PRESERVING THE RIGHT TO TREATMENT: A CRITICAL ASSESSMENT AND CONSTRUCTIVE DEVELOPMENT OF CONSTITUTIONAL RIGHT TO TREATMENT THEORIES

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INTRODUCTION

The plight of those who suffer from "mental illness"[1] deserves the careful attention of legal scholars. Thousands whose degree of disorder seems to call for involuntary civil commitment particularly require our ministrations.[2] Treatment is their sole prospect—aside from spontaneous remission—for cure or improvement and consequent release or enhanced institutional freedom.

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1. Despite general acceptance of the term "mental illness," there are questions such as whether *mental* problems or illnesses in fact exist. A considerable number of professionals purport to deal solely with *behavioral* maladjustments or problems in living. For an intriguing and imaginative discussion of these and related points, see Shapiro, *Therapeutic Justifications for Intervention into Mentation and Behavior*, 13 DUQ. L. REV. 673 (1975). At times, the present article will assume the validity of contentions that there are certain diagnostic categories of "mental illnesses" within which particular patients can be placed and for which certain treatments might be indicated or contraindicated. In so doing, however, the article does not embrace all such categorizations.

2. In the year 1972, state and county mental hospitals admitted 403,924 patients, of whom 169,032, or 41.8%, were involuntarily committed. Another 6,190, or 1.5%, were admitted as transferees from prisons, and 9,261, or 2.3%, were admitted after being found incompetent to stand trial. The remaining 54.4% was made up of 196,346 voluntary admissions and 23,095 nonprotesting admissions. Letter from National Institute of Mental Health to *Harvard Law Review*, Apr. 5, 1974 (enclosure A). The percentage of voluntary admissions has been rising steadily from levels which prevailed in the early 1960's. In 1961, only 23.7% of all admissions to state mental hospitals were voluntary. AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 17 (rev. ed. S. Brakel & R. Rock 1971). By the late 1960's, the percentage had risen to approximately 40%. *Id.*

Developments in the Law-Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1193 n.4 (1974) [hereinafter cited as *Developments*].

Many courts and commentators have recognized the importance of treatment to involuntarily committed persons ("patients" or "committees") and have devoted an extraordinary amount of attention to establishing a constitutional right to treatment.[3] The conceptual basis of the right is, nevertheless, in a state of disarray.

If the sound notion of a right to treatment is eventually to gain acceptance by the Supreme Court and continue to be looked upon with favor in the lower courts,[4] it must be insulated from logical assaults similar to one ventured recently by Chief Justice Burger in *O'Connor v. Donaldson*.[5] Insulation can be accomplished only by carefully examining and discarding the deficiencies of most right to treatment theories, and searching for a theory more solidly based upon logic and precedent.

To that end, this Article will demonstrate the theoretical and practical weaknesses of five right to treatment arguments which I have derived from several important mental health law cases: three so-called "quid pro quo" theories,[6] the eighth amendment/*Robinson v. California* theory,[7] and the protection from harm theory.[8] It will be demonstrated that the reasoning in those cases does not comport with proper application of constitutional standards of review and that they

3. An excellent bibliography of the extensive right to treatment literature is contained in COMMITTEE ON THE OFFICE OF ATTORNEY GENERAL, THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL, THE RIGHT TO TREATMENT IN MENTAL HEALTH LAW 83-95 (1976) [hereinafter cited as THE RIGHT TO TREATMENT].

4. The generally favorable attitude lower courts have had toward the right is documented in *id.* at 6-14.

5. 422 U.S. 563 (1975). In *Donaldson*, a recent case in which the Court limited the circumstances justifying civil commitment and at the same time surprised many by avoiding the question whether the Constitution guarantees committees a right to treatment, the Chief Justice went beyond the holding of the Court and took the opportunity to analyze the paradigm and pseudo quid pro quo theories which the Fifth Circuit had embraced below and which will be explored in text & notes 13-53 *infra*. He found them to be both internally inconsistent and at odds with precedent, all to indicate that the Fifth Circuit had incorrectly concluded that respondent possessed a right to treatment. 422 U.S. at 582-87 (Burger, C.J., concurring). Justice Burger also argued that the Court's opinion divested the Fifth Circuit decision in support of the right to treatment of all precedential value and that the Fifth Circuit's analysis had no support in prior decisions of the Supreme Court. *Id.* at 580. Ironically, the Chief Justice had years earlier embraced the quid pro quo rationale he so vigorously attacked in *Donaldson*. *See* Carter v. United States, 306 F.2d 283, 285 (D.C. Cir. 1962) (juvenile "commitment" case). Also ironically, the Court's opinion in *Donaldson* adopted, at a minimum, the least restrictive alternative standard of review which, as demonstrated in this Article, supports the right to treatment. *See* 422 U.S. at 576; text accompanying notes 112-57 *infra*. Therefore, although the Chief Justice was correct that the Fifth Circuit's analysis was erroneous, the lower court's judgment in favor of the right to treatment was supported by the standard of review adopted in the Supreme Court's unanimous opinion in which Justice Burger joined and to which he filed a concurring opinion. *See also* Morales v. Turman, 562 F.2d 993, 997-98 (5th Cir. 1977) (dictum questioning the right to treatment for juveniles, principally because of the infirmity of arguments supporting it).

6. See text accompanying notes 13-53 *infra*, where the three quid pro quo theories are discussed. Another "theory" not worthy of textual consideration is simply (literally) that the right to treatment is a fundamental right which cannot be taken by the state. *See* Note, *The Right to Treatment, Alternative Rationales*, 10 DUQ. L. REV. 626 (1972).

7. Robinson v. California, 370 U.S. 660 (1962). See text accompanying notes 56-95 *infra*.

8. See text accompanying notes 96-113 *infra*.

support at best a small or undifferentiated amount of treatment for a limited number of patients. The Article will also analyze a sixth theory—the "least restrictive alternative" right to treatment theory. Though that theory has not yet been fully developed and it rests on certain assumptions concerning constitutional standards of review which will be supported in a separate article,[9] it may well be the sole firm constitutional foundation for a comprehensive[10] right to treatment. It is based upon a proper application of constitutional standards of review, and has firm support in both logic and reasoning in prior cases which posit that the state cannot involuntarily commit persons if it can achieve its objectives through less restrictive alternatives.[11] Reliance upon and extension of those cases to require treatment once commitment is found to be justified does not mean that commitment should be too readily accepted. Rather, it demonstrates that the same principle which courts and commentators have firmly argued as calling for a careful examination of whether commitment is justified also requires treatment once commitment is found to be permissible.

9. Spece, *Justifying Invigorated Scrutiny and the Least Restrictive Alternative as a Superior Form of Intermediate Review: Civil Commitment and the Right to Treatment as a Case Study*, 21 ARIZ. L. REV. — (1978) (manuscript on file in the *Arizona Law Review* office). The least restrictive alternative theory has been mentioned in several articles. *See, e.g.*, Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1108, 1192 & n.379, 1193 (1972); Saphire, *The Civilly Committed Public Mental Patient and the Right to Aftercare*, 4 FLA. ST. U.L. REV. 232, 280-87 (1976); *Developments*, *supra* note 2, at 1245-50, 1328-29. See text accompanying notes 112-57 *infra*. So far the best exposition of the theory is found in THE RIGHT TO TREATMENT, *supra* note 3, at 46-54. For a discussion of the assumptions upon which the theory is based, see text & notes 122-24 *infra*.

10. A right to treatment is posited for virtually all civil committees, whatever the purpose of their commitment, leaving open the possibility that a negligible number might not possess such a right because it can be shown either that they simply cannot be treated or cannot be treated consistent with attainment of the state's commitment goals. See text accompanying notes 147-48 *infra*.

For a discussion of the statutory bases for the right to treatment, see THE RIGHT TO TREATMENT, *supra* note 3, at 97 app. A.

11. *See, e.g.*, Covington v. Harris, 419 F.2d 617, 623-24 (D.C. Cir. 1969) (mandatory placement within the least restrictive ward within an institution); Lake v. Cameron, 364 F.2d 657, 660 (D.C. Cir.), *cert. denied*, 382 U.S. 863 (1966) (formally relying upon statutory grounds); Halderman v. Pennhurst State School and Hospital, 446 F. Supp. 1295, 1319 (E.D. Pa. 1977) (mentally retarded have a constitutional right to minimally adequate habilitation in the least restrictive setting); Eubanks v. Clarke, 434 F. Supp. 1022, 1028 (E.D. Pa. 1977) (constitutional rights to pretransfer hearing and to placement in least restrictive setting consonant with legitimate safety, care, and treatment objectives); Dixon v. Weinberger, 405 F. Supp. 974, 979 (D.D.C. 1975) (statutory obligation to create less restrictive facilities); *In re* Jones, 338 F. Supp. 428, 429 (D.D.C. 1972) (deprivation of liberty of a dangerous patient should not go beyond what is necessary for the patient's protection); Dixon v. Attorney General, 325 F. Supp. 966, 969-70 (M.D. Pa. 1971) (consent decree); Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 165-66, 305 N.E.2d 903, 905, 350 N.Y.S.2d 889, 892 (1973) (violation of due process to subject a person to greater deprivation of personal liberty than necessary to achieve the purpose for which he is being confined). A case which is sometimes erroneously cited as directly supporting use of the principle is *In re* Anonymous, 69 Misc. 2d 181, 187-89, 329 N.Y.S.2d 542, 549-51 (Sup. Ct. 1972). It strictly relates to prohibiting placement of civil committees "not in a civil hospital, but in an institution operated by the Department of Correction . . . ." *Id.* at 184, 329 N.Y.S.2d at 546.

I. FIVE INFIRM RIGHT TO TREATMENT THEORIES

A. *Quid Pro Quo Theories: The Coup de Grace for Quid Pro Quo*

1. Three Discrete Quid Pro Quo Theories

The right to treatment had its origins in an early article by Dr. Morton Birnbaum[12] and in Judge Bazelon's opinion in *Rouse v. Cameron*.[13] Although neither Birnbaum nor Bazelon was concerned with fully articulating a constitutional basis for the right to treatment, the theoretical foundation for the right has advanced little beyond their early outlines.[14] The gist of the early comments regarding the quid pro quo rationale is that involuntarily civilly committed persons are given fewer procedural or substantive safeguards than others who are subject to forced confinement, and that treatment must be tendered as a quid pro quo or compensation for such disparity in protections.[15]

As will be demonstrated below, the quid pro quo rationale is patently erroneous.[16] "Quid pro quo" has nevertheless become a talismanic phrase which authorities invoke to replace or bolster supposed constitutional analysis. Its label has been attached even to right to treatment arguments which, although as opaque as the original quid pro quo argument, do not depend upon its curious taking/compensation logic.[17] It is useful to sort out the precise reasoning which courts have at least ostensibly used. The purpose in so doing is not to engage in sterile theoretical exercises, but to isolate and shore up weak points in cases which support the sound and important precept that committees possess a constitutional right to treatment.

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12. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

13. 373 F.2d 451 (D.C. Cir. 1966). In this landmark case, Judge Bazelon found a statutory right to treatment for certain committees. He also outlined several possible constitutional theories, each resting essentially on the quid pro quo rationale discussed in the text. *See id.* at 452-53. For a tracing of the origins of the right, see THE RIGHT TO TREATMENT, *supra* note 3, at 1-10.

14. Dr. Birnbaum, who is also an attorney, spoke mainly in his role as a medical professional. *See* Birnbaum, *supra* note 12. Judge Bazelon, in dictum, merely suggested the broad outlines of possible constitutional bases for the right. *See* 373 F.2d at 452-53.

15. An examination of each of the five theories suggested in *Rouse* reveals this basic rationale; each argument differs only in the particular safeguard(s) which are the *quo* for which a *quid* must be paid. Judge Bazelon suggested due process and equal protection theories based on the absence of procedural protections, similar arguments grounded on the lack of a definite term of confinement, and an eighth amendment rationale founded on nonexistence of criminal responsibility. The theories are summarized in Spece, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 SO. CAL. L. REV. 616, 641-42, 644-45 (1972). Judge Bazelon did not place the label quid pro quo on his arguments. This moniker was attached to the taking/compensation reasoning espoused in *Rouse* by Judge Wisdom in *Donaldson v. O'Connor*, 493 F.2d 507, 522 n.21 (5th Cir. 1974), *vacated on other grounds and remanded*, 422 U.S. 563 (1975) (rejecting *Rouse's* procedural quid pro quo theory). The label had been mentioned earlier. *See* Goodman, *Right to Treatment: Responsibility of the Courts*, 57 GEO. L.J. 680, 689-90 (1969); Kittrie, *Can the Right to Treatment Remedy the Ills of the Juvenile Process?*, 57 GEO. L.J. 848, 870 (1969).

16. See text accompanying notes 19-35 *infra*.

17. For discussion of a pseudo quid pro quo theory and cases adopting it, see text accompanying notes 40-54 *infra*.

2. The Paradigm Quid Pro Quo Theory[18]

The quid pro quo theory is most often formulated as it was by the Fifth Circuit in *Donaldson v. O'Connor*,[19] and the reasoning adopted

18. The paradigm quid pro quo theory is an amalgam of five separate theories suggested in *Rouse*. These theories are based upon either due process, equal protection, or the eighth amendment, and are dependent upon the absence of either procedural protections, limited confinement, or criminal responsibility. See discussion note 15 *supra*. The paradigm quid pro quo theory depends on each of the three disparities. See text & notes 22-25 *infra*. It has been articulated as founded upon due process, *see* Donaldson v. O'Connor, 493 F.2d 507, 521-22 (5th Cir. 1974), *vacated on other grounds and remanded*, 422 U.S. 563 (1975); Gary W. v. Louisiana, 437 F. Supp. 1209, 1216 (E.D. La. 1976), but since it emphasizes disparities between protections afforded criminals and committees, it would rest more comfortably upon equal protection. Therefore, it appears in the text of this Article as depending upon either due process or equal protection. Because it has been given independent attention in the authorities, the procedural quid pro quo theory, which is the progeny of the procedural ones suggested in *Rouse*, receives separate attention. See text & notes 36-39 *infra*. The due process/equal protection rationale mentioned in *Rouse* as resting upon absence of limited duration of confinement is also a theoretically separate quid pro quo argument. It is subject to the same criticisms as the paradigm and procedural quid pro quo theories.

19. 493 F.2d 507, 520-25 (5th Cir. 1974), *vacated on other grounds and remanded*, 422 U.S. 563 (1975). Although the vacation and remand of the case leave its precedential authority in question, particularly in light of the Chief Justice's comments in his concurring opinion, see discussion note 5 *supra*, *Donaldson* remains a landmark case which is of interest to mental health law scholars. It rests on both the paradigm theory discussed at this point and the pseudo quid pro quo theory, see text accompanying notes 40-55 *infra*. The paradigm quid pro quo theory was also relied upon in Gary W. v. Louisiana, 437 F. Supp. 1209, 1216-18 (E.D. La. 1976). The court gave supplemental reasons for its order, revoking its earlier reliance upon the quid pro quo theory because of Justice Burger's criticisms of it in *Donaldson*. *Id.* at 1222. It mentioned the least restrictive alternative as a standard to judge the necessary geographical setting of plaintiffs' treatment, but not as a source for the right to treatment. *Id.* at 1223. Therefore, when the court revoked its reliance on the quid pro quo theory, it left its holding in support of treatment without foundation. The court should have employed the least restrictive alternative principle to determine the obligation to provide treatment as well as its geographical setting. See text accompanying notes 114-34 *infra*. *Gary W.* was cited with approval in Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295, 1318-19 (E.D. Pa. 1977), where the court used the reasoning in *Gary W.* and the pseudo quid pro quo and eighth amendment/*Robinson v. California* right to treatment theories, see text accompanying notes 40-95 *infra*. The *Pennhurst* Court also endorsed the protection from harm theory, see text accompanying notes 96-113 *infra*, but while discussing *physical* abuse. *Id.* at 1320-21. In addition, citing Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania, 343 F. Supp. 279 (E.D. Pa. 1972), the court hinted at the outlines of still another novel right to treatment theory: training and education of the mentally retarded in institutions, or at least certain institutions, is separate and therefore inherently unequal. *Id.* at 1321-22. Yet, the underlying premise of the decision is that the mentally retarded must be given training and education suited to their unique needs, i.e., that literally equal training and education would be inherently unequal. Such might be true, but only pursuant to proper justification and use of an invigorated constitutional standard of review. Compare the discussion in text and note 36 *infra*. The *Pennhurst* court did hint at the justification and use of invigorated scrutiny: "All admissions to state facilities. . . entail an infringement on fundamental rights and freedoms. Because of this, due process demands that if a state undertakes the habilitation of a retarded person, it must do so in the least restrictive setting. . . ." *Id.* at 1319 (cite omitted). Such a cryptic reference is not, however, likely to be successful in light of the United States Supreme Court's decision in Campbell v. Kruse, 434 U.S. 808 (1977). There, the Court vacated a district court judgment that Virginia's limited tuition grant system for handicapped children was irrational and constituted a denial of equal protection. The Court remanded and directed the district court to decide the case on the basis of the Federal Rehabilitation Act of 1973, citing to Westby v. Doe, 433 U.S. 901 (1977). In the latter case, the Court vacated and remanded a district court judgment that South Dakota could not, consistent with the Social Security Act of 1935 and the United States Constitution, fund only medical aid for full term deliveries and therapeutic abortions as opposed to nontherapeutic abortions. The Court cited to Beal v. Doe, 432 U.S. 438 (1977), and Maher v. Roe, 432 U.S. 464 (1977), in which it upheld such limited funding of pregnancy-related medical services on statutory and constitutional grounds, respectively. *See also* Morgan v. Sprout, 432 F. Supp. 1130, 1135-36 (S.D. Miss. 1977) (employing the paradigm and pseudo quid pro quo theories to create a

there can therefore be described as the paradigm quid pro quo theory. Under this theory there are at least four distinct and possibly constitutional purposes of involuntary civil commitment: (1) protection of others; (2) protection of the committee from actively self-inflicted harm; (3) protection of the committee from passively self-inflicted harm; and (4) provision of treatment to the committee.[20] The civilly committed are often confined for one or more of the above purposes without three necessary conditions to confinement which protect criminal defendants: (1) strict procedural safeguards; (2) the requirement of an offense for which retribution is due;[21] and (3) a limited duration of confinement.[22] If, for any of the above four purposes, one is civilly committed without each of the three protections provided criminal defendants, then, as a matter of due process or equal protection, he must be given the quid pro quo of treatment to compensate him for those disparities. Conversely and by implication, if he is given any one[23] of

right to treatment for a 16-year old adjudicated delinquent). For discussion of the quid pro quo theory, see Goodman, *supra* note 15, at 668; Kittrie, *supra* note 15, at 870, 882; Note, *Constitutional Law—Mental Health—A Patient Involuntarily Civilly Committed to a State Mental Hospital Has a Constitutional Right to Treatment*, 20 VILL. L. REV. 214, 222 (1974). Even after the Chief Justice's concurrence in *Donaldson*, commentators accept the viability of the quid pro quo theory. *See, e.g.*, Note, *O'Connor v. Donaldson: The Supreme Court Sidesteps the Right to Treatment*, 13 CAL. W.L. REV. 168, 180-81 (1976); Comment, *O'Connor v. Donaldson: The Death of the Quid Pro Quo Argument for a Right to Treatment?*, 24 CLEV. ST. L. REV. 557, 570-71 (1975); *Behavior Modification: Manipulation or Treatment?*, 3 LAW & BEHAVIOR 6 (1978).

