(5)

IN THE

Supreme Court of the United States

No. 1711 Misc.

KENNETH DONALDSON,

Petitioner,

—v.—

J. B. O'CONNOR, M.D., *et al.*,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF FLORIDA

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE OF AMERICAN CIVIL LIBERTIES UNION

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Amicus Curiae

"Civil Commitment"

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Motion for Leave to File Brief Amicus Curiae

The American Civil Liberties Union respectfully moves for leave to file a brief amicus curiae in this case. Petitioner's attorney has consented to the filing of the brief; respondents' attorney has refused our request for consent.

Though aware, of course, of Rule 42 (1) of the Rules of the Supreme Court of the United States, which discourages motions to file amicus curiae briefs in support of petitions for certiorari, amicus departs from its normal compliance with the spirit of that Rule because of special circumstances in this case.

The case at bar involves the constitutional rights of persons held in custody by the state in institutions for the "mentally ill" under "civil" commitment proceedings. Though this Court has addressed itself on several occasions

to constitutional issues presented by the commitment in criminal cases of defendants said to be mentally ill, it has not had occasion to assess from a constitutional point of view the civil commitment of non-criminals to institutions for the mentally ill. We believe that this case presents the Court with the opportunity to explore the urgent constitutional issues which pervade the civil commitment process.

Our reasons for believing that the Court should grant certiorari are set out in the accompanying brief. The views set forth in the brief are the product of a special program established a year ago by the New York Civil Liberties Union to protect and expand the liberties of the very large number of persons who are said by the state to be mentally ill. The project, the only one of its kind in the United States, is devoted entirely to an exploration of the theoretical and applied constitutional problems which abound in the field. The undersigned's co-counsel in the accompanying brief is the attorney engaged full time in the operation of this special project. We believe that the experience gained in the course of his work will be useful to the Court in its deliberations upon the petition for certiorari in the case at bar.

Respectfully submitted,

MELVIN L. WULF
Attorney for Movant

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BRIEF OF THE AMERICAN CIVIL LIBERTIES UNION, AMICUS CURIAE

Interest of Amicus

The interest of Amicus is set out in the preceding Motion for Leave to File this Brief.

Statement of the Case

In 1956, petitioner was committed to a civil mental institution, where he is still confined. He was not properly represented by counsel, even though he was (and remains) indigent. During his thirteen years of confinement petitioner has never threatened or committed any dangerous or violent act. He has never been convicted or even charged with any crime. Petitioner claims, as he has claimed for the past ten years, that he is no longer mentally ill. He claims

(a claim which is apparently not disputed) that during virtually all of his thirteen years' confinement the ratio of physicians to inmates in the petitioner's section of the institution has varied from 1 to 1000 to 1 to 950. He claims that he receives no medication and no individual or group psychotherapy. The present petition is the latest in a series of at least eighteen unsuccessful attempts by petitioner to obtain, for the first time since his commitment, judicial review of his current mental condition. In each of his previous attempts, petitioner claimed that his initial commitment was unconstitutional because he was not properly represented by counsel, and claimed also that his continued confinement was unconstitutional because he was not receiving adequate treatment. Petitioner's latest petition for a writ of habeas corpus was denied on October 5, 1968, without a hearing, and that denial was ultimately affirmed by the Supreme Court of Florida on November 19, 1969.

REASONS FOR GRANTING THE WRIT

Introduction

In the past decade this Court has shown great concern for the constitutional rights of mentally ill "criminals." E.g., *Dusky* v. *United States,* 362 U.S. 402 (1960); *Lynch* v. *Overholser,* 369 U.S. 705 (1962); *Baxstrom* v. *Herold,* 383 U.S. 107 (1966); *Pate* v. *Robinson,* 383 U.S. 375 (1966); *Specht* v. *Patterson,* 386 U.S. 605 (1967). See also, *Robinson* v. *California,* 370 U.S. 660 (1962) (narcotics addiction); and *Powell* v. *Texas,* 392 U.S. 514 (1968), *reh. den.,* 393 U.S. 898 (1969) (chronic alcoholism). For persons caught in the criminal process, those decisions have meant a great deal. There are, however, hundreds of thousands of "civil" mental patients who have not been affected at all by those decisions.[1] This brief is submitted in the belief that it is imperative for this Court to clarify the constitutional rights of "civil" mental patients.

[1] In the United States over ten per cent of the population will at some time be hospitalized because of "mental illness." There are more than a half-million hospital beds for mental patients. That is more beds than are available for physical illness. Approximately 17 million persons are thought to be currently suffering from some degree of mental illness. In New York, more than 25,000 people are committed to state mental hospitals each year. See generally *Mental Illness & Due Process* (Association of the Bar of the City of New York), pp. v, 11 (1962); *The Myth of Mental Illness,* Szasz, p. x (1961).

I.

Civil mental patients are constitutionally entitled to procedural safeguards at least equivalent to those afforded criminal defendants.

It cannot be stressed too urgently that we are here concerned with physical liberty, the most fundamental of rights, and the right without which all others are of little value. Because liberty is as precious to the civilian as to the criminal, lower courts have subjected civil commitment procedures to rigid scrutiny. In *Denton* v. *Commonwealth,* 383 S.W.2d 681, 682 (Ky. 1964), for example, the Court of Appeals of Kentucky ruled that prospective mental patients are constitutionally entitled to all of the traditional criminal safeguards:

> Although lunacy inquests are not concerned with criminal intent or criminal acts they may result in depriving the defendant of his liberty and his property. This deprival should be obtained only by the due process of law under constitutional guarantees.
>
> We have therefore concluded that when a proceeding may lead to the loss of personal liberty, the defendant in that proceeding should be afforded the same constitutional protection as is given to the accused in a criminal prosecution.

Similarly, in *People ex rel. St. Saviour Sanitarium,* 34 App. Div. 363, 372, 56 N.Y.S. 431, 437 (1st Dept. 1898), the court remarked:

> An alleged criminal is hedged about with safeguards and protections. Why should not an alleged incompetent or dangerous person receive the same protection? Shall *ex parte* proof that would only avail to hold an alleged criminal for trial be regarded as conclusive proof against a supposed unfortunate? Constitutional immunities are precisely the same as to each.

This Court, too, has disregarded the civil-criminal label. *Specht* v. *Patterson,* 386 U.S. 605, 608 (1967) ruled that "commitment proceedings whether denominated civil or criminal are subject both to the Equal Protection Clause of the Fourteenth Amendment as we held in *Baxstrom* v. *Herold,* 383 U.S. 107, and to the Due Process Clause." *Specht* also cited with approval a lower court decision which granted to a person alleged to be "an habitual [sex] offender and mentally ill" the "full panoply of the relevant protections which due process guarantees in state criminal proceedings" (386 U.S. at 609).[2]

And in *In Re Gault,* 387 U.S. 1, 50 (1967), this Court expressly disregarded "the 'civil' label-of-convenience which has been attached to juvenile proceedings," and ruled that alleged delinquents were entitled to procedural protections traditionally afforded to "criminals" because ". . . commitment is a deprivation of liberty. It is incarceration against one's will, whether it is called 'criminal' or 'civil'" (387 U.S. at 50).[3] In *Gault,* the traditional re-

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[2] Quoting from *Gerchman* v. *Maroney,* 355 F.2d 302, 312 (3rd Cir. 1966).

[3] See also, *Heryford* v. *Parker,* 396 F.2d 393, 396 (10th Cir. 1968): "It matters not whether the proceedings be labeled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process."

habilitative purpose of juvenile delinquency proceedings was considered less important, for constitutional purposes, than the consequence of those proceedings.

Read together, these cases establish the proposition that persons accused of mental illness must be afforded no fewer constitutional protections than persons accused of crime.

A. *Indigent Mental Patients Are Constitutionally Entitled to Assigned Counsel.*

The Draft Act Governing Hospitalization of the Mentally Ill provides in section 9(f) that "an opportunity to be represented by counsel shall be afforded to every proposed patient, and if neither he nor others provide counsel, the court shall appoint counsel" (reprinted in Lindman and McIntyre, *The Mentally Disabled and the Law* (1961), at p. 402). *In Re Gault, supra,* ruled, in the context of a "civil" commitment proceeding, that an alleged juvenile delinquent was constitutionally entitled to assigned counsel. In *Heryford* v. *Parker, supra,* the Tenth Circuit followed *Gault* in ruling that a prospective mental patient was constitutionally entitled to assigned counsel.

In *Lynch* v. *Overholser, supra* at 711, this Court noted that "representation by counsel or by a guardian ad litem is necessary" in a civil commitment proceeding, citing *Dooling* v. *Overholser,* 243 F.2d 825 (D.C. Cir. 1957). The statutory provisions before the court in *Dooling* authorized but did not expressly require representation by counsel. In order "to avoid any question of their failure to meet the due process requirements," the court construed those provisions to provide that "the alleged insane person has the right to be represented by counsel, and if not so represented independently then the court shall appoint either

an attorney or a guardian ad litem" (243 F.2d at 827). See also, *Specht* v. *Patterson, supra,* where this Court held that a person charged with being "an habitual offender and mentally ill" had a due process right to "be present with counsel" at the commitment hearing (386 U.S. at 610).

Other courts, too, have recognized that indigent mental patients have a constitutional right to assigned counsel. E.g., *People ex rel. Woodall* v. *Bigelow,* 20 N.Y.2d 852, 285 N.Y.S.2d 85 (1967); and *People ex rel. Rogers* v. *Stanley,* 17 N.Y.2d 256, 270 N.Y.S.2d 573 (1966).

In the present case, Donaldson, like Gerald Gault, faced "the awesome prospect of incarceration in a state institution" (387 U.S. at 366-37). Although Donaldson was and is indigent, he was not provided legal representation in the initial commitment proceeding or in his subsequent efforts to obtain release.

B. *Involuntary Confinement Is Justified, if at All, Only if the Necessity for Confinement Is Proved Beyond a Reasonable Doubt.*

It is not entirely clear whether Donaldson was committed for his own "welfare" or because he was thought to be dangerous to others. In either event, it appears that the necessity for his confinement was judged under a "preponderance of the evidence" rather than a "reasonable doubt" standard.

In *Denton* v. *Commonwealth,* 383 S.W.2d 681, 683 (Ky. 1964), however, the court ruled, relying upon the due process clause, that "the burden of proof" in a civil proceeding for the commitment of an allegedly mentally ill person "should be the same as those in any criminal or quasi criminal proceeding."

Now pending before this Court is a case which challenges the constitutionality of the "preponderance" test in a juvenile delinquency proceeding. *In Re Winship,* No. 778, probable jurisdiction noted October 27, 1969, 38 U.S. L.W. 3153. If this Court should hold that an alleged delinquent can constitutionally be committed only upon proof "beyond a reasonable doubt," it would follow, *a fortiori,* that Donaldson's commitment was unconstitutional.[4] But even if this Court were to approve a "preponderance" test for delinquency proceedings, there would still remain cogent reasons for applying the stricter test in mental commitment proceedings. The prospective mental patient, unlike the prospective delinquent, is not charged with commission of any specific act or acts. He is charged either with being "mentally ill" or with being dangerous to himself or others, or both. We should be especially solicitous of liberty when it rests upon concepts so imprecise as "mental illness" or "dangerousness." Unlike tuberculosis or cancer, "mental illness" is not a "cause" of disorder; it is, at most a "theory" to explain unconventional conduct or belief. As such, its boundaries expand or contract according to the life styles and value judgments of the theorist.[5] Some psychiatrists, for example, believe that all "hippies" are mentally ill; others disagree.[6]

[4] E.g., *Dexter* v. *Hall,* 82 U.S. 9 (1873), in which this Court noted that an alleged lunatic requires greater judicial protection than a minor.

[5] Szasz, *Law, Liberty and Psychiatry* (1963), pp. 11-17; Leifer, *In the Name of Mental Health* (1968).

[6] E.g., *In Re Sealy,* 218 So.2d 765 (D. Ct. App. Fla. 1969), in which two doctors testified that a self-proclaimed "hippie" who believed in free-love, non-violence and the use of hallucinogenic drugs, was mentally ill. A psychologist disagreed. The Appellate Court set aside an order of commitment because "the fact that he decided to lead the kind of life, entertain beliefs and engage in

Similarly, we should be slow to condition human liberty upon a concept as vague as "dangerousness." Except as applied to mental patients, preventive detention is still an ugly phrase.[7] Our society is remarkably, though properly, reluctant to confine persons solely because of what they might do in the future. Probably fifty to eighty per cent of all ex-felons will commit future crimes,[8] but we do not confine them. Ghetto residents and teenage males are also much more likely to commit dangerous acts than the "average" member of the population,[9] but we do not

conduct which was offensive, repulsive, and objectionable to others does not necessarily indicate mental incompetence, nor does it justify confining him to a mental institution . . ." (218 So.2d at 768).

[7] A somewhat more detailed discussion of this point will be found in Ennis, "Mental Illness," 1969-1970 Annual Survey of American Law 29, 45-48. See also, Dershowitz, "On Preventive Detention," New York Review of Books (March 13, 1969), p. 22 at p. 23: "The most widespread form of preventive detention employed in the United States today is commitment of the mentally ill."

[8] For example, the recidivism rate in New York City is 73%. In New York federal institutions the rate is 63%. In New York State institutions the rate is 52%. Khiss, "Albany Report Calls Jails 'Crime Breeding Grounds,'" *The New York Times,* November 10, 1969, p. 30.

[9] *E.g.,* Report of the National Advisory Commission on Civil Disorders (1968), pp. 128-135; *Youth in the Ghetto* (Harlem Youth Opportunities Unlimited, Inc., 1964), pp. 137-160: Juvenile delinquency rate for Central Harlem is two to three times higher than the New York City average; narcotics use in Central Harlem is ten times the city rate; and the homicide rate is six times the city rate. See also, Livermore, Malmquist & Meehl, "On the Justifications for Civil Commitment," 117 U. Pa. L. Rev. 75 (1968), pp. 76-77: "By combining background environmental data, we can identify categories of persons in which we can say that fifty to eighty per cent. will engage in criminal activity within a short period of time. If social protection is a sufficient justification for incarceration, this group should be confined as are those criminals who are likely to sin again."

confine them. Of all the identifiably dangerous groups in society, only the "mentally ill" are singled out for preventive detention,[10] and they are probably the least dangerous, as a group, of the groups here mentioned. Why should society confine a person if he is dangerous and mentally ill but not if he is dangerous and sane?[11] If a sane man is dangerous, then, by definition, his "rationality" and awareness of the consequences of apprehension do not deter his dangerous acts. It is not enough to say that the mentally ill and dangerous person might be treated and rendered non-dangerous. That argument assumes that the person is dangerous *because* he is mentally ill, and would not be so if sane. Courts have difficulty enough in deciding whether a *past* act, under known circumstances, was the "product" of a mental disease, or was, instead, the product of cultural, educational, economic, familial, or other factors.

[10] Only recently have states begun to confine sexual psychopaths. Their confinement, too, raises substantial constitutional questions. E.g., *Cross* v. *Harris*, —— F.2d ——, 38 U.S. Law Week 2247 (D.C. Cir., October 2, 1969).

