Justice in the Books or Justice in Action – An Institutional Approach to Involuntary Hospitalization for Mental Illness

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"... [T]o have this occur in the national capital which ought to be a model for the nation and a showplace for the world was little short of disaster." Chief Justice Warren E. Burger**

On April twelfth of this year, the United States Court of Appeals for the District of Columbia Circuit, sitting en banc, heard arguments and received briefs on a question it had posed itself—should the Durham rule be discarded? Recent surveys emphasize that insanity defense procedures have not worked well in the District of Columbia. In a jurisprudential focus, I will offer some evidence recently compiled to support the position that the court-hospital-court transmission belt has broken down. Its need for repair is so drastic that a new rule of criminal responsibility becomes almost peripheral. Nothing less than the introduction of new institutional elements will bring about justice—"justice in action," that is, not mere "justice in the books."

I. JURISPRUDENTIAL FOCUS: HAUROU AND POUND

After creating French droit administratif and observing its period of greatest development, Maurice Hauriou concluded that the most significant ele-
ments in society are not its rules of law but its institutions. 4 Dean Roscoe Pound, a contemporary of Hauriou, approached this thought when he contrasted “Law in Books and Law in Action.” 5 Because law can be put in action only by men operating within an institution, we must examine the law with an eye to the presuppositions of that institution.

Hauriou's institutionalist thought emphasizes two factors. One is now somewhat accepted “in the books,” if not “in action.” That is, to ascertain whether legal rules lead to justice, they must be tested within the operating context of an institutional system—as they are applied. 6 The problem here, as Hauriou and others 7 see it, becomes difficult when the efficacy of the rules depends on the interplay of varied, often divergent, sets of institutions and institutional elements. 8 Hauriou's second factor is more original, and gives a basis for arguing the direction which rules and other institutional arrangements should take. It starts by asking: What are the fundamental ideas upon which a particular society is based, lives and grows? And what


4. See Hauriou, The Theory of the Institution [hereinafter cited as Hauriou], in THE FRENCH INSTITUTIONALISTS 123 (A. Broderick ed., M. Welling transl. 1970) [hereinafter cited as THE FRENCH INSTITUTIONALISTS]: “In a world that wishes to live and act while harmonizing action with continuity and duration, corporate institutions, like individuals, are in the front rank because they represent both action and continuity. Juridical rules are in the second because, while they may represent continuity, they do not represent action.” This essay was written in 1925.


6. Here Hauriou's thought parallels Pound, and other sociological jurists. I shall develop this thought from the context of Pound's famous dichotomy, "Law in Books and Law in Action."

7. See, e.g., T. PARSONS, STRUCTURE AND PROCESS IN MODERN SOCIETIES (1960) and THE STRUCTURE OF SOCIAL ACTION (1937), which approach the problem from the viewpoint of a theoretical sociologist.

8. For example, in our mental health context, the set includes institutions such as hospitals, and courts (lower and appellate), and institutional roles such as doctor, psychiatrist, hospital administrator, judge, prosecutor, defense counsel, and, possibly, ombudsman. Where mental hospitals are part of a state or federal administration, the higher echelon bureaucracy and the legislature (not only as lawmaker, but also by governing priorities through appropriations) are also involved.
are the basic ideas which different sub-institutions of the society are designed to achieve? In Hauriou's view the central aspect of any institution (the state, a corporation, a labor union, a university, or a hospital) is the directing idea or ideas which the institution has been established to realize. In a specific context the sub-institutions may be at odds with one another. Overall resolution of their conflicts depends upon judgematic factors exercised within the focus of the fundamental (basic, core) ideas of the larger society.9

In every “corporate” or “group” institution Hauriou sees three elements: (1) “The idea of work or enterprise to be realized.” Hauriou also refers to it as “the directing idea of the enterprise.” This is “the most important element of every corporate institution.”10 (2) “The organized power put
at the service of the idea for its realization.”  

This is government. (3) "The manifestations of communion that occur within the social group with respect to the idea and its realization.”  

The institution is perfected when the maximum number of its members share in its life, and profess its directing ideas.

But how are the directing ideas of an institution identified? Hauriou used the state as an illustration:

What laws of the state, for example, precisely express the idea of the state? As we have already observed, juridical rules are essentially limits, they merely delineate the contours of things. But indirectly, in this delineation of contours, the positive content of the directing idea can be revealed to a certain degree. This consequence occurs most often in what concerns fundamental and constitutional rules.

In his quest for a society's directing ideas, Hauriou would search beyond its enacted rules, even beyond its written constitution. He states: “the highest forms under which the directing idea of an institution tends to express itself subjectively are not properly juridical. They are moral or intellectual, or, if they become juridical, they do so as higher principles of law.” These opposed to the state that is unbalanced in favor of a single class that plays the role of dictator, unstable because imperialistic, organized exclusively in view of economic needs, set up so that there is no legal order—a regime that the adversaries of the bourgeois state oppose to it under the name of the soviet regime. And for this reason alone Hauriou deserves to be ranked, in the history of ideas, in as important a place as is Marx, for example. The state regime is the organization of the nation upon the basis of the balances I have enumerated.” Waline, Maurice Hauriou, in THE FRENCH INSTITUTIONALISTS 154.

12. Id.
13. Here Hauriou is opposing Léon Duguit, whose juridicial theory attributed a primacy to rules: “The error that Léon Duguit made when he built his system of objective law was to stake everything on droit objectif, to stake everything on the juridical rule. The true objective element of the juridical system is the institution. It does contain a subjective seed that develops by the phenomenon of personification [of the institution]. But the objective element subsists in the corpus of the institution, and this corpus alone, with its directing idea and organized power, is far superior in juridical quality to the juridical rule. Institutions make juridical rules; juridical rules do not make institutions.” Id. at 123.
14. Id. at 114.
15. Cf. Duncan v. Kahanamoku, 327 U.S. 304, 319 (1946): “Since both the language of the Organic Act and its legislative history fail to indicate that the scope of 'martial law' in Hawaii includes the supplanting of courts by military tribunals, we must look to other sources in order to interpret that term. We think the answer may be found in the birth, development and growth of our governmental institutions up to the time Congress passed the Organic Act.” (per Black, J.)
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directing or core ideas which Hauriou identifies as the "institution" itself,17 "are made to last for a long time." They may develop. But they are "also perishable like everything that exists."18

The feature of Hauriou's notion of "institution," which distinguishes it from the structure and process notions of recent sociological and legal thought, is this emphasis upon "directing ideas."19 His analysis applies not only to formal organizations (its prime target), but also to those elements that have stable and enduring places within the main institution. "Institu-

17. This statement is more than a dramatic exaggeration. It underscores the fundamental aspect of Hauriou's theory—that it is unsound to stress the bureaucratic (structure and process) aspect as the institutional element. Contemporary sociological (and often philosophical) writing has often done so—sometimes in contrast with the "person or "individual" aspect. Hauriou is himself a personalist in the sense that he conceives human institutions as constituting various organized efforts for the fulfillment of personal-social aspirations. To the extent that they succeed in realizing their ideas they are more fully legitimized. This legitimization is objectified (made apparent) in what he calls "manifestations of communion" (not "manifestations of a collective conscience [but] individuals . . . moved by their contact with a common idea and who, by a phenomenon of interpsychology, become aware of their common emotion").

Hauriou, in THE FRENCH INSTITUTIONALISTS 107. Not all institutions, Hauriou concedes, come up to this mark.


19. The most common sociological use of the concept "institution" is in the sense of an organized group. Sometimes this use is coupled with the sense of group or societal traditions ("ideas, beliefs, symbols, customs and common usage"). Thus Reuter designated institutions as "the organisations, the traditions and the basic rules of a particular society." P. REUTER, Foreword to INTERNATIONAL INSTITUTIONS (1958). The "organized group" concept of institution corresponds to the influential notion Max Weber popularized as a rationalized, hierarchical bureaucracy. See J. MAYER, MAX WEBER AND GERMAN POLITICS (1943) and P. BLAU, BUREAUCRACY IN MODERN SOCIETY (1946) (passim). See also Alpert, Sociology: Its Present Interests, in THE BEHAVIORAL SCIENCES TODAY 52 (B. Berelson ed. 1963): "Institutions are seen as established, determinate forms in accordance with which men enter into relations with one another." Id. at 55. To Radcliffe-Brown, the English anthropologist, institutions were "established norms of conduct of a particular form of social life . . . recognized as such by a distinguishable social group or class of which therefore it is an institution.

A. RADCLIFFE-BROWN, STRUCTURE AND FUNCTION IN PRIMITIVE SOCIETY 10 (1952). He was, like Hauriou, influenced by Montesquieu ("social systems") and by Comte ("social statics" and "social dynamics"). However, Radcliffe-Brown used the term "organisation" (a type of social system "closely related to the concept of social structures") rather than "institutions" for the concept of organized group. See Id. at 10-11. In this sense "institution" becomes completely "structure" or government. Veblen contributed the notion of "process" (Comtean as well as Darwinian in origin). Cf. J. COMMONS, INSTITUTIONAL ECONOMICS 658 (1934). Commons, an economist, emphasized the notion of "Going Concern" in dealing with organized institutional groups, but he also stressed the ideas of the institution. Id. at 620, 682. Parsons, a theoretical sociologist, combines the notions of structure and process in his mature work. See T. PARSONS, STRUCTURE AND PROCESS IN MODERN SOCIETIES 170-87 (1960). For a recent recognition of Parsons's significance in American sociology, by a severe critic, see A. GOULDNER, THE COMING CRISIS OF WESTERN SOCIOLOGY 167-338 (1970). Goffman, also a sociologist, uses "institutions" in another common sense—as "places . . . in which activity of a particular kind regularly goes on." E. GOFFMAN, ASYLUMS 3 (1961). And in his study of St. Elizabeths Hospital in Washington he noted that certain institutions, or "establishments," are "symbolized by the barrier to social intercourse with
"institution" in this secondary sense has a familiar ring, perhaps more familiar than its primary sense of "institution group." Thus the courts, the jury, the prosecutor, the legal profession, and the medical profession are institutions in the American way of life. Each has a function in the overall society. Hauriou would say this function must be clarified as much as possible to relate the subsidiary institution to its proper work. It is clarified by attending to its basic idea. There is a basic directing idea that applies to courts, prosecutors, doctors, and the professions of which they are members. The idea in each has a stable core, and also knows a degree of development. Hauriou's analysis here is not nearly so original as with the institution group. But we can clarify the court-hospital problem considerably by asking: What are the directing ideas here? And where have they been forsaken in practice?

This paper will not follow exactly the design of Pound's celebrated article. He used two sets of examples for his "distinctions between the rules that purport to govern the relations of man and man and those that in fact govern them." The first set instanced legal rules of dubious merit which were softened in practice, either by the very judges who professed them, or by another agency of the legal system, such as the jury. The second set consisted of situations where a wholesome principle was scandalously contravened in the actual administration of justice. Pound's second distinction between "law in the books and law in action" has lost little of its timeliness. Witness his illustration: the handling of criminal suspects. Pound suggests as generally accepted "law in the books" that "[t]he prisoner is absolutely protected against all judicial questioning before or at the trial." But the "law in action" is quite another thing:

The "third degree" has become an every day feature of police investigation of crime. [Remember this was 1910] . . . [T]he most searching, rigid and brutal examinations of accused or sus-

the outside and to departure that is often built right into the physical plant." These he calls "total institutions." Id. at 4. For a study of the Church of England influenced by Max Weber's institutional thought see K. THOMPSON, BUREAUCRACY AND CHURCH REFORM (1970). Of these authors Reuter and Commons are closest to Hauriou's sense of "institution."

20. Pound 15.
21. In this first set, Pound included judicial departures in practice from the professed rules as to the presumption of constitutionality of a statute, and as to an unconstitututional statute being "simply a nullity. There never was a statute." Pound 16. He also recalled that the "American ritual of written opinions" often covers up a [great] deal of 'raw equity'." Pound 19.
22. Here Pound cited jury award of verdicts "against the law" in the employers liability field and in prosecutions under unpopular statutes. "Jury lawlessness is the great corrective of law in its actual administration." Pound 18.
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expected persons, with all the appearance of legality and of having the power of the state behind them [are commonplace].

Pound concedes that this statement must be qualified. For "no rich man is ever subjected to this process to obtain proof of violation of anti-trust or rebate legislation and no powerful politician is thus dealt with in order to obtain proof of bribery and graft." He notes that this divergence between "books" and "action" impinges on a special social group, and "until the law has evolved by some device by which they may use it [i.e., the "law in books"], in all cases the weak and friendless and lowly will be at a practical disadvantage, despite the legal theory."

In a celebrated series of cases, most of them decided a half century after Pound wrote, the United States Supreme Court fashioned institutional devices to help this disadvantaged group: exclusionary rules as to evidence illegally obtained, right to counsel at "crucial stages", other safeguards against physically and psychologically coercive police and courtroom practices; and expansion of "equal protection of the laws" to rule out certain disadvantages deriving directly from indigency.

Pound did not offer explicit remedies to correct this divergence between "law in books" and "law in action." He did suggest updating the "law in books" to bring it more in "accord with current social, economic and philosophical thinking." He also blamed "a certain backwardness of the art of legislation," and recommended that legislators provide not universal rules, but "principles from which to deduce, not rules, but decisions." In the mental

23. Pound 16-17.
25. Id.
26. Or, put another way, the court most often "found" these rules in the interstices of the Bill of Rights, and applied them to the states by virtue of the fourteenth amendment.
27. This safeguard, early established against federal violation (Weeks v. United States, 232 U.S. 383 (1914)), was in 1961 extended to state cases in Mapp v. Ohio, 367 U.S. 643 (1961).
31. Griffin v. Illinois, 351 U.S. 12 (1956) was the trail blazer here. Although only this line of cases was specifically addressed to indigency, the others (notes 27-30 supra) had their chief impact on the "weak and friendless," as Pound would have noted, and not on well-counselled, "organized" criminal defendants.
33. Pound 34.
health field we will find that both legislatures and appellate courts have, in- 
deed, followed Pound's counsel and formulated standards: "right to treat-
ment," 34 "less drastic alternatives to hospitalization," 35 and, in the habeas
 corpus situation, "as law and justice require." 36 This approach has had little
practical impact on a category of persons which Pound had not considered—
those hospitalized for mental illness. Here again those most disadvantaged
by the divergence between "law in books" and "law in action" are "the weak
and friendless and lowly." Pound's explanation—that the "law in the books
seeks to surround accused persons with safeguards which the practical ex-
igencies of prosecutors will not put up with" 37—is too simple to provide an
answer to the mental health anomaly. A dragging judicial philosophy or
medical unconcern is not at the root of the present mental health crisis.
Rather we will find there another factor—which Pound emphasized 60 years
ago, and which is stressed today by Chief Justice Burger—the shortcomings
in our judicial and administrative machinery. Hospitalizations for mental
illness are at an alltime high, and no decline is visible. The size of court
dockets and the length of delay in hearings and trials are matters of na-
tional concern. In this light, the facts we shall develop show a need for
some device by which "weak, friendless and lowly" involuntarily hospitalized
patients may avail themselves "in action" of the "law in the books," which
would not be all that inadequate if actually applied.

What alternatives, or supplements, are plausible to meet present short-
comings, if such they be? The experience of other jurisdictions in this area
brings to light four "devices" which merit serious consideration: (1) inde-
pendent factual reporting of mental health status to the court, (2) regular
review of cases and representation of patients by independent counsel, (3)
independent quasi-judicial boards regularly meeting within hospital units, and
(4) an ombudsman.

To develop the case that the District of Columbia is nearing a breakdown
with respect to involuntary mental health hospitalization and release, I shall
stay close to Pound's "books vs. action" model for analysis. But even if my
contention—that a yawning gap now exists between the rules professed and
those enforced—is correct, an objection may properly be raised: Perhaps
other considerations are paramount to health, and liberty, and equality,
e.g., public safety, higher budgetary priority to other areas, and unavailability

34. See Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); Wyatt v. Stickney,
(1967).
35. See Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966).
37. Pound 18.
of professional personnel. In Pound's spirit of realism, perhaps the assurances (rights) given by the present rules should be withdrawn. This objection cannot be answered within Pound's dialectic.\textsuperscript{38} Hauriou's admonition that hard choices must be made with attention to the particular directing ideas of the other institutions concerned, and always within the focus of the directing ideas of the total society, gives more guidance. An analysis, in Hauriou's terms, will be undertaken in a subsequent article.\textsuperscript{39}

The mental health disaster in the District of Columbia is a particularly good focal point for testing the theoretical and practical insights of both Hauriou and Pound. First, because its catastrophic proportions can be objectively and convincingly presented by data from a recent factual survey.\textsuperscript{40} Second, because it concerns a situation for which the executive, judicial and legislative branches of the United States government must share responsibility. Third, because it underscores the perils of allowing governmental activity involving human rights to remain only barely visible to the public eye. Fourth, because the officials involved in decision-making (executive, judicial and legislative) appear highly qualified professionally, concerned, and desirous of a constitutional and just solution.\textsuperscript{43} Fifth, because despite evident...
expertise and good will there is a failure to recognize the clear symptoms of an unconscionable institutional deficiency.\textsuperscript{44} Equally ignored are those fundamental ideas of American society\textsuperscript{45} that, unless consciously repudiated, dictate a thoroughgoing reconsideration of plans which have been presently formulated without adequate attention to the impact on these core ideas.\textsuperscript{46} Sixth, the unprotested development of this situation in the nation's capital (which has the largest per capita concentration of psychiatrists in the country)\textsuperscript{47} forbodes danger in comparable situations in less richly endowed jurisdictions. Finally, because it underscores the costly result of the failure of professional groups in an "advanced" society to establish sympathetic intercommunications in the interest of society at large.

II. THE COURT AND THE MENTAL HOSPITAL

Commencing a discussion of the court-mental hospital-accused relationship by recounting the origins and history of the Durham rule is somewhat misleading, and a word of explanation is needed. The problem of the court and the mental hospital exists in the District of Columbia, as it does elsewhere, apart

earlier reputation as a leader among public mental health hospitals, in large part due to its being grossly undermanned in professional staff in recent years. However, in two and a half years working with the administrative officials and psychiatrists at the Hospital (and to a lesser extent with the overseeing officials at NIMH), I have been impressed by their earnestness, apparent competence, interest in patients, and by their understandable frustration. Administrators and psychiatrists, and local judges as well, manifested their deep concern in Project interviews. The self-appraisals of these men on the job support the view taken in this article: that there are gross defects in the product of this court-hospital-court transmission belt in the District of Columbia, but that the shortcomings are more often "institutional" (systemic) than personal or professional.

44. The defects in the operation of the court-hospital complex considered as a social system dealing with involuntary mental hospitalization are systemic rather than personal. That is, they are caused by faulty "habitual assumptions," failure in "adjustments to changing situations," or lag in "adaptation" of "institutional arrangements." Cf. J. Commons, Institutional Economics 701 (1934); T. Parsons, Structure and Process in Modern Societies 27 (1960); A. Radcliffe-Brown, Structure and Function in Primitive Society 9 (1952).

45. In Evolving Due Process and the French Institutionalis: Reflections on the Right to Counsel and the Adamson Dissent, 13 Cath. U.L. Rev. 95 (1964), I undertook a preliminary suggestion of some "fundamental ideas" (in Hauriou's sense) in United States society. They included: the increasingly high value placed upon liberty; equality; a shifting emphasis in federalism; separation of powers; and a high premium upon liberty of conscience and personal responsibility. Id. 127-32.

46. Reference here is to the contemplated transfer of St. Elizabeths Hospital from HEW to the District of Columbia government. See text at note 295 infra.

47. "There are more psychiatrists per capita in Washington than any other city in the country. The Washington chapter of the American Psychiatric Association has over 600 members (which represents about 75% of those who practice psychiatry here). Combined with the suburban Virginia and Maryland chapters more than 1,000 psychiatrists in the metropolitan area belong to the American Psychiatric Association." Raskin, You Think You Need a Psychiatrist, THE WASHINGTONIAN, Feb. 1971, at 42-43.
from any particular rule of criminal responsibility. But, in 1954, the Durham rule was designed to relieve the problem. The evidence which we shall discuss indicates that it did not. Blame should not be fixed on Durham as such. The evidence does not imply that the problem will be solved by a change in the rule of criminal responsibility, any more than it implies that the situation will be rectified by inserting another court system to bear the main stress at one end of the court-hospital-court transmission belt. These areas will be examined later. First, we shall briefly review, both in theory ("in the books") and in practical operation ("in action"), the pre-Durham legal standard of commitment and the standard established by Durham and its progeny.

A. The Durham Rule

Prior to 1954, the almost universal standard by which the judicial system tested the accused's plea of not guilty by reason of insanity was the familiar M'Naghten rules: did he know the nature and quality of his offending act, and did he know it was wrong? In some jurisdictions, the District of Columbia among them, there was added to M'Naghten the "irresistible impulse" test. In Durham v. United States, Circuit Judge Bazelon fo-

48. The problem is involuntary deprivation of liberty for an action or a condition to which the law does not attribute responsibility. The place of confinement, a hospital, and the reason for confinement, mental illness, connote treatment and not mere detention. For a controversial discussion of the problem by a psychiatrist see T. Szasz, LAW, LIBERTY AND PSYCHIATRY (1963).

49. Under the District of Columbia Court Reform and Criminal Procedure Act of 1970, 84 Stat. 473 [hereinafter cited as the D.C. Court Reform Act], the Superior Court of the District of Columbia (formerly Court of General Sessions) will ordinarily be the court considering the commitment and release of involuntarily hospitalized patients. These functions were previously conducted (except for misdemeanors and sexual psychopaths) by the United States District Court. See text at notes 258-81 infra.

50. As used in this paper this term refers to the process by which the first stage (commitment for examination, mental observation) is at the court; the second stage (examination; later, treatment) is at the hospital; and the third stage (hearing on release or denial thereof) is at the court. The process may be repeated many times with respect to one patient—e.g., commitment for examination (court); examination (hospital); commitment as mentally incompetent to stand trial (court); treatment (hospital); return for trial, trial and recommitment as not guilty by reason of insanity (court); further treatment (hospital); and subsequent returns to court for adjudication as to release (initiated by the hospital or by the patient, e.g., on petition for writ of habeas corpus).


52. "[T]he accused must be capable, not only of distinguishing between right and wrong, but that he was not impelled to do the act by an irresistible impulse, which means . . . that his reasoning powers were so far dethroned by his diseased mental condition as to deprive him of the will power to resist the insane impulse to perpetrate the deed, though knowing it to be wrong." Smith v. United States, 36 F.2d 548, 549 (D.C. Cir. 1929).

53. 214 F.2d 862 (D.C. Cir. 1954). The author of the opinion is now Chief Judge of the District of Columbia Circuit.
mulated a new test of criminal responsibility: “an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect.”54 By “disease” the court intended “a condition which is considered capable of either improving or deteriorating”; and by “defect” a condition “not considered as capable of either improving or deteriorating.” The defect might be “congenital, or the result of injury or the residual effect of a physical or mental disease.”55

Judge Bazelon criticized the M'Naghten test as “inadequate in that (a) it does not take sufficient account of psychic realities and scientific knowledge, and (b) it is based upon one symptom and so cannot validly be applied in all circumstances.”56 His criticism of “irresistible impulse” was that it gives “no recognition to mental illness characterized by brooding and reflection and so relegates acts caused by such illness to the inadequate right-wrong test.”57

Congress immediately responded to the Durham rule by amending the chapter in the D.C. Code on “Insane Criminals” to provide that any accused acquitted of a crime or offense solely by reason of insanity should automatically be committed to a mental hospital.58 St. Elizabeths Hospital, where most accused were sent for examination when they sought to avail themselves of the Durham test,59 responded with a uniform staff policy of reporting persons having sociopathic personality60 disturbances as “without

54. Id. at 874-75.
55. Id. at 875.
56. Id. at 874.
57. Id. Judge Bazelon also suggested that “[t]he term ‘irresistible impulse’... carries the misleading implication that ‘diseased mental condition[s]’ produce only sudden, momentary or spontaneous inclinations to commit unlawful acts.” Id. at 873.
58. D.C. CODE ANN. § 24-301(d) (1967). This statute was enacted in 1955. Previously one found not guilty by reason of insanity might be certified by the court to the Secretary of HEW “who may order such person to be confined in the hospital for insane.” D.C. CODE ANN. § 24-301 (1951).
59. Until 1967 there was some division of responsibility between D.C. General Hospital and St. Elizabeths. In that year, when D.C. General commenced its system of “open wards,” the courts concentrated their examinations at St. Elizabeths. As Dr. Louis Jacobs, Acting Superintendent of St. Elizabeths Hospital during the Project period, pointed out, this fact does much to explain the unusual increase of examinations at St. Elizabeths from 1967. See statistics in note 78 infra.
60. The terminology with respect to sociopathic personality disturbances is difficult. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (1952) [hereinafter cited as DSM-I] identified them (among “personality disorders”) as persons “ill primarily in terms of society and of conformity with the prevailing milieu, and not only in terms of personal discomfort and relations with other individuals. However sociopathic reactions are very often symptomatic of severe underlying personality disorder, neurosis, or psychosis, or occur as the result of organic brain injury or disease.” The 1968 Diagnostic and Statistical Manual of Mental Disorders (2d ed.) [hereinafter cited as DSM II] breaks down the group differently. The classification closest to what are commonly referred to as sociopaths or psychopaths (terms used equivalently in this study) is “antisocial personality.” “This term is reserved for individuals who are basically unsocialized and whose behavior brings
mental disorder." Meanwhile the Court of Appeals elaborated and qualified its new standard in a series of cases culminating in *McDonald v. United States*. There the court, for the first time, defined "mental disease or defect" as "any abnormal condition of the mind which *substantially* affects mental or emotional processes and *substantially* impairs behavior controls." In *McDonald* the court also stressed that "neither the court nor the jury is bound by *ad hoc* conclusions as to what experts state is a disease or a defect." The court's formulation was designed as a "legal definition" to be given to the jury.

The Hospital soon reversed its preliminary decision not to report psychopaths as suffering from a mental disease. In *Briscoe v. United States* the court made clear that sociopaths were not excluded from the legal definition of "disease." Nevertheless, strong opposition to *Durham* developed them repeatedly into conflict with society . . . A mere history of repeated legal or social offenses is not sufficient to justify this diagnosis." (DSM II at 301.7). A respected psychiatric treatise identifies "antisocial personality" with "those chronically antisocial individuals without the capacity to form significant attachments or loyalties to others, to groups, or to codes of living. Thus they are callous and given to immediate pleasures, appear devoid of a sense of responsibility, and in spite of repeated humiliations and punishments, fail to learn to modify their behavior." L. Kolb, NOYES' MODERN CLINICAL PSYCHIATRY 503 (7th ed. 1968). In commonly used shorthand, psychopaths are understood simply as sociopaths with an antisocial reaction. Unless otherwise indicated the two terms are used here interchangeably in this sense.

61. The following testimony of a St. Elizabeths psychiatrist is quoted by Circuit Judge Miller (dissenting) in *Blocker v. United States*, 274 F.2d 572 (D.C. Cir. 1959):

"Q. Tell me, Doctor [Duval], has there been any determination by your institution as to whether or not persons with merely sociopathic personality disturbance are with or without mental disorder?

"A. Late in 1954, after the Durham decision, we had a staff meeting at which the psychiatrists discussed [this question].

. . .

"The decision at that time was that in the agreed-upon consensus of our psychiatric staff this group of individuals so classified would be considered without mental disorder. . . .

"[I]t was the policy of the hospital to insert the words 'without mental disorder' after the diagnosis of sociopathic personality disturbance in our records."

*Id.* at 579.

62. 312 F.2d 847 (D.C. Cir. 1962).

63. *Id.* at 851 (emphasis added).

64. *Id.*

65. In *Blocker v. United States*, 274 F.2d 572 (D.C. Cir. 1959), Dr. Addison Duval conceded that the American Psychiatric Association's Diagnostic and Statistical Manual (see note 60 *supra*) classified sociopathic personality disturbance as a disease, and added: "[A]s of today . . . the superintendent and I have both agreed that hereafter we will eliminate from our records the words 'without mental disorder,' where the diagnosis of this particular group of personality disorders is made. And we will hereafter let the diagnosis stand on its own feet." *Id.* at 579 (dissenting opinion, emphasis omitted).

66. 248 F.2d 640 (D.C. Cir. 1957).
within the Court of Appeals itself. The Court developed a special category for "release" of those who had been mandatorily hospitalized following a successful plea of the insanity defense: "There must be freedom from such abnormal mental condition as would make the individual dangerous to himself or the community in the reasonably foreseeable future." At the same time, a curious heads-I-win-tails-you-lose methodology developed in the District of Columbia judicial process. When the accused sought relief from criminal responsibility through an insanity defense, judges tended (in charges, in judicial intonations, and in handling witnesses) to discourage sociopathic defendants from availing themselves of Durham. But when the patient sought release from confinement claiming he was no longer mentally ill, the court almost uniformly agreed with the Hospital psychiatrist's diagnosis that the patient was still mentally ill.

In the mid-Sixties, the emphasis in Court of Appeals cases shifted away from Durham jurisprudence. Only a detailed and specific reiteration in Washington v. United States of the limited role of the psychiatrists intervened before the court, in January, 1971, set Brawner for a hearing en banc to reconsider the entire question of the Durham rule.

67. This opposition is highlighted by the court's opinions in Simpson v. United States, 320 F.2d 803 (D.C. Cir. 1963) (refusing to disturb verdict following M'Naghten rule instructions); Blocker v. United States, 274 F.2d 572 (D.C. Cir. 1959); Overholser v. Leach, 257 F.2d 667 (D.C. Cir. 1958) ("freedom from such abnormal mental condition as would make the individual dangerous to himself or the community in the reasonably foreseeable future" as criterion for release); and culminated in the definitive modification of Durham in McDonal v. United States, 312 F.2d 847 (D.C. Cir. 1962).


68. Overholser v. Leach, 257 F.2d 667, 670 (D.C. Cir. 1958) (emphasis added). The freedom from dangerousness requirement was in the applicable statute, D.C. CODE ANN. § 24-301(e) (1967): "The court shall weigh the evidence and, if the court finds that such person has recovered his sanity and will not in the reasonable future be dangerous to himself or others, the court shall order such person unconditionally released from further confinement in said hospital."

69. A study made in 1961 suggests that even before McDonald, judges and jurors in the district court applied a criminal responsibility standard that hardly differed from pre-Durham days. See Arens, Granfield & Susman, Jurors, Jury Charges and Insanity, 14 CATH. U.L. REV. 1 (1965).

70. Under Leach the court would hold that he was not free from the "abnormal mental condition." See text at notes 181-93 infra, for confirmation of this in interviews with psychiatrists and judges.

71. 390 F.2d 444 (D.C. Cir. 1967).

As an appellate rule of law, the Durham rule—now called, even by its author, the “Durham-McDonald” rule—is still the official standard of criminal responsibility in 1971. However, it has been seriously qualified even in theory if we consider those appellate decisions which left charges given in M’Naghten terms undisturbed. The attempts of the Court of Appeals to free the jury from slavish dependence on the psychiatrists failed sadly. As Chief Judge Bazelon admitted in United States v. Eichberg, Washington’s specific effort to ban psychiatric testimony on “productivity” had been largely unsuccessful. When doctors sought to accommodate themselves either to limitations of their art or to the more modest role marked out for them by the Court of Appeals, District Court judges pressed them to give strong testimony.

The practical impact of Durham cannot be realistically measured by its effect on the actual number of defendants found not guilty by reason of insanity. Although the number of defendants so adjudged increased appreciably beyond those under the M’Naghten rule, Durham’s true impact can best be measured by considering the total number of accused who have been sent to the Hospital for psychiatric examination (mental observation—MO)

73. Cf. Simpson v. United States, 320 F.2d 803 (D.C. Cir. 1963). See note 67 supra. Durham ruled that “as an exclusive criterion the right-wrong [M’Naghten] test is inadequate.” However, the Durham court added that “the jury’s range of inquiry will not be limited to, but may include, for example, whether an accused, who suffered from a mental disease or defect did not know the difference between right and wrong, acted under the compulsion of an irresistible impulse, or had ‘been deprived of or lost the power of his will . . . .’” 214 F.2d at 874, 876.

74. United States v. Eichberg, 439 F.2d 620 (D.C. Cir. 1971) was the last effort of this kind. Washington v. United States, 390 F.2d 444 (D.C. Cir. 1967) also involved the jury responsibility point which had its origins in Durham itself. Judge Bazelon had stressed there the jury’s responsibility “for determining the ultimate question of fact upon which the claim [of insanity] depends” He added that this permits the jury “to perform its traditional function . . . [i.e.] to ‘apply our inherited ideas of moral responsibility to individuals prosecuted for crime’, and that the new (Durham) rule was simply a guide to their “moral judgments,” one which stressed “whether the accused acted because of a mental disorder, and not whether he displayed particular symptoms. . . .” 214 F.2d at 875-76. In practice trial courts seem inclined to hedging in juries with “strong” (government) psychiatric evidence (See text at notes 158 & 162 infra).

75. 439 F.2d 620 passim (D.C. Cir. 1971).

76. In Carter v. United States, 252 F.2d 608 D.C. Cir. 1957), the Court of Appeals explained “product of” and “causal connection” as follows: “[T]he facts concerning the act are such as to justify reasonably the conclusion that ‘But for this disease the act would not have been committed.’” Id. at 617. This theoretically left the inference to the jury, but the 1961 observation of Krash has lost none of its accuracy: “Psychiatric experts who testify at the trial are commonly pressed by counsel to state, in the language of Durham, whether the alleged criminal act was the ‘product' of mental disease.” Krash, 70 YALE L.J. 905, 929.

77. See text at note 162 infra. See also PR 227.
with a view towards presenting an insanity defense. The overwhelming predominance of those examined are found "without mental disorder." This data along with the relatively low number of not-guilty-by-reason-of-insanity (NGI) patients entering St. Elizabeths Hospital as compared with the number sent for preliminary examination, is the most persuasive evi-

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78. Disposition of defendants in the United States District Court for the District of Columbia:

<table>
<thead>
<tr>
<th>INSANITY ACQUITTALS (NGI)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Defendants</td>
<td>A**</td>
<td>B**</td>
<td>No. Found NGI</td>
<td>C***</td>
<td>% Found NGI</td>
</tr>
<tr>
<td>1951</td>
<td>1936</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1952</td>
<td>1692</td>
<td></td>
<td>3</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td>1953</td>
<td>2103</td>
<td></td>
<td>3</td>
<td>.19</td>
<td></td>
</tr>
<tr>
<td>1954</td>
<td>1932</td>
<td>1870</td>
<td>7</td>
<td>.49</td>
<td></td>
</tr>
<tr>
<td>1955</td>
<td>1416</td>
<td>1384</td>
<td>10</td>
<td>.86</td>
<td></td>
</tr>
<tr>
<td>1956</td>
<td>1650</td>
<td>1595</td>
<td>14</td>
<td>1.14</td>
<td>1.0</td>
</tr>
<tr>
<td>1957</td>
<td>1517</td>
<td>1454</td>
<td>7</td>
<td>.58</td>
<td>.5</td>
</tr>
<tr>
<td>1958</td>
<td>1714</td>
<td>1666</td>
<td>17</td>
<td>1.33</td>
<td>1.0</td>
</tr>
<tr>
<td>1959</td>
<td></td>
<td></td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1960</td>
<td></td>
<td></td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961</td>
<td></td>
<td></td>
<td>66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1962</td>
<td></td>
<td></td>
<td>66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1963</td>
<td></td>
<td></td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td></td>
<td></td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1965</td>
<td></td>
<td></td>
<td>59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1966</td>
<td></td>
<td></td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1967</td>
<td></td>
<td></td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1968</td>
<td></td>
<td></td>
<td>51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1969</td>
<td></td>
<td></td>
<td>23</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** from *PRESIDENT'S COMM'N ON CRIME IN THE DIST. OF COLUMBIA, REPORT 535* (1966).
*** for years 1951 through 1963, from NIMH figures; for years 1964 through 1969, from Project Report.

79. Discharge from John Howard Pavilion:

<table>
<thead>
<tr>
<th>WITHOUT MENTAL DISORDER (WMD) DISCHARGES</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year (Oct.-Sept.)</td>
<td>Total</td>
<td>WMD</td>
<td>WMD + Unimproved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharges</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>1966-67</td>
<td>318</td>
<td>182</td>
<td>57.2</td>
<td>249</td>
<td>78.3</td>
</tr>
<tr>
<td>1967-68</td>
<td>427</td>
<td>225</td>
<td>52.7</td>
<td>321</td>
<td>75.2</td>
</tr>
<tr>
<td>1968-69</td>
<td>349</td>
<td>203</td>
<td>58.1</td>
<td>264</td>
<td>75.6</td>
</tr>
</tbody>
</table>

By contrast, the total discharges designated "recovered" or "social recovery" was 18.6 percent for 1966-67, 18.4 percent for 1967-68, and 19.5 percent for 1968-69.

---

80. NGI AND MI FINDINGS AS COMPARED WITH EXAMINATIONS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Exams</td>
<td>163</td>
<td>201</td>
<td>227</td>
<td>398</td>
<td>685</td>
<td>687</td>
</tr>
<tr>
<td>No. NGI</td>
<td>40</td>
<td>59</td>
<td>40</td>
<td>36</td>
<td>51</td>
<td>23</td>
</tr>
<tr>
<td>% NGI</td>
<td>24.5</td>
<td>26.3</td>
<td>17.6</td>
<td>9.0</td>
<td>7.4</td>
<td>3.3</td>
</tr>
<tr>
<td>No. MI</td>
<td>94</td>
<td>81</td>
<td>102</td>
<td>78</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>% MI</td>
<td>57.7</td>
<td>40.3</td>
<td>44.9</td>
<td>19.6</td>
<td>2.9</td>
<td>0.8</td>
</tr>
<tr>
<td>No. NGI + MI</td>
<td>134</td>
<td>140</td>
<td>142</td>
<td>114</td>
<td>71</td>
<td>48</td>
</tr>
<tr>
<td>% NGI + MI</td>
<td>82.2</td>
<td>69.7</td>
<td>62.5</td>
<td>28.6</td>
<td>10.4</td>
<td>4.1</td>
</tr>
</tbody>
</table>
idence of the true impact of Durham. Although sociopathic “antisocial reaction” diagnoses are infrequent among those found not guilty by reason of insanity, the overwhelming number of NGI patients at the maximum se-

81. The statistics in notes 78-80 show certain fluctuations in not-guilty-by-reason-of-insanity (NGI) verdicts and in judges’ findings of mental incompetency to stand trial (MI). But in recent years the number of examinations has steadily and rapidly accelerated while NGI and MI commitments have decreased considerably. The direct correlation between the increased examination load and the decreased NGI and MI findings is the recent history of Durham. Durham may get an accused an examination, but its force stops at the hospital gate. See psychiatrists’ comments at notes 163-66 infra.

82. Diagnoses of John Howard Pavilion patients:

<table>
<thead>
<tr>
<th></th>
<th>1959</th>
<th>1964-67</th>
<th>1967-69</th>
<th>11/1/69*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic Reaction</td>
<td>51</td>
<td>68</td>
<td>71</td>
<td>85</td>
</tr>
<tr>
<td>Psychoneurotic Reaction</td>
<td>11</td>
<td>8</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Paranoid &amp; Schizoid Personalities</td>
<td>0</td>
<td>17</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Sociopathic Personality Disorder</td>
<td>12</td>
<td>53</td>
<td>34</td>
<td>40</td>
</tr>
<tr>
<td>Antisocial Reaction**</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
</tbody>
</table>

* Patients on JHP roster as of Nov. 1, 1969. See note 136 for explanation of other headings.
** This is the sociopathic personality category less the drug and alcohol classes, i.e., the hardcore psychopaths.

St. Elizabeths Hospital statistics on psychiatric diagnoses at the date of admission of persons found not guilty by reason of insanity have been made available through 1965 only. The reason for the nonavailability of statistics beyond that date is not clear; perhaps they do not exist. Cf. Brief of William H. Dempsey, Jr., Esq. as Amicus Curiae at 64, United States v. Brawner, No. 22,714 D.C. Cir., filed Feb. 6, 1969). For the years 1954 through 1965, 23.9 percent of all diagnoses were personality disorders as compared to 42.7 percent for schizophrenic and other psychoses and 14.4 percent for psychoneuroses. Dempsey Brief, supra at table 4. The breakdown of these figures by years shows the expected result that personality disorder diagnoses reached a higher percentage (but not significantly higher) after 1959, the year of the Blocker decision (see note 65 supra).

The breakdown of personality disorders by crime charged reveals a high incidence of narcotic offenses (53.3 percent), forgery (48.4 percent), and housebreaking (26.5 percent). All other crimes were below the 24.1 percent average. (These figures deal exclusively with commitments from the United States District Court. Dempsey Brief, supra at table 6). Schizophrenia was the most common diagnosis for those found NGI of murder (47.2 percent) and robbery (51 percent). Id.

Though available statistics are suggestive rather than dispositive, some hint as to the relation between the duration of “treatment” at St. Elizabeths and time served in prison for a comparable felony is available from an interesting list compiled by Mr. Dempsey for his Brawner brief.

