

Washington University Law Review

Volume 1968 | Issue 4

January 1968

Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study

George E. Dix
University of Texas

Follow this and additional works at: https://openscholarship.wustl.edu/law_lawreview



Part of the [Health Law and Policy Commons](#), and the [Law and Psychology Commons](#)

Recommended Citation

George E. Dix, *Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 WASH. U. L. Q. 485 (1968).

Available at: https://openscholarship.wustl.edu/law_lawreview/vol1968/iss4/1

This Article is brought to you for free and open access by the Law School at Washington University Open Scholarship. It has been accepted for inclusion in Washington University Law Review by an authorized administrator of Washington University Open Scholarship. For more information, please contact digital@wumail.wustl.edu.

WASHINGTON UNIVERSITY LAW QUARTERLY

Volume 1968

Fall 1968

Number 4

ACUTE PSYCHIATRIC HOSPITALIZATION OF THE MENTALLY ILL IN THE METROPOLIS: AN EMPIRICAL STUDY

GEORGE E. DIX*

Nonvoluntary hospitalization of those believed to be mentally ill has been a frequent source of legal, medical, and lay controversy.¹ At the core of most discussions have been two principal issues: who should be subject to nonvoluntary psychiatric hospitalization, and when, if ever, should hospitalization be effected without a prior judicial determination of the justification for the action. Proponents of a broad substantive criteria for defining those subject to nonvoluntary hos-

* The author would like to express his appreciation to the staff of Malcolm Bliss Mental Health Center, who tolerated his presence and questions during the research for this article. Special thanks are also due Dr. Kathleen Smith, Superintendent of Malcolm Bliss, and Professor Frank W. Miller of Washington University Law School, who made preliminary suggestions regarding the project, read early drafts of the article, and made helpful comments regarding the presentation of the research.

1. See generally AMERICAN BAR FOUNDATION, *THE MENTALLY DISABLED AND THE LAW* 15-43 (F. Lindman & D. McIntyre eds. 1961); Kadish, *A Case Study in the Significance of Due Process—Institutionalizing the Mentally Ill*, 9 W. POL. Q. 93 (1956); Ross, *Hospitalizing the Mentally Ill—Emergency and Temporary Commitments*, in CURRENT TRENDS IN STATE LEGISLATION 1955-56 459 (1957). Among the general literature in this field, see M. GUTTMACHER and H. WEIHOFFEN, *PSYCHIATRY AND THE LAW* 288-322 (1952); Curran, *Hospitalization of the Mentally Ill*, 31 N. CAR. L. REV. 274 (1953); Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945 (1959); Tao, *Some Problems Relating to Compulsory Hospitalization of the Mentally Ill*, 44 J. URBAN L. 459 (1967); Note, *Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill*, 56 YALE L.J. 1178 (1947). The earlier pieces are of little practical help, however, as most were written prior to the recent dramatic changes in hospital environments and procedures caused by increased use of drugs. Immediately before publication, the results of the American Bar Foundation's extensive study of hospitalization procedures became available. R. ROCK, M. JACOBSON & R. JANOPOL, *HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL* (1968). For the author's reaction to this study, see Dix, Book Review (to be published in 1969 LAW & THE SOCIAL ORDER).

pitalization emphasize the discomfort experienced by mentally ill persons, the burdens they impose on their families and the community, and the advances in psychiatric knowledge and treatment opportunities. Opponents of liberal criteria emphasize the right of each individual to choose for himself whether to participate in treatment programs and argue that this right should be respected even in those cases where the person's refusal to submit to treatment places a burden on others. Proponents of judicial participation in the decision to hospitalize urge that judicial proceedings constitute an essential safeguard against unjustified hospitalization of "sane" individuals. Opponents counter that judicial proceedings delay treatment, distress mentally ill persons, humiliate their families, and serve no constructive purpose because the need for hospitalization is a medical determination best left to experts who can be relied upon to hospitalize only when necessary.²

Much of the discussion, however, has been built around widely publicized cases which, when viewed with the improved vision of hindsight, can be seen to have involved either hospitalization unnecessary under any reasonable criteria or delay of hospitalization which would clearly have benefited the person or prevented some disastrous event.³ While the need for protection against even infrequent abuses of the hospitalization power must not be minimized, the available literature is significantly deficient, since it lacks any detailed discussion of the everyday operations of well developed hospitalization systems and the relationship of this routine to the legal framework within which the systems operate. Such an examination of one system, the acute psychiatric hospitalization system in St. Louis, Missouri, is the purpose of this paper. From this study, perhaps it will be possible to draw some general conclusions concerning the dynamics of the system, the necessity of outside supervision, and the potential for effective supervision of the system by inserting at some point a judicial officer with the task of enforcing legally-proscribed criteria for nonvoluntary hospitalization.

Part I describes the development of the "legal framework." Part II is a description of how the purportedly regulated system actually works,

2. E.g., *Editorial Comment, Law's Labor Lost*, 40 *PSYCHIATRIC Q.* 150, 150-51 (1966).

3. See, e.g., Kutner, *The Illusion of Due Process in Commitment Proceedings*, 57 *Nw. U.L. REV.* 383 (1962), building on the unfortunate case of Michael Duzynski, a Polish immigrant who hanged himself in the State Hospital after being placed there by the Chicago police upon the complaint of Duzynski's building manager that he was insane. Cf. Arens, *Due Process and the Rights of the Mentally Ill: The Strange Case of Fredrick Lynch*, 13 *CATH. U. OF AM. L. REV.* 3 (1964).

with emphasis upon the role of the court and the substantive criteria applied at various points in the process. While the discussion is structured as a description of the steps from the community to full-time hospitalization, the descriptions and the illustrative examples should present a fairly complete picture of the variety of situations with which a metropolitan public acute psychiatric hospitalization service is called upon to deal. Part III is a discussion of one central legal issue, the role of the judiciary in the hospitalization process, in light of the conclusions reached in Parts I and II.

I. THE LEGAL FRAMEWORK

Prior to 1945,⁴ control over admission of St. Louis' mentally ill to full time public hospitalization was exercised by the administrative officials of the city's health facilities. Essentially a certification procedure seems to have been used.⁵ Less emphasis was placed on assuring that the proposed patient actually needed hospitalization than on ac-

4. Early in the history of the state, the violent "insane" were restrained under deplorable conditions, sometimes in jails, cellars, garrets or log pens. The nonviolent insane were frequently left to roam and fare as best they could. In the late 1830's, the city constructed a poorhouse and many of the insane found their way into this institution. The mental hospital reformer, Dortha Lynde Dix, visited Missouri in 1846-47 and, responding at least in part to her efforts, the first State Hospital for the Insane was opened in 1851. Some of the city's insane were placed in this institution, but it was clearly inadequate to fulfill the need. In 1869, the city opened its own facility, the St. Louis County Insane Asylum. This served as the primary public source of care and treatment for mental illness until 1939, when Malcolm Bliss Hospital was opened. See generally R. Glickman, *Development of Public Care of the Insane in St. Louis with Special Reference to the City Sanitarium*, Chapter II, pp. 6-14 (1933) (unpublished M.S. dissertation on file in Olin Library, Washington University). Ownership of these facilities has since been transferred to the state, but they both continue to serve patients from the city.

