Michigan's Revised Mental Health Code

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LEGISLATIVE NOTES:

MICHIGAN'S REVISED MENTAL HEALTH CODE

In May 1974 Michigan's civil commitment procedures were declared unconstitutional in *Bell v. Wayne County General Hospital*.¹ The court found that several provisions deprived involuntarily committed persons of their liberty without due process of law.² Similar procedures in other jurisdictions were under attack by courts and commentators for this reason,³ and because they failed to adequately safeguard the individual's constitutional rights once he has been confined in a mental institution.⁴ Michigan enacted a new Mental Health Code in August 1974, in an attempt to modernize its outdated procedures and protect the constitutional rights of the mentally ill.⁵ In addition, Michigan needed new legislation to safeguard the newly recognized constitutional rights of persons committed because they are incompetent to stand trial, or have been acquitted of crimes by reason of insanity.⁶

This note will evaluate the three chapters of the Michigan Code which present the most significant legislative attempts to safeguard the rights of the mentally ill. Chapter Four of the Code extends several traditional due process guarantees to the civil commitment process. By guaranteeing the right to adequate notice, the right to be present at the hearing, the right to be represented by counsel, and the right to notice of trial by jury, the Code offers better protection from unwarranted commitment. However, due to the difficulty of defining mental illness and accurately identifying those in need of treatment, the possibility of improper commitment still exists. Chapter Seven protects the rights of residents of mental health facilities by ensuring that each resident re-

ceives treatment suited to his condition, and by restricting the use of psychosurgery, electroshock therapy, restraint, and seclusion. While these statutes are often vague and permit the hospital to exercise its discretion, the administrative rules of the Department of Mental Health augment the Code, and often provide the necessary substance to a broadly worded statute. Chapter Ten of the Code governs the disposition of persons found incompetent to stand trial or acquitted by reason of insanity, and protects them from indeterminate commitments by requiring the state either to commit them pursuant to the civil commitment process or to release them from custody. It is these criminal provisions of the Code which have been most criticized by those who fear that the extension of due process and equal protection safeguards to criminals has resulted in inadequate protection of the rights of society.

I. CIVIL COMMITMENT IN MICHIGAN

According to Bell,7 Michigan's civil commitment procedures deprived subjects of commitment petitions of due process. This occurred while the legislature was already considering a new mental health code. When the new Code was enacted three months later, it implemented the due process guarantees found lacking in Michigan's prior commitment statute.

A. Procedural Guarantees

1. Right to Notice—The Bell court found Michigan's existing notice procedures defective in merely requiring that notice of the petition be served at least twenty-four hours before the hearing, with no requirement that the petition itself be served upon the person facing commitment.8 The new Code requires that notice of the petition be served early enough to permit adequate preparation of that person's case, and directs the court to send a copy of the petition itself to the subject.9 This procedure enables the subject of the petition to discover the allegations against him and to ascertain who is seeking his commitment.10

8 Id. at 1092-93.
9 Mich. Comp. Laws Ann. § 330.1453 (1975). This section also requires notice of the time and place of the hearing to be sent to the subject and his attorney, as well as notice of the right to a full court hearing, to be present, to demand a jury trial, to be represented by counsel, and to secure an independent medical examination. The Michigan Supreme Court's Administrative Order 1974-7, 392 Mich. xxxv (Nov. 6, 1974) [hereinafter cited as Administrative Order] requires such notice to be served at least two days before the preliminary hearing and at least five days before the time of other hearings, unless a lesser time is agreed to by the subject or his attorney.
10 See S. Brakel & R. Rock, American Bar Foundation, The Mentally Disabled and the Law 51-53 (rev. ed. 1971) for a discussion on the propriety of affording notice to an allegedly mentally ill person. Psychiatrists contend that legal procedures and papers produce anxiety and confusion, causing more harm than good. However, the editors assert that the receipt of notice could not be more traumatic than sudden institutional confinement. The latter view is supported in Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1274
2. Right to Be Present—Bell held that Michigan law did not adequately safeguard the fundamental due process right to be present at one’s hearing.11 Under the prior statute a court could exclude the subject of a petition merely upon certification by two physicians that his presence would be “improper and unsafe.”12 The court reasoned that since the threat to liberty is as significant in the context of civil commitments as it is in criminal trials, the right to be present should be as broad in the former as it is in the latter.13 Michigan law now provides that a person “shall be present at all hearings,” unless he waives that right, and the court is satisfied that his presence would be “injurious” to him.14 Furthermore, the statute requires the court to convene hearings in the hospital whenever practicable, thereby securing the right to be present to those whose condition would otherwise prevent their appearance in court.15

While it might be argued that an individual’s presence promotes fairness by enabling the court to speak with and observe the individual, and compare these observations with psychiatric testimony,16 this may also have prejudicial consequences. For instance, it is possible that an individual, who has been hospitalized against his will after physical apprehension by police or health officers, subjected to demeaning hospital admission procedures, given tranquilizers which intensify his disorientation, and now faces imprisonment, will exhibit anxiety and hostility when he finally gets into the courtroom.17 If he appears agitated and nervous as a result of hospital custody, or incoherent and uncoordinated from sedation, his behavior will corroborate the psychiatric testimony.18

3. Right to Counsel—Bell also declared that the right to counsel in civil commitment proceedings is a fundamental due process right for

(1974) [hereinafter cited as Developments—Civil Commitment] where it is argued that the expectation of trauma as a result of the service of notice presupposes that the subject of the petition is in fact mentally ill, an issue which has not yet been determined by the court. In fact, service of papers informing the individual of his protections may reduce rather than increase his anxiety.

11 384 F. Supp. at 1094.
13 384 F. Supp. at 1094.
14 Mich. Comp. Laws Ann. § 330.1455 (1975). The Michigan Supreme Court’s Administrative Order, supra note 9, at xxxv, provides that the subject may waive the right to be present if the waiver is in open court. There is no explicit requirement that this waiver be voluntary and intelligent. This should be compared with provisions for waiver of the right to counsel, note 26 and accompanying text infra. Moreover, the court is permitted to exclude the subject from the hearing where his behavior makes it impossible to continue.
16 Developments—Civil Commitment, supra note 10, at 1282-83.
18 Id. Michigan law now requires that no chemotherapy be administered to a hospitalized individual until after the preliminary hearing, nor can it be administered on the day before the full court hearing unless the patient consents, or unless administration is necessary to prevent physical injury to the individual or others. Mich. Comp. Laws Ann. § 330.1718 (1975).
which prior Michigan law did not adequately provide. Relying upon Lessard v. Schmidt, Bell held that there is a right to counsel, to be court appointed if necessary, at every stage of the commitment proceedings. The new Code guarantees to every subject of a petition the right to counsel, appointed counsel if the individual is indigent, and requires that notice of this right be given in all cases. Although the Michigan Supreme Court's Administrative Order, which promulgates court rules necessary to the effective implementation of the new law, permits the subject of a petition to waive counsel if done voluntarily and understandingly in open court, it provides that no waiver may be accepted until the individual has consulted counsel. Based upon the individual's behavior at such a consultation an attorney should theoretically be able to encourage the individual to accept representation or to submit evidence to the court that any waiver would be incompetent. However, this could place the attorney in the unenviable position of asserting his client's incapacity to waive counsel, thereby corroborating psychiatric testimony as to the subject's mental condition. However, one's capacity to make a knowing waiver of the right to counsel should be distinguished from the quantity

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20 349 F. Supp. 1078 (E.D. Wis. 1972) in which the court stated that [t]here seems to be little doubt that a person detained on grounds of mental illness has a right to counsel, and to appointed counsel if the individual is indigent.

Id. at 1097.

21 384 F. Supp. at 1093.