<table>
<thead>
<tr>
<th></th>
<th>St. E. Patient</th>
<th>Prison (D.C.)</th>
<th>Prison (National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide</td>
<td>23.1</td>
<td>180+</td>
<td>52.0</td>
</tr>
<tr>
<td>Sex Offenses</td>
<td>20.7</td>
<td>35.3</td>
<td>30.0</td>
</tr>
</tbody>
</table>

TABLE CONTINUED ON PAGE 566
curity facility at St. Elizabeths Hospital are admittedly not psychotic, i.e., they are in touch with reality. This paradox results from the doctors' readiness to employ psychosis terminology to secure an insanity acquittal when they believe an accused can be helped, or when they believe he should not be held responsible for the crime; they know the practical result would be different if they used "character disorder" terminology in their diagnoses.

The great design of Judge Bazelon in formulating the Durham rule was to bring the legal test of criminal responsibility in line with current findings of the science of psychiatry and, thereby, with "[t]he legal and moral traditions of 

<table>
<thead>
<tr>
<th>Crime</th>
<th>St. Elizabeths</th>
<th>District of Columbia</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robbery</td>
<td>30.0</td>
<td>38.1</td>
<td>33.9</td>
</tr>
<tr>
<td>Aggressive Assault</td>
<td>20.6</td>
<td>28.7</td>
<td>19.5</td>
</tr>
<tr>
<td>Housebreaking (burglary)</td>
<td>34.0</td>
<td>34.0</td>
<td>20.4</td>
</tr>
<tr>
<td>Grand Larceny</td>
<td>18.9</td>
<td>18.0</td>
<td>16.7</td>
</tr>
<tr>
<td>Forger</td>
<td>18.8</td>
<td>29.2</td>
<td>17.4</td>
</tr>
<tr>
<td>Auto Theft</td>
<td>22.5</td>
<td>22.5</td>
<td>18.9</td>
</tr>
<tr>
<td>Narcotics</td>
<td>27.0</td>
<td>47.4</td>
<td>29.4</td>
</tr>
<tr>
<td>Other felonies</td>
<td>11.0</td>
<td>24.9</td>
<td>14.1</td>
</tr>
<tr>
<td>All Crimes</td>
<td>22.7</td>
<td>33.4</td>
<td>20.9</td>
</tr>
</tbody>
</table>

From Dempsey Brief, table 9.

The reliability of the above table is somewhat mitigated by the lack of complete compatibility in its basic data. The St. Elizabeths figures are based on the entire 1954-65 period; the District of Columbia data is for 1964 alone; and the national figures are for 1960 alone. Also the table incorporates only those patients committed by the United States District Court.

83. Psychiatrists interviewed had appraisals of the number of non-psychotic patients in John Howard:

Dr. E: In the John Howard Pavilion population, one-third are mentally incompetent and accidentally commit crime. As soon as their mental incompetence is under control they are not dangerous. Another one-third are no more mentally incompetent than the average criminal—the court does anything the psychiatrist tells him, however arbitrary and capricious . . . . Another one-third are psychotic criminal. PR 194.

You can't be accurate in assessing a patient at a pretrial examination. They are under a considerable strain not to tell the truth as they see it; it may make the difference between 20 years in prison and two years here. We often make a mistake that doesn't come to light until after the trial, when he is honest. PR 209.

This appraisal of "one-third psychotic criminal" corresponds with the persistent, if unscientific, estimates of members of the Catholic University Law School team that gave legal assistance at John Howard Pavilion over a 2½ year period (1967-69). Reports received from John Howard Pavilion since the conclusion of the Project indicate that there may be a substantially higher proportion of psychotics under present management policy.

84. There is apparent difficulty in drawing the line between a diagnosis of a psychotic disorder (e.g., paranoid state, No. 297 in DSM II (see note 60)), and a form of "personality disorder" e.g., paranoid personality, DSM II, No. 301). More obvious overlaps exist between personality (sociopathic) disorders and psychoneuroses, e.g., should the diagnosis be No. 301.3 explosive personality (personality disorder), or No. 300.1 hysterical neurosis; non-psychotic organic brain syndrome with epilepsy (309.4) (neuroses)—or, indeed, psychosis with epilepsy (293.2)?

The chart in note 82 shows a high percentage of schizophrenic (psychotic) diagnoses; the professional estimates in note 83 show a disproportionate presence of nonpsychotics in John Howard Pavilion, surprising in view of these statistics on diagnoses. A psychiatrist's comment memorialized in Professor Chambers' Report throws some light
Involuntary Hospitalization for Mental Illness

the western world.” Judge Bazelon, “that a man is an integrated personality and that reason, which is only one element in that personality, is not the sole determinant of his conduct.” And so the “right-wrong test, which considers knowledge or reason alone is . . . an inadequate guide” to responsibility. Judge Bazelon’s “legal and moral traditions” attribute criminal responsibility only to those violating the law by acts committed “of their own free will and with evil intent.” Conversely, “[o]ur traditions also require that where such acts stem from and are the product of a mental disease or defect as those terms are used herein, moral blame shall not attach, and hence there will not be criminal responsibility.” The corollary, he concedes, is not necessarily that such persons should go free—it is, rather, that they be dealt with for what they are—sick, and not criminal now that the science of psychiatry has shown this to be so. The place for them is not a prison, but a mental hospital where they can receive treatment.

A large part of the criticism leveled at Durham has challenged the legal or moral philosophy involved. Critics, including some psychiatrists themselves, have ridiculed as pretentious Durham’s suggestion of what psychiatrists can do for such persons. The unarticulated premise of the Durham debate on this: “As yet another doctor said of the pretrial diagnostic process, ‘If we think there’s something we can do for the man, we’ll find some label to give him and bring him back.’” Chambers Report 21.

85. 214 F.2d at 876.
86. Id. at 871.
87. Id. at 876.
89. The strongest criticism is perhaps that of the controversial psychiatrist, Dr. Thomas S. Szasz: “According to the jurists who formulated the Durham decision, it was based on the ethical principle that ‘our collective conscience does not allow punishment where it cannot impose blame.’ This seems self-evident and commendable. Actually, it is neither. The quotation lays claim to a moral principle as a regulatory force in social behavior. However, such an assertion should not be regarded as a description of a ‘natural law.’ Rather, it is a prescription of principles that ought to govern social living. And what is prescribed? That there should be no punishment without blameworthiness. The logical corollary of this is that there should be no reward without praiseworthiness. The fact is, however, that our society is not constructed along these lines. Moreover, acceptance of these principles would change our society into an organization quite unknown to us, and hardly imaginable. It would be a human society that would have dispensed not only with punishment for bad performance but also with reward for good performance.” T. Szasz, LAW, LIBERTY AND PSYCHIATRY 132 (1963).
90. “The medical characteristics (instrumentally defined) of hospitals for the criminally insane are virtually nil. They, too, have an infinitesimally small physician-patient ratio. Even if it were raised, and even if this were advisable, the fact would remain that such hospitals are thinly disguised prisons. Commonly called ‘maximum
from beginning to end concerns nonpsychotics. The pure detention which is imposed upon them often exceeds prison time and offers little, if anything, to improve their mental health. If we were to assume with Judge Bazelon that criminal liability based only on "free will and with evil intent"

security institutions,' they are more strictly guarded than many prisons." Id. at 83.

"As a social institution, psychiatry is now in its infancy. Perhaps, like all babies, it is better at dominating than at serving or cooperating with others. Institutions, no less than persons, may need to be socialized. If so, the question is: Which social values should psychiatrists foster, while they are defining their own institutionalized roles and statuses?" Id. at 86-87.

"If we—whether as psychiatrists, patients, or individuals not involved with psychiatry—wish to enlarge, rather than constrict, the area of political freedom, then our central concern must be to ensure the liberty of the people from, and indeed against, psychiatry as a social institution." Id. at 87.

A more sympathetic observer of the Durham rule says that "[T]he outlook of a mental hospital differs, of course, from that of a prison," but immediately adds that "in terms of deprivation of liberty there is little to choose between the maximum security section of a mental institution and a jailhouse." Krash, 70 Yale L.J. 905, 950.

91. Again, I speak of the sociopathic personality disorders. See notes 60, 65 & 82 supra. In Stewart v. United States, 214 F.2d 879 (D.C. Cir. 1954), decided two weeks after Durham, the Court of Appeals, in reversing, quoted in full the lower court's charge on the insanity issue. The judicial contempt registered for psychopaths, or sociopaths, in this charge does not seem greatly out of date:

Now, have in mind ladies and gentlemen, that the law does not recognize as insanity a mental disorder unless it is a real mental disease. There are many people who are psychopathic to one degree or another; they are maladjusted; emotionally unstable; resentful, for one reason or another, society; of low intelligence; indifference [sic] toward the rights of others, and so on. That is a psychopath. He is not insane within the meaning of the law; he is simply an abnormal, maladjusted, person, or subnormal, as the case may be; he is a misfit; he does not care about others; indifferent to them, and so on. You must distinguish in your mind between that kind of mental disorder, because it obviously is a mental disorder, and a real mental disease.

The man who is in this court, as a defendant in a criminal case, time and time again, is an extreme example of what I am talking about. There is something wrong with his mind or he would not do it in the first place, but it does not follow that he is insane. Id. at 881.

The criteria for release is recovery from mental illness or prediction of lack of dangerousness. If a psychotic has recovered he is, according to the law, expected to be released whether or not he is dangerous (but see text at notes 181-93 infra). The release problem with sociopaths (since there is rarely a serious effort or capacity to cure them) turns entirely on prediction of their dangerousness. This has led to a rash of psychiatric imprecision which, in other areas of the law, is recognized as arbitrariness.

92. Dr. Szasz opposes the M'Naghten (see text at note 51 supra) and American Law Institute rules (see note 245 infra) as well as Durham: None of them "is 'humanitarian,' for all diminish personal responsibility and thus impair human dignity; nor is any of them 'liberal,' for none promotes individual freedom under the rule of law," T. Szasz, Ideology and Insanity 111 (1970). "In the final analysis, the insanity plea and the insanity verdict, together with the prison sentences called 'treatments' served in buildings called 'hospitals' are all parts of the complex structure of institutional psychiatry, which . . . is slavery disguised as therapy. Those who value and wish to defend individual liberty can be satisfied with nothing less than the abolition of this crime against humanity." Id. at 112.
is one of the fundamental ideas of our polity, a question remains: Did the Durham rule merely reformulate this idea "in the books" (in the light of modern psychiatric discovery), or did it further it "in action?" At the time of its formulation, the rule itself was a prediction. Now, 17 years later, the state of the psychiatric art, the unavailability of adequate psychiatric personnel, and inadequate funds, seem to indicate that the prediction was over-optimistic. The court-hospital-court transmission belt is disastrous in operation. Can this scene fairly be called a "product" of Durham? The balance of this study will argue that it is not. The disaster will not be corrected by mere substitution of a new or different rule of criminal responsibility. Restoration of sanity in this area seems to lie elsewhere than the appellate courts.

B. The Problem of Release:
"Equal Protection of the Laws" and "Right to Treatment"

From 1965 on, the most significant mental health commitment decisions of the Court of Appeals hardened along lines outside the strict confines of Durham jurisprudence. These new decisions took note of Supreme Court decisions implementing the "equal protection of the laws" clause of the fourteenth amendment, in light of the 1964 Hospitalization of the Mentally Ill Act regarding civil commitment in the District of Columbia. A landmark contribution to this "justice in the books" was made in Lake v. Cameron. This en banc decision on habeas corpus took the statutory mandate to "dispose of the matter as law and justice require" to mean that "the court is not restricted to the alternative of returning appellant to Saint Elizabeths or unconditionally releasing her." Then, in Rouse v. Cameron, the court took note of the "right to treatment" afforded to civilly committed patients by the 1964 statute, and, without specifying what "treatment" consists of,
held that treatment was also due to persons committed as not guilty by reason of insanity. A third major ruling, *Bolton v. Harris*, 100 substantially amended the commitment and release statute, again with reference to constitutional implications. As will be seen, none of these cases made any substantial impact upon the conduct of affairs by either the Hospital or the district court. Although the 1970 Court Reform Act 101 considerably changes the "law in the books" as written by the court in *Bolton*, the discussion here can usefully center upon that case.

The standard method of release for criminal proceedings patients in the District of Columbia was prescribed in the chapter entitled "Insane Criminals." 102 A patient committed to a mental hospital as incompetent to stand trial remains there until the superintendent of the hospital certifies him to the court as competent. The court may enter an order of competency based upon this certification unless there is objection by the accused or the government. Should the government object, the "judicial determination" will take place "after hearing without a jury." 103 What happens when the hospital refuses or omits to make such a certification to the court? Unless initiative is taken by the government to bring him to court, the accused's only resort has been to petition for a writ of habeas corpus in the district court.

As we have seen, the pre-*Bolton* Subsection 24-301 (d) established an automatic commitment for those acquitted solely by reason of insanity. Subsection 24-301 (e) gave these persons two prospective avenues of relief from involuntary incarceration. The superintendent of the hospital might certify to the court that the patient "has recovered his sanity" and that he believes that the patient "will not in the reasonable future be dangerous to himself or others." Such a certificate filed with the court is the predicate to an unconditional release. But the court may hold a hearing on the matter, taking testimony including that of psychiatrists from the hospital. This is mandatory upon government request. A less enthusiastic certification may lead to a conditional release. The one-sided nature of these release provisions is compensated only by Subsection 24-301 (g) saving the accused's

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100. 395 F.2d 642 (D.C. Cir. 1968). A fourth significant case was Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969) in which the court undertook oversight of certain internal personnel transfers at the hospital. Further developments in court oversight of internal hospital transfers came in Jones v. Robinson, 440 F.2d 249 (D.C. Cir. 1971) and Williams v. Robinson, 432 F.2d 637 (D.C. Cir. 1970), which were initiated in the course of the Catholic University Project.

101. D.C. Court Reform Act, 84 Stat. 473. See discussion of this Act at notes 258-81 infra.


103. *Id.* § 24-301(b).
right to establish his “eligibility for release under the provisions [i.e., standards] of this section by writ of habeas corpus.”

After prolonged hearings by Congress,\(^{104}\) the Hospitalization of the Mentally Ill Act\(^ {105}\) was passed in 1964 and was widely heralded as forward-looking legislation. Reflecting the influence of the Durham-McDonald rule, the statute defined “mental illness” as “a psychosis or other disease which substantially impairs the mental health of a person.”\(^ {106}\) Certain of the Act’s provisions, though directed to civil commitment, became influential in the development of the law bearing on release of criminal-process patients.\(^ {107}\) Normally, involuntary civil hospitalization is a two-step process: (1) hearing before a panel of the Mental Health Commission,\(^ {108}\) and (2) trial before a court or jury, if requested. At both steps counsel is to be provided.\(^ {109}\) Once committed, the civil patient is entitled to demand examination from the hospital’s chief of service 90 days after commitment and every six months thereafter. An indigent patient might also obtain an independent psychiatric examination, secured and paid for by the District of Columbia Department of Public Health. The chief of service was to order the patient’s release if, after reading both medical reports, he concluded that the patient was no longer mentally ill to the extent that he was likely to injure himself or other persons if not hospitalized. If the chief of service does not so decide, and one of the two examining psychiatrists disagrees, the patient is entitled to petition the court for release.\(^ {110}\) The statute’s generosity with respect to the civilly committed patient lay not only in its liberal standard for release, but also in the responsibility it imposed upon the hospital to take the initiative “as often as practicable, but not less often than every six months” to ascertain whether “the conditions which justified the involuntary hospitalization . . . no

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\(^{105}\) *D.C. Code Ann. §§ 21-501 to -591 (1966).*

\(^{106}\) *Id. § 21-501. Cf. McDonald v. United States, 312 F.2d 847 (D.C. Cir. 1962), discussed in text at note 62 supra.*

\(^{107}\) Notably Sections 21-544 to -545 (right to jury trial), 21-546 (right to periodic examination), and 21-562 (right to treatment).

\(^{108}\) The Mental Health Commission has been in operation in the District of Columbia since 1939. It consists of nine members: the Chairman is a lawyer, and rest are physicians with “not less than five years’ experience in the diagnosis and treatment of mental illnesses.” (D.C. Code Ann. § 21-502(a) (1967). The Commission, which sits in panels of three, one of which is the lawyer-member, deals exclusively with civil commitments. The Commission came in for strong criticism in November, 1969, in the special Judicial Conference Committee Study (see note 3 supra). The operation of the Commission is discussed in the Project Report at 314-23. *See Appendix D.*

\(^{109}\) *D.C. Code Ann. § 21-543 (1967).*

\(^{110}\) *Id. § 21-546.*
longer exist." Furthermore, the statute specifies that such hospitalized patients are "entitled to medical and psychiatric care and treatment." The Hospitalization of the Mentally Ill Act was the first statute to affirm a "right to treatment" for involuntarily hospitalized patients. The statute also noted that the availability of these other procedures does "not prohibit a person from exercising a right presently available to him for obtaining release from confinement, including the right to petition for a writ of habeas corpus." So that its beneficent provisions might not blush unseen, the 1964 Act provided in Section 21-565 that "upon the admission of a person to the hospital . . . the administrator shall deliver to him, and to his spouse, parents or other nearest known adult relative, a written statement outlining in simple, nontechnical language all release procedures provided by this chapter."

In the best of all possible worlds, it is hard to divine legal provisions that show greater concern for the rights of involuntarily hospitalized mental patients. The manner in which this justice in the books became a disaster in action with respect to civilly committed patients will not be recited here. But we are concerned with the circumstances involving the ricochet effect of the disaster of civil patients upon the already scanty rights afforded criminal process patients in Section 24-301.

The first effects of the 1964 Act upon criminal process patients appeared favorable. Rouse v. Cameron affirmed that those patients committed to the hospital under Section 24-301 had a "right to treatment". In Bolton v. Harris, impelled by the Supreme Court's decision in Baxstrom v. Herold, the Court of Appeals defused the automatic commitment provision of Section 24-301 (d) by requiring a new hearing after trial on "present mental illness." The court conceded that in its earlier decisions it had found it

111. Id. § 21-548.
112. Id. § 21-562.
113. Id. § 21-549.
114. This aspect is explored in the 1969 Judicial Conference Committee Study and discussed in the Project Report at 304-23.
115. 373 F.2d 451 (D.C. Cir. 1966).
118. 395 F.2d 648-49. This aspect of Bolton had been foreshadowed in Cameron v. Mullen, 387 F.2d 193, 199 (D.C. Cir. 1967). Mullen, strongly influenced by Baxstrom, refused to permit post-verdict indefinite commitment under Section 24-301(a), that is, where a defendant who had refused to plead insanity as a defense was committed. In Lynch v. Overholser, 369 U.S. 705 (1962), the Supreme Court held that Section 24-301(d) did not authorize involuntary hospitalization of a defendant who had not himself pleaded the insanity defense, but suggested that Subsection (a) was available for this purpose. In Mullen the Court of Appeals treated this suggestion in Lynch as mere dictum, and pre-Baxstrom dictum at that.
“reasonable to treat those not guilty by reason of insanity differently from other mentally ill persons because of the greater likelihood that the former will be dangerous to society, and that habeas corpus provided a sufficient safeguard for their rights.” But 

_Baxstrom_ and the 1964 Act undercut this premise. “[I]n view of [these two authorities] prior criminal conduct cannot be deemed a sufficient justification for substantial differences in the procedures and requirements for commitment.”

The court found that the shortcomings of Subsection (d) after _Baxstrom_ were so glaring as to be “constitutionally suspect.” In order to avoid declaring Subsection (d) unconstitutional on equal protection grounds, the court undertook a patchwork construction of the statute. Its reasoning took the following course: (1) Sufficient differences exist between civil and criminal process commitment to establish that “commitment without a hearing is permissible for the period required to determine present mental condition.” (2) Once the examination period is over “persons found not guilty by reason of insanity must be given a judicial hearing with procedures substantially similar to those in civil commitment proceedings.” (3) The hearing on “present mental condition” seems now constitutionally required by _Specht v. Patterson._ (4) The Section 24-301 (e) requirement of court review before release by the superintendent is upheld, although court review is not required with civil release. (5) The periodic examinations by the hospital staff and right to be examined by outside psychiatrists which are made available to civilly committed patients must also be furnished to criminal process patients. “Because we find no rational justification for withholding these safeguards from a Subsection (d) patient, we construe Subsection (e) to require them.” (6) With respect to relief by habeas corpus, the court

119. 395 F.2d at 649.
120. Id.
121. Id. at 651. The court declined to generalize concerning the length of time required for such examination, leaving it for the hearing court to adapt to the case at hand. It is customary to assign longer periods of examination for capital offenses. See discussion and statistics on this matter at notes 136-37 and accompanying text infra.
122. 395 F.2d at 651. The court here recalls that “[r]eference to the Mental Health Commission is not required.” Id. at 651 n.50.
123. 386 U.S. 605 (1967).
124. 395 F.2d at 652.
126. 395 F.2d at 652. Subsections (d) and (e) of Section 24-301 are a pair, the first dealing with commitment, the second with release. Interestingly, the same court had declined in _Mullen_ to “import all of the civil standards into Subsection (a) [in order] to avoid the constitutional difficulties suggested by _Baxstrom_ v. _Herold._” 387 F.2d at 203. The _Bolton_ decision points out that “court” for purposes of civil commitment is defined by the 1964 Hospitalization of the Mentally Ill Act as the “United States District Court for the District of Columbia”, whereas Mrs. Mullen’s case had been in the Court of General Sessions (now the Superior Court). 395 F.2d at 652.
approved a rule entitling petitioner to release upon his establishing a preponderance of the evidence, although it agreed that "the cases in this jurisdiction do not make clear what the burden of proof is in habeas proceedings challenging civil commitment." For a criminal-process petitioner to prevail on a writ, the court must find, by the preponderance of the evidence, that the patient's commitment is no longer valid, i.e., that he is no longer "likely to injure himself or other persons due to mental illness."127

While all these modifications softened the automatic commitment and disparate release provisions, and purported to extend many civil rights to criminal process patients, the product of Bolton in practice has been spare. It has, in fact, stimulated new frustrations.128 One would look far to find a sponsor for the proposition that Bolton had added a jot to justice in action129.

The cases we have just discussed: Durham, its progeny, Rouse, and the equal protection cases typified by Lake and Bolton comprise the "law in the books" on involuntary mental hospitalization of criminal process patients in the District of Columbia. We now turn to the question of how they have fared "in action." The analysis of their operation is based largely upon statistical and interview data compiled in the course of the 1969 Ombudsman Project at the Catholic University of America Law School. It also draws on two other recent reports—the 1968 report of the Ad Hoc Committee Appointed to Study the Security Facilities at St. Elizabeths Hospital, and the 1969 report of Professor David Chambers of Michigan Law School.130

III. THE RULES IN THEORY AND PRACTICE

How has all this legal theory—legislative, decisional and constitutional—worked in practice? An answer requires isolating a few distinct elements of the court-hospital-court process—and, contrasting "law in books" and "law in action" for each. Although some other categories would do as well,131 I

127. 395 F.2d at 653.
128. For a hypostasis of some of these frustrations see the "Thomas Smith" case infra.
129. The D.C. Court Reform Act has shown some respect for the insight of Bolton into the implications of Baxstrom (see text at notes 261-73 infra). The question remains: will the Superior Court now listen to Bolton, or to Chief Judge Bazelon's earlier reflection in Mullen concerning the applicability of rights given civilly committed patients by the 1964 Hospitalization of the Mentally Ill Act to criminal process patients?
130. See note 3 supra. In addition reference will be made to NIMH statistics acquired during the Law and Psychiatry Project.
131. For example, attention might have been given to internal hospital grievances, relations of patients to attendants (nursing assistants) and social work personnel, internal transfers within the hospital. These matters (and others, such as social security, veterans benefits, and other property problems of patients) are dealt with in the Law and Psychiatry Project Report.
have chosen for consideration: (a) examinations, (b) psychiatric trial testimony, (c) treatment, (d) release, and (e) patient rights.

A. Examinations

In the Books

If the court itself observes, or receives prima facie evidence, that an accused is “unable to understand the proceedings against him or properly to assist in his own defense” it may commit the accused to St. Elizabeths Hospital for a reasonable time for examination as to his competence to stand trial. Furthermore, if an insanity defense is contemplated the court may order a mental examination prior to trial. The court usually sets these examination periods at 60 days; in capital offenses they are usually set at 90 days.

In Action

The first obvious discordance between “books” and “action” may be seen in the gradually increasing length of examination periods over the years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Less than 30 days</th>
<th>30-60 days</th>
<th>60-90 days</th>
<th>Over 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1959</td>
<td>31</td>
<td>13%</td>
<td>48%</td>
<td>35%</td>
<td>3%</td>
</tr>
<tr>
<td>1964-67</td>
<td>550</td>
<td>5%</td>
<td>75%</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td>(Nov. 1-Oct. 31)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1967-69</td>
<td>477</td>
<td>4%</td>
<td>3%</td>
<td>34%</td>
<td>60%</td>
</tr>
<tr>
<td>(Nov. 1-Oct. 31)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JHP Roster</td>
<td>89</td>
<td>6%</td>
<td>7%</td>
<td>11%</td>
<td>76%</td>
</tr>
<tr>
<td>11/1/69</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Despite the number of court orders for examinations of 30 days or

133. D.C. CODE ANN. § 24-301(j) (Supp. III, 1970). This provision was added in 1967.
134. The Project's 14-month survey of court-directed mental examinations (November 1967-December 1968) at John Howard Pavilion (JHP) showed that 80 percent of the examinations were directed to be completed in 60 days; eight percent were 30-day exams, four percent were 90-day exams, and two percent were miscellaneous short time exams (7, 14, 15 days, etc.). Six percent of the court-directed examinations were post-trial examinations based on the *Bolton* decision (see following note). The overall total of patients admitted to JHP for psychiatric examinations in this period was 486, of the total admissions of 570. PR ch. 5, n.28.
135. In addition to the pre-trial examinations, the court may order an examination, usually for a shorter period, as to the present mental condition of a patient who has been found not guilty by reason of insanity. *Bolton v. Harris*, 395 F.2d 642 (D.C. Cir. 1968). But see text at notes 261-73 infra concerning the effect of the D.C. Court Reform Act here.
136. This chart appears in the Project Report at 111. It is based upon discharges
less.\textsuperscript{137} the average stay of all examination patients at JHP was computed by the Project as follows:\textsuperscript{138}

<table>
<thead>
<tr>
<th>Year</th>
<th>1959</th>
<th>1964-67</th>
<th>1967-69</th>
<th>11/1/69 (roster)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.4 mos.</td>
<td>2.4 mos.</td>
<td>3.1 mos.</td>
<td>4.5 mos. (exam not complete)</td>
</tr>
</tbody>
</table>

These ascending figures must be considered in light of the mounting number of examinations which the court has called on the hospital to handle.\textsuperscript{139}

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>163</td>
<td>201</td>
<td>227</td>
<td>398</td>
<td>685</td>
<td>657</td>
</tr>
</tbody>
</table>

The number of psychiatric personnel assigned to JHP has not kept up with the ascending examination requirements. The official statistics on psychiatrists assigned in these years may be compared with the American Psychiatric Association standards, and with the number of psychiatrists which the Project estimates in fact worked at John Howard Pavilion.\textsuperscript{140}

<table>
<thead>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>APA Standard</td>
<td>NIMH</td>
<td>Project Estimate</td>
<td>Other</td>
<td></td>
<td>APA Standard</td>
<td>NIMH</td>
<td>Project Estimate</td>
<td>Other</td>
<td>APA Standard</td>
<td>NIMH</td>
<td>Project Estimate</td>
<td>Other</td>
</tr>
<tr>
<td>1966</td>
<td>11</td>
<td>8%\textsuperscript{*}</td>
<td>8</td>
<td>—</td>
<td></td>
<td>11</td>
<td>8%</td>
<td>8</td>
<td>—</td>
<td></td>
<td>11</td>
<td>10</td>
<td>8%</td>
</tr>
<tr>
<td>1967</td>
<td>11</td>
<td>8½%</td>
<td>8</td>
<td>—</td>
<td></td>
<td>11</td>
<td>9½%</td>
<td>7½%</td>
<td>—</td>
<td></td>
<td>11</td>
<td>11</td>
<td>8½%</td>
</tr>
<tr>
<td>1968</td>
<td>11</td>
<td>10%</td>
<td>8½%</td>
<td>—</td>
<td></td>
<td>11</td>
<td>9%</td>
<td>5½%</td>
<td>8</td>
<td>(Ad Hoc Comm.)</td>
<td>11</td>
<td>9%</td>
<td>6½%</td>
</tr>
<tr>
<td>1969</td>
<td>12</td>
<td>8%</td>
<td>—</td>
<td>—</td>
<td></td>
<td>12</td>
<td>8%</td>
<td>—</td>
<td>—</td>
<td></td>
<td>12</td>
<td>8%</td>
<td>—</td>
</tr>
</tbody>
</table>


from John Howard Pavilion for the years noted and thus excludes examinations at the medium security services of West Side and Cruvant (since discontinued). It does not cover court-directed examinations at D.C. General Hospital, which have been comparatively infrequent since 1967. The 1959 and 1964-67 figures in the chart are based on all discharges from JHP for the period; the figures for 1967-69 are based upon a 47.5 percent sample of discharges. The column labeled "JHP Roster 11/1/69" covers all patients on the Pavilion roster on that date and represents the time these patients have been in the hospital without the examination being completed.

137. The "30 days or less" examinations were ten percent of all examinations (excluding from consideration here the Bolton-type examinations, which were six percent) noted in the 14-month survey.

138. PR 112.

139. These figures were furnished the Project by NIMH officials. They are noted as prepared by the Biometrics Division of St. Elizabeths Hospital. PR 115.

140. There was a discrepancy between statistics furnished to the Project by NIMH.
In light of those figures, it is interesting to note the following comments:\textsuperscript{141}

\textit{Psychiatrist A}: I am very unhappy with the hospital administration. In a short time the staff at John Howard Pavilion could be down to zero the way things are going [July, 1969]. The reports given to the newspapers concerning the increase in the staff at John Howard are false. In fact, the staff of doctor-psychiatrists has decreased from eight to four.

The staff at John Howard Pavilion cannot handle both diagnosis and treatment; treatment should be handled separately. Few patients now sent for diagnosis are given treatment. Now a few patients who are sent by the courts for 30-day examinations and who could be handled in that time are at the hospital for five or six months. The reason for this and for other persons getting lost in the woodwork is insufficient staff, and no assistance from the hospital administration. And the ones who suffer are those people upstairs [the patients].\textsuperscript{142}

In view of the increased admissions for examinations, and decreased psychiatric availability, extended examination stays are not surprising. But what of the quality of the examinations in this congestion? The Project claimed neither the expertise, nor the access to data, which would qualify its members to judge the quality of examinations. However, it compiled professional opinion on this question.

\textit{Psychiatrist A (JHP)}: Being assigned to admissions I see each [patient] alone, and each for an average of three hours.\textsuperscript{143}
**Psychiatrist E:** The need for examinations will break the insanity defense—the needs double every two years. One doctor is giving 90 percent of his time to examinations, and it will continue. I don't think that the whole D.C. psychiatric community could handle it. Exams are done sloppily and cursorily. We need more manpower to do them right. This requires a change in the law.\textsuperscript{144}

**Psychiatrist E:** I don't think that the psychiatrist has any firm scientific evidence of value to the court in reaching these determinations [from pre-trial exams].\textsuperscript{145}

**Judge D:** I have often had the feeling that reports of some doctors were tied in to housing requirements at St. Elizabeths rather than being an accurate reflection of a patient's mental condition.\textsuperscript{146}

**Psychiatrist F:** You can't be accurate in assessing a patient in a pre-trial examination. They are under a considerable strain not to tell the truth as they see it; it may make the difference between 20 years in prison and two years here.\textsuperscript{147}

**Professor Chambers:** It is highly questionable whether any real observation takes place in John Howard, for whatever nursing staff observations are made, or even recorded were rarely mentioned in staff conferences.

That John Howard consistently finds twenty to twenty five percent of those it examines mentally ill, while West Side [medium security service, now terminated] finds over 90 percent, can hardly be explained in terms of the differences of their clientele. Rather, it illustrates either the differing political contexts in which the two services operate or the uncertain content of the diagnostic labels.\textsuperscript{148}

**NIMH Ad Hoc Committee:** Although the hospital is unusual in the amount of time it devotes to these examinations—taking 30 days \textit{[sic]} of hospitalization to make examinations that elsewhere are done informally in a matter of hours—what it produces as a result is merely a standard form report, which contains hardly more than a diagnostic conclusion . . . . [A]t the present time there is a very lengthy period of observation where largely irrelevant material is collected and inappropriately handled in the court setting.\textsuperscript{149}

\textsuperscript{144} PR 192.
\textsuperscript{145} PR 214.
\textsuperscript{146} PR 219.
\textsuperscript{147} PR 209.
\textsuperscript{148} Chambers Report 6, 23.
\textsuperscript{149} NIMH Ad Hoc Committee Report 11.
The psychiatric witness is to give nonconclusory expert medical testimony concerning whether or not the defendant is suffering from a mental disease or defect which may substantially have affected his control of the conduct that led to the criminal act of which he is charged. The testimony is not to be given in medical jargon; nor is there to be conclusory testimony with respect to "productivity", i.e., whether the disease or defect was the cause of the criminal act. This question is for jury determination.

"Mental disease or defect" is understood to encompass more than psychoses. It includes neuroses and may include character or personality disorders possessed by persons sometimes designated as sociopaths or psychopaths. As we have seen, the hospital, after first excluding this category by reporting it as without mental disorder officially withdrew the ban.

In strict theory, most defendants committed to the mental hospital for examinations are sent there for determination of the issue of their mental competency to stand trial—i.e., their capacity to communicate with their attorneys in the interests of their own defense. Nevertheless, the hospital in its examination, purports to treat a second problem: the basic relation of his mental condition to the crime charged. In some instances both defense

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150. See discussion of Durham v. United States, 214 F.2d 862 (D.C. Cir. 1954) and McDonald v. United States, 312 F.2d 847 (D.C. Cir. 1962) at notes 53-64 supra.
151. The most recent expression of the Court of Appeals on this issue was in United States v. Eichberg, 439 F.2d 620 (D.C. Cir. 1971). See also Washington v. United States, 390 F.2d 444 (D.C. Cir. 1967).
152. Stewart v. United States, 214 F.2d 879 (D.C. Cir. 1954). Whether or not a psychopath (sociopath with an anti-social personality, see note 60 supra) should be relieved of responsibility as mentally ill is, as in other mental illness, a jury question—in theory.
153. The statutory authority is D.C. CODE ANN. § 24-301(a) (1967).
154. The two issues are in fact quite distinct. Many a disastrously disoriented schizophrenic has coherent periods which might make him quite "competent" in a standing-trial sense. Conversely, a man may have acquired a mental condition after the offense was committed that would, while it lasted, make him incompetent to stand trial; and yet when he came to trial he might be found to have been mentally sound at the time the alleged criminal act was committed. Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968) touched the third possibility—that a person may not have been responsible for the criminal act because of substantial mental impairment at that time and yet be no longer committable because he has recovered by the time of the trial. It is not easy to justify sending a person to a mental hospital for a competency examination (which can be quite a simple thing) and then keeping him in the long line awaiting full examination (the 4.5-month average in 1969) before ascertaining whether or not he committed the offense charged.
and prosecution expect an insanity defense. Where there is no substantial controversy that an accused performed the criminal act, judicial economy dictates that all testing be done on the first commitment to the hospital.\textsuperscript{155}

The most vexing problems are those at the trial itself. Despite repeated admonitions from the Court of Appeals, psychiatrists, apparently with the acquiescence of the trial judges, continue to use medical terms when testifying and make precise statements that the act charged was, or was not, the "product of the mental disease or defect." Psychiatrists admit considerable disagreement among themselves as to what they are to do, and show considerable professional reserve over their capacity to do it. Nevertheless, courts follow them almost blindly with respect to commitment and release.\textsuperscript{156}

Comparable "strong testimony" is given by the doctors at habeas corpus hearings on the question of release. They are encouraged to wax forth on such broad standards as "abnormal mental condition" and "dangerousness."\textsuperscript{157} These characteristics of psychiatric testimony are illustrated in the following excerpts from the Project Report.

\textbf{Judge E:} Some people complain about Dr. \underline{\hspace{1cm}} as being too indefinite and unconvincing. I know that he tries to be precise and fair to the patients. But sometimes this presents a difficulty. He won't charge a man with malingering unless he admits that he lied. This is a pretty difficult standard. I have no criticism of certain testimony of the doctors. The chief problem is not lack of communication between judges and psychiatrists, but arises from the need for clear testimony by the doctor so as to convince the jury.\textsuperscript{158}

\textbf{Psychiatrist F:} The court does anything the psychiatrist tells him, however arbitrary or capricious (everyone is the same under the Durham rule).\textsuperscript{159}

\begin{table}[h]
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\textsuperscript{155} & A 1967 amendment to the Code insures that notice of intention to plead an insanity defense is given well before trial: "Insanity shall not be a defense . . . unless the accused or his attorney in such proceeding, at the time the accused enters his plea of not guilty or within fifteen days thereafter or at such later time as the court may for good cause permit, filed with the court and serves upon the prosecuting attorney written notice of his intention to rely on such defense." D.C. CODE ANN. § 24-301(j) (Supp. III, 1970). This statute, conceived as insuring government medical examination of the accused before trial, and thus avoiding interruption of a trial and duplication of examinations, has proved dysfunctional. \\
\textsuperscript{156} & Such independence as judges show is on questions of release when they sometimes prove more cautious and reluctant than psychiatrists. For example, in 1968-69 only eight habeas corpus petitions for release among the 270 writs filed by mental patients, were granted by the district court in whole or in part. PR 352. \\
\textsuperscript{157} & See discussion of Overholser v. Leach, 257 F.2d 667 (D.C. Cir. 1958) at notes 68-70 supra. \\
\textsuperscript{158} & PR 225. \\
\textsuperscript{159} & PR 194. \\
\hline
\end{tabular}
\end{table}
Administrator A: Even if we had enough psychiatrists, we couldn’t deal with the cases. The big problem is understanding with the courts. Take the question of competency—examinations as to whether a man is competent to stand trial. We agreed with the liaison judge we would do 14-day examinations—simply on the question whether the man could understand the charge and talk to his lawyer in defending against the charge, nothing on productivity. Then Judge ............... gets some of these reports and he complains: “Why no psychological?”

Judge I: I am troubled by the productivity reports . . . . I am concerned at the too liberal notion of productivity. But I feel dependent on the psychiatrists. What can a judge do, he’s not an expert on mental health.

Judge H: I admit that I don’t have much confidence in the state of the psychiatric art. But I am not a psychiatrist. So I have to take their word for it—both as to competency and as to not guilty by reason of insanity. I’m very timid, because of the Court of Appeals, to let the psychiatrist depart from specific canned language. I’m not strong for “hedging” psychiatrists. I need strong testimony so as not to get overruled upstairs [i.e., by the D.C. Circuit].

C. Treatment

In the Books

The underlying premise of Durham v. United States is that persons found not responsible for crimes by reason of insanity may not be punished or imprisoned; instead, they may be sent to a mental hospital for treatment. In Rouse v. Cameron the Court of Appeals held that such involuntarily hospitalized defendants had a “right to treatment,” and strongly implied that where no treatment was given, they might be released from custody. These principles assume that upon admission: (a) criminal process patients are treatable; and (b) professional and other treatment resources are available and will be used to treat them.

In Action

Hospital administrators frankly view John Howard Pavilion as a prison and are not bothered with the problem of treatment.

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160. PR 228.
161. PR 227. Not all the judges were so diffident. Judge D: “The judges have a responsibility to the community to go against the doctors when they are for release of a patient without giving adequate grounds. I have had occasions to resist the recommendations of psychiatrists on this basis.” PR 225.
162. PR 227.
Administrator D: The whole problem at St. Elizabeths is John Howard. It's not a hospital; it's a prison.

Psychiatrist F: If there is no treatment within a security environment, according to Rouse the patient gets released. I don't think that this solves the problem. The trial judges persistently ignore it.

Psychiatrist A: There are a group of patients for which no treatment has been developed. No matter what we do they will revert. There are some, though, that you can't let out on the street.

Psychiatrist C: Operationally anything is classified as treatment that doctors determine to be treatment. There are no strict criteria. The psychiatrist has all the words on his side.

One doctor noted that courts have refused to release a patient even when the doctors find him improved. When he was asked why such a person remains at the hospital, the psychiatrist replied, "I don't know. He's doing time here. This does serve as a prison." Patients who are under sentence and transferred from prison present a special case. According to Psychiatrist C: "Prisoner transfer is usually black and white—he won't get any care at the hospital."

The therapy at the hospital consists chiefly of drugs. Patients rarely see doctors. And doctors rely heavily upon nonprofessional ward personnel for appraisals of patients' mental condition.

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163. PR 228.
164. PR 190.
165. PR 212.
166. PR 191.
167. PR 209.
168. PR 211.
169. The only other significant factor is group therapy, of which we have the following account: "Two or possibly three of the 271 committed patients [in John Howard Pavilion in June, 1969] receive individual therapy. Staff psychologists treat another half dozen patients individually and thirty to thirty five more in groups. Around 220 patients do not receive individual or group therapy, but several John Howard doctors thought such therapy had limited value ..."
170. Patients interviewed (in a ten percent Project sample of John Howard Pavilion) said they saw a psychiatrist: Once or twice a week (12 percent); once or twice a month (12 percent); every few months (15 percent); once a year (three percent); once or twice (nine percent); three or four times (12 percent); six times (three percent); no answer (nine percent); never (26 percent). PR 176.