5. The 1887 Ordinances, for example, set up a detailed procedure for the admission of an indigent person to the city's mental hospital. A person applying for the admission of another was required to obtain the certificate of one physician "that said party is insane and destitute of means; and that the natural guardians of said party are unable to support said insane person. . . ." ST. LOUIS, MO., REV. ORDINANCES § 321 (1887). An examination was to be conducted by a physician of the health department. *Id.* at § 329. The Board of Health was then to examine the proposed patient and pass on his sanity, residence and financial condition. *Id.* at § 330. Provision was also made for "pay patients," but apparently they were to be admitted (by the Board of Health) only if their estate was inadequate to provide for their care in a private facility. *Id.* at § 339. The provisions had not changed significantly in 1936. See ST. LOUIS, MO., REV. CODE § 4205 (1936) (providing for admission to the psychopathic ward at City Hospital) and § 4207 (providing for transfer from City Hospital to the sanitarium on the certification of two physicians). The hospital commissioner was directed to make a "full investigation of all cases . . . before admission to determine the true state of affairs." *Id.* at § 4207.

curately determining whether he was indigent and met residence requirements for public care.⁶ In 1945, however, the Missouri legislature conferred on the city's probate court jurisdiction over proceedings to determine whether an allegedly insane person was "a fit subject to be sent to a state hospital."⁷ If the proposed patient did not have an attorney, the court was directed to appoint one to represent him.⁸ This jurisdiction was resisted by the city's probate judge on the ground that the limited task conferred—"to charge the upkeep of the indigent insane . . . to . . . [the] city"—was ministerial and could not constitutionally be conferred upon a judicial body.⁹ Arguing that as a matter of policy as well the legislative action was unwise, he wrote:

For seventy years, no court has exercised jurisdiction over the commitment or admission of literally thousands of pauper and pay patients to [the] . . . asylums and hospitals, for the insane. During those long years, that jurisdiction has always been exercised by the City's Hospital Boards, Commissioners, psychiatric staffs and its Comptroller . . . of course, always subject to a wrongly-omitted [sic] patient's right to release by habeas corpus . . . [T]he transfer to this court of the City's long control of the admission of its patients to those institutions would not only be impractical, unnecessarily expensive, but a violation of Article II of the [Missouri] Constitution.¹⁰

6. This distinction between paying and nonpaying patients and the emphasis on preventing patients with means from obtaining free hospitalization under the poor laws originated in the early English procedures for hospitalization. See Kadish, *A Case Study in the Significance of Procedural Due Process—Institutionalizing the Mentally Ill*, 9 W. POL. Q. 93, 105-06 (1956). Although the distinction was condemned in *State ex rel. Fuller v. Mullinax*, 364 Mo. 858, 866, 269 S.W.2d 72, 77 (1954) on the basis that requiring a judicial procedure for indigents but not for affluent patients violated Equal Protection, it is still retained in the statutes. MO. REV. STAT. § 202.863 (3), (4) (1959).

7. Ch. 51, § 9345, 1945 Mo. Laws 912. Despite failure to use criteria more precise than that in this early statute, definitions of those subject to nonvoluntary hospitalization have been upheld against constitutional attack based on alleged vagueness. See *State ex rel. Anderson v. United States Veterans Hosp.*, 268 Minn. 213, 219, 128 N.W.2d 710, 716 (1964), upholding a statutory criteria phrased in terms of "any person of unsound mind and in need of treatment, control or care"; this, the court asserted, had "a meaning generally adequate." Given the complexities of the decision to hospitalize as discussed in Part II, *infra*, the constitutional adequacy of such imprecise statutory criteria is certainly open to question.

8. Ch. 51, § 9338, 1945 Mo. Laws 909-10. Appointment of an attorney had been required since 1937 in the procedures applicable to the rest of the state. Ch. 46, § 8646, 1937 Mo. Laws 511.

9. *In re Rodell Crawford, Alleged to be Insane and Indigent*, No. C.P. 1, Probate Court of the City of St. Louis, Oct. 28, 1946. The probate court's memorandum opinion is printed in full in Brief for Relator, pp. 6-13, *State ex rel. Kowats v. Arnold*, 356 Mo. 661, 204 S.W.2d 254 (1947).

10. Brief for Relator, *supra* note 9 at 9.

The Missouri Supreme Court disagreed, however, and in *State ex rel. Kowatz v. Arnold*¹¹ held that the commitment power (whatever its earlier nature) was now judicial and properly conferred on the probate court. The policy objections raised by the probate judge, it indicated, were "a question for the General Assembly." The court's comments indicate that it believed the city's probate judge took too narrow a view of his function under the newly created jurisdiction: his duty was not solely to prevent public funds from being squandered on the affluent insane but also to prevent unjustified hospitalizations before they had an opportunity to occur:

The exercise of the [commitment] power may deprive the subjects of precious constitutional rights, liberty and the enjoyment of property, which cannot be done without due process of law. And it will not do to say in such a case that relief can be obtained by habeas corpus.¹²

No substantial changes in the statutes took place until 1954, when the legislature enacted (with only minor changes) the Draft Act for the Hospitalization of the Mentally Ill.¹³ This provided for a voluntary admission procedure; any patient admitted pursuant to this procedure was to be released "forthwith," unless the hospital filed with the probate court a certification that "release of the patient would be unsafe for the patient or others" and the court ordered the continued retention of the patient pending commitment proceedings.¹⁴ Three procedures for nonvoluntary admissions were established. First, a "standard nonjudicial procedure" provided for admission upon the certification of two physicians that the pre-patient was mentally ill and met the criteria for involuntary hospitalization.¹⁵ Second, an emergency certification procedure provided for admission upon the certification of one physician that the pre-patient was mentally ill and "because of his illness is likely to injure himself or others if not immediately restrained."¹⁶ An alternative emergency procedure authorized a health

11. 356 Mo. 661, 204 S.W.2d 254 (1947).

12. *Id.* at 673, 204 S.W.2d at 260.

13. §§ 1-27, 1953 Mo. Laws 647-59. See also National Institute of Mental Health, Federal Security Agency, A Draft Act Governing Hospitalization of the Mentally Ill (Public Health Service Pub. No. 51, 1952). The Act, prepared by the National Institute of Mental Health and the Office of the General Counsel of the Federal Security Agency, appears as Appendix A of AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW (F. Lindman & D. McIntyre eds. 1961).

