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Disposition of the Irresponsible: Protection Following Commitment

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DISPOSITION OF THE IRRESPONSIBLE: PROTECTION FOLLOWING COMMITMENT

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EACH year more of our fellow citizens are involuntarily committed to a mental institution of one sort or another than are incarcerated for the commission of a crime.[1] To those committed, the walls and barred windows of the hospital, as well as the treatment and mode of living, are probably not significantly different from those of a prison. This is particularly the case with those confined for treatment by court order or by some special statutory procedure following acquittal of a crime on grounds of insanity. Yet these mentally ill, even after perpetrating what would otherwise have been a criminal act, are not criminals; their involuntary stay in the hospital is, at least in part, intended for their own protection and treatment, not as punishment for their actions.[2]

Another reason for their commitment lies, of course, in the societal interest in protecting the general populace from those persons who have shown themselves to be dangerous.[3] Those who commit antisocial acts, whether we choose to brand them as criminals or excuse them because they are so ill that reason and rational motivation are impossible, may have an enhanced potential for committing future acts dangerous to others.[4] As our attitudes toward criminal

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1. *See Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 87th Cong., 1st Sess. 11 (1961) [hereinafter cited as *Hearings*].

2. *See* People v. Nunes, 58 Ill. App. 2d 55, 207 N.E.2d 143 (1965). *See also* Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134, 1139-40 (1967); *cf.* Rice, *Mental Capacity To Stand Trial—Part II, Constitutional Issues*, 1 WASHBURN L. REV. 176, 179 (1961).

3. *See* S. GLUECK, LAW AND PSYCHIATRY 122 (1962); H. WEIHOFEN, THE URGE TO PUNISH 118-19 (1956); Figinski, *Commitment After Acquittal on Grounds of Insanity*, 22 MD. L. REV. 293, 298 (1962); Comment, *Compulsory Commitment Following a Successful Insanity Defense*, 56 NW. U.L. REV. 409, 421 (1961). *See also* Overholser v. O'Beirne, 302 F.2d 852 (D.C. Cir. 1961); Ragsdale v. Overholser, 281 F.2d 943 (D.C. Cir. 1960); State v. Toon, 172 La. 631, 135 S. 7 (1931).

Involuntary commitment procedures, other than those statutes providing for automatic commitment following an insanity acquittal, typically require a judicial finding that the subject is, in fact, "dangerous." If this, rather than protection or treatment of the committed, is the proper rationale, the standard of proof to justify detention for treatment should be correspondingly higher. *See* Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1291 (1966).

4. It has been pointed out, however, that there is no empiric evidence that the

responsibility become more liberal and the concept of legal insanity expands,[5] this society-protection interest is likely to emerge in a provision for the commitment to a mental hospital of all those acquitted on grounds of insanity.[6] Indeed today, although not all states provide for automatic commitment—that is, commitment immediately following an insanity acquittal without a hearing of further evidence or a finding as to the subject's present state of mind—commitment typically follows an insanity acquittal in most of the courts in this country.[7]

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mentally ill are any more dangerous to society than the mentally healthy. *Hearings* at 270.

5. *See, e.g.*, Durham v. United States, 241 F.2d 862, 874 (D.C. Cir. 1954) ("It is simply that an accused is not responsible if his unlawful act was the product of mental disease or defects."). This definition, however, has subsequently been tightened. *See* Hightower v. United States, 325 F.2d 616 (D.C. Cir. 1963); McDonald v. United States, 312 F.2d 847 (D.C. Cir. 1962); Carter v. United States, 252 F.2d 608 (D.C. Cir. 1957).

6. The District of Columbia automatic commitment statute, for example, was enacted in direct response to the *Durham* decision. *See* Lynch v. Overholser, 369 U.S. 705, 715 (1962); Krash, *The Durham Rule and Judicial Administration of the Insanity Defense in the District of Columbia*, 70 YALE L.J. 905, 941-42 (1961).

7. This is the common procedure in every American jurisdiction with the possible exception of the federal courts outside the District of Columbia. *See* H. WEIHOFEN, MENTAL DISORDER AS A CRIMINAL DEFENSE 365 (1954). Although legislation now pending would provide for automatic commitment in federal courts outside the District of Columbia [S. 3689, 89th Cong., 2d Sess. (1966); H.R. 17033, 89th Cong., 2d Sess. (1966)], no such procedure is currently authorized. Rather, most federal courts have taken the position that they must release the defendant after an insanity acquittal. Pope v. United States, 372 F.2d 710, 731 (8th Cir. 1967); Freeman v. United States, 357 F.2d 606, 625 (2d Cir. 1966); Pope v. United States, 298 F.2d 507 (5th Cir. 1962); Sauer v. United States, 241 F.2d 640, 651 (9th Cir.), *cert. denied*, 354 U.S. 940 (1957); Dixon v. Steele, 104 F. Supp. 904 (W.D. Mo. 1951). *See also* United States v. Currens, 290 F.2d 751 (3d Cir. 1961). *Contra*, Pollard v. United States, 282 F.2d 450 (6th Cir. 1960).

