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Paternalism, Civil Commitment and Illness Politics: Assessing the Current Debate and Outlining a Future Direction

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PATERNALISM, CIVIL COMMITMENT AND ILLNESS POLITICS:
ASSESSING THE CURRENT DEBATE AND OUTLINING A FUTURE
DIRECTION

BRUCE A. ARRIGO¹

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I. INTRODUCTION

The history of civil commitment and confinement law in general reflects longstanding attitudinal divisions among the psychiatric and legal communities, patients' rights advocates, governmental agencies, legislative bodies and other invested constituencies.²

At the center of this controversy are two well established and, at times, competing social values that attempt to fashion appropriate mental health policy. On the one hand, involuntary hospitalization for mentally ill persons diagnosed as dangerous or otherwise disabled is encouraged. On the other hand, the slightest abridgement of personal autonomy and individual liberty for these citizens is discouraged. While the medical profession asserts its responsibility to treat dangerous³ and obviously ill persons⁴ so that they are effectively controlled,⁵ civil libertarians seek to challenge psychiatric judgements altogether. These advocates maintain that mental illness is manufactured,⁶ that civilly confined persons are in fact prisoners⁷ and that the "preciousness of liberty" doctrine demands that the practice of involuntary hospitalization be abolished.⁸

The results of this and prior debates have produced large scale reforms with disappointing consumer-oriented outcomes. From the introduction of the asylum and public intervention in the form of moral treatment;⁹ to the emergence of the psychopathic hospital and the mental hygiene

²See ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA* (Columbia Univ. Press 2d ed., 1949)(1937) (providing a compelling, though dated, analysis of civil commitment history). GERALD N. GROB, *MENTAL INSTITUTIONS IN AMERICA* 4-12 (1973) (giving a balanced account of constituency involvement in the cure and treatment of the mentally ill in Colonial America). ANDREW T. SCULL, *SOCIAL ORDER/MENTAL DISORDER: ANGLO-AMERICAN PSYCHIATRY IN HISTORICAL PERSPECTIVE* 4, 10 (1989) (examining the historical developments of mental disorder and the varying accounts of civil commitment by others).

³Paul Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976).

⁴Darold A. Treffert, *The Obviously Ill Patient in Need of Treatment: A Fourth Standard for Civil Commitment*, 36 HOSP. & COMMUNITY PSYCHIATRY 259 (1985).

⁵JACK ZUSMAN, *THE NEED FOR INTERVENTION: THE REASONS FOR STATE CONTROL OF THE MENTALLY DISORDERED*, in CAROL A. B. WARREN, *THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW* 110-13 (1982).

⁶See generally, THOMAS S. SZASZ, *THE MANUFACTURE OF MADNESS: A COMPARATIVE STUDY OF THE INQUISITION AND THE MENTAL HEALTH MOVEMENT* 1-15 (1970).

⁷BRUCE J. ENNIS, *PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRY AND THE LAW* 2 (1972).

⁸Stephen J. Morse, *A Preference For Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 106 (1982).

⁹Joseph P. Morrissey & Howard H. Goldman, *Cycles of Reform In the Care of the Chronically Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 786 (1984).

movement,¹⁰ to the more recent spawning of community mental health and its emphasis on deinstitutionalization,¹¹ one reality has endured: "while cyclical patterns of institutional reform" have been the hallmark of America's response to the mentally ill,¹² the politics of abandonment has been and continues to be its legacy.¹³

This statement is not so much an indictment of those forces that largely shape civil commitment laws or develop intervention strategies for effective treatment. It is, however, a recognition that although we have journeyed beyond the institutional "snakepits" of the past,¹⁴ the "right to rot" is not an acceptable path.¹⁵ Our contemporary social landscape, especially over the last twenty-five years, poignantly reflects this theme of abandonment. Psychiatric facilities, viewed in the past as nightmarish warehouses servicing chronically mentally ill persons have been replaced by ill-conceived and poorly managed new "asylums" in the community.¹⁶ And while treatment regimens for persons committed against their will continue to evolve through psychopharmacological and other therapy-based discoveries, the best available evidence shows that these interventions are only minimally better than doing nothing at all.¹⁷

Coupled with these disturbing realities are the commitment laws themselves. No where else are the entrenched tensions that beset the

¹⁰GERALD N. GROB, *MENTAL ILLNESS AND AMERICAN SOCIETY, 1875-1940* 144 (1983).

¹¹Leona L. Bachrach, *A Conceptual Approach To Deinstitutionalization*, 29 *HOSP. & COMMUNITY PSYCHIATRY* 573, 574 (1978). David R. Musto, *What Ever Happened To "Community Mental Health"?*, 39 *PUB. INTEREST* 53 (1975). John A. Talbott, *Deinstitutionalization: Avoiding The Disasters of The Past*, 30 *HOSP. & COMMUNITY PSYCHIATRY* 621, 622 (1979).

¹²Morrissey & Goldman, *supra* note 9, at 790. Joseph P. Morrissey & Howard H. Goldman, *Care and Treatment of The Mentally Ill in the United States: Historical Development and Reforms*, 484 *ANNALS AM. ACAD. POL. & SOC. SCI.* 12, 13 (1986).

¹³Nancy K. Rhoden, *The Limits Of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 *EMORY L. J.* 375 (1982). Rael J. Isaac and Virginia C. Armet, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL*, 250 (1990).

¹⁴ALBERT DEUTSCH, *THE SHAME OF THE STATES*, 3-21 (1948).

¹⁵Paul S. Appelbaum and Thomas G. Gutheil, *The Boston State Hospital Case: "Involuntary Mind Control, The Constitution and The Right To Rot"*, 137 *AM. J. PSYCHIATRY*, 720-23 (1980).

¹⁶Howard H. Goldman and Joseph P. Morrissey, *The Alchemy Of Mental Health Policy: Homelessness and The Fourth Cycle Of Reform*, 75 *AM. J. PUB. HEALTH*, 722 (1985). H. Richard Lamb, *The New Asylums In The Community*, 36 *ARCHIVES GEN. PSYCHIATRY*, 129 (1979).

¹⁷Alexander D. Brooks, *The Right To Refuse Antipsychotic Medications: Law and Policy*, 39 *RUTGERS L. REV.*, 339, 341 (1987). Mary L. Durham and John Q. LaFond, *A Search For The Missing Premise Of Involuntary Therapeutic Commitment Effective Treatment of The Mentally Ill*, 40 *RUTGERS L. REV.*, 305 (1988).

psychiatric and legal communities more evident. Challenges to the scientific meaning of mental illness,¹⁸ pitfalls in predicting dangerousness,¹⁹ debate over the promise and peril of involuntary outpatient commitment,²⁰ division over the patient's right to refuse treatment,²¹ disagreement about the efficacy of the least restrictive alternative doctrine²² and other such matters, demonstrate a woeful lack of consensus on how best to deliver much needed services to psychiatrically disabled citizens, while respecting the intrinsic dignity and right to self determination these consumers possess. It is not surprising that in the wake of such acrimony over appropriate mental health policy, deinstitutionalization remains a dream deferred for the chronically disordered,²³ involuntary treatment for the homeless mentally ill continues to escalate²⁴ and an alarming number of mental health systems users find themselves displaced throughout the criminal justice system.²⁵

The purpose of this article is to examine critically the role that both law and psychiatry have played in casting mentally ill persons as deviants, citizen/

¹⁸Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis Of Mental Health Law*, 51 S. CAL. L. REV., 527, 528 (1978). THOMAS J. SCHEFF, *BEING MENTALLY ILL: A SOCIOLOGICAL THEORY*, 1-3 (1984 2d ed.). R.D. LAING, *THE DIVIDED SELF*, 7-10 (1969).

¹⁹Morse, *supra* note 8, at 95. Saleem A. Shah, *Dangerousness: Some Definitional, Conceptual and Public Policy Issues*, PERSPECTIVES IN LAW AND PSYCHOLOGY: VOL. 1, THE CRIMINAL JUSTICE SYSTEM 91, 98 (1977).

²⁰Edward P. Mulvey, et al., *The Promise and Peril Of Involuntary Outpatient Commitment*, 42 AM. PSYCHOL., 571, 571 (1987). Robert D. Miller, *Commitment To Outpatient Treatment: A National Survey*, 36 HOSP. & COMMUNITY PSYCHIATRY, 265, 267 (1985). Jillane T. Hinds, *Involuntary Outpatient Commitment For The Chronically Mentally Ill*, 69 NEB. L. REV. 346, 349 (1990).

²¹Loren H. Roth, *The Right To Refuse Treatment: Law and Medicine At The Interface*, 35 EMORY L. J., 139, 142 (1986). Brooks, *supra* note 17, at 339.

²²Bruce A. Arrigo, *The Logic Of Indentity and The Politics of Justice: Establishing A Right To Community-based Treatment For The Institutionalized Mentally Disabled*, 18 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 18 (1): 1-31 (1992). Winsor C. Schmidt, *Critique of the American Psychiatric Association's Guidelines For State Legislation on Civil Commitment of the Mentally Ill*, 11 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 13 (1985). Virginia A. Hiday and Rodney R. Goodman, *The Least Restrictive Alternative To Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness*, 10 J. PSYCHIATRY & L., 81, 83 (1982).

²³Robert A. Dorwart, *A Ten-year Follow-up Study of the Effects of Deinstitutionalization*, 39 HOSP. & COMMUNITY PSYCHIATRY, 287, 290 (1988).

²⁴John R. Belcher, *Defining the Service Needs of Homeless Mentally Ill Persons*, 39 HOSP. & COMMUNITY PSYCHIATRY 1203 (1988). H. Richard Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899, 899-903 (1984).

²⁵See generally, SAMUEL J. BRAKEL ET. AL., *THE MENTALLY DISABLED AND THE LAW* 1-15 (3d. ed. 1985). H. Richard Lamb, *The Mentally Ill in an Urban County Jail*, 39 ARCHIVES GEN. PSYCHIATRY 17 (1982). Ralph Slovenko, *Criminal Justice Procedures in Civil Commitment*, 28 HOSP. & COMMUNITY PSYCHIATRY, 817, 818 (1977).

outsiders caught in a crossfire of illness politics.²⁶ This examination will focus on those values protected and privileged by the medical and legal professions as reflected in confinement law and policy primarily during the last quarter of the twentieth century. The social, economic and political power these disciplines exercise in the lives of psychiatric citizens raises significant questions concerning the future of involuntary civil commitment both from a clinical and justice policy perspective. As such, these matters will be addressed as well. No attempt will be made here to detail the historical dimensions of abandonment in the care and treatment of the mentally ill. Similarly, assessing other environmental influences contributing to this phenomenon (e.g., urbanization, immigration, industrialization, transinstitutionalization) is beyond the scope of this article. While these factors are significant components in the development of civil commitment laws, they are decidedly more global in nature than the focus here.

Our aim is to provide a current account of how law and psychiatry, despite their respective calls to safeguard individual rights and to treat the sick, have fashioned an ineffective system of care. We begin with a brief history emphasizing the social, scientific and legal developments that set the stage for present day civil commitment policy; we then outline in what context law and psychiatry speak for the mentally ill, evaluate some controversial and significant areas where treatment and/or liberty are sacrificed, and describe the inherent social values law and psychiatry promote through confinement practices. By carefully considering the manner in which involuntarily committed persons are simultaneously subjected to and repeatedly forced to choose among principles of freedom in the abstract and clinical interventions in the extreme, we aim to move beyond the present climate of uncertainty in civil commitment matters. To that end, we conclude with some tangible recommendations for the future.

II. HISTORICAL BACKGROUND

The first half of the twentieth century was marked by minimal activity regarding civil commitment laws or policy making.²⁷ While state statutes reflected regional or even local interests in appropriate service delivery to the mentally ill, many states provided only modest procedural protections to these citizens.²⁸ In addition, some states recognized a practice of indeterminate commitment on the basis of what can only be described as vague statutory

²⁶See THOMAS S. SZASZ, *INSANITY: THE IDEA AND ITS CONSEQUENCES* (1987) (giving a polemical account on the sociology of mental illness).

²⁷PAUL S. APPELBAUM & THOMAS G. GUTHEIL, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 46 (2ed 1991).

