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# RELEASE PROCEDURE UNDER THE PENNSYLVANIA MENTAL HEALTH AND MENTAL RETARDATION ACT OF 1966<sup>1</sup>

## INTRODUCTION

A person suffering from a mental illness has no constitutional right to liberty as long as the mental illness exists.<sup>2</sup> The state exercises control over the locomotion of such individuals to prevent injury either to the patient himself or to other citizens and property. Power to protect the patient flows from the general duty of the sovereign to care for the members of society, *i.e.*, the *parens patriae* doctrine.<sup>3</sup> Similarly, the state police power includes the power to safeguard citizens and their property.<sup>4</sup>

However, once the patient has recovered from the mental disability<sup>5</sup> which occasioned the original commitment, there should at least be certain minimal procedural safeguards to prevent a deprivation of liberty by continued confinement. The duty to determine releasability is generally imposed on one of three generic societal units: the judiciary, an integrated medico-legal decision making panel or the medical profession.

Judicial control has been criticized on the ground that judges are often so skeptical of the effectiveness of psychiatric treatment of the mentally ill that judicial decisions in favor of release would rarely occur.<sup>6</sup> On the other hand, if the patient has successfully defended a criminal prosecution on the ground of insanity at the time of the crime, the decision to release him necessarily involves a determination of the extent of risk which society is willing to assume that the releasee will engage in subsequent dangerous conduct. Specifically, the community has a survival interest in the release of "a person who, though acquitted, has demonstrated an ability, not merely a propensity, to commit dangerous acts."<sup>7</sup>

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1. PA. STAT. ANN. tit. 50, §§ 4101-04 (Supp. 1966) (hereinafter cited as the Act of 1966).

2. If a mental disability is severe enough to justify initial commitment to a facility, the patient should not be released until the reason for the confinement no longer exists. *Maxwell v. Maxwell*, 189 Iowa 7, 177 N.W. 541, 543 (1920); *Martin v. Beuter*, 79 W.Va. 604, 91 S.E. 452, 453 (1917). Cf. Note, *Procedure for the Commitment and Release of the Criminally Insane*, 4 WILLAMETTE L.J. 64, 72 (1966).

3. Bassiouni, *The Right of the Mentally Ill*, 15 DE PAUL L. REV. 291, 300 (1966). See *Hammon v. Hill*, 228 F. 999 (W.D. Pa. 1915).

4. Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945 (1959).

5. "Mental disability" means any mental illness, mental impairment, mental retardation, or mental deficiency, which so lessens the capacity of a person to use his customary self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care as provided in this act." PA. STAT. ANN. tit. 50, § 4102 (Supp. 1966).

6. Note, *Releasing Criminal Defendants Acquitted and Committed Because of Insanity: The Need for Balanced Administration*, 68 YALE L.J. 293, 301-02 (1958).

7. Goldstein & Katz, *Dangerousness and Mental Illness: Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity*, 70 YALE L.J. 225, 228 (1960).

The consequences of a medically incorrect determination of the present existence of mental disability either in terms of danger to citizens who confront the mentally disabled releasee or a denial of due process of law by reason of continued confinement in the absence of mental disability, are severe. While mathematical certainty is impossible, it has been suggested that a panel, composed of members with diverse backgrounds, could render decisions satisfying both to the medical and legal professions.<sup>8</sup> Although psychiatrists are especially suited to help a court determine a prisoner's fitness for and the conditions of probation or parole,<sup>9</sup> the very factor giving rise to the suggested panel, *i.e.*, a need for diversified opinion on the desirability of release, probably would render smooth and effective operation of such a panel unlikely.<sup>10</sup>

Hospital authorities acting alone are likely to render medically correct decisions:

It should require no argument to demonstrate that the authorities of the hospital where the patient is under daily supervision and to whom the facts of previous history and of his mental state are best known are the persons who should determine his fitness to be returned to the community.<sup>11</sup>

Similarly, the draftsmen of Article 4 of the Model Penal Code suggest that the hospital authorities are competent to determine releasability because

. . . the judgments of whether a mentally disordered individual is of danger to himself or to others and whether he will profit from treatment for which he sees no need are primarily medical decisions and should not be left to the court.<sup>12</sup>

8. E.g. OHIO REV. CODE ANN. § 2945.39 (Page 1953) providing that persons committed after an acquittal on the ground of insanity ". . . shall not be released from confinement in said hospital until the judge of the court of common pleas of Allen County, the superintendent of the Lima state hospital, an alienist to be designated by said judge and superintendent, or a majority of them . . . determine that said defendant's sanity has been restored, and that his release will not be dangerous . . . ."

