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Dignifying Madness: Rethinking Commitment Law in an Age of Mass Incarceration

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ARTICLES

Dignifying Madness: Rethinking Commitment Law in an Age of Mass Incarceration*

JONATHAN SIMON* & STEPHEN A. ROSENBAUM*

Modern nation-states have been trapped in recurring cycles of incarcerating and emancipating residents with psychiatric disabilities. New cycles of enthusiasm for incarceration generally commence with well-defined claims about the evils of allowing “the mad” to remain at liberty and the benefits incarceration would bring to the afflicted. A generation or two later, at most, reports of terrible conditions in institutions circulate and new laws follow, setting high burdens for

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those seeking to imprison and demanding exacting legal procedures with an emphasis on individual civil liberties. Today, we seem to be arriving at another turn in the familiar cycle. A growing movement led by professionals and family members of people with mental health disabilities is calling for new laws enabling earlier and more assertive treatment.

After reviewing the history of civil commitment law, this essay suggests that the time is ripe in the United States to end this recurring cycle and make conservation of human dignity the core legal authority behind the state's power of civil commitment and the major normative guide for both legal procedure and treatment. We conclude that the dignity approach has the potential to move the debate beyond the current face-off between consumer and peer advocates, who wish to avoid any revision of the civil commitment reforms enacted forty years ago, and families and professionals, who favor significant changes.

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INTRODUCTION

Ever since the “Great Confinement” of the sixteenth and seventeenth centuries,¹ modern nation-states have been trapped in recurring cycles of incarcerating and emancipating residents with symptomatic psychiatric disabilities. New cycles of enthusiasm for incarceration generally commence with well-defined claims about the evils of allowing the mad to remain at liberty and the benefits incarceration would bring to those afflicted. A generation or two later, at most, reports of terrible conditions in institutions circulate and new laws follow, setting high burdens for those seeking to incarcerate the mad and demanding exacting legal procedures. The cycle begins again as a new group of reformers argue that people with psychiatric disabilities have been abandoned to even worse forms of incarceration than the asylums from which they were emancipated.

We use the admittedly archaic terms “mad” and “madness”—along with the more acceptable “people with mental illness” or “persons with psychiatric disabilities”—as a way of shaking up the categories that have shaped our most recent cycles.² It is important to

¹ MICHEL FOUCAULT, *HISTORY OF MADNESS* 44 (Jean Khalfa ed., Jonathan Murphy & Jean Khalfa trans., Routledge 2006) (1961).

² The line dividing acceptable terminology from unacceptable can be blurry. No matter what term we employ, there is virtual disagreement amongst consumers, advocates and other professionals. See e.g., Charles O’Mahony, *The United Nations Convention on the Rights of Persons with Disabilities and the Abolition of the Insanity Defense* 6 (unpublished paper) (on file with authors) (citing “mad” and “crazy” as politically incorrect terms which nonetheless reclaim the stigma). On the linguistic politics, see, e.g., Stephen A. Rosenbaum, *Hammerin’ Hank: The*

bear in mind that we use those terms not to describe people, or illnesses of the mind, but those social situations in which people with mental illness find themselves caught up in homelessness, drug abuse or crime victimization. Or else, they become a subject of police concern or (in the eyes of their families or neighbors) are at risk of becoming the subject of police concern, and they end up incarcerated.³

After reviewing the history of civil commitment law, this essay takes up the foundations for the dignity approach and its core principles. We conclude that the dignity approach has the potential to move the debate beyond the current face-off between consumer advocates who wish to avoid any revision of the civil commitment reforms enacted forty years ago and families who favor significant changes.

I. HISTORY OF ASYLUMS

Prior to the sixteenth century, the mad, along with other categories of the nomadic poor, were tolerated in varying degrees or they were abandoned and ignored—at least within European societies.⁴ They were perceived as curiosities, objects of charity and signs of divine or satanic powers—a focus for family and religious control, rather than the state (Figures 1 and 2). By the middle of the seventeenth century, the presence of the mad in public was taken to be a direct threat to public health. Institutions to confine them, along with

Right to be Raunchy or FM Freak Show?, 23 *Disability Studies Qtrly*, nn. 51–57 (2003), <http://www.brandeis.edu/lemborg/SGHL/DSQ.html> (discussing the reclaiming of outmoded identity terms and epithets). *But see* Richard Fung, *Looking for My Penis: The Eroticized Asian in Gay Porn*, in *How Do I Look? Queer Film and Video* 168, n.8 (1991) (Bad-Object Choices, eds.) (“too much time spent on the politics of ‘naming’ can in the end be diversionary”).

³ See Pfeiffer, *infra* note 33. By using “subject of police concern,” we deliberately avoid the invocation of a particular standard for dangerousness or other justification for officer intervention.

⁴ FOUCAULT, *supra* note 1, at 48, 53 (describing the terms of the establishment by royal decree in 1656 Paris’s *Hôpital General* consolidating the city’s existing institutions for confinement and relief under the King’s authority and with substantial investment from the Crown).

other disconnected and troubled individuals, were viewed as requisite to the sovereignty of emerging nation-states.⁵ Within a century and a half, reformers throughout Europe, such as John Howard in England and Philippe Pinel in France, would decry this carceral archipelago, especially the cruelty of confining the mad without treatment (Figures 4 and 5).⁶



Fig. 1 Heronymus Bosch, “Ship of Fools” (1490).

⁵ In 1575, for example, Elizabeth I’s Parliament enacted a law ordering the construction of poor houses for “the punishment of vagabonds and the relief of the poor” beginning the spread of all sorts of small jails and houses of corrections in England and Wales. See JOHN PORTER, *HISTORY OF THE FYLDE OF LANCASHIRE* 476 (1876).

⁶ The asylum movement of the nineteenth and twentieth century was informed by a more scientific categorization of madness and carefully distinguished between the mad, criminals, and the indigent, assigning them to distinct institutions (hospital, prison, and workhouse), but the scale of confinement actually grew. See *generally* DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* (1st ed. 1971).



Fig. 2 Hieronymus Bosch, "The *Cure of Folly: Extraction of the Stone of Madness*" (1475-1480).



Fig. 3 Pieter Breughel, "Mad Meg" (1563).



Fig. 4 Francisco Goya, "Yard with Mad Men" (1794)



Fig. 5 Tony Robert-Fleury, "Pinel Liberating the Madwomen of the Salpêtrière" (1795)

Today, we seem to be arriving at another turn in the familiar cycle. In the United States, where the first asylums for people with psychiatric disabilities were built in the early nineteenth century and revitalized in the early twentieth century,⁷ we now seem poised to begin our third cycle. A growing movement led by professionals and family members of people with psychiatric disabilities is calling for new laws enabling earlier and more assertive treatment. The new reformers are pointing to unprecedented numbers of mentally ill people in jails and prisons, citing alarming reports of armed assaults by people with known psychiatric disabilities that have gone untreated—like Jared Loughner, who shot Representative Gabriel Gifford in Arizona in 2010—and citing the benefits of a newer generation of psychiatric treatment drugs.⁸ In this essay, we suggest that the time is ripe in the United States to end this recurring cycle of incarceration and emancipation. It is time to make conservation of human dignity the core legal authority behind the state's power of civil commitment and the major normative guide for both legal procedure and treatment.

Historically, incarceration of people with psychiatric disabilities has been based on one or two historic powers of the modern state, inherited from its monarchical ancestors. One is *parens patriae*, the state's power to protect citizens and residents against death or injury when they have become disabled and are unable to care for themselves and their affairs.⁹ The second is the state's power to protect

⁷ See Patricia D'Antonio, *History of Psychiatric Hospitals*, <http://www.nursing.upenn.edu/nhhc/Pages/HistoryofPsychiatricHospitals.aspx> (last visited Aug. 19, 2015).

⁸ For example, the National Alliance on Mental Illness (NAMI), an advocacy organization for families of people with mental illness that supports significant reform of civil commitment laws, states the following in the opening lines of one of its online publications: "Since 1990, remarkably effective medications have become available for the treatment of mental illnesses. The introduction of these medications represents an unprecedented turning point for the more than five million Americans who have severe mental illnesses and for their families." *Access to Effective Medications: A Critical Link to Mental Illness Recovery*, NAT'L ALL. ON MENTAL ILLNESS, http://www2.nami.org/Content/Content-Groups/E-News/20003/July_20002/Access_to_Effective_Medications_A_Critical_Link_to_Mental_Illness_Recovery1.htm (last visited June 15, 2015).

⁹ *Parens patriae* invokes the historical concept that the sovereign is literally "a father" to the people of the land. BRUCE J. WINICK, *CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL* 42 (2005); see Jonathan Simon, *Power*

its citizens or residents against violent assaults from others, typically called the state's "police power."¹⁰ Modern civil commitment law is based on both powers. After the last pro-emancipation reform turn of the cycle in the 1970s, most states established parallel standards that protect persons against incarceration based on symptoms of psychiatric disability alone. In addition to evidence of that disability, the state must show they are too disabled to care for themselves or are a danger to themselves or others.¹¹ The United States Supreme Court has recognized that protecting human dignity is an independent basis for state power that informs and goes beyond the exercise of *parens patriae* or police powers. A careful reading of past precedents¹² and the Court's most recent decision on the rights of people with serious mental illness¹³ suggest that revised mental health codes do pass constitutional muster. These decisions embrace the principles of a "dignity-based" approach to civil commitment.

Dignity as a legal value has long animated movements to reform treatment of people with psychiatric disabilities and was at the core of the last wave of reform laws in the 1970s, which largely favored emancipation.¹⁴ The concept has evolved rapidly in recent decades.

Without Parents: Juvenile Justice in a Postmodern Society, 16 CARDOZO L. REV. 1363, 1367 (1995).

¹⁰ WINICK, *supra* note 9, at 42.

¹¹ See ROBERT M. LEVY & LEONARD S. RUBENSTEIN, *THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES* 15 (1996) (explaining that the government's power includes both "powers to shield vulnerable citizens from harm and to protect society from danger"); see also *id.* at 26–30 (characterizing most states as adopting an imminent dangerousness standard).

¹² *Jackson v. Indiana*, 406 U.S. 715, 720 (1972) (holding that "Indiana cannot constitutionally commit the petitioner for an indefinite period simply on account of his incompetency to stand trial . . ."); *O'Connor v. Donaldson*, 422 U.S. 563, 574–75 (1975) (explaining that mental illness, without more, is an insufficient ground for confining a person who is not a danger to herself or others); see *Zinerman v. Burch*, 494 U.S. 113, 123, 138 (1990) (explaining the need for informed consent for voluntary admission to mental hospitals); *Foucha v. Louisiana*, 504 U.S. 71, 84–86 (1992) (holding that a "[s]tate must have a particularly convincing reason . . . for [] discriminat[ing] against insanity acquittees who are no longer mentally ill").

¹³ *Indiana v. Edwards*, 554 U.S. 164, 176 (2008) (holding that a state may deny a defendant her right to self-representation at trial if doing so under conditions of mental illness would place her dignity at risk).

¹⁴ As one advocate put it, "[d]einstitutionalization will have accomplished a tremendous amount if the mentally ill can live lives of dignity and a reasonable

The first wave of international human rights law, following World War II, was based on dignity, was focused on civil and political rights associated with equality and autonomy, the so-called “negative liberties.”¹⁵ In more recent decades, human rights law has moved towards a concern with the full range of conditions that enable a recognizably human existence. These social, economic, and cultural rights include treatment of the body and mind, and the processes of suffering, disease and mortality.¹⁶

These norms find confirmation in empirically developed insights on the therapeutic effects of legal procedures.¹⁷ Moreover, developments in the jurisprudential context of civil commitment have become even more urgent and practical due to a sweeping change in the social context of civil commitment. When the last major wave of civil commitment law reform swept the country, prison population was at a twentieth-century low, as official crime policy continued to shift away from imprisonment as a tool of crime control.¹⁸ Meanwhile, state mental hospitals—the major place for incarceration of people with psychiatric disabilities—were in the midst of deinstitutionalization, a population reduction that had begun a decade earlier and was accelerating.¹⁹ In recent memory, these hospitals had

amount of comfort in the community” H. Richard Lamb, *What Did We Really Expect From Deinstitutionalization?*, 32 HOSP. & COMMUNITY PSYCHIATRY 105 (1981). Another example is found in Robert K. Patch, *The Mentally Disabled and His Lawyer*, 2 J. PSYCHIATRY & L. 33, 34 (1974) (describing mentally disabled people as being denied their dignity).

¹⁵ See, e.g., Michael Ashley Stein, *Disability Human Rights*, 95 CAL. L. REV. 75, 77–78 (2007) (describing “negative rights” as the dominant focus of early human rights work); MICHAEL IGNATIEFF ET AL., HUMAN RIGHTS AS POLITICS AND IDOLATRY 56–57 (Amy Gutmann ed., 2001) (explaining that “human rights is only a systematic agenda of ‘negative liberty’”).

¹⁶ See Stein, *supra* note 15, at 78 (describing a second generation of rights focused on social and cultural needs).

¹⁷ WINICK, *supra* note 9, at 47; see TOM R. TYLER, WHY PEOPLE OBEY THE LAW 6–7 (2006).