20. *See* Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974) *vacated on other grounds and remanded*, 422 U.S. 536 (1975). See discussion note 28 *infra*, which points out that most recent cases invoke a strict standard of review and limit commitment to cases of active or passive danger to self or others. Protection of others, just as protection of the committee, might be broken into protection from active and passive danger. However, those in the mental health law field have not made that distinction, apparently for the reason that the state cannot commit persons to prevent the dangers they might present to others simply by being mentally ill. Such "dangers" would include psychological harm which might be caused to relatives because of the presence of their afflicted kin. This raises the question whether psychological harm caused by affirmative actions or threats might justify commitment. Compare ARIZ. REV. STAT. ANN. § 36-501(3) (requiring physical harm) with Cross v. Harris, 418 F.2d 1095, 1108-10 (D.C. Cir. 1969) (Burger, J., dissenting in part) (noting that dangerousness could include psychic trauma to others).

21. At this point one might expect the word "punishment" instead of "retribution," the latter connoting only one of several purposes of punishing offenses. *Donaldson* uses "retribution," however, perhaps either equating it with "punishment" or assuming it is one purpose always associated with punishment. 493 F.2d at 522. The latter finds support in H.L.A. Hart's view that some notion of individual desert, which might be captured by the term "retribution," is almost always part of the justification of punishment. Even utilitarians would presumably not generally accept the distribution of punishment to individuals in specific cases without some notion of desert. *See* H.L.A. HART, PUNISHMENT AND RESPONSIBILITY 81-83 (1968).

22. In *Donaldson*, 422 U.S. 563 (1975), Justice Burger attacked the quid pro quo theory by observing that even criminals are not always given definite sentences. *Id.* at 586 n.7. That attack is, however, a weak one because although some criminals are given indeterminate life sentences, the vast majority of them have some maximum term of confinement. An identifiable maximum duration to confinement, rather than a definite period of confinement, seems to be the important element.

23. It would be reasonable to assume that, within the logic of the quid pro quo rationale, a patient would be owed the compensation of treatment unless he were given all three of the criminal protections. The theory does consider the absence of each of the three to be significant, and thus suggests that each is owed to the patient and must be paid for if taken. The theory provides, however, that the compensation of treatment is due only if all three of the protections are taken.

the three criminal protections, he need not be given treatment because no compensation or quid pro quo is due.

What follows is a fairly elaborate analysis of the theory. The hardy reader who goes through it might feel that this analytical effort is supererogatory. However, despite obvious criticisms such as those outlined by Justice Burger in his concurring opinion in *Donaldson*,[24] the paradigm quid pro quo theory has proven to be refractory. The purpose here is to discourage its further use as it is a weak foundation for the right to treatment.

a. *The Erroneous Notion that Liberty can be Condemned*

Though there are at best a handful of virtually indisputable principles of constitutional adjudication, it is revealing that *Donaldson*'s paradigm quid pro quo theory fails to comport with one of them: government action which intrudes upon individual rights or which treats similarly situated persons in different ways can be justified only if it is properly related to the advancement of some valid state interest.[25] The quid pro quo rationale, however, does not even ask whether

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As developed in the text accompanying note 29 *infra*, this suggests an analogy to eminent domain cases which turn on the degree of a person's interests which are "taken."

24. See discussion note 5 *supra*.

25. *See* Jackson v. Indiana, 406 U.S. 715, 738 (1972). In *Donaldson*, the Fifth Circuit characterized the proposition in the text as "fundamental, and all but universally accepted . . . ." 493 F.2d at 520. The nature of the relation between the government's action and its goals is usually examined under the rational basis test. Although there is considerable scholarly dispute concerning the precise nature of that test, it generally requires one questioning government action to demonstrate that the state does not have a legitimate interest which can reasonably be presumed to be advanced by the action in question. *See* Gunther, *The Supreme Court, 1971 Term—Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 20-21 (1972); Linde, *Due Process of Lawmaking*, 55 NEB. L. REV. 197, 204-05 (1976) (discussing the test and arguing that the due process clause ought not to be read to require a telic relationship between the state's ends and means). There are at least four purposes for involuntary civil commitment that clearly qualify as legitimate, if not compelling, state interests: (1) to protect others from the dangerous committee; (2) to protect the committee from actively self-inflicted injury; (3) to protect the committee from passively harming himself; and (4) to provide needed treatment. *See Developments, supra* note 2, at 1223; *Legal Issues in State Mental Health Care: Proposals for Change—Civil Commitment*, 2 MENTAL DISABILITY L. REP. 73, 80-81 (1977).

When government action intrudes on certain fundamental individual rights, however, the compelling state interest test is invoked. *See* Shapiro v. Thompson, 394 U.S. 618, 634 (1969) (striking down residency requirements for welfare benefits which interferred with or penalized the fundamental right to travel interstate). A necessary requirement of this standard of review is that the state's interest be "compelling," the precise definition of which is the subject of considerable debate. *See* Note, *Of Interests Fundamental and Compelling: The Emerging Constitutional Balance*, 57 B.U.L. REV. 462 (1977). It is clear, at least, that this test is both rarely applied and difficult to meet. *See* Roe v. Wade, 410 U.S. 113, 174-75 (1973) (Rehnquist, J., dissenting). Courts are not in agreement concerning which test should be applied to involuntary civil commitment. Most recent decisions, however, have applied the stricter standard. *See, e.g.*, Suzuki v. Alba, 438 F. Supp. 1106, 1110 (D. Hawaii 1977) (striking down commitment statute failing to require recent act, attempt, or threat of imminent and substantial physical danger); Doremus v. Farrell, 407 F. Supp. 509, 514 (D. Neb. 1975) (applying compelling state interest test and requiring active or passive danger to self or others, as opposed to providing treatment, as prerequisites to commitment); Bell v. Wayne County Gen. Hosp., 384 F. Supp. 378, 390 (M.D. Ala. 1974) (same); Lessard v. Schmidt, 349 F. Supp. 1078, 1093-94 (E.D. Wis. 1972), *vacated on procedural grounds and remanded*, 414

there is a proper state interest advanced by confining a person or by confining him with fewer protections than are given others. A sound constitutional theory, including one supporting treatment for committees, must provide instructions regarding when an initial deprivation is permissible. But the quid pro quo rationale does not provide any such instructions.

Instead, the quid pro quo argument assumes that all persons are entitled to liberty unless they (1) have been given strict procedural safeguards, (2) have committed an offense for which retribution is due, and[26] (3) have been promised a limited or definite duration of confinement. That is the only reasonable explanation of the theory, for if civil committees are not, in the first instance, owed protections similar to those provided to criminal confinees, the lack of such protections would be irrelevant in triggering an obligation to provide the quid pro quo of treatment.

The paradigm quid pro quo theory does not recognize and attempt to justify either the denial of these "criminal protections" or the massive deprivation of liberty entailed in civil commitment by alluding to proper state goals and means which might independently support the deprivations. For example, it does not recognize that civil committees might arguably be committed pursuant to a standard different from the criminal "beyond a reasonable doubt" test simply because of the implausibility of applying the more onerous test in civil commitment cases.[27] In addition, it does not allow for the argument that the massive deprivation of liberty entailed in commitment is arguably justified simply by important state goals such as protecting society or the committee from his dangerous propensities. Instead, the paradigm quid pro quo theory assumes that civil commitment, as it is distinguished from criminal confinement, is basically an unjustified practice which can be tolerated only if the state "atones" by providing the quid pro quo or compensation of treatment.

U.S. 473 (1974) (reading commitment statute requiring imminent danger to constitute the necessary compelling state interest); *In re* Levias, 83 Wash. 2d 253, 256-58, 517 P.2d 588, 591 (1973) (applying compelling state interest test and requiring active or passive danger to self or others, as opposed to necessity of treatment, as prerequisites to commitment); State *ex rel.* Hawks v. Lazaro, — W. Va. —, —, 202 S.E.2d 109, 123-24 (1974) (same).

26. See discussion note 25 *supra*.

27. For discussion of what standard of proof ought to or can plausibly be used in commitment proceedings, see, *e.g.*, United States *ex rel.* Stachulak v. Coughlin, 520 F.2d 931, 935-37 (7th Cir. 1975); *In re* Ballay, 482 F.2d 648, 653-69 (D.C. Cir. 1973); Suzuki v. Quisenberry, 411 F. Supp. 1113, 1132 (D. Hawaii 1976); Lynch v. Baxley, 386 F. Supp. 378, 393 (M.D. Ala. 1973); Lessard v. Schmidt, 349 F. Supp. 1078, 1094-95 (E.D. Wis. 1972), *vacated on procedural grounds and remanded*, 414 U.S. 473 (1974); Myerson v. Hagberg, — Mass. App. Ct. —, —, Civ. No. 179 (Mass. App. Ct., filed Dec. 8, 1976), explained in 2 MENTAL DISABILITY L.R. 7 (July-Aug. 1977); State *ex rel.* Hawks v. Lazaro, — W. Va. —, —, 202 S.E.2d 109, 126-27 (1974).

The analogy between such a theory and eminent domain is both clear and unsettling. If it is permissible for the state to "condemn" a person's rights to freedom from confinement, and to certain procedural and substantive safeguards which insulate him from arbitrary restraint, by giving the "just" compensation of treatment, it could presumably just as well compensate him with money instead of treatment.[28] Indeed, the theory is wholly consistent with the proposition that the state could abrogate any civil liberty if it were willing to pay enough!

One can also ask: Why must the state tender the compensation of treatment only when it takes three, as opposed to one or two, of a civil committee's rights? The theory, as it is literally stated, depends upon each of the three disparities between civil and criminal confinement as necessary conditions to the obligation to provide treatment. Perhaps some analogy has been drawn to those eminent domain cases which hold that there is only a "taking," and thus a duty to provide just compensation, when there has been a substantial intrusion upon rights.[29] This is not an insignificant point because in many jurisdictions strict procedural safeguards or limited duration of confinement *are* among the protections afforded civil committees.[30] Similarly, certain patients have committed criminal acts.[31] Would the paradigm quid pro quo theory create a right to treatment in jurisdictions which guarantee strict procedural safeguards or limited terms of confinement? Would it establish such a right for those who have committed criminal acts? The logic of the theory ("when the three central limitations . . . are absent")

28. The illusory nature of the compensation posited by the paradigm quid pro quo theory is best illustrated by reference to commitments based upon the need for treatment rationale. Applied to such commitments, the theory would reason that the state need not determine with strict procedural safeguards whether an individual is in need of treatment because it tenders to him the quid pro quo of treatment. That is begging the question at its best, as was recognized in Spece, *supra* note 15, at 642-43. The theory is also inconsistent with the Supreme Court's admonition that one cannot justify the absence of strict procedural safeguards by some vague promise of rehabilitative confinement. *See In re* Gault, 387 U.S. 1, 17-24 (1967).

29. *See* Pennsylvania Coal Co. v. Mahon, 260 U.S. 393, 413 (1922).

30. *See* R. ROCK, M. JACOBSON, & R. JANOPUAL, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 16-21 (development of stricter procedural protections), 47-53 (duration of commitment) (1968).

31. One example is the patient who has been charged with a crime, found not guilty by reason of insanity, and then committed. Others found in the *Mental Disability Law Reporter* subject matter index are some of those incompetent to stand trial, sexual psychopaths, psychopathic offenders, defective delinquents, transferees from penal institutions, and mentally retarded offenders. 1 MENTAL DISABILITY L. REP. 7-8 (July/Aug. 1976). *See also* W. Hickey, CIVIL COMMITMENT OF SPECIAL CATEGORIES OF OFFENDERS (1971); D. Wexler, CRIMINAL COMMITMENTS AND DANGEROUS MENTAL PATIENTS— LEGAL ISSUES OF CONFINEMENT, TREATMENT, AND RELEASE 38-56 (1976) *reviewed at* 19 ARIZ. L. REV. 435 (1977). At least some of these patients might be deserving of at least a trace of retribution because of their possible association with what would be, absent their disability, criminal conduct. Indeed, transferees from prison have been found guilty of such conduct. Ironically, although its logic would not support a right to treatment for those who committed criminal acts, the *Donaldson* court indicated that it would extend a right to treatment to such persons. 493 F.2d at 524-25.

would, ironically, indicate a negative answer.[32]

In summary, the paradigm quid pro quo theory creates a right to treatment for all patients, irrespective of the purpose of their commitment, but, ironically, only if they have not committed a criminal act and they are "fortunate enough" to have been committed in a state which does not provide either strict procedural safeguards or limited terms of confinement.

b. *The Erroneous Notions that Differences in Criminal and Civil Confinement Automatically Assume Constitutional Significance and that All Patients Must Automatically Be Treated the Same Irrespective of the Purpose of Their Commitment*

Conversely, the paradigm quid pro quo theory is infirm as it assumes that all committees who are denied all three criminal protections automatically have a right to treatment, and does not ask whether there are justifications for the state's disparate treatment of civil and criminal confinees. And, under the presumptively applicable rational basis test which must apply in the absence of any statement to the contrary,[33] one does not have to squint hard to espy such justifications.

Consider the commitment, for example, of a person who, due to mental illness, is supposedly passively dangerous to self. It would be unsound to criticize the commitment of such a person as wholly irrational by pointing out that he had not committed an offense for which retribution was appropriate. Furthermore, it is difficult to call irrational the reasoning that this patient should be confined not for a definite period, but until some indefinite time in the future when he is able to live safely outside an institution.[34] Finally, although there is much

32. *Id.* at 522. Such a result would be anomalous because courts or legislatures in jurisdictions which have established strict procedural safeguards and limited terms of commitment have done so out of deference to the important personal interests trammeled by commitment. It would also be at odds with the Supreme Court's holding in Jackson v. Indiana, 406 U.S. 715, 729-30 (1972), forbidding disparities in protections accorded committees based solely upon the commission of a criminal act and establishing some durational limit (the duration of commitment must bear a reasonable relationship to its purpose) as an independent constitutional requirement. Because courts are usually more generous in extending procedural as opposed to substantive rights, it would be especially odd to deny a right to treatment only in jurisdictions where strict procedurals safeguards have not been afforded to civil committees. Perhaps nowhere is this preference for procedure more marked than in the criminal law. There seems to be a de facto reverse quid pro quo rationale in the criminal context which "justifies" virtual total deprivation of substantive rights by extending strict procedural safeguards. *See* Singer, *Sending Men to Prison: Constitutional Aspects of the Burden of Proof and the Doctrine of the Least Drastic Alternative as Applied to Sentencing Determinations*, 58 CORNELL L. REV. 51, 51-55 (1972), regarding the substantive plight of prisoners.

33. See note 25 *supra* for a discussion of the rational basis test. Since the test is commonly used, it can be fairly said to be the presumptively applicable one. Moreover, its common use is more than historical accident; it embodies a principle of deference to political decisionmaking which is an accepted part of our constitutional system. For a recent discussion of the principle, see Bishin, *Judicial Review in Democratic Theory*, 50 So. CAL. L. REV. 1099 (1977).

34. *But see Developments, supra* note 2, at 1382, which argues that the due process require-

controversy about the procedural protections which should be accorded to civil committees, it is not irrational to assume that a full-blown "criminal-like" trial might be disadvantageous to our hypothetical committee or that criminal standards of proof simply could not be applied to the complex questions presented concerning his dangerousness.[35]

Just as the paradigm quid pro quo theory ignores possible explanations for treating criminal and civil confinees differently, it overlooks justifications, under the presumptively applicable rational basis test, for rationally treating varying classes of civil committees in different ways. It posits that all patients deprived of the three criminal protections must be given treatment irrespective of the purpose of their commitment. However, treatment is not, in principle, necessary to achieve the purposes or goals behind commitments for protection from active or passive danger to self or others.[36]

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ment of a reasonable connection between the purpose and duration of confinement mandates limited terms of commitment. That authority de facto applies a rigorous due process test. The argument would be stronger if it explicitly adopted invigorated scrutiny and reasoned that limited terms of confinement are required because only then would the state's commitment goals be compelling (compelling connoting a balancing of state and individual interests) or its means the least restrictive. *Cf.* Fasulo v. Arafeh, 173 Conn. 473, 479-83, 378 A.2d 553, 556 (1977) (procedural due process under state constitution requires periodic judicial review of involuntary civil commitments).

35. See cases cited note 27 *supra* for a discussion regarding the appropriate standard of proof. For a discussion of the possible anti-therapeutic thrust of strict commitment procedures, see *Special Project—The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 69-73 (1971). A less deferential balancing test might be used to settle these procedural due process questions. *See* Thorn v. Superior Court, 1 Cal. 3d 666, 673-76, 464 P.2d 56, 61-63, 83 Cal. Rptr. 600, 605-07 (1970) (discussing procedures necessary to protect rights of incompetent inmates); Fasulo v. Arafeh, 173 Conn. 473, 475-80, 378 A.2d 553, 554-56 (1977) (requiring periodic judicial review of involuntary civil commitment). Even such a balancing test might support limited procedural protections because of the suggested therapeutic and administrative problems which strict procedures might create.

36. Protection can at least theoretically be achieved solely by confinement, supervision, and restraint. This Article contends that, under the least restrictive alternative rationale, a right to treatment is possessed by all committees for whom treatment might hasten release or enhance freedom within the institution. This contention rests, however, upon an invigorated standard of review which requires more than mere rationality to justify the massive deprivation of liberty which virtually defines forced institutionalization. Those who use the quid pro quo theory do not purport to justify the use of an invigorated standard of review or to apply such a standard to create a right to treatment. There is virtually no mention of invigorated scrutiny in the cited quid pro quo cases, *see* discussion in note 19 *supra*. One could perhaps stretch the theory to require treatment for those committed for purposes other than need for treatment by invoking a strict standard of review which would require a very precise connection between the state's goals (such as protecting others) and means (confinement). It could then perhaps be established that the state could better or only adequately further its goal of alleviating danger by committing *and* providing treatment for the malady which might cause the danger. Confinement alone might, for example, leave others within the institution unprotected. As explained in the text accompanying notes 40-54 *infra*, the pseudo quid pro quo theory rests upon a less rigorous standard of review which only requires a reasonable connection between the state's means and goals. A more rigorous standard might require a substantial connection. Confinement seems, however, to substantially, if not maximally, alleviate danger. Even those within the institution can be protected from a dangerous patient by his more secure confinement.

It might be suggested that a finding that confinement with treatment would better or more substantially further the goal of alleviating danger would suffice. Even the vigorous compelling state interest test, however, has not been formulated to require the state to use the best possible

3. The Procedural Quid Pro Quo Theory

The procedural quid pro quo theory was first suggested in *Rouse v. Cameron*.[37] It is substantially identical to the paradigm quid pro quo theory except that it rests solely on the absence of strict procedural protections without regard to lack of an offense or limited duration of confinement. Since it differs from the paradigm quid pro quo argument only in the latter respect, both theories are infirm for the same reasons.[38] The apparent allure of the procedural quid pro quo theory is the erroneous notion that it is based upon procedural due process. The paradigm quid pro quo theory has been criticized for being inconsistent with the presumptively applicable rational basis test and for not resting on proper justification and use of an invigorated form of substantive review.[39] If the theory were to rest on procedural due process, those criticisms relating to substantive review would lose their force.[40] The irony is that the procedural quid pro quo theory does not depend upon procedural due process but instead rests upon the *denial* of it.[41] It is specifically inconsistent with the Supreme Court's indication that the state cannot justify denial of strict procedural safeguards with a vague promise of treatment or rehabilitation.[42]

4. The Pseudo or False Quid Pro Quo Theory

The pseudo or false quid pro quo theory is so named because the cases which espouse it invoke the talisman of quid pro quo even though

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means. The least restrictive alternative theory developed in this Article is superior to the theory suggested in this footnote because it rests upon the well-established principle of minimizing intrusions upon individual rights rather than a controversial requirement that the state use the best possible means. It is also stronger as it requires treatment to minimize intrusions upon liberty rather than to maximize state protective goals.

