Parens Patriae "Treatment": Legal Punishment in Disguise

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The rationale of state intervention in individual affairs under the doctrine of parens patriae is that the state has a right and a duty to help and protect those who cannot help themselves.[1] All measures taken under the doctrine are justified as intended ultimately for the individual's own good. Cast in the mold of the medical model, which has gained increasing influence since the end of the nineteenth century, this intervention has been denominated "therapy" or "treatment."[2]

By the process termed divestment, many areas of the criminal law have been either abandoned outright, in favor of parens patriae civil interventions, or profoundly influenced in ways discussed below.[3] Until

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1. N. KITTRIE, THE RIGHT TO BE DIFFERENT (1971) [hereinafter cited as KITTRIE], is probably the best single source for direction to the literature of parens patriae interventions. Noting that the term is "derived from the English concept of the King's role as father of the country," Kittrie states, "[w]ithin this system, little or no emphasis is placed upon an individual's guilt of a particular crime; but much weight is given to his physical, mental, or social shortcomings. In dealing with the deviant . . . society is said to be acting in a parental role (*parens patriae*)—seeking not to punish but to change or socialize the nonconformist through treatment and therapy." *Id.* at 3.

2. A fundamental tenet of the state's role in parens patriae is the viewing of deviant behavior as symptomatic of disease or illness rather than as a reflection of political and social norms that define unacceptable behavior. For a critical discussion of the assumptions underlying the medical or psychiatric approach to deviance, see R. LEIFER, IN THE NAME OF MENTAL HEALTH 17-53 (1969). KITTRIE, *supra* note 1, at 1-49, provides an introduction to the historical development of the medical model.

3. Kittrie makes an important point when he notes: "This process of divestment has not been motivated, on the whole, by societal willingness to begin tolerating the conduct or condition previously designated as criminal. Instead, divestment has most frequently indicated a shift from criminal sanctions to a different system of social controls. Thus divestment, carried out in the name of the new social emphasis upon therapy, rehabilitation, and prevention—as contrasted with criminal law's emphasis upon retribution, incapacitation, and deterrence—has produced new types of borderland [sic] pro-

recently, this divestment process has been almost universally applauded. Rather than meting out criminal sanctions, the state has promised treatment to wayward youth, the mentally disordered, drug addicts, and even many criminals.[4] The due process concerns of the criminal sanction were ignored; one should not need protection from one's therapist. Such constraints would, in fact, amount to an outright interference with the treatment process.

The state's benevolence has been questioned in recent years. Case law indicates that the courts are abandoning their hands-off attitude, and have begun to realize that due process protections are important, even in allegedly therapeutic or rehabilitative interventions.[5] Civil commitment statutes are being revised by state legislatures to reflect greater concern for civil liberties.[6] Prison therapy and indeterminate sentencing are increasingly recognized as potentially powerful tools of control, rather than as instruments of rehabilitation.[7] Benevolent in-

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ceedings and sanctions, lodged between the civil and criminal law." KITTRIE, *supra* note 1, at 5 (footnote omitted).

4. The optimism of nineteenth century reformers is well chronicled in D. ROTHMAN, THE DISCOVERY OF THE ASYLUM (1971) [hereinafter cited as ROTHMAN].

5. *See, e.g.*, Morrissey v. Brewer, 408 U.S. 471 (1972) (requiring an informal hearing as a prerequisite to revocation of parole); *In re* Gault, 387 U.S. 1 (1966) (holding that the Arizona juvenile code impliedly includes the requirements of due process in delinquency proceedings); Specht v. Patterson, 386 U.S. 605 (1967) (requiring hearings as a prerequisite to imposition of an indeterminate sentence under the Colorado Sex Offenders Act).

6. B. ENNIS & L. SIEGEL, THE RIGHTS OF MENTAL PATIENTS 93-282 (1973) [hereinafter cited as ENNIS & SIEGEL], summarizes the commitment statutes for each of the fifty states as of the time of its printing. The general trend in recent years is away from an "in need of treatment" standard of commitment, in which serious mental disorder is sufficient cause for confinement, toward a "dangerousness" standard, in which the mental disorder must portend the likelihood of injury to self (i.e., suicide or inability to care for basic needs) or to others prior to involuntary commitment. *See* A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 675-726 (1974) [hereinafter cited as BROOKS]. Simultaneously, however, massive documentation has demonstrated that psychiatrists lack the ability to make these judgments, and that they consistently overpredict dangerousness. *See, e.g.*, Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974). *See also* AMERICAN PSYCHIATRIC ASSOCIATION, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL (Task Force Report No. 8, July 1974), which concludes: "Psychiatric expertise in the prediction of 'dangerousness' is not established and clinicians should avoid 'conclusory' judgments in this regard." *Id.* at 33.

7. Widespread disillusionment is replacing the optimism that initially accompanied the promise of the rehabilitation or corrections model of criminal sentencing—that individualized sentencing and treatment would promote shorter sentences and increased motivation for personal reform. California, which in 1917 became the first state to adopt indeterminate sentencing and became a leader in the length of time it kept its convicts confined, has now abandoned this approach. S.B. 42 (signed, Sept. 20, 1976).

tent is no longer an acceptable justification for the wholesale denial of due process for juveniles.[8] In addition to this emphasis on constitutional rights, recent judicial decisions have developed a new doctrine, the "right to treatment," regarded by many as a welcome development.[9] In short, psychiatry and the law are gradually reflecting a greater awareness of the individual freedoms at stake in parens patriae interventions.