Other evidence corroborates strongly the patients' testimony, which might be suspect if it stood alone. Cf. note 169. One highly regarded and straightforward psychiatrist in charge of John Howard wards told the Project interviewer in October, 1969: "The basis for my ward work is the administrative call. . . . At first I did it every day. But I kept falling behind on examinations. Then it worked well at once a week. But when Drs. Kunev and Platkin left [July, 1969] the administrative rounds became impossible, and they became limited to emergencies. It is still that way somewhat, but I have a hope to do it again once a week." PR 192.
Psychiatrist E: I think that the nursing service has too much authority—they work out of A [Administration] Building. There are times when they won't do what the doctors say. By tradition, the charge-aids [senior ward attendants] do run the wards, and they think that they do. The result of this is that they feel the doctors and the others are intruding and resent it.171

Q: [The Acting Superintendent] had referred to a 'code group', an autonomous nursing staff group which he had been unable to penetrate. Have you observed this?

Psychiatrist F: Yes; its autonomy is tremendous. It is under no one's control. The nursing supervisor never goes on the ward.

Q: What control does the doctor have?

Psychiatrist F: Not very much. They [nursing staff] do what the doctor says in terms of medication and transfer. But they make policy: Who should be transferred, who should receive medication.172

Psychiatrist C: Then there is the case of ________, a patient at John Howard. I would be careful with him, but he must be given some hope. He changed from being a slick artist to one interested in others. He began to fight for other patients—kick up a fuss if they were beaten up, mistreated. One time he was out and his room got inspected. One attendant said he found there dirty pictures of children, but he tore them up. On the strength of this [the patient] was sent up to the top floor [disturbed ward]. I complained up the line to Dr. ________, and told him, "You can't rely on this about the pictures." He said, "Oh, you don't think an attendant would lie, do you?" I told him, "Yes," and went a step higher. The "discipline" was revoked there, because he didn't think this reasoning would stand up in A Building [Superintendent's office].173

D. Release

In the Books

The basic statute174 states two qualifications for release. The patient must show that he is not mentally ill; or, if he is, that upon release he would not be dangerous to himself or others.175

Under Bolton, the criminal-process patient is entitled to a re-examination

171. PR 198.
172. PR 198-99.
173. PR 229-30.
175. The bare words of Subsection (e) require that he be neither mentally ill nor dangerous. Bolton, assimilating the civil commitment provision, requires release if a patient can show either that he is no longer mentally ill, or (even if he is) that he is not dangerous.
by the hospital every six months. If the hospital is not ready to release him, he is then entitled to examination by an independent psychiatrist, and then, if the hospital still will not release him, he is entitled to a court hearing. The patient may bring a writ of habeas corpus to test out the hospital’s right to retain him on the above standards. In the habeas proceedings for an indigent patient, the government has the burden of investigating less drastic alternatives than hospitalization.

In Action

Early in Durham jurisprudence the Court of Appeals construed the relief criteria to justify retention if a patient, although without a mental disease or defect, was suffering from “abnormal mental condition.” So sociopathic character disorder became the basis for retaining a patient although in practice it was not a ground for committing him in the first place. Since the patient had the burden of proof, he had to show by a “preponderance of the evidence” that he did not have an “abnormal mental condition,” a difficult task for most persons—in or out of a mental hospital. With rare exceptions this left the patient in the hospital until the doctors were ready to recommend his release.

1. Criteria for Release

Psychiatrist A: There are no set criteria. It depends on what brought the patient here, e.g., drug problem. Does he have any insight into the problem? Have we helped him to get along better on the street?

Psychiatrist B: [For] John Howard Pavilion patients . . . [y]ou had to be able to truthfully say [to the court] that the man had improved, and that he was not dangerous. Also, the man had to show evidence of a job, or plans for one.

Psychiatrist C: I don’t know the criteria. In general they are unstructured and unwritten. Cooperation on the ward, since the nursing assistant makes

179. See Krash, The Durham Rule and Judicial Administration of the Insanity Defense in the District of Columbia, 70 YALE L.J. 905, 926: “In form, the law in the District applicable to psychopaths differs from the generally accepted view that evidence of psychopathy will not justify acquittal on grounds of insanity . . . In practice, however, psychopaths are almost invariably held accountable in the District.”
180. See comments of Psychiatrist F., PR 209.
181. PR 212.
182. Id.
the decision. Also participation in activities. . . The nursing assistant makes policy.183

Psychiatrist E: For not-guilty-by-reason-of-insanity patients: that they are not dangerous, or apt to be so in the foreseeable future; for competency cases: that the patients are able to assist counsel at the trial.184

Psychiatrist F: For unconditional release: recovered and not dangerous to himself or others.185

Psychiatrist F: The United States Attorney has said that if the patient has recovered, no matter how dangerous, he must be released. It doesn't always work out that way.186

2. Dangerousness

Psychiatrist A: Inside John Howard Pavilion [the definition of "dangerousness"] is up to the individual doctor. I once diagnosed a person who was dangerous as "well".187

Psychiatrist C: The nursing assistant [ward attendant] makes all these evaluations as to dangerousness of a patient. One nursing assistant wouldn't let me see a patient in seclusion because he was too dangerous. The man wasn't dangerous. The nursing assistant always makes these determinations. He will decide when a patient is competent and when he will be transferred out.188

Psychiatrist F: I feel the safety of the community is more important than the patient even if you can't effectively treat the illness.189

Psychiatrist D: I don't have any criteria of dangerousness. . . . The issue is what the court has been willing to go along with. It is the court's decision. We have made recommendations for a patient's release and have been turned down by the court, even though we felt the patient was improved.190

Psychiatrist E: I consider him dangerous if he actually hurts someone rather than the danger of his committing crimes. . . . actual physical danger.191

Psychiatrist B: I don't know criteria of dangerousness. Color in the

183. PR 213.
184. PR 214.
185. Id.
186. PR 209.
187. PR 207.
188. Id.
189. PR 208-09.
190. PR 211.
191. Id.
Rorschach test is the ultimate thing to determine it. Only a psychological test can show it. Quiet ones are more dangerous than the loud ones.\textsuperscript{192}

\textit{Psychiatrist C:} There are two criteria of 'dangerousness': (1) the likelihood of recommitting soon the same crime or a related crime; and (2) physical dangerousness, \textit{i.e.}, assaultive character.\textsuperscript{193}

The habeas corpus writ outlet is of limited value. Writs filed by JHP patients in the United States District Court in 1968 and 1969 were studied with the following result:\textsuperscript{194}

\begin{tabular}{|l|c|c|c|}
\hline
Year & Total No. of Writs filed & No Attorney Appointed \textsuperscript{195} and No Hearing & Releases \textsuperscript{196} \\
\hline
1968 & 128 & 40\% (48) & 3 \\
1969 & 147 & 50\% (68) & 5 \\
\hline
\end{tabular}

The reason suggested for the no-attorney, no-hearing cases listed above was that these persons were chronic writ-filers.\textsuperscript{197} The court attended carefully to only those writs from people who had not filed within the past six months. This argument was tested in fact for this period, and it was found that only nine percent of the no-attorney, no-hearing petitioners had had a hearing within the previous six-month period, and thus only five percent of all petitioners during these years could be pegged as repeaters.\textsuperscript{198}

With rare exceptions, the only medical evidence presented at habeas hearings was that given by the hospital psychiatrists. This was always extremely defensive with respect to the Hospital's recommendations.\textsuperscript{199} In this situation

\begin{itemize}
\item \textsuperscript{192} PR 210.
\item \textsuperscript{193} \textit{Id.}
\item \textsuperscript{194} PR 352-54.
\item \textsuperscript{195} In addition, there were seven petitions withdrawn in 1968 and 13 in 1969 without counsel being appointed.
\item However, failure to grant a hearing on a habeas corpus petition does not seem to be a general practice of the judges of the District Court. Two judges accounted for 73 percent of the no-attorney dismissals in 1968 and two judges accounted for 88 percent of such dismissals in 1969. \textit{See} Appendix A.
\item \textsuperscript{196} Figures in this column reflect all cases in which the relief sought was granted in whole or in part.
\item \textsuperscript{197} This reason was common parlance among the John Howard Pavilion psychiatrists and ward attendants during my close to three years at St. Elizabeths. This reason was given by the Hospital Registrar, by some judges and by others.
\item \textsuperscript{198} In many instances there had been a prior writ filed within the six-month period, but that writ had been itself dismissed without a hearing, often for alleged failure to exhaust nonexistent administrative remedies. See the "Thomas Smith" case, \textit{infra} and Appendix A.
\item \textsuperscript{199} This is to be expected, since the Hospital's recommendations usually derive from the patient's administrative (supervising) psychiatrist at the Hospital, who is almost always the only psychiatrist witness in the case. In only a few instances in the 1968-69 writ survey did we find that independent psychiatrists were appointed for indigents, and then the "independent" psychiatrist was invariably from the Legal Psychiatric Services on the St. Elizabeths Hospital grounds. Differences among Hospital psychia-
\end{itemize}
most judges felt compelled to accept the Hospital’s conclusion.200

Although character disorders of a substantial nature may be included within the scope of mental illness, the psychiatrists have been erratic in their testimony—some include them and some don’t. Despite the reluctance to specifically include sociopaths within their mental illness testimony, in late 1969 only a small percentage of the tenants of the maximum security pavilion was psychotic, and at least one-third were regarded by their doctors as suffering from no more than sociopathy.201 Whenever a doctor wished to testify on a writ that such a patient had an abnormal mental condition the patient could do little to secure release.

**Psychiatrist F:** In the John Howard Pavilion population, one-third are no more mentally incompetent than the average criminal—the court does anything the psychiatrist tells him, however arbitrary and capricious. Everyone is the same under the Durham rule.202

**Psychiatrist B:** There aren’t enough dangerous patients in JHP to warrant consideration of the minimum period question. There is pure frustration from being locked up, and subjected to this environment.203

In this context, there is little help presently available from appointed counsel to the patients.

**Judge I:** The chief problem I have about the present system is that people who come up before me generally get sent over to St. Elizabeths (for mental examination) with the consent of an attorney. When they come back here if the finding is mental incompetency they are entitled to a hearing.
Yet at this time there is generally no hearing—almost always there is consent by [invariably appointed] counsel, who is generally glad to get rid of the case. . . . Of course there is a hospital report—but one which may be prepared in a hurry. The judge has no independent judgment to make, and a man is sent away indefinitely—until the hospital gets ready to release him. . . . I have often wondered what happened to those men we send over there. Certainly there should be counsel for these people; and they are not getting “effective counsel” at present.

In summary, defendants are sent to the mental hospital for examination and kept for an excessive period; the examinations given are admitted to be “sloppy” by the psychiatrists themselves; the reports made to the court are inadequate; and patients are often returned to the hospital without a hearing. They seldom benefit from effective assistance of counsel. Thereafter, they receive little treatment and are generally unable to secure a periodic hearing. When they do so ordinarily the only psychiatric testimony before the court is that of the hospital psychiatrist who feels committed to sustain the institutional judgment. Without other assistance, the judge has only this single basis for decision. The psychiatrists admit the institutional judgment is based in uncertain standards and in practice is often derived not by them but by nonprofessional chief ward attendants.

No wonder participants in the court-hospital-court process are uniformly dissatisfied with its present operation. Some administrators blame the courts; some psychiatrists blame the administration; some judges blame ineffective counsel; other judges blame the hospital administration.

204. The 1968-69 survey of habeas corpus writs (see text at note 194 supra and Appendix A) very seldom showed retained counsel. The small number (7 percent) of cases where retained counsel is indicated includes occasional Legal Aid Agency attorneys. The Hospital, we found in the course of the Project, will not ordinarily allow a patient to use his own funds to pay private counsel on habeas corpus writs. Exceptions to this policy are extremely rare.

205. PR 221-222.

206. See text at note 138 supra.

207. See text at note 144 supra.

208. See text at notes 145-49 supra.

209. See text at note 205 supra, and Appendix A.

210. See text at note 205 supra, and Appendix A.

211. See text at notes 163-70 supra.

212. See note 199 and accompanying text supra.

213. See note 199 supra.

214. See text at notes 156, 159, 161-62 supra.

215. See text at notes 181-93 supra.

216. See text at notes 183, 188 supra.

217. See text at note 160 supra.

218. See text at note 142 supra.

219. See text at note 205 supra.

220. See text at notes 146, 158 supra.
seem to agree upon the need for significant change. That men of talent and good will have reacted as these have done suggests that the blame may well rest not on the manfully struggling personnel, but on the need for entirely new safeguards in the institutional process.

E. Rights

Is the phrase “rights of mental patients” a hollow sham? One answer is suggested by the “Thomas Smith” case discussed below, which crystallizes many of the shortcomings reviewed above.

In the Books

We have already seen many of the rights which the patient had, in theory, with respect to securing release. He could request release from the Hospital Superintendent; he could ask for an independent psychiatrist. In case of a difference between the hospital psychiatrist and the independent psychiatrist he was entitled to a court hearing. He had the right to be heard on a writ of habeas corpus at least every six months. Furthermore, after Bolton he was entitled to be informed by the hospital of just what these rights were.

In Action

We have seen the slight practical value of the “right to treatment” and right to petition for a writ of habeas corpus. The most effective way to present the gossamer quality of other rights is in the form of an actual case which developed during the Ombudsman Project. The name of the patient has been changed.

The “Thomas Smith” Case

On July 11, 1969 the following memorandum was sent by the Registrar at St. Elizabeths Hospital to the Motions Commissioner of the United States District Court:

Subject: Writ of habeas corpus Thomas Smith. You will receive shortly a petition for writ of habeas corpus from this patient. We wish to bring to your attention the fact that this patient had a previous Habeas Corpus, No. 118-69, issued June 11, 1969. On June 27, 1969, a hearing on this writ was held before Judge __________, at which time the writ was discharged and the petition dismissed.

This, not unusual, informal communication between the official of the Hospital (whose Superintendent was the defendant in the writ situation) and

221. See notes 43-44 and accompanying text supra.
the official of the District Court (the impartial arbiter in deciding on the writ the respective claims of the patient and the hospital) was explained to me, in a more general context as follows:

The Registrar:222 We have fellows here who constantly are sending up writs. To save unnecessary duplication of labor, both on the part of the court and on the part of our doctors, whose valuable time should not be consumed by futile return trips to the court, we signal the Motions Commissioner, sometimes in writing and sometimes by phone when such a case is on its way up there. This helps the court to distinguish between the real ones and these repeaters.

The Judges: It is clear, even under the statute223 and the Bolton decision, that we need only to hear one writ from any one man every six months. If he has just been up with a writ within six months, and had a hearing, there is no need for another.224 And so such writs can be expeditiously dismissed. Besides, you should see the hopelessly inadequate letters that we receive and construe as a writ.225

One might suggest another reason in the case of Thomas Smith, that derives from the peculiar seriousness of the crime with which he had been charged. Picked up by the police in 1961, he was charged with second de-

222. The Registrar is the Hospital official in general charge of supervising administrative aspects of admissions and discharges of patients, and their classification, assignment and transfer within the hospital. For example, on receipt of a “prisoner-patient” (a term embracing patients who are: mentally incompetent for trial; not guilty by reason of insanity; committed for examination; or under sentence), “(t)he Registrar will examine the commitment papers to ascertain that they are complete. He will assign a Hospital number and establish the patient’s legal category.” St. Elizabeths Hospital, General Instructions Manual, Part II Medical Administration, Chapter 6, Nos. 3 & 4(a). Although the Registrar is not an attorney, and there is no attorney in the Registrar’s office, he takes the operative role for the Hospital with respect to writs of habeas corpus. “The Registrar is responsible for preparation of all answers to Orders to Show Cause and Writs of Habeas Corpus . . . The Registrar will prepare the Answers and Returns to Court Orders to Show Cause. . . . The Registrar will have responsibility of completing and forwarding the ‘Answer and Return’ to the Court within the specified time limit.” Id. In fulfilling these responsibilities he is to “consult and cooperate with the designated Assistant United States Attorney.” Id. Nos. 4, 6, & 8. In practice the Hospital papers on writs are prepared at the Hospital and reviewed by the United States Attorney’s office, as legal counsel to the Hospital for this purpose. The Registrar and his assistant, and the Assistant United States Attorney charged with the consultative function, were interviewed in the course of the Project. The source here quoted is the office of the Registrar, and is not attributed to any particular person in that office.

223. From the context, the reference appears to be to the District of Columbia Hospitalization of the Mentally Ill Act, D.C. CODE ANN. §§ 21-501 to -591 (1967).

224. This interpretation by the interviewed judges was confirmed by the Court of Appeals in Dixon v. Jacobs, 427 F.2d 589 (D.C. Cir. 1970), a case referred by the Project.

225. In reviewing the 1968-69 mental health habeas corpus writs (see text at note 194 supra) we found ample support of this claim.
gree murder and assault with a deadly weapon. Like many other patients he first arrived at St. Elizabeths for a 60-day psychiatric examination to determine whether he was mentally competent to stand trial. The Hospital reported to the court that he was not, and Smith was returned to John Howard Pavilion in November, 1961. By May 22, 1964, the Hospital determined that he was competent to stand trial, that is, he was capable of understanding the nature of the charges, and of communicating with his lawyer so as to be able to participate meaningfully in his defense. At the trial Smith was represented by an attorney, and found not guilty by reason of insanity. The Hospital encouraged this verdict. Its doctor had testified that, at the time of the alleged offense, Smith was mentally ill and his criminal act was a product of this mental illness. The Hospital's diagnosis was schizophrenic reaction, catatonic type. This was the going style of applying Durham. Having been found not guilty by reason of insanity, under the rule then in force, Smith was automatically and indefinitely committed to St. Elizabeths Hospital. He could thereafter secure release only if the Hospital certified to the court that he had recovered, or that he was no longer dangerous to himself or others; or by a favorable decision on a writ of habeas corpus. By March 7, 1966, the Hospital was sufficiently satisfied with his progress that it transferred him from John Howard Pavilion, with its prison-like security, to a more open service elsewhere “on the grounds.” This was the traditional first step towards eventual release. “On the grounds” there were more privileges, and opportunities to relate to other patients, both male and female, on a less supervised basis. Unfortunately for Thomas Smith he was impatient. On December 5, 1966, he petitioned for a writ (HC No. 496-66), which was denied. And on January 29, 1967 he “eloped,” escaped from the Hospital grounds. He was returned to the Hospital and on September 30, 1968, he was sent back to JHP, St. Elizabeths’ traditional penalty for elopement.

**The Doctor:** Such security measures must be taken with respect to court-committed patients. We have a responsibility to the court to maintain control over them. If a man has shown that he is an escape risk, it is only reasonable that we should return him to John Howard.227

A stigma is attached to such a returnee to John Howard. The Hospital is unlikely to take another chance with him in the outside wards. Generally,  

226. *i.e.*, under Section 24-301(a), the D.C. Code's automatic commitment provision, before its defusing by *Bolton v. Harris*. See discussion in text at notes 116-27 supra.  
227. John Howard Pavilion has security features equivalent to maximum security prison conditions.
he must wait until the Hospital is prepared to recommend him for outright release. Needless to say, such an elopee does not have high priority on the doctors’ list of prospective releases, even though in sending him to the grounds the Hospital had decided that his recovery was sufficiently advanced to allow him to mix safely with other patients on a relatively unsupervised basis.

As soon as he returned to John Howard in September, 1968, Smith determined that he would seek release through the courts. The Bolton decision of the previous winter had decreed that a patient was entitled to a redetermination as to his “dangerousness” at least when his last previous determination was over six months past. So, in September, 1968, Smith filed an application for a writ of habeas corpus with the District Court, alleging that he was no longer mentally ill, not dangerous to himself or others, and therefore unlawfully kept in custody by the Hospital (H.C. No. 241-68). In its reply to the writ, the Hospital denied the allegations, claimed Smith was still mentally ill and dangerous, and further alleged that the writ must be denied because the patient has failed to exhaust his administrative remedies.

This last claim of the Hospital specifically referred to a footnote of Chief Judge Bazelon in the Bolton case. The court appointed an attorney for Smith, and when the writ came on for a hearing in December, the judge agreed with the Hospital’s exhaustion defense. However, he did not dismiss the writ; he adjourned the hearing “in order to give the petitioner an opportunity to exhaust his administrative remedies.” In fact, he seems to have suggested to Smith what concrete steps to take to do so.

The Judge: Dr. Kunev told me that the administrative remedies were simple and that he had offered to write them out and make this information available to every patient, but that his superiors at the Hospital had turned him down.

As soon as Smith returned from court on December 2, 1968, he started to take the necessary steps to exhaust his administrative remedies. Not his lawyer, but Smith himself, then sent a notarized document headed “Letter in Legal Form for Mental Examinations by D.C. Mental Health Commission and Staff Physician of St. Elizabeths Hospital Medical Staff. Request.” to the Superintendent of the Hospital, Dr. Jacobs, the head of his service, Dr. Platkin, and his ward doctor, Dr. Kunev. The document read as follows:

Dear Sir
I feel that after my long stay here at St. Elizabeths Hospital, I

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228. 395 F.2d at 653 n.59.
229. PR 53.
have fully recovered from any mental illness that I may once had. I have recovered to the extent that I am no longer a danger to society or myself. Since this may differ with the opinion of the hospital, I therefore request that I be granted an examination by the D.C. Mental Health Commission and while I am waiting to hear from the D.C. Mental Health Commission that I also be examined by a member of the hospital medical staff, to determine my mental condition. This I understand to be my right under the Bolton vs Cameron [sic] decision of February, 1968.

The document, dated December 3, 1968, was notarized six days later by the official Hospital notary. After four weeks without an answer, on December 30, 1968, Smith again wrote Dr. Jacobs recalling the prior letter and its requests, and adding: "It [?]230 me greatly should I received some reply from your office as to what disposition the hospital has decided regarding this request. I would be appreciated to receive some sort of answer from your office."

The following day he wrote a similar reminder to his ward doctor, Dr. Kunev:

Although I sent a copy of the same letter to the Superintendent of the Hospital and also the Chief of Service as I was instructed to do by the Honorable Judge ___________ 12-2-68 would you be kind enough to forward to me what disposition the Hospital has decided to take on the issue. Thanking you in advance for a prompt reply.

On the same day, December 31, 1968, although he was still "exhausting his administrative remedies", Smith's writ was dismissed without prejudice to a further application. He was now without the attorney who had been appointed by the court to represent him on that writ.

It seems that on January 10, 1969, Smith addressed yet another letter to Dr. Jacobs. Dr. Platkin, the Chief of Service, referred to it in a handwritten note to "Mr. Smith" on January fourteenth:

Dr. Kunev advises me that you have already requested an examination by a psychiatrist from outside of St. Elizabeths Hospital. Please advise if this is so. We do not have the authority to have you examined by the D.C. Mental Health Commission. Such an examination must be ordered by the Court. Please let me know if you have requested an examination by the Department of Health. If you have not I would suggest that you address

Department of Public Health
300 Indiana Ave. N.W.
Washington, D.C.

Let me know if you require further assistance.

230. An illegible word is omitted.
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The hospital's first formal reply to Smith's letter request of December third was dated January 28, 1969:

Your request dated December 3rd, 1968, for examination by a member of the Hospital staff has been referred to me for reply. The record shows that you have been examined within the past six months by a member of the Hospital staff. It was found that further hospitalization is necessary. You may request further examination by making a request to

Dr. Murray Grant
Department of Public Health
300 Indiana Ave., N.W.
Washington, D.C.

This letter was signed by George D. Weickhardt, M.D., Acting Physician-in-Charge, John Howard Division.

On the day before Dr. Weickhardt wrote Smith, Smith had written to the Department of Health requesting appointment of an independent psychiatrist. This letter of January twenty-seventh was answered two months later under the letterhead “Government of the District of Columbia, Department of Public Health” by John D. Schultz, M.D., Associate Director for Mental Health and Retardation:

This has reference to your letter of January 27, 1969, with regard to an examination of your mental condition as provided for by the statutes. Although your letter does not so indicate, it would appear that you were committed pursuant to criminal law with respect to which the Corporation Counsel concludes that such a patient at St. Elizabeths is entitled to the benefits of Section 21-546 D.C. Code, 1967 Edition, with respect to medical assistance.

The Code indicates that the Department of Public Health must meet the cost of this service out of “unobligated funds”. The number of these requests has recently increased very substantially and there is no way at this time to divert funds budgeted for other purposes to meet this need. Our projected budget situation is such that it was necessary to severely curtail needed service programs to stay within a balanced budget. I have brought this situation to the attention of the D.C. Budget Office and will make every effort to obtain the funds necessary to provide this service.

As of March 27, 1969, Smith and the Hospital knew: his first writ of habeas corpus had been dismissed; he had been given an examination by the hospital within the past six months and the hospital considered him still mentally ill; and that there were no available resources by which he, an indigent, might obtain the independent psychiatric examination which was acknowledged by the Corporation Counsel of the District of Columbia to be
his right under the prevailing statute, as interpreted by the Court of Appeals in Bolton. Now we are ready for the second round.

Smith had prepared himself for this unavailing result by filing a second application for a writ of habeas corpus (HC No. 25-69) in February, 1969. But on March 7, 1969, it was promptly dismissed; counsel was not appointed and a hearing was not held. After all, Smith’s previous writ had been dismissed as recently as December 31, 1968. He was one of those “repeaters.”

On May 8, 1969, Smith had sufficiently recovered from the second dismissal to write Chief Judge Bazelon of the Court of Appeals, asking to appeal the March dismissal. On June 11, 1969 he received in reply a letter from the Clerk of the Court of Appeals which gave little satisfaction for the past but hinted as to his best future move:

I note from your letter that you desire an examination by a private doctor and you indicate that you have tried to obtain such examination through all known channels.

I have been informed by the Clerk of the District Court that in February, 1969 you filed a petition for issuance of a writ of habeas corpus and said petition was denied on March 7, 1969. It does not appear from the docket records of the District Court that you thereafter attempted to appeal to this court. If you desire to have this Court review the action of the District Court, the Federal Rules of Appellate Procedure require that you file with the Clerk of the District Court a notice of appeal. Since the time for appealing in habeas corpus 25-69 [the March turn-down] would appear to have passed, I suggest that you consider filing a notice of appeal at some future date in the event you again petition the District Court for the issuance of a writ of habeas corpus. For your convenience I am enclosing a notice of appeal form.

The grim assumption of this letter seemed to be that a further writ would again be turned down, but that perhaps, on appeal, something might be done about it. The letter sensed that Smith had been operating since the denial of the December writ without benefit of counsel. It intimated that Smith would be on his own in the third round. Although it has no practical effect, the letter did suggest Smith’s next step: he must file a third writ.

Smith filed his third writ (HC No. 118-69) on June 6, 1969. On June 17, 1969 the Hospital filed its answer, subscribed by the office of the United States Attorney, which represents the Hospital in these matters. This reply requested dismissal of the writ citing two principal grounds. First, the petitioner had submitted previous writs: “469-66, of December 5, 1966, and 241-68 of December 31, 1968 [sic].” “In each case,” the Hospital answer
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went on, "the presiding judge discharged the writ, dismissed the petition and remanded the petitioner to the custody of the respondent for further care and treatment." No mention was made that almost immediately after the 1966 writ the Hospital had decided that Smith had recovered sufficiently to be sent from maximum security to lesser confinement on the Hospital grounds; nor that the 1968 writ had been discharged in the very midst of Smith's carrying out the suggestions of the presiding judge as to how to exhaust his administrative remedies. Furthermore, as we have seen, the asserted remedies had in fact proven unavailable.

The second ground for dismissal urged by the Hospital and its government attorneys was that Smith had failed to exhaust his administrative remedies:

The respondent [Hospital] moves to dismiss the petition on the ground that the petitioner had failed to exhaust his administrative remedies, including the right to periodic examination by the hospital staff and the right to be examined by an outside psychiatrist, pursuant to 21 D.C. Code Section 546. The hospital records reveal that the petitioner had not submitted a written request to the Chief of Service for a current medical examination within the last six months. In *Bolton v. Harris* No. 21032 D.C. Circuit, Feb. 16, 1968 the Court of Appeals expressly held that subsection (d) patients must exhaust these remedies before applying for a writ of habeas corpus (page 17, footnote 59.)

Without appointing counsel or holding a hearing the same judge who had dismissed without prejudice the first writ on December 31, 1968, dismissed this third writ. It is hard to believe that the writ, much less the facts as we have seen them, ever reached the eyes of this judge. But it is hardly likely that the Hospital and its counsel did not have intimate knowledge of these details we have reviewed.

An interesting parallel fact is worth noting here. In April 1969, several patients informed the Chairman of the Patients Administrative Council (PAC), of their bewilderment as to the exhaustion of administrative remedies grounds which was preventing them from securing judicial hearings on writs. The PAC Chairman wrote to the Chief of Service of John Howard Pavilion asking precisely what these administrative remedies were which the patients were expected to exhaust. On June 21, 1969, the Chairman received a handwritten note from Dr. Weickhardt, Acting Physician in Charge: "Miss Nash and Mr. Altschuler are still working on this." Miss Winifred Nash is the HEW attorney who gives part-time legal counsel to the Hospital; Mr. Altschuler has been handling St. Elizabeths writ matters for the United States Attorney's Office for 15 years. It is beside the point to ask whether the true inference is that these attorneys "were still working" on the ques-
tion of what these remedies were, or that they were working on a format for bringing the information to the attention of the patients. The fact remains that the Hospital as late as June 1969 was still asserting a "remedy" it knew was nonexistent as a ground for denying a hearing on the writ which was the only access these patients had for release. Furthermore the Hospital was still unwilling to inform patients of their administrative remedies (assuming it had clear ideas as to what they were). This technique was successful in denying patients a hearing in at least 35 cases in 1968 and 1969.

Thomas Smith was ready to fight another round. For some reason he did not file a notice of appeal from the June denial of his third writ, as he had been advised to do. Instead he drafted a fourth writ. It was this fourth writ, which was never filed, that formed the basis for the notation from the Registrar to the Motions Commissioner of the United States District Court with which we commenced this chapter.

At this point I learned of the sequence of events in the case of Thomas Smith. Our approach to the project for formulating an ombudsman model required us to act upon complaints and justifiable grievances which were brought to our attention. We commenced a study of the Hospital policy on exhaustion as applied to habeas corpus writs, first in the office of the Registrar, then in the files of the District Court. We discussed the exhaustion problem with Hospital counsel, and with the Registrar, but they appeared firm. Accordingly, we secured a volunteer attorney to represent Mr. Smith on his fourth writ. The attorney decided that it would be more satisfactory to prepare an entirely new writ which could set forth much of the background that we have just outlined. On August 4, 1969 this new writ and an affidavit of indigency were signed by Mr. Smith and notarized; and on the following day filed personally by his attorney in the United States District Court. The fifth round provided even more startling surprises. It may be tellingly presented in a brief timetable.

**August 5, 1969:** The writ and application for nonpayment of costs on grounds of indigency was given to the Clerk of the Court. The order directing proceeding without payment of costs was signed by Judge  who directed that it be filed and served.

**August 7, 1969:** Smith's attorney was called by the Clerk's office and told that Thomas Smith's petition was incomplete and could not be processed. No further details were given. Later that afternoon the attorney's

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231. Compare Dr. Kunev's statement to judge in November, 1968 in text at note 229 supra.

232. PR 61.
clerk went to the court and was told that the in forma pauperis (nonpayment of costs) affidavit had not been notarized. The attorney's clerk, knowing the sense of urgency felt by the attorney as to his client's long overdue hearing, asked if a filing fee could be paid instead. The Clerk advised that the petition had been returned to Mr. Smith and therefore any attempt to pay a filing fee would be of no avail.

August 8, 1969: Smith's attorney went to St. Elizabeths Hospital to see his client and found that the petition had not been returned to him. The attorney then had Mr. Smith sign a new, identical writ and affidavit in forma pauperis, and filed this second writ with the required filing fee. This writ was given Habeas Corpus No. 168-69.

August 12, 1969: First writ now marked No. 169-69 and filed with No. 168-69.

August 13, 1969: The attorney received a letter from the Clerk's office, dated August 8, 1969, stating that on August 5, Judge ................. had authorized Smith's filing without payment of costs, and directing the Hospital to show cause why the writ should not issue. Attorney was informed by Clerk's office that two writs had been filed by him in an identical manner, and that they had been consolidated by the Court.

August 18, 1969: The Hospital filed its return to the writ which read in part as follows: "The physicians of this hospital feel that the petitioner is no longer mentally ill to the extent that he is likely to injure himself or others, and on August 16, 1969 we petitioned the court for the petitioner's unconditional release."

Mr. Smith learned of the news some days later, only after his attorneys checked the file in the office of the Clerk of Court. No copy of this return had been served on them. Several months went by before Mr. Smith was released. His attorneys felt that his interest would be better served by his receiving an unconditional release, than by ventilating the sad story which these pages have retold.

Mr. Smith's case is not unique. Four other cases were referred to private volunteer attorneys as a result of the Ombudsman Project. Three involved comparable misuse of the alleged exhaustion of remedies doctrine. The fourth concerned the hospital's assertion of power to reverse the direction of a patient charged with a serious infraction of hospital rules. He had been transferred from "the grounds," on the verge of release, to the "disturbed

233. One of these cases reached the Court of Appeals early in 1970. The court reversed dismissal of the writ and soundly lectured both the Hospital and the government on their abuse of the exhaustion of remedies doctrine. Dixon v. Jacobs, 427 F.2d 589 (1970).
ward" at John Howard Pavilion, without any right of hearing even as to identification.234

Research in the District Court revealed that in 1968 and 1969 the court disposed of the writs of 116 patients (42 percent of all filing writs) without allowing them the benefits of an attorney or a hearing. In at least 60 cases (22 percent of all writs filed) the Hospital based its defense on the patient's failure to exhaust his administrative remedies.235

The errors of process here are many. It is highly questionable that the Court of Appeals intended that habeas writs should be arrested when independent physicians were not available when it stated (in the Bolton footnote) that patients should exhaust remedies. This reading seems especially doubtful since the statute specified that habeas corpus rights were still available. The Hospital and its counsel erred in resting its answer on grounds which it must have known were indefensible.236 Smith's attorney put it this way in the affidavit that led the Hospital to admit that substantively it was unwilling to challenge the fact of Smith's recovery: "Administrative 'remedies' at St. Elizabeths have indeed proved physically and emotionally exhausting, but beyond that futile, ludicrous, time consuming, and above all conducive to nothing but mental suffering and to flagrant violations of administrative and all other known forms of due process of law." He then adverted to the secretiveness of the Hospital despite its statutory responsibility to advise patients of their legal rights and remedies:237

The situation of administrative remedies at St. Elizabeths hospital—if indeed the argument on this score is to be entertained at all—appears worse than the practice attributed to Caligula by Suetonius, who, as Suetonius described it, published the law but saw to it that it was written in a small hand, and posted in a high corner, where none could see it.238

But St. Elizabeths, he then suggests, out-Caligulas Caligula, for "as matters now stand, diligent inquiry fails to hint at even the shadow of the beginning

234. This case was also reversed by the Court of Appeals, and after remand to the District Court the petitioner was promptly released upon the recommendation of the Hospital. Williams v. Robinson, 432 F.2d 637 (1970). See also Jones v. Robinson, 440 F.2d 249 (D.C. Cir. 1971), a third project case which the Court of Appeals has treated favorably.

235. PR 64. See text at note 194 supra.

236. The contentions made in this paragraph, first written in November, 1969, parallel the later decision in Dixon: "If the hospital has ignored its duty to the patient in its care, its misconduct may not be imputed to the patient." 427 F.2d at 598-99. In a footnote the court alluded to the Hospital's failure to disclose the circumstances of its exhaustion defense: "With some regret, we cannot avoid the conclusion that the hospital was less than candid in this respect with the [district court]." Id. at 599 n.33.


of a structure of administrative remedies” at St. Elizabeths Hospital. The plain purpose of the Court of Appeals in *Rouse, Bolton* and *Covington* had been to suggest to the Hospital that some procedural reforms would make the work of the courts more meaningful in matters in which the Hospital now makes judgments without standards by which the courts can measure its conclusions.

The legal and administrative process has failed here in another respect for which the hospitals and courts can have no blame. One can appreciate the plight of the District of Columbia Department of Public Health when faced by the new budgetary problems implicit in *Bolton*. In the 1964 Hospitalization of the Mentally Ill Act, Congress was directing its attention to civilly committed patients, not to those sent to St. Elizabeths after brushes in the criminal courts. History had shown that each year only a handful of patients who are civilly committed were likely to ask for the services of such independent psychiatrists. When *Bolton* extended these privileges to those committed by the court in its criminal process, the potential increase in costs for psychiatrists was staggering. When the Corporation Counsel frankly faced the fact that the law required the District Government to pay this expense, no one in the executive branch was sufficiently concerned to petition Congress to appropriate those funds. Potential beneficiaries of this new budget item were nonvoting, nonvocal, and nonpopular. So the funds to implement their “right” sank far, far down the priority list of congressional appropriations desired by the harassed District of Columbia government.

**IV. Partial Remedies**

The proposed change in the *Durham* rule is one of a series of half-measures which have been recently considered as repairs for the court-hospital-court transmission belt. These include administrative and judicial maneuvering with respect to hospitalization and release; formalization of a “six-months rule” concerning habeas corpus petitions; transfer of the basic responsibilities for hospitalization and release to the new District of Columbia Superior Court as part of the 1970 court reorganization; fixing more responsibility

239. *i.e.*, with respect to extending the right to an independent psychiatrist, to be paid for by the District government (D.C. Code Ann. § 21-565 (1967)) to what the Hospital calls “prisoner-patients,” *i.e.*, those committed for examination, or otherwise, after being charged with a crime or offense.

240. This refers to items such as the exhaustion of remedies defense; the dismissal of habeas corpus petitions without hearings; and the informal hospital-court communication system.

on appointed counsel in mental health cases (also by the 1970 Act);\textsuperscript{242} reduction in the St. Elizabeths Hospital security facilities (already accomplished); and the impending and long-threatened transfer of St. Elizabeths Hospital from federal responsibility (HEW and NIMH) to the District of Columbia Government.\textsuperscript{243} The only one of these measures which moves in the right direction is the upgrading of the Public Defender Service; that, so far, is token in extent.

\section*{A. Modification or Replacement of the Durham Rule}

In shaping the issues in \textit{Brawner} the Court of Appeals for the District of Columbia directed the attention of the amici curiae to several distinct questions:\textsuperscript{244}

1. Should the separate inquiry as to productivity be eliminated from our test of responsibility?
2. What are the theoretical and practical differences between the \textit{Durham-McDonald} test, the ALI test,\textsuperscript{245} and the various other recently accepted tests?\textsuperscript{246}
3. If \textit{Durham-McDonald} should be discarded should the ALI formulation be adopted? Should the \textit{McDonald} definition of "mental disease or defect"\textsuperscript{247} be added to the ALI formulation?
4. Is it appropriate to tie a test of criminal responsibility to the medical model of mental illness?\textsuperscript{248}

\footnotesize
\begin{itemize}
\item \textsuperscript{242} See D.C. Court Reform Act §§ 302(a) & (b), 84 Stat. 473 and text at note 265 infra.
\item \textsuperscript{243} See text at notes 294-99 infra.
\item \textsuperscript{244} The questions listed here and in note 251 infra, are contained in the letter from the Clerk, United States Court of Appeals for the District of Columbia Circuit, to Allen Ashman, Esq., National Legal Aid and Defender Association, Chicago, Illinois, an amicus curiae, February 5, 1971. Copies were furnished to the parties and to amici curiae.
\item \textsuperscript{245} ALI \textit{MODEL PENAL CODE}, § 4.01 (Proposed Official Draft, 1962), Mental Disease or Defect Excluding Responsibility: "(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law. (2) [T]he terms 'mental disease or defect' does not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct."
\item \textsuperscript{246} For example, the test in United States v. Currens, 290 F.2d 751 (3d Cir. 1961): "The jury must be satisfied that at the time of committing the prohibited act the defendant, as a result of mental disease or defect, lacked substantial capacity to conform his conduct to the requirements of the law which he is alleged to have violated." \textit{Id.} at 774. This test is criticized in Goldstein & Katz, \textit{Abolish the "Insanity Defense"—Why Not?} 72 \textit{Yale L.J.} 853, 862-64 (1963).
\item \textsuperscript{247} See text at notes 62-64 supra.
\item \textsuperscript{248} There is a clarity in recent cases such as Eichberg v. United States, 439 F.2d 620 (D.C. Cir. 1971) and Washington v. United States, 390 F.2d 444 (D.C. Cir. 1967), that perhaps was missing before. But this notion was present in \textit{Durham} itself
\end{itemize}
5. Would it be sound as a matter of policy to abolish the insanity defense? Would it be possible to do so as a matter of law? If so what are the possible alternatives? Should the issues presently treated under that heading be subsumed under the inquiry into mens rea?

These questions, and others proposed by the court, intimate the total disillusionment with the functioning of the District of Columbia court-hospital-court transmission belt. The emphasis placed on the ALI test and the problem of "behavior controls" attests that the central concern is not safeguarding the civil rights of involuntarily hospitalized patients or furnishing adequate treatment facilities. Rather it is what to do with patients suffering from nonpsychotic disorders, particularly those generally identified as character or personality trait disorders.

"Law in the Books" identifies these disorders with the Durham-McDonald standard of mental disease or defect. We have seen that the hospital initially returned character disorder cases as "without mental disorder," then reversed this policy, and subsequently certified some of these cases as suffering from mental disease or defect—often under some other diagnosis. It has been estimated that one-third of those found mentally incompetent or not guilty by reason of insanity were sociopathic character disorder cases. Clearly the enormous increase in mental examinations (however fruitless) has been tied to the Durham theory that character disorders may constitute a mental disease or defect.