9. Slovenko, *The Psychiatric Patient, Liberty and the Law*, 13 KAN. L. REV. 59, 74-75 (1964).

10. Hamann, *Confinement and Release of Persons Acquitted by Reason of Insanity*, 4 HARV. J. LEGIS. 55, 74 (1966). The author feels that such a panel is "unrealistic" and of only "utopian appeal" because it is likely that one or another of the panel will dominate the investigation. In addition, he criticizes the use of jury trials to determine the issue of releasability because of the difficult medical judgments involved.

11. Weihofen & Overholser, *Commitment of the Mentally Ill*, 24 TEXAS L. REV. 307, 333 (1946).

12. MODEL PENAL CODE § 4.01, app. B. at 178. (Tent. Draft No. 4, 1955). Section 420 of the Act of 1966 authorizes a departmental discharge of any civilly committed patient. PA. STAT. ANN. tit. 50 § 4420 (Supp. 1966).

## RELEASE PROCEDURE: ADMINISTRATIVE OR INITIATED BY PATIENT

The procedural safeguards against deprivations of liberty caused by a refusal to release are contained in three sections of the Act of 1966. Section 419 of the Act of 1966 provides that:

. . . whenever a leave of absence is granted or extended to a period of three years and such leave is not terminated by the director . . . upon expiration of such three year period, the person admitted or committed shall be deemed discharged.<sup>13</sup>

This provision applies without regard to the nature of the commitment proceeding, *i.e.*, whether the patient was civilly or criminally committed although practically it affords an avenue of release only to the former.

Section 420 of the Act of 1966 authorizes:

The department (to) review any commitment made under this act other than a criminal commitment and the secretary may order the discharge of any person so committed whenever he finds that such committed person is no longer in need of care and treatment in a facility. The department may also review criminal commitments and the secretary may make recommendations to the court which committed such person that he be discharged or returned to a penal or correctional institution.<sup>14</sup>

This classification of patients is a reasonable discrimination which denies the criminally committed patient the opportunity for a non-judicial discharge. Two factors justify this judicial control. First, the patient has manifested a propensity toward dangerous conduct which may recur. Secondly, the factors which are considered in determining the existence of "mental disability," for purposes of criminal commitment are peculiarly within the cognizance of a court. Section 408 of the Act of 1966 provides that the committing court, to determine the existence of mental disability, may consider:

. . . the capacity of such person to understand the nature and object of the proceedings against him, to comprehend his own condition in reference to such proceedings, to understand the nature of the punishment which might be inflicted upon him, to confer with counsel with reference to such proceedings, to make a rational defense, and the probable effect of the trial on such person's physical and mental condition.<sup>15</sup>

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13. PA. STAT. ANN. tit. 50, § 4419(c) (Supp. 1966). This section also gives the director of the facility the power to terminate leaves of absence.

14. PA. STAT. ANN. tit. 50, § 4420 (Supp. 1966).

15. PA. STAT. ANN. tit. 50, § 4408 (Supp. 1966).

Any inquiry into the desirability of releasing such a patient involves a reconsideration of the listed indices, all of which depend on the patient's capacity to react and function in the *judicial* arena.

An analysis of Section 426 of the Act of 1966 is more difficult. The right guaranteed to every person committed to a facility is:

. . . at any time, to petition for a writ of Habeas Corpus . . . upon the following grounds: (1) the insufficiency or illegality of the proceedings leading to such person's commitment, or (2) although the commitment proceedings were proper, such person's continued detention or hospitalization is not warranted by reason of mental disability. Where the petition is based on this ground: (i) it shall be accompanied by the affidavit of a physician stating that he has examined the person and is of the opinion that such person is not mentally disabled, or that such mental disability does not require care or treatment in a facility, and (ii) the burden of proof shall rest upon the director responsible for such person's continued detention.<sup>16</sup>

The affidavit requirement is an express condition precedent to access to a habeas corpus court on the ground of present competency. Several courts have recognized that a patient has a constitutional right to initiate *judicial* release proceedings upon recovery from the mental disability which occasioned the commitment.<sup>17</sup> However, courts have generally not invalidated statutory release procedures which require a certificate of recovery from the hospital superintendent as a precondition to a hearing on present competency.<sup>18</sup>

