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# Criteria in Civil Commitment Proceedings

Robert T. Benton

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## CRITERIA IN CIVIL COMMITMENT PROCEEDINGS

ROBERT T. BENTON\*

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### I. INTRODUCTION

More than 800,000 persons are presently in public and private mental hospitals or in psychiatric wards in general hospitals in the United States.<sup>1</sup> Of this number, some 90% are confined by virtue of having been subjects of involuntary commitment proceedings.<sup>2</sup> It is estimated that 20,000,000 Americans "will at some time . . . have some form of mental or emotional illness."<sup>3</sup> The problem of formulating criteria to be applied

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1. Nat'l Ass'n for Mental Health, Inc., Facts About Mental Illness in *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st & 2d Sess., 502 (1970) [hereinafter cited as *1970 Hearings*]. In 1957, there were some 1,430,000 persons in mental health facilities. F. LINDMAN & D. MCINTYRE, *THE MENTALLY DISABLED AND THE LAW* (1961) [hereinafter cited as *LINDMAN*]. For statistics broken down by states showing steadily declining number of patients per 100,000 population in recent years, see Birnbaum, *A Rationale for the Right*, 57 GEO. L.J. 752, 781 (1969).

2. J. KATZ, J. GOLDSTEIN & A. DERSHOWITZ, *PSYCHOANALYSIS, PSYCHIATRY AND LAW* 466 (1967) [hereinafter cited as *KATZ*]. A person may enter a mental institution under involuntary procedures even when he does not object to confinement; conversely, persons entering voluntarily may not be free to leave.

3. *1970 Hearings*, *supra* note 1, at 502.

in civil commitment proceedings is, then, a problem of great practical significance.

An important problem in establishing appropriate standards for civil commitment is that of preserving, so far as possible, the traditionally protected civil liberties and the values of fairness and evenhandedness fostered by the law. On the other hand, the community has an important interest in the maintenance of peace and good order, an ideal which the law has traditionally sought to achieve, but one which certain types of noncriminal behavior have tended to frustrate. This article will discuss legal criteria which, hopefully, may help society attain its overall goals while protecting the rights of the individual.

## II. EQUAL PROTECTION OF THE LAW

Involuntary commitment to mental institutions occurs in a number of legal contexts, notably upon a finding of incompetency to stand trial<sup>4</sup> and after acquittal by reason of insanity.<sup>5</sup> Although commitment in such situations has been viewed as presenting different problems than those which "ordinary" civil commitment presents, the courts have recently rejected many distinctions formerly made between criminal and civil commitment. This change in attitude has been in response to the United States Supreme Court's ruling in *Baxstrom v. Herold*.<sup>6</sup> There, a prisoner sentenced to two and a half to three years imprisonment in New York was certified insane after serving a little more than a year of his sentence. Upon the expiration of his sentence, he was transferred to an institution for the criminally insane, after which he petitioned for habeas corpus. In reversing the second denial of Baxstrom's petition for habeas corpus, the Court rested its decision on equal protection grounds. Under New York law, "[a]ll persons civilly committed . . . other than those committed at the expiration of a penal term, are expressly granted the right to *de novo* review by jury trial of the question of their sanity. . . ."<sup>7</sup> Since "[e]qual protection . . . does require that a distinction made have some relevance to the purpose for which the classification is made . . ."<sup>8</sup> and since "in the context of the opportunity to show whether a person is mentally ill *at all* . . ."<sup>9</sup> the distinction between criminally insane and civilly insane "had no relevance whatever,"<sup>10</sup> the failure to afford Baxstrom the procedural safeguards available to persons not convicted of crime was held a denial

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4. See KATZ, *supra* note 2, at 566-93; LINDMAN, *supra* note 1, at 357-66; A. MATTHEWS, JR., MENTAL DISABILITY AND THE CRIMINAL LAW 72-100 (1970) [hereinafter cited as MATTHEWS].

5. See KATZ, *supra* note 2, at 593-629; LINDMAN, *supra* note 1, at 330-55; MATTHEWS, *supra* note 4, at 22-71.

6. 383 U.S. 107 (1966).

7. *Id.* at 111.

8. *Id.*

9. *Id.*

10. *Id.*

of equal protection of the laws. Additionally, when a prisoner is committed under New York law, the decision of whether to incarcerate him in a civil institution or in a criminal institution is made without a hearing, whereas a civilian can be committed to an institution for the criminally insane only after a hearing and upon a showing of dangerousness. For this reason, too, the Court found a denial of equal protection.

Later the same year, the New York Court of Appeals held that a statute directing the commitment of persons acquitted of crimes by reason of insanity should be read to require the same procedural safeguards available to persons never accused of crime.<sup>11</sup> In the District of Columbia, the same result was reached in *Bolton v. Harris*.<sup>12</sup> However, in *Bolton* the court eschewed a "[r]igid application of the equal protection doctrine."<sup>13</sup> It reasoned that the finding of insanity at the time of the commission of the act with which a defendant is charged affords sufficient basis for a temporary commitment for observation purposes. This is simply a parallel to the familiar presumption of continuing incompetency.<sup>14</sup> Less easily understood are the remarks of the court on the question of procedures for release. The court found that judicial review, with an opportunity for the government to object to release, should be required for patients whose original commitment followed a successful insanity defense. This would be true even in situations where more expeditious procedures are available to patients whose original commitment occurs in different settings. It is not clear, however, why equal protection of the laws should require equal safeguards against unwarranted confinement, but not against the unwarranted prolonging of confinement.

Paralleling the decision on procedures applicable after a successful plea of not guilty by reason of insanity, at least one court has held that "[t]he procedure for committing an accused but unconvicted felon should contain safeguards at least equivalent to those provided in the procedures for civil commitment."<sup>15</sup> There is dictum to the same effect in *Commonwealth v. Druken*.<sup>16</sup> In that case, the question was whether, after conviction for a crime, it was permissible to incarcerate a person in a mental institution (rather than a prison) without affording him the procedural safeguards "applicable to all other inhabitants not convicted of crime."<sup>17</sup>

11. *People v. Lally*, 19 N.Y.2d 27, 224 N.E.2d 87, 277 N.Y.S.2d 654 (1966). See also *In re Commitment of Anonymous*, 69 Misc. 2d 181, 329 N.Y.S.2d 542 (Sup. Ct. 1972).

12. 395 F.2d 642 (D.C. Cir. 1968). See also *Cameron v. Mullen*, 387 F.2d 193 (D.C. Cir. 1967); *Cameron v. Fischer*, 320 F.2d 730 (D.C. Cir. 1963).

13. *Bolton v. Harris*, 395 F.2d 642, 651 (D.C. Cir. 1968).

14. Cf. FLA. STAT. § 393.12 (1971).

15. *Miller v. Blalock*, 411 F.2d 548, 549 (4th Cir. 1969).

16. 356 Mass. 503, 254 N.E.2d 779 (1969).

17. *Id.* at 507, 254 N.E.2d at 781. Last term, the Supreme Court held that a person accused of a crime but adjudged incompetent to stand trial may be detained only for "the reasonable period of time necessary to determine whether there is a substantial probability that he will . . . [regain his competency] in the foreseeable future." *Jackson v. Indiana*, 92 S. Ct. 1845, 1858 (1972). After this point equal protection requires that the accused be afforded the same procedural rights as are available to subjects of civil commitment pro-

The court decided that the principle of *Baxstrom v. Herold* extended to this situation, and held that Druken was entitled to the benefit of the same procedures provided for in the Massachusetts civil commitment statute.

### III. CURRENT STATUTORY CRITERIA

Statutory definitions of "mental illness" and other criteria for involuntary commitment are characteristically broad, vague and circular. Texas, for example, defines a "mentally ill person" . . . [as] a person whose mental health is substantially impaired.<sup>18</sup> The commitment laws of every state require, *inter alia*, the existence of mental illness or some equally vague variant;<sup>19</sup> and the statutes of seven states have this as their sole criterion.<sup>20</sup> Massachusetts, until recently, had the distinction of being the only state to authorize involuntary commitment of a person "likely to conduct himself in a manner which clearly violates the established laws, ordinances, conventions or morals of the community."<sup>21</sup> The law now requires that the person be a proper subject for treatment and custody.<sup>22</sup> In seven other states, the sole criterion (in addition to mental illness) is that a person be in need of care or treatment.<sup>23</sup> In Kansas, a person must be in need of care or treatment and be "or probably . . . become dangerous to himself or the person or property of others."<sup>24</sup>

Eleven states require both dangerousness and need of treatment.<sup>25</sup> Eight states and the District of Columbia specify that the person be dangerous as well as mentally ill.<sup>26</sup> Involuntary hospitalization is authorized in Arkansas, Georgia, and Louisiana if the subject is dangerous or if it appears that hospitalization is required for his own welfare.<sup>27</sup> The statutes of seven states call for involuntary commitment when required for the welfare of the subject or of other persons.<sup>28</sup> Similarly, Florida law

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ceedings, unless it can be demonstrated that efforts to enable the accused to stand trial result in "progress toward that goal." *Id.*

18. TEX. REV. CIV. STAT. ANN. art. 5547-4(k) (Supp. 1972).

19. See note 20 *infra*.

20. Delaware, Hawaii, Michigan, North Dakota, South Dakota, Tennessee, and West Virginia. LINDMAN, *supra* note 1, at 17, 49-51; Project, *Civil Commitment of the Mentally Ill*, 14 U.C.L.A.L. REV. 822, 872-73 (1967); S. BRAKEL & R. ROCK, *THE MENTALLY DISABLED AND THE LAW* 34-64 (rev. ed. 1971) [hereinafter cited as BRAKEL].

21. Act of August 4, 1955, ch. 123, § 1, [1955] Mass. Gen. Laws (repealed 1971).

22. MASS. GEN. LAWS ANN. ch. 123, § 1 (Supp. 1972).

23. Iowa, Missouri, Oklahoma, Oregon, Pennsylvania, South Carolina, and Wisconsin.

24. KAN. STAT. ANN. § 59-2902(1) (Supp. 1971).

25. Alaska, Connecticut, Idaho, Illinois, Kentucky, Maine, New Mexico, Ohio, Utah, Vermont, and Wyoming.

26. Arizona, California, Montana, Nebraska, Nevada, New Hampshire, North Carolina, and Washington.

27. ARK. STAT. ANN. ch. 59, § 417 (1947); GA. CODE ANN. § 88-507.1 (1971); LA. REV. STAT. § 28:53 A (Supp. 1972).

28. Alabama, Indiana, Minnesota, New Jersey, New York, Rhode Island, and Virginia.

provides: "A person may be involuntarily hospitalized if he is mentally ill and likely to injure himself or others if not hospitalized."<sup>29</sup>

#### IV. PROCEDURES: MORE IMPORTANT THAN STATUTES

Because the statutory criteria fail to "specify independent, objective distinctions between those who require intervention [by the state in the form of commitment] and those who do not,"<sup>30</sup> they reveal little of what considerations actually underlie decisions about commitment. For this reason, the procedural law assumes paramount importance: "Who decides what, based on what information, and under what circumstances—these procedural issues in aggregate *are* the substantive law of commitment proceedings."<sup>31</sup>

Procedural variations from jurisdiction to jurisdiction are more pronounced than are variations in the formal statutory designations of the class of persons subject to involuntary commitment. They may be subdivided into two general categories on the basis of the nature of the public authority under whose auspices they are conducted—judicial commitment, which is more common,<sup>32</sup> and administrative commitment by medical certification. One state may use both procedures, and most states provide alternative routes into their mental institutions.