²⁸Deutsch, *supra* note 14, at 215.

construction; i.e., the person was a "social menace" or "a fit and proper candidate for institutionalization."²⁹

Coupled with these lenient commitment standards was a belief on the part of many psychiatrists that institutional confinement was far more humane than the ravages of poverty or incarceration.³⁰ Through reliance on a "need-for-treatment" approach,³¹ physicians were afforded a great deal of latitude in civil confinement matters. This latitude was indicative of a period marked by discretion rather than procedure in the care and treatment of the mentally ill.³² In fact, the majority of the states adopted this standard for civil commitment from the 1930s through the 1960s.³³ The net effect of these scientific and socio-legal practices was the swelling number of persons that found themselves involuntarily hospitalized. In 1955, for example, the average daily census of persons committed in state and county mental hospitals was a staggering 560,000.³⁴

The excesses of this period in civil confinement matters were substantially the result of the state's unbridled authority to impose involuntary commitment.³⁵ This authority is derived from two sources: the police power and the *parens patriae* power.³⁶ The police power accords the states "a plenary power to make laws and regulations for the protection of the public health, safety, welfare and morals."³⁷ Moreover, this authority bestows upon states the responsibility to involuntarily commit mentally disordered persons whose behaviors demonstrate that they are a danger to self or others. The other prong of authority vested in the states is the *parens patriae* power. Under this doctrine, states are entrusted with civilly confining persons against their will when they are unable to care for themselves. This is generally understood to include an inability to provide for one's basic needs; e.g., food, clothing, safety and shelter.

²⁹John E. B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 381 (1983-84).

³⁰See Stanley Cohen, *The Punitive City: Notes on the Dispersal of Social Control*, 3 CONTEMP. CRISES 339, 340-51 (1979) (compelling sociological analysis of control and punishment). See generally, Deutsch, *supra* note 14, at 73.

³¹Deutsch, *supra* note 2, at 171.

³²Mulvey, *supra* note 20, at 575.

³³Myers, *supra* note 29, at 381.

³⁴Howard H. Goldman et. al., *Deinstitutionalization: The Data Demythologized*, 34 HOSP. & COMMUNITY PSYCHIATRY, 129 (1983).

³⁵Morse, *supra* note 18, at 529.

³⁶John Q. LaFond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFF. L. REV., 499, 502 (1981). NICHOLAS A. KITTRIE, *THE RIGHT TO BE DIFFERENT: ENFORCED THERAPY*, 59 (1972).

³⁷Note, *Developments In The Law: Civil Commitment Of The Mentally Ill*, 87 HARV. L. REV., 1191, 1222 (1974).

What is most significant about the concept of *parens patriae*, is the historical value attributed to this practice of paternalism. It is deeply embedded in Western culture and thought. Indeed, the disturbing dimensions of *parens patriae* can be traced from Roman law to English law to colonial American jurisprudence.³⁸ Designed to protect "idiots and lunatics" while managing their estates³⁹ these duties were abused by avaricious and profit-minded persons, leaving the mentally disabled all too frequently to their own devices.⁴⁰ Based in large measure on the law of property, the Crown protected the heirs of wealthy "idiots and lunatics" from disinheritance by invoking the right of *parens patriae*.⁴¹ And, as for the impecunious, English law required that the Crown assume societal responsibility to care for those individuals unable to care for themselves.⁴²

With the independence of the American colonies, *parens patriae* was understood to be vested in the state legislatures.⁴³ Later, this authority was generally (but explicitly) reaffirmed by the Supreme Court to be vested in the "[s]tate as [the] sovereign."⁴⁴ Early appellate cases like *In re Barker*⁴⁵ and *In re Oakes*⁴⁶ firmly established the court's jurisdictional claim in matters pertaining to the protection of the psychiatrically disordered. All available evidence indicates that *parens patriae* was relied upon as much for the protection of the mentally disordered as for matters of property and wealth.⁴⁷ In 1890, for example, the U.S. Supreme Court described the state's parental power in the following manner: "[I]t is a most beneficent function, and often necessary to be exercised in the interests of humanity, and for the prevention of injury to those who cannot protect themselves."⁴⁸

With the dawn of the twentieth century, this *parens patriae* theme was renewed when a federal district court stated that "[a] state would indeed be derelict of its duty if it failed to make adequate provision for the care and treatment of the insane. The state is the *parens patriae* of the insane."⁴⁹ (emphasis

³⁸ See generally Sir William S. Holdsworth, *A HISTORY OF ENGLISH LAW*, (Sir Arthur L. Goodhart and H.G. Hanbury, Eds. 1956). Kittrie, *supra* note 36, at 12-40.

³⁹ WILLIAM BLACKSTONE, *COMMENTARIES* *426.

⁴⁰ Myers, *supra* note 29, at 403.

⁴¹ *Hawks v. Lazaro*, 202 S.E.2d 109 (Sup. Ct. App. W.Va. 1974).

⁴² Note, 87 HARV. L. REV., 1191, *supra* note 37, at 1239.

⁴³ *Hawaii v. Standard Oil Co.*, 415 U.S. 251, 257 (1972).

⁴⁴ *Fontain v. Ravenel*, 58 U.S. 369, 394 (1855).

⁴⁵ *Johns. Ch. 232* (N.Y. Ch. 1816).

⁴⁶ Law Rep. 122 (Mass. 1845).

⁴⁷ Myers, *supra* note 29, at 384.

⁴⁸ *Mormon Church v. United States*, 136 U.S. 1, 57 (1890).

⁴⁹ *Hammon v. Hill*, 228 F. 999, 1000 (D. Pa. 1915).

added). Soon thereafter, the Oklahoma Supreme Court reasserted the notion of *parens patriae* as a viable state mechanism for protecting the incapacitated and for overseeing matters of property and wealth.⁵⁰ As the Court maintained, "[t]he doctrine . . . may be defined as the inherent power and authority of a Legislature of a state to provide protection of the person and property of persons *non sui juris*."⁵¹ (emphasis added).

In the late 1970s, Utah expressly upheld the *parens patriae* justification for civil commitment by declaring it to be a legitimate source of state power when hospitalizing mentally ill persons against their will.⁵² And finally, a New York appellate court recently enunciated the state's *parens patriae* authority by declaring that a respondent's homelessness was the result of "serious mental illness" and not a "lack of housing for the poor."⁵³

What the foregoing discussion reveals is how deeply interwoven the *parens patriae* concept is in the fabric of American jurisprudence. In recent years, some commentators have staunchly criticized the medical profession's widespread reliance upon it when involuntarily hospitalizing the mentally ill.⁵⁴ Despite concerns for abuses in and sacrifices of personal liberties, other commentators find the doctrine's underlying theme of social responsibility for dangerous and gravely disabled persons to be sound.⁵⁵ As we shall demonstrate shortly, however, it is precisely this valued notion of paternalism (in its police power and *parens patriae* form) that continues to underscore both the psychiatric and legal approach in matters of civil commitment; an approach that has resulted in casting the mentally ill as deviants and contributing to a legacy of abandonment. In other words, the historical value of paternalism as currently expressed in the law, is responsible for the present climate of uncertainty that plagues the mental health system.

By the mid-twentieth century, it was evident that social reform in the care and treatment of the mentally ill was essential. Large state hospitals functioned as primary care-takers for the growing number of patients committed against their will.⁵⁶ Conditions in these institutions were abominable.⁵⁷ Not only was

⁵⁰McIntosh v. Dill, 205 P. 917, 925 (Okla. 1922), *cert. denied*, 260 U.S. 721 (1922).

⁵¹*Id.* at 925.

⁵²Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424, 429 (D. Utah 1979).

⁵³Boggs v. N.Y. City Health and Hosps. Corp., 132 A.D.2d 340, 365 (1st Dep't 1987).

⁵⁴See Mary L. Durham & John Q. LaFond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395, 397 (1985). LaFond, *supra* note 36, at 526-35. Morse, *supra* note 18, at 628-40.

⁵⁵See Paul S. Appelbaum, *Standards for Civil Commitment: A Critical Review of Empirical Research*, 7 INT'L J.L. & PSYCHIATRY 133, 134.

⁵⁶Grob, *supra* note 10, at 184, 189.

⁵⁷Deutsch, *supra* note 2, at 448-49.

understaffing rampant,⁵⁸ but the qualifications and skill level of many hospital employees providing basic services to mental health consumers was dangerously suspect.⁵⁹ Soft shackle restraints and seclusion rooms were found in most psychiatric facilities.⁶⁰ Long-term chronic patients deteriorated to a state of helpless institutional dependency.⁶¹ Brutish attacks by residents and staff, at times resulting in death, were not uncommon.⁶² And the vision of social reform anticipated by the mental hygiene movement and the psychopathic hospital was reduced to obscurity, not unlike those involuntarily hospitalized persons whose promise of treatment translated into the perils of lifetime confinement.⁶³

These abuses signalled a need to alter significantly service delivered to mental health consumers. In 1946, the National Institute of Mental Health was founded, and funding for community mental health care was made available.⁶⁴ In 1952 the introduction of chlorpromazine, an antipsychotic medication, was hailed as a curative chemical agent for treating the symptoms of psychotic patients.⁶⁵ At the same time, a nascent humanitarian belief that long-term confinement of the profoundly ill produced warehousing, dehumanizing and, therefore, harmful effects was popularized.⁶⁶ Court cases decided during the late 1960s and early 1970s extended this awareness. Specifically, a number of landmark decrees recognizing the fundamental liberty interests of the mentally ill were upheld; e.g., community-situated treatment,⁶⁷ due process procedural

⁵⁸See *Wyatt v. Stickney*, 344 F. Supp. 373, 375 (M.D. Ala. 1972).

⁵⁹See generally *Halderman v. Pennhurst State School & Hospital*, 446 F. Supp. 1295, (E.D. Pa. 1977), *aff'd*, 612 F.2d (3d Cir. 1979) (*en banc*); *rev'd*, 451 U.S. 1 (1981).

⁶⁰See generally ANDREW T. SCULL, *MADHOUSES MAD-DOCTORS AND MADMEN: THE SOCIAL HISTORY OF PSYCHIATRY IN THE VICTORIAN ERA*, 1-18 (1981).

⁶¹See ERVING GOFFMAN, *ASYLUMS ESSAYS ON THE SOCIAL SITUATION OF MENTAL HEALTH PATIENTS AND OTHER INMATES* 47 (1961). See, Nancy K. Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 HARV. C.R.-C.L. L. REV. 363, 403 (1980). See DAVID J. VAIL, *DEHUMANIZATION AND THE INSTITUTIONAL CAREER*, 22-23, (1966).

⁶²*Wyatt v. Aderholt*, 503 F.2d 1305, 1311 (5th Cir. Ala. 1974).

⁶³See Scull, *supra* note 59, at 171. See Scull, *supra* note 1 at 143.

⁶⁴Steven C. Schoonover & Ellen L. Bassuk, *Deinstitutionalization and the Private General Hospital: Inpatient Unit Implications for Clinical Care*, 34 HOSP. & COMMUNITY PSYCHIATRY, 135, 135 (1983).

⁶⁵Bert Pepper and Hilary Ryglewicz, *Testimony for the Neglected: The Mentally Ill in the Post-deinstitutionalization Age*, 52 AM. J. ORTHOPSYCHIATRY, 388, 389 (1982). ANDREW T. SCULL, *DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT—A RADICAL VIEW* 189 (2d ed. 1984).

⁶⁶See generally Goffman, *supra* note 61, at 4-10 (explaining anti-psychiatry). See Pepper & Ryglewicz, *supra* note 64, at 388 (discussing devastating affects on long term hospitalization). See Scull, *supra* note 65, at 189.

⁶⁷See *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966), *cert. denied*, 382 U.S. 863 (1966).

protections,⁶⁸ the right to treatment,⁶⁹ medical and Constitutional minimal standards in treatment⁷⁰ and the right to refuse treatment.⁷¹ In addition, state hospital administrators alarmed by conditions of population overcrowding⁷² and structural decay,⁷³ considered their hospitals "bankrupt beyond remedy."⁷⁴ And finally, legislators, responding to the clamor for institutional reform, adopted a series of statutory remedies. In 1963, the Community Mental Health Centers Construction Act (CMHC) was passed by Congress, making community-based mental health a crucial service available throughout the country.⁷⁵ In 1965, the Medicare and Medicaid programs were enacted, providing relief for mental health consumers receiving community-based services and care.⁷⁶ And, in 1969, California passed the Lanterman-Petris-Short Act; legislation that set a nationwide standard for civil commitment based on the criterion of dangerousness.⁷⁷ Now, not only was the need-for-treatment approach essential in involuntary civil commitment decision making, but so too was the patient's demonstrated danger to self or others.⁷⁸

These events triggered the massive deinstitutionalization movement that occurred during the late 1960s.⁷⁹ So sweeping were these measures that the per day number of residents in state and county mental hospitals reached a low of

⁶⁸*Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded for a more specific order*, 414 U.S. 743, *ordered on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *order reinstated on remand*, 413 F. Supp. 1318, 1319 (E.D. Wis. 1976).