[11] *E.g.*, Livermore, Malmquist & Meehl, *supra* note 9, at pp. 76-77, 83, and 85. Dershowitz, "The Role of Law and the Prediction of Harmful Conduct," reprinted in Katz, Goldstein and Dershowitz, *Psychoanalysis, Psychiatry & Law* (1967), at p. 588: "If the function of involuntary hospitalization is the preventive detention of dangerous people, then why should it matter whether such people are, or are not, 'mentally ill.' If a 'mentally healthy' person is sufficiently dangerous, why should he not be confined?" Similarly, approximately 70% of all suicides are committed by persons who are not mentally ill. Clinard, *Sociology of Deviant Behavior* (1957), p. 425. See also, Durkheim, *Suicide* (Free Press, 1951), especially pp. 66-67. If prevention of suicide is a legitimate social goal, why should we not confine all potential suicides, whether sane or insane?

Psychiatrists have not been very helpful in that regard,[12] and it is naive to assume they can be more helpful in predicting whether an unspecified *future* act, under unknown circumstances, will be the "product" of a mental disease. Preventive detention of persons who are thought to be both dangerous and mentally ill may appear to be more reasonable than preventive detention of the "sane," but it is not.

What little evidence there is suggests that the mentally ill are probably less dangerous than the mentally healthy. For example, a five and a half year study of 5,000 patients discharged from New York State mental hospitals showed that "patients with no record of prior arrest have a strikingly low rate of arrest after release. . . . Their over-all rate of arrest is less than 1/12 that of the general population and the rate for each separate offense is also far lower, especially for more serious charges."[13] Another psychia-

[12] E.g., *Washington* v. *United States*, 390 F.2d 444 (D.C. Cir. 1967), in which the court ruled that psychiatrists should not be permitted to give an opinion on whether a criminal act was the "product" or "result" of mental illness.

[13] Brill and Malzberg, "Statistical Report Based on the Arrest Record of 5354 Male Ex-Patients Released from New York State Mental Hospitals During the Period 1946-1948" (unpublished report). See also, *The Clinical Evaluation of the Dangerousness of the Mentally Ill* (Jonas R. Rappaport, M.D., ed., 1967); Pollock, "Is the Paroled Patient a Menace to the Community?" Psychiat. Q., V. 12 (1938); Rappaport, Lassen & Gruenwald, "Evaluation and Follow-up of State Hospital Patients Who Had Sanity Hearings," 118 Am. J. Psychiat. 1079 (June 1962); Giovanni and Gurel, "Socially Disruptive Behavior of Ex-Mental Patients," 67 Archives Gen. Psychiat. 146-153 (1967). Similarly, the frequency of automobile accidents and driving violations by ex-mental patients does not vary significantly from the frequency rate for a large comparison group. Buttliglieri, "Temporal Relationship Between Automobile Accidents and Psychiatric Hospitalization," Perceptual and Motor Skills, V. 24 (1967), pp. 1327-1332.

trist states that there is "not a shred of evidence that the mentally ill are any more dangerous than the mentally healthy." [14] A diagnosis of mental illness tells us nothing about whether the person so diagnosed is or is not dangerous. Some mental patients are dangerous, some are not. Perhaps the psychiatrist is an expert at deciding whether a person is mentally ill, but is he an expert at predicting which of the persons so diagnosed are dangerous? Sane people, too, are dangerous, and it may legitimately be inquired whether there is anything in the education, training or experience of psychiatrists which renders them particularly adept at predicting dangerous behavior. Predictions of dangerous behavior, no matter who makes them, are incredibly inaccurate,[15] and there is a growing consensus that psychiatrists are not uniquely qualified to predict dangerous behavior and are, in fact, less accurate in their predictions than other professionals.[16]

[14] Szasz, Hearings before the Subcommittee on Constitutional Rights of the Committee of the Judiciary, United States Senate, 87th Cong., 1st Sess., Part I—Civil Aspects, March 28, 29 and 30, 1961, at p. 271.

[15] The best study of this problem, which cites and discusses numerous other studies, is Livermore, Malmquist & Meehl, "On the Justifications for Civil Commitment," 117 U. Pa. L. Rev. 75 (1968), see especially pp. 82-86. See also, Foote, "The Coming Crisis in Bail," 113 U. Pa. L. Rev. 1125 (1965), and Rosen, "Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events," 18 J. Consul. Psychol. 397, 402 (1954).

[16] *E.g.*, Dershowitz, "The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways," Psychology Today (Feb., 1969), p. 43 at p. 47: "Surprisingly enough, we were able to discover fewer than a dozen studies which followed up psychiatric predictions of anti-social conduct. And even more surprisingly, these few studies strongly suggest that psychiatrists are rather inaccurate predictors—inaccurate in an absolute sense—and even less accurate when compared with other professionals, such as psychologists, social workers and correctional officials; and when compared to actuarial devices such as prediction or experience tables. Even more significant for legal purposes, it seems that psychiatrists are particularly prone to one type of error—overprediction. They tend to predict anti-social conduct in many instances where it would not, in fact, occur. Indeed, our research suggests that for every correct psychiatric prediction of violence, there are numerous erroneous predictions. That is, among every group of inmates presently confined on the basis of psychiatric predictions of violence, there are only a few who would, and many more who would not, actually engage in such conduct if released." And see, in a different context, Halleck, "The Psychiatrist and the Legal Process," Psychology Today (Feb., 1969), p. 25, in which the author states that "assignment of responsibility [*i.e.*, was the criminal act the product of mental disease—should the criminal be found guilty?] primarily involves philosophical considerations. In this area every citizen has an opinion and it is unlikely that the psychiatrist's training or experience makes him more of an expert." See also, Morris, "Psychiatry and the Dangerous Criminal," 41 S. Cal. L. Rev. 514, 532-36 (1968).

Because predictions of dangerous behavior are so grossly unreliable, and because "mental illness" is, at best, an illusive concept,[17] we should authorize involuntary confinement only if the necessity for confinement is proved "beyond a reasonable doubt." That is the standard urged by one of this country's most respected jurists.[18]

[17] In 1950, Justice Frankfurter noted "the present state of the tentative and dubious knowledge as to mental diseases and the great strife in schools in regard to them . . ." and expressed concern over the "treacherous uncertainties in the present state of psychiatric knowledge." *Solesbee* v. *Balkom,* 339 U.S. 9, 24-25 (1950) (dissenting opinion). What Justice Frankfurter said then remains true today. E.g., *Powell* v. *Texas,* 392 U.S. 514, 526, 559-560 (1968). *Mental Illness & Due Process* (Association of the Bar of the City of New York, 1962), pp. 17-18; Szasz, *Law, Liberty and Psychiatry* (1963), p. 137; Leifer, *In the Name of Mental Health* (1968).

[18] Chief Judge David L. Bazelon, "Implementing the Right to Treatment," 36 U. Chi. L. Rev. 742, 748-749 (1969).

II.

Civil mental patients are constitutionally entitled to periodic judicial review of their mental condition.

The assumption underlying civil commitment is that mental illness can be cured. The corollary to this assumption is that mental patients have a right to periodic review of their mental condition, to determine if they have recovered. It is inconceivable that respondents would dispute Donaldson's right to periodic review by *someone*. Surely respondents would concede, at the least, that the hospital authorities where Donaldson is confined are under an obligation periodically to review his mental condition. The question here is whether Donaldson has a right to periodic *judicial* review. He has been denied judicial scrutiny of his mental condition for almost fourteen years. Each time he requests a judicial hearing, the court defers to the opinion of the very psychiatrists whose judgment Donaldson contests. Basic to our jurisprudence, however, is the belief that those who urge the necessity of deprivation of liberty should not judge the validity of their own opinion. In a closely analogous situation, lower courts have ruled that any court which finds a defendant incompetent to stand trial "has a duty to inquire from time to time into the mental status of persons committed by it." *Arco* v. *Ciccone,* 252 F. Supp. 347, 349 (W.D. Mo. 1965), *aff'd,* 359 F.2d 796 (8th Cir. 1966). See also, to the same effect, *Tyler* v. *Harris,* 226 F. Supp. 852, 854 (W.D. Mo. 1964); *Birnbaum* v. *Harris,* 222 F. Supp. 919, 920 (W.D. Mo. 1963); *Hogan* v. *Settle,* 202 F. Supp. 804, 805 (W.D. Mo. 1962); *Crescioni* v. *Settle,* 202 F. Supp. 868 (W.D. Mo. 1962); *Johnson* v. *Settle,* 184 F. Supp. 103, 106 (W.D. Mo. 1960); *United States* v. *Morris,* 154 F. Supp. 695,

697 (S.D. Calif. 1957); and *Higgins* v. *McGrath,* 98 F. Supp. 670, 674-675 (W.D. Mo. 1951). Similarly, the Association of the Bar of the City of New York has recommended that allegedly mentally ill convicts should receive periodic judicial review. *Mental Illness, Due Process and the Criminal Defendant* (1968), pp. 22-26. Even more closely in point is the decision in *Nelson* v. *Sandritter,* 351 F.2d 284, 285 (9th Cir. 1965), which involved a patient in a state mental hospital:

> Unquestionably, such a patient is entitled to periodic judicial reconsideration of the causes for his involuntary confinement. Progress in the mental health sciences and in the treatment of the mentally ill will alone justify such reconsideration. How frequently a patient is entitled to judicial review of the causes of his confinement must depend upon the circumstances of each case.

With respect to Donaldson's *initial* commitment, respondents would concede that anything longer than a "temporary" or "emergency" commitment would be unconstitutional, even though based on medical opinion, unless Donaldson were afforded the opportunity of a judicial hearing. The same reasons which require an opportunity for a judicial hearing at the initial commitment are equally applicable at periodic intervals.

This point is discussed in Lindman and McIntyre, *The Mentally Disabled and the Law* (1961), pp. 150-151. As Lindman and McIntyre there note, Section 18 of the Draft Act Governing Hospitalization of the Mentally Ill, prepared by the National Institute of Mental Health, specifically provides for periodic judicial review of the civil patient's men-

tal condition (the Act is reprinted in Lindman and McIntyre at pp. 397-416). New York, too, requires periodic judicial review (New York Mental Hygiene Law, section 73). Petitioner believes that Florida cannot, consistent with the Constitution, do less.

III.

Civil mental patients are constitutionally entitled to adequate psychiatric treatment.

No court has yet held that mental patients have a constitutional right to adequate psychiatric treatment, but several courts have indicated they would so hold if relief could not otherwise be obtained.[19] Secondary authorities

[19] E.g., *Rouse* v. *Cameron,* 373 F.2d 451 (D.C. Cir. 1966) (relying on both substantive and procedural due process, equal protection, and cruel and unusual punishment clauses); *Sas* v. *Maryland,* 334 F.2d 506 (4th Cir. 1964) (relying on equal protection clause); *Nason* v. *Superintendent of Bridgewater State Hospital,* 353 Mass. 604, 233 N.E.2d 908 (1968) (relying on equal protection clause and substantive due process); *United States ex rel. Schuster* v. *Herold,* 410 F.2d 1071 (2d Cir.), *cert. denied* 24 L. Ed.2d 96 (1969). See also, *United States* v. *Jackson,* 306 F. Supp. 4 (N.D. Calif. 1969); *Darnell* v. *Cameron,* 348 F.2d 64 (D.C. Cir. 1965); *Millard* v. *Cameron,* 373 F.2d 468 (D.C. Cir. 1966); *Miller* v. *Overholser,* 206 F.2d 415 (D.C. Cir. 1953); *People ex rel. Meltsner* v. *Warden of Green Haven Prison,* 32 A.D.2d 389, 302 N.Y.S.2d 624 (2d Dept. 1969); *People ex rel. Berdaguer* v. *Morrow,* 60 Misc.2d 189, 302 N.Y.S.2d 628 (Sup. Ct. Sullivan Co. 1969); *Whitree* v. *State of New York,* 56 Misc.2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968); *People* v. *Fuller,* 24 N.Y.S.2d 292, 300 N.Y.S.2d 102, 248 N.E.2d 17 (1969) (narcotics addict); *People ex rel. Blunt* v. *Narcotic Addiction Control Commission,* 58 Misc.2d 57, 295 N.Y.S.2d 276 (Sup. Ct. Bronx Co. 1968), *aff'd,* 24 N.Y.2d 850, 301 N.Y.S.2d 89, 248 N.E.2d 918 (1969) (narcotics addict); *People ex rel. Kaganovitch* v. *Wilkins,* 23 A.D.2d 178, 259 N.Y.S.2d 462 (1965) (sex offender); *People* v. *Bailey,* 21 N.Y.2d 588, 237 N.E.2d 205, 289 N.Y.S.2d 943 (1968); *People ex rel. Cescini* v. *Warden,* 30 A.D.2d 649, 291 N.Y.S.2d 200 (1968); *People* v. *Mosher,* 24 A.D.2d 47, 263 N.Y.S.2d 765 (1965); *People* v. *Jackson,* 20 A.D.2d 170, 245 N.Y.S.2d 534 (1963).

are virtually unanimous that there is a constitutional right to treatment.[20]

This Court, too, has at least implicitly recognized the constitutional infirmities inherent in "civil" confinement without treatment. In *Powell* v. *Texas,* 392 U.S. 514 (1968), for example, this Court rejected the suggestion that chronic alcoholics should be dealt with only under civil auspices, because civil "facilities for the attempted treatment of indigent alcoholics are woefully lacking throughout the country" (392 U.S. at 528). Of course, "criminal" facilities for treating alcoholics are also grossly inadequate, but, as the Court noted, "one virtue of the criminal process is, at least, that the duration of penal incarceration typically has some outside statutory limit . . . 'Therapeutic civil commitment' lacks this feature; one is typically committed until one is 'cured.' Thus, to do otherwise than affirm might subject indigent alcoholics to the risk that they may be locked up for an indefinite period of time under the same conditions as before, with no more hope than before of receiving effective treatment and no prospect of periodic 'freedom'" (392 U.S. at 529).

The decision in *Powell* rested upon this Court's willingness to recognize the "unpleasant reality" that treatment facilities for alcoholics are woefully inadequate (392 U.S. at 530). Petitioner asks no more. He asks only that this

[20] For a comprehensive and recent analysis of this burgeoning area of the law, see "A Symposium: The Right to Treatment," 57 Georgetown L.J. 673 (1969). See also, Bazelon, "Implementing the Right to Treatment," 36 U. Chi. L. Rev. 742 (1969); Katz, "The Right to Treatment—An Enchanting Legal Fiction?" 36 U. Chi. L. Rev. 755 (1969); Morris, "Criminality and the Right to Treatment," 36 U. Chi. L. Rev. 784 (1969); Comment, "The Nascent Right to Treatment," 53 Va. L. Rev. 1134 (1967); Birnbaum, "The Right to Treatment," 46 A.B.A.J. 499 (1960).

Court recognize that there are in this country thousands of citizens confined to institutions labeled "hospitals" but which are, in reality, jails.