#### V. ROADS TO THE ASYLUM DOOR

##### A. *Voluntary Admission*

Professor Ross, in his article on commitment proceedings, has separated hospitalization procedures into six categories. The first category is voluntary admission, which he explains as follows:

This involves a written request for admission by a patient who is competent to make such a request. A number of states also authorize the parent or guardian of a minor to make the application. In most states, the patient may be detained, either for a fixed period after admission (typically 60 days), or for a brief period after he requests release (typically 10 days).<sup>33</sup>

29. Fla. Laws 1971, ch. 71-131, § 9(1), *creating* FLA. STAT. § 394.467(1) (1971). *See* Fla. Laws 1971, ch. 71-131, *amending* FLA. STAT. § 744.31 (1969); *creating* FLA. STAT. §§ 394.451, 394.453, 394.455, 394.459, 394.461, 394.463, 394.465, 394.467, 394.469, 394.471, 394.473, 394.475, and 394.477 (1971); *repealing* FLA. STAT. §§ 394.01, 394.011, 394.012, 394.013, 394.02, 394.03, 394.031, 394.04-.18, 394.191-.192, 394.20, 394.201, 394.23, 394.25, 394.251, 394.26-.27, 394.271-.272, 394.39-.43, 394.45 (1969), FLA. STAT. §§ 394.22 and 394.24 (Supp. 1970); *transferring* FLA. STAT. § 402.10 (1969) to FLA. STAT. § 394.457 (1971) [hereinafter cited as the Baker Act].

30. R. ROCK, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 11 (1968) [hereinafter cited as ROCK].

31. *Id.* at 18.

32. *Id.* at 41.

33. Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 953 (1959) [hereinafter cited as Ross]. Professor Ross treats admission by guardian

The issue of competency may present a problem in the context of involuntary admissions. However, there is virtual unanimity in the view that voluntary submission to treatment is both medically<sup>34</sup> and legally<sup>35</sup> desirable. Therefore, strong policy considerations militate in favor of judicial or, preferably, legislative recognition of competency for the purpose of voluntary admission. In Florida, The Baker Act recognizes such competency by implication.<sup>36</sup> The only countervailing consideration is that in some other jurisdictions, admission to a mental institution, even when voluntary, results in the automatic suspension of civil rights.<sup>37</sup> In light of "findings [which] suggest that the client is brought into therapy solely by subjective feelings of discomfort with himself [when therapy is voluntarily sought] rather than by 'reality' factors,"<sup>38</sup> there is an element of unfairness in permitting a person to take the drastic step of forfeiting his civil rights when he is feeling out of sorts. The rule of automatic forfeiture is widely condemned,<sup>39</sup> and it seems clear that the best way to eliminate the problem is to eliminate the rule itself, as has been done in Florida.

Voluntary procedures are rarely used. One reason is uncertainty concerning the legal efficacy of voluntary commitment and the possible corresponding liability for false imprisonment. In addition, the decision to accept an applicant for voluntary admission is generally in the "essentially unfettered discretion"<sup>40</sup> of an institution's personnel, who are inclined to reject such applications both because mental institutions are characteristically badly overcrowded and because voluntary procedures create administrative difficulties that coercive procedures avoid.<sup>41</sup> Persons voluntarily admitted are likely to ask for release soon after arrival. Many are ambivalent about submitting to institutionalization in the first instance, and they are often disappointed by the nature and extent of

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as a separate category: "A number of states authorize the guardian of an adjudicated incompetent to commit the ward to a mental hospital, either with or without the consent of the court which supervises the guardian." *Id.*

34. *E.g.*, Mendel & Rapport, *Determinants of the Decision for Psychiatric Hospitalization*, 20 ARCHIVES OF GENERAL PSYCHIATRY 321 (1969) [hereinafter cited as Mendel].

35. *E.g.*, Comment, *Liberty and Required Mental Health Treatment*, 114 U. PA. L. REV. 1067, 1074 (1966).

36. The Baker Act, Fla. Laws 1971, ch. 71-131, § 8(1)(a), *creating* FLA. STAT. § 394.465 (1)(a) (1971). See note 29 *supra*.

37. LINDMAN, *supra* note 1, at 235-39. In Florida, a separate proceeding is required in order to limit the rights of a mentally ill person "to the same extent the rights of any incompetent person are limited by general law." The Baker Act, Fla. Laws 1971, ch. 71-131, § 5(1), *creating* FLA. STAT. § 394.459(1) (1971). Such proceeding must be conducted pursuant to the Baker Act, Fla. Laws 1971, ch. 71-131, § 12, *amending* FLA. STAT. § 744.31 (1971). See note 29 *supra*.

38. Terwilliger & Fiedler, *An Investigation of Determinants Inducing Individuals to Seek Personal Counseling*, 22 J. CONSULTING PSYCH. 288 (1958).

39. *E.g.*, KATZ, *supra* note 2, at 468.

40. ROCK, *supra* note 30, at 34.

41. Administrators in Florida apparently have broad discretion in accepting voluntary patients. The Baker Act, Fla. Laws 1971, ch. 71-131, § 8(1), *creating* FLA. STAT. § 394.465(1) (1971). See note 29 *supra*.

the facilities provided for their care. Statutes that make a minimum stay mandatory are designed, in part, to foster the principle of voluntary admissions by making such admissions administratively feasible. Paradoxically, statutes that require voluntary patients' release immediately upon request have a tendency to defeat the policy of voluntary admissions since the institutions are likely to refuse applications in the first place. This necessitates resort to other (involuntary) procedures to effect admission.<sup>42</sup>

Another purpose served by statutes requiring a minimum stay, and the primary purpose of statutes requiring a person to stay for a week or more after requesting release, is to afford the authorities opportunity to institute proceedings for involuntary detention. These statutes constitute a strong deterrent to voluntary admissions to the extent they are known to the patient in advance. Indeed, they may be administered in such a fashion as to make voluntary stays in mental institutions voluntary in name only.<sup>43</sup> The effect of present practices is that in many jurisdictions persons unable to afford private hospitalization—the *per diem* cost starts at \$50, exclusive of drugs and doctors' fees<sup>44</sup>—are unable to obtain admission to a mental hospital except by involuntary commitment proceedings. A satisfactory alternative would be a rule providing that a person voluntarily admitted and later released at his own insistence not be permitted voluntarily to re-enter for a six month period, coupled with a rule requiring automatic acceptance of voluntary applicants not disqualified by previous release.<sup>45</sup> This rule would permit the repeal of the minimum-stay and stay-after-request statutes. In addition to humanitarian policies requiring workable, genuinely voluntary procedures, the law has a compelling interest in such procedures. Judicial resources should focus on the serious issues raised by involuntary commitment, without the distraction of cases where commitment is clearly voluntary.

### B. *Non-Contested Admission*

Non-contested admission is explained by Professor Ross, as follows:

This procedure is sometimes referred to as "involuntary admission." Non-contested admission is not the same as voluntary admission, since no affirmative action is required of the patient, nor is it compulsory since a protest by the patient is effective. A number of states authorize the hospital to receive a patient who is presented for admission by a friend, relative or physician. If he protests at the time of admission, he may not be received,

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42. ROCK, *supra* note 30, at 34-38.

43. LINDMAN, *supra* note 1, at 113-14. T. SZASZ, LAW, LIBERTY AND PSYCHIATRY 40 (1963).

44. ROCK, *supra* note 30, at 57.

45. If the officials feel hospitalization would be inappropriate they would, of course, be free to suggest alternatives. Adequate counselling "at the hospital door" should minimize unwarranted admissions.



and if he protests after admission, he must be discharged within a short period, or compulsory proceedings must be instituted.<sup>46</sup>

Procedures of this kind permit the operation of medical-administrative machinery to dispose of the "normal run" of cases while preserving for judicial consideration those cases where the element of protest exists in fact. This is a desirable procedure both for ease of administration, and for safeguarding individual liberty.<sup>47</sup> Non-protested admission is not possible under Florida law. However, the written waiver provisions of section 9(2) of The Baker Act permit transfer from temporary<sup>48</sup> to full-time<sup>49</sup> involuntary status without judicial participation, unless the aid of the courts is invoked by the subject of the proceedings.

If non-protested admissions procedures are to foster the principle of voluntariness, it is crucial that persons be given notice of their right to, and an effective means of invoking, a judicial determination before confinement. New York has sought to meet these needs by establishing an administrative agency, the Mental Health Information Service.<sup>50</sup> The

46. Ross, *supra* note 33, at 953.

47. Rock, *supra* note 30, at 174-86.

48. Persons detained for court-ordered evaluation pursuant to § 7(2) of the Baker Act have this temporary involuntary status. Fla. Laws 1971, ch. 71-131, § 7(2), *creating* FLA. STAT. § 394.463(2) (1971). See note 29 *supra*.

49. The Baker Act, Fla. Laws 1971, ch. 71-131, § 9(2), *creating* FLA. STAT. § 394.467(2) (1971). § 9(2) provides that this "full-time" involuntary status shall not exceed six months. After this period, "the administrator shall apply to the hearing examiner for an order authorizing continued hospitalization." *Id.*

50. N.Y. MENTAL HYGIENE LAW § 88 (McKinney Supp. 1966). The New York procedures are based on medical certification and are premised on the legitimacy of compulsory hospitalization in a wide spectrum of situations. New York's "Mental Hygiene Law dispenses with notice and a hearing prior to institutionalization." Note, *The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill*, 67 COLUM. L. REV. 672, 685 (1967) [hereinafter cited as *A New Approach to Hospitalization*]. The policy behind these provisions is predicated on a fear of the supposed "debilitating effect such hearings would have on the patient as well as [their] antitherapeutic nature." Note, *Hospitalization of the Mentally Ill: Due Process and Equal Protection*, 35 BROOKLYN L. REV. 187, 195 (1969). They have been upheld against constitutional attack. In the Matter of Coates, 9 N.Y.2d 242, 173 N.E.2d 797, 213 N.Y.S.2d 74, *appeal dismissed sub nom.* Coates v. Walters, 368 U.S. 34 (1961). *But cf.* Fhagen v. Miller, 29 N.Y.2d 348, 278 N.E.2d 615, 328 N.Y.S.2d 393 (1972); Narcotic Addiction Control Comm'n v. James, 22 N.Y.2d 545, 240 N.E.2d 29, 293 N.Y.S.2d 531 (1968); 75 HARV. L. REV. 847 (1962). See generally Kittrie, *Compulsory Mental Treatment and the Requirement of "Due Process,"* 21 OHIO ST. L.J. 28 (1960).

Once inside a mental institution in New York, having been certified mentally ill by two physicians, "the patient is entitled, upon request, to judicial review of his confinement . . . and the statute requires that written notice of the right to a hearing, and of various other rights retained by the patient, be given upon admission." *A New Approach to Hospitalization*, *supra* at 685; N.Y. MENTAL HYGIENE LAW § 72(2)-(3) (McKinney Supp. 1966). Thus, procedures under New York law present the same mechanical problems as (noncompulsory) non-protested admissions procedures. In addition to service of written notice on the patient as part of the admissions procedures, notice is served on "the nearest relative . . . and to as many as three additional persons if designated [by the patient] . . ." N.Y. MENTAL HYGIENE LAW § 72(2) (McKinney Supp. 1966). Finally,

[Mental Health Information] service personnel explain to patients their various rights . . . . If the patient is temporarily incapacitated, the Service representative will return later and convey information. The explanation assures that the patient

use of an agency modeled after New York's Mental Health Information Service seems to offer an appropriately sensitive means of removing persons wishing to oppose commitment from what is essentially a medical-administrative admissions process, without unduly impairing its efficiency. In view of the fact that there are "a very large number . . . [of persons entering mental institutions] who do not object to hospitalization but who do not qualify as voluntary patients,"<sup>51</sup> there is much to be said for non-protested admissions procedures, as long as they include adequate provisions for judicial review of protested commitments.