Have these limitations on the therapeutic sanction arisen from a re-evaluation of the actual *basis* of parens patriae? We think not, for the fundamental premise is still accepted *that there is a valid distinction between criminal punishment and state ordered "treatment."* The thesis presented here is that both psychiatry and the law have yet to confront the inherent and *irreconcilable* differences between bona fide treatment and state sanctioned parens patriae intervention. Until this fundamental confrontation takes place, civil rights reforms, although necessary in and of themselves, only blunt our sensitivity while we proceed to replace old forms of benevolent control with new ones. For reasons discussed below, this exchange may be far more ominous than is generally recognized.

Our aim is to question the very roots of parens patriae, and the analysis of language is a crucial element in achieving this end. Any effort by one individual to influence another is profoundly affected by what both parties believe to be the purpose of the effort; furthermore, this common understanding depends as much on the *words chosen* as on the practices themselves.[10] Thus, despite recent judicial and legis-

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For a discussion of the destructive psychological impact of indeterminacy, see Coleman, *Prisons: The Crime of Treatment*, 2 PSYCHIATRIC OPINION 5 (June 1974). For examples of specific abuses of treatment in prisons, see Opton, *Psychiatric Violence Against Prisoners: When Therapy is Punishment*, 45 MISS. L.J. 605 (1974) [hereinafter cited as Opton].

8. A. PLATT, THE CHILD SAVERS: THE INVENTION OF DELINQUENCY (1969) [hereinafter cited as PLATT] is an excellent account of the historical developments underlying the benevolent facade of the juvenile court movement.

9. After initially taking a defensive posture, the American Psychiatric Association (APA) has now come out in support of the doctrine. Psychiatric News, July 16, 1975, at 1, col. 1. In our view, this stems from the APA's belated recognition that the right to treatment doctrine lends support to involuntary psychiatric treatment. In addition, the promulgation of standards of treatment, such as those enunciated in Wyatt v. Stickney, 334 F. Supp. 1341 (M.D. Ala. 1971), encourages increased funding for mental hospitals.

10. For a discussion of the impact of changing labels within a psychiatric context, see T. SZASZ, THE MYTH OF MENTAL ILLNESS (1961) [hereinafter cited as SZASZ]. *Cf.* P. FARB, WORD PLAY: WHAT HAPPENS WHEN PEOPLE TALK 83-95 (1973). Within the context of what Farb calls "the passion for relegating certain words to taboo status and

lative recognition of the civil rights questions inherent in parens patriae interventions, these interventions continue to be considered as benevolent treatment. In questioning this assumption and providing an alternative framework, we will first analyze, through language, the assumptions underlying state-sanctioned psychiatric "treatment." Historic examples of control viewed as benevolence, considered together with current developments of that view, provide a broad perspective within which to view the future dangers of the therapeutic sanction.

Treatment Reconsidered

If treatment is to justify either civil intervention in the absence of criminal conviction or vastly broadened discretionary power within the criminal sanction, a clear understanding of the concept of treatment is crucial. Surprisingly, the literature dealing with parens patriae has been virtually silent on this fundamental issue.[11]

Clearly linked with medicine, the concept of treatment is defined as the "management in the application of remedies; medical or surgical application or service."[12] In the debate about whether psychiatric interventions should properly be designated as treatments, the controversy hinges on whether one considers emotional problems to be true diseases or emotional responses to problems of living.[13] The denomination of mental problems as diseases and psychiatric interventions as treatments is unfortunate. But a far more compelling distinction between bona fide treatment and parens patriae treatment is the element of volition.

Both medical ethics and the law clearly differentiate between treatment and battery.[14] The distinction disregards issues of effective-

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then substituting euphemisms for them . . . ," we wonder whether the word "punishment" may not have achieved a taboo status.

11. *See, e.g.*, KITTRIE, *supra* note 1. Despite his comprehensive review of parens patriae literature in general, Kittrie fails to deal with what should or should not be considered treatment. Another recent overview, BROOKS, *supra* note 6, deals with the vagaries of such concepts as mental illness and psychiatric diagnoses, but it too fails to discuss the nature of treatment.

12. 11 THE OXFORD ENGLISH DICTIONARY 309 (1933).

13. SZASZ, *supra* note 10, questions whether psychiatric problems are a form of illness, whether psychiatric classifications are true diagnoses, and whether psychiatric help is true treatment. Szasz's critique of the medical model has been widely misunderstood as implying that mental problems are a myth; in fact he recognizes the reality of emotional problems but questions whether such problems are medical in nature and should therefore be classified as illnesses. *But see* D. AUSUBEL, *Personality Disorder is Disease*, 16 AM. PSYCHOLOGIST 69 (1961).

14. In Cobbs v. Grant, 8 Cal. 3d 229, 239, 502 P.2d 1, 7, 104 Cal. Rptr. 505, 511

ness, side effects, skillfulness, and intent. The crucial point is whether voluntary consent precedes the physician's actions. Without consent, what would by all medical standards be considered treatment becomes unlawful activity. Thus, the psychiatry practiced as parens patriae intervention upon patients who do not consent to it cannot qualify as bona fide treatment. The careless acceptance of these interventions as treatment has led not only to the waiving of due process guarantees, but also to nonrecognition of the punitive quality of all parens patriae controls.[15]

Punishment Reconsidered

The nature of punishment is the second element of the traditional treatment/punishment dichotomy at the logical core of parens patriae philosophy. According to the *Encyclopaedia Britannica*, punishment is:

> the infliction of some pain, suffering, loss, or social disability as a direct consequence of some action or omission on the part of the person punished. . . . [T]he agent of punishment must be in a position of legitimate authority over the punished. . . .[16]

This definition speaks neither of intent nor of the professional identity of the agent of punishment. Instead, the emphasis is on *infliction* of something by one person upon another within the context of delegated

(1972), it was held that "[w]here a doctor obtains consent of the patient to perform one type of treatment and subsequently performs a substantially different treatment for which consent was not obtained, there is a clear case of battery." *See also* Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969).

