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INTO THE ABYSS: PSYCHIATRIC RELIABILITY AND EMERGENCY COMMITMENT STATUTES

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INTRODUCTION

Mental illness, a concept accepted by many without serious question, is a term of such ambiguity that its application to a particular individual is inherently subjective. When such a vague concept forms the basis for involuntary commitment, there are serious due process problems.

The purpose of this article is to demonstrate the inherently subjective nature of the label "mental illness" and the failure of psychiatry to validate that label through utilization of the scientific method. Involuntary commitment based on psychiatry and the labels which it applies must be viewed as dependent on a defective rationale. This article will focus specifically on the statutory provisions for emergency mental hospitalization. The emergency provisions point with particular clarity to the dangers and weaknesses of the concept of mental illness. The peculiar nature of the emergency statutes resides in their imposition of varying periods of temporary incarceration on the basis of an alleged *medical* emergency without normal procedural safeguards. Forms of treatment and methods of diagnosis which occur during emergency commitment may prevent a fair hearing later as to long-term commitment and may work to fulfill their own prediction of mental illness.

It is also our goal in presenting this material to provide the practicing attorney with some rudimentary arguments for use at sanity hearings in the cross-examination of expert state witnesses recommending commitment. We hope to give a sufficient idea of

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the difficulty which psychology and psychiatry are having in defining "mental illness" to indicate some areas for the productive use of critical cross-examination and/or the presentation of adversary defense witnesses. A number of practitioners in psychiatry and psychology openly acknowledge the disarray of their disciplines and actively oppose the involuntary imposition of any psychotherapeutic treatment modalities.[1] In addition, there are undoubtedly others who are aware of these difficulties, although they may not be public campaigners against involuntary mental hospitalization or may even believe that involuntary commitment is justified in some circumstances. The appearance of such witnesses on behalf of the defense can raise factual questions concerning the very notion of mental illness itself, and certainly concerning its application in a given context.

We hope more generally to introduce attorneys and other readers to the situation and consequences faced by the person accused of mental illness in an effort to interest more trial lawyers, and the legal profession generally, in this field. An apparently fashionable response to the question of legal advocacy in the commitment area is to treat the matter as a question of fact best decided by medical experts, while the consequences of commitment are justified as therapeutic.[2] In this article, on the other

1. *See* letter of fourteen psychiatric residents expressing their opposition to involuntary mental hospitalization. THE RADICAL THERAPIST (now ROUGH TIMES), P.O. Box 89, West Somerville, Massachusetts 02144, Dec. 1971, at 22; Platform Statement of the American Association for the Abolition of Involuntary Mental Hospitalization, 301 Sedgwick Drive, Syracuse, New York 13203. Perhaps the best criticism of psychiatric theory on scientific-methodological grounds is found in T. SZASZ, THE MYTH OF MENTAL ILLNESS (1961). More sociologically oriented but equally impressive is T. SZASZ, THE MANUFACTURE OF MADNESS (1970). In each of these works, Dr. Szasz presents critical formulations of current psychiatric theory and practice which are comprehensive, well reasoned and heavily documented.

Dr. Thomas Scheff gives his own formulation of the inadequacies of current psychological theories of mental illness and presents a sociological reformulation. T. SCHEFF, BEING MENTALLY ILL 55 (1966). A number of criticisms are summarized in A. ROGOW, THE PSYCHIATRISTS, 21-30 (1970).

2. We do not deal at length herein with the root question of whether lawyers have a legitimate role in commitment proceedings, but restrict ourselves to a consideration of the form that role should take. The consequences of commitment alone would seem sufficient to indicate a position of active advocacy as the appropriate role of the defense attorney in commitment proceedings. A three-judge federal court has recently gone far toward recognition of this reality. *See* Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972). For a discussion of the respective positions of the medical and legal professions in this regard see Wenger and Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital*, 10 J. HEALTH & SOC. PROB. 66 (1969). For the personal statement of one lawyer's position see Matonis, *The Rights of Mental Patients*, NATIONAL HEALTH FEDERATION BULLETIN, July-Aug. 1970, at 4. A number of ex-mental patient associations express themselves on this and related issues in ROUGH TIMES (formerly THE RADICAL THERAPIST), Nov. 1972.

hand, we present materials indicating that the questions involved are not legitimately medical, and that even if they were, contemporary practitioners of psychiatry and psychology are not qualified to answer them authoritatively. In the absence of a genuinely scientific or objective standard of "mental illness," we urge the abolition of involuntary incarceration which is grounded in that label and in particular of the practice of emergency commitment, which authorizes detention on the authority of medical judgment alone, without judicial safeguards or a hearing of any kind. The practicalities of the situation may not permit the abolition of this practice in the immediate future; however, sufficient factual ambiguities are presented by the concept of mental illness to warrant adversary defense against commitment actions as a matter of course. Only such active involvement on the part of the legal profession can secure adequate attention to the difficult questions involved in the commitment process. We emphasize the emergency statutes herein as a paradigm of reliance on the concept of "mental illness" and the consequences which flow from such reliance.

PSYCHIATRY AS NONSCIENCE

The popular assumption that psychiatry qualifies as a medical science is open to serious question. A number of individuals possessing psychiatric and social science credentials and experience have raised very basic questions, not only about the adequacy of particular psychiatric theories of mental illness, but also about the very proposition that *any* of the psychiatric theories currently popular among practitioners qualifies as science at all.[3] As the question involved is one of science and logic, the criteria of its evaluation are qualitative, not quantitative; which is to say, critics of psychiatry who base their attack on scientific grounds must be judged by their methods and arguments rather than by their number.[4]

The Importance of Experimental Method in Scientific Theory and Research

It is essential to the nature of science that its practitioners utilize experimental methods in the formulation and testing of

3. T. SZASZ, THE MYTH OF MENTAL ILLNESS, *supra* note 1, 1-96.

4. In attempting to determine whether psychiatry can qualify as a viable science, it would be self-defeating to rely on the authority of psychiatric experts since it is this very expert authority which we question. Rather, we rely for our evaluations of contemporary psychiatry and psychology upon a rational analysis of the methods of psychiatry and the arguments of psychiatrists.

hypotheses or theories of predictive value. The formulation of concepts which can be experimentally tested is an essential element of science, for an evaluation of a given researcher's results depends on having independent researchers check their validity in similar or identical circumstances. Terms or concepts which are too vague to be communicated precisely result in theories which are too vague to be either tested or disproven.[5]

Much of the contemporary psychiatric and psychological theory is not subject to empirical validation. The basic tenets of psychiatric theory, such as the concept of mental illness itself, are so loosely defined that the same phenomenon may be perceived differently by independent researchers, and the same researcher may even describe the same phenomenon differently during different experiments. Thus, for example, experiments performed with a number of clinicians found that those tested did *no better than "chance"* in identifying which of a certain set of stories were written by men and which by women; which of a battery of clinical test results were the products of homosexuals and which were the products of heterosexuals; and which, of a battery of clinical test results *and* interviews, were products of psychotics, neurotics, psychosamatics, or normals.[6]

Dr. Naomi Weisstein summarizes the significance of these experiments:

> [S]exuality is of fundamental importance in the deep dynamic of personality; if what is considered gross sexual deviance cannot be caught, then what are psychologists talking about when they, for example, claim that at the basis of paranoid psychosis is "latent homosexual panic." They can't even identify what homosexual anything is, let alone "latent homosexual panic." More frightening, expert clinicians cannot be consistent on what category to assign a person, again on the basis of both tests and interviews; a number of normals in [one of the studies] were described as psychotic, in such categories as "schizophrenic with homosexual tendencies" or "schizoid character with depressive trends." But perhaps most disheartening, when the judges were asked to rejudge the test protocols some weeks later, their diagnoses of the same subjects on the basis of the same protocol differed markedly from their initial judgment. It is obvious that even simple descriptive conventions in clinical psychology cannot be consistently applied; that these descriptive con-

5. For a discussion of the nature of scientific method from this point of view see POPPER, CONJECTURES AND REFUTATIONS (1962).

6. *See* Weisstein, *Kinder, Küche, Kirche,* in GOING CRAZY 233-38 (H. Ruitenbeck ed. 1972), and sources cited therein.

> ventions have any explanatory significance is therefore, of course, out of the question.[7]

This unreliability of psychiatric theory is not due to a paucity of research. For example, there have been at least five thousand papers reporting on schizophrenia in the five decades since 1920.[8] There is some indication that the results of this massive research output have been negligible.[9] Not only have systematic studies failed to produce significant findings with respect to causation, but a number of theorists have even expressed the belief that "the problem itself has not been formulated correctly."[10]

Unreliable results in the application of psychiatric theory necessarily follow from the conceptual ambiguity of much of the most basic diagnostic terminology. Thus, it has been pointed out that,

> [o]ne need only glance at the diagnostic manual of the American Psychiatric Association to learn what an elastic concept mental illness is . . . . [T]he definition of mental illness is left largely to the user and is dependent upon the norms of adjustment that he employs. Usually the phrase "mental illness" effectively masks the actual norms being applied. And, because of the unavoidably ambiguous generalities in which the American Psychiatric Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there.[11]

This conceptual ambiguity, which goes to the very roots of contemporary psychiatry, arises from the ways in which the discipline is conceived and practiced. Such conceptual ambiguity is inherent in the current set of assumptions which comprise the conceptual framework of psychiatry and therefore could not be elim-

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7. *Id.* at 238. Perhaps it should be noted that this result could be explained by hypothesizing that they were misapplied prior to the experiment, as an alternative to the proposition that they are inherently vague. But for whatever reason, "at any given point in time, psychiatrists find a substantial proportion of persons in normal populations to be 'mentally ill.'" T. Scheff, *Screening Mental Patients,* in DEVIANCE: THE INTERACTIONIST PERSPECTIVE 172, 183 (Rubington & Weinberg ed. 1968) *citing* PLUNKETT & GORDON, EPIDEMIOLOGY AND MENTAL ILLNESS Part III (1961).

8. T. SCHEFF, *supra* note 1, at 7.

9. S. ARIETI, INTERPRETATIONS OF SCHIZOPHRENIA 9 (1955) and D. JACKSON, THE ETIOLOGY OF SCHIZOPHRENIA 3-4 (1960) *cited* in T. SCHEFF, *supra* note 1, at 8.

10. T. SCHEFF, *supra* note 1, at 9. *See also* Apter, *Our Growing Restlessness with Problems of Chronic Schizophrenia,* in CHRONIC SCHIZOPHRENIA (L. Appleby, et al., ed. 1960).

11. Livermore, Malmquist, & Meehl, *On the Justifications for Civil Commitment,* 117 U. PA. L. REV. 75, 80 (1968).

inated by more detailed formulation or testing.[12] Dr. Szasz, a psychiatrist and teacher, formulates the problem this way:

> Psychiatry is said to be a medical specialty concerned with the study and treatment of mental illness. Similarly, astrology was the study of the influence of planetary movements and positions on human behavior and destiny. These are typical instances of defining a science by specifying the subject matter of study. These definitions completely disregard method and are based instead on false substantives.[13]

Nearly everyone has had the experience of reading the daily newspaper horoscope to find, at first glance, a remarkable depth of "meaning" in it. Over time and with further reflection, it becomes apparent that the applicability of these "predictions" is based in large measure upon their formulation in terms vague enough to apply to a wide variety of situations which have nothing of significance in common. In other words, the newspaper horoscope is formulated with such generality that it is scarcely capable of disproof by application to a particular fact situation. A reading of the critical literature suggests that the problem of contemporary psychiatric terminology is similar.

Formulation of the problem in terms of inadequacy of method provides a perspective essential to an understanding of the inadequacies of contemporary psychology and psychiatry. Without this understanding one may be led to believe that a greater degree of care in experimentation or a sharper formulation of terms already in use could lead to a satisfactory resolution of present difficulties. However, as Dr. Thomas Szasz points out, psychiatrists are not bound by publicly disclosed methods of observation and inference,[14] and in partial consequence, they have constructed a wide range of theories which are not intersubjectively testable or even, according to the experiments outlined above, communicable.[15] Moreover, each of many conflicting

12. For an introduction to some consideration of scientific development and the place of conceptual frameworks in science see T. KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS (1962).

13. T. SZASZ, THE MYTH OF MENTAL ILLNESS, *supra* note 1, at 1 (1961). *See also* T. Szasz, *Psychoanalysis as Method and as Theory*, 27 PSYCHOANALYT. QUART. 89 (1958) and T. Szasz, *The Classification of "Mental Illness": A Situational Analysis of Psychiatric Operations*, 33 PSYCHIAT. QUART. 77 (1959), *cited* in T. SZASZ, *supra* note 1, at 1.

14. T. SZASZ, THE MYTH OF MENTAL ILLNESS, *supra* note 1, at 1.

15. Intersubjective testability is the quality of being capable of observation and description by more than one individual. For example, the "chemistry sets" which were popular some years back featured a wide range of chemicals, some rudimentary apparatus, and an instruction booklet which anyone could follow to produce desired "experimental" results. Similarly, using the booklet one could telephone a friend who had similar materials at hand and describe an experiment which the friend could then perform from the verbal

theories[16] now has its own adherents among the members of the particular "school" it represents within the discipline.[17] The rivalries of these contending factions make the construction of a truly scientific psychiatric theory a complicated political as well as rational-scientific enterprise. This is a task not likely to be completed for decades, if indeed its roots can catch hold at all in the loose soil of what is now psychiatric theory.

Conceptualization and Application of Psychiatric Labels

The failure to institutionalize the scientific method in psychiatry has permitted various subjective factors to form the bases for the conceptualization and application of psychiatric terminology. These subjective factors, as opposed to scientific testing, have been responsible for the redefinition of various forms of behavior as "mental illness." One example of this redefinition of behavior is illustrated by Dr. Szasz in reviewing the contribution of Charcot, a French physician.[18] Dr. Szasz indicates that Charcot was able to use his reputation as an expert neurologist to achieve a redefinition of what had previously been called "malingering," or "faking it," as "hysteria," which is considered to be a genuine disease by the psychiatric profession. Dr. Szasz does not deny that malingering/hysteria may correlate with or result from a physical-chemical disorder. He simply points out that the change in conceptualization was due to the social status of the discoverer rather than such scientific factors as a methodological or technological advance.

The process utilized by Charcot in redefining malingering involves the labelling of certain types of behavior as "functional

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description with predictable results if the instructions were followed properly. By contrast, no psychiatric "instruction book" or even prolonged course of study has been shown to enable separate practitioners to achieve consistent or predictable results. Individual clinicians have even been shown to be inconsistent in formulating diagnoses from the same phenomena. *See* note 10 *supra* and accompanying text. It may be that the failures of method and inadequacies of conceptualization indicated herein provide a partial explanation for the contention that "We do not yet know what about psychotherapy is . . . teachable." Werry, *Psychotherapy—A Medical Procedure?*, in GOING CRAZY, *supra* note 6, at 172.