It might be asked at this point why the text even speaks of treating the dangerous. It is not to suggest a medical model to deal with all deviant behavior. The only argument is that those committed because they are mentally ill and dangerous have a right to demand, but generally not an obligation to accept, treatment. This Article takes no position regarding those few persons who might be committed under provisions in statutes in the state or two which allow confinement without a finding of "mental illness." It also takes no position regarding the constitutionality of such provisions. For a discussion of these points, see Shapiro, *supra* note 1, at 761-79.

37. 373 F.2d 451, 453 (D.C. Cir. 1966). The procedural quid pro quo argument was followed in the juvenile context in Inmates of Boy's Training School v. Affleck, 346 F. Supp. 1354, 1368 (D.R.I. 1972). It was expressly rejected, however, in both Donaldson v. O'Connor, 493 F.2d 507, 522 n.21 (5th Cir. 1974), *vacated on other grounds and remanded*, 422 U.S. 563 (1975) and Welsch v. Likins, 373 F. Supp. 487, 496 (D. Minn. 1974).

38. The procedural quid pro quo theory does not suggest, however, as does the paradigm argument, the curious notion of compensation being owed only if a sufficient number of protections are taken; the taking of procedural protections alone is sufficient. Ironically, although the procedural quid pro quo theory is infirm for the same reasons as the paradigm quid pro quo rationale, the *Donaldson* court explicitly rejected the former while embracing the latter. 493 F.2d at 522 & n.21.

39. See text accompanying notes 25-28 *supra*.

40. It would still be assailable, however, for not explicitly invoking procedural due process and its balancing notions. See discussion note 34 *supra*.

41. *See* Spece, *supra* note 15, at 641-44.

42. *In re* Gault, 387 U.S. 1, 22 n.30 (1967).

it does not depend on the taking/compensation rationale of the paradigm and procedural quid pro quo arguments.[43] Under this theory also there are at least four distinct and possibly constitutional purposes of involuntary civil commitment: (1) protection of others; (2) protection of the committee from actively self-inflicted harm; (3) protection of the committee from passively self-inflicted harm; and (4) provision of treatment to the committee.[44] If one is committed for the fourth purpose above, he must be given treatment because due process demands that the nature of confinement must, at a minimum, bear some reasonable relationship to the purpose thereof.

If properly cabined, the theory is a strong one. It rests on the notion, formulated by the Supreme Court in *Jackson v. Indiana*[45] and carried forward in *Donaldson*,[46] that the nature of confinement must bear some reasonable relationship to its purpose. It is also compatible with the unquestionable principle of constitutional judicial review mentioned above: government action (commitment) intruding upon individual rights (not to be confined or not to be confined on a basis different from others) must be justified by advancement of valid state interests (protection from danger to self or others or providing treatment).[47] Inasmuch as the theory is, in principle, a strong one, it is important to discover how far it properly extends. And, since the theory is only as good as its application, it is critical to limit it to appropriate cases.

Because it rests on the notion that the state must treat *if it commits for that purpose*, the theory can only properly extend to those committed as in need of treatment. Many persons are committed for reasons distinct from treatment: protection of others and protection of self from active and passive danger. Those purposes can at least in principle be

43. As explained in the text accompanying notes 47-54 *infra*, the pseudo quid pro quo theory was used in Wyatt v. Stickney, 325 F. Supp. 781, *enforced*, 334 F. Supp. 1341 (1971), *supplemented*, 344 F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part, rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974), and Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), *vacated on other grounds and remanded*, 422 U.S. 563 (1975). The *Wyatt* court mentioned that most of the plaintiffs had been denied "criminal protections," invoked the talisman of quid pro quo, and then went on to develop the pseudo quid pro quo reasoning. 325 F. Supp. at 784. The *Donaldson* court indirectly attached the label of quid pro quo to the pseudo quid pro quo theory by describing the latter as the first part of a comprehensive two-part due process right to treatment theory; the talisman of quid pro quo was explicitly invoked in discussing the second part of the comprehensive theory—the paradigm quid pro quo theory. 493 F.2d at 521-22. *See also* Gary W. v. Louisiana, 437 F. Supp. 1209, 1216-18 (E.D. La. 1976); Morgan v. Sprout, 432 F. Supp. 1130, 1135-36 (S.D. Miss. 1977) discussed in note 19 *supra*.

44. See notes 20 & 25 *supra*.

45. 406 U.S. 715, 738 (1972).

46. 422 U.S. at 574-76 (1975). The Court indicated that commitment must cease when the condition requiring it ends and indicated that the nondangerous cannot be confined "without more"; the latter comment was probably a reference to treatment, and suggests that commitment of the nondangerous might bear a proper relationship to its purpose if treatment is the goal and it is actually provided. *Id.* at 576.

47. See text & notes 25 & 33 *supra*.

achieved *without* treatment.[48] Therefore, commitment without treatment bears a reasonable relationship to those purposes.

In short, the pseudo quid pro quo theory is unassailable insofar as it applies to those committed for the purpose of treatment, but those are only a portion of all committees. Sensing the strength of the theory and desiring to promote the important right to treatment for all patients, the courts in *Wyatt v. Stickney*[49] and *Donaldson v. O'Connor*[50] apparently tried to extend it beyond its comfortable application. The *Donaldson* opinion can be read as attempting to extend the theory to those committed for protection from passive danger to self.[51] Similarly, the court employed the theory in *Wyatt* even though at least some of those before it demanding treatment had not been committed for treatment purposes.[52]

Strangely, although some of the plaintiffs in *Wyatt* had been committed for purposes other than treatment and the court did not indicate

48. Once again, protection can at least theoretically be achieved by confinement, supervision, and restraint without more. Even if the reasonable relationship required by *Jackson* and *Donaldson* were read to require more than the conceivable connection called for by the rational basis test, adequate confinement, supervision, and restraint could probably be demonstrated to provide in fact considerable physical protection.

49. 325 F. Supp. 781, *enforced*, 334 F. Supp. 1341 (1971), *supplemented*, 344 F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part, rev'd in part, remanded in part sub. nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

50. 493 F.2d 507, 524 (5th Cir. 1974), *vacated on other grounds and remanded*, 422 U.S. 563 (1975).

51. *Id.* at 520-21. The court discussed the pseudo quid pro quo theory as extending to, on the one hand, at least the nondangerous and as protecting, on the other hand, those committed as in need of treatment, care, custody, or supervision. Those who are passively dangerous because of being unable to take care of their own physical needs are in need of care, custody, or supervision. One might reconcile the apparent inconsistency between limiting the theory to the nondangerous and extending it to those in need of care, custody, or supervision by supposing that the court's reference to the nondangerous was an uncareful allusion to those not actively dangerous to self or others. Overlooking this ambiguity, the pseudo quid pro quo theory cannot even extend to the passively dangerous because the goal of protecting them can be met solely by confinement, supervision, and restraint. The only way the theory can be extended to all those not actively dangerous is to stipulate that the passively dangerous cannot be committed. In his concurring opinion in *Donaldson*, Chief Justice Burger read the Fifth Circuit's opinion to indeed hold that the passively dangerous cannot be committed. 422 U.S. at 581. Such a result would be at odds with the weight of authority, *see* authorities cited note 25 *supra*, and it was probably not the Fifth Circuit's intent. The court was most likely simply careless in establishing a basis for its ultimately sound conclusion that those passively dangerous to others possess a right to treatment. The least restrictive alternative theory, see text accompanying notes 114-57 *infra*, would provide firm support for the Fifth Circuit's conclusion. In any event, the court's stretching of this point, whatever its outcome, undoubtedly leaves the actively dangerous without protection. And it is not clear why the court discussed the rights of any dangerous patients as Mr. Donaldson was apparently not dangerous and the holding was summarized as extending to nondangerous committees. 493 F.2d at 527. Finally, one might suggest that the pseudo quid pro quo theory properly extends to those committed for care, custody, or supervision as those terms—especially "care"— connote treatment. However, certain statutes mention *"care"* and *"treatment,"* suggesting that they are discrete concepts. *See* IDAHO CODE § 66-317 (Supp. 1972) ("in such mental condition that he is in need of supervision, treatment, care or restraint"). "In need of care," just as the related phrase "gravely disabled," probably captures notions of passive danger to self because of inability to provide basic needs, notions which are distinct from "in need of treatment." *Cf.* Estate of Chambers, 71 Cal. App. 3d 277, 139 Cal. Rptr. 357, 362 (1977) (defining grave disability as inability to provide for one's food, clothing, or shelter).

52. 325 F. Supp. at 784.

that any of them had been improperly confined, certain language in the case can be read as limiting the valid purposes of commitment to one—need for treatment.[53] If treatment were the only valid purpose of commitment, then all committees would be guaranteed treatment. The problem is that the state's commitment power would then be severely restricted to exclude the purposes of protecting others and of protecting the committee from active and passive danger. The court in *Wyatt* was apparently not willing to restrict the commitment power in that manner, and its general use of the pseudo quid pro quo rationale and its broad statement that treatment is the only valid purpose of commitment are therefore difficult to explain.

In any event, limiting the purposes of commitment to providing treatment is not a promising approach for those supportive of a right to treatment. Surely, the protection of others and of committees are legitimate purposes under the presumptively applicable rational basis test.[54] And if one were to justify and use an invigorated standard of review to limit the purposes of commitment, the purpose of dispensing treatment would perhaps be the most vulnerable.[55]

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53. Holding that plaintiffs had a constitutional right to treatment, the court reasoned:

> 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 such as Bryce.*
>
> . . . .
>
> . . . 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.

325 F. Supp. at 784-85 (emphasis supplied). This language could be construed to allow commitment only for the purpose of providing treatment or to extend a right to treatment only to patients committed for treatment purposes. The subsequent enforcement opinion, however, clearly extended treatment to all involuntary civil committees in Bryce State Hospital, irrespective of the state's initial purpose for confining them there, and that included patients committed for purposes other than treatment. 344 F. Supp. 373, 379 (M.D. Ala. 1972) (Appendix A) (defining patients, or those covered by the opinion, as all persons confined pursuant to involuntary commitment procedures). Indeed, in Lynch v. Baxley, 386 F. Supp. 378, 390 (M.D. Ala. 1974), the court interpreted the Alabama commitment statutes in effect when *Wyatt* was decided as requiring a finding of a real threat of substantial harm to self or others as a prerequisite to commitment; presumably need for treatment would be neither necessary nor sufficient. Since the court's reasoning that the nature of commitment must be reasonably related to its purpose can guarantee a right only to those committed as in need of treatment, the *Wyatt* court either meant it when it said that "treatment . . . is the only justification . . . that allows civil commitments," 325 F.2d at 784, or, more likely in light of the above, was very careless in establishing a foundation for its sound judgment that all those before it, including patients committed for purposes other than treatment, were entitled to treatment. Once again, the least restrictive alternative theory provides such a foundation. See text accompanying notes 114-57 *infra*. On appeal, the Fifth Circuit expressly affirmed that treatment was constitutionally required for all committees, relying upon its loose reasoning in *Donaldson*. Wyatt v. Aderholt, 503 F.2d 1305, 1312 (5th Cir. 1974).

54. See discussion note 25 *supra*.

55. *See, e.g.*, Suzuki v. Alba, 438 F. Supp. 1106, 1109-10 (D. Hawaii 1977) (striking down commitment statute failing to require recent act, attempt, or threat of imminent and substantial physical danger); Doremus v. Farrell, 407 F. Supp. 509, 514 (D. Neb. 1975) (applying compelling state interest test and requiring active or passive danger to self or others, as opposed to providing treatment, as prerequisites to commitment); Bell v. Wayne County Gen. Hosp., 384 F. Supp. 378, 390 (M.D. Ala. 1974) (same); Lessard v. Schmidt, 349 F. Supp. 1078, 1093-94 (E.D. Wis. 1972), *vacated and remanded on procedural grounds*, 414 U.S. 473 (1974) (reading commitment statute

B. *Non-Quid Pro Quo Right to Treatment Theories*

The primary weaknesses of each of the three quid pro quo theories analyzed above are logical inconsistency and failure to justify and properly apply a constitutional standard of judicial review. These weaknesses may be attributed to a sweeping application of the colorable but mistaken notions that confinement with or for the purpose of treatment is a uniformly beneficial phenomenon and that confinement without treatment is by definition a terrible practice.[56]

Though the view that treatment is always beneficial, and that confinement without it always harmful, to some extent underlies all the major theories advanced to justify a right to treatment, it is especially evident in the two remaining theories: the eighth amendment/*Robinson*

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requiring imminent danger to constitute the necessary compelling state interest); *In re* Levias, 83 Wash. 2d 253, 256-58, 517 P.2d 588, 591 (1973) (applying compelling state interest test and requiring active or passive danger to self or others, as opposed to necessity of treatment, as prerequisite to commitment); State *ex rel.* Hawks v. Lazaro, — W. Va. —, —, 202 S.E.2d 109, 123-24 (1974) (same). These authorities require a finding of dangerousness as a prerequisite to commitment even if one is treatable. Need for treatment is considered neither a necessary nor sufficient condition for commitment. *But see Developments, supra* note 2, at 1223-28 (suggesting that need for treatment might be a necessary but not sufficient condition).

56. Thus, under the paradigm and procedural quid pro quo theories, for example, treatment can serve as a quid or compensation for the deprivation of substantive or procedural rights. The problems with the notions are twofold. First, a rough intuitive notion cannot substitute for a proper application of constitutional standards of review. The surrealistic nature of the various quid pro quo theories is a testament to the danger of applying rough concepts as opposed to constitutional standards of review which ask broad, but focused, questions concerning competing goals, means, and their relationships. A much ignored question concerns the purposes served by the existence of standards of review. One answer is hinted at in the preceding sentence—to force judges to approach issues in a somewhat logical, limited, and predictable manner. Second, confinement with treatment is not necessarily beneficial, nor is commitment without treatment uniformly detrimental. Although often beneficial, treatment may constitute a very drastic intrusion upon important personal rights, an intrusion which must be carefully justified and undertaken. Conversely, for example, confinement of a self-mutilator solely to protect him from himself, irrespective of treatment, is not necessarily detrimental to the individual.

That treatment is not a uniformly positive phenomenon is evidenced by a considerable amount of right *against* treatment literature. A good bibliography on this literature is contained in THE RIGHT TO TREATMENT, *supra* note 3, at 93-95. Concerning self-mutilation see Maycock v. Martin, 157 Conn. 56, 245 A.2d 574 (1968), where the committee, to please God, first plucked out his right eye and then removed his right hand. In Kaimowitz v. Department of Mental Health, Civil No. 73-1934-AW (Wayne County, Mich., Cir. Ct. July 10, 1973), *reprinted in* 1 MENTAL DISABILITY L. REP. 147-159 (1976), the court held that a patient allegedly incompetent to consent could not be treated with psychosurgery, despite his request for it, partially because of a question whether it would be beneficial to him. The court somewhat oddly emphasized the patient's right *against* treatment although he asserted a right *to* treatment. For a discussion of this landmark case and questions such as whether institutionalized persons can ever give informed consent, and, if so, whether there ought to be a presumption one way or the other regarding competency in order to protect either the right to or against treatment, see Shapiro, *supra* note 1, at 737-43. Shapiro takes the moderate position that only psychosurgery and electronic stimulation of the brain, see J. DELGADO, PHYSICAL CONTROL OF THE MIND: TOWARD A PSYCHO-CIVILIZED SOCIETY 257 (1969) for a discussion of electronic stimulation of the brain, should be denied to incompetent patients, and he appropriately points out that even this might threaten the important right to treatment or to access to treatment. He accepts the use and demonstrates the utility of other somewhat drastic therapies. *See* Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 SO. CAL. L. REV. 237, 244 n.8, 324-38 (1974). Others take the radical and probably erroneous view that virtually all treatment, including psychotherapy (roughly, one-on-one counseling), is pernicious. *See* Coleman & Solomon, *Parens Patriae "Treatment": Legal Punishment in Disguise*, 3 HASTINGS CONST. L.Q. 345 (1976).

v. California argument[57] and the protection from harm rationale.[58]

1. *The Eighth Amendment/Robinson v. California Right to Treatment Theory*

Certain authorities[59] have argued that the civilly committed have a right to treatment under the eighth amendment and the Supreme Court's reasoning in *Robinson v. California*[60] that punishment of at least certain statuses (drug addiction in *Robinson*) constitutes cruel and unusual punishment.[61] A notable example is *Welsh v. Likins*,[62] one of the leading right to treatment cases. The better authorities agree, however, that the eighth amendment and *Robinson* do not create a right to treatment.[63] The only way to argue that they do is to use assailable reasoning which, as with the various quid pro quo theories, could eventually undermine the right to treatment. The purpose here is not to give a comprehensive theory of the reach of the eighth amendment and the Supreme Court's rationale in *Robinson*; it is to demonstrate that they are not promising bases upon which to construct a right to treatment

57. *See* text & notes 59-95 *infra*.

58. *See* text & notes 96-113 *infra*.

59. The argument was first hinted at in Rouse v. Cameron, 373 F.2d 451, 453 (D.C. Cir. 1967), and has since been argued frequently. *See, e.g.*, Halderman v. Pennhurst State School and Hospital, 446 F. Supp. 1295, 1318 (E.D. Pa. 1977) (employing *Robinson* to create a right to minimally adequate habilitation for mentally retarded residents of state institution); Martarella v. Kelley, 349 F. Supp. 575, 585, 599 (S.D.N.Y. 1972) (discussing adequacy of treatment given to juveniles); United States *ex rel.* Von Wolfersdorf v. Johnston, 317 F. Supp. 66, 68 (S.D.N.Y. 1970) (incarceration violated the eighth amendment as there was no likelihood that the patient would be brought to trial if he were found able to stand trial); People v. Feagley, 14 Cal. 3d 338, 359, 375-76, 535 P.2d 373, 386, 398, 121 Cal. Rptr. 509, 522, 534 (1975) (holding that an indefinite sentence for one not amenable to treatment constitutes cruel and unusual punishment); People *ex rel.* Kaganovitch v. Wilkins, 23 App. Div. 2d 178, 182, 259 N.Y.S.2d 462, 466 (1965) (noting that an indeterminate sentence may be cruel and unusual punishment if psychiatric examination and treatment are not given); Ferleger, *Loosing the Chains: In-Hospital Civil Liberties of Mental Patients*, 13 SANTA CLARA LAW. 447, 490-92 (1973); Saphire, *supra* note 9, at 268-74 (emphasizing post release care); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 97-100 (1967) (recognizing certain limitations of the argument); *cf.* Rozecki v. Gaughan, 459 F.2d 6, 7 (1st Cir. 1972) (involving grossly inadequate heating at a treatment center); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 764-65 (E.D.N.Y. 1973) (based upon the eighth amendment, equal protection clause, or due process clause, confined mentally retarded entitled to at least the same living conditions as prisoners); Burt, *Eighth Amendment Rights of Mental Patients*, in 2 LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 735, 737 (B. Ennis & P. Freedman eds. 1973) (dealing with eighth amendment rights of those confined in mental institutions).