15. See Opton, *supra* note 7, for examples of therapy-punishment in prison. He discusses electro-convulsive shock, drugs, brainwashing, and segregation as examples of punishment as therapy. He argues that these practices may be viewed as both therapy and punishment, and should therefore be regulated as punishments. He reaches this conclusion despite his statement that "[w]hen a medical procedure is done at the request of a patient and for his benefit, it is a treatment. When the identical medical procedure is done against a person's interests or will, it is either a battery, if lacking legal sanction, or a punishment, if imposed by legal authority." *Id.* at 608. This statement seems inconsistent with Opton's conclusion that a procedure could be simultaneously treatment and punishment, but appears to support our hypothesis that all treatment without consent is punishment.

16. 15 ENCYCLOPAEDIA BRITANNICA: MACROPAEDIA 281 (15th ed. 1974). The concept of punishment has received much more attention than the concept of treatment, perhaps because punishment is generally recognized as an ethical question whereas treatment, which is usually left to physicians and scientists, has been considered beyond the review of lay commentaries. We have found that the *Britannica*'s definition of punishment is generally mirrored by other commentators. *See* CONTEMPORARY PUNISHMENT: VIEWS, EXPLANATIONS, AND JUSTIFICATIONS (R. Gerber & P. McAnany eds. 1972), particularly Flew, *Definition of Punishment*, at 31-35. *See also* Bittner & Platt, *The Meaning of Punishment*, 2 ISSUES IN CRIMINOLOGY 79 (1966).

state authority. We posit that the above definition of punishment provides a conceptual framework for the realistic analysis of state sanctioned intervention.

While prosecutors, judges, and prison guards are assumed to be in the business of punishment, however fairly or unfairly administered, it is assumed that therapists, as humanitarian professionals, offer treatment. A marvelous circularity results. If your intent (however measured or defined) is benevolent, you are a therapist; if you are a therapist, your intent is prima facie benevolent, and whatever you do is therapy.

These false criteria—benevolent intent and professional identity —upon which the parens patriae distinction between punishment and treatment has been drawn, have become the cornerstones of the therapeutic sanction. In the early years of this century, George Ives formulated a philosophy of treatment which remains basically unchanged. His initial comment was that punishment is an irrational remedy;[17] his expressed hope was that,

> in the Future, when the Courts convict a prisoner, he will not merely disappear from view, to undergo a senseless, indiscriminating punishment. He will not, in fact, be punished more than any other patient; but he may have to undergo a course of treatment varied according to his special need, which may, or may not, be painful in its operation. The difference between the cut of the surgeon and the stab of the assassin lies mainly in the motive which made the wound. They will inflict no moment of unnecessary suffering; if they have to give any pain, there will be purpose in it, and a friendly purpose.[18]

Despite Ives and the century-old rationale of parens patriae, the crucial difference between the surgeon and the assassin lies neither in the motive nor in the degree of skill of each, but rather in the consent given the surgeon and denied the assassin. The surgeon, absent such consent, may be considered an assassin of sorts:

> Anglo-Saxon law does not recognize . . . nonconsensual treatment. . . . [A]n operation without the patient's consent . . . is not treatment but battery. . . . [U]nconsented surgery is, in the eyes of the law, tantamount to attack with a knife.[19]

Parens Patriae Treatment as Punishment

We have seen that the concept of parens patriae treatment is a

17. G. IVES, A HISTORY OF PENAL METHODS 266 (1914).

18. *Id.* at 335.

19. G. Alexander & T. Szasz, *From Contract to Status via Psychiatry*, 13 SANTA CLARA LAW. 537, 548 (1973).

semantic fiction since this treatment lacks the consent that is the *sine qua non* of bona fide treatment. Is state ordered "help" thus inherently punishment? In light of the elements of punishment, as discussed above, no valid distinction exists between parens patriae treatment and legal punishment. Pain, suffering, loss, and disability can be inflicted by the legal agent of punishment and can also result from bona fide treatment. But in bona fide treatment they are a side-effect of procedures undertaken to lure or alleviate an illness, whereas in parens patriae treatment they are inflicted because of some act or omission.[20] Although in parens patriae treatment the agent has legitimate authority to intervene, the intervention is nonetheless coercive, whereas the agent of bona fide treatment intervenes only with the consent of the patient.[21]

Parens patriae treatment involves not only the physical pain and suffering that may result from particular forced interventions, but also the psychological pain and suffering that may result from disculturation, isolation, dehumanization, and loss of freedom, all direct consequences of the intervention itself.[22] Regardless of the manner in which it occurs or the intent with which it is done, forcing something on someone represents a loss of freedom of choice and frequently results in pain and suffering. When we add that this pain, suffering, loss, or disability is sanctioned by law and is justified by action or omission on the part of the subject, it becomes evident that all parens patriae treatment constitutes legal punishment.[23]

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20. Although civil commitment of mental patients is often rationalized as a response to mental illness, it is the individual's *behavior* which leads to interference in his life. Even were we to ignore the inability of psychiatrists to demonstrate either the reliability or validity of their diagnoses (*supra* note 6), the fact is that most individuals with a particular diagnosis, such as paranoid schizophrenic, are not committed. The difference between those who are committed and those who are not lies in their behavior—whether it appears that they are attempting to harm themselves or others, or are generally acting in a way that is intolerable to others.