16. A few theories, like behaviorism, have achieved a reputation for greater predictive ability, but appear to achieve this result through oversimplification. For example, compare B. SKINNER, BEYOND FREEDOM AND DIGNITY (1971) with BERTALANFFY, ROBOTS, MEN AND MINDS (1967), or R.D. LAING, THE POLITICS OF EXPERIENCE (1967). Bertalanffy presents the criticism of a biologist. Dr. Laing presents a less apparently systematic, but nevertheless compelling, critique of behaviorism in the context of constructing the foundations of an alternative theory which might account for experience as well as behavior.

17. For a discussion of how the values of individual psychiatrists enter into the development of psychiatric theory see A. ROGOW, THE PSYCHIATRISTS (1970).

18. T. SZASZ, THE MYTH OF MENTAL ILLNESS, *supra* note 1, at 25-26.

illness"—illness with no known explanation in physicochemical or ordinary medical terms. In determining what is a "functional illness," however, a nonscientific subjective decison is necessarily made. This is a social rather than a medical or scientific decision.[19] This social decision is based on a subjective determination of how a person should act or what is "normal" behavior. Mental illness or insanity, then, is at least arguably a label the application of which will vary from culture to culture depending on what is considered "normal." In apparent agreement with this view another physician, Dr. Joseph Berke, contends that insanity is synonymous with behavior that is unacceptable within a given cultural framework.[20] In addition, the application of "mental illness" may be influenced by social and political factors operating within the cultural framework. Thus, Dr. David Cooper, a British psychiatrist, postulates that social and political factors in a particular culture may be influential in the diagnosis of schizophrenia.[21] Given the existence of such intangible and variable influences, the fallability of psychiatric diagnosis and labelling becomes apparent.

An Illustration: Sexism in Psychiatry

In view of the role played by subjective factors and the vagueness of psychiatric labels, it is not surprising that diagnoses of mental illness may often focus on various subgroups and minority groups which are under-represented in the psychiatric profession. Thus, behavior which may not be abnormal within a particular minority group may be considered abnormal by the majority of psychiatrists. Some psychiatrists, for example, believe that all "hippies" are mentally ill, while others disagree.[22] Many psychiatrists believe that certain forms of sexual activity, such as prostitution and the use of prostitutes, and masturbation, are symptoms of mental illness.[23] Being poor and un-

19. RECENT SOCIOLOGY NO. 3: THE SOCIAL ORGANIZATION OF HEALTH viii (Dreitzel ed. 1971).

20. Rossabi, *Anti-Psychiatry: An Interview with Dr. Joseph Berke*, in R.D. LAING AND ANTI-PSYCHIATRY 273, 274 (Boyers and Orrill eds. 1971). For further references on the difficulty of specifically defining mental illness see sources cited in Elliott, *Procedures for Involuntary Commitment on the Basis of Alleged Mental Illness*, 42 U. COLO. L. REV. 231, 232, n. 8 (1970).

21. D. COOPER, PSYCHIATRY AND ANTI-PSYCHIATRY 2-3 (1967). *See generally* R.D. LAING, THE DIVIDED SELF (1965). For the statement of an attorney see Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1131, n.102 (1972).

22. Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101, 103 n.8 (1971).

23. MENNINGER, INTRODUCTION TO THE WOLFENDEN REPORT: REPORT OF

wanted predisposes a person to being cast in the role of mental patient,[24] and the unhappiness of many elderly persons is often treated as an illness.[25]

Perhaps the role of subjective bias in the formulation and application of psychiatric labels is most explicit with regard to women.[26] This area is considered in some detail because it serves to illustrate the nature and extent of the larger problem.

Many of the major figures in the literature of psychology exhibit a large degree of sexual bias. Sigmund Freud, the founder of psychoanalysis, believed that a woman's desire for an intellectual career should be attributed to penis envy. Thus, Freud wrote:

> The desire after all to obtain the penis for which she so longs may even contribute to the motives that impel a grown-up woman to come to analysis; and what she . . . expects to get from analysis, such as the capacity to pursue an intellectual career, can often be recognized as a sublimated modification of this repressed wish.[27]

Carl Jung, another eminent psychological theoretician, felt that

> no one can evade the fact, that in taking up a masculine calling, studying, and working in a man's way, a woman is doing something not wholly in agreement with, if not directly injurious to, her feminine nature.[28]

Joseph Rheingold, a contemporary theoretician, reiterates the notion of biological determinism as scientific fact:

THE COMMITTEE ON HOMOSEXUAL OFFENSES 6 (1964). *See also* T. SZASZ, THE MANUFACTURE OF MADNESS, *supra* note 1, at 180-206, and Coleman, *Surviving Psychotherapy*, THE RADICAL THERAPIST, Sept. 1971, at 11-12.

24. *See, e.g.*, T. SZASZ, THE MANUFACTURE OF MADNESS, *supra* note 1, at xxiv and HALLECK, THE POLITICS OF THERAPY at 110-12 (1971).

25. HALLECK, THE POLITICS OF THERAPY at 112-14 (1971).

26. The best source presently available on this subject is P. CHESLER, WOMEN AND MADNESS (1972). The prevalence of sexism in psychiatric diagnosis and treatment is so apparent that arguments concerning a denial of equal protection under the fourteenth amendment may be in order in every case of actual or prospective involuntary hospitalization of a woman on the basis of psychiatric authority. This thesis has been developed in Lerner, *Women and Involuntary Hospitalization: An Equal Protection Problem* (1972) (unpublished paper on file with the Center for the Study of Legal Authority and Mental Patient Status). With a factual basis adjusted to the context, the arguments presented in this paper suggest the possibility of analogous application of the equal protection clause in cases involving actual or prospective commitment of low-income individuals, non-white persons, and cultural minorities.

27. FREUD, NEW INTRODUCTORY LECTURES ON PSYCHOANALYSIS 154 (1933). *See also* Benjamin, *Anatomy Is Destiny?—Reflections by the Editor*, FORUM (Wisconsin Psychiatric Institute, 1300 University Avenue, Madison, Wisconsin 53706), No. 2, 1971, at 27-30, and Brown, *Male Supremacy in Freud*, THE RADICAL THERAPIST, Sept. 1971, at 2-4.

28. CHESLER, *supra* note 26, at 77 *citing* Pollack, Redick, & Taube, *The Application of Census Socioeconomic and Familial Data to the Study of Morbidity from Mental Disorders*, 58 AMER. J. PUBL. HEALTH 1 (1968).

> [W]oman is nurturance . . . . [A]natomy decrees the life of a woman. . . . When women grow up without subversion by feminist doctrines and therefore enter upon motherhood with a sense of fulfillment and altruistic sentiment we shall attain the goal of a good life and a secure world in which to live.[29]

Finally, for present purposes, Dr. Theodore Lidz, Chairman of the Department of Psychiatry of the Yale University School of Medicine, in a discussion of personality development differentiating the normal roles in sexual or, perhaps more accurately, sexist terms, states:

> The little girl usually comes to terms in one way or another with the absence of the desired penis. . . . Obviously, not all girls will accept their feminity. Some will simply enter masculine occupations, but some will seek to act out and live a male role, including a sexual role. . . .[30]

There is evidence to indicate that these sexist doctrines are reflected in the views of the average contemporary clinician, with interesting consequences. Thus, a recent study, based on a questionnaire answered by seventy-nine clinicians, forty-six male and thirty-three female, indicated no differences among male and female clinicians with regard to a sexist clinical orientation.[31] In the course of the study, clinicians checked off traits representing the qualities of healthy males, healthy females, and healthy adults, sex unspecified. What was considered healthy for adults, sex unspecified, was similar to what was considered healthy for adult males, and correlated with previous studies of social desirability as perceived by nonprofessional subjects. "Healthy" women, however, were seen as more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more easily hurt, more emotional, more vain, and less objective. Dr. Robert Seidenberg remarks about such attitudes that "we learn from good psychoanalytic authority that not only is a woman to be dominated but she will become neurotic if she is not. To be dominated then becomes an imperative for mental health for women; this, the doctor's prescription!"[32]

Dr. Phyllis Chesler, a clinical psychologist, has concluded

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29. CHESLER, *supra* note 26, at 77 *citing* RHEINGOLD, THE FEAR OF BEING A WOMAN (1964).

30. LIDZ, THE PERSON: HIS DEVELOPMENT THROUGHOUT THE LIFE CYCLE 214-17 (1968).

31. Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel, *Sex Role Stereotypes and Clinical Judgments of Mental Health*, 34 J. CONSULTING & CLINICAL PSYCHOLOGY 1, 5 (1970).

32. Seidenberg, *Oedipus and Male Supremacy*, THE RADICAL THERAPIST 147-48 (The Radical Therapist Collective ed. 1971).

that there is, in effect, a "masculine standard of mental health," in which women are "psychiatrically impaired—whether they accept or reject the female role—simply because they are women."[33] Dr. Judith Bardwick similarly notes that the psychiatric view of women makes femininity "a sort of natural pathology."[34] Women who rebel against their restricting "normal" role will be powerful, active, rational, possibly not interested in children—and sick according to a psychiatric viewpoint which considers such traits abnormalities in women.

The forms of "treatment" which follow upon the application of psychiatric labels according to the criteria indicated in the foregoing analysis reflect the sexist bias of psychiatric prescription as well as diagnosis. Sex roles are strictly indoctrinated and enforced in mental institutions. Wearing skirts and nylons, using cosmetics, and performing similar "female" activities are frequently required as evidence of "rehabilitation."[35] For example, an ex-inmate of a Pennsylvania mental institution reports that her doctor told her she could not be released until she stopped wearing boots and jeans and started wearing a skirt.[36]

A second report concerning a Pennsylvania institution indicates that female patients in a behavior modification "therapy" program must earn tokens to pay for meals, bedding, admission to the dayroom, or any other "privileges." To earn tokens, an inmate must wear lipstick, make the beds in the men's ward, cut up rags for rag rugs, perform janitorial tasks, or wear a girdle.[37]

Submissiveness and obedience are also demanded of women patients.[38] Four doctors published a study in which they described their attempts to reduce the aggressive behavior of a woman by shocking her with a cattle prod whenever she threatened an aggressive act.[39] Of course, this "experiment" is among

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33. CHESLER, *supra* note 26, at 115.

34. BARDWICK, PSYCHOLOGY OF WOMEN: A BIO-CULTURAL CONFLICT (1971).

35. CHESLER, *supra* note 26, at 226; Grogan, *Psychiatry By Any Other Name Is Sexist Oppression* (1972) (unpublished paper on file with the Center for the Study of Legal Authority and Mental Patient Status).

36. This same woman indicated that her admitting diagnosis was "Sexual acting out—if not hospitalized might get pregnant or get VD." Cekala, *If This Be Insanity,* ROUGH TIMES, Sept. 1972, at 2. *Cf.* Henley, *Feminist Research,* ROUGH TIMES, Sept. 1972, at 18. *See also* Grogan, *supra* note 35.

37. Levering, *She Must Be Some Kind of Nut,* ROUGH TIMES, Sept. 1972, at 3.

38. Dr. Chesler reports that if female "anger or aggressiveness persists, the women are isolated, straitjacketed, and given shock therapy." CHESLER, *supra* note 26, at 36.

39. Ludwig, Marx, Hill, & Browning, *The Control of Violent Behavior Through Faradic Shock: A Case Study,* 148 J. NERV. & MENTAL DISEASES 624 (1969).

the more bizarre, but not entirely atypical, forms of "therapy." It was in fact a supervised experiment. The results were considered worthy of publication in a professional journal. Such an experiment serves as an indication of the extent to which sexual bias has played a role in psychiatric diagnosis, labelling and treatment. Sexual bias is just of one of many forms of cultural bias. We have explored it in depth because it furnishes a dramatic and timely example of the larger problem.

Problems Transcending Methodology

None of the foregoing is intended to deny that physicians and psychiatrists have devised a number of systems of interaction and medication which might be of substantial benefit to a variety of individuals experiencing problems in living or difficulties in communication resulting in a micro-social breakdown. Our point is rather that these practitioners have failed to delimit a recognizable area of human behavior as their material. In attempting to deal with "mental disease," their errors of conceptualization and method have resulted in diagnostic terms of sufficient generality and abstraction that virtually anyone can manifest symptoms or fit some category of mental "illness." In short, medical science has not succeeded in defining pathology; consequently psychiatric labels are applied on the basis of purely subjective considerations rather than as a function of objective medical-scientific diagnosis.

Our criticism has thus far dealt with the *form* of "psychiatric science." We have pointed to methodological difficulties: the failure to apply a genuinely scientific approach, and resulting ambiguity in the development and bias in the application of critical terms.[40] The basis of the discipline, apart from the question of methodological and conceptual rigor, must remain in those definitions of health and illness which arise from the value systems of individual scientists. No amount of methodological discipline and collective agreement can yield an *objective* definition of health and illness, which are inherently value-laden terms when applied to behavior or patterns of thought.[41]

40. A summary of a number of criticisms of psychiatry and psychoanalysis is given in A. ROGOW, THE PSYCHIATRISTS, 17-30 (1970).

41. For an illustration of one attempt to define "schizophrenia" in biochemical terms see *Clue to Cause of Dreaded Mental Illness,* San Francisco Chronicle, Jan. 24, 1972, at 3. Even the correlation of allegedly pathological behaviors with unusual biochemical conditions is not scientific proof of the pathological nature of such conditions. The task of correlating deviant behavior with pathology in a medical-scientific sense would require value judgments about behavior. Such an exercise is inherently subjective. For a more ex-

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We have attempted thus far to articulate and support our position that mental illness is a term both ambiguous and overbroad. We have also indicated several areas in which the ambiguity of this concept in conjunction with the subjective biases of individual theorists and clinicians may result in its arbitrary or discriminatory application. In cases involving a court hearing on the question of commitment, the legal process poses a barrier between unfettered psychiatric discretion and the patient/victim. That barrier is often flimsy, but it is at least there. In one area, however, the law has abdicated, surrendering decision-making to the health professionals. An examination of that area should further illustrate the dangers of concentrating power over others in the hands of those who, benevolent or not, use suspect tools of classification. The next sections therefore present an analysis of emergency commitment statutes and of the events which befall individuals who are detained for at least temporary observation, diagnosis, and treatment under authority of these statutes.

