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LEGAL REPRESENTATION OF THE MENTALLY ILL[†]

JAMES R. ELKINS*

The "rights revolution," sparked by the United States Supreme Court under the leadership of former Chief Justice Earl Warren, has abated as the Court modifies and in some instances emasculates the constitutional rights afforded criminal defendants. While the Supreme Court assumes a more "moderate" position regarding the rights of criminal defendants and takes a closer look at due process decisions generally, the "rights revolution" has had substantial spillover effect in the case of individuals confined involuntarily in mental institutions.¹ The courts, especially federal courts, have recognized the constitutional basis of procedural and substantive safeguards for individuals subject to commitment in state mental institutions. Judicially mandated procedural safeguards for committing persons and insuring their rights to proper treatment once confined have necessitated widespread legislative reform of state mental health statutes.

One of the rights now afforded individuals subject to involuntary civil commitment is representation by legal counsel. By one

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¹ The effort to secure additional legal rights for the mentally ill has received a setback in recent decisions of the Supreme Court. The Court in *Addington v. Texas*, 99 S. Ct. 1804 (1979), refused to analogize involuntary confinement to criminal incarceration for purposes of determining the state's burden of proof in interfering with the liberty of the mentally ill. In *Parham v. J. R.*, 99 S. Ct. 2493 (1979), the Supreme Court held that constitutional due process for children whose parents seek to confine them in mental institutions is satisfied by a psychiatric determination that appropriate legal standards have been met. These decisions indicated that the Court is unwilling to curb the power of institutional psychiatry through the creation of additional procedural safeguards for the mentally ill. The Court may be signaling that the spill-over of rights from the criminal justice system to the mental health system has ended.

count, forty-two of the states now provide for legal representation,² and the presence of defense counsel or a guardian ad litem³ in civil commitment proceedings is now routine. By statute, the majority of states require that legal counsel be appointed for individuals subject to involuntary commitment.⁴ Where statutes fail to provide for counsel, counsel may still be required as a matter of constitutional right.⁵ West Virginia, by statute, specifically provides that

² Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 YALE L.J. 1540, 1540 n.2 (1975).

The representation of counsel is not mandatory in some states. For example, some states require the appointment of counsel only where the individual specifically requests the assistance of an attorney. See, e.g., ILL. REV. STAT. ch. 91½, § 8-22 (Supp. 1975); MD. ANN. CODE art. 59, § 13(c) (1972 Replacement Vol.); NEB. REV. STAT. § 83-1049 (Cum. Supp. 1976); N.D. CENT. CODE § 25-03.1 - 13 (1978 Replacement Vol.); OKLA STAT. ANN. tit. 42, § 54.1 (West 1978); WASH. REV. CODE ANN. § 71.05.200 (1)(b) (1975).

A second group of states makes the appointment of counsel discretionary with the court. See NEV. REV. STAT. § 433A.270 (1975); N.Y. MENTAL HYG. LAW § 88(c) (McKinney 1971); OHIO REV. CODE ANN. § 5122.15 (Page 1970).

A few states require the appointment of a guardian ad litem who may, but is not required to be, an attorney. See, e.g., HAW REV. STAT. § 334-82 (1976 Replacement Vol.).

³ One state provides for the appointment of a guardian ad litem without reference to whether such individual should be a lawyer. See MISS. CODE ANN. § 41-21-3 (1972).

⁴ In the majority of states, state mental health codes specifically provide for the appointment of counsel for indigents subject to civil commitment hearings. A list of the states and relevant statutory provisions is contained in Brunetti, *The Right to Counsel, Waiver Thereof, and Effective Assistance of Counsel in Civil Commitment Proceedings*, 29 Sw. L.J. 684, 689 n.21 (1975).

⁵ For a discussion of the constitutional basis for the right to counsel, see Brunetti, *supra* note 4, at 691-98. The author argues that the Sixth Amendment and the general principles of due process furnish constitutional grounds for requiring the presence of counsel and that the provisions of those states that do not require appointment of counsel or make such appointment discretionary with the courts are constitutionally deficient.

The federal courts that have considered the issue have upheld the indigent mental patient's right to counsel. See, e.g., *In Re Barnard*, 455 F.2d 1370 (D.C. Cir. 1971); *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972); *Dixon v. Attorney Gen.*, 325 F. Supp. 966 (M.D. Pa. 1971). While the United States Supreme Court has not specifically ruled on the issue, its rulings in other areas suggest that the Court will endorse the trend of decisions in the lower federal courts. See *Andalman & Chambers, Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and a Proposal*, 45 Miss. L.J. 43, 44-45 (1974). See generally Note, *Civil Commitments: Should There Be A Constitutional Right to Counsel*, 2 CAP. U.L. REV. 126 (1973); Note, *The Right to Counsel at Civil Competency Proceedings*, 40 TEMP. L.Q. 381 (1967).

counsel be appointed to represent the mentally ill in a commitment hearing⁶ and makes mandatory counsel's presence at the hearing.⁷ While the right to counsel in civil commitment hearings is now secured by statutory provision buttressed by judicial suggestion that counsel is constitutionally required, there remains a question concerning the appropriate role of an attorney in representing the mentally ill.⁸ This article will explore the function of

⁶ The West Virginia statute provides that "[i]n the event that the individual has not retained counsel, the court or mental hygiene commissioner at least seven days prior to hearing shall appoint a competent attorney" W. VA. CODE § 27-5-4(g) (Cum. Supp. 1979).

⁷ The West Virginia statute makes appointment of counsel mandatory and makes no reference to a client's waiver of counsel. The language of the statute suggests, however, that both the individual who is subject to the hearing and the attorney "shall" be present. W. VA. CODE § 27-5-4(h)(1) (Cum. Supp. 1979). The statute does not envision waiver of counsel. Some 25 other states have statutory provisions which do not mention waiver of counsel. See Brunetti, *supra* note 4, at 700. For a discussion of the waiver issue, see Brunetti, *supra* note 4, at 701-06. See generally Corder, Haizlip, & Spears, *Legal Issues in the Treatment of Adolescent Psychiatric Inpatients*, 27 HOSP. & COMMUNITY PSYCHIAT. 712 (1976); Note, *The Right to Counsel at Civil Competency Proceedings*, 40 TEMP. L.Q. 381, 389-92 (1967); Comment, *Mental Health — Applicable Standards in Waiver of Right to Counsel in Civil Commitment Proceedings*, 7 U. TOL. L. REV. 607 (1976).

⁸ See generally R. ROCK, M. JACOBSON, R. JANOPOL, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 157-60 (1968); Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and A Proposal*, 45 MISS. L.J. 43 (1974); Blinick, *Mental Disability, Legal Ethics, and Professional Responsibility*, 33 ALB. L. REV. 92 (1968); Brakel, *The Role of the Lawyer in the Mental Health Field*, 2 A.B.F. RESEARCH J. 467 (1977); Broderick, *Justice in the Books or Justice in Action — An Institutional Approach to Involuntary Hospitalization for Mental Illness*, 20 CATH. U.L. REV. 547, 620-32 (1971); Brunetti, *The Right to Counsel, Waiver Thereof, and Effective Assistance of Counsel in Civil Commitment Proceedings*, 29 SW. L.J. 684 (1975); Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424 (1966); Cyr, *The Role and Functions of the Attorney in the Civil Commitment Process: The District of Columbia Approach*, 6 J. PSYCHIAT. & L. 107 (1978); Dix, *The Role of the Lawyer in Proceedings Under the Texas Mental Health Code*, 39 TEX. B.J. 982 (Nov. 1976); Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101 (1971); Galie, *An Essay on the Civil Commitment Lawyer: Or How I Learned to Hate the Adversary System*, 6 J. PSYCHIAT. & L. 71 (1978); Gassel, Levy-Warren & Weiss, *Representing the Helpless: Toward an Ethical Guide for the Perplexed Attorney*, 5 W. ST. U.L. REV. 173 (1978); Herr, *The New Clients: Legal Services for Mentally Retarded Persons*, 31 STAN. L. REV. 553 (1979); Hiday, *The Role of Counsel in Civil Commitment: Changes, Effects, and Determinants*, 5 J. PSYCHIAT. & L. 551 (1977); Kirtpatrick, *Oregon's New Mental Commitment Statute: The Expanded Responsibilities of Courts and Counsel*, 53 OR. L. REV. 245 (1974); Kumasaka & Gupta, *Lawyers and Psychiatrists in the Court: Issues on Civil Commitment*, 32 MD. L.

the attorney assigned or engaged to represent a client in a civil commitment hearing. The author will present specific suggestions for a more adequate and effective representation of the mental patient/client. Finally, the article will explore other alternatives to the present system of representation of the mentally ill in West Virginia.

Exposing the inadequacies in the legal representation of the mentally ill has been left in large part to legal commentators. The civil commitment process historically has been of little concern either to the public or to the practicing bar.⁹ The low visibility of

REV. 6 (1972); Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CALIF. L. REV. 816 (1974); Mutnick & Lazar, *A Practical Guide to Involuntary Commitment Proceedings*, 11 WILLAMETTE L.J. 315 (1975); Patch, *The Mentally Disabled and His Lawyer*, 2 J. PSYCHIAT. & L. 33 (1974); Perlin & Siggers, *The Role of the Lawyer in Mental Health Advocacy*, 4 BULL. AM. ACAD. PSYCHIAT. & L. 204 (1976); Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. HEALTH & SOC. BEHAVIOR 66 (1969); Wexler & Scoville, *Special Project: The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 51-60 (1971); *How to Represent Clients at Mental Commitment Hearings*, 23 LEGAL AID BRIEF CASES 19 (1964); *Practice Manual, The Attorney's Role at the Commitment Hearings: Guidelines and Practical Considerations*, 2 MENTAL DISABILITY L. RPTR. 427 (Jan.-Feb. 1978); Note, *Compulsory Counsel for California's New Mental Health Law*, 17 U.C.L.A. L. REV. 851 (1970); Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 YALE L.J. 1540 (1975); Comment, *The Expanding Role of the Lawyer and the Court in Securing Psychiatric Treatment for Patients Confined Pursuant to Civil Commitment Procedures*, 6 HOUS. L. REV. 519, 531-32 (1969).

⁹ The civil commitment process has, however, received substantial attention in the legal literature, resulting in an almost state-by-state analysis. See, e.g.: ALABAMA: Cole, *The Nadir of Due Process: An Analysis of Involuntary Civil Commitment Procedure In Alabama*, 3 CUM.-SAM. L. REV. 8 (1972). ARIZONA: Wexler & Scoville, *Special Project: The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1 (1971). ARKANSAS: Gazman, *Hospitalization of the Mentally Ill Defendant in Arkansas*, 24 ARK. L. REV. 19 (1970); Comment, *Arkansas Involuntary Civil Commitment: In The Rear Guard of the Due Process Revolution*, 32 ARK. L. REV. 294 (1978). CALIFORNIA: E. BARDACH, *THE SKILL FACTOR IN POLITICS: REPEALING THE MENTAL COMMITMENT LAWS IN CALIFORNIA* (1972); Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIAT. 101 (1972); Harrington, *Involuntary Commitment of Mentally Disordered Persons Under the Lanterman-Petris-Short Act*, 8 LINCOLN L. REV. 55 (1973); Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 L. & SOC'Y REV. 629 (1972); Note, *Civil Commitment of the Mentally Ill in California: The Lanterman-Petris-Short Act*, 7 LOV. L.A.L. REV. 93 (1974); Note, "Who Says I'm Crazy?" — A Proposal for Mandatory

Judicial Review of Emergency Detention in California, 51 S. CAL. L. REV. 695 (1978); (For a bibliography of articles on civil commitment in California, see A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 602-03 (1974)). COLORADO: Brofman, *Civil Commitment of the Mentally Ill in the Denver Probate Court*, 46 DEN. L.J. 496 (1969); Elliott, *Procedures for Involuntary Commitment on the Basis of Alleged Mental Illness*, 42 U. COLO. L. REV. 231 (1970); Steingarten, *Report from Colorado: The New Commitment Law*, 4 J. PSYCHIAT. & L. 105 (1976). CONNECTICUT: Comment, *The Mentally Ill in Connecticut — A Survey*, 6 CONN. L. REV. 303 (1973-74). DISTRICT OF COLUMBIA: Peele, Chodoff & Taub, *Involuntary Hospitalization and Treatability: Observations from the District of Columbia Experience*, 23 CATH. U. L. REV. 744 (1974). FLORIDA: Deasy & Steele, *Analysis of a State Hospital Population Subject to Release Under Florida Law*, 27 HOSP. & COMMUNITY PSYCHIAT. 42 (1976); Flaschner, *Florida's New Mental Health Law*, 46 FLA. B.J. 344 (1972); Note, *Involuntary Hospitalization of the Mentally Ill Under Florida's Baker Act: Procedural Due Process and The Role of the Attorney*, 26 U. FLA. L. REV. 508 (1974). HAWAII: Wexler, *Comments and Questions About Mental Health in Hawaii*, 13 HAW. B.J. 3 (Winter, 1978). ILLINOIS: Schlensky, *Constitutional Problems with Mental Commitment in Illinois*, 62 ILL. B.J. 552 (1974); Comment, *Mental Health — Clarifying Statutory and Constitutional Guidelines for Involuntary Civil Commitment Procedure Under the Illinois Mental Health Code*, 6 LOY. CHI. L.J. 208 (1975). IOWA: Bezanson, *Involuntary Treatment of the Mentally Ill in Iowa: The 1975 Legislation*, 61 IOWA L. REV. 261 (1975); Contemporary Studies Project: *Facts and Fallacies About Iowa Civil Commitment*, 55 IOWA L. REV. 895 (1970); Note, *Due Process Deficiencies in Iowa's Civil Commitment Procedure*, 64 IOWA L. REV. 65 (1978). KENTUCKY: Note, *Civil Commitment of the Mentally Ill in Kentucky*, 62 KY. L.J. 769 (1974). LOUISIANA: Comment, *Civil Commitment Procedure in Louisiana*, 31 LA. L. REV. 149 (1970); Comment, *The Louisiana Mental Health Law of 1977: An Analysis and a Critique*, 52 TUL. L. REV. 542 (1978). MASSACHUSETTS: Flaschner, *The New Massachusetts Mental Health Code — A "Magna Carta" or a Magna Maze?*, 56 MASS. L.Q. 49 (1971); Joorst & McGarry, *Massachusetts Mental Health Code: Promise and Performance*, 60 A.B.A.J. 95 (1975); McGarry, *Massachusetts' New Mental Health Act: Process & Performance*, MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 179 (F. Ayd ed. 1974); Walker, *Mental Health Law Reform in Massachusetts*, 53 B.U.L. REV. 986 (1973). MICHIGAN: Morris & Luby, *Civil Commitment in a Suburban County: An Investigation by Law Students*, 13 SANTA CLARA LAW. 518 (1973); Note, *Michigan's Revised Mental Health Code*, 9 U. MICH. J.L. REF. 620 (1976); Note, *Language of Involuntary Mental Hospitalizations: A Study in Sound and Fury*, 4 U. MICH. J.L. REF. 195 (1970); Comment, *Problems of Chapters 4, 5, & 8 of the New Michigan Mental Health Code*, 1975 DET. C.L. REV. 229. MISSOURI: Note, *Missouri's New Mental Health Act: The Problems With Progress*, 1979 WASH. U.L.Q. 209; Comment, *Legal Fiction, Misguided Paternalism, and Unfounded Prediction: Standards for Involuntary Civil Commitment in Missouri*, 20 St. Louis U.L.J. 120 (1975). MONTANA: Note, *Involuntary Commitment of the Mentally Ill*, 38 MONT. L. REV. 307 (1977). NEBRASKA: Hagel, *Defending the Mentally Ill: A Discussion of Nebraska's Involuntary Commitment Proceedings*, 57 NEB. L. REV. 1 (1978); Levie, *The New Mental Health Commitment Act: How Does It Work?*, 62 NEB. MED. J. 196 (June, 1977); Peters, et al, *Administrative Civil Commitment: The Ins and Outs of the Nebraska System*, 9 CREIGHTON L. REV. 266 (1975); Peters, et al, *Administrative Civil Commitment: The Nebraska Experience and Legislative*

Reform Under the Nebraska Mental Health Commitment Act of 1976, 10 CREIGHTON L. REV. 243 (1976); Comment, *Civil Commitment: The Nebraska Substantive Standard*, 7 CREIGHTON L. REV. 265 (1974). NEW MEXICO: Note, *Constitutional Problems of Civil Commitment Procedures in New Mexico*, 6 N.M.L. REV. 113 (1976). NEW YORK: J. ZUSMAN & W. CARNAHAN, *MENTAL HEALTH: NEW YORK LAW AND PRACTICE* (2 Vols.) (1975); Dawidoff, *Commitment of the Mentally Ill in New York: Some Comments and Suggestions*, 3 J. PSYCHIAT. & L. 79 (1975); Faust, *New Mental Hygiene Law of New York: A Recodification*, 19 N.Y.L.F. 83 (1973). NORTH CAROLINA: Hiday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom*, 11 LAW & SOC'Y REV. 651 (1977); Note, *North Carolina's New Mental Health Laws: More Due Process*, 52 N.C. L. REV. 589 (1974). NORTH DAKOTA: Lockney, *Constitutional Problems With Civil Commitment of the Mentally Ill in North Dakota*, 52 N.D.L. REV. 83 (1975). OHIO: Dewey, *Imprisonment of the Mentally Ill: An Inquiry into the Deprivation of Civil Liberties Under Ohio Laws and Procedures*, 1 CAP. U.L. REV. 1 (1972); Comment, *The New Ohio Mental Health Act*, 11 AKRON L. REV. 104 (1977); Comment, *Reforming the Mental Health Law of Ohio*, 7 AKRON L. REV. 475 (1974). OKLAHOMA: McDougal, *Mental Health Laws in Oklahoma: Who Needs Commitment?*, 13 TULSA L.J. 258 (1977). OREGON: Kirkpatrick, *Oregon's New Mental Health Commitment Statute: The Expanded Responsibilities of Courts and Counsel*, 53 OR. L. REV. 245 (1974); Mutnick & Lazar, *A Practical Guide to Involuntary Commitment Proceedings*, 11 WILLAMETTE L.J. 315 (1975); Comment, *Involuntary Civil Commitment in Oregon*, 9 WILLAMETTE L.J. 63 (1973). PENNSYLVANIA: Belsky, *Pennsylvania's New Mental Health Law*, 48 PA. B.A.Q. 482 (1977); Meisel, *Pennsylvania Civil Commitment Procedures: A Practical Guide*, 77(3) PA. MED. 47 (1974); Note, *Pennsylvania's Mental Health Procedures Act*, 15 DUQ. L. REV. 669 (1978); Note, *Gates of Cerberus: Involuntary Civil Commitment in Philadelphia*, 49 TEMP. L.Q. 323 (1976); Note, *Standards for Involuntary Civil Commitment in Pennsylvania*, 38 U. PITT. L. REV. 535 (1977); Note, *Revising Pennsylvania's Involuntary Civil Commitment Statute*, 37 U. PITT. L. REV. 180 (1975); Comment, *Pennsylvania's Commitment: The Mental Health Procedures Act*, 50 TEMP. L.Q. 1035 (1977); Comment, *Involuntary Civil Commitment and the Right to Treatment in Pennsylvania*, 15 VILL. L. REV. 951 (1970). SOUTH DAKOTA: Note, *Involuntary Civil Commitment in South Dakota: A Step Closer to Constitutional Legitimacy*, 19 S.D.L. REV. 447 (1974); Note, *Involuntary Civil Commitment of the Nondangerous Mentally Ill: Substantive Limitations*, 18 S.D.L. REV. 407 (1973). TENNESSEE: Brenner, *Commitment Procedures: 1975 Amendments*, 68 J. TENN. MED. A. 630 (1975); Note, *Civil Commitment in Tennessee — What Process is Due?*, 8 MEM. ST. U.L. REV. 135 (1977); Comment, *Constitutional — Right to Liberty — Involuntary Confinement of Mental Patients*, 43 TENN. L. REV. 366 (1976). TEXAS: Note, *Texas Involuntary Commitment Laws — Unconstitutional?*, 25 BAYLOR L. REV. 273 (1973); Note, *Involuntary Commitment in Texas*, 14 HOUS. L. REV. 474 (1977); Comment, *Civil Commitment in Texas — An Illusion of Due Process*, 8 ST. MARY'S L.J. 486 (1976). VIRGINIA: Note, *Involuntary Civil Commitment in Virginia: A Constitutional Perspective*, 30 WASH. & LEE L. REV. 646 (1973). WASHINGTON: Note, *Striking a Balance Between Liberty and Health: The Washington Mental Health Act*, 11 GONZAGA L. REV. 720 (1976); Comment, *Progress in Involuntary Commitment*, 49 WASH. L. REV. 617 (1974). WISCONSIN: Dix, *Hospitalization of the Mentally Ill in Wisconsin: A Need for Re-Examination*, 51 MARQ. L. REV. 1 (1967); Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 WIS. L. REV. 503.

the civil commitment process can be attributed to both social and legal factors, including the tendency to ignore complex social problems. For years, the mentally ill were warehoused in geographically remote state mental institutions, in part, to isolate and distance ourselves from social "undesirables." The tendency to hide the problem of the mentally ill is also reflected in the legal process. Civil commitment proceedings and records are not open to public scrutiny.¹⁰ Of even greater significance is the fact that civil commitment hearings are held without juries.¹¹

In order to provide a factual framework in which to analyze the role of the lawyer, the Appendix contains transcripts of three civil commitment hearings. The hearings reported in the Appendix and those observed by other legal commentators demonstrate that assigned counsel frequently serve as a "legitimizing force" in the commitment process. Attorneys often do little more than insure that the legal proceedings satisfy statutory and constitutional requirements. Few attorneys understand the nature of mental illness, the social, political, and psychological issues which are raised by "labeling" an individual mentally ill.¹² It is with these issues in mind that this article suggests a more active role for the lawyer in

¹⁰ The West Virginia Code provides that "[t]he circuit court or mental hygiene commissioner shall hear evidence from all interested parties in chamber" W. VA. CODE § 27-5-4(i)(1) (Cum. Supp. 1979).

The statute also provides that:

[t]he written application, certificate, affidavit and any warrants issued pursuant thereto, including any papers and documents related thereto filed with any circuit court or mental hygiene commissioner for the involuntary hospitalization of any individual shall not be open to inspection by any person other than the individual, except upon authorization of the individual or his legal representative or by order of the circuit court and such records shall not be published except upon the authorization of the individual or his legal representative.

W. VA. CODE § 27-5-4(c)(3) (Cum. Supp. 1979).

¹¹ The West Virginia Mentally Ill Persons Act makes no reference to the right to have a jury make the determination that an individual should be involuntarily committed to a mental institution and, consequently, civil commitment hearings in West Virginia are heard by either a circuit judge or a mental hygiene commissioner. See text accompanying notes 60-64, *infra*. The West Virginia Supreme Court of Appeals has recently ruled that state and federal due process requirements do not mandate jury trials in civil commitment proceedings. *Markey v. Wachtel*, No. 144-79 (filed Dec. 11, 1979), ___ S.E.2d ___ (W. Va. 1979).

¹² For an introduction to the "labeling theory" of mental illness, see LABELING MADNESS (T. Scheff ed. 1975).

the civil commitment hearing and a more vigorous defense for the mentally ill client.

The decision to confine the mentally ill against their will is not an isolated act solely dependent upon the family and a consenting psychiatrist. The determination to confine a person for the protection of society or from harm that the person might cause himself or herself should be considered in a broader social, political, historical,¹³ and legal context. While a complete socio-political-historical perspective is beyond the scope of this article,^{13.1} a brief sketch

¹³ See N. DAIN, CONCEPTS OF INSANITY IN THE UNITED STATES 1789-1865 (1964); A. DEUTSCH, THE MENTALLY ILL IN AMERICA (2d ed. 1949); M. FOUCAULT, MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN AN AGE OF REASON (1973); G. GROB, MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875 (1973); G. ROSEN, MADNESS IN SOCIETY (1968); D. ROTHMAN, THE DISCOVERY OF THE ASYLUM (1971); V. SKULTANS, MADNESS AND MORALS: IDEAS OF INSANITY IN THE NINETEENTH CENTURY (1975); THE AGE OF MADNESS: THE HISTORY OF INVOLUNTARY HOSPITALIZATION (T. Szasz ed. 1973); Dershowitz, *The Origins of Preventive Confinement in Anglo-American Law — Part II, The American Experience*, 43 U. CIN. L. REV. 781 (1974).

^{13.1} The work of Dr. Thomas Szasz has been perhaps the most influential (especially in the legal community) in bringing about a critical scrutiny of institutional psychiatry and the social and legally approved practice of confining the mentally ill against their will.

Szasz's overall impact on involuntary institutionalization is unclear. His work parallels a decade of fundamental change in the era of massive state institutions. The decade was characterized by activism committed to "the sanctity of the individual, the absolute priority of the needs of minorities and the poor, and a distrust of institutional ways of dealing with social issues." Miller, *The "Right to Treatment": Can the Courts Rehabilitate and Cure?*, 46 PUB. INTEREST 96 (1977).

Dr. Szasz's charge to the legal profession during this period of extensive institutionalization was to "cease all further collaboration with agencies or institutions entrusted with the drafting or enforcement of mental health law . . ." Szasz, *A Psychiatrist Views Mental Health Legislation*, 9 WASHBURN L.J. 224, 225 (1970). The anomaly in Szasz's position is that he also viewed the usual efforts at mental health law reform as useless and harmful. *Id.* at 224. This position was based on the view that involuntary mental hospitalization is a form of slavery and should be abolished. Szasz finds no situations and no circumstances which would justify involuntary confinement. *Id.* at 234. "It is an unqualified moral evil." *Id.* at 236.

Szasz's views have been spelled out in numerous law review articles, books, and in psychiatric literature. In the legal literature, see Szasz, *The Danger of Coercive Psychiatry*, 61 A.B.A.J. 1246 (1975); Szasz, *The Sane Slave: Social Control and Legal Psychiatry*, 10 AM. CRIM. L. REV. 337 (1972); Szasz, *Hospital Refusal to Release Mental Patient*, 9 CLEV.-MAR. L. REV. 220 (1960); Szasz, *The Control of Conduct: Authority vs. Autonomy*, 11 CRIM. L. BULL. 617 (1975); Szasz, *The Right to Health*, 57 GEO. L.J. 734 (1969); Szasz, *Medicine & Madness*, 3 J. PSYCHIAT. & L. 215 (1975); Szasz, *The Child As Involuntary Mental Patient: The Threat of Child Therapy to the Child's Dignity, Privacy and Self-Esteem*, 14 SAN DIEGO L. REV.

of the history of institutionalization of the mentally ill will provide the attorney with a point of departure for further study.

AN HISTORICAL PERSPECTIVE: THE EARLY YEARS

Mental illness was not viewed as a critical social problem in the eighteenth and early nineteenth centuries. David Rothman, in his book, *The Discovery of the Asylum*, argues that insanity, during the colonial period, was treated no differently from other forms of disability and social deviance. The mentally ill were simply viewed as needy persons who were dependent upon the community for care¹⁴ and there was little or no systematic effort to isolate the mentally ill from the community.¹⁵ Much of the colonial legislation

1005 (1977); Szasz, *From Contract to Status Via Psychiatry*, 13 SANTA CLARA LAW, 537 (1973); Szasz, *Involuntary Psychiatry*, 45 U. CIN. L. REV. 347 (1976).