21. See text accompanying note 14 *supra.*

22. A number of recent psychological works have questioned whether the negative side effects of institutionalization itself are counterproductive of effective treatment. Most notably, the writings of Goffman and Scheff have emphasized that mental institutions make little serious effort to equip their patients with the ability to become free and independent people. Instead of learning how to cope effectively with the problems that initially catapulted them into the hospital, institutionalized individuals are forced to undergo a variety of counter-therapeutic measures that ultimately render most of them incapable of ever achieving the institution's supposed goal—a return to society. *See* E. GOFFMAN, ASYLUMS (1961); T. SCHEFF, BEING MENTALLY ILL (1966).

23. Our insistence that all parens patriae treatment is, in truth, legal punishment, and is therefore indefensible in the absence of criminal offense, nonetheless leaves room for the possibility of certain other parens patriae interventions. These are genuinely based on status rather than on behavior and therefore should not be considered legal

The use of the word "punishment" to describe a therapist's best efforts, or of the word "prison" to describe a humanely appointed hospital facility, will strike many as unduly harsh. Words have had the power to comfort us, and have played and continue to play a major role in the deception inherent in parens patriae interventions. The California Welfare and Institutions Code provides a typical example:

> It is hereby declared that the provisions of this code reflect the concern of the Legislature that mentally disordered persons are to be regarded as patients to be provided care and treatment and not as inmates of institutions for the purposes of secluding them from the rest of the public.
>
> Whenever any provision of this code theretofore or hereafter uses the term "inmate," it shall be construed to mean "patient."[24]

Such linguistic manipulation is not new. A nineteenth century example of the power of words is the dialogue between Elizabeth Ware Packard, a critic of mental asylums, and her psychiatrist, following Packard's incarceration:

> [Doctor:] "I don't like your calling this place a prison so much; for it isn't so. . . . You may call it a place of confinement if you choose, but not a prison."
>
> . . . .
>
> [Packard:] "It is a prison to me . . . . I intend to clothe truth in its own drapery and to call things by their true names as I apprehend them."
>
> . . . .
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> [Doctor:] "But you will acknowledge, Mrs. Packard, that the penitentiary inmates are on a different plane as prisoners, from what you are?"
>
> . . . .
>
> [Packard:] "The penitentiary is our government's place of punishing the guilty; insane asylums are our government's place of punishing the innocent . . . ."
>
> . . . .
>
> [Doctor:] "You would not, in writing a dictionary, describe each as alike, would you?"
>
> [Packard:] "I should say they are one and the same thing, as to being prisoners."[25]

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punishment. Guardianships for certain retarded children or brain damaged individuals, and compulsory education are examples of legally sanctioned interference that may impose pain, suffering, loss, and disability. The intervention results not from any action or omission of the individual, however, but rather from their state of being. Whether or not each of these parens patriae interventions is wise social policy is beyond the scope of this commentary.

24. CAL. WELF. & INST'NS CODE § 4132 (West 1972).

25. 2 E. PACKARD, MODERN PERSECUTION 132-35 (1873) (emphasis deleted). In 1863 Elizabeth Packard's husband, a clergyman, kidnapped and imprisoned her in an Illinois asylum because she dared to teach in her Bible class that human beings are born good and not evil. Elizabeth Packard, a free-thinker in far more than religious matters,

We desperately need the kind of linguistic honesty that Packard advocated. Just as the misuse of words has, in the past, been a powerful element in the successful effort to disguise punishment as treatment, such misuse continues to hamper psychiatric and legal decisionmaking.

Prisons are now "medical facilities," prison guards are "correctional officers," and prisoners are "inmates" or "patients";[26] the list of such linguistic sleights-of-hand is long. This commentary will focus on one example of the continuing power of language to sanitize policies that pose grave threats to free society, the emerging doctrine of the right to treatment.

A Strange New Right

The right to treatment has its legal roots in the relatively recent judicial finding that involuntary hospitalization without treatment does in fact constitute punishment.[27] The corollary is that involuntary hos-

challenged the system by bringing charges against both her husband and the superintendent of the asylum to which she had been confined. Her case was later to be hailed by R.B. Caplan in her book, PSYCHIATRY AND THE COMMUNITY IN 19TH CENTURY AMERICA (1969), as "[o]ne of the most notorious and significant of the American false commitment cases." Caplan goes on to state that "[n]ot only did Mrs. Packard win her case, a fact which horrified the superintendents, who always insisted that she had been, and still was, insane, but she launched a national crusade to prevent false commitment of others." *Id.* at 191. As a result of this crusade, Illinois in 1867 passed the "Personal Liberty Law," popularly known as the "Packard Law," and a number of other states enacted similar legislation requiring a jury trial on the issue of lunacy before any patient could be admitted to an asylum. For a more in-depth account of Packard's efforts in this area, see her two-volume work, MODERN PERSECUTION, *supra.* The first volume deals with mental institutions and the second concerns married women's rights. In addition, Phyllis Chesler's WOMEN AND MADNESS (1972) can provide some useful insights into how and why women have historically suffered at the hands of psychiatry and its advocates.

26. *See* J. MITFORD, KIND AND USUAL PUNISHMENT 104 (1973). A 1960 *ABA Journal* article included an entire section on terminology, which remains as instructive today as it was in 1960. "The reader may have been disturbed by the use of the terms 'inmate' instead of 'patient,' 'institutionalization' or 'imprisonment' instead of 'hospitalization,' and 'mental institution' or 'mental prison' instead of 'mental hospital.' There is an undoubted therapeutic value in mentally ill persons being told that they are patients who are being hospitalized in a mental hospital for care and treatment. Their families want to feel that their relatives are in a mental hospital. The community feels satisfied that its mentally ill are hospitalized. The morale and efficiency of the medical staff and other personnel are kept up by the feeling that they are working in a hospital.