14. §§ 2-4, 1953 Mo. Laws 648-49.

15. *Id.* § 6, at 649-50.

16. *Id.* § 7, at 650.

or police officer to take a pre-patient to a hospital for admission and "temporary confinement" if he had reason to believe that the pre-patient was mentally ill and "because of his illness . . . likely to injure himself or others if allowed to remain at liberty pending examination and certification by a . . . physician."¹⁷ Finally, provision was made for admission upon court order and detailed procedures were established for probate court proceedings.¹⁸ (These included a requirement for the court to appoint counsel if an attorney was not retained by the patient.)¹⁹ Another section provided that any patient hospitalized pursuant to the standard nonjudicial procedure or the emergency procedures could, upon request, obtain release within 48 hours, unless the hospital certified that such release would be "unsafe for the patient or others." In that case the probate court could order the release delayed for five days for the purpose of commencing a judicial commitment proceeding.²⁰

Adoption of the Draft Act significantly changed the legal criteria for identifying those subject to nonvoluntary hospitalization. In the absence of an emergency situation, an individual could be hospitalized on a nonvoluntary basis if he were "mentally ill," and either "because of his illness" was dangerous to himself or others, or was in need of care or treatment in a mental hospital and lacked "sufficient insight or capacity to make responsible application" for admission to a mental hospital.²¹ Existence of mental illness and a determination that the pre-patient "because of his illness, is likely to injure himself or others" justified hospitalization pursuant to not only the judicial procedure and the standard nonjudicial procedure but also the emergency certification procedure.²² A "mentally ill individual" was defined as "an individual having a psychiatric or other disease which substantially impairs his mental health."²³

The new provisions were almost immediately challenged. On October 23, 1953, Mrs. Lillian Fuller presented her daughter Ester Porter at Fulton State Hospital with certifications by two physicians and demanded her admission pursuant to the standard nonjudicial procedure. The superintendent refused on the ground that he had "been in-

17. *Id.* § 8, at 650.

18. *Id.* § 9, at 650-52.

19. *Id.* § 9(6), at 651.

20. *Id.* § 17, at 655.

21. *Id.* § 6(2), at 649; § 9(7), at 650-52.

22. *Id.* §§ 7(1) & (2), 8, at 650.

23. *Id.* § 1(1), at 647.

formed" that the legislation was unconstitutional and therefore void. The Missouri Supreme Court, in a mandamus action brought by Mrs. Fuller, agreed. "Both sides," the court began in *State ex rel. Fuller v. Mullinax*,²⁴ "recognize that the state, in the exercise of the police power, may provide for the summary apprehension of an allegedly insane person, dangerous to self or others, and his temporary detention (without notice or hearing) until the truth of the charges can be investigated."²⁵ No disagreement was registered by the court. But "admission to a mental hospital under the nonjudicial procedures . . . could always result in indeterminate confinement . . . without the proposed patient's knowledge that impairment of his mental condition was even suspected," the court observed, and "for want of subsequent action (however induced) on the patient's part, or in his behalf . . . such hospitalization might conceivably continue for the remainder of the patient's life."²⁶ Consequently, concluded the court,

we are clearly of the opinion, and so hold, that for the statute in operation to thus deprive a person of his liberty without an opportunity to be heard in advance of commitment, if he or those acting for him desire it, would constitute a denial of due process, and accordingly render the statute, in its present form, unconstitutional. No reason is advanced why appropriate provisions embodying this safeguard cannot be fitted into the present framework of the act.²⁷

There was no direct authority on which to rely. In 1933, the court in *In re Moynihan*²⁸ had declined to disapprove a court order for emergency detention of a patient prior to hearing on the application for indeterminate commitment. It had cautioned, however, against indiscriminate use of this power:

The practice of sending a person to an insane asylum before the hearing might result in preventing the person claimed to be insane from employing counsel or being present at the hearing. Of course, there may be circumstances in which such action is advisable . . . but such action should be taken with caution not to impair the rights of the alleged insane person.²⁹

24. 364 Mo. 858, 269 S.W.2d 72 (1954).

25. *Id.* at 865, 269 S.W.2d at 76.

26. *Id.* at 866, 269 S.W.2d at 76-77.

27. *Id.* at 866, 269 S.W.2d at 77.

28. 332 Mo. 1022, 62 S.W.2d 410 (1933).

29. *Id.* at 1039, 62 S.W.2d at 418. Interestingly, in neither *Fuller* nor *Moynihan* did the court consider its decision in *Ex parte Lewis*, 328 Mo. 843, 42 S.W.2d 21 (1931), upholding

The *Fuller* court did not read *Moynihan* as inconsistent with earlier cases cited for the proposition that notice and an opportunity to participate actively in a judicial hearing were constitutionally necessary prerequisites to hospitalization. The cases upon which the *Fuller* court relied to reject other case authority that due process requirements were satisfied by an opportunity to obtain a judicial hearing after hospitalization were not strong support for this proposition. *Hunt v. Searcy*,³⁰ decided in 1902, was an action for ejectment in which the plaintiff claimed that defendant's title was defective because a prior grantor had been declared insane in an earlier wardship proceeding. Affirming the trial court's exclusion of the evidence of the guardianship proceeding on the basis that the record of that proceeding did not affirmatively show prior notice to the potential ward, the court commented, "[W]hat if the person was not really insane at all, and without notice was adjudicated insane and confined in an asylum?"³¹ This, the court indicated, was more than a theoretical possibility, and pointed to the 1885 case of *In the Matter of Marquis*.³² In *Marquis*, the probate court, on a petition filed by a son, had found Washington Marquis of unsound mind and had appointed a guardian of the person and the estate. No notice had been given to the senior Marquis of the proceeding and the probate court, "upon proof that he is not in condition of mind and body to be brought into court," ordered that he not be present. At the next term of court, however, Washington Marquis appeared and moved to set aside the judgment. He successfully maintained that he was not—and had not been—of unsound mind and should have been given notice. *Hunt* was followed in 1918 by *Shanklin v. Boyce*,³³ an action by a former ward to set aside the sale of his property by his former guardian. Affirming judgment for the plaintiff, the court held, relying on *Hunt*, that since the guardianship proceedings had been conducted without notice to the prospective ward they were without effect, and the guardian was consequently without authority to affect the ward's rights in his property.

Hunt, then, which provided the basic case support for the result in *Fuller*, not only involved different subject matter, but the issue had come to the court in a context in which the pressure undoubtedly felt

administrative detention and quarantine of those believed to have infectious venereal disease. See note 104 *infra*.

30. 167 Mo. 158, 67 S.W. 206 (1902).

31. *Id.* at 183, 67 S.W. at 214.

32. 85 Mo. 615 (1885).