Dr. Szasz's views are expounded in their most comprehensive form in his various books. *E.g.*, THE THEOLOGY OF MEDICINE (1977); PSYCHIATRIC JUSTICE (1965); LAW, LIBERTY, AND PSYCHIATRY (1963); THE MYTH OF MENTAL ILLNESS (1961). It should come as little surprise that the views of Dr. Szasz have generated considerable debate, especially within the psychiatric profession. The real anomaly is that Dr. Szasz is a practicing psychoanalyst, a fact that many of his critics would like to overlook. He has become the *bete noir* of the psychiatric profession. The body of literature in response to Szasz is substantial and no attempt will be made here to list it all. The following is a representative sampling. Begelman, *A Taste of Honey: Dr. Guttmacher on Dr. Szasz*, 18 PSYCH. REP. 531 (April, 1966); Grenander, *Thomas Szasz and the Right to Choose*, 2 CIV. LIB. REV. 130 (Spring, 1975); Guttmacher, *Critique of Views of Thomas Szasz on Legal Psychiatry*, 10 ARCH. GEN. PSYCHIAT. 238 (1964); Kubie, *The Myths of Thomas Szasz*, 38 BULL. MENNINGER CLINIC 497 (1974); Robitscher, *Controversial Crusades*, 4 MED. OP. & REV. 188 (1968); Robitscher, *The Impact of New Legal Standards on Psychiatry or Who are David Bazelon and Thomas Szasz and Why Are They Saying Such Terrible Things About Us? or Authoritarianism Versus Nihilism in Legal Psychiatry*, 3 J. PSYCHIAT. & L. 151 (1975); Schoenfeld, *An Analysis of the Views of Thomas Szasz*, 4 J. PSYCHIAT. & L. 245 (1976); Schur, *Psychiatrist Under Attack: The Rebellious Szasz*, 217 ATLANTIC MONTHLY 72 (June, 1966); Slovenko, *Civil Commitment in Perspective*, 20 J. PUB. L. 3 (1971); Stone, *Hanging the Psychiatrists*, 62 A.B.A.J. 773 (1976); Stone, *Law, Property & Liberty: A Polemic That Fails*, 42 AM. J. ORTHOPSYCHIAT. 627 (1972); Stone, *Psychiatry Kills: A Critical Evaluation of Dr. Thomas Szasz*, J. PSYCHIAT. & L. 23 (1973); Goldberg, Book Review, 50 A.B.A.J. 1073 (1964); Morris, Book Review, 18 U.C.L.A. L. REV. 1164 (1971).

¹⁴ D. ROTHMAN, THE DISCOVERY OF THE ASYLUM 4, 130 (1971). "The insane received public attention and sympathy as one group among the poor whose incapacitating ailment made them permanently dependent upon relatives or upon the community. But the biological or social agents of mental disease and the precise nature of the affliction prompted little reflection." *Id.* at 109.

¹⁵ The failure to segregate the mentally ill from the community at large is not

applicable to the mentally ill dealt primarily with those who interfered with or could not or would not contribute to the survival task of society. "Since illness and dependency were intimately related, the care of the mentally ill usually came under the jurisdiction of the local community as a result of the poor laws."¹⁶ The colonial laws applicable to the insane dealt with their property rather than any notion of treatment.¹⁷ For example, Massachusetts Province adopted a legal code in 1641 which made reference to "distracted" persons and idiots and provided for a "General Court" to validate the transfer of property from the control of such persons.¹⁸ One writer, Gerald Grob, reports that:

By 1676 the General Court noting the rise in the number of 'distracted persons' and the problems stemming from their behavior, ordered town selectmen to care for such persons so that 'they do not Damnify others.' Selectmen were also empowered to manage the estates of such individuals and to pay all expenses incurred from the property owned by them.¹⁹

* * * *

By the end of the eighteenth century another law authorized commitment to a house of correction of any person "[l]unatic and so furiously mad as to render it dangerous to the peace or safety of the good people, for such lunatic person to go at large."²⁰

The essential purpose of these early laws was to authorize community care for the assets and physical persons of those unable to care for themselves. "Provision was made for guardianship, for the support of the indigent insane, and, somewhat later, for the confinement of those regarded as a threat to the well-being of the community."²¹

It is significant that "[v]irtually none of the legislation enacted by colonial legislatures referred to the medical treatment of

surprising since "there is no reason for believing that the condition of the insane was appreciably worse than that of other dependent groups within colonial society." G. GROB, *MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875*, at 12 (1973).

¹⁶ *Id.* at 8.

¹⁷ Justice Neely finds the historical roots of *parens patriae*, the doctrine which underlies state intervention to care and treat the mentally ill, in efforts at protecting the property of the mentally ill. *Hawks v. Lararo*, 202 S.E.2d 109 (W. Va. 1974).

¹⁸ GROB, *supra* note 15, at 8.

¹⁹ *Id.*

²⁰ *Id.* at 9.

²¹ *Id.* at 10.

the insane; it emphasized mainly the social and economic side of mental illness."²² The care of the mentally ill prior to the nineteenth century did not reflect widespread public concern with the problems growing out of insanity. The community became involved only when an individual seemed to threaten public safety or had no means of support.

By the Jacksonian era (1830's), the view of insanity had changed. While the colonists "had assumed that its cause, like that of other diseases, rested with God's will . . . ,"²³ social activists, psychiatrists,²⁴ general practitioners, and asylum administrators²⁵ insisted that insanity was curable and the asylum was the means by which the cure could be effected.²⁶ During the 1830's, 1840's, and 1850's, the institutionalization of the insane became a standard practice as the states began to construct asylums.²⁷ By 1860, twenty-eight of the thirty-three then existing states had built public institutions for the mentally ill.²⁸ As David Rothman puts it, "[a] cult of asylum swept the country."²⁹

Insanity in this period was no longer viewed as God's will but a result of social chaos and disorder. "The style of life in the new republic seemed willfully designed to produce mental illness. Everywhere they looked, they found chaos and disorder, a lack of fixity and stability. The community's inherited traditions and procedures were dissolving, leaving incredible stresses and

²² *Id.*

²³ ROTHMAN, *supra* note 14, at 109.

²⁴ "Although psychiatrists preferred to conceive of the mental hospital as a strictly medical institution, their analysis of the nature and etiology of mental illness and their modes of care and treatment were not far removed from the values of American society." GROB, *supra* note 15, at 133.

²⁵ Asylum administrators or "medical superintendents," as David Rothman refers to them, tended "to come from the ranks of socially concerned physicians." GROB, *supra* note 15, at 134. On the professionalization of mental hospital superintendents and the ideology of this professional group, *see id.* at 134-50.

²⁶ ROTHMAN, *supra* note 14, at 131.

²⁷ *Id.* at 130.

²⁸ *Id.*

²⁹ *Id.* It should be noted here that, as in colonial times, the issue of the care and treatment of the insane was usually raised within the framework of welfare and dependency. The establishment of mental hospitals, therefore, was but one phase of the larger thrust toward the creation of public structures for dependent groups." GROB, *supra* note 15, at 85. *See, Symposium: Mentally Retarded People and the Law*, 31 STAN. L. REV. 541 (1979).

strains."³⁰ From this view of society, the psychiatrist "linked mental illness to social organization."³¹ Logically, the first step in the cure of insanity which results from social disorganization is to remove the "distracted individual" from society. The removal was accomplished by literally segregating both the insane individual and the institution from the community.³² What better way to restore a disordered mind than to isolate the individual from the source of the illness and society — in an institution with a country location and a "tranquil, natural, and rural" scene.³³

To expedite this process:

Medical superintendents were also eager to have commitment laws as simple and as uncomplicated as possible. Most superintendents preferred to allow relatives to bring the patients directly to the institution and arrange for commitment on the spot; only a few believed that prior judicial examination or jury decisions were necessary. The managers of the Utiça asylum, for example, objected strenuously to legal formalities in its incorporation act that made the certification of insanity under oath by two 'respectable physicians' a prerequisite for admission.³⁴

David Rothman describes the rationale for this attitude as follows:

Confinement, . . . [the medical superintendents] believed was not a punishment but a cure, and hence there was little cause to begin a legal proceeding before the insane entered an asylum as there was to require it for persons going to any other type of hospital. Furthermore, they found no need to rely upon legal processes when they themselves could easily differentiate between sanity and insanity and every cumbersome requirement might discourage someone from sending a patient to the asylum, a risk which medical superintendents wanted to minimize. Finally, judicial routines too often consumed valuable time, and the longer the delay in admissions, the less the likelihood of a cure These objections were generally persuasive. Managers were comparatively free to confine the mentally ill at their own discretion.³⁵

³⁰ ROTHMAN, *supra* note 14, at 114.

³¹ *Id.* at 125.

³² *Id.* at 137-38.

³³ *Id.* at 138.

³⁴ *Id.* at 143.

³⁵ *Id.* at 144.

The ideals reflected in the "cult of the asylum" were soon undermined. Superintendents, in many cases, were unable to control the admission and discharge of patients³⁶ and the institutions "found that a significant part of their capacity was being devoted to providing custodial care for chronic patients whose chances for recovery seemed at best remote."³⁷ The legal system contributed to the problem. "Commitment and discharge laws forced asylums to accept the types of disorder that the community considered particularly troublesome. Alcoholics, the criminally insane, epileptics, and the mentally retarded poured into hospitals and became chronic patients. Superintendents were forbidden to discharge such court-referred cases if they might still menace the community."³⁸ With little planning and no hope of "curing" their wards, mental institutions took on increasing numbers and built larger physical plants to accommodate them. Superintendents failed "to communicate their plight to the courts and to stem the flow of cases"³⁹ or to carry out therapeutic objectives.⁴⁰ The presence of larger hospitals tended "to accelerate the thrust toward greater reliance on institutional care of the mentally ill, which in turn increased the demand for more facilities. The result was a constant cycle of growth that resulted in larger and larger institutions"⁴¹

The mental health system of the mid-nineteenth century, characterized by large isolated institutions, filled with chronic patients from families unable to cope with the "crazy," disruptive behavior of one of its members, was a function not only of social factors but also of legal commitment procedures which made it

³⁶ *Id.* at 186-96; R. CAPLAN, *PSYCHIATRY AND THE COMMUNITY IN NINETEENTH-CENTURY AMERICA* 65-69 (1969).

³⁷ GROB, *supra* note 15, at 187.

³⁸ CAPLAN, *supra* note 36, at 68. GROB, *supra* note 15, at 193.

³⁹ CAPLAN, *supra* note 36, at 68.

⁴⁰ GROB, *supra* note 15, at 191, 202-04, 219, 306-07, 340.

⁴¹ *Id.* at 191.

The reasons for this situation were not difficult to understand. The existence of an alternative to family care of confinement in an almshouse or jail, a growing social acceptance of institutionalization, the increase in population and the migration to the United States of impoverished groups who used hospitals with a far greater frequency than native groups all combined to increase sharply the pressure on the hospital to accept more patients.

Id. at 192.

easy for the system to function.⁴² “[T]herapeutic concerns were slowly being pushed into the background. Over a period of time psychiatry began to lose the charismatic aura of its early years and became endowed with some of the qualities often associated with managerial occupations — order, regularity, efficiency, rationality.”⁴³

During the 1850’s there was evidence of growing public concern over the failure of mental institutions to solve the problem of insanity. The hospitals themselves came under attack.⁴⁴ As early as the 1850’s, the complaints of illegal commitments resulted in a campaign to secure laws to limit the authority of hospital superintendents and to guard patient rights. “Throughout the 1860’s and 1870’s the furor over the alleged abuses of the rights of the insane continued unabated.”⁴⁵

In 1867, Illinois passed a “Personal Liberty Law” and other states followed with similar legislation requiring a jury trial before a patient could be admitted to an asylum.⁴⁶ In 1872, Iowa passed a law requiring a jury trial and provided that patients have “complete freedom to write to whomever they desired and which forbade the superintendent or staff to open and to censor mail.”⁴⁷

The period of 1860-1900 saw the appearance of new mental hospitals,⁴⁸ the growth of existing ones, and a growing controversy over commitment itself. West Virginia opened its first asylum, West Virginia Hospital for the Insane, in 1864. In less than ten years, the new hospital grew from an average patient population of forty in 1865, to 350 in 1875.

The majority of states did not have explicit commitment laws

⁴² “The number and type of patients, the time spent in the hospital, and the quality of care were all dependent to a significant degree upon the framework established by law.” *Id.* at 194.

⁴³ *Id.* at 205.

⁴⁴ *Id.* at 263-69.

⁴⁵ The furor resulted in a number of court cases by patients and their relatives against asylums. CAPLAN, *supra* note 36, at 190-91.

⁴⁶ *Id.* at 191.

⁴⁷ GROB, *supra* note 15, at 267. Similar legislation was passed in Massachusetts in 1874. CAPLAN, *supra* note 36, at 233-34.

⁴⁸ “Between 1870 and 1880 nearly thirty new institutions were opened For the remainder of the nineteenth century, the movement to expand public facilities continued unabated; not until the twentieth century was there a clear diminution in the opening of new hospitals.” GROB, *supra* note 15, at 303.

for the mentally ill "because the insane had traditionally been secreted away by families, or had been confined in prisons and poorhouses under other legal provisions. In time, however, this vagueness became dangerous, both to those who might easily be unjustly deprived of their freedom and to asylums receiving patients in good faith, but later accused of malpractice."⁴⁹ "By the late 1870's and 1880's, criticism of asylums had become organized and powerful. Reform societies included many professionals and intellectuals, philanthropic businessmen, lawyers, clergymen, and medical practitioners"⁵⁰

The legal control over confinement varied from state to state. Some of the early commitment laws (prior to 1875) allowed commitment on the basis of certification by two physicians. In Massachusetts, the law required, in addition, "an affidavit of some authoritative person of good character, usually the trustee of an asylum."⁵¹ In 1890, New York enacted a commitment law which required a judicial order and "a certificate of lunacy signed by two qualified examiners in lunacy."⁵² The patient could appeal from the order and demand a jury trial. One commentator, in reviewing this period, finds that "[i]n retrospect, the commitment law movement, and particularly the emphasis given jury trials, seems to have been a hysterical reaction to a more serious but unresolved set of problems: the shortage of mental health treatment facilities and the lack of sophistication in technique, accompanied by public horror of mental illness."⁵³

A BRIEF DESCRIPTION OF WEST VIRGINIA CIVIL COMMITMENT PROCEDURES

Voluntary Admissions

In West Virginia there are two types of patients covered by the Mentally Ill Persons statute — voluntary and involuntary patients. The West Virginia Code authorizes mental health facilities to admit "for diagnosis, care and treatment" those patients who apply for hospitalization.⁵⁴ Today, the number of voluntary pa-

⁴⁹ CAPLAN, *supra* note 36, at 194.

⁵⁰ *Id.* at 199. *See generally id.* at 199-211.

⁵¹ *Id.* at 194.

⁵² *Id.* at 242.

⁵³ R. ROCK, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 17 (1968).

⁵⁴ W. VA. CODE § 27-4-1(c) (Cum. Supp. 1979); W. VA. CODE § 27-4-1(b) (Cum. Supp. 1979).

tients substantially exceeds those who are committed involuntarily. There is no requirement for any type of judicial hearing prior to a voluntary admission and, consequently, legal control on the admission of such individuals has been historically non-existent.

The voluntary admission of children to state mental institutions without judicial supervision was recently challenged in a case decided by the United States Supreme Court. In *Parham v. J.R.*, 99 S. Ct. 2493, 2503 (1979), the Court found that children have "a substantial liberty interest in not being confined unnecessarily for medical treatment . . ." This liberty interest is protected by the due process standards of the Constitution. However, in deciding what process is due, the second level of inquiry, the Court is unwilling to mandate a full-dress judicial review of the parental and institutional decision to commit the child. Rather, the Court will, in this case, require only an inquiry by a "neutral factfinder." *Id.* at 2506. The Court goes on to suggest that the review by the staff psychiatrist which determines whether commitment is appropriate is sufficient to protect the constitutional liberty interest of the child. *Id.* at 2506-07. See also *Secretary of Public Welfare v. Institutionalized Juveniles*, 99 S. Ct. 2523 (1979) (decided with *Parham*, upholding the Pennsylvania statute governing voluntary commitment of mentally ill juveniles).

For a review of the issues in the commitment of children, see generally Beyer & Wilson, *The Reluctant Volunteer: A Child's Right to Resist Commitment*, in CHILDREN'S RIGHTS AND THE MENTAL HEALTH PROFESSIONS 133-48 (G. Koocher ed. 1976); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840 (1974); Meisel & Roth, *The Child's Right to Object to Hospitalization: Some Empirical Data*, 4 J. PSYCHIAT. & L. 377 (1976); Panneton, *Children, Commitment & Consent: A Constitutional Crisis*, 10 FAM. L.Q. 295 (1976); Rolfe & MacClintock, *The Due Process Rights of Minors Voluntarily Admitted to Mental Institutions*, 4 J. PSYCHIAT. & L. 333 (1976); Szasz, *The Child as Involuntary Mental Patient: The Threat of Child Therapy to the Child's Dignity, Privacy, and Self Esteem*, 14 SAN DIEGO L. REV. 1005 (1977); Note, *Voluntary Admission of Children to Mental Hospitals: A Conflict of Interest Between Parent and Child*, 36 MD. L. REV. 153 (1976); Note, *Minor's Right to Due Process: Does it Extend to Commitment to Mental Institutions?*, 52 NOTRE DAME LAW. 136 (1976); Note, *Due Process Limitations on Parental Rights to Commit Children to Mental Institutions*, 48 U. COLO. L. REV. 235 (1977); Note, *On the Voluntary Admission of Minors*, 8 U. MICH. J.L. REF. 189 (1974); series of articles on *Kremens v. Bartley*, in 27 HOSP. & COMMUNITY PSYCHIAT. 705 (1976).

The legal rights of children in the mental health system is part of a broader problem—of legal rights and children generally. See generally Bersoff, *Developing Legal Theories in Child Advocacy*, 29 CLIN. PSYCH. 20 (1976); Beyer, *Changes in the Parent-Child Legal Relationship: What They Mean to the Clinician and Researcher*, 7 J. AUTISM & CHILDHOOD SCHIZOPHRENIA 84 (1977); Curtis, *The Checkered Career of Parens Patriae: The State as Parent or Tyrant*, 25 DE PAUL L. REV. 895 (1976); Garvey, *Child, Parent, State, and the Due Process Clause: An Essay on the Supreme Court's Recent Work*, 51 S. CAL. L. REV. 769 (1978); Levy, et al, *Symposium: Children's Rights — Psychiatry and the Law*, 3 J. PSYCHIAT. & L. 475 (1975); Rodham, *Children Under the Law*, 43 HARV. EDUC. REV. 487 (1973); Comments, *The Rights of Children: A Trust Model*, 46 FORDHAM L. REV. 669 (1978).

The 1978 amendments to the Mentally Ill Persons provisions of the West Virginia Code, however, substantially changed the legal status of the voluntary patient in West Virginia.

The 1978 amendments impose new requirements on mental health facilities and mental health professionals who evaluate individuals for purposes of voluntary admission to mental health institutions. The most significant feature of the newly enacted procedures for voluntary patients is the requirement that all voluntary patients be given a written statement containing a warning that their voluntary status can be changed and the patient confined involuntarily for an indefinite period of time. The statute specifically requires that the written statement be in "bold print" and disclose that:

- (1) voluntary admission does not mean voluntary release;
- (2) voluntary admission may result in a decision of the mental health facility to subject the patient to a legal proceeding which could result in a legally sanctioned confinement in the mental health facility for an indefinite period of time;
- (3) regardless of the ultimate outcome of the legal decision to commit the individual for an indefinite period, the individual may be held in the mental institution for up to 30 days to facilitate the legal proceedings; and
- (4) the patient is entitled to request release at any time.⁵⁵

The 1978 amendments further extended voluntary patients' legal rights by requiring that they be given written notice of their rights while a patient in the mental health facility.⁵⁶ By statute, this requirement includes the "right to treatment" and civil rights outlined in section 27-5-9 of the old statute. The new amendment makes clear, however, that the written statement of patient rights is not to be limited to the rights presently outlined in section 27-5-9. Consequently, the new amendment requires mental health facilities to ascertain and give written notice to the voluntary patient of any and all rights which are now afforded the patient by virtue of the administrative regulations of the Department of Health and the constitution as interpreted by state and federal courts. The amendment also provides that the name of the mental health personnel who makes the oral and written disclosure to the patient be made a part of the patient's records along with a copy

⁵⁵ W. VA. CODE § 27-4-4 (Cum. Supp. 1979).

⁵⁶ W. VA. CODE § 27-4-4(a) (Cum. Supp. 1979).

of the written and signed patient rights statement.

The 1978 amendments require written consent for "any course of treatment"⁵⁷ provided voluntary in-patients. The new provision further states that: "Such consent shall be revocable at any time and shall not be valid for a period exceeding six months."⁵⁸ This provision means quite simply that the patient may withdraw his or her consent at any time before or during the course of therapy and, secondly, that consent for treatment is valid only for a period of six months. Consequently, during the course of on-going therapy, the mental health professionals will be required to confirm the patient's desire to continue the course of treatment after each six month period.

The provisions should also be interpreted to mean that written consent is required for *each* course of treatment. If the mental health facility proceeds with a course of chemotherapy with consent of the patient and then decides to place the patient in a group for psychotherapy, the patient's written consent for the new therapeutic procedures must be obtained.

To implement the new provisions, each mental health facility is required to designate a staff person as a "voluntary patient coordinator."⁵⁹ The voluntary patient coordinator is responsible for notifying individuals currently in mental health facilities and persons subsequently admitted as voluntary patients of their rights under the new amendments.

Involuntary Admissions

There are essentially three criterion for the involuntary confinement of individuals in West Virginia mental institutions. First, the individual must be shown to be mentally ill, mentally retarded, or an alcohol or narcotics addict. Second, the individual must be likely to cause serious harm to himself or others because of the condition. Finally, there must be no less restrictive alternative than to confine the person in the state mental institution.

In most cases, the *initial* decision as to whether these criteria are met is made by psychiatrists. The statute simply requires that

⁵⁷ W. VA. CODE § 27-4-4(b) (Cum. Supp. 1979).

⁵⁸ *Id.*

⁵⁹ W. VA. CODE § 27-4-4 (Cum. Supp. 1979).

one physician or a psychologist⁶⁰ certify that the individual has been examined, that he or she is mentally ill (or mentally retarded or addicted) and, as a result, is likely to cause serious harm to self or others.⁶¹

The statute provides that the individual must be given a probable cause hearing and have a full trial type hearing completed within thirty days.⁶² The hearing requirement means that the final determination of whether an individual is mentally ill and dangerous lies with the court. In West Virginia the circuit court has jurisdiction over civil commitment hearings but is directed by statute to appoint lawyers, designated as mental hygiene commissioners, to serve as judges in all civil commitment proceedings.⁶³ The statute requires the mental hygiene commissioners to make findings which are set forth in a written report to the circuit court. The mental hygiene commissioner [MHC] is specifically charged with safeguarding the interests of the patient as well as the state.⁶⁴

The probable cause hearing was first mandated by the 1978 amendments to the statute. In the 1978 amendments, the hearing

⁶⁰ On the use of psychologist in civil commitment proceedings, see Miller, Lower, & Bleachmore, *The Clinical Psychologist as an Expert Witness on Questions of Mental Illness and Competency*, 4 LAW & PSYCH. REV. 115 (1978).

⁶¹ W. VA. CODE § 27-5-3(a) (Cum. Supp. 1979).

⁶² *Id.* § 27-5-2(b)(5) (Cum. Supp. 1979) (probable cause hearing).

⁶³ *Id.* § 27-5-1(a) (Cum. Supp. 1979). In West Virginia involuntary civil commitments are generally heard by a Mental Hygiene Commissioner (MHC) appointed by the circuit court of each county. The MHC holds office at the pleasure of the circuit court and "may be removed at any time by the court." W. VA. CODE § 27-5-1(b) (Cum. Supp. 1979). The statute requires that the Mental Hygiene Commissioner "be a person of good moral character, and of standing in his profession" and that he take the oath required of special commissioners. W. VA. CODE § 27-5-1(a) (Cum. Supp. 1979).

The MHC is empowered to issue summons and subpoenas, take sworn testimony, and make appropriate findings of fact and conclusions of law. W. VA. CODE § 27-5-1(b) (Cum. Supp. 1979). The MHC is statutorily charged with safeguarding "at all times the rights and interests of the individual as well as the interests of the State." *Id.*

The findings and legal conclusions of the MHC are reported to, but not binding on, the circuit court, and a final order of commitment is entered by the court. *Id.* Although the findings and conclusions of the MHC are not binding on the circuit court, the statute makes no provision for appeal of the findings of the MHC to the circuit court. Rather, the statute provides for judicial review of only the order of commitment entered by the circuit court which is directed to the West Virginia Supreme Court of Appeals. W. VA. CODE § 27-5-5 (1976 Replacement Vol.).

⁶⁴ W. VA. CODE § 27-5-1(b) (Cum. Supp. 1979).

was to be held within seventy-two hours of admission to the mental health facility.⁶⁵ The statute was again amended in 1979 to remove the seventy-two hour requirement. The present statute sets no specific time within which the probable cause hearing must be held.

The statute sets forth certain rights that the patient has at the preliminary or probable cause hearing. These rights are: the right to be present at the hearing; the right to present evidence; the right to examine testimony offered (this should include the right to cross-examine witnesses for the applicant and to present arguments in opposition to the inference to be drawn from such evidence); the right to remain silent at the hearing;⁶⁶ and the right to

⁶⁵ W. VA. CODE § 27-5-2(a) (Cum. Supp. 1978) (repealed 1979).

⁶⁶ In West Virginia, the individual who is subject to commitment cannot be compelled to testify at either the probable cause hearing, W. VA. CODE § 27-5-2(b)(5) (Cum. Supp. 1979), or the final hearing, W. VA. CODE § 27-5-4(g)(4) (Cum. Supp. 1979). The West Virginia Supreme Court of Appeals has ruled, however, that the privilege is not applicable to the psychiatric interviews conducted prior to the hearings. *Hawks v. Lazaro*, 202 S.E.2d 109 (W. Va. 1974). Other courts have found the Fifth Amendment applicable to the psychiatric interview. *See, e.g., Lessard v. Schmidt*, 349 F. Supp. 1078, 1100 (E.D. Wis. 1972). The chief critic of the *Lessard* decision extending the Fifth Amendment to psychiatric interviews has been Dr. Alan Stone, the current president of the American Psychiatric Association.

Dr. Stone's concern for the implications of the *Lessard* opinion which requires warnings of the effects of incriminating statements to a psychiatrist are well founded, at least from the standpoint of the institutional psychiatrist. Patients who invoke the privilege, remain silent, and refuse to cooperate with the psychiatrist may preclude the possibility of a psychiatric diagnosis. *See A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM* 808 (1974). If the patient does not "tell" on himself or herself, how can the psychiatrist determine the patient's condition? Pragmatic concerns and preserving the involuntary commitment system are also revealed in the *Hawks* decision: "To recognize the same rights against self-incrimination which would be required in a criminal proceeding would make almost any commitment impossible, and would make the procedures so burdensome that medical conclusions obtained through examination . . . would be inadmissible." 202 S.E.2d at 126. Using *parens patriae* grounds, the court justified sacrificing the privilege against incrimination, finding it "unreasonable to hold that the State can never act in the best interest of an individual. There is justification for deviation in the case of emergency procedures where an individual's life may be in jeopardy." *Id.* The court's rationale for not extending the privilege against self-incrimination would apply in a limited number of cases. While a deviation from strict due process might be a basis for disallowing the privilege in some cases, such instances would be few compared to the vast number of involuntary civil commitments. It is simply not the case that all involuntarily civilly committed patients are suicidal or maniacal and bent on total destruction of them-

have the preliminary hearing conducted by rules of evidence.⁶⁷ The anomaly in this section of the statute is that no reference is made to the patient's right to counsel. The 1978 amendments specifically provided that the patient was to be appointed counsel twelve hours prior to the hearing. It is unclear whether the legislature intended to remove the patient's right to counsel in the 1979 amendments and whether an effort to deny counsel at the probable cause hearing would be constitutional.⁶⁸ Regardless of whether the constitution mandates a right to counsel, it can be argued that no change was actually intended. First, while there is no specific provision for appointment of counsel, the statute does contain reference to counsel. The statute states that: "If requested by the individual or his counsel, the hearing may be postponed for a period not to exceed forty-eight hours."⁶⁹ More significant than this oblique reference to counsel is the fact that the other rights afforded the patient require the presence of counsel. It would be meaningless to afford a patient the right to present testimony, cross-examine witnesses and have the hearing governed by the rules of evidence unless a lawyer was present to insure that the rights were exercised.

The Rights of Mental Patients

The courts⁷⁰ and state legislatures are now moving to recognize greater patient rights⁷¹ by imposing limitations on the discretion

selves or others. Thus, to reach the few truly dangerous mentally ill, the court refuses to extend a basic constitutional right to a substantially larger class. On the legal and psychiatric issues raised by the application of the Fifth Amendment to civil commitment hearings, see Aronson, *Should the Privilege Against Self-Incrimination Apply to Compelled Psychiatric Examinations?*, 26 STAN. L. REV. 55 (1973); Fielding, *Compulsory Psychiatric Examination in Civil Commitment and Self-Incrimination*, 9 GONZ. L. REV. 117 (1973); Note, *Application of the Fifth Amendment Privilege Against Self-Incrimination to the Civil Commitment Proceeding*, 1973 DUKE L.J. 729.