⁶⁹*See Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966).

⁷⁰*See supra* note 58, at 373.

⁷¹*See Winter v. Miller*, 404 U.S. 985 (1971).

⁷²EUGENE BARDACH, *THE SKILL FACTOR IN POLITICS: REPEALING THE MENTAL COMMITMENT LAWS IN CALIFORNIA*, 52 (1972). KATHLEEN JONES, *A HISTORY OF THE MENTAL HEALTH SERVICES*, 83 (1972).

⁷³Bardach, *supra* note 72, at 52.

⁷⁴Jonas B. Robitscher, *Implementing the Rights of the Mentally Disabled: Judicial, Legislative and Psychiatric*, in *MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE* 142, 146 (Frank J. Ayd ed., 1975).

⁷⁵Myers, *supra* note 29, at 418.

⁷⁶H. Richard Lamb and M. J. Mills, *Needed Changes in Law and Procedure for the Chronically Mentally Ill*, 37 *HOSP. & COMMUNITY PSYCHIATRY*, 475, 475 (1988).

⁷⁷*Id.*

⁷⁸The "dangerousness" standard was a more liberal-minded approach, emphasizing the patients probability of harm to self and/or others. *See generally* DAVID B. WEXLER, *MENTAL HEALTH LAW: MAJOR ISSUES* (1981)(covering issues and policies in mental health law).

⁷⁹Gerald N. Grob, *Historical Origins of Deinstitutionalization, in DEINSTITUTIONALIZATION*, 121 (Leona L. Bachrach Ed., 1983). Scull, *supra* note 65, at 33.

138,000 in 1981.⁸⁰ Deinstitutionalization brought with it an expanding array of neighborhood services for mental health consumers. Outreach, residential care, day programming, crisis intervention and other maintenance-based strategies, reduced general reliance on psychiatric facilities for many chronically mentally ill citizens.⁸¹

Notwithstanding these advances; measures promulgated by the social, scientific and legal developments outlined above, deinstitutionalization was not without its shortcomings. Community support was not immediately forthcoming.⁸² To this day, many mentally disordered persons find themselves unwelcomed residents or guests of board-and-care homes, single room occupancies, welfare hotels and flophouses.⁸³ Others filter through the criminal justice system, somehow surviving in local lock-up and detention centers or security prisons.⁸⁴ And still other psychiatrically disabled persons marginally exist on the streets where they sometimes die homeless.⁸⁵ These disturbing realities are exacerbated by bouts of involuntary re-hospitalization or multiple hospitalization for the chronically mentally ill.⁸⁶ Even when community placements are secured, the results are not always rewarding.⁸⁷ The clinical, controlled and predictable delivery of psychiatric services in these environments often echoes the familiar regimen of asylum practices.

Many mentally ill lives have been punctuated by intrusive institutional confinement. This confinement has been replaced by a neglectful community care system, when featuring on-going cycles of short-term civil commitment, incarceration or homelessness.⁸⁸ Perhaps most troublesome is the woeful lack of effective community mental health services for mentally ill young adults (between the age of 18-35). Possessing limited social skills, complicated by

⁸⁰Howard H. Goldman et al., *The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform*, 34 AM. J. OF PUB. HEALTH 129, 132 (1983).

⁸¹*Id.* at 129-34.

⁸²See Rhoden, *supra* note 13, at 431. John A. Talbott, *Toward A Public Policy On The Chronic Mentally Ill Patient*, 50 AM. J. ORTHOPSYCHIATRY 43, 47 (1980).

⁸³CHARLES HOCH & ROBERT A. SLAYTON, *NEW HOMELESS AND OLD: COMMUNITY AND THE SKID ROW HOTEL*, 189 (1989).

⁸⁴Darold A. Treffert, *Legal "Rites" Criminalizing the Mentally Ill*, 3 HILLSIDE J. CLINICAL PSYCHIATRY 123, 123-25 (1982).

⁸⁵H. Richard Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY, 899, 903 (1984). H. Richard Lamb, *Involuntary Treatment for the Homeless Mentally Ill*, 4 NOTRE DAME J. L., ETHICS & PUB. POL'Y, 269, 269 (1989).

⁸⁶LEONA L. BACHRACH, *DEINSTITUTIONALIZATION*, 73-91 (1983).

⁸⁷Scull, *supra* note 65, at 99-101.

⁸⁸Jan C. Costello and James J. Preis, *Beyond Least Restrictive Alternative: A Constitutional Right To Treatment For Mentally Disabled Person In The Community*, 20 LOY. L.A. L. REV. 1527, 1538 (1987).

persistent, and at times severe psychiatric impairments, these individuals wander through life confronted by its stress and their own psychosis.⁸⁹

To be sure, the magnitude of society's failure to adequately provide for the needs of the mentally ill during the last twenty-five years is immense. The devastating effects "in terms of human suffering is incalculable."⁹⁰ Driven by paternalistic intentions, current state civil commitment laws and policies bear out these unpleasant circumstances. Chronic patients are forced to choose between two dichotomous and altogether dissatisfying alternatives: total freedom from involuntary hospitalization or total confinement in the restrictive setting of a psychiatric facility (or its functional equivalent in the community).⁹¹ Advocates from our legal and scientific professions have bequeathed to the mentally ill an uncertain future in civil commitment matters; a future where psychiatric persons remain citizen/outsideers. This legacy of abandonment is directly linked to the specific areas in which both disciplines speak for the psychiatric consumer. Because these issues begin to disclose the values that law and psychiatry privilege, an examination of these topic areas is in order.⁹²

III. WHEN THE COURTS AND PSYCHIATRY SPEAK FOR THE CITIZEN/OUTSIDER

A. *On the Meaning of Mental Illness*

Scheff⁹³ maintains that in the face of uncertainty both the legal and psychiatric communities strongly favor a presumption of illness when rendering decisions in the care and treatment of the mentally disordered. Nowhere else is this more evident than in their consideration of the meaning of mental illness. In most jurisdictions, the process leading to involuntary civil commitment initially requires a showing of the substantive standard of mental illness or a showing that the individual is suffering from a mental disorder.⁹⁴ The inability on the part of most state legislatures to operationalize this construct has given the courts the role of "fashion[ing] a definition for the words "mentally ill . . . thereby fill[ing] the void in the statutory hospital law."⁹⁵ This responsibility is complicated when considering the due process liberty interests of the psychiatric citizen protected under the fourteenth amendment. Any law which impinges on these rights (e.g., rights pertaining to freedom of movement

⁸⁹Pepper and Ryglewicz, *supra* note 65, at 389.

⁹⁰*Id.*

⁹¹Myers, *supra* note 29.

⁹²*Id.* at 409.

⁹³Scheff, *supra* note 18, at 6-30.

⁹⁴RALPH REISNER & CHRISTOPHER SLOBOGIN, *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL* 453 (1990).

⁹⁵*Dodd v. Hughes*, 398 P.2d 540, 542 (Nev. 1965).

and freedom from bodily restraint), requires "reasonably clear guidelines" as to their reach.⁹⁶

Confronted with the task of determining whether or not a person is mentally sane, courts typically rely on the expert testimony of physicians and mental health professionals.⁹⁷ This diagnostic judgement by experts subjects the commitment proceeding and its outcome to the available medical evidence. Some important strides have been made to assess mental illness as more than deviation from the psychiatric norm in both Great Britain,⁹⁸ and the United States.⁹⁹ Additionally, other necessary efforts to construct commitment laws satisfying patients, doctors and lawyers¹⁰⁰ have been attempted. Nonetheless, the greatest difficulty with psychiatric testimony is its unreliability in the courtroom,¹⁰¹ especially when vague labels are relied upon to describe mental illness.¹⁰²

Despite the numerous studies and research protocols documenting the differences in diagnoses among psychiatrists and other mental health clinicians,¹⁰³ courts encourage and depend upon this testimony in civil commitment matters. The deferential posturing of most courts allows the meaning of mental illness to be shaped by the attending physician and treatment team. Charged with diagnosing and treating particular maladies,¹⁰⁴

⁹⁶Smith v. Goguen, 415 U.S. 566, 573 (1974). See also Youngberg v. Romeo, 457 U.S. 307 (1982) (essential question explored in the *Youngberg* case assessed the liberty interests of a severely disabled adult male, prone to self-injurious and dangerous outbursts and subsequently forced to wear soft shackle restraints restricting his mobility).

⁹⁷Reisner & Slobogin, *supra* note 93, at 455. CAROL A.B. WARREN, *THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW* 106-22 (1982).

⁹⁸R.D. LAING, *THE POLITICS OF EXPERIENCE* 1-50 (1967). R.D. LAING, *THE DIVIDED SELF* 33-69 (1969) (phenomenological account of mental disorder).

⁹⁹THOMAS S. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES* 1-15 (1963). THOMAS S. SZASZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* 1-35 (1974) (describing the sociological treatment of the moral entrepreneurship of psychiatry in the care and treatment of the psychiatrically ill).

¹⁰⁰Applebaum, *supra* note 55. Loren H. Roth, *A Commitment Law for Patients, Doctors, and Lawyers*, 136 AM. J. PSYCHIATRY 1121 (1979). Clifford D. Stromberg & Alan A. Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275 (1983).

¹⁰¹Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 712 (1974).

¹⁰²See, e.g., Laura K. Haddad, *Predicting the Supreme Court's Response to the Criticism of Psychiatric Predictions of Dangerousness in Civil Commitment Proceedings*, 123 U. PA. L. REV. 439 (1974-75). Roberta W. Shell, *Psychiatric Testimony: Science or Fortune-Telling?*, BARRISTER, 1979-1980, at 6.

¹⁰³Shell, *supra* note 102, at 6.

¹⁰⁴Scheff, *supra* note 18, at 17.

the psychiatrist defines mental illness as disease.¹⁰⁵ Given that the medical imperative is to presume sickness, this same logic is applied when rendering decisions for purposes of civil commitment, regardless of uncertainty.¹⁰⁶ In sum, then, the norms of cooperation and accommodation govern the commitment proceedings;¹⁰⁷ a process in which both legal and psychiatric role playing have evolved into what one critic has coined a consensual and "commonsense model" of madness.¹⁰⁸

B. Pitfalls in Predicting Dangerousness

A second substantive element required by most states in the wording of their civil commitment laws is the finding that some specified adverse consequence will follow if the person is not involuntarily hospitalized.¹⁰⁹ This is generally understood to mean that the person is a danger to self and/or others. While mental illness as the sole basis for commitment was first rejected by the U.S. Supreme Court in *O'Connor v. Donaldson*,¹¹⁰ this did not eliminate the inherent difficulties subsequent courts found in applying such a standard; specifically, there is an assessment of probability of dangerousness in every instance of civil commitment.¹¹¹ Despite both legal and psychiatric efforts to understand adequately and consistently apply this standard, the practical results have not been promising. In short, this requirement is disturbing because of its propensity for over and under-inclusivity.¹¹²

A representative body of literature indicates that psychiatrists are inclined to prefer safety and caution in their predictions of dangerousness,¹¹³ and that over-inclusivity tends to be more common than its counterpart.¹¹⁴ More disturbing than these findings are studies that report the low rate of accurate predictions of dangerousness or studies that demonstrate how harmless persons are routinely diagnosed as dangerous.¹¹⁵

¹⁰⁵Szasz, *supra* note 26, at 45-103.

¹⁰⁶See, e.g., Luis Kutner, *The Illusion of Due Process in Commitment Proceedings*, 57 NW. U. L. REV. 383 (1962-63),

¹⁰⁷Scull, *supra* note 2, at 130-89.

¹⁰⁸Warren, *supra* note 97, at 38.

¹⁰⁹Reisner & Slobogin, *supra* note 94, at 460.

¹¹⁰*O'Connor v. Donaldson*, 422 U.S. 563 (1975).

¹¹¹Bernard Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV., 439, 444 (1974), DAVID B. WEXLER, *MENTAL HEALTH LAW: MAJOR ISSUES* 11, (1981).

¹¹²Diamond, *supra* note 111.

¹¹³David L. Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperative*, 70 MICH. L. REV. 1107, 1153.