The states have explicitly labelled as emergency statutes those which provide for immediate apprehension and hospitalization of persons accused of mental illness by designated officials, typically health or police officers. On the theory of some form of medical emergency, forty-four jurisdictions provide for immediate apprehension and incarceration of the "mentally ill."[42] The be-

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tended discussion and critique of this kind of hypothesis see Rossabi, *Anti-Psychiatry: An Interview with Dr. Joseph Berke*, in R.D. LAING AND ANTI-PSYCHIATRY 277-80 (Boyers and Orrill eds. 1971). For an illustrative exchange of arguments on this issue see *Balancing Terms*, letter of Franklin E. Kemeny, and the editorial reply, in PLAYBOY, June 1972, at 74.

42. ALASKA STAT. § 47.30.030 (1972); ARIZ. REV. STAT. ANN. §§ 36-501, 36-507 (1972); ARK. STAT. ANN. §§ 59-102, 59-406 (1971); CAL. WELF. & INST'NS CODE § 5150 (West 1972); COLO. REV. STAT. ANN. § 71-1-3 (1963); CONN. GEN. STAT. ANN. § 17-183 (Supp. 1971); DEL. CODE ANN. tit. 16 § 5122 (Cum. Supp. 1970); D.C. CODE ANN. § 21-521 (Supp. 1971); FLA. STAT. ANN. § 394.463 (Supp. 1973); GA. CODE ANN. § 88-504.2 (1971); HAWAII REV. STAT. § 334-54 (1968); ILL. REV. STAT. ch. 91½, § 7-1 (Smith-Hurd; Supp. 1971); IND. ANN. STAT. § 22-1222 (1964); KAN. STAT. ANN. § 59-2908 (Supp. 1971); KY. REV. STAT. §§ 202.027, 202.117 (1972); LA. REV. STAT. ANN. § 28:57 (1969); ME. REV. STAT. ANN. tit. 34, § 2333 (Supp. 1971); MD. ANN. CODE, art. 59, § 22 (Supp. 1972); MASS. GEN. LAWS ANN. ch. 123, § 12 (1972); MICH. COMP. LAWS ANN. § 330.19 (Supp. 1972); MINN. STAT. ANN. § 253A.04 (1971); MO. REV. STAT. §§ 202.800, 202.803, 475.355 (Supp. 1971); MONT. REV. CODES ANN. § 38-208.1 (1961); NEB. REV. STAT. § 83-357 (1971); NEV. REV. STAT. § 433-671 (1971); N.H. REV. STAT. ANN. § 135.21-a (1964); N.J. STAT. ANN. § 30:4-37 (1964); N.M. STAT. ANN. § 34-2-18 (Supp. 1971); N.Y. MENTAL HYGIENE LAW § 76 (McKinney 1971); N.C. GEN. STAT. § 122-59 (Supp. 1971); N.D. CENT. CODE § 25-03-08 (1970); OHIO REV. CODE ANN. § 5122.10 (Page 195, 1970); ORE. REV. STAT. §§ 426.175, 426.180, 426.215 (1971); P.R. LAWS ANN. tit. 24, § 141 (1955); PA. STAT. tit. 50, § 4405 (1969); S.C. CODE ANN. § 32-956 (1962); TENN. CODE ANN. § 33-603 (Supp.

havior warranting immediate confinement need not be a violation of any criminal statute. Rather, a diagnosis of mental illness grounds the legislative inference that what may in itself be a harmless act is indicative of potential danger.

Twenty-seven of the provisions designated as emergency statutes by the states impose a standard of dangerousness to self or to the person or property of others.[43] In ten of the forty-four jurisdictions, the sole or an alternative criterion for immediate confinement is still more vague.[44] Wisconsin, for example, provides for emergency commitment when "safety requires it. . . ."[45] Arkansas authorizes immediate detention of "any insane . . . person . . . at large. . . ."[46]

In thirty of the forty-four jurisdictions in question, incarceration is possible without a prior medical examination.[47] Typically, under these statutes the initial decision regarding commitment is made by a sheriff or a health or police officer. Thus, initial confinement is permitted without judicial safeguards.

A second type of emergency procedure operates in twenty-seven jurisdictions.[48] This mode authorizes treatment upon medical certification of the need for it by one or two doctors. This pro-

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1972); TEX. REV. CIV. STAT. ANN. art. 5547-27 (Supp. 1972); UTAH CODE ANN. §§ 64-7-34, 64-7-35 (1971); VT. STAT. ANN. tit. 18, § 7505 (1968); WASH. REV. CODE ANN. § 71.03.020 (1962); W. VA. CODE ANN. §§ 27-5-1 (1971), 27-5-2 (1972); WIS. STAT. ANN. § 51.04 (Supp. 1973); WYO. STAT. ANN. § 25-58 (1967).

43. The standard in Del. is typical, providing for emergency commitment if the person is "so mentally ill as to be likely to cause injury to himself or others and to require immediate care, treatment or restraint." DEL. CODE ANN. tit. 16, § 5122 (Cum. Supp. 1970). Similar provisions in other jurisdictions are *cited* at note 42, *supra,* for Alaska, Ariz., Cal., Colo., D.C., Fla., Ga., Ill., Ind., Kan., Ky., Md., Mass., Mich., Minn., Mo., Nev., N.C., N.D., Ohio, Ore., Tex., Vt., Wash., Wis., Wyo.

Dangerousness, even as an alleged function or product of mental illness, is not a quality susceptible of objective definition or perception. Any method for emergency detention based on such a criterion relies on the examiner's subjective impressions of what past acts, thoughts, or present demeanors warrant a prediction of future "dangerous" behavior.

44. *See* statutes *cited* at note 42, *supra,* for Ark., Cal., Hawaii, La., Neb., N.Y., Ore., P.R., Utah, & Wis. Puerto Rico authorizes emergency commitment with *no* specified standard but simply with notice *to the prosecuting attorney* within 24 hours after admission. P.R. LAWS ANN. tit. 24, § 141 (1955). A legislative statement of motives for this provision mentions that there are many persons who cannot afford the judicial process but whose mental condition requires that treatment of their disorders be commenced at the earliest possible moment without the delays and deferments which such proceedings in court would require. Statement of Motives Act, May 12, 1945, No. 235, *cited* at P.R. LAWS ANN. tit. 24, § 141 (1955).

45. WIS. STAT. ANN. § 51.04 (Supp. 1973).

46. ARK. STAT. ANN. § 59-102 (1971).

47. *See* statutes note 42 *supra* for Alaska, Ariz., Ark., Cal., Colo., D.C., Fla., Hawaii, Ill., Ind., Kan., Ky., Md., Mass., Mich., Minn., Mo., Nev., N.Y., N.C., N.D., Ohio, Ore., P.R., Tex., Utah, Vt., Wash., Wis., Wyo.

cedure also dispenses with judicial safeguards, but provides for at least one medical examination prior to admission.[49] Of the twenty-seven jurisdictions with this type of provision, twenty-four require some form of danger,[50] while three are more general.[51]

These two types of emergency provisions authorize, in most jurisdictions, long periods of observation and treatment with no meaningful judicial protection.

A third type, emergency observation and diagnosis, is provided for in three states.[52] The time limitation on permissible detention under these provisions ranges from one day[53] to sixty days.[54] For instance, in Colorado, a statement may be filed by "any reputable person," accompanied by a doctor's certificate that observation and treatment would be in the person's "best interest." If the documents present a "satisfactory showing" to a judge, he may authorize a three-month period of detention without a hearing. This initial period may be extended for an additional three months by a further court order.[55]

After the expiration of the initial emergency period, the person may continue to be hospitalized under provisions which permit detention pending the judicial proceeding for involuntary hospitalization.[56] Thus, a long period of incarceration is possible without any judicial review. Some jurisdictions provide minor

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48. *See* statutes note 42 *supra* for Alaska, Ariz., Ark., Conn., Del., Fla., Ga., Hawaii, Ill., Ky., Me., Mass., Mich., Minn., Mo., Mont., N.H., N.J., N.M., N.Y., Ohio, Ore., Pa., S.C., Tenn., Utah, W. Va.

49. *See, e.g.*, ALASKA STAT. § 47.30.020 (1972) and MINN. STAT. ANN. § 253A.04 (1971).

50. *See* statutes at note 42 *supra* for Alaska, Ariz., Ark., Conn., Del., Fla., Ga., Ill., Ky., Me., Mass., Minn., Mo., N.H., N.J., N.M., N.Y., Ohio, Ore., Penn., S.C., Tenn., Utah, W.Va.

51. *See* statutes at note 42 *supra* for Hawaii, Mich., Mont. The Montana criterion is "suffering from acute mania or circular insanity and requires immediate hospitalization. . . ." The Alaska statute has a requirement of injury to self as a criterion or the general criterion of "in need of immediate hospitalization. . . ." ALASKA STAT. § 47.30.030 (1972).

52. *See* COLO. REV. STAT. ANN. § 71-1-4 (1963); LA. REV. STAT. ANN. § 28:57 (1969); and N.Y. MENTAL HYGIENE LAW § 78 (McKinney 1971).

53. FLA. STAT. ANN. § 394.463 (Supp. 1973).

54. OHIO REV. STAT. ANN. § 5122.08 (Page 61, 1970). A court order on receipt of the doctor's certificate must authorize the sixty-day detention, but no hearing is required.

55. COLO. REV. STAT. ANN. § 71-1-4 (1963).

56. *See, e.g.*, COLO. REV. STAT. ANN. § 71-1-4 (1963) providing for extension of the initial three-month involuntary hospitalization for an additional period not to exceed a total of six months. Section 71-1-5 provides for incarceration of a mentally ill person pending final determination of his mental condition. The time within which final determination must be made is left unclear.

safeguards, such as notice to relatives or friends[57] or examination by a staff doctor upon admission or shortly thereafter[58] for patients admitted without medical certification. Nevertheless, a person accused of mental illness may be incarcerated under these emergency procedures on the basis of medical authority before legal safeguards are available. Thus, he may have to prepare for any subsequent judicial hearing from within the confines of the disorienting hospital environment and often under heavy sedation.[59]

The use of extraordinary procedures in handling accusations of mental illness and incarcerating the person so accused is usually defended on the ground that the problem situation is medical, rather than moral or political. The proceeding is therefore said to be civil, not criminal and the purpose of confinement is not punishment, but rehabilitation.

This rationale for emergency commitment procedures also underlies involuntary commitment generally. However, the procedural apparatus and programs for diagnosis and treatment which exist pursuant to these emergency statutes are peculiarly

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57. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-507 (1972); DEL. CODE ANN. tit. 16, § 5122 (Cum. Supp. 1970); HAWAII REV. STAT. § 334-54 (1968); N.D. CENT. CODE § 25-03-10 (1970); N.M. STAT. ANN. § 34-2-18 (Supp. 1971); S.C. CODE ANN. § 32-956 (1962); WASH. REV. CODE ANN. § 71.03.030 (1962); W. VA. CODE ANN. § 27-5-2 (1971); and WYO. STAT. ANN. § 25-58 (1967).

The Lanterman-Petris-Short Act, CAL. WELF. & INST'NS CODE §§ 5000-5401, provides some safeguards for persons involuntarily detained. Detention for evaluation is limited to a 72-hour period, sec. 5151; evaluation and treatment is to be provided as soon as possible after admission, sec. 5152; reasonable precautions must be taken to safeguard the personal property of the person taken into custody, secs. 5156, 5210; certification for involuntary treatment may not exceed 14 days, sec. 5250; additional intensive treatment may not exceed 14 days, sec. 5260.

58. *See, e.g.*, FLA. STAT. ANN. § 369.463 (Supp. 1973); GA. CODE ANN. § 88-504.4 (1971); MASS. GEN. LAWS ANN. ch. 123, § 12 (1972); N.D. CENT. CODE § 25-03-10 (1970) (within twenty days of admission); ORE. REV. STAT. § 426.215 (1971); TEX. REV. CIV. STAT. ANN. art. 5547-30 (Supp. 1972); VT. STAT. ANN. tit. 18, § 7505 (1968); and WASH. REV. CODE ANN. § 71.03.030 (1962).

59. In addition to the emergency provisions, there are other types of statutes which are functionally similar in that they permit incarceration of the alleged mentally ill person on the basis of medical authority prior to the availability of procedural safeguards. These statutes include: voluntary provisions, which typically authorize immediate temporary involuntary detention for a person who entered the hospital voluntarily but subsequently decides to leave against medical advice; the medical certification type statutes, which authorize commitment entirely on medical authority; and the provisions for judicial commitment pending a hearing, which authorize immediate detention on a court order solely on the basis of medical testimony and the concept of mental illness. *See, e.g.*, DEL. CODE ANN. tit. 16 § 5125 (Cum. Supp. 1970); N.H. REV. STAT. ANN. § 135:21-a (1964). Del. allows detention in the state hospital for an indeterminate period on the basis of a certificate signed by two medical doctors, licensed to practice medicine or surgery in the state, who have examined the allegedly ill person. The New Hampshire provision is similar.

dependent upon the medical/civil model. The statutes we have discussed concern situations of urgency which can be understood only in terms of medical authority. Supposedly, the predictive character of medical categories tells us on the basis of past behavior what a person will do in future. The nature of the presumed emergency consists in a putatively rational inference concerning the accused person's *future* behavior. The inference is rational only if the premise is correct; as we have seen, however, psychiatry is not capable of predicting future behavior with any degree of certainty. Presently, on the basis of the predictive value of psychiatry, procedural safeguards are suspended to permit immediate detention without bail. Preventive detention which would not be allowed for a person accused of a specific criminal act is thus routinely allowed for one accused of merely aberrant behavior or "dangerous mental illness."

THE EXPERIENCE OF THE PERSON ACCUSED OF MENTAL ILLNESS UNDER AN EMERGENCY COMMITMENT STATUTE

The accused person's experience of involuntary mental hospitalization under the emergency provisions begins with apprehension and incarceration and proceeds through intake procedures to preliminary treatments. Under emergency commitment provisions, the prospective patient's introduction to "therapy" typically consists of physical apprehension by a health or police officer.[60] Erving Goffman, a sociologist, has described the situa-

60. The Colorado statute is typical, providing in pertinent part: "Any sheriff or peace officer, who in good faith believes that a person is mentally ill . . ., and that such person is apt to injure or endanger himself or others if allowed to remain at liberty, may take the person into protective custody and place him in a suitable place of custody pending an order of the court. . . ." COLO. REV. STAT. ANN. § 71-1-3 (1963). In California, where the standard commitment provision, CAL. WELF. & INST'NS CODE § 5150 (West 1972), provides for a 72-hour incarceration prior to the possibility of a hearing, each county specifies the individual or agency authorized to take prospective involuntary patients into custody, and each county does this differently.