⁶⁷ W. VA. CODE § 27-5-2(b)(5) (Cum. Supp. 1979).

⁶⁸ See note 2, *supra*.

⁶⁹ W. VA. CODE § 27-5-2(b)(5) (Cum. Supp. 1979).

⁷⁰ Courts are now generally viewed as the writing edge of social reform, and this is certainly true in the mental health field. One observer states that "[j]udicial activism has taken over the field of psychiatric reform." Robitscher, *Implementing the Rights of the Mentally Disabled: Judicial, Legislative and Psychiatric Action*, in MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 142, 151 (F. Ayd ed. 1974).

⁷¹ For a summary of patient's rights, see B. ENNIS & L. SIEGEL, *THE RIGHTS OF MENTAL PATIENTS* (1973). *But see* note 1, *supra*.

of mental health professionals. The necessity of greater procedural safeguards has been urged to prevent deprivations of liberty by involuntary confinement based on subjective psychiatric and medical decisionmaking. The prevailing trend in the states is to require not only a finding of mental illness but also the likelihood that the mentally ill person will be harmful to self or others if he or she is not institutionalized.⁷² The trend in the current legal reform of state mental health codes is primarily towards requiring more objective indices of harm as a precondition to involuntary confinement. This trend is evidence of a partial rejection of the medical model under which treatment is involuntarily imposed for the good of the patient based on the patient's inability to make rational decisions. The statutory requirement that individuals be harmful as well as mentally ill has reduced the number of individuals subject to involuntary hospitalization on the basis that they need care and treatment. West Virginia has followed this trend.⁷³

⁷² By one count, 44 states utilize the dangerousness criteria for civil commitment. Albers, Pasewark & Meyer, *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 CAP. U.L. REV. 11, 22 (1976).

The Supreme Court in *O'Connor v. Donaldson*, 422 U.S. 563 (1975), expressly declined to decide whether dangerousness is a specific requirement for confinement. One of the federal courts has noted that while the Supreme Court "did not directly address itself to the degree of dangerousness that is constitutionally required before a person may be involuntarily deprived of liberty, . . . its approval of a requirement that the potential for doing harm be 'great enough to justify such a massive curtailment of liberty' implies a balancing test in which the state must bear the burden of proving that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others." *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1974). See also *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972). But see *Logan v. Arafeh*, 346 F. Supp. 1265 (D. Conn. 1972), *aff'd*, 411 U.S. 911; *Fhagen v. Miller*, 29 N.Y.2d 348, 350, 278 N.E.2d 615, 617 (1972), *cert. denied*, 409 U.S. 845 (1972).

⁷³ For a comparison of involuntary civil commitment statutes now outdated by statutory changes in the states, see S. BRAKEL & R. ROCK, *THE MENTALLY DISABLED AND THE LAW* (Rev. ed. 1971); B. ENNIS & L. SIEGEL, *THE RIGHTS OF MENTAL PATIENTS* (1973); R. ROCK, M. JACOBSON & R. JANOPAUL, *HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL* (1968); Roth, Dayley & Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 SANTA CLARA LAW. 400, 412-15 (1973). See also: *Hawks v. Lazaro*, 202 S.E.2d 109 (W. Va. 1974); W. Va. Code §§ 27-5-2(a)(2), -3(a), -4(c)(2), -4(d)(1), -4(j)(1) (Cum. Supp. 1979).

DEFINING THE ROLE OF THE ATTORNEY WHO REPRESENTS THE MENTALLY ILL

At the outset, the attorney is presented with a client who has been labeled by important individuals in the community as "mentally ill" or "sick" and in need of treatment. While the process of labeling the client begins with family, friends, or possibly the police, the label must be confirmed by a psychiatrist or psychologist.⁷⁴ The involvement of medical and mental health professionals raises a number of questions. What role will the medical and psychiatric professional play in deciding the fate of the client? How does the defense attorney define the role of such professionals in deciding his client's fate? More importantly, to what extent is the defense lawyer prepared by training and personality to challenge the pronouncements of medical and psychiatric professionals? In essence, how does the attorney view his or her role in the context of other involved professionals?⁷⁵

The attorney's role in representing mental patients can be analyzed from a sociological perspective. The sociologist views "role" as the social expectations of an individual who occupies a certain position and status. One of the most salient characteristics of "role" is that it is external to the individual and reflects a public view of what the individual should do in his position.

The expectations of defense counsel representing a person alleged to be mentally ill and dangerous are now limited because civil commitment hearings are closed to the public,⁷⁶ are of little interest to the legal profession, and are not subject to critical scru-

⁷⁴ The labeling process is a complex one. One commentator has pointed out that the patient's path to the hospital is "determined by a large number of behavioral, familiar, social, and situational variables rather than simply by the patient's symptoms, diagnosis, or degree of distress." Flynn & Henisz, *Criteria for Psychiatric Hospitalization: Experience with a Checklist for Chart Review*, 132 AM. J. PSYCHIAT. 847, 847 (1975). The authors admit, however, that ultimately the decision to hospitalize is based "on the clinical judgment of referring professionals and the admitting hospital clinicians." *Id.*

⁷⁵ The author of a study of the New York Mental Health Information Service found that: "[l]awyers are generally more factually oriented and concerned about unnecessary deprivation of individual liberty, while social workers tend to view their role as that of 'helping' the patient." Gupta, *New York's Mental Health Information Service: An Experiment in Due Process*, 25 RUTGERS L. REV. 405, 442 (1971).

⁷⁶ See note 10 and accompanying text, *supra*.

tiny by patients and their relatives. The only potentially critical observers are the circuit judge, the mental hygiene commissioner, and the opposing counsel.⁷⁷ Typically, the mental hygiene commissioner will have no greater expertise than defense counsel and is, therefore, an unlikely candidate to clearly define defense counsel's role.⁷⁸ Efforts at a more precise role definition have been presented

⁷⁷ Opposing counsel is a prosecuting attorney who appears on behalf of the applicants for involuntary commitment. W. VA. CODE § 27-5-1(c) (Cum. Supp. 1979). See also W. VA. CODE § 27-5-1a (Cum. Supp. 1979).

In West Virginia, the civil commitment hearing is in the format of a traditional adversary hearing with defense counsel opposing a prosecuting attorney before a MHC who is, in effect, a substitute for the circuit judge.

Dr. Alan Stone has criticized civil commitment proceedings where patients are represented by counsel and there is no prosecuting attorney. Stone feels that in the absence of a prosecuting attorney, psychiatrists are placed in the prosecutorial role. Stone, *Recent Mental Health Litigation: A Critical Perspective*, 134 AM. J. PSYCHIAT. 273, 274-75 (1977). The problem with the psychiatrist as prosecutor, Stone finds, is that it is destructive of professional identity. Stone is not clear about how this destructive impact can be avoided where there is a "real" prosecutor and the psychiatrist testifies "against" the patient. Perhaps, the absence of the prosecutor simply reveals the true role of the prosecutor in the involuntary civil commitment process. See T. SZASZ, LAW, LIBERTY AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICE 230 (1963):

We must begin by candidly acknowledging the role of the hospital psychiatrist vis-a-vis his patient. Such a psychiatrist, especially if he works in a state hospital, is not the patient's agent. The law, the mental patient, and the public must cease to look on hospital psychiatrists — and perhaps even current psychiatry as a profession — as the patient's helpers and friends. To be sure, sometimes they *try* to be. But more often they are the patient's adversaries . . .

The relationship between hospital psychiatrist and mental patient is one of oppression disguised as benefaction. The institutional psychiatrist, though not necessarily the patient's enemy, is neither his friend nor his therapist.

⁷⁸ In a study of the systems for providing counsel to indigent mental health patients in Chicago, New York, Cleveland, and Memphis, the authors concluded that "judge and counsel seem to have developed a working relationship in which each appeared to act on a shared conception of the attorney's proper role. Judges did not either exhort counsel to be more active or chastise them for being too aggressive." Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and a Proposal*, 45 MISS. L.J. 43, 74 (1974). The authors point out that the judge may shape the attorney's role through an implicit assumption by the attorney that zealotry is undesirable. *Id.* at 74-75. See also A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 233 (1975).

In a 1977 survey of West Virginia Mental Hygiene Commissioners [hereinafter MHCs] Jerry Dambro, a law student at West Virginia University College of Law, found that over 50% of the Commissioners believed they had either special training

in the legal literature,⁷⁹ but the impact of such academic attempts at preventing deficiencies in role performance is unclear.

In the absence of a clearly defined role, the attorney is often satisfied to "stand by" as the client/patient is civilly committed.⁸⁰ This minimal effort is justified on a number of grounds. First, the attorney may view his or her role as limited to insuring that the patient's statutory and constitutional rights are not violated during the legal process of commitment. The attorney following this view serves simply to insure that required procedures have been followed.⁸¹ With such a view, appointment of counsel has "become a mere procedural ritual which helps to sanctify the judgment of commitment without injecting any substantial protection."⁸²

or other special qualifications for the position. Only one of the MHCs responding had taken a law course directly related to mental health. Of the 22 MHCs responding to the survey, several indicated they had undergraduate majors in psychology, four had been active in local mental health associations, and eight others felt they had special qualifications based on previous appointments as guardian ad litem and board membership of a local mental health center. One had a member of the family who was mentally ill.

Twenty percent of the respondents thought special training would be "very helpful"; 60% felt it would be "somewhat helpful"; the remaining 20% felt it was "not necessary." Significantly, 90% indicated that they would attend a workshop or seminar on civil commitment.

⁷⁹ See note 8, *supra*.

⁸⁰ This observation is based on the author's attendance of involuntary civil commitment hearings in West Virginia. See also Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424 (1966); Wexler & Scoville, *Special Project — The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 51-60 (1971); Note, *Involuntary Hospitalization of the Mentally Ill Under Florida's Baker Act: Procedural Due Process and the Role of the Attorney*, 26 U. FLA. L. REV. 508, 526 (1974).

⁸¹ In general, the procedural view of the lawyer's role can be traced to the "legalism" which pervades the legal profession. See J. SHKLAR, *LEGALISM* (1964).

Certainly, one function of the attorney is to advise the client of procedural aspects of the involuntary commitment hearing. "The attorney should explain how the proceedings will be conducted, the types of questions that will be asked, and describe in detail the setting of the hearing." Nutnick, *A Practical Guide to Involuntary Commitment Proceedings*, 11 WILLAMETTE L.J. 315, 320-21 (1975).

⁸² Brunetti, *supra* note 4, at 707. The role of the lawyer is essentially system maintenance. Playing the role of lawyer by being "present," insuring procedural safeguards (the "legal niceties") while ignoring or remaining oblivious to the simple fact that human beings are being warehoused for social deviance, "is a massive failure and a festering evil." Shaffer, *Introduction*, 13 SANTA CLARA LAW. 369 (1973).

'ndalman and Chambers have suggested that the presence of lawyers and their perfunctory performance serves in many jurisdictions only to "add a falsely reassur-

In the sections which follow, various aspects of legal representation in the civil commitment process are explored and alternatives to the attorney's ritual presence and limited effectiveness in protecting the client against involuntary hospitalization are suggested.

Interviewing the Mental Patient/Client

Interviewing the mental patient/client is a difficult task for the attorney. The client who is disoriented, suffering from thought disorders, hallucinating or delusional is sometimes unable to communicate with the attorney. In such cases, the attorney representing an uncommunicative client (or one whose illness substantially impairs communication) simply cannot rely upon the patient as a source of information.⁸³ While problems in communication are often part of mental illness, such difficulties may be a result of prior institutionalization or because a patient has problems with English.⁸⁴

The patient's inability to communicate does not relieve the attorney of the responsibility of zealously representing the client. The attorney should, if possible, attempt to interview the patient/client on more than one occasion. The ability of the client to communicate may vary over time, in which case multiple interviews will increase the chances of finding the client lucid and communicative. Moreover, if this is not done, the attorney may obtain a distorted view of the patient's condition.⁸⁵ A second interview can also be used to avoid the idiosyncratic effects of medication on the

ing patina of respectability to the proceedings." Andalman & Chambers, *supra* note 8, at 72.

⁸³ *But see* D. VAIL, *DEHUMANIZATION AND THE INSTITUTIONAL CAREER* (1966). The author argues that mental patients are more capable of rational decisions than is commonly thought.

⁸⁴ *See, e.g.*, Case 2 in Appendix.

⁸⁵ The need for multiple interviews is equally applicable to psychiatrists who attempt to use the interview as the basis of a diagnosis of mental illness. The reliability of the psychiatric diagnosis is integrally related to the thoroughness of the psychiatric interviews which lead to the diagnosis. If the psychiatrist testifies that only one interview was conducted, the attorney may seek to discredit such testimony by showing that the patient's condition has changed or that the patient actually suffers from a different condition than that described by the psychiatrist. *See* Spitzer, Endicott & Robins, *Clinical Criteria for Psychiatric Diagnosis and DSM-III*, 132 AM. J. PSYCHIAT. 1187 (1975).

patient.⁸⁶ Regardless of whether a second interview is possible, the attorney should determine from the client and the patient files whether medication has been prescribed and if so, its dosage, purpose, and effects on the patient. Finally, the patient's history of medical drug use and his or her ability and willingness to self-administer prescribed drug medication is of importance.

The patient/client interview should be supplemented with a thorough review of the patient's medical and psychiatric records.⁸⁷ If the client was previously or is currently hospitalized, interviews with the hospital staff, the physicians who admitted the patient, and those who have conducted subsequent examinations are also essential.⁸⁸ Obviously, this review should include an investigation into any previous hospitalization for mental illness.

The main purpose of the interviews and review of patient files is to obtain a realistic view of the patient as a person and the circumstances which have occasioned the civil commitment proceedings.⁸⁹ Who is the patient? What are his or her strengths and

⁸⁶ Client medication, especially tranquilizers, can have a profound influence not only on the attorney-client interview but the commitment hearing itself. See Wexler & Scoville, *Special Project — The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 66-69 (1971).

The goal . . . to achieve for each patient is to strike a balance by administering drugs, if required, to remove psychotic, disabling and disruptive symptoms without impairing the patient's right to converse with his attorney and to carry out his defense effectively. The patient's attorney should play an active part in helping to strike the appropriate balance.

Id. at 68.

⁸⁷ Medical records should be examined for observations and recommendations of physicians and statements made by the client. Where the client's statements appear helpful, as where they indicate a willingness to secure voluntary treatment, or where the physician's observations point to exculpatory behavior, the attorney may wish to highlight such statements and observations . . . Counsel may, however, want to attempt to exclude medical records where they are damaging to the client's prospects for maintaining his or her freedom.

Mutnick & Lazar, *supra* note 8, at 328 n.71. On analyzing a psychiatric report see Rubin, *The Psychiatric Report*, in READINGS IN LAW AND PSYCHIATRY 69 (R. Allen, et al., eds. 1968).

⁸⁸ "The attorney has a responsibility to consult with the examining physician concerning the medical history of the patient, the diagnosis, the proposed [or past] treatment and the prognosis." Wexler & Scoville, *Special Projects—The Administration of Psychiatric Justice: Theory and Practice*, 13 ARIZ. L. REV. 1, 56 (1971).

⁸⁹ "The attorney should work towards an understanding of the events that led

weaknesses in laymen's terms? What particular feature of the patient's behavior seems to be offensive or anxiety provoking? Does the patient have any "insight" into these features of his or her personality and behavior?⁹⁰ By focusing the attention of the hospital staff, social workers, and psychiatrists on such questions, the attorney may find the significant features of the client's mental problem.⁹¹

In the course of the client interview, the attorney should obtain the patient's view of the factors which led to the petition for commitment or the hospital's attempts to continue the confinement. The lawyer has an obligation to investigate any story which the psychiatrist claims is delusional.⁹² Prior to the hearing, the attorney should insure, to the extent possible, that the client has "an understanding of why the hearing is being held to determine his or her mental health, what the consequences of the hearing may be, and what facts caused the person to be taken into custody or a notice of mental illness to be filed."⁹³

These factors are of special importance if the client has not been committed previously. The statutory criteria for commitment

up to and contributed to the filing of the petition. Only in this way can he attempt to develop possible alternatives to hospitalization." Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424, 452 (1966).

⁹⁰ The client's "insight" is significant as it is one element that the psychiatrist uses to determine the degree of mental disorder. For example, "[e]xaminers' reports often contain the statement 'lacks insight into illness,' based on the client's refusal to recognize in himself or herself what the examiner speculates is a mental disorder." Mutnick & Lazar, *supra* note 8, at 324. On the use of "insight" as a factor influencing the psychiatric diagnosis, see Dix, *Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 WASH. U.L.Q. 485, 529.

⁹¹ It is important for the attorney to recognize that the official medical psychiatric view of the client is based on a diagnosis. The client/patient's behavior is then seen within the framework of the diagnosis. Behavior which does not support the diagnosed mental illness is selectively screened out.

⁹² See, e.g., Case 3 in Appendix. The patient's explanation for his hospitalization problems involved an attempt by others to run him out of the garbage collection business, which was labeled as delusional. In fact, the psychiatrist labeled this concern with the garbage business "an isolated delusional system." The defense lawyer assigned to represent the patient failed to investigate the patient's story or to question the psychiatrist as to its potential factual basis. In this case the story would have been difficult to confirm as the patient had been involuntarily confined for 14 years at the time of the hearing.

⁹³ Mutnick & Lazar, *supra* note 8, at 323.

require that the patient constitute a danger to self or others if not committed.⁹⁴ The attorney should discuss with the client the allegation that he or she is dangerous. This discussion can be used to determine the facts and circumstances which will be used to support the psychiatrist's view that the client's behavior is likely to cause serious harm. The attorney will want to consider the context in which the violent or suicidal behavior occurred and particularly whether the allegations of dangerousness were based on behavior which occurred during the effort to hospitalize the patient or during the hospitalization prior to the hearing. The attorney's efforts in this area follow the traditional role of the criminal lawyer in fact determination and thorough preparation. An understanding of the events leading to the petition to commit should afford the basis for a more comprehensive and adequate legal defense.

Questioning Psychiatric Judgments

Overcoming the Myth of Psychiatric Expertise

The defense lawyer faces a formidable challenge in overcoming the judicial weight given to medical testimony. Unquestioned deference by the judicial decisionmaker to the psychiatrist must be overcome through a defense which encourages the decisionmaker to focus on the limitations⁹⁵ and contradictions in the expert's testimony. In short, the defense of a patient will falter unless the defense lawyer can convince the judge that the psychiatrist's or medical expert's judgment is open to challenge. The judge should be warned that:

Before a psychiatrist's conclusory judgment can be considered an admissible expert judgment — much less worthy of special attention — the psychiatrist must employ techniques and apply knowledge that have been shown to produce substantially more reliable and valid results than could the techniques and knowledge available to laymen. It has been assumed that something in the education, training, experience and techniques of psychiatrists makes their judgments more reliable and

⁹⁴ See note 72, *supra*.

⁹⁵ For a succinct overview of the limits of psychiatric expertise in civil commitment cases, see Morse, *Law and Mental Health Professionals: The Limits of Expertise*, 9 PROF. PSYCH. 389 (1978). For an expanded version, see Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978).

more valid than those judgments would be in the absence of such education, training, experience and techniques. That assumption may be incorrect.⁹⁶

In effect, the judge must be asked to reevaluate the presumption of psychiatric expertise.⁹⁷

Of more immediate concern than judicial deference to psychiatric judgments is the deference of defense counsel. Defense attorneys often take the position that the psychiatrist and hospital staff are acting in the best interest of the client and that the attorney's role is to insure only that the statutory criteria for commitment are satisfied and proper procedures have been followed.⁹⁸ Deference to medical and psychiatric judgments may also be attributed to the attorney's fear that she or he is unprepared to question the judgment of the doctor or psychiatrist. Mental health professionals often communicate their judgment in a technical language which is difficult for lawyers to penetrate. As a consequence, many do not try. Psychiatric testimony is often presented in conclusory form by way of the technical labels applicable to the mentally ill. For example, the psychiatrist may testify that the patient is a paranoid schizophrenic. If questioned, the psychiatrist will testify that the basis for the diagnosis was the patient's hallucinations, paranoid delusions, and distortions in thinking. Thus, even as the psychiatrist moves from conclusory labels (paranoid schizophrenia) to rationale for the diagnosis, the attorney is still confronted with unfamiliar language (e.g., hallucinations, paranoid delusions). The

⁹⁶ Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 699 (1974). See also Dix, *The Death Penalty, "Dangerousness," Psychiatric Testimony, and Professional Ethics*, 5 AM. J. CRIM. L. 151, 170-71 (1977).

⁹⁷ See, e.g., *McDonald v. United States*, 312 F.2d 847 (D.C. Cir. 1962), where the court made "it very clear that neither the court nor the jury is bound by the ad hoc definitions or conclusions as to what experts state is a [mental] disease or [mental] defect." *Id.* at 851. *Accord*, *Washington v. United States*, 390 F.2d 444 (D.C. Cir. 1967).

⁹⁸ A lawyer can take the approach that the hospital knows best, that his client really doesn't know what he wants, and that the whole case can and should be handled as perfunctorily as possible; such position is one which is inimical to true legal representation and is very likely violative of the Canons of Professional Ethics.

Perlin & Siggers, *The Role of the Lawyer in Mental Health Advocacy*, 4 BULL. AM. ACAD. PSYCHIAT. & L. 204, 208 (1976); see Blinick, *Mental Disability, Legal Ethics and Professional Responsibility*, 33 ALB. L. REV. 92 (1968).

lawyer's deference to medical and psychiatric opinion may be attributed in part to the obstacles in understanding the language. All too often the lawyer is mesmerized by the magic language of psychiatry.

The most persistent argument advanced by attorneys to justify their limited role in defending mental patients is the lack of training and preparation necessary to play an active role.⁹⁹ Alan Stone suggests that the concepts of mental illness, mental competency, patient dangerousness, and treatment are "formidably metaphysical."¹⁰⁰ Such concepts are equally metaphysical to the psychiatrist, although the psychiatrist has both theory and clinical experience to help explain these metaphysical concepts. Every attorney who expects to represent those who may be mentally ill has an obligation to attain enough knowledge to formulate a coherent theory of mental health and mental illness which can be used as the basis for a viable legal defense against involuntary commitment. This obligation is an ethical duty mandated by the ABA Code of Professional Responsibility [hereinafter cited as CPR]. Disciplinary Rule 6-101 mandates that a lawyer *shall not*: "(1) Handle a legal matter which he knows or should know that he is not competent to handle . . . (2) Handle a legal matter without preparation adequate in the circumstances." It should be obvious that a lawyer who knows nothing about mental illness and the problems associated with psychiatric judgments cannot be competent to represent the mentally ill. The CPR recognizes that a lawyer may not have the specialized knowledge needed to represent a particular client. However, a lawyer without specialized expertise may represent a client who he or she would otherwise not be competent to represent "if in good faith he expects to become qualified

⁹⁹ The need for special training in the mental health field is clear. The West Virginia College of Law now offers a course in Law and Mental Health and there is a growing awareness of the difficulties in representing mental health patients. Alan Stone, a psychiatrist who holds appointment on the Harvard Law School faculty, has recently noted that mental health statutes are typically:

open-ended, the legislative intent vague, and the case law, until quite recently, so limited, routinized, and unilluminating And the classic legal considerations are supplanted by notions of mental illness, competency, dangerousness, and treatability which are themselves formidably metaphysical and as to which the average attorney is unschooled.

A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 233 (1975).

¹⁰⁰ *Id.*

through study and investigation"¹⁰¹ In the absence of study and thorough preparation, the attorney cannot adequately represent an individual in an involuntary civil commitment hearing.

Basis for Challenging the Myth of Expertise
Psychiatric Testimony Consists of Statements
About Human Behavior.

The factors which influence and determine specific human actions and the human personality are diverse and multifaceted. These factors can be understood only when presented as elements of a model or theory of human behavior. The anomaly is that there is as yet no single, commonly accepted scientific theory of human

¹⁰¹ ABA CODE OF PROFESSIONAL RESPONSIBILITY, ETHICAL CONSIDERATION 6-3.

In the author's view, the *minimal* preparation for representing any mental patient in an involuntary civil commitment requires a close reading of J. ZISKIN, *COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY* (2d ed. 1970), and/or Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693 (1974). Both works present sufficient information and data to formulate a defense in a specific case and consequently should be viewed as required reading. The attorney who wants a more general review of the mental health system, yet one which focuses on the legal aspects of involuntary civil commitment, should read A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* (1975). A copy of Dr. Stone's book can be obtained free from the National Institute of Mental Health, Center for Studies of Crime and Delinquency, 5600 Fishers Lane, Rockville, Maryland 20852. When writing NIMH for the Stone book one should also request a free copy of *DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH* (C. Frederick ed. 1978). Dangerousness is one of the statutory elements necessary for commitment and presents substantial legal, ethical, and psychiatric issues which are at present unresolved in the various disciplines which have addressed the subject.

The attorney who desires a more theoretical orientation to the legal issues of involuntary civil commitment may want to review Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978). Professor Morse has informed the author that he is at work on a book on law and mental health for West's Nutshell Series. If the book contains the insights of the article, it will become a standard reference work for lawyers representing the mentally ill.

Attorneys can become sensitized to the problems of mental illness by reading personal accounts of involuntary hospitalization such as K. DONALDSON, *INSANITY INSIDE OUT* (1976), or personal accounts of mental illness such as MARK VONNEGUT, *THE EDEN EXPRESS* (1975) and P. KNAUTH, *A SEASON IN HELL* (1975), which details the author's effort to combat depression. Finally, there are numerous fictional and historical works which contain excellent descriptions of mental illness. See, e.g., M. BRAND, *SAVAGE SLEEP* (1968); K. KESEY, *ONE FLEW OVER THE CUCKOO'S NEST* (1962); A. STONE & S. STONE, *THE ABNORMAL PERSONALITY THROUGH LITERATURE* (1966).

behavior. Psychologists, psychiatrists, and mental health workers subscribe to different theories of human motivation and mental health which are often unarticulated. In many instances, the mental health professional will eschew "grand" theories of human behavior. Such professionals are more likely to express concern only with the treatment aspects of the "mentally ill." Even here, one must have a theory or model to explain mental illness and its treatment.¹⁰² A theory of "mental illness" subsumes within it a theory of mental health or human behavior. Even within the field of psychiatry, different schools have "a different view of what mental illness is, how it is caused, and how it should be treated."¹⁰³ Of interest are those professionals who argue that they follow no model or theory. Arguably, all have a theory or model, whether it is recognized and articulated, or unarticulated and unconscious.

This discussion of theories has a direct application for the mental health lawyer. It is of utmost importance to determine the expert witness's theory or theories of mental illness. The articulation of such theories provides the attorney with a number of options including exploration of the witness's understanding of the theory underlying his or her diagnosis and its effectiveness as a guiding model, the specific limitations and exceptions to the guiding theory or theories, and finally, competing, contradictory, or alternative theories.¹⁰⁴

¹⁰² "In order to make deductions and inferences about the mind and the affective aspect of behavior — both in its normal and pathological functions — the observer must have a theoretical framework in which to order, explain, and interpret his observations of the mental derivatives." Diamond & Louisell, *The Psychiatrist As An Expert Witness: Some Ruminations and Speculations*, 63 MICH. L. REV. 1335, 1341 (1965). The theoretical framework is elevated to the level of necessity primarily because the mental processes in question can, for the most part, be neither observed, described or measured. *Id.*

¹⁰³ Ennis & Litwack, *supra* note 96, at 721. "Today American psychiatry is a complex amalgamation of Freudian, Neo-Freudian, socio-cultural, and biological concepts and theories." Diamond & Louisell, *supra* note 102, at 1335.

¹⁰⁴ "In the field of psychiatric opinion, divergent assumptions and conceptual orientations often constitute the sole reason for the widely conflicting conclusions reached by different alienists [psychiatrists] testifying in the same trial." Pollack, *Psychiatric Consultation for the Court*, in EFFECTIVE UTILIZATION OF PSYCHIATRIC EVIDENCE 71 (1970) (reprinted from MENDEL & SOLOMON, THE PSYCHIATRIC CONSULTATION (1968)). See J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 118-45 (2d ed. 1970).

Psychiatric Evidence is Subjective

The psychiatrist's and mental health professional's view of the patient and the data and behavior which they find significant are influenced by academic background, training, experience, adherence to a particular theory, and finally, their identification with, or skepticism of, institutional psychiatry. A psychiatrist, in particular, will be affected by whether his or her clinical training was in a setting which was disposition-oriented or in a university or psychoanalytic training institute which was therapy-oriented. Association with a legal or social agency also influences attitudes toward patients. The psychiatrist in full-time private practice may be much more willing to accept individual vagaries in the patient than the institutional psychiatrist and in contrast to the latter, the private practitioner may focus more upon the patient's psychological strengths than on his weaknesses and liabilities.