22 Mich. Comp. Laws Ann. § 330.1454 (1975). This section also requires that the court appoint an attorney for an individual who has no attorney. Counsel must be appointed within forty-eight hours of the court's receipt of any petition seeking involuntary commitment, or within twenty-four hours after the subject is hospitalized pursuant to medical certification or court order. For a discussion of the role and impact of the attorney in commitment proceedings see Andalman & Chambers, Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal, 45 Miss. L.J. 43 (1974); Cohen, The Function of the Attorney and the Commitment of the Mentally Ill, 44 Texas L. Rev. 424 (1966); Developments—Civil Commitment, supra note 10, at 1283-91; Note, Involuntary Hospitalization of the Mentally Ill Under Florida's Baker Act: Procedural Due Process and the Role of the Attorney, 26 U. Fla. L. Rev. 508 (1974); Note, The Role of Counsel in the Civil Commitment Process: A Theoretical Framework, 84 Yale L.J. 1540 (1975).


24 Administrative Order, supra note 9, at xxxiv.

25 A more questionable practice is allowing persons facing involuntary commitment to agree to sign a voluntary commitment form without first consulting an attorney. The right to counsel should include the right to consultation with counsel before signing a voluntary commitment form as well as consultation before executing a valid waiver of counsel. One Detroit attorney suggests that the signing of a voluntary commitment form should be closely scrutinized in view of the "suspiciously high" ratio of voluntary commitment forms signed in certain hospitals. (Letter on file in the office of the University of Michigan Journal of Law Reform).
and quality of evidence required to establish that the individual is a person requiring treatment under the statutory standard.26

4. Right to Trial by Jury—Prior to Bell, Michigan did not require that the subject of a petition be informed of his right to a jury trial, but permitted such trials upon the individual's request or the court's initiative.27 Although Michigan law now requires that notice of the right to demand a jury trial be served upon the subject of a petition,28 Bell did not hold that the right to a jury trial is an element of due process in an involuntary civil commitment hearing. The court merely relied upon the Lessard holding that a person should be informed of his statutory right to a jury trial, and that adequate notice is necessary to inform an individual of all such statutory rights.29 One commentator predicts that if the Supreme Court were faced with the issue of whether a constitutional right to a jury trial exists in a civil commitment proceeding, it would balance the procedural fairness and community involvement offered by the jury against the state's interest in judicial economy and informality.30 This commentator suggests that this balancing process would result in a finding that such a requirement would place too great a burden on the state, and hence is not constitutionally required.

5. Right to a Preliminary Hearing—Perhaps the most glaring constitutional defect of Michigan's prior law was its authorization of temporary commitment for a period of up to 120 days without a judicial hearing on the necessity of detention.31 The Bell court, citing Lessard,32 found the

26 Cf. Von Moltke v. Gillies, 332 U.S. 708 (1948) in which four Justices concluded that the constitutional right of a criminal defendant to counsel imposes a weighty responsibility on the trial judge to determine whether there has been an intelligent and competent waiver. To be valid, a waiver had to be made with an understanding of the nature of the charges, the range of allowable punishments, possible defenses or mitigating circumstances, and a broad understanding of the entire matter. In order to safeguard the sixth amendment right to counsel in voluntary commitment cases, it is arguable that there should be a presumption against the validity of any waiver of counsel. However, a presumption of inability to waive counsel should not be permitted since the individual facing commitment is presumed not to be mentally ill and in need of treatment until the court finds otherwise.


29 384 F. Supp. at 1094.

30 Developments—Civil Commitment, supra note 10, at 1295.


[I]f it shall appear, upon the certificate of 2 legally qualified physicians, . . . to be necessary and essential to do so, the court may order such alleged mentally diseased person to be . . . detained until such petition can be heard and determined or to be removed to any state hospital for custody and treatment. The period of such temporary detention shall not exceed 60 days, which period may be extended up to an additional 60 days by special order of the court . . . .

32 349 F. Supp. at 1090-91. The Wisconsin statute at issue in Lessard permitted involuntary detention for up to 145 days without a hearing. The court conceded the state's compelling interest in emergency detention but held that such an emergency measure can be justified only for the length of time
Michigan provision to be a deprivation of due process and suggested that a preliminary hearing within five days of the initial detention would satisfy procedural due process. Michigan law now guarantees a preliminary hearing within five days of hospitalization as well as the right of the subject to be present and to be represented by counsel at the hearing.

Despite substantial administrative difficulties, preliminary hearings for persons detained without a hearing could be provided sooner than five days after hospitalization. If the individual is hospitalized pursuant to medical certification, his condition must be certified by a psychiatrist within twenty-four hours of his hospitalization. If the individual is taken into custody by police or brought to the hospital by a person seeking commitment, the subject of the petition must be examined by a physician within twenty-four hours. He may then be hospitalized but must be examined by a psychiatrist within an additional twenty-four hours. If he is taken into custody pursuant to court order, and is not examined within twenty-four hours, he must be released. Thus, in all prehearing detention cases, the individual has been examined by a physician and a psychiatrist within forty-eight hours of his arrival, yet he may have to wait at least three additional days for the preliminary hearing. If evidence exists to establish probable cause, it will be available to the state within forty-eight hours. An individual could not be prejudiced by an earlier hearing since, if he had no attorney, the court would be required to appoint counsel within twenty-four hours after he is hospitalized. If the court-appointed attorney were unprepared or unable to appear at an earlier hearing, it could then be delayed in the interest of the subject. An earlier prelim-
inary hearing would mitigate the prejudicial effects of pretrial detention\textsuperscript{40} and enable an individual to refute the evidence against him sooner than is now possible.\textsuperscript{41}

6. No Commitments for Diagnosis—The \textit{Bell} decision also nullified a Michigan provision which enabled courts to commit individuals for diagnosis for periods of up to 120 days.\textsuperscript{42} Such commitments had been permitted where the court or jury determined that the individual was mentally ill, but not to a degree which would warrant a final commitment order.\textsuperscript{43} Thus, involuntary commitment for diagnosis could be ordered under a less stringent standard than that applied to final involuntary commitment.\textsuperscript{44} Michigan no longer permits commitments for diagnosis or observation upon a finding of mental illness which does not meet the statutory standard for final commitment.\textsuperscript{45} The court may only decide whether or not the person requires treatment. If treatment is required, the court may order commitment to a public or private hospital, or it may order a program of treatment other than hospitalization. An alternative to hospitalization may be ordered only if the individual would have been hospitalized had no alternatives existed.\textsuperscript{46} The court retains control of the individual ordered to undergo the alternative, similar to the control exercised by a court in its ability to revoke the probation of a criminal defendant. If the person does not comply with the ordered treatment, or if the treatment is insufficient, the court may revoke the alternative treatment and hospitalize the individual without a hearing.\textsuperscript{47} Nevertheless, there can be no involuntary commitment on evidence which would not satisfy the statutory requirement of a "person requiring treatment."\textsuperscript{48}
B. Admission and Release Provisions

1. Admission Standards

Michigan's civil commitment standard was struck down in *Bell* as unconstitutionally overbroad and vague. The court noted that under that standard "virtually any mental disorder would qualify" including many which "could not be classified as other than harmless." *Bell* held that the state had no power to commit persons who were not dangerous to themselves or others and, because the statute permitted commitment upon a finding of mental illness alone, it was fatally overinclusive.

It is widely acknowledged that most involuntary commitment statutes are worded so broadly that they do not precisely define the degree of mental illness required to justify commitment. The present Michigan standards are similar to those in fifteen other jurisdictions which authorize commitment only if the individual is mentally ill and dangerous to himself or others, or unable to care for his own physical needs. The effectiveness of these standards depends on psychiatric ability to diagnose dangerousness. To the extent dangerousness can be accurately determined, the state can more effectively protect its citizens from harm and preserve the freedom of nondangerous individuals who do not warrant institutionalization. However, there is substantial support for the view that psychiatric ability to diagnose mental illness or predict "dangerousness" is at best unreliable.

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50 384 F. Supp. at 1095-96. Formerly, mental illness was defined to include every species of insanity and extend to every mentally disabled person, and to all of unsound mind other than... persons who manifest the general deterioration of mental processes, including disorientation, confusion or impairment of memory, associated with senility, but without psychotic implications.


52 S. Braikel & R. Rock, supra note 10, at 39. *See also R. Rock, Hospitalization and Discharge of the Mentally Ill 11 (1968)* in which the author observes that from the psychiatric viewpoint, a loose definition may be desirable since the question is not who is ill, but rather of those who are ill, how many require hospitalization. The author argues that a statute with rigid definitions may not be helpful since mental disorders are widespread and the effect of a particular illness on an individual's ability to function is subject to change.


