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## NOTE

### PROCEDURAL SAFEGUARDS FOR THE INVOLUNTARY COMMITMENT OF THE MENTALLY ILL IN THE DISTRICT OF COLUMBIA

One of the more active areas of the law to develop in recent years has addressed the need to guard against unwarranted hospitalization of the mentally ill.<sup>1</sup> The courts have recognized that extreme deprivations of physical liberty require a significant degree of due process, including notice, counsel, and a swift judicial hearing to determine the appropriateness of commitment.<sup>2</sup> Substantive due process concerns have been addressed by recent Supreme Court limitations on those state interests sufficient to justify compulsory hospitalization for mental illness.<sup>3</sup> While it is well settled that involuntary commitment is a valid exercise of the state's police power when there is sufficient evidence that the patient is a danger to society,<sup>4</sup> it is questionable whether the state's protective role as *parens patriae*<sup>5</sup>

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1. See, e.g., *Parham v. J.R.*, 99 S. Ct. 2493 (1979); *Addington v. Texas*, 99 S. Ct. 1804 (1979); *French v. Blackburn*, 428 F. Supp. 1351 (M.D.N.C. 1977); *Coll v. Hyland*, 411 F. Supp. 905 (D.N.J. 1976); *Doremus v. Farrel*, 407 F. Supp. 509 (D. Neb. 1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Bell v. Wayne County Gen. Hosp.*, 384 F. Supp. 1085 (E.D. Mich. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473, *on remand*, 379 F. Supp. 1376 (E.D. Wis.) 1974, *vacated*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976); *Logan v. Arafah*, 346 F. Supp. 1265 (D. Conn. 1972), *aff'd mem. sub nom.*, *Briggs v. Arafah*, 411 U.S. 911 (1973). See generally Slovenko, *Criminal Justice Procedures in Civil Commitment*, 24 WAYNE L. REV. 1 (1977); Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974); *Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on Judiciary*, 91st Cong., 1st & 2d Sess. (1969-1970).

2. In *Humphrey v. Cady*, 405 U.S. 504 (1972), the Court characterized involuntary commitments as a "massive curtailment of liberty." *Id.* at 509. It is now well settled that commitment cannot be accomplished without due process of law. *Addington v. Texas*, 99 S. Ct. 1804, 1809 (1979); *O'Connor v. Donaldson*, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring); *Jackson v. Indiana*, 406 U.S. 715, 724 (1972); *In re Ballay*, 482 F.2d 648, 655 (D.C. Cir. 1973); *In re Kossow*, 393 A.2d 97 (D.C. 1978). For examples of how much process is due, see the cases cited in note 1 *supra*.

3. For example, the Court has constitutionally forbidden the states from committing persons who are dangerous to no one and can live safely in freedom. It has been unwilling to permit "public intolerance or animosity" as a basis for commitment. See *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

4. See *id.* at 575-76.

5. Most state statutes permit some form of involuntary commitment based upon *parens*

can justify involuntary hospitalization of a person who is in need of treatment for mental illness but is not a present danger to himself or others.<sup>6</sup>

The District of Columbia has been in the forefront of many of these developments in mental health law,<sup>7</sup> but its record has been inconsistent, especially when the civil and criminal commitment schemes are compared. For example, the 1964 Hospitalization of the Mentally Ill Act (Ervin Act)<sup>8</sup> has become a model for nationwide reform through guarantees of civil rights for civilly committed patients<sup>9</sup> and through the establishment of protective commitment processes.<sup>10</sup> The Act, however, is inapplicable to many involuntarily hospitalized persons, including arrested persons subject to inpatient competency examinations,<sup>11</sup> persons acquitted by reason of insanity,<sup>12</sup> and juveniles in delinquency, neglect, and need of supervi-

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*patriae* which can be defined as the state's obligation to care for those who are unable to care for themselves. See *Addington v. Texas*, 99 S. Ct. 1804, 1809 (1979); Note, *supra* note 1, at 1207-22. The D.C. standard allowing for the commitment of persons who are dangerous to themselves has become a typical example of the limited applicability of *parens patriae* commitments. See D.C. CODE ANN. § 21-545 (1973). Somewhat instructive on the limits of *parens patriae* is the Supreme Court's language that "a finding of 'mental illness' alone cannot justify a State's locking up a person against his will and keeping him indefinitely in simple custodial confinement." *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

6. The Supreme Court did little to clarify substantive due process concerns of the mentally ill with its enigmatic pronouncement that a "State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself . . . ." *O'Connor v. Donaldson* 422 U.S. 573, 576 (1975). While this language clearly implies that commitment of the dangerously mentally ill is permissible, it also seems to allow commitment in order to save a person from harm. *Id.* at 575. A more liberal reading interprets the phrase "without more" as laying the groundwork for a constitutional right to appropriate treatment, something more than simple custodial confinement, as a condition for the involuntary commitment of the dangerously mentally ill. See Note, "Without More: A Constitutional Right to Treatment?" 22 LOY. L. REV. 373, 380-83 (1976). The *Donaldson* Court, however, specifically declined to rule on whether committed patients have a constitutional right to treatment. 422 U.S. at 573.

7. See, e.g., District of Columbia Hospitalization of the Mentally Ill Act, D.C. CODE ANN. §§ 21-501 to -592 (1973) (civil commitment procedures and the rights of the mentally ill); *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966) (statutory right to treatment); *Bolton v. Harris*, 395 F.2d 642 (D.C. Cir. 1968) (equal protection demands substantial equivalence between civil and criminal commitment schemes); *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973) (indeterminate involuntary civil commitment constitutionally requires a finding of mental illness and dangerousness beyond a reasonable doubt); *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975) (statutory right to clinically appropriate placement and treatment in less restrictive alternatives).

8. D.C. CODE ANN. §§ 21-501 to -592 (1973).

9. See *id.* §§ 21-561 to -564 (1973); note 17 and accompanying text *infra*.

10. See *id.* §§ 21-521 to -551 (1973).

11. Hospitalization of these persons is covered by the criminal commitment scheme. See *id.* §§ 24-301(a) & (b) (1973).

12. *Id.* §§ 24-301(c) to (k) (1973).

sion proceedings.<sup>13</sup> The independent statutory schemes regulating the commitment of these classes of mentally ill persons are generally less protective than the Ervin Act and the scope of their reform remains problematical.

Given the need for more consistent and comprehensive development of mental health procedures in the District of Columbia, a survey of the present wide array of means of commitment is desirable. Accordingly, this note will explain and compare the civil and criminal commitment schemes with separate consideration given to the plight of juveniles under each. In order to concentrate on the procedural aspects, this note will not discuss the rights of patients during their hospitalization, such as the right to treatment<sup>14</sup> and the presumption of compe-

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13. *Id.* §§ 16-2313 to -2321 (1973). The Ervin Act also does not apply to the commitment of retarded persons, sexual psychopaths, and persons detained on federal reservations in suburban counties surrounding Washington, D.C.

The commitment of the substantially retarded is covered by a recently revised statutory scheme distinct from the Ervin Act. *See* Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, D.C. Act 2-297, 25 D.C. Reg. 5094 (Nov. 8, 1978), *noted in* 3 MENTAL DISABILITY L. REP. 38 (1979). The legislation is designed to be consistent with the recent decision in *Evans v. Washington*, 459 F. Supp. 483 (D.D.C. 1978).

A rarely used 1948 statute governs the commitment of dangerous sexual psychopaths. D.C. CODE ANN. §§ 22-3503 to -3511 (1973). Its procedures are not limited to criminal defendants and they permit the U.S. Attorney to initiate proceedings against persons who are "not insane," *id.* § 22-3503 (1973), and who "appear" to be sexual psychopaths, *id.* § 22-3504 (1973). The patient has the right to counsel and examination by two psychiatrists, *id.* § 22-3505 to -3506 (1973). If one of the psychiatrists determines that the patient is not a dangerous sexual psychopath, the court will dismiss the proceeding. Otherwise, a hearing will be held on the issue, with a right to a jury. *Id.* § 22-2507 (1973). For cases interpreting this procedure, see *Norwood v. Jacobs*, 430 F.2d 903 (D.C. Cir. 1970); *Cross v. Harris*, 418 F.2d 1095 (D.C. Cir. 1969); *Millard v. Harris*, 406 F.2d 964 (D.C. Cir. 1968).

Another type of hospitalization not covered by the Ervin Act is the emergency detention in D.C. facilities of persons found on federal reservations in Maryland and Virginia counties surrounding the District of Columbia. *See* D.C. CODE ANN. §§ 21-901 to -909 (1973). The Federal Reservations Act permits 30-day detentions of the mentally ill and provides for a hearing before a U.S. magistrate within 72 hours of apprehension. *Id.* §§ 21-902 to -903 (1973). The United States District Court for the District of Columbia has recently required the magistrate to make a finding of probable cause that the person is mentally ill and likely to injure himself or herself or others in order for the 30-day commitment to take place. *Bension v. Meredith*, 455 F. Supp. 662, 669 & 672 (D.D.C. 1978). *See also* *Medynski v. Margolis*, 389 F. Supp. 743 (D.D.C. 1975). *Cf.* D.C. CODE ANN. § 21-521 (1973) (the same "likely to injure self or others" standard applies to emergency detainees found in the District of Columbia).

14. The Ervin Act provides a statutory right to treatment for those hospitalized under its provisions. D.C. CODE ANN. § 21-562 (1973); *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966). Some federal courts have also recognized that there is a constitutional right to treatment. *See, e.g.,* *Woe v. Mathews*, 408 F. Supp. 419, 427 (E.D.N.Y. 1976), *remanded in part sub nom. Woe v. Weinberger*, 556 F.2d 563 (2d Cir. 1977); *Dixon v. Weinberger*, 405 F. Supp. 974, 977-78 (D.D.C. 1975); *Welsch v. Likins*, 373 F. Supp. 487, 500 (D. Minn. 1974),

tency.<sup>15</sup> Emphasis will be placed on those procedures which are still problematical and on the inconsistencies between the various groups of allegedly mentally ill persons.

### I. CIVIL COMMITMENT: THE ERVIN ACT

The procedures for involuntary civil commitment in the District of Columbia are found in the 1964 Hospitalization of the Mentally Ill Act,<sup>16</sup> commonly known as the Ervin Act. It was intended by Congress as a model for the revision of state procedures, emphasizing appropriate treatment, voluntary admissions, and the protection of civil rights.<sup>17</sup> Among its major innovations were the exclusion of nondangerous persons from the class of mentally ill persons subject to involuntary hospitalization and the development of administrative procedures that encourage compromise and guarantee informed judicial determinations of the appropriateness of com-

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*aff'd in part*, 550 F.2d 1122 (8th Cir. 1977); *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971) & 344 F. Supp. 387, 390 (N.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholdt*, 503 F.2d 1305, 1312-15 (5th Cir. 1974). See generally Spece, *Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories*, 20 ARIZ. L. REV. 1 (1978); Note, *supra* note 1, at 1316-44; Comment, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282 (1973).

Several courts have expanded the scope of the right to treatment to include the right to placement and treatment in less restrictive alternatives than psychiatric hospitals. See, e.g., *Eubanks v. Clarke*, 434 F. Supp. 1022, 1027-28 (E.D. Pa. 1977); *Dixon v. Weinberger*, 405 F. Supp. 974, 977-78 (D.D.C. 1975). See generally Barnett, *Treatment Rights of Mentally Ill Nursing Home Residents*, 126 U. PA. L. REV. 578, 590 (1978); Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897 (1975). For discussions of the parallel right to refuse treatment, see *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978); Plotkin, *Limiting the Therapeutic Orgy: Mental Patients Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1977); Comment, *Advances in Mental Health: A Case for the Right to Refuse Treatment*, 48 TEMP. L.Q. 354, 364 (1975); Comment, *The Right Against Treatment: Behavior Modification and the Involuntarily Committed*, 23 CATH. U.L. REV. 774 (1974).