(see text at notes 53-57 supra). However, criticism of Durham jurisprudence seems justified in practice. See, e.g., United States v. Freeman, 357 F.2d 606, 621 (2d Cir. 1966): "Durham . . . fails to give the fact-finder any standard by which to measure the competency [sic] of the accused [and therefore] psychiatrists when testifying . . . in effect usurped the jury's function." (per Kaufman, J.). See interview comments in text at notes 158-62 supra.

249. See Katz & Goldstein, supra note 246.
251. One question (subsumed above) asked: "Should the Durham-McDonald formulation be retained as it is?" Others included: "If a defendant's behavior controls are impaired, should a test of criminal responsibility distinguish between physiological, emotional, social and cultural sources of impairment?"; "Should the results of psychological tests such as the Rorschach [ink-blot] test be admitted in evidence? If so, what kind of testimony is necessary or appropriate in order to put the test results in proper perspective?"; "Have we departed in practice, if not in theory, from the rule that the government has the burden of proving criminal responsibility beyond a reasonable doubt?"; And "Should we reconsider the possibility of 'diminished' or 'partial' responsibility?"
252. See discussion in text at notes 201-03 supra.
The formulation of issues for Brawner suggests that the Court of Appeals may be preparing to shift from the moralizing tones of Durham. It may be preparing to pose a new question—more pragmatic than moral: Under what circumstances should a defendant be held criminally responsible for proscribed antisocial conduct? Already the court has asked: "Is it appropriate to tie a test of criminal responsibility to the medical model of mental illness?" These problems have arisen from the court's own handiwork. Durham held that if a person charged as a criminal is not responsible, he must not be punished. The question whether he must be treated did not arise in that case. Rouse went on to say that if an accused is hospitalized for treatment but not treated, he must be discharged. Together, Durham and Rouse imply that a defendant who is neither criminally responsible nor treated by the Hospital must be discharged. In fact this conclusion has not

254. However, of the eight federal circuits which have adopted the ALI rule, or some variation of it, only three (the Second, Fourth and Fifth Circuits) have unequivocally adopted Section 2, which may be read to exclude character disorders. See note 245 supra. In the First Circuit no clear pronouncement has yet been made on ALI (Cf. Beltran v. United States, 302 F.2d 48 (1st Cir. 1962)). In the Eighth Circuit the ALI rule (and also M’Naghten and “irresistible impulse”) may be used. The Second (United States v. Freeman, 357 F.2d 606 (2d Cir. 1966) ), Fourth (United States v. Chandler, 393 F.2d 920 (4th Cir. 1968) ) and Fifth (Blake v. United States, 407 F.2d 908 (5th Cir. 1969) ) Circuits have explicitly adopted both paragraphs. The Third Circuit has a variation of ALI that is generally given distinctive designation as the “Currens rule,” and explicitly includes sociopaths (United States v. Currens, 290 F.2d 751 (3d Cir. 1961) ). The Currens rule was favorably commented on (in Beltran, supra) in the First Circuit, which is still hanging loose. The Sixth Circuit (United States v. Smith, 404 F.2d 720 (6th Cir. 1968) ) and the Ninth Circuit (Wade v. United States, 426 F.2d 64 (9th Cir. 1970) ) specifically rejected Section 2 of ALI. If the Seventh Circuit has not excluded Section 2, it construes it to include sociopaths among potential non-responsibles (United States v. Shapiro, 383 F.2d 680 (7th Cir. 1967) ). And while the matter is not free from doubt in the Tenth Circuit (Wion v. United States, 325 F.2d 420 (10th Cir. 1963) ), the question does not seem pressing, for there as in the Fourth Circuit the ALI rule is construed as not substantially changing M’Naghten plus “irresistible impulse.” For this analysis I am indebted to the thoughtful amicus curiae brief submitted in Brawner by William H. Dempsey, Jr., Esq. of the District of Columbia Bar.

256. But the Durham court noted that “[a]n accused person who is acquitted by reason of insanity is presumed to be insane . . . and may be committed for an indefinite period to a ‘hospital for the insane.’ D.C. Code § 24-301 (1951).” 214 F.2d at 876 n.57. Such commitment, however, did not become mandatory until the amendment of this section of the statute the following year, a congressional response to Durham. See note 58 supra.
been implemented in either the District of Columbia or any other jurisdiction.257

The question "Has Durham failed?" can be answered only in Chesterton's terms. When asked the same question about Christianity, he replied: "It has not failed, it has not been tried." The reasons that Durham has not been tried are many: lack of beds, insufficient medical personnel, inadequate appropriations, possible abuse of the commitment process by attorneys. The most important reason is the dearth of specialized facilities and lack of accepted techniques for the treatment of character disorders manifested by antisocial conduct. These disorders are among the most difficult of all mental diseases to treat.

Arguably changing the Durham role into the ALI rule or some comparable formulation will eliminate a portion of the sociopaths, who comprise one-third of all involuntarily hospitalized patients. As a solution to the deficiencies of the present system, such a reformation is grossly inadequate, no different from other palliatives presently contemplated or recently implemented in the District. In the area of involuntary hospitalization, the D.C. Court Reform Act of 1970 exemplifies a half-measure of the second type.

B. Court Reform Act of 1970

The District of Columbia Court Reform and Criminal Procedure Act of 1970 was intended to create a court system in the District analogous to a state court

257. But see Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971). This case was a class action brought by guardians of patients, and certain employees, at Bryce Hospital, a state hospital in Tuscaloosa, Alabama. The court (per Johnson, C.J.) reserved ruling on plaintiffs' motion for a preliminary injunction to enjoin a unit-team approach to treatment. However, the court ordered that defendants (state medical officials) file with the court within 90 days, among other things, "[a] specific plan whereby appropriate and adequate treatment will be provided to the patients" and "[a] report reflecting in detail the progress on the implementation of the unit-team approach." Id. at 785-86. In addition the court directed that "records are to be maintained detailing the names of the patients entitled to receive—from a medical standpoint—psychiatric care and treatment, and the type and extent of the treatment being administered." Id. at 786. Citing favorably Rouse v. Cameron and Covington v. Harris, Chief Judge Johnson said: "There can be no legal (or moral) justification for the State of Alabama's failing to afford treatment—and adequate treatment from a medical standpoint—to the several thousand patients who have been civilly committed to Bryce's for treatment purposes. To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." 325 F. Supp. at 785. The court invited the United States Department of Health, Education and Welfare "to appear in this cause as amicus for the purpose of assisting this Court in evaluating the treatment programs." Id. at 786. Perhaps a copy of this brief might be furnished to the National Institute of Mental Health, as the agency responsible for St. Elizabeths Hospital.

See also Note, Civil Restraint, Mental Illness, and the Right to Treatment, 77 Yale L.J. 87 (1967).
system. Those matters not ordinarily handled by federal courts in the 50 states were withdrawn from the United States District Court and the United States Court of Appeals for the District of Columbia Circuit. However, the Washington bar was aware that an underlying basis for the measure was dissatisfaction with the Court of Appeals' superintendence of criminal matters, the insanity defense included. In the insanity defense area the cases we have been discussing, Durham, McDonald, Rouse, Lake, Covington, and Bolton, were considered particularly disturbing. Dixon and Williams, handed down in the course of hearings and debates on the new bill, doubtless furnished fresh fuel.

What portions of the 1970 Act have a bearing on the court-hospital-court transmission belt in involuntary hospitalization matters? How did these provisions alter the previous law? Finally, how do these reforms propose to improve the situation? I will treat these questions briefly.

Two sections of the 1970 Act directly affect the future handling of matters concerning mental health hospitalization which arise in the criminal process. The first section deals with commitment, release and post-adjudication relief. The second deals with the new, enlarged role of the Public Defender Service, formerly the Legal Aid Agency.

Commitment, Release and Postadjudication Relief

Section 207(2) of the 1970 Act revives automatic commitment to St. Elizabeths Hospital for those found not guilty by reason of insanity. The old automatic commitment provision (Section 24-301(d)) had been nullified by the equal protection radiation in Bolton v. Harris. The new statute insures the accused of retained or appointed counsel, and of a hearing on the issue of present insanity within 50 days of commitment. Within ten days following the hearing, judges are directed to decide the insanity issue, and furnish findings of fact and conclusions of law. The statute changes the burden of proof on the question of insanity. Formerly if a defendant raised a prima facie issue of insanity, the government had the burden of proving his sanity. Now, whoever raises the issue of insanity has the burden of proving it. When the defendant is brought back to court within

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258. These are beyond the obvious fact that as the transfer becomes progressively effective during the 30-month period following July 27, 1970, the courts ordinarily concerned will be the Superior Court of the District of Columbia, and the District of Columbia Court of Appeals, rather than the federal courts. Formerly the District of Columbia courts were involved only in misdemeanor and sexual psychopath cases.


260. Id. §§ 301-09.

261. See text at notes 116-29 supra.

the statutory 50 days—he has the burden of proving that he is no longer mentally ill.

In theory, this arrangement is less advantageous to a defendant than that under *Bolton*; and some constitutional questions are left unresolved.263 “In action” the *Bolton* decision was administered almost as a formality by the District Court: the insanity defendant went to the Hospital and the Hospital after its examination faithfully transmitted the “*Bolton* letter” reaffirming his continued insanity.264 In practice the present arrangement could better protect a defendant’s rights. He is now assured of counsel (either the counsel of trial, or a newly appointed counsel), who is expected to take more seriously his advocate’s responsibility than at the *Bolton* hearing.265

The new provisions for securing release from confinement after the initial 50-day hearing are not as progressive. Beyond some general language in the Public Defender sections of the statute,266 the posture of the patient’s application for release is little changed. In form, the statute provides that the insanity defendant “may move the court having jurisdiction” for relief.267 In the past, despite *Bolton*, leverage for relief was available only through the writ of habeas corpus.268 Now the patient will ordinarily apply to the Superior Court,269 hopefully to the judge who had made the decision at the 50-day hearing.270 The statute expressly provides that the habeas corpus

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263. For example, the question of burden of proof in a criminal case, raised to constitutional dimension by *In Re Winship*, 397 U.S. 358 (1970).

264. Statistics furnished by NIMH cited only six such commitments in 1968, and 14 for 1969 (projected as of September 20, 1969). PR Ch. 3 n.16.

265. The Public Defender Service is directed “to establish and coordinate the operation of an effective and adequate system for appointment of private attorneys . . . [and to] report to the courts at least quarterly on matters relating to the operation of the appointment system . . .” D.C. Court Reform Act, § 302(b), 84 Stat. 473. See also *Id.* Sec. 207(d)(2). The lack of attention of appointed counsel under the prior system, after commitment for examination, or certainly after trial, was proverbial. See text at note 205 *supra* and Appendix A.

266. §§ 302(a)(7) & 302(b), 84 Stat. 473. These will be discussed below.

267. *Id.* § 207(d)(7) amends Section 24-301 of the D.C. Code (see text at notes 102-14 *supra*) by adding a new Subsection (k).

268. We have seen (text at note 194 and the “Thomas Smith” case *supra*) how ephemeral the habeas corpus relief was in practice.

269. With respect to federal crimes, of course, the United States District Court will continue to have jurisdiction. This considerably limited jurisdiction means the federal court rule of criminal responsibility in the District (whether *Durham*, or another) will be less significant than before. (This point was not lost at the en banc argument in *Brawner*). District lawyers are speculating as to how long it will take the District of Columbia Court of Appeals (the new highest court) to depart from *Durham* when the lines mooring it to the D.C. Circuit have been cast off.

270. This is not mandatory under the statute. However, judicial economy and continuity usually make it preferable. On the other hand, in some instances it would be advantageous to a petitioner to come before a different judge than the one who had turned him down before.
is an exceptional remedy available only to those who have followed the prescribed procedure.\textsuperscript{271} If the state analogy is carried through one would expect federal habeas corpus to be available only under the familiar "exhaustion of state remedies" doctrine.\textsuperscript{272} The statute's further limitation—restricting patients to one habeas corpus petition every six months—merely parallels the Court of Appeals Dixon holding on "abuse of writ."\textsuperscript{273} One can hardly say that a defendant will be worse off under the 1970 Act than under the previous system. The real question is: Will he be any better off? It seems unlikely.

\textit{The Public Defender Service}

A ray of hope may be seen in the provisions dealing with the Public Defender Service (PDS).\textsuperscript{274} Under previous law, the Public Defender, then the Legal Aid Agency, had a commission to participate in civil proceedings under the civil commitment statute. Until two years ago, only one attorney was assigned to this work.\textsuperscript{275} The new statute expressly extends PDS's responsibility to those patients incompetent to stand trial and those availing themselves of the insanity defense, and includes both pre- and post-conviction proceedings.\textsuperscript{276} The manner of assigning personnel is left to the internal management of the Service. Since the 1970 Act the Service has somewhat expanded its coverage of St. Elizabeths Hospital matters.\textsuperscript{277} Perhaps its resources are extended to the maximum—considering its limited appropriations, and its extensive responsibilities in other matters.

Unless the Public Defender's appropriations earmarked for service to criminal-proceedings patients is substantially increased, the same routine disposition of relief petitions and the same helpless acceptance of hospital

\textsuperscript{271} D.C. CODE ANN. \S 24-301(k)(7) (1967) as amended by 84 Stat. 473.


\textsuperscript{273} D.C. CODE ANN. \S 24-301(k)(5) (1967) as amended by 84 Stat. 473. Cf. Dixon v. Jacobs, 427 F.2d 589 (D.C. Cir. 1970), which purports to implement the "abuse of writ" doctrine of Sanders v. United States, 373 U.S. 1 (1963). The six months period has been, in theory, the minimum period between hearings on writs in the District of Columbia. The actual practice has been described in the text (the "Thomas Smith" case) supra. See Appendix A.

\textsuperscript{274} D.C. Court Reform Act \S\S 301-309, 84 Stat. 473, especially \S 302(a).

\textsuperscript{275} The attorney, Edward O'Neill, concentrated largely on hearings before the Mental Health Commission (civil commitments). But there he occasionally acquired indigent clients whom he was appointed to represent in the district court.

\textsuperscript{276} This is a fair construction of Section 302(a)(7) in light of the sentence which immediately follows it: "Representation may be furnished at any stage of a proceeding, including appellate, ancillary and collateral proceedings." 84 Stat. 473.

\textsuperscript{277} In response to criticism in the Judicial Conference Committee Study of November, 1969 (see note 3 \textit{supra}), and pursuant to expanded authority under the 1970 Court Reform Act, the Public Defender Service has set up an expanded Mental
testimony, which have characterized recent history will undoubtedly continue. It would be unfair to prejudge the care which the District of Columbia Court of Appeals will give this problem. But unless it insures effective counsel or mandatory independent reporting as in New York, and establishes by court rule what the statute failed to accord—mandatory periodic review—the fate of the involuntarily hospitalized is likely to continue to be that of forgotten men. The extremely heavy criminal caseload that may be expected in this jurisdiction for some time makes it unlikely (if not impossible) that the Public Defender or the courts will make spontaneous efforts in behalf of the mentally ill.

The new legislation has, in theory perhaps, worsened the patients' lot. But in practice it has only left it in the same desperate state as before. The realist might muse that the situation is improved by relieving the courts of the burden of ignoring such rules as Lake, Bolton, Covington and Rouse. However, there is small evidence that judges below the level of the Court of Appeals were bothered by this task.

C. Reduction of Hospital Security Facilities

In recent months the medium security facilities at West Side and Cruant,
which had received 56 percent of the court referrals\textsuperscript{282} have been closed down. All examinations referred to St. Elizabeths now take place at John Howard Pavilion. This reduction in available bed space is a relevant factor in the formulation of court policy with respect to the insanity defense.\textsuperscript{283}

It is doubtful that this closedown was intended as a partial solution of the involuntary hospitalization problem. More likely, it represented the Hospital's response to the large number of patients committed for examination by the courts, numbers sufficient to overtax available resources and lead to neglect of programs for treatable patients. There is also basis to assume that the change is related to a strong professional antagonism between the courts and Hospital and NIMH officials. This surfaced clearly in the Project interviews.\textsuperscript{284}

\textit{Judge A:} I don't have confidence that the doctors are really addressing themselves to the legal test of dangerousness. I believe they are using the health model, and keep people (whether "dangerous" or not) whenever the doctors think they can be treated.\textsuperscript{285}

\textit{Judge D:} I have often had the feeling that reports of some doctors were tied in to housing requirements at St. Elizabeths, rather than being an accurate reflection of a patient's mental condition.\textsuperscript{286}

\textit{Judge H:} Sometimes we send a man to St. Elizabeths, and months go by without hearing any more about the matter. I sent a man to St. Elizabeths last March [nine months ago]. Despite my request for a report I still have heard nothing. I am at the point of following it up further.\textsuperscript{287}

\textsuperscript{282} Of the court-directed examinations in 1968 and 1969, 43 percent took place at John Howard, 44 percent at West Side and 12 percent at Cruvant.

\textsuperscript{283} The Hospital's intake is measured by its bedspace. In July, 1969 the decrease began by withdrawing one of John Howard's 12 wards for an experimental transition ward, and another as an "education" ward. In 1970, West Side and Cruvant were closed. West Side had accommodated 275 court-enrolled patients and Cruvant accommodated 123 criminal-proceedings patients (about three-fourths of them women).

\textsuperscript{284} One section of the Project Report (PR 223-31) consists of interview statements of administrators, psychiatrists and judges arranged in dialog form. The comments which follow here are typical. The dialog is presented more fully in Appendix B.

\textsuperscript{285} PR 218.

\textsuperscript{286} PR 219.

\textsuperscript{287} PR 221.
Judge I: Of course there is a hospital report—but one which may be prepared in a hurry. The judge has no independent judgment to make, and a man is sent away indefinitely—until the hospital gets ready to release him. I have often wondered what happened to those men we send over there.288

Judge A: I do press the psychiatrists when they are not giving satisfactory reasons, not doing their job, and they probably resent it. But that is part of their job.289

Administrator A: I have to cajole people (psychiatrists) to undertake the kind of work that John Howard demands—to go up to court and be twisted around by some lawyer.290

Administrator B: Doctors [psychiatrists] are constantly being criticized by the courts for failure to carry out their mandate. It is coming to be that an administrator can be called upon by any relative to shift the hospital about.291

Administrator C: This unsatisfactory court-doctor relationship means we can’t get doctors to work at John Howard Pavilion. They feel it derogates from their professional standing.292

Judge K: The communication between the court and psychiatrists admittedly is not good.293

D. Contemplated Transfer of St. Elizabeths Hospital to the District of Columbia Government

Since April 1, 1968 the administrative hierarchy responsible for St. Elizabeths Hospital has been as follows in descending order: Secretary of Department of Health, Education and Welfare; Assistant Secretary for Health and Security Affairs; Public Health Service (Surgeon General); Health Services and Mental Health Administration (Administrator); National Institute of Mental Health (Director); St. Elizabeths Hospital (Superintendent).294

288. PR 221-222.
289. PR 224. The dissatisfaction of the judges with St. Elizabeths psychiatrists was not unanimous. Judge B: “I am a great admirer of the doctors at St. Elizabeths Hospital, and of their contribution to the community.” Id.
290. PR 223.
291. PR 224.
292. Id.
293. PR 228.
294. An Act of Congress in 1855 established the Government Hospital for the Insane (Act of March 3, 1855, 10 Stat. 682). In 1916 the name of this federal hospital was changed to St. Elizabeths Hospital, after the geographic section of the District of Columbia in which it was located (Act of July 1, 1916, 24 U.S.C. 161 (1964) ). During this period, and until 1940, the Hospital was under the Department of Interior. In 1939 the Federal Security Agency was established—a combination of agencies "whose major purposes were to promote social and economic security [and the] edu-
During the pendency of the Project, the Hospital’s possible transfer to the District of Columbia government was under consideration by a committee appointed by the Secretary of Health, Education and Welfare and headed by Dr. Harold Rome. Repeatedly, Hospital administrators and psychiatrists, and NIMH officials responsible for overseeing the administration of the Hospital, referred to this possibility unfavorably.\footnote{295}

Administrator E: We can’t recruit administrative men or doctors with the overhanging prospect of the transfer of the Hospital from HEW to the D.C. government.\footnote{296}

Administrator A: If the Hospital is transferred to the District, it will present a staggering problem just in recruiting personnel. Some men I had interested backed off so long as this possibility was present that the Hospital would be turned over to the District. For one thing you would lose the services of 43 Public Health Service doctors who are now serving there.\footnote{297}

The Rome Report, completed in the summer of 1970, reportedly recommended transfer of the Hospital to the District government within a period of 18 months. Although no public discussion of the issue has since taken place, a number of the Hospital staff believe that this transfer is imminent—perhaps as early as the summer of 1971.

Transfer would do worse than postpone the solution of this most difficult and urgent human problem; it would almost put it beyond practical hope.
The mess at St. Elizabeths was produced under the auspices of NIMIH, an agency of the United States Government specifically established to impart a sense of direction to the whole nation regarding mental health programs. It is inconceivable that the overburdened, underfinanced District of Columbia government can cope with the professional and financial responsibility for the sprawling Hospital complex any better than HEW. At what level of local priorities can mental health emerge? And, within those priorities where will funds and personnel to protect the rights of criminal-process patients be placed? To turn the Hospital over to the District in its present condition would constitute a national disgrace. By abdicating its moral responsibility with such blatant indifference, the federal government will provide the states with an unfortunate example. The pill is being unconvincingly sweetened by citing the transfer as a further friendly stride towards home rule. The mot comes to mind: with friends like these, who needs enemies.

E. Some Other Partial Solutions

Of the partial solutions discussed above only transfer of the Hospital complex seems clearly irresponsible. However, the others are demonstrably incomplete legal and medical reactions to the mental health crisis. Nevertheless some other partial solutions are worth recalling.

Minimizing the Commitment Aspects of Incompetency Examinations

A respectable body of medical opinion takes the position that psychiatric advice is unnecessary to determine whether a defendant is “unable to under-

298. See text at notes 206-21 supra.
299. The following table may give an indication of the size of the complex:

<table>
<thead>
<tr>
<th>Year</th>
<th>Appropriations*</th>
<th>Avg. Patients on Rolls**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1965</td>
<td>$31,401,000</td>
<td>7,585</td>
</tr>
<tr>
<td>1966</td>
<td>32,590,000</td>
<td>7,569</td>
</tr>
<tr>
<td>1967</td>
<td>34,903,000***</td>
<td>7,426</td>
</tr>
</tbody>
</table>

** From Annual Statistical Report for Fiscal Year, 1968, St. Elizabeths Hosp. which was furnished to the Project by an official at NIMH.
*** Includes a proposed supplemental appropriation of $1,047,000 to cover general schedule and wage board salary increases.

These are the latest figures available to the Project. In recent years St. Elizabeths Hospital has discontinued sending its annual report to university libraries (at least to some of them), even those specializing in nursing and social work. On the unavailability and slight interest of D.C. health officials in this area, see text at note 239 supra. Their reaction is understandable in the light of the District’s annual struggle with Congress for funds. These facts, plus the change of direction at NIMH on the question of the proposed transfer of the Hospital, underscore the enormity of the contemplated event.
stand the proceedings against him or properly assist in his own defense.\textsuperscript{300}

Some psychiatrists urge that the defendant's lawyer and the court are best able to determine this question.\textsuperscript{301} Few psychiatrists suggest that more than a brief interview is needed for them to input their advice.\textsuperscript{302} The present charade\textsuperscript{303} in the District of Columbia, in which a patient averages over four months in the Hospital before the court receives an answer on his competency,\textsuperscript{304} is caused by: (1) the court's insistence on holding all hearings at the courthouse\textsuperscript{305} and on coupling the insanity defense examination with the incompetency examination;\textsuperscript{306} and (2) the Hospital's insistence that all examinations handled by psychiatrists take place at the Hospital.\textsuperscript{307} Neither of these positions should be inflexible.\textsuperscript{308}

\textbf{Compulsory Court Review Proceedings}

Presently, no law or agency assures that patients committed to St. Elizabeths Hospital receive judicial reconsideration of the justification for their detention. The 1964 Hospitalization of the Mentally Ill Act made review possible, but not mandatory, for civilly committed patients.\textsuperscript{309} The Court of Appeals' attempt, in Bolton to make these provisions available to criminal patients was futile. "In the books" the initiative for release is left to the Hos-

\textsuperscript{300} D.C. CODE ANN. § 24-301(a) (1967).
\textsuperscript{301} This was a view expressed by a high official of the Hospital, among others. See PR 214.
\textsuperscript{302} Some judges interviewed agreed that an examination by psychiatrists in the courtroom, or rooms adjoining, might suffice. The possibility of out-patient examinations at the hospital is resisted by the psychiatrists. These possibilities should be evaluated, not in terms of an ideal world, but in the context recounted above, where unconvicted, often unindicted persons, are sent to a hospital, held under security conditions, and kept there three to six months before being returned to court—and then ordinarily as "without mental disorder."
\textsuperscript{303} This characterization seems accurate in light of the statistics cited above. Cf. Chambers Report 21.
\textsuperscript{304} PR 111-12. See text at note 138 supra.
\textsuperscript{305} The following judicial reaction was typical: Judge F: "I am absolutely opposed to having court hearings at the Hospital. It was suggested before and shot down by the Committee of Judges. The hearing should be held in the normal place—not somewhere the psychiatrist feels he has an advantage. It would be a grave inconvenience to the court, tie up a judge and staff." PR 225-26. A Hospital administrator thought differently: "[I]f the judges would come to the Hospital, that would represent a decided advantage to us. . . . We could do the job better. But they turned down this proposal." PR 225.
\textsuperscript{306} See text at notes 158-54, 160 supra.
\textsuperscript{307} This view was unanimous among medical personnel interviewed.
\textsuperscript{308} Many judges and doctors dig in here on an issue of professional dignity. Administrator D.: "[I]f the doctors have to go to the courts, taking all the time involved, this means the courts are saying their function is much more important than our prime function of healing." PR 225. See also the comments of Judge F, in note 305 supra.
\textsuperscript{309} D.C. CODE ANN. § 21-546 (1967).
hospital and to the patient; "in action" it is left entirely to the Hospital. Recall that only 3 percent of the 1968 and 1969 habeas corpus petitions were granted in whole or in part. In view of the demonstrated inertia of the Hospital.

310. In 1968-69 there were 275 mental health petitions for writs filed. These were made by 187 patients. PR 352. This means that almost 97 percent of the Hospital residents awaited Hospital initiative for release. The possibility of "forgotten men" at St. Elizabeths is hardly ephemeral. Cf. Judge D: "I not only think that there should be someone within St. Elizabeths Hospital like an ombudsman—someone to prevent patients from being lost and forgotten—I don't know how a mental hospital could be run in any other way." PR 219 and Judge I: "I have often wondered what happened to those men we send over there." PR 222.

311. See text at note 194 supra and Appendix A. The more active presence of the Public Defender Service at St. Elizabeths as a result of the 1969 D.C. Crime Act and the 1970 Court Reform Act has borne real fruit with respect to representation on civil commitments. However, the PDS Mental Health Division is meeting from strong to passive resistance at the Hospital. The degree of cooperation in servicing patients at John Howard Pavillion is far less than that received during the Catholic University Project (see note 43 supra), when Dr. Mauris Platkin was Chief of Service. The PDS has also met resistance from the officials at NIMH who make the significant internal decisions for the Hospital, with respect to establishing procedures to comply with the admonitions of the Court of Appeals decisions in Covington, Williams, and Jones. See note 100 supra. Complaints by PDS to these officials in February, 1971 was accompanied by suggestion that the head of the PDS Mental Health Division might act as a kind of ombudsman on institutional matters and on individual grievances. This suggestion lost out, and a procedure was agreed upon whereby a hospital doctor was assigned as a liason official (I.o.) between PDS and the Hospital. The I.o. was to receive from PDS memoranda embodying institutional complaints (such as "rejection by John Howard Pavillion of student legal assistance program for inmates [sic]") and individual grievances. The I.o. would "make, or cause to be made, an immediate inquiry into the problem, where appropriate call in the relevant parties, and in general attempt to mediate and resolve the controversy. In all events, a decision on the matter presented will be made by [the I.o.] within 30 days from the time of submission, in writing, with reasons therefor briefly stated for the record." Memorandum signed by the head of the PDS Mental Health Division, the Superintendent of St. Elizabeths Hospital and the "liason official," Feb. 1971.

Four months later, personal relations between the liason official and PDS remain pleasant, but the arrangement has proven sterile (predictably so, since the I.o. was in the hierarchical chain—and low level, at that). The PDS appraisal is frankly revealed in a memorandum dated May 25, 1971, to the liason official:

It was contemplated when we set up the Liason Official arrangement that it operate more or less as a forum for discussion, then resolution, of a problem. As it is developing, however, it is beginning to look more and more like a bureaucratic passing back and forth of papers—we've rarely sat down and discussed the problems, and it would appear that you are viewing your role pretty much as a conduit between our complaints and the appropriate response office in the hospital. The procedure is becoming sterile and merely an exercise in memorandum writing . . . .

An earlier memorandum (dated May 11, 1971) between the same parties had recited that "[t]here seems to be an edict (at least on Dr. __________'s ward) that lawyers are not to be permitted on the ward. This effectively denies patients a random opportunity to talk to us [PDS]; and since we are virtually the only lawyers that visit the Pavillion, it seriously circumscribes what we feel is an important, if not Constitutional, right to counsel."

The old hands from the Project had hoped that things must have improved at the Hospital. These recent reports affirm that any steps taken by the Hospital and NIMH
Hospital and the arbitrary or confused approach psychiatrists have taken toward legal standards, mandatory review becomes imperative.

Provision for periodic review could be established by legislation, or by court rule. In either case some institutional element is necessary to oversee the practical application of the automatic review program. Periodic review is not a total solution. Properly implemented it would be a vital step towards fidelity to the present law "in the books."

Less Drastic Solutions

The most ignored of all Court of Appeals decisions on mental health seems to be the Lake case, which held that the government must investigate solutions less drastic than involuntary hospitalization. The obvious reason for Lake's ineffectiveness was the total unavailability of personnel and financial resources to implement its principles. Such implementation requires congressional action, as do the next two points.

Experimental Hospitals for Defendants with Character Disorders

Limited as it is, the European experience in the treatment of psychopathic character disorders indicates that this is the most difficult and frontier-like of psychiatric problems. Special experimental institutions are necessary if we are to be serious about confining such defendants for "treatment."

with respect to patients' rights since 1969 have been backward. Present denial to patients in John Howard Pavilion of access to counsel is strenuously urged by PDS as shocking.

312. See discussion of New York's periodic review of mental hospitalization in text at note 345 infra.

313. One judge said that he intended to make it a personal rule henceforward, that at the time of committing a patient, or turning down an application for release, he would fix a date for the patient to be returned to court by the Hospital. If such a policy were made uniform by court rule, and properly supervised, it would be a step forward.


315. One judge interviewed said that Lake was the worst of all the Court of Appeals decisions in the mental health field. Certainly it is the most ignored. But see note 277 supra, for recent activity of the Public Defender Service in searching out less drastic alternatives. See note 98 supra. There is strong need in the District for halfway houses.

316. The European psychiatric experiments with sociopaths (psychopaths) do not stress their lack of moral responsibility (as in Durham), nor a right to treatment (as in Rouse). Dr. George Sturup, the Danish pioneer in treating psychopaths stresses something else: "As a medical man and psychiatrist, I am in charge of a group of people removed from society because they have demonstrated by their lack of self-restraint that they are unfit to live in society. They have all been sentenced to a special institution in order to protect society." G. STURUP, TREATING THE "UNTREATABLE" 2 (1968).

England has had an experimental psychiatric prison at Grendon Underwood since 1962. Unlike Denmark (where the courts send prisoners to Dr. Sturup's Herdster-
tinuing to send them to live with a melange of psychotics, sex offenders, convicted criminals, and drug addicts is indefensible—even if more than a gesture was made toward treating them. The alternative, special institutions, is admittedly expensive; but countries less opulent than our own have undertaken serious psychiatric experiments of this nature.

There are various ways of integrating such experimental hospitals into the present system: commitment (1) by direction of the court after a finding of not guilty by reason of insanity;³¹⁷ (2) after conviction, by sentence of the court,³¹⁸ or by consent of defendants, i.e. with foreknowledge that they would ordinarily remain in the hospital longer than the minimum prison sentence.

Upgrading the Prison System by Integrating Substantial Psychiatric Resources

There is a generally recognized need for substantially more psychiatric input

vester), in England convicted prisoners “are transferred on direction from the prison department after selection, and preliminary investigation, by medical officers in prisons and hospitals.” Pickering, Introduction to T. PARKER, THE FRYING PAN xi (1970). Another British experiment in treatment for sociopaths is Henderson Hospital near London which is exclusively devoted to treatment of “young people variously described as having personality disorders, character disorders, sociopathic or psychopathic personalities.” Its patients are not derived exclusively from the courts—although about half have a criminal record. Patients are “free to leave” at any time, although those sent by a court have rather restricted alternatives to remaining. See Sunderland, The Henderson Hospital in INTERACTION 55 (P. de Berker ed. 1969). This hospital is small, typically accommodating 20-30 men and 5-15 women, although its capacity is almost twice this. It is cited here to illustrate that serious treatment of sociopaths requires programs designed for their special problems.

In the Netherlands there are two well-known experiments with psychiatric prisons: the van der Hoeven Clinic at Utrecht, and the more recently founded State Asylum at Groningen. (A useful recent account of the Groningen experience by its former superintendent, a psychiatrist—van Belkum, From Prison to Treatment Center—is contained in P. de Berker, supra at 119. This volume also contains an account of England's Holloway Prison—Scarlett, A Therapeutic Community for Borstal Girls in Holloway Prison—at 95-118).

The question arises, which group of psychopaths are being less fairly treated—those who are sent to a hospital for “treatment,” rather than being convicted of crime; or those who are convicted for objectively anti-social conduct and sent to an institution with facilities that are designed for treatment of this special type. The Danish legislation avoids the word “psychopath,” referring instead to “defective development or impairment or disturbance of his mental faculties of a more permanent type.” (Sturup, supra at 5). Dr. Sturup accepts Dr. Henderson's definition of his inmates as people who “irrespective of their will and desire are driven by impulses of thought and conduct which compel them to antisocial conduct.” Id. at 7. See Henderson, The Classification and Treatment of Mental States, 6 BRITISH J. OF PSYCHIATRY 8 (1955).

³¹⁷. This is the more traditional American system, and certainly is the core of the moral philosophy of Durham.

³¹⁸. Cf. the European approach described in notes 448-50 infra. One judge favored this approach. Judge J: "The preferable way to handle the St. Elizabeths problem is to convict the defendants, and thereafter have them sent to the mental hospital as sentenced. Or better yet, have them sent to the prison at Lorton and arrange for psychiatrists to treat them there." PR 227.
in the prison system. The further need for a seriously financed and conducted model hospital for psychopaths must be stressed. The shortage of American psychiatrists interested in careers in criminological and forensic psychiatric work presents a problem. Long range solution of this difficulty may require recruiting and educating psychiatrists in return for their commitment to work in this field for a specified period.

Interdisciplinary Communication in Law and Psychiatry

The wretched state of communications among professionals engaged in psychiatry, social work, and law also presents a formidable obstacle to increased psychiatric input. Interviews with judges and psychiatrists reinforced the impressions that communication between members of the legal and psychiatric professions must be improved in the District of Columbia. A model is available. Interdisciplinary communication in California improved markedly as a result of the continuing series of law-psychiatry conferences arranged by Psychiatrist Seymour Pollack under the joint auspices of the University of Southern California Medical and Law Schools.

These suggestions are only partial answers. The basic problem goes far deeper. There is an urgent need to safeguard the rights of mental patients: their freedom, their property, their family and other personal rights, and their freedom from internal institutional harassment. This need affects the entire court-hospital-court transmission belt and cannot be fully met by good will, appropriations, or better interprofessional communications.

In the next section, I will discuss various institutional forms adopted by other jurisdictions, which do not place undue burden on either hospitals or

319. See the description of Patuxent Institution, Maryland's prison-hospital experiment in Tippett v. Maryland, 436 F.2d 1153 (4th Cir. 1971). The court rejected petitioner's premise that Patuxent is in fact a penal institution, and that defective delinquency proceedings are equivalent in practice to criminal prosecutions. Id. at 1156-57.

320. There was almost uniform agreement among psychiatrists and judges on the poor state of communications between the two professions most intimately connected with the court-hospital-court transmission belt in the District of Columbia.

321. The series of seminars over the past decade has had outstanding collaboration from California lawyers and judges, as well as from leaders in the psychiatric community.

322. This last complaint was not frequently met in the three-years experience at John Howard Pavilion which ended with the Law and Psychiatry Project; however, there were instances. Cf. text at notes 183, 188 supra, concerning the extensive powers of ward attendants (nursing assistants). In a milieu where eligibility for release is determined so significantly by recommendations of nonprofessional personnel a premium is put upon the patient's charm or sequaciousness, rather than upon improved mental condition. See note 385 infra, concerning the 1970 English experience with harassment of patients by hospital personnel that has led to the recommendation for a special Parliamentary Commissioner for Health (ombudsman).
courts, and their possible applicability to the situation in the District of Columbia.

V. INSTITUTIONAL FORMS IN OTHER JURISDICTIONS

In contrast to the District of Columbia, other jurisdictions have confronted the need to protect the rights of the involuntarily hospitalized mental patient. Such diverse polities as New York, Denmark, France, England, Norway, the Netherlands and Sweden have designed novel institutions. They have experimented with independent reports to the courts, quasi-judicial hearings at the hospitals, and ombudsmen; and they have combined these new ideas with such staple common-law devices as effective representation by counsel and ultimate access to courts.

In 1969, a three-month ombudsman experiment was conducted at St. Elizabeths Hospital in the District of Columbia. The activity of the ombudsman team323 centered largely in the maximum security unit, John Howard Pavilion, which contained most of those hospitalized as a result of felony charges.324 In addition to accumulating a certain amount of action data, the ombudsman endeavor compiled statistics concerning the operation of John Howard and conducted extensive interviews with patients, nursing assistants, social workers, psychiatrists, administrators and judges.325 In acting out the ombudsman role, several cases were referred to private attorneys.326 Three

323. The ombudsman phase of the Law and Psychiatry Project of the Catholic University Law School was assisted, in part, by a grant from the National Institute of Mental Health, and continued well beyond the three and a half months (July-October, 1969) for which it was budgeted. I was director (chief investigator); Joseph Di Stefano (now of the Department of Justice) was associate director from July, 1969 until October 1, 1969 and directed the questionnaire and hospital interview phase with respect to patients and nursing assistants. Other members of the ombudsman team were James Rourke (see note 141 supra) and Miss Karen Krempa, 1971 graduates of Catholic University Law School, and Kenneth Donnelly a member of that school’s class of 1972. Miss Ann De Lessio and Miss Mary Elizabeth Murphy from Catholic University's graduate School of Social Work contributed significantly to the questionnaire and interview elements of the study. Richard B. Williams, a student in law (Tulane) and in theology, gave volunteer assistance in July-August, 1969.

324. Limitation of resources and two and a half years’ experience at JHP dictated this choice.

326. Since the Project was designed to act out the role of ombudsman at St. Elizabeths Hospital as well as gather data, it was imperative that an outside legal resource be available to accept clients who could not be helped by the intervention of the internal “ombudsman.” Professor Richard Arens of the University of Toronto Law School, a member of the District of Columbia bar, volunteered his services in July-August, 1969 for this purpose. Although he was not a member of the Project, he represented several patients we referred to him and in several cases, initiated court proceedings for their relief. Cases were also referred by the “ombudsman” to other private counsel.
of these cases have been decided in favor of the patients by the Court of Appeals of the District of Columbia.\textsuperscript{327} The ombudsman experiment demonstrated the need for an independent, patient-oriented entity—in addition to private counsel—within institutions housing involuntary patients. It also called attention to the need for establishing treatment and decision-making procedures and criteria in such institutions.\textsuperscript{328} Chief Judge Bazelon had stressed this in a series of opinions dating from 1965.\textsuperscript{329} The ombudsman project provided the foundation for a comparative study of analogous procedures used in other jurisdictions. This section will present aspects of the second phase of the Law and Psychiatry Project which concluded with concrete proposals for adopting the ombudsman concept for the District of Columbia presented to the Administrative Conference of the United States, and to Senator Ervin, the Chairman of the United States Senate Judiciary Committee’s Subcommittee on Constitutional Rights.\textsuperscript{330}

This comparative study investigated the efforts of seven other jurisdictions in dealing with involuntary mental hospitalization. Although none of them treat the problem in precisely the same way, all interpose one or more independent agencies (institutions) between the hospital and the hearing court.\textsuperscript{331} New York uses a Mental Health Information Service, independent of the hospital and supervised by the appellate court.\textsuperscript{332} In Sweden and Norway a quasi-judicial board which meets regularly within the hospital complex serves this purpose. England has tried a system of special courts known as Mental Health Review Tribunals. The reviewing body in Denmark is a high-level medical council, with an ombudsman in the background.\textsuperscript{333}

\textsuperscript{327} The Dixon, Williams, and Jones cases cited in note 329 infra.

\textsuperscript{328} PR 240-56. See Appendix B: “D.C. Judges Appraisal of Ombudsman Proposal.”