> Much of the care received today in our gigantic state mental institutions is merely custodial. Most of these institutions are woefully overcrowded and include within their walls many senile patients and others who could be more effectively cared for elsewhere if society wanted to provide for them. Complicating the situation still further is a severe and continuing manpower shortage, which includes both psychiatrists and other personnel such as psychologists, nurses, social workers, and attendants. Our state mental hospitals have not attracted a sufficient number of trained psychiatrists, who often feel greater professional satisfaction and earn higher incomes in private practice.[21]

Powell is not the only relevant decision. *Robinson* v. *California,* 370 U.S. 660 (1962), for example, suggests that civil confinement without treatment would be cruel and unusual punishment for the mere "status" of being mentally ill. There is no doubt that petitioner is confined because of his status, rather than because of his behavior. There is absolutely no indication either before or during his thirteen year confinement that Donaldson has ever threatened or committed any act that could be considered dangerous to himself or others. And it is clear that, absent such acts, confinement because of a prediction of possibly dangerous future conduct would be unconstitutional. *Min-*

[21] Comment, "Civil Restraint, Mental Illness, and the Right to Treatment," 77 Yale L.J. 87, 88 (1967), and the authorities cited therein.

nesota ex rel. Pearson v. *Probate Court,* 309 U.S. 270, 274 (1940). See also, *Powell* v. *Texas,* 392 U.S. 514, 533, 543 (1968); *Robinson* v. *California,* 370 U.S. 660, 678-679 (1962) (Harlan, *J.,* concurring); and *Lynch* v. *Overholser,* 369 U.S. 705, 714 (1962).

Assuming for the moment that there is a constitutional right to adequate treatment, Donaldson's petition could be resolved in one of several ways. This Court could find that the gross disparity between the physician-patient ratio in Florida State Hospital (1 to 950) is so far below the *minimum* standard established by the American Psychiatric Association (1 to 150), that Donaldson's confinement is, on its face, unconstitutional. Similarly, this Court could find, on the basis of those ratios, that Donaldson's petition raises a substantial question as to the adequacy of his treatment which entitles him to an administrative or judicial hearing, or both, and that if such hearing is not held in the immediate future, he will be entitled to release. Finally, this Court could recognize that some persons are not treatable and that if they have not been "cured" and released within a year or two, they are more likely to leave in a coffin than on their own two feet.[22] It would then be the duty of the persons recommending Donaldson's continued confinement to show not only that he is receiving adequate

[22] W. Bloomberg, "A Proposal for a Community-based Hospital as a Branch of a State Hospital," 116 Am. J. Psychiatry 814-817 (1960): "There is repetitive evidence that once a patient has remained in a large mental hospital for two years or more, he is not likely to leave except by death." See also, Penn, Sindberg & Roberts, "The Dilemma of Involuntary Commitment," 53 Mental Hygiene 5 (Jan. 1969); Dunham & Weinberg, *The Culture of the State Mental Hospital* 244 (1960); S. Frazier and A. Carr, *Introduction to Psychopathology* 129 (1964).

treatment, but also that he is treatable.[23] Placing an absolute or presumptive time limit on confinement would do much to ensure adequate treatment. The concept of a deadline is necessary in the law, in education, and in business. It is equally necessary in psychiatry.

CONCLUSION

For the reasons stated above, certiorari should be granted to review the important federal questions presented in this case.

Respectfully submitted,

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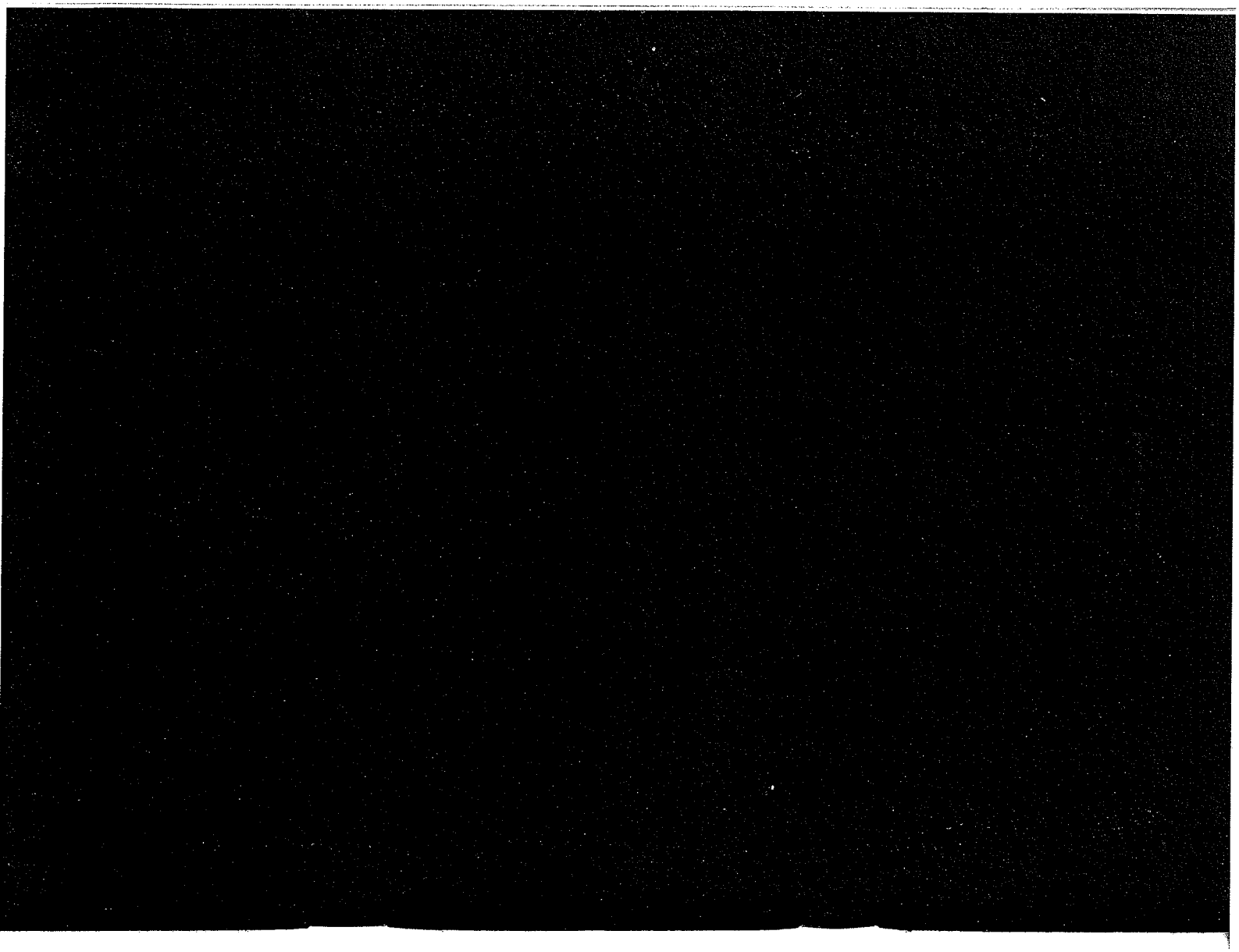
March 1970

[23] E.g., *United States ex rel. Schuster* v. *Herold,* 410 F.2d 107 (2d Cir. 1969), *cert. denied,* 24 L. ed.2d 96 (1969). The hospital admitted that Schuster's illness "would not respond to therapy" (410 F.2d at 1076), and the court therefore questioned the propriety of "purely custodial detention" (410 F.2d at 1088, 1087). priety of "purely custodial detention" (410 F.2d at 1088).



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IN THE

Supreme Court of the United States

OCTOBER TERM 1974

No. 74-8

J. B. O'CONNOR, M.D., *Petitioner*

v.

KENNETH DONALDSON, *Respondent*

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR THE RESPONDENT

OPINION BELOW

The Opinion of the Court of Appeals for the Fifth Circuit is reported at 493 F.2d 507.

QUESTIONS PRESENTED

1. Did respondent, who was involuntarily confined to a mental hospital for the purpose of treatment for nearly fifteen years, and who was dangerous neither to himself nor to others, have a constitutional right to be restored to liberty either by treatment or release?

2. Is there no evidence from which the jury could have concluded, as it did, that petitioner did not reasonably believe in good faith that respondent's continued confinement was lawful or proper, and that petitioner's acts were sufficiently malicious, wanton and oppressive to justify both compensatory and punitive damages?

STATEMENT OF THE CASE

A. Introduction

Petitioner O'Connor deprived respondent Donaldson of his liberty for nearly fifteen years, even though he was under no statutory or judicial obligation to do so. He did so even though he knew respondent was not dangerous to himself or to others. He did so even though he knew respondent was receiving only the same custodial care he would have received in a prison. And, having the authority to release respondent, he instead blocked respondent's efforts to be released to the custody of responsible friends and organizations. His acts, as a jury found, showed bad faith, and were so malicious, wanton and oppressive as to justify not only compensatory damages of $17,000, but punitive damages of $5,000.

Properly understood, this case raises important but narrow issues. In order to identify issues that are, and are not, raised by this case, it will be necessary to review the extensive facts developed at trial in some detail. Many of the "facts" contained in petitioner's brief are unsupported by any citations, and have literally no basis in the record. And petitioner has ignored material facts that were overwhelmingly established at trial.

B. Facts

From the evidence of record, the jury could reasonably have found the following facts:

1. Respondent was committed to Florida State Hospital in January, 1957 for the purpose of treatment.

Respondent's commitment papers, which accompanied him to Florida State Hospital, expressly stated that respondent was committed "to the Superintendent of the Florida State Hospital, Chattahoochee, Florida, for care, maintenance *and treatment.*" Plaintiff's Exhibit No. 13, "Order for Delivery of Mentally Incompetent." (Emphasis added.)

That order, by itself, made it clear that respondent was to receive something more than mere custodial care. The order, in turn, was consistent with, and required by, the statutes in effect at the time of respondent's commitment, which leave no doubt that the statutory purpose of his confinement was treatment.

Title 27 Florida Statutes § 394.09 (Laws 1877, Ch. 3036 § 1) (repealed July 1, 1972), then in effect, provided that persons committed to "hospitals" were committed "for the purpose of care, custody *and treatment. . . .*" (Emphasis added.) The word "treatment" was not fortuitous. The same section provided that persons committed not to hospitals but to "any other person" were committed "for care, custody or maintenance. . . ." [1]

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[1] Title 27, Florida Statutes, § 394.21(1) (Laws 1945, Ch. 23157 § 3) (repealed July 1, 1972) provided that the "head of a hospital" could admit involuntary patients "for observation, diagnosis, care *and treatment . . . .*" (Emphasis added.) Title 27, Florida Statutes, §§ 394.21(6) and 394.22(13) (repealed July 1, 1972) authorized recovery from the estates of patients of "reasonable charges" for the "care, maintenance *and treatment*" of patients, and provided that advance payment could not be "a prerequisite to the care, maintenance *and treatment*" of patients in public hospitals. (Emphasis added.) In order to implement this legislative purpose, Title 27, Florida Statutes § 394.08 (Laws 1945, Ch. 22858 § 7) (repealed July 1, 1972) required the "superintendent of the Florida State Hospital" (that is, petitioner, for 7½ years of the period respondent was confined) to "cause" the chief physician to "keep a com-

In addition, in 1967, four years before respondent was discharged, petitioner promulgated the *By-Laws, Rules and Regulations of the Medical Staff of the Florida State Hospital* (cited hereafter as "Hospital Regulations"). Plaintiff's Exhibit 2, and answers 14-a, 14-b and 15 of petitioner's *Answers to Interrogatories* dated January 4, 1972. The Hospital Regulations (at 4) stated that Florida State Hospital "was established to provide a *treatment facility* for the mentally ill in the State of Florida," and provided further:

> "Generally, it is our responsibility to the patients *to provide the best psychiatric and physical care possible.* It is expected that all physicians shall, at all times, conform with the ethical standards of medical practice. *Our primary objective is to return the patients as useful citizens, to their own community, as soon as possible. The mental hospital should only be an intermediate step in the treatment and rehabilitation of the patient.* Aside from providing the *best standards of treatment,* it is the responsibility of every physician to encourage and participate in whatever hospital programs in which he is asked to participate." Hospital Regulations at 54. (Emphasis added.)

The Hospital Regulations stated that the "*superintendent is responsible* . . . for the proper management of the hospital in order *to insure the best possible care and treatment* for the patients." Hospital Regulations at 55. (Emphasis added.)

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pletc clinical record of each patient, which record shall contain the name of the patient, the diagnosis, the date of beginning of *each treatment,* each day's prescription while under *treatment,* and such other therapy as may be indicated." (Emphasis added.) Subsequent statutes, effective in 1965 and 1967 (respondent was released July 31, 1971), continued to speak in terms of "treatment." *E.g.,* Title 27, Florida Statutes, §§ 394.272 (Laws 1965, Ch. 65-23 § 1) and 394.201 (6)(a) and (b) (Laws 1967, Ch. 67-7 § 4) (repealed July 1, 1972).

In summary, the court order which committed respondent, the statutes under which he was committed, and the Hospital Regulations all show that respondent was confined for the purpose of treatment.

2. Petitioner knew that respondent received no treatment, and that respondent received only custodial care.

Respondent's first witness was Dr. Walter Fox, an unusually distinguished psychiatrist, who had intimate knowledge of the standards applicable in public mental hospitals during the period of respondent's confinement.[2] Dr. Fox was asked, for the period 1957-1967, if there was evidence in respondent's hospital record that respondent "received psychiatric treatment." He replied (A at 2; T 11/21/72 at 65-66):[3]

> "A. No. In my opinion *there is no evidence that he received psychiatric treatment.* There are a number of progress notes which are generally brief and which make no reference to a treatment plan which frequently refer to continue custodial care or words

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[2] At the time of trial, Dr. Fox was Director of Mental Health Services for the state of Arizona. He had served as superintendent of public mental hospitals in Kentucky (1956-1965) and Iowa (1966-1972), and for two years as President of the Association of Medical Superintendents of Mental Hospitals (1968-1970). Accordingly, he was intimately familiar with the problems and the capacities of public mental hospitals during the period respondent was confined, and his evaluation of respondent's hospital record was made in that context. Dr. Fox is a Diplomat in Psychiatry of the American Board of Psychiatry and Neurology and a Fellow of the American Psychiatric Association. T11/21/72 at 59-64.

[3] "A" refers to the Appendix. "T" refers to the transcript of trial. Because there are several transcripts, each for a separate day of trial, and they are not all consecutively paginated, citations to the transcript are followed by the date of the particular transcript to which reference is being made. There are two transcripts for the final day of trial. The one which primarily reproduced the "oral charge" to the jury is so designated (T Oral Charge 11/28/72). "H" refers to respondent's hospital record, which was received in evidence as Plaintiff's Exhibit No. 1.

to that effect, which I interpret to mean provide food, clothing and shelter, and that is not psychiatric treatment." (Emphasis added.)

The very first progress note in respondent's hospital record, written nearly three months after admission by co-defendant John Gumanis, says "continue custodial care." A at 199; H at 64. That note was written while petitioner was respondent's attending physician, and thus directly in charge of respondent's care. Petr. Brief at 6. Twenty-one months later, in another progress note, co-defendant Gumanis repeated the order to "continue custodial care." A at 199(a); H at 64. Similar orders to continue custodial care were written by co-defendant Gumanis on March 21, 1959, April 23, 1959 (all while petitioner was respondent's attending physician), and on April 3, 1962. A at 200(b); H at 64-65. According to a progress note signed by a Dr. Chacon on August 30, 1965, nearly nine years after his admission, respondent was still receiving only "custodial care." A at 201(a)(i); H at 67. Gumanis testified, and petitioner did not deny, that custodial care would not help a paranoid schizophrenic, the diagnosis applied to respondent by petitioner. A at 113-14; T 11/27/72 at 38. A co-defendant, Dr. Walls, testified that respondent only received "milieu therapy," and that "custodial care is what we now call milieu therapy." A at 142-43; T 11/27/72 at 118-20. A letter Walls wrote on June 2, 1970, confirms this is what "milieu therapy" meant at Florida State Hospital. H at 838-40.