Psychiatric Evidence is Opinion Testimony

The weight to be accorded psychological evidence in the form of opinion testimony depends essentially upon two factors: the qualifications of the expert and the basis on which the opinion was formulated. In order to properly assess the opinion, it is most important that the mental health lawyer explore in detail the background data which forms the basis upon which the ultimate opinion was formulated.¹⁰⁵ The lawyer may attempt to show the unreliability of any psychiatric opinion based on its source. The diagnoses and predictions that psychiatrists make in court can be based on a variety of information from diverse sources. In some cases, the opinion is the result of extensive interviews with the patient and direct observations of his behavior. In other cases, the

¹⁰⁵ The West Virginia Supreme Court of Appeals has recognized the principle that full disclosure may be necessary to adequately support the psychiatric judgment. In *State v. Myers*, 222 S.E.2d 300 (W. Va. 1976) the Court held that the trial court erred in not permitting information elicited during a psychiatric interview to be fully disclosed to the jury. The court found the information given to the psychiatrist by the patient to be crucial to diagnosis and may therefore be fully disclosed to the jury as an explanation for the diagnosis. *Id.* at 303-04. The court found it prejudicial "to preclude a doctor from making reference to information which comes to him in the form of records or documents prepared in the normal course of either his examination or treatment of the patient." *Id.* at 304. The court, in a footnote, makes it clear that it is not ruling on the admissibility of the records as such or the situation where the expert bases an opinion on the opinion of others. *Id.* at 304 n.1.

opinion will be based partly or primarily on the reports of others.

The foremost question for the attorney is whether the psychological opinion is based solely on a personal examination of the patient or whether other sources were utilized. The expert witness may have observed the patient over a long period of time and/or may have established a therapeutic relationship. In such cases, the mental health professional may effectively utilize frequent personal examinations and the long-standing relationship to support the opinions presented to the court.

Although expert opinion testimony founded on knowledge gained from personal observation is probably the most acceptable basis for an expert opinion, it should not be considered as lying beyond successful cross-examination. For example, can the expert describe the patient's appearance, mannerisms, speech content, and other patterns which support the opinion of "mental illness" or "dangerousness?" What was the time period over which the examination was conducted? When and where was the examination conducted? How many times was the patient interviewed? How long was each interview?¹⁰⁶ Did the examination take place solely for the purpose of allowing the mental health professional to testify at trial? Did the patient consent to the examination and cooperate with the examiner, or was the patient uncooperative?

More frequently, however, the opinion will be based on both personal examination and secondary sources. Secondary medical sources are diverse in nature. They include the patient's medical, psychiatric, and criminal records as well as information in the possession of hospital staff, legal counsel, friends, and neighbors. Information from some or all of these sources may be the basis of an expert opinion which will result in involuntary hospitalization.

Defense counsel, aware of this fundamental aspect of opinion testimony, should make full inquiry into the basis for the expert's opinion. Obviously, the goal here is to probe the accuracy of the facts, the basis for the diagnosis, and the prediction of a likelihood

¹⁰⁶ One commentator has noted that in criminal cases where an insanity defense is raised the length of the psychiatric interview has been used as a basis for attack on the admissibility of the testimony. Note, *Involuntary Hospitalization of the Mentally Ill Under Florida's Baker Act: Procedural Due Process and the Role of the Attorney*, 26 U. FLA. L. REV. 508, 527 n.186 (1974) (citing *United States v. Taylor*, 437 F.2d 371, 378 (4th Cir. 1971); *Bush v. McCollum*, 231 F. Supp. 560, 563-64 (N.D. Tex. 1964), *aff'd*, 344 F.2d 672 (5th Cir. 1965)).

of future harm. The cross-examination can begin by simply asking:

Doctor, is there any data in the patient's records and from your personal examination from which one could conclude that the patient is *not* mentally ill and/or dangerous? Doctor, did the patient exhibit any normal or healthy behavior during your examination? Could you describe that behavior?

Not inconceivably, the psychiatrist might report only those portions of the prospective patient's comments and actions which would support an inference that the individual was disturbed, even though ninety-nine percent of what he or she said and did would be entirely consistent with what we regard as normal behavior. Nor is it uncommon for psychiatrists to omit qualifying remarks, thereby making the prospective patient's statements seem more irrational than they are.¹⁰⁷

Finally, the doctor can be asked to simply describe what the patient is "like," that is, what are the obvious assets and liabilities of the patient? "Can you describe the patient in human terms without the psychiatric labels?" The point is simply that psychiatrists render subjective observations in the course of their examinations and this should be brought to the court's attention.

Questioning the Psychiatrist on the Ultimate Legal Issues: Is the Patient Mentally Ill and Dangerous to Self or Others?

There are essentially two criteria for involuntary civil commitment established by statute in West Virginia and throughout the United States. The crux of the involuntary commitment hearing lies in the resolution of two questions: (1) Is the individual mentally ill?¹⁰⁸ (2) Is he or she likely to cause harm to self or others?

¹⁰⁷ Ennis & Litwack, *supra* note 96, at 745.

The examiner is selective in what he will notice in the clinical situation and what he will remember from the clinical situation. This is extremely important when one bears in mind that all one gets in the psychiatrist's report or in his testimony in the courtroom are those data which he has selectively noted and selectively remembered. The raw data in its entirety is seldom, if ever, available.

ZISKIN, *supra* note 104, at 118.

¹⁰⁸ While this article is concerned solely with involuntary civil commitment for mental illness, West Virginia also provides for commitment of the mentally re-

Affirmative answers to these questions by the testifying psychiatrist provide the basis for involuntary confinement in a state mental hospital. The failure of defense counsel to question the psychiatric testimony on these matters is tantamount to acquiescence in the state's decision to commit the individual.

§

Diagnosis of Mental Illness

There is considerable debate in the United States as to what constitutes mental illness and how it should be defined.¹⁰⁹ The uncertainty underlying concepts of mental illness limits the certainty and objectivity which can be accorded any psychiatric diagnosis.¹¹⁰ Notwithstanding the debate in the psychiatric literature concerning diagnoses of schizophrenia, manic depression, and mental retardation, these diagnoses are generally left unchallenged by defense counsel in civil commitment hearings.

An example of how inadequate lawyers are in questioning psychiatric diagnosis is illustrated in a civil commitment hearing observed by the author.¹¹¹ The first psychiatrist testified that the

tarded and addicted. W. VA. CODE § 27-5-2(a)(1) (1979 Cum. Supp.). The statute specifically includes the alcoholic and the narcotic addict. W. VA. CODE § 27-1-11 (1976 Replacement Vol.).

On the commitment of narcotics addicts see Abromosky & McCarthy, *Civil Commitment of Non-Criminal Narcotic Addicts: Parens Patriae; A Valid Exercise of a State's Police Power; Or An Unconscionable Disregard of Individual Liberty?*, 38 U. PITT. L. REV. 477 (1977). See generally N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY* 210-60 (1973). On the commitment of alcoholics see generally, KITTRIE, *supra*, at 262-96.

¹⁰⁹ On the definitional problems inherent in the concept of mental illness see Blinick, *Mental Disability, Legal Ethics, and Professional Responsibility*, 33 ALB. L. REV. 92, 92-96 (1968); Note, *Mental Illness: A Suspect Classification?*, 83 YALE L.J. 1237, 1237 n.1 (1974).

¹¹⁰ On the problem of diagnosis, see Schwartz, *In the Name of Treatment: Autonomy, Civil Commitment, and Right to Refuse Treatment*, 50 NOTRE DAME LAW. 808, 809-12 (1975). See generally *Diagnosis and the Difference It Makes, Proceedings of the Scientific Conference in Honor of the Fiftieth Anniversary of the Menninger Foundation*, 40 BULL. MENNINGER CLINIC 411-602 (1976). A psychiatric diagnosis is not an end in itself. It is only a means to serve the goal of treatment. "In the last resort all diagnostic concepts stand or fall by the strength of the prognostic and therapeutic implications they embody." R. KENDALL, *THE ROLE OF DIAGNOSIS IN PSYCHIATRY* 40 (1975). For a review of the ways psychiatrists err in diagnosing mental illness, see Morrison & Flanagan, *Diagnostic Errors in Psychiatry*, 19 COMPREHENSIVE PSYCHIAT. 109 (1978).

¹¹¹ See explanatory footnotes to Appendix.

patient was admitted to Weston State Hospital in 1942. The examination for the civil commitment hearing took place on August 15, 1977. The psychiatrist testified that in 1942 the patient was diagnosed as a manic depressive, depressed type,¹¹² but that there was doubt in the psychiatrist's mind as to the accuracy of the diagnosis. The correct diagnosis, the psychiatrist argued, should have been schizophrenia. The testimony elicited by the prosecutor was as follows:

Prosecutor: What is schizophrenia?

Psychiatrist: If you ask ten psychiatrists, you'll get eleven different answers. I won't try to define it, but you could say that it is characterized by withdrawal from reality, dissociation of thoughts, irrationality, and hallucinations.

Prosecutor: What is the patient's current diagnosis?

Psychiatrist: Schizophrenia.

After further testimony on the issue of dangerousness, the defense counsel conducted the following cross examination:

Defense Counsel: From your examination, what can you say about his ability to keep up his own appearance?

Psychiatrist: He needs some help. He needs to be pushed a little.

At this point, defense counsel requested the MHC to take notice of reports which indicated that the patient could take care of himself.

¹¹² Manic depressive reaction has been defined as:

[a] group of affective psychotic reactions characterized by a predominant mood of elation or depression, accompanied by related disturbances of thought and activity. The behavioral changes that occur range from relatively mild to extremely severe and uncontrolled reactions, but in most cases they appear to be exaggerations of normal tendencies rather than bizarre distortions.

2 R. GOLDENSON, *THE ENCYCLOPEDIA OF HUMAN BEHAVIOR: PSYCHOLOGY, PSYCHIATRY, AND MENTAL HEALTH* 727 (1970). In the depressive phase, the features range from "inertia, loss of interest and enthusiasm, and physical complaints without organic basis," dejection and thoughts of suicide to an acute depression where there is an impairment of thought and speech. *Id.* at 727. In this advanced phase:

[r]esponse to question is slow and hesitant, physical activity is almost at a standstill, and contacts with other people are rarely initiated. The patient is a picture of dejection: his body is stooped, his forehead furrowed, his face troubled, his gaze fixed downward.

Id.

- Defense Counsel: Did he cooperate with you?
Psychiatrist: I had to ask him questions several times.
MHC: Are you testifying that the diagnosis was wrong in 1942 or today?
Psychiatrist: The original diagnosis was made on the basis of a suicide attempt and that, in my opinion, is not enough.
MHC: Is the patient mentally ill today?
Psychiatrist: With medication, the schizophrenia is under control.
MHC: Is he oriented?
Psychiatrist: He is not oriented as to time and place. We're getting into the organic stages.
MHC: From a visual observation, would not an alternative be a nursing home?
Psychiatrist: Yes.
MHC: Will he wander off or hurt himself?
Psychiatrist: I don't think he would wander off.

In reviewing this transcript of an actual civil commitment hearing reconstructed from the author's notes, the ineffectiveness of defense counsel in questioning the psychiatric diagnosis is apparent. Even after the psychiatrist testified that an earlier diagnosis of manic depressive psychosis was doubtful, the defense lawyer did not attempt to explore the basis for either the diagnosis at the time of admission or at the time of the hearing. Rather, the attorney asked about the patient's "ability to keep up his own appearance" and whether he cooperated with the psychiatrist. It is unclear why the defense attorney pursued such a line of questioning. The MHC in this case did, however, show concern over the diagnosis and whether the patient was, at the time of the hearing, mentally ill.¹¹³

This example is reflective of a general failure of attorneys representing the mentally ill to adequately probe psychiatric judgments about mental illness. There is generally no attempt by West Virginia lawyers to determine how particular psychiatric labels are selected or why the label applies to the particular individual in question. The diagnosis is simply left unquestioned.

The West Virginia statute governing mentally ill persons attempts to define the elusive concept of mental illness but with less

¹¹³ The MHC in this case was carrying out the statutory duty of safeguarding the rights and interests of the patient as well as the state. See W. VA. CODE § 27-5-1(b) (Cum. Supp. 1979).

than total success. The statute defines mental illness as "a manifestation in a person of significantly impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion and physical well-being."¹¹⁴ The definition presents more questions than it provides answers. What are the common "manifestations" of intellectual and emotional impairment? When is intellectual and emotional impairment "significant?" What is an "acceptable level of functioning in the areas of intellect and emotion?" Why does the definition of mental illness include reference to "physical well-being?" It is apparent that the statute fails to define mental illness for purposes of determining what specific behavior, conduct, or mental state will subject the person to confinement. The statute simply does not provide a sufficient guide for the public or for the courts to determine when and in what circumstances the state will use its power to involuntarily commit an individual.¹¹⁵ Under such circumstances, the courts are under great pressure to accede to psychiatric judgments on mental illness. It should be obvious that defense counsel has a duty to represent the client by focusing the court's attention on the special danger presented by psychiatric judgments which are unguided by statutory standards.¹¹⁶

Defense counsel faces a difficult but not insurmountable burden in questioning a psychiatric diagnosis of mental illness. If

¹¹⁴ W. VA. CODE § 27-1-2 (1976 Replacement Vol.).

¹¹⁵ The failure of the West Virginia Mental Health Code to provide a definition of mental illness which would permit objective application is reflected in the civil commitment statutes of the other states. See Note, *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1202 (1974). The note points out that: "Even those states which have attempted more detailed definitions of mental illness have not clearly or precisely identified the type and degree of mental disorder which makes compulsory hospitalization appropriate." *Id.* at 1202-03. On the conceptual and pragmatic problems in defining mental illness, see Mechanic, *Some Factors in Identifying and Defining Mental Illness*, in MENTAL ILLNESS AND SOCIAL PROCESSES 23-32 (T. Scheff ed. 1967); T. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY (1966); and the works of Thomas Szasz, THE MANUFACTURE OF MADNESS (1970); LAW, LIBERTY AND PSYCHIATRY (1963); THE MYTH OF MENTAL ILLNESS (1961).

¹¹⁶ Two recent opinions of the Supreme Court suggest that the Court may not be willing to support the civil libertarian effort to further "legalize" the civil commitment process. (By "legalize" this author refers to the development of legal procedural mechanisms to reduce the influence of psychiatrists in civil commitment hearings.) See *Parham v. J. R.*, 99 S. Ct. 2493 (1979); *Addington v. Texas*, 99 S. Ct. 1804 (1979).

defense counsel has a working knowledge of the psychiatric literature and the criticism of involuntary hospitalization based on expansive definitions of mental illness similar to that found in the West Virginia statute, the psychiatrist can simply be asked: "Doctor, how would you define mental illness?" The answer to this simple, straightforward question should provide a good source of background data for use in further cross-examination or for argument to the court that the individual is not, in fact, mentally ill. First, the psychiatrist's definition of mental illness may be substantially different from that provided in the statute. If that is the case, it can be argued that the psychiatrist has found the patient mentally ill based on his or her personal conception of mental illness as opposed to the definition established by statute.¹¹⁷ Given the broad statutory definition, this argument will seldom be effective, but will serve to highlight the defense counsel's intention to scrutinize the psychiatric judgement.

A more promising attack on the psychiatric diagnosis of mental illness is to show the questionable reliability and validity of psychiatric diagnoses in general. This attack can begin with an attempt to show that a diagnosis of mental illness is substantially different from a diagnosis of physical illness by a medical doctor.¹¹⁸ To consider a psychiatric diagnosis to be as scientifically valid as a medical diagnosis is, at present, unjustified. Bruce Ennis, a civil liberties lawyer active in mental health litigation, and Dr. Thomas Litwack, a psychologist, conducted a comprehensive survey of the professional literature on psychiatric diagnoses and judgments and found that psychiatrists themselves question the reliability and validity of psychiatric judgments.¹¹⁹ The work of Ennis and Lit-

¹¹⁷ S. SCHWARTZ & D. STERN, A TRIAL MANUAL FOR CIVIL COMMITMENT VI-16 (1976).

¹¹⁸ The foremost exponent of the argument that psychiatric diagnosis is inexorably different from medical diagnosis is Thomas Szasz. Dr. Szasz, a psychiatrist, argues that psychiatrists have failed to establish a successful classificatory scheme for mental illness. T. SZASZ, LAW, LIBERTY, AND PSYCHIATRY 24 (1963). Szasz finds that "the significance of a psychiatric label depends more on the social situation in which it occurs than on the nature of the object labeled." *Id.* at 35. For a philosophical comparison of the medical and psychiatric approaches to health problem diagnosis, see Mischel, *The Concept of Mental Health and Disease: An Analysis of the Controversy Between Behavioral and Psychodynamic Approaches*, 2 J. MED. & PHIL. 197 (1977). See generally, J. ZISKIN, *supra* note 101.

¹¹⁹ Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974). Reliability and validity are

wack suggests that a psychiatrist should be questioned along the following lines:

Doctor, you have testified that the patient is mentally ill based on your diagnosis of schizophrenia. Is schizophrenia an established diagnostic category?

Doctor, isn't it true that a psychiatric diagnosis using a criteria such as schizophrenia or manic depressive is not reliable?¹²⁰

Doctor, doesn't the research literature on psychiatric diagnosis show that psychiatrists are often unable to agree with each other in their diagnoses?

Doctor, have you conducted any studies to determine the validity of your own predictions, that is, how accurate your judgments are?¹²¹

If not, have you relied upon the studies of others?

If so, which ones?

One of the most frequently used diagnoses in institutional psychiatry is schizophrenia.¹²² Its frequent usage suggests that de-

terms of art without clearly different meanings. Reliability means "the probability or frequency of agreement" as to a diagnosis. Would two psychiatrists reach the same conclusion as to the diagnosis? *Id.* at 697. Validity refers to the accuracy of a judgment or diagnosis. *Id.* The question of validity asks whether the psychiatric diagnosis or judgment has been verified over time. For example, did the patient, found by the psychiatrist likely to be dangerous to others, actually cause harm to others?

¹²⁰ The studies which show unreliability of psychiatric diagnosis are summarized in ZISKIN, *supra* note 101, at ch. 8 and Ennis & Litwack, *supra* note 119, at 701-08. Dr. Alan Stone, after citing some of the studies reviewed by Ziskin and Ennis and Litwack notes that "reliability could be improved for purposes of civil commitment if psychiatrists would confine themselves to the broad diagnostic categories and in addition diagnose only severe conditions." A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 66 (1975).

¹²¹ See J. ZISKIN, *COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY* 37-47, 181-214 (2d ed. 1970).

After a comprehensive review of the psychiatric literature, Ennis and Litwack found few studies of the validity of *psychiatric diagnosis* and the few studies which do exist suggest that diagnostic validity is low. Ennis & Litwack, *supra* note 119, at 708-09. On the even more important question of dangerousness, the authors could find no empirical studies which establish the validity of psychiatric predictions of dangerousness to self and others. *Id.* at 711-16. Accord, Albers, Pasewark & Meyer, *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 CAP. U. L. REV. 11 (1976).^o

¹²² See ZISKIN, *supra* note 101, at 112. Schizophrenia "constitutes the largest group of severe behavior disorders in our culture. Its victims occupy about 25% of

fense attorneys should be especially knowledgeable as to this particular form of mental illness.¹²³ A leading critic of psychiatric expertise, Jay Ziskin, indicates that there is no generally accepted definition of schizophrenia.¹²⁴ To add to the conceptual confusion, there are social, genetic, and biochemical theories which compete as causal theories for schizophrenia.¹²⁵ The observable symptoms used to describe schizophrenia are also found in other forms of mental illness (and in individuals not thought to be mentally ill), making an objective criteria for diagnosis difficult, if not impossible. A psychiatric diagnosis of schizophrenia can be cross-examined as follows:

Doctor, is there a generally accepted or acceptable definition of schizophrenia?¹²⁶

Is there agreement among the medical profession as to what constitutes the so-called condition of schizophrenia?

all the hospital beds in the United States." G. ULETT & W. GOODRICH, A SYNOPSIS OF CONTEMPORARY PSYCHIATRY 73 (3d ed. 1965).

In the legal literature, *see generally*, Goldzband, *Schizophrenia in the Adversary Arena*, 12 CALIF. W. L. REV. 247 (1976); DuBose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment*, 60 MINN. L. REV. 1149 (1976). The psychiatric literature on schizophrenia is vast, numbering several thousand articles. For a readable account of schizophrenia see S. ARIETI, INTERPRETATION OF SCHIZOPHRENIA (Rev. ed. 1974).

¹²³ For a review of the current thinking on schizophrenia *see* ANNUAL REVIEW OF THE SCHIZOPHRENIA SYNDROME (R. Cancro ed. 1978); BEYOND THE DOUBLE BIND (M. Berger ed. 1979); SCHIZOPHRENIA: TOWARDS A NEW SYNTHESIS (J. Wing ed. 1978); THE NATURE OF SCHIZOPHRENIA (L. Wynne, R. Cromwell & S. Matthyse eds. 1978).

¹²⁴ *See generally*, ZISKIN, *supra* note 101, at 112-16 (1977 Pocket Supplement at 66-71).

¹²⁵ *See* note 123, *supra*.

¹²⁶ Schizophrenia is defined in the American Psychiatric Association's DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (1968) (known as DSM II) as follows:

Schizophrenia

This large category includes a group of disorders manifested by characteristic disturbances of thinking, mood and behavior. Disturbances in thinking are marked by alterations of concept formation which may lead to misinterpretations of reality and sometimes to delusions and hallucinations, which frequently appear psychologically self-protective. Corollary mood changes include ambivalence, constricted and inappropriate emotional responsiveness and loss of empathy with others. Behavior may be withdrawn, regressive and bizarre.

Id. at 33.

Is it true that there is in fact no commonly accepted definition of schizophrenia nor agreement as to the appropriate criteria for labeling someone as schizophrenic?¹²⁷

In fact, is there not a continuing controversy over what constitutes schizophrenia?

Doctor, with regard to your diagnosis of schizophrenia, what is the likelihood that another psychiatrist would reach a similar diagnosis?

Doctor, was your diagnosis of schizophrenia made only because the patient's behavior could not be given one of the other labels of psychosis, e.g., manic depression?¹²⁸

The most effective means of rebutting psychiatric testimony of mental illness or a particular diagnosis is to present rebuttal testimony by a psychiatrist or psychologist. In West Virginia, individuals have a statutory right to examination and testimony from an independent expert of his or her choice.¹²⁹ An indigent is entitled to use an independent expert with costs to be borne by the state.¹³⁰

¹²⁷ See ZISKIN, *supra* note 101. Here the lawyer seeks to challenge the reliability of the diagnosis. *Id.* at 181-87; Ennis & Litwack, *supra* note 119; Albers, Pasewark & Meyer, *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 CAP. U.L. REV. 11 (1976). In each of these sources, the authors review the psychiatric literature and conclude that psychiatric diagnoses are of doubtful validity. Thus, "[t]he testifying expert should be led to admit that the chances of another expert, similarly qualified, agreeing with his findings are barely better than 50-50 . . ." ZISKIN, *supra* note 101, at 186. On the fallacies in the diagnosis of schizophrenia which make reliability and validity doubtful, see Kubie, *Multiple Fallacies in the Concept of Schizophrenia*, 153 J. NERVOUS & MENTAL DISEASES 331 (1971).

¹²⁸ If the answer is yes, it would make schizophrenia a waste basket diagnosis to be applied when nothing else fits. If the answer is no, then the psychiatrist should be questioned to determine the specific factors which led to the diagnosis. *E.g.*, the psychiatrist may contend that the patient reported hallucinations which are commonly linked to schizophrenia. In this case, the psychiatrist can be questioned as to whether the presence of hallucinations is a reliable and valid indicator of schizophrenia. A number of studies now conclude that hallucinations occur in so-called normal people. See ZISKIN, *supra* note 101 (1977 Pocket Supplement at 46-48) (citing Goldstein, *Case Report: Hallucinatory Experience: A Personal Account*, 85 J. ABN. PSYCH. 423 (1976) and Holden, *Altered States of Consciousness: Mind Researchers Meet to Discuss Exploration and Mapping of "Inner Space,"* 179 Sci. 982 (1973)).

¹²⁹ W. VA. CODE § 27-5-4(c) (Cum. Supp. 1979).

¹³⁰ *Id.* See also, Farrell, *Right of an Indigent Civil Commitment Defendant to Psychiatric Assistance of His Own Choice at State Expense*, 11 IDAHO L. REV. 141 (1975).

Psychiatric Testimony as to Dangerousness

Defense counsel may frequently find it difficult to discredit a psychiatric diagnosis of mental illness. The attempt will find the attorney opposing the psychiatrist at the point of least vulnerability and on an issue which will insure a strong defense of professional opinion. A more productive area for defense cross-examination will be the psychiatric testimony as to dangerousness. Even the most reticent, ill-equipped defense counsel should be able to force the expert to recognize the uncertainty and subjectivity in predictions of dangerousness.¹³¹

Dangerousness to Others

The West Virginia Supreme Court of Appeals has noted with approval the dangerousness criterion¹³² but has not provided meaningful guidance as to what constitutes harmful or dangerous action towards others.¹³³ A minimal effort at guidance is found in the West

¹³¹ Whenever a psychiatrist or psychologist testifies that a person is likely to be harmful to self or others, he or she is making a prediction about the probability of future occurrences of certain types of behavior. Given the number of factors which interact to influence behavior, the ability to predict any particular behavior is limited. For a useful review of the theoretical issues in predicting future behavior, see Underwood, *Law and the Crystal Ball: Predicting Behavior With Statistical Inference and Individualized Judgment*, 88 YALE L.J. 1408 (1979).

¹³² "Society is entitled to protect itself against predatory acts on the part of anti-social people, regardless of the cause of their anti-social actions. Therefore, if the State can prove that an individual is likely to injure others if left at liberty, it may hospitalize him." *Hawks v. Lazaro*, 202 S.E.2d 109, 123 (W. Va. 1974).

¹³³ The subjectivity of the harm criteria lies initially with the potentially broad range of meaning which can be given to harm and dangerousness. Thus, dangerousness could be interpreted to mean:

crimes involving a serious risk of physical or psychical harm to another. Murder, arson and rape are the obvious examples. Even in criminal law, however, the notion of dangerousness can be much broader. If one believes that acts that have adverse effects on social interests are dangerous, and if one accepts as a generality that the criminal law is devoted to such acts, any crime can be considered dangerous. For example, speeding in a motor vehicle, although traditionally regarded as a minor crime, bears great risk of life and property, and thus may be viewed as a dangerous act. Dangerousness can bear an even more extensive definition as well. An act may be considered dangerous if it is offensive or disquieting to others. Thus, the man who walks the street repeating, in a loud monotone, "fuck, fuck, fuck," is going to wound many sensibilities even if he does not violate the criminal law. Other examples would be the man,

Virginia statute. The code requires that one be "likely to cause serious harm" and that the "substantial tendency to physically harm other persons" be "manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm."¹³⁴

Presently, proof of a propensity¹³⁵ "to cause serious harm" is satisfied by the testimonial "predictions" of psychiatric professionals. In some instances, the prediction is based solely on the theory that individuals in certain diagnosed categories of mental illness are dangerous. For example, once a diagnosis of paranoid schizophrenia is made, the individual is predictably dangerous since paranoid schizophrenics are dangerous. The attorney should oppose psychiatric predictions of dangerousness which appear to be based on the diagnostic label which a psychiatrist has attached. For example, a conclusion that the patient is dangerous because he or she is a paranoid schizophrenic ignores the fact that such individuals "may be dangerous in only certain types of situations

found in most cities, striding about town lecturing at the top of his lungs, or the similar character in San Francisco who spends his time shadow boxing in public. If such people are dangerous, it is not because they threaten physical harm but because we are made uncomfortable when we see aberrancies. And, of course, if dangerousness is so defined, it is at least as broad a concept as mental illness. The cases are unfortunately silent about what meaning the concept of danger bears in the commitment process.

Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 82 (1968).