"There is a limit, however, to the benefits of this terminology . . . . For as long as one thinks about patients, doctors, mental hospitals and hospitalization, one can easily be deluded into misinterpreting reality." Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499, 504 (1960) (footnote omitted) [hereinafter cited as Birnbaum]. *See also* Goffman, *Characteristics of Total Institutions,* SYMPOSIUM ON PREVENTIVE AND SOCIAL PSYCHIATRY 43 (1957).

27. The landmark decision in this area was Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966). In his majority opinion, Judge Bazelon identified treatment as a necessary condition of incarceration for the mentally disordered. He noted that "[a]bsent treat-

pitalization with treatment is not punishment. Such logic is fast becoming conventional wisdom among progressives, both psychiatric and legal.[28] Any skepticism that has arisen focuses on the issue of effectiveness: whether psychiatric diagnosis and treatment is sufficiently quantifiable, and if so, whether there is evidence that the psychiatric interventions are actually effective enough to justify involuntary hospitalization.[29] Repeated efforts to document effectiveness have shown the difficulty, if not the impossibility, of demonstrating the outcome of psychiatric therapy.[30] This in no way proves that psychiatric interventions are ineffective, as some critics suggest, but simply that the use of effective treatment as a legal quid pro quo for deprivation of liberty is based

ment, the hospital is 'transform[ed] . . . into a penitentiary where one could be held indefinitely for no convicted offense . . . ." *Id.* at 453, *quoting* Ragsdale v. Overholser, 281 F.2d 943, 950 (1960) (Fahy, J., concurring).

Because the opinion in *Rouse* is based on statutes enacted by Congress, D.C. Code §§ 21-501, 21-543, 21-561 to -564, 24-301 (Supp. V, 1966), its value as a precedent may be limited; at least one circuit judge suggested that later statutory interpretation by the same court of appeals has implicitly revised the holding of *Rouse*. *See* Dobson v. Cameron, 383 F.2d 519, 523 (D.C. Cir. 1967) (Burger, J., concurring). Nevertheless the impact of Judge Bazelon's decision in *Rouse* was that parens patriae considerations, which had permitted the confinement of individuals who had not been convicted of any crime, now required treatment for such individuals.

At least one circuit has gone even further by holding that "persons committed under what we have termed a *parens patriae* ground for commitment must be given treatment lest the involuntary commitment amount to an arbitrary exercise of government power proscribed by the due process clause." Donaldson v. O'Connor, 493 F.2d 507, 521 (5th Cir. 1974), *vacated*, 422 U.S. 563 (1975). The court claimed this right of treatment exists regardless of whether those to be treated were committed under a parens patriae or police power rationale. *Id. Donaldson* is a significant decision because it finds constitutional rather than statutory underpinnings for a right of treatment. *Cf.* Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971).

28. It is ironic that one of the first pronouncements of this new philosophy was made in an *ABA Journal* article that appeared long before the initial *Rouse* decision. *See* Birnbaum, *supra* note 26. Birnbaum, pleading with the legal system to create a new constitutional right, the right to treatment, said in part that "an institution that involuntarily institutionalizes the mentally ill without giving them adequate medical treatment for their mental illness is a mental prison and not a mental hospital. . . ." *Id.* at 503. *See also* Stone, *Overview: The Right to Treatment—Comments on the Law & Its Impact*, 132 AM. J. PSYCHIATRY 1125 (1975); Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742 (1969); *A Symposium—the Right to Treatment*, 57 GEO. L.J. 673 (1969); Comment, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134 (1967).

29. *See, e.g.*, Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 765-69 (1969) [hereinafter cited as Katz].

30. Hans Eysenck, an outspoken critic of the ineffectiveness of psychotherapeutic treatment provides an extensive review of the evaluation research undertaken thus far in the area. *See* H. EYSENCK, THE EFFECTS OF PSYCHOTHERAPY (1966). *See also* Bergin, *Some Implications of Psychotherapy Research for Therapeutic Practice*, 71 J. ABNORMAL PSYCH. 235 (1966).

more on pious hope than on proven results. Judge Johnson's recent mandate that there must be a "treatment available for the illness,"[31] is typical of the legal and judicial faith that, with adequate safeguards, psychiatric treatments may be sufficiently effective to form the basis for civil commitment. The bench continues to hold tenaciously to the century-old belief that psychiatry, as a legitimate branch of medicine, has specific and demonstrably effective treatments for reliably diagnosable diseases.

But what if we could prove, either now or in the future, that psychiatry is capable of specific diagnoses and effective treatments? Would the right to treatment then be a legally and ethically supportable doctrine? The preoccupation with effectiveness, on the part of the bench, the bar, and the psychiatrists, suggests that we have failed once again, to ask the fundamental questions: What is a right, and what is treatment?