15. See D.C. CODE ANN. § 21-564 (1973).

16. *Id.* §§ 21-501 to -592 (1973).

17. S. REP. NO. 925, 88th Cong., 2d Sess. 9-12 (1964). H.R. REP. NO. 1833, 88th Cong., 2d Sess. 2 (1964). Senator Ervin explained the Act's purpose:

Our concern has been with hospitalization procedures, with the protection of the rights of patients after, as well as before, they enter the hospital, and with the encouragement of voluntary admissions . . . . Our concern has been to assure that when an individual is deprived of his liberty because he is mentally ill, he will receive appropriate attention and the treatment necessary to restore him to his place in society.

110 CONG. REC. 2134-36 (1964). See *In re Ballay*, 482 F.2d 648, 660-61 (D.C. Cir. 1973). See generally Cantor & Sherman, *Hospitalization of the Mentally Ill in the District of Columbia*, 15 AM. U.L. REV. 203 (1966); Note, *District of Columbia Hospitalization of the Mentally Ill Act*, 65 COLUM. L. REV. 1062 (1965).

mitment.<sup>18</sup>

The Ervin Act's procedures are guided by the standard that only those persons who are both mentally ill and likely to injure themselves or others can be involuntarily hospitalized.<sup>19</sup> Congress broadly defined the term "mental illness" as a psychosis or other disease which substantially impairs the mental health of a person,<sup>20</sup> but it made no effort to clarify the meaning of the phrase "likely to injure" self or others.<sup>21</sup> While the standard is not a model of clear notice or guidance about the types of behavior or

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18. Primary responsibility for the administrative procedures under the Act is placed upon psychiatrists. See *In re Alexander*, 336 F. Supp. 1305, 1307 (D.D.C. 1972) (mem.). For example, the Act requires frequent psychiatric examinations to determine the appropriateness of hospitalization, D.C. CODE ANN. §§ 21-522, -527 & -546 (1973), and all but one of the members of the Commission on Mental Health are psychiatrists. *Id.* § 21-502 (1973). The ultimate decision about commitment, however, is always made by a judge or jury. D.C. CODE ANN. § 21-544 (1973). For a discussion of the reliability of psychiatric judgments, see Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 697-734 (1974).

19. The likely to injure standard is set out as an instruction to the various persons given responsibilities under the Act: (1) public health officials, physicians, and police officers, D.C. CODE ANN. §§ 21-521, -541 (1973); (2) the examining psychiatrist at the hospital, *id.* §§ 21-522, -527 & -546 (1973); (3) the hospital chief of service, *id.* §§ 21-527 & -546 (1973); (4) the spouse, parents, or legal guardian of the patient, *id.* § 21-541 (1973); (5) the Commission on Mental Health, *id.* § 21-544 (1973); (6) the trial court and jury, *id.* § 21-545.

20. The D.C. Circuit has restated the definition of mental illness as "an abnormal condition of the mind that substantially affects mental or emotional processes, and substantially impairs behavioral controls." *Dixon v. Jacobs*, 427 F.2d 589, 595 n.17 (D.C. Cir. 1970). As originally introduced, the Ervin Act would have specifically excluded epilepsy, alcoholism, drug addiction, or mental deficiency from the definition of mental illness. The Senate committee removed these exclusions, noting that they are symptoms often accompanying mental illness. S. REP. NO. 925, 88th Cong., 2d Sess. 13 (1964).

21. Judge Bazelon has stated that a finding of dangerousness must be based on a "high probability of substantial injury." *Cross v. Harris*, 418 F.2d 1095, 1097 (D.C. Cir. 1969). See *Millard v. Harris*, 406 F.2d 964, 971-78 (D.C. Cir. 1968). Three factors have been identified in determining whether a person meets this standard: (1) the likelihood and probable frequency of future misconduct; (2) the type of misconduct to be expected; (3) whether the expected harm is sufficient to warrant state intervention. See *Dixon v. Jacobs*, 427 F.2d 589, 595 n.17 (D.C. Cir. 1970); *Cross v. Harris*, 418 F.2d 1095, 1099-100 (D.C. Cir. 1969); *Millard v. Harris*, 406 F.2d 964, 973 (D.C. Cir. 1968). Recently, D.C. courts have been reluctant to clarify further the meaning of the likely to injure standard, noting that attempts to turn a largely medical concept into a precise legal definition risk over-definition. See, e.g., *In re Alexander*, 336 F. Supp. 1305, 1308 (D.D.C. 1972) (mem.). Courts in other jurisdictions, however, have added requirements that the risk of potential harm be immediate and evidenced by recent overt acts. See, e.g., *Suzuki v. Alba*, 438 F. Supp. 1106, 1110 (D. Hawaii 1977); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093-94 (E.D. Wis. 1972), *vacated*, 414 U.S. 773, *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976). See generally Comment, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562 (1977).

psychiatric disorders that might result in commitment,<sup>22</sup> it does require a finding of dangerousness.<sup>23</sup> As it relates to the protection of others, the likely to injure standard is a traditional exercise of the police power to protect society from the dangerously insane; but as it relates to protecting a person from self injury, the standard derives from the state's protective role as *parens patriae*.<sup>24</sup> In applying the likely to injure standard, District of Columbia courts have generally accepted both powers as an adequate basis for civil commitment.<sup>25</sup> The vagueness of both the broad mental illness definition and the likely to injure terminology have been challenged, but the courts have considered the indefiniteness of the commitment standard largely unavoidable because of the inherently imprecise nature of psychiatric judgments and clinical terminology.<sup>26</sup>

Despite the vagueness of the commitment standard, District of Columbia courts have been generally satisfied with the constitutionality of liberty interest protections afforded by the Ervin Act.<sup>27</sup> From a procedural stand-

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22. See *In re Alexander*, 336 F. Supp. 1305, 1307 (D.D.C. 1972) (mem.).

23. See *O'Connor v. Donaldson*, 422 U.S. 563, 575-76 (1975).

24. *In re Ballay*, 482 F.2d 648, 658-60 (D.C. Cir. 1973). The use of *parens patriae* in the Ervin Act is limited to the likely to injure self aspect of the commitment standard. *Id.* at 658. The Act has no provision permitting involuntary commitment of a nondangerous person who lacks sufficient capacity to make a treatment decision. *Id.* at 661. Such persons may be admitted to a psychiatric facility, however, under the provisions covering "non-protesting" persons which allow a friend or relative to apply for admission on behalf of a prospective patient. D.C. CODE ANN. § 21-513 (1973). If the patient signs a statement that he does not object to hospitalization and if the admitting psychiatrist certifies need for treatment, the patient will be admitted to a public facility. *Id.* If the patient refuses to sign the statement, he probably cannot be admitted. The issue of whether the emergency provisions can be used against him, however, has never been litigated. Furthermore, unless a petition for indeterminate involuntary commitment has been filed after admission, nonprotesting patients must be released from the hospital immediately upon a written request. *Id.* § 21-514.

25. See, e.g., *In re Kossow*, 393 A.2d 97, 105 (D.C. 1978). The D.C. Circuit has applied the *parens patriae* justification only because the Ervin Act entitles all committed persons to a right to treatment. *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973); *In re Curry*, 452 F.2d 1360, 1362-63 (D.C. Cir. 1971) (per curiam). See also *Rouse v. Cameron*, 373 F.2d 451, 453-54 (D.C. Cir. 1966); D.C. CODE ANN. § 21-562 (1973). The same court has limited the scope of *parens patriae* commitments under the Act by stating: "[d]eprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection." *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966) (en banc). See also *Dixon v. Weinberger*, 405 F. Supp. 974, 977-78 (D.D.C. 1975) (all persons hospitalized under the Ervin Act are entitled to treatment in the least restrictive alternative); *In re Jones*, 338 F. Supp. 428 (D.D.C. 1972) (the hospital bears a burden of exploring alternative placements both within and without the hospital).

26. See *Addington v. Texas*, 99 S. Ct. 1804, 1811 (1979); *In re Alexander*, 336 F. Supp. 1305, 1308 (D.D.C. 1972) (mem.).

27. See *In re Alexander*, 336 F. Supp. 1305, 1307-08 (D.D.C. 1972) (mem.); note 21 *supra*. In *In re Ballay*, the D. C. Circuit explained that in order to avoid dominance by

point, the major safeguards under the Act are judicial oversight during the course of any admission and final judicial determination of the commitment issue.<sup>28</sup> Specifically, authorities may not detain an allegedly mentally ill person for more than a brief period unless adequate justification is shown to the court and the patient is afforded the right to an adversarial hearing.<sup>29</sup> Moreover, every involuntary hospitalization must be continuously justifiable, and hospital authorities have an affirmative duty to release immediately any involuntary patient who, in their opinion, is no longer dangerously mentally ill and who does not wish to become a voluntary patient.<sup>30</sup>

### *A. Emergency Hospitalization*

The Ervin Act establishes specific procedures for the temporary hospitalization of the dangerously mentally ill.<sup>31</sup> Emergency detentions, because of their urgency and limited duration, do not require the full panoply of procedural rights afforded in cases of indeterminate commitment. Nevertheless, there is judicial oversight through a probable cause hearing.<sup>32</sup> There has been little litigation concerning the sufficiency of these procedures, possibly because of the drafters' attempts to create new protections for the civil rights of patients.<sup>33</sup> Nonetheless, even today there are problems with the Act's detention procedures, including the duration of detention prior to the probable cause hearing and a lack of adequate procedural protections to guard against inappropriate detentions of admitted voluntary patients who seek discharge.

An emergency commitment begins when officials detain a person appearing to be mentally ill and likely to injure himself or others.<sup>34</sup> No court

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clinicians over the determination of the commitment issue, the court or jury must find mental illness and dangerousness beyond a reasonable doubt. 482 F.2d 648, 664-67 (D.C. Cir. 1973). *See also* Ennis & Litwak, *supra* note 18, at 699-732. *But see* Addington v. Texas, 99 S. Ct. 1804, 1812 (1979) (clear and convincing evidence standard is constitutionally sufficient for civil commitments).

28. *See In re Walls*, 442 F.2d 749, 750 (D.C. Cir. 1971) (per curiam); D.C. CODE ANN. §§ 21-523 & -545 to -547 (1973).

29. *See* D.C. CODE ANN. §§ 21-521 to -528 (1973). The D.C. Circuit has noted: "When personal freedom is at issue due process at least demands that a person's legal status be determined at the earliest possible time." *In re Barnard*, 455 F.2d 1370, 1375 (D.C. Cir. 1971) (per curiam).

30. *See* D.C. CODE ANN. §§ 21-522, -527 & -548 (1973).

31. *See id.* §§ 21-521 to -528; *In re Barnard*, 455 F.2d 1370 (D.C. Cir. 1971) (per curiam).

32. *See* D.C. CODE ANN. § 21-525 (1973); *In re Barnard*, 455 F.2d at 1373-74.

33. *See* note 17 *supra*.

34. D.C. CODE ANN. § 21-521 (1973). The Act forbids the holding of any patient in a penal institution. *Id.* § 21-585.



order is necessary, but officials must conform to the fourth amendment's requirement of probable cause.<sup>35</sup> Upon arrival at the hospital, the "arresting" official must make application for emergency hospitalization,<sup>36</sup> however, a patient may be admitted only after a hospital psychiatrist has examined him and certified that the patient meets the commitment standard.<sup>37</sup> If the patient is hospitalized, he may not be detained for more than forty-eight hours unless the hospital petitions the Superior Court for an *ex parte* order authorizing commitment for up to seven additional days.<sup>38</sup> After the court initially grants the hospital's petition, the patient may demand an adversarial hearing on whether there is probable cause to believe he meets the commitment standard,<sup>39</sup> in such case, the seven-day commitment may continue only if the court upholds its *ex parte* order.<sup>40</sup> To de-

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35. See *In re Barnard*, 455 F.2d at 1373-74; *Benson v. Meredith*, 455 F. Supp. 662, 669-70 (D.D.C. 1978).

