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The Facts of Stigma: What's Missing from the Procedural Due Process of Mental Health Commitment

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Abstract:

This is the first systematic review of federal, judicial opinions that engage the stigma of mental health commitment in the context of procedural due process. In 1979, in *Addington v. Texas*, the Supreme Court held that the stigma, or adverse social consequences, of civil commitment is relevant to the procedural due process analysis. The following year, in *Vitek v. Jones*, the Court held that the stigmatizing consequences of a transfer from a prison to a mental health facility, coupled with mandatory treatment, triggered procedural protections. While these cases importantly suggested a role for stigma in procedural due process, they left many questions related to the implementation of these standards unanswered. As a result, across the cases analyzed in this review, judges expressed different views of this stigma and consistently underestimated the real impact of this stigma. This in turn resulted in judges consistently underestimating the liberty interest created by commitment and the need for procedural due process. In order to properly protect individuals against the risk of erroneous commitment, judges must engage in further fact finding to determine the real harm that results from the stigma of mental health commitment.

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I. INTRODUCTION

A study published in 2000 found that 54 percent of respondents believed an individual with any mental illness was a danger to others. That same study found that 58 percent of respondents would not want an individual with any mental illness as a coworker and that 68 percent would not want that same individual marrying into their family.[1] Research suggests that the stigma associated with serious mental illness, mental illness that might require either voluntary or involuntary inpatient hospitalization, is even more profound. A 2008 survey on the public perception of one serious mental illness, schizophrenia, found that 77 percent of people would feel uncomfortable and 80 percent would fear for their safety around a person with untreated schizophrenia; 77 percent would feel uncomfortable working with that person; and 80 percent expressed discomfort related to dating that person.[2] Such stigma is unsurprising when viewed in light of how serious mental illness and mental hospitals are portrayed in popular culture—think *One Flew Over the Cuckoo's Nest*, the more recent *American Horror Story: Asylum* (a hospital physician experiments on patients and then leaves them to feed on other patients), or the mental-hospital-themed haunted houses that pop up all over the country for Halloween.[3]

This Note examines how that stigma affects the procedural due process afforded to individuals subject to involuntary hospitalization for mental illness. Nearly forty years ago, the Supreme Court recognized the severity of the stigma associated with involuntary commitment to a mental health hospital in a pair of cases related to civil and criminal mental health commitment, respectively. In *Addington v. Texas*, the Court considered the appropriate standard of proof to be applied in civil commitment hearings. Justice Burger, writing for the Court, stated that civil commitment constitutes a deprivation of liberty in part because

1 Jack K. Martin et al., *Of Fear and Loathing: The Role of 'Disturbing Behavior,' Labels, and Causal Attributions in Shaping Public Attitudes toward People with Mental Illness*, 41 J. HEALTH & SOC. BEHAV. 208, 216 (2000).

2 *Schizophrenia: Public Attitudes, Personal Needs*, NAT'L ALL. ON MENTAL ILLNESS 8 (May 13, 2008), https://www.nami.org/schizophreniasurvey.

3 Colby Itkowitz, *Halloween Attractions Use Mental Illness to Scare Us. Here's Why Advocates Say It Must Stop*, WASH. POST (Oct. 25, 2016), https://www.washingtonpost.com/news/inspired-life/wp/2016/10/25/this-halloween-mental-health-advocates-are-taking-a-powerful-stand-against-attractions-depicting-asylums/?utm_term=.80e98b67420a. An amusement park on the border of North and South Carolina includes this description for its "7th Ward Asylum": "You would be crazy to tour this twisted asylum. Lost and tortured souls are all that remain, but you'll see plenty that will make you question your sanity . . . . The 7th Ward was home to the Carolina's most chronically insane. From murderers to crazed psychopaths, many of the poor souls trapped behind the Gothic walls would spend their entire lives there. As you walk these halls today, be sure to stay with your group. This is one place you don't want to be committed." *Id.*

commitment creates "adverse social consequences . . . whether we label this phenomena 'stigma' or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual."[4] In the following year, in *Vitek v. Jones*, the Court considered a procedural due process challenge to a Nebraska statute that gave the Director of Correctional Services the authority to transfer an incarcerated individual to a mental health facility without notice or hearing. The plaintiff argued that the Due Process clause entitled him to procedural protections before commitment because he had a liberty interest in not being stigmatized by commitment to a mental health facility. The Court agreed, to the extent that this stigma existed and was relevant to the procedural due process analysis. Justice Burger wrote "the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections."[5]

These two cases suggested, for the first time, a role for stigma in procedural due process analysis with respect to mental health commitment. Yet in so doing, the Supreme Court provided only minimal explanation for how it arrived at the underlying conclusion that stigma results from commitment or how this conclusion fits into the broader procedural due process analysis. In the nearly forty years since these holdings, the Supreme Court has offered little clarification. Instead, it has left it to lower court judges to determine how to engage with the stigma of mental health commitment in the context of procedural due process.

This study seeks to determine how judges have applied the holdings in *Addington* and *Vitek* to measure their real impact on the procedural due process protections afforded to individuals facing mental health commitment proceedings. A systematic review was conducted of all federal, judicial opinions that discussed the stigma of mental health commitment in the context of procedural due process analysis since the Supreme Court decided these two cases. This methodology was utilized for its application in analyzing the variability in how judges have interpreted these standards across all opinions that have engaged with them.[6]

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4 Addington v. Texas, 441 U.S. 418, 425–26 (1979).

5 Vitek v. Jones, 445 U.S. 480, 494 (1980).

6 For further discussion of the advantages of systematic review in the context of legal doctrinal analysis, see William Baude et al., *Making Doctrinal Work More Rigorous: Lessons from Systematic Reviews*, 84 U. CHI. L. REV. 37, 42 (2017) (arguing that systematic review reduces the need for the reader to rely on the author's credibility to believe her claims, makes it easier for the reader to access the uncertainty associated with a claim, creates more complete documentation which can support progress in the field, decreases real or perceived bias, and can reduce error); Mark A. Hall & Ronald F. Wright, *Systematic Content Analysis of Judicial Opinions*, 96 CAL. L.

The results of the following analysis suggest that there is immense variation in how judges have engaged with the stigma of mental health commitment in the context of procedural due process, since *Addington* and *Vitek*. Among some opinions, judges determined that the presence of this stigma clearly required procedural protection. Among others, it was much more difficult to ascertain what role this stigma played in the procedural due process analysis. In general, across all opinions, judges spent very little time discussing the stigma of mental health commitment. The result is that judges seem to have profoundly different understandings of stigma in this context and its role in the procedural due process analysis. Additionally, judges consistently fail to engage with current empirical evidence related to the real consequences of this stigma. The variability in judges' treatment of stigma, as well as their anemic understanding of the many psychological, social, and economic consequences of stigma, has amounted to a systematic bias against plaintiffs seeking due process protection in commitment proceedings. While *Addington* and *Vitek* importantly included stigma in the procedural due process analysis in the context of mental health commitment, in many cases, judges have not implemented these standards properly. In these cases, judges must engage in their own fact finding to address those questions left unanswered by the Supreme Court. Given the limited fact-finding resources available to lower courts, this Note argues that a resource that aggregates relevant information on this subject, almost like a publicly available amicus brief, could assist judges in appropriately considering this issue while ensuring that judges engage with current research on the subject.

The following section will provide a brief overview of mental health commitment laws in the United States, research related to the stigma associated with mental illness and mental health commitment, and a discussion of cases that have established stigma as relevant to the procedural due process analysis, including *Addington* and *Vitek*.

II. BACKGROUND ON MENTAL HEALTH COMMITMENT AND THE ROLE OF STIGMA IN PROCEDURAL DUE PROCESS ANALYSIS

a. Mental health commitment laws

Involuntary, mental health commitment is the process by which the government compels an individual to receive mental health treatment in an inpatient, mental health facility.[7] There are different mechanisms and standards

REV. 63 (2008) (discussing other advantages of systematic review of judicial opinions).

7 Most states also have outpatient commitment or assisted outpatient treatment laws, which give judges the authority to compel individuals to receive outpatient, community-based, mental health treatment. See *What is AOT?*, TREATMENT ADVOCACY CTR. (Apr. 12, 2017), http://www.treatmentadvocacycenter.org/storage/documents/aot-one-pager.pdf. Outpatient

by which a person may be involuntarily committed. Although largely the province of state governments, there are also federal laws that dictate mental health commitment for certain populations.

i. Civil commitment laws

All fifty states and the District of Columbia have civil commitment laws. States have grounded their authority to enact such laws in two powers: the police power, to protect the state's citizens from potentially dangerous people, and the *patriae parens* power, to protect potentially dangerous people from themselves. Although the specifics of these laws vary across states, most reflect these dual purposes. These laws generally require some showing that the individual is in fact mentally ill and that the individual is either a danger to themselves or to others.[8] While the standards for dangerousness to others is and has been relatively consistent across states, the standard for dangerousness to one's self varies across states and has varied over time. Previous standards limited the consideration to whether an individual presented an immediate, intentional, violent threat to themselves, specifically whether an individual had attempted suicide or engaged in self-mutilation, and whether such behavior would likely result in serious harm or death.[9] Current standards still consider these factors but vary in what else they consider. For example, the Treatment Advocacy Center, a group that advocates for comprehensive mental health treatment including, when appropriate, mental health commitment, gives Pennsylvania's commitment law a failing grade for its limited definition of dangerousness to one's self.[10] In addition to considering the likelihood of intentional, violent self-harm, judges also consider whether there is evidence that an individual is unable to "to satisfy . . . [their] need for nourishment, personal or medical care, shelter, or self-protection and safety" and that their inability to do so creates a "reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded" through commitment.[11]. This standard is known as "grave disability."

By contrast, the Treatment Advocacy Center gives Illinois's civil commitment law its highest possible grade due to its expansive definition of

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commitment laws are not discussed in this Note and, to simplify, inpatient commitment is referred to as simply "mental health commitment."

8 See Megan Testa & Sara G. West, *Civil Commitment in the United States*, 10 PSYCHIATRY 30, 33 (2010).

9 *Mental Health Commitment Laws A Survey of the States*, TREATMENT ADVOCACY CTR. (Feb. 2014), http://www.treatmentadvocacycenter.org/storage/documents/2014-state-survey-abridged.pdf.