¹³⁴ W. VA. CODE § 27-1-12(2) (Cum. Supp. 1979). The West Virginia efforts to define dangerousness to others can be compared with the new Pennsylvania Mental Health Procedures Act which requires a showing that the mentally ill pose a clear and present danger of harm to others. PA. STAT. ANN. TIT. 50, § 7301 (1979-80 Cum. Supp. Purdon). A clear and present danger is shown in Pennsylvania only when, ". . . within the last thirty days the person has inflicted or attempted to inflict serious bodily harm on another and there is a reasonable probability that such conduct will be repeated." *Id.* § 7301(b)(1) (1979-80 Cum. Supp. Purdon). See also *Lynch v. Baxley*, 386 F. Supp. 378, 390-92 (M.D. Ala. 1974) (real and present threat of substantial harm required).

¹³⁵ It is not sufficient that the state establish a possibility that defendant might commit some dangerous acts at some time in the indefinite future. The risk of danger, a product of the likelihood of such conduct and the degree of harm which may ensue, must be substantial within the reasonably foreseeable future. On the other hand, certainty of prediction is not required and cannot reasonably be expected.

State v. Krol, 68 N.J. 236, 261, 344 A.2d 289, 302 (1975).

or in connection with relationships with certain individuals. An evaluation of dangerousness in such cases must take into account the likelihood that the defendant will be exposed to such situations or come into contact with such individuals."¹³⁶

Arguably, the requirement that the individual be shown to have a "substantial tendency" toward violence requires that the judgment as to potential harm be based, not on membership in a classified group of the mentally ill who can be given a distinctive psychiatric label, but on the actual likelihood of harm by the specific patient.¹³⁷ Moreover, any tendency toward harm to others must be "substantial." The "substantial tendency" requirement, while open to interpretation, must be viewed as a requirement that the patient demonstrate a likelihood of violence by a recent overt act, threat, or attempt.¹³⁸ The West Virginia statute was amended

¹³⁶ State v. Krol, 68 N.J. 236, 261, 344 A.2d 289, 302 (1975). See also, State v. Johnson, 493 P.2d 1386 (Or. App. 1972) (where the defendant was potentially dangerous to her children but was unlikely to have access to them); Dix, *supra* note 96, at 196.

¹³⁷ See People v. Sansone, 18 Ill. App. 3d 315, 309 N.E.2d 733 (1974), where a medical opinion of dangerousness towards others was premised on the testimony of a psychiatrist that persons he had known who had delusions similar to the patient's had injured or attempted to injure others. The court found the psychiatrist testimony "clear and convincing evidence" of dangerousness to others even though the psychiatrist could not state the degree of probability of dangerousness. *But see*, People v. Bradley, 22 Ill. App. 3d 1076, 318 N.E.2d 267 (1974), adhering to the standard established in *Sansone* but holding that the psychiatric testimony of dangerousness was less than "clear and convincing." Dr. Alan Stone, Professor of Law and Psychiatry at Harvard, has suggested that "psychiatry lacks the capacity to identify dangerous patients with sufficient reliability to meet a court's evidentiary test of either beyond a reasonable doubt (about 90 percent certainty) or clear and convincing proof (about 75 percent certainty)." Stone, 132 AM. J. PSYCHIAT. 829 (1975).

The "clear and convincing" evidence of dangerousness in *Sansone* is doubtful. The psychiatrist produced no data other than a personal conclusion that the defendant was more likely to commit a crime than any normal person. It is indeed doubtful whether there is any data available to support the proposition that delusional mental patients are more likely to be dangerous than a cross-section of the general community. More generally, it is improbable "that the likelihood of crime within a group of individuals with any particular psychosis would be greater than that to be expected in a normal community cross-section." Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 83 (1968).

¹³⁸ W. VA. CODE § 27-5-4(d)(1) (Cum. Supp. 1979). See also, Lynch v. Baxley, 386 F. Supp. 378, 390-92 (M.D. Ala. 1974). Compare People v. Sansone, 18 Ill. App. 3d 315, 309 N.E.2d 733 (1974), where the court rejected the proposition that a

in 1978 to require that psychiatric testimony concerning dangerousness be based on detailed, recent "overt acts" which "clearly demonstrate such likelihood."¹³⁹ Although this section of the statute has been repealed, all applications for civil commitment must state the overt acts which support the belief that the individual is dangerous.^{139,1} Psychiatrists in their predictions of dangerousness should still be required to state the overt behavior which supports their testimony at the civil commitment hearing.

One of the authors of a frequently cited study on dangerousness concludes that a "meticulous description" of actual behavior is the core of a prediction of dangerousness.¹⁴⁰ Due to the imprecise meaning of what constitutes an "overt act" demonstrating dangerousness,¹⁴¹ the attorney should inquire as to the exact nature of the

prediction of dangerousness must be based upon overt acts or threats. The absence of evidence of prior harmful conduct, the court ruled, does not per se violate due process. The court allowed the prediction of dangerousness on the basis of medical testimony that the person was reasonably expected to engage in dangerous conduct. The court, however, would limit such predictions to qualified psychiatrists who can conduct their predictions by appropriate experience and study.

¹³⁹ W. VA. CODE § 27-5-2(c) (repealed 1979).

^{139,1} See also W. VA. CODE § 27-5-4(d)(i) (Cum. Supp. 1979), which requires that an application to initiate civil commitment proceedings state "in detail the recent overt acts" which support the belief that the individual is dangerous.

A sound argument can be made for the proposition that an overt act requirement is constitutionally required and a number of courts have accepted the argument. See, *Stamus v. Leonhardt*, 414 F. Supp. 439 (S.D. Iowa 1976); *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Haw. 1976); *Doremus v. Farrell*, 407 F. Supp. 509 (D. Neb. 1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972). The contrary position was taken in *United States v. Nelson*, 461 F. Supp. 707 (N.D. Ill. 1978).

It has recently been suggested that psychiatrists adopt ethical standards to limit testimony concerning dangerousness. One of the proposed standards would require that: "[n]o expert opinion should be expressed unless the subject has *actually engaged* in dangerous behavior and an analysis of that behavior should be a major factor in the conclusion of the expert." *Dix, supra* note 96, at 195. (Emphasis added).

Where determinations of dangerousness are premised on overt acts, the role of the psychiatrist is arguably of less significance. See *Ochberg & Brown, Mental Health and the Law: Partners in Advancing Human Rights*, 123 U. PA. L. REV. 491, 506 (1974) *citing* H. Steadman, *The Determination of Dangerousness in New York* (unpublished paper presented at the 1974 Annual Meeting of the American Psychiatric Association).

¹⁴⁰ Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME AND DELINQUENCY 371, 384 (1972).

¹⁴¹ As one commentator has noted, overt act is "a term of art" which has been

overt act and how the conclusion of dangerousness is related to the specific act of the individual.

The attorney should be cautious not to assume that assaultive or violent behavior *always* supports an inference that the individual is dangerous to others. Situational factors may explain a patient's aggressive or violent behavior, especially where the assaultive behavior is an attempt on the part of the individual to obstruct confinement. The following questions are suggestive:

Doctor, is it possible that the patient was assaultive only because there was an effort to confine the patient against her will?

Doctor, is it possible that the aggressive behavior which you observed (reported) was a result of the institutional environment?

Even the presence of past dangerous acts, often viewed as the best indicator of dangerousness, is not conclusive proof. "Determination of dangerousness involves prediction of defendant's future conduct rather than mere characterization of his past conduct."¹⁴² The dangerous behavior must be related to and a re-

adopted from criminal conspiracy law and lacks precise meaning in the context here. NOTE, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562, 562 n.2 (1977). The difficulty is exacerbated by the absence of case law detailing what overt acts can be viewed as permitting a judgment of dangerousness. *Id.* at 576.

¹⁴² *State v. Krol*, 68 N.J. 236, 262, 344 A.2d 289, 303 (1975). Even a prior criminal act is not a per se showing of dangerousness. The court in *Krol* noted that:

The fact that defendant is presently suffering from some degree of mental illness and that at some point in the past mental illness caused him to commit a criminal act, while certainly sufficient to give probable cause to inquire into whether he is dangerous, does not, in and of itself, warrant the inference that he presently poses a significant threat of harm, either to himself or to others.

68 N.J. at 242, 344 A.2d at 295. The criminal act in *Krol* was the stabbing death of the defendant's wife. The psychiatric testimony was that the defendant was an acute schizophrenic and killed his wife because of a delusion that she was conspiring with his employer to murder him. See also, *In re Stephenson*, 36 Ill. App. 3d 746, 749, 344 N.E.2d 679, 682 (1976). The court in *Krol* does point out, however, that empirical studies suggest that criminal conduct is an important factor in prediction of future dangerous conduct. 68 N.J. at 261, 344 A.2d at 302 n.12 (citing Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME AND DELINQUENCY 371, 384 (1972) and Rubin, *Prediction of Dangerousness in the Mentally Ill Criminal*, 287 ARCH. GEN. PSYCHIAT. 297 (1972)). The Supreme Court has clearly established that proof of a criminal act is not a constitutionally

sult of the *present* mental illness. All members of society, regardless of mental health, are at times dangerous to others. Consequently, the threat of dangerousness must be directly associated with a current mental illness.¹⁴³

A growing body of psychiatric and legal literature is addressed to the issue of whether psychiatrists can reliably predict the likelihood of future dangerousness.¹⁴⁴ Bernard Diamond, an eminent

acceptable basis for involuntary commitment. See *Baxstrom v. Herold*, 383 U.S. 107 (1966). See also *Walker v. Jenkins*, 203 S.E.2d 353 (W. Va. 1974).

¹⁴³ See W. VA. CODE §§ 27-5-2(a)(2), -4(c)(2), -4(d)(1) (Cum. Supp. 1979).

¹⁴⁴ AM. PSYCHIAT. ASSOC., CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 23-30 (1975) (discussed in *News & Notes*, 26 HOSP. & COMMUNITY PSYCHIAT. 249 (1975)); AM. PSYCHIAT. ASSOC.: CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL, TASK FORCE REPORT 8, (1974); H. STEADMAN & J. COCOZZA, CAREERS OF THE CRIMINALLY INSANE: EXCESSIVE SOCIAL CONTROL OF DEVIANCE (1974); CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL (J. Rapoport ed. 1969); DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH (C. Frederick ed. 1978); Levine, *The Concept of Dangerousness: Criticism and Compromise*, in *PSYCHOLOGY IN THE LEGAL PROCESS* 147-61 (B. Sales ed. 1977); Cocozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976); Cocozza & Steadman, *Some Refinements in the Measurement and Prediction of Dangerous Behavior*, 131 AM. J. PSYCHIAT. 1012 (1974); Dershowitz, *Psychiatry in the Legal Process: A Knife that Cuts Both Ways*, 4 TRIAL 29 (1968) (reprinted in 2(9) PSYCH. TODAY 43 (1969)); Dershowitz, *The Law of Dangerousness: Some Fictions About Predictions*, 33 J. LEGAL ED. 24 (1970); Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439 (1975); Dix, "Civil" Commitments of the Mentally Ill and the Need for Data on the Prediction of Dangerousness, 19 AM. BEHAVIORAL SCI. 318 (1976); Ennis & Litwack, *supra* note 96; Goldstein & Katz, *Dangerousness and Mental Illness: Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity*, 70 YALE L.J. 225, 235-36 (1960); Hunt & Wiley, *Operation Baxstrom After One Year*, 124 AM. J. PSYCHIAT. 974 (1968); Katz & Goldstein, *Dangerousness and Mental Health*, 131 J. NERVOUS & MENTAL DISORDERS 404 (1960); Kozal, Boucher & Garofolo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME AND DELINQUENCY 371 (1972); Laves, *The Prediction of "Dangerousness" As A Criterion for Involuntary Civil Commitment: Constitutional Considerations*, 3 J. PSYCHIAT. & L. 291 (1975); Levinson & Zan York, *The Attribution of "Dangerousness" in Mental Health Evaluations*, 15 J. HEALTH & SOC. BEHAVIOR 328 (1974); Meyerson, *Panel Report: When is Dangerous, Dangerous?*, 1 J. PSYCHIAT. & L. 427 (1973); Monoham & Beis, *Controlling Dangerous People*, 433 ANNALS 142 (1976); Monoham & Cummings, *Prediction of Dangerousness as a Function of It's Perceived Consequences*, 2 J. CRIM. JUST. 239 (1974); Page & Yates, *Civil Commitment and the Danger Mandate*, 18 CANADIAN PSYCHIAT. ASSOC. J. 267 (Aug. 1973); Peszke, *Is Dangerousness An Issue for Physicians in Emergency Commitment?*, 132 AM. J. PSYCHIAT. 825 (1975); Roth, *et al.*, *Dangerousness, Confidentiality and the Duty to Warn*, 134 AM. J. PSYCHIAT. 408, 509 (1977); Schreiber, *Indeterminate Therapeutic Incarceration of Dangerous Criminals: Perspective and Problems*, 56 VA. L. REV. 602, 618-21 (1970); Shah,

forensic psychiatrist, stated flatly in 1974 that he knew of "no reports in the scientific literature which are supported by valid clinical experience and statistical evidence that describe psychological or physical signs or symptoms which can be readily used to discriminate between the potentially dangerous and the harmless individual."¹⁴⁵ A reading of the recent literature on dangerousness suggests that Diamond's assertion is still valid. At present, psychiatric predictions of dangerousness are unreliable, of doubtful validity, and fraught with imprecision; they consistently overpredict the likelihood of harm-producing behavior.¹⁴⁶

Dangerousness and Civil Commitment of the Mentally Ill: Some Public Policy Considerations, 132 AM. J. PSYCHIAT. 501 (1975); Steadman & Cocozza, *Stimulus/Response: We Can't Predict Who is Dangerous*, 8 PSYCH. TODAY 32 (1975); Steadman, *Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychology*, 1 J. PSYCHIAT. & L. 409 (1973); Stone, 132 AMER. J. PSYCHIAT. 829 (1975); Tanay, *Law and the Mentally Ill*, 22 WAYNE L. REV. 781, 785-88 (1976); Waelder, *Psychic Determination and the Possibility of Predictions*, 32 PSYCHOANALYTIC Q. 15 (1963); von Hirsh, *Prediction of Criminal Conduct and Preventative Confinement of Convicted Persons*, 21 BUFFALO L. REV. 717 (1972); Note, *Developments—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1240-45 (1974).

For a bibliography of statistical studies which show that psychiatric predictions of dangerousness are unreliable, see Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCH. GEN. PSYCHIAT. 397 (1972).

For judicial opinions recognizing problems with psychiatric predictions of dangerousness and citing studies showing doubtful validity and reliability, see *Dixon v. Commonwealth*, 325 F. Supp. 966 (M.D. Pa. 1971) (where the court heard testimony concerning the Baxstrom patients). See also, *Washington v. United States*, 390 F.2d 444, 453 n.25, 455-56 (D.C. Cir. 1967); *State v. Krol*, 68 N.J. 236, 242, 249 n.2, 344 A.2d 289, 295, 301 n.2 (1975); *State v. Carter*, 64 N.J. 382, 316 A.2d 449 (1974).

¹⁴⁵ Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439, 444 (1974). See also, Rappeport, Lassen & Hay, *A Review of the Literature of the Dangerousness of the Mentally Ill*, in *THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL*, 72, 79 (J. Rappeport ed. 1967).

¹⁴⁶ This problem of overprediction is the most serious consequence of psychiatric inexactitude. It is estimated that even with the most careful and painstaking testing approach to this problem (an approach rarely taken in the matter of civil commitments) the results will yield a minimum of 60% to 70% false positives—that is, those who are predicted to be dangerous but who in fact are not. Without elaborate testing, it may run well above 90%.

Note, *Standards for Involuntary Civil Commitment in Pennsylvania*, 38 U. PITT. L. REV. 535, 546 (1977). See T. SCHEFF, *BEING MENTALLY ILL* 105-27 (1966); Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways*, 2 PSYCH. TODAY 43, 47 (1969).

Serious consideration should be given to questioning any psychiatric prediction of dangerousness.¹⁴⁷ The first approach is to show that psychiatrists in general have no training or experience in making such predictions and that this general rule holds for the testifying psychiatrist as well.

Dr. Jones, did you receive any training in the diagnosis of mental illness?

Dr. Jones, have you had similar training in the prediction of dangerousness?

Doctor, are you familiar with the psychiatric literature on dangerousness?

Doctor, have you read the literature on dangerousness which does not appear in psychiatric journals?

Doctor, are you aware that much of the literature relevant to psychiatric prediction of dangerousness is not typically found in psychiatric journals?¹⁴⁸

¹⁴⁷ Dr. Alan Stone suggests that defense counsel can easily discredit the testimony of psychiatrists who testify as to the dangerousness of a patient in order to support commitment. Stone argues that:

the psychiatric community, insofar as they are proponents of therapeutic hospitalization and see themselves as doing good with limited resources, are particularly apt simply to 'cave in' when faced by hostile counsel.

It is just too damaging to the altruistic self-image of the psychiatrist to be cast as the coercive agent of the State and jailor of the helpless. Obviously his predictions of dangerousness cannot be validated, and if reforms of the commitment statutes move as they have been toward dangerousness as the central criterion, then the psychiatric witness will easily be discredited.

A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 234-35 (1975).

Dr. Stone concludes that dangerousness is "an unworkable standard" and "creates an impossible evidentiary problem, confines the untreatable, destroys important social resources, and may well be unconstitutional [as a form of civil preventive detention]." Stone, *Comment*, 132 *AM. J. PSYCHIAT.* 829, 829-30 (1975). Dr. Stone questions whether psychiatrists should not recognize their limitations in the prediction of dangerousness and "refuse to participate in this bizarre creation of legal process?" *Id.* at 830. He would move toward a result-oriented medical model with an emphasis on the right to treatment.

On the preventive detention aspects of confining the mentally ill who are dangerous see Dershowitz, *Preventive Confinement: A Suggested Framework for Constitutional Analysis*, 51 *TEX. L. REV.* 1277 (1973).

¹⁴⁸ Articles are often found in *CRIME AND DELINQUENCY*, *THE JOURNAL OF CRIMINAL LAW AND CRIMINOLOGY*, *CRIMINAL LAW BULLETIN*, *BULLETIN OF THE AMERICAN ACADEMY OF PSYCHIATRY AND LAW*, *THE JOURNAL OF PSYCHIATRY AND LAW*, and *SOCIAL PROBLEMS*.

The questions to the psychiatrist can be framed by inquiring about specific sources. For example:

Doctor, are you familiar with the report of the American Psychiatric Association Task Force on "Clinical Aspects of the Violent Individual?"¹⁴⁹ Doctor, don't you believe that a reasonably informed expert on dangerousness should be aware of the work of the American Psychiatric Association which reports and analyzes the existing research on the clinical issues concerning psychiatric evaluation and prediction of individual dangerousness?¹⁵⁰

In challenging a prediction of dangerousness, the following questions may be useful:

Doctor, could you describe what aspects of the defendant's behavior lead you to conclude she is dangerous? Is your conclusion based on behavior which you have not personally observed? If not, what is the source of your information about the described behavior?

Doctor, can you predict that the patient is dangerous based on a diagnosis which does not include observations of actual physical violence or threats of violence?

Doctor, isn't it true that many patients diagnosed as mentally ill are not dangerous?

Doctor, are there specific psychological, physical, or social criteria which permit a prediction of dangerousness?¹⁵¹

¹⁴⁹ APA TASK FORCE REPORT No. 8 (1974), *supra*, note 144.

¹⁵⁰ See Dix, *The Death Penalty, "Dangerousness," Psychiatric Testimony, and Professional Ethics*, 5 AM. J. CRIM. L. 151, 175 (1977). The Task Force Report specifically provides that "clinicians should avoid 'conclusory' judgments" on the predictions of dangerousness. APA TASK FORCE REPORT No. 8 (1974) at 33.

If the psychiatrist is not familiar with the TASK FORCE REPORT which is now more than five years in print, he can be asked whether he is familiar with more recent literature. For example, the psychiatrist could be asked whether he has read or reviewed DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH (C. Frederick ed. 1978) (a recently collected series of articles compiled by the National Institute of Mental Health). If the psychiatrist replies that he has not, then he can be asked how he maintains current expertise in his field if he does not read the publications of the National Institute of Mental Health and the American Psychiatric Association.

¹⁵¹ Diamond reports that he is unable to find anything in the psychiatric and scientific literature establishing psychological or physical criteria that permits ac-

Doctor, would it be fair to say that determinations of dangerousness are ultimately based on legal, social, and ethical perspectives as well as a psychological prediction?¹⁵²

Doctor, is dangerousness a psychiatric concept or is it merely a matter of making common sense inferences from what a person has done in the past?

In summary, defense counsel should seek to determine the qualifications of the mental health professional to testify on dangerousness; whether the psychiatrist can demonstrate a working knowledge of the literature concerning clinical prediction of future behavior; and the extent to which the psychiatrist has resolved the difficulties in making reliable and valid predictions of dangerousness.

Although it can be acknowledged that psychiatry and the psychological sciences now allow *some* understanding of the individual motivations and social determinants of past and present behavior, the present state of psychological knowledge still does not permit successful prophecy as to what a person will do in the future. The future behavior of any particular individual is a func-

curate prediction of dangerousness. Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439, 444 (1974).

One obvious influence on a psychiatric prediction of dangerousness is the patient's present disruptive and disorderly behavior. See Levinson & Zan York, *The Attribution of "Dangerousness" in Mental Health Evaluations*, 15 J. HEALTH & SOC. BEHAVIOR 328 (1974). See also Forst, *The Psychiatric Evaluation of Dangerousness in Two Trial Court Jurisdictions*, 5 BULL. AM. ACAD. PSYCHIAT. & L. 98 (1977). Other studies confirm that past behavior is the best statistical predictor of behavior, inadequate as it may be. Rosenblatt & Mayer, *The Recidivism of Mental Patients: A Review of Past Studies*, 44 AM. J. ORTHOPSYCHIAT. 697 (1974); Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCH. GEN. PSYCHIAT. 397 (1972).

¹⁵² "The determination of dangerousness involves a delicate balancing of society's interest in protection from harmful conduct against the individual's interest in personal liberty and autonomy. This decision, while requiring the court to make use of the assistance which medical testimony may provide, is ultimately a legal one, not a medical one." State v. Krol, 68 N.J. 236, 261, 344 A.2d 289, 302 (1975) (citing *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) and *Dixon v. Jacobs*, 427 F.2d 589, 595 n.17 (D.C. Cir. 1970)). "It should be emphasized that while courts in determining dangerousness should take full advantage of expert testimony presented by the State and by defendant, the decision is not one that can be left wholly to the technical expertise of the psychiatrists and psychologists." State v. Krol, 68 N.J. at 261, 344 A.2d at 302 (1975). See also *In re Ballay*, 482 F.2d 648, 654 (D.C. Cir. 1973). But see *In re Valdez*, 88 N.M. 338, 341, 540 P.2d 818, 821 (N.M. 1975).

tion of indeterminable individual and social factors.¹⁵³ Absent organic impairment which specifically constricts the range of behavior, man is "relatively" free to chart his own course in the world. We say relatively free since the free will-determinism debate still rages. At this time, standard psychiatric diagnostic sources provide no guide to accurate and reliable predictions of dangerousness. "[T]he terms used in standard psychiatric diagnosis are almost totally irrelevant to the determination of dangerousness."¹⁵⁴ Moreover, "[t]he concept of dangerousness is too broad to be psychiatrically defined. The capacity to engage in behavior which can be viewed as harmful is so universal that psychiatric differentiation of it is not feasible."¹⁵⁵

Dangerousness to Self

West Virginia, like other states, has procedures for involuntary civil commitment of those individuals whose mental illness creates a likelihood of serious harm to self or others.¹⁵⁶ The state seeks to protect the mentally ill from themselves based on the

¹⁵³ Dangerous behavior is "an *interactive* process of personality with social situations (provocations, stresses, etc.)" making a prediction of future behavior based on personality alone near impossible. Levinson & Zan York, *supra* note 151, at 329. At best, psychiatrists can make an "educated guess" as to potential dangerousness. *Id.* "Dangerousness seems to be a result of multiple forces. It cannot be attributed to a single factor, and it is not detectable through routine psychiatric examination. There is no single test for it." Kozol, *supra* note 140, at 383.

The process of prediction, far from being a relatively simple assessment of the consequences of certain triggering factors, is actually a rather complex feat involving a detailed understanding of the numerous possible interactions of those factors. The multiplicity of factors involved in this process, as well as the varying degrees to which any specific factor may or may not interact with the other factors, or even exist at all, make the actual prediction. Any psychiatric prediction based solely or primarily on the existence of a given factor, such as a particular diagnosis or even past violent behavior, is suspect in light of the literature which demonstrates the high degree of error in relying on any one factor as the basis for a prediction of future harm. Moreover, this same literature, supplemented by numerous studies, indicates the difficulty in determining how various factors interact and relate to future behavior.

S. SCHWARTZ & D. STERN, A TRIAL MANUAL FOR CIVIL COMMITMENT C-8 (1976).

¹⁵⁴ Kozol, *supra* note 140, at 383.

¹⁵⁵ Tanay, *Law and the Mentally Ill*, 22 WAYNE L. REV. 781, 787 (1976). Tanay contends that "[d]angerousness is an adjective describing a person as harmful from a classifier's frame of reference, not a clinical state in itself." *Id.*

¹⁵⁶ W. VA. CODE §§ 27-5-4(a)(2), 27-1-12(1) (Cum. Supp. 1979).

doctrine of *parens patriae*. This doctrine is premised on the assumption that an individual who poses a danger to his or her own health and well-being and who has lost the mental capacity to make rational judgments to act in his or her own best interests should be protected by the state even if the state's efforts are against the individual's will. The doctrine of *parens patriae* is increasingly being questioned as a legitimate rationale for protecting the mentally ill against their will.¹⁵⁷ The erosion of *parens patriae*

¹⁵⁷ See Abromovsky & McCarthy, *Civil Commitment of Non-Criminal Narcotic Addicts: Parens Patriae; A Valid Exercise of a State's Police Power; Or An Unconscionable Disregard of Individual Liberty?*, 38 U. PRR. L. REV. 477, 499-500 (1977). The psychiatric profession is, however, still enamored with the *parens patriae* doctrine. The following statement by a psychiatrist in an issue of the AMERICAN PSYCHIATRY JOURNAL is illustrative. "We are physicians. Our sole aim should be to ensure the welfare of our patients . . . Societal concerns are important, but these should be dealt with by the judicial system." Peszke, *Is Dangerousness An Issue for Physicians in Emergency Commitment?*, 132 AM. J. PSYCHIAT. 825, 826 (1975). For a recent attempt to devise a new *parens patriae* based commitment statute see Roth, *A Commitment Law for Patients, Doctors, and Lawyers*, 136 AM. J. PSYCHIAT. 1121 (1979).

This narrow view of the psychiatric role in furthering social justice should be subjected to close scrutiny. A former President of the American Psychiatric Association has called for "critical psychiatry" which would reexamine psychiatry in the light of the profession's duties to society. *APA Head Urges Scrutiny of Psychiatry, Review of Its Priorities*, Clinical Psychiatry News (1973). The problem with the "narrow view" is that it is used as a rationale for involuntary confinement for the purpose of allowing the physician to "care" for patients. For example, Peszke argues that:

to limit involuntary commitment to those who are considered dangerous is to assert that only those who are sick and dangerous can be treated, while those who are sick but not dangerous would be abandoned. To commit a mentally ill individual to a hospital simply because he fulfills the criterion of dangerousness while not committing a nondangerous mentally ill individual who is incapable of making rational decisions and could benefit from treatment is analogous to not hospitalizing an unconscious accident victim who is unable to ask for help but is not dangerous.

132 AM. J. PSYCHIAT. 825, 827 (1975). This argument is superficially attractive but problematic on closer analysis. First, the attempt to analogize the nondangerous mentally ill to the unconscious accident victim is simplistic. The mentally ill, for the most part, are not unconscious. They feel, hear, see, and observe the world around them. They are not oblivious to their environment. The consciousness of the mentally ill may be *different* as a result of distortions in thinking, disorientation as to time and space and the presence of auditory and visual hallucinations. However, it cannot be said that the mentally ill are unconscious. Rather, in one sense, they have greater consciousness if we consider the ability of the mentally ill to *know* their repressed unconscious.