For example, a Kansas statute, applicable to patients committed after an acquittal by reason of insanity, provided:

No person so acquitted shall be liberated therefrom except upon the order of the court committing him thereto and until the superintendent of the said asylum . . . shall certify in writing . . . that in his opinion such person is wholly recovered and that no person will be in danger by his discharge.<sup>19</sup>

In rejecting a patient's argument that ". . . he has no power to commence release provisions when restored to reason,"<sup>20</sup> the Kansas Supreme Court, in *Ex Parte Clark*,<sup>21</sup> held that the certificate requirement did not violate

16. PA. STAT. ANN. tit. 50, § 4426 (Supp. 1966).

17. *Underwood v. People*, 32 Mich. 1 (1875); *Doyle, Petitioner*, 16 R.I. 537 (1889); *In re Boyett*, 136 N.C. 415, 48 S.E. 789 (1904). See WEIHOFEN, *MENTAL DISEASE AS A CRIMINAL DEFENSE*, 380 (1954).

18. WEIHOFEN, *MENTAL DISEASE AS A CRIMINAL DEFENSE*, 382-84 (1954).

19. Section 5 of Chapter 299 of the Laws of Kansas of 1911.

20. 86 Kan. 539, 540, 121 P. 429, 493 (1912).

21. 86 Kan. 539, 121 P. 492 (1912).

due process of law. The majority in *Clark*, assuming that the certificate was a condition precedent to release on the ground of present competency, exercised judicial restraint by recognizing that the

. . . Legislature must have believed that the person qualified for the highly important duty of superintending such an institution, and who is in a position to observe the conduct and symptoms, is qualified to determine the condition of the mind of the inmate and will be just to him and the public alike.<sup>22</sup>

However, Chief Justice Johnston, who concurred only in the result in *Clark*, challenged the constitutionality of the certificate requirement as construed as a condition precedent:

. . . I reach this conclusion on the theory that the Legislature intended that a person so committed . . . may be liberated by the proper court with or without the consent of the superintendent of the asylum . . . the duty of that officer is in aid of a judicial proceeding for a discharge, but, in my view, it was not intended that his decision . . . would prevent a judicial inquiry as to the sanity of the inmate.<sup>23</sup>

The Pennsylvania procedure under the Act of 1966 is distinguishable from the Kansas requirement to the extent that the affidavit of present competency need not be made by the director of the facility. Apparently any physician can examine and affy, even though, prior to the instant examination, he has had no knowledge of the case.

#### COMPARISON WITH PRE-EXISTING PROCEDURE

Although the new release procedure has not yet been subjected to judicial scrutiny, a similar situation existed under the Mental Health Act of 1951.<sup>24</sup> Section 604 of the Act of 1951 provided:

(a) Any patient or person acting on his behalf may petition the court . . . for an order of discharge on the ground that his continued hospitalization is not warranted by reason of mental illness. . . The petition shall be in writing and shall be sworn to or affirmed *and shall be accompanied by an affidavit of a quali-*

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22. 86 Kan. at 544, 121 P. at 497. In *Clark* continued confinement was ordered. However, once the automatic commitment procedure was held valid, there was no need to consider the constitutionality of the certificate requirement because there had been no allegation of present competency.

23. 86 Kan. at 546, 121 P. at 498 (concurring opinion). The Chief Justice stated that: "Serious questions might arise if a statute were enacted which provided that a release from custody of one restored to sanity could not be had in a judicial proceeding until the consent of the superintendent of the asylum was obtained, or where application to the judicial department for release depended on the will of a ministerial officer." 86 Kan. at 547, 121 P. at 498-99.

24. PA. STAT. ANN. tit 50, §§ 1071-1622 (1951) (hereinafter cited as the Act of 1951).

*fied physician stating that he has examined the patient and is of the opinion that the patient is not mentally ill. . . .*

. . . The court shall conduct a hearing to determine the question of the patient's mental illness. . . . The burden of proof shall rest upon the person responsible for the patient's continued hospitalization. . . .<sup>25</sup> (Emphasis added.)

