubtedly cause reverberations in virtually every area of mental health law. A number of possible implications are suggested by the other contributors to the Symposium.

In criminal law, for example, there have been a number of proposals—one from the Nixon Administration—to abolish the insanity defense. Professors Ralph Reisner and Herbert Semmel describe a Swedish system which eliminates insanity as a defense and takes it into account only in determining the appropriateness of different dispositions.³ As the article notes, the Swedish scheme has moved toward a medical-administrative model of decision-making in which forensic-psychiatric institutions share much of the dispositional decision-making power with judicial officers. For example, the concurrence of institutional medical personnel is required before certain sanctions—such as psychiatric hospitalization—can be imposed.

Reisner and Semmel's discussion invites more careful evaluation of the impact of different structural arrangements on the diagnostic decision-making process in the United States. Little attention has been paid, so far, to the intended and latent consequences of the various possible models. For instance, when courts alone make dispositional decisions, they may well erroneously send to mental hospitals certain patients who clearly ought not to be there. Such a result is also quite capable of being reached even when the judiciary is assisted by medical experts, at least if those experts are unaffiliated with the receiving institutions and unaware of the precise programs that are available there. In a number of recorded instances, for example, civil commitment courts have committed patients to a state hospital on the advice of local psychiatrists who erroneously assumed that the hospital had treatment programs appropriate to the needs of those patients. Typically, hospitals are offended by having such patients thrust upon them, and it is not unusual to see the unwanted patients discharged almost immediately. Presumably, a commitment structure which enabled the hospitals to share in the decision-making responsibility would minimize these cases, thereby increasing efficiency and reduc-

3. Reisner & Semmel, *The Role of the "Impartial" Psychiatric Witness: A Look at the Proposed Federal Criminal Code Reform Act in Light of the Swedish Experience*, 62 CALIF. L. REV. 753 (1974).

ing unnecessary deprivations of liberty. On the other hand, a model in which responsibility for decision-making is shared by court and keeper may easily be abused by the introduction of nonmedical and nonlegal factors into the keeper's "diagnostic" judgment. Often, for example, a hospital will reject a proposed patient as clinically unsuitable when the actual reason is that the hospital simply does not wish to be burdened by a person likely to become a management problem.⁴ These issues are worthy of substantial scholarly attention. Indeed, if we are to begin seriously to think about abolishing the insanity defense and referring defendants to therapists for dispositional decisions, these matters must assume central importance.

The collection of articles relating to civil commitment constitutes the core of the Symposium. Within their treatment of commitment, the articles deal with a wide variety of issues, but each discusses the usefulness of psychiatric expertise in this form of coercive intervention in people's lives.

One particularly troubling aspect of the ambiguity and uncertainty inherent in the concept of mental illness is the manner in which it permits doctors to smuggle social and moral judgments and biases into the process of diagnosis. In particular, Robert Roth and Judith Lerner accuse psychiatry and psychiatrists of introducing sex-based biases into their diagnoses and treatment of mental illness.⁵ Their thesis is that classical psychiatric theory reflects sex-based discriminatory attitudes, and that this bias combines with a more general bias in society. They argue that clinicians apply a discriminatory double standard of mental health which, when utilized by the legal system, denies women equal protection of the laws. They suggest several areas

4. Nasatir, Dezzani, & Silbert, *Atascadero: Ramifications of a Maximum Security Treatment Institution*, 2 ISSUES IN 'CRIMINOLOGY 29, 40 (1966). See also Wexler, Scoville, et al., *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 174-88 (1971) [hereinafter cited as Wexler, Scoville]. In the context of civil commitment cases, this problem is often encountered by lawyers seeking county nursing home placement for a client as an alternative to state hospitalization; the nursing home's "veto power" over the admission of proposed patients is often abused by reliance on nonclinical criteria.

In addition to hospital rejection of technically admissible patients, there is the possibility of hospitals recommending admission of patients who should not be confined. Legally and medically extraneous factors—such as physician or hospital financial interest in filling beds—may lead to such a result. There is, for example, some evidence to suggest that a system, now revised, of calculating Veterans Administration psychiatric hospital budgets on the basis of the average daily patient population provided a nonclinical incentive to admit and retain patients. See Burt, *Admission and Release Processes of Veterans Administration Psychiatric Hospitals* 38-39 (January 1973) (unpublished report prepared for the Chairman of the Administrative Conference of the United States).

5. Roth & Lerner, *Sex-Based Discrimination in The Mental Institutionalization of Women*, 62 CALIF. L. REV. 789 (1974).

of inquiry helpful in detecting and challenging sex-based discrimination in the mental institutionalization of women.

Thomas Litwack argues for a more responsible role for lawyers in the commitment process.⁶ His review of New York's experience with the Mental Health Information Service suggests that a body of lawyers must be established within the bar who will specialize in the problems of psychiatric law. The existence of such a body of experienced attorneys can serve as a check on abuses in the commitment process described by the other contributors to the Symposium.

Commitments to protect persons from being "dangerous to themselves" or to hospitalize those "in need of treatment" are often justified as paternalistic interventions in aid of those who are mentally incompetent to know their own best interest. A well-researched article by James Ellis addresses paternalism in its purest form: the parent-child relationship. The paternalism discussed by Ellis involves the power of parents to sign their minor children into mental hospitals.⁷ Ellis observes that the parental decision to place a child in a mental hospital often involves factors very different from a decision to consent, for example, to a child's appendectomy, and that in practice the former decision may not involve wholly paternalistic considerations but may instead reflect the parent's desire to find a way out of a difficult family situation. Since the interests of the parents and of the child with regard to commitment may conflict, Ellis proposes that the law recognize the independent legal existence of the child, including his or her right to consult counsel prior to commitment.

Sterilization is another area in which paternalistic justifications are employed to limit the freedom of the mentally disabled. Professor Charles Murdock argues that paternalism is an inadequate rationale to justify the forced sterilization of the retarded.⁸ Additionally, Murdock suggests that the scientific basis for selecting persons to be sterilized is rarely, if ever, adequate. He concludes that in all cases the state's interest in performing such operations upon unwilling persons will need to be carefully defined and precisely served in order to pass constitutional muster.

Two authors have conducted careful explorations of the rights of patients within mental hospitals. Ralph Schwitzgebel, whose training is in psychology as well as in law, argues that any treatment program for involuntary patients must be designed to bring about the

6. Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CALIF. L. REV. 816 (1974).

7. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840 (1974).

8. Murdock, *Sterilization of the Retarded: A Problem or a Solution?*, 62 CALIF. L. REV. 917 (1974).

patient's earliest possible release.⁹ Therefore, Schwitzgebel argues for expanding the concept of the right to treatment to require treatment that is truly effective—effectiveness being measured by the extent to which the treatment promotes the patient's chances for discharge. While Schwitzgebel discusses the judicial remedies which may promote the interests of hospitalized patients, Professor Grant Morris examines the equally important area of legislative reform.¹⁰ Morris argues for the importance of "committing" the legislature to the rights of patients within hospitals, and criticizes the recent attempts at legislative reform in Michigan. Both of these articles endeavor to balance the areas in which psychiatric expertise and administrative responsibility should govern with the need for greater legal scrutiny of conditions and treatment programs in mental institutions.