10 *Id.*

11 50 PA CONS. STAT. § 7301(b)(2)(i).

danger to one's self.[12] Illinois' law applies a "need-for-treatment" standard such that judges also consider whether an individual refuses to comply with treatment or cannot understand the need for treatment and as a result will likely suffer "mental and emotional deterioration."[13] As such, an individual may be committed under Illinois' law before they become gravely disabled. Laws also vary across states with respect to who may commence proceedings; in some states, any party may commence proceedings, such as an individual's family member,[14] while in other states proceedings may only be commenced by mental health professionals.[15] The federal government does not have a civil commitment law, but federal courts may of course consider procedural due process challenges to state civil commitment laws.

ii. Criminal commitment

Mental health commitment can also occur within state and federal prison systems. Prior to 1820, most people deemed mentally ill were imprisoned, not as a means of punishment but to remove them from the larger population.[16] In the 1820s, activists began protesting conditions and the lack of adequate mental health treatment in prisons. These activists advocated for the building of hospitals dedicated to the proper treatment of individuals with mental health conditions. By 1880, there were seventy-five public mental health hospitals and the majority of people diagnosed with mental health conditions had been transferred from prisons to these hospitals. The census in that year reported that, of all "insane people," less than one percent were still residing in prisons or jails, while the remaining ninety-nine percent (nearly 59,000 people) were in public mental health facilities.[17]

Eventually, this system broke down as well. By the 1960s, the poor conditions of these facilities created a backlash known as the "deinstitutionalization" movement.[18] The deinstitutionalization movement called for and eventually succeeded in reducing the number of people confined to residential, mental health facilities. While seemingly well intentioned, this movement removed people from their residential treatment without providing

12 405 ILL. COMP. STAT. 5/1-119.

13 405 ILL. COMP. STAT. 5/1-119.

14 For example, any "responsible party" may commence the process of involuntary commitment in a Pennsylvania trial court. 50 PA CONS. STAT. § 7304(c)(1).

15 See, e.g., New York's inpatient commitment law. N.Y. MENTAL HYG. LAW § 9.27(a).

16 *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, TREATMENT ADVOCACY CTR. 9–11 (Apr. 8, 2014), http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

17 *Id.*

18 *Id.* at 11.

adequate alternative treatment. Without treatment, people were unable to successfully reincorporate into society and many committed crimes for which they were arrested and imprisoned. A prison psychologist was quoted in a seminal 1972 article saying, "[w]e are literally drowning in patients."[19] This trend has continued.[20] According to surveys done by the Department of Justice in 2002 and 2004, forty-four percent of all federal prisoners, fifty-six percent of all state prisoners, and sixty-four percent of all individuals in local jails reported experiencing mental health symptoms or receiving treatment from a mental health professional in the previous twelve months.[21] These estimates compare to roughly eighteen percent of the general population, according to a 2014 study done by the National Institute of Mental Health.[22]

Although many people with mental health conditions that are convicted of crimes are incarcerated and remain incarcerated, there are both state and federal laws that allow for commitment to mental health facilities within the criminal justice system. 18 U.S.C. §§ 4243–4246 provide procedure by which a federal criminal offender may be either initially placed in or transferred into a mental health facility.[23]

If an individual is found not guilty of an offense for reason of insanity, 18 U.S.C. § 4243 provides that that individual will be committed to a mental health facility unless it can be shown, by clear and convincing evidence, that their "release would not create a substantial risk of bodily injury to another person or serious damage of property of another."[24] If an individual is convicted of an offense and suffers from a mental health condition, but does not bring an insanity defense, 18 U.S.C. § 4244 provides that they may still be committed to a mental health facility rather than being incarcerated.[25] In this case, the Attorney General may request a hearing to demonstrate that that individual should still be committed to a mental health facility prior to sentencing.[26] Per 18 U.S.C. § 4245, if an individual was convicted of a crime, incarcerated, and then later determined

19 *Id.*

20 See HUMAN RIGHTS WATCH, ILL-EQUIPPED: US PRISONS AND OFFENDERS WITH MENTAL ILLNESS 24 (2001), www.hrw.org/reports/2003/usa1003 ("Thousands of mentally ill are left untreated and unhelped until they have deteriorated so greatly that they wind up arrested and prosecuted for crimes they might never have committed had they been able to access therapy, medication, and assisted living facilities in the community.").

21 DEP'T OF JUST., NCJ 213600, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), https://www.bjs.gov/content/pub/pdf/mhppji.pdf.

22 *Any Mental Illness (AMI) Among U.S. Adults*, NATIONAL INSTITUTE FOR MENTAL HEALTH (2014), https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml.

23 18 U.S.C. § 4243–4246 (2012).

24 18 U.S.C. § 4243(d) (2012).

25 18 U.S.C. § 4244 (2012).

26 *Id.*

to require inpatient treatment, they may be transferred to a mental health facility after a hearing is held.[27] The Nebraska analogue to this federal law, which was at issue in *Vitek v. Jones*, did not require a hearing prior to transfer. This law will be discussed further in Part II.c, *infra*. Finally, 18 U.S.C. § 4246 provides the procedure by which an individual may continue to be committed even after his initial sentence has elapsed.[28] All fifty states and the District of Columbia have similar laws allowing for commitment within the prison system.

b. Stigma associated with mental illness and mental health commitment

The classical sociological literature defines stigma as an "'attribute that is deeply discrediting' that reduces the bearer 'from a whole and usual person to a tainted, discounted one.'"[29]A more recent review of the literature provides several definitions of the term: "[a] deeply discrediting attribute; 'mark of shame'; 'mark of oppression'; devalued social identity."[30] The authors go on to describe four essential components of stigma. These elements include: "(a) distinguishing and labeling differences, (b) associating human differences with negative attributions or stereotypes, (c) separating 'us' from 'them,' and (d) experiencing status loss and discrimination."[31]

Both Justice Burger in *Addington* and Justice White in *Vitek* focused on the consequences of the stigma associated with mental health commitment. Much research has been done on this topic. The relevant literature in fact identifies two related though distinct types of stigma that can have different consequences for individuals: public stigma and internalized stigma.[32] Public stigma is "the phenomenon of large social groups endorsing stereotypes about and acting against a stigmatized group."[33] Studies have identified numerous consequences correlated with the public stigma associated with mental illness. These consequences include, for example, underemployment, joblessness, and the inability to live independently.[34] While mental illness itself can affect these

27 18 U.S.C. § 4245 (2012).

28 18 U.S.C. § 4246 (2012).

29 Paula Abrams, *The Scarlet Letter: The Supreme Court and the Language of Abortion Stigma*, 19 MICH. J. GENDER & L. 293, 299 (2013) (quoting ERVING GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY 3 (1963)).

30 Bernice A. Pescosolido & Jack K. Martin, The Stigma Complex, 41 ANN. REV. SOC. 87, 92 (2015).

31 *Id.* at 91.

32 J.D. Livingston & J.E. Boyd, *Correlates and Consequences of Internalized Stigma for People Living with Mental Illness: A Systematic Review and Meta-Analysis*, 71 SOC. SCI. & MED. 2150, 2151 (2010).

33 *See, e.g.*, Patrick W. Corrigan et al., *The Stigma of Mental Illness: Explanatory Models and Methods for Change*, 11 APPLIED & PREVENTIVE PSYCHOL. 179 (2005).

34 *Id.*

outcomes directly, these studies demonstrate that stigma has an independent, additional effect. Other studies have also found public stigma to be associated with social isolation and a lower likelihood of seeking treatment.[35]

Internalized stigma can affect how individuals view themselves. Individuals may come to believe that they do in fact possess the negative attributes that are ascribed to their broader stigmatized group. Individuals with mental illness may come to believe, for example, that they are dangerous or incompetent.[36] Studies have shown internalized stigma to be associated with negative consequences, including increased symptom severity and poorer treatment adherence.[37]

Although less frequently studied, involuntary commitment and hospitalization generally have been found to have an even greater stigmatizing effect than being perceived as mentally ill or receiving outpatient treatment.[38] A recent study of several hundred individuals with serious mental illness who had been involuntarily hospitalized found that hospitalization created additional internalized stigma. Specifically, the study found greater incidence of feelings of shame and self-contempt, which in turn was found to lead to lower self-esteem and lower quality of life.[39] Another qualitative study found that individuals reported higher levels of discrimination following hospitalization.[40] A Brazilian study conducted among a hundred and sixty individuals with a history of involuntary commitment found that individuals with families with more biased views towards mental illness were more likely to be re-committed.[41]

In the prison context, there are a number of negative consequences associated with being committed and being perceived as mentally ill. Prisoners, unsurprisingly, often possess the same biases against people with mental illness as do the general population. Prisoners labeled as mentally ill, experience social

35 Deborah A. Perlick et al., *Stigma as a Barrier to Recovery: Adverse Effects of Perceived Stigma on Social Adaptation of Persons Diagnosed with Bipolar Affective Disorder*, 52 PSYCHIATRIC SERVICES 1627 (2001); 2003 National Survey on Drug Use & Health: Results, Dep't of Health & Human Servs., Substance Abuse & Mental Health Servs. Admin., & Office of Applied Studies, (June 3, 2008), http:// www.oas.samhsa.gov/nhsda/2k3nsduh/2k3Results.htm.

36 *See, e.g.*, Corrigan, P.W. et al., *The Internalized Stigma of Mental Illness: Implications for Self-Esteem and Self-Efficacy*, 25 J. SOC. & CLINICAL PSYCHOL. 875 (2006); Jennifer Boyd Ritsher & Jo C. Phelan, *Internalized Stigma Predicts Erosion of Morale Among Psychiatric Outpatients*, 129 PSYCHIATRY RES. 257 (2004); Philip T. Yanos et al., *The Impact of Illness Identity on Recovery from Severe Mental Illness*, 13 AMER. J. PSYCHOL. REHABILITATION 73 (2010).

37 *See* Livingston & Boyd, *supra* note 32.

38 Nicolas Rüsch et al., *Emotional Reactions to Involuntary Psychiatric Hospitalization and Stigma-Related Stress Among People with Mental Illness*, 264 EUR. ARCHIVES PSYCHIATRY CLINICAL NEUROSCIENCE 35 (2014).

39 *Id.*

40 Ingrid Sibitz et al., *Impact of Coercive Measures on Life Stories: Qualitative Study*, 199 BRIT. J. PSYCHIATRY 239 (2011).