In addition, Section 351 of the Act of 1951, which also applied to all commitments, provided:

Every person committed or involuntarily admitted to or detained in an institution subject to the provisions of this act or anyone acting on his behalf may at any time petition for a writ of habeas corpus. . . .<sup>26</sup>

The interrelation of Sections 604 and 351 was considered by the Pennsylvania Supreme Court in *Commonwealth ex rel. Swann v. Schovlin*.<sup>27</sup> The court interpreted Section 604 as "the *exclusive* method by which release on the ground of present competency could be sought and that Section 604 represents the interposition of a statutory remedy which displaces habeas corpus for this limited purpose."<sup>28</sup> (Emphasis added.) In sustaining the affidavit as a condition precedent to judicial consideration of the Section 604 petition, even though the patient had no other access to a court on the present competency issue, the court relied on the need for efficient judicial administration:

Absent the submission requirement of Section 604 any petition, although consecutive and frivolous, which contained the bare, self-serving allegation of present competency would require judicial action, a profligate expenditure on our already overburdened judicial resources.<sup>29</sup>

Section 426 of the Act of 1966, requiring a physician's affidavit before hearing, is merely a legislative restatement of the *Swann* interpretation of Sections 604 and 351. Presumably, the judicial hearing will be re-

25. PA. STAT. ANN. tit. 50, § 1304 (Supp. 1966).

26. PA. STAT. ANN. tit. 50, § 1241 (Supp. 1966).

27. 423 Pa. 26, 233 A.2d 1 (1966).

28. 423 Pa. at 33, 223 A.2d at 5. The petitioner in *Swann* challenged continued confinement on two grounds: present competency, and irregularities in the commitment procedure. The Pennsylvania Supreme Court held that it was error for the habeas corpus court to insist on compliance with certain Wayne County Rules of Court (which required all petitions to be accompanied by either a physician's or psychiatrist's certificate of present competency or a submission of proof sufficient to rebut a presumption of present mental disability) because "relator may not be required to place his present mental status in issue in order to challenge the validity of the commitment proceedings." 423 Pa. at 31, 223 A.2d at 4.

29. 423 Pa. at 33, 233 A.2d at 6.

quired only if a Section 426(b)(2) petition is "self-sustaining," *i.e.*, if it is accompanied by the physician's affidavit.<sup>30</sup>

### DISCRETION OF THE PHYSICIAN CONTROLLED BY THE ATTORNEY

Although the writ of habeas corpus has been abused by patients seeking release on the ground of mental competency,<sup>31</sup> the need for efficient administration of the courts is not a convincing rationale for conditioning access thereto. The *Swann* approach was criticized by Justice Musmanno in *Commonwealth ex rel. Levine v. Fair*,<sup>32</sup> where he stated that:

If a procedure is authorized and justified under the law, it is no argument to say that such a procedure would place a burden on the Courts. The courts are open to do justice under the law, regardless of burden, and every aggrieved person has the right to be heard, especially if he claims he is being illegally deprived of his freedom. Justice is not limited by the size of the courtroom and freedom is not measured by the strength of a judge's back.<sup>33</sup>

Under the new release procedure the physician enjoys unusual discretion in determining who is fit for release from mental institutions. There are no provisions whereby the patient is able to challenge the examiner's conclusion that he should not be released. The very reason for the existence of a medical profession, *i.e.*, to restore good health and prevent further illness, suggests that the physician's affidavit will more than likely not be signed in those "borderline cases" where reasonable men might differ on the need for continued confinement.

Permitting the medical profession to determine when continued confinement is not required is consistent with provisions allowing *non judicial* involuntary commitment. Under the Act of 1966, any person may be committed to a facility upon the petition of any other person accompanied by the certificates of two physicians stating that the person is mentally disabled.<sup>34</sup>

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30. *Commonwealth ex rel. Tate v. Schovlin*, 205 Pa. Super 371, 208 A.2d 924 (1965) (no hearing where petition acknowledged mental condition requiring medical attention). In *Tate*, the patient had not requested an examination by an independent psychiatrist.

31. *Overholser v. Leach*, 257 F.2d 667 (D.C. Cir. 1945); *Overholser v. DeMarcos*, 149 F.2d 23 (D.C. Cir. 1945) *cert. denied*, 325 U.S. 889 (1945); *Dorsey v. Gill*, 148 F.2d 857, 862 (D.C. Cir. 1945). See Goodman, *Use and Abuse of the Writ of Habeas Corpus*, 7 F.R.D. 313 (1947).