> For example, Sacramento and Santa Barbara Counties designate the "professional staff" of their respective Mental Health Services as having authority to sign 72-hour holds for evaluation. San Mateo County just gives a list of seven hospitals or mental health centers which possess such authority. On the other hand, Santa Clara County lists licensed physicians, psychologists, social workers, public health nurses and clergymen, whereas Marin County designates peace officers, staff of their Mental Health Center and Mental Health Services, as well as ambulance staff under explicit instructions from the Mental Health Center or Services. Letter of Robert K. Patch, Attorney, California Department of Mental Hygiene, Bureau of Guardianship, July 18, 1972.

Although there are two statutory provisions governing the 72-hour hold in California, the judicial procedure, CAL. WELF. & INST'NS CODE § 5200 (West

tion of the inmate who is newly arrived at a state mental institution, whether for a temporary detention period or for a more prolonged stay.[61] The inmate comes into the establishment with a conception of self in part derived from and supported by a stable system of social arrangements in the home and "outside" world. The inmate is immediately stripped of the support provided by family and friends, perhaps a stable work situation, and other social supports.[62] In addition to this loss,

> [t]he process of entrance typically brings other kinds of loss and mortification as well. We very generally find staff employing what are called admission procedures, such as taking a life history, photographing, weighing, fingerprinting, assigning numbers, searching, listing personal possessions for storage, undressing, bathing, disinfecting, haircutting, issuing institutional clothing, instructing as to rules, and assigning to quarters. Admission procedures might better be called "trimming" or "programming" because in thus being squared away the new arrival allows himself to be shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations.[63]

Admission procedures also contribute to a loss of identity or self-image by permitting confiscation of personal possessions. An individual's possessions have a special relation to self, and a special function to perform in maintaining the self-image. One's appearance before others is maintained by what Goffman has called an "identity kit" consisting of clothing, hair style, and related paraphernalia.[64] Upon admission to a mental institution, however, the inmate is stripped of this equipment. Personal clothing, combs, needle and thread, cosmetics, towels, soap, shaving sets, bathing facilities—all may be taken away from or denied to the inmate, while "the institutional issue provided as a substitute for what has been taken away is typically of a 'coarse' variety, ill-suited, often old, and the same for a large category of inmates."[65]

1972), is apparently seldom used. Most commitments occur under the nonjudicial provision, CAL. WELF. & INST'NS CODE § 5150 (West 1972). A medical program consultant at Napa State Hospital states that in his experience, new inmates are typically brought in by a physician or a policeman, "most often by a peace officer." Interview with A.S. Linn, M.D. at Napa State Hospital, Imola, California, June 1, 1972.

61. GOFFMAN, ASYLUMS (1961) esp. at 12-48 and 131-46.

62. *Id.* at 14.

63. *Id.* at 16 (footnote omitted).

64. *Id.* at 20.

65. *Id.* at 20. Inmates of California mental institutions now have the right to wear their own clothing, to keep and use personal toilet articles, and to have access to individual storage space for private use. CAL. WELF. & INST'NS

Apart from the degrading implications of this potentially long-term deprivation of the "identity kit," the newly arrived inmate may suffer some indignity at the physical stripping which accompanies examination upon admission. "The admission procedure can be characterized as a leaving off and a taking on, with the midpoint marked by physical nakedness."[66]

Other forms of physical indignity which would be particularly distressing to a newly committed inmate abound in the institutional environment. For example, in some institutions all inmates are denied a knife and fork and forced to eat with a spoon.[67] Inmates also may face the necessity of begging or humbly asking for favors such as a light for a cigarette, a drink of water, or permission to use the telephone.[68]

In addition to such "incidental" forms of abasement, which might be seen as degrading the incidents of the individual's self-image, physical invasion of the inmate's body occurs in a variety of ways.[69] The administration of tranquilizing drugs is one example of such physical invasion. Administration of tranquilizers, while making the accused person more manageable, damages his sense of physical security and contributes to his overall feeling of disorientation in the alien environment of the mental institution. Apart from the occasionally brutal manner in which drugs are administered,[70] the evidence indicates that immediate heavy

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CODE § 5325 (West 1972). This so-called "patient bill of rights" provision in the Lanterman-Petris-Short Act has been cited by another author in a context which seems appropriate, as follows:

> A person's rights under Section 5325 may be denied for good cause only by the professional person in charge of the facility or his designee. . . . CAL. WELF. & INST'NS CODE § 5326 (West Supp. 1971)
> [A]nd the Lord gave, and the Lord hath taken away; blessed be the name of the Lord. Job 1:21 (italics omitted).

Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients,* 45 S. CAL. L. REV. 616 (1972) [hereinafter cited as Note].

66. GOFFMAN, *supra* note 61, at 18. One ex-patient who was briefly incarcerated at Napa State Hospital characterized her physical examination upon admission as an intensely humiliating experience. She was placed nude on an examining table in the presence of a number of female attendants, at least several of whom laughed at her physical appearance. One commented, "Isn't she a skinny one?" to the apparent amusement of the others. Following her internal examination, one of the attendants commented upon a particular gynecological symptom, in response to which another one of the women present said "Oh, let me see!" as several of them came over to "gawk and laugh." Interview with Carla B., December 9, 1972.

67. GOFFMAN, *supra* note 61, at 22 *citing* THE PLEA FOR THE SILENT 16 (D. McI. Johnson and N. Dodds, eds. 1957).

68. GOFFMAN, *supra* note 61, at 22.

69. *Id.* at 23.

70. An ex-patient reported that at one point during her stay at Napa State Hospital, repeated doses of drugs mixed with orange juice and administered orally were making her nauseated. When she complained, the supervising physi-

sedation by drugs is standard practice rather than extreme response applied only in unusual cases.[71] The chemical tranquilization of incoming inmates becomes a significant factor in the overall nullification of the accused person's ability to resist continued detention. It has been observed that Thorazine, for example, which is an agent commonly used in preliminary treatment, "has the undisputed effect of depriving the patient of initiative and the will to resist."[72]

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cian replied to the attending technician in her presence, " 'Tell her if she won't take it orally we'll give it to her with the needle, and it'll be worse.' " Interview with Carla B., June 2, 1972.

An ex-patient in Wisconsin wrote: "As a committed patient, I was forced to take drugs (Thorazine) even though I insisted that taking drugs violated my religious convictions . . . To settle the matter, a nurse called me into the treatment room and asked, 'How do you want to take this—by mouth or shall I give it to you in the butt?' I indicated that I preferred to take the drug by mouth. Her reply was, 'Well, since I have it already in a hypo, I think I'll give it to you in the butt.' That was my introduction to Thorazine. . . ." Anonymous, *An Ex-Patient Views Involuntary Commitment, Forum*, (a publication of the Wisc. Psychiatric Institute, 1300 Univ. Ave., Madison, Wisc. 53706) No. 1, 1972 at 9.

71. One person who reported to a psychiatric emergency room in California stated that shortly after her arrival a nurse gave her two tablets, mentioning they were Thorazine. A half hour later she was given two additional tablets. She decided to leave and ran out of the emergency room to her home. There she fell asleep for a period of three days with at most a few brief interruptions. Interview with Carla B., June 2, 1972. Another woman who was hospitalized several times wrote: "With each hospitalization, I was given an immediate sedative. For introduction it was always Thorazine, usually followed by mellaril or stelazine, haldol or some other shit." Written communication from Samantha D., June 13, 1972.

Interviews with medical personnel confirm the frequency of immediate sedation. Thus it is estimated that 90% of persons brought to Napa State Hospital under the 72-hour provision of CAL. WELF. & INST'NS CODE § 5150 (West 1972) are given medication immediately upon admission. Interview with A.S. Linn, M.D., Medical Program Consultant, at Napa State Hospital, Imola, California, June 1, 1972. "I cannot generalize as to the exact nature of the drugs used except to state that it is usually a tranquillizing drug of the phenothiazine type." Written communication from Dr. Linn, June 8, 1972. There are fifty wards at Napa, a dozen admitting wards. At the admission wards the philosophies differ, so that there are some where all persons admitted are drugged, some where none are, and some where the medication is temporary. Interview with Dr. Gordon Riley, Chief Psychologist, at Napa State Hospital, June 1, 1972.

Further data offer an additional perspective on this practice of immediate medication. "When a person first comes in, he or she is heavily doped up then the dosage is gradually adjusted. They dose them heavily at first because they don't know how much is needed to knock them out." Interview with Mr. Ted Adams, Director of the Stiles Hall Napa Volunteer Project, June 2, 1972. A volunteer in the Napa program who works on a chronic ward said that the staff is concerned simply with making it from day to day. "Perhaps the staff finds more placid behavior preferable, or that they are trying a new medication," but in any case most patients are under pharmaceutical medication constantly. Interview with Ms. Holly Floersch, Stiles Hall Napa Project Volunteer, June 2, 1972.

72. Ennis, *supra* note 22, at 116. *See, e.g., Mental Illness and Due Process,*

Besides drugging, other treatment modalities such as shock treatment and psychosurgery may be inflicted upon a person admitted under emergency procedures shortly after admission and prior to a court hearing. There are statutory safeguards against such treatment in only a few states.[73] The existence of such limi-

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Association of the Bar of the City of New York (1962) at 26: "*But tranquilizers reach the very source of the will to resist.* Since a patient who has been admitted to a mental hospital without his consent may not be in a position to object to his continued detention because of the nature of his illness *or the initial steps in its treatment,* his rights must be protected as fully as those of the patient who voices his protest." (Emphasis added).

It has been pointed out that "an important consideration in prescribing medicine is the physician's clear and honest awareness of the person for whom the medication is given; is it for the patient, for the family, for the physician, or for a social organization? . . . In the psychiatric practice, we see the wholesale application of tranquilizing drugs for the benefit of the institution, that is, physicians, nurses and administrators, and not always solely for the patient's sake." REDLICH & FREEDMAN, THE THEORY AND PRACTICE OF PSYCHIATRY 818 (1966).

Dr. Eli C. Messinger, instructor and psychiatrist certified by the Amer. Board of Psychiatry and Neurology states that

> [p]henothiazines are the drugs most often used on hospitalized mental patients. Chlorpromazine (Thorazine) is the most frequently used phenothiazine compound. All the phenothiazines have several characteristics in common which would have a bearing on the question of initiative and will to resist. First, they make the patient sleepy, particularly in the first few days of administration. Second, they cloud the mind and make thinking, especially independent thinking, difficult. Third, they make the patient more indifferent to his surroundings, his own symptoms, and his life situations. Fourth, they make the patient more tractable, passive and manageable. . . ." Dr. Messinger concludes that "the very common practice of using high doses of phenothiazines on recently admitted mental patients significantly reduces the possibility of legal action being initiated by the patient."

Letter of Eli C. Messinger, M.D., December 2, 1972.

73. Few jurisdictions limit the types of permissible treatment during the emergency period. In California, patients can refuse shock treatment and lobotomy during the initial 72-hour detention period. CAL. WELF. & INST'NS CODE § 5325 (West 1972). But these rights may be denied by the professional staff. CAL. WELF. & INST'NS CODE § 5326 (West 1972), and note 65, *supra.* In practice, the patient's objection to electro-shock within the 72-hour period at Napa State Hospital is disregarded upon agreement of three physicians and one administrator. Interview with A.S. Linn, M.D., Medical Program Consultant, at Napa State Hospital, Imola, California, June 1, 1972. Michigan prohibits shock treatment during the emergency period. MICH. COMP. LAWS ANN. § 330.19 (Supp. 1972). Tennessee prohibits "psychosurgery, convulsive treatment or insulin treatment until a court order is obtained." TENN. CODE ANN. § 33-603 (1972). Washington provides that treatment ". . . except for emergency surgery, shall be limited to medications and treatment procedures temporary and moderate in effect, and for the benefit of the person detained. . . ." WASH. REV. CODE ANN. § 71.03.04 (1962).

Other statutes provide very insubstantial limitations on treatment. Thus in Florida "a patient who is admitted for an emergency examination and treatment . . . may be given such treatment as is indicated by good medical practice." FLA. STAT. ANN. § 394.463 (Supp. 1973). In Georgia, a patient who is received by an emergency receiving facility ". . . may be given such emergency treatment as is indicated by good medical practice. . . ." GA. CODE ANN. § 88-504.4 (1971).

tations in these states may indicate that in most jurisdictions, where such provisions do not exist, doctors may have the legal right and power to use such extreme modes of treatment.[74]

It is not contended that such power is widely used by medical authorities. However, the knowledge that such treatment is possible will contribute to the newly arrived inmate's sense of insecurity if he feels that he is "in an environment that does not guarantee [his] physical integrity."[75] Certainly the newly arrived inmate at a mental institution, disoriented, unrepresented by counsel, and labelled mentally ill so that all his perceptions are suspect, is hardly in a position to wage an effective contest over treatment modalities with the hospital administration.

In addition to such personally disorienting factors as incarceration, physical insecurity, invasions of privacy, and heavy sedation, the accused person apprehended under emergency procedures faces a number of logistical difficulties in exercising his legal rights under hospital conditions. For example, though some states provide for notification of rights by statute, the hopsital administration is typically assigned to dispense this information.[76] Since the hospital is the adversary party in subsequent court proceedings, it would seem less than judicious to delegate this function to its administration.[77] While it is true that in the adminis-

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It would be extremely difficult methodologically to determine the extent of electric or chemical shock treatment administered to persons incarcerated under emergency provisions and awaiting a judicial hearing. For example, in California the only record of the administration of shock treatment over an inmate's objection would appear in his treatment record. This information is in turn available only to the person, his attorney, conservator or guardian, the State Dept. of Mental Hygiene, legislature, or a member of the county board of supervisors. CAL. WELF. & INST'NS CODE § 5326 (West 1972).

74. The procedure for authorizing the administration of electric shock treatment over a patient's objection during the emergency detention period at Napa State Hospital in California is outlined in note 73, *supra*. Dr. Linn indicated that such a step would be a rare occurrence. Interview with A.S. Linn, M.D., *supra* note 73. But of course the very existence of this procedure indicates the possibility of its exercise.

75. GOFFMAN, *supra* note 61, at 21.

76. *See* note 77, *infra*.

77. Even in states with the most elaborate mechanisms presently in existence for notification of legal rights to inmates accused of mental illness, there is evidence that such notice does not always occur. In a recent case rejecting a challenge to the constitutionality of sections 72 and 78 of NEW YORK MENTAL HYGIENE LAW, for example, the court noted that

> Upon admission, [the patient] must be immediately notified of his rights, including his right to a judicial hearing as to the need for hospitalization. . . . And, moreover, the Mental Health Information Service is charged with the duty of reviewing his admission and retention and of advising him, as well as others interested in his welfare, of his right to have a judicial hearing, with counsel, and to seek independent medical opinion. [N.Y. Mental Hygiene Law Sec. 78, subd. 2; Sec. 88] Fhagen v. Miller, 29 N.Y.2d 348, 354-55 (1972).