60. 370 U.S. 660 (1962).

61. *Id.* at 667.

62. 373 F. Supp. 487, 496-97 (D. Minn. 1974) (nominally and oddly using the due process clause of the fourteenth amendment alone rather than as incorporating the eighth amendment).

63. *See* Clark, *Civil and Criminal Penalties and Forfeitures: A Framework for Constitutional Analysis*, 60 MINN. L. REV. 379, 489 (1976); *Developments, supra* note 2, at 1259-64, 1330-33. It has been suggested by one commentator that the quid pro quo rationale also represents a *sub rosa* application of eighth amendment standards. *See* Note, *Constitutional Law—Mental Health—A Patient Involuntarily Civilly Committed to a State Mental Health Hospital Has a Constitutional Right to Treatment*, 20 VILL. L. REV. 214, 219-21 (1974). This would be consistent with the broad and mistaken notions that commitment with treatment is uniformly beneficial and commitment without treatment is uniformly detrimental which seem to inform the quid pro quo rationale.

for virtually *all* civil committees.[64] The principal concern of this section is the particular eighth amendment argument suggested in *Robinson*. To the extent that it demonstrates that there is considerable difficulty in applying the eighth amendment to civil commitment, however, the section in addition illustrates the frailty of the protection from harm theory considered below[65] which also probably rests upon the eighth amendment.

The argument that *Robinson* creates a right to treatment has been often but never clearly stated.[66] It can, in principle, be structured as

64. For example, this Article will not address the questions of whether or which treatments for civil committees might constitute cruel and unusual punishment. *See* Price v. Sheppard, 307 Minn. 250, 256, 239 N.W.2d 905, 906-07 (1976) (holding that certain electro-convulsive therapy treatments did not constitute punishment). Neither will it address whether *Robinson's* reasoning would apply to civil committees who have committed, or been convicted for, criminal acts and who might be subject to at least a modicum of retribution or deterrence. See note 31 *supra* for a cataloging of groups of such committees.

65. See text accompanying notes 96-113 *infra*.

66. *See* authorities cited note 59 *supra*. In Estelle v. Gambel, 429 U.S. 97, 105-06 (1977), the Court held that deliberate indifference to the medical needs of prisoners constitutes cruel and unusual punishment, but that inadvertent failure to treat is not sufficient to establish an eighth amendment violation. One might fashion an eighth amendment argument distinct from the one considered in the text by suggesting that under *Estelle* prisoners have a right to certain mental health or psychological treatment, or even to rehabilitation. If the state must not be deliberately indifferent to physical ills and if the line between physical and mental health is often hard to draw, *see generally* Shapiro, *supra* note 1, the obligation created by *Estelle* might extend to mental health treatment. Indeed, the Court might consider irrelevant any distinction between physical and psychological ills. In either event the obligation created in *Estelle* might be applied to mental patients by using the words in Ingraham v. Wright, 430 U.S. 651, 669 n.37 (1977), which suggest that the eighth amendment might reach closed institutions similar to prisons. See text & note 76 *infra*. But *Ingraham* leaves little hope for those who would apply the eighth amendment to the civil commitment context. See text accompanying notes 73-78 *infra*. Further, the obligation in *Estelle* only requires refraining from deliberate indifference; any right it creates is a diluted one. *Cf.* Bresolin v. Morris, 88 Wash. 2d 167, 172-74, 558 P.2d 1350, 1353-54 (1977) (holding that prisoner had no constitutional right to treatment for psychological addiction and pointing out absence of "deliberate indifference"). The obligation is, moreover, probably based upon the protection from harm rationale. See text accompanying notes 96-113 *infra*. That rationale requires that throughout confinement the patient be kept in as good condition as when he was institutionalized. Since civil committees must be mentally ill before institutionalization, any right based upon that rationale is a very flimsy one.

On the other hand, in Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977), the court found "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart," *id.* at 47, and held that a prisoner is entitled to psychological or psychiatric treatment if "(1) the prisoner's symptoms evidence a serious disease or injury; (2) . . . such disease or injury is curable or may be substantially alleviated; and (3) . . . the potential for harm to the prisoner by reason of delay or denial of care would be substantial." *Id.*

Moreover, in Laaman v. Helgemoe, 437 F. Supp. 269 (D.N.H. 1977), a recent case dealing with prison conditions, the court applied the protection from harm theory in a manner which might be used to establish a right to treatment for the mentally ill if one could overcome the eighth amendment problems. See text accompanying notes 69-95 *infra*. The court observed that prisoners do not have a full-blown right to rehabilitation, but that they have a right to resist degeneration. The court included within the latter the rights to work at a useful job, to learn a skill marketable in the jurisdiction of confinement, and to individual counseling and therapy. 437 F. Supp. at 328-30. Those rights seem to connote rehabilitation as opposed to resisting degeneration and a positive state duty to provide services as opposed to a negative obligation to refrain from inflicting harm. A similar argument could be used to extend those rights to the mentally ill. The problem is that the court's opinion depends upon an empirical proposition which may be difficult to prove: prisoners (or mental patients) will degenerate if not rehabilitated (treated). *See id.* at 324-25. The court did not even attempt to support this proposition or to justify an invigorated standard of review which might leave it to the state to disprove it. In short, the court's opinion is a weak one.

follows:

(1) *Robinson* holds that any "punishment," whether criminal or not, of certain statuses is inherently cruel and unusual;

(2) Being mentally ill *and* dangerous or in need of supervision or treatment is a "status" to which the *Robinson* rule applies;[67]

(3) Civil commitment not associated with treatment constitutes "punishment";[68]

(4) Since civil commitment without treatment constitutes punishment and is applied because of the status of being mentally ill *and* dangerous or in need of supervision or treatment, it is inherently cruel and unusual.

For the following reasons, however, the argument is a weak one which probably cannot be employed to justify a right to treatment broadly applicable to virtually all committees:[69]

(1) Punishment, as used in the eighth amendment and in *Robinson*, is almost certainly limited to criminal punishment, and civil commitment is not criminal punishment;[70]

(2) Indeed, civil commitment is not punishment at all; and

Moreover, even if one were to base a right to rehabilitation, or treatment, on the court's rationale, it would be a right only to those services minimally necessary to prevent deterioration. The court did, as noted above, create a broader right, but, in so doing, ignored its own reasoning. The least restrictive alternative theory, see text & notes 114-57 *infra*, supports a stronger right to superior, individual treatment. The *Laaman* analysis is not the last word on this issue, *see* 2 MENTAL DISABILITY L. REP. 172, 189 (Sept.-Dec. 1977) for a discussion of later cases.

67. One problem with the eighth amendment/*Robinson* argument is that *Robinson*'s rationale might not apply to the extent that civil commitment statutes require some act, threat, or attempt to evidence committable statuses. *See* Stamus v. Leonhardt, 414 F. Supp. 439, 451 (S.D. Iowa 1976). It might be argued that commitment can justifiably apply to the patient's act, threat, or attempt as opposed to his status.

68. The required association with treatment might be that the commitment be for the purpose of treatment, be accompanied by treatment, or be accompanied by a willingness to provide treatment. The first alternative would allow commitment only of those in need of treatment, while the second would allow confinement only of those whom the state could treat. The third option would allow commitment of all patients, even those who refuse treatment or for whom treatment may prove fruitless. The first alternative is very similar to one possible reading of Wyatt v. Stickney, 325 F. Supp. 781, *enforced*, 334 F. Supp. 1341 (1971), *supplemented*, 344 F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part, rev'd in part, remanded in part, sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974), and the pseudo quid pro quo theory. See text accompanying notes 40-55 *supra*.

69. One problem which, though difficult to evaluate, bears mentioning is the degree to which *Robinson* itself constitutes strong precedent for *any* proposition. Obviously, the argument outlined above depends totally upon the case being settled constitutional law, but the reasoning of the opinion was only clearly embraced by four of the Justices, not even a majority of those participating in the case. Justice Frankfurter did not participate, 370 U.S. at 668, and dissents were filed by both Justice Clark, *id.* at 679, and Justice White, *id.* at 685. Justice Douglas concurred, *id.* at 668, as did Justice Harlan, *id.* at 678, but both concurring opinions appear to rest on rationales which differ in some respects from that of the "majority." To the extent that these variations represent some degree of discomfort with the *Robinson* per se rule, the eighth amendment right to treatment theory is threatened at its foundation. Also, the Court quickly indicated its hesitance to extend *Robinson* in Powell v. Texas, 392 U.S. 514, 532 (1968), and the present Court has noted its discomfort with *Robinson*. *See* text & note 75 *infra*.

70. This proposition is directly in conflict with the first premise of the eighth amendment/*Robinson* right to treatment argument. See text accompanying notes 66-67 *supra*.

(3) Civil commitment might occur with respect to statuses volitionally incurred or maintained, and *Robinson* might permit the state to punish such voluntary statuses.

a. *Criminal versus Non-Criminal Punishment*

The first proposition in the eighth amendment/*Robinson* right to treatment argument may be seriously undermined, for it is possible that *Robinson* banned only the imposition of criminal sanctions. Indeed, in his concurrence, Justice Douglas observed that "[c]ruel and unusual punishment results not from confinement but from convicti[on] . . . of a crime."[71] Though not as explicitly stated, the opinion of the Court also appeared to recognize that the criminal label is accorded considerable significance in eighth amendment analysis.[72] Such a reading of *Robinson* would, of course, exclude civil commitment from the Court's reasoning because even if commitment constitutes punishment, it certainly is not criminal punishment.

The force of that exclusion and the importance of labels have been significantly enhanced by the Court's recent indication, in *Ingraham v. Wright*,[73] that the eighth amendment itself, not to mention *Robinson*, may not reach any state action other than criminal punishment. In *Ingraham*, the Court held that the prohibition of cruel and unusual punishments does not apply to disciplinary corporal punishment in public schools. Essentially, the Court reasoned that the eighth amendment applies only to criminal punishment.[74]

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71. 370 U.S. at 676.

72. The court stated:

> A State might determine that the general health and welfare require that the victims of [narcotics addiction] and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But a law which made a *criminal* offense of such a disease would doubtless be an infliction of cruel and unusual punishment.

Id. at 666 (emphasis supplied). This language indicates that the Court might have thought that it is not the imposition of involuntary confinement, but rather calling it a response to criminality, which raises the eighth amendment issue. That is not unreasonable because, without an explicit statement of a punitive purpose, commitment probably does not even constitute non-criminal punishment. See text accompanying notes 76-87 *infra*. There is, moreover, some sense in distinguishing between criminal and non-criminal punishment as the former implies a greater degree of societal outrage and therefore has a higher potential for stigmatization.

73. 430 U.S. 651 (1977).

74.

> An examination of the history of the Amendment and the decisions of this Court construing the proscription against cruel and unusual punishment confirms that it was designed to protect those convicted of crimes.
>
> . . . .
>
> . . . [T]he principal concern . . . appears to have been with the legislative definition of crimes and punishments . . . .
>
> [Even] if the American provision was intended to restrain government more broadly than its English model, the subject to which it was intended to apply—the criminal process—was the same.
>
> . . . .
>
> In light of this history, it is not surprising to find that every decision of this Court consid-

In two respects, however, the *Ingraham* Court did not completely foreclose the possibility of applying the eighth amendment to non-criminal areas. First, the Court in a footnote indicated that there might, in certain circumstances, be a "basis for wrenching the Eighth Amendment from its historical context,"[75] and explicitly reserved the question whether involuntarily committed mental patients were entitled to eighth amendment protection.[76] Second, the Court reasoned that the eighth amendment does not apply to public school children because of the open nature of schools.[77] But "openness" does not, of course, similarly inhere in the nature of mental institutions.

Although the above qualifications leave open a slight possibility that the Court might extend the eighth amendment to certain civil commitment questions, the *Ingraham* opinion surely indicates a hesitance to do so. Moreover, even if the *Ingraham* Court did not bar the eighth amendment from application to mental institutions, it explicitly indicated its extreme reluctance to extend in any respect *Robinson*'s approach to that amendment.[78]

b. *Does Commitment not Associated with Treatment Constitute "Punishment?"*

It has been seen that the *Robinson* rationale probably does not extend to civil commitment as it probably captures only criminal pun-

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ering whether a punishment is "cruel and unusual" within the meaning of the Eighth and Fourteenth Amendments has dealt with a criminal punishment.

. . . .

In the few cases where the Court has had occasion to confront claims that impositions outside the criminal process constituted cruel and unusual punishment, it has had no difficulty finding the Eighth Amendment inapplicable.

Id. at 664-68 (citations omitted).

75. *Id.* at 669 n.37.

76.

Some punishments, though not labeled "criminal" by the State, may be sufficiently analogous to criminal punishments in the circumstances in which they are administered to justify application of the Eighth Amendment . . . . We have no occasion in this case, for example, to consider whether or under what circumstances persons involuntarily confined in mental or juvenile institutions can claim the protection of the Eighth Amendment.

Id. (citation omitted).

77.

The schoolchild has little need for the protection of the Eighth Amendment. Though attendance may not always be voluntary, the public school remains an open institution. Except perhaps when very young, the child is not physically restrained from leaving school during school hours; and at the end of the school day, the child is invariably free to return home. Even while at school, the child brings with him the support of family and friends and is rarely apart from teachers and other pupils who may witness and protest any instances of mistreatment.

Id. at 670.

78. Speaking of *Robinson's* limitation on what might be made criminal, the *Ingraham* Court warned: "[W]e have recognized the last limitation as one to be applied sparingly." *Id.* at 667. That was not surprising in light of the Court's early refusal to extend *Robinson* in Powell v. Texas, 392 U.S. 514, 532-33 (1968) (upholding punishment of drunkenness in a public place as punishment of an act, not a status; this point was concurred in by at least six Justices although there was no

ishment. An even more fundamental problem is that even if *Robinson* were to reach non-criminal punishment, it would not apply to civil commitment if the latter did not constitute punishment of any sort.[79]

For the most part, those who argue that civil commitment does constitute punishment focus on the supposedly identical impact wrought by civil commitment and by criminal punishment.[80] There are several problems with that reasoning:

(1) "Punishment" subsumes within it not merely particular types or degrees of impact but primarily a limited number of immediate goals associated with the criminal law which might not be part of civil commitment;

(2) If civil commitment does encompass the requisite purposes commonly associated with the criminal law, then commitment for providing treatment might constitute punishment which is inherently cruel and unusual under *Robinson*; and

(3) A test relying solely upon impact would be at odds with precedent and would be unworkable; it would indicate either that civil commitment does not constitute punishment or that civil commitment even for the purpose of providing treatment is inherently cruel and unusual under *Robinson*.

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majority opinion). The *Ingraham* Court followed the above with a citation to *Powell*. 430 U.S. at 667.

79. The third premise in the eighth amendment right to treatment argument stated above, see text & note 66 *supra*, is that commitment constitutes punishment if it is for purposes other than treatment, without treatment, or without willingness to provide treatment (this alternative would allow commitment of the untreatable or those unwilling to be treated). Each alternative interpretation of this premise reads *Robinson* to say that civil commitment associated with treatment is not punishment, the differences being only in the degree of required association. If no commitment, irrespective of any association with treatment, is punishment, the premise is false and the argument must fall.

80. Certain wording in the *Robinson* opinion might be read as indicating a willingness to hold commitment unassociated with treatment to be a violation of its per se cruel and unusual standard:

> It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare require that the victims of these and other human afflictions be *dealt with by compulsory treatment, involving quarantine, confinement, or sequestration*. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.

370 U.S. at 666 (emphasis supplied). The word "involving" is ambiguous. Arguably it might mean "connected with," in which case the Court would be approving only commitments which were "connected" with treatment. There are several problems with such a reading. First, it is just as likely, and perhaps more so given the cursory, exemplary nature of the context, that "involving" should be read to mean "consisting of." In that case the Court would apparently be putting all commitments beyond the reach of the eighth amendment regardless of any association with treatment. Second, even if the Court meant "in connection with," it merely endorsed efforts to treat; it did not condemn absences of treatment. Finally, the Court was speaking in a context of burdens conceded to be punishment. Thus, whatever interpretation is given "involving," the quoted language wholly begs the threshold question of whether the burden constitutes "punishment." Recognizing these weaknesses, those who seek to establish a right to treatment through *Robinson* do not rely on the Court's language here.

(1) *Civil Commitment might not Constitute Punishment Because of the Requirement of Certain Immediate Goals*

It is intuitively troubling to think of civil commitment as punishment. With a little reflection, however, the trouble subsides and the common purposes or justifications of isolating the dangerous and treating or rehabilitating the abnormal suggest a unity between civil and criminal confinement. Still further thought should retrieve one's hesitance to label commitment as punishment. H.L.A. Hart's examination of the process of criminal punishment captures the essence of the problem:

> Before we reach any question of justification [of the institution of punishment generally or its distribution in individual cases] we must identify a preliminary question to which the answer is so simple that the question may not appear worth asking; yet it is clear that some curious 'theories' of punishment gain their only plausibility from ignoring it, and others from confusing it with other questions. This question is: Why are certain kinds of action forbidden by law and so made crimes or offences? The answer is: To announce to society that these actions are not to be done and to secure that fewer of them are done. These are the common immediate aims of making any conduct a criminal offence and until we have laws made with these primary aims we shall lack the notion of a 'crime' and so of a 'criminal.' Without recourse to the simple idea that the criminal law sets up, in its rules, standards of behaviour to encourage certain types of conduct and discourage others we cannot distinguish a punishment in the form of a fine from a tax on a course of conduct.[81]

81. H.L.A. HART, *supra* note 22, at 6-7. To understand Hart's point it is useful to distinguish three overlapping but discrete questions: First, what is punishment?; second, why do we punish?; and third, how do we justify punishment? The latter two questions can be addressed in two distinct contexts: punishment as an institution or general practice and punishment in individual cases. Thus, it might be asked why we punish generally and in specific cases and how we justify punishment as an institution and its application in individual cases. Most debate regarding punishment focuses on the justification of punishment, either as an institution or as applied in individual cases. Justifications invariably offered in that debate include isolation, general and specific deterrence, retribution, and rehabilitation. Given that debate, it is understandable how one might characterize something as punishment simply if it is associated with one of those justifications. Thus, if civil commitment is justified by isolating the dangerous, it might be thought of as punishment. Hart would answer, though, that an action is not punishment unless it is a response to the breach of a prohibition, a prohibition announcing that something is not to be done made in hopes that it will not be done. In other words, one cannot look simply to the justification of an action to determine whether it is punishment; he must look primarily to why the action was done. Hart claims, in essence, that the first question above—what is punishment?—can only be answered by looking to the second question above—why do we punish? Even if civil commitment is justified by isolation, it is not designed to announce that persons are not to be mentally ill and to ensure thereby that they are not. Of course, Hart assumes that all punishment is designed to announce a prohibition to secure certain conduct (or status) even if it is not justified by so doing. It might be answered that some would embrace a theory of punishment which would deem it irrelevant whether punishment were designed to, or could achieve, ensuring fewer incidents of an activity or status. Those who might not be concerned with the consequences of punishment, but rather with whether it is "just" to apply sanctions, are called retributivists. *See* Murphy, *Marxism and Retribution*, 3 PHILOSOPHY & PUB. AFF. 217, 227 (1973). However, retributivists would invariably

Whatever the common general justifications for the institutions of civil commitment and criminal confinement or for their application in individual cases, civil commitment is neither meant to announce that persons are not to be mentally ill nor to ensure thereby that less mental illness will occur. Civil commitment is not, in short, associated with the immediate aims Hart posits as necessary elements of "punishment." Mental illness and accompanying statuses which justify commitment are not made crimes or offenses, as Hart uses those terms, and therefore civil commitment perhaps cannot properly be thought of as punishment. Similarly, Hart observes that both retributivists[82] and utilitarians[83] would probably accept the notion that one generally ought not to be punished, no matter how beneficial the consequences, unless he has had some opportunity to avoid the act or status which allows the punishment.[84] In other words, neither retributivists nor utilitarians would embrace a theory of punishment which would generally reach those not responsible for their "offenses." And one does not usually think of committees as being responsible for, or as having the opportunity to avoid, their committable statuses.