32. 394 Pa. 262, 146 A.2d 834 (1958).

33. 394 Pa. at 268, 146 A.2d at 838.

34. PA. STAT. ANN. tit 50, § 4404 (Supp. 1966). Non judicial commitment procedures are usually justified by argument that the proceeding is non adversary and that the state is acting as *parens patriae*.

These two provisions involve essentially the same constitutional issue: Whether it is a violation of due process of law to deprive a person of his liberty solely on the basis of a physician's belief that the person is mentally disabled? There is no check on the physician's power to continue the confinement by refusing to affy to present competency. If the patient could demand a judicial hearing, at which he would be represented by counsel, these medical conclusions would be subject to cross-examination.

In *Lynch v. Overholser*<sup>35</sup> the release procedure, though not in issue, was said to be ". . . simple and effective, *i.e.*, a doctor's certificate recommending release filed with the court is sufficient. If the doctor refuses such certificate, the inmate may seek to prove his sanity on habeas corpus."<sup>36</sup> The safeguard against an arbitrary refusal to certify was a habeas corpus hearing on the issue of present competency.<sup>37</sup> Similarly, the Pennsylvania court could lay down guidelines based, for example, on the number of petitions for release filed by the particular patient, the time span between consecutive petitions, and the nature of the mental disability in question. Consequently, the affidavit requirement would not stand as a complete bar to judicial determination of present competency, but also, frivolous and consecutive petitions would not bog down the habeas corpus courts.

The Legislature recognized the plight of an indigent patient. To facilitate his access to the affidavit of present competency, Section 423(7) provides:

Every person admitted, committed or detained in any facility . . . shall have the right to request the department to arrange for the examination of such person's mental condition by a physician not associated with the department. The department may refuse to grant such requests only when it is made sooner than six months after such person's admission or commitment or sooner than one year after a previous examination hereunder.<sup>38</sup>

Without this right to an examination, the indigent would have no chance to secure an affidavit because he could not afford to pay the costs of an examination.<sup>39</sup> In fact, in a case where no affidavit was required, one court observed that:

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35. 369 U.S. 705 (1962).

36. *Id.* at 723.

37. *Id.* at 724.

38. PA. STAT. ANN. tit. 50, § 4423(7) (Supp. 1966).

39. The Act of 1966 provides that the patient, or persons owing a legal duty to support the patient, shall be liable "for all costs, payments or expenditures with reference" to the care, treatment, and commitment of the patient. PA. STAT. ANN. tit. 50, §§ 4501-02 (Supp.

. . . where an indigent confined in a mental hospital seeks habeas corpus it is more important to provide him with an independent psychiatric examination than to give him independent counsel. If such an examination is demanded and denied, the right of the indigent alleged insane person to a petition for habeas corpus is entirely meaningless.<sup>40</sup>

Whenever this examination fails to produce an affidavit of present competency, the patient should nevertheless be able to secure a judicial determination of his present competency, unless the aforementioned judicial guidelines indicate that such a petition is frivolous or consecutive.

During the first six months of confinement and during the one year following an adverse examination of the patient, there is no right to an examination by an outside physician. Consequently, there is no opportunity to secure an affidavit during these periods. A similar situation existed under a California statute which provided that all persons acquitted by reason of insanity "shall be confined in a hospital for the insane for one year before any application for their discharge shall be entertained by any court."<sup>41</sup> The California court held that this time restriction was not an unconstitutional suspension of the right to petition for a writ of habeas corpus. Basically, the rationale relied on the legislative power to impose reasonable time limitations on access to the courts in order to ". . . permit a sufficient length of time to elapse to enable those who may be called upon to pass upon the sanity of the patient to intelligently give their judgment as to whether or not he has recovered his reason."<sup>42</sup> There must be some reasonable period of detention after all commitments during which no patient can demand release on the ground of present competency. The remedy available immediately after commitment is a judicial hearing on the legality of the commitment proceedings.<sup>43</sup>

Assuming the commitment was proper, the initial examination six months thereafter may not produce an affidavit of present competency because the patient has not yet responded to treatment. The statute curiously provides that the next examination need not be arranged for one year thereafter. Why is it more likely that a patient who has not recovered after the initial six-months of treatment will recover twice as slowly as another patient who is committed on the last day of that six

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1966). However, the state and counties will be liable for the financial obligations of the patient who ". . . shall have exhausted his eligibility and receipt of benefits under all other existing or future, private, public, local, State or Federal programs." PA. STAT. ANN. tit. 50, § 4503 (Supp. 1966).