Finally, the problems of psychiatric inexactitude necessarily play an important role when the private psychotherapist, confronted with a patient who has disclosed a real or imagined intent to harm others, must choose between taking restrictive action in possible violation of confidentiality, or trust that the harm will not occur. This is the subject of the article by Professor John Fleming and Bruce Maximov.¹¹

II

If there is one message presented by the Symposium as a whole, it is that psychiatry's coercive control should be sharply curtailed. The commentators are decidedly against commitment and against forced treatment except in rather limited instances, and the law has been increasingly responsive to that view. It is noteworthy, however, that even the proposals of the most vocal opponents of the commitment process generally stop short of advocating the elimination of the role of psychiatry altogether. Rather, the critics have confined their disapproval to *coercive* psychiatry. Elsewhere, Bruce Ennis has summed up the prevailing view: "At the same time, we do not oppose *voluntary* psychiatric treatment, either in a hospital or on a private, outpatient basis. Our quarrel is not with psychiatry, but with coercive, institutional psychiatry."¹²

In conformity with the views of the commentators, the law will probably move increasingly away from coercive procedures and to-

9. Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936 (1974).

10. Morris, *Institutionalizing the Rights of Mental Patients: Committing the Legislature*, 62 CALIF. L. REV. 957 (1974).

11. Fleming & Maximov, *supra* note 1.

12. B. ENNIS & L. SIEGEL, *THE RIGHTS OF MENTAL PATIENTS* 13 (1973) (emphasis in original).

ward a model of voluntary hospitalization and treatment. The shift, however, will not occur without creating its own troublesome legal issues. While this Foreword is obviously not an appropriate format to discuss those issues in detail, it may be useful to raise some of these questions and to sketch a legal agenda for approaching and studying some future concerns of mental health law.¹³

It is important to recognize at the outset that the distinctions between voluntary and involuntary hospitalization and treatment are often murky. Many hospital admissions technically designated as voluntary actually involve substantial elements of coercion. Gilboy and Schmidt described the process of voluntary admission to Illinois hospitals as one in which the majority of voluntary admittees entered "voluntarily" only under the threat of involuntary commitment.¹⁴ James Ellis' article in the current Symposium shows that although commitments of minor children by parents are legally designated as "voluntary," the children concerned may often regard the process as compulsory.¹⁵ Indeed, even adults, found to be mentally incompetent or gravely disabled, may be signed into mental institutions and comparable facilities by their guardians or conservators pursuant to a process deemed "voluntary."¹⁶ As commitment itself falls into disfavor and becomes, by statute and case law, increasingly difficult to effectuate, the conservatorship route to mental hospital admission will probably increase markedly in popularity.¹⁷ Finally, compulsory control is sometimes based on the assumption that the patient's belated approval will be secured when his rationality is restored, and that it is accordingly appropriate to override a temporary—and presum-

13. In that connection, it would probably be most helpful to study the British mental health system, which has been described as overwhelmingly voluntary, and to ascertain what legal problems have arisen under it. *Id.* at 39 n.1.

14. Gilboy & Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 *Nw. U.L. Rev.* 429 (1971).

15. Ellis, *supra* note 7.

16. *E.g.*, CAL. WELF. & INST'NS CODE § 5358 (West Supp. 1973).

17. During the summer of 1972, when I taught a seminar in Law and Psychiatry at Stanford Law School, some of my students studied and observed the process of commitment and conservatorship in California. Their preliminary conclusions were that, in light of the strict substantive and procedural requirements needed for commitment under California's modern Lanterman-Petris-Short (LPS) Act, CAL. WELF. & INST'NS CODE § 5000 *et seq.* (West 1972), commitment is rarely resorted to, but that conservatorship proceedings, carrying far fewer protections, CAL. WELF. & INST'NS CODE § 5350 *et seq.* (West Supp. 1973), were relatively common. The conservators—who were typically public officials—rather routinely signed their conservatees into mental hospitals, nursing homes, and other institutions. Conservatorship proceedings, moreover, are as perfunctory in nature as were California commitment proceedings prior to the passage of the LPS Act and are no better than typical commitment hearings conducted elsewhere in the country. *See, e.g.*, Wexler, Scoville, *supra* note 4, at 38-51 (describing commitment hearings in Arizona).

ably irrational—objection.¹⁸ Clearly, these quasi-voluntary schemes are deserving of further analysis.

Even before we reach a time when hospital admission becomes primarily voluntary, the law will probably require, constitutionally or statutorily, that certain treatments, such as psychosurgery,¹⁹ electroconvulsive therapy,²⁰ and chemotherapy,²¹ not be thrust on committed patients without their consent. Indeed, all nonconsensual treatment may ultimately be prohibited. It seems, then, that the principle of free consent, particularly in the context of institutionalized patients agreeing to treatment, will gain in importance in mental health law.

The problem with respect to psychosurgery has recently received widespread attention because of the case of *Kaimowitz v. Department of Mental Health*.²² In *Kaimowitz*, a Michigan three-judge trial court held that, as a matter of law, involuntarily confined patients cannot give legally adequate consent to experimental psychosurgery. The *Kaimowitz* court concluded that “the three basic elements of informed consent—competency, knowledge, and voluntariness—cannot be ascertained with a degree of reliability warranting resort to use of such an invasive procedure.”²³

In finding confined patients incompetent to consent, the court did not make the mistake, often made in the past, of concluding that committable patients are automatically legally incompetent.²⁴ Rather, the court found that the process of institutionalization and the dependency that typically accompanies hospitalization lead to an atrophying of patients' decision-making powers and render them incapable of making decisions as serious and complex as whether to undergo experimental psychosurgery. With respect to the element of knowledge, the court viewed the risks of psychosurgery as profoundly uncertain and held that consent thereto cannot be truly informed. Finally, the court concluded that no consent given by a confined pa-

18. The future-oriented consent rationale for suicide and addiction prevention efforts is explored in Wexler, *Therapeutic Justice*, 57 MINN. L. REV. 289, 329-35 (1972). See also Dworkin, *Paternalism*, in R. WASSERSTROM, *MORALITY AND THE LAW* 107 (1971).

19. *Kaimowitz v. Dep't of Mental Health*, Civ. No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., July 10, 1973), abstracted in 13 CRIM. L. REP. 2452 (1973).

20. *New York City Health & Hosp. Corp. v. Stein*, 70 Misc. 2d 944, 335 N.Y.S.2d 461 (Sup. Ct. 1972).

21. Cf. *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971). See also *Knecht v. Gillman*, 488 F.2d 1136 (8th Cir. 1973) (apomorphine); *Mackey v. Proconier*, 477 F.2d 877 (9th Cir. 1973) (succinylcholine).