### C. *Short-Term Involuntary Commitment*

The next two types of hospitalization procedure in Professor Ross' classification are:

#### *Temporary [Observational] Commitment:*

This is the newest of the compulsory procedures and is primarily a device for diagnostic screening, although it is also used for short-term treatment. It developed from the older emergency procedures, but is not based on the existence of a clear emergency. The procedure is summary and authorizes detention for a limited period.

#### *Emergency Commitment:*

Almost every state has some authorization for compulsory commitment to a mental hospital in emergency cases, where the patient may be dangerous to himself or others and needs immediate care. The procedure is summary and permits detention only for a short period.<sup>52</sup>

Florida law provides for both involuntary emergency admission and involuntary observational commitment. The substantive criteria for emergency admission require that a person be held involuntarily only if "because of [his mental] illness, [he] is likely to physically injure himself or others if he is not immediately detained."<sup>53</sup> Involuntary emergency admissions may be effected judicially by an *ex parte* order, or by the certificate of a physician who has personally examined the subject within the preceding forty-eight hours. Finally, a law enforcement officer "may

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has sufficient information to make a knowing decision whether to contest his confinement. If the patient's condition prevents him from understanding the notice but does not preclude a release—for example, where a senile patient can be sheltered by a friend or relative—the service can request a hearing on his behalf.

*A New Approach to Hospitalization, supra* at 685-86.

In the event a person decides to contest his commitment, Service personnel gather data on "personal history, family background, financial status, and availability of area health facilities." *Id.* at 688. Armed with this, "a[n] MHIS representative attends every hearing contesting a mental patient's confinement . . ." *Id.* at 689.

51. Rock, *supra* note 30, at 38.

52. Ross, *supra* note 33, at 953.

53. The Baker Act, Fla. Laws 1971, ch. 71-131, § 7(1)(a), *creating* FLA. STAT. § 394.463 (1)(a) (1971). See note 29 *supra*.

take into custody a person who appears to meet the criteria for emergency admission."<sup>54</sup>

A person incarcerated under the emergency admission procedure must be examined promptly by a physician. If he is not examined within twenty-four hours, he must be released.<sup>55</sup> If he is examined, further detention pending court-ordered evaluation is authorized "when the examining physician concludes that there is reason to believe that the patient may require evaluation."<sup>56</sup> However, The Baker Act does not specify how promptly proceedings brought to obtain a court-ordered evaluation must be initiated.

Such proceedings require a hearing (unless waived) after notice to the person sought to be detained for evaluation and to his guardian. If there is no guardian, notice is given to two representatives selected from a statutory list.<sup>57</sup> The subject has a right to be represented by counsel at the hearing; if he is indigent, counsel will be appointed.<sup>58</sup> The standard for court-ordered evaluation is whether "there is reason to believe that he is mentally ill and a danger to himself or others."<sup>59</sup> Incarceration for this purpose may not exceed five days.<sup>60</sup>

#### D. Long-Term Involuntary Commitment

Despite the fact that legislation in many states provides a variety of procedures for hospitalization, procedures other than formal involuntary commitment are seldom used. One reason for this is the administrative problems voluntary procedural alternatives involve; another is widespread ignorance on the part of social welfare agencies, the police, doctors and lawyers, of the fact that procedural options other than involuntary commitment exist.<sup>61</sup>

The practice in Chicago in the early nineteen-sixties affords an example of administrative rigidity transforming statutory options into the uniform practice of involuntary commitment. Even though "[t]he Illinois statutes [then in force]<sup>62</sup> clearly provide[d] the alternative of voluntary

54. The Baker Act, Fla. Laws 1971, ch. 71-131, §§ 7(1)(b)(2), 7(1)(b), *creating* FLA. STAT. §§ 394.463(1)(b)(2), 394.463(1)(b) (1971). See note 29 *supra*.

55. The Baker Act, Fla. Laws 1971, ch. 71-131, § 7(1)(d), *creating* FLA. STAT. § 394.463(1)(d) (1971). See note 29 *supra*.

56. *Id.*

57. The Baker Act, Fla. Laws 1971, ch. 71-131, § 7(2)(c), *creating* FLA. STAT. § 394.463(2)(c) (1971). See note 29 *supra*.

58. *Id.*

59. The Baker Act, Fla. Laws 1971, ch. 71-131, § 7(2)(a), *creating* FLA. STAT. § 394.463(2)(a) (1971). See note 29 *supra*.

60. The Baker Act, Fla. Laws 1971, ch. 71-131, § 7(2)(e), *creating* FLA. STAT. § 394.463(2)(e) (1971). See note 29 *supra*.

61. "[T]he initiation of public hospitalization is generally viewed as a mysterious process about which little is accurately understood and about which it is difficult to obtain reliable information." ROCK, *supra* note 30, at 77.

62. ILL. ANN. STAT. ch. 91½, § 5-8 (Smith-Hurd 1956). The current law is ILL. ANN. STAT. ch. 91½, §§ 1-1 to 20-1 (Smith-Hurd Supp. 1972).

admission, even after the judicial procedure ha[d] begun,"<sup>63</sup> procedures at the Cook County Mental Health Clinic, which operated as a screening agency for the state mental institutions receiving persons from the Chicago area, had "become mechanical, unthinking, routine"<sup>64</sup> and unvaryingly involuntary. A petition for commitment, executed by a third party, and the certificate of one physician were necessary to meet the Illinois requirements for involuntary commitment. A person seeking hospitalization who presented himself *voluntarily* at the Cook County facility without either of these documents was erroneously advised of their necessity and turned away.<sup>65</sup>

Aside from the inflexible use of involuntary procedures, the practices in Chicago are of interest in two respects. The statutory provision for three independent assessments of a person's situation—by the clinic psychiatrists, by the commission doctors, and at the judicial hearing—was not realized in practice. In fact, what may be deemed the only real evaluation—the interview by the clinic psychiatrists—was a cursory one.<sup>66</sup> This can be explained, in part, as a manifestation of the familiar problem of inadequate resources. Another factor, however, was the diffusion of decision-making authority. With so many different people authorized to decide on commitment, perhaps it is not surprising that no one

63. Rock, *supra* note 30, at 81.

64. *Id.* at 176.

65. *Id.* at 178. Persons coming to the clinic, either on their own or brought by some other person, who had the requisite documents were taken into custody.

66. The clinic's staff included a number of clerks and four psychiatrists whose responsibility it was to evaluate the 160 persons the clinic processed in an average week. Because of other responsibilities—administrative tasks and court appearances—the psychiatrists devoted "only a third of their time, or less . . . to making personal clinical evaluations." *Id.* at 179. On an average, then, less than twenty minutes per patient was available for psychiatric evaluation, although persons were confined at the clinic for a period of a week or 10 days. It is a common complaint that "the amount of time spent directly with the patient in information-gathering is confined to a small portion of the time the patient actually spends in the hospital" when committed for the purpose of observation. Hartlage, Freeman & Horine, *Expediting Admissions Procedures*, 53 MENTAL HYGIENE 71, 72 (1969).

The clinic psychiatrists' interviews with patients were the basis for their classifying them either as psychotic or not. If it was decided that a person was not psychotic, he was nonetheless detained until his hearing. Between the clinic interview and the hearing, there occurred an examination by a commission of two doctors who decided for or against commitment, "with their decision being subject to judicial confirmation." Rock, *supra* note 30, at 180. In this examination

The commission doctors interview[ed] the patient for less than five minutes and rel[ied] primarily upon the petition and the available ward charts from the clinic to reach their decision. The examinations . . . were . . . pro forma and seemed to be carried out only because they were required by the judge.

*Id.* at 181.

Written notice of the hearing was served on a patient one or two days in advance. The hearing itself was conducted on the clinic premises and was marked by its informality; witnesses were not sworn. The judge talked to the allegedly mentally ill person who was then excused, whereupon the petitioner and other witnesses were summoned and questioned. The questions were "ordinarily ones relating to the incident which precipitated the petition." *Id.* at 182. A single judge heard an average of 60 cases a day (he did not sit every day). *Id.*

really did decide the issue in a thorough and independent fashion. Until procedures like these are restructured to permit careful judicial scrutiny of underlying facts and rationale, as well as careful application of rules, there is little hope for resolution of the legal issues involuntary commitment creates.

The second point of interest is that, under the Chicago procedures, the crucial stage was the determination by the clinic psychiatrist of whether or not a person suffered from "mental illness of psychotic proportions."<sup>67</sup> This "diagnosis . . . [was] transformed to a gross judgment of whether to commit."<sup>68</sup> The criterion for commitment actually used was not among the criteria specified by the applicable statute,<sup>69</sup> the term "psychosis" nowhere appearing in Illinois law. While the use of courts at some stage of commitment proceedings is a feature in most of the states, their role is often only a formal one as was the case in Chicago. Indeed, it has been said that "commitment is based upon a medical judgment in every case."<sup>70</sup>

In Florida, under The Baker Act, a judicial hearing on the question of formal commitment is available only after as many as three independent decisions in favor of commitment have been made by physicians and hospital administrators. Apparently, a person may be detained involuntarily for the time necessary to make these decisions, without prior notice or hearing.<sup>71</sup> He does, however, have a waivable right to a judicial hearing before formal commitment becomes final.<sup>72</sup> At this hearing he has a right to be represented by counsel even if he is indigent.<sup>73</sup> Notice of the hearing is given not only to the subject of the proceedings, but to his representatives or guardians as well.

## VI. THE IMPROPRIETY OF PSYCHIATRIC (DIAGNOSTIC) CATEGORIES AS CRITERIA

The practical consequences of treating involuntary commitment decisions as questions of "medical judgment" are to invite arbitrary results in individual cases and to obscure the legal issues involved. Neither "mental illness" nor "psychosis" is a satisfactory criterion for deciding whether or not an individual ought to be deprived of his liberty against

67. *Id.* at 180.

68. *Id.*

69. ILL. ANN. STAT. ch. 91½, § 1—8 (Smith-Hurd 1956).

70. ROCK, *supra* note 30, at 126.

71. *But cf.* The Baker Act, Fla. Laws 1971, ch. 71-131, § 9(2), *creating* FLA. STAT. § 394.467(2) (1971). See note 29 *supra*. That law provides that "[a] patient may be hospitalized . . . after notice and hearing, upon recommendation of the administrator . . ." (emphasis supplied). The section as a whole supports the text, although the matter is not free from doubt.

72. "If the patient does not waive a hearing . . . the judge . . . shall hold the hearing within five days unless a continuance is granted." The Baker Act, Fla. Laws 1971, ch. 71-131, § 9(3), *creating* FLA. STAT. § 394.467(3) (1971). See note 29 *supra*.

73. *Id.*

his will. The question of whether or not a person is ill is altogether different from the question of whether or not a person ought to be confined against his will.<sup>74</sup> Certainly this distinction is evident when dealing with physical disease. By establishing that a person is ill, grounds for prescribing treatment are afforded. But knowing whether or not a person is healthy is of little help in deciding whether or not to deprive him of his liberty by incarcerating him in an institution in disregard of his wishes.<sup>75</sup>

The argument that these criteria *are* proper is riddled with propositions that are philosophically difficult or factually implausible. The first proposition is that everyone ought to be healthy. As appealing as this prospect may sound, a number of problems are involved. First, health is not a scientific concept, but a cultural, ethical one.<sup>76</sup> Second, denying an individual the prerogative of being ill presents a political and ethical question distinct from whether it would be good for everyone to be healthy. Third, a necessary premise to this proposition is that involuntary commitment in mental institutions is an effective means of making persons healthy.<sup>77</sup> It is not at all clear that this is true; more than one

74. Professor Dershowitz graphically illustrates the irrational consequences of using psychiatric criteria as the basis for decisions about incarceration. Dershowitz, *Psychiatry in the Legal Process: A Knife that Cuts Both Ways*, 4 TRIAL 29 (Feb., March 1968).