40. DeMarcos v. Overholser, 137 F.2d 698, 699 (D.C. Cir. 1943), *cert. denied*, 320 U.S. 785 (1943), *rehearing denied*, 320 U.S. 813 (1943).

41. In Re Slayback, 209 Cal. 480, 491, 288 P. 769, 774 (1930).

42. *Ibid.* See Guardianship of Gestner's Estate, 90 Cal. App. 2d 680, 204 P.2d 77 (1949).

43. PA. STAT. ANN. tit. 50, § 4426 (Supp. 1966).

month period? Arguably, the former patient will have acclimated himself to the facility during the first six months so that subsequent treatment will be more effective. The discretion to refuse a second requested examination should have been limited to those requests made within the second six months, rather than within one year, after a prior examination. A hearing on the issue of present competency should be granted if the second examination does not produce the physician's affidavit, unless, of course, an application of the aforementioned guidelines indicate that the petition does not merit a hearing. In addition, the patient should be represented by counsel at this and all subsequent hearings.

Finally, under the Act of 1966, only one group of patients is not a proper subject for either partial hospitalization<sup>44</sup> or outpatient care,<sup>45</sup> *i.e.*, persons committed because of a mental disability discovered while undergoing sentence in a penal institution.<sup>46</sup> Nevertheless, the Act of 1966 provides that any person convicted of a crime punishable by sentence to a penal institution may be committed by the court "in lieu of sentence . . ." if found to be mentally disabled at the time of sentencing.<sup>47</sup> Such patients are expressly guaranteed the right to either partial hospitalization or outpatient services when, in the discretion of the director, such "would be beneficial to the person so committed."<sup>48</sup> Arguably, there should be no distinction between a patient committed in lieu of sentence and one committed while undergoing sentence. The purpose of a commitment is not detention of the patient. On the contrary, the theory of commitment should be to make available *whatever* treatment is necessary to effectuate cure of the mental disability and return of the patient to his place in society.

## CONCLUSION

The release procedure under the Act of 1966 is substantially identical to the pre-existing procedure under the Act of 1951. Neither procedure adequately protects the patient against the possibility that confinement will not end when the mental disability is sufficiently cured. Pennsylvania's judiciary should accept the challenge presented by the affidavit

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44. "Partial hospitalization" is defined as ". . . treatment or rehabilitation rendered to a mentally disabled person admitted or committed to a facility for some portion of one or more twenty-four hour periods." PA. STAT. ANN. tit. 50, § 4102 (Supp. 1966).

45. "Outpatient services" is defined as "diagnosis, evaluation, classification, counseling, care, treatment or rehabilitation rendered under this act at a facility, to a mentally disabled person not admitted or committed thereto." PA. STAT. ANN. tit. 50, § 4102 (Supp. 1966).

46. PA. STAT. ANN. tit. 50, § 4411 (Supp. 1966). However, both partial hospitalization and outpatient services may be ordered by a court under the appropriate authorization for all other patients. PA. STAT. ANN. tit. 50, §§ 4406(b), 4407(b), 4408(e), 7710(d) (Supp. 1966).

47. PA. STAT. ANN. tit. 50, § 4410(c) (Supp. 1966).

48. PA. STAT. ANN. tit. 50, § 4410(d) (Supp. 1966).

requirement. Workable administrative rules can be formulated to protect the courts from abuse by consecutive and frivolous petitions for release. However, the rules must be primarily designed to prevent the unconstitutional deprivation of liberty caused by a refusal to release a recovered patient.

It may require extensive analysis to determine whether a particular degree of mental disability is such that confinement is necessary. Patients should be deprived of liberty only when there is danger to their own person or other persons and property. The medical conclusion not to release a patient should be subjected to the scrutiny of cross-examination at a judicial hearing. A patient must have the advice and services of an attorney to effectively challenge the decision not to release. The legal profession can play a vital role in defining what mental disabilities are serious enough to justify continued confinement. Vague and inaccurate language has too often been used in describing mental illness. Hopefully, precision will not only secure liberty to those unjustly confined patients, but will also be a step toward more successful treatment and prevention of mental illness.

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