\textsuperscript{329} From Rouse to Bolton; see text at notes 115-29 supra. The ombudsman’s study of the Hospital’s abuse of the exhaustion of remedies defense led to the following cases which were referred to and prosecuted by private counsel: The “Thomas Smith” case, supra; Dixon v. Jacobs, 427 F.2d 589 (D.C. Cir. 1970); and Jones v. Robinson, 440 F.2d 249 (D.C. Cir. 1971). The intervention against abuse of internal transfers led to Williams v. Robinson, 432 F.2d 637 (D.C. Cir. 1970).

\textsuperscript{330} These proposals are annexed as Appendix C (administrative change), and Appendix D (legislative change), amended only to reflect the terminological and jurisdictional changes of the 1970 legislation. As of this writing neither the subcommittee nor the Administrative Conference has taken any action on the proposals.

\textsuperscript{331} In some countries (e.g., Sweden) there is no practical access to the court, in others (e.g., Denmark, and the Netherlands) access is minimal. In Norway the access is new (1970) and not sufficiently tried for an appraisal.

\textsuperscript{332} The New York legislation designates the Presiding Justice of each of the four intermediate appellate courts to supervise the unit of the Mental Health Information Service (MHIS) within his judicial department. See text at notes 343-44 infra.

\textsuperscript{333} For discussion of the mental health activities of ombudsmen in Sweden, Norway, and England as well as Denmark, see text at notes 383-400 infra. In France and the Netherlands there is emphasis on the functions of review sections in the Ministry of Justice.
A. New York

In 1961, the Association of the Bar of the City of New York appointed a special committee to study commitment procedures. This committee was composed of lawyers concerned with mental health work, judges of the New York courts, law school professors, psychiatrists, and directors of state mental hospitals. The work of this committee was completed in 1962, and its report was published in the same year. Its principal recommendation was that:

A new state-wide agency, called provisionally the Mental Health Review Service, shall be established as an agency independent of the hospitals and of the Department of Mental Hygiene and shall be responsible to the courts handling mental admissions.

The Committee recommended that the new service be organized and supervised under the direction of the Presiding Justice of each of the state's four judicial departments, and that it "have the duty of studying and reviewing the admission and retention of every nonvoluntary patient." The law, which was enacted by the legislature in 1964 and took effect in 1965, incorporated this recommendation, creating the New York Mental Health Information Service (MHIS).

The basic commitment procedure prior to the new law required application to a court. No one could be compelled to go to a psychiatric hospital without a court order. The Bar Association committee found this procedure had two chief defects. First, the hearings were largely formalities:

The stories are bare; the judge has little chance to learn the patient's background, the home or lodgings from which he has come, the surrounding facts and influences. On the basis of skeleton evidence, the judge must decide whether a man or woman will be "sent away," that is, confined in a state mental institution for an initial period of sixty days, which may become six months or six years.

Judges with whom I spoke stated that under the old law they had been forced to commit people with insufficient convincing evidence upon which to base an independent judgment. They routinely followed the hospital

335. MENTAL HEALTH AND DUE PROCESS, supra note 334 at 20.
336. Id.
337. N.Y. Mental Hygiene Law § 88 (McKinney 1971).
338. MENTAL HEALTH AND DUE PROCESS, supra note 334 at 4-5.
339. See text at note 370 infra for interviews with New York judges and administrators concerning MHIS.
recommendation, which was usually not contested in a truly adversary manner.

The second shortcoming of the pre-1965 law was the ease with which a hearing could be circumvented or avoided. The formal requirement of a hearing after notice to a patient of his right to be present could be avoided by medical certification that such notice or presence would be harmful to the patient. In the words of one of the MHIS directors, "In certain areas of the State, such certifications were routinely made, and in other areas, hospitalization proceedings became routine."\(^{340}\) The Bar Association committee noted that

In practice only a small proportion of patients—less than 10 per cent throughout the state—ever had a hearing. Outside New York City the hearing is hardly ever held; the patient generally gets no notice of his right to one.\(^{341}\)

In addition the Committee reported:

No one points out the factors and developments in his work or family life which may have created temporary emotional strain or which may now ease his return to normal life in the community.

No one is charged with this responsibility.\(^{342}\)

The 1964 law,\(^{343}\) which established the Mental Health Information Service itemized the Service's duties: (1) to study and review the cases of involuntary patients; (2) to inform patients and others interested in them of the established procedures for review and of their rights, including the right to counsel and independent psychiatric opinion; (3) to provide assistance to patients and their families as required by the court under the regulations of the Presiding Justice of each department; and (4) to assemble information for the court in cases for which hearings have been demanded.\(^{344}\) In addition

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340. S. Rosenzweig, Budgetary Needs of Mental Health Information Service 2 (Dec. 2, 1969; unpublished memorandum of the Director of MHIS in the First Dep't, on file at Catholic Univ. L. Rev. offices).
341. \textit{Mental Health and Due Process}, \textit{supra} note 334 at 4.
342. \textit{Id.} at 20.
343. N.Y. Mental Hygiene Law § 88 (McKinney 1971).
344. \textit{Id.} § 88. The Act also required that copies of all records of involuntarily hospitalized patients be forwarded to MHIS by the hospital director within five days after admission of the patient. \textit{Id.} at 70, and that MHIS be provided with the hospital records of all patients \textit{Id.} § 34. The hospital must inform each patient of the availability of MHIS and permit him to communicate with the service and "avail himself of the facilities thereof." \textit{Id.} § 70. After a patient is admitted to a hospital under an application for compulsory hospitalization, notice of the application must be given to the patient, to those interested in him, and to MHIS, within five days. \textit{Id.} § 72. If a request for a hearing is not made within 60 days of hospitalization and the hospital elects to retain the patient longer, it must give MHIS notice of its application for an order of retention. \textit{Id.} § 73. MHIS itself may request a hearing on behalf of the patient. \textit{Id.} § 72. A report of each "county health officer admission" together with the
the legislation provides for periodic judicial reexamination of the retention of involuntary patients. The Bar Committee had stressed that MHIS "will have a primary duty to guarantee that patients know their rights and that the court has before it the facts necessary for deciding the question of the propriety of a patient's retention." It added that MHIS "will help to assure that no patient becomes a 'forgotten man'." After the bill was passed by the legislature, while it was awaiting the Governor's approval, the President of the Association of the Bar of the City of New York (whose committee has proposed the legislation) wrote the Governor that

"[t]he Service is to operate as an arm of the court, informing the patients and their families, on the one hand, of their rights under the law, and assembling and providing information to the courts, on the other hand, with respect to each case coming before the courts."

In a statement made when signing the bill Governor Rockefeller noted that among the

"[m]ost significant . . . changes accomplished by the bill . . . [was the] establishment of a Mental Health Information Service, as an arm of the judiciary, to gather information for the court and to advise patients and their relatives of their rights under the law."

Analysis of the actual operation of MHIS in the first four years, 1965-1969, involves two independent considerations: (1) the development of further judge-made and legislative rules in the area of the involuntarily hospitalized; and (2) the unique course of "institutionalization" of the new approach to mental patients' rights represented by MHIS. It is particularly unique in that the administration of MHIS took different forms in each of the four autonomous judicial department units. I shall treat these two matters separately.

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345. Id. § 76. When a hospital director refuses to discharge a patient "and so certifies in writing"(giving his reasons), a copy of the certification must be given to MHIS. Id. § 87. And when a patient seeks release by habeas corpus the hospital director must notify MHIS and "provide it with information as to the case and nature of hospitalization and the condition of the patient." Id. § 426.

346. Mental Health and Due Process, supra note 334 at 21.

347. Id.


349. Id. at 21. The Governor added that the bill "represents a balanced approach to the interests of the individual and the community in the positive treatment of the hospitalized mentally ill." Rosenzweig, Memorandum on Budgetary Needs, supra note 340 at 5-6.
First, I shall consider the enlargement of MHIS' area of responsibility. In 1966, the legislature required MHIS to intervene in committeeship (guardianship) proceedings, especially the summary procedure for appointment of committees for state hospital patients. In the same year it gave MHIS jurisdiction over those civil patients transferred to the Department of Correction hospital at Matteawan as too dangerous to be kept in civil hospital facilities. In 1969 the legislature again extended MHIS' responsibilities, this time to include all patients under 21 years of age, no matter how they were committed or held.

The courts also found ways to expand the duties of MHIS. Two recent decisions of the state's highest court have concerned the patient's constitutional right to counsel. *People ex rel. Rogers v. Stanley* held that counsel is required in habeas corpus proceedings brought to secure release from the hospital. *People ex rel. Woodall v. Bigelow* provided counsel in statutory proceedings concerning hospitalization. The four departments do not agree as to the proper role of MHIS here. The First Department requires MHIS to provide the legal representation required by *Rogers* and *Woodall*. The other departments handle the matter by judicial appointment of independent counsel.

The legislation creating MHIS expressly limited its role to serving involuntary patients. It also encouraged the Department of Mental Hygiene to convert involuntary patients to a voluntary status whenever possible. In *In re Buttonow*, the court of appeals extended the service of MHIS to voluntary patients. It is not agreed whether the *Buttonow* decision extends to all voluntary patients, or only to those who have been converted from an involuntary status. However, since the decision is founded on constitutional requirements of equal protection, all four MHIS departments believe that even if *Buttonow* is not now interpreted to cover all voluntary patients, a decision to that effect will be forthcoming. Where it applies, *Buttonow* forces MHIS to take the initiative in furnishing services to voluntary patients. Formerly, it had awaited the patient's request.

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353. Id. § 88.
354. 17 N.Y.2d 256, 217 N.E.2d 636, 270 N.Y.S.2d 273 (1966). The United States Supreme Court has not yet taken this position. The prevailing opinion in the New York case is less than persuasive.
356. The 1964 Act did authorize MHIS to act on behalf of a voluntary patient when its service was requested by the patient.
357. 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968).
358. This view was shared by the Directors of MHIS in December, 1969 and January, 1970, when I visited all four MHIS departments.
The 1964 legislation did not purport to extend MHIS' responsibilities to patients in Department of Correction hospitals pursuant to a criminal proceeding. However, the United States Court of Appeals for the Second Circuit in *People ex rel. Schuster v. Herold*, held that the equal protection clause of the fourteenth amendment required that prisoners be afforded substantially the same MHIS benefits as civil patients. This decision seems to indicate that the functions should also be extended to all nonconvict "criminal" patients, i.e., those found incompetent to stand trial and those found not guilty by reason of insanity, in Department of Correction hospitals. As of early 1970 such service was not being rendered in three of the four departments; however, paucity of funds and personnel, not irresponsibility, was the cause for this shortcoming.

The MHIS Director in the First Department cites a 1966 New York Court of Appeals decision as indicative of MHIS' responsibility for effectuating a patient's right to treatment. That case suggested that the duty is set forth in Section 86 of the Mental Hygiene Law which authorizes the Commissioner of Mental Hygiene to conduct investigations "whereby the care and treatment of the involuntarily confined mentally ill may be investigated with the purpose of rectifying any inadequacies and injustices prevalent therein." But, the court continued, "the Legislature has provided a further agency to aid in the supervision of the mentally ill in connection with the retention of involuntary patients such as appellant and their care and treatment." The Director conceded that this "aspect of mental patients' rights has not received adequate attention—chiefly because of staff limitations."

The New York experience is unique in that the four autonomous units have proceeded to effectuate the same legislation in four distinct ways. In all

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359. 410 F.2d 1071 (2d Cir. 1969).
360. *Schuster* stressed the constitutional implications of Baxstrom v. Herold, 383 U.S. 107 (1966) and the D.C. Circuit's decision in Bolton v. Harris, 395 F.2d 642 (1968). Unlike Bolton, Schuster was not found not guilty by reason of insanity; he was a prisoner under sentence. Unlike Baxstrom, Schuster's prison sentence had not yet expired. But on his original transfer from prison to the mental hospital Schuster had been certified by only one physician, and not by two physicians as was the case with civil mental commitments. The court found this discrepancy fatal to the state's case, and also noted that in prison Schuster would have had parole opportunities not available in the mental hospital. 410 F.2d at 1076, 1080-83.
362. *Id.* at 740, 217 N.E.2d at 32, 270 N.Y.S.2d at 207.
363. *Id.*, 217 N.E.2d at 32-33, 270 N.Y.S.2d at 207.
365. The information on administration comes from the interviews in text at note 370 *supra*. 
Involuntary Hospitalization for Mental Illness

four departments, each time a patient's case comes before a court for decision (i.e., in all cases of the original decision for detention, and of periodic statutory review of detention) the Service presents a full investigation report of: (1) the patient's history, (2) the circumstances of hospitalization, and (3) any alternatives to hospitalization. Also, each of the four departments affords patients a ready avenue for presenting complaints. These complaints are directed informally and without official leverage, to administrative officials. The success of this informal persuasion varies with the particular hospital. However, all the hospital directors and doctors with whom I spoke suggested that the hospital administration viewed this penetration of the chain of command as helpful. The informal communications between the area Director of MHIS and the hospital director was deemed particularly helpful. Beyond these two features, MHIS development varies from department to department.

**Fourth Department:** This is the western part of the state. The MHIS office is centered in Rochester, a large city. However, the local offices are not in the hospitals as they are in the other three departments. The head of the service is a former probation officer and aside from the general counsel, the entire staff is composed of former probation officers or court-oriented social workers. Other than the forwarding of informal complaints (and this on a small scale), services are limited to the formal report-making.

**Third Department:** This Department takes in the eastern and central part of New York State. Here again, the service is chiefly social-work oriented. During my visit (early 1970) only one staff member was an attorney; however the legal component of the staff was to be expanded. MHIS work is conducted in much the same manner as in the Fourth Department, except the offices are in the hospitals. However, the hearings are not held in the hospitals, but in the local supreme and county courts.

**Second Department:** Seventy percent of the mental patients in the state are located in the Second Department (Brooklyn, Long Island, Staten Island and counties immediately north of New York City). Here the staff consists totally of attorneys. Reports to the courts are prepared in much the same way as in the Third and Fourth Departments. Staff members appear in courts and present their reports to the judges, who seem to rely heavily upon them. However, the staff attorneys are careful not to act as advocates for the patients, who are represented at hearings by court-appointed attorneys. When appropriate, the MHIS staff attorneys assist the patients in preparing petitions for writs of habeas corpus. The Second Department pursues patients' complaints within the hospital hierarchy somewhat more actively than in the Third and Fourth Departments. In this department judicial hearings
are generally held in special courtrooms situated in the hospitals. There seems to be a growing tendency to accept the contentions, being made and implemented in the First Department, that MHIS staff attorneys should actively represent patients. However the rules in the Second Department do not, as yet, provide for representation.

First Department: The administration in this department (Manhattan and The Bronx) is unique among the four autonomous MHIS units. Under the frank encouragement of the Presiding Justice, MHIS attorneys (100 percent of the staff are attorneys) actively represent patients before the courts in all contested hearings. No other attorney is appointed to represent a patient in the same case. While judges theoretically may elect to appoint independent counsel, they do not do so. The staff of the First Department displays a more aggressive attitude than elsewhere in pursuing complaints from within the hospitals; their role is more adversarial, and less in the nature of an ombudsman. This attitude is fostered by the MHIS Department Director with the full support of his Presiding Justice. The interviewed hospital directors seemed well-satisfied with this method of functioning, although one mentioned that occasionally undue enthusiasm is not appreciated by staff doctors. However, even this director's overall evaluation was favorable. I told another hospital director of the other MHIS departments' methods, and asked his preference. He declared that the First Department's method was the only way to do it and that the other ways were a "foolish" waste of personnel. He expressed the opinion that the vigorous pursuit of patients' rights and complaints aided the hospital. In this department, the court hearings are held in the hospitals. The hospital directors reacted strongly against my suggestion that the hearing might be returned to the courts.

As we have seen, Section 86 of the Mental Hygiene Law authorizes the

366. Representation is explicitly provided for in the Presiding Justice's MHIS Rules, and he added this in an interview in January, 1970: "Introducing legal assistance into the MHIS program did not detract from the value of a neutral report to the court. I realize that the problems are not the same everywhere that they are here. I speak from experience sitting on courts in this city—urban experience. I remember the time when if the doctor had the slightest doubt, the person could be confined. The judge had no more information than that, and he was not going to take the chance. There should, in my opinion, be legal assistance and service—both." PR 233.

367. The Presiding Justice of the Judicial Departments is an influential figure in New York judicial arrangements. Since the legislation specifically put the MHIS under the Presiding Justice (and not his court), his wishes are especially important. The previous Presiding Justice made clear his wishes to judges in this matter, and they have respected it. His successor has strongly adhered to the same course.

368. For example, Hospital Director D: "I would oppose changing the present system of having court hearings in the hospital. Even as it is—with the hearings in the hospital—the hearings are resented by doctors. The time involved is enormous. To hold hearings in the courthouse would make it much more difficult for patients." PR 238.
Commissioner of Mental Hygiene to conduct investigations "whereby the care and treatment of the involuntarily confined mentally ill may be investigated with the purpose of rectifying any inadequacies and injustices prevalent therein." There is little evidence to indicate that this is a viable control of detention. Arguably it could be so.

In New York control over the detention of the mentally ill remains in the judiciary. MHIS is conceived as an arm of the court. All four departments take the initiative to secure hearings in detention cases, and to see that the court is adequately armed with information upon which to base its judgment. Clearly this is a step forward and a striking contrast to the situation in the District of Columbia. Even in the First Department, where MHIS represents patients in court, it effects a more meaningful hearing, better operation of the judicial process, and perhaps provides more skillful counsel than those obtained by court appointment. While judicial control at a meaningful hearing is a wholesome development, judicial reluctance to oppose hospital judgment still remains a problem.3

The second important feature of the New York control, which is also recurrent in the European pattern, is the statutory requirement of periodic review. The lack of this clear requirement constitutes a grave defect in the District of Columbia legislation. Habeas corpus, the ultimate recourse, in which MHIS functions, is obviously judicial in nature. Unlike the District of Columbia practice which we have discussed above, New York has held the right to counsel to be constitutionally required in habeas corpus proceedings.

Appraisal of MHIS By New York Judges and Hospital Directors

The following interviews with three of the Presiding Justices of the four New York judicial departments, and with a supreme court justice experienced in hearing mental health cases at the hospital courtroom in the remaining department, are presented here together with comments by hospital directors in these departments.876

Presiding Justice A: The supervision of the Mental Health Information Service program in each department is assigned by the legislation to the pre-

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369. I witnessed a day's hearings before one judge. Three cases seemed rather closely balanced, the hospital urging detention, the patients' counsel arguing for release. When the judge, who conducted eminently fair hearings, decided all three cases from the bench in favor of the hospital, a legally-trained observer could hardly fault him. After the hearing at an interview in chambers the judge explained that he rarely went against the judgment of the hospital, although he thought the MHIS attorneys were doing a very effective job for the court.

370. These interviews were given in December, 1969, and January 1970. See PR 232-39.
siding justice, not to the appellate division [as a whole court]. Statewide there is a degree of coordination through the Administrative Board of Judges. I believe that the way we work it here is the nearest thing to a model. We have had no complaints with our mode of operation. The problems of upstate are not the same as the problems faced by the courts in the metropolitan area downstate.

I am satisfied that the use of [appointed] private attorneys for legal aid [to indigent persons] is satisfactory. If we were going to have public assistance I would be inclined to stay with existing institutions, such as the Legal Aid Agency. But I am not yet convinced that patients would get better representation with experienced specialists [instead of private counsel]. Such specialists tend to get into formalism.

This MHIS is one of the greatest things that has happened. We are, of course, under a constant urgency to expand [the scope of the operation]. Eventually we may want to go further. But I am not inclined to rush it.

Presiding Justice B: I am thoroughly sold on the Mental Health Information Service as we operate it here [which includes legal representation of patients]. We have, I believe, the best system and under the best director. It serves a need that has been too long neglected. In New York we have a pattern of legislation for the country.

We have had no complaints from directors of hospitals. They, too, recognize that people heretofore neglected in and by the law are now served for the first time. There is a drop in persons confined in mental hospitals. And we don’t have the situation of people forgotten after being hospitalized. In addition we are moving to a needed attention to arranging programs of aftercare.

Introducing legal assistance into the MHIS program did not detract from the value of a neutral report to the court. Although I realize that the problems are not the same everywhere that they are here, I speak from experience sitting on courts in this city—urban experience. I remember the time when if the doctor had the slightest doubt the person could be confined. The judge had no more information than that, and he was not going to take the chance. There should, in my opinion, be legal assistance and service—both!

We are aware of patients’ property problems. We approach this from two standpoints. The needs are evident. Then the timing [of expansion] must depend upon the vision of the director of the program as to how far we should render service at any particular time. I recognize the different approaches taken in other departments. [The judge had just come from a meeting of the presiding justices of the four departments and the chief
judge of the court of appeals]. However, one other Department is moving further along the same direction as our own.

**Presiding Justice C:** There are good reasons for the MHIS program being conducted one way upstate [with reports to the court and operation by non-lawyers] and another way downstate. I recognize that the pool of private attorneys who are assigned by the court in mental health cases is not bottomless. Not as many attorneys are willing to get involved *pro bono publico* as in an earlier period when I was a young lawyer.

It is a tremendous help to a court to have these MHIS reports. As a supreme court judge I used to feel that I had a mass of these mental health cases which I had to act upon without adequate information.

**Supreme Court Justice D:** [After watching Justice D conduct a day of mental health hearings I interviewed him in his chambers in the courtroom at the mental hospital].

I find the reports of the MHIS personnel extremely helpful to me in disposing of these mental health matters. While I rarely go against the testimony of the hospital psychiatrists, the availability of these reports gives me assurance of having adequate information upon which to act. As you saw, there are private attorneys appointed to represent the patients, and I find their work satisfactory—although concededly few of the attorneys get sufficient of these cases to become experienced in the field.

**Hospital Director A:** I was on the original [Bar Association] committee which looked into the reform of the Mental Hygiene Law from the standpoint of the legal rights of the patients. I was vigorously against the product of that committee, the Mental Health Information Service—at first. I have completely changed my position. I am now very much for it. It makes us take good care of the patients. Under the operation of this law I am convinced that the patients' right are protected.

**Hospital Director B:** The system is far from perfect. One imperfection is the large amount of meaningless paper which it produces. The lawyer-doctor relationships here have developed well. This is largely a personal matter. Here we are not working at cross-purposes. If they [MHIS personnel] have a difficulty they call and talk [with me] personally. If the doctor doesn't like what they're doing and tells me, I call them up and ask them to make life livable for him. MHIS' presence here has had a significant impact on this hospital. The major difficulty was developing an attitude of live and let live. In the beginning there was a certain mistrust for a short time. They soon found that we are not body-snatchers, and that the object of therapy was to fix people right for living in society. At first I thought we'd be better without anything at all. Then I preferred changes. Now my
main complaint is too much paper. Mr. [MHIS chief at the hospital] would agree with me on this.

*Hospital Director C:* My reflection on having MHIS in my hospital is mixed. Let me start with what is good. The principle of having MHIS here giving legal assistance is a good one and important. It helps in securing compliance with the Mental Hygiene Laws. Just the fact of having an extra [outside] person around who is available for involvement with a patient and his family is a good thing, though this is not in the strict province of the MHIS people. The more persons around for contact with the family the better it is. Sometimes they can reassure a family of the desirability of a person's being here. For this purpose it is profitable that such a person be in another profession than the medical. They can even occasionally pick up a medical issue, after they have been around a while, one which a heavily pressured hospital may sometimes miss. And this is helpful to all concerned. Their presence here in this way often results in elimination of court hearings rather than their increase. A family may have the suspicion that the hospital or doctor has a personal bias for retention—this is not true, of course, but there may be such suspicions. Just recently one of the [MHIS] attorneys talked a husband, who was greatly troubled, into leaving his wife here for 10 days. I think they are doing a great job. It is a big step forward, although some perhaps wish it would disappear.

On the other hand there are certain problems. The chief difficulty derives from the adversary role. By intention or by accident we find that sometimes the medical staff and the MHIS staff are cast as adversaries. Some of the attorneys get quite upset with psychiatrists if there is disagreement on disposition of a case. And this is not simply intruding on a medical question, for some of our psychiatrists presume to be lawyers. I see this as a general problem, a tendency. It is not simply a question of personalities. I understand what is happening. The MHIS staff is devoted and committed. They get to know something about psychiatric questions. And a person in the hospital like this should be encouraged to raise questions. But I see a definite tendency to develop an adversary relationship. Sometimes in a particular case it gets down to a battle [between the attorney and the psychiatrist] over who is going to be right. Very often this problem arises concerning the adjournment of cases. We try to minimize this question. In some of the wards it is a real problem and in others it is minimum. It involves the use of pressures, some of which are psychiatric and some of which are legal devices.

Interestingly, this adversary tendency is itself part of the reason for the marked drop in the number of [judicial] hearings. This is sometimes good, and sometimes not good. A very small percentage of our psychiatrists, if
challenged by MHIS and pressured for a hearing, will say: "the court will probably agree with MHIS. It is so much trouble and time [to have a hearing]. The devil with it." And then [they] discharge the patient. There is a "power and pride" problem with certain individuals. These hearings when they are held should be held in the hospital—as they are at present. Otherwise the time involved is enormous. To change the arrangement, to hold the hearings in court, would make it impossible for us to operate. There is also the privacy consideration, keeping the patients in a hospital atmosphere.

We have no wards for "most disturbed" patients. We abandoned that practice. They got to be snake pits. If we have to keep patients as "most disturbed" it is only for two or three days. The criminal patients under Section 616 [mentally incompetent to stand trial] are here for 15 days. There is no testimony given on them. Those that are here after being found not guilty by reason of insanity are kept 30 days. This is the "hard psychiatric testimony."

My leading suggestion for developing a model program for handling criminal [proceedings] patients is to develop good relations with the administrative judge of the criminal [supreme] court. Sometimes you want a special court day. It pays to have good relations with the criminal judge.

Hospital Administrator D: The presence of MHIS at this hospital has contributed to better relationships. The doctor-lawyer relationship is always, of course, a sensitive area. It is always an unpleasantness for a doctor to be in court. Here the working relationship between the doctors and the MHIS people has worked to improve this situation. The lawyers also act, in a certain way, as a tranquilizer in the hospital. Just their availability to the patients serves a useful purpose. There are many fruitful lower echelon contacts in connection with the MHIS work here.

It is true that there are some frictions. But this depends in large part on particular personality traits of individual doctors and lawyers. In this connection I have a suggestion—a general principle that involves psychology, logic and education. When people in two disciplines work with each other they tend to learn more and more about each other's discipline. At first the lawyer tends to take over, on the premise that what is involved is the freedom of his client. The doctor tends to view primarily the matter of health. Actually, it is chiefly a matter of communication. There is much to be gained from the formalization of the mutual education process.

The presence of MHIS attorneys here has not accelerated the amount of litigation. There was a flood of writs at first. However, it gradually diminished to a low level. Partially this was a result of judicial review [of
This system of periodic review has proved very helpful to all concerned, hospital and patients alike. The amount of litigation on retention hearings has been about the same since MHIS representation became a factor.

I would oppose changing the present system of having court hearings in the hospital. Even as it is—with the hearings in the hospital—the hearings are resented by doctors. The time involved is enormous. To hold hearings in the courthouse would make it much more difficult for patients.

_Hospital Administrator E:_ I feel that the representation being given patients by MHIS is working out very well in my area. I feel it is a necessary service for the patients. I didn’t know that it [MHIS] was not working the same way throughout the state. What other way could it operate? Is there any other way that makes sense? [I explained the simple reporting-to-the-court, nonrepresentation approach in other judicial departments]. In my opinion it is foolish to limit it that way. From my observation there has been no serious difficulty in the representation approach. I feel that we psychiatrists have to, and are willing to, accept the fact that patients need protection as to their legal rights. The refusal to accept this can surely not be a professional position of psychiatrists. It is rather something deriving from personality conflicts between individual doctors and lawyers, which can be ironed out. The tone is set from on top, and my position has been to accept it as a natural and necessary development.

_B. Denmark_

In Denmark, if a patient’s request for release is denied by the medical superintendent, he may have his request forwarded to the Minister of Justice. The Minister, who has a section handling such requests, refers each to the Council of Doctors—an independent professional group available to advise

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371. In Denmark the central applicable statute is the Hospitalization of Mental Patients Act, Act No. 118, April 13, 1938, as amended by Act No. 175, June 11, 1954. Also relevant is the Administration of Justice, etc. Amendment Act, Act No. 173, June 11, 1954, pt. 43a, which deals with judicial trial of compulsory detention by administrative order. A third relevant official document is the “circular” dated July 24, 1954 issued by the Minister of Justice with respect to the two statutes.

While in Denmark I conferred with Dr. C. Toftemark, Director General of the National Health Council, Dr. Bjorklund Borensen, Director, Directorate for State Hospitals, Dr. Borup Svendsen and Miss J. Andreassen on the Ministry of Justice, Dr. Georg K. Sturup, founder and Director of the pioneer chronic criminal detention center at Herstedvester, and Professor Stephan Hurwitz, the Danish ombudsman. I also conferred with administrators and psychiatrists in three public mental hospitals in different parts of the country. Arrangements for the study in Denmark were made by the Danish Health and Justice ministry officials, following preliminary arrangements made by the Administrative Conference of the United States and the United States Embassy in Copenhagen.
any government department on health matters. Two Council psychiatrists re-
view the file only, and make a recommendation to the Council, which then
forwards its recommendation to the Minister. The decision is the Minister's,
but in practice, the doctors' recommendation is usually followed. Since 1954
the patient has been permitted to appeal the decision of the Minister of Jus-
tice to a court of general jurisdiction. The patient may also petition the Na-
tional Health Council, a board composed of present and past members of
Parliament whose task is to visit hospitals. In practice, the visits are rather
sporadic. As a third alternative, the patient may apply to the ombudsman,
whose role here is extremely limited.372 In Denmark, the key control seems
to be the appeal to the Minister of Justice.

C. Sweden

If refused release by the Chief Psychiatrist of his hospital, or division, the
Swedish patient may appeal to the Local Discharge Board (LDB). This
Board is composed of three persons: one law member (a present or former
judge); one medical member (a psychiatrist who actually examines the pa-
tient); and one layman. The LDB meets at the hospital every two weeks;
prior to the hearing, it reads the relevant papers, and sees doctor and pa-
tient separately. For its disposition of the appeal to take effect, the vote
must be unanimous. Otherwise, the LDB must refer the case to the Central
Psychiatric Board. This appeal board is also composed of medical, legal
and lay personnel, and is chaired by a law-trained Section Head of the Na-
tional Board of Health and Welfare. A patient who is turned down by the
Local Discharge Board may appeal to the Central Psychiatric Board, even if
the LDB is not required to refer the case. My investigation of the practices
of the Local Discharge Boards at hospitals indicated that they very faithfully
carry out the duties outlined above. They are independent and considered a
"nuisance" by some hospital directors. However, even those directors found
the Board's work important in establishing effective doctor-patient relations.
The patient may also complain to the ombudsman.374

372. See discussion of ombudsman infra.
373. In Sweden the applicable statute is the Mental Care Law of January 1, 1967
(which replaced a 1929 law), as amended on July 1, 1969 making the 1967 act ap-
plicable to drug dependents.
I conferred in Sweden with two public mental hospital administrators (Professor
Sten Martens and Dr. Gustave Beander), with Dr. Hans-Gunnar Leche, Chief Inspec-
tor of the Central Psychiatric Board, with Dr. R. Charpentier, Secretary of the National
Board of Health and Welfare, with Judge B. Hamdahl of the Swedish Administrative
Court, and with Judge Alfred Bexelius, Ombudsman. I visited two public mental hos-
pitals in Sweden. As in Denmark, arrangements were made through national health
officials (National Board of Health and Welfare), the Administrative Conference of
374. See discussion of ombudsman infra.
In Sweden, there is no judicial access. The Chairman of the Central Psychiatric Board gave me figures for 1968 as to the operation of Local Discharge Boards at three of the 29 hospitals. The hospitals were chosen at random. Each had a range of 1000 to 1500 patients.

<table>
<thead>
<tr>
<th>No. of Requests to LDBs</th>
<th>Definite Discharge Granted</th>
<th>Conditional Discharge (up to six months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>1075</td>
<td>22</td>
</tr>
<tr>
<td>Hospital B</td>
<td>699</td>
<td>128</td>
</tr>
<tr>
<td>Hospital C</td>
<td>482</td>
<td>73</td>
</tr>
</tbody>
</table>

These figures show that the Local Discharge Boards are not simply rubber stamps of hospital opinion.375 In 1968, the Central Psychiatric Board had 97 appeals which passed through Local Discharge Boards. Of those decided in 1968, 68 affirmed the Local Discharge Board and only 1 reversed its action. The Chairman of the Central Psychiatric Board told me: “We are the last resort. We know it and everyone else knows it.” In practical terms there is no higher recourse in Sweden.876

D. Norway

If refused release by the Medical Superintendent, the Norwegian patient may appeal to the local Control Commission assigned to each mental hospital. If the Superintendent refuses the request for release he must personally inform the Control Commission.

The Control Commission is composed of four members appointed by the Minister of Health: one is a judge, one a medical doctor (not necessarily a psychiatrist), and the other two are lay members. All are appointed for a six-year term. They meet at the hospital every two weeks. Each case must be decided within two weeks of the hearing. If the vote is deadlocked (2-2), the chairman’s (judge’s) vote is decisive. The public authority may appeal a hospital’s decision to discharge to the Control Commission. The patient

375. The chairman of the appeal board also cited a fourth hospital of only 70 patients, mostly psychopaths, which had 1208 applications in 1968. Figures were not available, or not given me, as to the results here. But the central official suggested that this was a different situation entirely.

376. But see discussion of ombudsman, infra.

377. In Norway the applicable statute is the Mental Health Act of April 28, 1961, which replaced the Lunacy Act of 1848.

While in Norway I was assisted by Dr. Stenfelt Foss, Assistant Medical Director for Psychiatry, National Directorate of Health, by the internationally celebrated psychiatric hospital director, Professor Ornulf Odegard of Gaustad Hospital, by Dr. Helg Rostad of the Ministry of Justice, and by the Norwegian ombudsman, Judge Andreas Schei. The interviews and visits were arranged by the National Health Directorate, with the cooperation of the United States Embassy, Oslo.
may similarly appeal, and also may write the Health Directorate or complain to the ombudsman. Under a new law, in effect since January 1, 1970, the patient may appeal an adverse decision of the Control Commission to the general courts. In Norway, the Control Commission serves as the mainstay of the appellate process.

E. The Netherlands

If the Medical Superintendent refuses release, a mental patient in the Netherlands\textsuperscript{378} may appeal to the Hospital Board (the board of managers of the hospital); or he may write the Chief Inspector of the Department of Health and Social Welfare, whose regional inspector will investigate the complaint. Generally, the regional inspector relies heavily upon the Medical Superintendent of the hospital. By a third method of appeal, the patient may bring the matter to the attention of the local Public Prosecutor. He is charged with the task of visiting the hospital monthly and faithfully does so.\textsuperscript{379} The Prosecutor then refers the detention question to the local general court, which asks the Medical Superintendent for a report. The key control in the Netherlands is the Public Prosecutor, as an avenue of access to the court.

F. England

The English law\textsuperscript{380} requires periodic judicial reconsideration of involuntary detention: the first review is after one year; thereafter, the case is reviewed at two year intervals. Should the Hospital Manager refuse to release him, the patient may appeal to his area Mental Health Review Tribunal. The fifteen Tribunals in England and Wales are empowered to release all pa-

\textsuperscript{378} The Netherlands still operates under an old basic mental health statute, the Insanity Act of 1848. A new piece of legislation has long been in preparation, but seems no closer to realization than in 1964, when a government publication noted that it was "long overdue." \textit{Mental Health in the Netherlands} 37. Also germane, with respect to criminal-proceedings mental health patients is Title III (Articles 37-44) of the Netherlands Penal Code. In the Netherlands my investigation was under the guidance of the Ministry of Social Affairs and Public Health (Dr. P. Siderius, Director-General of Public Health), and the Ministry of Justice, Department of Care for Psychopaths (Mr. G.W. van Gessel and Dr. J.A. van Belkum). Accompanied by Dr. van Belkum (now Psychiatric Adviser to the Ministry of Justice and formerly Director of the Prison Hospital at Groningen) I visited the new prison hospital at Nijmegen. I also visited the Office of Social Psychiatric Services (community psychiatry) at The Hague (Dr. F. Frets) and the State Psychiatric Institution at Eindhoven (Dr. J.B. van Borssen Waalkes, Medical Superintendent), and interviewed Dr. P. Siderius, the Director-General of Public Health, and Dr. R. Zijlstra, Inspector-General of the national Generalate of Public Health.

\textsuperscript{379} I was informed that the Public Prosecutor conceives his role here as quasi-judicial.

\textsuperscript{380} In England the chief applicable statute is the Mental Health Act, 7 & 8 Eliz. 2, c.72 (1959), which repealed the Lunacy and Mental Treatment Acts, 1890 to 1930, and the Mental Deficiency Acts, 1913 to 1938. Also applicable to matters discussed
patients except those held under the restrictions of a court order. The court order restriction applies to both criminal-proceedings and preventive detention patients. Release of court order patients requires the consent of the Home Office even when the medical authorities agree to release. A patient under a court restriction may still have a hearing before a Mental Health Review Tribunal; but, its decision will be merely advisory to the Home Office. The Mental Health Review Tribunals are the key in England. However, judicial control is available on a periodic basis.

G. France

France makes a sharp distinction between voluntary and involuntary detention. It has two forms of what other countries call involuntary detention. One consists in “family placement” and is called, oddly enough, placement volontaire. The second is placement d’office. It is an official detention

here is the Criminal Procedure (Insanity) Act c.84 (1964).

My investigation in England was guided by the Department of Health and Social Security, Sir George Godber, Director, and particularly by Dr. W. Oldham and Mrs. J. Lee of that ministry. I visited several psychiatric hospitals, and psychiatric divisions of general hospitals, under the guidance of psychiatric administrators: St. Thomas Hospital (Ward 5, Psychiatric, of Royal Waterloo Hospital) (Dr. J. Sargent); St. Olave’s Hospital (where Dr. Oldham had done pioneer work in community psychiatry); Bexley Hospital (Dr. N. Kaur); and Holloway Sanatorium, Virginia Water. I also visited Broadmoor Hospital, one of the three “special hospitals” for the treatment, in conditions of special security, of patients of “dangerous, violent, or criminal propensities” (Mental Health Act § 97), under the guidance of Dr. Patrick G. McGrath, Physician Superintendent. This “special hospital,” of all those visited, most closely resembles the District’s John Howard Pavilion. Finally, I visited Grendon Underwood Prison, under the guidance of Dr. W. J. Gray, Governor/Medical Superintendent. This last unit is Britain’s first and only psychiatric prison, most closely resembling Denmark’s Herstedvester Detention Center. The limited area of involvement of the Parliamentary Commissioner (ombudsman) in mental health matters was reviewed with me by Sir Edward Compton, Parliamentary Commissioner, in March 1970. See also Schwartz, The Parliamentary Commissioner and His Office: the British Ombudsman in Operation, 45 N.Y.U.L. Rev. 963 (1970).

381. In matters of commitment in mental hospitals, France is still governed by a law of June 30, 1838. Of the two kinds of involuntary commitment, placements volontaires (commitment at the instance of “family” taken in an extended sense) are covered by Articles 8-17 of the 1838 law, and placements d’office (commitment on grounds affecting public order) are dealt with in Articles 18-24. The law of July 31, 1968, which sets the new tone of mental health administration in France, revised the 1838 act with respect to administration of patients’ property, has not as yet led to any change in the 1838 law’s provisions (as described in the text) concerning admission and release. In France the investigation was assisted by the Ministry of Public Health, in particularly Mme. J. Laurenceau, Inspector-General, Office of Director of Bureau of Medical-Social Action, and by the United States Embassy in Paris, each of which arranged visits at mental hospitals and community psychiatric centers in the Paris area. Particularly valuable assistance was given by Dr. P. Pichot of St. Anne’s Psychiatric Hospital and by M.H. Menteur, Administrative Director, and the staff at the Association Santé Mentale et Lutte Contre l’Alcoolisme (community psychiatry) in the thirteenth Arrondissement in Paris. Recent developments in French public psychiatry are summarized in Sauvaire, Le Malade et les Pouvoirs Publics (1969).
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founded frankly upon considerations of public order. In a “family placement” case if the hospital refuses the request of the family or the patient for release, they have immediate access to the common-law court to vindicate a right of the person. However, only the Prefect of the Department can authorize release of an “official placement” patient. The Prefect's discretion is limited by a Ministry of Justice official, the Procureur de la Republique, or his local counterpart who regularly (every three months) visits mental hospitals. During these visits, the Procureur reviews the hospital records which are required to contain continual entries concerning the progress of every involuntary patient. In France, the Procureur de la Republique, seems to be the key control.

VI. THE OMBUDSMAN PROPOSAL

A. Ombudsmen Experience

The experience of existing ombudsmen in the area of mental hospitalization obviously provides useful data for present purposes. Interviews with the four ombudsmen functioning in the countries researched, certified that, however good the procedures for protecting rights of the mentally ill, the ombudsman is a valuable backstop to ensure effective enforcement of those rights. Ombudsmen in the three Scandinavian countries did not have a great number of mental health cases. However, they did have a continuing annual mental patient clientele, even in Sweden and Norway which have the most elaborate protective procedural machinery. The ombudsman, who is always available to patients and who has power to visit hospitals and examine files, has a smartening effect on the quality of administrative attentiveness to patients' rights. England limits the ombudsman's jurisdiction in mental health

382. In France's dual system of judicial tribunals, the ordinary civil courts are referred to as “common law” courts, as distinguished from the courts which administer droit administratif. To vindicate a “right of the person” (here personal liberty)—as distinguished from seeking to reprove official action—access to the civil courts is assured.