75. "Whether or not these persons are sick, commitment is fundamentally a social question, and ought to be decided accordingly." Slovenko, *The Psychiatric Patient, Liberty, and the Law*, 121 AM. J. PSYCHIATRY 534, 537 (1964).

76. [O]ur concepts of disease are very closely related to our values . . . China, for example, did not regard as diseased those upper-class women whose feet were bound, and who thereby suffered pain and diminution in function. Our contemporary culture takes a different view. Which means that our conventions and values of health are different from the Chinese. In most of our western civilization the seeing of visions we consider a sign of a diseased state. But in some epochs of our civilization the seer of visions was a leader in the community, receiving special honor because of his unusual endowment. Certainly the egregious and unusual, the literally ab-normal, represent disease only if judged by indigenous cultural values. Convention plays a very important part in shaping our values. And the quantity of our knowledge plays a very important part in shaping our conventions.

Disease is the aggregate of those conditions which, judged by the prevailing culture, are deemed painful, or disabling, and which, at the same time, deviate from either the statistical norm or from some idealized status.

King, *What is Disease?*, 21 PHILOSOPHY OF SCIENCE 193, 197 (1954). Cf. Papanek, *Ethical Values in Psychotherapy*, 14 J. INDIVIDUAL PSYCH. 160, 161 (1958): "Psychotherapy can achieve its goal only if it helps the patient to establish a consistent set of ethical values . . ."

77. The last decade has seen the emergence of a "right to treatment" doctrine, which holds that a failure to afford treatment to a person involuntarily committed constitutes a denial of due process. The doctrine was first proposed by Dr. Martin Birnbaum. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960). See also Birnbaum, *A Rationale for the Right*, 57 GEO. L.J. 752 (1969); Comment, *Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633 (1967); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134 (1967); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967).

Two jurisdictions have received the doctrine favorably. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *Millard v. Cameron*, 373 F.2d 468 (D.C. Cir. 1966); *Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 233 N.E.2d 908 (1968). One jurisdiction has rejected it. *People ex rel. Anonymous v. La Burt*, 14 App. Div. 2d 560, 218 N.Y.S.2d 738 (1961). The decision, in each case, turned on statutory construction. *But see Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 611-13, 233 N.E.2d 908, 913

study has concluded that the results of hospitalization, even of voluntary, cooperative persons, has proved harmful rather than beneficial.<sup>78</sup> The adoption of health criteria as the sole basis for the commitment decision involves the judgment that it is immaterial that a person might be better cared for elsewhere in a manner more in keeping with his wishes. Moreover, "enforcing health" by committing the unhealthy to mental institutions would be the most comprehensive of undertakings: "Mental 'illness' is defined so broadly that every human being is at times mentally ill.

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(1968). See The Baker Act, Fla. Laws 1971, ch. 71-131, § 5(2), creating FLA. STAT. § 394.459 (2) (1971). See note 29 *supra*. The question is presented in habeas corpus proceedings where an inmate alleges inadequate treatment. No one has ever been released on the strength of such allegations even when they have been substantiated; instead, the courts have required that adequate treatment be given in the future, intimating that they will free the petitioners if it is not provided.

The sentiment on which the right to treatment doctrine is grounded is that conditions in mental institutions ought to be better than they are, a proposition with which few would quarrel. There is a logical difficulty with the doctrine, however. It is said, for example, "if medical attention . . . is not given [to a person involuntarily in a mental institution], the victim is not a patient but is virtually a prisoner." Editorial, *A New Right*, 46 A.B.A.J. 516, 517 (1960). Yet it must be clear that the categories "patient" and "prisoner" are not mutually exclusive. If a person is not free to leave he is in a very real sense imprisoned, however kindly he may be treated. The basic and distinct question of when the deprivation of an individual's liberty is justified other than as punishment for crime needs to be confronted and carefully worked through. The answer to this question, implicit in the right to treatment doctrine, is that a person may be incarcerated whenever it is possible to afford him treatment. It is highly unlikely that a careful working through of the problem would result in the acceptance of so broad a justification, and to the extent the doctrine of a right to treatment offers an inducement to the evasion of the task it is an unfortunate one.

There are, moreover, practical problems with the implementation of a right to treatment doctrine. Disagreement among psychiatrists as to what constitutes proper treatment is widespread and profound. Some psychiatrists take the position that simply being in the environment a mental institution provides is beneficial; they speak of "environmental" or "milieu" therapy. *E.g.*, KATZ, *supra* note 2, at 606-08. On the other hand, other psychiatrists state:

Studies . . . have shown that patients who are treated without the use of the hospital in the management of their acute and chronic illness tend to display less morbidity and make more satisfactory extramural adjustment than those who have been hospitalized.

Mendel, *supra* note 34, at 321.

The inference to be drawn from the frequency with which tranquilizing drugs are administered in mental institutions—see KATZ, *supra* note 2, at 466—is that this is thought by some psychiatrists to be appropriate therapy for nearly every class of patients, yet the use of these drugs is viewed by other psychiatrists as non- or anti-therapeutic, a replacement for the straightjacket of another day. 1970 Hearings, *supra* note 1, at 426; T. SZASZ, LAW, LIBERTY AND PSYCHIATRY 55 (1963). The great range of psychiatric technique—from frontal lobotomies, which are no longer in vogue but are not unheard of,<sup>a</sup> to "poetry therapy"<sup>b</sup> (the wave of the future?)—suggests the scope and difficulty of the problems the courts will face if they undertake to enforce a right to treatment.

a. LINDMAN, *supra* note 1, at 148. "Psychosurgery has been carried out on probably some 30,000 mentally ill persons in the United States" (footnotes omitted).

b. "Dr. Leedy, the president of the Association for Poetic Therapy, says there are now about 400 therapists who use the technique, which has been found useful for patients as various as the violently insane, disturbed children and drug addicts.

"The time is ripe for poetry therapy now because the psychiatric profession is more flexible in its willingness to use new techniques," Dr. Leedy said."

N.Y. Times, April 17, 1971, at 31, col. 1.

78. Mendel, *supra* note 34, at 321; 1970 Hearings, *supra* note 1, at 425-33.

As one Commission doctor stated, 'Mental illness means any problem in living.'<sup>79</sup>

As the vagueness of some of the American Psychiatric Association's diagnostic categories might suggest,<sup>80</sup> the line between illness and health is sufficiently blurred so that different diagnosticians often reach different conclusions. In order to evaluate the suitability of diagnostic categories as legal criteria, their reliability must be examined. The question of reliability is distinct from the question of whether these classifications are scientifically valid or useful, a question lawyers and judges can properly ignore. Reliability simply means "the degree to which the same category is chosen upon repetition of the diagnostic procedure."<sup>81</sup>

#### A. *The Reliability of Psychiatric Diagnosis*

Infrequently, psychiatric patients suffer from identifiable organic maladies such as syphilis. With respect to such cases, the diagnosis is as reliable as in many other areas of medicine. In the case of "pure" psychiatric disorders,<sup>82</sup> however, interpsychiatrist agreement on a specific

79. 1970 Hearings, *supra* note 1, at 415.

A few more quotes from the American Psychiatric Association's diagnostic manual of mental disorders should convince anyone that every human being can be appropriately diagnosed as mentally ill.

307.4 Adjustment reaction of late life. Example: Feelings of rejection associated with forced retirement and manifested by social withdrawal.

303.0 Episodic excessive drinking. If alcoholism is present and the individual becomes intoxicated as frequently as four times a year, the condition should be classified here. Intoxication is defined as a state in which the individual's coordination or speech is definitely impaired or his behavior is clearly altered.

301.82 Inadequate personality. This behavior pattern is characterized by ineffectual responses to emotional, social, intellectual and physical demands. While the patient seems neither physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgment, social instability and lack of physical and emotional stamina.

301.6 Asthenic personality. This behavior pattern is characterized by easy fatigability, low energy level, lack of enthusiasm, marked incapacity for enjoyment, and oversensitivity to physical and emotional stress. This disorder must be differentiated from *Neurasthenic Neurosis* (q.v.).

301.81 Passive-Aggressive personality. This behavior pattern is characterized by both passivity and aggressiveness. The aggressiveness may be expressed passively, for example by obstructionism, pouting, procrastination, intentional inefficiency, or stubbornness. This behavior commonly reflects hostility which the individual feels he dare not express openly. Often the behavior is one expression of the patient's resentment at failing to find gratification in a relationship with an individual or institution upon which he is over-dependent.

300.4 Depressive Neurosis. This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable even (*sic*) such as the loss of a love object of cherished possession . . . .

295.1 Schizophrenia, hebephrenic type. This psychosis is characterized by disorganized thinking, shallow and inappropriate affect, unpredictable giggling, silly and regressive behavior and mannerisms, and frequently hypochondriacal complaints. Delusions and hallucinations, if present, are transient and not well organized.

1970 Hearings, *supra* note 1, at 415-16.

80. See note 79 *supra*.

81. Beck, *Reliability of Psychiatric Diagnosis: 1. A Critique of Systematic Studies*, 119 AM. J. PSYCHIATRY 210 (1962) [hereinafter cited as Beck].

82. The overwhelming majority of persons committed to mental institutions are in this category. See N. KITTRIE, *THE RIGHT TO BE DIFFERENT* 79 (1971).



diagnosis had, before 1962, never been found to be higher than 42 percent.<sup>83</sup> In 1962, a study was made in which 54 percent reliability was attained.<sup>84</sup> Four psychiatrists were involved and care was taken to prevent the judgment of one from influencing another. However,

[b]efore engaging in the formal aspects of the investigation, the psychiatrists had several preliminary meetings during which they discussed the various diagnostic categories, ironed out semantic differences, and reached a consensus regarding the specific criteria for each of the nosological entities.<sup>85</sup>

They found it necessary to revise the categories to some extent before beginning. This kind of "fudging" makes the 54 percent figure irrelevant as an index of the degree of reliability that can be expected in day-to-day psychiatric diagnosis.

Apparently because it is generally accepted that specific diagnoses are unreliable, investigators have recently focussed on the reliability of gross classifications. The results of these studies have been better—although not uniformly so<sup>86</sup>—but still fall short of the reliability that legal criteria ought to have. One study found 64 percent agreement among diagnosticians on whether persons were psychotic, neurotic, or suffering from character disorders, but a review of this study indicated that "the conference method favored agreement through the inevitable communication of ideas."<sup>87</sup> That is, the diagnosticians, whose consistency was being investigated, discussed among themselves beforehand what their diagnosis would be in each case. Another study<sup>88</sup> found very high agreement—(79 percent)—on the gross categories of schizophrenia, affective psychosis and "others."<sup>89</sup> Again, however, the second diagnostician knew what the

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83. Even this figure is suspect, because it was obtained by comparing diagnoses made by psychiatrists who knew, at the time they made their diagnosis, what diagnosis had previously been made. One way to view these results is that in 58% of the cases, the second diagnostician felt that this colleague's judgment was so clearly erroneous that a change in diagnosis was necessary. The figure of 42% is also suspect because other studies have found significantly lower rates of agreement on a specific diagnosis. Beck, *supra* note 81, at 211.

84. Beck, Ward, Mendelson, Mock and Erbaugh, *Reliability of Psychiatric Diagnoses: 2. A Study of Consistency of Clinical Judgments and Ratings*, 119 AM. J. PSYCHIATRY 351 (1962).

85. *Id.*

86. The ability of judges, chosen for their clinical expertise, to distinguish male heterosexuals from male homosexuals on the basis of three widely used clinical projective tests—the Rorschach, the TAT, and the MAP, was *no better than chance*. The reason this is such devastating news, of course, is that clinicians and psychiatrists assume sexuality to be of fundamental importance in the deep dynamic of personality. . . .