36. The application must reveal the circumstances under which the person was taken into custody. D.C. CODE ANN. § 21-521 (1973). The Act expressly permits applications for admission of patients from officers authorized to make arrests, licensed physicians, and accredited officials of the Department of Public Health. *Id.* There is no provision authorizing the patient's family or friends to make such applications. *But cf. id.* §§ 21-513 & -514 (friends and relatives may apply for a "nonprotesting" person if patient signs a statement indicating that he does not object). See generally note 24 *supra*.

37. D.C. CODE ANN. § 21-522 (1973). Admission by a private hospital is discretionary; public hospitals must admit persons who are certified by the admitting psychiatrist. *Id.* Under the Ervin Act, petitions, applications, and certifications are invalid unless based on an examination made in the preceding 72 hours; nor may they be drawn up by a physician who is related by blood or marriage to the patient. *Id.* § 21-582.

38. *Id.* § 21-523. Within 24 hours after receipt of the hospital's petition, the court must order continued hospitalization or immediate release. *Id.* § 21-524(a). The petition itself must contain the official application for admission and the certificate of the admitting psychiatrist. *Id.* § 21-524(b). The D.C. Circuit has also required the petition to contain sufficient factual background to show probable cause justifying continued hospitalization. See *In re Barnard*, 455 F.2d 1370, 1375 (D.C. Cir. 1971) (*per curiam*).

The drafters explained that a period of emergency hospitalization was necessary to provide sufficient opportunity for a full examination and diagnosis prior to proceedings for long term commitment. S. REP. NO. 925, 88th Cong., 2d Sess. 16 (1964).

39. D.C. CODE ANN. § 21-525 (1973). The provisions do not specifically explain what kind of hearing should be held, but it must occur within 24 hours of the patient's request. *Id.* The D.C. Circuit has required that notice of the *ex parte* seven-day order and the right to a hearing must be given to the patient within 24 hours of the entry of the order. *In re Barnard*, 455 F.2d at 1375. The court has also found it constitutionally necessary that the hearing be held in open court with the patient having the right to be present, to have court appointed counsel, to present evidence and to cross examine witnesses, and to have a record made of the proceeding. See *id.* at 1373-76.

40. See D.C. CODE ANN. § 21-527 (1973). All patients must be reexamined prior to the hearing, or, if no hearing is requested, within 48 hours of the entry of the *ex parte* seven-day order. See *In re Barnard*, 455 F.2d 1370, 1375 (D.C. Cir. 1971) (*per curiam*). If the examining psychiatrist determines that the patient is no longer likely to injure himself or others if not presently detained, he must be immediately released. *Id.*

tain the patient beyond seven days, the hospital must file a petition for indeterminate commitment.<sup>41</sup>

Because of the number of steps required, the probable cause hearing is not held until four to eight days after the patient's admission.<sup>42</sup> While this period may be sufficiently short to satisfy constitutional due process demands, a requirement of a hearing prior to the court's order within twenty-four or forty-eight hours would not only be more protective but also easier to administer.<sup>43</sup> Furthermore, it would better conform to the District of Columbia Circuit's rule that the patient's legal status be determined at the earliest possible date.<sup>44</sup>

Another issue raised by the Ervin Act's detention procedures is their applicability to persons voluntarily seeking treatment as well as to those already voluntarily admitted. In *In re Curry*,<sup>45</sup> a person requesting psychiatric treatment at George Washington University Hospital was refused admission, instead receiving a suggestion to file an application for voluntary treatment at Saint Elizabeth's Hospital. Because the patient was unwilling to admit himself to the public institution, a doctor at George Washington University Hospital initiated the emergency procedure. The District of Columbia Circuit voided the subsequent admission to Saint Elizabeth's on the basis of Mr. Curry's willingness to accept voluntary treatment.<sup>46</sup> In the court's view, the emergency provisions could not be used against a person seeking treatment voluntarily because of the Act's policy of encouraging

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41. See D.C. CODE ANN. § 21-528 (1973). This section applies only to persons hospitalized under the emergency procedure, and it permits continued detention beyond the seven-day period pending judicial proceedings for long term commitment. For a discussion of indeterminate judicial hospitalization procedures, see notes 50-70 and accompanying text *infra*.

42. The hospital may detain the patient for 48 hours before filing the petition, D.C. CODE ANN. § 21-523 (1973); the court has 24 hours to respond to the petition, *id.* § 21-524; the patient must be notified within 24 hours after entry of the seven day order, *In re Barnard*, 455 F.2d at 1375, and the court must hold a hearing within 24 hours of receipt of the patient's request for a hearing, D.C. CODE ANN. § 21-525 (1973). The Act also provides for extensions of the maximum periods during which any action or determination under the emergency provisions must be taken if the period expires on a Saturday, Sunday, or legal holiday. *Id.* § 21-526. Thus, the actual period of time before which a probable cause hearing must be held on the likely to injure standard is four to eight days.

43. Under the Federal Reservations Act, for example, allegedly mentally ill persons detained on a federal reservation and brought to a psychiatric hospital in D.C. have a right to a probable cause hearing within 72 hours. See *Bension v. Meredith*, 455 F. Supp. 662, 667-72 (D.D.C. 1978); D.C. CODE ANN. § 21-903 (1973). See generally note 13 *supra*.

44. *In re Barnard*, 455 F.2d at 1375.

45. 470 F.2d 368 (D.C. Cir. 1972).

46. *Id.* at 371-72. See also *Lightfoot v. Sirica*, No. 72-1460 (D.C. Cir. May 25, 1972), quoted in *In re Curry*, 470 F.2d at 371-72.

admissions without legal proceedings.<sup>47</sup>

Since the threat of being involuntarily detained after admission could discourage voluntary patients, *Curry's* rationale should preclude the use of the emergency provisions not only against those voluntarily seeking treatment but also against those patients already voluntarily admitted. The Act, however, specifically permits the hospital to hold an admitted voluntary patient for forty-eight hours after his request for discharge.<sup>48</sup> The legislative history of the Act does not explain this provision, nor have any reported cases challenged its lack of standards to guide the hospital's discretion. In any event, *Curry* would preclude attempts to extend the detention of an admitted voluntary patient beyond forty-eight hours.<sup>49</sup>

### B. Indeterminate Judicial Commitment

The Ervin Act's emergency provisions are limited to persons who are not voluntarily seeking treatment and need temporary detention. In order to commit persons not subject to the emergency provisions or to continue the hospitalization of an emergency detainee after the expiration of a seven-day order, a petition for judicial hospitalization must be filed with

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47. 470 F.2d at 371-72. *Curry* is consistent with the Ervin Act's policy of placing no significant restraints on the release of voluntary patients. See S. REP. NO. 925, 88th Cong., 2d Sess. 15 (1964) and the authorities cited in note 17 *supra*. But cf. Gilboy & Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 NW. U.L. REV. 429 (1971) (voluntary admissions after a person is already in custody are of questionable validity). See generally Wexler, *Forward: Mental Health Law and the Movement Toward Voluntary Treatment*, 62 CALIF. L. REV. 671 (1974).

Nothing in the Ervin Act precludes the administrative practice of permitting patients to change their status from involuntary to voluntary. The voluntary provisions of the Ervin Act require an application for admission to both public and private hospitals which must be followed by an examination by an admitting psychiatrist to determine need for treatment. D.C. CODE ANN. § 21-511 (1973). A voluntary patient may remain in the hospital as long as he is willing to stay and as long as staff continue to find need for treatment. The Act relies on clinical judgments to assure that the decision for voluntary treatment is informed and freely made. But cf. Barnett, *supra* note 14, at 615 (coercive pressure on the patient at the time of conversion to voluntary status raises question of denial of due process rights).

48. D.C. CODE ANN. § 21-512 (1973). On its face, the provision does not prohibit the use of the 48 hour detention period to hospitalize temporarily a voluntary patient who has been placed on outpatient status. Recent decisions in other jurisdictions, however, have required due process protections against such an infringement of the liberty interest of involuntary patients, and there is little justification for treating voluntary patients differently. See *Lewis v. Donahue*, 437 F. Supp. 112 (W.D. Okla. 1977); *In re Anderson*, 73 Cal. App. 3d 38, 140 Cal. Rptr. 546 (1977).

49. Nothing in the Ervin Act precludes filing a petition for involuntary hospitalization against admitted voluntary patients. See notes 50-72 and accompanying text *supra*. There is no authority under the Act, however, for detentions of such patients beyond 48 hours pending the outcome of judicial proceedings. See *In re Robinson*, 101 DAILY WASH. L. REP. 1501 (D.C. Super. Ct. 1973).

the Commission on Mental Health.<sup>50</sup> In the case of an emergency detainee, the petition is generally filed by hospital physicians, but the Act also permits physicians, certain government officials, spouses, or parents to file "off the street" petitions against persons who have not been detained under the emergency provisions.<sup>51</sup> Upon receipt of a petition, the Commission on Mental Health is required to examine the allegedly mentally ill person and to conduct an informal hearing to determine if the person meets the likely to injure standard.<sup>52</sup> If its findings are negative, the Commission must order the person's immediate release; otherwise, it must make a written report of its findings and recommendations to the Superior Court.<sup>53</sup> In order to commit a person indeterminately, the court, or jury when requested, must find beyond a reasonable doubt that he is mentally ill and likely to injure himself or others.<sup>54</sup>

While many of the procedural rights of the allegedly mentally ill person under the Ervin Act have been settled by the courts for some time, the extent of the petitioner's role in pursuing civil commitment was uncertain

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50. See D.C. CODE ANN. §§ 21-528 & -541 (1973). The Act does not explain what the petition must contain, but it does require notice to the patient within three days and an accompanying physician's certificate that the person meets the likely to injure standard or a sworn statement by the petitioner that he has reason to believe the person meets the likely to injure standard and has refused to submit to an examination. D.C. CODE ANN. § 21-541 (1973). It is also a criminal offense to execute a petition without probable cause. *Id.* § 21-591.

51. *Id.* § 21-541(a) permits petitions from physicians, public health officials, police officers, or a spouse, parent or legal guardian. Notably absent from this list are friends and relatives other than a parent or spouse.

52. *Id.* § 21-542. The Commission on Mental Health is composed of two physician members rotating from a pool of eight and a member of the bar. *Id.* § 21-502. Proceedings before the Commission are informal, but the Act specifically grants the allegedly mentally ill person rights to counsel, to be present, to testify, and to present and cross examine witnesses. *Id.* §§ 21-542 & -543.

53. *Id.* § 21-544. If the Commission makes an affirmative finding, it has five days to file a report with the court containing findings of fact, conclusions of law, recommendations for disposition, and the name of any dissenting member. A copy of the report is served on the allegedly mentally ill person and his attorney. *Id.*; D.C. SUPER. CT. MENTAL HEALTH R. 3(b).