Nevertheless at least one ex-patient who had been hospitalized several times in

tration of the criminal law, the same officers charged with enforcement are also responsible for informing suspects of their legal rights, a number of factors distinguish emergency commitments from the apprehension of criminal suspects. Perhaps the most significant of these is that the criminal defendant typically knows from the moment he is apprehended that he is involved in an adversary proceeding. He is thus likely to think in terms of "protecting his rights" and to that end of "getting a lawyer." In addition, as a result of popular controversy over a number of Supreme Court decisions[78] concerning the rights of criminal defendants, he is more likely than the person accused of mental illness to be aware that he has certain rights and that among these is the right of access to counsel.

By contrast, the person accused of mental illness is likely to be reassured at every stage of the commitment process that the people responsible for his incarceration want only to "help" him and are acting "for his own good."[79] The medical professionals

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New York mental hospitals wrote: "Never once was I informed of my rights and I never received legal assistance of any kind." Written communication from Samantha D., June 13, 1972.

CAL. WELF. & INST'NS CODE § 5325 (West 1972) enumerates patients' rights and provides that a list of rights be prominently posted in English and Spanish at all psychiatric facilities. One ex-patient familiar with such facilities stated that she never saw any rights posted in any language, and that she was never informed either orally or otherwise of her rights to obtain counsel, to file a writ of habeas corpus, to refuse shock treatment and lobotomy, and to make and receive confidential telephone calls. Nor was she ever offered voluntary treatment as provided in CAL. WELF. & INST'NS CODE §§ 5250 and 5260.

Following the initial 72-hour detention period, California permits certification for intensive treatment for an additional 14-day period only in the case of a dangerous or gravely disabled person. CAL. WELF. & INST'NS CODE § 5250(a). The patient must receive notice of the certification, delivered personally. The person delivering notice must inform him of his right to judicial review by a writ of habeas corpus and explain the nature of this right. The same ex-patient who complained of the failure of notice under sec. 5325 declared that she never received *any* document of 14-day certification or any explanation although she was detained under this provision. Interview with Carla B., June 2, 1972.

78. *See, e.g.*, Miranda v. Arizona, 384 U.S. 436 (1966).

79. The position of the medical profession is discussed in Wenger & Fletcher, *supra* note 2, at 66. Typical of the medical viewpoint is the statement that "We would like our hospitals . . . to be looked upon as treatment centers for sick people, and we want to be . . . considered as doctors and not jailers." Braceland, Testimony, in CONSTITUTIONAL RIGHTS OF THE MENTALLY ILL: PART I, CIVIL ASPECTS, 64-65 (1961), *cited* in SZASZ, *Id.* at 51. This desire for an exclusively medical-scientific, to the exclusion of a legal-policy, perspective on commitment is reflected in the statement of the Committee on Psychiatry and Law of the Group for the Advancement of Psychiatry. This statement specifically criticizes as "major defects" in present commitment laws such elements as mandatory or optional trial by jury, retention of procedures drawn from the criminal law, and mandatory appearance of the patient in court. *Laws Governing Hospitalization of the Mentally Ill*, READINGS IN LAW AND PSYCHIATRY 95 (Allen, Ferster and Rubin ed. 1968) [hereinafter cited as READINGS]. "Hospital authorities are strongly opposed to the practice of jail deten-

encourage him to take a cooperative, nonadversary attitude. The new inmate may also be demoralized by the nature of the proceedings against him, which at least formally constitute not a charge of wrongdoing but an inquisition into the question of his sanity. These factors are likely to combine with the disorienting factors previously described to effectively prevent the accused from securing the rights to which he is legally entitled. Furthermore, as sociologist Thomas Scheff has observed:

> It is difficult to understand the commitment process and the organization of mental hospitals unless you understand that commitments to mental hospitals are largely people without social power, position or wealth. . . . Of course they can be inarticulate, not familiar with their rights and legal procedures. Notions of getting a lawyer, for example, I would think are rather foreign to these people even in their ordinary life. . . . It seems to me that research on characteristics in mental hospitals has established this beyond a reasonable doubt.[80]

The person accused of mental illness, then, unlike the criminal defendant, is not likely to be in either a position or a frame of mind conducive to securing information as to his legal rights upon admission to the hospital.

The deficiencies in present procedures for notification of legal rights are exacerbated by conflicts of interest between the patient and the hospital. As stated by one commentator:

> There is an inherent conflict of interest between the hospital and the patient on many matters. The patient may be interested in optimal freedom to come and go, to socialize, to have visitors and activities, to be free from arbitrary transfers and punishments and searches. The hospital's interests may be in administrative convenience and quietude.[81]

Thus, administrative convenience for the hospital may conflict with effective notice of the inmate's legal rights and the prospect of "having a lot of lawyers around." This is not to suggest any

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tion as well as to the transportation of patients in police conveyances." THE MENTALLY DISABLED AND THE LAW 43, n.88 (S. Brakel & R. Rock rev. ed. 1971) [hereinafter cited as BRAKEL & R. ROCK]. For an elaboration and analysis of these attitudes on the part of medical professionals see SZASZ, THE MANUFACTURE OF MADNESS, *supra* note 1, at 51-52 and sources cited therein. Dr. Szasz concludes that:

> If psychiatrists really wanted all those things, all they would have to do is unlock the doors of mental hospitals, abolish commitment, and treat only those persons who, like in nonpsychiatric hospitals, want to be treated. *Id.* at 52.

80. Scheff, Testimony, *Edited Transcript of Hearing of the Subcommittee on Mental Health* 39, Dec. 20, 1965.

81. Ferleger, *Mental Patient Civil Liberties Project*, ROUGH TIMES, Nov. 1972 at 7.

cynical avoidance of these issues by hospital authorities, but merely to point out that functional conflicts of interest do exist between inmates and the institutional staff and administration. The institutional psychiatrist plays a double role. On the one hand, he must be a therapist to his patient, and on the other, a protector of society against the patient.[82] Since the *possibility* of inmate-hospital conflicts of interest is obvious, "it becomes necessary to try to avoid situations in which persons are placed in the position of simultaneously representing opposing interests."[83]

The absence of effective notice of legal rights is an obvious handicap in preparing for the court proceedings which typically follow upon, rather than precede, incarceration under emergency commitment laws.[84] More generally, the purely mechanical problems involved in the preparation of any lawsuit are aggravated for a person preparing his case from within a mental hospital in the status of patient. His access to the telephone and the opportunity to make and receive confidential calls may be restricted. His mail may be censored. These problems are magni-

82. Szasz, *Hospital Refusal to Release Mental Patient*, in READINGS, *supra* note 79, at 222.

83. *Id.* at 222.

84. A study completed in 1968 for the American Bar Foundation states that although detention is usually a function delegated to the police and other administrative officers, judicial approval of the action remains a prerequisite in fourteen states of those which have emergency commitment provisions. BRAKEL & R. ROCK, *supra* note 79, at 43, n.90. The reader is then referred to Table 3.11, Certification columns and footnotes thereto. The certification columns make reference to 18 states wherein judicial certification of emergency detention is a "prerequisite." A review of statutes currently in force in these jurisdictions reveals only a few of the statutes named in the column in fact require judicial certification of an emergency commitment application as a prerequisite. The remainder of the states cited as requiring judicial certification do not always do so, and some never do. *See* KAN. STAT. ANN. § 59-2908 (Supp. 1971) provides only right to contact counsel *or* next of kin immediately and § 59-2909 (Supp. 1971) suspends the requirement of judicial certification upon application by peace officer or any person, stating that a probate court is not available; KY. REV. STAT. § 202.117 (1972) allows detention for 48 hours excluding weekends and holidays); MICH. COMP. LAWS ANN. § 330.19 (Supp. 1972) allows 48-hour detentions, excluding Sundays and holidays, with approval of the *prosecuting attorney*; NEV. REV. STAT. § 433.672 (1971) provides that the *district attorney* may order detention; N.J. REV. STAT. § 30:4-38 (1964) states a court order may come *after* commitment; N.C. GEN. STAT. § 122-59 (Cum. Supp. 1971) provides that consent may be given by any licensed physician; N.D. CENT. CODE § 25-03-08 (1970) provides that consent may be given by member of county mental health board; OHIO REV. CODE ANN. § 5122.10 (Page 195) (1970) authorizes detention for 5 days; TEX. REV. CIV. STAT. ANN. art. 5547-27 (Supp. 1972) limits detention to 24 hours, excluding Saturdays, Sundays, and holidays, unless a written court order is obtained; UTAH CODE ANN. § 64-7-34 (1971) requires endorsement by judge *or* head of the local board of health *or* a member of the city board of commissioners; W. VA. CODE ANN. § 27-5-3 (1971) allows the *clerk* of the county court to issue warrants for detention and examination by a physician, whose word in turn authorizes hospitalization.

fied if the accused is indigent.[85] For instance, finding a sympathetic specialist attorney as an alternative to the court appointee (if there is one) is difficult and expensive. Filling out writs and similar legal papers leaves any nonlawyer, patient or not, at a loss. Thus, by a variety of means the accused person may be made virtually incapable of exercising his guaranteed rights and severely handicapped in preparing for trial even if he manages to maintain the motivation to defend himself.

It might be suggested that this entire range of problems could be rectified by a statutory or administrative modification of procedures within mental hospitals. However, a very limited range of improvements is possible in the absence of adequate recognition of the powerless and very likely disoriented status of the accused person and of the inherent conflicts of interest between patient-inmate and hospital. The first necessity, in our view, is active, adversary legal representation for all persons alleged to be mentally ill under emergency commitment laws. An essential characteristic of this representation is that it takes a genuinely adversary stance on behalf of the accused, and remains independent of vested interests which conflict with those of the prospective inmate.[86]

EMERGENCY COMMITMENT AS A SELF-FULFILLING PREDICTION

Without the intervention of active adversary counsel, it seems likely that many persons incarcerated under present emergency commitment procedures will have possibly insurmountable difficulty in obtaining genuine hearings on the question of their release.[87] It is difficult to imagine how any person suddenly

85. Statutory rights may not be available in practice to indigent persons. An excellent example is provided in CONN. GEN. STAT. ANN. § 17-183 (Supp. 1973). This provision allows for initial emergency detention by medical certification for a period of up to 45 days without any hearing or court order. The only safeguard provided is the right to have one's private doctor as one of the certifying doctors. If the person's own doctor does not find him mentally ill, he cannot be confined under this provision. Obviously since this privilege can only be exercised by persons under the regular care of a family physician or who are able to retain one, indigents will often be denied this safeguard.

86. The Mental Patient Civil Liberties Project of Philadelphia, Penn., is an example of a type of legal services agency which could perhaps be a model for future efforts. The Project, which is privately funded, has contracted with a Pennsylvania state mental institution to provide legal and advocacy services to patient-inmates. *See Letter of David Ferleger, Mental Patient Civil Liberties Project*, 6 CLEARINGHOUSE REVIEW 430 (Nov. 1972).

87. The situation of the accused person in the typical case is perhaps illuminated by the New York situation, which has the nationally atypical feature of providing adversary counsel in a high proportion of cases. Studies conducted at Bellevue Psychiatric Hospital by New York University Medical School per-

and coercively detained, heavily drugged, and subjected to the disorienting environment of a mental hospital could retain full presence of mind. In this sense, under present procedures the statutory provisions in question may effectively fulfill their own prediction that the accused is mentally ill (and that therefore emergency commitment is justified). The combination of pressures to which the hospitalized person is immediately subject, in conjunction with the threat of indefinite incarceration, must understandably create a certain amount of anxiety in any individual. By the time of the hearing, if there is one, many characteristics which might be expected of the normal individual under such circumstances, such as tension or nervousness, anxiety, suspicion, and the like, may well have been observed in the accused person and duly recorded in the treatment record prior to trial. Or perhaps the person has remained calm under such adversity, either out of extraordinary self-control or as a result of sedation. From the medical perspective this behavior may be interpreted as flat affect. Any impairment of coordination resulting from heavy drugging may be diagnosed as naturally impaired coordination. In addition, if the accused is indignant at his incarceration and treatment, he may be described as exhibiting symptoms of hostility or aggression.[88] Whether because of the flexibility of diagnostic categories or as a result of the experience of hospitalization, the accused person in these circumstances may well exhibit "agitation," "disorientation," "loss of context," or "depression," which in turn will be taken to indicate the presence of "mental illness." On the basis of such "symptoms," the person in question can be held for a lengthy period pending the out-

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sonnel indicate that the percentage of patients discharged by judges after a hearing was only 8.9 per cent in 1969. However, 40.4 per cent of all patients who had requested a hearing were discharged by psychiatrists before the hearing, despite initial recommendations for continued detention. While it has been suggested that this phenomenon may be due in part to "the persistence of the MHIS [Mental Health Information Service] in investigating suitable alternatives to hospitalization," it is submitted that this remarkable situation must result at least in part from the availability of counsel employed by the MHIS, and the consequent "reluctance of psychiatrists to appear in court." Kramer, *Protective Legal Services for the Mentally Ill*, 23 HOSP. & COMMUNITY PSYCHIATRY 253-54 (Aug. 1972). The presentation of a diagnosis based in conceptually vague terms is no doubt simpler in the absence of an articulate and experienced advocate prepared to subject medical conclusions to the scrutiny of cross-examination, even when hearings are relatively informal.

88. For a description of at least two actual cases, *see* Solomon, *Commitment*, ROUGH TIMES, Nov. 1972, at 8 and Greenberg, *Become Mentally Healthy or I'll Kill You*, ROUGH TIMES, April 1972, at 16. The conclusion that such superficial diagnoses may be common or even typical is supported by SZASZ, THE MANUFACTURE OF MADNESS, *supra* note 1, at 50 and Diamond, *The Fallacy of the Impartial Expert* in READINGS, *supra* note 79, at 148.

come of an eventual hearing.[89] Of course it does not take any very extraordinary powers of imagination to speculate that such traits may well be observed in *any* person who has just been transported against his will and without explanation to a mental hospital, drugged, and stored on the locked ward for a period of several days.