Weisstein, "Kinder, Kuche, Kirche" as Scientific Law: Psychology Constructs the Female, in *SISTERHOOD IS POWERFUL* 205, 211 (R. Morgan ed. 1970).

87. Beck, *supra* note 81, at 211.

88. Babigian, Gardner, Miles & Romano, *Diagnostic Consistency and Change in a Follow-Up Study of 1215 Patients*, 121 AM. J. PSYCHIATRY 895 (1965) [hereinafter cited as Babigian].

89. See also Kendell & Gourlay, *The Clinical Distinction between the Affective Psychoses and Schizophrenia*, 117 BRIT. J. PSYCHIATRY 261 (1970). "[W]e are nearer to discriminating

first diagnostician had concluded. This is a vital defect, because there is no way to know how and to what extent subsequent diagnoses were affected by this prior knowledge.<sup>90</sup>

In the civil commitment context the crucial distinction is ordinarily psychotic versus nonpsychotic. One team of investigators sought to delineate the difference between psychotic and neurotic depressions, but found themselves unable to do so. They cautiously explained that their failure "does not prove that psychotic and neurotic depressions are not distinct entities" but remarked that "many factors in the design of this present analysis were calculated to maximize the chance of demonstrating bimodality, and the attempt still failed."<sup>91</sup> Clearly, the use of such a legal criterion is not only irrelevant to the problem for which it is employed, but may be impossible to apply rationally.

### B. *Application of Psychiatric Categories in the Commitment Process*

A recent study illustrates some of the difficulties in applying criteria for use in involuntary commitment proceedings.<sup>92</sup> It is not clear, how-

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successfully between schizophrenia and affective psychoses than we are to discriminating between the two types [psychotic and neurotic] of depression." *Id.* at 265.

90. It was found in this study that "time between contacts [diagnoses] did not appear to be a significant factor in diagnostic consistency." Babigian, *supra* note 87, at 899. This might be because people do not grow "better" or "worse" over time, although this is unlikely. It can be accounted for on the hypothesis that in this particular locale the various mental health workers give deference to the judgments of their peers, inasmuch as the data for the study were obtained not under test conditions, but from the normal workings of psychiatric services in Monroe County, New York.

91. Kendell & Gourlay, *The Clinical Distinction between Psychotic and Neurotic Depressions*, 117 *BRIT. J. PSYCHIATRY* 257, 260 (1970).

92. Sandifer, Hordern & Green, *The Psychiatric Interview: The Impact of the First Three Minutes*, 126 *AM. J. PSYCHIATRY* 968 (1970). Headed by two psychiatrists, the team who conducted the study began by filming sixty diagnostic interviews. These they showed to a group of psychiatrists, varying from 14 to 18 in number, who "represented experienced clinicians with diverse backgrounds." *Id.* at 969. Each of the first thirty films shown—they averaged 25 minutes in length—was stopped after the first three minutes. At this point, the psychiatrist observers were asked to record any symptoms or other impressions they had gotten from the interviews.

[An] analysis of symptoms reported within the first three minutes of observation, compared with the symptoms reported for the total period of observation [the complete films plus time for perusal of written histories] . . . [revealed that, of] 850 total symptoms . . . reported . . . 425, or half, were reported within the first three minutes! The observers had the option of using a question mark if they wished to report a symptom tentatively, but three out of four symptoms reported in the first three minutes were reported as being definitely present.

*Id.* at 970.

[Because it was feared] that the early appearance of symptom reporting and diagnostic hunches in the first 30 films might have been an artifact [*sic*] of stopping the film at three minutes . . . in the second series of 30 cases the film was not stopped at all. There was, however, a desk clock showing the number of minutes that had elapsed since the film was started, and the observer was asked, whenever he made an entry, to note the number of minutes that had passed.

*Id.* The results this approach produced were generally confirmatory of the first results. One additional observation was made in connection with the diagnosis of "[s]chizophrenia [which] was selected because . . . [it] is a relatively important and complex diagnosis," *viz.*, "the peak appearance for the consideration of the diagnosis of schizophrenia, when

ever, that nosological criteria actually do govern administrative hospitalization decisions.

Investigators in the Midwest have concluded that "[t]he patient's current social situation contains the information most directly affecting the decision [of whether to admit],"<sup>93</sup> and psychiatrists who conducted a study in Los Angeles concluded that

[t]he decision for hospitalization was not related to severity of symptoms of the patient at the time of decision. That is, the group of patients who were hospitalized could not be distinguished from those who were not hospitalized on the basis of the decision maker's estimate of the severity of symptoms.<sup>94</sup>

The California investigators found that "[t]he existence or absence of social support resources [a sympathetic family or an appropriate social agency in the community] played a critically important part in the decision as to whether a patient was hospitalized."<sup>95</sup> Other significant factors were found to be the background and training of the decision makers<sup>96</sup> and a history of previous hospitalization.<sup>97</sup>

## VII. CRITERIA FOR RELEASE

Discharge from mental institutions occurs most frequently by virtue of administrative action by hospital authorities.<sup>98</sup> The second most frequent means by which hospitalization is terminated is death.<sup>99</sup> A number of persons terminate their status as patients simply by leaving the institutions or, more often, by failing to return from furloughs. If a person remains absent for some months, the institution's personnel will often classify the person as discharged.<sup>100</sup> Finally, there is judicial discharge,<sup>101</sup>

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this was indeed the final diagnosis, came somewhere during the second minute of observation!" *Id.* If the results of this test can be taken to suggest a proclivity for "snap judgments," it is reasonable to believe that such a tendency may be accentuated because of external pressures when the diagnostic setting is an understaffed public facility.

93. Hartlage, Freeman & Horine, *Expediting Admissions Procedures*, 53 *MENTAL HYGIENE* 71, 73 (1969).

94. Mendel, *supra* note 34, at 323.

95. *Id.* at 328.

96. "[T]he social workers hospitalized the fewest patients. [Interns] who had less than six months of clinical experience hospitalized a significantly larger group of patients than did those [who were more experienced]." *Id.* at 326.

97. [I]f the patient had been hospitalized previously, his chance for being hospitalized at the time of this study was more than doubled.

The history of previous hospitalization was not, however, related to severity of symptoms . . . [T]hose previously hospitalized and those not previously hospitalized, were indistinguishable on the basis of severity of symptoms [again on the basis of the decision maker's own estimates].

*Id.* at 323-24.

98. LINDMAN, *supra* note 1, at 125, 131-36.

99. "Death accounted for 19 per cent of the separations from institutions for the mentally ill in 1956." *Id.* at 124.

100. See, e.g., KATZ, *supra* note 2, at 457-59.

101. For applicable statutes see LINDMAN, *supra* note 1, at 137-41.

which is ordinarily by habeas corpus,<sup>102</sup> but this is extremely infrequent. "The number of patients discharged by unauthorized absences represents many times the number of judicial discharges while constituting only about 1 or 2 percent of total discharges."<sup>103</sup>

More than one-fifth of the states have statutes requiring periodic re-evaluation of patients. Florida is typical, requiring a decision on discharge to be made every six months.<sup>104</sup> However, in the view of one hospital superintendent, "[u]nder present conditions of staffing the requirement is a pious expression of hope, impossible to conform to on a hospital-wide basis."<sup>105</sup>

The criteria for discharge, which may be conditional<sup>106</sup> as well as absolute, are extremely flexible and are applied in a highly individualistic fashion. "If there is no single criterion for discharge, the general standard is, 'Can the patient get along in the community?'"<sup>107</sup> Release is then dependent on an administrator's evaluation of such factors as the "environment to which a patient will be discharged."<sup>108</sup> "[N]o effort is made to release a patient who will go back to a disrupted and uncomfortable family situation."<sup>109</sup> Because the administrative procedures for release are characteristically informal, the problem of ascertaining the criteria actually applied is compounded. "Although the statutes provide that the superintendent shall decide when the patient is to be discharged, he normally delegates this power to the staff doctors . . . [who,] in turn, are often free to establish their own policy in their wards."<sup>110</sup>

Nor are such criteria necessarily interpreted in a constant fashion. The experience at Maryland's Patuxent Institution is illustrative.

In 1964 the staff found 84 percent of the convicts whom they evaluated to be defective delinquents. Since 1964 this figure has dropped to the 45 percent level, although neither the statutory definition of "defective delinquent" nor the type of convicts referred to Patuxent has changed. It is openly recognized by members of the Board of Review that the staff's present concept of "defective delinquency" differs from its concept of 1964.<sup>111</sup>

102. *E.g.*, *Ex parte Perry*, 137 N.J. Eq. 161, 43 A.2d 885 (Ct. Ch. 1945). The Baker Act designates a petition for writ of habeas corpus as the appropriate means of invoking judicial review of compliance with the Act. Fla. Laws 1971, ch. 71-131, § 5(9)(a), *creating* FLA. STAT. § 394.459(9)(a) (1971). See note 29 *supra*.

103. Rock, *supra* note 30, at 234.

104. The Baker Act, Fla. Laws 1971, ch. 71-131, § 9(3)-(4), *creating* FLA. STAT. § 394.467(3)-(4) (1971). See note 29 *supra*.

105. Rock, *supra* note 30, at 219.

106. The Baker Act authorizes conditional releases. Fla. Laws 1971, ch. 71-131, § 10(3), *creating* FLA. STAT. § 394.469(3) (1971). See note 29 *supra*.

107. Rock, *supra* note 30, at 215.

108. *Id.* at 218.

109. *Id.*

110. *Id.* at 230.

111. Schreiber, *Indeterminate Therapeutic Incarceration of Dangerous Criminals: Perspectives and Problems*, 56 VA. L. REV. 602, 616 (1970) [hereinafter cited as Schreiber].

The phenomenon at Patuxent Institution might well be indicative of the administrative procedures by which the discharge of persons involuntarily committed to mental institutions are governed. "Dramatic shifts in interpreting a statute that allows indefinite confinement of individuals should be made by the courts or by specific legislative amendment—not by unarticulated, clinical diagnoses by administrative officials."<sup>112</sup>

#### VIII. CRITERIA FOR INVOLUNTARY COMMITMENT SUGGESTED BY TRADITIONAL LEGAL RATIONALES

The great number of persons involuntarily committed to mental institutions are classified as "dangerous to themselves" or "in need of care and treatment."<sup>113</sup> Some of the persons so classified are confined because their conduct has proved a nuisance to the community.<sup>114</sup> Although committing such persons under the "need for treatment" rubric tends to obscure the issues, such persons are in fact committed by virtue of the state's police power.<sup>115</sup> A person may of course be eccentric as well as being a nuisance, but it is necessary to keep the police power rationale<sup>116</sup> and the *parens patriae* rationale distinct, something the courts often fail to do.<sup>117</sup> This separation is necessary because "the scope of the state's power of civil commitment depends on whether its ground for commitment is compassion or public safety."<sup>118</sup> "The state cannot fuse an inadequate police power justification and an inappropriate exercise of paternalism into a jointly sufficient basis for commitment."<sup>119</sup>

##### A. *Dangerousness to Others*

The principle of preventive restraint is not a novelty in the law.<sup>120</sup> The English practice requiring sureties for good behavior and, in their absence, ordering imprisonment of a person never accused of crime solely as a preventive measure "may well ante-date the Statute of Justices, 1391 . . . , from which it is sometimes said to derive."<sup>121</sup> The antiquity of this practice notwithstanding, debate continues over the wisdom and propriety of preventive restraint except as a temporary emergency mea-

112. *Id.*

113. In California, persons falling into these categories contribute 18 percent and 74 percent, respectively, of all persons involuntarily committed. Project, *Civil Commitment of the Mentally Ill*, 14 U.C.L.A.L. REV. 822, 878 (1967).