54. If the Commission reports an affirmative finding, the court must set a hearing and give notice of a right to a jury trial. If no trial is demanded, the court may take any additional evidence it requires and may accept or reject the Commission's findings. D.C. CODE ANN. § 21-545 (1973). The D.C. courts have made it constitutionally necessary for indeterminate commitment that the judge or jury find beyond a reasonable doubt that a person is mentally ill and likely to injure himself or others if allowed to remain at liberty. *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973); *In re Hodges*, 325 A.2d 605 (D.C. 1974). *But see* *Addington v. Texas*, 99 S. Ct. 1804, 1812 (1979) (clear and convincing standard of proof is constitutionally sufficient for civil commitments). See generally Note, *Due Process and the Development of "Criminal" Safeguards in Civil Commitment Adjudications*, 42 *FORDHAM L. REV.* 611, 624-25 (1974).

until recently. In *In re Kossow*,<sup>55</sup> for example, the Commission on Mental Health had recommended that each of three patients be indeterminately committed, but the Corporation Counsel, in its role as public prosecutor, declined to pursue the commitments in court.<sup>56</sup> In each case, however, the original private petitioners obtained private counsel and prevailed in the commitment proceeding before the Superior Court. In a consolidated appeal, the patients argued that private petitioners could not proceed beyond the initial filing and that the decision to seek a long term commitment order lay within the exclusive discretion of the prosecuting authority. The Court of Appeals upheld the commitments, however, finding private mental health litigation before the Superior Court permissible under both the Ervin Act and the due process clause.<sup>57</sup> The court noted that the Commission performs a function analogous to the public prosecutor in criminal cases by screening petitions and by encouraging compromises prior to any judicial determination of the commitment issue.<sup>58</sup> In so reasoning, the court impliedly limited its holding to cases in which the Commission has made an affirmative recommendation of commitment.<sup>59</sup>

A related issue arose in *In re Lomax*<sup>60</sup> in which the government sought to appeal the Superior Court's dismissal of a commitment petition after a jury finding in favor of the patient. The Court of Appeals, sitting *en banc*, decided that even though the Ervin Act was silent on the issue, it would circumvent the statutory scheme to allow the government's appeal.<sup>61</sup> The court reasoned that the length of time consumed by the appeals process was inconsistent with the Ervin Act's explicit and swift timetable for the determination of the commitment issue and contravened its policy mandating the immediate release of detainees not meeting the commitment standard after any hearing or examination.<sup>62</sup> Moreover, since the Act re-

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55. 393 A.2d 97 (D.C. 1978).

56. *Id.* at 99-101.

57. *Id.* at 109. In the case of an indigent petitioner, the trial court will appoint counsel. *See* District of Columbia v. Pryor, 366 A.2d 141 (D.C. 1976).

58. 393 A.2d at 106-07.

59. *See* D.C. CODE ANN. § 21-544 (1973). The Ervin Act's specific directive that the Commission "immediately order the patient's release" if its findings are negative on the commitment issue suggests that no review of the Commission's decision was intended by Congress. *See id.*

60. 386 A.2d 1185 (D.C. 1978) (*en banc*).

61. *Id.* at 1189. The court's *en banc* ruling reversed an earlier opinion in the same case by Judge Harris in which he found appellate review of the trial court's proceedings consistent with the Ervin Act. *See In re Lomax*, 367 A.2d 1272 (D.C. 1976). Judge Harris relied on the general rule of reviewability found in D.C. CODE ANN. § 11-721(a)(1) (1973) which makes all final Superior Court orders appealable to the D.C. Court of Appeals. He explained that nothing in the Ervin Act created an exception. 367 A.2d at 1278.

62. 386 A.2d at 1188-89. Mr. Lomax's case began in August of 1975 with an emergency

quires a determination of current mental status, the court explained that the patient's past condition could not be a basis for commitment even if the trial court's findings were shown to be erroneous.<sup>63</sup> In the court's reasoning, the alternative to an appeal would be filing a new petition if the petitioner has reason to believe the patient currently meets the commitment standard.<sup>64</sup> This emphasis on present mental status would clearly apply to cases involving private petitioners who, following *Kossow*, may pursue a patient's commitment. The court's holding in *Lomax* is inapplicable, however, to the patient himself, whose appeal has always been maintainable in order to correct any trial irregularities resulting in an inappropriate commitment.<sup>65</sup>

In summary, the Ervin Act allows indeterminate civil commitment only if a judge or jury finds beyond a reasonable doubt that the person is mentally ill and likely to injure himself or others.<sup>66</sup> Neither public nor private petitioners may go forward to trial unless the Commission makes an affirmative recommendation for commitment to the court. On such recommendation, the allegedly mentally ill person has the right to a jury trial and a right of appeal if he is committed by the court.<sup>67</sup> The prosecuting party, however, has no right to appeal from the trial court.

If the private petitioner or the government succeeds in having the allegedly mentally ill person committed, the length of the commitment is indeterminate, but its restrictiveness is subject to the discretion of the court. If the court finds that it is in the best interests of the person or the public, it may order placement in a public psychiatric institution, usually Saint Elizabeth's Hospital, or it may order any less restrictive course of treatment.<sup>68</sup>

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admission to Saint Elizabeth's Hospital. Four months later, a jury found he was not committable. *Id.* at 1186-87. The Superior Court order for his release was stayed by the D.C. Court of Appeals until September 23, 1977 when it was dissolved without comment after a constitutional challenge. *Id.* at 1187 n.6. Thus, Mr. Lomax was held for over 21 months after a jury had found that he did not meet the commitment standard. *But see In re Lomax*, 367 A.2d at 1280-81 (Judge Harris' comments favoring the stay of Mr. Lomax's release pending the government's appeal).

63. 386 A.2d at 1189.

64. *Id.*

65. D.C. SUPER. CT. MENTAL HEALTH R. 6(c) requires that the patient be notified of his right to an appeal following an adverse order in a commitment proceeding.

66. *See* D.C. CODE ANN. § 21-545(b) (1973). *See also In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973); *In re Hodges*, 325 A.2d 605 (D.C. 1974).

67. *See* D.C. CODE ANN. §§ 21-544 & -545 (1973); D.C. SUPER. CT. MENTAL HEALTH R. 6(c).

68. D.C. CODE ANN. § 21-545(b) (1973). *See* note 25 *supra*. The court may order, for example, the placement of an elderly patient in a private nursing home in lieu of commitment to Saint Elizabeth's Hospital. *See In re Johnson*, 103 DAILY WASH. L. REP. 505 (D.C. Super. Ct. 1975). For more examples of possible placements other than an institution, see

Regardless of his placement, a committed patient also has the right to immediate release once he has recovered sufficiently so that he is no longer dangerous to himself or others. The right to release is determined through obligatory administrative examinations by the hospital with the participation of the patient's own private physician.<sup>69</sup> If the hospital refuses to release the patient after the mandatory examination, he may petition the court to order his release; but a court order is not required for release if hospital authorities at any time consider the patient to be sufficiently recovered.<sup>70</sup>

The emphasis in the Ervin Act, therefore, is on involuntary commitment lasting only as long as necessary in the least restrictive setting possible. A committed patient may be released or placed on leave by clinical decision alone, and the court may directly order placements with psychiatric programs other than restrictive institutions. The Commission on Mental Health serves a complementary function by screening patients and by encouraging compromises, thus avoiding the need for judicial involvement in many cases.<sup>71</sup> The success of these aspects of the Ervin Act, however, is highly dependent on the availability of alternatives to the traditional psychiatric institution and the willingness of Congress or the local community to accept and fund less restrictive services. The Ervin Act, nevertheless, makes no provision for the creation of these services and allocates no funds for such a purpose.<sup>72</sup>

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Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1108, 1112-19 (1972).

69. See D.C. CODE ANN. § 21-546 (1973). The first such examination is 90 days after commitment with follow-ups every six months. If the hospital refuses to release the patient after the examination, the patient may petition the court for a ruling on whether he should be released. *Id.* The patient may also petition for *habeas corpus* in between the required examinations. The exhaustion of administrative remedies requirement is the mandatory six-month examination rather than a request for discretionary examination. *Dixon v. Jacobs*, 427 F.2d 589, 598-99 (D.C. Cir. 1970).

70. D.C. CODE ANN. § 21-548 (1973). Hospital authorities are required to conduct their own independent examinations "as often as practicable" but not less often than every six months to determine if the patient is still committable; if not, he must be released. *Id.*

71. See *In re Kossow*, 393 A.2d 97, 106-07 (D.C. 1978).

72. The D.C. Superior Court has occasionally ordered hospitalization at Saint Elizabeth's Hospital when no alternative facilities have been available for residential care. See, e.g., *In re Randolph*, 102 DAILY WASH. L. REP. 2225 (D.C. Super. Ct. 1974).

Despite the well documented need for new facilities, a recurring problem in right to treatment class actions, especially those involving the right to placement in less restrictive alternatives, is the development and funding of expanded services. See Armstrong, *Saint Elizabeth's Hospital: Case Study of a Court Order*, 20 HOSPITAL AND COMMUNITY PSYCH. 42 (1979) for a description of the remedial problems in implementing the order to develop less restrictive alternatives in *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975). See generally J. RUBIN, *ECONOMICS, MENTAL HEALTH AND THE LAW* (1978); Special Project,

C. "Voluntary" Admission of Persons Under Eighteen Years of Age by Their Parents

The Ervin Act's protective involuntary commitment procedures do not apply to "voluntary" admissions of children under the age of eighteen at the request of parents or legal guardians.<sup>73</sup> The only procedural protection prior to admission is an examination by a hospital psychiatrist who makes a medical determination of the need for hospital treatment.<sup>74</sup> The statute provides little guidance for the discretion of the clinician, and it requires no finding of dangerousness since the admission is considered voluntary. Once admitted, the youth's subsequent release is discretionary with the hospital or is granted upon the demand of the child's parents or legal guardian.<sup>75</sup> The child himself has no right to release upon demand.

In recent years, litigants and commentators have questioned ostensibly voluntary admissions procedures similar to those of the Ervin Act.<sup>76</sup> It has often been explained that such procedures have great potential for inappropriate hospitalization against the child's will, especially when a less restrictive alternative placement is available.<sup>77</sup> The child generally has no one to represent his interests exclusively;<sup>78</sup> nor is there an opportunity to

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*The Remedial Process in Institutional Reform Litigation*, 78 COLUM. L. REV. 784 (1978); Note, *Implementation Problems in Institutional Reform Litigation*, 91 HARV. L. REV. 428 (1977).

73. See D.C. CODE ANN. §§ 21-511 & -512 (1973). The involuntary admission process does apply, however, to hospitalizations of juveniles against the wishes of both the child and his parents. See *id.* §§ 21-521 to -545.

74. *Id.* § 21-511.

75. *Id.* § 21-512.

76. See, e.g., *Parham v. J.R.*, 99 S. Ct. 2493 (1979); *Secretary of Public Welfare v. Institutionalized Juveniles*, 99 S. Ct. 2523 (1979); *Kidd v. Schmidt*, 399 F. Supp. 301 (E.D. Wis. 1974); *Saville v. Treadway*, 404 F. Supp. 430 (M.D. Tenn. 1975); *In re Roger S.*, 19 Cal. 3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977). See generally *Ellis, Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840 (1974); *Rolfe & Mac Clintock, The Due Process Rights of Minors "Voluntarily Admitted" to Mental Institutions*, 4 J. PSYCH. & L. 333, 351 (1976); *Teitelbaum & Ellis, The Liberty Interest of Children: Due Process Rights and Their Application*, 12 FAM. L.Q. 153 (1978); Note, *The Mental Hospitalization of Children and the Limits of Parental Authority*, 88 YALE L.J. 186 (1978).

77. See generally authorities cited in note 76 *supra*. In a recent study, the National Institute of Mental Health found that only 36% of Saint Elizabeth's Hospital patients under the age of 20 actually required hospitalization. National Institute of Mental Health, *Statistical Note 115, Children and State Mental Hospitals* (1975) — cited in *Parham v. J.R.* 99 S. Ct. 2493, 2518 n.15 (Brennan, J., concurring and dissenting).