¹⁸ JEREMY TRAVIS, BRUCE WESTERN & STEVE REDBURN, THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES 3 (2014) (ebook) (explaining that growth in incarceration began in the early 1970s).

¹⁹ PHIL BROWN, THE TRANSFER OF CARE: PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS AFTERMATH 47 (1985) (noting a rapid decline between 1955 and 1971 in the percentage of psychiatric episodes that were treated in state hospitals).

operated much like prisons without rehabilitation or release dates.²⁰ Indeed, the most significant goal of reform was to place significant and repeated legal obstacles in the path of further incarceration of people with psychiatric disabilities who posed no significant risk to themselves or others and who could receive more effective treatment in the community.²¹

In the intervening forty years, a revolution in criminal justice policies led to an enormous expansion of the prison population. As prison sentences became less individualized through a variety of mechanisms—including determinate sentences, mandatory minimums, and prosecutorial discretion—unprecedented numbers of people with serious mental illness found themselves confined in prisons and jails.²² For a long time this problem was largely invisible, but, since the 1990s, a growing tide of evidence and litigation has focused attention on the fact that jails and prisons have become the new mental hospitals. In California, more than a quarter of prisoners are diagnosed with a major mental illness.²³ The conditions facing these prisoners have been especially horrific because prisons have lost what little capacity for individualized surveillance and care they once had. These prisons were built to maximize the size of the confined population and have not emphasized treatment, education, or training.²⁴ In one of the strongest prisoner-rights decisions in a generation, a narrow majority of the United States Supreme Court

²⁰ See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563, 569, 576 (describing the hospital where Donaldson was confined for fifteen years as a “simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness”).

²¹ WINICK, *supra* note 9, at 2.

²² See E. FULLER TORREY ET AL., TREATMENT ADVOC. CTR., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 1 (2010) (finding that, as of 2005, there were “more than three times more seriously mentally ill people in jails and prisons than in hospitals”).

²³ *Coleman v. Brown*, 28 F. Supp. 3d 1068, 1074 (E.D. Cal. 2014).

²⁴ See, e.g., JONATHAN SIMON, MASS INCARCERATION ON TRIAL: A REMARKABLE COURT DECISION AND THE FUTURE OF PRISONS IN AMERICA 11 (2014) (discussing California’s prison system and the “zero-sum contest between the dignity of prisoners and public safety, which promoted deliberate indifference to the needs of prisoners, from physical and mental health care needs to the need for decent accommodation free from overcrowding and other forms of cruel and unusual punishment”).

recently upheld a gargantuan prison population reduction order against California.²⁵ The Court focused on the fate of prisoners with serious psychiatric disabilities, which was extensively documented in the record.²⁶ Since then, there has been growing recognition of the cruelty of imprisoning people with severe psychiatric disabilities.²⁷ This recognition provides common ground between consumers or survivors of psychiatric medicine, who view any increase in coercion as a setback from the gains achieved in the last period of reform²⁸ and family members, who have in recent years advocated for more intervention-friendly laws.²⁹

The way to build on that common ground is with a dignity-based approach to civil commitment law, informed by contemporary de-

²⁵ *Brown v. Plata*, 131 S. Ct. 1910, 1922, 1928–29 (2011) (holding that prison conditions that deny human dignity, including the failure to provide adequate medical and mental health care, violated the Eight Amendment).

²⁶ *Id.* The order required the state to reduce its chronic hyper-incarceration from nearly 200% of its prisons' design capacity to a mere 137.5% of design capacity within two years. *See Brown*, 131 S. Ct. at 1923–24, 1928.

²⁷ *See, e.g.*, Jonathan Simon, *Mass Imprisonment: From Social Policy to Social Problem*, in *THE OXFORD HANDBOOK OF SENTENCING AND CORRECTIONS* 23, 23–52 (Joan Petersilia & Kevin R. Reitz eds., 2012); Jennifer L. Skeem & Jillian K. Peterson, *Identifying, Treating, and Reducing Risk for Offenders with Mental Illness*, in *THE OXFORD HANDBOOK OF SENTENCING AND CORRECTIONS*, *supra*, at 521 (Joan Petersilia & Kevin R. Reitz, eds., 2012); Craig Haney, *The Psychological Effects of Imprisonment*, in *THE OXFORD HANDBOOK OF SENTENCING AND CORRECTIONS*, *supra*, at 584 (Joan Petersilia & Kevin R. Reitz eds., 2012).

²⁸ Michael Rembis, *The New Asylums: Madness and Mass Incarceration in the Neoliberal Era*, in *DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA* 139, 152 (Liat Ben-Moshe et al. eds., 2014) (describing the work of mental health survivors and “mad activists,” who are concerned about mass incarceration but wary about expanding treatment powers).

²⁹ *See* E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 128 (2008) (noting a “massive increase in the number of mentally ill persons in jails and prisons” as a “consequence of emptying public psychiatric hospitals and then passing laws that prevent the treatment of individuals after their release”); MARY BETH PFEIFFER, *CRAZY IN AMERICA: THE HIDDEN TRAGEDY OF OUR CRIMINALIZED MENTALLY ILL* xiii (2007) (describing the more than 300,000 people with mental illnesses in prisons and jails as a major reason to reform the system for involuntary treatment).

velopments in disability human rights and therapeutic jurisprudence. In this essay we discuss three core principles that could provide a way out of the cycles of incarceration and emancipation.³⁰

A. Narrative Autonomy

A dignified approach requires that those subject to commitment proceedings be treated as persons whose own narrative is given specific and genuine consideration throughout the legal process itself and in any clinical treatment process that follows. This should be the approach notwithstanding the gravity of their disease. One way of conceptualizing this principle is to observe that civil commitment temporarily separates the narrative side of human dignity from the executive, or decision-making side, but leaves the former intact. The suspension of executive autonomy is a harsh blow to human dignity and should be done with great reluctance. But, it should never mean a suspension of narrative autonomy. Indeed, the more decision-making autonomy is impeded, the more closely and sincerely narrative autonomy should be honored.³¹

B. Minimization of Incarceration

The second core principle is for courts to minimize the chance and severity of incarceration, while being mindful of the high risks confinement poses to the dignity and health of people with psychiatric disabilities. Under the *parens patriae* or police power theories,³² persons who are not an immediate existential threat to themselves or another, should not be incarcerated for treatment under this

³⁰ We make no claim of originality here; these principles are well established in both human rights law and therapeutic jurisprudence. Our contribution is strategic: we suggest how a reform agenda can take up and build support for these principles.

³¹ In Germany (and other European countries), where dignity has formed the core value behind an elaboration of rules for prisons and psychiatric hospitals, inmates must be addressed by formal name and with the honorific title used commonly to address a citizen. See JAMES Q. WHITMAN, *HARSH JUSTICE: CRIMINAL PUNISHMENT AND THE WIDENING DIVIDE BETWEEN AMERICA AND EUROPE* 8 (2003).

³² Most states couple this with the closely related form of conservatorship, which is typically applied when persons with mental illness are unable to care for themselves sufficiently to assure survival. It is different than a threat to self posed in civil commitment, which amounts to a suicide risk.

dignity-based principle. In a society where harsh penal laws and uncompromising policing make it highly likely that many of the most marginal and vulnerable people will end up detained largely as a result of their disabilities, the state must minimize detention. It must also assure that access to treatment is guaranteed and that the length of incarceration is limited.

When the last wave of civil commitment reform took place, the potential for hospitals to become places of long-term or permanent exclusion from the community remained fresh in memory and often a real threat. Today, incarceration through civil commitment has diminished to the point where it is dwarfed by the number of those with psychiatric disabilities who inhabit prisons and jails.³³ When hospitalization is ordered, the pressure of institutional incentives, primarily economic incentives, favors early release.³⁴ Few efforts are made to re-imprison those who might relapse until they do.³⁵ In contrast, penal incarceration through criminalization has become routine to the point of social normality in some communities.³⁶ When it does occur, extended prison terms have become commonplace, and powerful institutional incentives favoring recidivism make re-incarceration highly likely.³⁷

C. Progressivity

Third, we advocate an approach to civil commitment that recognizes that incarceration is inherently damaging and becomes moreso with time. The damage is compounded when there is evidence that incarceration is achieving little positive effect. Even when based on

³³ TORREY, *supra* note 29, at 2, 129 (noting that there were approximately 40,000 Americans in public mental hospitals in 2006, as opposed to an estimated 218,600 seriously mentally ill prisoners in mid-2005).

³⁴ PAUL R. LINDE, DANGER TO SELF: ON THE FRONT LINE WITH AN ER PSYCHIATRIST 101–02 (2010) (ebook) (describing the legal and insurance pressures on psychiatrists to release patients from involuntary treatment quickly).

³⁵ *Id.* at 103 (observing the “revolving door” between release and relapse).

³⁶ TRAVIS, *supra* note 18, at 68 (observing that, “[a]mong recent cohorts of African American men, 70 percent of those who dropped out of [high] school served time in state or federal prison”).

³⁷ JOAN PETERSILIA, WHEN PRISONERS COME HOME: PAROLE AND PRISONER REENTRY 139–41 (2003) (documenting high recidivism rates associated with policies that favor simple custody over the development of rehabilitative programs in prison or re-entry programs for released prisoners).

criminal behavior, prison sentences violate the Eighth Amendment when they continue past the point where further incarceration will deepen the prisoner's psychiatric disabilities.³⁸ States have an affirmative obligation to protect the human dignity of their residents by developing prosecution and sentencing policies that prevent the state from imprisoning people with psychiatric disabilities, especially for prolonged periods. These three principles have broad support in contemporary human rights law and in academic research on therapeutic jurisprudence and procedural justice. They form the core of a dignified civil commitment regime that aims to prevent cycles of over-incarceration. They also form a practical framework for advancing common ground between multiple stakeholders.

II. CYCLES OF INCARCERATION AND EMANCIPATION IN THE UNITED STATES

Since this country's independence, we have witnessed two complete turns of this cycle. The first began as Americans in the early Republic responded to the wrenching social transformations unleashed by the Revolution. They embraced "asylums" as the so-called new total institutions dedicated to the care of people with psychiatric disabilities.³⁹ By the Civil War, however, the failure of significant new treatments to emerge, and gross underinvestment in operating these total institutions, led to a public scandal over inhumane treatment and unnecessary confinement in horrible conditions. Many elites were convinced that new laws should zealously guard the citizen against involuntary commitment.⁴⁰

Enthusiasm for incarceration returned at the turn of the twentieth century. Asylums, now rebranded with terms like "psychopathic

³⁸ See *Madrid v. Gomez*, 889 F. Supp. 1146, 1244–45, 1258–59 (N.D. Cal. 1995).

³⁹ DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* xiv (1st ed. 1971).

⁴⁰ *Id.* at 242–43.

hospital,” were once again seen as an instrument of social improvement.⁴¹ Although reformers were venerated as liberators who unbound the mad, they sought less to eliminate confinement than to reinvent it in new, more medically effective forms. Virtually every state built public hospitals in the nineteenth century and expanded them into multi-hospital systems in the twentieth century.⁴² The latter wave was inspired, in large part, by new concerns for the consequences of eugenics. This was part of the broader reaction to mass immigration, but it cast in a new light the danger of allowing the mentally and morally defective to remain free.⁴³

Concerns over the fate of impoverished laborers living in cities swollen with uneducated immigrants displaced an earlier generation’s concerns about over-incarceration without due process.⁴⁴ “Progressives” saw expert-guided administrative discretion as the key to addressing many of the social problems of this class. They enacted laws from World War I through the Great Depression aimed at making it easier to imprison individuals believed to be psychiatrically disabled or “defective” with a minimum of legal oversight.⁴⁵

Despite the promise of more effective short-term hospitalization, the long-term hospitalized population expanded to unprecedented levels, peaking in 1955.⁴⁶ Their poor conditions became a major focus of investigative journalists and political reformers.⁴⁷

This set the scene for the close of the second cycle. Animated by evidence that the enlarged hospital system was failing to provide either treatment or humane conditions, and by the post-War concern with human rights and civil liberties, reformers went to both courts and state legislatures. They sought to enact new laws protecting people with mental illness against incarceration. This culminated in key

⁴¹ See generally IAN ROBERT DOWBIGGIN, *KEEPING AMERICA SANE: PSYCHIATRY AND EUGENICS IN THE UNITED STATES AND CANADA, 1880 TO 1940* (Cornell University Press, 1997).

⁴² *Id.*

⁴³ *Id.*

⁴⁴ See Roscoe Pound, *The Administration of Justice in the Modern City*, 26 HARV. L. REV. 302, 311 (1913).

⁴⁵ DAVID J. ROTHMAN & SHEILA M. ROTHMAN, *THE WILLOWBROOK WARS: BRINGING THE MENTALLY DISABLED INTO THE COMMUNITY* 4 (2005).

⁴⁶ WINICK, *supra* note 9, at 2.

⁴⁷ PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 210–14 (1994).

judicial precedents and new statutes from 1965 to 1980.⁴⁸ It took at least a decade for new statutes to generate new practice norms and routines.