Petitioner knew that an adequate hospital record, containing an individualized treatment plan and frequent progress notes, is an essential prerequisite to treatment, and he knew that respondent's hospital record was inadequate (*see*, Florida Statutes § 394.08, note 1, *supra*,

requiring a "complete clinical record"), and could not serve as the basis of a treatment program.[4]

Dr. Fox, who in the previous two years had been called upon as a "consultant for the National Institute of Mental Health" to examine 400-500 patient records "to determine whether or not they were adequate records," and "whether or not the patients described in those records were receiving adequate treatment," testified that respondent's record was not an adequate record. A at 1, 10; T 11/21/72 at 64-65, 77-78. For example, Dr. Fox testified that he found "no evidence" of an "individualized treatment plan" in respondent's hospital record during the first ten years of his confinement (A at 4; T 11/21/72 at 69), even though "a treatment plan is basic to discharging a person." A at 10; T 11/21/72 at 78. Petitioner testified that respondent's treatment plan "would be incorporated no doubt in progress notes made by the patient's attending physician." A at 172; T 11/28/72 at 46. But during the period he was respondent's attending physician, petitioner did not "incorporate" a treatment plan in respondent's progress notes. In fact, he entered *nothing* in respondent's record. A co-defendant testified that it was petitioner's practice not to make "any notes." A at 105; T 11/27/72 at 11.

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[4] The Hospital Regulations promulgated by petitioner provided that "the attending physician shall be responsible for an adequate record of the patient . . . ." Article XI, ¶ 7. The specified purpose of the Hospital Regulations was "to insure that all patients admitted to the hospital receive the best possible care." Article II, ¶ 1. To that end, the Regulations required that an "individual comprehensive treatment plan [be] recorded, based on an inventory of the patient's strengths as well as his disabilities . . . ." Article VII, § 8, ¶ 5, Factor 8. The individual treatment plan was required to include "a substantiated diagnosis," "short-term and long-range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it provides adequate justification and documentation for the diagnosis and for the treatment and rehabilitation activities carried out." *Id.*

That practice, according to Dr. Fox, was contrary to the "standard practice in mental hospitals" under which a note would be entered in the record after each "significant contact" with a patient. A at 11-12; T 11/21/72 at 79.

The most vivid description of the prison-like custodial conditions in which he was forced to live from 1957 to 1967 comes from respondent's testimony (A at 40-44; T 11/22/72 at 245-48):

"Q. Now, in the buildings you lived in in Department A, were those buildings locked?
A. Yes, sir.
Q. Were the wards you lived on locked?
A. Yes.
Q. Were there metal enclosures on the windows?
A. Yes, padlocks on each window.
Q. Approximately how many beds were there in the rooms where you slept?
A. Some sixty beds.
Q. How close together were they?
A. Some of the beds were touching, the sides touched, and others there was room enough to put a straight chair if we had had a chair.
Q. Did you have chairs in the dormitory areas?
A. There wasn't a chair in the room I was in.
Q. All right, was there an outside exercise yard for your department?
A. Yes, there was a space outside the building, a good sized space enclosed with a cyclone fence topped with barbwire.
Q. Did you go out to that exercise yard?
A. I went out from time to time when the other patients went out.
Q. Was there ever a period of time when you did not go out to the exercise yard?
A. Yes, there was one period in particular when nobody went out for two years.

Q. Now, Mr. Donaldson, you were civilly committed. You had not been charged with any crime, is that right?
A. That is right.
Q. Were there criminal patients on your ward?
A. There were criminal patients on the ward.
Q. Approximately what percent of the population on your ward were criminals?
A. Looking back, roughly, I would say a third. I do not know the figures for the whole department.
Q. Let's talk just about your ward.
A. Okay. I would say about a third in the wards I was in.
Q. Now, did you sleep in the same rooms as the criminal patients?
A. Yes.
Q. Did you get up at the same time?
A. Yes.
Q. Did you eat the same food?
A. Yes.
Q. In the same dining room?
A. Yes.
Q. Did you wear the same clothes?
A. Yes. The entire operation of the wards I was on was geared to the criminal patients.
Q. Let me ask you, were you treated any differently from the criminal patients?
A. I was treated worse than the criminal patients.
Q. In what sense were you treated worse?
A. The criminal patients got the attention of the doctors. Generally a doctor makes a report to the court every month.
Q. For the criminal?
A. On the criminal patients, and that would be a pretty heavy case load. It didn't give them time to see the ones who weren't criminal patients.
Q. Was there a place on the ward you had access to for keeping personal possessions?
A. No, not at that time.

Q. What did you do with your personal possessions?
A. I kept mine in a cedar box under the mattress of my bed.
Q. Was there a place in the wards where you could get some privacy?
A. No, not anytime in all of the years I was locked up.
Q. Were you able to get a good night's sleep?
A. No.
Q. Why not?
A. On all of the wards there was the same mixture of patients. There were some patients who had fits during the night. There were some patients who would torment other patients, screaming and hollering, and the fear, always the fear you have in your mind, I suppose, when you go to sleep that maybe somebody will jump on you during the night. They never did, but you think about those things. It was a lunatic asylum."

Accordingly, the jury could have concluded that petitioner knew respondent lived on a locked ward, with criminal patients, and received only the "custodial care" he would have received in a prison.

3. Despite the inadequate staffing and resources at Florida State Hospital, there were standard modes of treatment that were available, but were not provided for respondent.

Petitioner knew respondent did not receive even those types of treatment that *were* available at Florida State Hospital.

Grounds privileges. Since the express goal of hospitalization, as stated in the Hospital Regulations, was to restore the capacity for independent community living, one of the most basic forms of treatment was to give patients an increasing degree of independence and personal responsibility. Co-defendant Walls confirmed that

Florida State Hospital "often" gave "grounds privileges" to the involuntary male patients, which allowed them to walk around the hospital's extensive grounds unattended. T 11/27/72 at 106. Dr. Fox testified that confining respondent to a locked building, with no opportunity for grounds privileges, was inconsistent with a psychiatric treatment plan for him. A at 4; T 11/21/72 at 70. Further, even in "an institution with limited resources" it would have been "standard psychiatric practice . . . in the case of Mr. Donaldson" to give him "grounds privileges," "weekend passes" and "trial visits for a month or two." A at 13-14; T 11/21/72 at 80-81.

Twice in 1957 petitioner approved respondent's assignment to institution-maintaining work assignments but crossed out that portion of the work assignment forms which would have given respondent grounds privileges while on the way to and from work. A at 193(a)-(b); H at 13-14.[5] Respondent specifically requested grounds privileges, but co-defendant Gumanis denied his request. T 11/22/72 at 240-41; A at 200(b); H at 65. Gumanis testified that the decision to deny grounds privileges was made in consultation with petitioner. A at 118; T 11/27/72 at 42. In fact, Gumanis testified that respondent "never" had grounds privileges during his ten years in Department A because Gumanis "consulted the superintendent" (petitioner), who "advised" Gumanis "not to give any." A at 118; T 11/27/72 at 42. No reason for the denial is contained in the hospital record and, although the matter was in dispute, no explanation was offered at trial. When respondent later came under Dr. Hanenson's care in Department C, Dr. Hanenson gave him grounds privileges. T 11/22/72 at 271.

[5] Copies of various documents retyped by petitioner for use in the Appendix are incomplete or inaccurate. For example, petitioner's signature and the denial of grounds privileges show quite clearly on the original work forms but do not show up on the retyped copies of the work forms used in the Appendix.

Occupational Therapy. Dr. Fox also testified that even with the "limited resources" of Florida State Hospital, petitioner could have assigned respondent to Occupational Therapy, which, given respondent's "social history," would have been an "excellent" treatment mode. A at 14-15; T 11/21/72 at 81-82.[6] Petitioner admitted that the hospital had a "well-regulated occupational therapy program" (T 11/28/72 at 36), and he knew from the hospital record (A at 201(i)) that his co-defendant Gumanis had denied respondent's request to be assigned to Occupational Therapy. No reason for the denial is contained in the hospital record and, although the matter was in dispute, no explanation was offered at trial. Within a month of his transfer to Dr. Hanenson's care (A at 202(b)(i); H at 70), respondent was permitted to engage in Occupational Therapy. *Id.*; T 11/22/72 at 271.

Contacts with physicians. Petitioner also knew that respondent's contacts with physicians were infrequent and administrative rather than therapeutic in nature. According to respondent's testimony, which petitioner did not dispute, during the period that petitioner was "directly responsible" for respondent's care, petitioner only spoke to respondent six times, less than one hour in all, and asked only the same three questions in each interview. T 11/22/72 at 216-19, 224, 241. The questions were: "What ward are you on?" "Are you taking any medication?" "Are you working any place?" A at 36; T 11/22/72 at 241. Respondent testified, again without contradiction, that he requested permission "many times" to speak with petitioner, but petitioner refused to speak with him. A at 38-39; T 11/22/72 at 243-44. Even if petitioner refused to speak with respondent only because petitioner was overworked (and there is no claim or evidence that that was the reason), the refusals surely demonstrate petitioner's awareness that respondent rarely spoke with physicians. In fact, the refusals are relevant not only to show that petitioner knew respondent was not receiving treatment, but also as evidence of petitioner's bad faith. As petitioner testified, there were "numerous opportunities [for the attending psychiatrist] to work out the patient's problems." T 11/28/72 at 35. Thus, the jury could have concluded that at least some of petitioner's refusals to speak with respondent could constitute evidence of bad faith.

[6] The work respondent performed was not the equivalent of occupational therapy, which teaches patients new employment skills. Petitioner never claimed that respondent's work assignments were, or were intended to be, therapeutic. Nor could he. Respondent's work requests were initiated by non-medical staff (*see*, H at 13-14), and were solely for the benefit of the institution. Respondent received no pay, and performed only menial tasks, such as dumping garbage, mopping floors, making beds, digging ditches, and helping retarded residents take showers. A at 45-51; T 11/22/72 at 249-54. The work assignments made it impossible for respondent to participate in occupational therapy, group therapy, or other treatment modes. For example, during his kitchen assignment, respondent worked "seven days a week" "from 6:00 o'clock in the morning to 7:00 o'clock that night," and was "locked in the kitchen all of that time." A at 48; T 11/22/72 at 252.

Social Services. Petitioner testified that the patient's physician "could, at his discretion, be aided by the efforts of a social service worker . . . ." T 11/28/72 at 35. But petitioner chose not to use that available service. In 1958, the Social Service Department received a letter from respondent stating he was not "receiving treatment of any kind." A at 206(a); H at 238. The Social Service Department brought that claim to petitioner's attention and asked if petitioner wanted "to refer this patient to Social Service." A at 206(b); H at 239. Even after this express offer, petitioner declined to utilize the proferred services of the Social Service Department. A at 206(b); H at 239.

In response to the overwhelming evidence that respondent received no treatment, and did not receive even those forms of treatment that were available, petitioner *now*

ims, although he did not so claim or testify at trial, l cites in his brief to no evidence in the record to port that claim, that respondent "did participate in ieu therapy, religious therapy and recreational ther-." Petr. Brief at 10. Respondent has shown that, at rida State Hospital, "milieu therapy" meant no more n "custodial care." A at 142-43. Petitioner's co-endant John Gumanis conceded at trial that "religious rapy" meant that respondent "could have gone to rch," and that "recreational therapy" meant little re than that respondent "could have amused himself way he wanted." A at 96-97; T 11/22/72 at 470-71. en if religion and recreation could be considered "ther-," and were available for other patients, there is no ication in respondent's hospital record that such thera- were ever prescribed for respondent. To the con-ry, at least to the extent that physical exercise is a n of recreation, there was evidence that for two years pondent was not even permitted to "go out to the rcise yard." A at 41-42.

rom this evidence the jury could have concluded that tioner knew respondent did not receive even those les of treatment that were available at Florida State pital, and that petitioner even "unjustifiably with-l . . . specific forms of treatment" from respondent. F.2d at 513.

. Petitioner knew respondent was not dangerous to himself or to others.

s respondent will demonstrate *infra* (pp. 39-40), er the instructions in this case, the jury could not e returned a verdict for respondent unless it first id that respondent was not dangerous to himself or thers, and that petitioner *knew* that respondent was dangerous. There was ample evidence to support finding.

The trial court did not determine whether, under Florida law, a finding of dangerousness was prerequisite to involuntary and indeterminate commitment, and the commitment papers which accompanied respondent to Florida State Hospital (Plaintiff's Exhibit No. 13) are sketchy and inconsistent on the issue of dangerousness.[7] However, even if the commitment papers could have justified a belief that respondent was dangerous at the time of commitment, petitioner knew that it was his responsibility to review whether respondent continued to be dangerous.[8]

Following respondent's hospitalization, the evidence that he was not, in fact, dangerous to himself or to others,

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[7] Respondent was committed under Title 27, Florida Statutes, § 394.22(11)(a): "Whenever any person who has been adjudged mentally incompetent requires confinement or restraint to prevent self-injury or violence to others, the said judge *shall* direct that such person be committed . . . ." (Emphasis added.) Thus, the judge was *required* to commit dangerous persons, but he may have had the *authority* to commit non-dangerous persons. The commitment papers, though inconsistent and composed primarily of "boiler-plate," suggest that respondent might have been committed even though he was not considered to be dangerous. For example, the actual "Order For Delivery" of respondent to Florida State Hospital provided that respondent required "confinement or restraint to prevent self-injury or violence to others, *or* to insure proper treatment . . . ." Plaintiff's Exhibit No. 13. (Emphasis added.) Thus, respondent may have been committed solely to insure proper treatment. Respondent did not challenge his original commitment, but it should be emphasized that respondent did not, and does not, concede that he was dangerous at the time of commitment. It was not necessary to litigate that issue because under the theory of this case the jury had only to find that *after* commitment respondent was not dangerous, and petitioner knew he was not dangerous.

[8] Petitioner conceded that although the hospital superintendent need not "question the right or wisdom of a court in committing a patient," it was the "duty" of the superintendent "to determine whether the patient having once reached the hospital was in such condition as to suggest that he be considered for release from the hospital." A at 164-65; T 11/28/72 at 24; there is a typographical error in the retyped copy of p. 24 used as p. 165 of the Appendix.

was overwhelming. Petitioner admitted he had no knowledge or recollection that respondent had ever injured anyone, or been arrested for or convicted of any crime. A at 128; T 11/27/72 at 84. Petitioner had neither personal nor second-hand knowledge of *any* occasion during respondent's hospitalization when he either committed or threatened to commit any act that was or would have been dangerous to himself or others, and admitted that "as far as I know, plaintiff was not harming anyone else." A at 127; T 11/27/72 at 82. Letters petitioner wrote[9] stated that respondent was "cooperative" (H at 182), and "causes no particular trouble in management." H at 185. In 1957, petitioner approved respondent's assignment to work in the kitchen, and expressed no concern that respondent would thereby gain access to knives and other dangerous implements. A at 193(b); H at 14.[10]

Experts testified that there was "no evidence" anywhere in respondent's hospital record to indicate that he "ever hit anyone or ever even threatened anyone verbally" (A at 3; T 11/21/72 at 69; Dr. Walter Fox); and that "the overwhelming impression of the test results and the hospital record was of non-violent behavior and non-probability of any kind of acting out behavior." A at 65; T 11/22/72 at 395; Dr. Raymond Fowler.[11]

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[9] The initials below the signature block on carbons of letters written at Florida State Hospital are the initials of the person who dictated or wrote the letter. Defendants' Exhibit 4, p. 8; T 11/22/72 at 456. Thus, while the letters referred to in text were signed by the Clinical Director, petitioner wrote them, as the JBOC initials indicate.