The state statutes which provide for commitment following an insanity acquittal are of two types: "automatic" and "non-compulsory." Under the "automatic" variety (sometimes termed "mandatory" or "compulsory"), the trial court has no discretion whatsoever following an insanity acquittal, but must commit the defendant to an appropriate institution. *See* Figinski, *supra* note 3; Comment, *supra* note 3. Seventeen jurisdictions now have this sort of automatic scheme: Colorado, Georgia, Hawaii, Kansas, Louisiana, Maine, Massachusetts (murder and manslaughter cases only), Michigan, Minnesota, Missouri, Nebraska, Nevada, New York, Ohio, Wisconsin, the District of Columbia, and the Virgin Islands.

The remainder of the states provide for some form of noncompulsory commitment after an insanity acquittal, but the provisions take on a variety of forms. Seventeen states eschew any specified commitment procedure, leaving it entirely up to the discretion of the trial court: Alaska, Arkansas, Connecticut, Delaware, Iowa, Massachusetts (cases other than murder and manslaughter), New Mexico, North Dakota, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, and West Virginia. Other states furnish commitment standards and require that either the judge or jury make a specific finding as to commitment—either at trial or at a separate hearing, which then becomes mandatory: Alabama, Arizona, California, Florida, Idaho, Illinois, Indiana, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, Oklahoma, Texas, Washington, and Wyoming. A few states have a variant of this last procedure, leaving it to the court's discretion whether to cause an inquiry into the defendant's mental state following an insanity acquittal, but pro-

The various state procedures for commitment following an insanity acquittal raise a whole range of questions, from their constitutionality to their wisdom and efficacy.[8] Intelligent analysis of these methods of disposition of the irresponsible cannot, of course, ignore any of these questions. One inquiry, however, has seldom been made and seems of especially great import today: if mandatory commitment is to be justified on the basis that society has a right to at least a reasonable period of close examination to insure that the defen-

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viding that the court be bound thereafter by the results of the inquiry: Idaho, Louisiana (noncapital felonies and misdemeanor cases), and Tennessee. And, of course, some statutory schemes do not fit even these categorizations. *E.g.*, MD. CODE ANN. art. 59, §§ 7, 8(a) (1957). These two sections have not yet been judicially reconciled, but seem to provide that if the jury acquits and finds that the defendant continues to be insane, commitment is mandatory. If, however, the jury acquits on insanity grounds but neglects to make such a finding, the court apparently has discretion to order commitment.

8. For representative literature on some of these questions, *see generally* M. GUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW (1952); F. LINDMAN & D. MCINTYRE, THE MENTALLY ILL AND THE LAW (1961); T. SZASZ, LAW, LIBERTY AND PSYCHIATRY (1963); Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945 (1959); Comment, *supra* note 2; Note, *supra* note 3.

Perhaps at the core of the problem is the fact that the philosophy and administration of the commitment-following-insanity statutes have changed but little in the 168 years since the attempted assassination of King George III by a mentally deranged Englishman, one Hadfield, prompted the first automatic commitment statute. *See* Hadfield's Case, 27 How. St. Tr. 1281 (1800), 40 Geo. 3, ch. 94 (1800). Only a small minority of American states, for example, have established procedures for an adequate psychiatric examination of the defendant either before or after commitment. Only three states require that the accused be given a psychiatric examination within a prescribed period after commitment or provide for periodic examinations: Georgia, Louisiana, and Missouri. Only two of the automatic commitment states provide for a hearing on the question of recovery before commitment: Hawaii by statute, HAWAII REV. LAWS § 258-38 (Supp. 1963), and Ohio by judicial decision, Collins v. Campbell, 4 Ohio App. 2d 42, 211 N.E.2d 96 (1965). In an important case decided while this article was in galley, the Court of Appeals for the District of Columbia, drawing from Baxstrom v. Herold, 383 U.S. 107 (1966), held that although a defendant may be automatically committed following an insanity acquittal for a period of time sufficient for examination and determination of his present mental condition, failure to provide a judicial hearing at the end of this period would be a denial of equal protection of the laws. That is, some judicial procedure corresponding to that for civil commitment must be afforded. Bolton v. Harris, 36 U.S.L.W. 2535 (D.C. Cir. Feb. 1, 1968) (Bazelon, C.J.). This case may presage a reexamination of the constitutionality of automatic commitment statutes. Furthermore, no jurisdiction with an automatic commitment statute has seen fit to provide the indigent defendant with an attorney to represent and assist him during his period of confinement, although most states provide an attorney to help with a specific petition or hearing. *E.g.*, Robertson v. Cameron, 224 F. Supp. 60 (D.D.C. 1963) (attorney provided at hearing in absence of statutory provision); KAN. GEN. STAT. ANN. § 59-2260 (1964) (counsel for indigents at civil commitment hearings). Only one state has provided the automatically committed indigent with funds to hire a psychiatrist of his own choice. COLO. REV. STAT. ANN. § 39-8-4(16) (Supp. 1965). Some courts have, however, indicated that they would appoint such experts for indigent patients. Watson v. Cameron, 312 F.2d 878 (D.C. Cir. 1962); People *ex. rel.* Anonymous No. 1 v. La Burt, 17 N.Y.2d 738, 217 N.E.2d 31 (1966). It seems apparent, then, that as of this writing, the aims of the states are something other than rehabilitative.