114. MATTHEWS, *supra* note 4, at 176.

115. *Cf.* Fenster v. Leary, 20 N.Y.2d 309, 314, 229 N.E.2d 426, 429, 282 N.Y.S.2d 739, 743-44 (1967).

116. *See* 20 STAN. L. REV. 782, 785 (1968).

117. *See, e.g.,* People v. Levy, 151 Cal. App. 2d 460, 311 P.2d 897 (Ct. App. 1st 1957); *In re Perry*, 137 N.J. Eq. 161, 43 A.2d 885 (Ct. Ch. 1945).

118. Note, *Civil Commitment of Narcotic Addicts*, 76 YALE L.J. 1160, 1167 (1967).

119. *Id.* at 1168.

120. *See, e.g.,* Dershowitz, *On "Preventive Detention,"* XII N.Y. REV. OF BOOKS 5 at 22 (1969).

121. Keane, *Preventive Justice*, 2 IRISH JURIST 233, 235 (N.S. 1967) [hereinafter cited as Keane].

sure.<sup>122</sup> The recent amendments<sup>123</sup> to the Bail Reform Act of 1966,<sup>124</sup> providing for pretrial detention of persons accused of certain crimes as a means of preventing the commission of additional crimes, serve as a contemporary focus for this debate.<sup>125</sup>

Paradoxically, the writ of habeas corpus, whose use in the service of individual liberty has been so widespread, was created precisely in response to unwarranted pretrial detention.<sup>126</sup> However, the first steps in the implementation of "forms of preventive justice [such as involuntary commitment, sexual psychopath<sup>127</sup> and defective delinquent laws] involve as a direct consequence the deprivation of the individual's liberty."<sup>128</sup> This is opposed to the traditional peace bond form which may involve the deprivation of liberty as an indirect or conditional consequence.

A case often cited as support for the proposition that preventive detention is a constitutionally permissible use of, *inter alia*, the civil commitment laws, is *Minnesota ex rel. Pearson v. Probate Court*.<sup>129</sup> Since the case dealt with an appeal from the denial of a writ of prohibition, the Court was appropriately cautious in dealing with the validity of the statute in question:

We fully recognize the danger of a deprivation of due process in proceedings dealing with persons charged with insanity or, as here, with a psychopathic personality . . . and the special importance of maintaining the basic interests of liberty in a class of cases where the law though "fair on its face and impartial in appearance" may be open to serious abuses in administration . . . .<sup>130</sup>

The statute under consideration in *Minnesota ex rel. Pearson* was remarkable for the breadth and vagueness of its language. However, the statute had been narrowly construed by the Minnesota courts "to include [only] those persons who, by an habitual course of misconduct in sexual matters, have evidenced an utter lack of power to control their sexual impulses and who, as a result, are likely . . . to inflict injury . . . ."<sup>131</sup> Under the statute, then, a finding of habitual sexual misconduct was required. It was neces-

122. See, e.g., *Korematsu v. United States*, 323 U.S. 214 (1944).

123. District of Columbia Court Reform and Criminal Procedure Act of 1970, Pub. L. No. 91-358, § 23-1321-22, 84 Stat. 473.

124. 18 U.S.C. §§ 3146-52 (1970).

125. One commentator fears this recent enactment "may well become the first step of a profound shift in our system of criminal justice." Tribe, *An Ounce of Detention: Preventive Justice in the World of John Mitchell*, 56 VA. L. REV. 371, 375 (1970) [hereinafter cited as Tribe]. See also Mitchell, *Bail Reform and the Constitutionality of Pretrial Detention*, 55 VA. L. REV. 1223 (1969).

126. Foote, *The Coming Constitutional Crisis in Bail: I*, 113 U. PA. L. REV. 959, 967 (1965).

127. See LINDMAN, *supra* note 1, at 319-26.

128. Keane, *supra* note 121, at 236.

129. 309 U.S. 270 (1940) [hereinafter cited as *Minnesota ex rel. Pearson*].

130. *Id.* at 276-77. See *Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964).

131. *Minnesota ex rel. Pearson v. Probate Court*, 309 U.S. 270, 273 (1940).

sary to establish the commission of acts proscribed in advance in order to incarcerate someone under the statute. This was fully in keeping with traditional notions of due process. "These underlying conditions, calling for evidence of past conduct pointing to probable consequences are as susceptible of proof as many of the criteria constantly applied in prosecutions for crime."<sup>132</sup> "Habitual sexual misconduct" is, to be sure, somewhat less than the ideal definition of a crime, but it might serve that function in a way that "dangerousness" never can.

There is, however, a body of law that provides support for the view that due process would not be offended by the confinement of persons demonstrably dangerous to the community. This practice has regularly met with approval in the application of various quarantine laws.<sup>133</sup> "No one seriously doubts that the state may commit persons suffering from contagious diseases."<sup>134</sup> The contagious disease must, of course, be a relatively serious one; but the principle is clear that under the police power a person may be confined in the interest of the community in checking the spread of the disease. The standard of dangerousness thought to warrant quarantine may fairly be inferred to be a substantial threat of serious bodily harm. Quarantine laws thus lend support to the proposition that substantive due process is not offended by the internment of persons whose freedom threatens serious bodily harm to members of the community at large. They are probably distinguishable, however, from preventive detention on the grounds that ordinarily a person poses such a danger only to one other member of the community. The carrier of smallpox contagion may be the instrument for ravaging a whole population.<sup>135</sup>

132. *Id.* at 274.

133. *E.g.*, *Moore v. Draper*, 57 So.2d 648 (Fla. 1952) (tuberculosis).

134. Note, *Civil Commitment of Narcotic Addicts*, 76 YALE L.J. 1160, 1179 (1967).

135. The most striking difference between persons with contagious diseases and persons who will commit acts of violence is the relative ease of ascertaining who is contagious. As a practical matter, it is virtually impossible to predict with accuracy who will wound, maim or kill and who will not. Experience at the Patuxent Institution bears witness to the inability of psychiatrists to make such predictions. See note 158 *infra*. The most promising approach to the problem of prediction involves large scale testing as a means of identifying specific factors which occur with markedly different frequencies in the group of persons who do eventually inflict serious bodily harm, and in the group of persons who never do. It is not unreasonable to believe that such discriminating factors exist. But these factors may be difficult to perceive and measure for any number of reasons. Because of such difficulties, "75% . . . probably represents the maximum effectiveness generally achieved with cross-validated prediction and classification devices." Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events*, 18 J. CONSULTING PSYCH. 397, 398 n.4 (1954). If it be assumed that one person in fifty will inflict serious bodily harm—it is unlikely that, in fact, the proportion of bad apples is so great—what will the results be on the generous assumption that a predictive device with 90% accuracy can be devised? By 90% accuracy it is meant that, on one hand, 9 out of 10 persons can be correctly identified as potential perpetrators of serious bodily harm (the remainder being misidentified) while, on the other hand, 9 out of 10 persons can be correctly identified as having no such potentiality (the remainder being misidentified).

Suppose that one million people are tested with such a device, of whom, by hypothesis, twenty thousand are potential malefactors. The result would be the correct identification of eighteen thousand of the potential malefactors who might then be incarcerated together with

Even if the principle of preventive detention, based on a prediction of harmful conduct, is held to be consistent with the requirements of substantive due process,<sup>136</sup> procedural due process must surely require a greater degree of predictive accuracy than is presently available. The reason that criminal adjudication is circumscribed by procedural safeguards grows out of a conviction that the punishment of the innocent is an evil to be avoided even at the cost of setting the guilty free. No predictive instrument has been, or is likely to be, devised that comes close to making possible the incarceration of as few as one "innocent" person for each person who would otherwise inflict serious bodily harm.

The objective of preventing unjustified incarceration loses none of its importance because a law is denominated as civil rather than criminal. A noteworthy feature of the opinion in *Minnesota ex rel. Pearson* is the complete absence of discussion of this civil-criminal dichotomy. Instead, the Court canvassed the elaborate procedural safeguards provided under the Minnesota law in light of the protection they afforded against unwarranted interference with personal liberty.<sup>137</sup> The Supreme Court has recently taken this same common sense approach,<sup>138</sup> notably with respect to proceedings in juvenile courts. Foreshadowing the landmark *Gault* decision,<sup>139</sup> the Court remarked in *Kent v. United States*<sup>140</sup> that notwithstanding

the original laudable purpose of juvenile courts, studies and critiques in recent years raise serious questions as to whether actual performance measures well enough against theoretical purpose to make tolerable the immunity of the process from the reach of constitutional guaranties applicable to adults.<sup>141</sup>

Judged in this realistic fashion, when the incarceration of persons on the ground of dangerousness to others is sought to be obfuscated by an additional therapeutic rationale, as in civil commitment proceedings, full procedural safeguards ought to be constitutionally required. The analogy between the *Gault* situation—incarceration of a juvenile on a finding of "delinquency" for the supposed good of the juvenile—and the

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the ninety-eight thousand persons incorrectly identified as malefactors. Two thousand potential malefactors would remain free, together with eight hundred eighty two thousand of their more benign neighbors. *Id.* at 398-99; Livermore, Malmquist, Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 80 (1968) [hereinafter cited as Livermore]. Another way of viewing these results, which, it should be emphasized, are much better than could actually be hoped for, is by comparing them with the "predictive accuracy" of not incarcerating anyone. That course might be viewed as a prediction that no one will inflict serious bodily harm and, as such, it would be ninety-eight percent accurate.

136. *Robinson v. California*, 370 U.S. 660 (1962), suggests that there is no substantive due process objection when proceedings are "clearly civil in nature with a purpose of rehabilitation and cure." *Id.* at 681.

137. *Minnesota ex rel. Pearson v. Probate Court*, 309 U.S. 270, 275-76 (1940).

138. *See, e.g., One 1958 Plymouth Sedan v. Pennsylvania*, 380 U.S. 693 (1965).

139. *In re Gault*, 387 U.S. 1 (1967).

140. 383 U.S. 541 (1966).

141. *Id.* at 555.



incarceration of mentally ill persons on a finding of "dangerousness" or "dangerous mental illness" for their supposed good is very close. The only real difference is that in the latter case, no antisocial behavior need be established. This situation calls for more, not fewer, safeguards. The terms "mental illness" and "delinquency" are equally vague and equally inappropriate bases for prolonged confinement under the police power, confused as the latter concept is with inapposite *parens patriae* notions.

Another avenue of constitutional attack is the prohibition against *ex post facto* laws. What constitutes punishment for purposes of the *ex post facto* prohibition, and the sister provision barring bills of attainder, has never been held to depend on whether a law is characterized as civil or criminal.<sup>142</sup> In *Cummings v. Missouri*,<sup>143</sup> provisions of a state constitution were stricken as operating *ex post facto* even though they did "not, in terms, define any crimes, or declare that any punishment shall be inflicted . . . [because] they produce[d] the same result upon the parties."<sup>144</sup> There is little doubt that involuntary confinement constitutes punishment within the scope of the prohibition against *ex post facto* laws.

It is less clear, however, that preventive detention should be viewed in the context of the *ex post facto* ban. However, preventive detention bears a close resemblance to confinement under *ex post facto* laws in that persons may be incarcerated, not for the commission of crimes defined in advance, but simply by virtue of a status they are powerless to change when a law is enacted. It is this powerlessness that makes punishment unjust. In the classic *ex post facto* situation, a person is subjected to punishment because of his status as the doer of a deed not proscribed at the time of its doing, about which status, of course, he can do nothing. In the case of the subject of preventive detention proceedings, a person is subjected to incarceration (punishment) because of his status as a person dangerous to others, about which status he can do nothing.