33. 275 Mo. 5, 204 S.W. 187 (1918).

by the court to uphold a completed real property transaction may well have influenced the result. In *Shanklin* (where the pressure went in the opposite direction) the court clearly felt bound by *Hunt*. But most important, the only factual information before the court in *Fuller* regarding the psychiatric hospitalization system was a single appellate decision from the court's own reports ambiguously suggesting that a single unjustified appointment of a guardian of the estate had occurred long before.

The legislature was not slow to respond to the court's suggestion in *Fuller* that the defects in the statutory procedure could be corrected. The following year two major changes were made in the statutory framework.³⁴ First, the standard nonjudicial procedure was amended to provide that copies of the application and supporting certificates be filed with the County Welfare Department. This department was then ordered to inform the pre-patient, both orally and by service of a written notice, that unless he made known to the welfare department within five days that he desired a judicial hearing, he would be subject to hospitalization without judicial action. In the event that the individual mailed a signed request for a hearing to the welfare department "or otherwise notified the department," a full judicial hearing was to be held.³⁵

The second revision dealt with the emergency admission procedure. An admitting hospital was required to notify the probate court of the admission of a patient under either emergency procedure within five days after the admission. (This was changed to ten days in 1957.)³⁶ Unless proceedings for hospitalization under the court order procedure were initiated within five days from receipt of this notice, the probate court was to order release of the patient. If such proceedings were instituted, the court was directed to hold a hearing within ten days and to render its judgment within five days after the end of this hearing. Until the judgment was rendered temporary confinement of the patient could be authorized by the court.³⁷

There has been no substantial change in the statutes since 1955. Although there has been no judicial test of the amended statutes, the Attorney General's office has taken the position that the 1955 amend-

34. §§ 1-28, 1955 Mo. Laws 656-68.

35. § 4(3), 1955 Mo. Laws 650-60.

36. § 1, 1957 Mo. Laws 72-73.

37. § 7, 1955 Mo. Laws 661-62.

ments met the Supreme Court's objections and that the prescribed procedure is constitutionally valid.³⁸

In Missouri, then, as in all states, the system of providing care for the mentally ill operates within a detailed legal framework. Unlike many other states, however, Missouri's framework has been significantly affected by judicial decisions based on constitutional considerations. The development of this framework reveals that little attention has been given to the practical problems of the operation of a public psychiatric hospitalization system and the feasibility of changing its operation by legal fiat. Prior to 1945, nonvoluntary admission was regarded as a "medical" matter to be determined by the system's administrators and their delegates. Hospitalization in public facilities was regarded as the last resort for individuals who lacked financial resources for any alternative; and while the legal framework did prescribe certain procedures with which the medical personnel were expected to comply, the apparent purpose—and clearly the emphasis—of these procedures was not to prevent the unjustified hospitalization of a "sane" individual, but rather to avoid the public cost of hospitalizing a nonindigent "insane" person. The 1945 legislation attempted a wholesale conversion of the procedure to one of commitment by court order after a judicial investigation of the justification for hospitalization; if the Missouri Supreme Court was correct, this change was at least in part intended to establish a safeguard against improper hospitalizations. The 1954 legislation, in addition to redefining those subject to nonvoluntary hospitalization, backtracked to the extent of making available a procedure whereby judicial involvement was delayed until after hospitalization and was required only if expressly requested by the patient. This alternative was struck down in reliance upon case precedent developed in contexts far different from the contemporary systems of public psychiatric hospitalization; apparently the court saw in the 1883 surreptitious appointment of Washington Marquis' guardian sufficient danger of abuse of contemporary hospitalization to override the objections to judicial participation in the process raised before the court several years before. After curative revision by the legislature, the statutory framework provided that in the absence of dangerousness, each proposed patient was to be given an opportunity to obtain a judicial hearing prior to hospitalization. If dangerousness existed (and this procedure thereby became unworkable),

38. Opinion Letter from John M. Dalton, Attorney General of Missouri, to Honorable Gordon R. Boyer, September 29, 1955.

immediate hospitalization was available, but care was taken to impose upon the probate court the duty to see that such emergency hospitalization did not exceed a specified short period.

Several basic factual assumptions underly this statutory structure, as well as most other legal frameworks within which psychiatric hospitalization systems presently operate. First, it was assumed that manipulation of the legal framework would have a direct and predictable effect on the regulated system. By imposing a legal directive that all prospective patients be extended an effective opportunity to obtain a judicial hearing for the resolution of any doubt as to the justification for their hospitalization, it was assumed that the system would be forced to extend such an opportunity. By directing that only a limited category of the mentally ill be subjected to nonvoluntary hospitalization, it was assumed that the system would be forced to reject those not within this category. Second, it was assumed that the "need" for psychiatric hospitalization was dependent upon characteristics of the mentally ill person himself—existence of mental illness plus symptoms which either created a danger to the proposed patient or others or so disrupted his ability to function intellectually that he could not make a reasoned choice as to his own need for treatment. Third, it was assumed that uncertainty as to the existence of these factors could be resolved by a judicial body. Fourth, it was assumed that use of adversary court proceedings would result in the presentation of these matters in such a way that the court would have available sufficient information on which to resolve the uncertainty. Finally, it was assumed that only occasionally would situations be presented in which the continued liberty of the prospective patient would create an intolerable burden for the family or community. In those cases, there was to be no judicial involvement in the initial decision to hospitalize. But in the majority of cases, actual hospitalization was to be postponed until the prospective patient was afforded an opportunity to obtain a judicial hearing on the validity of the proposed hospitalization.

II. THE SYSTEM IN ACTION: ACUTE PSYCHIATRIC HOSPITALIZATION IN ST. LOUIS

Whether the assumptions made during the development of the legal framework were then, or are now, correct cannot be discussed without detailed reference to the everyday operations of the system that the legal framework purports to regulate. This section is devoted to a de-

scription and analysis of the public acute hospitalization process in metropolitan St. Louis for the purpose of testing the validity of these assumptions. Although the scope of the study is somewhat arbitrarily limited, it does encompass the problems encountered in the administration of a system that services the majority of a large city's publicly treated mentally ill.³⁹

A. *The Basic System*

There are two public facilities available to the mentally ill of St. Louis. One, the Acute Facility, provides twenty-four hour emergency room service as well as short term full time hospitalization and out-patient services; the average length of stay for a patient in the Acute Facility's full time psychiatric service in 1966-67 was 32 days. The other, the State Hospital, provides primarily longer term hospitalization as well as out-patient and followup service.⁴⁰

The treatment approach of the Acute Facility does not emphasize "cure" as that term is used in regard to physical illness. In part, this is because of the general lack of agreement as to the nature of the affliction with which the system deals as well as upon appropriate methods of treatment. The nature of the psychopathology of the so-called "functional mental illnesses"⁴¹—psychoses, neuroses, and behavior

39. As Part I indicated, the hospitalization system in St. Louis developed separately from that of the rest of the state; not until 1945 was the legal framework applicable to the rest of the state extended to the city. Nevertheless, the city is the source of a large portion of the state's public psychiatric care problem; although (according to the 1960 census figures) the city contains about 17 per cent of the state's population, in 1967 it accounted for about 26 per cent of the total population of the state's State Hospital population.