22. No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., July 10, 1973), abstracted in 13 CRIM. L. REP. 2452 (1973).

23. *Id.*, slip opinion at 31-32.

24. E.g., Wexler, Scoville, *supra* note 4, at 88-96.

tient is voluntary. The lure of release, which might be made possible by successful psychosurgery, is so powerful that it would be virtually impossible for a patient to refuse consent.

The conclusion in *Kaimowitz* that the current level of scientific knowledge makes psychosurgery an unacceptable treatment for institutionalized patients may be sound, but the court's reasoning is unsatisfactory. Though the court was careful to confine its holding to the facts before it, its reliance on the consent concept makes it analytically difficult to distinguish *Kaimowitz* from other situations in which consent perhaps should be deemed effective.

If institutionalization leads to the deterioration of decision-making abilities and renders a patient incompetent to elect to undergo experimental psychosurgery, it would seem that same deterioration must render the person incompetent to make other important and complex decisions—to submit to other operations, to other therapies, to dispose of property, etc. But any real extension of the concept beyond the area of psychosurgery would be unacceptable because it would virtually resurrect the rule that mental patient status *per se* establishes legal incompetence—a rule which the law has been dismantling rather successfully for some time.²⁵

The *Kaimowitz* court's remarks regarding knowledge and informed consent are likewise difficult to confine logically to the facts of the case. For instance, if the risks of psychosurgery are so uncertain that a committed patient cannot render truly informed consent to the operation, informed consent should be similarly unobtainable from non-institutionalized subjects, for the risks of the experimental operation are equally unknown with respect to them. Actually, the extension of *Kaimowitz* to noninstitutionalized subjects might be a welcome development. Some will surely argue, however, that whatever the risks, nonconfined persons ought to be able to participate in psychosurgery and other experimental research, as long as they recognize the wholly speculative and perhaps irreversible nature of the venture.

Finally, *Kaimowitz's* conception of coercion is difficult to contain, and if the courts allowed its expansion, the result would be ironic indeed. Theoretically, if the carrot of release is viewed as coerc-

25. The old rule, which has fallen into disrepute, equated committability itself (not the later fact of hospitalization) with incompetence, and assumed that if a person was sufficiently mentally ill to warrant commitment, the person should also be stripped of the right to perform other legal functions. *Id.* But both the old rule and the resurrected version discussed in the text, relying on the effects of hospitalization rather than on mental status at the time of commitment, would achieve the same result—automatic incompetence—if applied to populations of involuntarily confined patients. Note that the new rule also rests on a doubtful premise in assuming that the syndrome of institutionalization will operate on confined patients immediately, rather than only after a prolonged period of hospitalization.

ing confined patients into psychosurgery, it should also be viewed as "coercing" them into electroconvulsive therapy, chemotherapy, group therapy, etc. Involuntary confinement could therefore be considered to coerce all decisions to engage in therapy. The absurdity of such an extension can be easily demonstrated by considering its application in a legal system which already widely recognizes a committed patient's right to treatment²⁶ and which is beginning to recognize as well a right *not* to be treated in the absence of consent.²⁷ If involuntary confinement itself creates coercion, administering any therapy to the patient violates his right *not* to be treated without free consent²⁸—which obviously vitiates entirely the right *to* treatment.

Surely, the courts would not extend the concept of coercion to cover more conventional types of therapy, even though the inducement to submit to such therapies may be identical to the inducement to submit to psychosurgery. What this indicates, I think, is that this area of the law, like many others, uses the concept of coercion not simply to invalidate choices made under impermissible pressure, but rather invokes the concept as camouflage when condemning choices the consequences of which are unacceptable. Choices deemed beneficial are typically sustained despite the presence of indisputable, and perhaps overwhelming, pressure to select a particular option. "Voluntary" acceptance of a program of outpatient psychiatric treatment in lieu of criminal prosecution is one clear example, as is "voluntary" agreement to comply with reasonable conditions of probation and parole. In both examples, the strong desire to avoid incarceration must overwhelmingly shape a person's decision to consent to the conditions of release; yet *precisely because those conditions are regarded as reasonable*, the consent is not legally condemned as being coerced.²⁹

26. *E.g.*, *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972).

27. See text accompanying notes 19-21 *supra*.

28. At best, therapy could be administered only with the consent of a patient's guardian. For a discussion of the *Kaimowitz* court's ruling regarding surrogate consent to psychosurgery, see note 51 *infra*.

29. Similarly, although it is axiomatic that a guilty plea must be given voluntarily in order to be binding, pleas resulting from bargains entered into in the hope of avoiding incarceration—or even death—have been upheld. *See, e.g.*, *Parker v. North Carolina*, 397 U.S. 790 (1970); *Brady v. United States*, 397 U.S. 742 (1970). Justice Brennan's combined *Parker* dissent and *Brady* concurrence, 397 U.S. at 800-12, in which he was joined by Justices Douglas and Marshall, provides an excellent analysis of voluntariness as an ambiguous and abstract legal concept. Brennan notes that "the concept has been employed to analyze a variety of pressures to surrender constitutional rights, which are not all equally coercive or obvious in their coercive effect." *Id.* at 801. As such, the concept embraces not only situations of literally overborne wills, but also "situations in which an individual, while perfectly capable of rational choice, has been confronted with factors which the government may not constitutionally inject

In light of these difficulties in applying the reasoning of *Kaimowitz*, the "coercion" holding may simply mean that psychosurgery, because it is experimental, drastic, and irreversible, with no known lasting benefits and many possible unknown side effects, is at present an inappropriate and impermissible treatment or research choice for involuntarily confined patients.³⁰ In other words, inducing involuntary patients to submit to therapy may be regarded as reasonable, but inducing them to submit to no-benefit or low-benefit high-risk experimentation is unreasonable.

If that is all the *Kaimowitz* court intended to hold, it should have been more explicit and should not have used such broad language regarding the concepts of knowledge, competency, and coercion. Actually, a careful reading of *Kaimowitz* indicates that, despite its conceptual confusion and ambiguity, its holding should *not* be read as turning on the question of competence, nor on the question of coercion by inducement of possible cure and release.

At the close of its opinion, the *Kaimowitz* court took pains to emphasize that its conclusion was based on the state of existing medical knowledge and that, if and when psychosurgery sheds its experimental status and becomes an accepted neurosurgical procedure, involuntarily confined patients might be able to consent to such a procedure.³¹ Indeed, the court specifically held that committed patients can today give adequate consent to conventional neurosurgery,³² even though the lure of release might be equally influential whether

into the decision-making process." *Id.* at 802. See also *Schneckloth v. Bustamonte*, 412 U.S. 218, 224 (1973) (voluntariness reflects a "complex of values"). *Bustamonte* also recognizes that, except in extremely rare instances, most decisions are "voluntary" in the sense of representing a choice between alternatives, even though one or both of the alternatives may be disagreeable. *Id.* at 224, and n.7. The law, however, may deem a decision involuntary when it regards the choice as an unfair or unacceptable one, such as a choice between the rack and a confession. *Id.* Perhaps the clearest example of the use of voluntariness as a notion of fairness rather than of coercion is provided by cases involving plea bargains broken by prosecutors. A plea induced by a prosecutive promise (such as to recommend leniency in sentencing) will, despite the inducement, be upheld as voluntary so long as the prosecutive promise is kept, but if the prosecutor should renege on the bargain, many courts will upset the plea on the grounds that it was involuntarily obtained. See *Santobello v. New York*, 404 U.S. 257, 266 (1971) (Douglas, J., concurring).