54 *See Developments—Civil Commitment, supra note 10, at 1203.*

55 *See Note, The Language of Involuntary Mental Hospitalization: A Study in Sound and Fury, 4 U. MICH. J.L. REFORM 195, 197 (1970)* in which a study to "determine the reliability and validity of the bases for involuntary mental hospitalization" concluded that the diagnoses and recommendations of physicians "reflect a procedure where obscure and questionable labels are offered by diagnosticians and accepted by the court as conclusive of the underlying malady." *Id.* at 205. The study suggests that involuntary commitment based upon unreliable diagnostic labels constitutes a deprivation of liberty without due process. In fairness to the psychiatric
Indeed, some commentators advocate the abolition of the entire involuntary
civil commitment process in view of the lack of any scientifically reliable
method of predicting future dangerousness. In view of the difficulty of
predicting the type and extent of an individual’s future dangerous be-

havior, statutes which authorize such police power commitments may be
consstitutionally suspect.

Despite these problems, Michigan’s new commitment standard is clearly
more precise than the standard held unconstitutional in Bell. The “dan-
gerousness” standard requires a reasonable expectation of physical harm
and requires actual acts or threats which support that expectation. Based
on the language of the statute, anticipated or actual harm to property alone
does not justify commitment. Psychiatric testimony that an individual’s
symptoms could lead to violent behavior should not justify commitment
without evidence that violent behavior has occurred or that there is reason-
able fear of such behavior. While the court need not rely solely on psy-

chiatric testimony, the possibility of unwarranted commitment still exists.
This danger is present under any standard which contains such imprecise
phrases as “reasonably be expected” and “significant and substantially
supportive of that expectation.” Judges may have differing conceptions of
behavior which may reasonably be expected to be dangerous. However,
discretion is inherent in any statute which attempts to prevent anticipated
harm.

profession, however, the study should have noted that the fault may more properly
be attributed to the court and legal profession which demand these labels, rather
than to the psychiatric profession which offers them.

See also R. Rock, supra note 52, at 259; Comment, An End to Incompetency to
Stand Trial, 13 Santa Clara Law. 560, 577 (1973) (concluding that the prosecu-
tion and court rely heavily, if not exclusively, on psychiatric reports).

439 (1974) in which the author states:

I know of no reports in the scientific literature which are supported
by valid clinical experience and statistical evidence that describe
psychological or physical signs or symptoms which can be reliably
used to discriminate between the potentially dangerous and the harm-
less individual.

Id. at 444. Diamond concludes that courts should no longer ask for expert opinions
on the subject, and that experts should reveal their inability to make such predictions
when asked to do so. Id. at 452.

See also Roth, Dayley & Lerner, supra note 17, at 443-44:

Based on our analysis of psychiatry as unscientific and mental illness
as an arbitrary concept, we would favor the abolition of involuntary
mental hospitalization. Involuntary commitment of those considered
dangerous should be based on specific violations of the criminal law.

Developments—Civil Commitment, supra note 10, at 1245.

See note 50 supra.


See Walker, Mental Health Law Reform in Massachusetts, 53 B.U.L. Rev. 986,
994 (1973) in which the author suggests that, in order to commit an individual
under the Massachusetts dangerousness standard, the court should be presented
with evidence of suicide attempts or threats of violence to himself or others.
Evidence of serious depression would not be sufficient. The standard also contem-
plates proof of past violence or testimony that a witness is in fear of such behavior.

Id. at 994. The author points out that while, in one judge’s opinion, a 20 per-
Michigan's second commitment standard permits involuntary commitment of mentally ill persons who are unable to attend to their "basic physical needs." The state utilizes its parens patriae power to protect the interests and welfare of those citizens unable to care for themselves. Since the state's justification is furthering the individual's interest rather than protecting society, involuntary commitment on this basis should only be permitted where an individual is proven incapable of making his own determination as to his need for psychiatric treatment. Nevertheless, Michigan permits commitment of persons unable to care for themselves despite their personal desire to remain free. As a policy matter, where the individual is not dangerous to himself or others, his preference for autonomy and privacy should be respected. Some observers suggest that "incapacity" should be a prerequisite to parens patriae commitment, so that, of those persons who refuse treatment, the state could validly over-ride the choice only of those "incapable of evaluating the desirability of psychiatric care."

The Michigan Legislature recently amended the Code by adopting a broad commitment standard which appears certain to face constitutional challenge. It permits the commitment of persons who are mentally ill and unable to understand their need for treatment, and whose behavior may result in harm to themselves or to others. Because such a commit-
ment is pursuant to the state's police power, a clear showing of potential dangerousness should be required. Yet it appears that less proof is required by this section than by the original dangerousness section since only the prediction of a competent medical practitioner is required. The statute requires a finding that a person's "continued behavior" be dangerous. While this language may presuppose an overt act requirement, no acts or threats are explicitly required to support the prediction of dangerousness. The statute seems to encompass all mentally ill persons, including those who may not actually be dangerous. Such a standard was found unconstitutional in Bell. The statute does suggest that the commitment of a person dangerous to himself should only be ordered upon a showing of the individual's capacity to make his own treatment decision, yet section 330.1401(b), the "basic needs" standard, allows such commitments regardless of the individual's capacity. Thus, this final standard provides a "pigeonhole" for persons who could not be committed under the other two criteria.

It is clear that Michigan's new commitment standard was adopted in order to facilitate civil commitment of persons acquitted of crimes by reason of insanity. The Code provides that persons acquitted for this reason may not be committed automatically, but may be committed only after a full civil commitment hearing to determine the individual's present mental condition. Legislators became alarmed at the prospect of releasing acquitted persons who had committed crimes, but were not presently mentally ill, and adopted more restrictive procedures governing the disposition of persons found not guilty by reason of insanity. Since the Michigan Supreme Court has ruled that criminal defendants must be subject to the same commitment standards as those committed under civil stand-

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67 When the state seeks to vindicate a societal interest rather than to further the interest of the mentally ill individual, it acts under its police power. This is the justification for the use of involuntary civil commitment procedures to protect other citizens from harm. See Developments—Civil Commitment, supra note 10, at 1222.


69 See note 50 and accompanying text supra.

70 See note 62 and accompanying text supra.

71 State Representative Paul Rosenbaum said he recognized that the bill may be held unconstitutional, but that it was intended as a stopgap measure to fill the void created when the Michigan Supreme Court ruled that the state cannot hold a person in a mental institution when he has been acquitted by reason of insanity. 14 Gongwer News Serv., Mich. Report No. 48, at 1 (March 11, 1975). See part III B infra.


73 The new commitment standard was part of Mich. H.B. 4362, 78th Leg., 1975 Sess. (1975). The other provisions of that bill defined the duties of the court and prosecuting attorney in reference to a person ordered committed for and after a successful defense of insanity. Mich. H.B. 4362, 78th Leg., 1975 Sess. § 2 (1975) provided that the bill would not take effect unless Mich. H.B. 4363, 78th Leg., 1975 Sess. (1975) was also enacted into law. Mich. H.B. 4363, 78th Leg., 1975 Sess. (1975) added an alternative to handling mentally ill criminal defendants by providing for a verdict of "guilty but mentally ill." See notes 203-06 and accompanying text infra. The logical inference is that the broad new commitment standard was enacted to facilitate the civil commitment of defendants acquitted by reason of insanity.
ards, a broader standard applied to persons acquitted by reason of insanity may violate due process and equal protection requirements. 74

2. Review and Release Provisions 75—a. Review—An initial commitment order may not exceed sixty days. Before this period expires, the hospital director may petition the court for a ninety-day order. The same procedure is followed if an order for continuing hospitalization is sought. An individual is entitled to a hearing within fourteen days of the court's receipt of all such petitions. 76 Michigan guarantees that, every six months after the court enters an order for continuing hospitalization, every mental patient is entitled to a review of his status by the hospital director. 77 If the resident objects to the finding of any particular review he has the right to petition the court for a discharge. 78 He is also entitled to a court hearing once each year after the date of the first order of continuing hospitalization. 79 However, this review is limited by the requirement that the resident present a physician's report to support his claim for release. If no certificate accompanies the petition as a result of the resident's indigence or inability to procure such a report, the court must appoint a physician. If the physician's report does not support the resident's claim for release, the petition for discharge is dismissed. While many states require the resident to pay for this outside examination, Michigan pays the expenses of indigent residents. 80 One disadvantage of these hearings is that they require initiation by the patient rather than occurring as a matter of course. This is detrimental to poorly represented residents.

b. Release—The hospital director is permitted to discharge patients whom he deems clinically suitable for release but is required to discharge persons committed under court order who no longer meet the criteria for persons requiring treatment. 81 Prior law empowered the director to release persons no longer dangerous but did not require him to do so. 82 Since the release of nondangerous mental patients has become the subject of public controversy, this issue will be discussed in conjunction with the release of criminally committed patients in part III infra.