It could be answered that it does make some sense to ascribe responsibility to committees.[85] More fundamentally, it could be suggested that civil commitment is punishment as it can be thought of as preventing mental illness, accompanying statuses, and the dangers they present by isolation and treatment, just as criminal confinement can be thought of as preventing criminal conduct through isolation and rehabilitation. These are plausible contentions, but they present some problems[86] and they do not seem to come as close as Hart's reasoning to common intuitions about punishment.

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require at least the notion of breach of a prohibition as a necessary part of punishment, thus excluding civil commitment. Finally, it might be suggested that some would embrace a theory of punishment which would ensure fewer incidents of a behavior or status irrespective of the breach of a prohibition. It is sometimes asserted that utilitarians—those who are primarily concerned with the consequences of punishment—embrace a theory of punishment which would accept punishment of the innocent to bring about good social consequences. *Id.* at 218. Thus, if civil commitment might ameliorate the incidence of mental illness, it might be considered punishment. Hart would answer that utilitarians would invariably resist punishment of the innocent and would require the breach of a prohibition as a necessary element of punishment. H.L.A. HART, *supra*, at 79-83. If so, civil commitment would not constitute punishment.

82. See discussion note 81 *supra*.

83. See discussion note 78 *supra*.

84. H.L.A. HART, *supra* note 81, at 79-83.

85. *Cf.* text accompanying note 95 *infra* (some mental illnesses might be volitionally incurred or maintained).

86. It is arguable that characterizing civil commitment as punishment would have detrimental impacts because of the perception of laymen not attuned to neat philosophical distinctions. They might lose faith in their government and suffer some insecurity to find that the state punishes the sick. The latter might especially apply to committees. Conversely, characterizing commitment as punishment might teach the terrible lesson that it is permissible to punish even those who generally cannot avoid that which constitutes an offense or even that statuses alone should generally justify intervention, as in a therapeutic state.

In any event, the definition and justification of punishment and their relation to civil commitment raise many complex problems which have never been fully examined and which cannot be adequately dealt with here. Suffice it to say that there are considerable difficulties in characterizing civil commitment as punishment. And these difficulties are more than interesting philosophical questions as the Supreme Court has indicated some hesitance to apply the label punishment unless there is a governmental prohibition and individual responsibility for that which is prohibited.[87] Its intuitions about punishment are, at

87. These elements are implicit in Kennedy v. Mendoza-Martinez, 372 U.S. 144 (1963). The *Kennedy* Court held that federal statutes denationalizing citizens for draft evasion during time of war constituted punishment. The Court reached this conclusion because of a clear legislative intent to punish. *Id.* at 165-66, 169-70. Civil commitment statutes do not clearly manifest an intent to punish. State legislatures are either almost silent regarding the intent of those statutes or try to make it clear that the statutes are teeming with beneficial motives. To the extent that the apparent or express purposes of commitment are not associated with punishment, those who would have the Court characterize civil commitment as punishment face an almost insurmountable burden. The Court has made it clear that it is invariably most difficult for a litigant to impute to the state something other than its apparent or ostensible purpose. *See* United States v. O'Brien, 391 U.S. 367, 382-86 (1968). Despite the rather cogent argument which could be made that the congressional purpose behind the law under which O'Brien was prosecuted was aimed primarily at punishing expressive activity of draft-card burning, the Court refused to look beyond the express congressional purpose of securing the efficiency of the selective service process. *Id.* at 382-84.

However, the *Kennedy* Court entertained the possibility of a litigant proving a punitive intent in the absence of an objective manifestation of legislative intent. It even went so far as to distill from prior cases seven factors to be weighed in determining purpose in the absence of a clear, objective manifestation of legislative intent:

> [1 w]hether the sanction involves an affirmative disability or restraint, [2] whether it has historically been regarded as a punishment, [3] whether it comes into play only on a finding of *scienter*, [4] whether its operation will promote the traditional aims of punishment—retribution and deterrence, [5] whether the behavior to which it applies is already a crime, [6] whether an alternative purpose to which it may rationally be connected is assignable to it, and [7] whether it appears excessive in relation to the alternative purpose assigned.

372 U.S. at 168-69 (footnotes omitted).

These criteria indicate that punishment announces that an activity is not to be done and that one will be responsible for not heeding the admonition. They also independently suggest that civil commitment is not punishment. First, civil commitment does involve an affirmative restraint, but so do most government regulations, and the task is to distinguish regulations from punishment. That is, this criterion is of little help, indicating only that a case deserves a second look.

The second criterion—historical attitude—would clearly favor not characterizing civil commitment as punishment because whatever the remote historical perception of it might have been, it is clear that for many years civil commitment has not been considered punishment. Only in antiquity was mental illness considered a crime. *See* Robinson v. California, 370 U.S. 660, 668 (Douglas, J., concurring). For a discussion of contemporary understanding, see *Developments, supra* note 2, at 1262. Similarly, the third criterion indicates both that civil commitment is not punishment and that punishment connotes announcing that an activity is not to be done and that one will be responsible for not heeding the admonition. Civil commitment does not depend upon scienter, and, indeed, it is connected with impaired mental functioning which might indicate the absence of scienter even if it were relevant. And scienter is relevant to punishment because it makes little sense to tell someone not to do, or at least hold him responsible for, that which he does not perceive with a guilty mind. Again, civil commitment, whether associated with treatment or not, is generally neither calculated to promote retribution or deterrence (the fourth criterion) nor applied to behavior which is already a crime (the fifth criterion). The fourth criterion's concern with retribution and deterrence once again makes clear that punishment assumes ability to comprehend, and responsibility for ignoring, a prohibition. Retribution connotes responsibility, while deterrence makes little sense without comprehension. Still again, civil commitment can be assignable to purposes other than those associated with punishment (the sixth criterion), such as protection of the patient. The seventh and final criterion focuses on whether the sanction appears

least in some respects, close to those of Hart.

(2) *If Civil Commitment Constitutes Punishment, Commitment for Treatment might be Inherently Cruel and Unusual*

If the analogies between civil and criminal confinement suggested above were accepted and civil commitment were characterized as punishment, *Robinson* might *bar* rather than require commitment with treatment. It might characterize commitment for treatment as punishment and that punishment would be applied because of the status of mental illness requiring treatment. *Robinson* holds that such punishment of status is per se cruel and unusual.[88] Of course, the eighth amendment right to treatment argument depends upon the opposite conclusion: commitment for the purpose of, or at least associated with, treatment is the only commitment which is not inherently cruel and unusual. It is ironic that while some base the right to treatment upon *Robinson*, to avoid the conclusion that it precludes civil commitment designed to provide treatment, one must recognize that *Robinson* and the eighth amendment simply do not apply to civil commitment and therefore certainly cannot support a right to treatment for committees.

(3) *An Impact Test is at Odds with Precedent and Unworkable; It Indicates either that Civil Commitment is not Punishment or that Commitment for Treatment is Inherently Cruel and Unusual*

There would be no way to limit a test which defines government action as punishment according to the impact of that action. Any onerous government regulation such as a tax, a land use regulation, or a

excessive in relation to the alternative or non-punitive purpose (such as protection of self). The Supreme Court has held that the nature and duration of commitment must bear a reasonable relationship to its purpose, Jackson v. Indiana, 406 U.S. 715, 738 (1972), and so civil commitment ipso facto cannot legally (irrespective of the eighth amendment) appear excessive in relation to its purpose. It might be suggested that excessiveness should be measured by a more rigorous standard than a reasonable relationship, and that commitment without treatment is excessively burdensome as it is more onerous than commitment with treatment. Excessiveness within the eighth amendment has been judged, however, by the same reasonable relationship test as is applicable in the due process and equal protection contexts. See text & note 110 *infra*. Even if a more rigorous standard were appropriate, this single criterion in *Kennedy* seems an unlikely source for it, especially since the other *Kennedy* criteria favor not characterizing commitment as punishment. The notion of excessive burden is best dealt with under the least restrictive alternative theory. See text accompanying notes 114-57 *infra*.

88. 370 U.S. at 667. It might be answered that *Robinson* would not hold punishment of status to be cruel and unusual if it were associated with treatment, but that is doubtful. The contention rests on the erroneous notion that commitment with treatment is universally beneficial and that commitment without treatment is uniformly detrimental. Giving or offering treatment does not, for example, significantly change the character of the commitment of one dangerous to others who is either untreatable or unwilling to be treated. And the criminal provisions at issue in *Robinson* evinced a willingness to provide treatment but were nevertheless struck down. This is pointed out in Justice Clark's dissent. 370 U.S. at 679-83.

corporate code could be considered punishment.[89] Apparently anticipating this problem, the Supreme Court has explicitly stated that degree of impact is not sufficient to characterize government action as punishment.[90] Moreover, the impact of civil commitment is different from that of criminal confinement.[91] Civil commitment undoubtedly involves a serious stigma of being sick of mind and perhaps even dangerous, but it is not the more serious, in a moral sense at least, stigma of being a conscious, calculating wrongdoer.[92]

Even if one were to accept the analogy between criminal sanctions and civil commitment, it is not clear that only civil commitment not associated with treatment should be considered cruel and unusual punishment. It could be said that some committees would consider their confinement more beneficial with treatment, but what of those who do not want treatment or who are willing to be treated but are untreatable? Their lot is not better simply because the state is willing to provide

89. One could argue that only those affirmative disabilities similar to sanctions most often used in the criminal law should be considered punishment. But taxes bear a close resemblance to the common criminal sanction of monetary fines, and yet have generally not been considered punishments. If one insists on focusing on perhaps the most common criminal sanction—incarceration—there can still be no proper analogy between criminal and civil confinement; the Supreme Court has held that incarceration for civil contempt does not constitute punishment. Shillitani v. United States, 384 U.S. 364, 368-70 (1966). Although *Shillitani* dealt with the sixth amendment right to jury trial, there is no reason to believe that its reasoning would not be applied in the eighth amendment context. Aside from the failure of the suggested analogies, there would be no way to limit the impact test once adopted. It would lead to applying the murky eighth amendment "acceptance by contemporary moral standards" test to a broad range of government action. See note 110 *infra* for a discussion of the moral standards test. In certain cases this might represent a significant and inappropriate departure from the deferential rational basis standard which the courts have used to review most government action. Eighth amendment review is substantially identical to that under the rational basis test. See discussion note 110 *infra*. This is not inconsistent with arguing that the former might be much less deferential than the latter in one important respect—requiring public acceptance. A state action might not be wholly irrational and might thus be valid under the rational basis test. If the same action were not popular with the public, it could nevertheless fall under the public acceptance standard. That might violate the general notion of deference to political decisionmaking implicit in the rational basis test. See discussion note 33 *supra*.

Accepting an impact test might also lead to the requirement that the state forego certain traditional regulatory activities unless it were willing to provide strict procedural protections, and such strict procedures as proof beyond a reasonable doubt might well be inappropriate in certain civil contexts. *Cf. Developments, supra* note 2, at 1332 (indicating the undesirability of broadly using "criminal procedures").

90. *See* Flemming v. Nestor, 363 U.S. 603, 614-17 (1960).

91. *See Developments, supra* note 2, at 1332-33.

92. Indeed, it is a premise of the criminal law that its reach carries a most serious stigma, a stigma which can, except in rare cases, only be applied to those responsible for their actions. *Cf.* Murphy, *Preventive Detention and Psychiatry* in PUNISHMENT AND REHABILITATION 211 (J. Murphy ed. 1973) (arguing that preventive detention is unconscionable although teeming with beneficial motives). *But see* text accompanying note 95 *infra* (there might be some responsibility associated with mental illness). Although the *Robinson* Court did not extend its analysis to acts and the Court refused to do so in Powell v. Texas, 392 U.S. 514, 532-33 (1968), it is basically this premise which probably was behind the *Robinson* decision: applying the moral stigma of being an offender to that for which one is not or may not be "responsible" is so serious that it is per se unconstitutional. The practical impact of the stigma of civil commitment might, on the other hand, be greater than that of criminal confinement. This indicates that it is difficult to rank order stigmas.

treatment. Indeed, out of concern for civil committees, some courts and commentators have indicated that need for treatment is not a valid justification for commitment, and have thereby indicated that treatment is not a uniformly beneficial phenomenon.[93] It is ironic that the impact theory rests on the notion that perhaps the only invalid, and certainly a very controversial, purpose of contemporary commitment statutes—dispensing treatment— is the model of legitimacy. Indeed, if an impact test were adopted, a likely outcome would be that commitment for treatment would be characterized as punishment and considered inherently cruel and unusual under *Robinson*.[94]

c. *Which Statuses are Captured within the Robinson Rationale?*

Whether or not the eighth amendment and *Robinson* extend to non-criminal punishment, and whether or not civil commitment (or only civil commitment not associated with treatment) constitutes punishment, there is a question about the statuses *Robinson* reaches. There is some dispute whether the rationale of *Robinson* captures statuses either volitionally or culpably "incurred" or "maintained."[95] The ambiguity concerning which statuses might and might not fit within the Court's reasoning represents another difficulty in using the eighth amendment/*Robinson* right to treatment argument to guarantee a right to treatment to virtually all committees.

2. The Protection from Harm Theory

Although it is gaining increasing attention, the protection from harm theory owes its existence in large part to one case: *New York State Association for Retarded Children, Inc. v. Carey*.[96] In a prelimi-

93. *Cf.* text & note 55 *supra* (indicating that treatment in and of itself is not a sufficient reason to commit).

94. Compare the reasoning in the text accompanying note 88 *supra*.

95. *See* Fingarette, *Addiction and Criminal Responsibility*, 84 YALE L.J. 413, 426-33 (1975). The *Robinson* Court pointed out that narcotic addiction might be innocently incurred, but it did not directly address the question whether Mr. Robinson had innocently incurred his addiction or whether he or anyone could volitionally withdraw from his addiction. 370 U.S. at 667. The Court also drew an analogy to punishment for the status of mental illness, a practice which it said would certainly be inherently cruel and unusual. *Id.* at 666. This might indicate that the Court's main concern was with prohibiting punishment of statuses which are either innocently incurred or maintained, the Court assuming that mental illness is innocently obtained or kept. On the other hand, since certain mental illnesses, just like certain addictions, can be partially self-imposed and probably somewhat volitionally maintained, the Court might have been unconcerned with the question of volition. *See* E. KRETSCHMER, HYSTERIA, REFLEX, AND INSTINCT 79-109 (1960) (noting that "in light of contemporary human knowledge" one may apparently contribute to his own hysteria). *See also* T. SZASZ, THE MYTH OF MENTAL ILLNESS 241-58 (1961) (detailing how one may assume a role voluntarily and then become unaware of it). Perhaps the Court was unaware that certain mental illnesses or addictions might entail some elements of volition, and perhaps it would not apply the *Robinson* rationale to such statuses if sufficient evidence were presented to it in an appropriate case. It would be reasonable to punish "volitional" statuses because the element of volition makes responsibility and deterrence possible.

96. 393 F. Supp. 715 (E.D.N.Y. 1975). This and a previous opinion in the case, New York

nary order,[97] the court rejected plaintiffs' contention that residents of a state school for the mentally retarded had a constitutional right to treatment.[98] The court did hold, however, that the state had a constitutional duty to protect the residents from physical harm.[99] Two years later the court was asked to approve a consent decree[100] which required services well beyond the protection from physical harm which the court had originally envisioned.[101] The decree was, in its own words, "based on the recognition that retarded persons, regardless of the degree of handicapping conditions, are capable of physical, intellectual, emotional and social growth, and . . . that a certain level of affirmative intervention and programming is necessary if that capacity is to be preserved, and regression prevented."[102] Thus, what had been a right merely to be protected from physical harm was transformed, by agreement of the parties, into a right to at least a maintenance level of psychological treatment.

State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973), are often called the *Willowbrook* cases after the institution involved. The protection from harm theory was referred to with approval in Halderman v. Pennhurst State School and Hospital, 446 F. Supp. 1295, 1321 (E.D. Pa. 1977) and in Woe v. Mathews, 408 F. Supp. 419, 428-29 (E.D.N.Y. 1976). *See also* Vanderzeil v. Hudspeth, Civ. Act. No. J76-262(R) (S.D. Miss. Feb. 11, 1977) (mentioning a vague due process right to treatment and a nebulous eighth amendment right to protection from harm). The protection from harm theory was relied upon in the prison context in Bowring v. Godwin, 551 F.2d 44, 46-48 (4th Cir. 1977) and Laaman v. Helgemoe, 437 F. Supp. 269, 309-10, 319 (D.N.H. 1977), discussed in note 66 *supra*.

97. *See* New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973), where the court ordered that certain remedial steps be taken to ensure minimally acceptable living conditions for the residents. *Id.* at 768-70. The court retained jurisdiction to order any further actions necessary to achieve such conditions. The plaintiffs claimed a right to treatment. *Id.* at 757. However, most of them were severely retarded persons who could never be treated and cured. It might be more accurate to speak of a right to habilitation for such persons.

98. *Id.* at 758-64.

99. *Id.* at 764-65. Based in part on Dandridge v. Williams, 397 U.S. 471 (1970), the court reasoned that because the state had no affirmative obligation to provide services to its citizens, the provision of treatment could not be required. 357 F. Supp. at 761-62. On the other hand, the court indicated that the state did have an obligation not to worsen an individual's condition. 357 F. Supp. at 761-65. It drew an analogy to several cases in which other courts had, under the eighth amendment, guaranteed prisoners certain minimum living conditions to protect them from physical harm or deterioration, *id.* at 764-65, and concluded:

> Since Willowbrook residents are for the most part confined behind locked gates, and are held without the possibility of a meaningful waiver of their right to freedom, they must be entitled to at least the same living conditions as prisoners. The rights of Willowbrook residents may rest on the Eighth Amendment, the due process clause of the Fourteenth Amendment or the equal protection clause of the Fourteenth Amendment (based on irrational discrimination between prisoners and innocent mentally retarded persons). It is not necessary now to determine which source of rights is controlling.

Id. at 764.

100. The consent decree is published in 1 MENTAL DISABILITY L. REP. 58-68 (July/August 1976).

101. New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715, 718 (E.D.N.Y. 1975). Once again, the court had originally limited the state's duty to protect the residents to such gross physical dangers as attacks by staff or clear denial of medical care, inadequate heat, exercise and hygienic conditions, and other factors "which violate 'basic standards of human decency.'" New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 764-65 (E.D.N.Y. 1973).

102. New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715, 717 (E.D.N.Y. 1975).

For several reasons, the protection from harm theory is not a promising basis for the right to treatment. It was initially articulated as part and parcel of reasoning providing only limited rights to physical amenities and rejecting any right to psychological treatment. The extension of the theory to the provision of psychological services was not the result of a holding by the court, but of a stipulation by the parties. The court approved the stipulation, but in doing so explicitly declined to decide whether it could be based upon the protection from harm theory.[103] It even suggested that the stipulation might be supported by the erroneous right to treatment arguments advanced in *Donaldson v. O'Connor*,[104] *Welsch v. Likins*,[105] and *Wyatt v. Stickney*.[106] Moreover, and more importantly, there are several indications that the theory is based upon the eighth amendment,[107] which, as was explained at length above, at best cannot be applied to most civil committees.