The jurisprudence that emerged limited confinement to situations in which the state presents evidence of imminent danger.⁴⁹ The Supreme Court held that incarcerating people who are not a threat to themselves or others, and who are not receiving treatment, violates their right to due process under the Fifth and Fourteenth Amendments.⁵⁰ Although this leaves room under the constitutional limit for incarcerating people with psychiatric disabilities who are actually receiving treatment, most states have further limited confinement by adopting “danger to self or others” or “grave disability” (defined as incapable of self-care or life sustaining activities) standards as the limit on civil commitment authority.⁵¹

California’s reform statute became a model for the highly anti-carceral approach to civil commitment law.⁵² The state followed the nation in the two cycles of incarceration and emancipation described above, but in a characteristically extreme version.⁵³ When the state was founded in 1851, California embraced with fervor the

⁴⁸ See ANDREW T. SCULL, *DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT—A RADICAL VIEW* 41–58 (2d ed. 1984); BROWN, *supra* note 19, at 29 (noting that “war had prevented much attention [from] being given to asylum conditions, but in the postwar period impetus was provided by journalists’ exposés of the hospitals and by lobbying efforts of the mental health professions which had expanded in wartime service”); RAELEEN ISAAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* 109, 125 (1990).

⁴⁹ See TORREY, *supra* note 29, at 28 (discussing the origin of the dangerousness standard).

⁵⁰ See *Jackson v. Indiana*, 406 U.S. 715, 731 (1972) (holding that “Indiana’s indefinite commitment of a criminal defendant solely on account of his incompetency to stand trial does not square with the Fourteenth Amendment’s guarantee of due process”).

⁵¹ WINICK, *supra* note 9, at 42.

⁵² APPELBAUM, *supra* note 47, at 26–27.

⁵³ California has been at the forefront of most important social, political, and economic trends since at least the beginning of the twentieth century. See KEVIN STARR, *INVENTING THE DREAM: CALIFORNIA THROUGH THE PROGRESSIVE ERA* 199 (1985).

asylum project initiated half a century earlier in the Northeast, building state hospitals on an unprecedented basis.⁵⁴ While advocates “back East” emphasized the asylum’s aspirations for treatment, California embraced the asylum largely as a mechanism to segregate a segment of the population viewed as dangerous, or at least burdensome.⁵⁵

Waves of domestic migrants arriving from the East, along with Mexican and Asian immigrants, led to a deficit in social trust and solidarity.⁵⁶ This dynamic demography made the state’s voters prone to anxiety about deviance of all sorts.⁵⁷ At the same time, Californians’ progressive confidence in the ability of government to solve problems with science and technology must have made the mental hospital highly attractive, with its aura of medical treatment. By the time professional and public opinion began turning against hospitals in the 1950s, California had one of the highest involuntary hospitalization rates in the nation⁵⁸ and a troubling history of human rights abuses, including forced sterilization of patients.⁵⁹ The backlash was particularly strong, and the state established an early and influential approach that would define the extreme wing of the anti-hospitalization trend. The Lanterman Petris Short Act (LPS Act), adopted in 1969, established a new substantive legal standard for coerced treatment or hospitalization.⁶⁰ No longer would a diagnosis of mental illness and a doctor’s judgment that an individual would

⁵⁴ RICHARD W. FOX, *SO FAR DISORDERED IN MIND: INSANITY IN CALIFORNIA, 1870–1930* 17–18, 42 (1978).

⁵⁵ *Id.* at 17 (explaining that “[f]rom their very beginnings in the 1850s they were clearly understood to be not simply treatment facilities for the mentally disturbed, but also detention facilities for ‘imbeciles, dotards, idiots, drunkards, simpletons, fools,’ for the ‘aged, the vagabond, the helpless[.]’”).

⁵⁶ David Ward, *Population Growth, Migration, and Urbanization, 1860–1920*, in *NORTH AMERICA: THE HISTORICAL GEOGRAPHY OF A CHANGING CONTINENT* 292 (Thomas F. McIlwraith & Edward K. Muller eds., 2d ed. 2002).

⁵⁷ See generally JOAN DIDION, *WHERE I WAS FROM* 106–07, 171–73 (2003).

⁵⁸ FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA’S MENTAL ILLNESS CRISIS* 206 (1997).

⁵⁹ DIDION, *supra* note 57, at 194; TORREY, *supra* note 58, at 82.

⁶⁰ CAL. WELF. & INST. CODE § 5000 (West 2015).

benefit from treatment suffice. Only when persons with mental illness pose a threat to themselves or others or are shown to be “gravely disabled” may a court order hospitalization or treatment.⁶¹

Under LPS, police have the authority to arrest someone they have probable cause to believe meets the dangerousness or grave disability standard as a result of a psychiatric emergency.⁶² They may take that person to a hospital where psychiatric professionals have up to 72 hours to evaluate the person.⁶³ Confinement for treatment after that is generally limited to periods of no more than 14 days based on an ongoing assessment that the person is a threat to self or others.⁶⁴ Those who meet the grave disability criteria can be incarcerated for longer periods, up to 180 days.⁶⁵ Both these forms of extended detention and treatment must be approved by a hearing officer at which the detained individual is entitled to be present and represented.⁶⁶

Since the late 1990s, growing recognition of the failure of community treatment programs to become widely available has led to a movement for legal reforms permitting earlier treatment, if not easier incarceration.⁶⁷ This recognition has been punctuated by highly publicized, albeit rare, instances of sudden violence against

⁶¹ *Id.* § 5250. In addition to the new standards, LPS imposed a strict time line. A person could be held on an emergency basis for up to seventy-two hours for evaluation. Following that, if medical professionals found that the person continued to pose an imminent threat of violence they could authorize another fourteen days of custody, an order which could be renewed once for a total of twenty-eight days. After the first fourteen days the law requires a court to consider whether the standard is met, and the patient can seek an earlier review through a writ of habeas corpus. LPS represents the most restrictive of the legal standards adopted by states in the 1970s under the prod of Supreme Court decisions holding the older permissive admission standards unconstitutional. *See* Jackson v. Indiana, 406 U.S. 715, 730 (1972); O’Connor v. Donaldson, 422 U.S. 563, 575 (1975).

⁶² CAL. WELF. & INST. CODE § 5150 (West 2015); *see* A.B.A., ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS § 7-2.1 (1989).

⁶³ *Id.*

⁶⁴ WELF. & INST. § 5250; *see* 1 HEALTH L. PRAC. GUIDE § 17:16, Westlaw (database updated May 2015).

⁶⁵ WELF. & INST. §§ 5008, 5300; *see* 1 HEALTH L. PRAC. GUIDE § 17:16, *supra* note 64.

⁶⁶ WELF. & INST. §§ 5275, 5276.

⁶⁷ John Petrila & Annette Christy, *Florida’s Outpatient Commitment Law: A Lesson in Failed Reform?*, 59 PSYCHIATRIC SERVS. 21, 21–23 (2008).

strangers by mentally ill individuals.⁶⁸ A number of states have adopted laws allowing forms of “outpatient treatment,” which provide a legal mandate to supervise and provide treatment to a person with a psychiatric disability whose symptoms are becoming alarming but do not necessarily meet the LPS or similar civil commitment standards.⁶⁹ These laws attempt to use the promise of supportive services in the community and the threat of time-limited emergency incarceration for evaluation, to persuade reluctant patients to resume a treatment strategy that will be overseen by state professionals.⁷⁰ Empirical research on the most extensive outpatient commitment system, New York’s “Kendra’s Law,”⁷¹ suggests that participants have lower rates of return hospitalizations.⁷²

⁶⁸ *Id.*

⁶⁹ *Id.*; see §§ 5349, 5150; N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2013); WELF. & INST. § 5150 (AB 1421) (2002). The primary justification for this form of treatment is that the population, which the law targets, is currently suffering the consequences of a critical gap in services between voluntary programs and involuntary commitment. See, e.g., *Mental Health: Involuntary Treatment: Hearing on AB 1421 Before the S. Health and Human Serv.’s Comm.*, 2002 Legis., 2001-2002 Sess. 9 (Cal. 2002) (statement of Helen Thomson), http://www.leginfo.ca.gov/pub/01-02/bill/asm/ab_1401-1450/ab_1421_cfa_20020621_100959_sen_comm.html. Professor Elyn Saks argues that individuals may not realize the benefits of consistent medication until they have the opportunity to experience its benefits over time, an opportunity that assisted outpatient treatment orders can provide. Elyn R. Saks, *Involuntary Outpatient Commitment*, 9 PSYCHOL. PUB. POL’Y & L. 94 (2003). Whether referred to as “assisted” or “involuntary,” outpatient treatment tends to reflect one’s support or opposition. Opponents usually stress the *involuntary* aspect or *commitment*, whereas proponents prefer the kinder, gentler *assisted* treatment.

⁷⁰ WELF. & INST. § 5150.

⁷¹ *Id.* It is noteworthy that in both New York and California the outpatient commitment laws are named after victims of lethal assaults by mentally ill individuals, “Kendra’s Law” (N.Y. MENTAL HYG. LAW § 9.60) and “Laura’s Law” (WELF. & INST. § 5345) respectively. See *An Explanation of Kendra’s Law*, OFFICE OF MENTAL HEALTH, http://www.omh.ny.gov/omhweb/Kendra_web/Ksummary.htm (last visited August 4, 2015); *Laura’s Law*, TREATMENT ADVOC. CTR., <http://www.treatmentadvocacycenter.org/lauras-law> (last visited Aug. 4, 2015).

⁷² John Petrila, M. Susan Ridgely & Randy Borum, *Debating Outpatient Commitment: Controversy, Trends, and Empirical Data*, 49 CRIME & DELINQUENCY 157, 161–62 (2003).

However, it is not clear that outpatient commitment laws add new powers not already present under the prevailing civil commitment regime.⁷³ Most contemporary laws already favor outpatient treatment when it is clinically effective as a matter of using the least intrusive means to effectuate the state interest.⁷⁴ Thus, if outpatient commitment laws leave in place the existing legal standards for civil commitment, they seem to offer little promise of preventing over-incarceration. If, however, these laws are intended to change the standard to one that is more facilitative of coercive treatment, they leave that standard implicit and subject to arbitrary and uncertain application.⁷⁵

III. A DIGNITY APPROACH TO CIVIL COMMITMENT

While dignity has been treated as a central topic in both moral philosophy and theology, it is perhaps in law that reference to the modern conception of dignity has been most significant in our time.⁷⁶ Long limited to issues arising from special status holders like judges or government officials, dignity has been given a universal endorsement by post-World War II human rights laws, as noted above. Despite not appearing in the text of the U.S. Constitution, dignity has also long figured into the constitutional jurisprudence of the United States Supreme Court, especially in the last decade.⁷⁷

⁷³ This was the late Bruce Winick's objection to outpatient commitment laws. See WINICK, *supra* note 9, at 42, 47.

⁷⁴ See *id.*; John D. Cameron, *Balancing the Interests: The Move Towards Less Restrictive Commitment of New York's Mentally Ill*, 14 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 91, 92 (1988).

⁷⁵ Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183, 196–99 (2003) (listing many unanswered questions about Kendra's Law).

⁷⁶ JEREMY WALDRON, *DIGNITY, RANK, AND RIGHTS* 13 (Meir Dan-Cohen ed., 2012).

⁷⁷ See Leslie Meltzer Henry, *The Jurisprudence of Dignity*, 160 U. PA. L. REV. 169, 171–72 (2011) (noting an increasing prominence of dignity in the Supreme Court's jurisprudence and a shift in location from dissenting opinions to majority opinions and from the Court's most liberal members to some of its most conservative).

The concept of dignity shaping modern law has its roots in two traditions of the ancient world.⁷⁸ According to Biblical sources of the Abrahamic religions, human beings are envisioned as embodying an essential and inalienable dignity.⁷⁹ This is derived from their special place in creation, i.e. created in God's image (*b'tzelem Elohim* or *imago Dei*).⁸⁰ A second conception of dignity emerges from Greek and Roman conceptions of the legal meaning of noble status.⁸¹ High-status male individuals were endowed with dignity.⁸² This quality was strictly limited to the elite class, and was not so much earned, as it was reflected in virtuous conduct.⁸³ Over time, this high-status meaning of dignity has been extended to whole populations through mechanisms like universal national citizenship and human rights treaties, albeit with uneven results.⁸⁴

In his recent work, legal philosopher Jeremy Waldron has argued that, despite their contradictions, the Greco-Roman concept of honor and the Judeo-Christian concept of equal relationship to the divine have merged into modern legal concepts of dignity.⁸⁵ Of course, not all of the privileges once accorded to high-status individuals have survived in the development of the modern rights and privileges of citizenship. However, those that have survived apply to all of us.⁸⁶

⁷⁸ WALDRON, *supra* note 76, at 30–32 (explaining how the Roman-Greek conception of dignity was not so much superseded as transvalued by the Judeo-Christian conception).

⁷⁹ Nora Jacobson, *Dignity and Health: A Review*, 64 SOC. SCI. & MED. 292, 293 (2007); Margit Cohen & Dieter Grimm, *Human Dignity as a Constitutional Doctrine*, in THE ROUTLEDGE HANDBOOK OF CONSTITUTIONAL LAW 193, 193 (Mark Tushnet et al. eds., 2013).

⁸⁰ *Id.*

⁸¹ Jacobson, *supra* note 79, at 293; Cohen & Grimm, *supra* note 79, at 193.