75 See generally Developments—Civil Commitment, supra note 10, at 1376-98.
82 Law of June 22, 1937, no. 104, § 25(a), [1937] Mich. Laws 108 (repealed 1974). See also R. Rock, supra note 52, at 215-18 discussing the decision to discharge. Generally, the decision depends on circumstances over which the patient has little control. For example, the environment to which the patient will be discharged constitutes a major factor in the release decision. A hospital will make more of an effort to treat and release patients with family, friends, or social support than it will to treat and release individuals who lack this support.
II. RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

While violations of procedural due process in the commitment proceedings are highly visible and easily reviewable by a higher court, it is more difficult to effectively monitor and safeguard the rights of those inside the mental institution. Although the new Code implements several humane and innovative protections, it remains difficult to ascertain whether residents are receiving the benefits of these new provisions.

A. Right to Treatment

1. Case Law—A constitutional right to treatment was not expressly recognized until Wyatt v. Stickney. In Wyatt, a federal district court held that the state’s failure to provide adequate treatment to persons involuntarily committed violated due process. The court later issued a decree which set out minimum constitutional standards for the treatment of mental patients and for the physical conditions of mental facilities. The Wyatt standards include the rights to privacy, visitation, communication, and freedom from excessive medication and unnecessary physical restraint or seclusion. The order declared that each patient is entitled to an individualized plan of treatment and to the least restrictive conditions necessary to achieve the purposes of commitment.

On appeal Wyatt was consolidated with Burnham v. Department of Public Health, in which another district court had held that no constitutional right to treatment existed and that even if it did, the courts were unable to enforce that right due to the lack of judicially manageable standards. The Fifth Circuit upheld Wyatt and reversed and remanded Burnham, thereby approving the constitutional right to treatment and rejecting the Burnham conclusion that the courts are not suited to the task of implementing the right to treatment.

No Supreme Court case has yet ruled directly on the issue of the constitutional right to treatment. In Donaldson v. O’Connor, the Fifth Circuit upheld a district court’s award of damages to a former involuntarily committed patient for deprivation of his constitutional right to liberty. The court held that a

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87 503 F.2d 1305 (5th Cir. 1974).

88 503 F.2d 1305, 1319 (5th Cir. 1974), cert. denied, 422 U.S. 1057 (1975).

89 493 F.2d 507 (5th Cir. 1974), vacated and remanded, 422 U.S. 563 (1975).
person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition. The court limited this broad right to nondangerous patients who were committed because of their need for treatment. Due process, the court of appeals held, requires that treatment be provided for parens patriae commitments, or that patients be released.

The Supreme Court, vacating and remanding the Fifth Circuit decision, based its decision on very narrow grounds. Justice Stewart, writing for the majority, found it unnecessary to decide whether dangerous patients have a right to treatment after involuntary commitment. He also declined to consider whether the State may "compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment." The Court held that it is unconstitutional for a state to merely confine a nondangerous person who could survive in society with the help of family and friends, and that the facts of the particular case revealed that the state's confinement of Donaldson violated his constitutional right to freedom. Justice Burger's concurring opinion clearly evidences an intent to avoid approval of the Fifth Circuit's finding of a constitutional right to treatment. Thus, the Court avoided the right to treatment issue by focusing on the deprivation of the appellant's liberty without due process.

2. Michigan Right to Treatment Statutes—Michigan law does not expressly grant a right to treatment which will afford a resident an opportunity to be cured or improve his condition as Wyatt suggests. However, the statutes guarantee the same basic rights that Wyatt held to be elements of the constitutional right to treatment. Each resident is entitled to "mental health services suited to his condition and to a safe, sanitary, and humane living environment." Professor Morris criticizes this statute as merely establishing a "bare bones" right to treatment without providing any substance to that right. A right to an individualized, written plan of services

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90 Id. at 520.
91 Id. at 527.
93 Id. at 573.
94 Id. at 580.
95 While Donaldson does little to support the existence of a constitutional right to treatment, a few days later the Supreme Court denied certiorari to Burnham, see note 86 and accompanying text supra, leaving intact the Wyatt decision guaranteeing the right to treatment.
96 See Morris, Institutionalizing the Rights of Mental Patients: Committing the Legislature, 62 CALIF. L. REV. 957 (1974). Professor Morris analyzed the Michigan provisions dealing with the rights of mental patients confined in an institution. He found that in many cases, the statutes are worded so broadly that excessive discretion is permitted. Id. at 986-87. Although his criticism is valid in several instances, the Emergency Administrative Rules adopted to implement the Michigan Mental Health Code (filed with the Secretary of State Nov. 6, 1974 and Aug. 15, 1975) often clarify such vagueness. Furthermore, an overly rigid statute does not lend itself to expansive interpretation and therefore, is not conducive to growth in the law.
98 Morris, supra note 96, at 986.
is also provided, but without detail as to the required elements of the plan.\textsuperscript{99} Morris criticizes the legislature for enacting no standards, yet suggests that an independent "Mental Treatment Standards Board" would be a more suitable body to prepare minimum treatment standards, since legislative standards could only be improved through the slower legislative process.\textsuperscript{100}

Despite Professor Morris' fear that the Department of Mental Health would be an improper body to set standards since it must also adhere to them, the Department's Emergency Rules\textsuperscript{101} appear as demanding as any that would be established by an independent body. According to these Rules, a "safe, sanitary and humane living environment" includes the right to basic human dignity and privacy, adequate clothing, facilities for physical exercise and social interaction, adequate sanitary facilities, and extensive quantitative requirements designed to maintain the physical condition of the institution.\textsuperscript{102} Significantly, these standards closely parallel the Wyatt standards.\textsuperscript{103}

The Rules outline extensive requirements for the individualized plan of services which appear to be modeled on the Wyatt order.\textsuperscript{104} Both require that a plan be developed by mental health professionals within five days of the patient's admission, and require that the plan include a statement of the patient's specific problems, needs, strengths and weaknesses, a determination of the least restrictive treatment or setting necessary to achieve the purposes of the commitment, a statement of goals with a projected timetable for attainment, and criteria to be met for release or discharge. The Rules also require that notation of all medication, restraint, surgical

\textsuperscript{99}\textsuperscript{\textit{MICH. COMP. LAWS ANN.} § 330.1712 (1975). One wonders whether it is beyond the expertise of a legislature to enact comprehensive statutes defining what treatment is "adequate" for a particular mental condition.

\textsuperscript{100} Morris, supra note 96, at 986-87.

\textsuperscript{101}\textsuperscript{\textit{MICH. DEP'T OF MENTAL HEALTH, MENTAL HEALTH CODE EMERGENCY RULES}, ch. 7 (1975).

\textsuperscript{102}\textsuperscript{\textit{MICH. DEP'T OF MENTAL HEALTH, MENTAL HEALTH CODE EMERGENCY RULES R. 330.7151 (1975).