¹¹⁴JOHN MONAHAN, U.S. Department of Health and Human Services, the CLINICAL PREDICTION OF VIOLENT BEHAVIOR 112 (1981).

¹¹⁵Ennis & Litwack, *supra* note 101, at 693.

While the psychiatric profession's inaccurate predictions of dangerousness have fashioned a system of wrongful preventive detention,¹¹⁶ "both federal and state courts continue to sustain police power authority in involuntary civil commitment proceedings."¹¹⁷ The complicity of the legal community regarding the dangerousness criterion endorses the consensual values of cooperation and accommodation previously referenced. Despite empirical arguments advanced by legal and social commentators documenting why psychiatric evidence should be significantly circumscribed¹¹⁸ or altogether eliminated,¹¹⁹ it appears that in matters of civil commitment it is "better to be safe than sorry." Expert testimony is admitted into evidence because it is believed that it "will aid the trier in his search for truth."¹²⁰ The underlying presupposition is that experts can draw inferences from a set of circumstances that lay persons cannot. Whether or not psychiatric predictions of future dangerousness meet this general test of admissibility, given the unreliability of psychiatric judgements, does not appear to be particularly relevant from the standpoint of the courts.

C. The Gravely Disabled Criterion

A number of states allow for the civil commitment of nondangerous mentally ill persons by protecting those who cannot provide for their own physical needs.¹²¹ The American Psychiatric Association's Guidelines for State Legislation on civil commitment of the mentally ill, has, in pertinent part, defined this criterion as follows:

[The person] . . . is substantially unable to provide for some of his basic needs, such as food, clothing, shelter, health, or safety or [the person] will, if not treated, suffer or continue to suffer severe mental and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgement, reason, or behavior causing a substantial deterioration of his previous ability to function on his own.¹²²

With such a criterion in mind, some commentators assert that the American Psychiatric Association is attempting to expand the scope of the state's *parens*

¹¹⁶Morse, *supra* note 8, at 85.

¹¹⁷Haddad, *supra* note 102, at 225.

¹¹⁸Ennis & Litwack, *supra* note 101, at 733.

¹¹⁹C. McCORMICK, LAWS OF EVIDENCE, 29 (2d ed. 1972).

¹²⁰EDWARD W. CLEARY, McCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE § 13, at 30 (2d ed. 1972).

¹²¹Note, *supra*, note 37, at 1223.

¹²²Schmidt, *supra* note 22, at 29.

patriae power.¹²³ This "distress and deterioration" provision is targeted at the large numbers of second generation mental health consumers; chronically ill patients living in the community, cycling in and out of hospitals, somehow surviving in abandoned buildings and alleyways.¹²⁴

Coupled with these APA guidelines are efforts by some state legislative bodies to extend civil commitment to persons deemed obviously ill,¹²⁵ or to generally broaden the statutory criteria for civil commitment.¹²⁶ These measures are, in part, acknowledged as a response to libertarian critics of involuntary hospitalization. As one commentator opposed to restrictive commitment standards put it, "how real is the promise of individual autonomy for a confused person set adrift in a hostile world."¹²⁷

Patients' rights attorneys and other critics of this more recent trend in civil commitment matters are concerned with the justice policy implications for increasing the state's authority to involuntarily hospitalize people.¹²⁸ While the psychiatric community and supporters of the psychiatric ideology favor commitment standards based on medical criteria,¹²⁹ albeit with constructive legal safeguards,¹³⁰ civil libertarians believe such guidelines will only foster more unwarranted¹³¹ and improper¹³² commitments. In addition, these critics maintain that the practical assessment of the "distress and deterioration" criterion will subject mental health consumers to the increased and relative treatment discretion of psychiatrists.¹³³ Perhaps most troubling for these advocates is the potential loss of liberty interests secured during a flourish of mental health litigation during the late 1960s and early 1970s. One of these cases addressed,¹³⁴ why mentally disordered persons needed to be singled out as a special class deserving treatment, especially when the treatment typically

¹²³*Id.*

¹²⁴Stromberg & Stone, *supra* note 100, at 278.

¹²⁵Treffert, *supra* note 4, at 260.

¹²⁶*See*, WASH. REV. CODE ANN. § 71.05.150 (1985).

¹²⁷David L. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 907 (1975).

¹²⁸*See*, Durham & LaFond, *supra* note 17, at 317, 330.

¹²⁹Darold A. Treffert & P.A. Krajeck, *In Search of a Sane Commitment Statute*, 6 PSYCHIATRIC ANNALS 283, 283-94 (1976).

¹³⁰*See*, Chodoff, *supra* note 3, at 499-501. Loren H. Roth, *A Commitment Law for Patients, Doctors, and Lawyers*, 136 AM. J. PSYCHIATRY 1121, 1123-27 (1979).

¹³¹Mary L. Durham & Glenn L. Pierce, *Beyond Deinstitutionalization: A Commitment Law in Evolution*, 33 HOSP. & COMMUNITY PSYCHIATRY, 216 (1982).

¹³²Morse, *supra* note 8, at 54.

¹³³*See*, Leonard S. Rubenstein, *The American Psychiatric Association's Proposals on Civil Commitment*, 17 CLEARINGHOUSE REV. 558, 559 (1983).

¹³⁴*Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966).

resulted in institutional confinement?¹³⁵ These objections are predicated upon what civil libertarians view as the psychiatric community's continued use of questionable and imprecise criteria regarding definitions of mental illness and crazy behavior.¹³⁶ Although acknowledging the "scandalous conditions" in which many psychiatrically disabled persons live,¹³⁷ these critics do not accept the suggestion that civil commitment criteria should therefore be expanded. As one analyst exploring this relationship has argued, too much discretion has already been given individual psychiatrists in commitment matters, thus arrogating what "is fundamentally a moral, social, and legal question- not a scientific one."¹³⁸

The foregoing discussion demonstrates that both the legal and scientific communities contribute greatly to the policy formulation of substantive standards in civil commitment. While some psychiatrists perceive the intervention on the part of mental health lawyers as a "holy legal war" against state hospital psychiatry¹³⁹ or as a "legal onslaught,"¹⁴⁰ other psychiatrists regard the judicial involvement as a welcomed move toward shared decision-making.¹⁴¹ Notwithstanding these opinions, some level of legal and mental health systems interaction is evident in civil commitment matters;¹⁴² specifically, in defining mental illness, assessing dangerousness and interpreting gravely disabled criteria. While some accommodation is operative in commitment hearings (i.e, the courts reliance upon psychiatric diagnoses and predictions of dangerousness), this value does not appear to be as forthcoming in issues relating to increasing the state's *parens patriae* authority.

In both instances, however, it is clear that the courts and psychiatry speak for the disabled citizen. In this context, both disciplines exercise a level of paternalism, despite their apparent intentions to represent the best interests of the mental health consumer. It is precisely this value which places mentally disordered persons outside the normative social order, subjecting them to a neglectful system of care. This dilemma is magnified when strong adversarial and antagonistic situations develop. What follows are some selected areas of intense controversy.

¹³⁵See Ennis, *supra* note 7, at 33. See also Note, *Mental Illness: A Suspect Classification?*, 83 YALE L. J. 1264 (1974).

¹³⁶See Morse, *supra* note 18, 527-654.

¹³⁷See Schmidt, *supra* note 22, at 11-15.

¹³⁸Morse, *supra* note 8, at 60.

¹³⁹SEYMOUR L. HALLECK, *COPING WITH THE LEGAL ONSLAUGHT*, 2-7 (1975).

¹⁴⁰A. Louis McGarry, *The Holy Legal War against State-Hospital Psychiatry*, 295 NEW ENG. J. MED. 320 (1976).

¹⁴¹Browning Hoffman, *Living With Your Rights Off*, 7 PSYCHIATRIC ANNALS 84, 87 (May 1977).

¹⁴²See Saleem A. Shah, *Legal and Mental Health System Interactions: Major Developments and Research Needs*, 4 INT'L J. L. & PSYCHIATRY 219, 219-59 (1981).

IV. CAUGHT IN THE CROSSFIRE: PSYCHIATRIC TREATMENT AND A PREFERENCE FOR LIBERTY

A. *The Right to Refuse Antipsychotic Medications*

Of particular importance during the deinstitutionalization movement, was hospital reliance upon psychotropic drugs which facilitated massive patient discharge from public mental institutions.¹⁴³ These new medications were praised by psychiatrists and mental health policy makers because of their primary capacity to relieve psychotic symptoms; specifically, delusions, hallucinations and agitation. Thus, persons previously unable to live in the community were now able to do so, sometimes with only minimal support or supervision. While the initial impact of antipsychotic drugs significantly helped to reduce patient assaultiveness and disruptiveness, a dark side to these medications surfaced in the 1960s and 1970s.¹⁴⁴ An alarming number of mental health consumers experienced physical, emotional and mental side effects that diminished the person's quality of life.¹⁴⁵ While some hospital experts believed that the harm caused by these chemical agents were more damaging to the patient than the psychosis itself,¹⁴⁶ other psychiatric physicians minimized their unavoidable impact, insisting that the side effects could be controlled.¹⁴⁷

Amidst this climate of psychiatric uncertainty, civil libertarian attorneys, patients' rights advocates and other concerned citizens began exploring the extent to which the administration of psychotropic medication was both unnecessary and avoidable.¹⁴⁸ In some instances, courts have found that medication reliance is administered strictly for staff convenience not patient treatment.¹⁴⁹ In addition, inaccurate diagnoses have subjected many mental

¹⁴³See Scull, *supra* note 65, at 171. See also Brooks, *supra* note 17, at 345.

¹⁴⁴See Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179, 180-81 (1980). See Brooks, *supra* note 17, at 342-45. See also Nancy K. Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 HARV. C.R.-C.L. L. REV. 363, 401 (1987).

¹⁴⁵Donal T. Conley, *A Szasian Approach To The Right To Refuse Treatment: My View From The Trenches*, in THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION, 64 (David Rapoport and John Parry eds., 1986).

¹⁴⁶Brooks, *supra* note 17, *passim*.

¹⁴⁷DONALD E. KLEIN & JOHN M. DAVIS, THE DIAGNOSIS AND DRUG TREATMENT OF PSYCHIATRIC DISORDERS, 42 (1969).

¹⁴⁸See generally, Joel I. Klein, *A Legal Advocate's Perspective on the Right to Refuse Treatment*, in THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION 80-86 (David Rapoport and John Parry eds., 1986). Emanuel Tanay, *The Right to Refuse Treatment and the Abolition of Involuntary Hospitalization of the Mentally Ill*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 1 (1980). Bruce J. Winick, *The Right to Refuse Psychotropic Medication: Current State of the Law and Beyond*, in THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION, *supra*, at 7-31.

¹⁴⁹Davis v. Hubbard, 506 F. Supp. 915, 926 (N.D. Ohio 1980).

health consumers to a forced regimen of harmful neuroleptics.¹⁵⁰ Compounding these problems is the counter-therapeutic use of antipsychotic drugs for purposes of punishment and control.¹⁵¹ All of these factors recently led a district court judge to conclude that the administration of antipsychotic medications by public hospital staff has occurred in a "grossly irresponsible" fashion.¹⁵²

Despite increasing evidence detailing the harmful effects and inappropriate administration of drug treatment for psychiatrically ill citizens, most state mental hospitals continued to rely upon this intervention believing it to be the most effective mode of treatment. In the wake of this controversy, the constitutional right of involuntarily committed mental patients to refuse antipsychotic medications was born.¹⁵³ The establishment of this liberty interest was based on a right to privacy which emphasized autonomy and self-determination.¹⁵⁴ This right does not pertain to persons either dangerous to self or others, in an emergency situation, or to those individuals unable to make a rational treatment decision.¹⁵⁵ The purpose of this right was originally drafted so as to place final refusal in the hands of the consumer not the clinician.¹⁵⁶ The practical effect, however, has been to grant the patient a right of objection and to insist that the hospital staff review the person's medication regimen.¹⁵⁷ Final authority regarding treatment decisions continues to be

¹⁵⁰Alan A. Lipton, & Franklin S. Simon, *Psychiatric Diagnosis in a State Hospital: Manhattan State Revisited*, 36 HOSP. & COMMUNITY PSYCHIATRY 368, 369 (1985). Harrison G. Pope, Jr., & Joseph F. Lipinski, Jr., *Diagnosis in Schizophrenia and Manic-Depressive Illness*, 35 ARCHIVES GEN. PSYCHIATRY 811, 825-26 (1978).