41 Alexandre Andrade Loch, *Stigma and Higher Rates of Psychiatric Re-hospitalization: São Paulo Public Mental Health System*, 34 REVISTA BRASILEIRA DE PSIQUIATRIA 185 (2012).

isolation and additional stigmatization.[42] One account of prison life by Victor Hassine, a formerly incarcerated person, described individuals perceived as mentally ill as fundamentally disruptive to prison life. He wrote, "Their helplessness often made them the favorite victims of predatory inmates. Worst of all, their special needs and peculiar behavior destroyed the stability of the prison system."[43] It has been found that mentally ill prisoners are disproportionately victims of physical and sexual violence while in prison. A 2007 study of over 7,500 prisoners (randomly sampled from a population of roughly 20,000 prisoners) found that the number of incarcerated men that reported being victims of sexual violence was three times higher among men with mental health conditions than among men without diagnosed mental health conditions (one in twelve compared to one in thirty-three).[44] The study also found a higher likelihood of reported sexual victimization among women with mental health conditions than among women without mental health conditions.[45] It has also been found that women diagnosed with mental illness are less likely to receive parole.[46]

c. Supreme Court jurisprudence on stigma in the procedural due process analysis

Procedural due process guarantees that no state nor the federal government "shall . . . deprive any person of life, liberty, or property, without due process of law."[47] State-imposed stigma has for a long time been considered relevant to the existence of a liberty interest. Prior to 1976, several cases decided by the Supreme Court suggested that stigma, or reputational harm, created by the state was enough to implicate a liberty interest, thereby triggering due process protection.[48] Yet in 1976, in *Paul v. Davis*, the Supreme Court reversed course, holding that reputational harm created by a state-imposed label was relevant but not sufficient to trigger procedural protection under the Due Process clause of the

42 HUMAN RIGHTS WATCH, ILL-EQUIPPED: US PRISONS AND OFFENDERS WITH MENTAL ILLNESS 24 (2001) (citing TERRY KUPERS, PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT 20 (1999)).

43 VICTOR HASSINE, LIFE WITHOUT PAROLE: LIVING IN PRISON TODAY 29 (1996).

44 Nancy Wolff et al., *Rates of Sexual Victimization in Prison for Inmates With and Without Mental Disorders*, 58 PSYCHIATRIC SERVICES 1087, 1090 (2007).

45 *Id.* at 1091.

46 Kelly Hannah-Moffat, *Losing Ground: Gendered Knowledges, Parole Risk, and Responsibility*, 11 SOC. POL. 363 (2004).

47 U.S. Const. amends. V, XIV.

48 Eric J. Mitnick, *Procedural Due Process and Reputational Harm: Liberty as Self-Invention*, 43 U.C. DAVIS L. REV. 79, 83–86 (2009) (citing Jenkins v. McKeithen, 395 U.S. 411, 429 (1969); Wisconsin v. Constantineau, 400 U.S. 433, 437 (1971); Bd. of Regents v. Roth, 408 U.S. 564, 573–74 (1972)).

Fourteenth Amendment.[49] The Court held that state-created stigma only triggers procedural due process protection when it is accompanied by the abridgement of some "right or status previously recognized by state law" or "guaranteed in one of the provisions of the Bill of Rights."[50]

In September 1971, Edward Charles Davis III was arrested in Louisville, Kentucky for shoplifting. The charge was later dismissed. A year later, the chief of police of Louisville, acting in his official capacity, distributed a flyer identifying "Active Shoplifters."[51] A photo of Davis along with his name was included on the flyer. When Davis's employer found out that he had been listed in this flyer, he was not fired but was told that another arrest could lead to his termination. Although not actually fired, Davis stated that he felt "humiliation and ridicule" from members of his department and he ultimately left the job.[52] After leaving this job, he found it difficult to find new employment. At the time of the lawsuit, he was unemployed.[53]

Davis filed a 42 U.S.C. § 1983 claim, arguing that his inclusion on the flyer by the police chief without appropriate procedural protections violated his right to procedural due process.[54] The District Court found for the police chief, but when Davis appealed, the Sixth Circuit reversed. The Supreme Court granted certiorari and held that stigma was relevant but insufficient to garner procedural protections.[55] The court explained that due process protection was intended to protect those rights guaranteed through either state law or the Constitution. Reputation alone, without some additional harm, was not protected by either.[56] This standard, that stigma coupled with some tangible harm recognized by law, such as loss of employment or property, triggers due process protection, became known as the "stigma plus" standard.[57]

Three years later, in *Addington v. Texas*, the court considered how stigma that results from a state-imposed label affects the procedural due process analysis in the context of civil commitment proceedings.[58] Appellant, Frank O'Neal Addington, had been temporarily committed several times from 1969–1975. After he was arrested for "assault by threat" against his mother, she filed a

49 Paul v. Davis, 424 U.S. 693 (1976).

50 *Paul*, 424 U.S. at 710 n.5, 711.

51 *Id.* at 695; Mitnick, *supra* note 48 at 87.

52 Mitnick, *supra* note 48 at 88 (citing Edward Charles Davis III, *A "Keep Out" Sign on the Courthouse Doors?*, JURIS DR., (1976)).

53 *Id.*

54 *Paul*, 424 U.S. at 694.

55 *Id.* at 696–97.

56 *Id.* at 708.

57 See Lindsey Webb, The Procedural Due Process Rights of the Stigmatized Prisoner, 15 U. PA. J. CONST. L. 1055, 1069 (2013).

58 *Addington*, 441 U.S. at 418.

petition to have him committed indefinitely.[59] At trial, the judge instructed the jury that to commit Addington, their findings must be substantiated by clear and convincing evidence. Following the jury's finding that Addington should be committed, Addington appealed on procedural due process grounds. He argued that because civil commitment results in the same deprivation of liberty as imprisonment, due process requires the application of the higher, beyond a reasonable doubt evidentiary standard.[60] The state appellate court agreed and reversed, but on appeal, the Texas Supreme Court reversed again. The Texas Supreme Court found that procedural due process only required proof based on a preponderance of the evidence, an even lower standard than the trial court had initially required. Addington appealed to the Supreme Court and the Court granted *certiorari*.

Ultimately, the Supreme Court held that, in fact, while the highest standard was not required, the intermediate clear and convincing evidence standard was appropriate, because civil commitment "constitutes a significant deprivation of liberty that requires due process protection."[61] In reaching this conclusion, Justice Burger, writing for the Court,[62] stated that civil commitment following the determination that an individual is dangerous (which was required by the Texas law) creates "adverse social consequences" for the committed individual."[63] He further elaborated: "whether we label this phenomena [sic] 'stigma' or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual."[64]

Vitek v. Jones was decided the following year.[65] On May 31, 1974, appellant Larry D. Jones was convicted of robbery and sentenced to three to nine years in Nebraska state prison. Nine months later he was transferred to the prison hospital and then placed in solitary confinement. While in solitary confinement, he burned his mattress and burned himself in the process. After being treated for the resulting burns, he was transferred to a state mental hospital.[66] The transfer was authorized by a Nebraska statute, which stated that: "[w]hen a designated physician or psychologist finds that a prisoner 'suffers from a mental disease or defect' and 'cannot be given proper treatment in that facility,'" the Director of Correctional Services may transfer that prisoner to any suitable facility within or outside of the correctional system.[67]

59 *Id.* at 419.
60 *Id.* at 421.
61 *Id.* at 425.
62 Justice Powell took no part in the consideration of the case or the decision.
63 *Id.* at 426.
64 *Addington*, 441 U.S. at 425–26.
65 *Vitek*, 445 U.S. at 480.
66 *Id.* at 484.
67 Id. at 483 (citing NEBRASKA REV. STAT. § 83–180(1) (1976)).

Following his transfer, Jones joined a suit challenging the constitutionality of the Nebraska statute. Although people lose many freedoms upon incarceration, the Supreme Court has held that "[p]risoners may . . . claim the protections of the Due Process Clause. They may not be deprived of life, liberty, or property without due process of law."[68] A three-judge District Court, empaneled pursuant to 28 U.S.C. § 2281 (1970) (now repealed), found for Jones and his fellow plaintiffs, determining that the statute was unconstitutional because a transfer to a mental health facility invoked a liberty interest that requires additional procedural protections."[69] The District Court enjoined the state from transferring Jones to the mental hospital without appropriate due process.[70] The state appealed to the Supreme Court directly.[71] The Supreme Court upheld the judgment of the District Court. [72] Justice White, writing for the majority, stated its holding:

> the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections.[73]

As in Paul, the Court held that stigma was insufficient alone to create a liberty interest, but that stigma that resulted from a transfer coupled with mandated treatment implicated a liberty interest and therefore required procedural protections.[74] This was the first time the Supreme Court explicitly

68 Wolff v. McDonnell, 418 U.S. 539, 556 (1974).

69 *Id.* at 488.

70 28 U.S.C. § 2281 provided: "An interlocutory or permanent injunction restraining the enforcement, operation or execution of any State statute by restraining the action of any officer of such State in the enforcement or execution of such statute or of an order made by an administrative board or commission acting under State statutes, shall not be granted by any district court or judge thereof upon the ground of the unconstitutionality of such statute unless the application therefor is heard and determined by a district court of three judges under section 2284 of this title. 28 U.S.C. § 2281 (1970).

71 28 U.S.C. § 1253 provided for direct appeal to the Supreme Court of this type of injunction ("Except as otherwise provided by law, any party may appeal to the Supreme Court from an order granting or denying, after notice and hearing, an interlocutory or permanent injunction in any civil action, suit or proceeding required by an Act of Congress to be heard and determined by a district court of three judges."). 28 U.S.C. § 1253 (1970).

72 *Vitek*, 445 U.S. at 485 (citing Vitek v. Miller, 434 U.S. 1060 (1978)). While it was ultimately a 5–4 decision, those writing in concurrence and dissent did not disagree with the court's holding that this type of transfer required due process protections. Rather, these justices disagreed with respect to the appropriate level of procedural protections and whether the Court could hear the case at all. See *id.* at 497 (Powell, J., concurring in part); *id.* at 501 (Stewart, J., dissenting); *id.* at 501 (Blackmun, J., dissenting).

73 *Id.* at 494.

74 Webb, supra note 57 at 1073–74 (quoting Vitek, 445 U.S. at 494) ("The Vitek Court, like Paul, found a liberty interest in the

included stigma in the due process analysis associated with transfer from a prison to a mental health facility, or any involuntary commitment in the prison context.

In holding the Nebraska statute unconstitutional the District Court had based its conclusion in part on the fact that commitment creates stigmatizing consequences. Justice White agreed with this conclusion, stating that "commitment to a mental hospital" has "adverse social consequences."[75] He offered two case citations to support this assertion. First, he quoted Justice Burger's consequences language in *Addington*.[76] Second, he cited to a statement in a case decided by the Supreme Court earlier that year, to be discussed more in Part IV.c.ii, *infra*.[77] In this case, the Court stated that commitment, in this case the commitment of a child, might trigger some negative, social consequences "because of the reaction of some to the discovery that the child has received psychiatric care."[78] To substantiate this conclusion, the Supreme Court in that case had cited to the same "adverse social consequences" language in *Addington*.