Although the patient population of the Acute Facility is far smaller than that of the State Hospital that serves the city, the rapid turnover of patients in the Acute Facility means that over a period of time it services far more patients than does the State Hospital. In 1966-67, for example, the State Hospital had an average patient population of 2,999 but only 68 "first admissions" and 153 admissions who were transferred from other public psychiatric facilities. The Acute Facility, on the other hand, had an average patient population of 152 but had 1917 admissions.

40. The difference in function between the two facilities is evident from a comparison of discharges. In 1966-67, although 67 per cent of patients leaving from the State Hospital were discharged back into the community, 31 per cent of this total were patients who had died in the hospital. Eighty-four per cent of patients discharged from the Acute Facility were discharged back to the community, less than one per cent died in the hospital, and about fourteen per cent were transferred to other hospitals. (Many of these were sent to the State Hospital.) Those hospitalized in the Acute Facility, then, were most frequently released back to the community after short-term treatment; if they did not respond, they were transferred elsewhere for longer term care. A significant portion of those cared for in the State Hospital, on the other hand, remained in that facility until their death.

41. There are certain mental disorders about which medical authorities are in wide-

disorders—is far from clear.⁴² The most widely accepted view, how-
 spread agreement as to the existence of a biological “cause.” One example is General
 Paresis, a result of brain damage caused by the syphilis agent, *treponema pallidum*;
 another consists of those disorders traceable to reduction of the blood supply to the brain
 caused by cerebral arteriosclerosis. See generally R. WHITE, *THE ABNORMAL PERSONALITY*
 483-512 (1964). The “functional” mental illnesses are so named because of uncertainty as
 to their cause; all that is agreed is that they interfere with the functioning of the afflicted
 individual.

The functional disorders are generally divided into three categories: psychoses, neuroses,
 and conduct or behavior disorders. A psychotic individual is considered to have lost
 contact with reality, in theory because he has been unable to develop methods of coping
 with subconscious anxiety which consequently overwhelms him. He develops a fantasy
 world in which he lives—and in which his needs are met. Two basic types are generally
 distinguished: the affective psychosis (including manic depressive reaction) in which the
 basic upset is one of emotions or moods; and schizophrenia, a term used to cover a wide
 variety of symptom syndromes which all are considered to involve a breakdown of
 integrated thinking and adoptive behavior. See A. CROWCROFT, *THE PSYCHOTIC*, ch. 1 (1967);
 R. WHITE, *supra*, at 515-16. In neurosis, the individual has developed “defense mechanisms”
 which have to some extent enabled him to avoid being overwhelmed by his anxieties; the
 symptoms arising from these include anxiety states (in which the individual consciously
 experiences his anxiety), obsessions and hysteria (a physical reaction such as paralysis).
 R. WHITE, *supra*, 266-304. While the neurotic generally conforms in outward ways to social
 expectations, individuals afflicted with personality or conduct disorders combat internal
 anxiety by “acting out,” frequently in antisocial ways. Categories of personality disorders
 include psychopathic personality (failure to have internalized parental and social standards),
 sexual deviation, alcoholism and similar patterns of “antisocial” behavior. R. WHITE,
supra, 382-417. The generality of the symptom syndromes, of course, makes for uncer-
 tainty in diagnosis; in this paper, however, the diagnostic categories will be used as set out
 in this note.

42. For an extensive discussion of the various theoretical explanations of the phenomena
 called “mental illness,” see T. MILLON, *THEORIES OF PSYCHOPATHOLOGY* (1967). Four basic
 alternative approaches are suggested: (1) “biophysical theories,” which assume that bio-
 physical defects in anatomy, physiology and biochemistry are responsible for the symptoms;
 (2) “intrapsychic theories,” which suggest that repressed childhood anxieties persist in the
 adult individual and what are designated symptoms of mental illness are manifestations
 of the unconscious adaptive processes which the personality uses to prevent the resurgence
 of these anxieties; (3) “phenomenological theories,” stressing the assertion that each
 individual reacts to reality only as he perceives that reality [Early in his life a child
 develops a need to obtain self-regard from experience; later, insofar as experience does not
 provide this self-regard, it is denied or perceived in a distorted manner and the individual
 reacts accordingly]; (4) “behavioral theories,” which assert that what is regarded as be-
 havior symptomatic of mental illness is not essentially different from any other human
 behavior and can be explained (if sufficient investigation is done) by the same scientific
 principles of learned behavior as are used to explain so-called “normal” behavior. Cf.
 T. SCHEFF, *BEING MENTALLY ILL* (1966), who suggests that the culture develops a “model”
 of mental illness which all individuals learn about and to which some resort when unable
 to otherwise cope with stresses of life.

In addition to “depth” or “insight” therapy, designed to eliminate or make unnecessary
 unsatisfactory defenses, there are a variety of procedures designed to operate in a less
 drastic manner. Sometimes called “surface” or “symptom-oriented” therapies, these tech-
 niques are designed to strengthen existing defenses or to simply suppress symptoms. E.

ever, has been that inappropriate behavior and malfunction of the thought process or inability accurately to perceive reality (regarded as symptoms of "mental illness") are manifestations of attempts by the defective personality to deal with subconscious tensions caused by his attempts to meet the problems of living. Each individual must interact with his environment in such a way that his basic needs are fulfilled. Failure to satisfy these needs results in subconscious tension or anxiety; the personality struggles to avoid anxiety or to relieve it. A "normal" individual is one whose needs are fulfilled by "normal" activity—employment, recreation, family and social life, etc. An "abnormal," or "mentally ill" individual, because of his personality structure, cannot fulfill his needs by "normal" activity, and must therefore develop ways of responding to his environment that enable his needs to be met, i.e., ways which relieve or avoid "anxiety." This inability to react "normally" without creating anxiety may be general or specific, depending on the number of situations that cannot be met "normally." "Mental illness," then, is the result of an individual with an abnormally developed personality coming into contact with a stress situation that his personality cannot handle; bizarre behavior or other "symptoms of mental illness" are manifestations of his desperate attempt to meet the stress situation in such a way that his basic needs continue to be filled and "anxiety" avoided. According to this view, the underlying psychopathology—the defective personality structure—can only be corrected by psychotherapy, which involves either reconstructing or making corrective changes in the personality itself. Although in theory the same result could be achieved by arranging for the individual to avoid those stress situations which he cannot meet in a "normal" manner, it is usually felt that this would require him to give up any attempt to lead a normal life. Only by "curing" this underlying psychopathology can the occurrence of the symptoms be permanently prevented, although short term relief can be obtained by means of medication or shock therapy, both of which temporarily repress the symptoms but have no effect upon their cause.