78. The law has historically recognized a legal presumption that "natural bonds of affection lead parents to act in the best interests of their children." *Parham v. J.R.*, 99 S. Ct. 2493, 2504 (1979). The stress and uncertainty associated with commitment, however, may cause parents to act contrary to their child's interests, especially when parents are ignorant of alternatives to a restrictive institution and rely on the judgments of psychiatrists who are oriented toward institutional care. See *id.* at 2519 (Brennan, J., concurring and dissenting).



subject clinical judgments to societal scrutiny.<sup>79</sup> Many inappropriate hospitalizations of children have undoubtedly occurred, given the tentativeness and subjectivity of psychiatric judgments<sup>80</sup> and the reliance of clinicians on the reports of lay parents who are significantly affected by the psychiatric decision.<sup>81</sup> Moreover, clinicians and parents are generally not required to seek out modes of treatment less restrictive than a psychiatric institution.

Despite the criticisms of the practice, the Supreme Court recently upheld state procedures for the "voluntary" hospitalization of juveniles at the request of their parents. In *Parham v. J.R.*,<sup>82</sup> the Court found that constitutional due process is satisfied when a staff physician, as a "neutral fact finder," makes an inquiry to determine whether the child is medically in need of hospital treatment.<sup>83</sup> The Court was convinced that such an inquiry is sufficient to guard the child's liberty interest and to prevent abuses of parental authority.<sup>84</sup> The inquiry itself does not have to take the form

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79. The Supreme Court has recently noted that psychiatric diagnosis "is to a large extent based on medical 'impressions' drawn from subjective analysis and filtered through the experience of the diagnostician. This process often makes it very difficult for the expert physician to offer definite conclusions about any particular patient." *Addington v. Texas*, 99 S. Ct. 1804, 1811 (1979). At its best, psychiatric diagnosis is "fraught with uncertainty." *Parham v. J.R.*, 99 S. Ct. 2493, 2517 (1979) (Brennan, J., concurring and dissenting). See *O'Connor v. Donaldson*, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring). See generally Rosenhan, *On Being Sane in Insane Places*, 179 *SCIENCE* 250 (1973). In the context of involuntary hospitalization, there is a need for some judicial check on the effect of such standardless clinical judgments on the individual's liberty interest. See Teitelbaum & Ellis, *supra* note 76, at 174-79; Ellis, *supra* note 76, at 863-71; note 27 *supra*.

80. As Justice Brennan has explained, the uncertainties of psychiatric diagnosis are aggravated when a child is committed at the request of his parents. *Parham v. J.R.*, 99 S. Ct. 2493, 2517 (1979) (Brennan, J., concurring and dissenting). The psychiatrist must evaluate the child during the abnormally stressful period of commitment and without an opportunity to become fully acquainted with the patient. Social and economic class differences between doctor and child may further aggravate the uncertainties of the evaluation. These uncertainties may "often lead to erroneous commitment since psychiatrists tend to err on the side of medical caution and therefore hospitalize patients for whom other dispositions would be more beneficial." *Id.* at 2517-18.

81. See Teitelbaum & Ellis, *supra* note 76, at 191-95.

82. 99 S. Ct. 2493 (1979). See also *Secretary of Public Welfare v. Institutionalized Juveniles*, 99 S. Ct. 2523 (1979).

83. 99 S. Ct. at 2506. The Court explained that due process does not require the fact finder to be "law-trained or a judicial or administrative officer." *Id.* Characterizing the admissions decision as essentially psychiatric in nature, the Court found that "a staff physician will suffice" as the fact finder, "so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment." *Id.* at 2507.

84. While recognizing that a child has a "substantial liberty interest in not being confined unnecessarily," *id.* at 2503, the Court permitted parents, in the absence of abuse or neglect, to have a substantial role in the decision to seek hospital treatment. *Id.* at 2305. The Court relied upon the traditional legal presumption that parents act in their child's best

of a hearing, but the fact finder should interview the child and carefully probe his background to determine his mental and emotional condition.<sup>85</sup> If the fact finder determines that hospitalization would be inappropriate, the request for admission must be denied.<sup>86</sup>

After *Parham*, the Ervin Act's procedures for the "voluntary" admission of juveniles should pass constitutional scrutiny. The required examination prior to admission can be a sufficient inquiry into the medical need for the hospitalization if it is conducted under *Parham's* guidelines.<sup>87</sup> Needless to say, the admitting physician must be informed of his duty to refuse requests for inappropriate admissions.

District of Columbia law in this area, however, is somewhat complicated by the recent consent decree in *Poe v. Califano*.<sup>88</sup> In *Poe*, the "voluntary" provisions for the admission of children were challenged on due process grounds. After considerable delay, the government defendants chose not to defend the constitutionality of the procedures and the court directed the parties to develop a remedy.<sup>89</sup> Following negotiations between the parties, the court declared the provisions violative of procedural due process because they lacked even the rudimentary requirements of notice, counsel, and the opportunity to be heard.<sup>90</sup> The court then also ordered the implementation of most of the procedures in a consent decree, but declined to rule on their constitutional adequacy. The new procedures established judicial review of parental decisions to seek the hospitalization of their children through mandatory court hearings with the right to independent counsel for the child.<sup>91</sup>

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interest and possess what a child lacks in experience and judgment "in making life's difficult decisions." *Id.* at 2504. In light of this presumption, the Court found a judicial hearing unnecessary to guard against abuses of parental authority. An inquiry by a staff physician at the hospital was deemed sufficient. *Id.* at 2507.

85. *Id.*

86. *See id.* The fact finder must have the authority to refuse to admit the child. Once admitted, the hospital must periodically review the need for continued inpatient treatment by a similar procedure. *Id.*

87. *See* D.C. CODE ANN. § 21-511 (1973). *Parham's* requirements should be strictly adhered to in order to make certain the admitting physician is acting as a neutral fact finder. *See* notes 83-85 *supra*.

88. No. 74-1800 (D.D.C. Sept. 25, 1978).

89. No. 74-1800, slip op. at 3.

90. *Id.*

91. *Id.* at 4. The *Poe* decree distinguished between overlapping categories of juveniles. Adolescents, persons 14 to 17 years of age, were admitted as voluntary patients on their own application. In order to insure that the request for admission was informed and freely made, the adolescent was required to consult with appointed counsel. *Id.* at 4-5. Youth, all persons under 16 years of age, were also given counsel, but they were admitted for a four-month period upon parental petition and Superior Court order, provided the proposed institution

The procedures established in *Poe*, however, were interim measures to permit continued hospitalizations of minors pending action by the District of Columbia City Council or by Congress.<sup>92</sup> The consent decree expired on June 30, 1979 and no legislative action had been taken by that date. In light of the Supreme Court's ruling in *Parham*, changes in the Ervin Act may no longer be necessary.<sup>93</sup> Of course, the legislature is free to provide for judicial hearings if it so chooses.<sup>94</sup> Given the substantial criticisms that have been levelled at the practice of nonjudicial admissions of juveniles upon parental request,<sup>95</sup> the District of Columbia City Council should consider procedures, such as those negotiated in *Poe*,<sup>96</sup> that are stricter than the constitutional minimum announced in *Parham*.

## II. COMMITMENT BY CRIMINAL PROCEEDING

The coverage of the Ervin Act does not extend to persons committed by court order in a criminal proceeding.<sup>97</sup> The statutory schemes for the involuntary hospitalization of such persons make broad use of judicial discretion and are in sharp contrast to the sophisticated and well defined procedures of the Ervin Act. The adult criminal commitment procedures, for example, provide for inpatient competency examinations,<sup>98</sup> the involuntary hospitalization of sentenced prisoners,<sup>99</sup> and the automatic commitment of persons acquitted by reason of insanity.<sup>100</sup> Juveniles, on the other

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first certified that hospitalization was appropriate. *Id.* at 6-10. In order to insure the appropriateness of hospitalization, a preadmission judicial hearing was required after which the court determined whether to authorize the admission. If the court permitted the admission, the hospital had the clinical discretion either to refuse admission or to release the patient when appropriate. *Id.* at 6 & 8. Adolescents admitted by their own request could demand their release at any time, and the hospital had to comply within 48 hours. *Id.* at 5. Youths admitted on the basis of parental petition had to be released within 48 hours of a parental demand or upon expiration of the four-month authorization order. *Id.* at 8. If their parents refused to make a release demand, youths could also personally petition the court for their release 60 days after admission. They had to be released if they could show by a preponderance of evidence that they were no longer in need of restrictive psychiatric hospitalization. *Id.* at 9.

92. *Id.* at 4.

93. *Id.* at 3. *Parham* left open, however, the issue of whether post commitment judicial procedures may be necessary to continue long term hospitalizations of minors. See 99 S. Ct. at 2511. The D.C. procedures may be vulnerable in this respect, because they permit continued hospitalization by parental and clinical discretion. See D.C. CODE ANN §§ 21-512 & -513 (1973).

94. See *Parham v. J.R.*, 99 S. Ct. 2493 (1979).

95. See notes 77-81 and accompanying text *supra*.

96. See note 91 *supra*.

97. D.C. CODE ANN. § 21-501 (1973).

98. *Id.* §§ 24-301(a), (b) & -303(a).

99. *Id.* §§ 24-302 & -303(b).

100. *Id.* § 24-301(d).

hand, can be involuntarily hospitalized by the court for examination or treatment at almost any stage of delinquency, neglect, or need of supervision proceedings.<sup>101</sup> Since these statutory schemes contain many interstices, one must look beyond the statute to the rules and procedures established by the judges themselves, as well as to developments in the cases, in order to discover the state of the law in this area.

### A. Examinations to Determine Competency

In order to insure the defendant's right to a fair trial, the District of Columbia Code provides for competency examinations and short-term commitments.<sup>102</sup> The court may order observation and examination of a person subject to its criminal jurisdiction in order to determine whether he is able to understand the proceedings against him or to assist in his own defense.<sup>103</sup> Such an order may issue on the basis of the judge's own obser-

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101. *Id.* §§ 16-2313(c), -2315, -2320(g)(4) & -2321.

102. *Id.* § 24-301(a). See D.C. SUPER. CT. CRIM. R. 109(c); Memorandum to the Judges, Procedures for Mental Examination of Criminal Defendants in the District of Columbia (1976) (Ugast Committee Report). Competency examinations for persons tried for federal offenses are provided for in 18 U.S.C. § 4244 (1976). See generally Pizzi, *Competency to Stand Trial in Federal Courts: Conceptual and Constitutional Problems*, 45 U. CHI. L. REV. 21 (1977).

103. D.C. CODE ANN. § 24-301(a) (1973). The examination may be ordered at anytime during the course of a criminal proceeding. The statute specifically permits competency examinations "prior to the imposition of sentence [or] the expiration of any period of probation." *Id.*

The traditional test for competency to stand trial requires more than orientation to time and place. The Supreme Court has explained that the proper test is whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him." *Dusky v. United States*, 362 U.S. 402 (1950) (per curiam). See also *United States v. Masters*, 539 F.2d 721, 725 (D.C. Cir. 1976). The Supreme Court has also held that due process considerations obligate the trial judge to raise the competency issue *sua sponte* when a *bona fide* doubt exists about the competence of the accused. *Pate v. Robinson*, 383 U.S. 375, 385 (1966). See also *Drope v. Missouri*, 420 U.S. 162 (1975).