Addington and *Vitek* were landmark decisions in mental health law. For the first time the Supreme Court held that the stigma of mental health commitment, in both the civil and criminal contexts, is real and so damaging to liberty that it was to be considered in procedural due process analysis.

d. Stigma of mental health commitment in procedural due process since Addington and Vitek

While *Addington* and *Vitek* importantly clarified that the stigma of mental health commitment was relevant to procedural due process analysis, these cases left a number of questions related to the application of these standards unanswered. First, the Court did not clarify which consequences of stigma were relevant to the analysis. In *Addington*, Justice Burger referred to the "adverse social consequences" that result from commitment, but then went on to say such consequences may accurately be labeled 'stigma' generally.[79] Justice White merely referred to "the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment" without additional clarification. As discussed in Part II.b, *supra*, there is both public and internalized stigma which can result in various, negative consequences. The justices did not specify

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combination of stigma and a specific type of consequence--the 'mandatory behavior modification' involved in mental health treatment--associated with that stigma. As under Paul, stigma must accompany the condition, just as a particular type of condition must accompany the stigma, in order for a liberty interest to exist. In Vitek, the Court noted that the conditions that Mr. Vitek experienced in the mental institution in which he was confined, considered alone, 'might not constitute the deprivation of a liberty interest retained by a prisoner.'").

75 *Vitek*, 445 U.S. at 492.

76 *Id.* (citing *Addington*, 441 U.S. at 425–26).

77 Parham v. J. R., 442 U.S. 584 (1979).

78 *Id.* at 600 (citing *Addington*, 441 U.S. at 425–26).

79 *Addington*, 441 U.S. at 425–26.

which of these consequences judges are to consider in the procedural due process analysis because they did not engage in any discussion of these specific consequences.

What is more, because both justices spent very little time discussing how they arrived at their conclusions that commitment causes stigma, it was left unclear how broadly these conclusions apply. Neither case explained, for example, whether a commitment order for several days would result in the same stigma as a commitment order for a longer period of time. In *Vitek*, Justice White did not clarify whether the stigma to which he referred was that in the eyes of the general public or that in the eyes of prison population. He did not clarify whether this stigma only attached because the plaintiff was transferred to a facility outside of the prison system or whether it would attach if transferred to any mental health facility.

Finally, it is not obvious from either decision how stigma fits into the overall procedural due process analysis. In Addington, Justice Burger noted the existence of the stigma and consequently upheld the use of an intermediate evidentiary standard but did not state explicitly what role stigma should play in the procedural due process analysis. In Vitek, Justice White held that stigma coupled with mandatory treatment implicated a liberty interest, akin to the "stigma plus" standard established in Paul. Yet it is not clear from Vitek whether any plus factor, such as demonstrable proof of any of the stigmatizing consequences of stigma would be sufficient to implicate a liberty interest, or whether under this standard, standard mandatory treatment is necessary to trigger procedural due process protections.

III. METHODOLOGY AND DESCRIPTION OF THE SAMPLE

a. Opinion collection and selection

To determine how federal judges have treated the stigma of mental health commitment in procedural due process analysis since *Addington* and *Vitek*, a systematic review was conducted of all federal judicial opinions that have discussed this topic since *Addington* was decided on April 29, 1979. Specifically, the search identified all federal cases, both published and unpublished, that discussed: stigma and related concepts (such as social consequences and shame), involuntary commitment and related concepts (such as involuntary treatment and inpatient commitment), and mental health and related concepts, within a single paragraph.[80] Search criteria were developed through reading case law, to

80 To find these opinions, a search was conducted in Westlaw, limiting to all federal jurisdictions, using the following search criteria: ((psychol! psychiat! personalit! mental!) /3 (disorder! ill! health! disabil! disease! diagnos!)) /p stigma! "social costs" "social consequences"

determine the terms judges use in this context, as well as literature related to mental illness, mental health commitment, and stigma. This search yielded 206 opinions.

From these 206 opinions, the study sample was selected based on four criteria. First, the sample was limited to those opinions issued after *Addington*. Second, opinions that included all of the search terms but did not actually discuss stigma in the context of mental health commitment were removed. These opinions might have, for example, discussed the mental health history of defendants, "commitment" of certain crimes, and the stigma of arrest. Or, these opinions may have presented issues related to the stigma of mental health commitment, say in a background section, but ultimately did not discuss the substance of the issues because they were decided on procedural grounds. These opinions may have even cited to the holdings in *Addington* and *Vitek* but did not include any larger discussion of mental health commitment. Many of these opinions were 42 U.S.C. § 1983 actions unrelated to mental health commitment brought by prisoners who merely analogized their situations to that described in Vitek, often in a footnote.[81] Ultimately, these opinions were all removed.

Third, opinions discussing issues related to sex offender treatment and labeling were removed. These opinions contained the search terms, because a number of Circuits have extended the holding in *Vitek* to apply to prisoners labeled as sex offenders. Although this topic is related to the issue of mental health commitment, these opinions were removed from the study sample to simplify analysis.

Fourth and finally, the sample was limited to those opinions that discussed procedural due process. Although the search criteria yielded opinions that discussed the stigma of mental health commitment in a variety of legal contexts, including substantive due process, equal protection, the Americans with Disabilities Act, and the Second Amendment, for this Note, the scope was limited to those opinions that discuss this issue in the context of procedural due process. Following these exclusions, the study sample consisted of fifty-three opinions. Table 1 shows how many opinions were excluded at each step of the opinion selection.

"scarlet letter" shame embarrassment disgrace curse /p commitment hospitalization (commit! /3 (civil! inpatient mental involun!)) "compelled treatment" "involun! treat!" "inpatient treatment" "mental hospital!" "involuntarily admit!".

81 Twelve (unpublished) opinions that included the following language as their only discussion of the relevant issue were excluded: "Vitek v. Jones, 445 U.S. 480, 493-94 (1980) (prisoner possesses liberty interest under the Due Process Clause in freedom from involuntary transfer to state mental hospital coupled with mandatory treatment for mental illness, a punishment carrying 'stigmatizing consequences' and 'qualitatively different' from punishment characteristically suffered by one convicted of a crime)."

Table 1. Opinion Selection

	No. of Opinions
1. All federal opinions containing search criteria,	206
2. Decided after Addington v. Texas (April 29, 1979),	185
3. That discuss stigma in the context of mental health commitment or sex offender treatment,	96
4. Limited to mental health commitment,	61
5. Limited to discussion in the context of procedural due process.	53

b. Content analysis

The remaining fifty-three opinions[82] were reviewed using ethnographic content analysis. This method required reviewing opinions without particular categories in mind, developing categories, and then re-reading the opinions to categorize them by the themes that emerged. To implement this methodology, all discussion of stigma of mental health commitment in the context of procedural due process from the opinions was identified and collected. Once this information was collected from all the opinions in the sample, it was reviewed to determine what similarities and differences existed between the opinions. These findings emerged into themes and each of the fifty-three opinions was assigned one or more of these themes, as will be discussed further in Part IV, *supra*.

There are of course limitations to this study. While this study focuses on federal courts, much of civil and criminal commitment occurs in state courts. This study does not account for how state court judges engage with the stigma of mental health commitment. Additionally, the information collected concerns judges' discussion of stigma in the context of procedural due process rather than case outcomes. While in general judges seemed to deny plaintiffs procedural due process protections, this information was not recorded systematically, because there are so many variables that could affect this outcome. As discussed above, this study was limited to the context of procedural due process. Findings do not necessarily translate to how judges engage the stigma of mental health commitment in other legal contexts. Finally, while the sample includes both published and unpublished opinions, it does not account for those cases in which judges have chosen not to write opinions at all.

82 *Vitek* is among the fifty-three opinions included in the sample since it was decided roughly a year after *Addington*.

c. Description of the sample

The fifty-three opinions analyzed were decided over the years 1979 to 2015. The first case was decided on June 20, 1979 and the last on February 10, 2015. The number of cases was relatively evenly distributed over time, although fewer seem to have been decided in the 1990's than in the other three decades in the sample. Figure 1 shows the number of opinions in the sample decided by year.

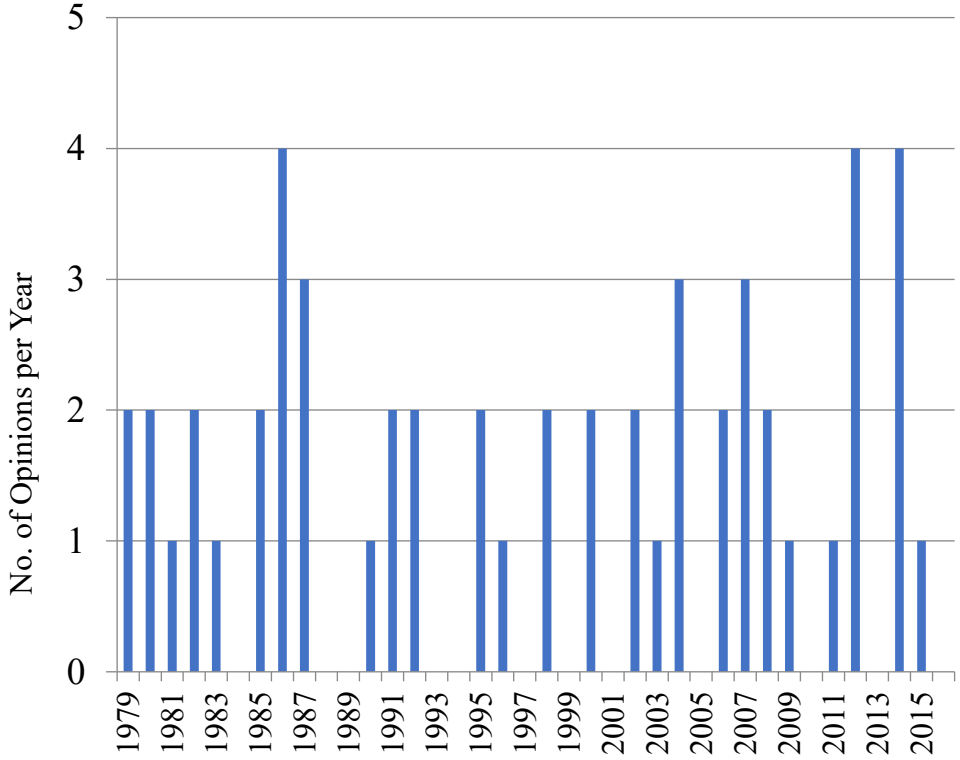

Figure 1. No. of Opinions by Year

The sample includes at least one opinion from every circuit as well as four Supreme Court cases, including *Vitek*. The opinions were also relatively evenly distributed by court type: roughly half were trial-court opinions and half appellate opinions. Table 2 shows the number of opinions decided by circuit, in total and broken out by whether the case was decided by a District Court or the Court of Appeals for that circuit. The court information provided by Westlaw was used to determine the circuit from which each opinion came. The sample includes several cases that were appealed and heard in multiple courts in the

sample, so there are multiple opinions in the sample for the same case.