⁸² Deryck Beyleveld & Roger Brownsword, *Human Dignity, Human Rights, and Human Genetics*, 61 MOD. L. REV. 661, 666–67 (1998).

⁸³ *Id.*

⁸⁴ See Christopher McCrudden, *Human Dignity and Judicial Interpretation of Human Rights*, 19 EUR. J. INT'L L. 655, 660 (2008); Jeremy Waldron, *Citizenship and Dignity* 8–13 (N.Y.U. Law Sch. Pub. Law & Legal Theory Research Paper Series, Working Paper No. 12-74, 2013), <http://ssrn.com/abstract=2196079>.

⁸⁵ WALDRON, *supra* note 76, at 14.

⁸⁶ Waldron frames the project of refining the legal meaning of dignity as “express[ing] the idea of the high and equal rank of every human person . . . we should look first at the bodies of law that relate status to rank (and to right and privilege)

“Liberty as Dignity” also stems from Greek and Roman sources, particularly Cicero, who was among the first philosophers to rely on the concept, which he tied to rationality.⁸⁷ The connection between rationality, liberty, and dignity was at the heart of the most influential modern philosophical treatment of dignity: the works of Immanuel Kant.⁸⁸

While dignity has thus far had “minimal direct application to the rights of persons with mental disabilities”⁸⁹ in the United States, the exponential increase in the frequency of criminal sentencing has created conditions of widespread degradation that urgently require a new approach. Confinement of the mad in jails and prisons is part of a much broader trend that caused the overall level of imprisonment in the U.S. to increase more than five-fold between the 1970s

and see what if anything is retained of these ancient conceptions when dignity is put to work in a new and egalitarian environment.” *Id.*

⁸⁷ See David Luban, *Human Rights Pragmatism and Human Dignity*, in PHILOSOPHICAL FOUNDATIONS OF HUMAN RIGHTS (Massimo Renzo et al. eds., forthcoming), at 19–20.

⁸⁸ IMMANUEL KANT, *GROUNDWORK OF THE METAPHYSICS OF MORALS* 17–18 (Mary Gregor ed. & trans., 1998) (1785) (noting the relationship between rationality and dignity in man). Kant’s work on dignity has been influentially interpreted by the contemporary U.S. philosopher Alan Gewirth. See Alan Gewirth, *Human Dignity as the Basis of Rights*, in *THE CONSTITUTION OF RIGHTS: HUMAN DIGNITY AND AMERICAN VALUES* 10, 11 (Michael J. Meyer & William A. Parent eds., 1992) (recognizing how Kant connected human rights, one’s duty to others, and dignity).

⁸⁹ Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 20, 33 (2004).

and the first decade of this century.⁹⁰ Sociologists describe this process as “mass imprisonment” or “mass incarceration.”⁹¹

Critics dismiss dignity as a legal concept on the ground that it is too indeterminate and subjective to provide judgments or even guidance to judges and other legal interpreters.⁹² Some defenders of dignity would seek to narrow its application to norms that moral philosophers can demonstrate with rigorous analysis.⁹³ These truly universal human norms would be products of pure reason, rather than culturally or historically specific standards.⁹⁴ On the other hand, we adopt the alternative approach—the pragmatist approach—that sees dignity as enhanced and made more objective by historical context.⁹⁵

A human rights pragmatist, on the other hand, insists that the meaning of the phrase ‘human dignity’ is not defined by a philosophical theory, but rather determined by its use in human rights practice. In a sense,

⁹⁰ There was no direct conversion of the hospitalized population to prison. Indeed, during the first half of the 1970s, both mental hospitals and prisons saw their populations dropping. See FRANKLIN ZIMRING, GORDON HAWKINS & SAM KAMIN, *PUNISHMENT AND DEMOCRACY: THREE STRIKES AND YOU’RE OUT IN CALIFORNIA* 155 (2001). It was in the 1980s that new policies, promoted by prosecutors and law enforcement and embraced by California’s tough-on-crime governor, George Deukmejian, began to change sentencing policies that in previous decades would have kept many people with untreated mental illness, even if they had remained in the criminal process, from being given state prison sentences. Many crimes that are particularly easy for people with untreated mental illness to fall into, like small-scale drug trafficking and burglary, are crimes where mass incarceration has tipped the scales decisively in favor of incarceration in state prison. See TORREY, *supra* note 29, at 39–53 (describing both deinstitutionalization and increasing imprisonment of mentally ill in California).

⁹¹ See MASS IMPRISONMENT: SOCIAL CAUSES AND CONSEQUENCES 1 (David Garland ed., 2001); BRUCE WESTERN, *PUNISHMENT AND INEQUALITY IN AMERICA* 28–29 (2006).

⁹² See Oscar Schachter, *Human Dignity as a Normative Concept*, 77 AM. J. INT’L L. 848, 849 (1983).

⁹³ This is sometimes discussed as the “foundationalist” approach to dignity. See Luban, *supra* note 87 (noting that foundationalism recognizes that human rights are universal and can be codified). For an example of such a foundationalist classic, see Gewirth, *supra* note 83, at 11 (noting the relationship between dignity and inherent human rights).

⁹⁴ *Id.*

⁹⁵ Luban, *supra* note 87, at 20.

the pragmatist reverses the order of explanation, defining ‘human dignity’ by its inferential commitments rather than the other way around.⁹⁶

A. *Five Cluster Approach to the History of Dignity*

Taking a historical approach can help make sense of what seems to be a plethora of meanings, even within the narrow lens of the U.S. Supreme Court’s use of the term. In a recent analysis of the Court’s treatment of dignity, Professor Leslie Henry identifies five core meanings that continue to have some relevance in contemporary law and that share overlapping features.⁹⁷ However, no single set of factors describes all of them.⁹⁸ Henry’s five clusters are: “institutional status as dignity,” “equality as dignity,” “liberty as dignity,” “personal integrity as dignity,” and “collective virtue as dignity.”⁹⁹ Despite dignity having ongoing relevance in the contemporary period, his analysis suggests there is also a temporal sequence.¹⁰⁰ When viewed historically, these clusters suggest there can be considerable reach, but also precision and limits to using dignity to shape constitutional doctrine.¹⁰¹

1. INSTITUTIONAL STATUS AS DIGNITY

For much of the period between the Revolution and the middle of the twentieth century, dignity was confined largely to the first category: institutional status as dignity.¹⁰² By the time of the adoption of the Constitution, the United States renounced the power to ennoble an aristocracy, but shifted that hierarchical sense of dignity to the state itself and its officials.¹⁰³ For much of the next century and a half, dignity figured into case law mostly as a property of government, especially states and courts.¹⁰⁴ This began to change in the

⁹⁶ *Id.*

⁹⁷ Henry, *supra* note 77, at 188–90 (“Dignity is not a fixed category, but rather a series of meanings that share a Wittgensteinian family resemblance.”).

⁹⁸ *Id.*

⁹⁹ *Id.* at 189–90.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 188–90.

¹⁰² *Id.* at 190, 193.

¹⁰³ *Id.* at 193–94.

¹⁰⁴ *Id.*

twentieth century and accelerated significantly after World War II.¹⁰⁵

This first phase of the modern emergence of dignity as a strong source of individual rights took place against the background of the Holocaust in Europe, the exposure of the crimes of Stalinism in the Soviet Union, and Jim Crow racism in the southern United States. These themes echo throughout the jurisprudence. Internationally, this first dignity wave produced the *Universal Declaration of Human Rights* in 1948.¹⁰⁶ In Europe, it gave rise to the European Convention on Human Rights in 1950.¹⁰⁷ The dignity that emerged in American Constitutional law around this same time was not always explicitly raised. Rather, it was expressed in more canonical constitutional words and phrases, like “due process,” “liberty,” and “equality.”¹⁰⁸ In *Miranda v. Arizona*,¹⁰⁹ one can find a strong example of the Court’s view of dignity as a larger value underlying many of the particular protections for the criminal suspect:

“All these policies [regarding the privilege against self-incrimination] point to one overriding thought: . . . the respect a government—state or federal—must accord to the dignity and integrity of its citizens.”¹¹⁰

Another key expression of this dignity pulse (although, again, often implicit) was in the jurisprudence of the Warren Court, beginning with *Brown v. Board of Education*.¹¹¹

¹⁰⁵ *Id.* at 178.

¹⁰⁶ See SAMUEL MOYN, *THE LAST UTOPIA: HUMAN RIGHTS IN HISTORY 2* (2010) (discussing context in which UDHR was framed).

¹⁰⁷ *Id.* at 191.

¹⁰⁸ Examples of due process cases include the following major criminal procedure decisions: *Mapp v. Ohio*, 367 U.S. 643, 650–51, 55 (1961); *Miranda v. Arizona*, 384 U.S. 436, 478 (1966); *Schmerber v. California*, 384 U.S. 757, 759 (1966). Examples of the latter include the following: *Brown v. Bd. of Educ.*, 347 U.S. 483, 488 (1954); *Loving v. Virginia*, 388 U.S. 1, 7–8 (1967); *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 437, 446 (1985).

¹⁰⁹ 384 U.S. 436 (1966).

¹¹⁰ *Id.* at 460.

¹¹¹ 347 U.S. 483, 493 (1954) (holding that racial segregation in schools is unequal treatment).

2. DIGNITY AS EQUALITY

Dignity as equality is a theme that finds expression as early as the Declaration of Independence, which proclaims that “all men are created equal.”¹¹² In the Constitution, there is a ban on all “title[s] of nobility.”¹¹³ This feature stems directly from the Judeo-Christian tradition and its premise that the common bond of divine creation trumps all forms of worldly status.¹¹⁴ The Fourteenth Amendment gives equality direct expression in its promise of Equal Protection under state law (and, which the Court has found, binds federal law as well through the Fifth Amendment).¹¹⁵ While equality can be conceived as a problem of formal comparisons between specified groups or individuals,¹¹⁶ the Supreme Court has frequently expressed a concern with how the government treats its citizens based on their status. For example, in *Loving v. Virginia*,¹¹⁷ where the Court held that laws criminalizing marriage between persons of different racial backgrounds were unconstitutional, the Court stated:

To deny this fundamental freedom on so unsupportable a basis as the racial classifications embodied in these statutes, classifications so directly subversive of the principle of equality at the heart of the Fourteenth Amendment, is surely to deprive all the State’s citizens of liberty without due process of law.¹¹⁸

The Court has also affirmed equal protection of the law for certain vulnerable minority groups, even without a finding of “suspect classification” or “fundamental right.”¹¹⁹ Protection is warranted

¹¹² THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776) (“We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.”).

¹¹³ U.S. CONST. art. I, § 9, cl. 8 (“No title of nobility shall be granted by the United States”); U.S. CONST. art. I, § 10, cl. 1 (“No State shall . . . grant any title of nobility.”); see Henry, *supra* note 77, at 200 (quoting uses of dignity by Thomas Jefferson and Alexander Hamilton).

¹¹⁴ Jacobson, *supra* note 79, at 293.

¹¹⁵ *Bolling v. Sharpe*, 347 U.S. 497, 498–99 (1954).

¹¹⁶ *Powell v. Pennsylvania*, 127 U.S. 678, 687 (1888) (discussing equal protection and enforcement of the laws “among those engaged in the same business”).

¹¹⁷ *Loving v. Virginia*, 388 U.S. 1 (1967).

¹¹⁸ *Id.* at 12.

¹¹⁹ See *City of Cleburne*, 473 U.S. at 435–36; *Romer v. Evans*, 517 U.S. 620, 635 (1996) (holding that gays and lesbians are protected under the Equal Protection Clause).

where the law or classification in question expresses hostility toward a group that is incompatible with the state's responsibility toward the dignity of its citizens.¹²⁰ In *City of Cleburne v. Cleburne Living Center*,¹²¹ the Court extended protections to regulations that negatively classified the intellectually disabled in terms that unusually invoked dignity explicitly:

For the retarded, just as for Negroes and women, much has changed in recent years, but much remains the same; out-dated statutes are still on the books, and irrational fears or ignorance, traceable to the prolonged social and cultural isolation of the retarded, continue to stymie recognition of the dignity and individuality of retarded people.¹²²

In *Romer v. Evans*,¹²³ the Court overturned a Colorado initiative that banned municipalities from enacting gay rights protections in terms that invoke this proper respect for the citizen, stating:

It is not within our constitutional tradition to enact laws of this sort. Central both to the idea of the rule of law and to our own Constitution's guarantee of equal protection is the principle that government and each of its parts remain open on impartial terms to all who seek its assistance.¹²⁴

3. LIBERTY AS DIGNITY

Liberty is also a key feature of the high court's post-World War II dignity jurisprudence. Concern for dignity as liberty runs through the Warren Court's decisions on free speech¹²⁵ and many criminal

¹²⁰ *Id.*

¹²¹ 473 U.S. 432 (1985).

¹²² *Id.* at 467.

¹²³ 517 U.S. 620, 635 (1996) (holding that gays and lesbians are protected under the Equal Protection Clause). _

¹²⁴ *Id.* at 633.