¹⁵¹Brooks, *supra* note 17, at 352. THOMAS S. SZASZ, PSYCHIATRIC SLAVERY 12 (1977), THOMAS S. SZASZ, THE THERAPEUTIC STATE: PSYCHIATRY IN THE MIRROR OF CURRENT EVENTS 86 (1984).

¹⁵²Rennie v. Klein, 476 F. Supp. 1294, 1301 (D. N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982).

¹⁵³Although the conditions under which this specific right emerged varied from case to case, the courts' position acknowledging this fundamental liberty guarantee was unmistakably clear. For more on the evolution of this right as articulated throughout the 1970's, *see generally* Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982). Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom.* Mills v. Rogers, 457 U.S. 291 (1982). Winters v. Miller, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971).

¹⁵⁴*See generally* Roe v. Wade, 410 U.S. 113 (1973), Griswold v. Connecticut, 381 U.S. 479 (1965).

¹⁵⁵*See generally* REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS-VALUES IN CONFLICT (A. Edward Doudera and Judith P. Swazey eds., 1982). Roth, *supra* note 21, at 139.

¹⁵⁶Brooks, *supra* note 17, at 358.

¹⁵⁷Loren H. Roth & Paul S. Appelbaum, *What We Do and Do Not Know About Treatment Refusals In Mental Institutions* in Doudera and Swazey, *supra* note 155, at 179.

vested with the psychiatrist and attending treatment team,¹⁵⁸ provided their judgements correspond with the agreed upon practices of the medical profession.¹⁵⁹

Although the right-to-refuse treatment doctrine was designed to curb psychiatric abuses in the care and treatment of the mentally ill, procedural safeguards ensuring this right have significantly hampered its effectiveness.¹⁶⁰ While the right to a due process hearing presided over by an independent psychiatrist not affiliated with the state mental health system ensures that the case is decided on the merits of the refusal, this private physician must consider issues of patient competence or dangerousness, must assess the side effects of the medication, and must evaluate the availability of a less intrusive treatment for the patient.¹⁶¹

This process was made more formidable with the decision in *Rogers v. Okin*.¹⁶² Here, the court ruled that a judicial hearing was required on the issue of competence and that the appointment of a guardian *ad litem* was necessary for refusing patients diagnosed as incompetent. As a result of the competency question, many mental health consumers declining medication return to their previous chronically ill state.¹⁶³ Additionally, this latter guardianship protection raises important ethical questions involving the substitution of one's judgement for the diagnosed incompetent mental health consumer,¹⁶⁴ and the role that informed consent plays in a patient's right-to-refuse decision making.¹⁶⁵ Psychiatrists have criticized the legal system for abuses in competency hearing delays, and have drawn attention to what they regard as the real issue; namely, quality of care¹⁶⁶ not the "right to rot."¹⁶⁷

¹⁵⁸*Youngberg v. Romeo*, 457 U.S. 307, 324 (1982).

¹⁵⁹Thomas G. Gutheil et al., *Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 AM. J. PSYCHIATRY, 347, 350 (1980). Thomas G. Gutheil, *Rogers v. Commissioner: Denouement of an Important Right-to-refuse Treatment Case*, 142 AM. J. PSYCHIATRY, 213-16 (1985).

¹⁶⁰Brooks, *supra* note 17, at 358.

¹⁶¹457 U.S. 291 (1982).

¹⁶²Isaac and Armat, *supra* note 13, at 289.

¹⁶³M.J. Gormley, *Substituted Judgement: A Modern Application*, 10 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT, 353, 366. Scott D. Hughes, *Civil Commitment: Guardianship, Substituted Judgment, and Right To Refuse Psychiatric Treatment*, 20 GONZ. L. REV., 479, 483 (1984). *In re* Guardianship of Roe, 421 N.E.2d 40 (Mass. 1981).

¹⁶⁴Treffert, *supra* note 84, at 123-37.

¹⁶⁵Paul S. Appelbaum & Thomas G. Gutheil, *The Right To Refuse Treatment: The Real Issue Is Quality Of Care*, 9 BULL. AM. ACAD. PSYCHIATRY & L., 199, 199-202 (1981).

¹⁶⁶Appelbaum and Gutheil, *supra* note 15, at 720.

¹⁶⁷*Project Release v. Prevost*, 722 F.2d 960, 971 (2d Cir. 1983). *U.S. v. Leatherman*, 580 F. Supp. 977, 979, (D.D.C. 1983).

Subsequent courts addressing the issue of a non-dangerous mentally ill person's right to refuse treatment have continued this focus on the matter of competence.¹⁶⁸ And, as we shall demonstrate shortly in our discussion on the least intrusive means or least restrictive alternative doctrine, the shifting tensions in the psycho-legal debate appear to be moving in the direction of the medical profession's preference for treatment. While the U.S. Supreme Court has declined to assess whether or not an involuntarily committed mental patient has a federal constitutional right to refuse antipsychotic drugs,¹⁶⁹ other federal district courts are addressing related matters.¹⁷⁰ Their judgements reflect an ever-increasing erosion of the right-to-refuse treatment phenomenon established by earlier decisions. As one court recently concluded, "an involuntary commitment is a finding of incompetency with respect to treatment decisions. Nonconsensual treatment is what involuntary commitment is all about."¹⁷¹

Notwithstanding recent legal trends, it is clear that civilly committed persons exercising their right to refuse antipsychotic medications conjures up strong adversarial sentiment among psychiatric and legal commentators. Governed by values of providing treatment and safeguarding liberty respectively, the results of their antagonism has alternatively fashioned a system of ineffective treatment¹⁷² and noncare for the mentally ill.¹⁷³ This dilemma is exacerbated by the controversial meaning and application of the least restrictive alternative phenomenon; a doctrine that not only challenges the quality of treatment but also the locus of care.

B. The Least Restrictive Alternative Doctrine

The central question posed by the least restrictive alternative doctrine in cases of civil commitment is whether or not the method of treatment is least intrusive¹⁷⁴ and the locus of care least confining.¹⁷⁵ These matters challenge clinical judgements regarding what constitutes the most effective psychiatric

¹⁶⁸Mills v. Rogers, 457 U.S. 291, 306 (1982).

¹⁶⁹Stensvad v. Reivitz, 601 F. Supp. 128, 131 (W.D. Wis. 1985)

¹⁷⁰*Id.*

¹⁷¹Durham & LaFond, *supra* note 54, at 434.

¹⁷²Issac and Armat, *supra* note 13, at 263.

¹⁷³Lake v. Cameron, 364 F.2d 657, 660 (D.C. Cir. 1966), *cert. denied*, 382 U.S. 863 (1966).
O'Connor v. Donaldson, 422 U.S. 563, 576 (1975).

¹⁷⁴Jackson v. Indiana, 406 U.S. 715, 729 (1972). Youngberg v. Romeo, 457 U.S. 307, 317 (1982). Thomas S. v. Morrow, 781 F.2d 367, 375 (4th Cir. N.C. 1986), *cert. denied*, 106 S. Ct. 1992 (1986).

¹⁷⁵Donald H.J. Hermann, *Autonomy, Self Determination, the Right of Involuntarily Committed Persons to Refuse Treatment, and the Use of Substituted Judgement in Medication Decisions Involving Incompetent Persons*, 13 INT'L J. L. & PSYCHIATRY, 361, 382-84 (1990).

intervention,¹⁷⁶ and medical and legal decisions about where that intervention can best be administered.¹⁷⁷ The obvious and persistent tensions created by such considerations are designed to satisfy the patient's interest in being free from unnecessary and harmful treatment.¹⁷⁸

In the involuntary hospitalization of the mentally ill, the least intrusive means analysis is an important consideration in right to refuse treatment cases.¹⁷⁹ At issue is the careful balancing of the mental health consumer's interests to be advanced by the administration of antipsychotic drugs.¹⁸⁰ Some commentators, suspicious of this approach, claim that rather than securing efficacious treatment, "legal advocates have imposed a system of noncare in the most restrictive alternative."¹⁸¹ Others point to the swelling number of chronically ill persons who, for lack of treatment, find themselves either homeless¹⁸² or filtering through the criminal justice system.¹⁸³

More recently, because of the fallout of the least restrictive alternative principle, courts are deferring to the medical community's agreed upon assessment of what treatment is least intrusive.¹⁸⁴ While some jurisdictions continue to recognize this doctrine on the basis of state statutes and common law,¹⁸⁵ this liberty interest is giving way to what the U.S. Supreme Court has called "the demands of an organized society."¹⁸⁶ In short, state mental hospitals are deciding what is in the best interest of the psychiatric citizen; judgements that carry with them a presumption of validity.

The problem with this approach in civil commitment matters is the unlikely probability that professional psychiatric consensus will opt to forego drug

¹⁷⁶Costello and Preis, *supra* note 88, at 1527, 1551.

¹⁷⁷Ingo Keilitz, et al., *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 ST. LOUIS U. L. J., 691, 703-10 (1985).

¹⁷⁸Brooks, *supra* note 17, at 351. Thomas G. Gutheil et al., *The Inappropriateness of Least Restrictive Alternative Analysis for Involuntary Interventions With the Mentally Ill*, 11 J. PSYCHIATRY & L., 7, 10 (1983). David Zlotkin, *First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment*, 83 W. VA. L. REV., 375, 412 (1981).

¹⁷⁹See generally Brooks, *supra* note 17, at 361. Gutheil et al. *supra* note 178, at 10. Zlotkin, *supra* note 178, at 423-28.

¹⁸⁰See *Rennie v. Klein*, 653 F.2d 836, 845-47 (3d Cir. N.J. 1981).

¹⁸¹Isaac and Armat, *supra* note 13, at 333.

¹⁸²See generally, Lamb (1984), *supra* note 85, at 902. Rhoden, *supra* note 13, at 408.

¹⁸³See generally Treffert, *supra* note 84, at 132. Myers, *supra* note 29, at 403.

¹⁸⁴*R.A.J. v. Miller*, 590 F. Supp. 1319, 1322 (N.D. Tex. 1984), *Rivers v. Katz*, 495 N.E.2d 337, 345 (N.Y. 1986).

¹⁸⁵See *Rodgers v. Comm'r of Dept. of Mental Health*, 458 N.E.2d 308, 317, 328-22 (Mass. 1983).

¹⁸⁶*Youngberg v. Romeo*, 457 U.S. 307, 320 (1982).

therapy or hospital confinement when treating mental health consumers.¹⁸⁷ Essentially, they would need to admit that a treatment regimen of antipsychotic medication and involuntary hospitalization possesses only limited effectiveness¹⁸⁸ and, therefore, is not consistent with reasonable professional standards in treating mentally ill persons.¹⁸⁹ Moreover, community-situated treatment would have to be consistent with reasonable professional standards, satisfying the "minimally adequate" treatment needs of the psychiatric consumer.¹⁹⁰ This kind of deliberate departure from the medical model approach does not appear to be forthcoming.

Aside from the problems of forced treatment and institutional care, are the disturbing consequences of the court's more recent wholesale support for psychiatric decision-making in confinement matters. The deference afforded the medical profession's mode of psychiatric intervention presupposes that mental health consumers are persons lacking control and judgement, needing to be confined for their own good.¹⁹¹ Some critics denounce psychiatric assessments citing what they believe to be the medical community's manufacturing of madness.¹⁹² Other commentators resist judicial support for total psychiatric decision-making in civil commitment and treatment matters, maintaining that "psychiatric opinions are essentially political judgements."¹⁹³

Whether opposed to heightened psychiatric authority in issues of patient treatment, or a firm believer that "the worst home is better than the best mental hospital,"¹⁹⁴ the results of the clinicolegal debate on the least restrictive alternative doctrine have only further stigmatized the mental health consumer.¹⁹⁵ The meaning of liberty for the involuntarily committed person is "social marginality, deprivation, and despair."¹⁹⁶ Both the courts and psychiatry have fashioned a system which one observer woefully concludes, "harms and kills the sick."¹⁹⁷ These outcomes are a product of the imposition of legal and medical values that unfortunately cast the psychiatric citizen as a social outcast. One attempt to minimize stigmatization that provides for

¹⁸⁷See Arrigo, *supra* note 22, at 26.

¹⁸⁸See generally, Durham and LaFond, *supra* note 17, at 346-51.

¹⁸⁹Clark v. Cohen, 794 F.2d 79 (3d Cir. Pa. 1986).

¹⁹⁰Costello & Preis, *supra* note 88, at 1548-49.