Table 2. No. of Opinions by Circuit and Court Type

Circuit	Total	Court of Appeals	District Courts
First Circuit	2	1	1
Second Circuit	8	3	5
Third Circuit	9	2	7
Fourth Circuit	4	2	2
Fifth Circuit	4	2	2
Sixth Circuit	6	3	3
Seventh Circuit	1	1	0
Eighth Circuit	4	2	2
Ninth Circuit	3	1	2
Tenth Circuit	6	4	2
Eleventh Circuit	1	1	0
D.C. Circuit	1	0	1
Supreme Court	4	-	-
Total	53	26	27

Finally, cases in the sample pertained to both civil commitment and criminal commitment. Cases were occasionally difficult to categorize. For example, if a person was detained by the police for psychiatric evaluation, this was categorized as a case relating to civil law, because the detainment is not considered an arrest. On the other hand, cases related to criminal defendants pleading not guilty for reason of insanity were categorized as criminal, even though, in some states, such defendants are subsequently committed under civil commitment laws.

Table 3. No. of Opinions in Civil and Criminal Cases

Case type	No. of Opinions
Civil	18
Criminal	35
Total	53

IV. RESULTS

Across the fifty-three opinions reviewed, judges consistently spent very little time discussing the stigma of mental health commitment relative to other issues. Within this limited discussion of mental health stigma, four main themes emerged. First, many opinions in the sample did not discuss stigma beyond restating the conclusions drawn in *Addington* and *Vitek* and either applying their holdings or distinguishing the facts at bar from those in *Addington* and *Vitek*. Among these opinions it was often unclear what role stigma played in the overall procedural due process analysis. There were also opinions that contained somewhat more extended discussion of stigma, and among these discussions, three themes emerged. First, there were opinions that compared the stigma of mental health commitment with stigma resulting from other circumstances. Second, there were opinions that contained more involved discussion of either the consequences or causes of stigma. Finally, some opinions stated explicitly that the stigma of mental health commitment and related issues were so obvious, there was no need to discuss them more broadly - despite the supposed obviousness of the stigma, many of these opinions found procedural due process was not required. None of even those opinions with a somewhat expanded discussion of stigma engaged the full scope of the harm caused by the consequences of stigma.

a. Discussion of stigma limited to quoting Addington and Vitek

Many of the opinions in the sample contained almost no discussion of stigma other than to cite to the consequences language in *Addington* and *Vitek*.[83] These cases arose in both the civil and prison contexts across the entire time period covered by the sample, although more seem to have been filed more recently. Among some of these cases, it was clear that the presence of stigma triggered or would trigger additional procedural protections.[84]

In many other cases, because there was so little additional discussion, it was not clear what role the stigma ultimately played in the judge's decision to grant or deny due process protections.[85] For example, in an opinion by the then Northern District of New York, the court denied defendants' motion for summary judgment against a prisoner claiming that his due process rights were violated when transferred to the mental health treatment wing of the prison without due

83 *Addington*, 441 U.S. at 426; *Vitek*, 445 U.S. at 494.

84 *E.g.*, United States v. Visinaiz, 96 F. App'x 594, 597 (10th Cir. 2004); Bucano v. Sibum, No. 3:12-CV-606, 2012 WL 2395262 (M.D. Pa. June 25, 2012).

85 *E.g.*, Doe v. Gallinot, 657 F.2d 1017 (9th Cir. 1981); United States v. Barajas, 331 F.3d 1141, 1147 (10th Cir. 2003); Cummings v. Darsey, No. CIV.A. 06-5925 (RBK), 2007 WL 174159, at *4 (D.N.J. Jan. 16, 2007).

process. Yet while the court ultimately decided that there were outstanding questions of fact that made summary judgment inappropriate, it is not clear what role stigma played in this decision or what role the judge believed stigma plays in procedural due process analysis more generally. The judge referenced stigma in two places in the opinion. First, the judge discussed *Vitek* but cited the case for the proposition that the plaintiff was entitled to prove he had a mental illness before "suffering the stigmatizing effects of transfer to a mental institution" rather than to discuss the stigma of the transfer itself.[86] Later in the discussion, the judge referenced stigma again in addressing the defendant's contention that being transferred to the mental health wing was better than being placed in protective custody and similar to remaining in the general population. He stated: "certainly from the plaintiff's point of view, the APPU [the mental health treatment wing] is less desirable than the general population, and it is claimed it has stigma attached to it by the general population inmates."[87] Yet, rather than suggesting that this stigma, coupled with mandatory treatment, implicated a liberty interest, per *Vitek*, the judge went on to undercut the defendants' point on other grounds. Based on this brief discussion, it was not clear how, in the judge's view, stigma fit within the procedural due process analysis in general.

Many other opinions also confined discussion of stigma to references to *Addington* and *Vitek*, but ultimately held procedural protections were inappropriate by distinguishing the facts of the case at bar from those in those two cases. In these cases, judges generally distinguished from *Addington* and *Vitek* without going into whether the facts of the instant cases could in themselves result in stigmatic consequences or, if they did not, why they did not.[88] For example, in a case before the District Court of Idaho, plaintiff David Tyler Hill, who had been incarcerated by the Idaho Department of Corrections (IDOC) at the Idaho Maximum Security Institution (IDSI), brought a 42 U.S.C. § 1983 action against the IDOC and its chief psychologist.[89] Specifically, Mr. Hill challenged his transfer to an area of the IDSI designated for mental health treatment without a hearing.[90] In considering whether his transfer implicated procedural due process, the judge cited to the *Vitek* "stigmatizing consequences" language but then distinguished Mr. Hill's situation from that in *Vitek*. He explained that Mr. Hill's transfer was different than the transfer in *Vitek*, because Mr. Hill never left IDOC facilities, whereas in *Vitek* the plaintiff was transferred

86 Flowers v. Coughlin, 551 F. Supp. 911, 915 (N.D.N.Y. 1982).

87 *Id.* at 916.

88 *See, e.g.*, Pierce v. Blaine, 467 F.3d 362, 371 (3rd Cir. 2006) (distinguishing from *Vitek*, because the judge determined that the plaintiff in *Vitek* had been transferred for an indefinite period of time while the plaintiff in the instant case was transferred for several weeks for psychiatric evaluation); Green v. Dormire, 691 F.3d 917, 922 (8th Cir. 2012) (same).

89 Hill v. Reinke, No. 1:13-CV-00038-BLW, 2014 WL 7272939 (D. Idaho Dec. 18, 2014).

90 *Id.* at *2.

out of a facility run by the Department of Corrections and into a "state agency run hospital."[91] The district judge did not explain why this type of transfer would be less stigmatizing nor did he examine the potentially stigmatizing consequences of Mr. Hill's transfer.[92] Ultimately, the judge concluded that the transfer did not implicate a liberty interest and the court granted defendants' motion for summary judgment.[93]

Judges distinguished from *Vitek* on other grounds and did not discuss why or if these distinguishing factors affected the stigma of the commitment. One such factor was length of commitment. According to these opinions, the plaintiff in *Vitek* was transferred to a state run hospital for an indefinite period of time[94] and so judges did not apply *Vitek* in situations in which plaintiffs were committed for finite amounts of time, for example, for several weeks for psychiatric evaluation.[95] Judges did so without discussing why this type of commitment would be less stigmatizing than commitment for an indefinite amount of time.

Among these opinions, there were some with very minimal discussion of stigma that found that procedural due process protections were or would be required, but more often judges distinguished from the facts in *Addington* and *Vitek* and determined that procedural due process protections were not appropriate with little discussion.

b. Comparison to stigma created by other circumstances

In a number of opinions in the sample, the discussion analogized the stigma of mental health commitment to the stigma associated with other circumstances. Judges examined a number of other potentially stigmatizing circumstances. This section begins with an extended discussion of the comparison made to the stigma of insanity pleas, because the issue split two Circuits and was ultimately decided by the Supreme Court, in one of the four opinions in the sample. The Supreme Court subsequently applied its ruling on this issue in another one of the four opinions in the sample.

i. Insanity pleas

In 1980, the Second Circuit considered a due process challenge to commitment proceedings following a determination that a defendant was not

91 *Id.* at *18.

92 *Id.*

93 *Id.* at *1.

94 In fact, the statute at issue in *Vitek* provided that in order to keep a prisoner committed after their sentence has elapsed, the hospital must hold a civil commitment hearing. *Vitek*, 445 U.S. at 484.

95 *E.g.*, *Pierce*, 467 F.3d at 371; *Green*, 691 F.3d at 922.

guilty of criminal charges by reason of insanity.[96] Per Connecticut law, after the defendant, Mr. Warren, was acquitted by reason of insanity, a hearing was held to determine whether he was a danger to himself or others and therefore should be committed to a mental health facility. At the hearing, it was determined, based on a preponderance of the evidence, that he was a danger and he was committed.[97] He petitioned the court for his release because he argued that this evidentiary standard, used at both his commitment hearing and subsequent release hearings, violated procedural due process.[98]

In considering the challenge, the Second Circuit took up the liberty interest and specifically the issue of stigma associated with mental health commitment in this situation. The court determined that commitment that follows from a pleading of not guilty by reason of insanity does not result in stigma, because the person is already stigmatized. The Court seemed to suggest that the defendant had reached a sort of stigma ceiling. The Second Circuit wrote: "[a]ny stigma resulting from the label 'mentally ill and dangerous' certainly attached at the time the accused was found not guilty by reason of insanity. Additional stigma which might result from subsequent commitment to a mental hospital must be regarded as minimal, if any."[99] The Court did not provide any explanation for this conclusion.