The theory also depends upon the proposition that the state has a duty to maintain a committee's status at the level existing at the time of confinement, but so provides without justifying and using a constitutional standard of review which would support the proposition. The *Carey* court mentioned that the protection from harm theory rests either upon due process, equal protection, or eighth amendment notions.[108] It did not discuss which particular standard would be appropriate. In the absence of a statement to the contrary, the rational basis test would be the presumptively appropriate due process or equal protection standard. The better view of that test is that it asks whether the state seeks a legitimate goal, and, if so, whether its action can reasonably be conceived to further that goal.[109] The Supreme Court also recently indicated that eighth amendment standards of review are very similar to the rational basis test.[110] Under all these tests, some intrusion

103. *See* 393 F. Supp. at 718-19.

104. 493 F.2d 507 (5th Cir. 1974), *vacated and remanded*, 422 U.S. 563 (1975); *see* 393 F. Supp. at 718-19.

105. 373 F. Supp. 487 (D. Minn. 1974); *see* 393 F. Supp. at 718-19.

106. 325 F. Supp. 781, *enforced*, 334 F. Supp. 1341 (1971), *supplemented*, 344 F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part, rev'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); see 393 F. Supp. at 718-19.

107. In determining the appropriate scope of preliminary relief, the court mentioned that the protection from harm theory might be based upon the eighth amendment. 357 F. Supp. at 764. It also relied upon eighth amendment cases guaranteeing certain rights to prisoners, and used eighth amendment standards announced in those cases to determine the parameters of the physical protections which would have to be provided by the state. *Id.* at 764-65. Moreover, the few commentators who have reviewed the theory have recognized its eighth amendment underpinnings. *See* Saphire, *supra* note 9, at 268-74; Note, *Voluntarily Confined Mental Retardates: The Right to Treatment v. The Right to Protection from Harm*, 23 CATH. U.L. REV. 787, 796-97 (1974).

108. 357 F. Supp. at 764-65.

109. See discussion note 25 *supra*.

110. It is beyond the scope of this Article to carefully examine eighth amendment standards, but a brief review is in order. One commentator has usefully isolated three eighth amendment tests: the inherently cruel and unusual test, the proportionality test, and the excessiveness test. Comment, *Aversion Therapy: Punishment as Treatment and Treatment as Cruel and Unusual*

into the patient's mental condition could be justified by the state's assertion of legitimate commitment goals.[111] The tests therefore do not

Punishment, 49 So. CAL. L. REV. 880, 934-46 (1976). In Gregg v. Georgia, 428 U.S. 153, 169-76 (1976), the plurality opinion of Justices Stewart, Powell, and Stevens recognized these three tests, even if under different names, as prongs of an inclusive eighth amendment standard. The comparison between eighth amendment and rational basis analysis is most apparent in the excessiveness test. In *Gregg*, Justices Stewart, Powell and Stevens read that test to disapprove of punishment only if it has no reasonable connection to the advancement of legitimate goals, with a heavy burden of proof being upon the one who challenges the punishment. *Id.* at 175. At least two other Justices (Burger and Rehnquist) would probably go along with this deferential standard. Coker v. Georgia, 433 U.S. 584, 604 (1977) (Burger, C.J. & Rehnquist, J., dissenting) (*Coker* struck down death as a penalty for rape of an adult woman because it was a disproportionate sanction. Justices Burger and Rehnquist took the extremely deferential position that the Court should not even examine whether a sanction is grossly disproportionate, and it is safe to assume that this attitude would apply to questions of excessiveness as well). Even Justice Marshall has read the eighth amendment to be similar to the rational basis test. Concurring in Furman v. Georgia, 408 U.S. 238, 314 (1972), he reasoned that one challenging the death penalty should have (and could meet) the burden of proving it unnecessary or excessive. Although that proposition was not succinctly stated, it is discernable from Justice Marshall's meticulous discussion of whether death is an excessive penalty. *Id.* at 342-59.

The proportionality test does go beyond the ends/means relationship central to rational basis analysis. However, it too has been read to incorporate the deferential nature of rational basis analysis. The opinion by Justices Stewart, Powell, and Stevens in *Gregg* referred to placing "a heavy burden on those who would attack the judgment of the people's representatives" regarding proportionality, 428 U.S. at 175, and this suggests that gross disproportionality would have to be shown. It might be suggested that the outcome in *Coker* indicates that a more "liberal" test would be used. The favorable decision for petitioner there, however, rested on the conclusion by Justices White, Stewart, Blackmun, and Stevens that death was a grossly disproportionate sanction for rape of an adult woman. 433 U.S. at 592. Once again, Justices Burger and Rehnquist reasoned in dissent that even the gross disproportionality test constitutes too great an intrusion upon legislative prerogative. *Id.* at 610.

The inherently cruel and unusual test takes content in the notion of contemporary acceptance by an enlightened public. See Comment, *supra*, at 935-38. *See also* Furman v. Georgia, 408 U.S. 238, 329 (1972) (Marshall, J., concurring) (utilizing the term "maturing society"). This prong of eighth amendment review has also been read, however, to incorporate deferential notions one associates with rational basis analysis; it has been interpreted to require acceptance by public opinion rather than enlightened public opinion. In *Gregg*, Justices Stewart, Powell and Stevens referred to historical approval and contemporary acceptance by state legislatures as proof that the ultimate sanction does not offend contemporary moral standards; they did not refer to enlightened acceptance. 428 U.S. at 176-83. In a companion case, Roberts v. Louisiana, 428 U.S. 325 (1976), Justices White, Burger, Blackmun, and Rehnquist reasoned in dissent that death is not inherently cruel and unusual, under all circumstances, because of contemporary legislative and lower court acceptance of the death penalty. *Id.* at 350-54. Thus, it is possible that seven Justices would accept the diluted public acceptance standard. *Coker* does not indicate that a more stringent test would be used. The judgment for petitioner there depended in part on a finding that legislatures had generally not accepted death as an appropriate sanction for rape. That indicates use rather than rejection of the public acceptance standard. 433 U.S. at 593-96. For further discussion of various Justices' approaches to eighth amendment standards, see Radin, *The Jurisprudence of Death: Evolving Standards for the Cruel and Unusual Punishments Clause*, 126 U. PA. L. REV. 989 (1978).

111. Two hypotheticals should suffice to support this point. Consider the commitment of one dangerous to others. Many have criticized current standards for commitment, but most would admit that protection of others is certainly a legitimate, and even a compelling, state goal which would justify the intrusion upon freedom from confinement. See discussion note 25 *supra*. The question then becomes whether confinement can reasonably be conceived to further that goal. Once again, the answer is clearly in the affirmative. But what of possible detrimental mental effects on the committee? Under the rational basis test, this question would not be reached unless it were by way of asking whether an individual has an independent right to maintain his mental status quo and whether the state has a legitimate purpose for intruding upon that right. It seems safe to assume that an individual does have the right to maintain his mental status quo (if he can prove what it is and whether it would be or has been changed by confinement). For a rigorous development of such a right based upon the first amendment and the emerging concept of privacy, see Shapiro, *supra* note 55, at 255-76. Once again, however, the answer would seem to be that

support the proposition that the state has a duty to maintain a patient's status.

Even disregarding the constitutional infirmity of the protection from harm theory and accepting the proposition that the state has a duty to maintain the patient's psychological status quo, the argument presents several other problems. First, the theory rests on what might be, for certain patients, a difficult to prove empirical assumption: without psychological treatment, a committee's condition will deteriorate from that existing at the time of his initial commitment. And even if this assumption were established, it would guarantee only the modicum of treatment necessary to maintain the patient's debilitated condition at the moment of confinement. Using traditional due process, equal protection, and even eighth amendment standards of review, the burden of proof would be upon the committee to establish that his condition would become even worse without treatment, and, more particularly,

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there is a legitimate purpose justifying the state's actions effecting the change in the committee's mental condition: protecting others.

The only way the committee could get around this would be to argue that it is unfair to require such a sacrifice from him or at least that the value of extra protection to society engendered by his commitment must outweigh the value of his sacrificed mental health. This resort to a fairness or meticulous balancing standard in which state and individual interests are compared is precisely what the courts have avoided or are supposed to avoid in applying the usual (rational basis) due process and equal protection tests, and under a proper application of those tests the claims would simply fail.

One might suggest that the provisions of the eighth amendment would enable the committee to reach beyond the specific questions one is limited to in applying traditional due process and equal protection standards. Although the eighth amendment standard is very similar to the rational basis test, it adds the requirement that state action comport with "contemporary concepts of common decency." See discussion note 110 *supra*. That requirement might be thought to capture the ideas of fairness and balancing which would be necessary to support a "protection from harm" right to treatment theory. The concept is not, however, as broad as it might seem. The Supreme Court seems to require a clear consensus that the punishment is morally unacceptable. In Gregg v. Georgia, 428 U.S. 153, 176-83 (1976), the Court found no clear consensus against the death penalty, relying in part on its approval by the legislatures of several states. See discussion note 110 *supra*. It would probably similarly find that civil commitment of the dangerous, even without treatment, has been and still is accepted by many state legislatures (if left unprodded by the courts) even though there is a very substantial and vocal segment of the population which decries this acceptance. Legislatures invariably allow commitment of the dangerous mentally ill, but several have either not mentioned a right to treatment or have explicitly limited it. See THE RIGHT TO TREATMENT, *supra* note 3, at 97 app. A.

Perhaps a harder case to consider under the rational basis and eighth amendment tests would be a commitment to protect a patient from passive inability to provide basic food, shelter, and clothing, a commitment which would most likely result in some deterioration of his mental condition. Once again, the legitimate goal of protecting the committee, see discussion note 25 *supra*, which conceivably could be furthered by confinement and supervision, would justify the commitment. There is some intuitive appeal to the notion that the state must be concerned with both the physical and mental health of the committee when it confines him for self-protection. But, once again, that notion does not fit into the deferential standards of review. If it is legitimate to attempt to protect the individual's physical well-being and if commitment might do that, then those tests are satisfied unless conceived to capture general notions of fairness and balancing. A possible alternative short of balancing would be to say that the state's goal must reasonably be conceived to be to make the individual better off in a net sense, weighing physical gains against mental losses. This would require the patient to meet the difficult burden of demonstrating a net loss. It could also be answered by diligent state efforts to disavow any purpose to assure a net benefit to the patient. Considerations of cost and the illusive nature of mental health and treatment could colorably explain such a narrow focus.

without a certain level of treatment.[112] This would entail, in turn, a definition of the relevant conditions one is to use as the base point which must be maintained throughout the duration of confinement and would raise substantial practical and conceptual difficulties.[113]

II. THE LEAST RESTRICTIVE ALTERNATIVE RIGHT TO TREATMENT THEORY

The eighth amendment/*Robinson v. California* argument and the protection from harm rationale are, either as conceived or as applied by the authorities, inconsistent with logic, with precedent, and with a proper application of constitutional standards of judicial review. The most they can support is a modicum or undifferentiated degree of treatment for a limited number of committees.[114] It is the thesis developed

112. The least restrictive alternative theory, see text & notes 114-57 *infra*, requires the state to demonstrate that treatment will not improve the patient's condition. The protection from harm theory would require the patient to show that confinement alone would worsen his condition and that treatment would prevent that deterioration. Confinement can cause problems and treatment often does work. For a discussion of the former statement, see authorities cited note 113 *infra*; for a discussion of the latter, see text & notes 143-46 *infra*. However, it might be difficult for certain patients to establish both propositions insofar as they apply to specific cases. See note 25 *supra* regarding due process and equal protection burdens of proof. For a discussion of the eighth amendment see note 110 *supra*. It might be suggested that the protection from harm theory could be read to require substantial affirmative services because otherwise the individual would suffer the "harm" of foregone benefits. The consent decree in New York State Ass'n for Retarded Children v. Carey, 393 F. Supp. 715, 718 (E.D.N.Y. 1975), *see* text & note 100 *supra*, came close to so arguing. See text accompanying note 102 *supra*. It can be explained, however, as preventing the state from destroying the potential to improve, rather than requiring it to assure that potential be fulfilled, because otherwise it would obliterate the distinction between state obligations to provide services, on the one hand, and state duties to refrain from inflicting harm, on the other. That distinction is at the heart of cases such as Dandridge v. Williams, 397 U.S. 471 (1970), discussed in note 99 *supra*, and it is not clear the Court would or should abandon it. The latter, normative statement raises complex issues that cannot be addressed here. On this topic, *see generally* Dienes, *To Feed the Hungry: Judicial Retrenchment in Welfare Adjudication*, 58 CALIF. L. REV. 555 (1970); Kurland, *Equal Educational Opportunity: The Limits of Constitutional Jurisprudence Undefined*, 35 U. CHI. L. REV. 583 (1968); Richards, *Equal Opportunity and School Financing: Towards a Moral Theory of Constitutional Adjudication*, 41 U. CHI. L. REV. 32 (1973).

113. Consider the commitment of a self-mutilator. It can be assumed, if his commitment comports with minimum legal requirements, that this patient's physical condition would be better than what would have likely resulted from freedom and self-mutilation. He might possess, however, both his original dangerous propensities and additional depressive feelings engendered by confinement. *See* Maler & Mason, *Changes in Number of Self-Reported Symptoms During Psychiatric Hospitalization*, 29 J. CONSULTING PSYCH. 385 (1965); *cf.*, Moffic & Paykel, *Depression in Medical In-Patients*, 126 BR. J. PSYCH. 346-54 (1975) (studying the prevalence of in-patient depression). If one were to focus solely on the committee's mental health, and if the committee were able to meet the substantial burden of demonstrating the deterioration in his condition, perhaps he would be considered to be worse off because of the commitment. If, however, one were to look to some net cost/benefit calculation which would offset the physical gains against the mental losses, the patient might be considered better off. What is the proper approach when applying the protection from harm theory? No answer has yet been given.

114. Once again, the pseudo quid pro quo theory only covers those committed as in need of treatment. And it has nothing to say regarding the nature or degree of treatment they are to be given. Since the theory is intuitively concerned with the curtailment of liberty involved in confinement, the treatment it requires probably must possess some relationship to ameliorating physical restraint. It provides no guidance beyond this rough notion. See text & notes 40-54 *supra*. The paradigm and procedural quid pro quo theories guarantee treatment only to those "fortunate enough" to have been denied substantive or procedural protections provided to criminal defend-

in this Article that there is nevertheless a firm basis for the right to treatment and that logic and precedent support deriving a right to superior treatment for virtually all patients[115] by applying the least restrictive alternative constitutional standard of review to determine whether, when, and what treatment is required.

While some authorities have already suggested that the least restrictive alternative standard supports a right to treatment, none has carefully examined or developed the point.[116] Although the proposition upon which the right to treatment as a logical corollary of the least restrictive alternative standard is grounded—confinement with treatment is less intrusive than confinement simpliciter—is a straightforward one, it is far from simple. For example, suppose the question is, as it was in *Kaimowitz v. Department of Mental Health*,[117] whether an incompetent patient can or should be treated with an intrusive form of "organic" therapy such as psychosurgery. Some civil libertarians would urge (as was done in *Kaimowitz*) that the main concern should be the committee's right against treatment, and that this right must certainly outweigh his supposed right to treatment. They would argue, in effect, that confinement simpliciter would surely be less intrusive than confinement with treatment.[118] In other words, many would argue the converse of the proposition which must be demonstrated to establish a right to treatment as a corollary of the least restrictive alternative standard. Similarly, confinement with treatment is said to be relevantly less intrusive than confinement simpliciter because it is calculated to ameliorate the intrusion upon individual liberty and freedom from confinement wrought by civil commitment. It might be claimed that certain patients cannot reasonably be expected to be curable to the point of allowing release from confinement or enhanced freedom within confinement.

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ants, and they too provide no guidance regarding the nature or degree of treatment required beyond the rough notion of its relationship to ameliorating physical restraint. See text & notes 19-39 *supra*. The eighth amendment/*Robinson* and protection from harm rationales extend to all committees. However, the former gives no guidance regarding the nature or degree of treatment beyond the rough notion spoken of above, while the latter guarantees only the modicum of treatment necessary to maintain the patient's already debilitated status quo. See text & notes 59-110 *infra*.

115. The state can avoid the obligation to provide treatment in a negligible number of cases by demonstrating either that treatment will neither hasten release nor enhance institutional freedom, or that treatment will interfere with state commitment goals. *See* text accompanying notes 147-48 *infra*.

116. *See, e.g.*, Chambers, *supra* note 9 (recognizing that the theory needs development); Saphire, *supra* note 9; *Developments, supra* note 2, at 1245-48, 1328-29. The best exposition of the theory is found in THE RIGHT TO TREATMENT, supra note 3, at 46-54.

117. Civil No. 73-1934-AW (Wayne County, Mich., Cir. Ct. July 10, 1973), *reprinted in* 1 MENTAL DISABILITY L. REP. 147-59 (Sept./Oct. 1976); *see* discussion note 55 *supra*.

118. *See* discussion note 55 *supra*.

The development of the least restrictive alternative theory will thus entail explaining why confinement with treatment is generally, and in specific cases, relevantly less intrusive than confinement simpliciter, and why virtually all patients can demand treatment. This Article cannot, of course, address every psychological ailment and its possible treatments,[119] but it will examine arguably typical cases involving each of the possibly constitutional purposes of commitment to suggest that confinement with treatment is relevantly less intrusive than confinement simpliciter in virtually every case.[120] It will also consider treatment of irreversible brain syndromes to suggest that this is true even as to the most intractable ills.[121] Some would question the efficacy of treatment even in the limited examples discussed herein. However, credible authority is given to support them. And, more importantly, it is the assumption here that the state bears a heavy burden of demonstrating the inefficacy of treatment, a burden which should ensure virtually every patient a right to treatment.[122]

Preliminarily, it is important to list the following assumptions upon which the thesis is based:

(1) The least restrictive alternative principle is an independent constitutional standard of judicial review;
(2) The form of the principle upon which the right to treatment rests entails that: a) the state must bear a heavy burden of proof; b) it need use only equally effective alternative means; c) it must not draw overinclusive classifications which include persons as to whom its purposes are not relevant; and d) it must also use alternative means which minimize intrusions upon those as to whom its purposes are relevant;
(3) The least restrictive alternative principle constitutes a relatively mild intrusion into the political process because it does not deny any goals to the state, but rather requires it to achieve its ends in certain ways; and
(4) Application of (at least) this mild form of review to determine whether, when, and what treatment is required can be thoroughly justified.

Other authorities who have ventured efforts similar to this one have understandably not adequately developed these important assumptions

119. For a general survey of psychological treatments, see Spece, *supra* note 15, at 619-40. Professor Bruce J. Winick of the University of Miami School of Law is completing a substantial piece on the right to refuse treatment which surveys both the theoretical bases of the right and the underlying empirical data. He more completely examines treatments addressed in Spece, *supra*, and their placement along a continuum of intrusiveness.