383. This section may be considered as a supplement to the fundamental study of European ombudsmen made by Professor Walter Gellhorn in 1964 and 1965, which was reported in his OMBUDSMEN AND OTHERS (1966). Our inquiry, unlike his, was exclusively into mental health activities of the ombudsmen. The most obvious additions here are the more extensive opportunity to evaluate the Norwegian ombudsman's style and work—he was in operation a bare two years at the time of Professor Gellhorn's field work, and the data with respect to the British Parliamentary Commissioner whose existence dates only from 1967. In addition to its rich descriptiveness of style and functioning of the ombudsmen in Sweden, Gellhorn's pages on Sweden contain useful specific data on their mental health activities (see Id. at 209, 215, 250).

384. Cf. observations of New York hospital administrators concerning effect on their work of the Mental Health Information Service in text at note 370 supra.
matters. There, despite elaborate procedural arrangements for handling patients' complaints, poor execution has led to public scandals (of patient abuse) in two hospitals, a series of angry questions in Parliament, and to the present consideration of legislation to provide for a Special Parliamentary Commissioner (ombudsman) for Health.\textsuperscript{385}

A part-time ombudsman whose role would closely approximate the backstop function performed by the Swedish and Norwegian ombudsmen is desirable. His initial role, upon receiving a complaint, would be to activate the proposed administrative and quasi-judicial machinery. He would present no specter of a super-administrator or chronic intervener in medical, or other hospital matters. His very availability would be insurance against the breakdown of the procedural machinery for handling patients' grievances, and against nonimplementation of statutory provisions designed to protect the mentally ill. Furthermore, his solid official standing would discourage the "keep your hands off my hospital" attitude of some doctor-administrators.\textsuperscript{386} Perhaps it would forestall a proliferation of the patient abuse trials which occurred in England despite the very civilized and advanced state of public psychiatry there.\textsuperscript{387} The quantum of the ombudsman's work initially would depend upon the effectiveness of the administrative and quasi-judicial procedures which are recommended here as the fulcrum of realistic protection of mental health rights.

The following notes, selected from interviews with the ombudsmen in Denmark, Norway, Sweden, and England in February, 1970 illuminate various implications of the ombudsman-type activity in the mental hospital field.\textsuperscript{388}

\textsuperscript{385} In the winter and spring of 1970 there was great public interest in two trials of mental hospital personnel for abuse of patients, which led to sharp questioning, in Parliament, of the Minister of Health. A government paper in private circulation indicated that establishment of a special ombudsman for the affairs of hospitals and other aspects of public health was under consideration.

\textsuperscript{386} The Mental Health Information Service directors in New York said that such administrative attitudes were encountered far more often when the program was beginning than in 1970. The doctor-administrators interviewed agreed that isolated cases of this hostile attitude persisted, but added that they did not share it.

\textsuperscript{387} See note 385, supra. See also the extensive writings of Dr. Patrick McGrath, Physician Superintendent of Broadmoor Hospital.

\textsuperscript{388} Detailed studies of the general activity of the ombudsmen discussed here (except in England, where the Parliamentary Commissioner only began to function in 1967) are contained in Professor Gellhorn's book, \textsc{Ombudsmen and Others} (1966): The notes below seek to avoid repetition of the data contained in that book, and also not to be unnecessarily duplicative of each other. Since the preparation of this section of the Report an article by Professor Bernard Schwartz has appeared, dealing with some aspects of the work of the British Parliamentary Commissioner. See note 380 supra.
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Denmark

The original Danish ombudsman, Professor Stephan Hurwitz, is still in office and after 25 years is still regarded by the man in the street as the one to whom all complaints against governmental action can be directed. Nevertheless, his jurisdiction in the mental health field is limited by article five of the governing statute. It directs the ombudsman to refer all complaints "about the treatment of persons deprived of their personal liberty through any procedure other than the administration of criminal justice" to the National Health Council. This board consists of members and ex-members of Parliament. Officials in both the Health Directorate and the Ministry of Justice led me to believe that Professor Hurwitz would classify his role in this field as a very narrow one.

His emphasis was quite otherwise. Patients in hospitals can, by law, write the ombudsman at any time. And while maltreatment questions belong to the Parliamentary Council, other faults are in the province of the ombudsman. In fact, the National Health Council often asks the ombudsman to look into maltreatment complaints. Professor Hurwitz visits mental hospitals himself (this is also in the sphere of the National Health Council). He recognizes that seriously insane persons give only part of the picture, but insists that it is important to look into their complaints. He asks the doctor or official complained of to give his point of view. Then, if necessary, he investigates. He can communicate with the doctors informally and get complete cooperation from them; they give him "all information," even that which cannot be given to the patients. Prevailing statistics show that 90 percent of complaints from mental hospitals are unfounded. I related to Professor Hurwitz that officials had indicated their satisfaction with the quality of hospital conditions and limited number of complaints in Denmark; he replied that "we shouldn't exaggerate pride in the present system." There is still the ten percent of complaints that are well-founded. Any mistreatment of a patient, such as a slap, said the Danish ombudsman, is something to take "very seriously."

Norway

In Norway too, the original ombudsman is still on the job. Since January

389. Denmark has had an ombudsman since 1954.
391. Interview with Professor Stephen Hurwitz, February, 1970.
392. Norway's ombudsman was instituted in 1963. He now has a staff of nine: a staff manager, four lawyers, and four secretaries.
1, 1969 his field of competence has been extended to municipal authorities. In the first year of expanded jurisdiction, total complaints soared from about 1,100 where they had leveled in 1967 and 1968, to 1,507. Judge Andreas Schei, the ombudsman, expects them to cut back to an average of about 1,400 a year. The following statistics are informative as to the operation of his office, and the minor part that mental health plays in his work:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Complaints Filed</th>
<th>Mental Health</th>
<th>Complaints Investigated</th>
<th>Investigations Completed</th>
<th>No change in Decision or Comment by Ombudsman</th>
</tr>
</thead>
<tbody>
<tr>
<td>1963</td>
<td>1257</td>
<td>15</td>
<td>407</td>
<td>327</td>
<td>250</td>
</tr>
<tr>
<td>1964</td>
<td>1060</td>
<td>17</td>
<td>368</td>
<td>388</td>
<td>270</td>
</tr>
<tr>
<td>1965</td>
<td>952</td>
<td>22</td>
<td>344</td>
<td>363</td>
<td>240</td>
</tr>
<tr>
<td>1966</td>
<td>998</td>
<td>27</td>
<td>312</td>
<td>315</td>
<td>216</td>
</tr>
<tr>
<td>1967</td>
<td>1089</td>
<td>23</td>
<td>293</td>
<td>287</td>
<td>208</td>
</tr>
<tr>
<td>1968</td>
<td>1078</td>
<td>17</td>
<td>272</td>
<td>237</td>
<td></td>
</tr>
<tr>
<td>1969</td>
<td>1507</td>
<td>15</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Of those decisions which the ombudsman investigated from 1963 to 1967 (Column C), the administrative decision was changed in 246 cases while his investigation was in progress. Of those cases where he completed his investigation (Column D), the ombudsman criticized administrative action in 496 cases—9.3 percent of the complaints filed.

The Norwegian ombudsman has found only ten percent of the mental health complaints proved justified. His method of investigation is basically to see if the prevailing rules of law and announced administrative procedures have been followed. He communicates both with the Control Commission and the hospital authorities. The new law in Norway, effective January 1, 1970, which entitles patients to appeal from the Control Commissions to the courts, will affect the ombudsman's operation in mental health cases. Since the patients are now entitled to go to court about detention, Judge Schei says that, "when he complains to me in this matter I shall advise him to go to court. I will, of course, continue to handle other complaints of patients in mental hospitals."394

Sweden

A major reorganization has taken place in the ombudsman situation in Sweden.395 Prior to 1968 there were two ombudsmen, one for civil affairs (Judge Alfred Bexelius) and one for military affairs. In addition, there is a Chancellor of Justice, a kind of "government ombudsman" as distinguished

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393. See text at note 377 supra.
394. Interview with Judge Andreas Schei, February, 1970.
395. Sweden's ombudsman experience dates from 1809.
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from the two “Parliamentary ombudsmen.” In 1968 a third ombudsman was appointed and the separate designation of Military Ombudsman was abolished. Now, according to Judge Bexelius, previously Justitieombudsman, the three ombudsmen divide the total work “according to our taste.” The mental health work falls in the province of Ombudsman Bexelius, with whom I spoke in February, 1970.

By 1968 the number of complaints involving mental health matters, which had averaged about 110 from 1960-1964, had mounted to 192. However the percentage of mental health complaints which were justified after investigation was only five percent. Judge Bexelius said this was unusually low, for the overall average of complaints which prove justified is 12 percent. Nevertheless, the ombudsman has had occasion to follow up patients’ complaints concerning doctors, the National Board of Health and Welfare (at the top of the system) and the local Control Board. When interviewed in February 1970, Judge Bexelius said:

> Sometimes I find it advisable to ask other doctors, in the hospital system, for their opinion with respect to the action complained of. I sometimes ask the National Board to hear more professors [of psychiatry] on a question, and to give reasons for their action. I have done this twice. They have the best professors in the country at the National Board. They are the ones who have to decide. And they have the utmost concern.

Only once, said the ombudsman, had a local Control Board been criticized as not being careful enough in deciding to release a patient.

The Swedish ombudsman continues to visit mental hospitals, but only about one a year. There are 29 in all. “Very seldom is there anything to criticize. It is a very good system.” Judge Bexelius cited the rapid turnover of mental patients in the Swedish system. Almost all the decisions with which he disagreed posed the question of whether patients should have been released at a particular time or in a particular way. Still, he said, “Doctors must take risks; it is their duty to do so. It would be abusive to let a person be in a hospital against his will for a very long time.”

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396. The distinction between the two offices was explained by a former Swedish Chancellor of Justice as follows: “When a citizen considers himself treated unjustly by a public office or official, he will as a rule find it more natural to apply to the Ombudsman as the Parliament’s and the voter’s own spokesman. If, on the other hand, a government office desires to have some action examined and verified as to its correctness, it is usually the JK [Chancellor of Justice] who is approached as the counsel of the office’s superior authority.” Rudholm, *The Chancellor of Justice*, in *The Ombudsman* 21 (D. Rowat ed. 1965).

397. Interview with Judge Alfred Bexelius, February, 1970.
The Parliamentary Commissioner for Administration, as the United Kingdom ombudsman is officially called, came into operation in 1967, too late to make Professor Gellhorn’s book. Because of this, and because he is the only ombudsman consulted who works in a common-law system, it is useful to refer briefly to his mode of operation. However, his activity in the mental health field is limited.

The Parliamentary Commissioner Sir Edmund Compton’s mode of operation has several distinctive features. Although he has a staff of 60, including himself and his deputy, it does not contain a single lawyer. Nor is there a social scientist. The staff is composed entirely of specialists in administration, recruited from the Civil Service. Sir Edmund was Auditor-General at the Treasury; his deputy (Assistant Commissioner) was at the Foreign Office. The Office of Parliamentary Commissioner when the staffing was first completed became known “in the city” as the “Whitehall Protective Association.” However, the staff is convinced that there has been no hesitation to oppose the government departments. Rather, an uncanny experience in the ins-and-outs of the 20 departments from which staff members have matriculated, proves useful in their work. A second unique feature of the English ombudsman is that his jurisdiction is limited by statute to complaints forwarded by members of Parliament. He cannot act directly upon a citizen-forwarded complaint. He has not found this to be a liability, though he freely avows there are critics who have. It helped establish the good relationship with Parliament which was necessary in the early years of organizing such an operation in a common-law system. The ombudsman described his mode of operation in an interview in March, 1970:

My basic search is for maladministration. Of course, I attempt to do “natural justice” as I go along. When I receive a complaint from a Member of Parliament and am clear what is being complained of, I begin by getting the comment of the Head of the Department. This may, in fact, kill the complaint. Then I generally begin an investigation in the Department. Our investigators would go in to study the files and relevant records. Then we take evidence from persons named in the complaint (for instance, a doctor named). The person named in the complaint is given notice of the complaint. If necessary we then check back to the complainant if there is a conflict in the facts. (We have not yet gone so far as to hold a hearing, or use the adversary process.) Then I have to form a judgment.

The official reports of the English ombudsman (who by special statute is also Parliamentary Commissioner in Northern Ireland), usually contain detailed summaries of the cases handled. He publishes overall statistics and a selection of specific cases (not all, but a generous number) are elaborately reported. His basic statistics for 1969 are as follows:

- Number of complaints received through Members: 761
- Number of cases completed during 1969: 790

The 790 cases have been completed as follows:
- After partial investigation, case discontinued: 43
- Outside jurisdiction: 445
- Case completed and result reported back to Member: 302

The Parliamentary Commissioner for Administration also notes that he received 814 written complaints direct from members of the public. As he pointed out in our interview,

> Under the present system we don't deal with complaints concerning National Health Service. This was specifically excluded by Parliament since for the most part the Health Service does not consist of government departments. Hospitals are a part of the Department of Health and Security but they were excluded by a Schedule to the Act. The Health Service and the Hospitals should be considered together.

Sir Edmund acknowledged that the Department of Health and Security was considering appointing a Parliamentary Commissioner for Health—a person, outside the Department, to whom appeal could be made. New legislation will be required to launch this proposal, which has recently received wide comment (favorable, for the most part) in the British press. Presently, the Parliamentary Commissioner is concerned with the administration of England's three prison mental hospitals.

> There are considerable references from prisoners in hospitals. There is a special problem for my office with respect to the medical profession. I have to make sure that I am not trespassing on the doctor-patient relationship. When necessary I handle this by availing myself of the certificate from an independent medical authority—preferably from within government service, but independent. My only question is whether it is in accord with accepted standards of the medical profession in such cases.

The ombudsman office supervises the system of Mental Health Review Tribunals. Sir Edmund stated that this was subject to the supervisory control of the Council on Tribunals (which oversees all statutory tribunals in the

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400. Ninety cases were discussed (in considerable detail) in the 180 pages of his 1969 report.
United Kingdom). As ombudsman he is a member of the Council of Tribunals. "I am not here to retry cases that are before tribunals or courts." Sir Edmund said the greatest contribution is the "presence factor of an ombudsman on the quality of administration. His worth can never be measured by the number of cases which he processes."

B. Inferences

These interviews reinforce the following conclusions: (1) The backstop factor of an ombudsman has a wholesome effect upon the attention the hospital administration pays to mental health rights.\(^4\)\(^0\)\(^1\) (2) The ombudsman institution is sometimes used by other governmental agencies to whom investigation has been entrusted, as a referral agency for action on complaints.\(^4\)\(^0\)\(^2\) (3) All the ombudsmen are extremely aware of the professional expertise and responsibilities of psychiatrists, and have been reluctant to interfere with medical judgments. However, they have occasionally sought out supplemental medical opinion on a complaint.\(^4\)\(^0\)\(^3\) (4) Sweden had the lowest percentage of justified complaints recorded by an ombudsman (five percent). It also has the most thoroughgoing system of effective local retention hearings combined with a carefully organized appeal mechanism, in which medical, law and lay opinion is represented. (5) The experience with an ombudsman in a country freshly introduced to the institution, but from which the mental health area was largely excluded, has led to current governmental consideration of new legislation to provide for a Parliamentary Commissioner (ombudsman) for Health.

VII. THE MODEL FOR ADMINISTRATIVE REFORM

A. The Focus: Detention Control

To properly formulate recommendations we must cover two points: hospital admissions, and the control of patients' complaints. Existing legislation on admissions is acceptable. Voluntary admission and transfers from involuntary status can be supervised within the framework of the proposals made here. The 1964 Hospitalization of Mentally Ill Act provisions for preliminary admissions on medical approval and for emergency admissions are in line with the current practice elsewhere. It is essential that these provisions, including the time periods specified, be enforced as written, and that some viable means of review be created to call attention to slackening enforcement. The need for adequate procedures for detention control and for dealing with patients' complaints\(^4\)\(^0\)\(^4\) is an important consideration.

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401. See comment by the English Parliamentary Commissioner in text supra.
402. See comment by Danish ombudsman, supra.
403. See comment of British Parliamentary Commissioner, supra.
404. I have largely excluded from this article the extensive discussions of patients'
The resolution towards which we are leading is a complex one: the proposals elaborated below call for utilization of quasi-judicial boards, expanded representation of patients by the Public Defender Service, a part-time ombudsman with limited specified functions, and retention of access to the courts as the ultimate backstop resource of a system of mental health justice.

While the main thrust of our proposals is toward the question of detention control, the processes proposed are also applicable to the complaint situation. Three main criteria have been used in sorting out control and grievance machineries to be adapted to the United States, specifically to St. Elizabeths hospital: (1) to select the machinery which has proven the most effective from the standpoint of results achieved; (2) to consider the question of adaptation to the United States' traditions and needs;405 (3) to use existing laws and institutions whenever possible. The District of Columbia provisions concerning the Mental Health Commission (with respect to admissions),406 judicial finality, and Hospital Superintendent's responsibility for internal operation, are undisturbed by these proposals. No consideration of this problem could omit the need for compulsory periodic judicial review for involuntarily confined mental patients, whether confined by civil or criminal process. Three of the proposals should be confirmed by legislative enactment and supported by special direct appropriations: The Mental Ward
Review Boards, the part-time ombudsman, and a Mental Health Division of the Public Defender Service.\(^{407}\)

Possible controls which might be instituted to meet present needs have already been discussed. Which of these are adequate, either alone, or in conjunction with others? We shall first consider the purely administrative controls. The prototype is the Chief Inspector associated with top echelons of a Health Ministry. European experience has shown that that alone it is not adequate. This possibility should not be discarded provided there is an independent resource elsewhere: as in Norway regarding both detention and complaints;\(^{408}\) or as in the ombudsman jurisdictions.\(^{409}\) The English experience warns us against the inadequacy of purely internal administrative procedures alone. An extra-administrative resource with mobility, independence, and influence is needed to insure that administrative procedures function properly.

The purely judicial resource is also obviously inadequate to handle the complaint aspect. But how about the control of detention? Is a knowledgeable judicial hearing, as in New York, sufficient? If we add adequate representation of patient-petitioners do we have enough? The judges do not want to have their process clogged up by multiple hearings.\(^{410}\) Psychiatrists are reluctant to step up occasions for their submission to lawyer cross-examining, which they feel is professionally demeaning. They complain of loss of hospital time through endless days in court.\(^{411}\) Leaving aside these important considerations, there is still a reason why a judicial hearing even under optimum adversary conditions is not totally satisfactory. There remains the practical problem that judges are reluctant to go against the medical testimony of the hospital doctor, even in the rare situations when the court is presented with conflicting psychiatric testimony.\(^{412}\) France presents

\(^{407}\) Since this proposal was first made the powers of the Public Defender Service have been increased. What is, in form, a Mental Health Division, has been established. However, it is obviously undermanned and underfinanced for the task suggested here. See note 311 supra.

\(^{408}\) See discussion of Norway's Control Commission in text at note 377 supra.

\(^{409}\) I.e., in Sweden and Norway and, to a certain extent in Denmark. But not in England, as yet, except in a limited area does the ombudsman have jurisdiction. In England, however, there is a strong system of Mental Health Tribunals.

\(^{410}\) See text at note 244 supra. But cf., the favorable experience in this regard of New York judges and hospital directors under the Mental Health Information Service system as recited in text at note 370 supra.

\(^{411}\) Cf., the strong differing views of psychiatric hospital administrator and judge on feasibility of holding court hearings at St. Elizabeths Hospital, at note 305 supra. Recall the distaste of one New York Hospital administrator, who presently enjoys hearings at the hospital, for any change in the other direction, text at note 370 supra.

\(^{412}\) See note 369 and accompanying text supra.
an interesting contrast. There the public order issue\textsuperscript{418} (in placements d'office-involuntary hospitalizations) is left squarely with the Prefect. When a case comes before a French judge the psychiatrist gives his opinion on the “medical” issue and a nonmedical official, the Prefect, pronounces on the “social” risk. The doctor may say he can still help the patient; the Prefect may say “He's not dangerous, let him go.” And the judge is at least in a better position to make an independent judgment than when he is given the medical-social judgment from the doctor alone. The legal test in the District of Columbia, and in all but two of the countries studied, is dangerousness to oneself or others. The Judicial Conference committee’s study of the District of Columbia Mental Health Commission provides evidence that doctors tend to follow the “medical model” (can I help this person?) rather than the statutory one (“dangerous to self or others”), even when they use the statutory formula in court.\textsuperscript{414}

All this suggests that a merely judicial hearing, even a full one in open court, is inadequate. Conversely I do not believe that our “institutional sense” would or should be satisfied if a judicial hearing were not available at the end of even a meaningful administrative process.

This brings us to the possibility of a quasi-judicial administrative hearing as in Norway and Sweden. The experience of Norway and Sweden shows that the local board is a highly effective means of sorting out the facts, and identifying the medical and social considerations. It utilizes medical, legal and lay members with adequate opportunity to examine the evidence, the files, the witnesses, and both patient and doctor. In Norway, the medical member actually examines the patient. This process is swift (two-week decision period), convenient (at the hospital), and has a remarkable history of satisfying all concerned.\textsuperscript{415} Yet the system depends much upon the quality of the personnel enlisted. Alone it would not satisfy our sense of the need for review of administrative justice. However, when coupled with judicial review on request and the availability of an ombudsman, it has much to recommend it, especially when the presence of counsel at the local board level is possible. Our adversary taste might widen this, and make Public Defender Service counsel available at all hearings.

As the answer to the detention and complaint problem an ombudsman alone makes no sense. This misconstrues the character of this institution; the ombudsman functions best when the administrative facilities are already well-organized and well-conducted. The Swedish experience verifies this.

\textsuperscript{413} See text at note 381 supra.
\textsuperscript{414} Judicial Conference Comm. Study, note 3 supra at 36.
\textsuperscript{415} See text at note 377 supra:
Even in the complaint area the ombudsman cannot operate alone: he would bog down in details and be tempted to become a super-administrator within the hospital. This is intolerable not only to hospital officials but also to aficionados of the ombudsman institution. Without recognized internal authority and prestige in such situations the ombudsman would not only be a nuisance but a futile one.

However, the ombudsman represents a valuable supplementary resource. He could be a great reassurance to patients as to their rights. Presumably he most often would activate existing procedures—of a Local Board or a Chief Inspector. But he would be particularly useful in perceiving common complaints which reach beyond the hospital. In our experience at St. Elizabeths, there were questions of inconsistent treatment on social security applications, of parole hearings for sentenced patients, and of the assignment of juveniles to the maximum security ward contrary to court order. In all these matters an ombudsman had a special service to offer that went beyond the role of an attorney in a particular case.

B. The Ingredients of the Proposal

A Chief Inspector does exist in Veterans’ Administration Hospitals. While administrative foresight on the part of the Secretary of HEW, or of its general counsel’s office might head off some difficulties, it does not seem appropriate to formally recommend that a Chief Inspector’s Service be established. It is one thing to oversee a nation’s hospitals, as in Norway, Sweden and the Netherlands; it is quite another to be concerned with a limited number of federal hospitals. While the doctors’ distaste for a lawyer takeover is thoroughly understandable, HEW should consider imitating those European countries in which the administration of hospitals is being turned over to nonmedical administrators—freeing the psychiatrists for “healing.” At the highest level of the Norwegian Health Ministry medical and legal personnel work side-by-side. I was told by the Assistant Chief of that Ministry, a psychiatrist, that he would not have it any other way. The breakdown at St. Elizabeths was highly predictable in light of the total psychiatric control that appeared to be the rule both there and at NIMH. So a Chief Inspector at any level below the office of Secretary would hardly be of value.

416. In some cases the Social Security Administration treated mental patients as qualified for disability benefits; other medically identical cases were dismissed as ineligible. Joseph Di Stefano, associate director of the ombudsman phase, discussed this problem with high level HEW officials. Miss Karen Krempa, a law student member of the project, argued and won the case for one patient at St. Elizabeths, for substantial backpayments of social security benefits which had been denied to him as without disability. See note 323 supra, and PR 88 & ch. 4 n.11.

417. There would be a supplemental role for a Chief Inspector, provided there is
A quasi-judicial local board as in Norway would prove a useful mechanism. It would handle both detention problems and complaints, but with no system of administrative appeal. Instead, a case process with a view to stabilizing Board procedures and identifying common concerns could be established at the ombudsman level. This would also incorporate a right to counsel at the local Mental Ward Review Board hearings. The Board’s members would be available as witnesses in court (like the Mental Health Commission) and its records admissible in evidence. The Public Defender Service would be available as counsel for indigent patients both before the Mental Ward Review Board, and in court. A special unit of the Service should be confirmed to which funds would be earmarked for protecting mental health rights.

Legal assistance for patients in special situations—whether internal (hospital) or external (property, personal problems)—would be handled by a part-time ombudsman. He would have access to a panel of attorneys for these purposes, and keep careful records on their activities on their client’s behalf. An experimental part-time ombudsman is therefore recommended. He could be the Chairman of the Administrative Conference of the United States or be appointed by him. He would be available to:

1. **Receive complaints from patients.** Initially he would refer them to the Mental Ward Review Board in patient’s hospital area. He might also direct inquiries on these complaints to an HEW official designated by the Secretary for this purpose. This decision could alternatively be left to the local MWR Board.

2. **Develop a panel of attorneys to handle special complaint cases which the ombudsman deemed in need of professional assistance.** Funds would be made available to compensate these attorneys. The ombudsman would oversee their work in a general way, especially as to delays. They would not be concerned with detention matters; these would be left to the Public Defender Service, Mental Health Division.

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418. The part-time aspect would emphasize the auxiliary function of the ombudsman—above all no super-administrator, but one who calls for the administrator’s attention when regular procedures have not been used or, more rarely one would hope, when procedures are inadequate to achieve justice. The auxiliary aspect reinforces another indispensable characteristic—his autonomy. It would make it more likely that someone would be available with a third needed quality, some clout, within the administration, and in Congress. See PR 462.

419. These would not include complaints as to detention, which would (in the plan recommended here) be handled in the first instance by the Mental Ward Review Board.
(3) Supervise Mental Ward Review Boards, to the extent of stabilizing procedures, compiling statistics and seeking out recurring issues. He would not review decisions of these boards. Legislation could be enacted to leave appeal to the courts. Still, the ombudsman would provide the factual basis on which the court could base an intelligent decision.

(4) Maintain a liaison among courts, hospital, and professional groups in the mental health field, and seek to improve their intercommunication by means of conferences and seminars.

Retention of the courts as an ultimate resource for detention matters is indispensable. The access to the courts by writs of habeas corpus must be kept open. On the other hand, the Mental Ward Review Board system is intended to afford satisfactory hearings on local levels which will alleviate the need for judicial hearings, and develop records which will make those that are necessary more meaningful. Legislation could make the MWR Board decisions appealable to the courts, but I do not recommend this step at this time.420

VIII. SUMMARY

If the basic object of a legal system in a society is to achieve the “idea of justice” for its members, its success at a given moment is not measured by the ideas it professes, or by the constitutional or legal rules to which it pays lip service “in the books.” Rather, success is measured by achievement of these ideas and rules “in action.” If a society professes, as its ideas and rules, equality before the law, imprisonment only where there is criminal responsibility, hospitalization for treatment but not for detention, it must constantly reexamine how well its institutions achieve these ideas. When society’s institutions are dysfunctional as to professed ideas, it must modify the institutions or frankly abandon the ideas.

The mental hospitalization arrangements in the District of Columbia are so much out of phase with the ideas and rules professed that one of two courses of action is in order: to create new institutional arrangements, or to discard, perhaps as visionary, some ideas and rules. Neither tinkering with the rule of criminal responsibility, nor establishing a new dominant court system, nor providing token legal representation of patients holds serious promise of realizing the professed ideas. Unless concern for such ideas be

420. The hope would be to build up a system of local boards which, with counsel available and the ombudsman in the background, would win general confidence by fair and full hearings, and make resort to the courts exceptional rather than routine. The exceptional (i.e. dissatisfied) cases would have available the habeas corpus resort, which must be kept open. One measure of the success of the system would be a reduced resort of patients to the courts.
abandoned, a fresh look is needed. New institutional actors, able to operate independently of the present conflicting forces, must be called upon. New processes, preferably (but not necessarily) those with favorable experience elsewhere, must be enlisted.

If as I have argued, a change in the Durham rule will not correct serious systemic defects,\(^\text{421}\) the question still remains: Would such a change (perhaps to the ALI rule)\(^\text{422}\) be promising as one element of a more extensive institutional reform? Indeed, one may urge that this is the only question which the courts are equipped to decide.\(^\text{428}\) In this more limited perspective, given the present state of the psychiatric art,\(^\text{424}\) there are strong arguments in favor of the revision of Durham. This revision becomes particularly attractive when we frankly identify the major factor underlying the distrust and uncertainties which have recently beset the District of Columbia court-hospital-court transmission belt. Once this factor is brought into the open, we are in a position to judge how best to use present psychiatric resources to deal with it.

In the turmoil of Durham's 17-year history, one disruptive factor stood out: the question whether nonpsychotic criminal defendants with character disorders, i.e., sociopaths and psychopaths, are, under Durham, to be reported as without mental disorder and "responsible" for their criminal acts. Initially Hospital policy established this conclusion. It was later changed.\(^\text{425}\) The Court of Appeals specifically held that such patients might be considered as having the exculpatory "mental disease or defect,"\(^\text{426}\) then specified that such abnormal mental condition might bar their release.\(^\text{427}\) The hospital rarely used such labels to recommend that patients be exculpated, but

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\(^{421}\) One obvious limitation is that the problem of involuntary commitments transcends the question of criminal responsibility. I have focused this paper upon criminal-process patients, but civil commitments should not be overlooked. See Chief Judge Johnson's opinion in Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971) discussed in note 257, supra.

\(^{422}\) Quoted in text at note 245 supra.

\(^{423}\) Narrowly speaking this is true. However, the expertise, experience, and prestige of judges and courts makes their sponsorship of extensive institutional reform within their field almost a prerequisite to its adoption. See Appendix B for comments of District of Columbia judges on the ombudsman proposal. The New York MHIS experience suggests that judicial oversight of a total program may be the most promising method of administration.

\(^{424}\) By this I mean the present state of psychiatric knowledge, the extent of general agreement among psychiatrists on a matter, and the present availability of psychiatric doctors, institutions, and programs for treating character disorders, particularly psychopaths. See discussion of European experience at note 316 supra.

\(^{425}\) See notes 61-63 supra.

\(^{426}\) See text at notes 66 & 152 supra as to "law in the books," and at notes 153-61 supra as to "law in action."

often recommended this under more acceptable labels. Many legal rules which developed following Durham provoked tension largely because they were viewed as "escape hatches" through which sociopaths might secure release. The judicial pressuring of psychiatrists for "strong testimony," and the Hospital administration's facile reference to John Howard Pavilion as a "prison" not a hospital, seem equally rooted in the premise that John Howard's inhabitants were largely men accused of crime who were in touch with reality (nonpsychotic), and for whom no effective treatment was available.

The shortcomings of the hospital-court system become intelligible only when they are seen in this context. To meet the demands of a rule which permits hospitalization rather than jailing of sociopaths, both hospital and court devised and lived under an "off-the-chart" justice which at least made it likely that hospitalized defendants would be detained as long as if they had been imprisoned. In the light of the apparent rationality of a client, and the often acknowledged absence of treatment (other than "being there"), the lawyer solicitous for his client's rights was understandably chagrined at the gap between the professed rules, such as Rouse's right to treatment," and Lake's "less drastic alternative," and his client's prolonged un-

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428. See text at note 84 supra.
429. "The right to treatment" of Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); and "other alternative course of treatment" than hospitalization of Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) are prime examples. The apparent cynicism of the exhaustion of administrative remedies defense to petitions for writs (pre-Dixon v. Jacobs, 427 F.2d 589 (D.C. Cir. 1970)), and the indifference to hearings and appointment of counsel on habeas corpus petitions, also appears rooted here.
430. See text at note 258 supra and Appendix A.
431. See text at notes 160-62 supra.
432. There was the latent, sometimes overt, conviction among psychiatrists that many John Howard Pavilion patients were malingerers, or unrepentant criminals, who had persuaded a doctor and jury that they could not help their criminality. Some John Howard doctors were more receptive than others to this suggestion. Cf. text at note 202 supra. Some of these afterwards concluded that they were "conned." See text at note 147 supra. In this report the six-month review of patients' mental condition (finally commenced on an admittedly pro forma basis in July, 1969) was not taken seriously. Psychiatrists claimed that there was not a minimum time prerequisite to release (see text at notes 181-93 supra); but the statistics show a preciseness of formula which puts these denials in question. PR 123-24.
433. In many cases (especially those involving misdemeanors and sex psychopathy) they spent a longer time than they would have spent in prison. No time was allowed for "good time" as with prospective prison parolees. In practice, however, "behaving" for a certain period was the most frequent prerequisite to release. See Judge Holtzoff's comment in the District Court hearing in Rouse v. Cameron: "... I think lawyers render bad services to their clients by pleading insanity in petty cases and find their clients in a mental institution for a much longer period than they would have been in jail." From Transcript of Proceedings (D.D.C., September 13, 1965), cited in J. Katz, J. Goldstein & A. Dershowitz, Psychoanalysis, Psychiatry and Law 603 (1967).
The administrative psychiatrist and the chief of service at John Howard Pavilion, if favorably disposed to granting early release, knew their recommendation had to get past the Hospital Superintendent and the committing court, each of whom were attuned to the "sociopath syndrome." Since few patients at John Howard Pavilion had interested attorneys, representation did not upset the improvised system. Those patients resorting to habeas corpus were disposed of easily. Assisted by coordination between the Registrar and the Motions Commissioner, "fruitless hearings" were dispensed with. Those hearings which were held rarely were hotly contested or troubled with conflicting psychiatric testimony. Only an occasional case broke through to the more inquisitive Court of Appeals.

Aside from undermining confidence in the administration of justice this arrangement for living with unpopular rules of law produced several other undesirable by-products. It greatly increased the number of untried defendants sent for mental examination, most of whom after three to six months were returned to court "without mental disorder." The likelihood that truly, or potentially, psychotic patients would be seriously invited into the process was reduced. Even if a defendant was found not guilty by reason of insanity, his chances of receiving more than "holding" treatment were miniscule. Because of the consequences involved, the meaning of "mental illness" and "dangerous" varied markedly in the psychiatric community. The ward attendants developed unjustifiable power over the retention or release of committed patients. Psychiatrists were not available

434. The familiar contrast between a medical model favored by the doctors (is he well?) and a legal model favored by lawyers (Has he the legal right to be free?) loses sharpness in the public mental hospital decisions in the criminal process. There is a pragmatic syndrome: How apt is the superintendent, the judge, to go along with the recommendation? How badly will I stumble in their eyes (thus affecting future recommendations) if I make a mistake here? Psychiatrists at St. Elisabeths frankly concede these factors. In three years working in this area at St. Elisabeths I found the occasionally interested lawyer intensely disaffected by and unsympathetic to these institutional considerations.

435. Both the hospital and court are heavily affected by possible adverse public reaction to a premature release followed by violent acts. In every country which I visited during the Project it was freely admitted that where a recent "mistake" of this kind had been made, the hospital superintendent, or the Ministry of Justice, as the case may be, was far less likely to call the next few close ones in favor of release.

436. See the "Thomas Smith" case, supra.

437. See note 199 and accompanying text supra.

438. See note 79 and accompanying text supra.

439. See acid discussion of this point in R. ARENS, MAKE MAD THE GUILTY 254-58 (1969). See also statistics cited on correlation between increased volume of examinations and increased percentage of patients found without mental disorder, text at notes 78-81 supra.

440. See text at notes 163-70 supra.

441. See text at notes 187-93 supra.

442. See text at notes 171-72, 183, 188 supra.
in sufficient numbers to promptly and adequately examine patients, much less to treat them. This "living arrangement" was responsible for the frankly "prison-detention" label which John Howard Pavilion earned in the post-Durham period. It reduced the likelihood that anything more than drug (or pseudo-milieu) treatment would be available even for the most severely psychotic patients. Even as qualified by McDonald, the Durham rule has reduced the effectiveness of John Howard Pavilion as a healing institution. Because of the general cynicism and lack of available staff, the Hospital cannot handle the examination overflow nor administer treatment other than "drug therapy." Character disorders such as sociopathy can be treated, if at all, only in a specialized milieu and over a more extended period of time than a rough "length of sentence" or "two-year" measuring rod would allow. Durham has also forced patients with such a "mental disease or defect" to be assigned to a "hospital" for "treatment" for an indefinite time in an unspecialized milieu. This leads to my final point.

The central theme of Durham, which is largely responsible for its unpopularity in other jurisdictions, is that a person should not be punished for a treatable mental disease, or an untreatable mental disease, which substantially contributed to his criminal act. Respectable psychiatric authority exists for the proposition that underlying mental conditions, short of psychoses, may contribute to criminal behavior to the extent that, but for the mental disease the defendant would not have performed the prohibited act. But the state of psychiatric learning today, 17 years after Durham, is surprisingly

443. See text at notes 140, 160 supra.
444. See text at notes 163, 167 supra.
446. The middle term, of course, was the moral conception of "responsibility." Because his mental illness substantially caused the objectively criminal act the defendant was not responsible. Because he was not responsible he may not be punished. But Judge Bazelon noted that he may, under existing law, be "committed for an indefinite period to a hospital for the insane." Durham v. United States, 214 F.2d 862, 876 n.57 (1954). The later jurisprudence in the District of Columbia focused upon the notion of hospital—that it connoted treatment and not mere detention. Rouse v. Cameron, 373 F.2d 451 (1966). But there was a legislative predicate for Rouse: "A person hospitalized in a public hospital for mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment." D.C. CODE ANN. § 21-562 (1967).
447. While many psychiatrists find it unscientific to separate a person's behavior from his total psyche and ascribe causality to mental illness and some even say it is not "rational" to do so (cf. T. Szasz, LAW, LIBERTY AND PSYCHIATRY 134 (1963)), others accept the analysis of the Royal Commission on Capital Punishment cited in Durham: "Where a person suffering from a mental abnormality commits a crime, there must always be some likelihood that the abnormality has played some part in the causation of the crime; and, generally speaking, the graver the abnormality, . . . the more probable it must be that there is a causal connection between them." 214 F.2d at 875, n.48. See also L. KOLB, NOYES' MODERN CLINICAL PSYCHIATRY 507 (7th ed. 1968): [F]rom a psychopathological standpoint the sociopathic personality may be looked upon as not responsible for his conduct . . . ."
imprecise both as to means of identifying such cases, and means of treating them.\textsuperscript{448}

The best known efforts in this field have been European. The pioneer endeavors of Dr. George Sturup at Herdstervester in Denmark, the Netherlands experiments at Groningen and Utrecht, and the English prison-hospital at Grendon Underwood are most noteworthy.\textsuperscript{449} None claims to have reached conclusive results. But all agree on three things: (1) that treatment of sociopaths is best conducted after they have been convicted of a crime;\textsuperscript{450} (2) that treatment of sociopaths is different in kind than treatment of other mentally ill, and requires a special and segregated milieu; and (3) that such treatment must be carried on for a substantial period of time for its effects to endure.

These findings raise nice questions as to the feasibility of: (1) hospitalizing sociopaths in a mixed community such as John Howard Pavilion; (2) seriously contemplating their treatment save under a long range, fully professional program; and (3) equating treatment of such patients with mere physical presence in conditions such as those furnished at St. Elizabeths Hospital. The evidence also warns against accepting too easy a solution for such a deep-seated difficulty. The suggestion of sentencing such persons as offenders and giving them "psychiatric treatment" at a general prison is hardly feasible.\textsuperscript{451} Such a course might render St. Elizabeths a more plausible mental institution,\textsuperscript{452} but without something more, it would not satisfy a community seeking to do justice. Communities in Europe have seen a responsibility to launch experimental efforts to expand psychiatric knowledge in hopes of restoring men to useful roles in society, and providing needed insight into psychological causes of crime.\textsuperscript{453} Justice will not be done through anything less than such a federal hospital. Yet the United States has given remarkably little attention to this European-style answer.\textsuperscript{454}

\textsuperscript{448} L. Kolb, supra note 447 at 505-08. See note 316 supra.
\textsuperscript{449} See text at note 316 supra.
\textsuperscript{450} Both Dr. Sturup (Denmark) and Dr. van Belkum (Netherlands) (cf. note 316 supra) insist that the acceptance of their responsibility for what they have done is a central element of therapy for criminal sociopaths.
\textsuperscript{451} See the suggestion to this effect by a District of Columbia judge, at note 318 supra, (PR 227). It was also suggested by one of the John Howard Pavilion psychiatrists, PR 209. The psychiatrists' own stress on the importance of milieu in treatment strikes at such a solution.
\textsuperscript{452} In the sense that there would be fewer examinations, and therefore more time for psychiatrists to treat patients. There is some basis for inference that the recent reorganization at St. Elizabeths Hospital, lessening the capacity available for criminal process patients (see text at note 283 supra), is designed, in part, to achieve this.
\textsuperscript{453} See note 316 supra.
\textsuperscript{454} Highfields Hospital in New Jersey and, to an extent, Patuxent Institution in Maryland (see text at note 319 supra) are the only illustrations of which I am aware.
If treatment is henceforth considered a "right" of those involuntarily detained at a public mental hospital, and "treatment" is to be defined in therapeutic, and not merely custodial terms, a strong argument can be made that the ALI responsibility formula is presently more realistic than Durham. However, if Congress was prepared to provide the needed leadership, Durham could well be adapted to stimulate experimentation with a mental hospital for unconvicted sociopaths.