Two years later, the Fifth Circuit considered the same question but disagreed with the Second Circuit, holding that a defendant that pleads not guilty by reason of insanity can become further stigmatized through commitment.[100] The Fifth Circuit interpreted the Second Circuit's holding as stating that the initial stigma that results from pleading not guilty by reason of insanity results from the "judicial determination . . . that they [the defendants] committed a crime and that no additional stigma attaches upon commitment."[101] This conclusion, the Fifth Circuit stated, was inconsistent with the holding in *Vitek*, because there the Supreme Court determined that a prisoner, an individual that has been convicted of a crime, can still face additional stigma upon transfer to a mental hospital.[102] It is possible the Fifth Circuit misinterpreted the Second Circuit's holding. The initial stigma referred to by the Second Circuit seems to have been that which results from the judicial determination that a defendant is not responsible for a crime because he is insane, rather than that from a judicial determination that an individual committed a crime. While this seems to be the more likely

96 Warren v. Harvey, 632 F.2d 925 (2d Cir. 1980).

97 *Id.* at 929.

98 *Id.* at 931.

99 *Id.* at 931–32.

100 Benham v. Edwards, 678 F.2d 511, 524–25 (5th Cir. 1982), *cert. granted, judgment vacated sub nom.* Ledbetter v. Benham, 463 U.S. 1222 (1983).

101 *Id.*

102 *Id.*

interpretation, it is hard to be sure since the Second Circuit spent so little time on the discussion, and, regardless, the Fifth Circuit clearly thought otherwise. Ultimately, the Fifth Circuit held that additional stigma could result from a transfer from prison to a mental health facility after pleading not guilty by reason of insanity.

The Supreme Court addressed the issue a year later.[103] The Court considered the issue of whether additional stigma could result from commitment following an insanity plea, in a footnote, and agreed with the Second Circuit. Footnote sixteen of Justice Powell's opinion stated only that: "[a] criminal defendant who successfully raises the insanity defense necessarily is stigmatized by the verdict itself, and thus the commitment causes little additional harm in this respect."[104] The Court seemed to endorse this idea of a stigma ceiling in this context, although it did so without reference to case law or external evidence. Justice Brennan, in dissent, commented on this conclusion, but did not disagree with it.[105] He stated only that Justice Powell put too much emphasis on the lack of additional stigma in his due process analysis and in fact there should be more emphasis place on the physical intrusion and restraint placed on committed individuals.[106] This was the first time since *Vitek* the Supreme Court directly addressed the role of the stigma of mental health commitment in procedural due process.

Shortly after this case was decided, the Fifth Circuit case discussed above, was remanded and vacated.[107] This issue arose in two other cases in the sample. Nearly a decade later, the Supreme Court took up another case related to commitment following an insanity plea and again held that no additional stigma resulted from commitment.[108] A decade after that, in a case before the Tenth Circuit, the Court also applied the Supreme Court's conclusion.[109]

ii. Criminal Conviction

Judges also compared the stigma of mental health commitment with that of criminal conviction, separately from pleading insanity. One of these opinions provides an example of a judge looking to cases beyond *Addington* and *Vitek* to inform a conclusion related to the stigma of mental health commitment. In a case before the Fourth Circuit, plaintiff Theresa Gooden brought a 42 U.S.C. § 1983

103 Jones v. United States, 463 U.S. 354 (1983).

104 *Id.* at 367 n.16.

105 *Id.* at 371 (Brennan, J., dissenting).

106 *Id.*

107 *Ledbetter*, 463 U.S. at 1222.

108 Foucha v. Louisiana, 504 U.S. 71, 114 (1992).

109 United States v. Weed, 389 F.3d 1060, 1068 (10th Cir. 2004) (citing Jones, 463 U.S. at 367 n.16).

action against police officers and her county after she was taken from her apartment to a hospital for emergency mental health commitment.[110] In discussing the potential harm that may arise from a seizure for civil commitment, the judge quoted a district court's assessment from 1979 that "such a deprivation can create 'a stigma of mental illness which can be as debilitating as that of criminal conviction.'"[111] This quotation, in turn cited to a 1973 D.C. Circuit case and a 1963 hearing before a Senate Subcommittee.[112] In grappling with this question, whether the stigma of involuntary civil commitment is as "as severe" as criminal conviction, the judge in the 1973 D.C. Circuit case looked to then current studies in addition to then current news stories and Congressional hearings from the previous decade on the issue.[113]

In relying on this case law, the judge was in fact relying on conclusions the judges in those cases drew based on external sources of information on stigma, including studies, news stories, and Congressional hearings. Yet, these sources of evidence, relied upon in 1990, were from the 1960's and 1970's. While it is possible that the stigma of both of these circumstances remained constant in the intervening twenty to thirty years, it is not clear why the judge did not just rely on similar, more current sources.

iii. History of Mental Illness

In other opinions, judges opined on whether a long history of mental illness erases any additional stigma that may be created by commitment. In one such opinion, the judge looked to how juries had thought about stigma in the past to inform his determination of whether the jury's damages award for a six-day commitment without adequate procedural protection was reasonable. [114] The jury had awarded the plaintiff, Robert Marion, $750,000 in compensatory damages for the deprivation of liberty he suffered over the course of his six-day commitment. In determining what amount of compensatory damages were appropriate, the judge compared Mr. Marion's situation to three cases in which

110 Gooden v. Howard Cty., Md., 917 F.2d 1355 (4th Cir. 1990), *opinion superseded on reh'g*, 954 F.2d 960 (4th Cir. 1992).

111 *Id.* at 1363 (quoting Gross v. Pomerleau, 465 F. Supp. 1167, 1173 (D. Md. 1979) (quoting Stamus v. Leonhardt, 414 F.Supp. 439, 444 (S.D.Iowa 1976)). Although, according to Westlaw, the relevant quotation is at *Stamus*, 414 F.Supp. at 449.

112 Stamus v. Leonhardt, 414 F.Supp. 439, 449 (S.D.Iowa 1976)) (" . . . the legal and social consequences of commitment constitute a stigma of mental illness which can be as debilitating as that of a criminal conviction. *See* In re Ballay, 157 U.S.App.D.C. 59, 482 F.2d 648, 668–69 (1973); Hearings on S. 935 Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, 88th Cong., 1st Sess., 38 (1963).").

113 In re Ballay, 482 F.2d 648, 668 (D.C. Cir. 1973).

114 Marion v. LaFargue, No. 00 CIV. 0840 (DFE), 2004 WL 330239 (S.D.N.Y. Feb. 23, 2004).

individuals had been committed without having previously been diagnosed as mentally ill. The judge concluded that the cases were distinguishable, and that "Marion's case for damages was significantly weaker."[115] He explained:

> It was undisputed that Marion has had serious mental illness for many years. It seems clear that the other three juries were convinced that the plaintiffs never had any mental illness. . . . Accordingly, the amounts that those plaintiffs received for emotional damages are attributable only in part to the days of confinement, and in large part to the lingering stigma that unfortunately attaches to findings of mental illness. . . .[116]

Consequently, the judge determined that Mr. Marion was entitled to less than the defendants in these cases and less than what the jury had awarded him. The judge reduced the award from $750,000 to $150,000. It seems his decision was driven in part by his conclusion (based on past jury behavior) that stigma attaches when an individual is labeled as mentally ill and if already labeled, additional stigma does not occur upon commitment. Like the person who brings an insanity defense and now faces commitment, Mr. Marion had reached his stigma ceiling and, consequently, was entitled to far less damages for the violation of his procedural due process than if he had not had a history of mental illness. The judge came to this conclusion by considering past jury behavior rather than engaging in fact finding related to the current stigma of mental health commitment.

These opinions provide examples of judges either comparing the stigma of mental health commitment to other types of stigma. Because these types of comparisons were largely not addressed in either *Addington* or *Vitek*, judges were forced to consider other sources of information, or rely on personal opinion, in coming to conclusions on this matter. In general, judges favored looking to information from the past, such as prior case law or past jury behavior, rather than current sources of information, such as recent studies. Additionally, different judges relied on the same sources of information but came to very different conclusions. As discussed above, two appellate courts considered the same question, whether commitment following an insanity plea creates additional stigma, and relying on the same case law, came to entirely different results. The Supreme Court ultimately resolved this issue, but this is one of only a few issues the Court has addressed since it decided *Addington* and *Vitek*. There were many other inconsistencies in how judges were comparing this stigma to other forms of stigma that the Court has not addressed.

115 *Id.* at *10.
116 *Id.*

c. Some discussion of the consequences and causes of the stigma of mental health commitment

i. Consequences of stigma

There were several opinions in the sample that included a broader discussion of the consequences discussed in *Addington* and *Vitek*. In both *Addington* and *Vitek*, the Supreme Court focused on consequences, specifically the "adverse social consequences" and the "stigmatizing consequences" of commitment without additional discussion of specific consequences.[117] Although many opinions did not discuss these consequences any further, there were some in the sample that expanded upon this idea. Several of these opinions kept the discussion very general. For example, in a 1986 D.C. Circuit opinion, the judge stated that the: "personal and social consequences of commitment have a profound impact on a person long after he has been treated and released."[118] He substantiated this conclusion by citing to *Addington*.[119]

There were just a few other opinions that discussed the consequences of stigma in more specific terms, identifying the individual consequences that may result from the stigma associated with commitment. For example, in a 1985 North Carolina District Court case, the judge considered whether due process protections were required for a transfer to a mental health facility within the Department of Corrections. The case came to the court from a magistrate judge who had determined that this type of transfer did not implicate a liberty interest and therefore did not require procedural protections, because unlike in *Vitek* the plaintiff was not transferred outside of the Department of Corrections. The magistrate judge determined that the distinction was dispositive because, even though Judge White did not state so explicitly, the stigma at issue in *Vitek* was that in the eyes of the public rather than that among other inmates.

The District Court judge disagreed with the magistrate judge's interpretation of *Vitek*. He concluded that the transfer did implicate a liberty interest because it created stigma within the prison system, which was as harmful as stigma outside of the prison system. The judge went on to list specific consequences of a transfer to a mental health facility within the prison system: "[d]enial or delay of parole, study release, work release, and gain time jobs."[120] Additionally, he stated

117 *Addington*, 441 U.S. at 425–26; *Vitek*, 445 U.S. at 494.