\textsuperscript{103} See 344 F. Supp. 373, 381-83, and notes 84-86 and accompanying text supra. Cf. Hoffman & Dunn, Beyond Rouse and Wyatt: An Administrative-Law Model for Expanding and Implementing the Mental Patient's Right to Treatment, 61 Va. L. REV. 297, 303-08 (1975) in which the authors warn that extensive quantitative standards to insure a clean environment and properly trained and licensed personnel do not always insure adequate treatment. The emphasis on numbers leads to "administrative manipulation" of patients, less individualized care, and reduction of resident population to improve ratios. The authors' view is corroborated by the experience of Michigan State Senator Joseph Snyder who, while touring one state institution, found a patient who had been lying on his bed in his own vomit for over two hours because of the lack of attendants on the floor. His inquiry revealed that the department report showed the facility had one employee for every two patients. Upon further investigation, it was discovered that the report included janitors, dishwashers, and every other employee of the facility. 14 Gongwer News Serv., Mich. Report No. 104 (May 30, 1975).

\textsuperscript{104} Compare \textsuperscript{\textit{MICH. DEP'T OF MENTAL HEALTH, MENTAL HEALTH CODE EMERGENCY RULES R. 330.7199 (1975) with Wyatt standards in 344 F. Supp. 373, 384-86 (M.D. Ala. 1972). See also note 102 and accompanying text supra.}
procedures, and limitations of privileges be entered into the record with the reasons therefore.\textsuperscript{105} Furthermore, the Rules adopt four of Professor Morris' suggestions for the content of treatment plans: an estimated date of release, a description of services to be provided after release, a requirement for periodic review of the plan every ninety days, and upon review an assessment of reasons that the goals in the plan were or were not met.\textsuperscript{106} The individualized plan will not always help the resident improve his condition, but it does provide a reviewing court with evidence to use in determining the adequacy of treatment provided by the hospital.\textsuperscript{107} If the plan merely amounts to custodial care, the court could release the resident on the basis of the statutory or constitutional right to treatment. The court also is in a position to expand the concepts of "humane environment" or "adequate treatment." The availability of judicial review of treatment conditions in addition to extensive departmental rules regarding the adequacy of treatment diminishes the need for legislatively prescribed standards.\textsuperscript{108}

\textbf{B. Right to Refuse Treatment: Psychosurgery, Electroshock Treatment, and Chemotherapy}

\textit{1. Constitutional Bases—}The volume of literature in the area of the right to refuse treatment appears to be growing faster than the commentary on the right to treatment.\textsuperscript{109} Therefore, this section will only briefly discuss the Michigan law pertaining to the patient's right to refuse treatment.

Several commentators argue that a constitutional right to refuse treatment can be derived from the first, fourth, and eighth amendments, as

\textsuperscript{106} \textit{Id. See Morris, supra note 96, at 988.}
\textsuperscript{107} \textit{Morris, supra note 96, was convinced that the Wyatt requirements for individualized treatment plans state with particularity items which can be evaluated by courts to determine [the] adequacy of treatment in individual cases.}
\textsuperscript{108} \textit{Id. at 987.}
\textsuperscript{109} \textit{Other sections adopted to insure a resident's right to treatment are \textit{Mich. Comp. Laws Ann. \$ 330.1710} (annual physical examination); \$ 330.1714 (right to be informed of one's clinical status at reasonable intervals); \$ 330.1715 (right to see one's private physician at any reasonable time); and \$ 330.1722 (no physical, sexual, or other abuse of recipient).}
well as from the developing right of privacy. These constitutional sources are viewed as creating rights to individual autonomy, self-determination, and bodily integrity. The fourth amendment can be construed as protecting one's bodily integrity from unwarranted governmental intrusion, and the due process clause has been used to exclude evidence obtained by violations of bodily integrity which "shock the conscience." Some courts have also recognized a constitutional right to refuse treatment. One of the constitutionally required minimums of the Wyatt decree was that a patient have the right not to be subjected to experimental research or to treatment procedures such as lobotomy, electroconvulsive treatment or other unusual and hazardous procedures without his express and informed consent after consultation with his attorney or any other party of his choice. In Kaimowitz v. Department of Mental Health the court found that the use of experimental psychosurgery on involuntarily confined mental patients, even with the patient's formal consent, violated a patient's first amendment right to generate ideas as well as his constitutional right to privacy. The crucial issue in Kaimowitz was the ability of a mental patient to render a competent, knowing, and voluntary consent. The court held that a mental patient could not give an informed consent to experimental psychosurgery due to the inherently coercive nature of the institutional environment.

2. Michigan Statutes—Michigan now provides that a resident "shall not have surgery performed upon him, nor shall he be the subject of electro-convulsive therapy" without his consent or the consent of a parent or guardian legally empowered to consent. In an emergency situation, consent need not be obtained. In the event that surgery or electroshock is "deemed advisable," and no one empowered to consent is available, the probate court may give the required consent after petition and hearing.

Professor Morris rightly criticizes this statute for not clearly defining

110 See, e.g., Schwartz, supra note 109, at 820.
111 See Terry v. Ohio, 392 U.S. 1 (1968); Mapp v. Ohio, 367 U.S. 643 (1961) (fourth amendment protects the individual from arbitrary governmental intrusion); Rochin v. California, 342 U.S. 165 (1952) (denial of due process for police to pump stomach of suspected narcotics dealer seen to swallow two capsules). See also Schwartz, supra note 109, at 819-25.
112 344 F. Supp. at 380.
113 Civil no. 73-19434 (Cir. Ct., Wayne County, Mich., July 10, 1973), summarized at 42 U.S.L.W. 2063, 2064 (July 31, 1973).
116 Id.
situations which require a patient's consent. Since a person can be mentally ill but not incompetent, the statute should require that a resident be found legally incompetent by a court before a guardian's consent may be substituted. The Department Rules eliminate some of the confusion by defining "guardian" as a "person empowered to execute a consent pursuant to a probate court order." This implies that a guardian is empowered to consent only after a court finds a resident incapable of rendering his own informed consent. The statute is also unclear as to the nature of the hearing and the type of evidence required for the probate court to substitute its consent for that of the incompetent patient or unavailable guardian. The statute should also provide the patient with an opportunity to contest any operation, therapy, or procedure. The Rules require only that the person in charge of the recipient's plan of service petition the court to hold the hearing, and do not state whether the patient may be represented at such a hearing.

The statute itself does not define what is required to establish an informed consent. It establishes a right to refuse psychosurgery but does not recognize that institutional coercion may impair the resident's ability to refuse. The Department Rules provide that an informed consent requires (1) competency to understand the procedures, risks, and consequences; (2) knowledge of the procedure and risks subject to the disclosure standards (that which a reasonable patient needs to know in order to make an intelligent decision); and (3) voluntariness, which assumes free choice without coercion, including promises or assurances of privileges or freedom. The patient must also be told that he is free to withdraw his consent to the procedure at any time. Not only is the statute unclear as to what constitutes a valid consent, it does not specify who is to determine when a person is incapable of executing a valid consent. If the proposed procedures would expose the patient to risk, either because the procedure is still experimental, or consists of electroshock, behavior modifying aversive therapy, or psychosurgery, the Rules require a review

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117 Morris, supra note 96, at 992.
118 Mich. Comp. Laws Ann. § 330.1489 (1975) provides that a finding that a person requires treatment does not give rise to a presumption of or constitute a finding of legal incompetence.
120 Mich. Comp. Laws Ann. § 330.1491 (1975) permits the court, upon petition, to consider and determine the issue of legal competence at the commitment hearing, and to appoint a guardian if necessary.
121 See notes 114-16 and accompanying text supra. The court, upon petition and hearing, may consent to a procedure which is "deemed advisable" if no one eligible to give consent can be found "after diligent effort." Mich. Comp. Laws Ann. § 330.1716(3) (1975).
122 Morris, supra note 96, at 993.
124 See note 113 and accompanying text supra.
committee to assess the benefits and risks of the procedure. If the review committee approves, a consent committee must then oversee the selection of subjects for the procedure and the manner in which consent is obtained. Thus, the Rules vest the determination of effective, capable consent in a committee appointed by the hospital director. The committee may determine that a subject has "sufficient mental capacity to understand what is proposed and to express an opinion as to participation even though not capable of legal consent." It has been persuasively argued that a decision concerning the capacity to consent to brain surgery or electroshock is of such magnitude that it should be made in the same manner as one to determine mental capacity during a commitment hearing or guardianship proceeding in a court of law. Capacity to consent is the exercise of a legal right and therefore involves a legal issue which should be decided accordingly.