dant can be safely returned to the community and if continuing hospitalization is premised upon the need to treat him until he is no longer dangerous to himself or to others, is the patient being released promptly upon qualifying for discharge? Does the law or medical practice afford the patient adequate assistance in implementing his treatment and rehabilitation? If these are answered in the negative, is there any remedy?

These questions are brought into sharp focus by the recent decision of the Court of Appeals for the District of Columbia Circuit in *Rouse v. Cameron*.[9] In that case, the same court which adopted an expanded notion of legal insanity in *Durham*[10] held that a person committed under the District of Columbia automatic commitment statute had a judicially enforceable statutory, and perhaps constitutional, right to treatment for his illness. The court declared that failing adequate treatment, the hospital must release him, and it reserved to itself the question of what is "adequate" in a particular case.[11] The court further intimated that were there not such a right to treatment, the statute might be unconstitutional on due process, equal protection, or cruel and unusual punishment grounds. Just as *Durham* stirred members of the legal and medical professions to re-examine and re-evaluate the question of criminal responsibility,[12] so should *Rouse* activate consideration of the care and treatment of those deemed irresponsible.

With this in mind, the writer participated in a study of inmates who were committed to a Michigan hospital for the criminally insane after an insanity acquittal. The study unearthed some troubling abuses of the treatment process. It demonstrated that patients without competent legal assistance were often abandoned in the hospital, spending many months and years beyond the time when they could and should have been released. It demonstrated that the judicial machinery sometimes deliberately and sometimes negligently interferred with treatment programs. Yet, significantly, it also showed that when patients were able to retain competent and active attorneys to protect their interests, these abuses were kept to a minimum. It is the

9. 373 F.2d 451 (D.C. Cir. 1967). The holding of *Rouse* was presaged by earlier warnings that failure to provide suitable treatment might call into question the validity of the automatic commitment statute. *See* Brown v. Cameron, 353 F.2d 835, 837 (D.C. Cir. 1966) (dissenting opinion); Darnel v. Cameron, 348 F.2d 64, 67-68 (D.C. Cir. 1965).

10. *See* note 5 *supra*.

11. The court, moreover, ruled that "continuing failure to provide suitable and adequate treatment cannot be justified by a lack of staff or facilities." 373 F.2d at 457.

12. *See, e.g., Hearings* at 433-64, 685-93, 753-96; GLUECK, *supra* note 3, at 41-103; S. RUBIN, PSYCHIATRY AND CRIMINAL LAW 1-86 (1965); WEIHOFEN, *supra* note 3; Moore, *M'Naghten is Dead—or Is It?*, 3 HOUSTON L. REV. 58, 62-76 (1965); Slovenko, *Psychiatry, Criminal Law and the Role of the Psychiatrist*, 1963 DUKE L.J. 395, 398-424.

thesis of this article that the availability of legal counsel is essential to the effective enforcement of the post-commitment rights of patients committed after insanity acquittals.

I. The Michigan Experience

The study focused particularly on the twenty-nine persons committed under the Michigan automatic statute since 1939.[13] At the time of the study, 1965-1967, that statute applied only to those acquitted of murder by reason of insanity, although it has since been broadened to cover all "crimes."[14] In addition, occasional reference is made to data concerning inmates who were acquitted of charges less than murder, and who were committed under other than the automatic procedures. It is important to note that the conclusions of this study are equally applicable to all types of commitment procedures following an insanity acquittal.

A. *Treatment Failures*

In reading this section, the warning of the *Rouse* court should be remembered: failure to provide adequate treatment might render a commitment statute constitutionally suspect. Treatment failures, then, might threaten the foundation of the entire scheme.[15]

The patients studied were hospitalized at the Michigan State Hospital for the Criminally Insane at Ionia (hereinafter referred to as Ionia). In 1965, the Michigan State Department of Mental Health authorized a medical audit investigation of Ionia which resulted in a recommendation that the hospital be phased out and that in the future persons eligible for commitment be sent to any of several regional hospitals which treat the noncriminal mentally ill.[16] The basic criticism of the audit was that the hospital had wholly failed to carry out its function of providing treatment to inmates. The investigation revealed: (1) that the hospital had been unable to attract physicians with the necessary medical and psychiatric skill and legal sophistication;[17] (2) that nurses were so fearful of the patients that

13. The study was conducted during the period 1965-1967 at the Michigan State Hospital for the Criminally Insane at Ionia, Michigan [hereinafter referred to as Ionia] and culminated in a report to the state mental health department. J. Acher, R. Guzman & T. Lewin, Psychiatric Evaluations in Criminal Cases—A Field Study and Report to the Michigan Department of Mental Health (1967).