An independent factual determination of competency must be made by the trial judge. He cannot simply rely on the advice of expert psychiatrists. *United States v. David*, 511 F.2d 355, 360 (D.C. Cir. 1975). However, his specific judicial finding is generally given great weight on appeal. *Bennet v. United States*, 107 DAILY WASH. L. REP. 865 (D.C. Ct. App. 1979). See *Whalem v. United States*, 379 A.2d 1152, 1160-62 (D.C. 1977). See generally *United States v. Caldwell*, 543 F.2d 1333, 1349 n.70 (D.C. Cir. 1974), *cert. denied*, 423 U.S. 1087 (1976) (mere difficulty in communication between client and attorney is not in itself enough to require a competency examination); *Clyburn v. United States*, 381 A.2d 260, 264 (D.C. 1977), *cert. denied*, 435 U.S. 999 (1978) (competency examination is not required merely because of the brutal nature of the crime); *Lopez v. United States*, 373 A.2d 882, 884 (D.C. 1977) (a defendant who is belligerent and uncooperative is not thereby rendered incompetent).

vations of the accused or upon a motion by either party.<sup>104</sup> The District of Columbia Circuit has favored, but has not required, that examinations be conducted on an outpatient basis.<sup>105</sup> If the defendant is hospitalized, however, the statute provides that it may be only for a reasonable period.<sup>106</sup> At the conclusion of the examination, the hospital must proffer an opinion on the defendant's competency by submitting a report to the court.<sup>107</sup> If either party objects to the hospital's opinion, the court must hold a nonjury hearing on the competency issue; otherwise, it may rely on the hospital's report to determine competency.<sup>108</sup> If the defendant is found incompetent, the court may commit him, but placement is limited to a psychiatric hospital.<sup>109</sup>

While the statutory scheme provides for indefinite commitment until the

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104. *Id.* § 24-301(a). When a judge receives a motion or believes a mental examination is appropriate, he should order the defendant to undergo a preliminary screening examination by a court psychiatrist. *See* D.C. SUPER. CT. CRIM. R. 109(c)(1). The psychiatrist's report should include a recommendation on whether a full competency examination should be conducted, and if so, whether it should be on an outpatient or an inpatient basis. Memorandum to the Judges, note 102 *supra*. If properly followed, this procedure can prevent much needless hospitalization.

When the court orders a competency examination, it must also order an evaluation of the accused's mental condition as it relates to criminal responsibility. *United States v. Henry*, 528 F.2d 661, 665 (D.C. Cir. 1976). *See* *Calloway v. United States*, 270 F.2d 334 (D.C. Cir. 1959); *Winn v. United States*, 270 F.2d 326 (D.C. Cir. 1959).

105. *Marcey v. Harris*, 400 F.2d 772, 774 (D.C. Cir. 1968). In *Marcey*, the D.C. Circuit held that examinations should be on an outpatient basis if the accused so requests. If the accused objects to inpatient examination, the examining psychiatrists must present reasonable grounds to support the necessity of an inpatient examination. *Id.* *See generally* Janis, *Incompetency Commitment: The Need for Procedural Safeguards and a Proposed Statutory Scheme*, 23 CATH. U.L. REV. 720, 736-43 (1974); Kaufman, *Evaluating Competency: Are Constitutional Deprivations Necessary?*, 10 AM. CRIM. L. REV. 465, 473-78 (1972).

106. D.C. CODE ANN. § 24-301(a) (1973). If bedspace is not available at the hospital, the court must set conditions for the accused's release. D.C. SUPER. CT. CRIM. R. 109(c)(2).

107. *See* D.C. CODE ANN. § 24-301(a) (1973). The hospital's report must do more than parrot the *Dusky* standard, *see* note 103 *supra*; it must contain supporting information and the reasons for the hospital's recommendations. *See* *Halloway v. United States*, 343 F.2d 265, 267 (D.C. Cir. 1964). The courts have been unwilling, however, to consider the hospital examination process as a critical stage of the proceedings that requires the presence of counsel. *United States v. Fletcher*, 329 F. Supp. 160 (D.D.C. 1971). *See also* *Thornton v. Corcoran*, 407 F.2d 695 (D.C. Cir. 1969).

108. On its face, the Code section only addresses the court's actions after a certification of incompetency by the hospital. *See* D.C. CODE ANN. § 24-301(a) (1973). The D.C. Circuit has held, however, that the provisions also apply when the hospital makes a certification of competency. *Whalem v. United States*, 346 F.2d 812, 815 (D.C. Cir.) (en banc), *cert. denied*, 382 U.S. 862 (1965).

109. D.C. CODE ANN. § 24-301(a) (1973). The statute limits competency commitments to confinement in a "hospital for the mentally ill" and less restrictive placements are presumably not permitted. *Id.*

accused regains his competency to stand trial,<sup>110</sup> the Supreme Court's ruling in *Jackson v. Indiana*<sup>111</sup> limits the length of hospitalization to a period reasonably necessary to determine whether the accused will be likely to regain competency in the near future.<sup>112</sup> If it is judicially determined that the defendant will probably remain incompetent to stand trial, he must be released unless he can be civilly committed.<sup>113</sup>

Competency commitments serve a limited purpose and are not intended as a means to detain a person otherwise eligible for release. Commitment affords the state the opportunity to restore the person to competency so that he can receive a fair trial or comprehend a sentencing proceeding, but such commitments can only last for a reasonable period. Since persons committed on competency grounds are often otherwise eligible for release pending trial, the requirement of inpatient hospitalization is of questionable validity. The Ervin Act permits less restrictive placements for persons found likely to injure themselves or others,<sup>114</sup> but persons hospitalized to restore competency have not been found by the court to be similarly dangerous. Placement in a less restrictive setting may often be clinically appropriate for persons found incompetent to stand trial and such placements should be made available.<sup>115</sup>

The lack of a public safety justification for inpatient competency commitments highlights fundamental differences between the civil and criminal commitment schemes. Persons hospitalized under the court's criminal jurisdiction are placed in a more restrictive section of Saint Elizabeth's Hospital,<sup>116</sup> and, as will be seen, they are generally afforded fewer procedural safeguards during the commitment process. District of Columbia courts have often examined whether there is sufficient constitutional justification for the differences in the treatment of civil and criminal commit-

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110. See D.C. CODE ANN. § 24-301(b) (1973).

111. 406 U.S. 715 (1972).

112. *Id.* at 738.

113. *Id.* Since the issue in any civil commitment hearing is whether the person is likely to injure himself or others, see notes 17-27 and accompanying text *supra*, it is by no means certain that an accused who is found incompetent to stand trial will be committable under the Ervin Act. See, e.g., *Wilson v. United States*, 391 F.2d 460, 463 (D.C. Cir. 1968). In addition, if the patient is unlikely to recover competency in the near future, the court has no statutory authority to order the patient's continued detention pending civil commitment unless the Ervin Act's emergency procedures are applicable. See D.C. CODE ANN. §§ 21-521 to -528 (1973); notes 31-44.

114. See note 68 *supra*.

115. See Janis, *supra* note 105, at 720.

116. Patients hospitalized under the criminal commitment process are placed in a separate and more secure building on the grounds of Saint Elizabeth's Hospital known as the John Howard Pavillion.

ees, but despite the ever present liberty interest, the courts have been unwilling to question the distinctions under a strict scrutiny analysis.<sup>117</sup> The legislature has been reluctant to unify the procedures because of concerns that persons subject to the present criminal commitment process pose a greater danger to society.<sup>118</sup> As a result, District of Columbia mental health law continues to be characterized by a wide array of commitment procedures.

### B. Sentenced Prisoners

One area where the courts have required the use of the Ervin Act's safeguards is the involuntary transfer of a sentenced prisoner to a mental hospital. On their face, the criminal statutory provisions permit such transfers solely upon the certification by a psychiatrist that the prisoner is mentally ill.<sup>119</sup> In *Matthews v. Hardy*,<sup>120</sup> however, an inmate challenged the constitutionality of this procedure on the grounds that it did not afford a hearing or judicial determination of whether a prisoner meets the likely to injure standard of the Ervin Act.<sup>121</sup> The District of Columbia Circuit agreed and held that the differences between a prison and a mental hospital were sufficiently substantial to require it to read into the transfer provisions the bulk of the Ervin Act's due process protections of the inmate's liberty interest.<sup>122</sup>

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117. See, e.g., *United States v. Ecker*, 543 F.2d 178 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 1063 (1977); *Bolton v. Harris*, 395 F.2d 642 (D.C. Cir. 1968); *Jones v. United States*, 396 A.2d 183 (D.C. 1978). *But see* Note, *Constitutional Standards for Release of the Civilly Committed and Not Guilty by Reason of Insanity: A Strict Scrutiny Analysis*, 20 ARIZ. L. REV. 233 (1978).

118. See *Jones v. United States*, 396 A.2d 183, 185-86 (D.C. 1978); Note, *Commitment of Persons Acquitted by Reason of Insanity in the District of Columbia*, 74 COLUM. L. REV. 733 (1974).

119. D.C. CODE ANN. § 24-302 (1973).

120. 420 F.2d 607 (D.C. Cir. 1969), *cert. denied*, 397 U.S. 1010 (1970).

121. See D.C. CODE ANN. §§ 21-501 to -512 (1973). Mr. Matthews' transfer had been accomplished on the basis of a ten-minute interview with a psychiatrist, 420 F.2d at 609 n.4.

122. 420 F.2d at 609 (citing *Schuster v. Herold*, 410 F.2d 1071, 1073 (2d Cir. 1969)). These included rights to a judicial hearing, jury trial, notice, and counsel. Calling a committed prisoner "twice cursed," the court noted that the stigma attached to involuntary hospitalization is distinct from that of incarceration in a prison. *Id.* at 610-11. The court also observed that mental hospitals have different restrictions from prisons, improper placement in a mental hospital has the potential of severe emotional and psychic harm, and transfer to a mental hospital might result in a longer total period of incarceration. *Id.* See also *Evans v. Paderick*, 443 F. Supp. 583 (E.D. Va. 1977).

The outer limit on placement of a prisoner in a mental hospital is the expiration of the inmate's maximum sentence. *Baxstrom v. Herold*, 383 U.S. 107, 110 (1966). At the end of the prison term authorities must reinstate civil commitment proceedings in order to continue hospitalization. *Id.* The D.C. Court of Appeals, however, has recently held that persons transferred to Saint Elizabeth's Hospital from a D.C. penal facility are "not entitled to

The *Matthews* court did not explain, however, whether its decision rested solely on due process grounds or the extent of any equal protection implications of its holding. For example, it did not explain whether there might be state interests sufficient to justify using less than the bulk of the Ervin Act's procedures for sentenced prisoners; nor did the government assert such interests. Public safety concerns, however, would probably have been held insufficient because the sentenced prisoner remains in custody while in a psychiatric institution.

### C. *Insanity Acquittees*

Concerns over dangers to the public safety are raised more appropriately as part of the decision on whether to commit or release a person acquitted by reason of insanity.<sup>123</sup> In this context, the courts have often addressed, but have not resolved, how much difference between civil and criminal commitment procedures is constitutionally permissible. The seminal case in this area is *Bolton v. Harris*,<sup>124</sup> in which the District of Columbia Circuit found that the commission of a criminal act alone did not raise a presumption of current dangerousness justifying substantial differences between the commitment schemes.<sup>125</sup> Prior to *Bolton*, the criminal commitment statute provided for automatic indeterminate commitment without a hearing on present mental condition; release could be obtained only by court order.<sup>126</sup> Using an equal protection analysis, the District of Columbia Circuit found no rational basis for denying acquittees a jury hearing prior to indeterminate commitment, given the right of civil commitees to a jury trial under the Ervin Act.<sup>127</sup> The court mandated the use of the Ervin Act's likely to injure self or others standard for commitment as well

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mandatory release at the expiration of" their short term sentences unless they have been administratively certified as "being restored to mental health" pursuant to section 24-303. *Dobbs v. Neverson*, 393 A.2d 147, 154 (D.C. 1978).

Under the recent ruling in *Campbell v. McGruder*, 580 F.2d 521 (D.C. Cir. 1978), officials are required to meet the mental health needs of pretrial detainees through mandatory transfer to a hospital if the detainee displays behavior suggestive of mental illness. *Id.* at 548-50. The court implied that *Matthews v. Hardy* applies when an inmate is to be transferred against his will. *Id.* at 549-59. See generally notes 115-18 and accompanying text *supra*.