If one accused of mental illness were required to report for an examination pursuant to a court order, and not hospitalized prior to that examination, he would be given adequate notice of the nature of the proceedings against him. He would know the stakes of the game and could prepare accordingly as far as his resources would permit. On the other hand, within the hospital there is nothing to insure that the patient will be informed of the purpose of one particular medical examination among others to which he may be subjected. It is difficult to say what response could plausibly be expected of a "sane" individual under such circumstances. Uninformed of the purpose of the encounter, the person might exhibit any of a variety of possible responses, including unresponsiveness (labelled hostility or flat affect, depending upon the mood or perception of the examiner). A sociologist who studied the medical examination process in one jurisdiction noted that

> one of the examiners always asked, "What year is it? What year was it seven years ago? Seventeen years before that?" etc. Only two of the five patients who were asked this series of questions were able to answer it correctly. However, it is a moot question whether a higher percentage of persons in a household survey would be able to do any better. To my knowledge, none of the orientation questions that are used have been checked in a normal population.[90]

Indeed, how many people, without any explanation of their purpose, would be willing to answer such inane questions at all, except perhaps out of a sympathetic concern for the obvious disorientation of the inquisitor? Only a person informed of the nature and purpose of such an inquiry and of its possible consequences could reasonably be expected to take it seriously.[91]

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89. *See, e.g.*, CONN. GEN. STAT. ANN. § 17-183 (Supp. 1973), where a person may be confined up to 45 days pending a court hearing upon filing of a certificate from a physician finding that such person is in need of care and a danger to himself or others.

90. T. Scheff, *Screening Mental Patients*, in DEVIANCE: THE INTERACTIONIST PERSPECTIVE 180 (Rubington and Weinberg ed. 1968).

91. A U.S. District Court in Wisconsin has held that individuals threatened with involuntary commitment were entitled to the privilege against self-incrimination under the fifth amendment to the U.S. Constitution. "The patient should be told by counsel and the psychiatrist that he is going to be examined

We thus suspect that any individual subjected to the emergency commitment process will have a difficult time proving his sanity under existing procedures. Nor do this suspicion and our suggested hypothetical diagnoses fail to take adequate account of psychiatric sensitivity and perception. On the contrary, psychiatrists involved with the commitment process do not seem particularly perceptive. Although it is difficult to pin the tag of malpractice upon them,[92] it is apparent that they are not altogether objective.

For example, sociologist Thomas Scheff examined the role played by court-appointed psychiatrists in justifying informal, nonadversary commitment procedures in one midwestern state.[93] In research to ascertain whether a presumption of mental illness occurred in the psychiatric screening process in that jurisdiction, intensive observations of screening procedures were conducted.[94] Scheff found that the procedures utilized usually

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with regard to his mental condition, that the statements he may make may be the basis for commitment, and that he does not have to speak to the psychiatrist." Lessard v. Schmidt, 349 F. Supp. 1078, 1101 (E.D. Wis. 1972).

92. Several recent cases deal with negligent or fraudulent psychiatric certification or diagnosis which authorized plaintiff's temporary or emergency detention. In many of these cases actions for damages for false imprisonment were dismissed for not stating a cause of action, notwithstanding proven fraud which resulted in deprivation of plaintiff's liberty. *See* U.S. *ex rel* Elliott v. Hendricks, 213 F.2d 922 (3rd Cir. 1954), *cert. denied*, 348 U.S. 851 (1954), and Mezullo v. Maletz, 331 Mass. 233, 118 N.E.2d 356 (1954) in which pleadings alleging negligent and malicious examination and certification were insufficient to state a cause of action; Keating v. Keller, 242 So. 2d 892 (La. App. 1970) where although the physician, who had never seen or examined plaintiff, falsely signed coroner's commitment order as examining physician, the commitment was upheld; Sukeforth v. Thegen, 256 A.2d 162 (Me. 1969) in which a doctor who falsely certified that he had examined the patient was held civilly liable; Di Giovanni v. Pessel, 104 N.J. Super. 550, 250 A.2d 756 (1969) where the court found no denial of due process although the court appointed a psychiatrist whose opinions were considered "unsound or dangerous" by most of the medical profession; Brady v. Collom, 68 R.I. 299, 27 A.2d 311 (1942) stating fraudulent testimony of doctors who had not made a full examination did not give the patient committed a cause of action where doctors did not institute proceedings; Pate v. Stevens, 257 S.W.2d 763 (Tex. Civ. App. 1953) holding a charge of malicious prosecution could not be maintained against the defendants, two doctors, merely because statements in the affidavit that they had examined patient within 5 days were false.

Several studies indicating the possibility of more rigorous and perhaps careful diagnostic work in at least some instances are cited in T. SCHEFF, BEING MENTALLY ILL, *supra* note 1, at 134, n.11.

93. T. SCHEFF, *supra* note 1, at 138.

94. *Id.* at 134-55. Lest it be thought that the results he obtained are unique to a particularly backward state, Scheff notes that the particular state studied is known for its progressive psychiatric practices, and that a number of the psychiatrists employed as examiners had finished their psychiatric residencies, which is not the case in many other states. *Id.* at 149. Scheff also notes informal discussions of screening with judges and other court officials disclosed that although the statutes give the courts responsibility for the decision to con-

did not serve the function of screening out persons who do not meet the statutory criteria governing who may be involuntarily incarcerated. Rather, at most decision points, retention of the accused was "virtually automatic."[95]

According to the Scheff study, explanations for the inadequacy of the psychiatric examinations as a screening device are not hard to find. Interviews ranged in length from five minutes to seveteen minutes, with the mean time being 10.2 minutes. The interviews were described as hurried, with the questions of the examiners coming "so rapidly that the examiner often interrupted the patient, or one examiner interrupted the other."[96] In weighing the prospective patient's responses during the interview, the physician appeared to the observer not to give the patient credit for the large number of correct answers he gave. The examiners seemed to feel that a wrong answer established lack of orientation, even when it was preceded by a series of correct answers. On this basis the manner of examination was seen as at times capricious. Thus one of the prospective patients, when asked, "In what ways are a banana, an orange, and an apple alike?" answered, "They are all something to eat." This answer was used as part of the examiner's explanation for his recommendation to commit. When asked for the grounds of this judgment, he stated that the person's behavior had been "bizarre" (possibly referring to her alleged promiscuity), her affect inappropriate ('When she talked about being pregnant, it was without feeling,') and with regard to the above question: 'She wasn't able to say a banana and an orange were fruit. She couldn't take it one step further, she had to say it was something to eat.' " It was thus suggested that the woman's thinking manifested concreteness, although in her other answers to classification questions, and to proverb interpretations, concreteness was not apparent. In another case, the physician stated that he thought the accused person was suspicious and distrustful, because he had asked about the possibility of being represented by counsel at the judicial hearing. One court-employed examiner spoke of having recommended a 30-

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fine or release persons alleged to be mentally ill, they would rarely if ever take the responsibility for releasing a mental patient without a medical recommendation to that effect. We take this factor as an indication of some of the limits of judicial review of even apparently superficial medical judgments, in the absence of adversary proceedings including vigorous cross-examination. Scheff concludes that under present procedures, the question which is "crucial, therefore, for the entire screening process is whether or not the court-appointed psychiatric examiners presume illness." *Id.* at 139.

95. *Id.* at 135-38. For a criticism of the function and evidentiary value of the application of judicial inquiry, *see id.* at 141-42.

96. *Id.* at 144.

day observation for a person whom he had thought *not* to be mentally ill, on the grounds that the person, a young man, could not get along with his parents, and "might get into trouble."[97] This examiner continued:

> We always take the conservative side (commitment or observation). Suppose a patient should commit suicide. We always make the conservative decision. I had rather play it safe. There's no harm in doing it that way.[98]

It appeared to the observer that "playing it safe" meant that even in those cases where the examination established nothing, the psychiatrists did not consider recommending release. In one case, for instance, the examination had established that the prospective patient had good memory, was oriented, and spoke quietly and seriously. The observer offered this record of his discussion with the physician after the examination:

> When the doctor told me he was recommending commitment for this patient too (he had also recommended commitment in the two examinations held earlier that day) he laughed because he could see what my next question was going to be. He said, "I already recommended the release of two patients this month." This sounded like it was the maximum the way he said it.[99]

Several additional statements in the Scheff study indicate an element of prejudgment.[100] Among these, perhaps the most striking was that of one physician who commented on cases in which the prospective patient's family or other private parties initiated hospitalization. In such cases, recommendations for commitment were generally automatic. The assumption seemed to be that, if a patient's own family or friends want to get rid of him, then surely something must be wrong with him.[101]

What Scheff calls the "lack of cure" evident in these examinations was indicated also on the forms on which the examiners made their recommendations. On most of these forms sections had been left unanswered and other sections were answered in a "peremptory and uninformative" way. For example, to the question "On what subject or in what way is derangement now manifested?" one of the examiners employed regularly by one of the committing courts always answered "Is mentally ill." Scheff concludes:

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97. *Id.* at 145-47.
98. *Id.* at 147.
99. *Id.* at 147-48.
100. *Id.* at 148-49.
101. *Id.* at 149. An alternative theory of the family situation is offered in LAING, ESTERSON, & LEE, SANITY, MADNESS AND THE FAMILY (1971).

> The omissions, and the almost flippant brevity of these forms, together with their arbitrariness, lack of evidence, and prejudicial character of the examinations . . . all support the observer's conclusion that, except in very unusual cases, the psychiatric examiner's recommendation to retain the patient is virtually automatic.[102]

The Scheff study indicates that various administrative considerations also influence the results of examinations.[103] The impact of financial considerations is reflected in the following comment of one examiner concerning the brevity of his examinations: "It's not remunerative. I'm taking a hell of a cut. I can't spend 45 minutes with a patient. I don't have the time, it doesn't pay."[104] In relating the financial factor to the results of the examination as well as to its length, Scheff points out that if they recommend retention, the examiners can avoid interrupting the hospitalization and commitment procedures already in process, while if they recommend release, they must build a case showing why these procedures should be interrupted. Building such a case would take much more time and, as Scheff observes, thereby reduce the examiner's rate of pay. Apart from the financial question, however, Scheff's analysis suggests a kind of bureaucratic process which constitutes the procedure for commitment. This process is inevitably attended by built-in amounts of inertia and momentum, so that any single actor involved in the process has a difficult time interrupting it.

On the basis of his analysis of these other factors involved in commitment, such as the motivations of the examiners, the tendency of the courts, and so on, Scheff concludes that the very element which theoretically should provide the entire basis for the proceedings, i.e., the mental condition of the person alleged to be mentally ill, is not usually an important factor in determining their outcome.

> The marginal nature of the majority of the cases, the peremptoriness and inadequacy of most of the examinations, when considered in light of the fact that virtually every patient is recommended for commitment, would appear to demonstrate this proposition.[105]

Additional analysis and research material support Scheff's conclusion. Thus, Dr. Bernard Diamond, in discussing court proceedings to determine sanity when the question has been raised as part of a criminal defense, suggests:

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102. T. SCHEFF, BEING MENTALLY ILL, *supra* note 1, at 149.

103. For a presentation of the ideological and political factors suggested by the Scheff study, *see id.* at 150-55.

104. *Id.* at 144.

105. *Id.* at 154.

> The selection of court-appointed psychiatrists is seldom made from the random universe of the psychiatric population. Certain psychiatrists tend to be appointed over and over again. These are generally men who have an active interest in forensic psychiatry. More often than not they tend to be Kraepelinian and less dynamic in their approach to cases. They are often drawn from the ranks of administrative psychiatry, an area deficient in psychoanalytically oriented therapists. They are less inclined to probe deeply, more inclined to accept uncritically surface manifestations, and prone to interpret the [criminal] legal criteria for sanity in a narrowly restricted way.[106]

Dr. Diamond's analysis and conclusions would seem to have analogous application in cases of involuntary mental hospitalization by nominally civil procedures.[107]

Greater depth in the psychiatric examination cannot in itself be counted upon to safeguard the defendant against improperly continued incarceration in the absence of adversary criticism of the resulting diagnosis. Dr. Diamond suggests that availability of sufficient funds for an extensive clinical examination might resolve some of the problems of the abbreviated examinations.[108] One of these problems is the lack of money for auxiliary examinations, such as projective tests (for instance, the Rorschach or ink blot test).[109] However, even if additional money were available, the deficiencies inherent in these testing procedures prevent them from serving as an adequate safeguard from arbitrary commitment. Dr. Szasz has criticized projective tests because of their inherent unreliability and the role played by financial, administrative, and political factors in determining the results of the tests.[110] Perhaps the best summary of the problems presented by psychiatric examination of a person accused of mental illness is his contention that "there is no behavior or person that a modern psychiatrist cannot plausibly diagnose as abnormal or ill."[111]

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106. Diamond, *supra* note 88, at 148 (footnote omitted). For a critical description of one Kraepelinian analysis, *see* LAING, THE POLITICS OF EXPERIENCE, *supra* note 16, at 106-07.

107. Diamond, *supra* note 88, at 145-51. Law students doing legal aid work at a Connecticut hospital reported that the same two physicians were employed in all probate proceedings there, and received a uniform sum per examination. Similar arrangements are described in the Scheff studies *cited*. *See* T. SCHEFF, *supra* note 1, at 140. *See also*, T. SCHEFF, *supra* note 1, at 132-33 *citing* Mechanic, *Some Factors in Identifying and Defining Mental Illness*, 46 MENTAL HYGIENE 66 (Jan. 1962). *See also* T. SCHEFF, *supra* note 1, at 133 *citing* Brown, *Newer Dimensions in Patient Care* Part I, at 60 (1961).

108. Diamond, *supra* note 88, at 150.

109. *Id.* at 147.

110. SZASZ, THE MANUFACTURE OF MADNESS, *supra* note 1, at 34-35.

111. *Id.* at 35. (citation omitted). Additional data are presented in SZASZ, THE MYTH OF MENTAL ILLNESS, *supra* note 1.

Whether or not one accepts this view, the accumulated weight of the available evidence indicates that it is unrealistic to expect the examining physician or the courts to perform their screening function effectively in the absence of active, adversary counsel for the defense.[112]

THE PUNITIVE NATURE OF THE INSTITUTIONAL ENVIRONMENT AND OF NOMINALLY THERAPEUTIC TREATMENT MODALITIES

It is frequently argued that formality in the commitment process is antitherapeutic and that an adversary proceeding is inappropriate to involuntary mental hospitalization.[113] However, even emergency commitment has grave consequences for the person subjected to such proceedings. Emergency commitment may additionally lead to prolonged hospitalization. Therefore, some consideration of the institutional setting which is faced by the inmates of mental hospitals is in order at this point.

Physicians understandably do not wish to be perceived as jailors; the conception of institutional psychiatrists and other hospital personnel as essentially prison guards is no doubt foreign to the self-perceptions of the employees of state mental hospitals. A number of ex-inmates of such institutions have nevertheless characterized hospital employees in this way.[114] We by no means consider that such a designation does justice to the goals, attitudes, and work of state hospital employees. But such a conceptualization can both highlight the existence of certain conflicts of interest between inmates and staff, and allude indirectly to the atmosphere and function of the mental hospital, which may tend to become far more oppressive than either staff or inmates desire it to be.