14. Public Act No. 266, [1966] Mich. Acts 378, *repealing* Mich. Comp. Laws § 766.15c (1948). Section 27b of the Act extends automatic commitment to all "crimes."

15. *See* 373 F.2d at 453; Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

16. Unpublished Final Report of the Ionia State Hospital Medical Audit Committee of October 4, 1965. Copy on file with the author.

17. The Medical Audit Committee noted that during the period of the study the doctor/patient ratio at Ionia was in the neighborhood of 300:1. *Id.* at 3-4.

they would not visit the wards at night even when medication was needed, leaving the matter of the administration of drugs to the guards; (3) that the physical plant was so old, of such poor design, and in such bad repair as to preclude modern psychiatric practice;[18] (4) that opportunities for occupational, industrial, or recreational therapy were almost wholly lacking due to the foregoing reasons; and (5) that, perhaps influenced by the fact that it operated in a small rural community near two state correctional institutions, the treatment program was primarily custodially oriented and that supervision of patients by professional personnel was minimal.

While Ionia, unlike some other mental institutions,[19] cannot justifiably be termed a "hell-hole," the shortages of facilities and staff have adversely affected the treatment afforded the patients. Our examination of the Ionia patient records revealed numerous examples of treatment failures. In some cases, patients had not been thoroughly psychiatrically examined for years on end. In others, years went by without patients even being observed in a "staffing conference"—wherein the patient's history and progress are reviewed by the hospital staff for counseling purposes. In one case, through apparent neglect, the hospital failed to follow up the scarcely arduous therapeutical recommendations of an experienced outside psychiatrist; predictably, the juvenile patient involved suffered a deteriorated mental condition. In another case, even though an inmate acquitted of murder had been recommended by the superintendent for release into the community, a security attendant cancelled all his athletic team therapy because someone forgot to amend the outdated "homicidal" label on his records jacket. Most of these sorts of treatment failures should in truth be attributed to understaffed and overcrowded hospital conditions, rather than to negligence, as such, on the part of the staff.

Negligence can, however, be attributed to the legal profession for hindering the treatment program in two respects: incorrect preparation of commitment orders and direct judicial interference in the hospital treatment program. It was not uncommon to find that the

18. The physical plant was characterized as "depressing overcrowded firetraps in which no one should be required to live." *Id.* at 3-4.

19. *See* State v. Gremillion, 168 S.2d 270, 273 (La. App. 1964). *See also Hearings* at 40-47 (testimony of Albert Deutsch); Halleck, *A Critique of Current Psychiatric Roles in the Legal Process*, 1966 WIS. L. REV. 379. Several commentators have indicted the nation's hospital system for the criminally insane as little more than a vast penal holding compound, with more emphasis on security than treatment of any kind. *E.g.*, RUBIN, *supra* note 12, at 41-42, 149-66 (1965); SZASZ, *supra* note 8, at 144; Goldstein & Katz, *Dangerousness and Mental Illness: Some Observations on the Decision To Release Persons Acquitted By Reasons of Insanity*, 70 YALE L.J. 225, 226-27 (1960); Halleck, *supra* at 392; Comment, *supra* note 3, at 417, n.24 (1961).

commitment order drafted by an attorney or a judge incorrectly stated the reason for the commitment. In fact, for the period from 1959 to 1964, twenty-seven erroneous or ambiguous court orders were found which misled the hospital as to the patient's legal status and which may have resulted in the application of wrong treatment goals. In one case, a patient was actually acquitted of a crime less than murder but the commitment order stated that he was incompetent to stand trial—a different legal status and one which has different treatment objectives.[20] In another case, a man charged with simple assault was found incompetent to stand trial and ordered committed. The commitment order, however, referred only to his mental condition at the time of the alleged criminal act and ordered that he be kept in confinement for his "natural life," a term reserved by statute exclusively for defendants acquitted of murder by reason of insanity. The hospital duly classified him as a "natural life inmate" and handled him as if he had been acquitted of murder and was homicidal. The effect of this sort of misclassification is not difficult to see: since the standard for competency to stand trial is lower than that of safe return to the community—the standard that must be achieved by "natural-life inmates"[21]—such a misclassified patient will likely remain committed longer than is necessary.

It was also not uncommon for courts to interject their edicts into the treatment process by attempting to define or restrict the type of activity that a patient should be permitted to engage in while at the hospital. One court, for example, appended to its commitment order the notation that the defendant was dangerous and should not be given outside privileges. Hospital personnel advised that they would abide by the court's directive if to do so would not interfere with the patient's treatment and would countermand the order only where they felt it necessary to do so.[22] Consequently, this patient would receive therapeutically valuable outside privileges only when "necessary" and not when merely desirable, as is the test for other patients.

20. The hospital was thus working toward the objective of returning the inmate so that he could stand trial instead of preparing him for release to the community. Since it is possible for a mental patient to reach a point in his recovery where he can safely be returned for trial but where he is not yet progressed to the point where he may be returned to the community, such an error risks premature release.