[10] Also, petitioner apparently read a hospital form (H at 220) which stated that respondent was not considered to be dangerous. T 11/27/72 at 82; H at 221-223.

[11] At the time of trial, Dr. Fowler, a Ph.D. psychologist, was Chairman of the Psychology Department at the University of Alabama, and past President of the Alabama Psychological Association and the Southeastern Psychological Association. He was a member of the Council of Representatives of the American Psychological Association (APA), and a Fellow and Diplomat of APA. He had developed a computer system for the scoring of the Minnesota Multiphasic Personality Index ("MMPI") that had been used by "approximately a third of the psychiatrists in private practice" in the United States, and that was used to grade or diagnose "about 75,000 [patients] a year." Dr. Fowler was qualified as an expert in clinical psychology, particularly in the field of interpreting the MMPI and other psychological tests. T 11/22/72 at 373-82.

Petitioner was intimately familiar with respondent's case and record,[12] and the jury could have concluded that he must have been aware of the uniform opinion of those who dealt with him that respondent was not dangerous. Co-defendant Gumanis conceded he did not think respondent was dangerous. A at 120-21; T 11/27/72 at 44. Julian Davis, Director of the Psychology Department at Florida State Hospital, confirmed at trial (T 11/22/72 at 364-65) his earlier opinion, expressed in a psychological report (H at 62), that respondent was not dangerous and that continued hospitalization was unnecessary. Co-defendant Walls, a psychiatrist at Florida State Hospital, agreed that respondent was not physically dangerous to self or others. A at 141; T 11/27/72 at 118, 126. And a Dr. Rodriguez confirmed in a progress note in February, 1971 that respondent had "never been a violent patient." A at 205(a).

John H. Lembcke, a Certified Public Accountant, college classmate, and close friend of respondent and his family for 46 years (T 11/21/72 at 119-20), who had personally discussed respondent's case with petitioner (T 11/21/72 at 125), testified that respondent was a "gen-

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[12] Petitioner wrote all outgoing correspondence concerning respondent from March 30, 1957 to July 15, 1959. H at 180-259. And from October 12, 1959 (H at 264) through June 25, 1963 (H at 496) virtually all correspondence concerning respondent went out over petitioner's signature. *See also*, as additional evidence of petitioner's continuing and extensive involvement with respondent's case, H at 67, 68-69, 382-83, 407, 482, 525, 538, 539, 554, 576, 656, 662, 679, and 749.

tle" man who had never been "violent," "belligerent," or "aggressive." T 11/21/72 at 133-34. Finally, respondent testified that he had never injured or threatened to injure himself or others. A at 34; T 11/21/72 at 179.

In summary, as the Court of Appeals noted, "there was no evidence in the record of Donaldson's ever having been violent in any way . . . the jury would have been justified in finding that Donaldson was non-dangerous, and in inferring that the defendants knew him to be so." 493 F.2d at 517.[13]

[13] Moreover, the jury could have found that respondent showed bad faith in falsely representing to others that other staff members considered respondent to be dangerous. For example, at the end of a staff conference on January 9, 1964, petitioner summed up by saying that the "consensus of opinion" was that respondent was "considered to be dangerous to others." A at 196(a); H at 33. However, co-defendant Gumanis, who had directed that staff conference (A at 195; H at 32), testified that the statement that respondent was dangerous was petitioner's "personal opinion." A at 81; T 11/22/72 at 447. No other doctor had expressed that opinion, as the stenographic record of the meeting reveals (A at 195-196(a); H at 32-33), and no evidence of dangerousness had been presented to the staff. T 11/22/72 at 447-49. Dr. Walter Fox, after reviewing the records of the staff conference, pointed out that petitioner, "the last person to speak," was "the first one to use the word dangerous," which petitioner then falsely described as the "consensus of opinion". T 11/21/72 at 111-14. When asked about that statement, petitioner, who admitted he had no personal knowledge that respondent was dangerous (A at 127-28; T 11/28/72 at 82-84), claimed that he was only "summing up the consensus of opinion expressed by others on the staff" and the opinion "of Doctor Franklin Calhoun, the psychologist from Jacksonville who examined the patient." A at 131-32; T 11/28/72 at 87-88. Of course, according to Gumanis and to the staff minutes, the staff had not said anything at all about dangerousness. And petitioner could not possibly have relied on Calhoun's opinion, as he claimed, because Calhoun did not even examine respondent until February 22, 1964, 44 days *after* the January 9, 1964 staff conference. H at 520-25, 530-32; Defendant's Exhibit No. 1 at 5. When petitioner reported the results of this staff conference to a state legislator interested in respondent's case, he again falsely claimed that it was the "unanimous" opinion of the staff that respondent "even may present some degree of danger to others." A at 214-15; H at 526-27. Petitioner also claimed that

5. If released, respondent would have been able to provide for his basic needs in the community: he did not need custodial care.

There was evidence from which the jury could have concluded that respondent was not so mentally ill as to require long-term involuntary confinement for his own welfare.

Dr. Fox testified that he found no evidence in the record to justify a diagnosis of schizophrenia or, in any event, to justify 15 years of confinement. A at 30; T 11/21/72 at 68-69, 106. He noted that respondent "was always finding jobs and was not a welfare case." A at 13; T 11/21/72 at 80. As Dr. Fox pointed out (A at 5; T 11/21/72 at 70-71):

> "There was nothing in his past history that showed that he wasn't a generally self-sustaining if frequently moving individual. Everything would point to the fact that here was an individual who had made it pretty well, who was responsible, who did have regard for his fellow human beings, and right off you look at this guy as somebody to get out of the hospital very soon, and one of the ways you would do that is by giving him as much freedom as possible as soon as possible."

Respondent's case, according to Dr. Fox, "wasn't that complicated a case." A at 16; T 11/21/72 at 83. In fact, "given the positive steps that could have been taken to treat Mr. Donaldson *even in an institution with limited resources*" it was Dr. Fox's opinion that it would have been necessary to confine him for no more than "two or three months," and "it probably would take less. It

letter was based in part on Calhoun's examination (A at 133; T 11/27/72 at 89), even though the letter was dated January 9, 1964, 44 days prior to Calhoun's examination.

hould take less." A at 16-17; T 11/21/72 at 82-83. Emphasis added.)[14]

Dr. Raymond D. Fowler, Chairman of the Department f Psychology at the University of Alabama (see note 11, *upra*), reviewed respondent's record, including all of re-pondent's psychological tests and the underlying raw lata. He found no evidence that respondent had been chizophrenic (A at 61; T 11/22/72 at 392), and testi-ied further that "at least 10 percent and probably more" f all "college students would have profiles as deviant or nore deviant than" respondent's on the Minnesota Multi-hasic Personality Index ("MMPI") (A at 74; T 11/22/ '2 at 403); that the raw data from these examinations howed that respondent's behavior was "quite well or-ganized" (A at 73; T 11/22/72 at 402); and that he 'doubted" that he would ever have recommended hos-italization for respondent. A at 72; T 11/22/72 at 401.

Petitioner's co-defendant John Gumanis conceded that espondent "probably could have earned a living if he had one out of the hospital." A at 113; T 11/27/72 at 37. n fact, after his discharge respondent took a bus to yracuse, New York, where, within a week, he found a teady and responsible hotel job which he had held over year by the time of trial. T 11/21/72 at 170-172. His mployer, John Colozzi, testified that respondent "caught n very fast and very well," "conducted himself as a ormal individual," showed up on time and never missed day of work, ran the entire hotel from midnight until :00 a.m., balanced the accounts, received all monies, and 'handled the job very well." T 11/21/72 at 159-168.

[14] Petitioner knew, as Dr. Fox pointed out on cross-examination, hat when respondent had been hospitalized 14 years earlier at Marcy State Hospital, with the same diagnosis petitioner later pplied to him, he had been released after only three months, and ad managed to care for himself and avoid re-hospitalization for he next 14 years. T 11/21/72 at 97-98; H at 1, 8, 30, 32, 64, 72.

There was additional evidence from which the jury could have concluded that respondent's mental condition did not change or improve during his fifteen-year confinement, indicating that he would have been equally capable of finding and holding a job throughout the period of his confinement. For example, Dr. Fowler testified that between 1958 and 1971, respondent's "test results were very much the same. . . . Specifically, the one that you can point to as a sort of an objective measure, the MMPI, looks about the same fourteen years later as it did previously." A at 62; T 11/22/72 at 393. Julian Davis, the hospital's psychologist, agreed with that conclusion, and agreed that respondent's mental condition, as reflected in the MMPI, was "basically the same" the day he was discharged as it was in 1958. A at 59; T 11/22/72 at 371-72. John Lembcke testified that respondent was, at the time of trial, "the same man that [he] knew back in college." T 11/21/72 at 134. And even petitioner agreed that there was no material change in respondent's mental condition during his hospitalization. T 11/27/72 at 81.[15]

From this evidence the jury could have concluded there was no reasonable basis to believe that, if released, respondent would not have been able to provide for his basic needs in the community.

[15] In addition, the jury was aware that, while confined, respondent wrote and published an article in a law review. T 11/22/72 at 277. The article, *Right to Treatment Inside Out*, 57 Georgetown L. J. 194 (1969), was offered but not received in evidence. The author of the article is identified only as a mental patient bearing hospital identification number A-25738, which was respondent's number at Florida State Hospital. A at 189.

i. Petitioner knew he had the authority, as attending physician and later as superintendent, to release respondent.

'etitioner concedes that he had the authority to grant)ondent a "permanent" and unconditional release from hospital if respondent had recovered. And there was lence, see note 17 *infra*, that even if respondent had ı mentally ill at the time of commitment, which)ondent did not and does not concede, shortly there- :r the hospital staff recognized that respondent's al- :d mental illness was "in remission," which would e allowed his release. Petitioner now claims, however, ; he did not have the authority to release respondent a "temporary" or conditional basis unless respondent "recovered." Petr. Brief at 57; *see also*, at 4, 52, 56. This claim was not advanced at trial, finds *no* port in the evidence, and is directly contrary to the lence. In this section, respondent will show that even)etitioner thought respondent was still mentally ill, tioner had the authority, both as attending physician later as superintendent, to restore respondent to rty by granting him a "temporary" or conditional ase.

'hroughout respondent's confinement there were two ic procedures for terminating hospitalization. The t, a "competency discharge," ordinarily required a aff conference" and a determination by a majority the medical staff that the patient had regained com- :ncy.[16] But the second procedure, which was variously :ribed as a "trial visit," a "home visit," a "furlough" an "out of state discharge," did *not* require a staff ference, and was *not* conditioned upon restoration of

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In fact, however, a staff conference was not essential, and, n a new superintendent replaced petitioner, in 1971, respondent finally given a competency discharge without appearing before aff conference. T 11/27/72 at 178-181; T 11/22/72 at 239.

competence. Every witness who testified confirmed these points.

Petitioner, for example, testified that "the typical trial visit was handled by the patient's attending psychiatrist." A at 163; T 11/28/72 at 22. A defense witness, Dr. W. D. Rogers, Director of the Florida Division of Mental Health, and Superintendent of Florida State Hospital from 1950 to 1963 (A at 148; T 11/27/72 at 144, 148), testified as follows (A at 150-51; T 11/27/72 at 150-51):

> "A. We have *always had in effect there a procedure for releasing a patient on a trial visit.* It was known as a trial visit. *This was a decision made by the treating psychiatrist.*
>
> "He can release the patient to *family, guardian or to some responsible person* who would assure the hospital of adequate care and supervision of the patient." (Emphasis added.)

Petitioner's co-defendant John Gumanis conceded that for "ordinary cases" the attending psychiatrist could release a patient on "furlough" without consulting the superintendent (A at 101-02; T 11/27/72 at 6), and confirmed that a patient could be released on furlough even if he had *not* regained competency and was still considered mentally ill. A at 100; T 11/27/72 at 5. Defendants' Exhibit No. 4, p. 10 (A at 242), the deposition of Dr. Rich, former Clinical Director at Florida State Hospital, confirms that even an "incompetent" patient *"could be released on trial visit strictly by his own doctor, without any other doctor being involved."* (Emphasis added.)

In addition, petitioner's brief mischaracterizes trial visits as solely "temporary" in nature. Petr. Brief at 57. As Dr. Rogers testified, trial visits could be for a full year, at the end of which the released patient would be "discharged." A at 150-51. Co-defendant Gumanis

curred. A at 100; T 11/27/72 at 5. Dr. Rich tes-ed that Florida State Hospital did not even keep ck of patients released on trial visit. Defendant's Ex-it No. 4 at 11. Finally, the Hospital Regulations (at provided:

> "Some patients who suffer from recurring mental illness or who cannot be declared completely mentally competent are released from the Hospital in the care of a responsible relative or other individual for a period of twelve months.
>
> * * * *
>
> "Those patients who have been absent from the Hospital for twelve consecutive months are automatically discharged and removed from the Hospital census."

summary, if petitioner had wanted to release respond-, he had the authority to do so.

7. Petitioner did not take the steps he could and should have taken to release respondent, and instead, intentionally blocked respondent's attempts to be released to the supervision of responsible friends and organizations.

Dr. Fox testified that the hospital record showed r the first few years . . . almost an indifference to charge. It was almost as if this was not one of the pital's goals." [17] A at 6-7; T 11/21/72 at 72-73. Later,

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Petitioner's co-defendant Gumanis testified that if respondent's ged illness had been "in remission," he would have been re-ed from the hospital. T 11/27/72 at 21. But despite the fact the first progress note in respondent's record stated that he pears to be in remission" (A at 199), petitioner, then respond-s attending physician, made no effort to release him. Instead, tioner responded to a contemporaneous inquiry from Travelers in Philadelphia by saying that respondent would need "further pitalization." H at 193. In March of 1957, while "in remission," pondent asked petitioner, then his attending physician, to initiate aff conference at which other physicians could consider his re-e. H at 168-69. Petitioner refused.

however, Dr. Fox found "more than just indifference," he found "actual resistance to the discharge of Mr. Donaldson." *Id.* The resistance Dr. Fox described was most pronounced when outsiders attempted to have respondent released to their care.

Release to Helping Hands, Inc. On June 6, 1963, the president of Helping Hands, Inc., a halfway house for former mental patients, wrote a letter to Florida State Hospital which read, in part, as follows (A at 207; H at 494):

> "We are interested in the possibility of signing out your patient, Kenneth Donaldson, and taking him as a resident at our halfway house at 3800 Columbus Avenue, Minneapolis. A maximum of six people live here, including our house mother, and myself, as president. At this time we have a room for Kenneth, who has interested us very much through his letters."