C. Restraint and Seclusion of Residents

The use of mechanical restraints is generally looked upon with disfavor in this country, yet only about one-half of the states have attempted to regulate their use by statute. Michigan authorizes the physical restraint or seclusion of a resident if "essential in order to prevent the resident from physically harming himself or others, or in order to prevent him from causing substantial property damage." Seclusion may also be ordered for the therapeutic benefit of the resident. Restraint may not be instituted except pursuant to a physician’s order after a personal examination. Seclusion requires the order of a qualified professional person. If an emergency situation arises, the resident may be restrained or secluded without such an order, but a physician or qualified professional must be contacted to examine the resident immediately after the restraint or seclusion is imposed.

In addition, the statute permits the restraint or seclusion of a resident upon the authorization of a physician or qualified professional. Such authorization remains in effect until the physician or professional can

128 Comment, supra note 114, at 754-56. California is considering requiring judicial determination of capacity to consent before shock treatment can be administered. Id. at 759.
129 Id. at 754-57.
130 S. Brakel & R. Rock, supra note 10, at 159.
personally examine the resident and determine whether an order should issue. Despite the apparent intent to shield residents from arbitrary or punitive restraint or seclusion orders, no clear guidelines are offered those physicians and staff members who must make the determination that restraint or seclusion is essential to prevent physical harm or property damage. While some measure of discretion is inherent in any legal standard governing treatment decisions, the statute should state those factors which may properly be considered in reaching any decision. Any restraint or seclusion order based in whole or in part on evidence of dangerousness adduced at the commitment hearing should be prohibited. Evidence of a resident's dangerousness compiled within the institution should be the sole basis for a finding that some form of restriction is essential. This will protect the resident from the improper inference that previous dangerous behavior makes it more likely that he will be dangerous within the controlled environment of the mental institution.

Once restraint or seclusion is deemed essential and an order is issued, the Rules provide some protections for the resident. Full documentation must be entered on the resident's record, including full justification for the action, and reasons why a less restrictive alternative would not have sufficed. The orders for restraint or seclusion automatically terminate twenty-four hours after they are given, although an order may be renewed for another twenty-four hour period. Unlike an order, an authorization for restraint or seclusion expires after one hour. A resident in restraint or seclusion must be evaluated by a mental health professional twice daily, inspected by ward personnel at least every fifteen minutes, and provided hourly access to toilet facilities.

There is no apparent reason for requiring that a physician execute the restraint order when the statutory justification is to prevent harm to persons or property, while not requiring a physician's order for seclusion, which may be based upon the therapeutic benefit of the resident. If seclusion is in fact beneficial, the law should require a physician to make that determination.

Even where some kind of restraint is essential, certain methods are preferable to others. The statute does not proscribe certain undesirable types of physical restraints. The Rules provide that physical restraint may only be used after quiet room, drugs, or seclusion have been utilized, and that the devices may not be steel or metal unless required because of crim-

138 Id. See note 141 accompanying text infra.
139 Id. supra note 96, at 1001.
139 Id. In other states such orders may terminate from two hours to thirty days after originally issued, with the majority of hospitals setting a three day limit. S. BRAKEL & R. ROCK, supra note 10, at 160.
141 Id.
142 Morris, supra note 96, at 1000.
inal arrest or conviction status.\textsuperscript{143} Since the use of restraints is inhumane and counterproductive in some situations, protection from outmoded or painful devices should be elevated to the statutory level.

Despite administrative regulations which protect the person once he is restrained or secluded, either by improving the physical and sanitary conditions or by regulating the length of each order, there is no way to prevent all abuses. Assuming the physician's good faith, requiring a physician's order is probably the best way to ensure that restraint or seclusion will not be used for punishment. However, a problem arises where punishment in the form of physical restraint is used for behavior modification treatment. In such cases it is difficult to distinguish "treatment" from abuses of restraint and seclusion.\textsuperscript{144}

The physical restraint statute ignores the prevalent and increasing use of drugs to accomplish physical restraint.\textsuperscript{145} Clearly, the use of chemical restraint is subject to the same abuse as the use of physical devices.\textsuperscript{146} Michigan's chemotherapy statute covers use of medication before the preliminary and commitment hearings, but does not deal with drug use once the person becomes a resident.\textsuperscript{147} Although the Rules provide that medication shall be administered only upon the order of a physician complying with federal standards and that it may not be used for punishment or for the convenience of the staff, a recent state audit has revealed the widespread use of psychotropic drugs in excess of recommended maximum doses in Michigan's state mental hospitals.\textsuperscript{148}

\textbf{D. Communication and Visitation}

A patient also enjoys rights preventing unwarranted seclusion from the outside world. The right of communication was the first right guaranteed by statute in most states.\textsuperscript{149} Today, forty states have legislation protecting patient correspondence, and over one-half of these protect visitation.\textsuperscript{150}

In Michigan, a resident is entitled to "unimpeded, private, and uncensored

\textsuperscript{144} S. Brakel & R. Rock, supra note 10, at 160.
\textsuperscript{145} Id. at 160-61.
\textsuperscript{146} Id.
\textsuperscript{148} Compare Mich. Dep't of Mental Health, Mental Health Code Emergency Rules R. 330.7158(1)-(3) (1975) with the findings of a state audit reported in the Detroit Free Press, March 19, 1976, § A, at 12, col. 1. The audit found that 97 percent of the patients surveyed receive at least one psychotropic drug and about one-half receive more than one, a practice "not clinically supported as a generally accepted practice in treating schizophrenic patients." The report also discovered that 30 percent of the patients receive drugs in excess of recommended maximums without an explanation of any medical rationale in their records. Over 70 percent of all records surveyed contained no documentation "of the therapeutic rationale for using psychotropic drugs."
\textsuperscript{149} S. Brakel & R. Rock, supra note 10, at 155.
\textsuperscript{150} Id.
communication" by mail, phone, or visitation except in cases where a limitation is "essential in order to prevent the resident from violating the law or to prevent substantial and serious physical or mental harm to the resident." Any limitation must be approved by the head of the facility or his designee and no limitation may apply to communication between a resident and his attorney.

The requirement that the hospital director approve each limitation offers greater protection where hospitals are understaffed and physicians have little time to make every decision for each individual patient. In such cases, patient correspondence decisions might otherwise be delegated to nonmedical personnel who are unqualified to decide what restrictions are necessary for a resident's welfare. Although a medical determination was probably intended, the Michigan statute does not require that a physician make the determination that a restriction is essential. Nevertheless, some protection from abuse is afforded by the requirements that limitation decisions be entered into the resident's record, that the resident be promptly notified of each limitation, and that he have an opportunity to bring an administrative appeal to contest the limitation.

By exempting attorney-client communication from limitation the statute appears to adequately protect the resident's right to petition for a writ of habeas corpus. Department Rules provide the resident a right to correspond by telephone or mail and to receive visits from his private physician, a mental health professional, an attorney, or another person where the communication involves "matters which are or may be the subject of legal inquiry."

The Department Rules properly place greater restrictions on incoming mail than on outgoing mail since limits on incoming mail are more essential to a resident's medical welfare. Outgoing mail or phone calls may be limited only if essential to prevent serious physical or mental harm or to prevent a resident from violating a law. Outgoing calls may also be

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152 Id.
153 S. Brakel & R. Rock, supra note 10, at 157. A ward attendant is not the proper person to decide what restrictions are necessary for the patient's medical welfare.
154 Morris, supra note 96, at 1009.
restricted to prevent future telephone harassment of an individual who has executed a written complaint.\textsuperscript{160}

The statute, therefore, appears to sufficiently protect a resident's right to communicate with the outside world, despite its failure to supply any legislative guidelines for determining when a restriction is essential, or to clearly identify those authorized to make such a determination.\textsuperscript{161}

III. CRIMINAL PROVISIONS OF CHAPTER TEN

The disposition of mentally ill individuals who are charged with crime but are incompetent to stand trial or who have been acquitted by reason of insanity raises special problems. Prior to Michigan's new Code, a defendant could be committed upon a finding of incompetency by the trial court, despite a probate court finding that he could not be committed under the standards for civil commitment. Michigan law also required automatic commitment without a hearing for persons acquitted by reason of insanity. Michigan now extends the protections of due process and equal protection to criminal defendants.