¹²⁵ Henry, *supra* note 77, at 173 (noting the importance of free expression (citing *Cohen v. California*, 403 U.S. 15, 24 (1971))). The Fourth Amendment's right to be free from unreasonable seizures was applied to even brief street encounters. *See Terry v. Ohio*, 392 U.S. 1, 4 (1968). In *Terry*, the Court does not explicitly use the term "dignity," but it is clearly concerned with the indignity of being subjected to even a brief interference with one's business. *See id.*

procedure decisions, but finds its strongest expression in the right to privacy—culminating in the right to abortion.¹²⁶

4. PERSONAL INTEGRITY AS DIGNITY

Much of this first dignity wave in US constitutional law took place from the 1950s through the 1970s in the Warren Court and the first part of the Burger Court.¹²⁷ During the Rehnquist Court, this modest dignity trend went into a “period of hibernation” in the 1980s and 1990s.¹²⁸ During this period, state interests and administrative discretion increasingly trumped concerns about human dignity.¹²⁹ It is tempting to attribute the waning of the first phase to the Court’s rightward trend under the increasingly conservative appointments of Presidents Reagan and George H.W. Bush. The second wave, however, that is emerging today during the Roberts Court has come when the Court is no less conservative. Indeed, some of the most important “dignity opinions” have come from the Court’s conservative majority.¹³⁰

¹²⁶ See *Eisenstadt v. Baird*, 405 U.S. 438, 454–55 (1972) (holding that the Equal Protection Clause ensures that married and unmarried individuals will be treated alike concerning contraceptive use); *Roe v. Wade*, 410 U.S. 113, 153 (1973) (relating the Fourteenth Amendment, the right to privacy, and personal liberty to a woman’s right to choose to have an abortion); *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, 476 U.S. 747, 772 (1986) (finding the Pennsylvania Abortion Control Act unconstitutional based on principles of liberty).

¹²⁷ The Warren Court’s dignity jurisprudence has already been discussed. See *supra* note 125 and accompanying text; see also Charles L. Black, Jr., *The Unfinished Business of the Warren Court*, 46 WASH. L. REV. 3, 9 (1970). Perhaps the strongest dignity opinion of the era took place after Justice Warren was replaced by the more conservative Chief Justice Warren Burger. The most important example is *Furman v. Georgia*, which uses the word “dignity” no less than twenty times. See *Furman v. Georgia*, 408 U.S. 238 (1972).

¹²⁸ Henry, *supra* note 77, at 171–72.

¹²⁹ *Id.*

¹³⁰ See *id.*; *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) (upholding the federal law Partial-Birth Abortions Ban Act of 2003, which was intended to “express[] respect for the dignity of human life”); *Hudson v. Michigan*, 547 U.S. 586, 594 (2006) (explaining that the “knock-and-announce” rule protects an individual’s privacy and dignity by giving the person an opportunity to “collect oneself” before the police enter).

Instead, the shift since the 1990s is one in emphasis. The key decisions of the early period, mostly in criminal procedure, highlighted the equality and especially the liberty aspects of respect for human dignity.¹³¹ This came into direct conflict with the massive expansion in aggressive policing and prosecution associated with the war on crime and drugs and mass incarceration.¹³² The renewal of dignity taking place in recent cases emphasizes a very different aspect, which Professor Henry describes as “personal integrity as dignity.”¹³³ This invokes very different practical demands on the state. Whereas liberty or even equality mostly call for negative rights, or forbearance of state intervention, dignity as integrity attends to one’s lived experience and the physical and social relations necessary to sustain the human body and a human life. Dignity as integrity highlights “people who become vulnerable to their circumstances, express unharnessed appetites, and expose their bodily nakedness or mental fragility.”¹³⁴

In recent cases, the Court has revitalized some traditional limits on state power. For example, in *Hudson v. Michigan*,¹³⁵ Justice Scalia explained the constitutional significance of the common law “knock-and-announce” rule, which protects individual dignity by affording “the opportunity to collect oneself before answering the door.”¹³⁶

¹³¹ See cases cited *supra* note 108.

¹³² JONATHAN SIMON, GOVERNING THROUGH CRIME: HOW THE WAR ON CRIME TRANSFORMED AMERICAN DEMOCRACY AND CREATED A CULTURE OF FEAR 130–31 (2007) (describing the response of the judicial system to the war on crime).

¹³³ Henry, *supra* note 77, at 215. This line of thought has origins in classical thought: Aristotle’s virtue ethics. See *Id.* “Personal integrity as dignity” is also expounded upon by contemporary philosophers, such as Martha Nussbaum. See MARTHA C. NUSSBAUM, FRONTIERS OF JUSTICE: DISABILITY, NATIONALITY, SPECIES MEMBERSHIP 159–60 (2006) (writing that the “capabilities approach sees the world as containing many different types of animal dignity, all of which deserve respect and even awe”).

¹³⁴ Henry, *supra* note 77, at 212.

¹³⁵ 547 U.S. 586 (2006).

¹³⁶ The rule, which has its origins in the common law of England, requires the police to signal their presence and intent to enter before forcing the entry. *Hudson*, 547 U.S. at 588, 594. The delay required is very brief and is expressly not a sufficient amount of time for a resident to escape or destroy evidence of a crime. See *id.* Although the Court in *Hudson* ultimately refused to suppress evidence gather

This notion of dignity has also been visible in a series of Eighth Amendment decisions in which the Court has ruled out certain punishments by instituting bans on sentencing juveniles to death¹³⁷ or life imprisonment without parole for a non-homicide crime.¹³⁸ Perhaps the most significant recent invocation of this notion of dignity as decency is the above-referenced *Brown v. Plata* decision, which found that California’s chronically overcrowded and medically under-resourced prisons had created a risk of suffering equivalent to torture—one which was “incompatible with the concept of human dignity and has no place in civilized society.”¹³⁹

5. COLLECTIVE VIRTUE AS DIGNITY

The pairing of “human dignity” and “civilized society” (and in other instances “a decent society”) suggests that states may have distinct responsibilities and concurrent powers that extend beyond those that have historically provided the legal foundations for civil commitment.¹⁴⁰ In *Gonzales v. Carhart*,¹⁴¹ the Supreme Court upheld the Partial-Birth Abortion Ban Act of 2003, which banned certain methods of performing late-term abortions.¹⁴² After describing

in violations of this rule, it did reaffirm its constitutional status as part of the Fourth Amendment requirements of a reasonable search. *See id.* The expression “collect oneself” is an almost poetic invocation of dignity as personal integrity, and it beautifully reminds us how much this depends on both belongings and social arrangements or norms.

¹³⁷ *Roper v. Simmons*, 543 U.S. 551, 578 (2005).

¹³⁸ *Graham v. Florida*, 130 S. Ct. 2011, 2034 (2010).

¹³⁹ *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011).

¹⁴⁰ *See Henry, supra* note 77, at 222–23.

¹⁴¹ 550 U.S. 124, 157 (2007). There is a clear parallel between the Court’s invocation of decency and civilization in the Eighth Amendment cases like *Brown v. Plata* and their deployment in *Gonzales v. Carhart*, even though the Court split in very different directions. Both share a focus on the dignitary treatment of the human body, complete with gory descriptions of medical procedures in *Gonzales* and photographs evocative of great human suffering in *Brown*. *See id.* at 135–40; *Brown*, 131 S. Ct. at 1923–27. Unlike the much controverted “regret” aspect of *Gonzales*, the dignitary interest in barring certain atrocious uses of human bodies seems to rest on a more objective foundation. *See Gonzales*, 550 U.S. at 159–60. The pairing of *Gonzales* and *Brown* suggests that both the left and the right of the Court are responsive to the personal integrity and collective virtue aspects of the new dignity jurisprudence.

¹⁴² 18 U.S.C. § 1531(a) (2012).

the physical nature of these methods and the difficulty of differentiating them from acts of deliberately killing a newborn infant, the Court held that Congress could constitutionally bar these methods as incompatible with “respect for the dignity of human life.”¹⁴³ One does not have to agree with the Court’s outcome or specific reasoning in *Gonzales* to see something promising in its recognition that state power exists beyond the narrow confines of *parens patriae* and police power to protect the community’s interest in common human dignity, not just on an individual basis, but collectively.¹⁴⁴ In many respects, this is the flip side of dignity as personal integrity. Conversely, an exercise of state power that risks the disintegration of a person (and thus the loss of dignity as personal integrity) would expose the collective or community authority as being indecent, inhuman, or uncivilized.

In the case with the most direct relevance to civil commitment law, *Indiana v. Edwards*, the Court upheld a trial court’s refusal to allow a defendant with a serious psychiatric disability (schizophrenia) to represent himself in a criminal case.¹⁴⁵ This is because self-representation carries a greater risk than representation through counsel that the resulting spectacle will not “affirm the dignity” of the individual.¹⁴⁶

B. Dignity-Based Reform

This shift in the focus of dignity jurisprudence from the mid-twentieth century to the early twenty-first century may be characterized as a second phase of the last reform period when many of the

¹⁴³ *Gonzales*, 550 U.S. at 157–60.

¹⁴⁴ We think the Court should have struck down the ban despite the state interest in this kind of common decency because of the plaintiff’s very significant countervailing dignity interest in controlling her reproductive organs and the long history of state and federal governments claiming to protect women against their reproductive choices.

¹⁴⁵ 554 U.S. 164, 177–78 (2008).

¹⁴⁶ *Id.* at 176. The 7-2 vote in *Edwards* suggests that a majority of the current Court might allow hospitalization to preserve the “dignity as personal integrity” of a person with mental illness, caught up in what we have called madness. This is a context where conditions like homelessness, self-medication with dangerous drugs, and the heavy hand of law enforcement pose an unacceptable risk of irreversible disintegration.

nation's laws were amended to protect the liberty and equality of people with psychiatric disabilities.

The cause of this surge in concern for the dignity of people with psychiatric disabilities in the 1950s was undoubtedly the exposure of mass human rights violations against civilian populations carried out by the Nazis and echoed in features of allied conduct as well.¹⁴⁷ Governments in the mid-twentieth century had proven all too willing to detain populations *en masse* that they deemed dangerous. This included the United States, which had detained its Japanese citizens and residents. The belief that people with disabilities could be managed to achieve primarily social hygiene goals was disturbingly close to the genocidal impulses of Third Reich social policy.

The concerns regarding dignity as respect for personal freedom or autonomy have not so much faded, as they have joined with concerns over the threat to dignity posed by incarceration in jails and prisons lacking treatment or individualized assessment. These concerns cannot simply be collapsed into the earlier ones. Respect for autonomy could well justify incarcerating psychiatrically disabled and vulnerable people whose conduct is felonious meets the legal definition of a felony. Dignity reflected in the fragility of human integrity, and in the regard a "decent society" has for that fragility, can complete the reforms of almost a half century ago.

We believe that three core principles can provide guidance for revising the reformed statutes of the 1970s: (1) the principle of narrative autonomy;¹⁴⁸ (2) the principle of minimization of incarceration;¹⁴⁹ and (3) the principle of progressivity.¹⁵⁰ Each of these, as we shall now attempt to show, protects the interests of psychiatrically disabled people in equality of civic standing and autonomy, but with a commitment to personal integrity and collective virtue that was left out of the 1970s reform argument.

1. NARRATIVE AUTONOMY

Dignity has been associated with the autonomy of the individual at least since the influential work of German philosopher Immanuel

¹⁴⁷ BROWN, *supra* note 19, at 7.

¹⁴⁸ See *infra* III.B.1 Narrative Autonomy.

¹⁴⁹ See *infra* III.B.2 Minimizing Incarceration.

¹⁵⁰ See *infra* III.B.3 Principles of Progressivity.

Kant in the late eighteenth century.¹⁵¹ Narrative autonomy can be honored even when there are good reasons for limiting liberty of action and decision-making, e.g., if a person is imprisoned for a crime. It can also be honored even when equality is denied, e.g., a child or a subordinate in a formal organizational hierarchy.

The late Ronald Dworkin provided one of the most influential accounts of this aspect of dignity.¹⁵² Dworkin argues that individuals have an interest in being treated with respect, even when they have justifiably been relieved of decisional autonomy or no longer have a meaningful capacity for decisional autonomy.¹⁵³ He writes: “[I]f his choices and demands, no matter how firmly expressed, systematically or randomly contradict one another, reflecting no coherent sense of self and no discernable even short-term aims, then he has presumably lost the capacity that it is the point of autonomy to protect.”¹⁵⁴ But, the departure of agency does not change the significance of dignity in guiding how that person should be treated. As Dworkin notes, “A person’s right to be treated with dignity . . . is the right that others acknowledge his genuine critical interests: that they acknowledge that he is the kind of creature, and has the moral standing, such that it is intrinsically, objectively important how his life goes.”¹⁵⁵

Legal philosopher David Luban describes this aspect of dignity as honoring a person’s “being” rather than her “willing”:

Honoring someone’s human dignity means honoring their being, not merely their willing. Their being transcends the choices they make. It includes the way they experience the world—their perceptions, their passions and sufferings, their reflections, their relationships and commitments, what they care about.¹⁵⁶

¹⁵¹ KANT, *supra* note 88, at 43.

¹⁵² RONALD DWORKIN, LIFE’S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM 233–37 (1993).

¹⁵³ *Id.* at 225.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* at 236.

¹⁵⁶ DAVID LUBAN, LEGAL ETHICS AND HUMAN DIGNITY 76 (2007).