The argument fails to accept the responsibility for the social implications of a

has been hastened by judicial action.¹⁵⁸

In *Hawks v. Lazaro*,¹⁵⁹ the West Virginia Supreme Court of Appeals declared unconstitutional an involuntary commitment provision which allowed confinement upon a showing that the person was mentally ill and "in need of custody, care or treatment in a hospital." The statute under consideration in *Hawks* gave the state of West Virginia the power to act for the mentally ill in its role as *parens patriae* and allowed a state determination of the need for care where the person had insufficient insight or capacity to make responsible decisions with respect to his or her own welfare.¹⁶⁰ The West Virginia Supreme Court of Appeals, however, found that the state was unable to demonstrate a compelling state

medical decision to treat when the patient will not submit voluntarily. Unconscious accident victims, because they are unconscious, submit without resistance to medical care. As soon as the accident victim regains consciousness he or she is free to resist medical treatment. The conscious mentally ill patient is denied the right to make this fundamental decision. The mentally ill are held involuntarily against their will so that "care" can be provided. Arguably, then the argument fails of its own weight without consideration of the individual harm in confinement and the inadequacy of treatment modalities.

A final deficiency in the argument is that there is an assumption that an involuntary patient will respond to "care" and treatment as if the patient had voluntarily submitted to the treatment. Voluntariness is itself an important factor in the outcome of treatment. This factor has traditionally been ignored in psychiatric studies of mental patients and by psychiatrists who defend the *parens patriae* medical model. See Lakovics, *Voluntariness of Hospitalization As An Important Research Variable and Legal Implications of Its Omission from the Psychiatric Research Literature*, MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 195-203 (F. Ayd. ed. 1974); Benedetti, *Crucial Problems in the Psychotherapy of Schizophrenia*, 35 AM. J. PSYCHOANALYSIS 67 (1975); Hardford, et al., *Effects of Legal Pressure on Prognosis for Treatment of Drug Dependence*, 133 AM. J. PSYCHIAT. 1399 (1976).

On the voluntary mental patient, see generally Appelbaum, *The Voluntary Patient—A Psychiatrist's Perspective*, 45 J. KAN. B.A. 37 (1976); Farney, "Voluntary" Psychiatric Patient, 45 J. KAN. B.A. 37 (1976); Gilboy & Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 NW. U.L. REV. 429 (1971); Olin & Olin, *Informed Consent in Voluntary Mental Hospital Admissions*, 132 AM. J. PSYCHIAT. 938 (1975); Payne, *Voluntary Admission to a Mental Hospital—Effect Upon the Patient's Rights*, 9 BEVERLY HILLS B. A. 20 (1975).

¹⁵⁸ The historical evolution of *parens patriae* in the civil commitment field has been charted by Justice Neely in *Hawks v. Lazaro*, 202 S.E.2d 109 (W. Va. 1974). See also, Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1207-12 (1974).

¹⁵⁹ 202 S.E.2d 109 (W. Va. 1974).

¹⁶⁰ *Id.* at 123.

interest "for hospitalizing a person in his own best interests."¹⁶¹ The individual's need for hospitalization because of an inability or failure to care for himself or herself due to mental illness was found to be inadequate to permit state intervention to protect the individual. The court expressly rejected an invitation to give a broad reading to the application of *parens patriae* by the state.¹⁶²

In repudiating the *parens patriae* doctrine which, the state argued, would permit confinement of the mentally ill in need of care and treatment, the West Virginia Court noted that:

it is possible for many nonviolent people, even those who suffer from a mental disease or retardation to such an extent that they are unable to earn a living, to live outside of an institution, and when these people prefer to do so, regardless of the wisdom of their decision, or the strength of their reasoning powers, the constitution guarantees them the right to follow their own desires.¹⁶³

The *Hawk's* decision is anomalous. Its comprehensive and systematic debunking of the *parens patriae* notion is followed by a definition of harm firmly rooted in *parens patriae*. The express purpose of the court in overturning the statutory standard for involuntary civil commitment was to substitute less subjective criteria which would satisfy constitutional due process requirements.¹⁶⁴ Objectivity of the judicially required standard was to be premised on the requirement that an individual be not only mentally ill but "likely to injure himself or others if allowed to remain at liberty."¹⁶⁵

While the objectivity of the "injurious" requirement is open to debate, the court in defining what constitutes harm to self has resurrected *parens patriae* and reopened the door to subjectivity and possible constitutional challenges. The court requires only a

¹⁶¹ *Id.*

¹⁶² The erosion of the *parens patriae* doctrine in West Virginia reflects a similar trend in the judicial decisions of the Supreme Court. *See, e.g., O'Connor v. Donaldson*, 422 U.S. 563 (1975); *In re Gault*, 387 U.S. 1 (1967); *Specht v. Patterson*, 386 U.S. 605 (1967).

¹⁶³ *Hawks v. Lazaro*, 202 S.E.2d at 123. *See O'Connor v. Donaldson*, 422 U.S. 563 (1975).

¹⁶⁴ The court was aware that "[t]he lack of a specific standard always creates opportunities for abuse . . ." 202 S.E.2d at 123.

¹⁶⁵ *Id.*

showing that the individual is a "passive" danger to self.¹⁶⁶ To meet a "passive" danger test, the state is required to show only that the individual is mentally ill and "that by sheer inactivity he will permit himself to die either of starvation or lack of care."¹⁶⁷ The court adds, cryptically, that involuntary commitment is also permitted where the mental illness "is likely to produce some form of injury other than direct physical injury, if the type of injury were definitely ascertainable, and if the State had a treatment program which it could be demonstrated offered a reasonable likelihood of ameliorating the illness or condition."¹⁶⁸ The court, in this passage, is clearly moving away from the objective requirement of specific physical harm to self where a non-physical injury (which the court does not describe) can be ascertained and successfully treated. Thus, where a need for treatment can be shown, and the treatment is available, the court's concept of "passive danger" would permit involuntary mental hospitalization.

The court's description of permissible involuntary commitment upon a showing of harm to self is totally inconsistent with its rejection of *parens patriae* and the concept of custodial commitments. The court specifically rejected any state interest in involuntary commitment based on the best interests of the individual. Yet, the court would allow a showing of passive harm to self where the individual is "so mentally retarded or mentally ill that by sheer inactivity he will permit himself to die either of starvation or lack of care"¹⁶⁹ It is indeed hard to distinguish the court's concept of passive danger from the "need of care" provision which it found unconstitutional. The court, unfortunately, fell prey to the lure of *parens patriae* in the definition of harm to self that it sought to avoid in the need of care or treatment provision.

The blurring of the concepts of harm to self and need for care and treatment occasioned by the court's analysis is now reflected in the statutory criteria for harm to self. The statute defines a person "likely to cause serious harm" as one who has: "(1) substantial tendency to physically harm himself which is manifested by

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 124.

¹⁶⁹ The present statutory delineation of harm does not adopt this suggestion by the court. Both the harm to self and others is statutorily prescribed as physical harm. See W. VA. CODE § 27-1-12 (1976 Replacement Vol.)

threats of or attempts at suicide or serious bodily harm or other conduct, either active or passive, which demonstrates that he is dangerous to himself"¹⁷⁰

The statutory definition of harm to self contains limiting criteria which would, if read alone, partially satisfy the West Virginia Court's concern for objectivity. The necessary harm to self requires: (1) a physical harm; (2) a serious harm;¹⁷¹ (3) a substantial likelihood of the occurrence of the harm; and (4) a harm manifested by threats or attempts at suicide or threats or attempts of bodily injury. If the statutory provision was so limited, some objectivity could be achieved. However, the statutory provision, in an attempt to track the judicial definition from *Hawks*, can be read to permit a finding of serious harm to self on the basis of "passive" conduct which demonstrates dangerousness.¹⁷² The statute itself does not define what constitutes "passive" conduct.

The following line of questioning may be an effective means of undermining the *parens patriae* rationale for commitment:

Defense Counsel: Doctor, is it your understanding that *all* mental patients are automatically rendered incapable of making rational decisions as to their personal safety and welfare?¹⁷³

Defense Counsel: Then the mere presence of mental illness does not in and of itself lead to the conclusion that the patient is dangerous to self?¹⁷⁴

¹⁷⁰ W. VA. CODE § 27-1-12 (1976 Replacement Vol.).

¹⁷¹ See Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1236-38 (1974).

¹⁷² *Id.*

¹⁷³ "A patient's competency to make decisions must be determined on an individualized and periodic basis, taking into consideration the nature of his mental illness, the degree of thought impairment, and the persistence of the symptoms of impairment." McGough & Carmichael, *The Right to Treatment and The Right to Refuse Treatment*, 47 AM. J. ORTHOPSYCHIAT. 307, 317 (1977).

¹⁷⁴ While there is little evidence to suggest that the mere presence of mental illness supports a psychiatric prediction that the patient is likely to be dangerous, this fact does not prevent psychiatrists from basing their testimony on such mistaken notions. For example, in one civil commitment hearing observed by the author, one psychiatrist testified that the patient was a chronic schizophrenic. In response to the prosecutor's question as to what schizophrenia was, the psychiatrist replied "it is a mental illness in which one is likely to be violent toward others or harm themselves." The second psychiatrist used a similar theory for her testimony that the patient was dangerous. In her testimony she noted that the patient was a

Defense Counsel: Doctor, are you aware of the psychiatric literature which indicates that many forms of mental illness have a highly specific impact on their victims, leaving reasoning and decisionmaking ability otherwise largely unimpaired?¹⁷⁵

Defense Counsel: Has the patient's mental illness in this case totally impaired his or her decisionmaking ability?

Defense Counsel: Doctor, isn't it possible that the patient is capable at times of relatively rational decisionmaking?

If the answer to the last question is yes, defense counsel can argue that the assumptions underlying and supporting *parens patriae* are no longer present. *Parens patriae* is premised on the theory that the decisionmaking ability of the patient has been impaired as a result of the mental illness and that the state is acting for the patient until such time as rational decisionmaking can be restored. Only when *parens patriae* commitments are restricted "to those mentally ill persons who are incapable of evaluating the desirability of psychiatric care" is there the necessary relationship between statutory means and ends to satisfy constitutional due process¹⁷⁶ and equal protection.¹⁷⁷ In the last analysis, *parens patriae* should be limited to "[p]ersons whose refusal to accept treatment results from a delusional system associated with their mental illness and individuals whose disorder renders them unable to relate or respond to others"¹⁷⁸ In such cases, *parens patriae* is used to justify commitment of only those individuals whose "mental disorder has destroyed the power to make choices or has prevented a decision based on relevant factors."¹⁷⁹

A second approach to questioning the psychiatrist on *parens patriae* commitments is suggested by this question:

Defense Counsel: Doctor, regardless of the presence of

schizophrenic and that "an individual suffering from this form of mental illness is likely to be dangerous to self or others."

¹⁷⁵ See Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1214 n.80 (1974).

¹⁷⁶ *Id.* at 1215.

¹⁷⁷ *Id.* at 1215-16.

¹⁷⁸ *Id.* at 1219.

¹⁷⁹ *Id.*

mental illness, don't you think one could make a rational decision to forego hospitalization in a mental institution?

An argument to support this line of questioning is found in *Hawks* where the West Virginia Supreme Court of Appeals, appalled by the conditions in the state's mental institutions, expressed concern over the state's failure to adequately fund and staff mental hospitals and the ineffectiveness of mental institutions as a means of solving the problems of mental illness.

Whenever the state asserts its role as *parens patriae*, it is appropriate to argue to the MHC that West Virginia's highest court recognizes that confinement in "the State of West Virginia offers to those unfortunates who are incarcerated in mental institutions Dickensian squalor of unconscionable magnitudes."¹⁸⁰ The court in *Hawks* outlined various factors which indicated that West Virginia is neglecting the mentally ill. The court found that state expenditures per patient ranked West Virginia forty-ninth among the states.¹⁸¹ The level of professional care, as administered by physicians and staff, was inordinately low. West Virginia ranked forty-seventh in physician hours per week and forty-ninth in the nation of professional staff to employees.¹⁸² The court labeled the financial support "parsimonious."¹⁸³

In *Hawks*, the West Virginia Court recognized that "institutionalization is frequently the worst treatment which can be provided a person suffering from mental problems" and that hospitalization under the conditions of West Virginia mental hospitals "may inflict positive harm on the patients."¹⁸⁴ In many cases

¹⁸⁰ *Hawks v. Lazaro*, 202 S.E.2d 109, 120 (W. Va. 1974).

¹⁸¹ *Id.*

¹⁸² *Id.* at 120-21.

¹⁸³ *Id.* at 121.

¹⁸⁴ *Id.* On the adverse harmful impact of hospitalization in a mental institution, see *Lessard v. Schmidt*, 349 F. Supp. 1078, 1088-90 (E.D. Wis. 1972); Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101, 105-06 (1971); Rosenhan, *On Being Sane in Insane Places*, 13 SANTA CLARA LAW. 379, 394-98 (1973) (reprinted from 179 Sci. 250 (1973)); Talbot, Miller & White, *Some Antitherapeutic Side Effects of Hospitalization and Psychotherapy*, 27 PSYCHIAT. & PSYCHOTHERAPY 170 (1964). See generally, E. GOFFMAN, *ASYLUMS* (1961); D. VAIL, *DEHUMANIZATION AND THE INSTITUTIONAL CAREER* (1966).

Given the high spontaneous remission rate for some symptoms of mental illness, the need for hospitalization should be subjected to close scrutiny. For example, the spontaneous remission rate for schizophrenia is from 20% to 40%. Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV.

it may be appropriate to ask whether, in fact, there isn't a greater likelihood of harm to the patient from being hospitalized than in remaining in the community?

The most extreme form of harm to self is suicide. Both the legal and psychiatric professions abhor suicide, and testimony of an individual who is potentially suicidal or has attempted suicide is especially difficult to overcome. There are, however, a number of ways to attack psychiatric testimony as to suicidal behavior. Even in the face of clear and convincing evidence that the client is bent on self-destruction, an argument can be made against commitment.¹⁸⁵ The statute speaks of *harm* to self. In some cases, the actual harm from suicide may be less than the agony from continued life. One author has pointed out that "it is hardly difficult to imagine circumstances where suicide, if not a positive good, would readily be recognizable as the lesser of evils."¹⁸⁶ The following questions are suggestive of a defense of the suicidal patient:

Defense Counsel: Are you familiar with the psychiatric literature which suggests that suicide may be just as likely linked to a planned, organized effort to reduce intolerable stress than obsessional aspects of depression and schizophrenia?¹⁸⁷

Defense Counsel: Doctor, is it possible that the patient poses a serious likelihood of harm to self only in the sense that she or he is willing to risk dying to call attention to his or her life situation?

The point here is that the patient rationally takes a risk to obtain sufficient attention so as to communicate the desire to live.

1190, 1220 n.100 (citing S. RACHMAN, *THE EFFECTS OF PSYCHOTHERAPY* 108-09 (1971)).

For a defense of the use of involuntary civil commitment as a benefit to patients by psychiatrists see Peele, Chodoff & Taub, *Involuntary Hospitalization and Treatability: Observations from the District of Columbia Experience*, 23 CATH. U.L. REV. 744 (1974).

¹⁸⁵ For a succinct review of the philosophical debate presented by this argument, see materials collected in W. BISHIN & C. STONE, *LAW, LANGUAGE, AND ETHICS* 1126-55 (1972).

¹⁸⁶ Greenberg, *Involuntary Psychiatric Commitments to Prevent Suicide*, 49 N.Y.U.L. REV. 227 (1974).

¹⁸⁷ See *Id.* at 234-36 and psychiatric studies cited therein. Greenberg summarizes that: "[t]o plan and carry through a suicide attempt may require more ability to think coherently and to act in a realistic, organized fashion than a patient with delusions or obsessions possesses." *Id.* at 235.

Defense Counsel: Are you familiar with the studies which suggest that attempted suicides are more likely to suggest an effort to live than to die?¹⁸⁸

Defense Counsel: What treatment for suicide is available within the hospital?

Defense counsel can raise the issue of whether involuntary commitment is likely to alleviate the suicidal tendencies. One commentator has noted that authorities on suicide question the effectiveness of hospitalization and find that it "rarely results in any increase of self responsibility on the part of the patient. He does not thereby gain any additional insight into the problems and conflicts which led him to a suicide-prone posture."¹⁸⁹ Moreover, recent literature on the suicide-prone patient does not stress the use of hospitalization. "Rather, emphasis is laid on person-to-person contact and continued sympathetic support for the individual."¹⁹⁰

Defense Counsel: Doctor, do you have any evidence to show that hospitalization prevents suicides, in general?¹⁹¹

Defense Counsel: Doctor, does the psychiatric profession know how to prevent suicide?

In fact, very little is known about suicide prevention.¹⁹² "Most individuals who commit suicide are not mentally ill, and most of the mentally ill do not commit suicide."¹⁹³

While the psychiatric testimony will undoubtedly make it appear that any suicide attempt or threat is related to the mental illness, an equally plausible argument can be made that the suicidal behavior is rational based on all the circumstances. If the psychiatrist has not investigated the circumstances surrounding the behavior, a rival hypothesis can be offered to undermine the "clear and convincing" nature of the psychiatric judgment.

In a variety of cases, the patient will not have actually at-

¹⁸⁸ *Id.* at 237-39 and psychiatric studies cited therein.

¹⁸⁹ Note, *Civil Commitment of the Mentally Ill in California: 1969 Style*, 10 SANTA CLARA LAW. 74, 94 (1969), cited in A. BROOKS, LAW, PSYCHIATRY AND MENTAL HEALTH SYSTEMS 708 (1974).

¹⁹⁰ A. BROOKS, LAW, PSYCHIATRY AND MENTAL HEALTH SYSTEMS 707 (1974).

¹⁹¹ See Greenberg, *supra* note 186, at 257-59.

¹⁹² *Id.* at 256.

¹⁹³ See *supra* note 184, at 1227.

tempted suicide but will have threatened suicide or confessed to the psychiatrist of suicidal thoughts or attempts. Such predictions are frequently made in the case of depressed patients. The psychiatrist who admits on cross-examination that suicidal thoughts alone support a diagnosis of mental illness should be questioned as follows:

Defense Counsel: Doctor, could you tell the court the manner in which you determined that the patient is suicidal and the basis for your judgment?

Defense Counsel: Is it your contention that the reporting of a suicidal thought can be taken as conclusory evidence of mental illness?

Defense Counsel: Then, your diagnosis of mental illness was not based on the suicidal thoughts?

Defense Counsel: Doctor, are you familiar with those studies which conclude that very few of the patients who are severely depressed or who express suicidal thoughts or threats actually commit suicide?¹⁹⁴

Defense Counsel: Doctor, statistically wouldn't you be on better grounds to predict that the patient is not dangerous to self?

Defense Counsel: Doctor, with what degree of certainty can you predict that this patient will commit suicide within the year?

Defense Counsel: How have you derived that measure of accuracy?

INVOLUNTARY HOSPITALIZATION — IS THERE A LESS RESTRICTIVE ALTERNATIVE?

Involuntary hospitalization of the mentally ill is increasingly being considered a drastic measure of last resort in caring for the mentally ill.¹⁹⁵ A number of factors have coalesced to focus national

¹⁹⁴ See Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events*, 18 J. CONSUL. PSYCH. 397, 401-02 (1954). The psychiatrist can be asked if he is aware that "[o]nly about 1% of all surviving attempters kill themselves within a year of the attempt." Greenberg, *supra* note 186, at 239, and psychiatric studies cited at 239 n.39. Over a longer time period, five to fifteen years, no more than 5% to 15% of attempters kill themselves. *Id.*

¹⁹⁵ *But see*, Slovenko, *Criminal Justice Procedures in Civil Commitment*, 28 HOSP. & COMMUNITY PSYCHIAT. 817 (1977). Slovenko laments the deinstitutionalization of mental patients and paints a rather bleak picture of their life in

attention on state mental hospitals. One factor is a movement, which began in the mid 1950's, to provide mental health services at the community level in contrast to large, isolated state mental hospitals.¹⁸⁸ The community mental health approach places a high value on treating the patient in the community and on a voluntary, out-patient basis. Community involvement in the problems of the mentally ill and decreased stigma of being treated for mental problems have resulted in greater scrutiny of decisions to commit individuals involuntarily to state mental hospitals under the *parens patriae* doctrine.

The trend in institutional psychiatry away from hospitalization and toward treatment on an out-patient basis, in a com-

the community. Such patients "end up abandoned, without even basic services, in ghettos or back alleys." *Id.* at 825. "In the hospital, the patients may have had nightmares, but in the so-called community they are living a nightmare." *Id.* See also, Slovenko, *Criminal Justice Procedures in Civil Commitment*, 24 WAYNE L. REV. 1 (1977).

¹⁸⁸ See WIESENTHAL, LEGISLATIVE ACTION FOR COMMUNITY MENTAL HEALTH CENTER PLANNING: AN EVALUATION (1969); Bleicher, *Compulsory Community Care for the Mentally Ill*, 16 CLEV.-MAR. L. REV. 93 (1967); Greenblatt & Glazier, *The Phasing Out of Mental Hospitals in the United States*, 132 AM. J. PSYCHIAT. 1135 (1975); Ochberg & Brown, *Mental Health and the Law: Partners in Advancing Human Rights*, 123 U. PA. L. REV. 491 (1974); Schwartz, *Community Mental Health in 1972: An Assessment*, in 2 PROGRESS IN COMMUNITY MENTAL HEALTH 3-34 (H. Barten & L. Bellak eds. 1972); Wexler & Scoville, *Special Project: The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 181-90 (1971).

The mid 1950's witnessed two developments which have changed the nature of our perspective on mental illness.

The first development was the introduction of rauwolfia and the phenothiazines, the first of the so-called tranquilizers. The therapeutic effects of these drugs contributed to improved treatment and management of many acute psychotic patients, facilitated reduction in the duration of hospital stay, and increased the percentage of patients discharged from hospitals for both chronic and acute illnesses.

The second development involved new psychosocial and behavioral methods of treatment in the mental hospital and revised attitudes toward the social treatment of patients . . . including the 'open door' policy, avoidance of seclusion and restraint, development of large group techniques such as therapeutic communities, upgrading of the education of nonprofessionals, conscious effort at early discharge, efforts to break down administrative and other barriers between the hospital and its community, involvement of the family, and a series of developments known at that time as 'social psychiatry.'

Klerman, *Mental Illness, the Medical Model, and Psychiatry*, 2 J. MED. & PHIL. 220, 223 (1977).

See also R. BALDESSARINI, CHEMOTHERAPY IN PSYCHIATRY 1-11 (1977).

munity or foster sheltered care home, or special nursing home care facilities, has been promoted by the courts¹⁹⁷ and, more recently, state legislatures¹⁹⁸ under the rubric of "least restrictive alternative."¹⁹⁹

The need for "less restrictive alternatives" has been recognized, statutorily mandated, and recently reconfirmed in West Virginia.²⁰⁰ The West Virginia Code specifically requires the MHC to make a finding as to whether there is a less restrictive alternative to commitment which is appropriate for the individual.²⁰¹ A recent statutory amendment prohibits involuntary hospitalization if the person can be treated in the community. "No person who can be treated as an out-patient at a community mental health center shall be admitted involuntarily into a state hospital."²⁰²

The West Virginia statute does not, however, offer suggestions as to alternatives to hospitalization except placement with a "responsible person who will agree to take care of the individual"²⁰³ This can hardly be considered a viable alternative. Individuals subject to involuntary commitment are generally those who have no immediate family or friends, or if they do, these

¹⁹⁷ See, e.g., *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969); *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966); *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972).

¹⁹⁸ See Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1138-40 (1972) (an early but seminal work on the "least restrictive alternative").

¹⁹⁹ See generally, Chambers, *supra* note 198; Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 1100 (1977). For a recent, critical view of the "least restrictive alternative" concept see Tanay, *Law and the Mentally Ill*, 22 WAYNE L. REV. 781, 800-03 (1976). One court has recently found that the "least restrictive alternative" applies not only to the type of confinement but to the type of treatment. *Rennie v. Klein*, 452 F. Supp. 1131, 1146-47 (D.N.J. 1978).

²⁰⁰ The Supreme Court of Appeals of West Virginia has recognized the least restrictive alternative concept in the incarceration of juvenile status offenders. (*Harris v. Calendine*, 233 S.E.2d 318 (W. Va. 1977)). "[I]n view of the fact that there are numerous alternatives to incarceration for status offenders we hold that the state must exhaust every reasonable alternative to incarceration before committing a status offender to a secure, prison-like facility." *Id.* at 329) and in confinement of the mentally ill. *Markey v. Wachtel*, No. 144-79 (filed Dec. 11, 1979), ___ S.E.2d ___ (W. Va. 1979).

²⁰¹ W. VA. CODE § 27-5-4(j)(2) (Cum. Supp. 1979). See also W. VA. CODE § 27-5-3(a) (Cum. Supp. 1979).

²⁰² W. VA. CODE § 27-2A-1(b)(4) (Cum. Supp. 1979).

²⁰³ W. VA. CODE § 27-5-4 (Cum. Supp. 1979).

significant others have given up in their efforts to care for the individual. Commitment proceedings are most often initiated when responsible persons have concluded that they can no longer take care of the individual.

An important question raised here is whether a MHC can order an individual committed to a local community mental health center which does not have in-patient facilities and which is not equipped to physically confine and restrain patients. The statute speaks throughout of commitment and admission to a mental health facility.²⁰⁴ The statute defines a mental health facility as "any in-patient, residential or out-patient facility for the care and treatment of the mentally ill, mentally retarded or addicted which is operated, or licensed to operate, by the department of health and shall include state hospitals . . . [and] a veterans administration hospital."²⁰⁵

It is not uncommon for mental health professionals to take the position that commitment for treatment at community mental health centers is desirable where the patient is capable of treatment on an out-patient basis. An essential question is whether the MHC has statutory authority to order treatment by a local community mental health center. The threshold legal question is whether community mental health centers are "mental health facilities" within the meaning of the West Virginia Code.

A further anomaly in the argument for commitment to community health centers is that patients who are mentally ill and likely to cause serious injury to self or others would be treated as out-patients rather than confined. Arguably, a mental patient who is sufficiently stable to be treated as an out-patient is not sufficiently dangerous to self or others to satisfy the clear, cogent, and convincing evidence of dangerousness which is required by the statute. If the patient is sufficiently dangerous to justify civil commitment under the statute, then an out-patient facility may incur civil liability for harm which occurs to the individual or others as a result of its failure to secure the individual's confinement in a manner reasonably likely to prevent the harm.²⁰⁶

²⁰⁴ See, e.g., W. VA. CODE §§ 27-5-3a, -4(a) (Cum. Supp. 1979).

²⁰⁵ W. VA. CODE § 27-1-9 (Cum. Supp. 1979).

²⁰⁶ See *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). See also, Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025 (1974); Griffith &

The statutory requirement that the "least restrictive alternative" be employed in the care and treatment of the mentally ill offers considerable opportunities for defense counsel representing both hospitalized and non-hospitalized clients. Defense counsel cannot, however, effectively utilize the "less restrictive alternative" requirement unless there is a thorough investigation of potential alternatives prior to the commitment hearing. As one legal commentator noted: "Prior to the hearing the attorney must explore the treatment and the custodial resources, in addition to the state hospital, that are available. He must understand the various services offered in the community and the techniques for making use of a potentially useful resource."²⁰⁷

While the investigative function may, as a result of inaction or inattention by the mental health professionals, fall to defense counsel,²⁰⁸ the burden of proof that involuntary commitment is necessary and that no less drastic means of treatment are available falls to the state. The West Virginia statute specifically places the burden of proof that no "less restrictive alternative" is available "on the persons seeking the commitment of the individual."²⁰⁹ As a practical matter, prosecutors satisfy the burden of proof by conclusory statements of psychiatrists that no alternatives to hospitalization are available.²¹⁰ Arguably, a mere conclusion as to the absence of alternatives does not satisfy the burden placed upon the state. At minimum, the state should be required to adduce testimony as to: "(1) [w]hat alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alterna-

Griffith, *Duty to Third Parties, Dangerousness, and the Right to Refuse Treatment: Problematic Concepts for Psychiatrist and Lawyer*, 14 CALIF. W. L. REV. 241 (1978); Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976).

²⁰⁷ Cohen, *supra* note 8, at 452-53.

²⁰⁸ On the search for alternatives and the institutional means for securing the right to "less restrictive" approaches to treatment, see Chambers, *supra* note 198, at 1168-77.

²⁰⁹ W. VA. CODE § 27-5-4(j)(2) (Cum. Supp. 1979).

²¹⁰ In one commitment hearing the author attended the testimony on least restrictive alternative was as follows:

Prosecutor: "What disposition would you recommend?"

Psychiatrist: "Indefinite commitment to Weston."

Prosecutor: "Are there other possibilities?"

Psychiatrist: "Not within the family or the State of West Virginia."