21. In theory one can be mentally ill and dangerous to himself and to others, yet still be competent to stand trial. For discharge of an automatically committed "natural life" patient, he must be found "not [to] be harmful to other persons or their property." MICH. COMP. LAWS § 766.15c (1948). Under the competency test, however, the defendant need only be "capable of understanding the nature and objects of the proceedings against him and of comprehending his own condition in reference to such proceedings and of assisting in his defense in a rational and reasonable manner." MICH. COMP. LAWS § 767.27 (1948). Both of these statutory provisions were replaced by Public Act No. 266, [1966] Mich. Acts 378. *See also* text following note 30 *infra*.

22. Interviews with A. A. Birzgalis, Superintendent of the Ionia State Hospital Administrative and Medical Staff Personnel, July 26, 29, 1966.

It should be apparent that such judicial restrictions may constitute an unwarranted interference with the hospital's primary role in treatment.

The types of treatment abuses discussed in this section point up the significance of the right to treatment recognized by *Rouse*. Yet the mere existence of the right is not meaningful without an effective means of enforcing it. As will be discussed in more detail later, effective enforcement depends upon the availability of an attorney to act on behalf of the patient.

B. *Detention Beyond the Point of Cure*

The most dramatic abuse noted in the Ionia study was the retention in confinement, for substantial periods, of patients who were apparently eligible for discharge. Significantly, the incidence of such prolonged unnecessary confinement was greater where the patient was without counsel; in those cases in which a private attorney was retained, the abuse was minimized.

For each of the twenty-nine murder defendants, an insanity acquittal meant commitment to Ionia until such time as he should become sufficiently restored to mental health to be able to rejoin the community. The mechanics of the study required, first, that the point of medical eligibility for release be determined in each individual case. It was then a simple matter to compute the patient's period of confinement subsequent to that point. From a study of the patient files for each of the twenty-nine, it was determined that the hospital, as a matter of routine, would generally inaugurate discharge or cooperate with discharge efforts whenever the patient's condition stabilized for a period of about six months, as observed and reported by the ward attendants, nurses, and staff psychiatrists, provided that the patient was no longer psychotic or otherwise mentally ill.[23] Where the patient was not psychotic on admission, discharge efforts would be made when it appeared that the patient was free of emotional disturbance, had gained "insight" into his crime, and was generally cooperative with hospital personnel. The time interval from this point of eligibility for discharge to actual discharge, or if no such discharge occurred, then to October 31, 1966, was determined in two classes of cases: those where the patient had the active assistance of an attorney during commitment and those where the patient lacked such assistance.

23. This practice was confirmed by a file study of approximately fifty incompetency-to-stand-trial patients, which at that time were subject to the same "restored to sanity" standard for discharge as those automatically committed. Ionia staff personnel were also consulted and agreed that our findings as to the discharge pattern were substantially correct. Interview with Ionia Medical Staff personnel, October 25, 1966.

The study revealed that twelve of the twenty-nine patients had been discharged, one died, and the remainder were still in the hospital. Only one patient secured a release without the active assistance of an attorney and she spent six and one-half years in the hospital beyond the eligibility point. The other eleven securing release had attorneys active in their behalf and were discharged within an average of four and one-half months from the eligibility point. Comparison of the total hospitalization time revealed an even more striking disparity. Excluding six patients whose commitment period was too short for meaningful comparison from our total of twenty-nine, the ten patients without legal assistance spent an average of over twelve years in the hospital,[24] while the thirteen with attorneys spent an average of one year and ten months there. This is a difference of nearly ten years. It should be noted, however, that three of the patients without legal assistance had such severely defective mental conditions that they were untreatable and no amount of legal assistance would have affected the length of their stay in the hospital. With these three patients excluded, the difference is still startling: those without active legal assistance spent an average of seven years and seven months at Ionia—five years and nine months longer than the patients with legal help.

Seven of the patients were released within one year of their commitment, and three of these within only three months, notwithstanding the hospital's general practice of requiring six month's stabilization. All seven had attorneys active in their behalf. Of those patients without attorneys who were not so severely ill as to be untreatable, six had attained the eligibility point for discharge and at the very least should have received an independent psychiatric examination to determine if they could safely be released. Yet as of October 31, 1966, these patients had spent an average of one year and ten months in Ionia *beyond* the point where they had apparently recovered. The average *total* hospitalization time for the thirteen patients with attorneys was a few days less than that.