120. See text accompanying notes 143-46 *infra*.

121. See text accompanying notes 154-55 *infra*.

122. This is one of the assumptions made immediately below in the text and which I have fully developed in a separate article. See Spece, *supra* note 9.

and the complex questions they raise;[123] they require the independent attention I have given them in a separate article to be published in a subsequent issue of the *Arizona Law Review*.[124]

Stated more fully the thesis is that: (A) as a derivative of the least restrictive alternative principle, and only under that standard of review or the more stringent compelling state interest test, virtually all patients are entitled to superior, individual[125] treatment,[126] (B) irrespective of

123. *See* Chambers, *supra* note 9, at 1145; Singer, *supra* note 32, at 55-59. Professor Chambers recognizes that there are competing versions of the principle, that it might constitute a relatively mild intrusion into the political process, and that there is a body of case law which probably supports use of the principle in the civil commitment context. The scope of these questions requires, however, independent treatment, especially since several cases bearing on them have been decided in the last few years. As pointed out in note 124 *infra*, O'Connor v. Donaldson, 422 U.S. 563 (1975), bears on these questions. *See also* Halderman v. Pennhurst State School and Hospital, 446 F. Supp. 1295, 1319 (E.D. Pa. 1977) (mentally retarded have a constitutional right to minimally adequate habilitation in the least restrictive setting); Eubanks v. Clarke, 434 F. Supp. 1022, 1028-29 (E.D. Pa. 1977) (constitutional rights to pre-transfer hearing and to placement in least restrictive setting consonant with legitimate safety, care, and treatment objectives); Dixon v. Weinberger, 405 F. Supp. 974, 979 (D.D.C. 1975) (statutory obligation to create less restrictive facilities); *In re* Jones, 338 F. Supp. 428, 429 (D.C. Cir. 1972) (deprivation of liberty of a dangerous patient should not go beyond what is necessary for patient's protection); Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 165-66, 305 N.E. 2d 903, 905, 350 N.Y.S.2d 889, 892 (1973) (violates due process to subject a person to a greater deprivation of personal liberty than is necessary to achieve the purpose for which he is being confined).

124. The assumptions made in the text are tested and developed in Spece, *supra* note 9. In assuming that the least restrictive alternative principle applies to determining whether, when, and what treatment is required, the Article specifically disavows any suggestion that the principle, as opposed to some more vigorous form of review such as the compelling state interest test, ought to be used to dispose of all questions raised by civil commitment. The only contention is that the least restrictive alternative test could and should be used in cases presenting solely the question whether treatment must accompany commitment. This would be a jurisprudentially sound way to defer for later consideration the controversial question whether some more vigorous standard such as the compelling state interest test ought to be applied in the civil commitment context. The latter question would have to be faced, for example, if the claim were that commitment could not be undertaken for certain (or any) legitimate purposes even if it were the only means by which those purposes could be obtained. Such a claim could be successful only if these legitimate purposes were found not to be compelling or important enough under some vigorous standard of review. Some lower courts have already invoked the compelling state interest test to examine the justifications for commitment. *See, e.g.*, Suzuki v. Alba, 438 F. Supp. 1106, 1110 (D. Hawaii 1977); Doremus v. Farrell, 407 F. Supp. 509, 514 (D. Neb. 1975); Bell v. Wayne County Gen. Hosp., 384 F. Supp. 378, 390 (M.D. Ala. 1974). *See* discussion note 25 *supra*.

As discussed fully in Spece, *supra* note 9, which supports the assumptions made in the text, the Court used the least restrictive alternative principle in O'Connor v. Donaldson, 422 U.S. 563, 573-76 (1975), and there is even some indication that it used the compelling state interest test. *Id.* at 575. That article indicates that use of the compelling state interest test to determine the permissible goals of commitment is justified. Finally, by demonstrating that the least restrictive alternative principle can be properly limited, the Article also deals with the argument that there might be no way to cabin the principle if it were accepted to determine whether, when, and what treatment is required.

125. "Individual" is used to convey the idea that the particular needs of each patient, as opposed to generalized groups of committees, must be given attention. See text & notes 135-37 *infra* regarding individual as opposed to group care.

126. It has been admitted that some civil libertarians would claim that confinement with treatment is more intrusive than confinement simpliciter, and a large body of right *against* treatment literature has been cited. See text & notes 55 & 118 *supra*. That objection is met, however, by positing that patients need not accept treatment (except, perhaps, arguably mild forms of intervention such as verbal counseling). For a discussion of the qualification, see Shapiro, *supra* note 55, at 251 n.38. If a patient is faced with alternatives of confinement with and without the choice to have treatment, the former, entailing a choice which might hasten release or enhance institutional freedom, is by definition less intrusive. Along these same lines, the least restrictive alternative

the purpose of their commitment, (C) unless the state can meet the

principle allows the confinement of those who refuse treatment but are otherwise committable; the other right to treatment arguments considered above, however, present considerable problems regarding such committees. Since the least restrictive alternative theory rests on the assumption that confinement with the choice to accept therapy is relevantly less intrusive than confinement simpliciter, if the choice is to refuse, the state's obligation to provide treatment is excused. The eighth amendment argument posits, however, that commitment not associated with treatment constitutes cruel and unusual punishment, and it rests on the broad assumption that treatment is uniformly beneficial. See text & notes 76-94 *supra*. The committee's refusal of treatment gainsays this assumption and suggests that the eighth amendment would not allow commitment of those who refuse treatment. The protection from harm theory, see text & notes 96-113 *supra*, rests on the same broad assumption that treatment is generally beneficial, and it too is severely tested when the patient refuses treatment. It would, however, probably excuse the state's obligation to maintain the patient's mental status quo if he were to refuse treatment. The pseudo quid pro quo theory can only apply if the purpose of commitment is treatment. See text & notes 45-53 *supra*. The purpose of commitment cannot be treatment, however, if the patient has the power and inclination to refuse. See notes 55 *supra* regarding the right against treatment. Finally, the paradigm and procedural quid pro quo theories assume that treatment is a compensation which can justify deprivation of substantive or procedural protections. If treatment is refused, however, the notion of it as a compensation becomes somewhat tenuous.

Some argue that free choice is ipso facto impossible within an institution and that all treatment is coercive and improper. *See* authorities cited in Shapiro, *supra*, at 316-18 nn.273-279. That view has been rejected, however, by the most informed and eminent authorities. They argue, and correctly so, that institutional free choice (1) interferes with patients' autonomy, (2) fails to accord them proper respect as persons, and (3) forecloses treatment which might well be in their best interests. *See, e.g.*, Murphy, *Total Institutions and the Possibility of Consent to Organic Therapies*, 5 HUMAN RIGHTS 25 (1975); Shapiro, *supra* at 316-20; Wexler, *supra* note 31, at 17-18.

At the other extreme, some would urge that patients are incompetent to refuse therapy—they are, after all, mentally ill. That view has been uniformly rejected; both medical and legal authorities have explained that mental illness does not necessarily make a person incompetent to make decisions. There must be a specific finding that a patient is incompetent to make decisions regarding treatment before his preference regarding treatment can be disregarded. *See Developments, supra* note 2, at 1213-14, 1228-35, 1351.

It is also posited here, however, that committees must be treated if such is in their best interests and they are incompetent to make therapeutic decisions. It might be thought that treatment supported by the least restrictive alternative theory would ipso facto be in a patient's best interests. After all, the theory supports only treatment which is designed to cure or ameliorate mental illness and thereby hasten release or enhance institutional freedom. Certain treatments designed to ameliorate the need for physical restraint might nevertheless entail such intrusion into a committee's mental functioning or involve such serious side effects that they would not be in his best interests. Psychosurgery is the treatment which has engendered the greatest amount of debate; some even claim that it ought not be used on competent patients. The literature on the efficacy of psychosurgery is immense and intriguing; there is even considerable dispute concerning the definition of psychosurgery (of which there are several forms). *See, e.g.*, S. SHUMAN, PSYCHOSURGERY AND THE MEDICAL CONTROL OF VIOLENCE: AUTONOMY AND DEVIANCE 24-47 (1977); Shapiro, *supra* note 1, at 684 n.20 (1975); Spece, *supra* note 15 at 632-33; *Symposium—Psychosurgery*, 54 B. U.L. REV. 215-353 (1974). The check of informed consent insulates competent patients from improper use of such therapies; they participate in choosing treatment and defining what is in their best interests. However, an independent requirement that treatment be in a patient's best interests is necessary to protect the incompetent as they cannot participate fully in the choice of therapies. Moreover, this limitation is consistent with the least restrictive alternative theory. Committees possess freedom of mentation as well as freedom from confinement. Both of these are deserving of special constitutional protection and both must be taken into account in determining what is the least restrictive alternative for achieving the state's commitment goals. See note 111 *supra* regarding the protection of mentation.

It might also be suggested that applying any treatment to an incompetent committee constitutes improper coercion and works against his best interests. Although there are certain dissenters, see discussion note 55 *supra*, the most eminent authorities have carefully addressed this question and agreed that the benefits of certain treatments outweigh the relatively limited coercion involved in forcibly treating an incompetent patient. *See* Shapiro, *supra* note 56, at 288-90, 294-96; *cf.* Murphy, *Rights and Borderline Cases*, 19 ARIZ. L. REV. 228, 239 (1977) (mentally retarded entitled to certain level of training). They go so far as to say that the state has a moral obligation to provide treatment to incompetent committees. *Cf. id.* (mentally retarded). For a discussion of

heavy burden of demonstrating either that treatment would neither hasten release nor enhance freedom within the institution or that confinement with treatment would be less effective than confinement simpliciter in achieving the state's commitment goals.

A. *As a Derivative of the Least Restrictive Alternative Standard of Review, and Only Under that Principle or the Stringent Compelling State Interest Test, All Patients Are Entitled to Superior, Individual Treatment*

The first proposition actually entails three: (1) a right to treatment can be derived from the least restrictive alternative principle *alone*; (2) this is a right to superior, individual treatment; and (3) this comprehensive right can be derived *only* from the least restrictive alternative standard or the stringent compelling state interest test.

These contentions rest on a proper application of constitutional standards of review. First, one must identify whether, under equal protection or due process, some protected right is interfered with by involuntary commitment. Several authorities[127] have persuasively described what the Supreme Court has called the massive curtailment of liberty entailed in civil commitment.[128] It is sufficient here simply to repeat that commitment intrudes upon the right to freedom from confinement or physical restraint and associated rights to travel, privacy, association, and communication.

Even under the laxest form of scrutiny, once it is established that commitment trammels individual rights, the state must justify its action by, at least, asserting a rational relationship to valid ends or goals.[129] And, under the least restrictive alternative test, the state must go beyond this and demonstrate that its action captures only those as to whom its goals are relevant, and then only in the least intrusive manner possible.[130] Thus, under the least restrictive alternative principle, the relevant question becomes: is there any alternative to confinement simpliciter by which the state can achieve the goals justifying any particular commitment and yet intrude less upon the right to freedom from

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Shapiro's position and a case on point, see note 55 *supra*. Some consideration ought to be given to both incompetent requests and refusals of treatment when determining whether specific therapies are in a patient's best interests. This recognizes the limited efficacy of an incompetent's expression of preference but gives it some weight.

127. *See, e.g.*, Chambers, *supra* note 9, at 1155-68; *Developments, supra* note 2, at 1193-1201; authorities cited note 25 *supra*.

128. *See* Humphrey v. Cady, 405 U.S. 504, 509 (1972) (characterizing civil commitment as a massive curtailment of liberty).

129. See note 25 *supra* for a discussion of the rational basis test.

130. Note, *The Less Restrictive Alternative in Constitutional Adjudication: An Analysis, A Justification, and Some Criteria*, 27 VAND. L. REV. 971, 1032-33 (1974). *See also* American Party of Texas v. White, 415 U.S. 767, 781 (1974); Kramer v. Union Free School Dist. No. 15, 395 U.S. 621, 632-33 (1969); Spece, *supra* note 9.

confinement or physical restraint (and associated rights)? This in turn requires identifying the possible constitutional goals of commitment: defending society; protecting the patient from affirmative self-inflicted harm; insulating the patient from passive, self-inflicted harm; and providing treatment.[131] Each of these objectives can be achieved respecting virtually all patients through the relevantly less restrictive alternative of confinement with treatment.[132]

To list possible constitutional goals of commitment and to argue that the least restrictive alternative theory supports a right to treatment for those committed for any of those purposes is not to concede that the goals are constitutional. Rather, it is to leave to others the question of the permissible purposes of commitment and to demonstrate that even if a court rejects suggested limitations on the goals of commitment, it cannot reject the right to treatment on the basis of the purpose of commitment.[133] Similarly, and as explained above, to argue that the least restrictive alternative standard supports a right to treatment for committees is not to overlook that it also places limits on the commitment power.[134] The purpose here is to construct a theory which supports a right to treatment for virtually all of the limited number of patients whom the state can validly commit.

The proposition is that committees possess a right not simply to some therapy, but to superior, individual treatment. Certain authorities have reasoned, to the contrary, that only a modicum of treatment as opposed to superior treatment need be provided and that the relevant inquiry is adequacy of treatment in the institution generally, not in individual cases.[135] Those statements are, however, at odds with the least

131. See discussion note 25 *supra*.

132. See text & notes 143-146 *infra*.

133. Recent decisions have applied the compelling state interest test and required danger to self or others as a necessary condition to commitment. *See, e.g.*, Suzuki v. Alba, 438 F. Supp. 1106, 1109-10 (D. Hawaii 1977); Doremus v. Farrell, 407 F. Supp. 509, 514 (D. Neb. 1975); Bell v. Wayne County Gen. Hosp., 384 F. Supp. 378, 390 (M.D. Ala. 1974); Lessard v. Schmidt, 349 F. Supp. 1078, 1093-94 (E.D. Wis. 1972), *vacated on procedural grounds and remanded*, 414 U.S. 473 (1974); *In re* Levias, 83 Wash. 2d 253, 256-58, 517 P.2d 588, 591 (1973); State *ex rel.* Hawks v. Lazaro, — W. Va. —, —, 202 S.E.2d 109, 123-24 (1974). See note 124 *supra* regarding limitations on the purposes of commitment as opposed to requiring treatment once commitment is found justified. Although the justifications for commitment and the obligation to treat after commitment are discrete issues, they may be related. A court might disallow commitment unless it appears that appropriate treatment will be given. This possibility raises a question which needs further study: when should the question of appropriate treatment be considered? *Cf.* Chambers, *supra* note 9, at 1178-82 (arguing that alternatives to commitment should be considered both prior to and after commitment).

134. The least restrictive alternative principle requires the state to use alternatives short of commitment if they will serve the state's goals. *See* O'Connor v. Donaldson, 422 U.S. 563, 575 (1975); Chambers, *supra* note 9, at 1121-37; *Developments, supra* note 2, at 1250; text & note 11 *supra*.

135. *See, e.g.*, Birnbaum, *A Rationale for the Right*, 57 GEO. L.J. 752, 753-55 (1969) (essentially arguing for an institutional standard); Morris, *Institutionalizing the Right of Mental Patients: Committing the Legislature*, 62 CALIF. L. REV. 957, 986 (1974); Reisner, *Psychiatric Hospitalization and the Constitution: Some Observation on Emerging Trends*, 1973 U. ILL. L. F. 9, 15-16 (1973);

restrictive alternative principle. The least restrictive alternative principle requires that the state employ means which draw precise distinctions rather than overbroad generalizations and which also minimize intrusions upon affected individuals. Treatment might vary considerably within an institution and among individual cases.[136] It is a prohibited, broad generalization, therefore, to conclude that each patient has been given proper treatment simply because he is housed in an institution with a generally excellent treatment record. Similarly, merely a modicum of treatment does not minimize intrusions upon the right to freedom from confinement or physical restraint (and related rights) in each individual case; only superior treatment will maximally cure or ameliorate illness and hasten release or enhance institutional freedom.[137]

Robitscher, *The Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient*, 18 VILL. L. REV. 11, 11-14, 35 (1972).

It might also be objected that confinement with a resort environment, including tennis courts, sauna baths, wine, cheese, and crackers, would be less intrusive than confinement alone, and that if one accepted the least restrictive alternative rationale, there would be no way to confine it. As has been pointed out, however, commitment with treatment is relevantly less intrusive that commitment alone. See text & notes 130-33 *supra*. That is because treatment is designed to ameliorate or cure the mental illness and accompanying status which justify civil commitment in the first instance. On the other hand, tennis courts, wine, cheese, and crackers presumably are not therapies which can be demonstrated to cure or ameliorate mental illness; confinement with them is less intrusive than confinement simpliciter, but not in a substantially relevant way.

136. Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782, 791 & n.44 (1969).

137. Although the least restrictive alternative principle does support a right to superior, individual treatment, some might claim that the courts cannot determine what is superior treatment for a particular committee or even perhaps for a group of similarly situated patients. The claim might be that because of the relative inability to formulate judicially manageable standards, the courts must refrain from creating a too potent right to treatment entailing a too stringent court review of institutional conduct. *See* authorities cited note 135 *supra*. *Cf.* Director of Patuxent Inst. v. Daniels, 243 Md. 16, 40-42, 221 A.2d 397, 411-12 (1966) (upholding Maryland Defective Delinquent Act and essentially deferring to legislative judgment that the Act was properly structured to achieve its therapeutic objectives). This would simply be a more moderate version of the position advanced and rejected in *O'Connor* that the right to treatment is a non-justiciable question. *See* 422 U.S. at 574 n.10. It is an indefensible position. Some fine writing has been done illustrating the feasibility of court administration of claims to adequate or superior, individual treatment. *See, e.g.*, Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782, 791-94 (1969); Schwitzgebel, *Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria*, 8 HARV. C.R.-C.L. L. REV. 513, 515-16 & n.147 (1973); Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936, 936-38 (1974); Dix, Book Review 11 ARIZ. L. REV. 822 (1969) (*Right to Treatment: A Symposium* (D. Burns ed.)). Halpern and Dix argue for adequate, individual treatment, while Schwitzgebel argues for an even higher standard—effective treatment—of individual care. *See also* In re C.S., Civ. No. HN CC 11-75 (Hunterdon County, New Jersey, Apr. 18, 1977) (reviewed in 2 MENTAL DISABILITY L. REP. 26 (Jul.-Aug., 1977) (ordering a plan be drawn up to ensure a mentally ill individual would receive constitutionally adequate habilitative care).

This Article will neither rehearse nor add to the arguments advanced in the above authorities. Its main contribution is to demonstrate a theory which can support a right to superior, individual treatment. It is noted, however, that continuing work needs to be done to formulate judicially manageable standards. An admirable step in this direction was taken in Wyatt v. Stickney, 325 F. Supp. 781, 784-85, *enforced*, 334 F. Supp. 1341 (1971), *supplemented*, 344 F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part, rev'd in part, remanded in part, sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

Professors Hoffman and Dunn might well be correct that an administrative model would be superior to a judicial one in protecting the right to treatment. Hoffman & Dunn, *Beyond Rouse*

Finally, it has not only been asserted that the least restrictive alternative standard supports a right to superior, individual treatment for virtually all committees, but that *only* it (or the more stringent compelling state interest test) does so. This is supported by the demonstration above that other constitutional right to treatment arguments support, at best, a diluted or undifferentiated degree of treatment for a limited

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and Wyatt: An Administrative-Law Model for Expanding the Mental Patient's Right to Treatment, 61 VA. L. REV. 297 (1975). The right to treatment is too important, however, to await legislative creation of administrative schemes. And judicially created rights might well provide an impetus for legislative action in the area. Pending such legislative action, Professors Hoffman and Dunn mention two devices which might assist the courts: appointment of masters and institutional human rights committees with the power to interpret judicially created rights, the power to order changes in administrations, and the authority and expertise to review individual treatment plans. *Id.* at 308-10.