IX. CONCLUSIONS

From the material presented we might conclude that: (1) The Hospital, the courts, the psychiatrists, hospital administrators, judges, prosecuting officials and private attorneys, have jointly produced a drastic departure from the law as written. Pound's law "in the books" cannot even be recognized "in action." (2) There is a measure of agreement by all contributing to the process that hardly anything about it is going well. (3) The recent piecemeal, almost frantic, responses to the mental health crisis have completely missed the point. Grave and fundamental commitments of the nation are at stake. (4) In the District of Columbia, the protective hand of the law has been largely withdrawn from those involuntarily hospitalized as mentally ill.

Pound warned us to measure law by action and not by books or words alone. Perhaps he was really counselling that public reaction is the ultimate standard and that the "law in the books" should be changed to conform to that reaction. Though empirical data is lacking there is some basis for concluding that raw public reaction today is not strongly opposed to mere custodial care, and is much more alarmed by the premature return of the mentally ill to society. In that event, Pound would be in accord with Professor Dershowitz' recent counsel: better that involuntary hospitalization be frankly labelled for what it is—"preventive detention"—than for what it is not—"treatment."

Hauriou's analysis takes us a step further. Is it the function of the law—as propounded by the legislature, court, or administration—to respond plastically to "raw public reaction?" Or is it the law's function, and the special function of courts, to conserve and develop the fundamental ideas of the national society and its legal system? Are there recognized national ideas such as due process of law, equality before the law, and liberty from imprison-

455. An eloquent plea to this effect is made by a controversial psychiatrist in T. Szasz, LAW, LIBERTY AND PSYCHIATRY 182-90, 212-22 (1963). See also T. Szasz, IDEOLOGY AND INSANITY 113-189 (1970), and text at notes 32-39 supra.
457. In Hauriou's sense; see text at note 10 supra.
Involuntary Hospitalization for Mental Illness

ment except after conviction of crime? If there are such fundamental ("constitutional") ideas, is it not the function of the courts to probe more deeply into their implications in current social contexts—forcing the legislature and administration to seek constitutional means to achieve even proper objectives?

Many problems can be solved by the legislature; but every legislative act is not a solution. New York's legislature found a solution to the pressing need for civil rights for mental patients by (1) establishing something "new";458 (2) plugging it into something established;459 and (3) furnishing adequate appropriations. That system, firmly funded, has proven itself to the legislature and to key professionals across the state. Congress and the Executive Department have taken an opposite course when faced with the same problem in the District of Columbia. Their full program seems to call for two choruses of "changing the chairs": (1) shift the jurisdiction of mental hospitalization out of the federal court system;460 and (2) (on the horizon) shift St. Elizabeths Hospital itself to the fund-starved District of Columbia government.461

In its broadest sense, the subject of this paper has been personal liberty as a fundamental idea of a free society. It has been examined within a small, but growing area where it is foundering. The paper has drawn a sharp contrast between government action, however sugar-coated, that is hostile to this personal liberty in the District of Columbia, and governmental action apparently fostering liberty in New York and some European jurisdictions.

Is insensitivity to liberty allied to insensitivity to life? Is life itself a fundamental idea of this society? Questions arise as to government's growing insensitivity to life: mass war-killings, capital punishment, euthanasia "reform," legislation and court orders authorizing, or directing, suppression of living but unborn foetuses. Does all this combine to dull an earlier national commitment to life as a fundamental idea? Are mental patients just our domestic "gooks"?462 Is the growing environmental interest in "quality of life" in tension with "quantity of life," as previously protected from govern-
sponsored interruption? Is such a "quality of life" rationale the basis for legitimizing continued destruction of Asians in a war from which the nation is committed to withdraw? Is there, then, a subtle coherence between government action hostile to personal liberty and government action hostile to life; or action stressing "quality of life" rather than "quantity of life" or human life itself? Is the judicial and administrative activity which I have reviewed, and the apparent legislative indifference, an indication of a new national "idea," that the living but unborn, the Asiatic peoples, the nonproductive aged and infirm, and the mentally ill, represent degrees of sub-human quality not entitled to the same legal or moral regard as "normal," productive, white westerns? These new "reforms" and attitudes have not legitimized themselves as fundamental ideas of the American society. But they represent serious claims which merit the careful attention afforded by an analysis in Hauriou's terms lest they intrude piecemeal and by default.

Such an analysis demands more than probing the fundamental ideas of the national society. We must analyze the component parts. What is the basic idea of the legal and medical professions? What is the accepted role-design of elements in each—hospital administrators, psychiatrists, defense counsel, prosecutors, judges, legislators, and executive governmental officials?

The present paper has suggested that these systems and their institutional actors have been functioning badly but almost unnoticed in a single area (mental health) in one important jurisdiction (the District of Columbia); and has compared their operation in the District of Columbia to that in other western jurisdictions. A second study will measure the performance of these social institutions in light of the fundamental ideas which they, and each of them, traditionally, and currently, accept. Can we, in fact, identify such ideas? Are they in accord with more fundamental conceptions, such as the American tradition of free individuals in a free society? Are there, in fact, historically identifiable national ideas? If there are, will not history itself witness that even the most fundamental ideas of a society change? Hauriou writes that the directing (fundamental or core) ideas of an institution "are made to last for a long time." But, he swiftly adds that they are "also perishable like everything that exists." His analysis helps reassure us that drastic change does not occur by drift, or without awareness. With awareness the roots of these ideas may be nourished again if men still value them—if they value them enough.

463. Hauriou in THE FRENCH INSTITUTIONALISTS 121.
Appendix A

SUPPLEMENTARY DATA ON HABEAS CORPUS PETITIONS IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

The data in Chart A below was compiled during the Project. In connection with the present article further research was undertaken in the area of appointment of attorneys and holding (and denial) of hearings to furnish answers to three problem areas pinpointed by this data: (1) the varying practices of judges; (2) the “myth” of repeaters; and (3) the quality and quantity of service by attorneys appointed in these matters. This appendix summarizes the answers derived from this supplementary research.

Varying Practices of Judges

The Project survey showed that only seven percent of petitioners have their own attorneys (Column B, supra). The court appointed counsel in 55 percent of the remaining cases (Columns C and D). But 42 percent of the petitions (Column A) were disposed of without assistance of counsel (Column G). We are not concerned here with the reasons for declining to appoint counsel; that will be discussed in the next section. We are now interested in the question whether this nonappointment statistic reflects a policy shared by all the judges of the United States District Court. The series of interviews with district judges (see note 41 supra and Appendix B) raised the hypothesis that it did not, and the following research substantiates this hypothesis.

Of the 23 judges who served in the District Court in 1968 and 1969 only eight were concerned in each year with the issue of appointment of attorneys (Column C). And in each year two judges (Judges A and C in 1968 and Judges A and B in 1969) made the substantial part of these determinations. It is in this light that we must consider the facts that in 1968, 73 percent of all refusals to appoint counsel, and in 1969, 88 percent of all such refusals were made by two judges. The most reliable indicator of the varying practice among judges on this point would seem to be a nonappointment ratio in which the denominator is the judge’s total considerations (Column C), and the numerator his refusals to appoint counsel (Column E). The results are shown in Chart B.

Thus although the average nonappointment ratio for the court considered as a whole was 45 percent for the two years (Column E, Chart A), only four judges of the court performed above this high percentage; and two more were slightly below; four of the eight judges engaged in these decisions denied counsel in a below-average percentage of cases. Of the three judges principally engaged, two were in the higher (but not the highest) percentages mea-
## Chart A

**Attorney Appointment: 1968-1969**

<table>
<thead>
<tr>
<th></th>
<th>Moment of Filing</th>
<th>Moment of Judicial App't</th>
<th>Moment of Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A Total Petitions</td>
<td>B Own Att'y</td>
<td>C No Att'y</td>
</tr>
<tr>
<td>1968</td>
<td>128</td>
<td>9 (7%)</td>
<td>119 (93%)</td>
</tr>
<tr>
<td>1969</td>
<td>147</td>
<td>10 (7%)</td>
<td>137 (93%)</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>19 (7%)</td>
<td>256 (93%)</td>
</tr>
</tbody>
</table>
### Chart B

Nonappointment of Attorney by Individual Judges, 1968-1969

<table>
<thead>
<tr>
<th>1 Judge</th>
<th>1968</th>
<th>1969</th>
<th>1968 &amp; 1969</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 Writs</td>
<td>Appointment of Attorney</td>
<td>4 Non Appointment</td>
</tr>
<tr>
<td>A</td>
<td>62</td>
<td>42</td>
<td>20</td>
</tr>
<tr>
<td>B</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>25</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>D</td>
<td>13</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>E</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>F</td>
<td>9</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>G</td>
<td>8</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>H</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Note: All charts were compiled by the author from the records of the U.S. District Court for D.C.
sured by denial of counsel. The most active judge in these matters (Judge A) was slightly below the court average.

Further research revealed that substantial variations of practice among judges existed in other significant aspects of mental health petition cases. Statistical measure was taken concerning the practice of judges with respect to (a) holding of hearings; (b) appointment of additional psychiatrists; and (c) concluding dispositions with findings of fact and conclusions of law, as required by decisions of the Court of Appeals. See Tatem v. United States, 275 F.2d 894 (1960). Chart C below reproduces the court-wide statistics on these items. Chart D gives an account with respect to individual judges of the court.

**Chart C**

Hearings Granted, Appointments of Additional Psychiatrist, and Findings and Conclusions, by Entire District Court

<table>
<thead>
<tr>
<th>Individual Judges</th>
<th>Total Petitions</th>
<th>Hearing Held</th>
<th>Additional Psychiatrist App’t Granted</th>
<th>Additional Psychiatrist App’t Denied</th>
<th>Findings and Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1968</td>
<td>128</td>
<td>58 (46%)</td>
<td>10 (67%)</td>
<td>2</td>
<td>43 (34%)</td>
</tr>
<tr>
<td>1969</td>
<td>147</td>
<td>79 (56%)</td>
<td>13 (87%)</td>
<td>2</td>
<td>24 (16%)</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>137 (54%)</td>
<td>23 (85%)</td>
<td>4</td>
<td>67 (25%)</td>
</tr>
</tbody>
</table>

**Chart D**

<table>
<thead>
<tr>
<th>Judge</th>
<th>Hearing Granted</th>
<th>Hearing Denied</th>
<th>App’t of Psych. Granted</th>
<th>App’t of Psych. Denied</th>
<th>Findings &amp; Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>A</td>
<td>6</td>
<td>53</td>
<td>10%</td>
<td>2</td>
<td>67%</td>
</tr>
<tr>
<td>B</td>
<td>26</td>
<td>25</td>
<td>51%</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>C</td>
<td>3</td>
<td>14</td>
<td>18%</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>D</td>
<td>10</td>
<td>5</td>
<td>67%</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>E</td>
<td>7</td>
<td>2</td>
<td>78%</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>F</td>
<td>17</td>
<td>7</td>
<td>71%</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>G</td>
<td>8</td>
<td>2</td>
<td>80%</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>H</td>
<td>7</td>
<td>6</td>
<td>54%</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>I</td>
<td>15</td>
<td>0</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>J</td>
<td>7</td>
<td>0</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>K</td>
<td>9</td>
<td>0</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>L</td>
<td>6</td>
<td>0</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>M</td>
<td>5</td>
<td>0</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>N</td>
<td>4</td>
<td>0</td>
<td>100%</td>
<td>3</td>
<td>40%</td>
</tr>
<tr>
<td>O</td>
<td>2</td>
<td>0</td>
<td>100%</td>
<td>0</td>
<td>2%</td>
</tr>
<tr>
<td>Average</td>
<td>54%</td>
<td>23%</td>
<td>85%</td>
<td>67</td>
<td>75%</td>
</tr>
</tbody>
</table>

* Omits from consideration cases in which writ was withdrawn (23 such cases in all).
As already mentioned, the above charts only place the individual judges in relation to the average performance of the entire court. The next section takes up the basis generally asserted for denials of counsel and hearing—the question of alleged repeaters who, under the doctrine of Sanders v. United States, 373 U.S. 1 (1963) and Dixon v. Jacobs, 427 F.2d 589 (D.C. Cir. 1970) are asserted to have no rights to counsel and hearing because of "abuse of the writ." Before proceeding to that discussion one final chart is presented which gives in one glance the relative performance of judges in mental health habeas corpus cases. The factors included are those just presented in Chart D (hearing denial, appointment of additional psychiatrist, and furnishing findings and conclusions of law), plus the factor of denial of appointment of counsel. This last factor, however, is not presented here as in Chart B; the data of Chart B is corrected by anticipating the findings of the next section. The denial of counsel heading (Column 4) is individualized to reflect those cases in which counsel was legitimately denied according to the Sanders doctrine, i.e. where the petitioner had been given a hearing on a petition within the preceding six months. In other respects the following chart reflects Charts B and D precisely. In each column the figures signify the relation of the particular judge to the average performance of the court with respect to each factor. It attests that the greatest number of judges has performed in these matters significantly above the average, which has been severely distorted by the determinations of a few judges who have had the most numerous participation in habeas corpus decisions.

**Chart E**

Variation from Court Averages by Individual District Judges

<table>
<thead>
<tr>
<th>Average</th>
<th>Counsel Denial (Corrected)</th>
<th>Hearing (Granted)</th>
<th>Psychiatrist Appointment</th>
<th>Findings &amp; Concl.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>40%</td>
<td>54%</td>
<td>85%</td>
<td>25%</td>
<td>0</td>
</tr>
<tr>
<td>Judge A</td>
<td>+6</td>
<td>-44</td>
<td>-18</td>
<td>-25</td>
<td>-82</td>
</tr>
<tr>
<td>Judge B</td>
<td>-23</td>
<td>-3</td>
<td>+15</td>
<td>+1</td>
<td>-10</td>
</tr>
<tr>
<td>Judge C</td>
<td>-6</td>
<td>-36</td>
<td>+15</td>
<td>-25</td>
<td>-52</td>
</tr>
<tr>
<td>Judge D</td>
<td>+21</td>
<td>+13</td>
<td>+15</td>
<td>+13</td>
<td>+62</td>
</tr>
<tr>
<td>Judge E</td>
<td>0</td>
<td>+24</td>
<td>-</td>
<td>+11</td>
<td>+35</td>
</tr>
<tr>
<td>Judge F</td>
<td>-38</td>
<td>+17</td>
<td>+15</td>
<td>+29</td>
<td>+23</td>
</tr>
<tr>
<td>Judge G</td>
<td>+15</td>
<td>+26</td>
<td>+15</td>
<td>+22</td>
<td>+78</td>
</tr>
<tr>
<td>Judge H</td>
<td>-3</td>
<td>0</td>
<td>-35</td>
<td>-10</td>
<td>-48</td>
</tr>
<tr>
<td>Judge I</td>
<td>-</td>
<td>+46</td>
<td>-</td>
<td>+39</td>
<td>+85</td>
</tr>
<tr>
<td>Judge J</td>
<td>-</td>
<td>+46</td>
<td>+15</td>
<td>+46</td>
<td>+107</td>
</tr>
<tr>
<td>Judge K</td>
<td>-</td>
<td>+46</td>
<td>-</td>
<td>+17</td>
<td>+29</td>
</tr>
<tr>
<td>Judge L</td>
<td>-</td>
<td>+46</td>
<td>-</td>
<td>+25</td>
<td>+71</td>
</tr>
<tr>
<td>Judge M</td>
<td>-</td>
<td>+46</td>
<td>+15</td>
<td>+15</td>
<td>+76</td>
</tr>
<tr>
<td>Judge N</td>
<td>-</td>
<td>+46</td>
<td>-</td>
<td>+50</td>
<td>+96</td>
</tr>
<tr>
<td>Judge O</td>
<td>-</td>
<td>+46</td>
<td>-</td>
<td>-25</td>
<td>+21</td>
</tr>
</tbody>
</table>

The "Myth" of Repeaters

The previous scales, which merely compare the performance of each judge with the average performance of his brethren, abstracts from the question
whether the court mean in these matters is itself subject to objective criticism. This question is now met head on based upon the hypothesis that a case-by-case review of plural filers will reveal whether grounds for dismissal without a hearing actually existed in any particular case.

These grounds are narrow and clear: failure of the petition to state a viable claim for relief, and the doctrine of Sanders concerning "abuse of the writ."

Determination not to appoint counsel, or not to set the petition down for a hearing, or both, is made in the following ways: (1) By summary dismissal of the petition on its face, without requiring service upon the Hospital and thus without requiring its answer to the allegations of the petition. (2) By dismissal after service by the Hospital of its "Return and Answer."

Dismissal in the first way may be made if the petition fails to state a valid claim for relief. The District Court has been most liberal in construing almost any document from a patient which alleges improper detention on the ground of his recovery as sufficient to pass this preliminary hurdle. However, dismissal at this stage is also made, with the help of informal communications from the Hospital such as was revealed in the "Thomas Smith" case on the ground of "abuse of the writ." As explained by the Court of Appeals in Dixon v. Jacobs, which accepted the court's avowed practice in this regard, "abuse" is equated with having had a hearing on a writ within the prior six months.

The court's second opportunity to dismiss the petition without appointment of counsel or hearing follows upon receipt of the Hospital's "Return and Answer." This pleading is prepared by nonprofessionals in the office of the Hospital's Registrar and is overseen and signed by the Assistant United States Attorney who represents the Hospital in court in these matters. In addition to answering the allegations of the petition, the "Return and Answer" invariably calls the court's attention to prior writs filed by the petitioner, and makes no distinction between those which were denied after a hearing and those summarily dismissed. In at least 60 cases in 1968 and 1969 the Hospital's pleading asked for dismissal on the ground that the petitioner had failed to exhaust his administrative remedies (PR 356; and see discussion on this point in the "Thomas Smith" case). Since no case was found in which there was not a contested issue presented by the petition and the "Return and Answer" (generally the issue of continued mental illness or dangerousness), and the exhaustion defense has been deflated as spurious by the Dixon case, we can concentrate here on probing the dismissals in light of the last remaining legitimate basis for dismissing a petition for a writ of habeas corpus without a hearing, or without that indispensable attribute of a true hearing, the
appointment of counsel. This reduces the inquiry to the simple question: Has petitioner been given an opportunity for judicial consideration of his claim to release within the preceding six months? Only by evaluating the dismissals of 1968 and 1969 in this light can we see the extent to which these dismissals without hearing and counsel were according to law.

A close analysis of the 275 mental health petitions filed in the District Court in 1968 and 1969 furnishes persuasive evidence that the problem of such “repeaters” is minimal, and affords no justification for the wholesale dismissal of 46 percent of the writs without hearings and of 42 percent without appointment of counsel.

Only 58 patients filed more than a single writ in this two-year period. The breakdown according to patients by number of writs filed is set forth in Chart F below. Put another way, of the 187 patients filing petitions, 69 percent filed only one in the two-year period, 31 percent filed more than one, 9.6 percent filed more than two, and only five percent filed more than three. In our search for true “repeaters” we shall examine the cases of all patients who filed more than one writ in descending order of their activism. Admittedly a fuller picture would be obtained if we took as our universe all patients filing—for single filers in early 1968 might have filed within six months in late 1967.

**Five Writs Filed**

**F.B.:** Two of his five writs were summarily dismissed without hearing or counsel although he was beyond the six-month period. On a third writ he was a “repeater,” since it was within four months of a petition in which he had hearing and counsel. On his fifth writ F.B. received full judicial treatment and won release.

**R.B.:** He had been a civil commitment since July 30, 1965. His first two writs in 1968 were dismissed without hearing or counsel although properly spaced since his last previous hearing. His third and fourth writ were given proper attention. His fifth writ was improperly dismissed for failure to exhaust administrative remedies although counsel was appointed.

The four columns below (repeated throughout) indicate A if an attorney was appointed, H if there was a hearing, P if an additional psychiatric report was permitted, and FC if the judge supplied findings of fact and conclusions of law. In any case where one of these was lacking an O is inserted. An X on the right indicates summary treatment was given in violation of the six-month rule, and R on the right signifies that he was a genuine “repeater” on that particular writ. W signifies that the writ was withdrawn, and M that the issue was judged moot.
<table>
<thead>
<tr>
<th>No. of Pet'ns</th>
<th>Total Petitions</th>
<th>Patients</th>
<th>% of Pet'ns</th>
<th>Less than 6-months (Repeater) (R)</th>
<th>Over 6 months (Improper Denial of Att'y or Hearings) (X)</th>
<th>Eventually Won in '68-69</th>
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Four Writs Filed

One each of four writs filed by B.B. (a patient under sentence, in John Howard Pavilion (JHP) since July 26, 1966), J.C. (in St. Elizabeths (St. E’s) since June 1, 1965), W.J. (a civil commitment in St. E’s since August 19, 1965), and C.P. (in JHP since October 29, 1964) were in the “repeater” category. However, there were two improper summary dismissals with respect to J.C.; and C.P. had two withdrawals without representation.

There appear to have been no less than nine improper dismissals without counsel or hearing with respect to J.B. (in JHP since September 29, 1967), T.S. (The “Thomas Smith” discussed in the text who has been at St. E’s since June 17, 1964) and A.T. (in St. E’s since January 15, 1959 after a simple assault charge). And no less than seven of these four-petition patients’ summary dismissals were grounded in citation of previous improper summary dismissals.

Three Writs Filed

Nine patients were petitioners three times during the two-year period. In only one of these 27 writs could the petitioner be classed as a repeater. Yet of the 26 writs where the petitioner did not have his own attorney, in only 10 cases (46 percent) was an attorney appointed. Clearly in 13 cases there was no justification, from the “repeater” standpoint, in denying appointment of an attorney and hearing; and in each of these 13 cases there was an actual
or potential relevant factual issue raised by the petition. In another case a complaint was permitted to be withdrawn without an attorney; in the same case (and in six other cases in this series) the Return and Answer argued for dismissal on grounds of failure to exhaust administrative remedies.

Two Writs Filed

The remaining plural petitioners (40) filed only two writs each during 1968 and 1969. Of these 80 writs (four of whom won on their second try), only six may be classed as repeaters. On the other hand in 19 of the 28 cases in which appointment of an attorney and hearing were denied petitioners there was clear evidence of their entitlement under the existing rules. In at least six cases the government sought summary dismissal for failure to exhaust administrative remedies.
These statistics must not be read as if all petitioners cited were in the hospital for the full two-year period. Those who were would, on a strict reading of the six-month rule, be entitled to file four writs during the period. The statistics, however, are suggestive that the problem of “abuse of the writ” is not a serious justification for the general judicial failure to appoint counsel and to grant a hearing. For, as we have seen, in no more than 12 of the 145 plural writs reviewed (eight percent) could the dismissal of the petition be justified, as it persistently appears to have been by the “repeater”-“abuse of writ” doctrines. And in 49 instances (34 percent) summary dismissal was demonstrably improper.
We have already seen that in seven percent of the mental health habeas corpus cases petitioners were represented by retained counsel, and that in 45 percent of the remaining cases attorneys were not appointed by the court. In this section we consider the functioning of the attorneys who were appointed in 51 percent of the total cases.

A total of 163 appointments were made, including some co-counsel. In only 19 of these did the attorney refuse appointment or later seek to be relieved. The total number of attorneys serving by appointment was 123. Of these, 103 served only once in the two-year span. Twenty attorneys were appointed to as many as two petitions and only one attorney was appointed three times.

Of the 140 cases in which appointments were made in the two-year period, in only 23 (16 percent) did the appointed attorney ask for appointment of an independent psychiatrist, the only viable means of contesting the crucial testimony of the Hospital psychiatrist concerning continued mental illness. Only one instance was discovered in this period in which the court record reflects that the attorney gave effective opposition to the exhaustion of remedies defense (later seen as obvious by the Court of Appeals in Dixon). And in no case was appeal taken by an attorney to dismissal on this ground.

An instinct of an inevitable lack of success of habeas corpus petitions in mental health matters may be encouraged by the release statistics. However there is a striking disparity between the success percentage of appointed counsel and that of engaged counsel. Of the 22 petitioners who were totally successful, i.e. secured release, or arguably succeeded in some part as a result of that petition (e.g., where the Hospital gave them some part of the relief requested shortly after the withdrawal of their petition), nine were represented by their own counsel, and 13 had appointed counsel. This constitutes a 47 percent success percentage for private counsel as compared with nine percent for appointed counsel.

The inexperience (infrequent appointment) and lack of familiarity with the specialized refinements of habeas corpus practice in the mental health field, and the contrasting experience of government counsel, undoubtedly strongly contribute to this result. However one cannot too readily overlook the utter rareness (attested by Hospital psychiatrists) of attorneys' visits to the Hospital to consult doctors or their clients.

The court records lay bare the dedicated service of many appointed counsel in these matters. Some of it yielded success; but more often it simply assured their clients of a fair day in court in which their claims were heard. Many, notably those who had pressed for the additional psychiatric examina-
tion, satisfied themselves and their clients that withdrawal of the writs was the most advisable step to be taken at the particular time. That more could be done by attorneys for mental health petitioners than has been done was demonstrated in the record of the cases initiated as a result of the Project. They can now be read in the reports in the names of Dixon, Williams, and Jones. And in the records of the District Court in the case of "Thomas Smith."

Conclusion

The ultra-expeditious procedures for "disposing of" habeas corpus writs which have been examined in this survey should be viewed in the context of the extraordinary demands made upon District Court judges in these years, which Chief Justice Burger has capsuled in his discussion of the decrease in guilty pleas in criminal cases: After arguing that a reduction in the percentage of guilty pleas from 90 percent to 80 percent requires a doubling of judicial manpower, and a reduction to 70 percent trebles the judicial time required, he comments:

This was graphically illustrated in Washington, D.C. where the guilty plea rate dropped to 65 percent. As recently as 1950 three or four judges were able to handle all serious criminal cases. By 1965 12 judges out of 15 in active service were assigned to the criminal calendar and could barely keep up. Not unlikely few other federal districts experienced such a drastic change. But to have this occur in the national capital which ought to be a model for the nation and a show piece for the world was little short of disaster. *

But the entire complex subject might well be ventilated not only within the relative evaluation now made of order and personal freedom, but in light of the persistence of our commitment to "the rule of law."

Appendix B

INTERVIEWS WITH DISTRICT OF COLUMBIA JUDGES AND PSYCHIATRISTS

I

Judges’ Thoughts on the Ombudsman Proposal

The responses of the judges were to these questions: Should there be an ombudsman for mental health matters? How should he work? Would an ombudsman help or hinder the court?

Judge A: Yes, an ombudsman would be useful. I am particularly unhappy that it now depends on hospital initiative to bring patients back to court (especially those sent over as mentally incompetent to stand trial. I say this for two reasons: (1) because of their being understaffed; and (2) because I don’t have confidence that the doctors are really addressing themselves to the legal test of “dangerousness.” I believe they are using the health model, and keep people (whether “dangerous” or not) whenever the doctors think they can be treated. And so I see the need here for something like an ombudsman. Meanwhile, I don’t see why the judge couldn’t fix a date for a rehearing—not only when he commits a man, but also when he turns down an application for declaration of competency.

I would not make the ombudsman directly an arm of the court. I feel that it should be an independent agency with good relations with the court. [Reference was then made to the two New York models; see text at note 334 supra.] I would be against the advocate model. I would greatly prefer that it be a responsible independent agency with good relations with the court. A good local example would be the Bail Agency. But I wouldn’t want it to become an agency engaged in “sales jobs.”

Judge B: I wouldn’t see any objection to an ombudsman being inserted in this court-hospital-court picture. I would hope that he would not assume so active a role in counselling patients that he would overload the court with habeas corpus petitions. Perhaps one possible aspect of his role could be to file amicus curiae briefs for the court in certain special cases.

Judge C: I do not favor the notion of an ombudsman filing briefs. I believe that this would get in the way of counsel, something that an ombudsman should be careful to avoid. The greatest function that an ombudsman could perform would be to ferret out cases where representation was needed and refer such cases to counsel. I believe that such counsel would most satisfactorily be the Legal Aid Agency [now Public Defender Service] in the expanded form which is now contemplated. [I referred to our data concerning nonissuance of writs and nonappointment of counsel.] This should not be, except with notorious every-week repeaters. While I am not anxious for a lot of time-consuming hearings, this situation you speak of shows that there is
place for an ombudsman-type figure. I believe such a plan would help both the patients and the court.

*Judge D:* I have had many cases in which I have been convinced that there was not a concerned follow-up by the Hospital. There is definitely need for some agency which would help the court on these mental health matters, as well as insure that the patients are fairly treated. I not only think that there should be someone within St. Elizabeths Hospital like an ombudsman—someone to prevent patients from being lost and forgotten—I don’t know how a mental hospital could be run in any other way. I have often had the feeling that reports of some doctors were tied in to housing requirements at St. Elizabeths, rather than being an accurate reflection of a patient’s mental condition. I would give my total support to the creation of an ombudsman in this area.

*Judge E:* I can see room for an ombudsman within the Hospital to deal with such matters as social security and veterans’ benefits. But I don’t see any role which he could perform which would be helpful to the courts.

*Judge F:* The “ombudsman” is a general term. No one understands it. Before I could say whether I’d be in favor of it I would like to know exactly what he’s going to do. Is it to be a separate entity, or incorporated in some existing organization? This is important. I would be receptive to putting it in the Legal Aid Agency [now Public Defender Service]—that is here and we know what it is. If it is to be autonomous it would be important how he would be appointed. I would favor his being appointed by the Board of Judges. One reason for this is that the ombudsman would be, as I understand it, a quasi-judicial official. In the sense that he makes choices that must have roots in law. I would not like him to be a doctor, and have some hesitancy at his having other nonlegal credentials—such as a political scientist. [I called to his attention the reporting function of the New York Mental Health Information Service, which is handled in two of the four Judicial Departments by nonlawyers. See text at note supra.] I am not sure that such reports to the court are necessary. After a while about 75 percent could be mimeographed.

*Judge G:* I would be very much in favor of having a body or individual with enough statutory and representative authority and respect to intervene at any time to protect the rights of these patients. They could consider a batch of cases where nothing has happened on these patients. If there was no report from the hospital the ombudsman could bring the patients back to court and get release on habeas corpus. I am not concerned that such an ombudsman might intensify the amount of jury trials. Jury trials are not the big problem. The big problem is getting the people [involved] into [the court]
and trying to work out a disposition. There are critics of both court, and doctors, and family, here. We have the situation that people are being sent to an insane asylum, despite the new language [mental hospital]. True, St. Elizabeths is not a viper pit. But still . . . . Another thing we need is to enforce the “six-months rule”—I mean the Bolton decision giving the opportunities for rehearings on mental condition. If the ombudsman (or some other way) would help here it would be a good step.

Judge H: There could be value in the ombudsman concept here. Sometimes we send a man over to St. Elizabeths and months go by without hearing any more about the matter. I sent a man to St. Elizabeths last March [nine months ago]. Despite my request for a report I still have heard nothing. I am at the point of following it up further. The ombudsman would certainly be no hindrance to the court. But I would have caution on the suggestion that he file amicus briefs in certain cases. If he did this he might impair his standing at the hospital.

Judge J: The chief problem I have about the present system is that the people who come up before me generally get sent over to St. Elizabeths [for mental examination] with the consent of an attorney. When they come back here if the finding is mental incompetency they are entitled to a hearing. Yet at this time there is generally no hearing—almost always there is consent by counsel, who is generally glad to get rid of the case. So people get committed to the mental hospital with nothing more than the consent of a “fly-by-night” lawyer. Of course there is a hospital report—but one which may be prepared in a hurry. The judge has no independent judgment to make, and a man is sent away indefinitely—until the hospital gets ready to release him. If you have a list of some people who are buried over there I think you should do something to have them brought up. If you don’t then you or someone like the ombudsman you are describing should get them help. I have often wondered what happened to those men we send over there. Certainly there should be counsel for these people; and they are not getting “effective counsel” at present. Courts could use additional information, and the ombudsman might help here. He would also be a help in that someone would represent the defendant before commitment for incompetency. And then the ombudsman would prevent people getting lost and forgotten at the hospital.

Judge J: I can see a real possibility that such an ombudsman would be helpful to the court. Where he detected what he thought was a pattern of unfair action in the courts our new Calendar Committee would be glad to receive his complaints and suggestions for improvement in the administration of justice for these patients. I don’t see any objection to a member of the
bar acting as such an ombudsman. I don't accept the notion that a nonlawyer would be freer to complain to and about the courts. The Calendar Committee is looking for answers, and would welcome such assistance.

II

Dialog of Judges and Hospital Officials

As will be apparent, the following dialog is "arranged"; all the comments were made in isolated interviews.

Psychiatrist A: I am very unhappy with the Hospital administration. In a short time the staff at John Howard Pavilion could be down to zero the way things are going [July, 1969]. The reports given to the newspapers by the administration concerning the increase in the staff at John Howard are false. In fact, the staff of doctor-psychiatrists has decreased from eight to four.

The staff at John Howard Pavilion cannot handle both diagnosis and treatment; treatment should be handled separately. Few patients now sent for diagnosis are given any treatment. Now a few patients who are sent by the courts for 30-day examinations and who could be handled in that time are in the Hospital for five or six months. The reason for this and for other persons getting lost in the woodwork is insufficient staff, and no assistance from the Hospital administration. And the ones who suffer are those people upstairs [i.e., the patients].

Administrator A: The critical point on our being overloaded with examinations was May 1966 when the D.C. General Hospital "opened its doors" [established only open wards for patients]. Thereafter they kept no security wards. At a time when we were losing psychiatrists it became necessary to supply three or four [more] to John Howard out of the pool of psychiatrists available to the entire hospital. This meant lesser service elsewhere. The problem of recruiting psychiatrists became critical. I have to cajole people to undertake the kind of work that John Howard demands—to go up to court and be twisted around by some lawyer.

Judge A: I do press the psychiatrists when they are not giving satisfactory reasons, not doing their job, and they probably resent it. But that is part of their job.

Administrator B: The communications problem is not between "doctors and lawyers." The problem is between "doctors and lawyers in public life." Doctors [psychiatrists] are constantly being criticized by the courts for failure to carry out their mandate. It is coming to be that an administrator can be called upon by any relative to shift the Hospital about. The tendency is
for the "public life" lawyer to say of the doctor: "It is his fault and not mine." This criticism is a reflex of rivalry between branches of public service—and not a professional rivalry. The question is not one of difference of opinion. It is a tendency towards getting out from under responsibility.

Judge B: I am a great admirer of the doctors at St. Elizabeths Hospital, and of their contribution to the community.

Administrator C: This unsatisfactory court-doctor relationship means we can't get doctors to work at John Howard Pavilion. They feel it derogates from their professional standing. "We're witnesses all of a sudden." If we are to do the job they [the courts] want, they should make it as easy as possible—remove the annoyance and frustration. As it is we just get accused of changes of plans and continual postponements.

Judge C: The Hospital used to say they needed 60 days for examinations. Now they say they can do it in 30. How can they be right both times?

Judge D: The judges have a responsibility to the community to go against the doctors when they are for release of a patient without giving adequate grounds. I have had occasions to resist the recommendations of psychiatrists on this basis.

Judge E: Some people complain about Dr. As being too indefinite and unconvincing. I know that he tries to be precise and fair to the patients. But sometimes this presents a difficulty. He won't charge a man with malingering unless he admits he lied. This is a pretty difficult standard. I have no criticism of certain testimony of the doctors. The chief problem is not lack of communication between judges and psychiatrists, but arises from the need for clear testimony by the doctor so as to convince a jury.

Administrator D: I don't give a darn about the patients' civil rights—as a doctor. I want to make them well. Our job is healing people, and assisting the court to do its job. Take Judge . He says: "If you made a review of everything you did it would make my job a lot easier." But the ideal situation does not exist. We keep records on each patient, but there is neither money nor personnel for the kind of review he is talking about.

If the court made it extremely necessary for us to meet these decisions [Rouse and Bolton] there should be an accommodation. But if the doctors have to go to the courts, taking all the time involved, this means the courts are saying their function is much more important than our prime function of healing. Doctors don't like this. On the other hand, if the judges would come to the Hospital [for hearings], that would represent a decided advantage to us. I won't say that its value is just symbolic; it is also functional. We could do the job better. But they turned down this proposal.
Judge F: I am absolutely opposed to having court hearings at the Hospital. It was suggested before and shot down by the Committee of Judges. The hearing should be held in the normal place—not somewhere the psychiatrist feels he has an advantage. It would be a grave inconvenience to the court, tie up a judge and staff.

Psychiatrist B: NIMH [National Institute of Mental Health] has over-bureaucratized the Hospital. You can't tell who's on first [base]. They haven't been able to do what they promised [when NIMH took responsibility for St. Elizabeths Hospital] in part because of drag by holders-of-fiefdoms from Dr. Overholser's days. Petty baronies. NIMH has downgraded the Hospital. There is distinct need of an ombudsman—often decisions are made on a basis of vindictiveness and spite.

Administrator A: Of course when they are looking for a whipping boy it is always fashionable to pick on the "bureaucracy." The truth is that "the good old days" were not so good. For the present situation at St. Elizabeths—which admittedly is not good—the "old administration" is at fault. They allowed St. Elizabeths to become a wastebasket of the District. The D.C. Department of Public Health is notoriously neglectful of the community. The fact is that it has provided no facilities for the community, and more and more has been pushed off on St. Elizabeths—geriatrics, addicts, homosexuals, criminals, and now juveniles.

Judge G: The real need is for places in the community where medicine would be available, which will give people a chance to get stabilized. There is need for half-way houses and other facilities, too. There is often no "dangerousness" involved with what the community needs to have done. It breaks my heart to send the old people over there—but there is no place else for them to go. The facilities in the District of Columbia are woefully inadequate. Why shouldn't the D.C. government contract with Peoples Drug [to supply medicines?]

Administrator B: The psychiatrist has been cast in the role of a jailer. The doctors have to be forensic [courtroom] specialists working for the jail at a salary. They want to be doctors. This has a distinct effect on our inability to recruit administrators and psychiatrists.

Administrator C: There is a son of a former colleague of mine here. I asked him to do forensic psychiatry at the Hospital. He told me: "I think you're taking advantage of our friendship to ask me to demean myself that way.

Judge H: I admit that I don't have much confidence in the state of the psychiatric art. But I'm not a psychiatrist. So I have to take their word for it—both as to competency and as to not guilty by reason of insanity. I'm very
timid because of the Court of Appeals to let the psychiatrists depart from specific canned language. I'm not strong for "hedging" psychiatrists. I need strong testimony so as not to get overruled "upstairs" [in the Court of Appeals].

Judge I: I am troubled by the "productivity" reports [those citing whether the crime charged, if committed is a "product" of the mental illness] we used to get on mental incompetency [to stand trial] cases. And some of the "personality disorder" cases seem to be withdrawing all sense of responsibility for actions. I am concerned at the too liberal notion of productivity. But I feel dependent on psychiatrists. What can a judge do? He's not an expert on mental health.

Judge J: The preferable way to handle the St. Elizabeths problem is to convict the defendants, and thereafter have them sent to the mental hospital as sentenced. Or better yet, have them sent to the prison at Lorton [Virginia] and arrange for psychiatrists to treat them there.

Administrator D: The whole problem at St. Elizabeths is John Howard [the maximum security pavilion]. It's not a hospital; it's a prison. Everything is basically okay in the outside wards: treatment plan, etc. The basic problem is John Howard.

Administrator E: First of all we have to get the community to understand the miserable situation we are in. There are no doctors [available], though extra doctors were allocated to John Howard last summer. No one else in the community wants to share the burden. It is unfair for the courts not to understand the limitations we are working under. In fact they contribute to the critical delusional state simply because St. Elizabeths has the name. St. Elizabeths cannot be all things to all people at all times.

Administrator A: Even if we had enough psychiatrists we couldn't deal with the cases. The big problem is understanding with the courts. Take the question of competency—examinations as to whether a man is competent to stand trial. We agreed with the liaison judge we would do 14-day examinations—simply on the question whether the man could understand the charge and talk to his lawyer in defending against the charge, nothing on productivity. Then Judge ———— gets some of these reports and he complains: "Why no psychological?"

Judge K: The communication between the court and psychiatrists admittedly is not good. We [the court] should not send anyone to St. Elizabeths for an examination unless there has been a policy determination as to competency—in general.

Administrator B: The medical profession is a healing profession, and technical problems such as writs of habeas corpus are not the concern of doc-
tors. Lawyers should handle these. I don’t understand the lawyers’ vocabulary and definitions, and it is not my responsibility to do so. I have told inquiring attorneys that if they were so interested in patients’ rights they should come in and take their cases.

U.S. Attorney’s Office No. 1: I worked out forms of notice [of procedures to be followed by patients seeking release] last May [1969], with instructions that they be given to the patients in John Howard Pavilion—explaining Section 546 [D. C. Code, Section 21-546]. All they had to do was sign or check their name on the form. I thought the Hospital was not informing people. They don’t want a lawyer in the hospital.

Administrator C: Patients use the writ of habeas corpus as a source of exertion of their own will against the father image of the doctor, whom they view as the supreme authority. Patients use the writ as a threat, and repeatedly we hear this expression: “Doc, if you don’t do such and such I’ll throw you a writ.”