As our previous discussion of the concept of treatment indicated, bona fide treatment requires a consenting patient; anything forced on an individual through the authority of the state as a result of unacceptable behavior is properly regarded as punishment.[32] Under this analysis the right to treatment immediately presents basic contradictions. The treatment is said to be the quid pro quo for the deprivation of freedom, but since the treatment is coercive it is not really treatment at all, but punishment. Thus if words were used more honestly, the "right to treatment" would be the "right to punishment," the individual's right to be punished by the state for being mentally disturbed. However, we know of no mental patients or their advocates who have demanded that the state honor their right to be punished. Consequently the treatment to which incarcerated persons are said to have a right is at best a legal fiction.[33]

The other half of the right to treatment is the concept of a right. According to the Oxford English Dictionary, a right is "[a] legal, equitable, or moral title or claim to the possession of property or authority, the enjoyment of privileges or immunities. . . ."[34] The key concept

31. Lynch v. Baxley, 386 F. Supp. 378, 391 (M.D. Ala. 1974).

32. See text accompanying notes 11-15 *supra.*

33. Katz questions whether the right to treatment may be a legal and linguistic fiction: "[T]he right to treatment introduces the danger of an inevitable duty to be treated akin to thought reform or indefinite detention perniciously cloaked by therapeutic 'kindness.'" Katz, *supra* note 29, at 763. He also notes that "[i]n all calls for reform . . . there is the danger that after implementation of reform, the same abuses will emerge again in new, though initially disguised, forms." *Id.* at 782.

34. 8 THE OXFORD ENGLISH DICTIONARY 670 (1933).

is the freedom to enjoy certain things, such as speech, and the freedom to be spared certain things, such as unreasonable search and seizure. It makes no sense whatever to label as a right anything forced on an individual, and we see no reason to allow coercive psychiatric treatment to be an exception.

If both the terms "right" and "treatment" in the phrase "right to treatment" involve the deceptive use of language, there may be something gained by seeking out the real meaning of this legal doctrine. If, as we have attempted to show, forced treatment is correctly termed punishment, a more honest term for right to treatment is *justification* for treatment. This label discloses the state's effort to rationalize, and to cast in the light of benevolence, its continuing punishment and control of deviants who might be difficult to process within the criminal justice system. The depiction of forced treatment as a right obfuscates the reality that the right to treatment is a justification for punishment.

Punishment is, of course, not new, but the doctrine of a right to treatment provides a justification for continued non-criminal punishment in the face of a growing recognition of both ethical and constitutional problems within the therapeutic sanction. It is quite common for apologists of involuntary psychiatric interventions, particularly the psychiatrists, to claim that if we were to stop incarcerating mental patients we would be abandoning them and depriving them of their right to treatment.[35]

Some of the most knowledgeable critics have considered the right to treatment as a useful vehicle in the struggle against involuntary psychiatry.[36] This view, we feel, will prove extremely short-sighted. The right to treatment may well become a rationale for new forms of parens patriae control. It is to these new developments that we now turn.

From the Cage to the Net

The importance of state mental hospitals, first built in this country in the nineteenth century, appears to be waning. State mental hospitals were conceived and built in the midst of great hope, but repeated efforts at reform have wrought no real change in state warehousing.[37] Despite the latest therapeutic efforts to breathe life into state hospi-

35. *See, e.g.*, Peszke, *Is Dangerousness an Issue for Physicians in Emergency Commitment?*, 132 AM. J. PSYCHIATRY 825 (1975).

36. *See, e.g.*, Psychiatric News, Dec. 3, 1975, at 4, col. 1.

37. *See* ROTHMAN, *supra* note 4.

tals,[38] these isolated institutions do not have a bright future. While we applaud this decline, we must evaluate current and future alternatives. We are alarmed at what is emerging, and believe that the dangers of parens patriae are growing rather than diminishing.

With the growing recognition that institutions have been neither effective in providing much more than custodial care, nor sufficient in maintaining control over very many people, it was inevitable that methods would evolve to accomplish in communities what has been unworkable in institutions. Emerging at the same time as this transition from warehousing of a few to "treatment" of many, the right to treatment provides a philosophical rationale for extension of state interventions beyond institutions and into communities. Although recent case law deals with institutionalized persons,[39] we see a distinct possibility that this doctrine will be broadened in future years to justify new forms of forced community intervention as well. While state hospital populations have declined steadily, data from community programs indicate that more citizens than ever before are under psychiatric care;[40] but only recently has it become possible to reach more than those few who could be housed in institutions.

Given the predominating influence of psychiatry's medical approach to deviance,[41] it is not surprising that the principles of preventive medicine have guided community outreach programs.[42] The nineteenth century witnessed brilliant medical triumphs, particularly for the

38. In recent years, prisons, mental hospitals, juvenile institutions, schools, and nursing homes have seen the development of treatment programs oriented for the most part toward behavior modification. *See* Goodall, *Shapers at Work*, PSYCHOLOGY TODAY, Nov. 1972, at 53. Growing out of the predominance of behavioral psychology in academic circles these programs are spreading rapidly through many institutions—particularly those that deal with captive or semi-captive populations. In our view, a major factor in their selective appearance in closed settings is that these programs require a high degree of control over their subjects. A typical example is the widespread use of token economics in mental hospitals and juvenile institutions. Under such a system basic amenities must be purchased with tokens, which are given as rewards for behavior desired by the institution. Although token economics looks like a thinly disguised method of control, it has nonetheless been viewed by some as a great breakthrough in institutional treatment. *See* Davids, *Therapeutic Approaches to Children in Residential Treatment*, 30 AM. PSYCHOLOGIST 809-14 (Aug. 1975).