Defense Counsel in closing argument questioned in passing whether alternatives to hospitalization had actually been sought.

tives were not deemed suitable."²¹¹ The failure of defense counsel to personally explore alternatives to hospitalization and to require those seeking commitment to comply with the statutory burden of actual proof as to "less restrictive alternatives" seriously prejudices the interests of the client.²¹²

*Case Report: Least Restrictive Alternative and
Passive Danger to Self*

One of the most serious deficiencies in our present treatment of the mentally ill is the confinement of those who pose no serious threat to others but who are unable to look after their own needs. Such confinements are based on the absence of community inpatient facilities in West Virginia for the care of the mentally ill. These confinements are legally supported on the basis of the patient's "passive danger to self."

The civil commitment hearing herein reported²¹³ follows the pattern outlined above. It is a perfect example of how psychiatrists are willing to confine those whom they have no way to treat and how defense lawyers fail to push the mental health system to provide better facilities by blocking institutional confinement where a less restrictive alternative is feasible but simply unavailable.

This case involved the petition for recommitment of a fifty-seven year old man committed in June of 1959 to Weston State Hospital, Weston, West Virginia. The first psychiatrist testified that the patient had been examined a number of times and, for the purpose of the August 22, 1977 hearing, was examined on August 8 of that year. The psychiatrist, in a narrative fashion, stated that the patient had been admitted in 1959 with lesions and a variety

²¹¹ *Lessard v. Schmidt*, 349 F. Supp. 1078, 1096 (E.D. Wis. 1972). See also *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966), (where the court indicated that the state should "bear the burden of exploration of possible alternatives" to commitment). Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101, 113-14 (1971).

²¹² Arguably the "least restrictive alternative" requirement can be applied to decisions within the institution as well as to those decisions made at the time of the initial determination to involuntarily commit. See *Covington v. Harris*, 419 F.2d 617, 623-24 (D.C. Cir. 1969); Morris, *Institutionalizing the Rights of Mental Patients: Committing the Legislature*, 62 CALIF. L. REV. 957, 960-61 (1974). A recent study of a Connecticut state hospital suggests that the least restrictive alternative mandate is not being met. See note 233, *infra*.

²¹³ See Appendix, introductory footnote.

of medical problems. The psychiatrist's examination of the record indicated that the patient had never been married and had lived with his father until admitted to Weston. Prior to his commitment, he worked in the coal mines "until he became sick." The psychiatrist noted that during the course of his confinement the patient had been given every form of psychiatric treatment except pre-frontal lobotomy. At the August 8, 1977 examination, the psychiatrist found the patient "yelling, untidy, cursing God, hallucinating, auditorily and visually." At present:

the patient's affect varies from flat to inappropriate. He is not a real problem now. The patient is completely out of touch with reality. He can give you very little about his life. He is disoriented as to time and place. Memory is quite poor. We have here the effects of long hospitalization. In addition, there have been organic changes superimposed on the original schizophrenic illness.

Prosecutor: Is what you have outlined a mental illness?

Psychiatrist: Yes.

Prosecutor: What disposition would you recommend?

Psychiatrist: Indefinite commitment to Weston.²¹⁴

Prosecutor: Are there other possibilities?

Psychiatrist: Not within the family or the State of West Virginia.

Cross Examination:

Defense Counsel: Did you examine the patient weekly?

Psychiatrist: No. I frequently see the patient around the institution but have not actually examined him weekly.

Defense Counsel: Doctor, what do you observe as to the patient's dangerousness?

Psychiatrist: The patient yells, curses God, and obviously hallucinates about God. This can antagonize people and they could hurt him. The patient cannot take care of himself.

Defense Counsel: Has the patient ever attacked another patient?

Psychiatrist: No. There is a history of a pseudo-suicide attempt. The record indicates one vague story of a pseudo-suicide attempt in 1958 or 1959.

Defense Counsel then read from the patient's file and noted

²¹⁴ The psychiatrist's recommendation of an indefinite commitment exceeded statutory limitations on involuntary commitments. Orders for involuntary commitment in West Virginia are limited to a duration of two years. W. VA. CODE § 27-5-4(d) (Cum. Supp. 1979).

that at the time of admission to the institution in 1959 the patient spoke well and "to the point." The patient's record indicated that the "patient is oriented in all three spheres." The defense attorney then proceeded to read from the patient's record an entry of July 28, 1977 which indicated that the patient "is now disoriented in all three spheres."

Defense Counsel: Why has the patient regressed?

Psychiatrist: The illness itself can do it. Being hospitalized can make one have less need for orientation. He has regressed since his hospitalization.

Defense Counsel: The real reason he is defined as dangerous is because he can't take care of himself, is that right?

Psychiatrist: Yes.

MHC: This patient is out of touch with reality. Everything he is saying now is a result of hallucinations, is that right doctor?

Psychiatrist: Yes.

A second psychiatrist testified that she had examined the patient on August 16, 1977. At the time of examination:

the patient had not bathed. He was very disheveled, an older man. I would diagnose him as paranoid and delusional. He did know it was 1977 and that he was in Weston. He knew that the President was Jimmy Carter. I had trouble interacting with him. He had trouble answering questions, he was hallucinating. The patient is a paranoid schizophrenic with regression due to hospitalization.

Prosecutor: Is the patient dangerous to himself or others?

Psychiatrist: He is a passive danger to himself. He can feed himself, but cannot take care of other needs. He has episodes of withdrawal and yelling. I have not observed him as being violent. He could manage outside the hospital.²¹⁵

Cross Examination

Defense Counsel: Has the patient ever attempted suicide?

Psychiatrist: He did not display any suicidal tendencies.

MHC: What is the cause of his being unable to care for himself?

Psychiatrist: His mental illness.

²¹⁵ One study has suggested that 75% of the patients with a diagnosis of schizophrenia studied could be discharged from the hospital. Mendel, *Brief Hospitalization Techniques*, 6 CURRENT PSYCHIAT. THERAPIES 310 (1966). See also, Davis, *Overview: Maintenance Therapy in Psychiatry: I. Schizophrenia*, 132 AM. J. PSYCHIAT. 1237 (1975).

MHC: Can the regression be reversed?

Psychiatrist: I doubt it. I can't explain the regression except for lack of stimuli.

The defense attorney expressed concern that the hospital had created the problem and that alternatives to hospitalization should be sought. The MHC held that the patient was mentally ill and a "passive danger to self" and ordered commitment, not to exceed two years.

INSTITUTIONAL PROBLEMS IN LEGAL REPRESENTATION OF THE MENTALLY ILL

Legal representation of the mentally ill involves two problems: providing legal counsel for individuals subject to involuntary confinement and providing legal representation of the mental patient already confined.

Legal representation of the indigent in civil commitment hearings in West Virginia is now supplied by appointing private practitioners compensated by the state.²¹⁶ Personal observation of West Virginia civil commitment hearings, discussions with MHCs and appointed attorneys, and comparisons of the role of defense counsel in West Virginia to that described in the legal literature,²¹⁷ all lead to the conclusion that West Virginia fails to provide effective legal representation to the mentally ill at the time of commitment and during hospitalization.

The West Virginia statute requires the appointment of "competent" counsel²¹⁸ who can protect the interests of the client. "Competent" counsel, for purposes of the statute, is not simply competence in general lawyering skills. Competence must refer to the background, training, and expertise which are necessary for the effective representation of the mental health patient. Bruce Ennis, a leading and zealous guardian of mental patients rights, has argued that "[i]nexperienced attorneys cannot adequately represent mental patients."²¹⁹

The present system of legal representation at civil commitment hearings is unsound. The system does not promote strong

²¹⁶ W. VA. CODE §§ 27-5-4(g)(2), -4(h)(3) (Cum. Supp. 1979).

²¹⁷ See note 8, *supra*.

²¹⁸ See W. VA. CODE § 27-5-4(g)(2) (Cum. Supp. 1979). See also note 101, *supra*.

²¹⁹ Ennis, *Civil Liberties & Mental Illness*, 7 CRIM. L. BULL. 101; 126 (1971).

and zealous representation. Attorneys are appointed on an ad hoc basis using any system that the MHC and/or circuit court may devise. There is no systematic effort to encourage or to require the appointed attorneys to perform any specific functions other than their appearance at the hearing.²²⁰ Even the representation at the hearing is inadequate. In none of the observed cases reported in this article or in the Appendix did defense counsel question the credentials or expertise of the psychiatrists who testified as expert witnesses. In the cases observed by the author, one of the psychiatrists was a doctor with many years of experience in institutional and community psychiatry. A second psychiatrist, however, was doing a rotation in psychiatry at the West Virginia University Medical Center. Defense counsel in each case proceeded on the basis that *both* witnesses were equally qualified to present expert testimony. Moreover, defense counsel did not inquire as to whether the psychiatric resident was a physician.²²¹

This article has attempted to demonstrate that defense counsel can, with adequate knowledge and training, cross-examine the psychiatrist as to both the existence of mental illness and the likelihood of dangerousness. The overwhelming opinion in legal and psychiatric circles is that psychiatrists are unqualified to predict dangerousness and have been shown in numerous studies to have little reliability or validity in their predictions.²²² Yet, assigned attorneys in the observed cases did not attempt to bring in this information when cross-examining the "expert" psychiatrist.

The performance of defense counsel in the observed cases went uncriticized by the MHC notwithstanding that, for the most part,

²²⁰ In Monongalia County, the Mental Health Commission requires that appointed counsel consult with the patient on the day immediately prior to the hearing. Personal communication from Ward D. Stone, Jr., Mental Health Commissioner, Monongalia County.

²²¹ The West Virginia Code requires testimony of one physician or psychologist to support a finding of mental illness and likelihood of serious harm to self or others for commitment. W. VA. CODE § 27-5-4(f) (Cum. Supp. 1979). The code further requires that the "physician" be licensed to practice medicine in West Virginia or be a Federal government medical officer, W. VA. CODE § 27-1-5 (1976 Replacement Vol.) and a "psychologist" be licensed to engage in the practice of psychology. W. VA. CODE § 27-1-10 (1976 Replacement Vol.).

²²² See notes 145 to 150, *supra*.

²²³ In none of the observed cases did defense counsel prepare or file any legal memorandum for the hearing. In those cases in which the Mental Health Commission entered an order of commitment, no appeal was taken.

defense counsel's efforts were perfunctory.²²³ In those cases where the MHC ordered the release of the client, the results were necessitated by the view of the psychiatrist that even though mentally ill, the patient was not a danger to self or others.²²⁴ The failure of defense counsel to play a more active role could, in the future, result in legal challenges to commitment proceedings and judicial supervision of the appointment process.²²⁵

Recognition of the ineffectual role of defense counsel for mental patients is only the first step in insuring adequate protection for the legal rights of individuals subject to civil commitment.²²⁶

²²⁴ Cases 2 and 3 in Appendix.

²²³ Ineffective assistance of counsel can be raised in a habeas corpus proceeding. In *Sloan v. Wachtel*, 233 S.E.2d 137 (W. Va. 1977), the West Virginia Supreme Court of Appeals held that the trial court's denial of a habeas corpus hearing, which would have allowed petitioner an opportunity to present evidence in support of an allegation of ineffective assistance of counsel during the course of an involuntary commitment proceeding, was erroneous.

The West Virginia mental health code further provides that it "shall not be construed to in any way limit or precondition the right to seek release . . . by habeas corpus." W. VA. CODE § 27-5-5 (1976 Replacement Vol.).

In 1976 a circuit court in Milwaukee, Wisconsin overturned 827 of 838 civil commitments of the Milwaukee County Court on grounds that court-appointed attorneys had consistently failed to provide effective assistance of counsel. *Mommel v. Mundy*, No. 447-417 (Milwaukee County Cir. Ct., Aug. 18, 1976) (reported in 1 MENTAL DISABILITY L. RPT. 183 (1976) [hereinafter M.D.L.R.]). The court found that attorneys representing the mentally ill routinely waived the right to jury trial, the right to file written motions, and the right to appeal, and failed to object to procedural and evidentiary errors of the prosecution. 1 M.D.L.R. 183.

A lawyer who does nothing, or who assists the prosecution is obviously not the effective assistance of counsel that is envisioned by the 6th and 14th amendments to the Constitution. These petitioners would undoubtedly have been better off without any counsel whatever, rather than to be represented by counsel who became a part of the prosecution effort to detain or commit them.

1 M.D.L.R. at 184 (quoting from the circuit court's opinion).

The Wisconsin Supreme Court upheld the trial court decision which ordered release or rehearing for all those within the class receiving ineffective assistance of counsel and the emergency appointment of the Legal Aid Society to represent all indigent patients in involuntary commitment proceedings. 1 M.D.L.R. 328 (1977).

Regarding ineffective assistance of counsel as a basis for challenge to civil commitment, see Note, *Ineffective Representation as a Basis for Relief from Conviction: Principles for Appellate Review*, 13 COLUM. J.L. & SOC. PROB. 1, 3 n.6 (1977).

²²⁶ The movement to secure the legal rights of mental patients and secure adequate procedural safeguards against unnecessary institutionalization increasingly is being viewed in the broader context of "mental health advocacy." See

The duties of defense counsel should be specifically set forth in the mental health code and the state should move immediately to transfer the responsibility for legal representation to an existing or new legal services organization. West Virginia has taken the first small step in this direction by making it a duty of counsel representing mental patients to "conduct a timely interview, make investigation and secure appropriate witnesses, and . . . be present at the hearing and protect the interest of the individual."²²⁷ This statutory definition of the duties of counsel is inadequate, however, to compensate for the absence of effective and adequate training.

Private practitioners appointed sporadically to represent mental patients have little professional or financial interest in developing an expertise in the mental health field. It is little surprise that private practitioners content themselves with the procedural and legal aspects of commitment proceedings and leave questions concerning mental illness and dangerousness to the psychiatrists.²²⁸ Non-adversariness as to these crucial determinations deprives the patient of real advocacy.²²⁹ The lawyer, to fully represent the patient, must proceed as an *advocate*.²³⁰

The development of expertise in mental health law will occur only when the state adopts a system of representation where attorneys devote all or a substantial part of their work to mental health cases. This can be accomplished by the formation of a new state-

generally, MENTAL HEALTH ADVOCACY: AN EMERGING FORCE IN CONSUMERS' RIGHTS (L. Kopolow & H. Bloom eds. 1977); Wald & Friedman, *The Politics of Mental Health Advocacy in the United States*, in LAW AND PSYCHIATRY II: PROCEEDINGS OF THE SECOND INTERNATIONAL SYMPOSIUM 55-70 (D. Weisstub ed. 1979).

²²⁷ W. VA. CODE § 27-5-4(b)(1) (Cum. Supp. 1979). For a model statute which defines the duties of attorneys, see Andalman & Chambers, *supra* note 8, at 89-90.

²²⁸ Andalman and Chambers argue that statutory guidelines are necessary "[b]ecause of this tendency of lawyers to adopt constricted roles, and because in the area of civil commitment, attorneys have essentially no tradition to rely upon, no experience, no training, and no adequate source to consult for guidance . . ." *Id.* at 84-85.

²²⁹ "The non-adversary guardian ad litem necessarily does not afford realization of constitutional and statutory guarantees in regard to the assistance of counsel." Quesnell v. State, 83 Wash. 2d 224, 517 P.2d 568, 576 (1974). See Lessard v. Schmidt, 349 F. Supp. 1078, 1097-99 (E.D. Wis. 1972).

²³⁰ See Hawks v. Lazaro, 202 S.E.2d 109, 125-26 (W. Va. 1974); Quesnell v. State, 83 Wash. 2d 224, 517 P.2d 568, 576 (1974); Lessard v. Schmidt, 349 F. Supp. 1078, 1103 (E.D. Wis. 1972). But see the warning as to overzealousness in Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CALIF. L. REV. 816, 831 (1974).

wide mental health advocacy program²³¹ or the use of existing legal services organizations.²³² Another and, perhaps, final solution would be to simply remove the power to appoint counsel on a case-by-case basis from the MHC and require the circuit court to appoint a mental health advocate for the county to represent all cases arising in the county. The appointment of a mental health advocate whose duties are clearly defined by statutory provision could improve the existing system.

Legal representation at the time of the initial commitment is only one means of protecting the mentally ill from over-zealous use of institutionalization.²³³ Patients will, of course, have specific legal

²³¹ For a suggested system to provide effective assistance of counsel based on a state-wide agency, with full and part-time staff attorneys fashioned on the model of the New York Mental Health Information Service, see Andalman & Chambers, *supra*, note 8.

For an extensive bibliography on the New York Mental Health Information Service, see *id.* at 64-72. See also, Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CALIF. L. REV. 816 (1974); Broderick, *Justice in the Books or Justice in Action—An Institutional Approach to Involuntary Hospitalization for Mental Illness*, 20 CATH. U.L. REV. 547, 620-32 (1971); Meyer, *Lawyer in a Mental Hospital: The New York Experiment*, 53 MENTAL HYGIENE 14 (1969); Kumasaka, *The Lawyer's Role in Involuntary Commitment: New York's Experience*, 56 MENTAL HYGIENE 21 (1972); Gupta, *New York's Mental Health Information Service: An Experiment in Due Process*, 25 RUTGERS L. REV. 404 (1971).

²³² One alternative to fee payments to private practitioners is for the state to contract with a local legal aid agency to provide the services. Andalman & Chambers, *supra* note 8, at 83. This approach would be especially attractive in a state like West Virginia which has a relatively small number of commitment proceedings.

²³³ One recently publicized case of overzealousness in institutional psychiatry is *O'Connor v. Donaldson*, 422 U.S. 563 (1975). Donaldson was committed in 1957 and was not finally released until 1971. Donaldson's fifteen-year confinement included no psychiatric treatment (he had refused medication on religious grounds) and was continued even though psychiatrists at the institution did not believe him to be dangerous to himself or others and had good reason to know that he would be adequately cared for by others upon his release. *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974), *vacated and remanded*, 422 U.S. 563 (1975). The case raises an important question about the appropriateness of institutionalization of numbers of mentally ill individuals even though they are not considered to be dangerous. Until the decision of the West Virginia Supreme Court of Appeals in *Hawks v. Lazaro*, 202 S.E.2d 109 (W. Va. 1974), and a statutory enactment requiring dangerousness in addition to mental illness, West Virginia's mental institutions, as those throughout the country, were used for custodial care of the mentally ill. All of the cases reported in the Appendix involved long-term patients who were being afforded a new judicial hearing pursuant to the 1974 Statute.

A recent study in Connecticut undertaken jointly by the Yale University De-

problems but more often will consult legal counsel with a variety of complaints which deal with institutional life such as the denial of grounds privileges, inaccessibility of medical and psychiatric professionals,²³⁴ adverse effects of drug medications,²³⁵ the desire to

partment of Psychiatry and the Yale Law School reviewed the appropriateness of the 107 involuntary patients at the Connecticut Valley Hospital. Crane, Zonana & Wizner, *Implications of the Donaldson Decision: A Model for Periodic Review of Committed Patients*, 28 HOSP. & COMMUNITY PSYCHIAT. 827 (1977). The review, conducted by three panels each composed of a law student, a psychiatric resident, and a hospital social worker, resulted in a change in the status of 57 cases, or 53% of the patients reviewed. In 50 of the cases, discharge was recommended. *Id.* at 830.

This proportion is quite significant, considering the hospital's expectation that the project would identify few patients who did not belong in the hospital. It suggests that even in a hospital that has discouraged involuntary commitments and made legal services available to patients, there remains a large area of disagreement about the appropriateness of existing commitments.

Id.

Despite the merely advisory role of the panels and the severe and chronic nature of many of the cases reviewed, the project enabled the hospital to conclude that a significant sampling of committed patients no longer could be justifiably confined on an involuntary basis.

Id. at 832. Of interest is the fact that the review panels found no patients with circumstances similar to Donaldson's; that is, not dangerous, minimally impaired, desirous of leaving the hospital, and capable of living in the community.

The bias of the review panels was toward discharge, whereas hospital review, when it occurs, tends to be biased toward the retention of patients. The longer a patient is confined, the more likely it is for periodic reviews to become perfunctory if they occur at all. Thus external review encourages, if not compels, the hospital to assume a more active role in the review process and discharge planning.

Id. at 832-33. In summary, the panels found that approximately half the patients reviewed should no longer be maintained on an involuntary status. To date, the hospital has concurred in approximately half of these cases. *Id.* at 833.

²³⁴ The right to treatment is prescribed by statute in West Virginia. W. VA. CODE § 27-5-9(b) (Cum. Supp. 1979). The statute requires an individualized treatment program based on "appropriate examination and diagnosis." *Id.* § 27-5-9(c)(4). The treatment is to be specifically directed to the needs of the individual and is to be performed by trained personnel in a "skillful, safe and humane manner." *Id.* § 27-5-9(b). The treatment program and its administration must respect the patient's "dignity and personal integrity." *Id.* Specific time limits are provided within which the treatment program must be formulated as well as periodically reviewed. The statutory language is clear:

The chief medical officer shall cause to be developed within the clinical record of each patient a written treatment plan based on initial medical and psychiatric examination not later than seven days after he is admitted for treatment. The treatment plan shall be updated periodically, consistent with reevaluation of the patient. Failure to accord the patient

the requisite periodic examinations or treatment plan and reevaluations shall entitle the patient to release.

W. VA. CODE § 27-5-9(d) (Cum. Supp. 1979). As part of the treatment program the patient is to receive a psychiatric reevaluation at least once every three months and a physical examination by a physician once every six months. *Id.* § 27-5-9(c)(2).

The statutory requirement for a treatment plan is generally viewed as "the basis for a rational and humane therapeutic approach. It implies the consideration of the patient's needs, an examination of alternative approaches to meeting them, and it insures a certain degree of planning for each patient." Mechanic, *Judicial Action and Social Change*, in *THE RIGHT TO TREATMENT FOR MENTAL PATIENTS* 47, 64 (S. Golann & W. Fremouw eds. 1976).

There are two levels on which treatment can be analyzed: individual and institutional. In *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), the court was concerned with whether the institutions as a whole were providing sufficient treatment to satisfy constitutional standards. The West Virginia statute provides little in the way of guidelines on the institutional level except that treatment is to be provided by "trained personnel" and will consist of periodic physical and psychiatric examinations which shall be used to develop and carry out an individualized treatment plan. W. VA. CODE § 27-5-9(c)(1) (Cum. Supp. 1979).

Implementation of the statutory right to treatment depends not only upon effective treatment on a case-by-case basis but institutional resources sufficient to provide quality care and treatment. The current debate is whether treatment required by statute can be effectively implemented by court imposed minimum standards. There are questions raised as to whether court imposed minimum standards such as those in *Wyatt v. Stickney* "can be reasonably interpreted and monitored, what their long-term efforts on mental health policies and practices are likely to be, and their bearing on the untreatable patient and the patient who wishes to refuse treatment." Mechanic, *supra* at 59.

Obviously, court-imposed minimum standards alone are insufficient to guarantee adequate treatment of a diverse patient population. The West Virginia statute attacks this problem by requiring a specific treatment plan for the individual based on examination and diagnosis with periodic review and change in the plan where necessary. Thus, the West Virginia statute provides a framework in which treatment may be demanded.

The structural framework for treatment outlined in the statute and the individualized treatment plan are, in and of themselves, still insufficient to insure adequate treatment. One author has noted that the treatment plan, while an essential prerequisite to adequate treatment in an institutionalized setting, "can become a farcical ritual that has little to do with the daily conditions affecting the patient and, indeed, . . . may reallocate whatever staff time is available away from contact with patients. It is quite conceivable that professionals come to spend all of their time formulating and reviewing paper plans, while non-professional staff continue to run the institution and to have almost exclusive contact with patients." Mechanic, *supra* at 64-65.

While the present state of psychiatry would not permit conclusive or consensual proof as to the "right treatment" called for by the right to treatment, the demand can be enforced to the extent that it calls for the hospitalized patient to receive "some form of therapy that a respectable sector of the psychiatric profession regards as appropriate—and receives enough of that therapy to make his confinement more than a mockery." Bazelon, *Foreword, A Symposium—The Right to*

Treatment, 57 GEO. L.J. 676, 677 (1969). For a detailed discussion of the evaluation of treatment, see Cameron, *Nonmedical Judgment of Medical Matters*, 57 GEO. L.J. 716 (1969).

It is now commonly accepted that mental patients have a right to treatment. The literature exploring this new right is voluminous. See LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 275-92 (B. Ennis & P. Friedman eds. 1973); THE MENTALLY ILL AND THE RIGHT TO TREATMENT (G. Morris ed. 1970); THE RIGHT TO TREATMENT (D. Burris ed. 1969); THE RIGHT TO TREATMENT FOR MENTAL PATIENTS (S. Golann & W. Fremouw eds. 1976). See also Bailey & Pyfer, *Deprivation of Liberty and the Right to Treatment*, 7 CLEAR. REV. 519 (1974); Barnett, *Treatment Rights of Mentally Ill Nursing Home Residents*, 126 U. PA. L. REV. 578 (1978); Bassiouni, *The Right of the Mentally Ill to Cure and Treatment: Medical Due Process*, 15 DE PAUL L. REV. 291 (1966); Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742 (1969); Birnbaum, *Some Remarks on "The Right to Treatment,"* 23 ALA. L. REV. 623 (1971); Birnbaum, *Some Comments on "The Right to Treatment,"* 13 ARCH. GEN. PSYCHIAT. 34 (1965); Drake *Enforcing the Right to Treatment: Wyatt v. Stickney*, 10 AM. CRIM. L. REV. 587 (1972); Hoffman & Dunn, *Beyond Rouse and Wyatt: An Administrative-Law Model for Expanding and Implementing the Mental Patient's Right to Treatment*, 61 VA. L. REV. 297 (1975); Jacob, *The Right of the Mental Patient to His Psychosis*, 39 MOD. L. REV. 17 (1976); Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755 (1969); Kitztrie, *Compulsory Mental Treatment and the Requirements of "Due Process,"* 21 OHIO ST. L.J. 28 (1960); Leaf, *Wyatt v. Stickney: Assessing the Impact in Alabama*, 28 HOSP. & COMMUNITY PSYCHIAT. 351 (1977); LeVine & Bornstein, *Is the Sociopath Treatable? The Contribution of Psychiatry to a Legal Dilemma*, 1972 WASH. U.L. Q. 693; Mahan, et al., *A Mechanism for Enforcing the Right to Treatment: The Human Rights Committee*, 1975 LAW & PSYCHIAT. 131; Miller, *The "Right to Treatment: Can the Courts Rehabilitate and Cure?*, 46 PUB. INTEREST 96 (1977); Morris, *Institutionalizing the Rights of Mental Patients: Committing the Legislature*, 62 CALIF. L. REV. 957, 979-90 (1974); Pyfer, *The Juvenile's Right to Receive Treatment*, 6 FAM. L.Q. 279 (1972); Robitscher, *Courts, State Hospitals and the Right to Treatment*, 129 AM. J. PSYCHIAT. 298 (1972); Robitscher, *The Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient*, 18 VILL. L. REV. 11 (1972); Schwitzgebel, *Implementing a Right to Effective Treatment*, 1975 LAW & PSYCHIAT. REV. 117; Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936 (1974); Schwitzgebel, *Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria*, 8 HARV. C.R.-C.L. REV. 513 (1973); Stone, *Overview: The Right to Treatment — Comments on the Law and Its Impact*, 132 AM. J. PSYCHIAT. 1125 (1975); Stone, *The Right to Treatment and the Medical Establishment*, 2 BULL. ACAD. PSYCHIAT. & LAW 159 (1974); Tancredi & Clark, *Psychiatry and the Legal Rights of Patients*, 129 AM. J. PSYCHIAT. 328 (1972); Twerski, *Treating the Untreatable — A Critique of the Proposed Pennsylvania Right to Treatment Law*, 9 DUQ. L. REV. 220 (1970); A Symposium — *The Right to Treatment*, 57 GEO. L.J. 673 (1969).

See also Note, *Persons in Need of Supervision: Is There a Constitutional Right to Treatment?*, 39 BROOKLYN L. REV. 624 (1973); Note, *The Right to Treatment for Mentally Ill Juveniles in California*, 27 HASTINGS L.J. 865 (1976); Note, *"Without More: A Constitutional Right to Treatment?"*, 22 LOY. L. REV. 373 (1976); Note, *Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right*, 32 MD. L. REV. 42 (1972); Note, *Postcommitment: An Analysis and Reevaluation of the Right of Treatment*, 51 NOTRE DAME LAW. 287

refuse treatment²³⁶ and the failure to allow home visits or release

(1975); Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616 (1972); Note, *The Rights of the Mentally Ill During Incarceration: The Developing Law*, 25 U. FLA. L. REV. 494 (1973); Note, *Liberty and Required Mental Health Treatment*, 114 U. PA. L. REV. 1067 (1966); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134 (1967); Note, *A Right to Treatment for Juveniles?*, 1973 WASH. U.L.Q. 157; Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967); Comment, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282 (1973); Comment, *Relief for the Civilly Committed: A Constitutional Right to Treatment*, 63 KY. L.J. 469 (1975); Comment, *Toward a Right to Treatment for Civilly Committed Mental Patients*, 44 U. MO.-K.C.L. REV. 23 (1975).