The substantive due process question posed by involuntary commitment under the police power is analogous to the problem of "penal statutes directed solely at status offenses,"<sup>145</sup> of which vagrancy laws are the most typical. It is recognized that "there are important differences between crimes of condition and crimes of action, [and that] some of these differences may be regarded as infringements of the safeguards normally provided for those accused of crimes."<sup>146</sup> The substantive due process question becomes whether and to what extent a person has a right to be dangerous to others. Does a citizen have the right to be free unless and until he has been convicted of a crime?<sup>147</sup>

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142. See, e.g., *United States v. Lovett*, 328 U.S. 303 (1946).

143. 71 U.S. (4 Wall.) 277 (1866).

144. *Id.* at 327.

145. Murtagh, *Status Offenses and Due Process of Law*, 36 *FORDHAM L. REV.* 51 (1967).

146. Lacey, *Vagrancy and Other Crimes of Personal Condition*, 66 *HARV. L. REV.* 1203, 1219 (1953).

147. The view that he has "is generally rejected in those areas where the grant of bail is

It is argued that involuntary confinement under civil commitment laws on the ground of dangerousness is distinguishable from preventive detention in a pure form.<sup>148</sup> The basis for this argument is that civil commitment laws apply only to a limited category of persons—those who are insane. Since, the argument goes, “it is a principle of law that an insane person has no will of his own,”<sup>149</sup> the rationale behind reliance on the threat of subsequent punishment as a deterrent fails, and it is appropriate to resort to some other means of deterrence if an insane person is dangerous. However, in actuality, the commitment laws, both as written and as applied, require no finding that the subject of the proceedings “ha[ve] no will of his own” or be incapable of being deterred by the threat of punishment or being motivated by the promise of reward.<sup>150</sup>

When, if ever, is it proper to incarcerate an individual to prevent anticipated harm?<sup>151</sup> Civil commitment proceedings pose this broad question, rather than one narrowed by a concept of mental illness, partially because of the difficulties inherent in that concept,<sup>152</sup> which are such as to make it “devoid of that purposive content that a touchstone in the law ought to have.”<sup>153</sup> More fundamentally, “limiting [application of a standard of dangerousness] to the mentally ill is both factually and philosophically unjustifiable”<sup>154</sup> because persons who fall within the general category of the mentally ill are no more likely to be dangerous than those who fall outside that category.<sup>155</sup>

One kind of danger sometimes advanced as an appropriate justification for preventive detention is the danger of serious bodily harm.<sup>156</sup>

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presently a matter of discretion rather than of right.” Note, *Preventive Detention Before Trial*, 79 HARV. L. REV. 1489, 1502 (1966). A person accused of a capital crime is subject to incarceration pending trial in most states. Detention in this context, although it is sometimes motivated by the purpose to prevent the commission of future crimes, is ordinarily rationalized on the basis of a necessity that the accused be held to answer the charges against him, and recognition is given to the compelling inducement to flight the possibility of execution holds. In other words, incarceration before conviction is justified not as a substitute for the normal processes of the criminal law, but as a practical concession in order that those processes may prove workable.

148. See, e.g., Tribe, *supra* note 125, at 377-80.

149. Matter of Josiah Oakes, 8 Mass. Law Rptr. 122 (1845).

150. It is of interest in this connection that in some mental institutions inmates are paid small sums of money for doing work in the institution. ROCK, *supra* note 30, at 229. The promise of future reward inherent in such a scheme serves as an inducement to reliable and regular performance in a job, just as in the case of persons who are volitionally “normal.”

151. Among the difficult political and philosophical problems preventive detention poses is whether the law exceeds its rightful role by making civil disobedience impossible.

152. See discussion of this and related terms at section VI, *supra*.

153. Livermore, *supra* note 135, at 80.

154. *Id.* at 85.

155. It has, however, been asserted that there exists an “assumption that hospitalization of someone suffering from mental illness is likely to benefit him even if he is not dangerous” so that it may be permissible to incarcerate dangerous, mentally ill persons while incarceration of other dangerous persons could not be justified; but the writer is quick to add that “[t]his assumption is probably unrealistic in light of present hospital facilities.” Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1290 (1966). Even if the best of facilities were available, there are difficulties with this position.

156. *But cf.*, *Overholser v. Russell*, 283 F.2d 195, 198 (D.C. Cir. 1960):

We think the danger to the public need not be possible physical violence or a crime

This definition, standing alone, would seem to be insufficiently precise. It would easily embrace the person who customarily drives recklessly or when inebriated; but to such person it would seem more fitting to proceed by revoking his driver's license rather than by locking him up for an indefinite period. Another approach would be to select the commission of specified crimes of personal violence as the prospective harm justifying preventive jailing of the would-be perpetrator.<sup>157</sup>

A separate question is what degree of likelihood of the feared harm should be required. Must it be more likely than not that John Smith will stab someone? Or must there be a substantial likelihood or, perhaps, virtual certainty? Would it be helpful to express the standard in more explicitly actuarial terms? Must there be fifty-one chances in a hundred that John Smith will stab someone? Or eighty-five? Or ninety-eight? What period of time is the proper focus? Should the question be whether he will stab someone within the next ten days? Within the next 30 days? Six months? In his lifetime?

Who should be the factfinder? What should be the burden of proof? How is the scope of the relevant inquiry to be defined? Is a judicial inquiry suitable at all for the initial determination? Or should the courts be content to review the decisions of statisticians and psychological testers, working through the intricacies of statistical inference on the principle of *stare decisis*? Or, more in keeping with present practice, should the courts defer almost unquestioningly to supposed psychiatric expertise in predicting dangerous behavior, notwithstanding "the intensely individualistic, even intuitive, methodology of most contemporary psychiatric technique?"<sup>158</sup>

### B. *The Doctrine of Parens Patriae*

Paternalistic criteria pose the question of who should decide what is in an individual's best interest. This is a question to which "[t]he

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of violence. It is enough if there is competent evidence that he may commit any criminal act . . . . There is also the additional possible danger—not to be discounted even if remote—that a non-violent criminal act may expose the perpetrator to violent retaliatory acts . . . .

The question whether a person may be incarcerated solely on account of dangerousness to property was before the Supreme Court; however, after submission of briefs and oral argument, the Court dismissed certiorari as improvidently granted. *Murel v. Baltimore City Criminal Ct.*, 92 S. Ct. 2091 (1972).

157. This course would, however, give rise to an interesting conceptual problem inasmuch as intent is a necessary element of such crimes as murder and rape, and a very strong argument exists that only persons unable to form such an intent—those having "no will of their own"—are appropriate subjects for preventive detention.

158. *Rock*, *supra* note 30, at 9. An indication of the lack of soundness of this intuition is afforded by the results at the Patuxent Institution, a facility for the internment on the grounds of dangerousness of persons denominated "defective delinquents." There,

[A]pproximately 45 percent of those paroled [upon the recommendation of staff psychiatrists] . . . have violated the terms of their parole, 26 percent by committing a new crime. On the other hand, of the 432 inmates released by the courts contrary to the recommendations of [the same psychiatrists] . . . , all 432 of whom the staff believed were a danger to society at the time of their release, only 137, or 32 percent, committed new offenses.

Schreiber, *supra* note 111, at 619 [footnotes omitted].

American legal system presents no consistent answer."<sup>159</sup> The courts have been presented with this question by persons holding unorthodox religious beliefs and acting on the strength of them in a manner opposed by public authority. Perhaps the most colorful of these cases<sup>160</sup> arose out of the practices of a religious sect in the Appalachian Mountains. As a part of their liturgy, members of this group handled poisonous snakes, a practice made criminal by Tennessee law. In affirming the conviction of one of the faithful, the Tennessee Supreme Court relied partly on the police power—spectators were endangered—and partly on the ground that the state could protect an individual from his own foolhardiness.<sup>161</sup> Laws making attempted suicide a crime are likewise premised on a notion that the state may forbid an individual from harming himself.

On the other hand, people are free to choose to smoke cigarettes or race automobiles, or, for that matter, to drive them on the highways. Except under certain circumstances, people may refuse blood transfusions even if that refusal means death. An Illinois case held that a competent adult without minor children may, on religious grounds, refuse life-saving medical treatment.<sup>162</sup> However, a court may override the veto of a parent by appointing a guardian for the purpose of giving consent for a blood transfusion necessary to save the life of a child<sup>163</sup> or, in order to save a fetus, require a woman with child to submit to a transfusion.<sup>164</sup> Where an individual is a parent, there is authority for the state, acting as *parens patriae with respect to the child*, to require the parent's submission to a transfusion not for his own benefit, but for the benefit of the child.<sup>165</sup> Historically, the doctrine of *parens patriae*—whose "meaning is murky"<sup>166</sup>—has been recognized chiefly in connection with children. After *Gault*, the scope of its viability has shrunk even in this narrow sphere.<sup>167</sup>

The reasoning of the courts in the transfusion cases has respected the limitation to children inherent in the state's power of *parens patriae*, even when that power has been broadly applied to justify intervention to save the life of a parent. These cases arise because the Jehovah's Witnesses, a religious sect, is opposed to blood transfusions, understand-

159. Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1293 (1966).

160. *Harden v. State*, 188 Tenn. 17, 216 S.W.2d 708 (1949).

161. *Id.* at 21, 216 S.W.2d at 710. The same double rationale supports the same result under a similar law in another state. *Lawson v. Commonwealth*, 291 Ky. 437, 164 S.W.2d 972 (1942).

162. *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

163. *Morrison v. State*, 252 S.W.2d 97 (Mo. 1952).

164. *Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964).

165. *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir. 1964).

166. *In re Gault*, 387 U.S. 1, 16 (1967).

167. "The phrase was taken from chancery practice where . . . it was used to describe the power of the state to act *in loco parentis* for the purpose of protecting the property interests and the person of the child." *Id.*

ing them to be forbidden by certain biblical texts.<sup>168</sup> The cases present, then, questions under the fourteenth amendment and the free exercise clause and may, accordingly, be read narrowly as protecting religious freedom only. There is language, though, suggesting that a broader principle is at issue:

Mr. Justice Brandeis, whose views have inspired much of the "right to be let alone" philosophy, said in *Olmstead v. United States*, 227 U.S. 438, 478 . . . (1928), (dissenting opinion):

The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man.

Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas . . . .<sup>169</sup>

The implication is that there is a right to refuse medical treatment for reasons other than religion. Indeed, in another context, the Supreme Court has intimated that it may be improper for the scope of liberty to depend on an official determination of whether or not the motivation for its exercise is religious.<sup>170</sup>

Largely because of strong democratic and libertarian traditions in the United States, the courts have generally refused to countenance coercion of an individual solely on the ground of his own best interests.<sup>171</sup> Nonetheless, benefits may sometimes be imposed on unwilling beneficiaries in the exercise of the police power. Smallpox vaccination is justified as an exercise of the police power to preserve community health,

168. *Genesis* 9:3-4; *Leviticus* 17:10; *Deuteronomy* 12:23, *Acts of the Apostles* 15:28-29.

169. 331 F.2d 1000, 1016-17 (D.C. Cir. 1964).

170. [T]o condition the solicitation of aid for the perpetuation of religious views or systems upon a license, the grant of which rests in the exercise of a determination by state authority as to what is a religious cause, is to lay a forbidden burden upon the exercise of liberty . . . .

*Cantwell v. Connecticut*, 310 U.S. 296, 307 (1940). *But see Wisconsin v. Yoder*, 92 S. Ct. 1526, 1533 (1972):

Although a determination of what is a "religious belief" or practice entitled to constitutional protection may present a most delicate question, the very concept of ordered liberty precludes allowing every person to make his own standards on matters of conduct in which society as a whole has important interests.