118 Sanderlin v. United States, 794 F.2d 727, 736 (D.C. Cir. 1986).

119 *Id.*

120 Baugh v. Woodard, 604 F. Supp. 1529, 1535 (E.D.N.C. 1985), *aff'd in part, vacated in part*, 808 F.2d 333 (4th Cir. 1987) (the sole issue on appeal was the timing of the hearing required by due process: the District Court had held that such a hearing must take place prior to transfer whereas the Fourth Circuit concluded that the hearing could occur immediately after transfer but before admission to the mental health facility).

that "[t]here is also undisputed evidence that a prisoner returning to the general prison population from a mental health unit are viewed as 'bugs' by other inmates. These prisoners are ostracized and exploited by other prisoners."[121] While these assertions seem to be supported by the research discussed in Part II.b, *supra*, the judge made these assertions without reference to case law or any external evidence. Although many other opinions in the sample considered a transfer within the Department of Corrections, this is one of the few opinions that engaged in a more detailed analysis of the stigmatizing consequences in this context and one of the few to ultimately find that procedural protections were required. These opinions, particularly those that included a discussion of specific consequences, engaged the harm associated with this stigma more than did other opinions and found that procedural protections were appropriate more frequently than those opinions that did not engage this discussion.

ii. Causes of stigma

There were some opinions that included a discussion of the causes of the stigma of mental health commitment. Justice Burger, in *Addington*, did not directly address the causes of the stigma of mental health commitment but did discuss what he saw as causing the stigma associated with mental illness generally. He asserted: "[o]ne who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma." He cited to several articles in psychiatric publications to support this claim.[122] Justice White, in *Vitek*, did not engage in any discussion of the causes of the stigma associated with mental health commitment.

In a Third Circuit opinion, the judge considered an appeal from an award of attorney's fees in a class action brought by six named plaintiffs on behalf of all juveniles who had or would be committed to mental health facilities pursuant to Pennsylvania law by a parent or guardian.[123] In the underlying litigation, plaintiffs had alleged that this law violated both the due process and equal protection clauses of the Fourteenth Amendment. In discussing the liberty interest potentially affected by this type of commitment, the judge quoted another case in the sample, a 1979 Supreme Court opinion that identified at least one cause of the stigma of mental commitment for children: "'commitment sometimes produces adverse social consequences for the child because of the

121 *Id.*

122 *Addington*, 441 U.S. at 429 (citing Paul Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496, 498 (1976); Carol C. Schwartz et al., *Psychiatric Labeling and the Rehabilitation of the Mental Patient*, 31 ARCHIVES GEN. PSYCHIATRY 329, 334 (1974)).

123 Institutionalized Juveniles v. Sec'y of Pub. Welfare, 758 F.2d 897, 901 (3rd Cir. 1985).

reaction of some of the discovery that the child has received psychiatric care.'"[124] This quotation, which comes from *Parham v. J.R.*, seems to suggest that the stigma associated with commitment is not unique to commitment but would in fact result from any type of mental health treatment. Justice Burger, writing for the Court, followed this assertion with a citation to the "adverse social consequences" language in *Addington*.[125]

In *Parham v. J.R*, Justice Burger elaborated still further on what in his mind causes stigma for individuals facing commitment. The Court was considering a procedural due process challenge to a state civil commitment law and ultimately upheld its constitutionality. In coming to this conclusion, Justice Burger stated that making it more difficult to commit individuals in need of treatment could be the real cause of stigma, because "what is truly 'stigmatizing' is the symptomatology of a mental or emotional illness."[126] To support this contention, he cited to the assertion in *Addington* that to be mentally ill is to never be wholly free from stigma.[127]

Very few opinions in the sample addressed the causes of the stigma of mental health commitment. Those that did seemed to suggest that there is nothing uniquely stigmatizing about commitment, but rather that it is the underlying mental illness or treatment more generally that causes stigma. This in turn prompted these judges to deem procedural protections unnecessary, because the individual would experience the stigma regardless of the commitment.

d. Discussion of the obviousness of issues related to the stigma of mental health commitment (and yet often holding such stigma does not trigger procedural protections).

Finally, some opinions mentioned stigma but used language suggesting that the conclusions related to this stigma were so obvious there was no need for further discussion. In some instances, the obviousness of this stigma would lead judges to require procedural protections, yet more often, judges used this language, engaged in very minimal discussion of stigma, and ultimately held that procedural protections were not required.

For example, in an opinion from the Southern District of New York, the court considered a class action brought by civilly committed individuals arguing that it was a violation of procedural due process that the state did not appoint psychiatrists to assist in retention hearings.[128] Plaintiffs argued that committed

124 *Id.* at 913 (citing *Parham*, 442 U.S. at 600).

125 *Parham*, 442 U.S. at 600 (citing *Addington*, 441 U.S. at 425–26).

126 *Id.* at 601 (citing *Addington*, 441 U.S. at 429).

127 *Id.*

128 Goetz v. Crosson, 769 F. Supp. 132, 133 (S.D.N.Y. 1991), *aff'd in part, rev'd in part*, 967 F.2d 29 (2d Cir. 1992) (affirming the District Court's holding to the extent that in most cases due

individuals were due the same level of procedural protections as were criminal defendants, but the judge was not convinced. The judge conceded "there is an obvious stigma attached to confinement in a mental hospital,"[129] but the interest of the criminal defendant is "almost uniquely compelling."[130] He went on to explain why he found the criminal defendant's interest more compelling than that of the committed individual: the criminal, he asserted, was being punished, not treated and the committed individual was committed to protect society but also to protect himself. Yet, after describing the stigma as obvious, the judge entertained no further discussion of it. He did not consider the specific consequences of the stigma associated with commitment (or, incarceration for that matter). While he recognized the existence of the stigma, he seemed to give it minimal weight in comparison to other factors, without discussing why.

For another example, in the only Supreme Court case in the sample yet to be discussed, the Court engaged the topic of whether additional stigma attaches upon the commitment of a person who had plead not guilty by reason of insanity, the subject of Part IV.b.i, *supra*.[131] In this discussion, Judge White, writing for the Court, used language to suggest the obviousness of the conclusion that additional stigma does not in fact attach. To begin, Judge White applied the conclusion previously drawn by the Court in a footnote in the case discussed above. He wrote, "[s]tigmatization (our concern in *Vitek*) is simply not a relevant consideration where insanity acquittees are involved."[132] Despite this dismissive language, he cited to the Supreme Court case and the Second Circuit Court case that were discussed above to support this assertion. Yet in addition to citing to the Court's own precedent and the Second Circuit case, he also offered his own opinion on the subject.[133] He wrote, "[i]t is implausible, in my view, that a person who chooses to plead not guilty by reason of insanity and then spends several years in a mental institution becomes unconstitutionally stigmatized by continued confinement in the institution after 'regaining' sanity."[134] While this particular question had been previously decided by the Court, Justice White's assertion seemed to bely something else: that there are some conclusions so obvious there

process does not require the state to appoint of a psychiatrist but reversing and remanding back to the District Court to determine whether there may be some cases that are so factually complicated that a psychiatrist expert may be necessary).

129 *Id.* at 135.

130 *Id.* (citing Ake v. Oklahoma, 470 U.S. 68, 78).

131 *Foucha*, 504 U.S. at 71.

132 *Id.* at 114.

133 *Id.* ("As we explained in *Jones*: 'A criminal defendant who successfully raises the insanity defense necessarily is stigmatized by the verdict itself, and thus the commitment causes little additional harm in this respect.' 463 U.S., at 367, n. 16, 103 S.Ct., at 3051, n. 16; see also Warren v. Harvey, 632 F.2d, at 931-932.")

134 *Id.*

is no need to consider them further, to look to external research to corroborate.

While opinions that used this obviousness language did so in different contexts, some judges referring to the obviousness of the stigma itself and other referring to the obviousness of related conclusions, in general, use of the language was associated with very little additional discussion of any of the questions that were left unaddressed by *Addington* and *Vitek*. Often in these opinions judges would go on to find that the presence of stigma did not require procedural protections.

V. DISCUSSION

a. Judges have an incomplete view of the stigma of mental health commitment.

Among the fifty-three cases analyzed, there was variability in how and whether each opinion discussed stigma. There were those opinions that merely re-stated or cited to the language in either *Addington* or *Vitek* without any further discussion. There were those that drew comparisons between this type of stigma and other stigma and therefore engaged in longer discussion. Others engaged in some discussion about specific consequences of stigma or a broader discussion of consequences of stigma generally and other traced possible sources for that stigma. Some stated explicitly that no discussion was required because the stigma that results from commitment and other related issues are so obvious.

Yet, despite this variability, among all fifty-three opinions, judges consistently failed to consider the full consequences of stigma associated with mental health commitment. As discussed in Part II.b, *supra*, there are many more consequences to the stigma of mental illness and commitment than are described in any of the opinions in the sample. *Addington*, for example, references "adverse social consequences," but it is not clear whether this was meant to include all harms that result from stigma, such as employment discrimination, reduced income, and decreased ability to live independently. *Vitek* may have expanded the analysis to include all "stigmatizing consequences" but did not go into a discussion of what those consequences were. Neither opinion stated explicitly what about commitment causes the stigma: whether is it the mental illness, the treatment, or, in the prison context, the nature of the transfer itself. Accordingly, judges frequently distinguished from both *Addington* and *Vitek* based on the facts of a particular situation. Judges, for example, distinguished from *Vitek*, by determining that stigma only attaches when an incarcerated person is physically transferred out of a prison facility into a mental hospital or when that person is transferred for an indefinite amount of time. In distinguishing in this way, these judges failed to consider the stigma created by other circumstances.

Those judges that did engage in broader discussions of the consequences and

causes of stigma related to mental health commitment still failed to engage the full extent of this stigma. In cases in which judges considered one type of stigma relative to another type of stigma, judges determined, for example, that a person who was already incarcerated could not face further stigmatization if committed, without providing evidence to support that claim. In other opinions, judges failed to adequately address what created the stigma associated with mental health commitment, some determining that mental illness itself is the cause, others the manifestation of symptoms, and most providing no explanation at all. Across all fifty-three cases, judges did not consider the full scope of the harm associated with the stigma of mental health commitment.

b. A systematic bias against committed people bringing due process challenges.

Judges' incomplete understanding of stigma has created a systematic bias against individuals bringing procedural due process claims in the mental health commitment context. In *Addington*, the Supreme Court stated that the adverse social consequences of mental health commitment were relevant to the procedural due process analysis. *Vitek* further clarified in stating that, in the criminal context, the stigmatizing consequences of a transfer to a mental health facility, coupled with mandatory treatment, implicated a liberty interest and therefore triggered due process protections.

Yet, as discussed above, when judges have applied these standards they have not considered the full scope of the harm associated with stigma of mental health commitment, because of an incomplete view of that stigma. While some judges found that the presence of stigma compelled procedural protections, many did not.