30. Cf. *Fortner v. Koch*, 272 Mich. 273, 261 N.W. 762 (1935).

We recognize the fact that, if the general practice of medicine and surgery is to progress, there must be a certain amount of experimentation carried on; but such experiments must be done with the knowledge and consent of the patient or those responsible for him, and must not vary too radically from the accepted method of procedure.

Id. at 282, 261 N.W. at 765 (emphasis added).

31. No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., July 10, 1973), abstracted in 13 CRIM. L. REP. 2452 (1973), slip opinion at 40.

32. *Id.*

the surgical procedure proposed be deemed conventional or experimental, and even though conventional neurosurgery is very serious and should require a rather high level of competence.

The *Kaimowitz* holding should therefore not be read as premised on the incapacity of committed patients to give legal consent to experimental psychosurgery, nor on the coercion inherent in the desire to be released from the institution, but rather on the almost total absence of knowledge about the procedure (which perhaps precludes its performance on any human subjects) or on the impropriety of inducing committed patients to submit to such a low-benefit, high-risk research procedure.³³ Although this interpretation of *Kaimowitz* may be regarded as the more reasonable,³⁴ the conceptual confusion generated by the case indicates that as the law moves steadily toward a model of consensual therapy, it will be critical that the elements of competence, knowledge and coercion be kept analytically distinct.³⁵

A careful analysis of the decision to undergo a particular procedure is especially important because the legal status of that decision may depend on whether the procedure provides some real prospect of therapeutic benefit. It may be constitutionally impermissible for a court or legislature to deny a patient access to a drastic therapeutic technique and in effect mandate continued confinement if the technique, while possibly injurious, offers a likelihood of freedom.³⁶ The re-

33. This analysis seems consistent with—and indeed perhaps helps to explain—the otherwise curious statement in *Kaimowitz* that a guardian's consent to experimental psychosurgery would be legally insufficient: "Although guardian or parental consent may be legally adequate when arising out of traditional circumstances, it is legally ineffective in the psychosurgery situation. The guardian or parent cannot do that which the patient, absent a guardian, would be legally unable to do." *Id.*, slip opinion at 26.

By prohibiting substituted judgment in the psychosurgery situation, the *Kaimowitz* court could not be relying on the legal incompetence of institutionalized patients or on the factual coercion involved in luring confined patients into treatment, for competence and factual coercion are paradigm cases of problems that can be readily overcome by the substituted judgment of a competent and detached guardian. If, however, *Kaimowitz* is simply suggesting that knowledge about psychosurgery is so wholly inadequate that a patient could not make a legally informed judgment to undergo it, then surely a guardian would be in no better position to make such a judgment. Similarly, if *Kaimowitz* is suggesting that experimental psychosurgery is a no-benefit, high-risk procedure to which patients should not be induced to submit, the preclusion of guardian consent would follow from the proposition that guardians may not subject their wards to harmful or nontherapeutic experimentation.

34. The first interpretation may be regarded as an unreasonable result for the reasons discussed earlier. See text following note 25.

35. See generally Murphy, *Incompetence and Paternalism*, in ARCHIV FÜR RECHTS-UND-SOCIALPHILOSOPHIE (to be published in late 1974 or early 1975). Just as the *Kaimowitz* court analyzes consent in terms of the constituent elements of competence, knowledge, and coercion, Murphy discusses competence (or incompetence) as a catch-all concept including elements of rationality, ignorance, and compulsion.

36. With respect to psychosurgery, the American Orthopsychiatric Association

cent Supreme Court abortion cases³⁷ suggest that certain medical decisions made by a patient in consultation with a physician may be protected from state interference, absent a compelling state interest, by a fourteenth amendment right to privacy.

In *Roe v. Wade* and *Doe v. Bolton* the physician-patient decision regarding abortion was held to be protected from noncompelling and unnecessary governmental interference, and there is ample theoretical room for extending those cases beyond the context of the decision to abort. For example, in according fundamental status to a woman's decision to terminate her pregnancy and in deeming that decision to fall within the fourteenth amendment right to privacy, the Court in *Roe* was concerned particularly with "[t]he detriment that the State would impose upon the [patient] by denying this choice altogether."³⁸ Specifically, the Court mentioned the taxing of mental and physical health and, more generally, forcing upon the person "a distressful life and future."³⁹ If considerations of detriment and distress weigh heavily in determining whether the right to privacy embraces particular physician-patient decisions, many medical procedures other than abortion ought to receive substantial protection against state interference.

Thus, if psychosurgery, despite its serious risks and severely distasteful side-effects, were also to present a real prospect of lasting and beneficial behavioral change, it might be constitutionally offensive for a state, by statute or otherwise, to preclude its performance upon a patient when the patient and his physician conclude it is the

noted:

[S]uch judicial action [precluding psychosurgery on committed patients] would *not* deny to involuntary mental patients access to a procedure which would give them a substantial chance of prompt release to the community. This would be a more difficult case if involuntarily confined patients were given a stark choice between continued confinement, on the one hand, and the likelihood of freedom with a possibility of injury, on the other. Such a choice could exist if some disease entity had been defined, and if there were a clear likelihood that psychosurgery would treat the disease, ameliorating behavior and allowing mental patients to obtain release from the institution. But this is *not* such a situation.

Brief for American Orthopsychiatric Association as Amicus Curiae at 74, *Kaimowitz v. Dep't of Mental Health*, *supra* note 19 (emphasis in original). The Association then noted—and the court agreed:

[T]he benefits of psychosurgery to the research subject are highly uncertain, *at best*. There is no assurance that any behavior changes will remain effective in the long run, thereby justifying the subject's release. Moreover, there are substantial risks of harm—both known and unknown. And these harms . . . threaten the individual's autonomy and personality, in addition to posing a danger to physical well-being and possibly causing pain.

Id. at 74-75.

37. *Roe v. Wade*, 410 U.S. 113 (1973); *Doe v. Bolton*, 410 U.S. 179 (1973).

38. 410 U.S. at 153.