U.S. Attorney’s Office No. 2: I don’t make a policy of asking questions. I am careful not to tell the Hospital how to run its internal affairs.

Psychiatrist C: Then there is the case of ———, a patient at John Howard. I would be careful with him, but he must be given some hope. He changed from being a slick artist to one interested in others. He began to fight for other patients—would kick up a fuss if they were beaten up, mistreated. One time he was out and his room got inspected. One attendant said that he had found there dirty pictures of children—but he tore them up. On the strength of this, ——— was sent to the top floor [disturbed ward]. I complained up the line to Dr. ———, and told him: “You can’t rely upon that business about the pictures.” He said, “Oh, you don’t think an attendant would lie, do you?” I told him, “Yes,” and went a step higher. The “discipline” was revoked there, because he didn’t think this reasoning would stand up in A Building [the Superintendent’s office].

Psychiatrist D: I would be prepared to open up my wards to lawyers, and let them oppose me at all stages in representing [their] clients, even on the question of “dangerousness.”

Administrator D: Any administrator has the problem of what to do with the limited resources at his disposal. I can see need for legal services [at St. Elizabeths]. But frankly it is not a number one priority with me at this time. There are other needs I see as greater. There is need to get patients out of some of these old buildings. I have started that. We are working to develop the impact of the community center concept. There is need to upgrade the training of our personnel. We hope through this technique to improve the quality of services.
Administrator E: We can't recruit administrative men or doctors with the overhanging prospect of the transfer of the Hospital from HEW [Department of Health, Education and Welfare, parent of NIMH] to the D. C. government.

Administrator A: If the Hospital is transferred to the District it will present a staggering problem just in recruiting personnel. Some men I had interested backed off so long as this possibility was present that the Hospital would be turned over to the District. For one thing you would lose the services of 43 Public Health Service doctors who are now serving at St. Elizabeths.

Judge L: It used to be we could get things done at St. Elizabeths. We could call up Dr. Overholser when he was Superintendent and he'd get us the answer.

Administrator B: They're going to get used to the fact that things have changed. St. Elizabeths is now just one of a number of other units controlled by a larger organization. The Hospital is not a free, independent unit as it was for 100 years. They used to be able to grab hold of the Superintendent and drag him up to court—now they find it is something like punching into a pillow—and they don't like it. They are going to have to get used to it. The old days are gone forever. The Hospital is now part of a section of national health administration. It is now composed of career government officials rather than independent and nationally known figures. The change is from the monopolistic Superintendent to more cooperative team appraisal.
Appendix C

RECOMMENDATIONS FOR ADMINISTRATIVE CHANGE*


Persuasive evidence has been compiled that mental health rights of patients detained involuntarily at the Federal Mental Hospital operated by the Department of Health, Education and Welfare, through the National Institute of Mental Health, known as St. Elizabeths Hospital in Washington, D.C., are not adequately safeguarded by existing legislative, administrative and judicial arrangements.

Studies of legal and administrative arrangements in seven other jurisdictions (New York and six European countries) have been made for the Administrative Conference of the United States to furnish a comparative basis for proposing administrative procedures to safeguard mental health rights—both in the specific federal hospital under consideration, and as a model to be available to other hospitals, federal and state.

Administrative recommendations are made to safeguard mental health rights, especially with respect to controls of continued detention involuntarily in a federal mental hospital, to insure adequate legal representation of patients in certain cases. Two chief remedies are proposed to be adopted experimentally on an administrative basis at the initiative of the Administrative Conference, with the cooperation of the Secretary of Health, Education and Welfare and the Chief Judges of the Court of Appeals for the District of Columbia, the United States District Court, the District of Columbia Court of Appeals, and the Superior Court of the District of Columbia: (1) the establishment of independent Mental Ward Review Boards to review complaints of patients with respect to detention and other grievances; (2) the institution of a part-time Administrative Commissioner for Mental Health Rights to be an additional resource for patients' complaints and to develop a panel of attorneys to be available to patients in certain situations.

Recommendation for legislative change are endorsed which would provide for a legally required periodic review of the detention of involuntary patients by the committing courts, and furnish appropriations sufficient for the establishment of a special Mental Health Section of the Public Defender

* These recommendations were originally made (in March, 1970) to the Administrative Conference of the United States. See note 3 supra.
Service of the District of Columbia, whose members would represent patients at administrative and judicial hearings dealing with questions of detention.

Recommendation for continued study by the Administrative Conference on rights of detained persons, with a special emphasis on prison-hospitals and prisons.

I

Recommendations

That the Secretary of the Department of Health, Education and Welfare (which has ultimate responsibility for the management of St. Elizabeths Hospital, Washington, D. C.) provide by regulation as follows (with a view to giving adequate protection to mental health rights of patients in that federal hospital and of establishing there a system of effective protection that will be a model which other mental hospitals may be inspired to adopt):

1. At my invitation the Chairman of the Administrative Conference of the United States, in consultation with me and with the Chief Judges of the United States Court of Appeals for the District of Columbia Circuit, the United States District Court for the District of Columbia, the District of Columbia Court of Appeals and the Superior Court of the District of Columbia, has agreed to compile a panel of 36 citizens, resident in, or employed in, the District of Columbia (including attorneys, doctors and nonprofessional persons in approximately equal number).

2. From this panel I shall designate six Mental Ward Review Boards, each consisting of three members (one medical, one legal and one nonprofessional) and an alternate for each member from the same category to the extent feasible.

3. Two of these Boards shall be assigned to John Howard Pavilion (the maximum security facility at St. Elizabeths Hospital), and the others in such a way as to be regularly available to patients in the hospital, with a particular concern for those who are involuntarily detained.

4. Each Mental Ward Review Board shall meet twice monthly in the place assigned to hold hearings on complaints received from patients, including complaints that patients are being unjustly detained.

5. Any patient who files notice with his administrative doctor 48 hours before an appointed time of meeting of a Mental Ward Review Board shall be entitled to appear before the Board and present his complaint in person. The Board shall be entitled to prior access to all hospital records concerning the patient, and all other hospital records which it deems relevant. The Board may require to appear before it the patient, and any member of the hospital administration or staff to give testimony. The patient shall be entitled to be represented by counsel, and if the patient is indigent the Board shall in-
vite the Public Defender Service of the District of Columbia to represent him. A record (not necessarily stenographic) shall be kept of each hearing, and a decision, stating reasons, shall be given by the Board with respect to each complaint. The decision shall be rendered as promptly as possible, ordinarily not later than one week following the close of the hearing. The patient and the parties concerned shall be promptly advised of the Board's decision. A copy of each such decision shall be sent to the Chairman of the Administrative Conference or the officer designated by him pursuant to Article 10, below.

6. If a Mental Ward Review Board, after hearing, determines that the patient is being held unjustly it shall immediately advise the Superintendent of the Hospital, and the head of the service to which the patient is assigned, to this effect. Within 24 hours of receipt of this notice the Superintendent shall advise the Chairman of the MWR Board of his intention (a) to release the patient from the hospital within 24 hours, or (b) not to release him without direction by the Court. In the latter event the Chairman of the MWR Board shall forward the file, including the decision of the Board and the correspondence with the Superintendent, to the Director, Public Defender Service or the patient's other counsel of record, for initiation on behalf of the patient of appropriate court action.

7. If a MWR Board, after hearing, determines that the complaint of a patient is unfounded, it shall advise him promptly to that effect together with the reasons why it found lack of merit in the complaint.

8. With respect to patients' complaints concerning hospital matters other than release from the hospital, the MWR Board is empowered to adjourn a hearing until its next appointed meeting, and during the intervening time conduct such investigation as it deems advisable. If the Board, after investigation, deems the complaint to be well-grounded it shall advise the Superintendent, and the head of the service to which the patient is assigned to such effect. Within 24 hours thereafter the Superintendent shall advise the Chairman of the MWR Board what steps, if any, he proposes to take with respect to the grievance. The MWR Board may, if it thinks it advisable, forward copies of its decision, and such correspondence with the Superintendent, to the Secretary of Health, Education and Welfare. The Chairman of the MWR Board shall forward such decision and correspondence to the Chairman of the Administrative Conference, or to the officer designated by him pursuant to Article 10, below.

9. With respect to patients' complaints concerning matters external to the hospital (for example, property claims, social security matters, parole board communications, etc.), the MWR Board, if it determines that the complaint
warrants investigation, or requires legal assistance, shall forward the complaint file, together with its notation for favorable consideration, to the Chairman of the Administrative Conference, or to the officer designated by him pursuant to Article 10, below.

10. Independent of my authority as Secretary of Health, Education and Welfare, or of anyone within the Department chain of authority, but with the full cooperation of myself and all those responsible to me, there shall be an autonomous Administrative Commissioner for Mental Health Rights. This official, who is to be either the Chairman of the Administrative Conference of the United States, or a person designated by him after consultation with the Chief Judges named in Article 1 hereof, shall have access to all files and personnel of St. Elizabeths Hospital that are not categorically restricted by law. Any patient in any hospital unit under my jurisdiction shall have the right to communicate with him by unsealed letter, without any delay.

II

That the Chairman of the Administrative Conference shall, if agreeable to him, undertake the additional responsibilities of Administrative Commissioner for Mental Health Rights (Ombudsman), with duties as described below, or he shall designate such an official after consultation with the Secretary of Health, Education and Welfare, and the Chief Judges of the United States Court of Appeals for the District of Columbia Circuit, the United States District Court for the District of Columbia, the District of Columbia Court of Appeals and the Superior Court of the District of Columbia. The Administrative Commissioner for Mental Health Rights shall serve for three years and may be reappointed. He shall, if not already in full time government service, be compensated on a per diem basis for days actually working at the rate allowed to consultants of the Administrative Conference, out of funds appropriated to the Administrative Conference. In the event that the Chairman of the Administrative Conference undertakes the responsibilities of the office of Administrative Commissioner himself, he may detail members of his staff, as he deems appropriate, to assist him in carrying out the office. That the Administrative Commissioner for Mental Health Rights shall:

1. Receive and investigate, as necessary, complaints sent to him by patients in federal mental hospitals, directly or on their behalf.
2. Refer complaints received with respect to alleged unjust detention of patients, or other grievances internal to the hospital, to the appropriate Mental Ward Review Board, if such exists, advising the patient of such reference.
3. Consider the determinations of Mental Ward Review Boards and take such action with respect thereto as he deems appropriate.
4. Confer, as appropriate with the Superintendent of the hospital, the Director, Public Defender Service (or other attorney of a patient), with respect to resolution short of court action in cases where the local Mental Ward Review Board has recommended discharge, and the Superintendent has disagreed with this recommendation.

5. Investigate patients complaints concerning matters external to the hospital (for example, property claims, social security matters, parole communications, etc.), and take such remedial action with respect thereto, including securing independent legal assistance, as he deems appropriate.

6. Develop a panel of attorneys who may take references pursuant to Paragraph 5, above, and take steps to insure their fair compensation, and oversee that such matters are pursued without delays.

7. Oversee action or inaction of the hospital with respect to recommendations of Mental Ward Review Boards.

8. Communicate promptly with patients as to the disposition by the Administrative Commissioner of any complaint, together with his reasons for such disposition.

9. Give assistance to Mental Ward Review Boards in connection with stabilizing their procedures, and compiling statistical reports of their work annually.

10. Investigate the feasibility of introducing Mental Ward Review Boards in other federally-operated mental hospitals, or in psychiatric divisions of general federal hospitals, and make recommendations to the appropriate governmental authorities with respect thereto.

11. Make appropriate use of mass media to communicate to the public the work done by the Administrative Commissioner for Mental Health Rights.

12. Prepare an annual report giving a detailed account of the disposition of all complaints coming to his attention, in appropriate categories, and with accompanying statistics as to disposition. The report shall be made public and distributed through channels and in numbers approved by the Chairman of the Administrative Conference. Copies shall be furnished to each member of Congress and to all federal agencies participating in the Administrative Conference.

13. With the approval of the Chairman of the Administrative Conference, organize seminars and conferences enlisting the cooperation of the area Universities, with a view to improving interdisciplinary communication among the professions and disciplines concerned with mental health rights.

14. **Staff**—The Administrative Commissioner for Mental Health shall initially be furnished secretarial and stenographic assistance, as needed, by
the Chairman of the Administrative Conference. In addition he shall en-
deavor to enlist part-time investigative, legal and social work assistance (in
connection with cases arising under Paragraphs 1-12 above) from private law
firms and universities in the area concerned on an appropriate hourly com-
pensation basis approved by the Chairman of the Administrative Conference.
In his discretion, the Chairman of the Administrative Conference, may elect to
equip the Administrative Commissioner with outside, part-time, secretarial
and stenographic assistance.

Explanatory Note

This proposal is based upon American and European experience in the field
of affording protection to persons involuntarily confined in mental hospitals,
and at the same time respecting the needs of society and the legitimate respon-
sibilities of the medical profession, within the framework of existing legisla-
tion. It contemplates that each Mental Ward Review Board is an autonomous
unit. Its success will depend in large part on the quality of its personnel and
upon the degree of receptivity it establishes with the hospital officials and
with the courts.

It is designed to fulfill the pressing needs for a realistic examination of the
competing claims of individual patients, society, and the medical profession.
Experience elsewhere indicates that while hospital personnel would prefer
no such body at all to oversee detention, doctors have come to accept such
administrative procedures as affording a positive advantage to the patients,
and derivatively to themselves as medical persons. The percentage of di-
vergences of view between hospital recommendations and those of review
boards has been low. But the existence of serious procedures tend to reassure
patients, and keep medical work at peak performance.

The role envisaged for the Administrative Commissioner for Mental Health
Rights is comparable to that of the ombudsman in European countries. As
there, this official is not envisaged as a super-administrator, but as an auxil-
iary resource to oversee the proper operation of the administrative Mental
Ward Review Board system. These Boards are autonomous; they are the
primary source for review of a patient's detention. The Administrative
Commissioner will oversee the total work of the Boards, but not control
it in any sense. He will have an additional function in an area not as-
signed here to the Mental Ward Review Boards, that is with respect to com-
plaints or legal needs outside the hospital system. Many of these problems,
our experience shows, are recurring and can be handled most efficiently in a
central way—such problems as social security claims, parole situations. The
problem of legal assistance relating to detention is left to the existing insti-
tutions, for example, to the Public Defender Service of the District of Columbia and, when deemed appropriate, to assignment of counsel by the appropriate court. However, instances do develop when indigent patients need legal services on private matters. The Administrative Commissioner is in the position to most effectively organize such assistance by enlisting existing community facilities, such as private law firms and law school faculties and student bodies. In the pressing area which no one is servicing satisfactorily—that of ascertaining less drastic facilities than detention in a mental hospital, which is a problem in every jurisdiction visited, the Administrative Commissioner may appropriately be invited to organize social work assistance from the university facilities, at least as an interim measure.

It is proposed that the program be financed for a single year by the Administrative Conference. It is not only an experiment in solving the problem of mental health rights; it is also an experiment in an activist experimental role for the Administrative Conference in launching a pilot program which may furnish experience which will merit sustaining financing from Departmental or direct congressional sources. The block in this field has been that the problems not only cut across interested professions (law, medicine and social work), but also that the responsibilities cut across various administrative departments, and also between the executive and the courts. The proposal is moderate in its intrusions upon present administrative and judicial practices. In a field that has for too long fallen squarely between chairs, the Administrative Conference is ideally qualified to take the initiative.

III

Recommendations for legislative change are annexed hereto (Appendix D, infra). They were embodied in a recommendation to Senator Ervin, Chairman, Senate Sub-Committee on Constitutional Rights in requested testimony before his Subcommittee.

IV

It is recommended that there be a continuation of the study by the Administrative Conference on the civil rights of detained persons. It is particularly desirable that recommendations be forthcoming of appropriate administrative procedures for prison-hospitals and prisons in the near future. A further pursuit of forward European experience is to be encouraged in this regard.
Appendix D

RECOMMENDATIONS FOR LEGISLATIVE CHANGE

Five recommendations are made for legislative change: (1) Changes with respect to the composition and jurisdiction of the Mental Health Commission; (2) Compulsory periodic reexamination by the Courts of involuntarily hospitalized mental patients; (3) Direction, with adequate appropriations, to the Public Defender Service of the District of Columbia, to establish a Mental Health Section to represent indigent mental patients; (4) The establishment in mental hospitals and general hospitals with psychiatric divisions of autonomous Mental Ward Review Boards; (5) The establishment of an ombudsman, to be paid on a per diem basis, to furnish certain services with respect to patients in mental hospitals in the District of Columbia. These proposals are, in fuller detail, as follows:

I. Mental Health Commission

Revise Section 21-502 of the District of Columbia Code to read as follows:

"The Mental Health Commission, which shall be continued, shall be composed of a Chairman, a Vice-Chairman, and 16 other members. The Chairman and Vice-Chairman shall be members of the bar of the District of Columbia; eight public members shall be qualified in administration, social work, or some field offering equivalent experience; eight medical members shall be physicians with not less than five years experience in the diagnosis and treatment of mental illness. The Chairman or the Vice Chairman, or their alternates, shall preside at the hearings of the Commission, or of any panel thereof (as provided below). The Chairman shall act as the Administrative head of the Commission and its staff. The Mental Health Commission shall be appointed by the United States District Court for the District of Columbia.

"The Commission shall sit in two panels, one of which shall review recommendations of the Mental Ward Review Board with respect to civil commitment, and release therefrom, and report to the court thereon. The second panel shall be occupied with advising the District Court, and the Superior Court as requested, in respect to commitments for observation or treatment arising in the criminal process, pursuant to Section 24-301, and other matters.

"At hearings of the Commission, or any panel thereof, there shall be present, in addition to the Chairman or Vice Chairman, or their alternates, at least one member from the public-member and medical-member categories."
Involuntary Hospitalization for Mental Illness

Explanation

This proposal, presupposes the establishment of Mental Ward Review Boards (recommendation III, infra); nevertheless, it may stand on its own with a slight change of language. Its chief design is to introduce into the present instrumentality benefits which European experience has shown come from having law-medical-public interests face-to-face on the pre-court level. The medical element is highly significant but, as the present legislation recognizes, the legal viewpoint cannot be overlooked. What is now missing is the non-professional view, which is of great importance with respect to such community interests as “dangerousness,” and enforced deprivation of liberty. The proposal does not require additional psychiatric membership on the Commission, despite its expansion of the jurisdiction of the Commission to give needed assistance to the courts with respect to commitments arising in the criminal process. The introduction of Mental Ward Review Boards will make it possible for the Commission to act primarily as a “review” board, for an adequate medical and legal record will be made on the local level. It is believed that experience will show that an adequate local consideration will make resort to the Commission occasional rather than routine with respect to release matters. With respect to commitment it will continue to make recommendations to the court, approving or disapproving the recommendations made below.

A. Civil-Process Panel

This panel shall rotate as the Commission does at present, except that one lawyer (Chairman, Vice Chairman, or their alternates), one doctor and one public member shall always sit; its hearings will not ordinarily be evidentiary type hearings, but rather reviews of records made at the Mental Ward Review Board level. The panel may, however, in its discretion hold evidentiary hearings and require the attendance of physicians who have examined the patient.

This panel shall also be available to consider other matters referred to it by the court with respect to civil-process patients, including questions with respect to periodic judicial review of their continued commitment (as recommended in II infra), and requests by a patient for the appointment of an independent psychiatrist.

When directed by the court the civil-process panel shall hold hearings for elaboration of the record as to facts underlying determinations of “mental illness,” “dangerousness,” “treatment” or other matters, in release matters, whether arising before the Mental Ward Review Boards, or on applications for
writs of habeas corpus. It might be well to specify in the legislation itself that "With respect to writs of habeas corpus the report shall be made to the court within 72 hours of reference, unless the court shall specifically direct a greater, or lesser, time."

B. Criminal-Process Panel

This panel shall rotate, as above. Its chief responsibility shall be to assist the District Court, and the Superior Court in carrying out the responsibility fixed (for the District and Superior Courts) with respect to mental commitment for examination and observation under D.C. Code § 24-301. The design of operation for the panel is to process those patients for whom observation is requested by the accused, government, or on the initiative of the court itself. The back-up of such patients in the D.C. Jail is caused by the volume of such requests and the insistence of St. Elizabeths Hospital that observations referred there have bed space for the continually expanding period of such examination. I understand that the District Court has already commenced having some examinations done short of reference to the Hospital for observation. Under this proposal for a criminal-process panel there would be a continuing body, an arm of the court, which would be empowered to enlist outside psychiatrists; however, ordinarily the professional screening examination would be made by the medical members of the panel. This procedure would forestall repetition of instances in which persons needing immediate hospitalization were sent to jail, where in 1969 at least two committed suicide before being examined. A report would be made promptly to the court by the panel with respect to each accused referred to it for preliminary examination, encompassing the following information: (1) Whether the accused needs additional examination in order for a sound judgment to be made whether the accused is able to understand the proceedings against him or properly to assist in his own defense; (2) Whether such examination can be effectively carried out on an out-patient basis, or in-jail basis, as the case may be; (3) Whether the accused is in probable need of immediate hospitalization from the standpoint of the safety of himself or others. On the basis of such a report, it would appear that the court can limit the number of defendants either kept waiting at the jail for reception in St. Elizabeths, or kept at St. Elizabeths during the lengthy period now required to complete observation there.

The criminal-process panel shall also be available to consider other matters referred to it by the courts (District or Superior Court), with respect to criminal-process patients, including questions with respect to periodic judicial review of their commitment (as recommended below), or requests for issu-
Involuntary Hospitalization for Mental Illness

ance of writs of habeas corpus. Such questions might involve: request by patient for an independent psychiatrist, request by court for hearings to elaborate record as to facts underlying determinations by the Hospital or the Mental Ward Review Board as to “mental illness,” “dangerousness” or “treatment.” Again, it might be well to specify in the legislation itself that habeas corpus reports be made within 72 hours, unless the court directs otherwise (as elaborated above).

Note: Sections 21-502(b) to (e) of the District of Columbia Code will require revision in order to make possible the above proposed operation plan for the Mental Health Commission. It did not seem feasible to propose here concrete linguistic changes for these sections.

II. Periodic Judicial Reconsideration of Hospital Retention

Repeal Section 21-546 of the Code and insert the following paragraph:

"Upon the expiration of 90 days following hospitalization by court order under Section 21-545, and upon the expiration of six months following hospitalization by court order under any other provision of law [e.g. Section 24-301, criminal-process patients] who are recommended for release notice shall also be given to the United States Attorney for the District of Columbia. In the case of patients whom the hospital desires to retain, notice shall be given at the same time to the patient, and his attorney, (or if he has no attorney registered as active in the hospital record, to the Public Defender Service of the District of Columbia, Mental Health Section) and to the applicable court (identifying the judge who signed the last commitment or retention order and the date of such order).

"If the patient or his attorney objects to retention, the patient shall be entitled to a hearing before the applicable Mental Ward Review Board within one week of his filing notification with the Board. Within 72 hours of the hearing the Board shall file its recommendation with the applicable court. If the patient, or his attorney, so request, the court will hold a hearing upon the issue of continued hospitalization. The court, in its discretion, may request additional recommendations from the Mental Health Commission on this issue.

"Every six months thereafter the hospital shall give similar notices of its intention to release, or to retain, a patient, and the procedure stated above shall again be applicable."

Explanation

The present section, obviously designed to insure periodic review where needed, without becoming a routine burden on the hospital and the courts, has
in practice proven ineffective. It has, in fact, been used by the hospital as a device to circumvent practical recourse to the writ of habeas corpus, a recourse which was itself inflated beyond bounds because of the unavailability of internal procedures reviewing mental condition. The present proposal combines practical, meaningful internal reconsideration with an ultimate judicial consideration, if requested. The most likely result of such a process, if the European experience is a guide, is for the patients and attorneys to most often be satisfied with a fair and complete hearing at the Mental Ward Review Board level. However, even European countries with effective local procedure have amended their laws to include an ultimate judicial consideration (Denmark and Norway). In New York, there is automatic periodic review, ultimately at greater intervals than recommended here. A six-months period has been chosen because that is the unit that is now in the legislation. Experience may prove that it should be changed to provide for a longer interval after the first two years.

The provision for notification to the United States Attorney in the event of recommended release of criminal-process patients stops short of labelling retention (or detention) of some patients who are receiving little medical help (for example, psychopaths) as preventive detention. But it does bring into the open the public interest against release of patients whose past violence has had criminal consequences. This issue has been masked, in present practice, where the hospital and the United States Attorney (who appears as its counsel of record in detention litigation) communicate in some private (attorney-client) relationship on issues that should have, I believe, public ventilation in order to maintain the confidence of attorneys and patients, which is necessary if the courts are not to be hopelessly burdened with habeas corpus writs. Like the first recommendation, this one depends in great part upon the local consideration given by the Mental Ward Review Boards which are the subject of recommendation III.

III. Establishing Local System of Mental Ward Review Boards

Appropriate legislation shall provide as follows:

1. The Chairman of the Administrative Conference of the United States is hereby authorized to compile a panel of citizens resident in, or employed in the District of Columbia in whatever number is, at any time, necessary to fill the complement of Mental Ward Review Boards to be established for mental hospitals or general hospitals with psychiatric divisions, having involuntarily hospitalized patients, on an approximate ratio of one Mental Ward Review Board for each 1,000 patients. This panel shall consist of physicians with not less than three years experience in the diagnosis and treatment of
mental illness, members of the District of Columbia bar, and general public members qualified in administration, social work, or some field offering equivalent experience, in approximately equal number.

2. From this panel the Chairman of the Administrative Conference, in consultation with the Secretary of the Department of Health, Education and Welfare, and the Chief Judges of the United States Court of Appeals for the District of Columbia Circuit, the United States District Court for the District of Columbia, the District of Columbia Court of Appeals and the Superior Court of the District of Columbia, shall designate (initially six, and thereafter, as necessary) Mental Ward Review Boards. Each such Board shall consist of three members (one medical, one legal, and one public, as above described), and an alternate for each member from the same category.

3. Each Board shall meet twice monthly in the hospital assigned to perform the duties here described, and as necessary to hold hearings and deliberations, with respect to commitment, periodic review of detention, and complaints received from patients.

4. If the Chief of Service determines, after examination, that a patient committed to the hospital for observation, should, under applicable provisions of law, be retained for treatment, he shall notify the applicable Mental Ward Review Board to this effect seven days before the hospital's right of retention under law shall expire. The Mental Ward Review Board shall promptly hold a hearing, at which the patient shall be examined medically, and his administrative doctor shall be present. The Board shall be entitled, in advance of the hearing, to all hospital records and charts concerning the patient, and any member of the hospital staff to give testimony. The patient shall be entitled to be represented by counsel, and if the patient is indigent, the Board shall invite the Public Defender Service of the District of Columbia to represent him. A record (not necessarily stenographic) shall be kept of each such hearing and a decision, stating reasons, shall be given by the Board. The Board shall promptly make a decision, either affirming the hospital, or disagreeing with its decision to retain the patient. In either event the Board shall immediately notify the patient of its decision, and forward the entire file, including the transcript or summary of testimony, and its decision to the Mental Health Commission.

5. Within seven days after the receiving notice with respect to a patient hospitalized under Section 24-301 of the District of Columbia Code, of a mental hospital's decision to release a patient pursuant to Section 21-546 (as amended by recommendation II supra) the United States Attorney may request a hearing of the matter before the applicable Mental Ward Review Board. The patient may be represented by counsel at this hearing, and if he is
indigent, the Board shall request the Public Defender Service of the District of Columbia, Mental Health Section, to represent him.

Within seven days after receiving a hospital's notice of intention to retain a patient, involuntarily hospitalized under Section 21-502ff, the Mental Ward Review Board shall review the records upon which the hospital based its decision, and forward them with its recommendation to the appropriate court for periodic judicial review of detention pursuant to Section 21-546 (as amended by recommendation II supra). However, the patient or his attorney may request a hearing, and if made within five days following their receipt of notice of the hospital's intention the request shall be granted. If the patient has no active attorney the Board, at its discretion, may appoint an attorney for purposes of determining whether a request for a hearing should be made. The same procedure with respect to a hearing that was enumerated under the previous subsection shall here apply except that the Board shall, within 72 hours of the hearing, file its recommendation, together with the record on the case, with the appropriate court.

6. Any patient who files notice with his administrative doctor 48 hours before an appointed time of meeting of a Mental Ward Review Board shall be entitled to appear before the Board and present his complaint in person. The complaint may concern: (a) detention, in which event the Board may advise the patient of its willingness to proceed if it has not considered a similar request within the past six months; (b) matters other than requested release which involve situations primarily internal to the hospital; or (c) matters which are, in whole or part external to the hospital.

(a) If a Mental Ward Review Board, after hearing, determines that a patient is being held contrary to law, it shall immediately advise the Chief of Service to such effect. Within 24 hours after receipt of this notice the Chief of Service shall advise the Chairman of the Mental Ward Review Board of his intention (1) to release the patient within 24 hours, or such reasonable time as the Board deems appropriate, or (2) not to release the patient without direction by the court. In the latter event the Chairman of the Board shall forward its file, together with the decision of the Board and the correspondence with the Chief of Service to the Director, Public Defender Service for the District of Columbia, or to the patient's counsel, to consider initiation on behalf of patient of appropriate court action.

(b) With respect to patients' complaints concerning hospital matters other than release from the hospital, the Mental Ward Review Board is empowered to adjourn a hearing until its next appointed meeting. During the intervening time, it may conduct such investigations as it deems advisable. The Board shall be entitled to access to all hospital records which it deems relevant, and
may require any member of the hospital administration or staff to appear before it. If the Board, after investigation, deems the complaint well-grounded it shall advise the Chief of Service to such effect. Within 24 hours thereafter, unless the Board directs otherwise, the Chief of Service shall advise the Chairman of the Board what steps, if any, he proposes to take with respect to the grievance. In the event that the matter is not settled locally the Board may take such further action as it deems appropriate. All cases regarding this area of internal complaints, including summaries of facts and disposition, shall be forwarded by the Mental Ward Review Boards to the Chairman of the Administrative Conference, or to the official designated by him (in accordance with recommendation IV infra) to be Administrative Commissioner for Mental Health Rights (ombudsman).

(c) With respect to patients’ complaints concerning matters external to the hospital (for example, property claims, social security matters, parole board communications), the Board, if it determines that the complaint warrants investigation, or that the patient requires legal assistance, shall forward the complaint file, together with its recommendation for favorable consideration to the Chairman of the Administrative Conference of the United States, or to the official designated by him (pursuant to recommendation IV, infra) to be Administrative Commissioner for Mental Health Rights (ombudsman).

IV. Establishment of Administrative Commissioner for Mental Health Rights—a Part-time Ombudsman

Appropriate legislation shall provide that:

1. There shall be designated by the Chairman of the Administrative Conference of the United States an Administrative Commissioner for Mental Health Rights. He shall be appointed after consultation with the Secretary of Health, Education, and Welfare, and the Chief Judges of the United States Court of Appeals for the District of Columbia, the United States District Court for the District of Columbia, the District of Columbia Court of Appeals, and the Superior Court of the District of Columbia. He shall serve for three years and may be reappointed. If not already in full-time service of the government of the United States, he shall be compensated on a per diem basis for days actually at work, at the rate currently fixed for such officials. The Chairman of the Administrative Conference may himself, in lieu of making such appointment, fulfill the duties of the office of Administrative Commissioner for Mental Health Rights.

2. The Administrative Commissioner for Mental Health Rights shall:
(a) Receive and investigate, as he deems necessary, complaints sent to him directly by patients in federal mental hospitals, or on their behalf.

(b) Refer complaints received that involve alleged illegal detention of patients, or other grievances internal to the hospital, to the appropriate Mental Ward Review Board, if such exists, and if none exists to the Chief of Service of the hospital for preliminary investigation. He shall advise the patient of such references.

3. With respect to all matters not within the jurisdiction of the courts (i.e., as to internal complaints not involving commitment or release), oversee the determinations of Mental Ward Review Boards, and take such action with respect thereto as he deems appropriate, without interfering with the autonomy of these Boards.

4. Give assistance to Mental Ward Review Boards, as requested, especially with respect to stabilizing their procedures in a uniform way, and compiling statistical accounts of their collective work on an annual basis.

5. Oversee action or inaction of any mental hospital with respect to recommendations to them arising out of complaints, as made by Mental Ward Review Boards.

6. Confer, as appropriate, with the Chief of Service of the Hospital, the United States Attorney and the attorney of any patient, with respect to resolution short of court action in cases where the Mental Ward Review Board has recommended discharge, and the Chief of Service has disagreed with its recommendation.

7. Investigate patients' complaints concerning matters external to the hospital, whether received directly or referred by a Mental Ward Review Board, and take such remedial action, including securing such independent legal assistance as he deems appropriate.

8. Develop a panel of attorneys who may take reference of patients' cases pursuant to the preceding paragraph, take steps to insure their fair compensation, and oversee that matters referred are pursued without undue delay.

9. Communicate promptly with patients as to the disposition by the Administrative Commissioner for Mental Health Rights of any complaint, giving in writing his reasons for such disposition.

10. Investigate the feasibility of introducing Mental Ward Review Boards in all federally operated mental hospitals, or general hospitals with psychiatric divisions, and make recommendation to the appropriate authorities in this regard.

11. Prepare an annual report giving a detailed account of the disposition
of all complaints which he has officially received, in appropriate categories, with accompanying statistics as to disposition. Copies of this report shall be furnished to each member of Congress and to all federal agencies concerned.

**Explanation of Recommendations III and IV**

*Mental Ward Review Board*

The heart and soul of the proposed legislative change is the founding of local Mental Ward Review Boards. It is borrowed from the experience in Norway, Sweden, and England. These Boards, more like the Norwegian and Swedish models, would be assigned to fixed hospital wards or divisions. For a start, it would be expected that there would be, for example, two Boards in John Howard Pavilion, the maximum security unit, and one more for each approximate 1000 inpatients at St. Elizabeths Hospital.

The deliberate mixture on each local board of medical, legal and general public persons corresponds with the variety of considerations which is involved in incarceration in a mental hospital, and in release therefrom as well. The mechanism used in these other countries allows the local Board to direct release of patients (except in criminal matters, where the Ministry of Justice, or Home Office (England) has the controlling voice). This aspect has not been recommended here. It may, however, prove to be a next step. One great advantage of such a procedure was called to my attention by psychiatrists in Sweden: The psychiatrist recommends release; it is up to the local Board to make the “social” decision to retain. The doctor is not put in an adversary position with a patient, as he is in the United States; often a doctor will recommend release (in these European situations) warning a patient that the Board, from past experience is not apt to go along with it. He focuses upon the fact that he had done as much for the patient as he can; he can report on progress; it is up to the Board to take the social responsibility. Until it is seen how effective the personnel secured for the Boards proposed here will be, it is recommended that their role be restricted to: (a) furnishing a supplementary medical overview; (b) holding a hearing at which the record can be made of the range of issues in controversy upon which a court can act meaningfully; (c) furnishing in its recommendations the resultant of a dialogue among the different disciplines represented—something that never takes place under our present arrangements.

The intervention of the Mental Ward Review Board should fill the gap left by the limited activity of the Mental Health Commission on commitment; the Boards would free that Commission for a reviewing capacity, and permit its work to be expanded to give the Courts needed help in the criminal process sphere. The Boards should make the work of the Courts infinitely lighter
and more manageable. The number of writs should decrease; the records upon which the Courts act would be fuller. The Boards will not be welcomed at the outset by the hospitals. But the European psychiatrists with whom I conferred have found their work load in fact lightened, their relations with patients improved, and themselves freed of responsibility for implicit social judgments, which they did not feel qualified to make. The statement of one Hospital Superintendent in Norway was quite typical: "I would not be without the Board." The Board will also be an avenue towards securing legal assistance and psychiatric examination for patients. The present rule of a "right" to an independent psychiatric examination every six months has proved unattainable. I would say that it is also unrealistic. The Board will be in a position to recommend meaningfully when such full scale independent examination is necessary. There is no doubt that the effectiveness of such a Board is enhanced by the experience it acquires working in one particular unit. If European experience is repeated here the Board will develop a working basis with the hospital without sacrificing its autonomy and independence. Each Board will have to earn its own reputation for fairness and thoroughness from both patients and hospital personnel.

The Board also performs a critical role in two other fields—beyond the issue of detention. That is as a source to which grievances may be presented on a regular basis. These grievances may concern matters internal to the hospital. Here is the area where the English system has run into serious difficulties. They may also concern matters external to the hospital, which the patient would ordinarily be able to care for himself were he outside, or for which he would need the resources of an attorney (in such situations as the Neighborhood Legal Service Projects give assistance to indigents). Many of these problems in a mental hospital become type problems. In the course of the Ombudsman Project we found a pattern of situations at St. Elizabeths Hospital in social security matters, in parole board negotiations. But there are individual property, family and contract problems which often require an attorney's attention. I am also proposing that we draw again on the European experience and institute a part-time Administrative Commissioner for Mental Health Rights or Ombudsman. (1) To deal with serious complaints (internal) at a high level; (2) to route external complaints to outside attorneys when he can not handle them expeditiously himself, and (3) to give oversight and assistance to the autonomous Mental Ward Review Board system—as well as to be a respected available resource to patients.

Ombudsman

The Administrative Commissioner for Mental Health Rights would be au-
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Authorized to propose to the various Mental Ward Review Boards uniform methods of procedure, including methods for insuring adequate notice to patients of their rights. (A similar section of the 1964 Hospitalization of the Mentally Ill Act has been ignored to date by the federal hospital in Washington, D.C.) He could also (1) stimulate hospital investigation of alternatives to hospitalization, (2) oversee availability to patients of public and volunteer legal assistance, and (3) furnish a standard statistical method for compiling and communicating the results of the work of the Mental Ward Review Boards. He could call the attention of administrative authorities to the noncompliance with, or malfunctioning of, provisions of law at their hands (he would have been useful here these past few years), and if necessary report such matters to Congress. In addition he might propose, formally or informally, to the officials of the hospital administration, or to the courts, changes in rules or practices within his field of competence. Such proposals would be in no way binding upon those to whom made and would be, so to speak, an overflow from his ordinary activity and not a special function. A new component is thus brought into the picture: a high level figure with concern to receive complaints from patients and others (including officials) that bear upon malfunctioning of the process. He will be, in effect, an ombudsman for mental health rights. But this must be understood in a restricted sense—he is not a superofficial to displace either hospital administrative personnel, or the autonomous Mental Ward Review Boards, or the court's auxiliary, the Mental Health Commission. He shall, like the European ombudsmen, call attention to alleged oversights of these agencies with respect to complaints brought to his attention. Working in close harmony with the highest administrative officials (HEW and NIMH), with the independent boards and with the courts, and with the Public Defender Service, he will keep all advised as to the factual functioning of the new system. At the same time he will be a continual resource to whom patients may complain with confidence that some reasonable action will be put in motion as a result thereof.

It is desirable that the ombudsman originate from a source outside the various governmental organs most intimately concerned. Reactions which I received from the Chief Judges of two of the Washington courts, and from high officials in the hospital chain of command, indicate that the Chairman of the Administrative Conference of the United States, or someone appointed by him after conferring with the Secretary of HEW, or his designee for this purpose, and with the Chief Judges of the Court of Appeals for the District of Columbia, of the United States District Court for the District of Columbia, of the District of Columbia Court of Appeals, and of the Superior Court of the District of Columbia, would be satisfactory as Administrative Officer for Mental Health Rights.
While it is possible that such an Administrative Officer for Mental Health Rights might be funded for a brief time from the funds of the Administrative Conference, the Chief Judge of the United States District Court did volunteer that it would be more feasible if the official were legitimated by legislation, and perhaps by direct appropriation.

As in any structural change the success or failure will depend upon the quality, enthusiasm and determination of the personnel. Experience with European local boards has shown that keen professional and citizen interest may be enlisted in crucially important work of this kind when the boards are assigned to specific areas (small hospitals, or wards). In the case of a sprawling hospital like St. Elizabeths, it is believed such boards (even though they may need to be more numerous eventually than is here proposed) seem a critical need. The reviewing type activity proposed for the Mental Health Commission is more in line with the actual way the Judicial Conference Report shows it has worked, than the way the Hospitalization of the Mentally Ill Act envisioned. Perhaps it is best to adapt to the reality, and call upon the great talent of these men with help from a new category of public (nonprofessional) members in the critically necessary area of the criminal process. The division of the Mental Health Commission into Civil- and Criminal-Process panels will permit recruiting people interested in the two quite disparate kinds of work.

V. Beefing Up the Public Defender Service, Mental Health Section

Without in any way minimizing the great advantages furnished by the New York Mental Health Information Service system, I believe that more is needed than filing of reports for the courts (valuable as they are) in mental health cases. I agree with the assessment of the Director of the MHIS in the First Department (and his presiding justice) that adversary assistance is necessary for the patients, and that this assistance is best supplied by a section of the bar specially trained, and regularly involved, in that special form of legal work. For this reason I recommend that the Public Defender Service of the District of Columbia be given specific appropriations for the purpose of adequately financing a Mental Health Section, whose responsibility would be solely to attend to the legal requirements of mental patients. The appropriation should be earmarked to this "Mental Health Section," which shall represent patients in matters before the Mental Ward Review Boards, as specified above, where patients do not have their own counsel. They will follow cases, as necessary, to the Mental Health Commission, and to court. They will also represent patients on periodic review, and on habeas corpus writs. They would not, however be drawn into representing patients on private matters
(not involving detention). The need for assistance to patients in this area would be filled through the legal panel developed by the Administrative Commissioner for Mental Health Rights.