The Acute Facility places primary emphasis upon the repression of symptoms by means of drug and electroshock therapy.⁴³ Almost no

ROSEN & I. GREGORY, *ABNORMAL PSYCHOLOGY* 199-200 (1966). The behavioral theorists have, in addition to attacking the theoretical model of mental illness, offered a significantly different approach to treatment. Ullmann & Krasner, *Introduction to CASE STUDIES IN BEHAVIOR MODIFICATION* 29-59 (L. Ullmann & L. Krasner eds. 1965); J. WOLPE & A. LAZARUS, *BEHAVIOR THERAPY TECHNIQUES* (1966). Cf. W. GLASSER, *REALITY THERAPY* (1965).

43. These so-called "physical treatments" are relatively new. Electroshock was first used

“insight” therapy or psychotherapy is used. In part, this is because of time and personnel shortages; psychotherapy requires a relatively high commitment of manpower over an extensive period of time, and the Acute Facility frequently has neither sufficient manpower nor assurance of extended contact with the patient. Moreover, even assuming that the view summarized above does accurately reflect the nature of mental illness, it may nevertheless be true that those aspects of the general problem of community mental illness with which the acute public treatment facilities must deal are not susceptible to “cure” as that term was used above. The function of the Acute Facility is in large part “crisis treatment” of lower socioeconomic class individuals; these basic characteristics of the system may determine the type of treatment it can feasibly provide. In 1966-67, 38 per cent of the admissions to the Acute Facility were psychotics and 37 per cent were personality or behavioral disorders.⁴⁴ These types of psychiatric disorders are those most likely to cause a “crisis” which creates a strong demand for hospitalization. But those in an acute psychotic state are, by reason of their loss of contact with reality, not susceptible to insight therapy; and personality disorders, although a theoretically lesser gradation of psychopathology, are considered poor subjects for psychotherapy.⁴⁵ Only 3 per cent of admissions were neurotics, the type of patient for whom psychotherapy has traditionally been most widely used.

during the 1930's and use of drug therapy did not begin until about 1952. Widespread early optimism as to the potential value of drug therapy has since given way to a more restrained view. Especially on a long term basis, successful administration of the drugs has proven to be less simple than was at first supposed. R. KOEGLER & N. BRILL, *TREATMENT OF PSYCHIATRIC OUTPATIENTS* 1-12 (1967).

Medical experts frankly acknowledge that the means by which electroshock and drugs produce improvements in a patient's symptoms are not understood. P. POLATIN, *A GUIDE TO TREATMENT IN PSYCHIATRY* 122, 151 (1966). For a discussion of several theories of the dynamics of electroshock therapy, see Dies, *Electroconvulsive Therapy: A Social Learning Theory Interpretation*, 146 *J. NERVOUS AND MENTAL DISEASES* 334 (1968). There is, however, a respectable school of thought that drugs and electroshock are properly used only as a temporary means of making the patient susceptible to psychotherapy:

[T]he chief use of . . . [drugs] is to permit communication and consequently establish a therapeutic relationship between patient and physician. . . . When . . . [drugs] are introduced into treatment as a substitute for communication, they are being incorrectly utilized.

A. ENELow & M. WEXTER, *PSYCHIATRY IN THE PRACTICE OF MEDICINE* 211 (1966).

44. MALCOLM BLISS MENTAL HEALTH CENTER, ANNUAL REPORT (July 1, 1966 through June 30, 1967) (mimeographed unpaginated report).

45. AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL, MENTAL DISORDERS* 35 (1952) comments under personality disorders, personality pattern disturbance: “These are more or less cardinal personality types, which can rarely if ever be altered in their inherent structure by any form of therapy.”

In addition to the nature of the psychopathology encountered in public acute psychiatric treatment, the fact that the patients are almost exclusively of the lower socioeconomic class contributes to the difficulty of making effective use of psychotherapy. Psychotherapists are almost inevitably middle class individuals, and the gap between their cultural background and that of lower class patients may be too large to permit the development of the type of personal relationship essential to successful psychotherapy.⁴⁶ Moreover, the relatively low degree of psychiatric sophistication among lower class individuals causes them to be easily discouraged by the time and effort required for successful psychotherapy; consequently, they often fail to keep appointments or in other ways fail to maintain an active interest in a long term program of psychotherapy.⁴⁷

In addition to these somewhat mechanical difficulties of providing insight therapy to the clientele of public acute psychiatric treatment facilities, there is a substantial question whether effective psychotherapy, if it could be provided, would prove ultimately helpful for the recipients. It has been asserted that the mental health movement is "middle class oriented" and has adopted as the model of "mental health" what are essentially middle class values that cannot be instilled in a lower class individual without adverse results. For example, a lower class individual who accepts as a result of therapy "healthy" middle class attitudes towards employment, sex, drugs and similar matters may find himself alienated from his friends and family and ultimately in a worse condition than before "therapy." Until techniques and contents of lower class oriented psychotherapy are developed, then, the clientele of the acute psychiatric facilities of the large cities may be beyond the reach of therapy designed to "cure" underlying psychopathology.

46. See Spiegel, *Some Cultural Aspects of Transference and Countertransference*, in *MENTAL HEALTH OF THE POOR* 303 (F. Riessman, J. Cohen & A. Pearl eds. 1964), discussing the difficulties of the formation of a patient-therapist relationship when the two participants have different cultural backgrounds. The effects of this show up in treatment situations. For example, even in situations where ability to pay is of no importance, lower class patients tend to be less frequently found to be "proper subjects" for insight therapy than their higher class counterparts. Brill & Storrow, *Social Class and Psychiatric Treatment*, in *MENTAL HEALTH OF THE POOR*, *supra*, at 68.

47. See Overall & Aronson, *Expectations of Psychotherapy in Patients of Lower Socio-economic Class*, in *MENTAL HEALTH OF THE POOR*, *supra* note 46, at 76, reporting that lower class patients tend to become easily disenchanted with therapy and frequently fail to return for additional sessions in part, at least, because the sessions do not correspond to their idea of how a "sick" person should be "treated."

Whatever the justification, the program of the acute facilities is oriented towards obtaining as long-lasting a repression of symptoms as is possible within a minimum period of time. The need to make maximum use of available facilities and the current recognition that hospitalization is not therapeutically helpful⁴⁸ (and in fact may be harmful)⁴⁹ make it desirable for the process to be quick. Prolonged hospitalization may reduce a patient's motivation to return to the community. He may find that he derives gratification from his dependent position in the hospital. In addition, long absences from those problems of everyday living with which the patient must learn to deal—family and employment situations, for example—make readjustment more difficult both for the patient and for those to whom he returns.