39. *Id.*

most promising treatment alternative. For instance, a severely aggressive patient, confined indefinitely because of his violence and unresponsiveness to conventional and less drastic therapies, might agree with his physician that only psychosurgery might subdue his violence and gain his release. In such a situation, if the patient is willing to assume the risk of the operation and if he can be found competent to make such a decision, the state's interest in "safeguarding health and maintaining medical standards"⁴⁰ might not, on balance, be sufficiently compelling to require the patient to forego the operation and lead a distressful, violent life behind the walls of an institution. Indeed, the state seemingly has no interest in protecting a patient from even "an inherently hazardous procedure" when "it would be equally dangerous . . . to forego it,"⁴¹ and the concept of "danger" can reasonably be read to include factors—such as a distressful life and mental anguish—beyond purely physical risks.

In the mental health field, restrictions on governmental interference with voluntary treatment decisions made by physician and patient can extend well beyond the area of psychosurgery. Recently, for example, a Denver man awaiting trial on 14 counts of child molestation admitted to molesting, during his lifetime, between 400 and 500 girls under 12 years of age, and agreed to castration as the only medically feasible means of accommodating society's protective interest and his own interest in leading a productive life in his home community.⁴² The disclosure caused a stir among Colorado's psychiatric community, and the medical society was asked to conduct an ethical inquiry.⁴³ If the medical propriety of the procedure is assumed, however, attempted state regulation of it will surely raise *Roe* problems.

Roe may also be applicable to a procedure not nearly as emotionally charged as castration but perhaps equally controversial: heroin maintenance. An argument can surely be made, as was recognized but rejected by the National Commission on Marihuana and Drug Abuse,⁴⁴ that governmental interests in protecting the health of addicts and in protecting the public health and welfare are insuffi-

40. *Id.* at 154. As an original proposition, it could of course be argued that the state has no legitimate interest in safeguarding an individual's health and in protecting him from risky medical procedures, but in practice that argument has been squarely rejected—even in *Roe* itself. *Id.*

41. *Id.* at 149. Thus, even when, prior to the perfection of antiseptic techniques, abortion was considered medically hazardous and mortality rates from the operation were high, the state's interest in forbidding abortion to protect the mother gave way when pregnancy itself posed a threat to the mother's life. *Id.* at 148-49.

42. Arizona Daily Star, April 8, 1972, at 9A, col. 1.

43. *Id.*

44. NATIONAL COMMISSION ON MARIHUANA AND DRUG ABUSE, DRUG USE IN AMERICA: PROBLEM IN PERSPECTIVE 331-32 (1973).

ciently compelling to forbid heroin maintenance entirely, particularly when certain doctors and their addict-patients believe it to be appropriate.⁴⁵

From these examples, it seems clear that patients, whether committed or not, may in the future seek drastic therapies which their physicians regard as clinically warranted, and any state regulation of those therapies will be open to challenge under *Roe* as impermissible intrusions into their right to privacy. Whatever the ultimate outcome, *Roe* and its ramifications are likely to receive enormous attention in the future of mental health law.

Another area likely to receive enormous attention is the extension of the right to treatment beyond its traditional application to involuntarily confined patients.⁴⁶ While some commentators argue, as does Ralph Schwitzgebel in this Symposium,⁴⁷ for a more extensive right to treatment for committed patients, others are equally concerned with expanding the right to treatment to voluntary patients and to treatment at the community mental health center level.⁴⁸ In the context of mental health programs for the aged, Grant Morris has asked:

Should an elderly person have to be involuntarily confined in a mental institution before he can claim that he is not receiving adequate treatment? It seems senseless to so restrict the right to treatment. The voluntary aged mental patient should be accorded the right to complain of inadequate treatment as well. And what of the elderly person in a nursing home? Should he not also be entitled to complain of inadequate programs and services? And finally, what about the elderly person who still maintains his own home, or who lives with his children—does the state not owe him access to rehabilitative programs which he may want to voluntarily attend?⁴⁹

Although there is some basis for the proposition that equal protection principles may require similar treatment for voluntarily and involun-

45. A *Roe*-based challenge to narcotic maintenance prohibitions would, if successful, achieve constitutionally what some of the early Supreme Court decisions came close to holding as a matter of statutory interpretation—that doctors acting in good faith and in the course of professional practice could prescribe narcotics to addicted patients, even though the drugs were prescribed simply to relieve suffering and to maintain the patients rather than to effectuate an eventual abstinence-type cure. See *Boyd v. United States*, 271 U.S. 104 (1926); *Linder v. United States*, 268 U.S. 5 (1925).

46. See, e.g., *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972).

47. Schwitzgebel, *supra* note 9.

48. E.g., Kaplan, *Institutions and Community Mental Health: The Paradox in Wyatt v. Stickney*, 9 COMMUN. MENTAL HEALTH J. 34 (1973). Kaplan also notes, however, that given finite resources for mental health care, forcing huge expenditures to upgrade treatment at state hospitals may be inconsistent with the development of new, more effective community mental health programs.

49. Morris, *Legal Problems Involved in Implementing the Right to Treatment*, 1 BULL. AM. ACAD. OF PSYCHIATRY & THE LAW 1, 13 (1972).

tarily institutionalized patients,⁵⁰ recent Supreme Court rumblings indicate that a general right to community rehabilitative programs for voluntary mental patients will have difficulty finding a constitutional footing.⁵¹ Nonetheless, such a right may well find a legislative foun-

50. Cf. *In re Buttonow*, 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968) (involuntary patient who converts to voluntary status is entitled, on equal protection grounds, to procedures and services available to involuntary patient). To the extent that a *Buttonow* rationale makes applicable to voluntary patients those rights originally enunciated in a coercive context, voluntary patients will surely benefit from the existence of an involuntary system, for legal questions relating to the rights of patients will generally be raised in the best posture by patients confined against their will. For example, *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), the leading right to treatment case—which dictates in great detail how involuntarily committed patients must be provided with a humane psychological and physical environment, a sufficient number of qualified staff, and individualized treatment plans—would in all likelihood not have had the same outcome if the plaintiffs were voluntary patients. (If the right to treatment is viewed narrowly as a constitutional *quid pro quo* for the state's power to commit, voluntary patients could not legitimately assert such a claim. Even if the claim could be properly asserted by voluntary patients, the courts might be far less receptive to granting broad rights to patients who need not remain at the hospital if its conditions are unsatisfactory to them.) But once a case like *Wyatt* is decided, voluntary patients may, via a *Buttonow* approach, also become its beneficiaries.

One significant implication of the equal protection theory requiring roughly comparable treatment of voluntary and involuntary patients is that hospitals may be foreclosed from "conditioning" the admission or retention of voluntary patients on the patients' willingness to "waive" rights which must be provided to involuntary patients. For instance, *Wyatt* specified that all committed patients be granted comfortable beds, screens or curtains for privacy, and nutritionally adequate meals. One result of *Wyatt* is that, to the extent that beds, meals, curtains, and other items must be provided as a matter of right, they cannot be used by the hospital as rewards (reinforcers), dispensed only upon a patient's engaging in appropriate behavior. Hence, *Wyatt* will pose a substantial threat to the continued vitality of traditional "token economies"—therapeutic schemes of behavior modification that reward appropriate patient behavior with points or tokens which can later be exchanged for food, beds, screens, curtains, and the like. See generally Wexler, *Token and Taboo: Behavior Modification, Token Economies, and the Law*, 61 CALIF. L. REV. 81 (1973).