Enclosed was a brochure describing Helping Hands (H at 492) and a letter from the Minneapolis Clinic of Psychiatry and Neurology (A at 206(c)-206(c)(i)) (described by petitioner's co-defendant as a "good clinic" (T 11/22/72 at 483)), which praised Helping Hands and expressed the opinion that "it would be impossible in any of our State Hospitals for a patient to receive the type of attention and care" provided at Helping Hands. H at 493. Five days after that letter was received, petitioner replied that respondent could not be released to anyone other than his parents. A at 208; H at 495. The letter stated that respondent was then 55 years old. Petitioner therefore knew that respondent's parents were elderly, and he also knew they were quite infirm.[18]

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[18] Almost every letter received from respondent's parents from mid-1959 on spoke of their failing health and of the incapacities of their age. H at 263, 274, 286-87, 290-91, 355, 452-53, 455-56, and 461. In February of 1960 they had written quite straight-

Defendant Gumanis admitted that "Helping Hands could have helped Mr. Donaldson." T 11/22/72 at 483. Gumanis testified that he "was of the opinion the patient would be helped from Helping Hands. I still think the patient could have been helped by Helping Hands." A at 108; T 11/27/72 at 14. He then testified that "the decision [to reject] was made by Dr. O'Connor, the Superintendent." A at 108-09; T 11/27/72 at 14. Earlier, Gumanis had testified that the "final decision" would have "laid with Dr. O'Connor." T 11/22/72 at 484. Petitioner, for his part, though admitting that he knew "nothing" about Helping Hands when he signed the rejection letter, claimed that "apparently," the decision to reject the Helping Hands offer was based on "the opinion of the attending physician" who was, at that time, co-defendant Gumanis. A at 134; T 11/27/72 at 90. The initials below the signature block indicate that they jointly drafted the rejection letter.[19]

Release to John Lembcke. On July 3, 1964, Mr. John H. Lembcke wrote petitioner to ask if there were "any conditions" under which respondent, whom he described as "a friend of mine," could be released to Lembcke's custody. A at 217; H at 540. Lembcke was not an irresponsible, intermeddling do-gooder. He was a married man, with three children, and, as his letterhead indicated,

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forwardly that they thought they were "too old to be responsible" for respondent. H at 271.

[19] Moreover, the circumstances surrounding this rejection showed bad faith. Although the rejection letter claimed that respondent's parents were "legally responsible for him" (A at 208; H at 495-97), petitioner answered a contemporaneous letter from respondent's parents without even informing them of the Helping Hands offer. A at 209-11; H at 496-98. Gumanis placed responsibility for that omission on petitioner. A at 112; T 11/27/72 at 16-17. And elsewhere, petitioner expressly acknowledged that respondent could be released to someone other than his parents (A at 216(a); H at 539), despite his assertion to the contrary in the Helping Hands rejection letter.

was responsibly employed as a Certified Public Accountant. T 11/21/72 at 119. More importantly, he was probably respondent's oldest friend, and was known and respected by respondent's family, who had described him to petitioner as respondent's "pal and good friend." T 11/21/72 at 120, 136; H at 224-26. Nevertheless, the same day petitioner received Lembcke's request, without even mentioning the request to respondent, petitioner addressed to Gumanis a handwritten note which said: "Recommend turn it down." A at 216; H at 538. The note began by saying "This man himself [Lembcke] must not be well to want to get involved with someone like this patient . . . ." A at 216; H at 538. In his deposition submitted at trial, petitioner tried to minimize the importance of that note as "an off-hand remark made by one doctor to another doctor regarding a situation that had arisen calling for a decision to be made." A at 135-36; T 11/27/72 at 91. But it was that "off-hand remark" which caused Gumanis to draft a letter to Lembcke (A at 218), rejecting Lembcke's request. A at 85-86; T 11/22/72 at 457-58. Gumanis noted in respondent's record, under date of July 7, 1964: "A Mr. John Lembcke, a public accountant, wishes to sponsor him in New York, however Dr. O'Connor does not agree with this plan." A at 201(a); H at 67.

On November 24, 1964 petitioner received another letter from Lembcke asking to have respondent released to his care. A at 219; H at 553. The next day, petitioner instructed Gumanis to "please answer in negative." A at 220; H at 554. As reasons for this summary denial, petitioner listed a need for parental consent, the supposed unlikelihood of respondent's staying with Lembcke, and petitioner's lack of knowledge about Lembcke. *Id.* But petitioner never requested parental consent, and as will be seen below, the parents readily consented to releasing respondent to Lembcke's care when Lembcke subsequently requested consent. As in-

structed, Gumanis drafted another letter to Lembcke denying his request. A at 221; H at 555. He did not mention any of the reasons that petitioner had given, even though in his letter Lembcke had offered to "submit any information" that was needed. A at 219; H at 553. Gumanis testified that petitioner "told me to put it in a negative manner and that is exactly what I done." A at 93; T 11/22/72 at 468.

In May of 1966, Lembcke traveled from New York to Florida State Hospital, visited respondent, and talked with petitioner and Gumanis about respondent's release. T 11/21/72 at 125. Gumanis conceded that he "didn't see anything wrong with Mr. Lembcke" and "as far as I could tell," Lembcke "would have been adequate to manage Mr. Donaldson." A at 95. Lembcke also visited respondent's parents who, on May 14, 1966, jointly executed a notarized letter addressed to petitioner, in which they expressly gave "permission that our son, Kenneth Donaldson, be turned over to the care and supervision of John H. Lembcke." A at 228; Plaintiff's Exhibit No. 4. At that point, however, discouraged by his conversations earlier that week with petitioner and Gumanis, at which time they had refused to release respondent to his care (T 11/21/72 at 125, 138, 141), and aware that "Kenneth was exploring other ways to attain his release" (A at 227(a); H at 770), Lembcke did not pursue the matter further.

Finally, in 1968, when respondent was transferred to Dr. Hanenson's department, Hanenson called Lembcke long distance to arrange for respondent's release. T 11/21/72 at 125. He also scheduled respondent for a staff conference, which was not attended by petitioner. On March 21, the staff unanimously recommended that respondent be released "on trial visit or out of state discharge." A at 197; H at 47. There was some delay in working out the arrangements for release to Lembcke,

and in June of 1968 respondent wrote a letter to W. D. Rogers, by then Director of Mental Health for the State of Florida, asking if anything could be done to expedite the process. A at 225-26; H at 752. Dr. Rogers forwarded respondent's letter to petitioner, who apparently had no knowledge at that time of the staff plan to release respondent. Petitioner forwarded respondent's letter to Dr. Hanenson and asked Hanenson to give petitioner information about the contemplated release. Dr. Hanenson responded a few days later in a memorandum which explained and supported the staff plan for release to Lembcke. A at 224-224(a); H at 749. Across the bottom of that memorandum petitioner wrote, in his own hand, "the record will show, I believe, we have been through this before and decided Mr. Lembcke would not properly supervise the patient." H at 749; *see also*, A at 138; T 11/27/72 at 94.[20] When asked to do so, petitioner could not locate that decision in the hospital record (A at 139; T 11/27/72 at 94), and in fact, other than petitioner's notes to Gumanis, no such decision appears at any place in the record.

The staff plan to release respondent was thereupon abandoned and Lembcke was advised that respondent would not be released "at this time." A at 229; H at 775. That rejection letter imposed additional requirements, including "a more recent" parental release. As Lembcke put it, "after requirements were met, requirements were increased." T 11/21/72 at 132. From this evidence the jury could have found that the staff plan to release respondent was abandoned because of petitioner's discovery and disapproval of the plan. As the Court of Appeals noted, "the jury would have been justified in concluding that the frustration of Lembcke's effort to secure Donaldson's release in 1968 was en-

[20] The handwritten note was omitted when petitioner re-typed the memorandum for the Appendix (A at 224-224(a)), but appears clearly in the hospital record copy. H at 749.

tirely or primarily the result of O'Connor's bad faith intervention . . . ." 493 F.2d at 517.[21]

* * *

[21] There is further evidence in the record from which the jury could have concluded that petitioner willfully and maliciously blocked respondent's efforts to be released to the supervision of responsible friends and organizations because petitioner felt such efforts to be an attack upon his personal authority. During his confinement, respondent wrote letters to the Governor, to the state mental health commissioner, to state and federal legislators and judges, to lawyers, and to others, in nearly all of which respondent criticized conditions at petitioner's institution, and questioned the legality of his confinement. Those letters elicited personal replies from United States Senators Richard Russell and Stuart Symington, from George Meany, Governor Frank Lausche of Ohio, the editors of Time Magazine (who published one of respondent's letters) and others. T 11/21/72 at 203-04; Plaintiff's Exhibit No. 10. His letters also elicited inquiries from various officials, which caused petitioner to complain of "the constant burden of extra work [respondent] has placed upon the staff as a result of his baseless allegations . . . ." H at 681.

In fact, respondent's letters were not "baseless allegations" and were in part responsible for a legislative investigation of conditions at Florida State Hospital. On May 1, 1961, S. Chesterfield Smith, then Chairman of the Committee on State Institutions, and subsequently President of the American Bar Association, submitted a report that was highly critical of the hospital, noting that "the wards are maintained more as detention wards for inmates than they are as hospital wards for the sick." *Final Report of the General Findings of the Committee on State Institutions Relating to the Conditions at Florida State Hospital and the Alleged Mistreatment of Patients*, at 3.

Petitioner's own letters were preoccupied with, and constantly referred to, respondent's letters to public officials. *See*, for example, H at 232, 234, 239, 259, 382-83, 407-08, 483, 515-17, and 670-81. On at least one occasion, petitioner appeared to have initiated a search of respondent's hospital record to discover whether respondent had corresponded with a particular state legislator. *See*, H at 506. Thus, the jury could have concluded that petitioner was annoyed by respondent's challenge to his authority, and determined to continue respondent's confinement as punishment.

As the Court of Appeals noted, "there were suggestions in the record that Dr. O'Connor's conduct . . . was influenced by his knowledge of Donaldson's history of writing letters to the press and to outside officials." 493 F.2d at 517.

In summary, there was sufficient evidence for the jury to conclude that respondent was committed for the purpose of treatment; that petitioner knew respondent received no treatment; that petitioner knew respondent was not dangerous to himself or to others and would have been able to provide for his basic needs in the community; that petitioner knew he had the authority to release respondent but instead intentionally blocked his efforts to be released, and acted not only in bad faith, but also with malicious, wanton and oppressive disregard for respondent's rights and welfare. As the Court of Appeals ruled, "there was ample evidence" to support the jury's verdict. 493 F.2d at 513.

SUMMARY OF ARGUMENT

I.

Respondent was involuntarily committed to Florida State Hospital under non-criminal standards and procedures. Under the commitment order, the statutes then in effect, and the Hospital Regulations, respondent was confined expressly for the purpose of receiving treatment for his alleged mental illness. Petitioner knew that respondent was not receiving *any* treatment, and that he was receiving only the custodial care he would have received in a prison. Petitioner knew that respondent was not dangerous to himself or to others, and that respondent was capable of providing for his basic needs in the community. Petitioner had the authority to release respondent from the hospital, but instead allowed his confinement to continue for nearly fifteen years.

Involuntary commitment involves a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972), and affects "fundamental rights." *Baxstrom* v. *Herold*, 383 U.S. 107, 113 (1966). Avoiding such massive curtailment of fundamental rights is an interest of "transcending value." *In re Winship*, 397 U.S. 358, 364 (1970).

The due process clause of the Fourteenth Amendment requires that the "nature" of confinement bear a reasonable relation to the "purpose" for confinement. *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972). Where, as here, the stated purpose for confinement is the provision of treatment, it follows under *Jackson* that confinement without treatment would not bear a reasonable relation to the purpose for confinement. Accordingly, in the circumstances of this case, respondent had a right under the due process clause of the Fourteenth Amendment to treatment or else to release.

II.

In order to award even compensatory damages, the jury had to find (a) that petitioner knew respondent was not dangerous; (b) that petitioner knew respondent received only custodial care; *and* (c) that petitioner did not reasonably and in good faith believe that respondent's continued confinement was lawful. Before awarding punitive damages, the jury had to find, in addition, that petitioner's acts constituted "extraordinary misconduct" and were "malicious, wanton or oppressive."

Petitioner did not and does not challenge the propriety of the instructions regarding the award of compensatory or punitive damages, and the instructions were in accord with applicable law. Because the jury found that petitioner *knew* his acts were unlawful, there is no issue of "retroactivity" in this case. There is, therefore, no issue of law regarding damages before this Court. The only issue regarding damages is the sufficiency of the evidence to support the jury's verdict. The Court of Appeals found "ample evidence" to support the verdict, and petitioner has suggested no reason why this Court should review, much less reverse, the jury's determination that petitioner acted in bad faith, with malicious, wanton and oppressive disregard for respondent's rights and welfare.

ARGUMENT

I. UNDER THE DUE PROCESS CLAUSE, RESPONDENT, WHO WAS INVOLUNTARILY CONFINED AS MENTALLY ILL UNDER NON-CRIMINAL STANDARDS AND PROCEDURES FOR FIFTEEN YEARS AND WHO WAS DANGEROUS NEITHER TO HIMSELF NOR TO OTHERS, HAD A RIGHT TO BE RESTORED TO LIBERTY EITHER BY TREATMENT OF ELSE BY RELEASE

As this Court observed in *Jackson* v. *Indiana*, 406 U.S. 715, 737-38 (1972):

> "The States have traditionally exercised broad power to commit persons found to be mentally ill. . . . Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated." (Citations omitted.)

The central question in this case involves just such a limitation: did respondent, a mental patient who was involuntarily confined for 15 years in Florida State Hospital and who was dangerous neither to himself nor to others, have a substantive constitutional right to be restored to liberty either by treatment or else by release. This question, as it arises here, is a narrow but important one.

It is important because those mentally ill persons subjected to the states' involuntary, civil commitment processes, are one of the most vulnerable segments of society—usually destitute, often without families, and generally powerless to resist the arbitrary exercise of state authority affecting their most basic personal liberties.[22] The mentally ill are particularly vulnerable *after*

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[22] *See generally*, American Bar Foundation, The Mentally Disabled and the Law 1-14 (S. Brakel and R. Rock, eds.) (rev. ed. 1971) (hereinafter "ABF Study"); D. Rothman, Discovery of the

they have been involuntarily hospitalized by court order, since, historically, both case and statutory law have focused primarily on commitment procedures rather than on post-confinement rights.[23] To safeguard the constitutional rights of mental patients courts must scrutinize the conditions of involuntary confinement.[24] The most

Asylum (1971); R. Rock, M. Jacobson and R. Janopaul, Hospitalization and Discharge of the Mentally Ill (1968); E. Goffman, Asylums (1961); Joint Commission on Mental Illness and Health, Action for Mental Health (1961); A. Deutsch, The Mentally Ill in America (2d ed. 1949).

See also, Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constit. Rights of the Senate Comm. on the Judiciary, 87th Cong., 1st Sess., 1 (1961) (hereinafter, the "1961 Hearings"); *Hearings on The Constitutional Rights of the Mentally Ill Before the Subcomm. on Constit. Rights of the Senate Comm. on the Judiciary,* 91st Cong., 1st and 2d Sess. (1969-70) (hereinafter, "1970 Hearings").