Even as it succeeds in achieving the liberty of the person, current law fails to obtain respect for dignity in the sense of narrative autonomy. For those in situations of madness, assailed not only by symptoms, but also by homelessness, victimization, and/or incarceration, autonomy as liberty is often an empty autonomy. In contrast, a growing body of research suggests that narrative autonomy remains important to people in legal proceedings.¹⁵⁷

a. *Therapeutic Jurisprudence and Narrative Autonomy*

The idea that facilities should respect the narrative autonomy of a person with psychiatric disabilities undergoing coerced treatment is supported by empirical research. Researchers in the MacArthur studies on outcomes in psychiatric interventions found that, independent of the decision to commit, the person's subjective sense of coercion was lessened with "the degree of respect with which the treatment provider dealt with the patient."¹⁵⁸ From this perspective, a full civil commitment hearing is an opportunity to provide the subjects with an opportunity to be heard. By telling their story to a judge, a figure of both real and symbolic authority, individuals undergoing stressful symptoms and circumstances receive respect before the law and powerful reinforcement of their essential dignity.¹⁵⁹ Empirical research confirms this result, even when the subjects in question believe "what they say is having little or no influence over the third-party authority."¹⁶⁰ Professor Tom Tyler and his colleagues

¹⁵⁷ See Mark R. Munetz et al., *Mental Health Court and Assisted Outpatient Treatment: Perceived Coercion, Procedural Justice, and Program Impact*, 65 PSYCHIATRIC SERVS. 352, 357 (2014) (concluding that mental health courts achieve less coercion, more procedural justice, and more satisfaction because judges treat subjects with respect and listen to them); Sarah Kopelovich et al., *Procedural Justice in Mental Health Courts: Judicial Practices, Participant Perceptions, and Outcomes Related to Mental Health Recovery*, 36 INT'L J. L. & PSYCHIATRY 113, 118 (2013) (finding procedural justice correlated with fewer symptoms and more satisfaction).

¹⁵⁸ WINICK, *supra* note 9, at 25. Professor Winick goes on to explain that "those subjected to psychiatric hospitalization against their will may suffer a serious loss of dignity and of self-esteem and self-efficacy." *Id.* at 47.

¹⁵⁹ *Id.* at 147–48.

¹⁶⁰ Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 440 (1992).

found, across a variety of legal proceedings (including civil commitment), that the perception of the legitimacy of the resulting incarceration is increased by “the extent to which the patient was afforded an opportunity to express his or her opinion on the admission decision [and] . . . the extent to which what the patient had to say was taken seriously.”¹⁶¹

Voice is one of several dignity-enhancing elements that procedures can either assure or ignore. Others include whether (1) the decision maker appears neutral, (2) the individual who is subject to confinement is permitted to participate meaningfully, and (3) the individual is treated by the authorities in a manner worthy of dignity and trust.¹⁶² The evidence is consistent and strong that these procedural features create a positive feeling toward the individual’s encounter with the law, even where the procedural outcome goes against the subject’s stated wishes.¹⁶³ A procedure that communicates respect for the subject and his dignity may be especially important for those with mental illness, who often “already have been marginalized and stigmatized by a variety of social mechanisms”¹⁶⁴

b. *International Human Rights Law and Narrative Autonomy*

International human rights treaties, declarations, and developments in human rights law also reflect a growing parallel concern with narrative autonomy, directly linked to the legal value of conserving human dignity. These include key documents, such as the Universal Declaration of Human Rights (UDHR);¹⁶⁵ International Covenant on Civil and Political Rights (ICCPR);¹⁶⁶ International

¹⁶¹ See WINICK, *supra* note 9, at 25 (first citing E. ALLAN LIND & TOM R. TYLER, *THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE* 26–34 (1988); then citing TOM R. TYLER AND YUEN J. HUO, *TRUST IN THE LAW* (2002)).

¹⁶² Tyler, *supra* note 160, at 439–41.

¹⁶³ *Id.* at 436–37.

¹⁶⁴ WINICK, *supra* note 9, at 146.

¹⁶⁵ “Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world” G.A. Res. 217 (III) A, Universal Declaration of Human Rights, ¶ 1 (Dec. 10, 1948) [hereinafter UDHR].

¹⁶⁶ International Covenant on Civil and Political Rights, preamble, art. 10, 1966, 999 U.N.T.S. 14668 [hereinafter ICCPR].

Covenant on Economic, Social and Cultural Rights (ICESCR);¹⁶⁷ United Nations Convention on the Rights of Persons with Disabilities (UNCPD);¹⁶⁸ and regional treaties.¹⁶⁹ This concern is also referenced in the German constitution,¹⁷⁰ in the South African constitution,¹⁷¹ and in the jurisprudence of many national supreme courts.¹⁷²

¹⁶⁷ International Covenant on Economic, Social and Cultural Rights, preamble, art. 13, 1966, 993 U.N.T.S. 14531 [hereinafter ICESCR].

¹⁶⁸ Convention on the Rights of Persons with Disabilities, *opened for signature* May 30, 2007, 2515 U.N.T.S. 3 (entered into force May 3, 2008) [hereinafter CRPD]. The Convention's Preamble begins with "[r]espect for inherent dignity," which is listed along with "individual autonomy" and "independence of persons." *Id.* at art. 3(a) (suggesting that dignity means something more than autonomy).

¹⁶⁹ Although surprisingly not the preamble to the most elaborate of all treaties or regional charters, the language of the European Convention on Human Rights is nearly identical in most of its substantive provisions to other documents, seeming to adopt dignity by implication, and the preamble to the convention does cite the Universal Declaration of Human Rights, which is also clearly the source of many of its substantive provisions. *See* EUROPEAN CONVENTION ON HUMAN RIGHTS 5, 52, http://www.echr.coe.int/documents/convention_eng.pdf (last visited July 31, 2015) [hereinafter ECHR]. However, the word "dignity" only enters the text of the European Convention with Optional Protocol No. 13 to the Convention for the Protection of Human Rights and Fundamental Freedoms, concerning abolition of the death penalty, which was promulgated in 2002. The protocol preamble begins: "[c]onvinced that everyone's right to life is a basic value in a democratic society and that the abolition of the death penalty is essential for the protection of this right and for the full recognition of the inherent dignity of all human beings. . . ." *Id.* at 52.

Also, the Charter of Fundamental Rights of the European Union, which took effect in 2009, contains an entire chapter devoted to dignity. *See* EUROPEAN UNION CHARTER OF FUNDAMENTAL RIGHTS, ch. 1, http://www.europarl.europa.eu/charter/pdf/text_en.pdf, ch. 1 (last visited July 31, 2015) [hereinafter EU CFR].

¹⁷⁰ GRUNDGESETZ [GG] [BASIC LAW] [Constitution] (Ger.), *translation at* http://www.gesetze-im-internet.de/englisch_gg/.

¹⁷¹ S. AFR. CONST., 1996.

¹⁷² *See* Oliver Lepsius, *Human Dignity and the Downing of Aircraft*, 7 GER. L.J. 761, 763–64 (2006) (recognizing that the German Federal Constitutional Court held that a law permitting the shooting down of an airplane carrying innocent passengers in terrorist attack situations violated the guarantee of human dignity); Ariel L. Bendor & Michael Sachs, *The Constitutional Status of Human Dignity in Germany and Israel*, 44 ISR. L.R. 25, 29 (2011) (noting that Israel's Supreme Court, in *Katalan v. Prison Services*, held that "prison walls do not bar the prisoner from human dignity"); *National Coalition for Gay and Lesbian Equality v. Minister of Justice* 1998 (12) BCLR 1517 (CC) at 2–4 (S. Afr.) (holding that

The UNCPD preamble begins with “[r]espect for inherent dignity,” which is proclaimed along with “individual autonomy” and “independence of persons.”¹⁷³ It is this aspect of dignity that also informs the sweeping opening lines of the UDHR preamble: “Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world”¹⁷⁴ It is restated in the Declaration’s very first article.¹⁷⁵ This general promise of dignity is a key feature of the opening articles of the ICCPR,¹⁷⁶ the ICESCR,¹⁷⁷ and regional treaties.¹⁷⁸ While these broad principles create a “common standard” for human rights, they have had “minimal direct application to the rights of persons with mental disabilities.”¹⁷⁹

A second strand of meaning concerns the specific rights of individuals that comprise the elements of a dignified life. Abrogation of these rights would constitute a negation of the general promise of dignity. This strand is most evident in the political and civil rights enumerated in the UDHR and subsequent human rights treaties.

laws prohibiting sodomy violate the constitutional right to human dignity); *Kindler v. Canada*, [1991] 2 S.C.R. 779, 781 (Can.) (finding that capital punishment could constitute a serious violation of human dignity).

¹⁷³ CRPD, *supra* note 168, at art. 3(a) (suggesting that dignity means something more than autonomy).

¹⁷⁴ UDHR, *supra* note 165.

¹⁷⁵ *Id.* at art. 1 (“All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”).

¹⁷⁶ International Covenant on Civil and Political Rights, preamble, art. 10, 1966, 999 U.N.T.S. 14668 [hereinafter ICCPR].

¹⁷⁷ International Covenant on Economic, Social and Cultural Rights, preamble, art. 13, 1966, 993 U.N.T.S. 14531 [hereinafter ICESCR].

¹⁷⁸ Surprisingly, this principle is not in the preamble to the most elaborate of all regional charters, the European Union’s Human Rights charter. *See* ECHR, *supra* note 169. This omission has been corrected in the Charter of Fundamental Rights of the European Union, which took binding effect in 2009 and contains an entire chapter devoted to dignity. *See id.*; *see also* INTER-AMERICAN COMMISSION ON HUMAN RIGHTS, *American Declaration on the Rights and Duties of Man and American Convention on Human Rights* (1948), <http://www.oas.org/en/iachr/mandate/Basics/declaration.asp>.

¹⁷⁹ Gostin & Gable, *supra* note 89, at 33.

These include the rights to assembly, speech, and political participation, either directly or through representatives in government.¹⁸⁰ From the perspective of people with mental illness and the government of madness, it is striking that these provisions reflect great confidence in the state to carry out interventions based on welfare and policing without risk to dignity.

Article 5 of the Universal Declaration and article 3 of its more comprehensive regional counterpart, the European Convention on Human Rights (ECHR), declare that “no one shall be subjected to torture or to inhuman or degrading treatment or punishment.”¹⁸¹ Consistent with Article 5, detention for the purpose of appropriate medical treatment does not violate Article 3.¹⁸² Moreover, the European Court of Human Rights has held that the potential for abuse is so great in involuntary commitment that courts must carefully consider the individual circumstances of confined persons to determine whether that detention has become “inhuman or degrading.”¹⁸³

A similar balance has been struck by the United Nations General Assembly which, in 1991, adopted Resolution 46/119 titled “[t]he protection of persons with mental illness and the improvement of mental health care.”¹⁸⁴ This resolution places dignity as the second

¹⁸⁰ UDHR, *supra* note 165, at arts. 18–21.

¹⁸¹ The U.N. Declaration includes the word “cruel” as well, providing in full, “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” See UDHR, *supra* note 165, at art. 5.

¹⁸² “As a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading.” *Herczegfalvy v. Austria*, App. No. 10533/83, Eur. Ct. H.R. (1992); see also Philip Fennell, *Doctor Knows Best? Therapeutic Detention Under Common Law, the Mental Health Act, and the European Convention*, 6 MED. L.R. 322, 324 (1998) (stating “Article 5 allows detention on grounds of unsoundness of mind, provided it is carried out in accordance with a procedure prescribe by law . . .”).

¹⁸³ See *Herczegfalvy v. Austria*, App. No. 10533/83, Eur. Ct. H.R. (1992) (stating that a position of “inferiority and powerlessness” typical of patients confined in psychiatric hospitals, calls for increased vigilance in reviewing compliance with Convention). The Council of Europe’s Committee of Ministers has also adopted a recommendation concerning protection of the human rights and dignity of persons with mental disorder. See COUNCIL OF EUROPE COMMITTEE OF MINISTERS, *Recommendation No. Rec (2004)10*, (adopted Sept. 22, 2004), <https://wcd.coe.int/ViewDoc.jsp?id=775685> [hereinafter *Rec (2004)10*].

¹⁸⁴ G.A. Res. 46/119, annex, Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (Dec. 17, 1991).

of its “fundamental freedoms and basic rights,”¹⁸⁵ and it includes as a guiding principle that the “treatment of every patient shall be directed towards preserving and enhancing personal autonomy.”¹⁸⁶ As a further condition of involuntary treatment, the Resolution declares: “Where any treatment is authorized without the patient’s informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.”¹⁸⁷

As with much of human rights law, the resolutions of the U.N. General Assembly function as a form of “soft law.”¹⁸⁸ They operate on a level beneath the broad prefaces and specific clauses of human rights treaties in a penumbra of positive norms adopted by member governments. Governments may be obliged to adopt these provisions as practice objectives for their own institutions, rather than rights that can be easily enforced in court. At that the same, time they constitute standards against which institutions—and the governments that maintain them—are regularly reviewed by other organizations, such as the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and the European Court of Human Rights.