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112. The court in *Lessard, supra* note 91, held that a person detained on the grounds of mental illness has a constitutional right to counsel and to appointed counsel if the individual is indigent. The court found further that this requirement was not met by the appointment of a guardian ad litem who "happened to be an attorney," as the guardian in question had not acted "as legal counsel for the individual threatened with commitment." The detained person "must have counsel at the preliminary hearing, with time before that to prepare any initial defenses which are available." Lessard v. Schmidt, 349 F. Supp. 1078 at 1097-99. For a further indication of the inadequacy in practical terms of the guardian ad litem arrangement, *see* T. SCHEFF, *supra* note 1, at 137-38.

113. For a summary of this argument see Wenger & Fletcher, *supra* note 2, at 67.

114. *See* Statement of Mental Patients Resistance, Summer 1972, and Colletti, *Jailers of the People*, HEALTH RIGHTS NEWS, Dec. 1971 (both on file with the Center for the Study of Legal Authority and Mental Patient Status). For a brief summary of the suspicions of some former and potential patient-inmates, *see* KITTRIE, THE RIGHT TO BE DIFFERENT, xvii-xviii (1971).

Involuntary mental hospitalization in effect, if not in intent or by design, is analogous to imprisonment. As many state appellate courts have recognized, civil commitment entails a "massive constriction of freedom."[115] For example, civil commitment directly infringes on the freedoms of travel, association, and free exercise of religion and marital privacy in ways that do not differ from the infringements of criminal imprisonment.[116] Commitment, at both the long-term and emergency levels, involves detailed control and restriction of the inmate's life.[117]

The institutional staff experiences great difficulty in attempting to create a humane environment within the institutional context. In this regard some comparison of the nominal and real functions which society assigns to mental institutions may go far toward explaining the double-bind in which staff members find themselves.

Even the most conscientious staff person may often be unable to square his or her humane feelings for inmates with the demands of the institutional situation. Many hospital settings place great responsibility and authority on the shoulders of the staff while providing resources abysmally inadequate to the tasks assigned to them.[118] Professor Goffman describes the situation in these terms:

> Many total institutions, most of the time, seem to function merely as storage dumps for inmates, but . . . they usually present themselves to the public as rational organizations designed consciously, through and through, as effective machines for producing a few officially avowed and officially approved ends . . . . [O]ne frequent official objective is the reformation of inmates in the direction of some ideal standard. This contradiction, between what the institution does and what its officials must say it does, forms the basic context of the staff's daily activity.[119]

Without intending to attribute all the debilitating effects of hospitalization directly to staff intentions or actions, we note only that the inmate's experience of the institutional setting may accord more with his image of imprisonment than with anything one would ordinarily expect to find in a therapeutic environ-

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115. See cases cited in Chambers, *supra* note 20, at 1157, n.218.

116. For some further analysis of the curtailments on freedom entailed in civil commitment and a discussion of some of the relevant case law *see* Chambers, *supra* note 20, at 1151-68.

117. *See* GOFFMAN, *supra* note 61, at 38-43.

118. *See, e.g.*, CIVIL LIBERTIES (American Civil Liberties Union, 22 E. 40th St., N.Y., N.Y. 10016), Sept. 1972; PENDING FEDERAL RULING PROMISES HELP FOR MENTAL PATIENTS ACROSS THE COUNTRY, N.Y. Times, Mar. 26, 1972, sec. 1, at 35.

119. GOFFMAN, *supra* note 61, at 74.

ment. Furthermore, contrary to the impact hospitalization is normally expected to have upon patients, involuntary mental hospitalization may cause or exacerbate rather than alleviate the "illness" it is intended to cure. In this regard Dr. Stanley Yolles, former Director of the National Institute of Mental Health, once remarked, "Let the doctor beware, who does not realize the amount of mental illness he helped either to cause or to itensify by institutionalizing mental patients."[120] Even short-term hospitalization may undermine the individual's capacity to perform in the outside world,[121] and it is recognized that long-term hospitalization may have ill effects which the mere alleviation of staff and resource inadequacies cannot cure.[122]

In addition to the effects of incarceration itself and of the admissions procedures discussed earlier, the ongoing regimen of daily therapy in one form or another appears to have as much in common with a medieval chamber of horrors as with one's expectation of a twentieth century medical establishment. Certainly the analogy to a penal institution is not very strained. Dr. Thomas Szasz has pointedly referred to "tortures called treatments" in a critical comparison of the therapeutic state with the Inquisition:

> Descriptions and explanations of human behavior and social control are, most often than not, merely a papering over, with a fresh, scientific-sounding vocabulary, of earlier religious descriptions and explanations. This is especially clear . . . in the replacement of the theological concept of heresy with the medical concept of mental illness, and of the religious sanctions of confinement in a dungeon or burning at the stake with the psychiatric sanctions of confinement in a hospital or tortures called treatments.[123]

There is no apparent limit to the type of environment which can be characterized as "therapy." One inmate described the experience of electroshock therapy (ECT), for example, as follows:

> They hit you with the first jolt, and you experience pain that you would never believe possible. At the same moment, you see what could be described as a flash of lightening. You cannot breathe, and they apply oxygen. During all this, you are in convulsions. This lasts only a few moments, but it seems

120. Chambers, *supra* note 20, at 1129, *citing* Yolles, *Mental Health's Homeostatic State: A New Territory*, 7 INT'L J. PSYCHIATRY 327, 328 (1969).

121. *See* GOFFMAN, *supra* note 61, at 14-71, describing the immediate undermining of an individual's self-image that institutionalization entails.

122. *See* Chambers, *supra* note 20, at 1127, nn. 81-83 and sources therein cited.

123. SZASZ, THE MANUFACTURE OF MADNESS, *supra* note 1, at 138. For a survey of some of the more bizarre, though not necessarily rare, forms of "treatment" accorded, coincidentally enough, to both prisoners and mental patients, *see* Note, *supra* note 65.

> like a lifetime. A few seconds after that, the pain is so severe that you pass out.[124]

The inventor of ECT himself has remarked: "When I saw the patient's reaction, I thought to myself: This ought to be abolished!"[125] Possible side effects of ECT include disorientation in time and space, damaged muscles and brain tissue, broken bones, and loss of memory and inhibitions.[126]

Another form of treatment which has been administered to mental patients is "rage reduction therapy," which consists of physical attacks directed at passive-aggressive patients as treatment for their condition. This "therapy" involves a range of attacks from tickling to heavy physical blows. The administration of therapeutic beatings by psychiatrists applying rage reduction thereapy is reported to have caused the death of one patient and back injuries to another.[127] While such forms of treatment may be among the more radical in the repertoire of psychiatry, they serve to indicate the extent to which treatment may go in the name of therapy.

Lobotomy now seems to be making a comeback as a treatment modality of choice for a number of patients.[128] Despite claimed inprovements in the technique of its administration, however, each type of lobotomy has the same general side effects, including loss of memory, insight, affection and values.[129] Additional forms of treatment currently inflicted on inmates of mental institutions include aversive conditioning and other forms of behavior modification. Perhaps the most spectacular current use

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124. Letter of Samantha D., June 13, 1972. For a chilling experiential description of electroshock *see* Field, *Terror on Tuesdays and Thursdays,* THE WHITE SHIRTS, 5-8 (published by the author, 1964; on file with the Center for the Study of Legal Authority and Mental Patient Status.)

It has been remarked that the number of law suits arising as a result of the use of electroshock was in part responsible for the reduction in their number, which is now roughly ten per month at Napa State Hospital from an average of some fifty per month several years ago. Interview with A.S. Linn, M.D., Medical Program Consultant, at Napa State Hospital, Imola, California, June 1, 1972. This interesting advance in treatment modality is indicative of the relation between medical science and social policy, troublesome as this relation may sometimes be for institutional practitioners.

125. SZASZ, THE MANUFACTURE OF MADNESS, *supra* note 1, at 31.

126. Note, *supra* note 65, at 632, n.91 *citing* FOUNDATIONS OF ABNORMAL PSYCHOLOGY 562 (P. London and D. Rosenhan eds. 1968); A. NOYES & L. KOLB, MODERN CLINICAL PSYCHIATRY 540-41 (6th ed. 1963).

127. THE ABOLITIONIST 3 (Summer 1971) *citing* PSYCHIATRIC NEWS, Sept. 2, 1970, at 4.

128. *See Here Come the Lobotomists Again,* MEDICAL WORLD NEWS, Jan. 15, 1971, at 35; Note, *supra* note 65, at 632-33; Roberts, *Psychosurgery: The Final Solution to the Woman Problem,* ROUGH TIMES, Sept. 1972, at 16-17.

129. Note, *supra* note 65, at 633 *citing* A. NOYES & L. KOLB, MODERN CLINICAL PSYCHIATRY 553 (6th ed. 1963).

of aversion therapy is in the treatment of persons labelled homosexual.

> The patient has his or her genitalia hooked up to an electrical apparatus and is shown homosexually oriented pornography and given a shock. The patient . . . is then shown heterosexually oriented pornography and is given no shock.[130]

In explaining the function of such therapy, one psychologist has written:

> The major value of aversion procedures is that they provide a means of achieving control over injurious behavior for a period of time during which alternative, and more rewarding, modes of response can be established and strengthened. Used by itself, this method may bring about a temporary suppression of deviant tendencies.[131]

It has been suggested that this description indicates a concern on the part of the behavior therapist not only with extinguishing certain behavior, but also with establishing a new, and more acceptable behavior. Thus, another author has concluded that

> the behavioral therapist (or the state which directs his conduct) is not simply exercising an objective *clinical* choice. Rather, he is making moral or social judgments by identifying "unacceptable" behavior to extinguish and "acceptable" behavior to establish.[132]

Indeed, as the author went on to remark, "the use of any psychiatric technique involves such moral or social choices."[133]

Besides the possibility of subjection to one of these more dramatic therapeutic modalities, the inmate faces a situation within the instituion which permits the ongoing invention of treatments to fit the behavior (or "punishments" to fit the "crime"). A summary of some of the potential instruments of reward and punishment available to staff is provided in the Goffman study:

> The authority of the attendant in the operation of his control system is backed up by both positive and negative power. This power is an essential element in his control of the ward. He can give the patient privileges, and he can punish the patient. The privileges consist of having the best job, better rooms and beds, minor luxuries like coffee on the ward, a little more privacy than the average patient, going outside the ward without supervision, having more access than the average patient to the attendant's companionship or to profes-

130. *Florida Gays Protest Prison 'Treatment'*, ROUGH TIMES, Dec. 1972, at 19.
131. Note, *supra* note 65, at 630 *citing* A. BANDURA, PRINCIPLES OF BEHAVIOR MODIFICATION 509 (1969).
132. Note, *supra* note 65, at 630-31.
133. *Id.* at 631.

> sional personnel like the physicians, and enjoying such intangible but vital things as being treated with personal kindness and respect.
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> The punishments which can be applied by the ward attendant are suspension of all privileges, psychological mistreatment, such as ridicule, vicious ribbing, moderate and sometimes severe corporal punishment, locking up the patient in an isolated room, denial or distortion of access to the professional personnel, threatening to put, or putting, the patient on the list for electroshock therapy, transfer of the patient to undesirable wards, and regular assignment of the patient to unpleasant tasks such as cleaning up after the soilers.[134]

At some point, the forms of treatment which are rationalized as therapy shade into abusive behavior which must be attributed to sadism rather than to psychiatric or medical authority.[135] For example, an ex-patient reports this event from his first night at one institution:

> On the night of my admission to the state asylum, I was smoking a cigarette in the toilet when another inmate set off a thunderous slamming of doors in the corridor and then retreated to his room. Four uniformed screws rushed into the toilet and accused me of making the racket. When I denied it, one smashed me across the mouth with the back of his hand. I protested and all four joined in—throttling me, slugging me with their fists, knees and feet, dragging me along the hall and lashing me to a bed under a canvas restraining sheet.[136]

It is difficult to determine the extent to which medical practitioners are silently involved in sanctioning such practices. It must be noted that at least occasionally sadistic staff behavior is made possible, though not intentionally authorized, by the application of a diagnostic label. Subsequent abuses thus trace back to the exercise of medical authority, although not specifically attributable to the examining physician. Such incidents would seem to be a natural outgrowth of a situation in which one group of individuals is given virtually absolute control over the lives of a second group, in the context of a medical rationale which labels the controlled group as mentally ill and therefore somehow inferior.

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134. GOFFMAN, *supra* note 61, at 52-53 (footnote omitted).

135. *See, e.g.*, Shewbridge, *Mental Patients Oppressed*, THE CATHOLIC WORKER, Sept. 1972, at 7. Ms. Shewbridge notes that

> Writing under the pseudonym of Hannah Green, a former patient in the nationally reputed Chestbut Lodge told of being tied in an ice pack for five hours. The bindings were deliberately tied so as to prevent blood circulation, causing excessive pain after a period of two hours. The same writer recounts that another patient similarly restrained was struck in the face while immobilized, for refusing her medication.

136. Brown, *Memoirs of an Intermittent Madman*, PLAYBOY, June 1972, at 174.

The line between professional responsibility and random unsanctioned abuse is difficult to draw. We have tried only to indicate briefly some of the ways in which the rationale of mental illness may justify what can only be characterized as at best bizarre forms of treatment, and to indicate more generally the nature of the institutional setting to which commitment consigns an individual.

The example of drug therapy illustrates the connection between medical authority and the debasing process of institutional treatment. Cases of abusive administration or indefinite unsupervised prescription only serve to highlight the underlying problem. Patients are routinely drugged as part of their "treatment program." Yet the fact that a drug produces an alteration of consciousness and a modification of behavior does not justify its administration as medicine. The present widespread use of drug therapy is an attempt to control people rather than to treat some underlying disease entity. The question of implementing social control by such means is a question of social and political policy. It should be approached and treated as such rather than as a medical question, the answer to which may be grounded in the authority of objective science.