39. See notes 27 and 31 *supra*.

40. Greenblatt & Glazier, *The Phasing Out of Mental Hospitals in the United States*, 132 AM. J. PSYCHIATRY 1135 (1975).

41. See note 2 *supra*.

42. For a thorough overview of the theory and practice of preventive psychiatry from a community-based perspective, see G. CAPLAN, PRINCIPLES OF PREVENTIVE PSYCHIATRY (1964).

control of contagious diseases. The emerging behavioral sciences adopted the same preventive medical approach,[43] and policy makers of the day were convinced that the approach would succeed.[44] The efforts that ensued—institutionalization of the mentally disordered, rehabilitation of the criminal, and reform of wayward youth—have obviously floundered, but the reasons for the failure remain unresolved. Did it result from the misplaced emphasis on deviance as a reflection of illness, best approached through healing, with corresponding neglect of the political and economic roots of the problem?[45] Or did it result, as prevailing opinion contends, from inadequate effort in the application of basically sound principles of preventive psychiatry?[46]

General acceptance of the latter view has enabled us to rush headlong into a new attempt to use the principles of preventive medicine and the apparatus of the state to bring "help" to vastly increasing numbers of disturbed and disturbing citizens. Today's methods, unlike those of the past hundred years, appear to take a truly preventive approach, largely because today's technology has given the state the capacity to reach every citizen. While space will not allow a thorough review of these developments, a brief glimpse at some typical examples will help bring into perspective our present position and our future direction.

Early Periodic Screening Diagnosis and Treatment (EPSDT) is a federal Department of Health, Education and Welfare program through which the government intends to screen all children of welfare mothers.[47] The program includes pediatric, dental, and developmental screening, beginning at birth, with periodic re-examinations throughout childhood. The developmental screening is increasingly the target of

43. For a useful account of this nineteenth century optimism, see W. TRATTNER, FROM POOR LAW TO WELFARE STATE (1974). Trattner offers the following example from the charity movement of the 1870's: "The organized charity movement . . . hoped to treat poverty by . . . having 'friendly visitors' look into each case so as to *diagnose* the cause of destitution. Investigation was the keystone of treatment; granting relief without investigation was analogous to prescribing medicine without diagnosis." *Id.* at 84 (emphasis added).

44. *See, e.g.*, ROTHMAN, *supra* note 4; PLATT, *supra* note 8.

45. For useful discussions of social deviance and its various conceptualizations, see H. BECKER, OUTSIDERS (1963) and E. SCHUR, RADICAL NON-INTERVENTION (1973).

46. *E.g.*, K. MENNINGER, THE CRIME OF PUNISHMENT (1968).

47. *See* U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, MEDICAID PROGRAM REGULATION GUIDE, EARLY AND PERIODIC SCREENING, DIAGNOSIS, TREATMENT FOR INDIVIDUALS UNDER 21 (Social and Rehabilitation Service Pub. No. MSA-PRG-21, June 28, 1972) [hereinafter cited as PROGRAM REGULATION GUIDE].

attack.[48] Proponents of the program have recently denied that they intend to do psychiatric or behavioral screening, and have even admitted the dangers of such a plan. They insist they intend only developmental assessment, and that they have no intention of letting racial or economic factors skew their results. They insist, moreover, that the information will be kept confidential in computerized federal files that monitor each child's physical and mental health.[49] California has enacted its own version of EPSDT, known as Child Health Disability Prevention (CHDP),[50] which will not discriminate in favor of the poor but will screen all children, from birth to age twenty-one. At present, each California child must be screened before entering the first grade, but no one seems quite clear about what treatment will await those children said to show deviant development.[51]

Another example of the attempt to treat a social problem with preventive medicine is the current effort to develop screening for violence potential. Based on what amounts to a new phrenology, citizens would be screened for high violence potential indicators, such as chromosomal, hormonal, EEG, or psychological abnormalities.[52] A nationwide network of such violence screening centers has been advocated:

> [W]e must set certain basic standards of behavior (e.g., "golden rule" or "Ten Commandments") that any individual with a normal brain can follow. In addition, we need to find some way to detect those individuals with brain abnormalities who are unlikely to be able to follow those standards.[53]

Another recent development is the introduction of mandatory outpatient treatment. Just as one result of the community mental health

48. *See* Bauer, *U.S. Screens Children of the Poor for "Deviance,"* San Francisco Examiner & Chronicle, Nov. 9, 1975, § A, at 21, col. 1; McCabe, *Feds Spy on Poor Kids*, San Francisco Chronicle, Dec. 1, 1975, at 35, col. 2; McCabe, *Feds Spy on Poor Kids (2)*, San Francisco Chronicle, Dec. 2, 1975, at 39, col. 2.

49. Although the PROGRAM REGULATION GUIDE, *supra* note 47, at 6, states that the purposes of such a record system are to prevent "costly and unnecessary repetition of screening and diagnostic procedures" and to facilitate a "detailed analysis of the costs and benefits of the screening program," the potential dangers of such a record system are apparent.

50. *See* CAL. HEALTH & SAFETY CODE §§ 306-09 (West Supp. 1976).

51. Minority communities in particular are seriously concerned about the effect such screening programs may have on them. *See* The Black Panther, June 9, 1975, at 9, col. 1.

52. In an earlier article, a parallel was drawn between the original phrenologists who searched for "born criminals" by measuring supposed deformities of ear lobes, noses, and skulls, and the new phrenologists who perpetuate such beliefs by searching for deformities in physiological, genetic, and biochemical examinations. Coleman, *Perspectives on the Medical Research of Violence*, 44 AM. J. ORTHOPSYCH. 675 (1974).