Another qualification is in order. The least restrictive alternative and superior, individual treatment standards might be thought to countenance the unreasonable notion of requiring tremendous expenditures of resources such as a battery of psychiatrists and psychologists continually attentive to a single patient's needs. These standards must be reasonably interpreted and applied. Although it has been broadly indicated that saving money cannot justify otherwise impermissible state actions which touch important personal rights, *see* Shapiro v. Thompson, 394 U.S. 618, 633 (1968), cost considerations should, and most probably would, become dispositive at some reasonable point.

Freedom from confinement or physical restraint and associated rights to travel, privacy, association and communication have been identified as the rights trammeled by commitment. See text & note 128 *supra*. In the text, it is assumed that superior treatment is that which will hasten release from, or minimize physical restraint within, the institution. That assumption focuses upon the right to freedom from confinement or physical restraint. Related interests in travel, privacy, association, and communication are also generally enhanced by early release or absence of physical restraint. Cases can be imagined, however, in which those assumptions become questionable.

Consider a choice between psychosurgery, which would immediately remove a patient's dangerous propensities and enable release, and drug therapy with individual or group psychotherapy, which would accomplish the same in several weeks. Psychosurgery would minimize intrusion upon the right to freedom from confinement or physical restraint. It might, however, entail irreversible side effects which might interfere with, or intrude into, the committee's communication, association, and privacy. Drugs and psychotherapy might also involve side effects, but they would probably involve less interference with, or intrusion into, communication, association, and privacy. Which therapeutic regimen would be the least intrusive?

Fortunately, a primary concern with freedom from confinement or restraint will suffice in most cases because of its relationship to rights to travel, communication, association, and privacy. When more specific concerns appear, as in the posited example, the intrusion upon each right must be considered and the therapy chosen which entails the net minimization of intrusion. That venture should be assisted by prior work that has positioned treatments on a continuum of intrusiveness. *See* Shapiro, *supra* note 55, at 262-69; Spece, *supra* note 15, at 619-40. Shapiro more particularly describes both intervention or intrusion, Shapiro, *supra* at 243 n.6, and forms of communication and privacy (freedom of mentation) which might be intruded upon by various treatments, *id.* at 255-75.

Another complication in this equation which will not be explored here is the patient's stated preference. See *id.* at 327-28 for a discussion of the right to choose therapy. More attention also needs to be given to the discrete concepts of "efficiency" (how quickly can discharge be achieved) and "effectiveness" (how long can the patient be kept in the community once discharged) in working out the least restrictive alternative. See F. MILLER, R. DAWSON, G. DIX, & R. PARNUS, THE MENTAL HEALTH PROCESS 550-51 (1976).

Finally, those committed for purposes of treatment should, in a sense, have no less than a right to be cured after a reasonable period; they should be released if not cured within a reasonable period. If not, then the nature and duration of their commitment does not bear the required reasonable relationship to its purpose. *See, e.g.*, O'Connor v. Donaldson, 422 U.S. 563, 573-76 (1975); Jackson v. Indiana, 406 U.S. 715, 738 (1972); text & notes 42-44 *supra*. The Court indicated in *Jackson* that it is unreasonable to indefinitely confine a person while waiting for him to be made competent to stand trial, 406 U.S. at 738, and it is similarly unreasonable to indefinitely confine a person while waiting for him to be cured.

number of patients.[138] The least restrictive alternative theory not only provides a comprehensive right but also stands precisely where the others fall.[139]

B. *The Least Restrictive Alternative Right to Treatment Theory Holds Irrespective of the Purpose of Commitment*

To support the second proposition, one should consider paradigm, hypothetical cases involving each of the possible constitutional bases for commitment. These cases suggest that virtually all committees possess a right to treatment. Once again, consideration of these cases does not concede the constitutionality of the asserted purposes of commitment.[140] And it does not ignore that the feasibility of alternatives to commitment would have to be carefully examined in each case.[141] It will be assumed in each case that the serious degree of the patient's illness, the nature of the threat or problem that illness presents, and the absence of helpful family or friends make prohibitively expensive, continual out-patient surveillance the only alternative to commitment.[142]

First, consider a paranoid schizophrenic whose delusions include the belief that someone is after him and must therefore be destroyed. The goal of protecting the supposed enemy can be achieved by confining the paranoid schizophrenic with or without treatment. Drug therapy, however, might well bring the patient back to reality and make

138. See discussion note 114 *supra*.

139. The theory proceeds from a recognition that, under equal protection and due process concepts (not some inapplicable eighth amendment notions), deprivations of individual rights must be justified by considerations which require the intrusions rather than by some independent compensation. It rests on the sound ideas that commitment trenches on the very important right to freedom from confinement (and accompanying rights), and that this deprivation must be justified by important state interests which can be obtained only through commitment. It does not, as do the paradigm and procedural quid pro quo theories, assume either that criminal and civil confinement implicate the same interests, thus requiring differences between them to be justified by compensation, or that patients must be treated identically irrespective of the purpose of their commitment. It also, however, does not justify giving committees fewer protections than criminal defendants or giving certain committees fewer protections than others by invoking rational basis notions. It involves thoroughly justifying the use of an invigorated form of review which requires careful scrutiny of distinctions between criminal and civil confinement and supports a right to treatment for patients irrespective of the purpose of their commitment. The latter is so because treatment might well cure or improve mental illness, eliminate or ameliorate the status justifying commitment, and thus lead to release or enhanced freedom within the institution irrespective of the purpose of commitment.

140. See text & note 133 *supra*.

141. See text & notes 11, 134 *supra*.

142. Although fiscal considerations generally do not justify sacrificing individual rights, at some reasonable point they should, and most probably would, become dispositive. *See* note 137 *supra*. One issue which is usually associated with exploring alternatives to commitment, rather than with providing treatment once commitment takes place, is whether the state can be ordered to construct facilities. If new facilities and equipment are necessary for superior, individual treatment, the least restrictive alternative theory would require that they be constructed or obtained, subject to the limitation that at some point fiscal considerations would become dispositive. *See* Chambers, *supra* note 9, at 1191-200 regarding the construction of new facilities.

safe his release or greater freedom within the institution.[143] Therefore, confinement with the drugs would be relevantly less intrusive than confinement alone.

Similarly, imagine a person whose endogenous depression has led him to twice attempt suicide and to announce his intention to try again and again until he succeeds. He might be protected by confinement and careful surveillance or restraint until a spontaneous and more than transitory remission occurs. But a less drastic or intrusive mode of intervention would seem to be a term of confinement probably shortened by treatment with anti-depressant drugs.[144]

Again, suppose the case of a catatonic schizophrenic who sits idly without eating or drinking. He might eventually die unless confined and forcibly nourished. The term of such intervention might well be limited by provision of medication.[145]

Finally, take the case of a person suffering from manic-depressive psychosis, who, in a prolonged manic stage, begins running through his limited family finances, supposing himself to be a philanthropist with unlimited funds. This person could be committed under many paternalistically based state statutes, and he might be controlled merely by confinement. This restraint could be limited, however, by the use of lithium.[146]

The above four cases cover each of the possibly constitutional purposes of commitment—danger to others, affirmative danger to self, passive danger to self, and need for treatment, respectively. And each, when subjected to least restrictive alternative analysis, suggests that confinement with treatment would be relevantly less intrusive than confinement simpliciter.

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143. *See* Cameron, *Paranoid Reactions*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY § 16.1, at 673-74 (A. Freedman & H. Kaplan eds. 1967); Interview with Alan Levenson, M.D., Head of the Department of Psychiatry, University of Arizona College of Medicine, in Tucson, Arizona (May 11, 1977).

144. *See* Huston, *Psychotic Depressive Reaction*, in 1 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, § 18.1, at 1052-54 (2d ed. A. Freedman, H. Kaplan & B. Sadock eds. 1975); "Most clinicians concur that medication has a role in the treatment of the suicidal person . . . [b]ecause [the drug helps] the depressed person generally . . . feel better and . . . function better and do more." Mintz, *Basic Considerations in the Psychotherapy of the Depressed Suicidal Patient*, 25 AM. J. PSYCHOTHERAPY 67 (1971). Additionally, drug therapy allows the use of psychotherapy. Bombstein, *The Forcible Administration of Drugs to Prisoners and Mental Patients*, 9 CLEARINGHOUSE REV. 379 (1975); Interview with Alan Levenson, *supra* note 143.

145. Interview with Alan Levenson, *supra* note 143; see Fink & Itil, *Schizophrenia VI: Organic Therapy*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY § 15.6, at 663 (A. Freedman & H. Kaplan eds. 1967). It is noted that the incidence of catatonic schizophrenia is fairly low. A. Marinow, *Hospital Treatment and Rehabilitation in Schizophrenic Terminal Stages*, in STUDIES OF SCHIZOPHRENIA 125 (Lader ed. 1972).

146. R. Cohen, *Manic-Depressive Reactions*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 686-87 (M. Freedman & H. Kaplan eds. 1967); Interview with Alan Levenson, *supra* note 143; *see* MODERN CLINICAL PSYCHIATRY 352-54 (7th ed. A. Noyes & L. Kolb eds. 1968); P. POLATIN, A GUIDE TO TREATMENT IN PSYCHIATRY 215-17 (1966).

C. *The State can Avoid the Obligation to Provide Treatment Only if it can Meet the Heavy Burden of Demonstrating either that Confinement with Treatment would Be Less Effective than Confinement Simpliciter in Achieving the State's Commitment Goal(s) or that Treatment would neither Hasten Release nor Enhance Freedom within the Institution*

The final proposition in the thesis is that the state can avoid the obligation to provide treatment (1) if confinement with treatment would be less effective than confinement simpliciter in achieving the state's commitment goals, or (2) if treatment would neither hasten release nor enhance institutional freedom. These contentions logically follow from the definition of the least restrictive alternative principle posited above: the state must use any equally effective and less intrusive alternatives. First, if treatment will neither hasten release nor enhance institutional freedom, confinement with treatment is ipso facto not less intrusive than confinement alone.[147] The principle therefore comfortably accommodates the confinement of those who are untreatable but otherwise committable; the same cannot be said for the other right to treatment arguments considered above.[148] Second, if confinement with treatment is less effective than confinement simpliciter in achieving the state's commitment goals, it is by definition not an equally effective alternative, and it need not be used.

Nevertheless, because it is very difficult for the state to establish the propositions which would excuse its obligation to provide treatment, virtually all patients will possess that right.[149] The broad contention that treatment is generally ineffective appears to be simply untrue.[150] Drug treatment has, for example, engendered a revolution in

147. In this instance, therefore, treatment need not even be offered a competent patient who wants it, and treatment probably could not be forced on an incompetent committee as it would presumably not be in his best interests.

148. This is evident under reasoning substantially identical to that applied to those who refuse treatment. See discussion note 126 *supra*.

149. It must be recalled that the state is assumed to bear a heavy burden of proof under the least restrictive alternative principle. That notion must not be carried too far concerning proof of the inefficacy of treatment as otherwise the state might be, in a sense, forced to bombard patients (especially incompetent ones) with treatment. The problem is only partially alleviated by the consent of competent patients and the requirement that any treatment be in the best interests of incompetent committees. The former might agree to therapies which are so ineffective or unsafe that they ought not be offered in the first place, while the general admonition to treat might lead to approving the same sort of therapies for incompetent patients for whom no other treatment is available. Courts must determine questions regarding treatment keeping in mind that it is a two-edged sword. Questions regarding procedures by which such questions should be determined are beyond the scope of this Article. For discussion of a system calling for prior judicial approval of certain therapies, see Shapiro, *supra* note 55, at 320-24. Regarding administrative regulation see generally Hoffman & Dunn, *supra* note 137; Wexler, *supra* note 31, at 67-68.

150. Interview with Alan Levenson, *supra* note 143. *See* Jarvik, *Drugs Used in the Treatment of Psychiatric Disorders*, in THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 167 (4th ed. L. Goodman & A. Gilman eds. 1970) for the proposition that drugs "have enabled patients who otherwise would have been hospitalized to live at home and to work productively . . . . Some

the care of the mentally ill. It alone has in the past two decades substantially reduced the percentage of persons requiring institutionalization,[151] and release from confinement is precisely what the least restrictive alternative theory is concerned with. Taken more narrowly, the objection might be that treatment might not be effective in individual cases or classes of cases. But:

(1) Authority would support the efficacy of treatment in many such cases, including the four hypotheticals presented above involving each of the possibly constitutional purposes of commitment;[152]

(2) Beyond those four cases, authority would support the possible efficacy of treatment in many cases of virtually all mental illnesses which patients might suffer;[153]

(3) In any event, once again, a heavy burden is on the state to demonstrate that treatment is fruitless in hastening release or even enhancing freedom within the institution; and

(4) If the state can perform the peculiarly difficult task of demonstrating the inefficacy or disutility of treatment in a particular case, then in that particular instance it need not provide treatment.

The four hypothetical cases described above cover types of patients most likely to be committed. To prove a point, consider what is perhaps the strongest case for skeptics of a right to treatment for all patients—a committee suffering from a chronic or irreversible, organic brain syndrome.[154] This rare committee is, as his moniker suggests, probably headed for eventual oblivion. But accurate diagnosis of such a condition is a difficult task. Moreover, even if properly diagnosed, the condition might be ameliorated by medication designed to increase blood flow in the brain and to lessen possible paranoia or depression

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patients are so benefited by the drugs that psychopathology is not detectable even to highly skilled observers."

An interesting response to an inquiry into the effectiveness of the phenothiazines is offered by M. Ostow, M.D.: "[O]ne compelling piece of evidence for the usefulness of drugs is that if we give the wrong drug to a patient, the patient gets worse, whereas if we then substitute the right drug, the patient gets better." PSYCHIATRIC DRUGS 120 (P. Soloman ed. 1966).

For a preliminary examination of the various forms of treatment, their effectiveness, and their limitations see Spece, *supra* note 15, at 619-33.

151. *See* Jarvik, *Drugs Used in the Treatment of Psychiatric Disorders*, in THE PHARMACOLOGICAL BASIS OF THERAPEUTICS, *supra* note 150 (discussing chlorpromazine and its phenothiazine analogs); MODERN CLINICAL PSYCHIATRY 574 (7th ed. A. Noyes & L. Kolb eds. 1968). *But see* FOUNDATIONS OF ABNORMAL PSYCHIATRY 566 (P. London & D. Rosenhan eds. 1968) (noting that changes other than use of drugs—larger staffs for example—might bear on the improvement).

152. *See* text & notes 143-46 *supra*.

153. Interview with Alan Levenson, *supra* note 143. *See also* text & notes 150, *supra*, 154-55, *infra*; authorities cited note 119, *supra*.

154. Brain syndromes are "organic mental disorders due to a diffuse impairment of brain tissue function." H. Brosin, *Acute and Chronic Brain Syndromes*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY § 18.2, at 708 (A. Freedman & H. Kaplan eds. 1967). For a description of several categories and types of syndromes, see *id.* at 708-816.

associated with the disease.[155] No responsible private psychiatrist would risk liability and suppose such a person to be untreatable prior to attempting such drug therapy or some other mode of intervention; the state should, if it has forcibly confined someone, be held to no less of a standard. Indeed, such state behavior is in essence required by the state's heavy burden of proof regarding the inefficacy of treatment.

Once more, the state might also seek to avoid the obligation to provide treatment by contending that it might compromise the state's commitment goals. Again, the state should be unsuccessful. First of all, treatment probably enhances the state's commitment goals. Treatment surely cannot compromise the state's commitment goal if that goal is to provide treatment. The same is true if the state's goal is to protect the patient from passive inability to provide himself with food, shelter, and clothing. It is difficult to imagine any reasonable form of treatment compromising that goal.

If one refers, however, to protecting the committee or others from active danger, a treatment entailing relatively less restraint or more activity in an open environment might be imagined to compromise the state's protective goals.[156] But even in such esoteric cases treatment might in the long run enhance the state's goals by "curing" the illness and the danger it causes. And, even if this were not so, other treatments, such as drug therapy, not entailing lessened restraint and possible sacrifice in protective goals might be efficacious.[157]

155. T. DETRE & H. JARECKI, MODERN PSYCHIATRIC TREATMENT 411-13, 433-37 (1971); C. Kimball, *Medical Psychotherapy: A General Systems Approach*, in 5 AMERICAN HANDBOOK OF PSYCHIATRY 801-02 (2d ed. S. Arieti 1975); Interview with Alan Levenson, *supra* note 143. *See also* Peterson, *Psychiatric Aspects of Chronic Organic Brain Syndrome*, 60 POSTGRADUATE MED. 162 (1976). Lipper and Tuchman have noted the inadequacies of present therapies for chronic organic brain syndrome. Lipper & Tuchman, *Treatment of Chronic Post Traumatic Organic Brain Syndrome with Dextroamphetamine: First Reported Case*, 162 J. NERVOUS & MENTAL DISEASE 366 (1976). However, their conclusion was based on the desire for therapy which consistently allowed the patients to return to their families and vocations. The authors noted that "current pharmaco-therapy can increase the tractability of these . . . patients and make them more amenable to institutional and custodial care." *Id.* at 366. The report indicated that use of dextroamphetamine may be more successful in returning patients with chronic organic brain syndromes to society. It must be remembered that the least restrictive alternative theory requires treatment which might ameliorate institutional restraint as well as therapy which might hasten release.

The application of the least restrictive alternative theory to those with chronic brain syndromes is similar to its application to those who are retarded. The retarded cannot be treated and cured, but they can be given special training or habilitation which might enable them to function outside an institution or to require less restraint within an institution. But what if the state can demonstrate that a retarded person might be habilitated but not insofar as that might relate to hastening release or ameliorating restraint? Whether the courts should order the expenditure of resources which *might* have such limited habilitative effects should be carefully considered. Only the compelling state interest test would possibly support a right to treatment in these circumstances.

156. See Spece, *supra* note 15, at 621-22 (explaining milieu therapy).

157. See *id.* at 619-33 for an overview of possible therapies.

IV. CONCLUSION

A right to treatment is vital to thousands of involuntarily committed persons.[158] An uncommon number of authorities have recognized this and have supported the sound notion of a right to treatment. But perhaps because of the intuitive appeal of the idea, there has yet to be articulated a logically and precedentially sound basis for the right. It is no exaggeration to say that the conceptual basis of the right to treatment is in a state of disarray. That is of more than theoretical importance because the Chief Justice of the United States Supreme Court recently seemed to display some animosity for the right to treatment because of the frailty of the arguments which have been advanced to support it. Others might certainly follow suit.

This Article has identified the weaknesses of five right to treatment arguments which can be derived from important right to treatment cases. That effort was not a destructive one, but an attempt to shore up the ultimately sound judgment that virtually all committees possess a right to treatment. A right to treatment can be firmly supported only by abandoning weak foundations for it and relying on the least restrictive alternative theory developed above. Even if one overlooks the fundamental infirmities of the other right to treatment arguments, they cannot, as the least restrictive alternative theory does, support a right to superior, individual treatment for virtually all committees. What awaits is the formidable coupling of the compelling moral idea that the state must provide treatment to all those whom it involuntarily commits and of the accepted and attractive legal notion that the state must, when the pursuit of its policies touches important personal rights, use the least restrictive alternative.

158. For a discussion of "voluntary" patients, see Wexler, *Mental Health Law and the Movement Towards Voluntary Treatment*, 62 CALIF. L. REV. 671, 684-87 (1974).