Another way soft law can influence hard law is by modeling approaches that can be adopted in part or in whole by states and sub-national governments. The European and UN resolutions offer dignity-based models for reforming civil commitment law in the United States. As against the LPS reform statutes, this approach stands out in three ways and each approach is connected to a different way in which madness challenges dignity. First, the human-rights approach suggests a basis for intervention that is more care-oriented than the violence-prevention ethic embodied in the dangerousness standard.

¹⁸⁵ *Id.* at Principle 1 (“All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.”).

¹⁸⁶ *Id.* at Principle 11.

¹⁸⁷ *Id.*

¹⁸⁸ See generally David M. Trubek & Louise G. Trubek, *Hard and Soft Law in the Construction of Social Europe: The Role of the Open Method of Coordination*, 11 EUR. L.J. 343 (2005) (discussing the way guidelines work with more binding forms of law to achieve coordination in Europe with a focus on labor and employment rights).

Waiting for treatment until persons are deemed a danger of violence to themselves or others is a denial of human dignity.

Second, the human-rights approach insists that intervention be the least intrusive or restrictive. The 1970s reform era put too much emphasis on the in-and-out decision about hospitalization and not enough on providing the best balance of liberty and care that is achievable. This has led to campaigns for assisted outpatient treatment laws as a supplement to civil commitment in some states. The human-rights approach eliminates the need for a separate legal standard by insisting that treatment always be in the “least intrusive” or “least restrictive” setting possible.

Third, the human-rights approach makes it imperative that authorities consult with persons subject to mandatory treatment and take their participation into consideration, both in the design of an individualized treatment program and in prioritizing convergence with the subject’s preferences at the earliest possible point.

Individuals with psychiatric disabilities who are coerced into treatment are in an inescapably undignified position. When confined and forced to take mind-altering chemicals, their autonomy over their physical and mental world is violated in a profound way. However, this violation of autonomy is not identical to a violation of dignity. Involuntarily committed individuals can be shown respect. They can be listened to. They can develop meaningful relationships with their caretakers and can become invested in, and proud of, their progress.¹⁸⁹ However, as research on consumer law shows, legal rights do not always translate into meaningful voices.¹⁹⁰

2. MINIMIZING INCARCERATION

Throughout this article, we have used the term “incarceration” to refer to both psychiatric hospitalization and imprisonment. But, whatever its intentions, and however promising its resources for treatment, detention in a hospital or prison poses inevitable risks to

¹⁸⁹ One common way to frame the importance of dignity for mentally ill individuals receiving treatment is to refer to them as consumers or survivors, instead of patients. But, as noted above, there are no safe harbors when it comes to discerning acceptable and appropriate nomenclature.

¹⁹⁰ See Shaubin A. Talesh, *The Privatization of Public Legal Rights: How Manufacturers Construct the Meaning of Consumer Law*, 43 L. & SOC’Y REV. 527, 553–56 (2009).

the human dignity of all people, especially those with psychiatric disabilities. In this regard, we share with consumer advocates a sense that coerced confinement, no matter how well-justified, will continue to be problematic for people who can see to their own survival in the community (*parens patriae*), and who are not an imminent threat to themselves or others (the police power).¹⁹¹ But, even more weight must be given to preventing the pattern by which people with chronic psychiatric illness end up incarcerated as punishment. These individuals face severe risk of progressive illness, victimization, and suicide. A dignified approach to civil commitment should explicitly seek to minimize the overall amount and depth of incarceration that befalls the mad. In the 1970s, that could be done simply by limiting hospitalization to those who posed a serious risk of doing harm to people, or in some states, to property.¹⁹² Since the rise of mass imprisonment, that strategy has failed for a staggering number of people with psychiatric disabilities.¹⁹³

In the 1970s, no one necessarily advocated moving people with mental illness into the criminal justice system, nor was it a feared outcome. Penal procedures, from police through prisons, had been receiving substantial attention from a Supreme Court that appeared protective of defendants' due process rights.¹⁹⁴ Criminal justice does

¹⁹¹ Indeed, this was Professor Winick's position. *See* WINICK, *supra* note 9, at 47 ("Therapeutic jurisprudence and constitutional considerations thus both support a narrow scope for involuntary civil commitment.").

¹⁹² In the 1980s, for example, some states, like Washington, began to broaden their standards for commitment, as concerns about failures of treatment grew in the community. *See* Mary L. Durham & Glenn L. Pierce, *Beyond Deinstitutionalization: A Commitment Law in Evolution*, 33 HOSP. & COMMUNITY PSYCHIATRY 216, 218–19 (1982).

¹⁹³ *See* TORREY, *supra* note **Error! Bookmark not defined.**9, at 128 (discussing large numbers of prisoners with psychiatric disorders).

¹⁹⁴ Reform of civil commitment followed a decade or more of Supreme Court decisions increasing the reach of constitutional rights for criminal defendants. *See* Mapp v. Ohio, 367 U.S. 643, 660 (1961) (evidence collected without a warrant cannot be used in state court); Miranda v. Arizona, 384 U.S. 436, 478–79 (1966) (criminal suspects in police custody must be warned of their right to remain silent and have a lawyer to advise and accompany them); Edwards v. Arizona, 451 U.S. 164, 487 (2008) (interrogation must cease once a suspect in custody has asked for a lawyer and cannot resume until the lawyer has met with the suspect). None of these rights applied to the civil commitment process in the 1970s. Since then, a right to a formal hearing and representation by counsel has been clearly established. *See* WINICK, *supra* note 9, at 141.

assure a fuller range of due process rights and greater formal recognition of equality of citizenship between persons with psychiatric disabilities and those without. But, in an era of mass incarceration, when government has criminalized a broad array of social problems,¹⁹⁵ this practice has become powerfully counter-productive to the original goals of protecting civil rights and liberties.¹⁹⁶

Public attitudes about crime and punishment were still in the process of hardening into law-and-order populism during the last wave of reform. State statutes remained largely oriented toward rehabilitation¹⁹⁷ and the number of incarcerated persons nationwide was at or near a twentieth century low. Moreover, the entire prison population was a fraction of the size of the total mental health institutional population.¹⁹⁸ However, a decade or two later, popular attitudes and legislative activity had taken a decided turn toward punishment. Incarceration increased in scale, intensity and length of sentence.¹⁹⁹ Today, the national imprisonment rate remains near an all-time high,²⁰⁰ and the prisons hold many times the number of mentally ill people confined in mental hospitals.²⁰¹

As noted above, the Supreme Court upheld a sweeping population cap on California prisons and, at the same time, let stand a systemic remedy for decades-long deficits in health care.²⁰² While the population reduction was intended to make improvements in mental health treatment feasible, there is no evidence that prisoners with

¹⁹⁵ JONATHAN SIMON, *GOVERNING THROUGH CRIME: HOW THE WAR ON CRIME TRANSFORMED AMERICAN DEMOCRACY AND CREATED A CULTURE OF FEAR* (2009).

¹⁹⁶ Simon, *supra* note 27 (describing inhumane conditions for prisoners with psychiatric disabilities in California prisoners).

¹⁹⁷ See DAVID GARLAND, *THE CULTURE OF CONTROL: CRIME AND SOCIAL ORDER IN CONTEMPORARY SOCIETY* 3 (2001) (describing “penal welfarism” as the dominant approach to punishment through the 1970s).

¹⁹⁸ Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 55–63 (2011).

¹⁹⁹ GARLAND, *supra* note 197, at 8–9; Simon, *supra* note 195, at 18–30.

²⁰⁰ U. ALB., HINDELANG CRIM. JUST. RES. CTR., SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS TABLE (2009), <http://www.albany.edu/sourcebook/pdf/t6292009.pdf>.

²⁰¹ See TORREY, *supra* note 22, at 1.

²⁰² See *Brown v. Plata*, 131 S. Ct. 1910, 1923–26 (2011).

psychiatric disabilities are receiving constitutionally adequate treatment.²⁰³

Trying to repair the prison mental health delivery systems is a perverse way to address the inhumanity caused by long-term incarceration of people with serious mental illness. To protect the human dignity of people with psychiatric disabilities, civil commitment law should require judges to take into account this kind of carceral balance. A judge must find that the risk of incarceration is serious and that hospitalization with treatment and suitable follow-up care would reduce the overall length and severity of incarceration.²⁰⁴

a. *Therapeutic Jurisprudence and the Minimization of Incarceration*

The late Bruce Winnick, the leading proponent of therapeutic jurisprudence-based civil commitment reform, opposed both outpatient commitment reforms and expansive changes to *parens patriae* or police power bases for civil commitment.²⁰⁵ His opposition was on the ground that coercion was counter-therapeutic and should be reserved for those so disabled as to be a threat to their own survival or to others.²⁰⁶ He clearly endorsed the principle of narrative autonomy. It is noteworthy that Professor Winnick, whose therapeutic jurisprudence approach to revising civil commitment law has guided our own, did not see the major threat of the now widely recognized

²⁰³ In one of his last orders from the bench, Judge Lawrence Karlton denied defendants' motion to dismiss a case related to *Brown v. Plata*. *Coleman v. Brown*, 938 F. Supp. 2d 955, 990 (E.D. Cal. 2013). He found that "[s]ystemic failures persist in the form of inadequate suicide prevention measures, excessive administrative segregation of the mentally ill, lack of timely access to adequate care, insufficient treatment space and access to beds, and unmet staffing needs . . . [T]hese objectively unconstitutional conditions evidence the subjective component of deliberate indifference." *Id.* at 989.

²⁰⁴ In practice, combined with the principle of narrative autonomy, this should result in something very much like the combination of services and outpatient treatment mandated by current reforms like Kendra's Law in New York or Laura's Law in California. See sources cited *supra* note 71.

²⁰⁵ See generally WINNICK, *supra* note 9, at 6–11 (outlining elements for the "Therapeutic Jurisprudence Model of Civil Commitment" explored throughout the book).

²⁰⁶ See generally *id.*

mass imprisonment of people with psychiatric disabilities.²⁰⁷ At the same time, it is difficult to imagine that he would have been complacent about the mass-incarceration of people with mental illness and psychiatric disorders.²⁰⁸

Today, no one on any side of the debate about the hospitalization of people with mental illness can ignore the striking number of persons with psychiatric disabilities ending up in penal institutions and sometimes in the harshest possible versions.²⁰⁹ As a result of policies aimed at increasing the overall flow of troubled citizens to prisons, there has been a gradual, but now severe, accumulation of persons with psychiatric disabilities inside the nation's supersized prison systems.²¹⁰

3. PROGRESSIVITY

Incarceration is always a powerful challenge to human dignity, especially when the imprisoned person has a serious psychiatric disability. Any civil commitment system anchored in human dignity will seek to assure that every authorized incarceration rapidly advances the person toward emancipation and a stable life in the community, while honoring the subject's treatment preferences as much

²⁰⁷ His major treatise on the topic fails to even discuss incarceration. *See generally id.*

²⁰⁸ Indeed, Professor Winick's pioneering work promoting drug courts was powerfully motivated by a desire to reduce over-reliance on incarceration. *Cf.* Bruce J. Winick & David B. Wexler, *Drug Treatment Court: Therapeutic Jurisprudence Applied*, 18 *TOURO L. REV.* 479, 481 (2002) (discussing drug treatment court positively and writing that "sentencing [drug offenders] to prison did not change their addictive behavior. Instead, it led to a revolving door effect An important insight of therapeutic jurisprudence is that . . . drug treatment court judges consciously view themselves as therapeutic agents").

²⁰⁹ Under pressure from a federal court, California—which keeps the largest number of prisoners with psychiatric disabilities incarcerated—recently announced plans to remove most of their mentally ill prisoners from extreme isolation units, where they have languished for decades, despite a court ruling in the 1990s banning prisoners with psychiatric disabilities from being housed at one of the state's Security Housing Units at Pelican Bay. *See* Erica Goode, *Federal Judge Approves California Plan to Reduce Isolation of Mentally Ill Inmates*, *N.Y. TIMES*, Aug. 29, 2014, http://www.nytimes.com/2014/08/30/us/california-plans-to-reduce-isolation-of-mentally-ill-inmates.html?_r=1.

²¹⁰ *See* Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 *J. LEGAL STUD.* 187, 216 (2013).

as possible.²¹¹ Where a person requires prolonged hospitalization, while waiting for treatment to take effect or due to long-term incapacity, the environment should be the least restrictive and as closely linked to normal life in the community as is possible (normalization). Reassessments must also take place on a regular and individualized basis, including the procedural opportunities for narrative autonomy noted above. The goal is to protect the future interest in the autonomy of the person undergoing any involuntary treatment. This is accomplished by reducing the established tendency of incarceration to negatively alter behavior and self-understanding in ways that are profoundly anti-therapeutic and that tend to reproduce “symptoms” that justify incarceration.²¹²

Prolonged incarceration in a hospital setting of the sort suffered by Mr. Donaldson in *O'Connor v. Donaldson*²¹³ may no longer be the norm. For a portion of people with psychiatric disabilities, hospitalization has been replaced by a pattern of repeated short-term detentions for emergency evaluation, sometimes followed by a longer term in jail or prison.²¹⁴ This is not wholly a product of the current civil commitment legal standards. A major factor is the scarcity of appropriate and available psychiatric residential or community-based placements.²¹⁵ Indeed, this is a global phenomenon.²¹⁶

²¹¹ We take the view that, until scientists better understand treatment appropriateness to individual symptoms, a person undergoing a stable agreed-upon treatment plan will likely survive in the community without further incarcerations (of hospitals or prisons) longer than she would otherwise. That same person will likely have an increased subjective sense of well-being.