If *Wyatt* is read together with *Buttonow*, may a state hospital decide (as I have learned one is considering) to discontinue its token economy program for committed patients, but insist that certain voluntary patients either participate in such a program or leave the hospital? On the one hand, a logical equal protection argument seems to be available. On the other hand, if the hospital properly concludes that particular patients can benefit only by a token economy program, and if the patients refuse to participate in that program, how can the hospital help them, and why should they be permitted to remain at public expense? Cf. Ferleger, *Loosing the Chains: In-Hospital Civil Liberties of Mental Patients*, 13 SANTA CLARA LAW. 447, 469 (1973) (official policy of one state hospital, not always adhered to in practice, prohibits forced medication on voluntary patients, but permits giving voluntary patients the choice between cooperative medication and leaving the hospital).

51. Cf. *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1973). In *Rodriguez*, which involved a constitutional attack on the Texas scheme of financing education partly through local property taxes, the Court declined to find a fundamental constitutional right to education, seemed reluctant to recognize "implicit" constitutional rights, and stressed that the importance of a right is insufficient to accord it fundamental constitutional status, even if, as with education, the right is essential to the effective

dation, even under existing state statutes.⁵²

Obviously, many problems will arise in attempting to shape, define, and administer a statutory right to voluntary community treatment. Illustrative are some of the issues that have arisen or are likely to arise under the Arizona statutes authorizing counties to provide medical attention for the indigent sick.⁵³ This legislation has been interpreted by the courts as imposing a mandatory treatment duty on the counties,⁵⁴ by the Attorney General as imposing an obligation to treat mental as well as physical illness,⁵⁵ and by a lower court as requiring the counties to provide for the detoxification of indigent chronic alcoholics.⁵⁶

Despite this broad construction, however, the administration of the statute leaves much to be desired. For example, the counties have assumed that the statute obligates them to provide nursing home care for the indigent elderly, and many elderly patients who suffer from some form of disorientation are properly placed in nursing homes at county expense. But some patients with similar problems, though anxious to enter county nursing homes, find themselves removed from their communities and committed to the state hospital

exercise of explicitly recognized constitutional rights, such as effective freedom of expression. Because the Texas scheme did not absolutely deny anyone an education, however, the *Rodriguez* Court did not have to resolve the question whether the right to "some identifiable quantum" of education is constitutionally guaranteed. *Id.* at 36 (emphasis supplied). Further, the Court noted that, for equal protection purposes, indigency would not be viewed as a suspect classification unless, "because of their impecunty," the indigents "were completely unable to pay for some desired benefit, and as a consequence, they sustained an absolute deprivation of a meaningful opportunity to enjoy that benefit." *Id.* at 20. Because no Texas indigent was absolutely denied the benefit of an education, no suspect classification was found and the Court did not have to apply the strict "compelling state interest" test to the existing educational disparity. Under the broader "rational basis" test, the discrepant treatment was upheld.

Rodriguez should not provide much optimism to those seeking to establish a fundamental constitutional right of voluntary patients to a broad range of community mental health services. (For *involuntary* patients, community treatment may arguably be mandated pursuant to the "less drastic means" doctrine. See discussion and references in note 57 *infra*.) The right to mental health services, though obviously important (and perhaps essential to enable some patients to exercise effectively their first amendment rights) is, under most readings of *Rodriguez*, unlikely to receive recognition as implicitly constitutional in nature. Since we can expect all states to continue to make available at least a semblance of treatment for voluntary patients at state hospitals, the claim that mentally ill individuals are being wholly deprived of therapeutic attention would also probably fail.

52. *E.g.*, ARIZ. REV. STAT. ANN. §§ 11-251, -291 (Supp. 1973).

53. *Id.*

54. *Hernandez v. Yuma County*, 91 Ariz. 35, 369 P.2d 271 (1962); *Industrial Comm'n v. Navajo County*, 64 Ariz. 172, 167 P.2d 113 (1946).

55. Opinion 61-22, 1961 OP. ARIZ. ATT'Y GEN. 38.

56. *Sexton v. Pima County Bd. of Supervisors*, No. 121995 (Super. Ct. of Pima County, Ariz., Mar. 27, 1972).

because they do not meet the indigency requirements for county care and yet are unable to pay the cost of private nursing home care.⁵⁷ Further, the statute has been read as relieving the counties of responsibility for patients whose clinical conditions are serious enough to qualify them for admission to the state hospital.⁵⁸ These narrow interpretations of the statute have undermined what appeared to be a promising right to voluntary, community-based mental health care.

Controversy is also likely to arise over the definition and scope of the concept of treatment. Courts and legislatures will have to develop standards in this context just as they have done with respect to the involuntarily confined.⁵⁹ Moreover, medical and administrative views on the effective treatment of certain conditions can be expected to raise some difficult questions regarding voluntary patient status and the right to treatment. An illustration can help bring these questions into focus.

Many medical authorities hold the view that certain conditions, particularly alcoholism and drug addiction, cannot be dealt with effectively by abbreviated treatment, requiring instead a comprehensive program aimed at rehabilitation. Indeed, in the Arizona case alluded to earlier, which ordered detoxification services for indigent chronic alcoholics,⁶⁰ the defendant Board of Supervisors contended that "detoxi-

57. This problem would surely be improved by the adoption of an effective scheme of national health insurance, and it might even be assisted to some extent by the enactment of statutes imposing support obligations on relatives of the mentally ill. See Wexler, Scoville, *supra* note 4, at 80-83. The hospital commitment of patients who are clinically suitable for nursing home placement may also be found violative of the "less drastic means" rationale, which in the commitment context ought to preclude commitment when a less restrictive alternative is appropriate. *Id.* at 140-46. See *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966); Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107 (1972). Equal protection problems may also be present in the administration of the eligibility classifications. But apart from constitutional approaches, the statute itself should be read as requiring counties to provide care for those unable to afford private care, even if the patient is required to pay a *pro rata* proportion of his bill.

58. Opinion 61-22, 1961 OP. ARIZ. ATT'Y GEN. 38. Under the statute, in other words, such patients may be given the option of receiving treatment at the state hospital or not at all. Nor does the Constitution currently require that applications for state hospitalization be screened to ascertain whether less restrictive community treatment programs might be psychiatrically suitable and also preferred by the applicants. To date the "less drastic means" doctrine, discussed in note 57 *supra*, has not been applied to voluntary patients, but given the coercive elements operating in so many voluntary admissions (*see* Gilboy & Schmidt, *supra* note 14), commentators are beginning to urge the extension of the doctrine to the voluntary admission process. *See* Chambers, *supra* note 57, at 1182-84.

59. *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972) (right to treatment includes, among other things, specified ratios of treatment staff to patients); Kaplan, *supra* note 48.