¹⁹¹See generally, Morse, *supra* note 8, at 58-67.

¹⁹²See generally, Szasz, *supra* note 6, at 83-110.

¹⁹³STEPHEN PFOHL, PREDICTING DANGEROUSNESS 229 (1978).

¹⁹⁴ELAINE CUMMING & JOHN CUMMING, CLOSED RANKS: AN EXPERIMENT IN MENTAL HEALTH EDUCATION 34 (1957).

¹⁹⁵Scull, *supra* note 2, at 218.

¹⁹⁶Warren, *supra* note 108, at 203.

¹⁹⁷*Id.*

treatment while respecting legal safeguards, has been the suggestion of involuntary outpatient commitment. Amidst a climate of flux and uncertainty in matters of civil commitment, this strategy ostensibly offers hope for a necessary balance between individual and state interests.

C. *Involuntary Outpatient Civil Commitment*

A logical extension of the right to refuse treatment and least restrictive alternative controversies is the issue of involuntary outpatient commitment.¹⁹⁸ The mental health literature reflects that there is no standard definition, shared perception or agreed upon practice among states invoking this doctrine on what exactly it entails.¹⁹⁹ Quasi-experimental studies offer only limited information regarding outpatient commitment procedures²⁰⁰ and patient types admitted with expanding commitment laws.²⁰¹ Legal commentators, nonetheless, have relied upon it to construct arguments outlining when state intervention in the lives of psychiatric citizens is beneficial and problematic. Some reviewers argue that compulsory community treatment is essential so that the state does not discriminate against the poor; consumers disproportionately committed to psychiatric facilities.²⁰² Others propose a more selective reliance upon the practice of involuntary outpatient commitment, restricting its use to individuals committed under the *parens patriae* justification,²⁰³ or pursuant to conditional release or outpatient commitment statutes.²⁰⁴

Despite differing views on its meaning and its use from both the medical and legal professions, compelling treatment in the community is increasingly recommended for chronically mentally ill individuals.²⁰⁵ The hope is that those persons with a history of failing to follow through on their treatment plans (voluntarily taking prescribed antipsychotic medications and consistently

¹⁹⁸See generally, Hinds, *supra* note 20, at 847. Keilitz, *supra* note 177, at 693.

¹⁹⁹Miller, *supra* note 20, at 265.

²⁰⁰Hiday and Goodman, *supra* note 22, at 791-93.

²⁰¹Robert D. Miller & Paul B. Fiddleman, *Outpatient Commitment: Treatment in the Least Restrictive Environment*, 35 HOSP. & COMMUNITY PSYCHIATRY 147, 149 (1984).

²⁰²See generally Beatrice K. Bleicher, *Compulsory Community Care for the Mentally Ill*, 15 CLEV. ST. L. REV. 93 (1967).

²⁰³Myers, *supra* note 29, at 412.

²⁰⁴Hinds, *supra* note 20, at 381.

²⁰⁵*Id.*

maintaining scheduled therapy appointments), can be prevented from future inpatient hospitalization by involuntary outpatient civil commitment.²⁰⁶

A number of arguments have been put forth which address the advantages and disadvantages of compelling involuntary treatment in the community.²⁰⁷ Proponents argue that a population of some mentally ill persons cannot experience the full benefits of living freely and autonomously in our society without the impositions of some structure.²⁰⁸ Involuntary outpatient civil commitment ensures this structure, protects mental health consumers from becoming disenfranchised and abandoned, and safeguards their liberty to the fullest extent that their disability will allow. Supporters also point to the possibility for greater comprehensive service delivery when treating patients in the community; avoiding the reactive, crisis-oriented approach that governs most state mental hospital systems.²⁰⁹ And finally, advocates of this position maintain that psychosocial treatment in the community "introduces the patient to the experience of living . . . in a nonpsychotic state."²¹⁰ Therefore, involuntary outpatient commitment facilitates an on-going process of stable rehabilitation in a community setting.

Critics of this intervention strategy are primarily concerned with what they believe to be another effort at coerced treatment under threat of state action for noncompliance.²¹¹ Concerns about the limited efficacy of available treatment, especially when forced, suggests that individual liberty interests will be sacrificed at the expense of mere social monitoring functions.²¹² This raises additional questions about the extent of governmental intrusion in the lives of mental health consumers. Intervention in the form of compulsory community treatment may lead to unwarranted intrusions elsewhere for an expanded group of mental health clients. Specifically, because the dangerous standard for involuntary outpatient civil commitment would necessarily be lower than the inpatient standard, the need-for-treatment criterion would gain greater prominence. This could subject many mentally disordered persons to the same discretionary abuses psychiatry practiced prior to the inclusion of the dangerous criterion. In addition, the right-to-refuse treatment doctrine would

²⁰⁶Ben Bursten, *Posthospital Mandatory Outpatient Treatment*, 143 AM. J. PSYCHIATRY 1255, 1256 (1986). Virginia A. Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT'L J. OF LAW & HEALTH 215, 229 (1987).

²⁰⁷See generally Mulvey, et al., *supra* note 20, at 571.

²⁰⁸H.Richard Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899, 903 (1984).

²⁰⁹Carol L.M. Caton & Alexander Gralnick, *A Review of Issues Surrounding Length of Psychiatric Hospitalization*, 38 HOSP. & COMMUNITY PSYCHIATRY 858, 860 (1987).

²¹⁰Mulvey, et al., *supra* note 20, at 578.

²¹¹Hinds, *supra* note 20, at 388.

²¹²Morse, *supra* note 8, at 74.

not extend to cases involving compulsory community care. "By definition a person cannot refuse treatment while being involuntarily committed on an outpatient basis."²¹³ Another objection to the practice of involuntary outpatient civil commitment is the potential for abuse and the difficulty with ensuring quality control. The outpatient relationship occurs in a non-controlled environment between a patient and professional. Transactions are private and monitoring of actual service delivery, both in method and manner, are not easily verifiable. A final concern voiced by opponents of involuntary outpatient commitment is the harm caused to the therapeutic relationship. Reliance upon coercion significantly jeopardizes the likelihood that consumers will positively and willingly accept treatment, no matter how efficacious the intervention may be. A system predicated upon negative sanctions can only further stigmatize persons already suffering from acute alienation.²¹⁴

What the preceding analysis on involuntary outpatient civil commitment discloses, is how uncertain both the psychiatric and legal communities are when addressing issues of effective treatment that do not infringe upon an individual's fundamental liberty interests. Once again, both camps assume to know what is best for the psychiatric citizen. Whether asserting a need for treatment or a right to liberty, these professions exercise a degree of paternalism that significantly distances the mentally ill from the rest of society. Although some courts have recognized the right of *competent* mental health consumers to refuse medication absent an emergency,²¹⁵ and although arguments have been advanced that assert the right of a competent outpatient to refuse medication in a non-emergency situation²¹⁶ one thing is unequivocally clear: courts decide on the issue of competency²¹⁷ and clinicians treat consumers as patients that are sick²¹⁸ and incompetent.²¹⁹ The point is not that the legal and psychiatric communities have no role to play in the lives of mental health clients. Moreover, the point is not that the mentally disordered need no care. The real issue is understanding the implicit values that underpin clinicolegal decision-making and then evaluating what consumer needs are being met by such an approach. This undertaking will significantly help to contextualize the kind and quality of services provided to the mentally disabled. In addition, by

²¹³Mulvey, et al., *supra* note 20, at 516-17.

²¹⁴*Id.* at 577.

²¹⁵*Rogers v. Okin*, 634 F.2d 650, 656 (1st Cir. Mass. 1980); *In re Guardianship of Roe*, 421 N.E.2d 40, 55 (Mass. 1981).

²¹⁶Hinds, *supra* note 20, at 392.

²¹⁷Barbara A. Weiner, *Treatment Rights in* SAMUEL J. BRAKEL JOHN PARRY & BARBARA WEINER (eds.) *THE MENTALLY DISABLED AND THE LAW* 341 (Samuel J. Brakel, John Parry & Barbara Weiner eds. 1985).

²¹⁸Scheff, *supra* note 18, at 8-12.

²¹⁹Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 280 (1977).

comprehending just what values are protected by civil commitment and civil commitment laws, it may be possible to initiate a system that moves beyond the present climate of uncertainty and abandonment.

V. THE POLITICS OF ABANDONMENT

We have argued that existing psychiatric and legal decision-making practices in civil commitment matters foster a disturbing system of care for mental health consumers. Moreover, this system effectively treats these citizens as the outcasts neither profession necessarily intends them to be. One possible explanation for the failed service delivery system is the social values that underpin psychiatric and judicial intercession. While reference to the historical dimensions of paternalism has been cited as a contributory factor, scant attention has been given to the various forms in which paternalism currently manifests itself in relation to the mentally ill. As a point of departure, we recognize that there is a fundamental clash of interests operating in civil commitment matters;²²⁰ namely, the rights of an individual to engage in independent choice-making versus state interference justified on the basis of benevolently securing the happiness, welfare and needs of the coerced party.²²¹ Notwithstanding this tension, the intrusion into the lives of many mentally disturbed persons is significant and profound. In part, this is the product of law and psychiatry's commitment to paternalism, a social value that is recognizable by its three distinct forms.

VI. THE THREE FORMS OF PATERNALISM

A. Social Control

The social control argument essentially posits that involuntary hospitalization is a necessary and acceptable response to a disabled person's lack of behavioral control.²²² This position is further understood to assume that the individual mental health consumer, contrary to the ordinary citizen, lacks choice-making capacity and therefore cannot knowingly be deterred from engaging in violent or dangerous conduct.²²³

The contribution of the legal system in deferring to and then regulating what psychiatry labels incapacity through dangerousness and/or grave disability, demonstrates how this profession esteems social control interests. While many courts attempt to ensure that full disclosure of the risks/benefits inherent in a particular course of psychiatric treatment are made available to a consumer

²²⁰Herman, *supra* note 175, at 361.

²²¹Gerald Dworkin, *Paternalism in PHILOSOPHY, POLITICS & SOCIETY*, 78-90 (Peter Laslett and James Fishkin eds. 1979).

²²²Zusman, *supra* note 5, at 110, 118-25.

²²³Treffert, *supra* note 4, at 259.

with sufficient faculties to reasonably understand what is being proposed,²²⁴ questions involving the voluntariness of the consent²²⁵ and concerns about the patient's ability to comprehend the impact of treatment, are part of the court's decision-making role.²²⁶ As previously mentioned, courts are increasingly relying upon psychiatric expert testimony to ascertain whether or not individual mentally disturbed persons possess choice-making capacity to assume responsibility for their physical welfare.²²⁷ When an incompetency determination is made, the court may appoint a guardian to represent the interests of the consumer.²²⁸ When the psychiatric citizen is found incapable of rendering informed consent in matters of treatment or confinement, a substituted judgement must be made for the patient by the court.²²⁹

There is a striking parallel that we wish to draw between the court's interest in protecting the welfare of mentally ill citizens and wards of the state; specifically, minors. In fact, recent statutory language addressing guardianship law states the following: "[A] guardian of an incapacitated person is responsible for care, custody, and *control* of the ward. . . . [Such] guardian has the same duties, powers and responsibilities as a guardian for a minor."²³⁰ (emphasis added) Moreover, massive support for the enactment of Adult Protective Service statutes (APS) has occurred during the past fifteen years. This is evidenced by the majority of the states having adopted some sort of APS provision.²³¹ These statutes, designed to provide necessary treatment for the mentally ill, are modeled after comparable statutes representing the needs of children and youth.²³² And finally, while the U.S. Supreme Court has recognized that juveniles possess a panoply of procedural rights ensured to all citizens,²³³ the substantive liberty interests of involuntarily hospitalized minors are significantly circumscribed by parental judgements, provided they receive the medical profession's endorsement.²³⁴ In short, the Supreme Court

²²⁴Von Luce v. Rankin, 588 S.W.2d 445, 448 (Ark. 1979). Truman v. Thomas, 611 P.2d 902, 905 (Cal. 1980).

²²⁵Aden v. Younger, 57 Cal. 3d 662, (1976). Price v. Sheppard, 239 N.W.2d 905, 908 (1976).

²²⁶Gormley, *supra* note 163, at 361.

²²⁷Reiser and Slobogin, *supra* note 94, at 397.

²²⁸*In re* Guardianship of Roe, 421 N.E.2d 40 (Mass. 1981). *In re Colyar*, 660 P.2d 738 (1983).