²¹² Sociological analysis of the role of custodial regimes in creating the behavioral patterns associated with mental illness informed the reforms of the 1970s. See APPELBAUM, *supra* note 47, at 7–9. Especially important was ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* (1961).

²¹³ 422 U.S. 563, 564 (1975) (noting that Donaldson was held against his will for nearly fifteen years at the time of his court-ordered release).

²¹⁴ LINDE, *supra* note 34, at 101–03.

²¹⁵ E. Fuller Torrey et al., *The Shortage of Public Hospital Beds for Mentally Ill Persons*, TREATMENT ADVOC. CTR., <http://mentalillnesspolicy.org/imd/shortage-hosp-beds.pdf> (last visited Aug. 24, 2015).

²¹⁶ Jodi Morris et al., *Global Mental Health Resources and Services: A WHO Survey of 184 Countries*, 34 PUB. HEALTH REV. 1 (2012), http://www.publi-chealthreviews.eu/upload/pdf_files/12/00_Morris.pdf (last visited Aug. 24, 2015).

But, the current regime lacks an affirmative obligation to prevent incarceration, which is arguably imposed by the constitutional duty to respect human dignity. It includes providing services necessary to avoid repeated state coercion that is both degrading to the individual and costly to the system.²¹⁷

a. Therapeutic Jurisprudence and Progressivity

Most research on therapeutic jurisprudence and procedural justice focuses on the procedures themselves and on the mental health consumer's satisfaction. There is little investigation of the pattern of incarceration or what becomes of the mentally ill individual once incarcerated. However, this emphasis on procedure and narrative autonomy is ultimately empty if the outcomes lead only to repeated short incarcerations in hospitals or to prolonged incarceration in a jail or prison. No matter how empathetically civil commitment procedures are performed, they will be labeled a sham if they produce only coercion without beneficial results. Winick emphasized the urgency to redress the lack of delivery on the state's promise for meaningful care in the community:

A therapeutic jurisprudence model of commitment, therefore, would keep the unfulfilled promise of deinstitutionalization and provide considerably more clinical, social, and housing resources in the community for those suffering from mental illness. It would emphasize therapeutic needs and preventive approaches. It would respect patient dignity and autonomy when offering help. It would seek to preserve liberty and increase therapeutic effectiveness by minimizing legal coercion and maximizing patient choice.²¹⁸

A dignity approach to civil commitment reform would provide an affirmative state obligation to follow incarceration with an individualized treatment plan developed in collaboration with the person subject to civil commitment measures.

²¹⁷ The high cost of this cycling pattern is unnecessary to the affirmative obligation, but it makes it far more politically feasible to implement.

²¹⁸ WINICK, *supra* note 9, at 328.

b. *International Human Rights and Progressivity*

Both the UN Convention on the Rights of Persons with Disabilities²¹⁹ (CRPD) and the Council of Europe's Recommendation No. Rec. 10 support progressivity.²²⁰ The UN CRPD calls for any necessary treatment to be done "in the least restrictive environment and with the least restrictive or intrusive treatment" and to be based on "an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by [a] qualified professional staff."²²¹

Article 17 of the Council of Europe's recommendations combines a legal threshold for intervention. The "significant risk of serious harm to his or her health" standard is considerably more facilitative of intervention than that established by most American state laws reformed in the 1970s.²²² The Article contains a rule requiring less restrictive forms of care to be applied where possible (e.g., outpatient treatment) and a rule that "the opinion of the person concerned" be "taken into consideration."²²³

The entire package is designed to enhance the dignity of the person. Subsequent discussion is structured on the premise that persons receiving involuntary care are under a unique challenge to their dignity, both from the effects of illness and the effects of intervention. An important corollary is that a system that emphasizes honoring a patient's dignity will benefit the therapeutic process, improve outcomes, and be a more effective exercise of state power. Each reform is conceived to support a more holistic approach to dignifying the involuntary care process. This approach balances the patient's right to autonomy within the treatment and confinement process with their right to effective treatment and their right to respect.²²⁴

²¹⁹ CRPD, *supra* note 168.

²²⁰ *Rec (2004)10*, *supra* note 183.

²²¹ G.A. Res. 46/119, *supra* note 184, at 190.

²²² *Rec (2004)10*, *supra* note 183, at art. 17. Article 17 permits involuntary placement only if all five of the following conditions are met: "(i) the person has a mental disorder; (ii) the person's condition represents a significant risk of serious harm to his or her health or to other persons; (iii) the placement includes a therapeutic purpose; (iv) no less restrictive means of providing appropriate care are available; [and] (v) the opinion of the person concerned has been taken into consideration."

²²³ *Id.* at arts. 17–18.

²²⁴ *Id.* at explanatory memorandum 16, 75, 85, 91, 93, 142, 169.

C. Constitutionality of Dignity Principles

Would a dignity approach to civil commitment based on these three core principles be constitutional? The first and third principles are fully consistent with the key constitutional decisions on civil commitments because they would not expand the reasons justifying incarceration or coerced treatment. The second principle—reducing overall incarceration for individuals—raises a more difficult question, but also appears to be consistent with existing precedents.

As noted above, the Supreme Court has held that “a [s]tate cannot constitutionally confine *without more* a nondangerous individual who is capable of surviving safely in freedom”²²⁵ The Court further found that, “even if there is no foreseeable risk of self-injury or suicide, a person is literally ‘dangerous to himself’ if for physical or other reasons he is helpless to avoid the hazards of freedom”²²⁶ It is unclear if the Court meant “without more” would permit involuntary commitment, absent a showing of dangerousness. However, the Court’s broad conception of “danger to self” seems to allow substantial room for the development of grave disability standards that contemplate intervention before acute crisis.

One of the few instances where states have expanded hospital incarceration capacity and civil commitment laws concerns violent sexual predators. Under the laws of twenty states, these defendants can be civilly committed after completing their criminal sentence. Imprisonment can continue on the grounds that they pose an ongoing risk of sexual offenses due to an underlying disorder and cannot fully control their impulses.²²⁷ The Supreme Court has upheld these laws as consistent with traditional state police power to incapacitate people with psychiatric disabilities who pose a threat to themselves or others.²²⁸ Courts reviewing decisions to hospitalize under our

²²⁵ O’Connor v. Donaldson, 422 U.S. 563, 576 (1975) (emphasis added).

²²⁶ *Id.* at 574 n.9.

²²⁷ CHRYSANTHI S. LEON, SEX FIENDS, PERVERTS, AND PEDOPHILES: UNDERSTANDING SEX CRIME POLICY IN AMERICA 121 (2011).

²²⁸ *See* Kansas v. Hendricks, 521 U.S. 346, 371 (1997) (upholding civil commitment for incapacitative purposes of previously imprisoned sex offenders); Kansas v. Crane, 534 U.S. 407, 409–12 (2002) (holding that lack of control is a necessary finding for civil commitment on incapacitative grounds); United States v. Comstock, 560 U.S. 126, 130 (2010). *But see*, Karsjens v. Jesson, WL 3755870, at * 2 (D. Minn. 2015) (holding that post-sentencing civil commitment is “a pu-

principle of minimizing incarceration would have to undertake the kind of contextual examination of the real risks that face the person challenging hospitalization. We concluded above that such an examination would support the exercise of state power to protect the personal integrity and human dignity of that challenger.²²⁹

CONCLUSION: REALIGNING CIVIL COMMITMENT

There is a growing chorus of those arguing for reform of civil commitment laws either on the ground that too many dangerous people with psychiatric disabilities are currently ignored by the state until it is too late or that successful treatments are available.²³⁰ There may be merit to these claims, but they echo the claims that have preceded every cycle of incarceration for people with psychiatric disabilities. We assert here that states should revise their civil commitment laws to place dignity at the heart of their response to persons with mental illness, thereby informing, rather than displacing, the traditional police power and *parens patriae* bases for intervention. Today, we know that replacing one kind of incarceration with another that is more punitive, more stigmatizing, and less treatment-oriented cannot protect human dignity.²³¹

Our three principles, drawn from therapeutic justice, emerging norms in international human rights treaties, and the distinctive, compelling context of mass incarceration, are intended to conserve and protect human dignity by minimizing incarceration and coercion. The first principle—narrative autonomy—reflects the insight

nitive system that segregates and indefinitely detains a class of potentially dangerous individuals without the safeguards of the criminal justice system.”) While Minnesota has the highest number of civilly committed offenders per capita, other states are also beginning to question this practice. Monica Davey, *States Struggle with What to Do with Sex Offenders After Prison*, N.Y. TIMES (Oct. 29, 2015), http://www.nytimes.com/2015/10/30/us/states-struggle-with-what-to-do-with-sex-offenders-after-prison.html?_r=0.

²²⁹ See *supra* Section III.B.

²³⁰ Torrey, *supra* note 29, at 44 (describing homicides due to untreated mental illness), 195-96 (calling for research to determine whether treatments have improved but expressing optimism that successful means for treating those whose mental illness threatens violence exists).

²³¹ See WINICK, *supra* note 9, at 47 (explaining that “those subjected to psychiatric hospitalization against their will may suffer a serious loss of dignity”).

that coercion is, in substantial part, a matter of procedures. When procedures give people an opportunity to exercise voice, their words are given respect, decisions are explained to them their views taken into account, and they substantively feel less coercion. It may not be possible to eliminate coercion, but a radical increase in procedural justice for people with psychiatric disabilities can push that coercion to the minimum level.

Our second principle—minimizing incarceration—is a direct extension of the dignity-as-liberty emphasis of the last wave of reforms. Unlike other reform proposals that would change the legal definition of harm or incapacity, the minimization of incarceration gives courts guidance as to a substantive goal. It is a goal on which legal advocacy can be more meaningfully deployed.²³² At the same time, it is a flexible and realistic standard that requires courts to consider local conditions, law enforcement and incarceration practices and the views and understandings of the person facing incarceration for treatment.

The third and final principle—progressivity—is intended to assure that the length of incarceration for people with psychiatric disabilities is minimized and preparedness to return to the community is emphasized. The experience of both mass-hospitalization (in the middle of the twentieth century) and mass-imprisonment (at the end of the century) highlights the danger that separate and potentially insulated state bureaucracies will have incentives to develop an institutional hold on inmates that becomes self-perpetuating.²³³

In this essay, we have attempted to define core principles rather than draft new statutes. If courts were to adopt these principles as guiding norms for the interpretation of existing statutes, the need for significant statutory redrafting might be avoided. Moreover, some of the more contentious battles between consumer advocates and

²³² *Id.* at 143 (noting that commitment hearings tend to be brief, non-adversarial episodes).

²³³ Critics today discuss the “prison-industrial complex” to describe these incentives toward incarceration. *See* ANGELA DAVIS, *THE PRISON INDUSTRIAL COMPLEX* (1999). The same kinds of concerns were raised about the incentives of doctors in the large mid-twentieth century public mental hospitals. *See* BROWN, *supra* note 19.

proponents of more assertive treatment would be reframed.²³⁴ An example of the latter promise is outpatient treatment laws, which have been offered as a reform to enable earlier intervention without hospitalization.²³⁵ Consumer and peer advocates have largely criticized such laws as opening the gate for more coercion, and they have suggested that greater voluntary services should be provided without the lever of coercion.²³⁶

The combination of minimizing incarceration and providing non-intrusive sustainable treatment in the least restrictive environment would allow court-ordered outpatient treatment in areas where poor social service delivery and aggressive criminalization of people with psychiatric disabilities is occurring. This would also avoid adding unnecessary coercion in those jurisdictions where adequate community-based services and insightful law enforcement approaches prevail.

²³⁴ For a summary of the support and opposition players and their positions on California's optional outpatient treatment law, AB 1421, see Amy Yannello, *Support Laura's Law for better mental illness care*, SFGATE (May 13, 2014), <http://www.sfgate.com/opinion/openforum/article/Support-Laura-s-Law-for-better-mental-illness-care-5464392.php>.

²³⁵ See TORREY, *supra* note 29, at 178 (advocating assisted outpatient laws as a way to improve treatment).

²³⁶ The California Association of Mental Health Peer-Run Organizations, for example, has opposed expansion and funding of AB 1421 ("Laura's Law") on the bases that the perceived need for involuntary treatment is based on stigma and that coerced treatment undermines the relationship between therapist and client and is ineffective. The alternative, according to CAMHPRO, is adequately funded, enhanced, voluntary community services. California Association of Mental Health Peer-Run Organizations, CAMHPRO Policy Statement on Involuntary Outpatient Commitment; Anne Menasche & Delphine Brody, *AB 1421: Involuntary Commitment: A Coalition's Call for Self-Determination, Choice and Dignity in Mental Health*, <http://www.disabilityrightsca.org/OPR/PRAT2012/AB1421.pdf>; see Forum with Michael Krasny, *SF Supervisors Set to Vote on Laura's Law*, KQED NEWS RADIO (July 8, 2014, 9:00 AM), <http://www.kqed.org/a/forum/R201407080900>.