123. *But cf.* German & Singer, *Punishing the Not Guilty: Hospitalization of Persons Acquitted by Reason of Insanity*, 29 RUTGERS L. REV. 1011, 1023-25 (1976) (the presumption that insanity acquittees are more dangerous than civil commitees is not medically supportable).

124. 395 F.2d 642 (D.C. Cir. 1968).

125. *Id.* at 647. See also *Baxstrom v. Herold*, 383 U.S. 107 (1966).

126. 395 F.2d at 648-49.

127. *Id.* at 651. At the commitment stage, the burden of proof under *Bolton* is on the government to prove that the acquittee is currently mentally ill and likely to injure himself or others if allowed to remain at liberty. *Id.* at 653.



as "substantially similar" procedural safeguards, but conceded that a reasonable application of equal protection permitted different treatment of insanity acquitees and civil committees to the extent there are relevant differences between the groups.<sup>128</sup> Under this substantial-equivalence rationale, the jury's finding of reasonable doubt about the defendant's sanity at the time of the crime constituted sufficient warrant to permit a brief involuntary inpatient examination to further determine present mental condition.<sup>129</sup> The court also upheld the requirement of a court order for release of an insanity acquitee, reasoning that the government deserved the opportunity to insure that release standards were adhered to strictly.<sup>130</sup> Nevertheless, it mandated the same standard of release—that the patient is no longer mentally ill and dangerous—for both acquitees and civil committees.<sup>131</sup>

In response to *Bolton*, the 1970 amendments to the criminal commitment scheme increased the number of procedural distinctions between the civil and criminal commitment procedures.<sup>132</sup> Under the revised provisions, an acquitee who has personally raised the insanity defense is automatically committed for a fifty-day evaluation which culminates in a hearing to determine whether to make the commitment indeterminate.<sup>133</sup> Congress changed important specifics of the hearing by shifting the burden of proof, by a preponderance of evidence, to the acquitee and by removing the right to a jury trial.<sup>134</sup> It also added to the commitment and release

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128. *Id.* at 651.

129. *Id.*

130. *Id.* at 652.

131. *Id.* at 653. The court followed the traditional rule of *habeas corpus* proceedings in which the petitioner has the burden of proving by a preponderance of the evidence that his commitment is impermissible. *Id.*

132. See D.C. CODE ANN. §§ 24-301 to -303 (1973).

133. See *id.* §§ 24-301(d)(1) & (2). If the court has raised the insanity defense *sua sponte*, the accused can be hospitalized only through the civil commitment process. *United States v. Henry*, 107 DAILY WASH. L. REP. 801 (D.C. Cir. 1979); *United States v. Wright*, 511 F.2d 1311 (D.C. Cir. 1975). In *Wright*, the court allowed a 30-day detention of such an acquitee pending the outcome of the proceedings for civil commitment, but did not cite any statutory authority for the detention. See 511 F.2d at 1312. Another option for officials might be hospitalization following the more protective emergency provisions of the Ervin Act. See notes 31-44 *supra*. But see H.R. REP. No. 907, 91st Cong., 2d Sess. 74 (1970), where it is stated that automatic commitment under section 301(d) "applies only when the defendant himself has raised the defense of insanity. It does not apply when the court itself raises the defense . . ." *Id.* See also *Lynch v. Overholser*, 369 U.S. 705 (1962). The District of Columbia Court of Appeals, however, still considers it an open question whether automatic commitment under section 301(d)(1) applies to acquitees when the insanity defense has been raised *sua sponte*. *Bethea v. United States*, 365 A.2d 64, 91 n.59 (D.C. 1976), *cert. denied*, 433 U.S. 911 (1977).

134. D.C. CODE ANN. §§ 24-301(d)(2)(B) & (k)(3) (1973).

standard a requirement that the acquittee not only prove he is not presently likely to injure himself or others, but also that he will not be dangerous in the reasonable future.<sup>135</sup> In addition to the fifty-day hearing, the amendments provided for release by judicial order based upon a hospital certification that the acquittee has recovered his sanity,<sup>136</sup> and upon patient petitions for release which must be entertained by the court at least once every six months.<sup>137</sup>

Each of these avenues results in a release hearing on whether the patient still meets the commitment standard.<sup>138</sup> The District of Columbia Circuit has recently explained that if the issue of sanity has been raised by a hospital certification, the burden of proof rests on no party in particular and each party has an obligation to explore the patient's present mental condition.<sup>139</sup> If the proceeding has been initiated by the patient himself, however, he has the burden of proof by a preponderance of evidence.<sup>140</sup> The court may order either conditional or unconditional release, or it may modify conditions placed on a previous order. Any conditions placed on release are imposed on a case-by-case basis and should be designed to assure that the person will not be a danger to himself or others.<sup>141</sup> In practice, a conditional release is similar to the less restrictive placements permitted under the Ervin Act for civil committees, but the civil scheme permits hospital staff the administrative discretion to move a committed patient into a community setting without a court order. In order to out-place an insanity acquittee, the hospital must obtain a court order.

Although the issue is not completely resolved, the 1970 amendments have been generally upheld on the grounds that the distinctions between civil and criminal commitment policies are not more substantial than permitted under a *Bolton*-type analysis.<sup>142</sup> In *United States v. Ecker*,<sup>143</sup> for

135. *See id.* § 24-301(e).

136. *Id.* § 24-301(e). The D.C. Court of Appeals has recently held that hospital authorities must also give insanity acquitees periodic examinations similar to those afforded civil committees. *Jones v. United States*, 396 A.2d 183, 190 (D.C. 1978). *See generally* note 69 and accompanying text *supra*.

137. D.C. CODE ANN. § 24-301(k)(5) (1973). Nothing in the criminal commitment scheme prevents the acquittee from petitioning for *habeas corpus*. *See id.* § 24-301(g). *See generally* *Dixon v. Jacobs*, 427 F.2d 589 (D.C. Cir. 1970).

138. *See* D.C. CODE ANN. § 24-301(e) (1973).

139. *United States v. Ecker*, 543 F.2d 178 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 1063 (1977).

140. D.C. CODE ANN. § 24-301(k)(3) (1973).

141. *See id.* §§ 24-301(e) & (k)(3).

142. *See United States v. Ecker*, 543 F.2d 178, 187-88 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 1063 (1977) (not dangerous in the reasonable future standard for release upheld); *Betha v. United States*, 365 A.2d 64, 91-92 (D.C. 1976), *cert. denied*, 433 U.S. 911 (1977) (generally upholding criminal commitment procedures *in dicta*). The D.C. Circuit has often

example, the District of Columbia Circuit upheld the strict release procedures for insanity acquitees. In an unusual display of candor, perhaps because Mr. Ecker had been tried for an unusually brutal murder and rape,<sup>144</sup> the court had little trouble characterizing insanity acquitees as an exceptionally dangerous class.<sup>145</sup> Relying on the need to guard particularly the public safety interest, the court upheld the statutorily mandated *de novo* review of any proposed conditional or unconditional release.<sup>146</sup> The court held that an acquittee's prior criminal conduct, especially violent criminal conduct, was adequate justification for the differences in release procedures.<sup>147</sup> In so doing the court clearly relied on a presumption of dangerousness in permitting the procedural distinctions.

A major difficulty with *Ecker's* presumption of dangerousness is that not all insanity acquitees have committed violent crimes. A case in point is *Jones v. United States*,<sup>148</sup> in which the committee had been found not guilty by reason of insanity of attempting to steal a coat from a department store. It is difficult to justify such an act as raising a presumption of present dangerousness or to characterize persons who commit such acts as members of an exceptionally dangerous class. Nevertheless, the District of Columbia Court of Appeals affirmed the trial court's denial of the acquittee's post commitment motion that he either be released or recommitted under the Ervin Act's procedures.<sup>149</sup> By the time his motion was heard

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been unwilling to address directly the issue of whether the difference between *Bolton* and the 1970 amendments to the criminal commitment scheme are constitutionally justifiable. *See, e.g., United States v. Jackson*, 553 F.2d 109, 116 n.13 (D.C. Cir. 1976); *United States v. Wright*, 511 F.2d 1311, 1313 n.9 (D.C. Cir. 1975); *Johnson v. Robinson*, 509 F.2d 395, 399 n.18 (D.C. Cir. 1974); *United States v. Brown*, 478 F.2d 606, 608 n.3 (D.C. Cir. 1973).

143. 543 F.2d 178 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 1063 (1977).

144. *See id.* at 181.

145. *Id.* at 186. *But see* German & Singer, *supra* note 123, at 1023-25.

146. *Id.* at 187. The court found that "the district court must independently 'weigh the evidence' and make a *de novo* determination that the patient will not in the reasonable future endanger himself or others." *Id.* (emphasis in original).

147. *Id.* at 199. *Ecker* and *Bolton* are not easily reconciled. In *Bolton*, the court was willing to tolerate only insubstantial differences in commitment procedures because of societal concerns that the procedures be more strictly adhered to in the case of insanity acquitees. *See* text accompanying notes 124-129. *Ecker's* presumption of dangerousness from a prior criminal act, however, can be used as a basis for more substantial differences in procedures. Thus, *Ecker* not only impliedly upholds the 1970 amendments, but it also represents a significant erosion of *Bolton*. *See* text accompanying notes 132-42 for a description of the differences between *Bolton* and the 1970 amendments. *But cf.* *Baxstrom v. Herold*, 383 U.S. 107 (1966) (a sentenced prisoner's conviction for a criminal act does not give rise to a presumption of dangerousness justifying commitment for mental illness at the end of his prison term without the same procedural safeguards given all civilly committed patients).

148. 396 A.2d 183 (D.C. 1978).

149. *Id.* at 184. Mr. Jones may not have been committable under the Ervin Act since the

in the trial court, Mr. Jones had already been hospitalized for a substantial period. The court, therefore, determined that his appeal presented only the narrow question of whether it was constitutionally permissible to hold him under the criminal commitment scheme after the expiration of the maximum period for which he could have been imprisoned had he been convicted.<sup>150</sup> Despite language by the District of Columbia Circuit to the contrary,<sup>151</sup> the court held the expiration of the period to be irrelevant to the basis for continued hospitalization. The court reasoned that since the insanity acquittee has been found to be mentally ill and dangerous at the time of commitment, he should be held until he is sufficiently recovered to be eligible for release under the same standard.<sup>152</sup> The court was apparently satisfied that there was continuing justification for the distinctions in release procedures throughout an acquittee's commitment.<sup>153</sup>

The more fundamental issue in *Jones*, however, was whether there was any justification at all for subjecting Mr. Jones to a process distinct from civil commitment. Mr. Jones' criminal act hardly gave rise to a presumption of dangerousness that permitted the state to place upon him the extra

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government has the burden of establishing mental illness and dangerousness beyond a reasonable doubt. See note 54 *supra*.

150. See 396 A.2d at 184.

151. See *Waite v. Jacobs*, 475 F.2d 392, 395 & 399 (D.C. Cir. 1973) (after expiration of the maximum sentence period, distinguishing between committees and acquitees may be irrational within the meaning of equal protection); *United States v. Brown*, 478 F.2d 606, 612 (D.C. Cir. 1973) (standards and burdens of proof for acquitees and committees should be the same after five years in the case of a felony and should never vary after the maximum sentence period has passed).

The D.C. Court of Appeals was not obligated to follow these decisions because they were rendered after the effective date (February 1, 1971) of the District of Columbia Court Reorganization Act of 1970. See D.C. CODE ANN. § 11-102 (1973); *M.A.P. v. Ryan*, 285 A.2d 310, 310-12 (D.C. 1971). In *Ryan*, the D.C. Court of Appeals declared that the post reorganization decisions of the D.C. Circuit were entitled to great respect, but were no longer binding precedent. *Id.*

152. 396 A.2d at 189-90.