²²⁹Gormley, *supra* note 163, at 365.

²³⁰Uniform Probate Code § 5-309 (1990).

²³¹John E.B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV., 367, 416 (1983-84).

²³²*Id.* at 416.

²³³*In re* Gault, 387 U.S. 1 (1967).

²³⁴Parham v. J.R., 442 U.S. 584, 604 (1979).

held in *Parham* that Georgia's voluntary commitment guidelines did not violate the procedural protections guaranteed to minors in the *Gault* decision. "Parents retain plenary authority to seek institutional care for their children, subject to a hospital physician's independent examination and medical decision."²³⁵ Regardless of the child's protest, if the parent's judgement is that their son or daughter is mentally ill, can benefit from institutional care and is supported by a physician's assessment and diagnosis, then the child will be admitted involuntarily for psychiatric treatment. Such judicial decision-making underscores the court's preference for socially controlling not just chronic psychiatric patients but minors *suspected* of mental illness.

B. Custody

The paternalistic value of custody bears an important relationship to the issue of suspicion of illness and/or probability of dangerousness. As our socio-legal history on civil commitment and paternalism disclosed, visibility of the mentally ill has often resulted in incarceration or other forms of confinement. These outcomes follow today despite differences in diagnosis among physicians and low rates of accurate predictions. Critics of this approach have likened these police power commitments to preventive detention,²³⁶ and have dismissed the claim that a loss of liberty is warranted in order to prevent future possible harm.²³⁷ The American Psychiatric Association's guidelines on state legislation for civil commitment of the mentally ill, recommend limiting the police power function.²³⁸ By the same token, however, they encourage an expansion of the *parens patriae* commitment criteria. This would subject a greater number of mentally ill persons to custodial confinement for treatment purposes,²³⁹ especially when they are considered to be obviously ill.²⁴⁰

The legal system as well demonstrates its support for the paternalistic value of custody. Some observers have suggested that deinstitutionalization made the community the functional equivalent of the hospital.²⁴¹ Those services once availed in a psychiatric facility increasingly became the responsibility of the community.²⁴² As several commentators have indicated, the conditions in

²³⁵Grant H. Morris, *The Supreme Court Examines Civil Commitment Issues: A Retrospective and Prospective Assessment*, 60 TUL. L. REV. 927, 946 (1986).

²³⁶Donald H.J. Herman, *Preventive Detention, A Scientific View of Man, and State Power*, 1973 U. ILL. L. F. 673, 688.

²³⁷LaFond, *supra* note 36, at 527.

²³⁸Schmidt, *supra* note 22, at 39. Stromberg & Stone, *supra* note 100, at 383.

²³⁹Chodoff, *supra* note 3, at 499.

²⁴⁰Treffert, *supra* note 4, at 259.

²⁴¹Bachrach, *supra* note 86, at 83. Scull, *supra* note 65, at 177.

²⁴²Pepper & Ryglewicz, *supra* note 65, at 390.

which many mentally ill persons live in community settings is simply deplorable.²⁴³ Often care and services do not extend beyond the administration of medication.²⁴⁴ And the influence of mental health lawyers and the courts in promulgating such a system is immeasurable and well documented.²⁴⁵

Another aspect to the important social value of custody is the procedural standard of proof required at civil commitment hearings. Unlike criminal prosecutions where the state must demonstrate *beyond a reasonable doubt* (90% certain) that the accused is responsible for the commission of a crime, the burden of persuasion in confinement proceedings is based upon a showing of *clear and convincing evidence* (75% certain).²⁴⁶ The implication is that psychiatric patients are afforded a procedural safeguard less than what is availed to criminal defendants.²⁴⁷ It is therefore easier (and therefore desirable) to confine mental health consumers who *may* be dangerous to self or others or who *may* be gravely disabled than it is to incarcerate alleged felons. The only justification for such a policy is that a temporary loss of liberty (preventive detention) is in the best interest of society and the individual psychiatric citizen.²⁴⁸ In these instances, proponents argue, it is better to be safe than sorry.

C. Treatment

A third paternalistic value underscoring involuntary hospitalization, civil commitment laws, and policies is a concern for treatment. On psychiatry's part, this is manifested not only by the administration of antipsychotic medications and other clinical interventions, but by the medical community's conscious effort to control "crazy" behavior.²⁴⁹ This is accomplished by identifying those activities which fall outside the boundaries of normative conduct. The American Psychiatric Association relies upon its Diagnostic and Statistical Manual to categorize behavior along a continuum of craziness.²⁵⁰ Of course, the impact of such classifications is to "treat" behaviors that psychiatry, as reflected by prevailing social norms, deems unbecoming.²⁵¹ Judicial complicity in this scheme is evidenced by the court's deference to the medical

²⁴³Richard Rapson, *The Right of the Mentally Ill to Receive Treatment in the Community*, COLUM. J.L. & SOC. PROBS. 193, 243 (1980). MARY ELLEN HOMBS & MITCH SNYDER, HOMELESSNESS IN AMERICA: A FORCED MARCH TO NOWHERE 85 (1982).

²⁴⁴Myers, *supra* note 29.

²⁴⁵Scull, *supra* note 65, at 125. Rhoden, *supra* note 13, at 412.

²⁴⁶Addington v. Texas, 441 U.S. 418 (1979).

²⁴⁷Morse, *supra* note 8, at 98.

²⁴⁸Zusman, *supra* note 5, at 112. Treffert, *supra* note 4, at 259. Chodoff, *supra* note 3, at 497.

²⁴⁹Morse, *supra* note 18, at 610.

²⁵⁰Arrigo, *supra* note 22, at 10.

²⁵¹*Sec. e.g.,* Szasz, *supra* note 99, at 11-88. Szasz, *supra* note 26, at 9-132.

community's professional consensus in psychiatric matters.²⁵² As we have argued, such deference is present not simply in appellate case law, but in the administrative proceeding as well.

Further evidence of paternalism-as-treatment in current civil commitment laws and practices comes from an administrative court's determination that a particular consumer is *not* "crazy" ill. Consequently, involuntary hospitalization does not follow. In essence, courts and/or tribunal decision brokers determine that an individual is "well" in the clinicolegal sense and maintain that it is therapeutic to release the person from custody. This brand of treatment may include a discharge plan (a medication regimen and outpatient therapy). However, this plan, when disregarded by the mental health system user, can and does escalate the consumer to crisis and eventual re-hospitalization. A recent study of a model program in the state of Massachusetts found that the rate of re-petitions for civil commitment and/or re-hospitalization was staggering. Even when funds were provided for community-based services and support, and even when the chronically disabled persons of this model program were believed to be capable of living in the community (some 90%), only 5% did not suffer any psychiatric setbacks. As the outcome study's prime investigator concluded: "[L]ife for [many] patients [became one of] decompensation in the residential setting, stabilization in the hospital, return to the residential setting, decompensation again, and the cycle repeat[ed]."²⁵³ When a person is discharged and treated on an outpatient basis, there is considerable doubt about the therapeutic and efficacious consequence of this action, especially when the result is "revolving door" institutional care.

VII. RECOMMENDATIONS

Thusfar we have provided an historical account of events during the past twenty five years which are primarily responsible for present day confinement practices, discussed the context in which law and psychiatry speak for the mentally ill, evaluated three controversial policies that magnify clinicolegal tensions in commitment matters, and outlined values underpinning judicial and psychiatric decision-making. At this juncture, rather than rejecting outright the psychiatric and legal vision of treatment and liberty a more reasonable approach requires fashioning a policy that incorporates the salient contributions of both professions. Such an orientation is critical if a future-directed policy in civil commitment matters is to be established.

Striking a proper balance between confinement and liberty is not an easy task. In the past, while clinical intervention left unchecked produced

²⁵²See, e.g., *Youngberg v. Romeo*, 457 U.S. 307 (1982). *R.A.J. v. Miller*, 590 F. Supp. 1319 (N.D. Tex. 1984).

²⁵³JEFFREY L. GELLER, ET AL., *THE MASSACHUSETTS EXPERIENCE WITH FUNDED DEINSTITUTIONALIZATION: A DECADE OF PROMISES, PRODUCTS AND PROBLEMS UNDER THE BREWSTER V. DUKAKIS CONSENT DECREE* 17 (1989).

frightening asylum conditions,²⁵⁴ legal remedies worshipping the treasure of liberty only applaud an ideal at the expense of real human suffering.²⁵⁵ A middle ground position must accept the premise that limited psychiatric intervention for therapeutic purposes (including coercive treatment) is sometimes warranted. This holds true especially for persons so severely affected by their disorder that they are "no longer capable of making a rational choice whether to continue in [their] present state or to seek treatment for [their] mental illness."²⁵⁶ The difficulty with this proposition is the tendency on the part of psychiatrists to over-estimate the benefits of a particular treatment regimen and delimit the harm while mental health lawyers, on the other hand, acknowledge the harm and de-emphasize the benefits.²⁵⁷ These perspectives are understandable given medicine's deterministic affection for more and better science and the law's right-conscious esteem for more and better justice.²⁵⁸

In order to construct a civil commitment policy infused with the insights of both professions, understanding the essential needs of mental health consumers is a prerequisite to any future policy aimed at improving the mental health care system. Although this undertaking addresses only a limited aspect of involuntary hospitalization, the psychiatric and legal implications for such an approach refocuses critical attention on the disabled citizen's heretofore misplaced interests. We have identified five consumer-based needs that require psychiatric, legal and other constituency recognition before it is possible to move beyond the present climate of uncertainty and abandonment in civil commitment matters. Consideration of these issues could help reduce the mutual antagonisms that plague both professions by serving as the first step toward shaping a policy that is as well designed as it is well intentioned.

A. Quality Care

The constitutional right to quality care is the most fundamental interest at stake for psychiatric patients in civil commitment proceedings. Although this issue has received some attention from psychiatric²⁵⁹ and legal²⁶⁰ commentators, these investigations mostly address the right to such care in medication refusals. A more general right to quality care recognizes the intrinsic dignity of human beings no matter how disabled or dysfunctional. It

²⁵⁴See, e.g., DAVID J. ROTHMAN, CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA 17-40 (1980). Scull, *supra* note 65, at 117-33.

²⁵⁵Mulvey, et al., *supra* note 20, at 575.

²⁵⁶LaFond, *supra* note 36, at 526.

²⁵⁷See Brooks, *supra* note 17, at 344-53.

²⁵⁸Schmidt, *supra* note 22, at 40.

²⁵⁹Appelbaum and Cuthiel, *supra* note 165, at 199.

²⁶⁰BRUCE A. ARRIGO, MADNESS LANGUAGE AND THE LAW, (1993).

is a liberty interest that encompasses the right to be free from bodily intrusions,²⁶¹ the right to bodily integrity,²⁶² and the right to autonomy and self-determination.²⁶³ Each of these rights is directly linked to a more basic claim to personhood. Given past psychiatric abuses, a healthy skepticism regarding the role of mental health professionals to treat therapeutically rather than socially control is certainly understandable. Nonetheless, allowing treatment discretion for the psychiatric profession is acceptable *provided*: 1); the quality of intervention is recognized by the established medical community in which civil liberties are fully respected, 2); the clinical team's accountability for treatment decisions is monitored regularly, and 3); the consumer, a peer advocate if requested, and other affected, non-hospital personnel are participants in the commitment/treatment process. This is not to suggest that a costly and time-consuming system be erected as much as it is to underscore the importance of fully exploring the manner in which quality care can in fact be administered. It is an on-going process that requires an assessment by physicians, attorneys, community representatives and the consumer.

B. Protection Against Unnecessary Harm

An extension of the right to quality care is the right to be protected from harmful interventions.²⁶⁴ Although the literature is voluminous on the adverse effects of institutional confinement, benevolent coercion for chronically mentally ill persons can be more than custodial and the administration of antipsychotic medication can be more than heuristic. Part of the solution lies in understanding how psychiatric facilities are both physically and socially constructed in ways that institutionalize the mentally ill. Some recent social-psychological literature is examining the community model as an appropriate paradigm for greater social cohesion and personal well-being in diverse organizational settings.²⁶⁵ If the harm that is caused by commitment and the treatment course that follows is to be reduced, greater exploration in this area of social designing is necessary. Both physicians and patients' rights advocates need to demonstrate an increased sensitivity to how social and

²⁶¹Johnson v. Silvers, 742 F.2d 823, 823 (4th Cir. Md. 1984). Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966), *cert. denied*, 382 U.S. 863 (1966). Davis v. Hubbard, 506 F. Supp. 915, 916 (N.D. Ohio 1980). Dodd v. Hughes, 398 P.2d 540 (Nev. 1965).