[23] "Recognizing that commitment of the mentally ill is a serious deprivation of liberty, the law has encouraged the use of procedural safeguards . . . for commitment proceedings. However, there has been little corresponding consideration of an inmate's rights after commitment." Note, *The Nascent Right to Treatment,* 53 Va. L. Rev. 1134, 1135 (1967) (hereinafter, "Virginia Note"), citing A. Deutsch, note 22, *supra* and M. Guttmacher & H. Weihoffen, Psychiatry and the Law (1952). *See also,* ABF Study, *supra,* note 22, at 171 ("Statutes by and large do not adequately protect the rights of patients who have been hospitalized."); 1961 Hearings, *supra,* note 22, at 1 (remarks of Sen. Ervin: "the constitutional rights of hundreds of thousands of patients" after they are confined under governmental control "are of much greater significance" than the rights which attach before confinement during "hospitalization procedures."); Mental Health Law Project and Practicing Law Institute, Legal Rights of the Mentally Handicapped 275 (B. Ennis & P. Friedman eds. 1973).

[24] Conditions in large state mental hospitals have historically been inadequate at best. *Jackson* v. *Indiana,* 406 U.S. 715, 734-35, n.17 (1972). There "are substantial doubts about whether the rationale for pretrial commitment—that care and treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions." *Id. See also,* ABF Study, *supra,* note 22, at 417-18. *See generally,* A. Deutsch, *supra,* note 22; A. Deutsch, The Shame of the States (1948); Joint Commission on Mental Illness and Health, *supra,* note 22; Solomon, *The*

critical of the post-confinement rights—the right to be restored to liberty either by treatment or else by release—has been recognized and endorsed by medical experts,[25] by legal commentators,[26] and by the United

American Psychiatric Association in Relation to American Psychiatry, 115 Am. J. Psychiatry 1 (1958); Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Fifteen Indices: An Aid in Reviewing State and Local Mental Health Programs 6 (1966); American Psychiatric Association Task Force on the Right to Care and Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded 1 (4th Draft, Oct. 1974).

[25] *See, e.g., amici curiae* briefs in support of the constitutional right to treatment or release filed in the instant case by American Psychological Association, American Psychiatric Association, American Orthopsychiatric Association and National Association for Mental Health. *See also,* American Psychiatric Association Task Force on the Right to Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded 1 (4th Draft, Oct. 1974) ("The American Psychiatric Association, whose membership has always *implicitly* recognized and worked to implement the right to adequate care and treatment, now joins and endorses efforts towards this goal by stating its *explicit* support of this right.") (Emphasis in original.)

[26] The constitutional right to treatment or release for involuntarily committed mental patients has "received an unusual amount of scholarly discussion and support." *Donaldson* v. *O'Connor,* 493 F.2d 507 (5th Cir. 1974). The first articulation of the right is found in Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499 (1960). In the last 15 years more than 30 law review articles have been published on the subject, virtually all of them supporting a constitutional right to treatment or release for the involuntarily confined. *See, e.g.,* Comment, *Developments in the Law—Civil Commitment of the Mentally Ill,* 87 Harv. L. Rev. 1190 (1974) (hereinafter *"Developments—Civil Commitment"*); Note, *Rights of the Mentally Ill During Incarceration—the Developing Law,* 25 U. Fla. L. Rev. 494 (1973); Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment,* 86 Harv. L. Rev. 1282 (1973) (hereinafter *"Wyatt* Comment"); Robitscher, *Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient,* 18 Vill. L. Rev. 11 (1972); Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues,* 48 Notre Dame Lawyer 951 (1972); Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Con-*

States.[27] Most importantly, there exists "an enormous range of precedent" supporting such a right, *Donaldson* v. *O'Connor*, 493 F.2d 507, 519-20 (5th Cir. 1974.) [28]

stitutional Imperatives, 70 Mich. L. Rev. 1108 (1972); Goodman, *Right to Treatment: The Responsibility of the Courts*, 57 Georgetown L. J. 680 (1969); Katz, *The Right to Treatment—An Enchanting Legal Fiction*, 36 U. Chi. L. Rev. 755 (1969); Virginia Note, *supra*, note 23; Note, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 Yale L. J. 87 (1967); Drake, *Enforcing The Right To Treatment*, 10 Am. Crim. L. Rev. 587 (1972).

[27] The United States has participated in many of the important right to treatment cases. In *Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974), the United States stated that its interest as *amicus curiae* was to attack the "widespread and severe deprivation of the constitutional rights of citizens" who are civilly committed and urged the court to recognize that involuntarily confined mental patients "have a constitutional right to receive such treatment . . . as will give them a realistic opportunity to be cured or to improve their condition." Brief of *Amicus Curiae* United States, at 9. Early in 1974, the Justice Department filed suit in the name of the United States against Rosewood State Hospital in Maryland, alleging, *inter alia*, that the state had deprived civilly committed patients of their constitutional right to treatment. *United States* v. *Solomon, et al.*, Civ. Act. No. 74-181 (D. Md., filed Feb. 21, 1974). The United States has also participated as *amicus* with the rights of a party in another suit seeking a right to treatment or habilitation for the mentally retarded. *New York Ass'n for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973).

[28] The constitutional right to treatment or release for the mentally ill and the mentally retarded has been recognized by both federal and state courts. *See, e.g., Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) and 344 F. Supp. 387, 390 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974) (class actions on behalf of the mentally ill and the mentally retarded); *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974) (class action involving the mentally retarded); *Davis, et al.* v. *Watkins, et al.*, No. C 73-205, slip opinion at 1-2 (N.D. Ohio, Sept. 1974) (interim order) (class action on behalf of the mentally ill); *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973); *Kesselbrenner* v. *Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973); *Renelli* v. *Dept. of Mental Hygiene*, 340 N.Y.S.2d 498, —— N.E.2d —— (1973).

There is also a widening body of precedent holding that there is a constitutional right to treatment for persons committed under "non-penal" statutes for the purpose of care and treatment: (a)

The right to be restored to liberty either by treatment or else by release is a right that has been recognized in many different factual contexts, each with varying legal issues and societal interests. But in order to resolve the issues raised by the facts and jury instructions of this case, this Court need not resolve issues that have been (or might be) raised by other, quite different "right to treatment" cases. Here, a harmless mental patient who was confined for the express purpose of treatment sought damages for the failure of state officials to release him when they knew he was not re-

juvenile delinquents, Nelson v. *Heyne*, 355 F. Supp. 451, 459 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352, 360 (7th Cir. 1974), *cert. denied*, —— U.S. ——; *Inmates of Boys Training School* v. *Affleck*, 346 F. Supp. 1354, 1364 (D. R.I. 1972); *Morales* v. *Turman*, 364 F. Supp. 166, 175 (E.D. Tex. 1973); (b) *"persons in need of supervision," Martarella* v. *Kelley*, 349 F. Supp. 575, 585, 598-600 (S.D. N.Y. 1972), *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1973); *M* v. *M*, 336 N.Y.S.2d 304, 71 Misc.2d 396 (Fam. Ct. 1970); *In re I*, 316 N.Y.S.2d 356 (Fam. Ct. 1970); (c) *sexual offenders and defective delinquents, Stachulak* v. *Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973); *Davy* v. *Sullivan*, 354 F. Supp. 1320, 1328-1329 (M.D. Md. 1973) (three judge court); *Gomes* v. *Gaughn*, 471 F.2d 794, 800 (1st Cir. 1973); *Sas* v. *Maryland*, 334 F.2d 506 (4th Cir. 1964), *cert. denied*, 407 U.S. 355 (1972); *In re Maddox*, 351 Mich. 358, 88 N.W.2d 470 (1958); *Commonwealth* v. *Page*, 339 Mass. 313, 159 N.E.2d 82 (1959); *Director of Patuxent Institution* v. *Daniels*, 243 Md. 16, 221 A.2d 397 (1966); *Silvers* v. *People*, 22 Mich. App. 1, 176 N.W.2d 702 (1970); and (d) *persons incompetent to stand trial, United States* v. *Walker*, 335 F. Supp. 705, 708 (N.D. Cal. 1971); *United States* v. *Pardue*, 354 F. Supp. 1377, 1382 (D. Conn. 1973); *Nason* v. *Superintendent of Bridgewater State Hospital*, 253 Mass. 604, 612-613, 233 N.E.2d 908, 913-14 (1968); *Maatallah* v. *Warden, Nevada State Prison*, 86 Nev. 430, 420 P.2d 122 (1970)).

The right to treatment was rejected by the District Court in *Burnham* v. *Department of Public Health*, 349 F. Supp. 1335 (N.D. Ga. 1972), *reversed and remanded*, No. 72-3110 (5th Cir. Nov. 8, 1974). In *N.Y. State Ass'n for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973), the District Court did not recognize the right to treatment when deciding whether to grant a preliminary injunction but subsequently reserved decision on the issue pending presentation of evidence and further briefing, No. 72 Civ. 356, 357, Order of May 23, 1974, at 2.

ceiving treatment. Accordingly, in order to affirm the holding of the Court of Appeals, this Court need *not* decide:

1. Whether an involuntarily confined mental patient who is dangerous, either to self or to others, has a right to be treated or to be released;[29]
2. Whether civil commitment of the mentally ill for any purpose other than treatment is constitutionally permissible;
3. Whether the provision of treatment can itself justify the indeterminate or long-term confinement of mentally ill persons who are dangerous neither to self nor to others;
4. Whether courts can determine if the level of treatment received is "reasonable," in a constitutional sense, when, in contrast to this case, a patient receives more than the custodial care available in a prison;

[29] As will be discussed at pp. 58-59, *infra*, the Court of Appeals rested its decision on alternative holdings. The narrower one, which applies to the mentally ill who are dangerous neither to self nor to others, controls respondent's case. But respondent respectfully submits that the Court of Appeals' alternative holding, which applies to all involuntarily confined mental patients, was equally valid, *see* note 61, *infra*.

In any event, it should be emphasized that vast numbers of patients involuntarily confined in large mental institutions are not dangerous to self or to others. *See generally, Wyatt* Comment, *supra*, note 26, at 1289, n.43 (citing studies indicating that approximately 90% of patients involuntarily confined are not sufficiently dangerous to themselves or to others to require hospitalization). A 1970 study by the National Institute of Mental Health of the patient population at Saint Elizabeths Hospital in the District of Columbia revealed that nearly 70% of the patients confined therein did not have behavior problems and consequently could be discharged or released to such facilities as foster homes or half-way houses. National Center for Mental Health Services, Training and Research of NIMH, NCM-SEH Patient Inventory (1970).

5. Whether courts can establish institution-wide standards for ensuring the provision of treatment that is "reasonable" in a constitutional sense?[30]

Moreover, the impact of affirmance on Florida's mental health system will be negligible since, within the past two years, Florida has substantially altered its civil commitment law and has provided both a statutory right to treatment and a cause of action in damages against state doctors who abridge that right.[31]

The narrow "right to treatment" issue posed by this case is contained in the instructions to the jury. The oral charge, which will be discussed in greater detail below, was as follows:

> "In order to prove his claim under the Civil Rights Act, the burden is upon the Plaintiff in this case to establish by a preponderance of the evidence in this case the following facts:
>
> That the Defendants confined Plaintiff against his will, *knowing that he was not mentally ill or dangerous or knowing that if mentally ill he was not receiving treatment for his alleged mental illness.*
>
> Second, that the Defendants then and there acted under the color of state law.
>
> Third, that the Defendants' acts and conduct deprived the Plaintiff of his Federal Constitutional right not to be denied or deprived of his liberty without due process of law as that phrase is defined

[30] The instant case is, therefore, to be distingiushed from *Wyatt* v. *Aderholt, supra*, note 28, and from *Burnham* v. *Department of Public Health, supra*, note 28. Both *Wyatt* and *Burnham*, upon which petitioner relies, were class actions seeking declaratory and injunctive relief and the establishment of constitutionally required minimum standards governing conditions in state mental hospitals for the involuntarily confined.

[31] *See* pp. 70-71, 84-85, and notes 79 and 99, *infra*.

and explained in these instructions, and fourth, that the Defendants' acts and conduct were the proximate cause of his injury and consequent damages that he suffered. . . .

You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a *constitutional right to receive such treatment as will give him a realistic opportunity to be cured or to improve his mental condition.*

Now, *the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others.* Without such treatment there is no justification from a constitutional stand-point for continued confinement unless you should also find that the Plaintiff was dangerous either to himself or others." A at 183, 186.[32] (Emphasis added.)

In this section, respondent will demonstrate that these instructions were a correct statement of the applicable constitutional law. Although this Court has infrequently considered the rights of involuntarily confined mental patients, its concern for their constitutional rights is not new. The Court of Appeals' acknowledgement of respondent's post-commitment right to restoration of liberty by treatment or else by release, in the circumstances of this case, was consistent with the sensitive admonition of this Court issued nearly a quarter of a century ago:

> "We fully recognize the *danger of a deprivation of due process* in proceedings dealing with persons charged with insanity . . . and the *special importance of maintaining the basic interests of liberty* in a class of cases where the law though 'fair on its face and impartial in appearance' may be open to *serious abuses in administration* and courts may be imposed upon if the *substantial rights* of the persons charged are not adequately safeguarded at *every stage* of the proceedings."

Minnesota ex rel. Pearson v. *Probate Court*, 309 U.S. 270, 276-77 (1940). (Emphasis added.)

[32] This oral charge given to the jury was discussed in slightly different form in chambers as Plaintiff's Proposed Instructions #34, #37, and #38.

A. Respondent's Involuntary Civil Commitment Abridged His Constitutionally Protected Liberty

Recognition of respondent's right to treatment or release begins with the elementary principle that the civil commitment of the mentally ill infringes constitutionally protected liberty. In 1957, respondent was judged mentally incompetent, and was involuntarily and *indefinitely* committed to the Florida State Hospital at Chattahoochee under non-criminal standards and procedures. Not only did this commitment expressly impose civil disabilities by statute,[33] but, by placing him under the total control of state hospital authorities, it abridged the most basic aspect of constitutional liberty—the right to be free from physical confinement. *Arnett* v. *Kennedy*, 94 S.Ct. 1633, 1646 (1974) (core meaning of constitutional liberty is "the elemental freedom from external restraint."). Moreover, respondent's lengthy confinement as mentally ill infringed his due process right to be free from unwar-

[33] Title 27 Florida Statutes § 394.22(10) (Laws 1945, Ch. 23157 § 3) (repealed July 1, 1972) provided that

> After a judgment adjudicating a person to be mentally incompetent is filed in the office of the county judge, such person shall be presumed to be incapable, for the duration of such incompetence, of managing his own affairs or of making any gift, contract, or any instrument in writing which is binding on him or his estate.