153. The court's rational basis for the distinctions between the procedures given civil and criminal committees was unclear. It characterized the commitment of an acquittee as merely an updating process from the finding of insanity, but considered civil commitment to be completely *de novo*. The updating rationale is flawed, however, because the issue in both commitment and release hearings is the current applicability of the commitment standard. A past criminal act is a relevant piece of evidence, but it should be afforded the same weight in both criminal and civil commitments. A past criminal act is no basis for a short cut in procedures following acquittal if the civil committee is afforded the full panoply of rights having committed a similar act.

Another rationale that has often been presented for the differences in release procedures up to the time of maximum sentence is an acquittee's partial responsibility for the criminal act. See *Waite v. Jacobs*, 475 F.2d 392, 396 (D.C. Cir. 1973). *Jones*, however, rejected this justification as impermissibly punitive. 396 A.2d at 188-89.

burden of proving his sanity in a hearing without a jury. It is difficult to conceive of a public safety justification for treating a mentally ill misdemeanant, who has not committed a violent crime, differently from a civil commitee. There are undoubtedly many civil commitees who have committed acts similar to the minor offense for which Mr. Jones was acquitted. The mere fact that such a person is found not guilty by reason of insanity of the offense in a criminal trial is no basis to justify the use of less protective commitment procedures.

*D. Examination and Commitment in Proceedings Regarding  
Delinquency, Neglect, or Need of Supervision*

The problem of inconsistent procedural safeguards among the various commitment schemes is even more acute when civil commitment is compared to court ordered examinations and commitments of children during the course of proceedings within the Family Division. The court's jurisdiction in this area extends to three distinct populations of juveniles — delinquents, children in need of supervision, and abused and neglected children<sup>154</sup>—but procedures for inpatient mental examination and commitment are identical for each group.<sup>155</sup> In contrast to the strict procedures and standards for civil commitment, the determination of the appropriateness of these quasi-criminal commitments is based upon broad judicial discretion. The court is not guided on the face of the statute by a standard of dangerousness and there is no right to a jury trial on the commitment issue. The child is provided counsel,<sup>156</sup> but there is often little incentive to advocate against hospitalization, because the alternative for many children found inappropriate for mental examination and psychiatric treatment is a less desirable and restrictive detention center.<sup>157</sup>

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154. The reach of the Family Division's jurisdiction in this area extends to delinquents, children who are alleged to have committed a criminal offense, D.C. CODE ANN. §§ 16-2301(6) & (7) (1973); children in need of supervision, those who have committed an offense applicable only to children, *id.* § 16-2301(8); and abused and neglected children who have committed no offense, *id.* §§ 16-2301(9) & (23).

155. *Id.* § 16-2313(c) (temporary transfer for mental examination or treatment while in detention or shelter care); *id.* §§ 16-2315(a), (b) & (c) (physical and mental examination to determine competence to participate in proceedings); *id.* § 16-2320(a)(4) (commitment to a psychiatric hospital as a dispositional alternative); *id.* § 16-2321 (predispositional mental examinations). *See also* D.C. SUPER. CT. JUVENILE R. 110.

156. The right to counsel attaches at critical stages throughout the juvenile process, and it can be assumed that counsel participates in determinations of the need for an examination or commitment. *See* D.C. CODE ANN. §§ 16-2304(a) & (b)(2) (1973 & Supp. V 1978). Despite the presence of counsel, there is no appellate case law in D.C. in the area of mental examinations and commitment as part of juvenile proceedings.

157. *See generally In re Inquiry into Allegations of Misconduct against Juveniles De-*

Mental examinations may be ordered by the court at any time following the filing of a petition in a juvenile proceeding. The purpose of the examinations is to determine competency to participate in the proceedings and to inform the court about the child's mental condition.<sup>158</sup> Whenever possible, the examinations should be conducted on an outpatient basis,<sup>159</sup> and if the court finds the child incompetent after the examination, it must suspend further proceedings and order the commencement of the Ervin Act's procedures.<sup>160</sup> If the court finds the child competent, but subsequently finds him to be mentally ill or substantially retarded, it may order the initiation of the civil commitment process and the detention of the child in a suitable facility, presumably a psychiatric hospital, pending the outcome of the civil commitment proceedings.<sup>161</sup> The court also has the independent authority to order the child's indeterminate psychiatric commitment without resort to the civil commitment process.<sup>162</sup>

If the court elects to use its own power to commit directly the child, it must determine if inpatient hospitalization is necessary to the treatment of the child. No finding of dangerousness is required and the need for treatment standard applies even if the child's psychiatric hospitalization is

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tained and Committed at Cedar Knoll Inst., 106 DAILY WASH. L. REP. 1773 (D.C. Super. Ct. 1978).

158. D.C. CODE ANN. §§ 16-2315 & -2320 (1973).

159. *Id.* § 16-2315. Inpatient examinations must be by court order and may be for no longer than 45 days. *Id.* Upon a showing of cause, extensions of the commitment for up to 45 additional days is permissible. *Id.* There is no authority in the statute for examinations for longer than 90 days during the predispositional states of the proceedings. *But see* section 16-2313(c) which authorizes temporary transfer from detention or shelter care for mental health treatment.

160. D.C. CODE ANN. § 16-2315(c)(1) (1973). The initiation of civil commitment proceedings against an incompetent child alleged to be in need of supervision is discretionary, but it appears that civil commitment proceedings must be initiated in a delinquency case. *See id.* and § 16-2315(c)(3). If the Ervin Act proceedings do not result in commitment, the statute provides only a limited provision to permit commitment of an incompetent child by the Family Division. If a motion for transfer for criminal prosecution has been filed, the court should order the commitment of the child until his competency is restored. Civil commitment proceedings should be initiated if it appears the child will not regain his competency. D.C. CODE ANN. § 2315(c)(2) (1973). Presumably, *Jackson v. Indiana*, 406 U.S. 715 (1972), applies to such competency commitments. *See* notes 106-08 and accompanying text *supra*.

161. D.C. CODE ANN. § 16-2321(b) (1973).

162. D.C. CODE ANN. § 16-2320(4) (1973). The provision applies equally to delinquency, need of supervision, and neglect cases. The 1977 amendments to the neglect procedure retained this section.

If the juvenile's case proceeds to final disposition, the court's need for treatment decision will at least be guided by a predispositional study and report made by the Director of Social Services and presumably from other evidence at the hearing. D.C. CODE ANN. §§ 16-2317 & -2319 (1973 & Supp. V 1978).

against his or his parents' will.<sup>163</sup> This is in sharp contrast to the Ervin Act where need for treatment is permitted only as a basis for voluntary treatment or hospitalization upon the request of a parent or legal guardian.<sup>164</sup> Thus, children subject to juvenile court proceedings are the one remaining classification of the mentally ill who are subject to *parens patriae* involuntary commitments by the government.<sup>165</sup> The constitutionality of this questionable standard has never been tested on the appellate level in the District of Columbia.

When compared to the Ervin Act, commitments through juvenile court proceedings are also plagued with procedural defects. Unlike a child who is civilly committed, a child subject to juvenile court proceedings has no right to a jury trial on the commitment issue; nor does he have the right to administrative release when a hospital staff clinically determines that the child has sufficiently recovered. Unless the court orders otherwise, release can only be obtained by court order after a judicial review of the commitment. As in the case of adult criminals, there may be a public safety justi-

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163. In a recent neglect case, however, the government conceded that it must show that the child is both mentally ill and dangerous to himself or others for the court to accomplish an indeterminate commitment as a result of a juvenile court proceeding. *In re T.S.*, 106 DAILY WASH. L. REP. 2085, 2092 (D.C. Super. Ct. 1978). It was unwilling to concede that it has the burden of a reasonable doubt. The court did not reach the issue of burden of proof because it found the child met the more stringent standard. *Id.*

Under the recent Supreme Court decision in *Addington v. Texas*, 99 S. Ct. 1804 (1979), the clear and convincing standard of proof would be sufficient, but the rule in D.C. for adult commitment proceedings is the stricter reasonable doubt standard. *See* note 54 *supra*.

164. *See* notes 45-49, 73-96 and accompanying texts *supra*. In contrast to hospitalizations at the request of a parent or legal guardian, *see* D.C. CODE ANN. §§ 21-511 to -512 (1973), commitments in juvenile proceedings are made directly by the court, *see id.* §§ 16-2313(c) & -2320 (1973). While *Parham v. J.R.*, 99 S. Ct. 2493 (1979), clearly permits state authorities to apply directly to a hospital for the admission of its wards, *id.* at 2512, it is unlikely that the same procedure is permissible for children during the course of juvenile court proceedings against them. Such children have been generally not declared wards of the state and they remain subject to parental authority. Moreover, the Ervin Act offers no statutory authority for requests for hospitalization of a minor by officials who lack legal guardianship but have custody of the child during the course of juvenile court proceedings. The Act mentions only requests by a minor's "spouse, parent, or legal guardian." D.C. CODE ANN. § 21-511 (1973).

165. *See* notes 4-6 and accompanying text *supra*. *But see* note 163 *supra*. The courts could construe the Ervin Act as impliedly modifying the juvenile court procedure. The California Supreme Court, for example, has interpreted that state's civil commitment statute as repealing inconsistencies with procedures for the commitment of juvenile court wards. *In re Michael E.*, 15 Cal. 3d 183, 189, 538 P.2d 231, 234, 123 Cal. Rptr. 103, 106 (1975). A similar construction of the Ervin Act would remove the juvenile court's independent authority to order the child's psychiatric commitment, and it would require reference to the Commission on Mental Health and a court, or jury if requested, finding of dangerous mental illness. *See generally* notes 50-72, 60-63 and accompanying text *supra*.

fication for mandatory judicial release of delinquents,<sup>166</sup> but such a justification pales for neglect and need of supervision cases. Children in these two categories are indistinguishable from civil commitees because they have performed no acts that would be considered a crime if committed by adults. Thus, there is little rational basis under a *Bolton* type analysis to justify the substantially less protective safeguards afforded to children committed in juvenile court proceedings.

### III. TOWARD SUBSTANTIAL EQUIVALENCE IN STATUTORY COMMITMENT SCHEMES

The wide variety of means to commit a person to a mental hospital in the District of Columbia does not represent a coherent scheme. Procedures vary from the protective and complex timetable of the Ervin Act to the automatic commitment of persons found not guilty by reason of insanity. Standards for commitment range from the "necessary for treatment" criterion in juvenile court proceedings to the "likely to injure" test of the Ervin Act. The result has been an increasingly vague and complex puzzle that is most burdensome and little understood by patients, clinicians, and court personnel without the aid of highly competent legal counsel. This survey of commitment procedures in the District of Columbia will hopefully serve as a starting point for a closer examination of how the present scheme can be simplified and provide a more consistent and protective policy.

Because a liberty interest is involved, important due process and equal protection problems are raised by the variety of statutory classifications of the mentally ill and the inconsistency of the procedural safeguards afforded each. While equal protection generally requires that statutory classifications have at least a rational basis, the clear import of *Bolton* was that each group of allegedly mentally ill persons must be afforded substantial equivalence in procedural safeguards.<sup>167</sup> *Bolton* mandated that any differences in the due process protections afforded to each class of commitees must be justified by relevant differences in the characteristics of the classes. Thus, the test for the rationality of distinctions between types of commitees should be more than a presentation of any plausible reason or an unproven assumption that some groups are more dangerous than others. *Bolton* implied that similarity of procedures for groups of commitees should be the rule and not the exception.

The major practical advantage of a move toward greater equivalence in

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166. *But see* note 123 *supra*.

167. *See* notes 119-26 and accompanying text *supra*.



commitment procedures would be cohesion and simplification of the entire process. A single comprehensive procedure might assure more accurate application, especially on the clinical level. The District of Columbia City Council should consider such a revision of the overall commitment scheme in the near future.

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