60. *Sexton v. Pima County Bd. of Supervisors*, No. 121995 (Super. Ct. of Pima County, Ariz., Mar. 27, 1972).

fication of the alcoholic, absent an arrangement for a motivated and continuing program of rehabilitation, is useless,"⁶¹ and that "detoxification is just another form of revolving door, like jailing the alcoholic which is totally ineffectual, unless done in a context including motivation of the individual and long range rapport of programs, designed to bring about basic changes in the individual behavioral patterns."⁶²

While the county's strategy may be questionable,⁶³ the assertion that detoxification alone is not medical "treatment" is important. If doctors and administrators tire of providing revolving door treatment for alcoholics, addicts, and perhaps mental patients who repeatedly leave the hospital against medical advice after a brief stay,⁶⁴ they may well try to devise a scheme whereby voluntary patients will be admitted only upon condition that they remain for a specified period of time. The introduction of obligatory elements into a voluntary admission process is, however, a legally sensitive task.

If the courts reject the above medical contention and construe a statutory right to community treatment as obligating counties or local authorities to provide even short-term treatment, liability might be incurred for rejecting a patient who refused to agree to remain for a specified period.⁶⁵ But even if the courts or legislatures were to define

61. *Id.*, Defendant's Post-Trial Memorandum at 2-3.

62. *Id.* at 5.

63. If the county is statutorily obligated to provide treatment for indigent alcoholics and wants to avoid the expense and responsibility of providing such treatment, it seems unwise to argue against the need for county-provided detoxification on the ground that detoxification alone, without accompanying programs of counseling and rehabilitation, is insufficient. Such an approach might easily backfire, resulting in a county responsibility to provide both detoxification *and* counseling services.

64. Administrative concern for jamming the revolving door has also been evident in the enforcement of recent Arizona legislation aimed at the treatment of alcoholism. The legislation decriminalizes public intoxication, ARIZ. REV. STAT. ANN. § 13-379 (Supp. 1972), and provides that certain alcoholics may come or be brought to local alcoholic reception centers (LARCs), where they will be detained for approximately one day, during which they will be treated and encouraged to submit voluntarily to long-range programs of counseling and rehabilitation. See ARIZ. REV. STAT. ANN. §§ 36-2021 to -2031 (Supp. 1973). The legislation contains no provision for the involuntary commitment of alcoholics. Already, police and magistrates are expressing concern with the lack of control over the great bulk of patients who decide to leave the LARCs without follow-through treatment plans; there is much speculation that the police may begin to forego the therapeutic apprehension route and begin to hunt for criminal charges, such as disorderly conduct, to use as the basis for arresting alcoholics, hoping that criminal charges or convictions can be used as levers to increase the amount of time during which alcoholics could be subjected to treatment.

It is interesting to learn from those familiar with the LARC program in Tucson that many of the city's alcoholics are now traveling substantial distances to do their drinking in the vicinity of a LARC, since if they are apprehended near there, their chances of spending the night at the LARC—rather than in the far less attractive drunk tank of the jail—are vastly increased.

65. Liability might be incurred to a rejected patient for self-inflicted injury or to

the right to treatment as encompassing a correlative obligation on the part of a patient to remain for a given length of time, the enforcement of the patient's obligation could be exceedingly difficult, as evidenced by the troublesome federal experience in treating narcotic addicts.

The federal problems go back at least as far as 1936, when *Ex parte Lloyd*⁶⁶ was decided. *Lloyd* dealt with a congressional enactment which seemed to authorize the commission of voluntary patients to the federal facility at Lexington, Kentucky, only if the patients agreed to remain in treatment for a certain period of time.⁶⁷ While the opinion is by no means clear, the court in *Lloyd*, invoking constitutional considerations as well as canons of construction, interpreted the federal statute as not contemplating "specific enforcement" of Lloyd's promise to stay at Lexington for a specified period. It is apparent that the result was clearly contrary to congressional intent, but the statutory sacrifice can perhaps best be explained by the court's acknowledged apprehension that an opposite construction would conflict with a constitutional prohibition, presumably embodied in the due process clause, against the contracting away of liberty.⁶⁸

If a patient cannot constitutionally be compelled to abide by an

a person injured by a rejected patient. Cf. *Greenberg v. Barbour*, 322 F. Supp. 745 (E.D. Pa. 1971); Fleming & Maximov, *supra* note 1.

66. 13 F. Supp. 1005 (E.D. Ky. 1936).

67. Act of Jan. 19, 1929, ch. 82, § 12, 45 Stat. 1085, 1088, as amended 42 U.S.C. § 260(b) (1971).

68. 13 F. Supp. at 1007-09. The scope of such a prohibition, if indeed one does or should exist, and its varying application to addicts, alcoholics, minors, mental patients, and even the military (categories mentioned in *Lloyd*), are matters worthy of careful inquiry. Cf. Mill, *On Liberty*, in J.S. MILL & T. CARLYLE, *HARVARD CLASSICS* 203, 311-12 (1909) (agreement to sell oneself as a slave would be null and void). See also Feinberg, *Legal Paternalism*, 1 *CANADIAN J. PHILOSOPHY* 105 (1971).

One court has reached the same result as *Lloyd*, but by a very different—and questionable—reasoning process. In *Ex parte Romero*, 51 N.M. 201, 181 P.2d 811 (1947), a voluntary mental patient was, like *Lloyd*, ordered released prior to the expiration of the "agreed to" period of hospitalization, but the underlying theory was that *Romero*, being a mental patient, was automatically to be deemed legally incompetent and unable to contract, even with regard to matters such as hospital admission and length of treatment. *Romero*, if widely followed, would foreclose voluntary admissions and preclude consent to treatment. Modern psychology, of course, disputes the inevitability of legal incompetence accompanying the need for hospitalization, and modern statutes and cases recognize their separability. See Wexler, Scoville, *supra* note 4, at 88-96. Even with regard to patients who are legally incompetent, there is some movement to require even a lower standard of competency to agree to hospitalization and treatment, presumably to encourage voluntary processes as well as to serve other purposes. See *In re Buttonow*, 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 77 (1968) (legal capacity to contract not required of applicants for voluntary admission); Alexander & Szasz, *From Contract to Status Via Psychiatry*, 13 *SANTA CLARA LAW* 537, 552-56 (1973).

agreement to remain in treatment for a given period,⁶⁹ other legal devices must be relied upon by those seeking to jam the revolving door of ineffectual treatment. Another device was found in 1966 when, thirty years after *Lloyd*, Congress passed the Narcotic Addict Rehabilitation Act,⁷⁰ Title III⁷¹ of which deals in large part with the voluntary treatment of narcotic addicts in federal facilities. Congress decided to circumvent *Lloyd* problems⁷² by in effect converting voluntary applications for admission into legally binding involuntary commitments. When a patient makes application for voluntary treatment under Title III, he is advised that the procedure may result in his being committed to the Surgeon General for a forty-two month period of treatment (six months of which may be inpatient treatment) from which he may not voluntarily withdraw. At the same time, he is advised of his right to a judicial commitment hearing on the issue of whether he is a treatable addict, at which hearing he may be represented by retained or assigned counsel.⁷³

In practice, of course, if an addict-applicant truly desires treatment—even forty-two months' worth—he will not want an adversary hearing to give him an opportunity to prove he is *not* a treatable addict. Therefore, the applicant, upon being found a medically suitable treatment candidate, typically signs a waiver of hearing and a request for immediate commitment. Thus, the elaborate procedure designed to overcome *Lloyd's* objection to contracting away liberty actually still very much induces an explicit contracting away of liberty.