²³⁵ See Armstrong, *The Use of Psychotropic Drugs in State Hospitals: A Legal or Medical Decision?*, 29 HOSP. & COMMUNITY PSYCHIAT. 118 (1978); Note, *Mental Health—The Right to Refuse Drug Therapy Under "Emergency Restraint Statutes"*, 11 NEW ENG. L. REV. 509 (1976).

²³⁶ Prior to the 1978 amendments to the Mentally Ill Persons Act, West Virginia had not by statute or judicial decision declared a patient's right to refuse treatment. The only right to refuse treatment arose from constitutional requirements established by the federal courts. The cases generally prohibited certain forms of treatment, e.g., lobotomy, psychosurgery and other "unusual, hazardous or intrusive surgical procedures" affecting a patient's mental condition. See, e.g., *Wyatt v. Hardin*, (M.D. Ala. 1975) (unreported order reported in F. MILLER, R. DAWSON, G. DIX & R. PARNAS, *THE MENTAL HEALTH PROCESS* 556 (2d. ed. 1976) where the court held that the use of "aversive conditioning" and electro-convulsive shock treatment (ECT) required the patient's "informed consent." Other cases have established the right to refuse treatment on the basis of the free exercise of religion protected by the First Amendment. See *Winter v. Miller*, 446 F.2d 65 (2d Cir. 1971), cert. denied, 404 U.S. 985 (1971). Another constitutional basis for a right to refuse treatment can be found in the constitutional right to privacy. *Rennie v. Klein*, 462 F. Supp. 1131, 1144-45 (D.N.J. 1977). It seems clear from a reading of the cases that the courts have not assured all patients under all conditions a right to refuse treatment. Courts have generally established the right to refuse certain extraordinary treatments and less intrusive therapies such as the use of psychotropic drugs where there are religious objections. *Rennie v. Klein*, supra.

Some state statutes specifically prohibit certain forms of treatment. Though the West Virginia statute has no prohibited forms of treatment, it does provide that any treatment must be provided in a "safe and humane manner with full respect for his [the patient's] dignity and personal integrity." W. VA. CODE § 27-5-9(a) (Cum. Supp. 1979). There is indeed a substantial question as to whether lobotomies, ECT, and "aversive conditioning" meet this standard. Additionally, the Code requires the patient's written consent, which is revocable at any time and invalid after six months. *Id.* § 27-4-4(b) (Cum. Supp. 1979).

See also Roth, *Involuntary Civil Commitment: The Right to Treatment and the Right to Refuse Treatment*, in *PSYCHIATRISTS AND THE LEGAL PROCESS: DIAGNOSIS AND DEBATE* (R. Bonnie ed. 1977); Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1977); Comment, *The*

to a family member or community facility. There should be some institutional or administrative mechanism to secure patient rights and investigate specific patient complaints without legal intervention.²³⁷ Only when the institution fails to attend to patient complaints should attorneys be necessary. Of course in some instances, the bureaucratic decisions which lead to institutional constraints on the patient's life may ultimately require the intervention of an attorney.

In a patient advocacy program established at Bryce Hospital in Alabama, the advocates were able to help patients:

receive remuneration for labor, obtain clothes more appropriate to the season, receive more extended grounds privileges, secure less restrictive placements, and receive attention for medical problems. They have also been involved in broader issues, such as assisting in the development of hospital policies on searches, and procedures for dealing with resident abuse. The program has become a clearinghouse for information on patients' rights questions²³⁸

The internal mechanism should be designed broadly to guarantee patient legal rights and to encourage improvement in patient care. A variety of institutional structures could be devised to achieve this goal. One approach is a patient advocacy program²³⁹

Right Against Treatment: Behavior Modification and the Involuntariness Committed, 23 CATH. U.L. REV. 774 (1974).

On the right to refuse treatment, see generally, Coccozza & Melick, *The Right to Refuse Treatment: A Broad View*, 5 BULL. AM. ACAD. PSYCHIAT. & L. 3 (1977).

²³⁷ Broderick, *One-Legged Ombudsman in a Mental Hospital: An Over-the-Shoulder Glance at an Experimental Project*, 22 CATH. U.L. REV. 517 (1973); Broderick, *Justice in the Books or Justice in Action—An Institutional Approach to Involuntary Hospitalization for Mental Illness*, 20 CATH. U.L. REV. 547, 618-50 (1971).

²³⁸ Tauber & Houston, *The Advocacy Program, Implementing the Wyatt Standards at Bryce Hospital*, 28 HOSP. & COMMUNITY PSYCHIAT. 360, 361 (1977).

²³⁹ In Michigan, a patient's "rights advisers" program mandated by state statute was implemented in 23 institutions during the summer of 1975. During the first 17 months of the program in which patient complaints were administratively monitored, some 2258 complaints were received from an inpatient population of 31,000 and an outpatient population of 33,000.

The bulk of the complaints in the first year fell into six categories . . . right to services suited to one's condition; right to a safe, sanitary and humane living environment; right to protection from abuse; right to communicate and visit with persons of one's choice; right to have personal

that can be directed by an independent party who is given responsibility to investigate patient complaints.²⁴⁰ The patient advocate will need sufficient staff to investigate complaints, formulate specific recommendations for institutional action, and provide

property and access to one's own funds; and right to freedom of movement.

Coye, *Michigan's System for Protecting Patients' Rights*, 28 HOSP. & COMMUNITY PSYCHIAT. 375, 377 (1977). A complete report is contained in REPORT ON VIOLATIONS OF RIGHTS IN THE FIRST YEAR OF MICHIGAN'S INSTITUTIONAL RECIPIENT RIGHTS SYSTEM, OFFICE OF RECIPIENT RIGHTS, DEPARTMENT OF MENTAL HEALTH (1977).

See also Ferleger, *A Patients' Rights Organization: Advocacy and Collective Action By and For Inmates of Mental Institutions*, 8 CLEAR. REV. 587, 587n.1 (1975); Tauber & Houston, *supra* note 238.

Dr. Louis Kopolow, the coordinator of patient's rights and advocacy programs in the Division of Mental Health Service Programs of the National Institute of Mental Health has argued that:

[A] comprehensive advocacy program would consist of a tripartite system of patients' representatives, lawyers, and an ombudsman, with psychiatrists and other mental health professionals participating in the activities of each component. The primary element in the program is the patient's representative, who will be concerned with screening patients for the appropriateness of commitment, of guardianship, of forced medication and other form of treatment, of transfer or release from large institutions, and other matters. The patient's representative will also devote his or her efforts to preserving the right to noninstitutionalization whenever possible and to arranging for transfer of patients to other mental health personnel in the community.

Kopolow, *Meeting the Patients' Rights Challenge Through Mental Health Advocacy*, 28 HOSP. & COMMUNITY PSYCHIAT. 383, 383 (1977). See generally, Dickey & Remington, *Legal Assistance for Institutionalized Persons—An Overlooked Need*, 1976 S. ILL. U.L.J. 175.

Dr. Kopolow envisions the role of the ombudsman as one who "could address problems throughout the entire mental health system. His role would not be to resolve individual complaints, but rather to use his broad investigatory ability, independence, and objectivity to make recommendations to correct the system's malfunctioning." Kopolow, *supra*, at 383-84. On the role of the ombudsman, see Broderick, *supra* note 8.

²⁴⁰ One of the chief advantages of the patient advocate program is the ability of the staff members to respond to the day-to-day issues that are common to patient complaints. The advocate, as a part of the hospital administration, has advantages which are not present in outside legal counsel. The advocate has access to patients, and their records, and to the staff.

The relationship of the patients' rights advocate to the director of the mental institution and its staff, however, must be defined. Advocates appointed by institutional administrators are likely to have conflicting loyalties in representing individual patients. An additional problem exists in that advocates who receive no special training often come from background which produce biases similar to those of staff members which created the initial problem.

follow-up to insure that legitimate patient concerns are attended to. While there is little justification for an attorney serving as an internal patient advocate, the advocate should have access to attorneys for legal consultation.²⁴¹

VI. CONCLUSION

It is a fundamental axiom of the legal profession that lawyers will effectively and competently represent those whom they take, or those whom may be assigned, as clients. The Code of Professional Responsibility maintains this duty as one applicable to every attorney for the protection of every client. Yet, one should deduce from this article that lawyers are not effectively and competently representing individuals whose liberty is at stake due to mental illness.

Lawyers do not represent the mentally ill in the traditional sense of representation. A lawyer accompanying the client/patient to the hearing does not suffice for representation and effective advocacy. Competent and effective representation occurs only when the lawyer has the knowledge, expertise, and willingness to question psychiatric diagnoses of mental illness and psychiatric predictions of dangerousness.

This article is *not* to be taken as a suggestion that lawyers who represent the mentally ill should become amateur psychiatrists. Rather, we should understand enough about psychiatry to expose the opportunity for error in psychiatric diagnoses. At minimum, lawyers can show that psychiatric judgments are based on social, moral, philosophical and legal theories — theories on which the psychiatrist has no more claim to expertise than do lawyers or laymen. Lawyers abdicate their professional responsibility to the

²⁴¹ One advocacy program that involved approximately 2000 complaints consulted with attorney's in about 60% of the cases. Tauber & Houston, *supra*, note 238, at 361.

It will be useful for hospital patient advocates and attorneys to establish contact with the various private, state and federal organizations and agencies which are entering the mental health field. For attorneys, one of the most important new groups is the Mental Health Law Project (MHLP) organized in 1972 with the purpose of defining and securing through litigation the rights of mental patients. The project is sponsored by the American Orthopsychiatric Association and the American Civil Liberties Union. The MHLP has been instrumental in cases challenging commitment criteria for involuntary commitment and cases seeking a right to accept and refuse treatment and treatment by least restrictive alternative.

mentally ill when they allow the courts to defer to psychiatric testimony concerning dangerousness. Psychiatrists *cannot* predict dangerousness and a lawyer who allows such predictions to result in the confinement of his or her client without strenuous cross-examination is negligent in the advocacy required of all lawyers in representing those whose *liberty* is at stake.

Lawyers can and should defer to the expertise of professionals who have clinical experience with the diagnosis and treatment of mental illness. We must, however, insure that our deference is to real expertise—expertise founded on experience and a recognition that knowledge of human behavior and human mental states has limits. Lawyers, by their tenacious advocacy for the mentally ill, can insure appropriate respect by psychiatrists for the limits of their professional knowledge.

APPENDIX*

Case 1

The first psychiatrist testified that the patient was examined on three occasions in the week preceding the hearing and the day prior to the hearing. The psychiatrist further testified that the patient was a chronic schizophrenic. In response to the prosecutor's question, "What is schizophrenia," the psychiatrist replied that it is a mental illness in which one is likely to be violent to others or to himself. The psychiatrist noted that there was no other form of treatment for the patient other than institutionalization.

Defense Counsel: Doctor, how do you know that the patient is dangerous?

Psychiatrist: The patient tried to strike the doctor examining her at the time she was being admitted. She has also tried to strike her parents.

Defense counsel objected to the psychiatrist's testimony as hearsay. The MHC allowed the testimony since the alleged hearsay evidence consisted of the admitting doctor's statements which were contained in the medical record.

Defense Counsel: Doctor, have you ever witnessed any acts of violence by the patient?

Psychiatrist: Yes, I have seen her pinch and strike nurses, aides, and other patients. She could have caused serious harm to others if she had not been placed in isolation.

Defense Counsel: Are there any alternatives to commitment to Weston State Hospital?

Psychiatrist: The psychiatric unit at the University Medical Center won't take patients as far out of control as this patient. Nursing homes won't take her because they couldn't handle her.

* The transcripts are taken from actual civil commitment hearings held in Fairmont and Weston, West Virginia, during the summer of 1977. The cases are reproduced from notes taken by the author at the hearings and to the extent possible, represent verbatim accounts of the hearings. The mental hygiene commissioner and prosecuting and defense attorneys in each of the hearings authorized the author to observe the hearings. For other transcript materials of involuntary commitment proceedings which reflect the ritualistic role of the attorney, see Wexler & Scoville, *Special Project — The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 38-43 (1971). For a more thorough effort by defense counsel, although still deficient, see the transcript of *People v. Sansone*, 18 Ill. App. 3d 315, 309 N.E.2d 733 (1974), reprinted in F. MILLER, et al., *THE MENTAL HEALTH PROCESS* 348-56 (1976).

Redirect Examination by Prosecution:

Prosecutor: Do you recommend commitment for six months or two years?

Psychiatrist: Probably, one year.

The second psychiatrist testified that the patient had been examined and was a schizophrenic. The psychiatrist then testified that "an individual suffering from this form of mental illness is likely to be dangerous to self or others."

Defense Counsel: Do you have any specific instances of her dangerousness?

Psychiatrist: I have the reports of others. As for myself, I can say that the patient displayed hyperactivity and violent outbursts.

Defense Counsel: Is there any other alternative to the state hospital?

Psychiatrist: There is no other alternative. The patient needs physical restraint. She is hyperactive. She would be too much for nursing homes. She will not take her medication.

Defense Counsel: Isn't there a program at the University Medical Center which would take her?

Psychiatrist: No. The program takes only voluntary patients and does not use restraints. The patient is too hyperactive to be managed on an open ward.

Redirect Examination:

Prosecutor: Is medication required for continued treatment?

Psychiatrist: Yes. She has a history of not taking medication.

MHC: How long has the patient been confined?

MHC: Would her parents be able to take care of her, they are in their eighties, aren't they?

Psychiatrist: No.

The third witness was a staff member of a community mental health facility. He testified that the patient was a client of the community mental health center and that he became involved after an emergency call from the family. They told him she was very withdrawn and quiet and that they brought her in because she had destroyed her apartment and was running around nude. The staff member said that when one of the doctors tried to give her medication the patient attacked him.

Defense Counsel: You said she attacked the doctor?

Mental Health Worker: Yes.

Defense Counsel: Did she actually hit the doctor?

Mental Health Worker: No, she drew back to hit him.

The patient's mother, who was present, stood up and asked permission to ask a question. This was denied by the prosecutor.

MHC: Who is family?

Mental Health Worker: Her brother or brother-in-law.

The prosecutor called the father as a witness.

Prosecutor: Could you tell us why you got concerned about your daughter?

Father: She wasn't taking care of her apartment. She was throwing things out back.

Prosecutor: Is that all?

Father: She was running around the apartment without clothes, with the blinds up.

Prosecutor: Was your daughter violent?

Father: She hasn't been in the last couple of weeks. She was violent last year, before she went into the mental hospital.

Cross Examination:

Defense Counsel: Did you see her in a violent state?

Father: No, but her mother did.

Defense Counsel: Did she keep her apartment clean?

Father: At times, she did.

Defense Counsel: Could she return home?

Father: Not unless she's improved a lot.

The patient's mother interrupted the testimony of the mental health worker and her husband. Defense counsel called the patient's mother as a witness. The patient's mother testified that during her daughter's last commitment, she and her husband had received a call from the hospital to pick up their daughter. "The people at the hospital said she was capable of working. We got her a new typewriter. The social workers were supposed to help her get a job. We never heard from them. They made her live by herself. They wouldn't let her live with us."

MHC: Do you think your daughter is mentally ill?

Mother: Well, she can talk to you, when she wants to. Give her a chance and she'll do something.

MHC to Defense Counsel: Have you advised your client that she has a right to testify?

Defense Counsel: Yes, she voluntarily chooses not to testify.¹

¹ An individual subject to involuntary commitment has a statutory right not to appear as a witness at the commitment hearing. The West Virginia statute specifically provides that "[t]he individual shall not be compelled to be a witness against himself." W. VA. CODE § 27-5-4(g)(4) (Cum. Supp. 1979). The statute also

Defense Counsel, in closing, argued that the prosecution had not proved it's case "beyond a reasonable doubt."² The defense

provides, however, that: "If the designated physician or psychologist reports to the circuit court or mental hygiene commissioner that the individual has refused to submit to an examination, the circuit court or mental hygiene commissioner shall order him to submit to such examination." W. VA. CODE § 27-5-4(f)(2) (Cum. Supp. 1979). This provision clearly fails to recognize a privilege against self-incrimination during a psychiatric interview. Thus, West Virginia does not extend the Fifth Amendment privilege against self-incrimination to a crucial phase of the involuntary commitment process: the psychiatric interview which is the basis for commitment. The West Virginia Supreme Court of Appeals has refused to extend the privilege against self-incrimination to the prehearing psychiatric interview, *Hawks v. Lazaro*, 202 S.E.2d 109, 126 (1974), and by statute, provides that statements made to a physician or psychologist may be admitted as evidence without a Miranda-type warning to the individual. W. VA. CODE § 27-5-4(i)(2) (Cum. Supp. 1979).

The constitutionality of allowing a privilege against self-incrimination at a formal hearing and denying it at a critical prehearing stage is questionable. Some courts considering the issue have concluded that a Miranda-type warning is constitutionally required. See *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1975).

² Defense counsel has mistated the burden of proof which the state must meet. The findings of the MHC "must be based upon clear, cogent and convincing proof." W. VA. CODE § 27-5-4(j)(3) (Cum. Supp. 1979).

In the absence of a statutory provision setting forth the burden of proof, the courts split, some adopting the preponderance of evidence test, see *State v. Krol*, 68 N.J. 236, 257, 344 A.2d 289, 300 (1975) (Commitment following not guilty by reason of insanity) (decision to follow preponderance of evidence standard over a dissent which strongly favored beyond a reasonable doubt.); others, the reasonable doubt standard. *Stachulak v. Coughlin*, 520 F.2d 931, 935-37 (7th Cir. 1975), cert. denied, 424 U.S. 947 (1976); *In re Ballay*, 482 F.2d 648, 653 (D.C. Cir. 1973); *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1132 (D. Hawaii 1976); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1095 (E.D. Wis. 1972), vacated and remanded, 414 U.S. 473, aff'd on other grounds, 379 F. Supp. 1376 (1974), vacated and remanded, 421 U.S. 957, aff'd on other grounds, 413 F. Supp. 1318 (1975); *People v. Burnick*, 14 Cal. 3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975) (commitment under a mentally disordered sex offender statute).

Other courts have followed the West Virginia approach and adopted the clear and convincing evidence test. See *Doremus v. Farrell*, 407 F. Supp. 509, 516-17 (D. Neb. 1975); *Davis v. Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974); *Lynch v. Baxley*, 386 F. Supp. 378, 392-94 (M.D. Ala. 1974); *Dixon v. Attorney General*, 325 F. Supp. 966, 974 (M.D. Pa. 1971); *In re Valdez*, 88 N.M. 338, 342, 540 P.2d 818, 821 (1975).

The Supreme Court has recently ruled that the preponderance of evidence test does not meet constitutional due process standards and that due process requirements do not mandate proof beyond a reasonable doubt. *Addington v. Texas*, 99 S. Ct. 1804 (1979).

At least one court prior to *Addington* found little distinction between the clear

noted the inconsistency in the testimony as to the patient's dangerousness to others. Finally, the defense argued there are less restrictive alternatives for treatment and care of the patient. The prosecution closed by summarizing the testimony adduced at the hearing and asked for an order of commitment. The MHC ordered six months commitment.

Case 2

This case involved a petition for recommitment of a sixty-nine year old woman of Polish origin. The patient could not speak English.³ She had been hospitalized in May, 1963 because of "immature actions." The first psychiatrist:

found the patient neatly dressed, and cooperative through an interpreter. The patient did not know when she was born. She was disoriented as to date and location. She answered questions appropriately, with one exception when she inappropriately mentioned the death of her son. She could recognize familiar objects: a watch, a key, and her leg. She said she would prefer to stay at Weston. It is my impression that she is mentally retarded.⁴ She is able to take care of her personal hygiene.

and convincing evidence standard of proof and the criminal reasonable doubt standard. In Washington, the clear, cogent, and convincing standard for the state's burden of proof "exacts the duty that every element essential to proving committable mental illness be demonstrated to a degree essentially corresponding to that necessary for commitment in criminal proceedings." *In re Levias*, 83 Wash. 2d 253, 256, 517 P.2d 588, 590 (1973).

For an empirical analysis of the impact of the burden of proof on determinations of dangerousness, see Wexler & Scoville, *supra* Appendix note *, at 100-17.

See generally Combs, *Burden of Proof and Vagueness in Civil Commitment Proceedings*, 2 AM. J. CRIM. L. 47 (1973); Share, *The Standard of Proof in Involuntary Civil Commitment Proceedings*, 1977 DET. C.L. REV. 209 (1977); Note, *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1301 (1974); Comment, *The Standard of Proof in Civil Commitment Proceedings In Massachusetts: Superintendent of Worcester State Hosp. v. Haggberg*, 1 W. NEW ENG. 71, 80-88 (1978).

³ The patient had been interviewed by a Polish interpreter prior to the hearing and was accompanied by the interpreter at the hearing. The proceedings were not interpreted for the patient, in fact there was no communication between the interpreter and the patient during the entire proceeding.

⁴ Mental retardation is treated like mental illness in West Virginia for purposes of involuntary civil commitment. See W. VA. CODE § 27-5-3(a) (Cum. Supp. 1979). Mental retardation is statutorily defined as a "significantly subaverage intellectual functioning which manifests itself in a person during his developmental period and which is characterized by his inadequacy in adaptive behavior." W. VA. CODE § 27-1-3 (1976 Replacement Vol.).

Prosecutor: Is she dangerous to herself?

Psychiatrist: In a very supervised setting, she can function outside the hospital. She could care for herself, in a less restrictive environment.

Prosecutor: Any suicide attempts?

Psychiatrist: No.

Prosecutor: Summarize the diagnosis.

Psychiatrist: She is mentally retarded. She has deficiencies.

Cross Examination:

Defense Counsel: Is the patient dangerous to herself or others?

Psychiatrist: She is not actively dangerous to herself or others, perhaps dangerous in a passive sense. Because of the language barrier she can't communicate her needs. She has been able to function here. She recognizes people, etc.

Defense Counsel read from the patient's record for the period from 1963 to the present and noted that the Weston staff had repeatedly recommended that the patient be placed in a nursing home beginning as early as 1963 when she was initially confined.

MHC: She functioned outside the institution until committed?

Psychiatrist: She was living with her sister and became hard to manage.

The testimony of the second psychiatrist indicated that the patient was examined August 15, 1977 and found to be a:

sixty-nine year old white single female who is obviously severely retarded. I think there is a strong possibility the fall was just a fall, she was born with her difficulties. [The patient's file made reference to a fall at the age of three.] The family managed to take care of her until she reached fifty-five. Since her admission, May, 1963, she has been taken home on at least nineteen visits ranging from two days to two weeks, the last of which was in February. There were no problems with her home visits.

Prosecutor: Is she dangerous to self or others?

Psychiatrist: She is not dangerous to self or others.

Prosecutor: Can she function in a different environment?

Psychiatrist: Yes, if we could subsidize the family so they could look after her. Places to take care of her are hard to find.

Cross Examination:

For a discussion of the issues in the civil commitment of the mentally retarded see Ellis, *Issues in Mental Retardation*, 1975 LAW & PSYCH. REV. 9. See generally PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, *THE MENTALLY RETARDED CITIZEN AND THE LAW* (1976).

Defense Counsel: When did Weston start to try to place her?

Psychiatrist: It has been some time.

Defense Counsel: Since 1974?

Psychiatrist: It could have been since 1974.

Defense Counsel: Can the patient manage herself?

Psychiatrist: She could function in a personal care home.

The MHC, off the record, questioned the patient's sister, who was present at the hearing, and then proceeded to swear her as a witness. The sister testified that the patient was on Social Security which had been raised from \$117 to \$144 and that, in addition, the patient received a \$100 a month from workmen's compensation as a result of her father's death in a coal mine. Weston was paid \$3.00 to \$3.50 a day for her care. The patient had a savings account of a few thousand dollars.

MHC: Why was your sister committed?

Sister: We had trouble while she was living with mother. It began at menopause.

MHC: Does your sister visit?

Sister: She visits in Morgantown. On long visits she gets moody. Sometimes she hides when guests come.

Defense Counsel: I ask that the patient be released. I have no real argument.

Prosecutor: No argument.

MHC: I find that the patient is mentally retarded but not dangerous to self or others. The order will be stayed 60 days to find a suitable placement.

Case 3

The first psychiatrist testified that the patient was examined on August 16, 1977, and was seen from time to time on the hospital unit. The patient was diagnosed as a paranoid schizophrenic on admission in 1963. The psychiatrist basically defined a schizophrenic as one who has "grandiose ideas." The psychiatrist further noted that the patient's schizophrenia "is in a state of remission. The symptoms are pretty well in control." The psychiatrist "found the patient to be a friendly, active man. He has a hypertension muscular disease for which we are treating him. He still believes this is a prison and not a hospital. The patient has the leftover effects of schizophrenia."

Prosecutor: Is he mentally ill?

Psychiatrist: Yes, in a sense. We don't speak of a cancer patient being cured, it is just in remission.

Prosecutor: Is he dangerous to self or others?

Psychiatrist: No.

Prosecutor: Could he get along in a less restrictive environment?

Psychiatrist: Yes. He is a good candidate for a personal care home or to live with one of his kids.

Prosecutor: Is he on medication?

Psychiatrist: Yes, for his heart condition.

Cross Examination:

Defense Counsel: Does he take his medication voluntarily?

Psychiatrist: Yes, he is a good patient.

Defense Counsel: No further questions.

The second psychiatrist testified that the patient was examined on August 16. "It was the only time that I saw him. I reviewed his records."

Prosecutor: What were your medical findings?

Psychiatrist: On examination, he was neatly dressed, clean, gave a history of being in the hospital since 1963. He gave as a reason his problem with a garbage collection business. He gave a delusional explanation of the event.⁵ He is oriented as to person, place, time. He denied hallucinations and suicidal or homicidal urges. Except for the delusional system as to how he got here he has done well.

Prosecutor: Doctor, what is your diagnosis?

Psychiatrist: Schizophrenic, paranoid type, in good control and what seems like a delusional system.

Prosecutor: Is he dangerous to self or others?

Psychiatrist: No. He could be managed in a nursing home.

Defense Counsel: No questions.

MHC: What is an isolated delusional system?

Psychiatrist: It isn't pervasive, in that it doesn't effect most of his behavior.

MHC: It would be an easy job to order release, but what happens from there? The evidence here is ambiguous. The patient doesn't need a nursing home. I don't know whether there has been any dialogue between the hospital and the patient's family. It's been a long time since he was home.

MHC: [Talks with the patient off the record.] What do you want to do?

Patient: It doesn't really matter. I could get a room in Kingwood with my Social Security.

MHC to Social Worker: Does the patient ever leave Weston?

Social Worker: No.

⁵ See text note 92, *supra*.

The defense lawyer held a conference with family members. The defense attorney had not interviewed the patient or the family prior to the hearing. Following the conference defense counsel called the patient's wife to testify. She indicated that she had been married to the patient since 1937.

Defense Counsel: If the patient is released will you take care of him?

Wife: Yes, I took care of him for 10 years and am ready to if he is ready to come back home.

[Defense calls the patient's son who testifies that: He can stay with us. I have room for him. My wife's father was at Weston for three or four months, so we can handle it.]

MHC to Son: Why hasn't your father visited you during the past fourteen years?

Son: He didn't ask to come out on short visits. He wanted to be released.

Defense calls the patient as a witness. The patient refused to take the oath saying, "I'll leave that up to the court." The MHC allowed the patient to testify without taking an oath.

Defense Counsel: Are you ready to go home?

Patient: Yes, as ready as I ever was.

Defense Counsel: Are you ready to resume your place in society?

Patient: Yes, to be a preacher.

Defense Counsel: Will you try to get along with people?

Patient: Yes, I always did.

Defense Counsel: Do you need time to pack up?

Patient: My toothbrush and razor. Ha.

[MHC expressed reluctance to release the patient.]

MHC: Doctor, if I release the patient today, how soon can the community mental health center follow up?

Psychiatrist: Within ten days to two weeks.

The MHC requested that the time be reduced to no more than one week. The patient took his wife's arm, grinned at her and walked out.