For a discussion of the civil disabilities expressly imposed by civil commitment statutes, *see generally*, ABF Study, *supra*, note 22 at 155-341; *Developments—Civil Commitment, supra*, note 26, at 1198-1200.

nted stigma.[34] Further, long-term confinement in men-
l institutions which provide only custodial care, if that,
ten causes deterioration, not improvement, in patients'
ental conditions, leading to additional deprivations of
erty.[35] Finally, involuntary confinement abridges other
sic constitutional rights.[36]

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[34] Stigmatization constitutes a deprivation of constitutionally
otected liberty, *Board of Regents* v. *Roth*, 408 U.S. 564, 573
972). A "former mental patient may suffer from social op-
obrium which attaches to treatment for mental illness and which
y have more severe consequences than do . . . formally imposed
abilities. . . . The legal and social consequences of commitment
nstitute the stigma of mental illness, a stigma that could be as
cially debilitating as that of a criminal conviction," *Develop-
nts—Civil Commitment, supra*, note 26, at 1200-01 (and cases
ed therein). "Civil commitment involves stigmatizing the af-
cted individuals, and the stigma attached, though in theory less
vere than the stigma attached to criminal conviction, may in
ality be as sereve, *or more so.*" *Donaldson* v. *O'Connor, supra*,
3 F.2d at 520 (Emphasis added.)

[35] The deterioration of patients' intellectual, social and physical
nctioning *as a result* of custodial confinement in large under-
affed and overcrowded mental hospitals has been widely recog-
zed in the medical and social science literature. The popular
me for this phenomenon of deterioration is "institutionaliza-
n." *See, e.g.*, E. Goffman, Asylums (1961); R. Barton, Institu-
nal Neurosis (1966); Gruenberg, *The Social Breakdown Syndrone
Some Origins*, 123 Am. J. Psychiatry 12 (1967); I. Belknap,
man Problems of State Mental Hospitals (1956); M. Schwartz
Schwartz, Social Approaches to Mental Patient Care (1964);
Wing & G. Brown, Institutionalization and Schizophrenia (1970).
e also Chambers, *Alternatives to Civil Commitment of the Men-
ly Ill: Practical Guides and Constitutional Imperatives*, 70 Mich.
Rev. 1108, 1126-29 (1972); 1961 Hearings, *supra*, note 22, at
, 43-44, 124, 637.

One of respondent's expert witnesses, Dr. Walter Fox, testified
at respondent's lack of deterioration showed that respondent was
iquely independent: ". . . Mr. Donaldson had . . . more . . .
ternal strength than most of the people that would find them-
lves in that sort of total institution for that period of time."
6; T 11/21/72 at 71.

[36] Involuntary confinement severely limits the exercise of other
nstitutional rights such as the right to privacy and personal
tonomy, *Roe* v. *Wade*, 410 U.S. 113 (1973); the right to asocia-

This Court has recognized that involuntary confinement of persons on the ground of mental illness affects "fundamental rights", *Baxstrom* v. *Herold*, 383 U.S. 107, 113 (1966), and entails a "massive curtailment of liberty" in a constitutional sense, *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972). Avoiding such extreme restrictions on liberty is an interest of "transcending value," *In re Winship*, 397 U.S. 358, 364 (1970). As Judge Wisdom noted below:

> *"The destruction of an individual's personal freedoms effected by civil commitment is scarcely less total than that effected by confinement in a penitentiary.* Indeed, civil commitment, because it is for an indefinite term, may in some ways involve a more serious abridgement of personal freedom than imprisonment for commission of a crime usually does . . . . *Since civil commitment involves deprivations of liberty of the kind with which the due process clause is frequently concerned, that clause has the major role in regulating government actions in this area.*"

Donaldson v. *O'Connor, supra*, 493 F.2d at 520. (Emphasis added; citations omitted.) And, as Judge Tamm has stated, "There can no longer be any doubt that the nature of the interests involved when a person . . . [is] involuntarily committed . . . is 'one within the contemplation of the "liberty and property" language of the Fourteenth Amendment.'" *In re Ballay*, 482 F.2d 648, 655 (D.C. Cir. 1973), quoting *Morrissey* v. *Brewer*, 408 U.S. 471, 481 (1972).

Respondent, though he had committed no crime, was deprived of liberty for 175 months, or nearly 15 years.

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tion, *Shelton* v. *Tucker*, 364 U.S. 479 (1960); the right to travel, *Shapiro* v. *Thompson*, 394 U.S. 618 (1969); the "right to work for a living in the common occupations of the community", *Truax* v. *Raich*, 239 U.S. 33 (1915); and the right to movement, *Papachristou* v. *City of Jacksonville*, 405 U.S. 156 (1972).

That compares with an average time served for federal convicts of only 17.7 months.[37] Persons convicted of homicide or rape on federal property serve, on the average 80.1 and 38.4 months, respectively.[38] In short, the deprivation of physical liberty involved in this case was much longer than that which society ordinarily deems justified even for the most serious crimes.

B. The Stated Purpose of Respondent's Involuntary Confinement Was To Provide Him With Treatment for His Mental Illness in Order To Return Him to the Community

If liberties cognizable under the Due Process Clause have been abridged by state action, then there are two basic methods for challenging the validity of the abridgment. First, the aggrieved party may question whether the abridgement can be justified in terms of a permissible governmental goal. *Jackson* v. *Indiana*, *supra*, 406 U.S. at 738; *Roe* v. *Wade*, 410 U.S. 113, 173 (1973) (Rehnquist, J., dissenting); *Vlandis* v. *Kline*, 412 U.S. 441 (1973); *Williamson* v. *Lee Optical Co.*, 348 U.S. 483, 491 (1955); *Nebbia* v. *New York*, 291 U.S. 502, 525 (1934); *Meyer* v. *Nebraska*, 262 U.S. 390, 399-400 (1923). *Cf. James* v. *Strange*, 407 U.S. 128 (1972); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972).[39] Second, the aggrieved party may refrain from litigating the permissibility of the stated purpose, and simply question whether there is a rational relationship between the stated purpose of

[37] Federal Bureau of Prisons, Statistical Reports, Fiscal Year 1973, Table C-2, at 97-98.

[38] Federal Bureau of Prisons, Statistical Reports, Fiscal Year 1973, Table C-2, at 97-98.

[39] *See generally* Tribe, *Foreward: Toward a Model of Roles in the Due Process of Life Law*, 86 Harv. L. Rev. 1, 17 (1973). Cf. Gunther, *Foreward: In Search of Evolving Doctrine on a Changing Court: A Model for Newer Equal Protection*, 86 Harv. L. Rev. 1, 17-20 (1972).

the abridgement and the means for effecting that purpose. *Nebbia* v. *New York*, *supra*; *Meyer* v. *Nebraska*, *supra*; *Vlandis* v. *Kline*, *supra*; *Jackson* v. *Indiana*, *supra*.

Only this second approach was employed by respondent. Specifically, respondent neither challenged nor conceded the constitutional permissibility of abridging his constitutional right to liberty for the purpose of treatment. Instead, respondent proved at trial that there was no rational relation between the stated purpose of his confinement—treatment for mental illness in order to restore him to liberty—and the actual nature of that confinement.

1. *As petitioner knew, the stated purpose of respondent's confinement was to provide treatment so that respondent would be returned to the community.*

As has been noted above, *see* pp. 3-5, *supra*, the statute authorizing respondent's civil commitment expressly stated that involuntary confinement was "for the purpose of care, custody *and treatment*." Title 27 Florida Statutes 394.09 (1941) (Laws 1877, Ch. 3036 § 1) (repealed July 1, 1972). (Emphasis added.) Moreover, the judicial order delivering respondent to the state hospital expressly stated that respondent was committed "to the Superintendent of Florida State Hospital, Chattahoochee, Florida, for care, maintenance *and treatment*." Plaintiff's Exhibit 13, "Order for Delivery of Mentally Incompetent." (Emphasis added.) Both the statutory provision and the order were clear on their face that respondent was to receive more than mere custodial care. Because the phrases "care, custody and treatment" and "care, maintenance and treatment" are conjunctive in form, it follows that treatment was a necessary purpose of respondent's confinement. Moreover, as has also

been noted, *see* p. 4, *supra*, this purpose is reflected in the By-Laws, Rules and Regulations of the Medical Staff of Florida State Hospital, which were promulgated by petitioner during respondent's confinement. Those by-laws expressly state that the Florida State Hospital was "established to provide a *treatment facility* for the mentally ill", and state further: "Our *primary objective* is to return the patients as useful citizens, to their own community, as soon as possible. The mental hospital should only be an intermediate step in the *treatment and rehabilitation* of the patient." *See* p. 4, *supra*. (Emphasis added.)[40]

Thus express statute, order and regulation made clear that respondent was confined for the purpose of treatment. Moreover, the jury could have found, as fact, that

[40] There is increasing recognition that restoring the liberty of the mentally ill by returning the mentally ill to a productive normal life as soon as possible and insofar as possible should be the overarching objective of all civil commitment. Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A. J. 1371, 1371 (1974): "The major trend in mental health . . . is de-institutionalization. . . . The hypothesis of this trend is rehabilitation rather than incarceration. . . . The major provisons of the legislation and case law governing the commitment, admission, hospitalization and discharge of the mentally ill and retarded speak to maximizing the patient's opportunities to stay out, to get out, and while in to get the most advantages with the minimum of suffering." *See also* 1961 Hearings, note 22, *supra*, at 224 (Remarks of Sen. Ervin: ". . . the primary object of commitment is to treat people and restore them to society as soon as it is determined that they have the capacity to readjust themselves."); ABF Study, supra, note 22, at 39 ("primary mission" of state mental hospitals is "treatment of mental illness."); American Psychiatric Association, Standards for Psychiatric Facilities 2 (1969) ("The primary functions of any psychiatric facility are to diagnose, to treat and to restore mentally disordered persons to an optimal level of functioning, and return to the community.").

It would, therefore, be more analytically correct for courts and commentators to say that "treatment" is not a "purpose", but rather a "means" of effecting the only constitutionally permissible purpose of civil commitment, namely, the restoration of a mentally ill person's liberty and his return to the community.

petitioner knew that respondent was confined for the purpose of providing treatment that would restore respondent to the community.[41]

2. *Custodial care of a mentally ill person who is neither dangerous to himself nor to others is not a constitutionally permissible purpose for involuntary confinement.*

Petitioner asserts here for the first time that custodial care, *without more*, is a permissible purpose for involuntary confinement of the harmless mentally ill. Petr. Brief at 41-42. In making this assertion, petitioner simply ignores the state statutes, judicial order and Hospital Regulations in effect during respondent's confinement. These indicate that, although custodial care was a necessary purpose of confinement, it was not a necessary *and* sufficient purpose under state law, *i.e.*, it could not, by itself, justify involuntary confinement. Moreover, petitioner did not argue that custodial care alone justified confinement of a non-dangerous mental patient nor did he proposed a jury instruction to that effect.[42] Accord-

[41] The *By-Laws, Rules and Regulations of the Medical Staff of Florida State Hospital* promulgated by petitioner were introduced into evidence as Plaintiff's Exhibit #2. Petitioner also conceded that the purpose of confining respondent was to ensure that respondent could "make [an] adjustment" outside the hospital. A 130; T 11/28/72 at 86.

[42] To the contrary, petitioner did not object to the first sentence of Plaintiff's Proposed Instruction No. 38, which provided, as revised in chambers by the trial judge, that "the purpose of involuntary hospitalization is treatment, and not mere custodial care or punishment if a patient is not a danger to himself or others." T 11/28/72 at 8-9. In a pre-trial brief, petitioner had objected to that instruction as a whole, but only because of the second sentence, which provided "Without such treatment there is no justification, from a constitutional stand-point, for continued confinement." Petitioner *agreed* that confinement of non-dangerous persons without treatment was not justified, but proposed to limit the means by which such unjustifiably confined patients could secure release to

ingly, this issue is not properly before this Court.[43]

If, however, this Court chooses to reach the issue, it should decide that, for a mentally ill person, who is dangerous neither to himself nor to others, the provision of mere custodial care, which a person would receive in a prison, cannot justify the massive deprivation of liberty involuntary confinement entails.

Historically, states have justified civil commitment of the mentally ill according to two broad *purposes*: rehabilitation of the mentally ill individual pursuant to the state's beneficent *parens patriae* power or protection of society from dangerous persons pursuant to the state's police power. *See generally*, Note, *Civil Commitment of the Mentally Ill: Theories & Procedures*, 70 Harv. L. Rev. 1288 (1966); Note, *The Nascent Right to Treatment*, 53 Va. L. Rev. 1134, 1138-39 (1967) (hereinafter "Virginia Note"); Comment, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1207-1240 (1974) (hereinafter *"Developments—Civil Commitment"*).[44]

Under these broad *parens patriae* or police powers, states have traditionally sought involuntary commitment

'judicial process," thereby excusing petitioner from liability for failure or refusal to exercise his authority to effect an administrative release. 493 F.2d at 518-19, n.8.

[43] *See* note 92, *infra*.

[44] The state's *parens patriae* power, which originally lodged in the King and now resides in the legislature, *Hawaii* v. *Standard Oil Co.*, 405 U.S. 251, 257 (1972), is "inherent in the supreme power of every state." *Mormon Church* v. *United States*, 136 U.S. 1, 57 (1890). The core of the concept is that the state acts as "guardian" of citizens with disabilities. *Hawaii* v. *Standard Oil Co., supra*, 405 U.S. at 257. The power serves as the basis for state laws which protect minors, establish guardianships, and provide for the involuntary commitment of the mentally ill. *See generally, Developments—Civil Commitment, supra*, note 26, at 1207-10 (nature and origins of power).

of the mentally ill according to one of three *standards*: when mental illness results in (a) danger to others; (b) danger to self; or (c) the need for treatment. *Jackson* v. *Indiana, supra*, 406 U.S. at 737, n.19; American Bar Foundation, The Mentally Disabled and the Law 37-49 (S. Brakel & R. Rock eds.) (rev. ed. 1971) (hereinafter, "ABF Study") (summarizing the laws of the states as of 1971); *Developments—Civil Commitment, supra*, at 1203-4 (summarizing the laws of the states as of 1974).[45]

When the state civilly commits or continues to confine a mentally ill individual who is dangerous neither to himself nor to others, it is acting pursuant to its *parens patriae* power and the purpose of exercising that power is to promote the interests of the individual. *Id.*, at 1222; ABF Study, *supra*, at 34-40.[46] In such circumstances, civil commitment cannot be justified as an exercise of the police power for the protection of society. Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A. J. 1371 (1974).[47]

[45] The precise relationships between the broad *parens patriae* or police power goals which *justify* commitment and the statutory criteria which *trigger* commitment are "seldom spelled out" by state legislatures. Virginia Note, *supra*, note 26, at 1138. And the absence of litigation focusing on the legality of commitment standards has "left the boundaries of the state's commitment power largely undefined," *Developments—Civil Commitment, supra*, note 26, at 1207; *Jackson* v. *Indiana, supra*, 406 U.S. at 737-38.

[46] *See also*, Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 Harv. L. Rev. 1288, 1289, n.11 (1966) ("Unless proceedings against a person have met the standards for a dangerousness commitment, a hospital should only consider *his best interests* in treating him.") (Emphasis added); Virginia Note, *supra*, note 23, at 1138-39 (police power commitments look to dangerousness and protection of society not to the best interests of the individual).

[47] In *Donaldson* v. *O'Connor, supra*, 493 F.2d at 520-21, Judge Wisdom noted that it "is analytically useful to conceive of these grounds as falling into two categories, one consisting of 'police power' rationales for confinement, the other of *'parens patriae'*