Nonetheless, the revised procedure has been upheld by the lower courts, one of which stated that “[t]he Court will not permit the petitioner to terminate his treatment simply because the road to recovery

69. Note that *Lloyd* may invalidate statutes requiring voluntary patients to give notice (usually a matter of days, but in some states a week or two) of their intention to leave the hospital. But since the purpose of such statutes is typically to insure the hospital an opportunity to institute involuntary proceedings if they are warranted, perhaps *Lloyd* would be read a bit more narrowly—as invalidating those statutes only insofar as their periods of required notice exceed a length of time reasonably necessary to set the commitment machinery in motion. Cf. *Ex parte Romero*, 51 N.M. 201, 181 P.2d 811 (1947) (voluntary patient found incompetent to agree to remain for specified period and thus ordered released, but effectiveness of discharge order deferred for two days to allow for institution of involuntary proceedings). Of course, the entire question whether an initially voluntary patient should be later held involuntarily at the instance of the hospital is a matter subject to some dispute. See Wexler, Scoville, *supra* note 4, at 8 n.22.

70. Act of Nov. 8, 1966, 80 Stat. 1438. The Act is now classified to 18 U.S.C. §§ 4251-55 (1971), 28 U.S.C. §§ 2901-05 (1971), and 42 U.S.C. §§ 3411-26 (1971).

71. 42 U.S.C. §§ 3411-26 (1971).

72. Kane, *A Legal History of the Narcotic Addict Rehabilitation Act of 1966*, in *DRUG USE IN AMERICA: PROBLEM IN PERSPECTIVE*, *supra* note 44, app. IV at 485, 500, 508 (1973).

73. 42 U.S.C. § 3413 (1971).

is bumpy."⁷⁴ Accordingly, *habeas corpus* petitioners seeking release from the program have been unsuccessful.⁷⁵

In addition to the legal issues involved in retaining unwilling patients who initially volunteered for treatment, there is some possibility of legal restrictions being placed on the forced discharge of voluntary patients. For example, in *Burchett v. Bower*,⁷⁶ a case involving a mentally ill prisoner who had been transferred, in accordance with his wishes,⁷⁷ from a prison to a state hospital, a federal district court agreed with the prisoner-patient that the hospital could not terminate his treatment and return him to prison without first giving him a hearing. The court, relying on *Goldberg v. Kelly*,⁷⁸ concluded that rudimentary due process requires at least an administrative hearing on the question of the need for continued treatment before the government can terminate so substantial a benefit as public mental health care.

The extent to which *Burchett* problems will arise in the future is difficult to determine. Most mental patients, whether on voluntary or involuntary status, can be expected to acquiesce in a hospital decision that discharge is appropriate. But there may be objections from some types of patients, particularly those few who may abuse the availability of mental health services. For example, some prisoners might prefer life in a state hospital to prison life and feign mental illness to gain admission to the hospital.⁷⁹ One observer has urged

74. *Ortega v. Rasor*, 291 F. Supp. 748, 752 (S.D. Fla. 1968). Indeed, the revised scheme has been upheld by the federal district court for the Eastern District of Kentucky—the same court that decided *Lloyd*. See *Kelly v. Rasor*, 283 F. Supp. 445 (E.D. Ky. 1968). It may be, therefore, that *Lloyd* problems can be overcome by converting voluntary admissions into "compulsory" commitments. Nevertheless, it is unclear whether such a procedure could be effectively employed with patients who, though perhaps somewhat in need of treatment, could not have been involuntarily committed pursuant to the traditional *parens patriae* or police power.

75. For technical reasons, the government has been less effective in preventing release when proceeding by contempt or criminal actions against patients who have sought release through elopement rather than *habeas corpus*. Kane, *supra* note 72, at 508. Although Title III seems to provide a criminal penalty for escapes, 42 U.S.C. § 3425 (1970), the statute has been read in one unreported case as having no applicability to patients who are civilly, rather than criminally, confined. Kane, *supra* note 72, at 506. The Department of Justice has apparently accepted that ruling and has abandoned attempts at prosecuting Title III elopers. *Id.* It seems, however, that the problem has been viewed as simply one of statutory construction, not one of constitutionality, so that statutory surgery could remedy the situation. *Id.* at 508.

76. 355 F. Supp. 1278 (D. Ariz. 1973).

77. Technically, *Burchett* had been "involuntarily" committed, but only because local law did not provide a mechanism for the voluntary hospital admission of prisoners. See generally Wexler, Scoville, *supra* note 4, at 174-88.

78. 397 U.S. 254 (1970) (prior notice and hearing required for termination of welfare benefits).

79. Note, however, that many prisoners would prefer prison to a mental hospital. The various reasons for this preference are explored in Wexler, Scoville, *supra* note 4,

that we attempt to overcome the "entitlement ethos" that pervades the medical and psychiatric services provided veterans by the Veterans Administration in order to curb the less conscious abuses attendant to those programs.⁸⁰

Hospitals will probably be sensitive to the problem of abuse and attempt to discharge those who, for whatever reason, wish to remain but are not suitable candidates for treatment. Yet, if hospitals were given the right of summary discharge, they might sweep too broadly and in some instances discharge patients who were in fact appropriate subjects for treatment. Indeed, hospitals might also be tempted to discharge patients who, though treatable, were management problems or considered otherwise undesirable.⁸¹ Perhaps *Burchett*-type procedures will provide a means of balancing these competing considerations.⁸²

These, then, are some of the issues likely to surface as the mental health legal system moves increasingly away from compulsion and toward a voluntary model of hospitalization and treatment. The current Symposium provides additional fuel for that movement, exposing and analyzing some of the important issues that will be with us for a long time to come.

at 174-88. With regard to mental hospitals, one important study has unearthed evidence to the effect that many long-term chronic patients are desirous of remaining in the hospital, and that the patients are willing and able to manipulate the staff to insure their continued residence. See B. BRAGINSKY, D. BRAGINSKY, & K. RING, *METHODS MADNESS: THE MENTAL HOSPITAL AS A LAST RESORT* (1969).

80. Burt, *supra* note 4.

81. Cf. Nasatir, *supra* note 4, at 40.

82. Note, however, that *Burchett* applies the requirement of rudimentary due process only to the *termination* stage of treatment, not to the stage of its initial denial. Nonetheless, attention should be directed toward the creation of administrative procedures to deal with eligibility.