53. V. MARK & F. ERVIN, VIOLENCE AND THE BRAIN 160 (1970).

movement has been the use of forced hospitalization on more people than could be housed in state hospitals, the advent of forced out-patient programs will spread the net even wider. The California legislature, for example, in 1974 passed such legislation, but it was vetoed by the governor.[54] In 1975, California enacted legislation allowing conservators to require conservatees to undergo out-patient treatment.[55]

There is every likelihood that this pressure to broaden the forms of involuntary psychiatry will continue, and prophetic vision is hardly required to imagine that the favored form of treatment will be maintenance pharmacotherapy. This major tool of community psychiatry is said to offer for the first time a truly preventive approach to mental illness.[56] Much as an antitubercular drug may be required for a lifetime in order to keep a case of tuberculosis dormant, only lifetime drug treatment will keep major depressive and schizophrenic disorders in remission. Increasing numbers of patients are being diagnosed as "bipolar depressives," for which the highly toxic lithium carbonate is the usual treatment.[57] Clinics are opening whose sole function is to deliver maintenance doses of lithium on a lifetime prophylactic basis.[58] Maintenance or prophylactic drug treatment is also increasingly used for those diagnosed as "schizophrenic."[59] The primary drugs prescribed are the neuroleptic agents, which may cause severe side effects.[60]

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54. A.B. 4200 (introduced, May 2, 1974).

55. Ch. 960, § 6, 6 DEERING'S CAL. CODES, ADVANCE LEGISLATIVE SERVICE, at 287-88 (1975).

56. *See* Davis, *Overview: Maintenance Therapy in Psychiatry: I: Schizophrenia*, 132 AM. J. PSYCHIATRY 1237 (1975); *II: Affective Disorder*, 133 AM. J. PSYCHIATRY 1 (1976) [hereinafter cited as Davis].

57. Manic-depressive illness is a psychiatric diagnosis enjoying a renaissance. Implying the presence of periods of excitable, impulsive, and excessively elated behavior alternating with major depressions, the diagnosis was infrequently used until the past decade. The bipolar form is said to be a different illness from the unipolar type, which shows no manic phases between periods of depression.

Initially the manic phase was the target of treatment with lithium carbonate, a heavy metal salt having potential toxic effects on the major organs of the body. Recently, however, unipolar depressives were found to respond equally well to lithium prophylaxis. *See* Davis, *supra* note 56, pt. II. Only in recent years has lithium carbonate been taken out of the experimental category and made generally available to physicians. Its availability corresponded with the beginning of an increase in the use of the diagnostic category of manic-depressive illness. Apparently the presence of the newly available pharmaceutical product has been a major influence upon psychiatric diagnosis.

58. Fieve, *The Lithium Clinic: A New Model for the Delivery of Psychiatric Services*, 132 AM. J. PSYCHIATRY 1018 (1975).

59. *See* Davis, *supra* note 56, pt. I.

60. *See* Crane, *Persistent Dyskinesia*, 122 BRITISH J. PSYCHIATRY 395 (April

The development of depot forms of psychoactive drugs, in which the drug is suspended in a medium that the body absorbs slowly, has been considered a great breakthrough.[61] Given by injection, the drugs continue to exert their effect for two to three weeks. There can be little doubt that the pharmaceutical industry will recognize the potential of even longer-acting preparations. These depot drugs are preferred for the chronic, resistive patient who refuses to take regular medications. Psychiatrists are being urged to be therapeutically persistent and innovative in insuring that their patients, particularly those in the community, receive their medication.[62] In some communities, those patients who fail to appear on schedule for their injection are forcibly brought to a community clinic for their treatment. Frank Ayd, a leading proponent of depot drugs, gives some idea of the extent to which such treatment could be utilized:

> Eleven years ago, not one patient was being treated with a depot neuroleptic. Today, an estimated 400,000 patients have been and are being treated worldwide . . . . Cognizant of these facts, some pharmaceutical companies are making additional depot neuroleptics.
>
> . . . [M]ore and more psychiatric patients will be treated with long-acting oral and injectable preparations . . . . Of necessity, mental health care professionals will resort to pharmacotherapeutic regimens that enable them to care for the largest number of patients in the most convenient, expeditious, and economical way feasible. There is every reason to predict that pharmacotherapy with long-acting oral and injectable drugs will escalate and that the use of short-acting oral compounds will decline proportionately. It is conceivable that by the year 2000, the latter preparations will be prescribed sparingly.[63]

The current direction, then, is toward a massive program of screening for deviance, together with mandatory out-patient treatment, in the form of maintenance drug treatment for those found in need of "help." Because the drugs would be given to prevent something that has not appeared or is in remission, there would be no way to ensure either that the initial screening prediction was accurate, or that the in-

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1973); Crane, *Clinical Psychopharmacology in its Twentieth Year*, 181 SCIENCE 124 (July 13, 1973).

61. *See* Ayd, *The Depot Fluphenazines: A Reappraisal After 10 Years' Clinical Experience*, 132 AM. J. PSYCHIATRY 491 (1975) [hereinafter cited as Ayd].

62. *See* Ayd, *supra* note 61, at 491. Ayd considers those who resist taking these medications to be "drug defectors" and states that injectable long acting tranquilizers are "a most important step forward" because they "remove responsibility for taking medicine from patients unable to assume it." *Id.*

63. *See* Ayd, *supra* note 61, at 499.

dividual would not have another episode of a previous problem. But as with all preventive treatment, one does not wait until the disease appears; to do so would be to deprive the individual of his right to treatment.

To many, this analysis will seem alarmist in the extreme. Nevertheless, the danger is quite real that such a system of control could be instituted. The history of benevolent state intervention is filled with examples of sweet dreams becoming nightmares. We see no reason to believe this tendency has been reversed. Instead we find evidence of the continuing attempt by the state to maintain the status quo through the control of deviants. The seductions of our technology will only make sweeping programs of state benevolence more difficult to resist.

It is our belief that resistance begins with understanding, and that language has been a primary vehicle to prevent an understanding by the people that real treatment is incompatible with the power of the state. Until the state restricts itself to *offering* services, we must all recognize and assume responsibility for the fact that we live in a society that not only punishes the guiltless, but has not yet had the courage to admit it.