²⁶²Project Release v. Prevost, 722 F.2d 960, 962 (2d Cir. N.Y. 1983). State ex rel. Jones v. Gerhardtstein, 400 N.W.2d 1, 2 (Wis. Ct. App. 1986).

²⁶³Donald H.J. Hermann, *Autonomy, Self Determination, the Right of Involuntarily Committed Persons to Refuse Treatment, and the Use of Substituted Judgment In Medication Decisions Involving Incompetent Persons*, 13 INT'L J. L. & PSYCHIATRY, 361, 362 (1990).

²⁶⁴Brooks, *supra* note 17, at 350.

²⁶⁵Bruce A. Arrigo, *Rooms for the Misbegotten: On the Sociology of SRO Social Designing and Deviance*, 21:4 J. SOCIOLOGY AND SOCIAL WELFARE (forthcoming, 1994). John L. McKnight, *Regenerating Community*, 17 SOC. POL'Y, No. 3, 54-58 (1987).

physical space can be configured in such a way that benefits the mental health consumer.²⁶⁶

C. Safe, Supportive, and Affordable Housing

An evaluation of civil commitment raises important questions concerning alternative care that is as efficacious as hospital confinement but is as non-restrictive as one's disability will allow.²⁶⁷ An absence of affordable housing stock that is both structurally safe and interpersonally supportive, substantially narrows choice-making prospects for civil commitment parties. Nonetheless, for a system of involuntary treatment to be as effective in caring about the mentally disordered as it can be, pursuing the full spectrum of available treatment possibilities must be acknowledged as absolutely essential.²⁶⁸ Too often commitment proceedings are tainted by a dispassionate recounting of somatic symptoms and a detached verbalizing of adversarial rhetoric. Given that the goal of involuntary treatment is to return the consumer to a mental state in which the individual can make an informed and rational decision about their acceptance of the prescribed intervention,²⁶⁹ and given that this intervention is to be least restrictive upon one's liberty,²⁷⁰ then evaluating the safe, supportive, and affordable housing options in a particular jurisdiction must be factored into the decision-making equation that attorneys and physicians undertake. If the commitment hearing can delve into deeply personal renditions of human suffering and misery, then a deliberate evaluation of non-institutional, efficacious treatment is quite reasonable.

D. Understanding the Consumer's World

A significant problem confronting both medical and legal personalities in civil commitment matters is the version of truth/justice these individuals embrace as knowledge and understand as power. Advances in both the physical and social sciences have fostered a society in which people are normalized and de-pathologized.²⁷¹ This is especially the case with the mentally ill. The locus of responsibility for caring for these citizens has shifted from the family and local community to a group of trained psychiatric

²⁶⁶H. Richard Lamb and Victor Goertzel, *The Long-term Patient in the Era of Community Treatment*, 34 ARCHIVES GEN. PSYCHIATRY, 679, 679-82 (1977).

²⁶⁷Keilitz, *supra* note 177, at 692.

²⁶⁸Myers, *supra* note 29, at 425.

²⁶⁹Loren H. Roth, *A Commitment Law for Patients, Doctors, and Lawyers*, 136 AM. J. PSYCHIATRY, 1121, 1122 (1979).

²⁷⁰H. Rutherford Turnbull, III, (Editor), *The Least Restrictive Alternative: Principles and Practices*, Washington, DC: Task Force on Least Restriction, Legislative and Social Issues Committee, American Association on Mental Deficiency, Inc., 26 (1981).

²⁷¹MICHEL FOUCAULT, *POWER/KNOWLEDGE: SELECTED INTERVIEWS AND OTHER WRITINGS, 1972-1977*, 7-31 (1980).

professionals.²⁷² These experts assert the informed capacity to understand and treat mental health consumers.²⁷³ The result is that we have fashioned a system that esteems the psychiatric community's worldview.²⁷⁴ Social meanings and acceptable behaviors are governed by the moral treatment of those professionals who exercise treatment power. In a culture where respect is afforded science, scientific assertions are an exercise of power that reduce the merits of other knowledge claims as less rigorous and, therefore, less valid.²⁷⁵ The implications for such a monopoly of power are far-reaching. Not only are the mentally ill left to the moral entrepreneurship of the psychiatric profession, but this profession's version of truth, of power, is crystallized through the formation of laws affecting the care and treatment of the mentally disordered.

The "science" of law and psychiatry is representative of a certain approach that reflects the interests and attitudes of only certain members in society.²⁷⁶ It is an approach that relies upon linear, rational thinking to arrive at truth.²⁷⁷ There can only be one commitment outcome in a particular hearing. This outcome must be based upon only well-established and time-tested scientific truths, honored by only universally applicable legal precedents. This logic reduces uncertainty, ambiguity, unpredictability, multiplicity and difference to unity and sameness. Intuitively, such an orientation appears counter-productive. Clearly, psychiatric citizens do not easily fit this uni-dimensional worldview. The result is that they are often normalized and institutionalized to perpetuate "the demands of an organized society."²⁷⁸ The totalizing effect of this legal and medical perspective denies not only the heterogeneity of the mentally disordered as a class of people, but the individuality of those consumers within this group. Both law and psychiatry must be more open to an approach that is comfortable with the contradictions, inconsistencies and complexities that are the stuff of human existence. Adopting this point of view can only further serve to understand the interiorized needs of mentally disabled citizens.

E. *Re-examining the Civil Commitment Hearing Process*

On a practical level, successfully understanding the previous need entails reevaluating how the commitment process unfolds. One commentator has suggested that the "court of last resort" functions as a consensual and

²⁷²Bruce A. Arrigo, *Deconstructing Jurisprudence: An Experiential Feminist Critique*, 4(1) J. OF HUMAN JUSTICE 13 (1994) (forthcoming).

²⁷³Scull, *supra* note 2, at 216.

²⁷⁴Kittrie, *supra* note 36, at 18.

²⁷⁵Arrigo, *supra* note 272.

²⁷⁶LUCE IRIGARAY, *THIS SEX WHICH IS NOT ONE*, 76 (1985).

²⁷⁷IRIS M. YOUNG, *JUSTICE AND THE POLITICS OF DIFFERENCE*, 107-20 (1990).

²⁷⁸*Youngberg v. Romeo*, 457 U.S. 307, 320 (1982).

commonsense arena in which psychiatric and legal decision-brokers decide the fate of mental health clients.²⁷⁹ Our experience at these proceedings supports this claim. Deferential dialogue all too frequently anticipates the hearing outcome. The point is not that this result is unacceptable. Accommodation is essential but not at the expense of advocacy.²⁸⁰ Usually, the entire affair is audiotaped or a stenographer is present promoting an air of formality. The parties present include the attending psychiatrist, perhaps some members of the treatment team, an attorney representing the hospital, an administrative law judge, some hospital security if necessary, the petitioner a defense attorney and the consumer. There can be little doubt that such an atmosphere engenders limited patient warmth or comfort. This speaks to the sort of impersonal and perfunctory approach the legal and psychiatric professions typically rely upon in these instances.²⁸¹ The belief that a sterile and antiseptic environment somehow makes for friendly and open client discourse is at best short-sighted. This manner of communication demands a kind of perfection that compels the psychiatric citizen to live out the "crazy" role that she/he obviously knows all too well. On occasion, our experience has been that when this performance is not forthcoming, there is some suspicion about whether the client is perpetrating a hoax. Of course, when the disordered person performs as expected, the audience is generally willing to grant what, after all, the behavior only serves to affirm; namely, that the person is ill, dangerous and/or gravely disabled and requires involuntary hospitalization and treatment.

Not only is the commitment process questionable, but the hearing outcome is susceptible to greater risk of error and wrongful confinement.²⁸² Although the standard of proof required by the Constitution places a stricter burden of persuasion upon the state than the preponderance of the evidence criterion does,²⁸³ determining whether commitment is warranted should require no less a procedural safeguard than the reasonable doubt measure afforded criminal defendants.²⁸⁴ While the clear and convincing standard does reduce possible hearing outcome error, some courts have recognized the importance of applying the reasonable doubt measure in matters of involuntary treatment.²⁸⁵

²⁷⁹Warren, *supra* note 97, at 162.

²⁸⁰Norman G. Polythress, Jr., *Psychiatric Expertise In Civil Commitment: Training Attorneys To Cope With Expert Testimony*, 2 L. & HUM. BEHAV., 1, 18 (1978).

²⁸¹Morse, *supra* note 18, at 100.

²⁸²*Id.*

²⁸³Addington v. Texas, 441 U.S. 418, 418 (1979).

²⁸⁴Morse, *supra* note 8, at 103.

²⁸⁵Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded for a more specific order*, 414 U.S. 743, *ordered on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *order reinstated on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

A consumer-conscious approach recognizes the need for a supportive, comfortable environment governed by rules of informality and relationship-building, in which service needs are emphasized and liberty interests are *fully* protected. While we recognize this is the language of community,²⁸⁶ it is precisely this orientation that urges people to openly communicate rather than mechanically accommodate. The former is inviting and the latter is distancing. Other non-hospital staff, including a peer advocate or community residents affected by the proceeding's outcome, can offer valuable insight into the consumer's on-going behavioral patterns. This testimony could make the difference between in-patient commitment or total discharge. Because of this very real possibility, concerned citizens should be notified of the hearing date, encouraged to attend and asked to participate in the process. In a very meaningful way, the civil commitment hearing is like a town meeting: a member is in distress and all interested parties must work together to resolve the problem. Unfortunately, the present system does not fully adopt this point of view and commitment decisions are all too often made by those with limited information and resources.

VIII. CONCLUSIONS

In our analysis of civil commitment laws and confinement practices in general, we have endeavored to demonstrate how the past twenty-five years have been marked by disappointing clinicolegal decision-making specifically for the consumer. Influenced by a belief in treatment²⁸⁷ and a preference for liberty,²⁸⁸ the paternalistic tensions created by such a polarity of positions has taken a substantial toll on the lives of many psychiatrically ill citizens. Not only has the stigma of mental illness been further advanced by psychiatric and legal commitment practices, but the entire system of care has fallen short of its responsibility to deliver much needed services. While uncertainty and abandonment have more recently been the familiar catchwords in mental health law, the possibility for improving the present apparatus is within reach.

Our contention is that exploring the values that underscore the legal and medical approach to involuntary civil commitment helps to contextualize why antagonisms have been so intense and intervention has been so disappointing. Rather than dismantling the entire system, the first step to fashioning a well designed commitment strategy requires a synthesis of the inherent wisdom found in each position. To that end, the benevolence of coercive treatment is recognized in limited circumstances where the patient lacks sufficient judgement to make a rational choice about continuing or discontinuing the prescribed treatment regimen. In addition, we maintain that establishing a client-based assessment of what needs are in the best interest of the consumer

²⁸⁶McKnight, *supra* note 265, at 57.

²⁸⁷Treffert, *supra* note 4, at 259. Chodoff *supra* note 3, at 496. Appelbaum, *supra* note 55, at 133-44.

²⁸⁸Morse, *supra* note 8, at 54. Szasz, *supra* note 99, at 233. Szasz, *supra* note 6, at 33.

is a preliminary but necessary component to improving the present policy. This process reveals that there are five compelling client interests that require further consideration by both legal and psychiatric decision makers. A right to quality care, protection against unnecessary harm, decent, affordable housing, greater understanding of the consumer's worldview and a reconfiguration of the hearing process itself, are matters that significantly restore the interests of the consumer to their proper position of priority.

Perhaps the greatest difficulty with such an approach is in its implementation. It is one thing to assert basic human needs or an alternative perspective from which to consider the meaning of commitment, but it is another to have these rights and ideas accepted as a more balanced account that respect treatment needs and liberty demands. The extent to which physicians, hospital personnel, attorneys, community advocates, consumers and other invested constituencies participate in this process of debate and discovery, will determine the degree of success these recommendations will yield. The present crisis in civil commitment laws and practices is not an endless chasm filled with consternation and despair. The most reasonable solution seems to entail a recognition that law and psychiatry continue to offer insights that should not be readily dismissed. By starting from a position that affirms the consumer's needs and interests, this preliminary step initiates reform and invites resolution. To be sure, a system that values humane treatment and safeguards precious liberties can effect the type of change that will steer us away from abandonment, provided we remember that the fundamental needs of psychiatric citizens must always come first.