Despite the emphasis upon repression of symptoms rather than "cure," however, short-term intensive treatment provided by facilities such as the Acute Facility studied here, when compared to results achieved by traditional programs of public psychiatric hospitalization, probably works to the overall benefit of patients. A 1958 study concluded that patients admitted to the acute facilities not only had a significantly shorter length of hospitalization than comparable patients admitted to traditional state hospitals, but also were able upon release to avoid rehospitalization for a longer time.⁵⁰ In explanation, the study offered:

The difference in the entire atmosphere of the two types of hospitals probably account [*sic*] in large measure for the tremendous difference in their effectiveness. . . . It is only logical that more rapid recovery correlates highly with such factors as doctor-patient ratio, nurse-patient ratio, staff attitudes, patient attitudes, the attitudes of the patient's family, friends and community, . . . desirable attitudinal influence of patients on each other—in short, the milieu of the total therapeutic environment.⁵¹

48. A study of 2,926 patients released from a psychiatric facility revealed that ability to function outside of the hospital (judged by whether and how soon each patient returned for rehospitalization) did not vary with the number of days spent in the facility prior to release. Mendel, *Effect of Length of Hospitalization on Rate and Quality of Remission from Acute Psychotic Episodes*, 143 J. NERVOUS AND MENTAL DISEASES 226, 230-31 (1966).

49. R. BARTON, INSTITUTIONAL NEUROSIS 53 (1959) characterized the effect of hospitalization upon patients as "a disorder separate from the one which brought the patient into the hospital." This "disorder," which he named "institutional neurosis," was described as "a disease characterized by apathy, lack of initiative, loss of interest . . . submissiveness, apparent inability to make plans for the future, lack of individuality, and sometimes a characteristic posture or gait."

50. Ulett, Hardwicke, Cravens, & Masterman, *Intensive Psychiatric Treatment Hospitals and Missouri's State Mental Hospitals*, 59 MO. MEDICINE 867 (1962).

51. *Id.* at 874. But cf. *Editorial Comment, Law's Labor Lost*, 40 PSYCHIATRIC Q. 150

One other fact becomes immediately apparent from a brief overview of the system—the limited opportunity for judicial participation. In 1967, for example, about 30 per cent of the 1,917 admissions to the Acute Facility were nonvoluntary; yet during a comparable period, the probate court held far less than 575 hearings. In a large portion of nonvoluntary admissions, then, there was no formal procedural opportunity for judicial participation. This will be discussed in more detail later. Here, it is important insofar as it indicates that any study of the hospitalization procedure that concentrates on those patients that appear before the court will necessarily deal with only a small portion of those subjected to nonvoluntary hospitalization.

A more appropriate method of structuring an examination of the system is to consider several potential decision-making points along the route that patients take from the community to full-time hospitalization, to examine from empirical observation whether or not significant decisions are actually made at these points, and if so, to determine on what basis they are made. Three such points deserve discussion:

1. the decision made in the community to seek psychiatric attention for an individual and to present him for such attention, and
2. the decision made at the Acute Facility to admit the individual to full time hospitalization, and
3. the decision by the probate court to authorize further hospitalization of the patient.

B. *The Decision to Present an Individual to a Mental Facility*⁵²

A study conducted in Baltimore concluded that approximately one-tenth of the nonhospitalized population exhibited "obvious mental illness."⁵³ There is no reason to believe that the incidence of mental

(1966) which criticizes what it calls the "in-and-out" policy of short term treatment frequently followed by readmission. Many patients released under such a system, it argues, could benefit from further hospitalization and should be treated on a longer term basis. Moreover, it argues that if patients not "well" are released, they disrupt their families with the result that mental illness tends to develop in their children.

52. The basic approach in this section relies heavily upon Mechanic, *Some Factors in Identifying and Defining Mental Illness*, 46 MENTAL HYGIENE 66 (1962), reprinted in MENTAL ILLNESS AND SOCIAL PROCESSES (T. Scheff ed. 1967).

53. Pasamanick, Roberts, Lemkau & Kruger, *A Survey of Mental Disease in an Urban Population: Prevalance by Race and Income*, in MENTAL HEALTH OF THE POOR, *supra* 46, at 39, 48. Even more startling conclusions were reached in a study of the Manhattan population. Only 18.5 per cent were designated as "well." 58.1 per cent were considered mildly or moderately impaired by mental illness; despite significant symptoms, they were perform-

disorder is significantly lower in St. Louis, yet only a few of those exhibiting symptoms are presented to psychiatric facilities. Obviously, a very selective process operates in the community itself to choose those who are to be brought to the attention of persons in a position to offer and effect institutional treatment. The following comments concerning this selective process are based on a study of 45 randomly selected admissions to the Acute Facility. Heavy reliance was placed on medical records, but in numerous cases this was supplemented by interviews with the admitting resident.

1. *Community Selection in St. Louis*

Table 1 contains a basic breakdown of the admissions, categorized by the class of persons accompanying the patient when he appeared at the Acute Facility. In about one fifth of the cases the individual presented himself. In about four fifths someone other than the patient accompanied him to the Acute Facility and probably assisted in determining that he should be presented to a psychiatric facility. In one third of the total presentations, one or more members of the family (and no one else) accompanied the patient. In one fifth, the police alone presented him. In another fifth, both the police and a family member (or some other close associate) were involved.

Table 1 also suggests that the dynamics of admission varied significantly with the type of presentation involved. Self-Presentations, for example, constituted 22 per cent of total, but none of the nonvoluntary admissions. Family-Police Presentations, on the other hand, constituted only 18 per cent of total, but over 40 per cent of all nonvoluntary admissions. In fact, the most striking variation is the extensive participation by the police in the presentation of those patients who become nonvoluntary admissions: in over 60 per cent of the nonvoluntary admissions the police played a role, but they were involved in only about 25 per cent of the voluntary admissions. Since the dynamics of the process depended at least in part upon who was involved, a detailed examination of the several types of presentation listed in Table 1 is necessary.

a. Self-Presentation. The Self-Presentations were composed almost entirely of individuals who had observed in themselves what they in-

ing their everyday responsibilities satisfactorily. 23.4 per cent, however, were considered significantly impaired in their everyday lives by symptoms of mental illness. L. SROLE, T. LANGNER, S. MICHAEL, M. OPLER & T. RENNIE, *MENTAL HEALTH IN THE METROPOLIS* 138-39 (1962).

TABLE 1
PRESENTATION TO ACUTE FACILITY BY THOSE ACCOMPANYING PATIENT AND TYPE OF
SUBSEQUENT ADMISSION

	All Admissions Examined		Voluntary Admissions Only		Nonvoluntary Admissions Only	
	No.	%	No.	%	No.	%
Self	10	22	10	36	0	0
Police Only	9	20	5	18	4	24
Family Only	15	33	10	36	5	29
Family and Police	8	18	1	3.3	7	41
Friend and Police	1	2	1	3.3	0	0
Family and Ambulance	2	5	1	3.3	1	6
Total	45	100	28	99.9	17	100

terpreted as symptoms of illness, most often depression, anxiety, or hallucinations.