A. Incompetency to Stand Trial

1. The Incompetency Problem—Prior to Jackson v. Indiana,\textsuperscript{162} a defendant judged incompetent to stand trial usually faced indefinite and potentially unlimited incarceration. A person found incompetent to stand trial was committed to a mental health facility until he regained competency, since the conviction of a legally incompetent defendant had been held to be a violation of due process.\textsuperscript{163} One critic argued that a finding of incompetency had become "merely a diagnosis by psychiatrists of the defendant's mental illness" and was a tool to incarcerate persons for indefinite periods without a criminal conviction or civil commitment.\textsuperscript{164} Rather than protecting the individual's due process right, the incompetency label was often used for preventive detention of undesirables arrested on minor charges.

Jackson involved the constitutionality of an Indiana law which required that a person found incompetent to stand trial be committed to a mental institution until he regained sanity. Jackson argued that if the state sought

\begin{itemize}
  \item \textsuperscript{160}MICH. DEPT OF MENTAL HEALTH, MENTAL HEALTH CODE EMERGENCY RULES R. 330.7239(5)(c)(iii) (1975).
  \item \textsuperscript{161} In addition to the resident's right to unimpeded communication, Michigan has enacted several other statutes dealing with the privacy and autonomy of the resident inside the institution. Law of Aug. 21, 1975, no. 208, § 1, [1975] Mich. Laws 502, amending MICH. COMP. LAWS ANN. § 330.1724 (1975) (limits fingerprinting and photographing of residents except those criminally committed); § 330.1728 (right to receive, possess, and use all personal property unless limitation is essential); § 330.1730 (easy access to one's money unless denial essential to prevent unreasonable and significant dissipation of assets); § 330.1736 (regulating patient labor and compensation therefor); and § 330.1748 (information in resident's record is confidential).
  \item \textsuperscript{162}406 U.S. 715 (1972).
  \item \textsuperscript{163}Pate v. Robinson, 383 U.S. 375, 378 (1966); Comment, supra note 55, at 561.
  \item \textsuperscript{164}Comment, supra note 55, at 562-64.
\end{itemize}
to commit him indefinitely, it must do so through the civil commitment procedure. The Court agreed, and held that subjecting Jackson to a more lenient commitment standard than was applied to persons not charged with a criminal offense was a denial of equal protection since Jackson was in effect condemned to permanent institutionalization without the showing required for commitment. The Court also held that indefinite commitment on the ground of incompetency alone is a violation of due process, and that such persons

cannot be held more than a reasonable period of time necessary to determine whether there is a substantial probability that he will attain [competency] in the foreseeable future.165

Otherwise, the state must initiate commitment proceedings or release the defendant. Thus, Jackson requires that incompetency commitments be brief and that the defendant’s condition show progressive improvement in order to justify continued confinement.166

2. Michigan’s Incompetency Provisions—Prior to 1967, Michigan law required that persons found incompetent to stand trial be confined in Ionia State Hospital.167 By 1966, however, the legislature had become aware of abuses of the incompetency procedure. New legislation was enacted to prevent the use of this procedure as an expedient to dispose of the charges against defendants who were found incompetent to stand trial.168 The 1967 legislation forbade any criminal proceeding against a defendant while he was incompetent.169 The court could commit the defendant for a sixty-day psychiatric evaluation and if found incompetent to stand trial, the defendant could then be committed for up to eighteen months. Upon his release, the defendant could either be civilly committed by the probate court or transferred back to the original trial court for a determination of his competency. If the trial court found him incompetent, the probate court decision was reversed and the defendant immediately committed. The statute was criticized for its failure to distinguish between the standard for incompetence to stand trial and that for civil commitment.170 Since the two are not identical, a finding of incompetence should not suffice for involuntary hospitalization.171 The statute, however, allowed commitment upon a finding of incompetency, even after the probate court found the defendant not subject to civil commitment.172

Michigan’s new Code also requires the court to order the defendant to

165 406 U.S. at 738.
166 Comment, supra note 55, at 571.
168 Id.
170 Morris, supra note 167, at 32.
171 Id.
submit to an examination to determine his competency to stand trial. However, the defendant need not be committed to the examiner's custody unless he refuses to make himself available voluntarily. If the defendant is to be held in jail before trial, the examination will take place there. A defendant need not spend the full sixty days in the custody of the center for forensic psychiatry unless such confinement is necessary to complete the examination.

After the examination, the court has two alternatives. If it determines that the defendant is incompetent and has no probability of regaining competence within the lesser of fifteen months or one-third of the maximum sentence he could receive upon conviction, the court may authorize the prosecutor to initiate civil commitment proceedings. If the court determines that the defendant could regain competence, it may order him to undergo treatment, but it may only commit him to the custody of the Department of Mental Health if necessary to implement the treatment. If the defendant would have been in jail before trial, the court may in essence "commit" him to the facility in which he will be treated. Such an order expires after the fifteen months or one-third of the maximum sentence, or whenever charges are dropped. The defendant must then be released or committed under the standards for involuntary civil commitment. However, during this commitment, the examining psychiatrist must report to the court every ninety days, and the court must rehear and redetermine the issue of incompetency unless the defendant waives the hearing. In short, the new Code decreases the maximum length of incompetency commitments from eighteen months to fifteen months, or one-third of the maximum sentence if it is less, and provides for periodic redeterminations of the defendant's status. These provisions enable the defendant either to regain competency, to contest the findings of incompetency in the examining psychiatrist's report at reasonable intervals, or, in the event he does not become competent, to avoid the lengthier eighteen-month commitment of the previous Code.

The new provisions also eliminate the tendency to treat a finding of incompetency to stand trial as equivalent to a finding of mental illness requiring involuntary civil commitment. Whereas under prior law a trial court's finding of incompetency would automatically reverse a probate court finding that the defendant did not meet the civil commitment criteria, the new Code provides that a finding of incompetency to stand

178 Id.
180 Id. See notes 48-74 and accompanying text supra.
183 See note 172 and accompanying text supra.
trial cannot be used to hold the defendant after the initial fifteen-month commitment period. If the incompetency commitment period expires and the defendant is still unable to stand trial, the state must rely on civil commitment procedures to confine the individual.  

B. Disposition of Persons Found Not Guilty by Reason of Insanity  

1. Commitment—Prior to People v. McQuillan, Michigan law required automatic commitment of persons found not guilty by reason of insanity. The acquitted defendant was not given a hearing to determine whether he was presently mentally ill and in need of treatment. The Michigan Supreme Court in McQuillan interpreted the statute to require such a hearing before such persons could be committed. While the court agreed that past criminal conduct caused by insanity justifies temporary detention for examination, it said that such conduct does not justify permanent detention. It held that the statute required at most a sixty-day detention of such defendants to enable the hospital to examine and observe the individual. Immediately thereafter, the former defendant is entitled to notice and a hearing as to his present mental condition. Detention for more than sixty days as provided by the automatic commitment statute was held to be a violation of due process and equal protection. Although a defendant may have been insane at the time he committed the criminal act, he may not be insane for the purpose of civil commitment. Consequently, a deprivation of liberty without a hearing violates due process. The court also held that commitment without a hearing violates equal protection, since the state provides full judicial protection to those civilly committed. The court recognized that those civilly and criminally committed are not similarly situated, but that this difference in class only justifies the sixty-day period of detention for examination.