In any event, the argument that emergency hospitalization is a purely medical procedure is belied by the reality of the existence to which the accused person is immediately subjected and to which he may be consigned indefinitely by subsequent proceedings. As one author has commented:

> To be taken without consent from my home and friends; to lose my liberty; to undergo all those assaults on my personality which modern psychotherapy knows how to deliver; to be remade after some pattern of "normality" hatched in a Viennese laboratory to which I never professed allegiance; to know that this process will never end until either my captors have succeeded or I have grown wise enough to cheat them with apparent success—who cares whether this is called Punishment or not?[137]

AN EVALUATION OF EMERGENCY MEDICAL COMMITMENT

Emergency hospitalization or detention is a "temporary measure for the speedy processing of emergency situations."[138] The emergency statutes are said to "deal with the suppression and

137. Lewis, *The Humanitarian Theory of Punishment*, 6 RES JUDICATA 224, 227 (1953).

138. BRAKEL AND R. ROCK, *supra* note 79, at 41-42.

prevention of conduct likely to create a 'clear and present danger' to persons or property."[139] Yet in only eight states is the criterion for commitment limited to dangerousness to self or to the person or property of others.[140] In addition, it is not apparent that any criteria exist which might permit empirical determinations of the likelihood of future dangerous conduct. It has been observed that for commitment purposes generally,

> [T]he statutes are so broadly worded that they fail to identify with clarity or precision the type and degree of mental illness for which involuntary hospitalization, with the accompanying deprivation of many personal and civil rights, is justified. . . . Even those statutes which rely on the concept of dangerousness as a justification for hospitalization are in significant aspects vague. In application, such a standard can become as broad as the ingenuity of the person who must apply it allows.[141]

As presently written, then, even the standard commitment statutes are inextricably tied in with the concept of mental illness and the faith that medical practitioners are qualified to determine the existence of this "disease" objectively and thus authoritatively. It appears that the criterion of dangerousness adds nothing to the justifications for involuntary commitment. In commitment proceedings the term is applied by doctors on the basis of medical authority, which is no more capable of a valid prediction of dangerousness than it is of defining "mental illness" by objective standards. In this regard it has been observed:

> Psychiatrists are rather inaccurate predictors [of danger] —inaccurate in an absolute sense—and even less accurate when compared to actuarial devices such as experience and prediction tables. Even more significant for legal purposes, it seems that psychiatrists are particularly prone to one type of error—over-prediction.[142]

While the very question of psychiatric prediction is related in the first instance to psychiatric ability to diagnose mental illness as the presumed source of potentially dangerous behavior, it also depends upon a correlation between the notion of mental illness and

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139. *Id.* at 42.

140. Arizona, for example, provides for commitment if the court finds a person "mentally ill to such a degree that he is in danger of injuring himself or the person or property of others. . . ." ARIZ. REV. STAT. ANN. § 36-514 (Supp. 1972). Other statutes explicitly providing for commitment only on a finding of mental illness in correlation with some form of "dangerousness" are: ARK. STAT. ANN. § 59-417 (1971); D.C. CODE ANN. § 21-544 (Supp. 1971); FLA. STAT. ANN. § 394.467 (Supp. 1972); MONT. REV. CODES ANN. § 38-201 (1947); NEV. REV. STAT. § 433.685 (1971); N.H. REV. STAT. ANN. § 135:19 (1964); and WASH. REV. CODE ANN. § 71.02.010 (1962).

141. *Id.* at 39 (footnote omitted).

142. Dershowitz, *The Psychiatrist's Power in Civil Commitment*, PSYCHOLOGY TODAY, Feb. 1969, at 47.

the existence of violent behavior. No such correlation has in fact been shown. Regarding dangerousness to self, for example, it has been pointed out that approximately 70 per cent of all suicides are committed by people who are not identifiably mentally ill.[143] As for the relationship between mental illness and violent behavior, it has been shown that

> [v]ariations in the rates of psychiatric institutionalization, variations in the levels of care and treatment in public institutions, and variations in the rates of murder, nonnegligent manslaughter, and suicide do not appear to be related. This is significant in that many laymen frequently seem to erroneously view the institutionalized mentally ill as almost universally homicidal or suicidal. The figures do not support this position. Whether the mentally ill are allowed to remain in the community or whether they are insitutionalized would seem to have no significant effect on the overall rate of violent crime or suicide.[144]

It must be noted further that

> [f]or the typically aberrant individual . . . the matter of prediction is not susceptible of answer. However nervous a full-blown paranoiac may make us, there are no actuarial data indicating that he is more likely to commit a crime than any normal person. . . . [O]n a predictive basis we have, as yet, nothing to rely on.[145]

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143. CLINARD, SOCIOLOGY OF DEVIANT BEHAVIOR 425 (1957). *See also* DURKHEIM, SUICIDE 66-67 (1957). *See generally* sources cited in Ennis, *supra* note 22, at 108, n.24.

144. Birnbaum, *A Rationale for the Right*, 57 GEORGETOWN L.J. 752, 767 (1969). Regarding the basic policy questions beneath this factual dispute as to the probabilities of suicide, a persuasively argued piece against the use of the *parens patriae* power to prevent suicide is Comment, *Society's Right to Protect an Individual Against Himself*, 2 CONN. L. REV. 150 (1969).

145. Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 82 (1968). *See also* Chambers, *supra* note 20, at 1124, n.66 *citing Hearings Before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary*, 91st Cong., 2d Sess. 321 (1970) (statement of Dr. Sherman Keiffer, Director, National Center for Mental Health Services, Training, and Research, St. Elizabeth's Hospital, Washington, D.C.): "A number of studies conducted or supported by the [National Institute of Mental Health] have demonstrated that an extremely small percentage of civilly committed patients meet the statutory standard of danger to themselves or others to an extent that . . . necessitates inpatient care."

A conclusion somewhat to the contrary is reported in Rappeport and Lassen, *Dangerousness: Arrest Rate Comparisons of Discharged Patients and the General Population*, READINGS, *supra* note 79, at 221: "We . . . do not find any clear-cut indications that the mentally ill are to any great extent less involved in criminal behavior than those in the general community. Instead . . . for some offenses such as robbery and also probably rape, our patients were more frequently arrested than the general population." Even this report, however, found "no significant difference in the arrest rate experiences of our two populations." Compare Chambers, *supra* at 1124: "Indeed, as a group, persons labelled mentally ill may be less likely to engage in aggressive misconduct than the rest of the community who are considered sane."

It should be kept in mind that even a statistical indication that a certain percentage of the members of a given group may or will engage in some particular form of behavior such as violence, does not provide any indicator of future behavior for any particular member of that group. The application of probabilities to particular cases involving an insight into the individuals involved would be the task of psychiatry, if this task could be performed at all. However, accurate prediction in an individual case cannot be grounded in a percentage applicable only to group behavior.

In view of their inherent unreliability, the commitment standards as they are presently structured may be subject to attack as authorizing criminal sanctions on the basis of a standard which is unconstitutionally vague. Thus, in *Lanzetta v. New Jersey*[146] the Supreme Court of the United States held that an offense entailing criminal sanctions must be adequately defined so that those who are subject to it may be informed as to what the state commands or forbids. The statute struck down in *Lanzetta* attempted to make being "a gangster" a criminal offense. Applying the ruling to the emergency commitment context would require some development of the analogies between being declared a mentally ill person and being declared a gangster. Comparison might be drawn between the consequences of the respective labels—incarceration,[147] stigmatization, and the institutional setting to which application of the lable subjects the designated person.

Mr. Justice Douglas, concurring in *Robinson v. California*,[148] expressed his belief that the designation of a person as a "criminal" was an important distinction between criminal convictions and therapeutic judgments, stating that "[w]hile afflicted people may be confined either for treatment or for the protection of society, they are not branded as criminals."[149] On the other hand Judge Howard Zieman, speaking before the California State Senate Judiciary Subcommittee, noted that the public is so wary of mental illness that it is easier for an ex-convict to find employment than for a former mental patient.[150] Mr. Bruce Ennis,

146. 306 U.S. 451 (1939).

147. A report on Lessard v. Schmidt comments that "In actions for involuntary commitment, the interest involved is the loss of freedom through involuntary incarceration." 2 POV. L. REP. ¶ 16, 255, at 16, 720 (1972). The Lessard court noted that a person hospitalized for mental illness loses many civil rights, such as the right to contract, marry and to vote, and that in some respects, such as the loss of a driver's license, "the civil deprivations which follow civil commitment are more serious than the deprivations which accompany a criminal conviction." Lessard v. Schmidt, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972).

148. 370 U.S. 660 (1962).

149. *Id.* at 668-69.

150. L.A. Times, July 11, 1962, sec. 1, at 26, col. 1.

Director of the New York Civil Liberties Union and for several years an advocate in civil commitment cases has written that "Society's fear of the mentally ill is so great that *any* commitment to a mental hospital, no matter how informal, creates a terrible stigma. Hospitalization, even *voluntary* hospitalization, is an almost absolute bar to public employment."[151] In *Lessard v. Schmidt*, a Wisconsin federal district court also declared that the problems that follow a person committed for mental illness after release from the hospital can be greater than those following a released felon:

> Perhaps the most serious possible effect of a decision to commit an individual lies in the statistics which indicate that an individual committed to a mental institution has a much greater chance of dying than if he were left at large.[152]

The analogy between hospitalization and imprisonment may also provide a basis upon which to apply the Supreme Court's holding in *In re Gault*,[153] which may be argued as forbidding the relaxation of criminal procedural safeguards in cases of involuntary emergency and long-term commitment. The Court in *Gault* described the consequences of consignment to a juvenile home and concluded that the reality of such confinement effectively undercut any rationale for procedural laxity based upon the nominally benign purpose of the proceedings.[154] The *Lessard* court, rejecting the contention that less stringent procedural safeguards may be employed in commitment proceedings because such proceedings are civil rather than criminal, concluded that "that argument should have been laid to rest after the decision of the Supreme Court in *In re Gault*."[155]

Gault and related cases may also indicate that given the actual facts concerning the type of incarceration mental patients suffer and the possibility of indefinite confinement following emergency commitment, suspension of procedural safeguards in commitment proceedings is constitutionally impermissible. Again, the *Lessard* court concluded that "[s]trict adherence to stringent procedural requirements and narrow, precise standards were necessary in involuntary commitment actions."[156]

Based on our analysis of psychiatry as unscientific and men-

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151. Ennis, *supra* note 22, at 110 (footnotes omitted).
152. Lessard v. Schmidt, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972).
153. 387 U.S. 1 (1967).
154. *Id.* at 27-28.
155. Lessard v. Schmidt, 349 F. Supp. 1078, 1088 (E.D. Wis. 1972). *See also* Specht v. Patterson, 386 U.S. 605, 608 (1967) and Denton v. Commonwealth, 383 S.W.2d 681, 682 (Ky. 1964).
156. Lessard v. Schmidt, 2 POV. L. REP. ¶ 16, 255, at 16, 720 (1972).

tal illness as an arbitrary concept, we would favor the abolition of involuntary mental hospitalization. Involuntary commitment of those considered dangerous should be based on specific violations of the criminal law. However, assuming *arguendo* the continued acceptance in our society of the concept of mental illness, it should nevertheless be possible to devise a system of detention which is not based on inherently vague criteria. In addition, there is no demonstrable need for the suspension of ordinary procedural safeguards and the immediate imposition of an involuntary treatment program which may effectively and forever prejudice the prospect of a fair hearing. While the question of specific standards which would justify involuntary commitment is problematic, it may be possible for legislatures to devise a standard of "specific past acts." Under this standard, the "mentally ill" could be involuntarily confined only when found guilty of certain threatening or injurious acts. Under such a system, it might in practice be impossible to eliminate some dependence on the medical profession for differentiating persons accused of mental illness from criminal defendants; however, the determination of which of the mentally ill could be involuntarily confined and treated would depend on a legislatively established standard to be applied by a judge or jury.

Assuming the existence of a "specific past acts" standard or some more general nonmedical standard of dangerousness, what safeguards should an emergency commitment statute properly include? To make the availability of procedural safeguards meaningful, a person would have to be found guilty by a judge or jury prior to any involuntary hospitalization. The Indiana provision for the emergency commitment of "dangerous" or "violent" persons provides some basis for considering the prospect of immediate hearings in emergency commitment cases.[157] Allegedly dangerous persons are served with a warrant and brought before a judge for immediate examination. If the examiner finds that the person is dangerous, he may issue an order for incarceration in a jail "or suitable place of detention." Allegedly "violent" persons are also given an immediate hearing if the person, "unless restrained, will cause injury to his family or other persons." An immediate hearing would be desirable if the accused requests it, and should therefore be available upon his request. Whether an immediate hearing is required or optional, a hearing should also be available within 24 hours of apprehension if desired by the accused. Presently a judicial order must be obtained within 48 hours in South Carolina and within 24 hours in Texas after a per-

157. IND. ANN. STAT. § 22-1222 (1964).

son accused of mental illness has been taken into protective custody by a public officer.[158] At least the option of an early hearing is advisable to minimize the effects of detention and prevent the emergency commitment order from fulfilling its own prediction due to the unsettling consequences of admission to the medical detention facility.

As a second approach to the problem of prejudicial early treatment it would seem appropriate to authorize temporary detention in a jail, or better still, in a separate but nonmedical detention facility, which would serve to put the person on notice that he was about to be involved in an adversary proceeding in which his liberty would be at stake. Medical examinations could be made available to insure that there is not some physiological or ordinary medical cause for the accused person's behavior. This approach seems prefereable, from a civil liberties perspective, to temporary detention and treatment in a mental institution. Such an approach would avoid early subjection to chemical tranquillization which may improve "manageability" at the expense of a person's right to a fair hearing. Any hearing should also require that the accused person have the right to be present and to cross-examine the witnesses against him. The *Lessard* court held that an individual's right to be heard at his commitment hearing could be prejudicial because of incapacity caused by medication or lack of counsel.[159] If medication may prejudice a person's ability to be heard, certainly his absence from the hearing will have a similar effect. The accused should have the option of attending his own hearing. Arguments to the contrary concerning the traumatic effect of the hearing simply are not persuasive against the realities of hospitalization, which surely are as traumatic as the hearing itself. In addition, the accused person should have an absolute right to refuse medication prior to trial or minimally, the trier of fact should be informed of the nature of medication employed and its typical side effects.

CONCLUSION

We urge the abolition of involuntary mental hospitalization in any form—long-term or emergency. Involuntary commitment as it is presently structured depends on a medical screening process which is arbitrary and subjective while being rationalized as scientific and objective. Emergency medical commitment is particularly susceptible to this criticism in that it provides for con-

158. S.C. CODE ANN. § 32-957 (Supp. 1972); TEX. REV. CIV. STAT. ANN. art. 5547-27 (Supp. 1972).

159. Lessard v. Schmidt, 349 F. Supp. 1078, 1090-92 (E.D. Wis. 1972).

finement on the basis of medical authority prior to the availability of procedural safeguards. Such emergency commitment, because of the effects of treatment and the subjective factors influencing diagnosis during the period of temporary detention, may have the result of fulfilling its own prediction that an individual is mentally ill. In the absence of total abolition of involuntary commitment of the "mentally ill," legislators should strive to develop more specific standards upon which to base a judgment of commitment, and courts should require stringent procedural safeguards in order to protect the constitutional rights of those accused of mental illness.