By systematically underestimating the stigmatizing consequences of mental health commitment, judges have systematically underestimated the liberty interest itself implicated by mental health commitment. This in turn has meant that judges have consistently required less rigorous procedural due process protections for individuals subject to commitment orders. By requiring less rigorous procedural protection, these individuals are at greater risk for erroneous commitment. By undervaluing the harm these individuals suffer as a result of the stigma of mental health commitment, judges have increased the likelihood that individuals are subject to inappropriate commitment orders.

c. Judges have been overly deferential to Supreme Court fact finding

Two related issues seem to drive judges' incomplete engagement with the stigma of mental health commitment: overreliance on case law and insufficiency of information. This first issue, more specifically put, is that judges seem to be

overly deferential to the conclusions drawn by the Supreme Court in *Addington* and *Vitek*. That is, most judges merely recited the Supreme Court's conclusion that commitment causes stigma or if they did engage in a broader discussion of stigma they did so without engaging in their own fact finding related to this stigma, as if to suggest that the Supreme Court has already done most of the work, no need to do too much more.

Lower court judges should of course adhere to stare decisis with respect to legal rules, yet the conclusion that commitment leads to stigma is not, per se, a legal rule. Scholar Allison Orr Larsen and others have described this type of conclusion as a legislative fact, that is, "a generalized fact . . . [that] provides descriptive information about the world that judges use as foundational building blocks to form and apply legal rules."[135] Judges draw these factual conclusions based on many different sources, including information provided by parties' briefs, amicus briefs, and their own knowledge and assumptions about the world.[136] Lower courts choosing to accept and apply these conclusions is what Larsen refers to as following "factual precedent"[137] and it is not clear in all cases that lower courts must in fact do so.

In some cases, those in which a legal rule is dependent upon a factual finding of the Court, it is clear that lower courts must accept and follow the Supreme Court's factual precedent. To illustrate this point, Larsen points to one of the Court's conclusions in Citizens United v. Federal Election Commission.[138] After considering the record in the that case as well as the companion case, McConnell v. Federal Election Commission, Justice Kennedy, writing for the majority, concluded that politics are not corrupted by corporate money in campaigns.[139] When the Court ultimately granted First Amendment protection to corporations for such speech, the protection was based in part on this conclusion. In a subsequent case, the Supreme Court of Montana was presented with different evidence and ultimately held that corporate spending could (and did) influence politics. The Supreme Court quickly granted certiorari and reversed the Supreme Court of Montana in a several-paragraph, per curium opinion.[140] Although the Supreme Court of Montana may have had different evidence that could have reasonably supported a different factual conclusion, the Supreme Court made clear that its conclusion was controlling.

Larsen concedes that it is necessary for lower courts to defer to factual

135 Allison Orr Larsen, *Factual Precedents*, 162 U. PA. L. REV. 59, 72 (2013).

136 Allison Orr Larsen, *Confronting Supreme Court Fact Finding*, 98 VA. L. REV. 1255, 1258–60 (2012).

137 Allison Orr Larsen, *Factual Precedents*, *supra* note 135 at 72.

138 Citizens United v. Fed. Election Comm'n, 558 U.S. 310 (2010).

139 Allison Orr Larsen, Factual Precedents, *supra* note 135 at 94.

140 *Id.*

precedent in cases such as Citizens United. If a legal rule is dependent upon the Court's factual finding, as it was in Citizens United, allowing lower courts to reconsider that conclusion would essentially re-litigate the entire issue and could "run the risk of chaos or at least a serious weak spot in the Supreme Court's authority."[141]

Like that espoused in Citizens United, the legal rules in *Addington* and *Vitek* are in one sense dependent upon a factual conclusion made by the Court. Generally put, the legal rule that stigma should be considered in the procedural due process analysis in the context of mental health commitment is based upon the factual conclusion that commitment creates stigmatizing consequences. If lower court judges did not accept this factual conclusion, they could then conclude that stigma need not be considered in procedural due process. This would lead to the chaos of which Larsen warns. As such, lower courts cannot and should not do as the Supreme Court of Montana did, and re-litigate the issue of whether mental health commitment causes stigma. And, based on my review, judges are not doing this, to the extent that they are not explicitly contradicting the premise.

Yet, Larsen also concludes that lower courts are overly deferential to the Supreme Court's factual findings in situations they really should not be. She argues that the Supreme Court is no better equipped than are lower courts to engage in legislative fact finding and that, in general, lower courts reconsidering legislative facts allows for more flexible legal rulings without disrupting legal precedent.

This too applies to *Addington* and *Vitek*. While the Supreme Court resolved the question of whether commitment has stigmatizing consequences, as discussed in Part II.d, *supra*, the Supreme Court did not resolve many other questions relevant to the application of the *Addington* and *Vitek* rules. The Supreme Court did not discuss what the consequences of stigma are or, relatedly, what weight to apply to stigma in the overall procedural due process analysis. The Supreme Court did not address what causes the stigma and therefore in what situations this stigma may or may not occur. In *Vitek* specifically, Justice White did not clarify whether the relevant stigma was that in the eyes of other prisoners or the public at large. Judges have deferred to the Supreme Court's factual findings with respect to all of these questions even though they did not in fact resolve them. The fact that the Supreme Court did not consider these questions does not mean that lower courts should not consider these questions. In fact, to properly apply this test, lower courts must consider these questions.

While *Addington* and *Vitek* clarified that judges must consider the stigma of mental health commitment in procedural due process, these rulings did not

141 *Id.* at 108.

properly clarify how to do so. In order to properly implement these standards, in order to properly account for the full harm associated with the stigmatizing consequences of the stigma of mental health commitment, judges must do more than rely on the Supreme Court's fact finding in *Addington* and *Vitek*. Instead, judges must engage in their own fact finding to determine the full harm associated with the stigmatizing consequences the Supreme Court has instructed must be considered in the procedural due process analysis.

d. Remedies to assist in judges' fact finding related to the stigma of mental health commitment.

Accepting that judges must do more to implement the legal rules espoused in *Addington* and *Vitek* by determining what consequences result from mental health commitment, highlights the second issue that seems to drive judges' incomplete view of information: that is, insufficiency of information. If judges are to engage in fact finding related to the consequences of stigma, judges need access to that information and the expertise to make sense of it.[142]

One potential solution could be to divert procedural due process challenges to commitment to courts with particular expertise in mental health. The Department of Justice works with the Substance Abuse and Mental Health Services Administration (SAMHSA) to administer the Mental Health Courts Program, an integrated system of judges, lawyers, and mental health professionals that deals specifically with nonviolent offenders with mental health diagnoses.[143] The purpose of this program is to better serve these individuals by requiring specialized training for all those involved in the program, offering voluntary treatment in exchange for adjusting sentencing or even dropping charges, and coordinating case management with a mental health professional. The program currently operates roughly forty courts around the country.[144] These courts' jurisdiction could be broadened to include constitutional challenges to commitment orders. There could certainly be some benefits created by requiring all procedural due process challenges to mental commitment to be deferred to mental courts. These judges would have more direct and consistent access to mental health experts and would therefore have more information about mental

142 As discussed in Part IV, *supra*, there were some judges in the sample that relied on sources of information on the stigma of mental health commitment other than *Addington* and *Vitek*, yet these sources, such as prior case law or a judges' opinions, generally did not reflect the current research on the subject. For a fuller discussion of courts' reliance on antiquated information related to mental illness, see Joanmarie Ilaria Davoli, *Still Stuck in the Cuckoo's Nest: Why Do Courts Continue to Rely on Antiquated Mental Illness Research?*, 69 TENN. L. REV. 987 (2002).

143 OFFICE OF JUSTICE PROGRAMS, *Mental Health Court Programs*, https://www.bja.gov/ProgramDetails.aspx?Program_ID=68.

144 *Id.*

health in general. These mental health professionals may also have more expertise with respect to the real consequences of stigma about which they could educate judges.

On the other hand, these courts have potential drawbacks. Tailoring sentencing to include treatment may in itself present separate procedural due process issues, given that individuals may feel compelled to accept treatment over jail time without appropriate procedural protections. Additionally, given that these judges would primarily be engaged in trial litigation and sentencing, they may be less-equipped to engage with constitutional matters such as due process analysis than would other federal judges that engage deal with more varied litigation. Second, separating these individuals from the general population of litigants may in fact perpetuate stigma.[145] Finally, mental health professionals may not necessarily have more information about mental health stigma and may therefore not provide judges with the necessary, additional information to adequately implement the *Addington* and *Vitek* standards.

Instead, in matters related to legislative fact finding related to the stigma of mental health commitment, courts could rely on an independently maintained resource, like that discussed by Allison Orr Larsen in her article, *Confronting Supreme Court Fact Finding*.[146] She proposed that rather than relying primarily on amicus curie briefs or in-house research, as the Supreme Court does currently, the Court could rely on resources that aggregate the type of information contained within amicus briefs but reflect a broader range of ideas than are typically reflected in those briefs. This, Larsen argues, would provide the Court information without biasing that information in favor of groups with the resources to compile amicus briefs.[147] This type of resource could be created for the stigma of mental health commitment through collaboration between legal groups, like the American Bar Association, and mental health organizations, such as the American Psychological Association, or even multiple interest groups with differing agendas. This type of resource could allow judges at all levels greater access to information, created and maintained by individuals with the relevant

145 See E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 536 (2012) (arguing that mental health courts contribute to the stigmatization of mental illness by suggesting that offenders with mental illnesses lack the ability to control their actions, are so much more vulnerable to recidivism they should be isolated from the general population, and that they cannot be trusted to make their own health care treatment choices).

146 Allison Orr Larsen, *Confronting Supreme Court Fact Finding*, supra note 136 at 1311–12.

147 Larsen referenced a particular resource, the American Bar Association's The Citizen Amicus Project, which no longer exists. *Id.* at 1311. The Native Amicus Briefing Project (NAB) has a similar mission, but focuses on particularly on improving federal judges' understanding of federal Indian law. NAB tracks federal cases that deal with Indian law and drafts and submits amicus briefs in those cases. The organization is run by a small group of attorneys and works with other attorneys, Indian law scholars, law students, and Native organizations. *About Us*, NATIVE AMICUS BRIEFING PROJECT (NAB) (2018), http://nativebrief.sites.yale.edu/about-us.

expertise.

VI. CONCLUSION

This is the first systematic review of federal judicial opinions that discuss the stigma of mental health commitment in the context of procedural due process. Results show that many judges limit their discussion of the stigma of mental health commitment to citations to *Addington* or *Vitek*. While some opinions engaged in broader discussions of what specific consequences result from the stigma of commitment and the sources of that stigma, in general judges articulated an incomplete view of this stigma. This has led judges to consistently underestimate the stigma associated with mental health commitment, resulting in a systematic bias against plaintiffs bringing procedural due process challenges in the context mental health commitment. To address this bias, federal judges must engage in more fact finding about the real and complete consequences of stigma that results from mental health commitment.