These statistics indicate that there is a clear danger of prolonged commitment of non-mentally ill patients. They show that the patient who did not have legal assistance, either because of financial inability[25] or because he was a juvenile and lacked sufficient experience to enable him to retain an attorney, was denied equivalent access to the

24. This includes patients not discharged as of October 31, 1966.

25. In some of the cases it could not be determined from the files whether the patient was financially unable to obtain private counsel. It may be that funds were available but that the inmate's mental condition precluded any sort of initiative on his part or that his attempts were thwarted by relatives or hospital authorities. The latter was noted in at least one case history.

channels of discharge. Such a denial, in the case of patients who could medically and legally qualify for release if given an opportunity, is a most serious invasion of a patient's constitutional rights: for by reason of invidious economic discrimination, it deprives him of his most precious freedom—liberty of his person.[26] Not only is this violative of basic notions of due process and equal protection, but it arguably constitutes cruel and unusual punishment. Most courts have sustained commitment schemes against this latter challenge on the theory that the commitment is civil, not criminal.[27] But even this labeling device must fail after the patient has recovered from his illness, since he no longer needs treatment nor presents a danger to society.

The hypothesis that the most logical safeguard consists of an active attorney representing the patient can perhaps best be illustrated by two actual Ionia case histories.

> *Case History "A."* The patient was admitted to Ionia in 1940 following an insanity acquittal of murder and was diagnosed as having a "situational psychosis," "hysterical amnesia," and an "introverted personality." Although she had periodic contacts with her family, who retained an attorney, he was not active on her behalf, and she had no independent resources. Eight years after her admission, during which time she made steady progress, the hospital found her no longer psychotic. Her condition remained substantially unchanged for six more years. At that time the hospital concluded she could be discharged but advised her that only the Governor could set her free, and they notified her attorney that they were setting in motion administrative procedures which would culminate in the Governor acting to release her. The attorney took no active steps to gain her release and seven months went by before the Attorney General advised the hospital that the Governor would not act to pardon her. The attorney then obtained a writ of habeas corpus and the patient was ordered released by the court.

At the very least, this patient remained at Ionia eight months beyond the point when the hospital formally determined she should be released; since her condition had not changed in the six years preceding this determination, it is likely that she was confined almost *seven years* too long. Compare her plight with that of the well-to-do industrialist in the following illustration.

> *Case History "B."* The defendant, a wealthy industrialist, was automatically committed following an insanity acquittal on the charge of murdering his wife, whom he caught with an alleged paramour. The defendant retained three of the leading forensic psychia-

26. *Cf.* Griffin v. Illinois, 351 U.S. 12 (1956).
27. *E.g., In re* Golden's Petition, 341 Mass. 672, 171 N.E.2d 473 (1961).

trists in the country to testify at his trial. On admission to Ionia he was found to be suffering from a personality trait disturbance without psychosis. Two days later he was seen by a private psychiatrist, and his attorney moved for a hearing on a writ of habeas corpus which was actively resisted by the State. A compromise was reached whereby the patient was ordered committed to a Detroit clinic for a month of observation and study. The clinic examination resulted in a finding of no psychosis, although he was classed as an emotionally unstable person. On his return, his attorney secured a hearing on the writ, and six private psychiatrists testified that he was not psychotic and would not be harmful to society if released. Although the superintendent of Ionia testified against the release, the court ordered his discharge.

By actively working on behalf of his client, over the objections of the hospital superintendent and the prosecutor, the attorney was able to effect a discharge within four months from the initial commitment.

This comparison points up the effectiveness of the attorney in this sort of representational role. The lawyer who was successful in obtaining a timely discharge from Ionia for his client generally took most, if not all, of the following steps: (1) he made early contact with the Ionia Superintendent assuring him that the inmate's family desired his return and that proper facilities existed for the successful transition to freedom; (2) he made regular contacts with the patient, including personal visits; (3) he saw to it that members of the patient's family made frequent and regular visits both with the patient and the hospital staff; (4) he employed private psychiatrists and obtained periodic psychiatric examinations; (5) he discussed the patient's progress with the staff psychiatrist; and (6) he expeditiously moved for a hearing on a writ of habeas corpus whenever it appeared that either the private psychiatric testimony clearly supported a discharge or the Superintendent no longer actively opposed a release.[28] In short, one could perhaps best characterize the attorney's role as that of an expert catalyst and champion.

While the necessity for this sort of individual action implies that the hospital was less than diligent in fulfilling its duty of treatment and return of the patient, it would be unfair to place the blame solely with the hospital. On several occasions the hospital had to do all the work necessary to secure the release, and since there is no

28. The writ of habeas corpus was the only judicial method available for discharge. The Superintendent did not have power to release a patient automatically committed as the statute provided that only the Governor with the advice of the Mental Health Commission could discharge these patients. MICH. COMP. LAWS § 766.15c (1948), *repealed by* Public Act No. 266, [1966] Mich. Acts 378. Not one person was discharged by the Governor during the twenty-eight years the statute was in operation.

legal staff attached to the hospital, it was forced to turn to the Attorney General for legal assistance. The very fact that the Attorney General is obligated to act on behalf of the State to insure that a release is not improvident and will not endanger society would tend to put him in a position of serving two masters. It is reasonable to assume that the State will not act as quickly or as zealously in the sole interests of the patient as would a private lawyer. Another focal point of inertia is in the hospital staff itself. Every time a released patient commits an act of violence, the hospital comes under severe public censure and criticism. During the period of the study, Ionia was the subject of three separate public investigations, culminating in the recommendation that it be closed. Fighting for its very existence, there was every reason for the hospital to delay a patient's discharge until the staff was "absolutely certain of his harmlessness to society."