171. *Harden v. State*, 188 Tenn. 17, 216 S.W.2d 708 (1949), and *Lawson v. Commonwealth*, 291 Ky. 437, 164 S.W.2d 972 (1942), specified beneficent coercion as an independent ground of decision, but the decisions were sustainable on a police power rationale. *See generally* Weiss & Wizner, *Pot, Prayer, Politics and Privacy; The Right to Cut Your Own Throat in Your Own Way*, 54 IOWA L. REV. 709 (1969).

and it is irrelevant that the unwilling subject of the vaccination gains immunity to the disease.<sup>172</sup>

A well-recognized exception to this principle is in the case of a finding of incompetency. Commitment laws are included in this exception in a way that does violence to its historical scope. The paternalistic criteria in these statutes fail to provide workable standards by which competency *vel non* may be adjudged. What justifies the state's assuming responsibility for a person's care, over his objection, including taking him into physical custody?

The answer implicit in the commitment laws is that a finding of mental illness is a finding of the requisite incompetence. In the application of the laws, a finding of psychosis frequently operates as a determination of incompetency sufficient to take from a person his civil rights and place him under the supervision of public authority. Both the term "mental illness" and the term "psychosis" have abetted evasion, rather than resolution, of the constitutional question of precisely when the state may deprive an individual of his liberty on a purely paternalistic rationale.

A requirement of a finding that a person "has no will of his own" is an example of a standard well within constitutional requirements. In contrast, the paternalistic criteria for involuntary confinement in the DRAFT ACT<sup>173</sup> present a number of constitutional difficulties. Those criteria define as eligible for involuntary commitment a person who:

- (1) is mentally ill, and
- (2) because of his illness is likely to injure himself . . . or
- (3) is in need of custody, care or treatment in a mental hospital and, because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization . . .<sup>174</sup>

The definition of incompetence implicit in this scheme is a person's lack of "sufficient insight or capacity to make responsible decisions with respect to his hospitalization." The focus on the subject's ability to make decisions with respect to hospitalization is clearly appropriate. In commitment hearings, it is precisely the decision to hospitalize that the state proposes to make on behalf of an individual. If a person is *incompetent*

172. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

173. NATIONAL INSTITUTE OF MENTAL HEALTH, FEDERAL SECURITY AGENCY, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL. (Public Health Service Pub. No. 51, rev. ed. 1552) [hereinafter cited as DRAFT ACT].

174. *Id.* at § 9(g). Assuming that a person "is mentally ill"—putting aside definitional problems for the moment—and "is in need of custody, care or treatment in a mental hospital" and "lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization," on what possible theory is it relevant whether the insufficient "insight or capacity" is attributable to his mental illness?

to this task—unable to decide for or against hospitalization—someone else must do it.<sup>175</sup>

While the DRAFT ACT's use of the notion of specific incompetence goes a long way towards removing constitutional clouds, problems remain. The most obvious is that if a person is "likely to injure himself," he may be committed even though he is fully capable of deciding and does not choose to enter a mental institution, and thus assumes the risk of self-injury.<sup>176</sup> Additionally, the problem of predicting who is likely to injure himself—once that phrase is given content by specifying what degree of likelihood and what kind and degree of injury is meant—has proved no less baffling than the problem of predicting who will do harm to others.<sup>177</sup>

The subtler constitutional problems have to do with the DRAFT ACT's formulation of the requisite for a finding of specific incompetency. With reference to this test, Professor Ross comments:

[I]f all the experts agree that the benefits of hospitalization for a particular individual outweigh the disadvantages (loss of personal liberty), does not the patient's failure to heed the voice of authority give rise to a strong presumption that he is incapable of making a rational choice, or is it merely evidence of non-conformity? Unfortunately, no statute can by its terms indicate just where non-conformity ends and incapacity begins.<sup>178</sup>

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175. This does not mean that hospitalization ought to follow automatically. Whoever is substituted as a decision maker ought to explore fully the alternatives to hospitalization. Cf. Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1296-97 (1966). If some more appropriate course suggests itself as, for example, care in a relative's home, this ought to be proposed to the subject of the proceedings. If he protests, a second adjudication—this time of incompetency to decide whether or not to enter the relative's home—could lay the predicate for giving him into the care of the relative. This second adjudication might reveal, on the other hand, that while the subject was fundamentally ambivalent about whether or not to enter a mental institution, he was unequivocal about his relative's being anathema to him. A proper division of responsibility between the courts and such a "guardian" could avoid inappropriate judicial involvement in "social agency" kinds of problems.

176. The requirement that the likelihood of injury be caused by mental illness serves to exclude the lion tamer who imagines himself to be Napoleon when off the circus grounds, but the neurotically hyperactive business man with heart trouble is included among those subject to commitment.

177. See Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events*, 18 J. CONSULTING PSYCH. 397 (1954). If a person is intent on doing himself harm, he can probably manage it inside a mental institution. See Kardas v. New York, 24 App. Div. 2d 789, 263 N.Y.S.2d 727 (1965) (suicide).

178. Ross, *supra* note 33, at 960. If no statute can, it is nonetheless possible to improve on the DRAFT ACT in this regard. The Act permits involuntary commitment not only of persons lacking capacity to decide on the merits of hospitalization, but also of persons lacking the "insight" to make that decision "responsibly." The authors of the DRAFT ACT take care to point out that

[w]ithin the wide range of mental illnesses there are cases in which the sick individual, like the individual who is physically sick, retains sufficient capacity to make a responsible decision on the question of his hospitalization, weighing it against other factors in his life and affairs.

The apparent suggestion, that conscientious compliance with carefully drawn language must inevitably fail as a means of establishing in practice the principle of individual autonomy, is not convincing. Unquestionably, current practice fails to respect individual choice in commitment proceedings, and it is equally clear that there is a strong tendency to regard as evidence of incompetence a decision felt to be wrong. Exactly this kind of problem, however, exists in virtually every area of the law. Courts must defer to legislatures in their occasional "unwisdom" so long as they have not exceeded their competence. Likewise, courts are bound to uphold "irresponsible" testamentary dispositions on a finding of testamentary capacity.<sup>179</sup> The fact that competent and relevant evidence is admissible without regard to its veracity, reflects the fact that the whole process of adjudication is structured in terms of the competence of the fact finder vis-à-vis a distinct competence on questions of law. Even the problems of federalism are essentially ones of assigning and defining competence,<sup>180</sup> as are many of the problems in administrative law.<sup>181</sup> Few of these problems are easy ones, and it is readily apparent that careful delineation of the exact scope in which an individual ought to be free to decide what is best for himself proves subtly and intricately difficult.<sup>182</sup> This may help to explain why courts avoid these issues, denominating them as psychiatric problems and leaving them for ad hoc, individualistic, inconsistent, and shifting "resolution" by the psychiatrists and administrators upon whose shoulders they fall.

### IX. CONCLUSION

Admissions to and stays at mental institutions on a genuinely voluntary basis ought to be possible without the involvement of courts. In

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DRAFT ACT, *supra* note 174, at 28. On this premise, they reach the conclusion that if a person is able to choose, his choice ought to be respected even if it is unwise. *Id.* at 28-29.

This objective might be more readily realized by deleting the words "insight" and "responsible" from § 9(g) of the Act. "Insight," to the extent it has a widely agreed upon meaning in this context, ordinarily denotes the willingness of a person to agree with the psychiatrists' pronouncement that he is ill. 1970 Hearings, *supra* note 1, at 416-17. A failure to agree on this point seems to afford inadequate grounds for refusing to respect the choice about hospitalization a person makes after "weighing it against other factors in his life and affairs." Nor does the requirement that the decision with respect to hospitalization be a "responsible" one serve to foster the goal of deference to individual choice. "Responsible to whom?" it may be asked.

179. Such a finding is not incompatible with an adjudication of insanity. *In re Alexieff's Will*, 94 N.Y.S.2d 32 (Sur. Ct. 1949), *aff'd*, 277 App. Div. 790, 97 N.Y.S.2d 532, *motion for leave to appeal denied*, 277 App. Div. 901, 98 N.Y.S.2d 582 (1950).

180. *See, e.g.*, *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943) (dissenting opinion of Frankfurter, J.).

181. *See, e.g.*, *Securities and Exchange Comm'n v. Chenery Corp.*, 332 U.S. 194 (1947).

182. To the extent incompetence for the purpose of involuntary commitment on a paternalistic rationale is defined more broadly than the inability to decide re hospitalization, there is an analogy to the enforcement of penal laws punishing "crimes without victims." That is, if a person is adjudged incompetent because he insists on a course of conduct that does no one else harm, but offends the community's sense of propriety, his incarceration can be viewed as the enforcement of morality as such. *See generally* H. L. A. HART, *LAW, LIBERTY AND MORALITY* 1-6, 30-60, 77-83 (1963).



order to make this possible in Florida, The Baker Act should be amended to require mental health facilities to accept mentally ill persons, not disqualified by previous release, who voluntarily make application for admission, and to require automatic, prompt release upon application by a voluntary patient. This may be done by amending The Baker Act's section 8(1)(a) to read:

A facility may receive for observation, diagnosis, and treatment any individual eighteen (18) years of age or older making application for admission, any individual under eighteen (18) years of age for whom such application is made by his parent or guardian, and any person legally adjudged to be incompetent for whom such application is made by his guardian. If found to show evidence of mental illness and to be suitable for treatment, such person *shall* be admitted to the facility. *Provided, however, that if any person has, within the six months' period immediately preceding, been released at his own request from a facility in which he was a voluntary patient, his re-admission as a voluntary patient shall be within the discretion of the facility staff.*<sup>183</sup>

In addition, section 8(2)(a) of The Baker Act should be amended to read:

A facility shall discharge a voluntary patient who has sufficiently improved so that hospitalization is no longer desirable. A patient may also be discharged to the care of a community facility. A voluntary patient or his guardian, a representative, or attorney may request discharge in writing at any time following admission to the facility. This request may be submitted to a member of the staff of the facility for transmittal to the administrator. If the patient, or another on his behalf, makes an oral request for release to a staff member, such request shall be immediately entered in the patient's clinical record and the patient *shall be immediately furnished with a written form which requires only the signature of the patient, his guardian or representative to constitute a formal request for discharge. Within twenty-four (24) hours of receipt by a staff member of a formal request for discharge, the patient shall be discharged, unless the patient is under a criminal charge, in which case he shall be transferred to the custody of the appropriate law enforcement officer.*<sup>184</sup>

As an adjunct to voluntary procedures requiring affirmative action, provision may be made for non-protested admissions as long as adequate safeguards are incorporated.

Long-term incarceration predicated on the supposed dangerousness

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183. Proposed changes in italics.

184. Proposed changes in italics.

of an individual to others ought to await the arrival of a reliable predictive technique and ought not be arbitrarily limited to mentally ill persons. Emergency intervention by public authority sufficient to protect the community would be available if the legislature took the straightforward step of proscribing, as criminal, conduct such that a reasonable man must conclude that there is great likelihood that the actor will do serious bodily harm to another within the immediate future. Enacting such a law would secure to the citizen the safeguards available to persons criminally accused and permit the repeal of that section of The Baker Act which authorizes emergency involuntary admissions without notice or hearing.<sup>185</sup>

Incarceration of an unwilling individual for his own welfare ought to be possible only after a judicial hearing upon adequate notice. The sole issue at the hearing should be whether the individual is capable of deciding for or against hospitalization. All relevant evidence, including relevant psychiatric testimony, should be adduced at the hearing. That portion of The Baker Act<sup>186</sup> which authorizes involuntary confinement for up to five days for the purpose of psychiatric evaluation should be repealed, although the court should have authority to order psychiatric evaluation without confinement. If the individual is found incapable of deciding for or against hospitalization, a relative or other suitable person ought to be appointed to make the decision on his behalf.

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185. The Baker Act, Fla. Laws 1971, ch. 71-131, § 7(1), *creating* FLA. STAT. § 394.463(1) (1971). See note 29 *supra*.

186. The Baker Act, Fla. Laws 1971, ch. 71-131, § 7(2), *creating* FLA. STAT. § 394.463(2) (1971). See note 29 *supra*.