The Michigan Legislature responded to the McQuillan decision by replacing the automatic commitment statute with a statute requiring a sixty-

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186 Law of July 12, 1966, no. 266, § 1, [1966] Mich. Laws 378, amending Law of May 14, 1927, no. 175, ch. 11, § 7, [1927] Mich. Laws 281 (repealed 1975) provided that: Any person who is tried for a crime and is acquitted by the court or jury by reason of insanity, shall be committed immediately by order of the court to the department of mental health....
187 392 Mich. at 536-37, 211 N.W.2d at 580-81.
188 Id. at 525-29, 211 N.W.2d at 575-77.
189 Id. at 529-36, 221 N.W.2d at 577-80.
190 Id. at 529, 221 N.W.2d at 577.
191 Id. at 533, 221 N.W.2d at 579. The court reasoned that, since a verdict of not guilty by reason of insanity is not a finding of insanity but is rather a finding that the state has failed to prove beyond a reasonable doubt that the defendant was competent when he committed the crime, there should be no presumption of continuing insanity. Id. at 531, 221 N.W.2d at 578.
192 Id. at 533-36, 221 N.W.2d at 579-80.
day temporary detention for persons acquitted by reason of insanity.\textsuperscript{193} During this period the individual's present mental condition is observed and evaluated by the center for forensic psychiatry, which is required to file a report containing its opinion as to whether the person meets the criteria for civil commitment. The prosecutor may then file a petition seeking commitment pursuant to procedures for civil commitment. If the petition is not thereafter filed, the person must be released from custody. Thus, Michigan now provides the same standard and hearing for those committed on the basis of either criminal or civil proceedings. However, in a later amendment, the legislature allowed the report from the trial court, containing the facts concerning the crime for which the individual was acquitted, to be admitted in the hearings.\textsuperscript{194} The original statute made no provision for the admissibility of such evidence.\textsuperscript{195} Since the issues at the hearing are the individual's present mental condition and whether he is presently dangerous, evidence of past criminal behavior should not be conclusive as to the individual's present dangerousness. Indeed, such evidence could well be unjustifiably prejudicial considering the vagueness of the commitment criteria and the problems involved in predicting future dangerousness.\textsuperscript{196} Since an acquittal by reason of insanity does not give rise to a presumption of insanity,\textsuperscript{197} evidence of past criminal behavior, without more, should not result in a finding of dangerousness.

2. Release—McQuillan also held that discharge procedures similar to those provided for persons civilly committed must be provided for those acquitted by reason of insanity.\textsuperscript{198} In response, the Michigan Legislature enacted a bill requiring that the civil release provisions apply to the criminally committed, except that persons acquitted by reason of insanity may not be discharged without first being evaluated and recommended for

\textsuperscript{196} See part I B supra. It seems clear that evidence of past crimes could provide a court with the necessary "handle" to substantiate a finding that a person can "reasonably be expected in the near future" to cause serious harm. That is, past criminal behavior could provide the "act" which the statute requires to support any expectation of future dangerous behavior.

The case of Dr. Daniel Boucher illustrates the potential for prejudice caused by allowing evidence of the crime for which a defendant was acquitted by reason of insanity to be considered by the committing court. Dr. Boucher murdered his ex-wife and seven year old son. After his murder conviction was reversed, he was found incompetent to stand trial. He was later committed after being found mentally ill and dangerous. Although his crime was particularly violent, he claimed that his wife was the only person he ever wanted to kill and that he would never kill anyone again. Detroit Free Press, Nov. 2, 1975, § A, at 3, col. 1. It is possible that his dangerousness was limited to that one situation, and that, as to society at large, Boucher presented no threat. However, a judge or jury confronted with the details of his crime could not avoid the conclusion that Boucher was dangerous. The purpose of the hearing for persons acquitted by reason of insanity is to determine the individual's present mental condition. Evidence of a crime committed while the individual was insane may distract the fact-finder from the issue at hand.

\textsuperscript{197} See note 192 supra.
\textsuperscript{198} 392 Mich. at 540, 211 N.W.2d at 582.
discharge by the forensic psychiatry program. Therefore, a person criminally committed must be released when the hospital director finds him clinically suitable, or when he is no longer presently dangerous and therefore does not meet the criteria for a person requiring treatment.

Vigorous public reaction resulted from the prospect of the release of persons acquitted by reason of insanity who did not meet the civil commitment criteria, and the release of persons from mental institutions who were not presently dangerous and therefore could not be held. In response, the legislature enacted a statute which enables a court or jury to find a defendant “guilty but mentally ill” instead of acquitting him by reason of insanity, thereby removing the risk that he may not be civilly committable. The trier of fact must find beyond a reasonable doubt that the defendant is guilty, that he was mentally ill at the time of the offense, but that he was not legally insane at that time. A convicted defendant is then committed to the custody of the Department of Corrections under a criminal sentence. He may either receive psychiatric care there or be transferred to a mental health facility. Since he must be returned to prison after treatment, he will not be released upon a determination that he is no longer mentally ill and dangerous. The sponsors of the statute sought to circumvent the McQuillan decision by eliminating the release of persons after they are acquitted by reason of insanity. Whether such criminal punishment in the absence of criminal responsibility will survive constitutional challenge is open to conjecture. The purpose and intent of the “guilty but mentally ill” verdict is punitive and preventive rather than rehabilitative. It is a reflection of society's desire for protection from the violent crimes of the "deranged" or "criminally insane." This restrictive legislation will confine a person who was not criminally responsible for a full criminal sentence, even though he later regains his competency. Perhaps such legislation is to be expected, however, until...


201 See Comment, supra note 34, at 251 n.108, for a list of Michigan cases.

202 State Representative Otterback conducted public hearings to assess the impact of the new Code. He noted that concerns have been expressed dealing with the recent release of potentially dangerous mental patients. 14 Gongwer News Serv., Mich. Report No. 21 (Jan. 30, 1975).


The goal of their bills, State Rep. Rosenbaum said, is to prevent dangerous inmates of state hospitals from getting back on the streets to commit the same horrendous crimes they were committed for. According to 14 Gongwer News Serv., Mich. Report No. 37 (Feb. 24, 1975), the "severe" bills were introduced to "deal with problems brought to light" by hearings on the new Code. In addition, 14 Gongwer News Serv., Mich. Report No. 19 (Jan. 28, 1975) reports that, "Mr. Rosenbaum said the intent of the proposed verdict is to permit retaining dangerous persons in the corrective system."
psychiatry proves it can actually provide effective treatment for our criminally insane.

IV. CONCLUSION

Michigan's new Code provides extensive procedural guarantees and substantive rights to persons facing commitment or undergoing treatment in a state mental health facility. Any assessment of the effectiveness of these protections necessarily depends on vigorous enforcement by practicing attorneys and the newly created Office of Recipient Rights in the Department of Mental Health. To be effective, this office must prove itself independent from the department of which it is a part.

In addition to enforcing the Code, there remains the problem of interpreting it. Imprecise statutes with no legislative guidelines are incapable of accurate application and permit excessive discretion by courts, physicians, and administrators. The Code's failure to adequately define the parameters of the right to treatment has created disagreement between psychiatrists, who claim that "treatment" includes the conditional release of potentially dangerous patients into community settings, and local prosecutors who claim that the right to treatment does not extend to situations which place society in danger. Furthermore, several constitutional issues remain unresolved. For example, it is unclear whether a state may constitutionally commit an individual who is unable to care for himself yet desires to retain his liberty. It is also unclear whether the "guilty but mentally ill" verdict provides criminal punishment for one who was not criminally responsible.

Michigan's new Code represents the potential for long overdue enlightened treatment of the mentally ill. The application of due process protections will minimize the risk of unwarranted commitments, and, coupled with the rights guaranteed to residents of institutions, should afford the mentally ill a greater measure of self-respect and personal dignity. Involuntary incarceration is the state's most powerful weapon and should always be viewed as a last resort. While society's fear of violent behavior may be justified, that fear should not become a vehicle for more punitive and restrictive laws in the field of mental health. Hopefully, the courts will defend the progress already made and become a positive force by protecting the newly recognized rights of the mentally ill.

—William David Serwer

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207 Mich. Comp. Laws Ann. § 330.1754 (1975) authorizes the department and each facility to establish such an office to receive reports and investigate apparent violations of patients' rights. Mich. Dep't of Mental Health, Mental Health Code Emergency Rules R. 330.7037 (1975) outlines steps to be taken to protect the office from "pressures which could interfere with impartial, evenhanded and thorough performance of its duties." But see Morris, supra note 96, at 1020-23.