II. Conclusion and Proposal

It might be argued that a proposal for legislative reform in this area is like calling the fire department to put out a lighted match. After all, in twenty-eight years under the statute there were only twenty-nine automatic commitments in one of the largest states in the country. A related pilot study of the problems of the criminally mentally ill in Michigan, however, revealed that a considerable increase in commitments following insanity acquittals is likely to occur in the future. The study noted that for many years Michigan prosecutors have been using the incompetency-to-stand-trial procedure as a convenient but improper disposition of criminal cases.[29] Faced with a mentally ill defendant, it became the practice in many Michigan courts for the prosecution to raise the issue of incompetency and actively to work for pretrial commitment, often over the objection of the defense. Many courts required nothing beyond a showing of the existence of mental illness and a psychiatrist's recommendation of needed hospitalization to support its finding of incompetency.[30]

An incompetency commitment was a valuable prosecutorial device because the Ionia staff until late 1965 interpreted the relevant statute to require them to retain custody of the defendants until they were completely "cured" of their mental illness. As a result many such defendants were kept for treatment even though their mental

29. J. Acher, R. Guzman & T. Lewin, Psychiatric Evaluations in Criminal Cases 36 (1967).

30. *Id.* at 43.

condition had improved to the point at which the requirements for competency would have been satisfied. When these defendants were finally returned for trial, the charges would ordinarily be dismissed and the defendants released.[31]

As a result of a series of outside investigations, the hospital re-evaluated its interpretation of the incompetency treatment goals and began to return defendants to trial when they could meet the legal test of competency irrespective of the continuance of the underlying mental illness.[32] The result was a marked increase in insanity acquittals and subsequent commitment. Prior to the 1965 shift in the hospital's position, commitments following insanity acquittals averaged less than four per year; there were fourteen in the first ten months of 1966 alone. Further, the pre-1965 yearly average of less than one automatic commitment following an insanity acquittal of murder, was quickly surpassed when ten such commitments were made in the first ten months of 1966. There is evidence that many of these trials resulting in insanity acquittals were little more than informal hearings before the judge. After the prosecutor established an uncontested prima facie case, he would stipulate that mental illness existed at the time of the offense. Thus the defendant would be quickly acquitted and recommitted.

Although this Michigan experience is primarily a reaction to an unusual situation, it does indicate that proper utilization of the incompetency process coupled with the availability of automatic commitment, may result in increased irresponsibility commitments. A similar increase in prosecutive use of the insanity defense recently occurred in the District of Columbia for different reasons,[33] and with the increased availability of defense funds to indigents and expanded understanding and use of psychiatric concepts by lawyers,

31. For example, of the 180 defendants committed to Ionia from Detroit Recorder's Court who were returned to that court during fiscal 1966, 88% had their charges dismissed. *Id.* at 20. This was similar to the practice of many other state courts before and during this period.

32. IONIA STATE HOSPITAL, A STUDY OF PATIENTS RETURNED TO COURT BY THE IONIA STATE HOSPITAL AS COMPETENT TO STAND TRIAL AS OF AUGUST 31, 1966 (1966) (unpublished report to the Michigan Department of Mental Health). *See also* Hess & Thomas, *Incompetency To Stand Trial: Procedures, Results and Problems*, 119 AM. J. PSYCHIATRY 713-20 (1963); Note, *Criminal Law—Insane Persons—Competency To Stand Trial*, 59 MICH. L. REV. 1078 (1961).

33. Krash, *supra* note 6, at 949-51. Insanity acquittals in the District of Columbia went from none in 1951 to ten in 1955, fourteen in 1956, and thirty in 1959. Krash attributed this rise to the adoption of the more liberal *Durham* rule for insanity in that jurisdiction. At the same time, incompetency commitments diminished markedly from a yearly figure of between forty-five and sixty to only thirteen by 1963. JUDICIAL CONFERENCE OF THE DISTRICT OF COLUMBIA CIRCUIT, REPORT OF THE COMMITTEE ON PROBLEMS CONNECTED WITH MENTAL EXAMINATION OF THE ACCUSED IN CRIMINAL CASES BEFORE TRIAL 156 (1965).

the incidence of insanity acquittals may well increase generally across the country.

But irrespective of the increase the hospital is now under greater pressure to treat the ill and discharge the cured. There is no enforcement mechanism for these duties other than the courts—indeed, the lesson of *Rouse* is that the courts will enforce the duty to treat the ill as they have long enforced the duty to discharge the recovered. The most effective means of providing enforcement is to insure that attorneys are available to all patients committed after an insanity acquittal, regardless of their financial means. An alternative solution might be to provide periodic judicial review of each patient's case. This, however, would be unnecessary in a number of cases, significantly complicate hospital routine, and unduly burden already congested court dockets. As the Michigan study demonstrated, the assistance of an attorney representing the inmate on a continuing basis is more than adequate.

To implement such a broad and, in some respects, radical program, legislation is required. A model statute, appended hereto, is therefore proposed to provide any person committed after insanity acquittal with complete, continuing legal representation, including the ability to hire private psychiatric or other expert help when appropriate. The statute is drafted with but one class of patient in mind—those who are committed following an insanity acquittal. It may be that other classes or indeed all inmates ought to have the same protection. This would depend, in my view, upon whether they are abandoned much in the same manner as the Michigan inmate acquitted by reason of insanity. It is here that the need is most critical.

APPENDIX

A Proposed Model Statute

Section 1. *Title.* An act to provide for the representation of indigent persons committed to a mental institution following acquittal of a crime because of insanity, during the period of their commitment or while under the supervision of the said mental institution.

Section 2. (a) *Right to an Attorney.* In every criminal case in which the defendant is acquitted by court or jury of the crime charged on the grounds [of insanity] [that he was not legally responsible for his act by reason of mental illness existing at the time of the act] and who shall therefore be committed to a mental institution shall be entitled to be represented by an attorney during the entire

period of his confinement and any period of parole, temporary release, conditional release or convalescent care, until unconditionally discharged from confinement in accordance with law.

(b) *Appointment of Counsel.* The committing court, following acquittal by reason of insanity, if satisfied after an appropriate inquiry that the defendant is financially unable to obtain counsel, shall appoint counsel to represent him.

(c) *Duration and Substitution of Counsel.* A defendant for whom counsel is appointed shall be represented throughout the period of commitment to the custody of the hospital including any period of parole, temporary release, conditional release, or convalescent care. If at any time after the appointment of counsel, the court making initial appointment finds that the defendant is financially able to obtain counsel or to make partial payment for the representation, he may terminate the employment of counsel or authorize partial payment as the interests of justice may dictate. If at any time during confinement, either the committing court, or the court situate in the county where the defendant is confined or is a resident if on parole, temporary release, conditional release or convalescent care, finds that any person committed in the manner described in subsection (a) is financially unable to pay for counsel he had previously retained, the court may appoint counsel as provided in subsection (b) as the interests of justice may dictate. Either of said courts may, at any time during the aforesaid period of custody or supervision, in the interests of justice substitute one appointed counsel for another.

(d) *Payment for Representation.* An attorney appointed pursuant to this section shall at the end of the representation, or semiannually in the event that the representation extends six months or more, be compensated at a rate not exceeding $15 per hour for time spent in any court or administrative hearing and $10 per hour for time reasonably spent out of court and shall be reimbursed for expenses reasonably incurred. Each claim shall be supported by a written statement specifying the time spent, services rendered, and expenses incurred and, in addition, any compensation or reimbursement applied for and received on behalf of the said patient from any other source. Upon submission for approval to the court making the appointment, the court shall in each instance fix the compensation and reimbursement to be paid to the attorney. Compensation for time spent out of court, exclusive of reimbursement of expenses, to an attorney under this Act shall not exceed $150 in any six-month period. Compensation for time spent in court or in an administrative hearing shall not exceed $250 in any six-month period. In extra-

ordinary circumstances payment in excess of the limits set forth herein may be made if the court making the appointment certifies that such payment is necessary to provide fair compensation for protracted representation and the amount of the excess payment is approved by a judge of an appellate court. In the event of representation of the inmate in any appellate proceedings the attorney shall be entitled to receive in compensation and in addition to any other compensation such sums as may be approved in the discretion of the appellate court but in no event to exceed the sum of $250 together with reimbursement of any expenses reasonably necessary to prosecute such appeal.

(e) *Services Other Than Counsel.* Counsel for any inmate committed in accordance with the provisions of subsection (a) unable to obtain expert or other services necessary to reviewing the inmate's mental condition and recuperative progress while in the custody or under the supervision of the hospital may request such services by an application to the committing court or the court making the appointment of counsel. Upon finding after appropriate inquiry that the services are necessary and that the inmate is financially unable to obtain them, the court shall authorize counsel to obtain the services on behalf of the inmate. The court shall determine reasonable compensation for the services and direct payment to the organization or person who rendered them upon a filing of a claim for compensation supported by an affidavit specifying the time spent, services rendered and expenses incurred on behalf of the inmate and any compensation received for the same services from any other source. The compensation to be paid to a person for such services rendered by him to an inmate under this subsection, or to be paid to an organization for such services rendered by an employee thereof, shall not exceed $250 in any six-month period, exclusive of reimbursement for expenses reasonably incurred.

(f) *Payment Source.* Payment of compensation to the attorney or for the services set forth in subsection (e) together with expenses reasonably incurred shall be made by the County Treasurer of the county wherein the appointment was made. The county shall be entitled to reimbursement of such payment from the state.

(g) The term "inmate" as used in this section means the defendant committed to a hospital following acquittal of a crime by reason of insanity.