ILLUSTRATION 1.

The patient, a 32 year old woman, worked as a stenographer in a law office. On the day of admission she had experienced difficulty in concentrating on her work and had made numerous mistakes. At noon she left to return home but instead checked into a hotel. She reported hearing the sounds of a train depot and the voices of old friends. Later in the afternoon, she presented herself to the Acute Facility.

None of the Self-Presentations became nonvoluntary patients, probably because underlying each Self-Presentation was a belief on the part of the individual that he was "ill" and a concomitant willingness to submit to whatever "treatment" was suggested.

b. Police Presentations. Situations that appeared to have precipitated the presentation of those patients accompanied by police officers to the Acute Facility are summarized in Table 2. "Police Only Presentations" were those where only police officers accompanied the patient at the time of his presentation. Only one of these presentations was stimulated by events occurring within the patient's family; the others were about equally divided between situations in which officers came upon the patient during the performance of relatively routine police duties and those in which the patient was called to police attention by a complaining member of the community.

"Police-Family Presentations," those in which both a police officer and a member of the family accompanied the patient to the facility,

TABLE 2
SITUATIONS PRECIPITATING PRESENTATION: POLICE AND POLICE-FAMILY PRESENTATIONS

	Total	Police Only Presentations	Police-Family Presentations		
			Initial Contact With Patient by Police	Initial Family Decision to Present	Initial Contact With Police by Patient
Events Within Patient's Family Unit	8				
suicide attempt	1	0	0	1	0
assaultive behavior	2	1	0	1	0
bizarre behavior	5	0	0	4	1
Events Outside Patient's Family Unit	10				
suicide attempt	1	1	0	0	0
bizarre behavior observed by police during routine police activity	5	4	1	0	0
complaint to police by member of the community based on patient's assaultive conduct	2	2	0	0	0
based on patient's bizarre conduct	2	1	1	0	0
Total	18	9	2	6	1

are broken down in Table 2 according to whether or not the police made contact with the patient before or after the family had probably made the decision to present the patient. "Initial Contact with Patient by Police" were cases in which the patient came to the attention of the police by means other than the efforts of the family; in each, however, the family was subsequently contacted, the decision to present was made, and at least one member of the family accompanied the patient and the police to the Acute Facility. "Initial Family Decision to Present" were those cases in which the police were called to assist in implementing the family's decision to present the patient; these, as would be expected, were stimulated entirely by events within the family. (In one case, the patient himself called police to report that his spouse had attempted to kill him; responding officers found no

evidence of this, contacted the spouse and assisted in presenting the patient.) The family's decision to present is discussed in the next section; the concern here is with those cases in which the police were active in making the decision to present, i.e., "Police Only" and "Initial Contact with Patient by Police" presentations.

What appears to be the only study of the police decision to present a patient suggests that there are five situations in which a police officer is likely to take a person encountered to a psychiatric facility: (1) when the person has attempted suicide, (2) when symptoms of serious mental disorder are accompanied by distortions of normal physical appearance such as seizures or extreme dirtiness, (3) when symptoms are of a highly agitated form and are accompanied by actual violence or an indication of a danger of such violence, (4) when the person appears seriously disoriented, and (5) when the person by acting incongruously has created a nuisance in a public place.⁵⁴ The cases observed in this study generally confirm this analysis.

In five cases, police contact with the patient came during relatively routine police activity. In two of these, the patient had been the driver of an automobile that had been involved in an accident; investigating officers either observed or received reports that the patient in each case had been acting abnormally. (One patient had in fact been under the influence of drugs and the other had been responding to visual hallucinations.) In the third, the patient had been stopped by police officers pursuant to what was apparently a routine traffic stop; he was obviously psychotic and the officers found an Acute Facility outpatient appointment card in his wallet. In the remaining two cases, the patient came to police attention because of serious disorientation.

ILLUSTRATION 2.

The patient was observed by police wandering on the street wearing hospital pajamas and a surgical cap. He did not respond to attempts to elicit information from him. Several hospitals in the vicinity were contacted but reported that they were not missing any patients. The patient was then taken to the Acute Facility.

In the single case in which a Police Only Presentation was stimulated by events within the family unit, the police had been called by the patient's stepmother who reported that the patient had slapped her. Upon arrival, the police observed that the patient was disoriented

54. Bittner, *Police Discretion in Emergency Apprehension of Mentally Ill Persons*, 14 Soc. Prob. 278, 283-286 (1967).

and that she spoke loudly but in a rambling manner. Her clothing and hair were extremely dirty.

Similar observations may be made with regard to those patients encountered by the police in the investigation of complaints made by members of the community. In one, the patient was obviously disoriented; in another the patient's loud screaming disturbed neighbors and investigating officers found that she had lost contact with reality in several ways. The two remaining cases were situations in which the patient had inflicted violence on others or had indicated a definite intention to do so.

ILLUSTRATION 3.

A neighbor of the patient called police and reported that the patient had chased her with a hatchet. The patient, when approached, stated, "This is the hatchet Mr. Robinson used to kill me. I died once. I do not know how I came back into this world."

When the police officers were able to contact a relative or friend of an apparently "mentally ill" person, the responsibility for the individual was readily transferred to this person. Note in Table 2 the few presentations resulting from situations in which the police came into initial contact with the patient but were then able to locate the family. If the family insisted, however, the officers did assist in presentation.

ILLUSTRATION 4.

The patient, a middle aged woman who lived alone, was observed walking nude in the street late at night. Officers contacted her brother who requested that they take him and the patient to the Acute Facility. They did so.

In these cases, however, the family and not the police made the decision to present.

The position has been argued that police are frequently too selective in determining who will be presented to mental health facilities. A recent study of Negro male admissions to a Baltimore psychiatric facility, for example, reported that a large number of the patients had exhibited symptoms of serious disorder long before presentation and, while exhibiting these symptoms, had numerous contacts with the police which did not result in presentation.⁵⁵ In part, the study suggested this may have been due to general police attitudes towards lower class Negroes:

55. Brody, Derbyshire & Schleifer, *How the Young Adult Baltimore Negro Male Becomes a Maryland Mental Hospital Statistic*, PSYCHIATRIC RESEARCH REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION, PSYCHIATRIC EPIDIMIOLOGY AND MENTAL HEALTH PLANNING (1967).

The apparent tolerance of the urban policeman to psychiatrically disturbed behavior in lower class Negro men may . . . be coupled with a tendency to view it as the naturally expected consequence of the "lack of responsibility" of members of a simple or inferior race. It is plausible to suggest that these . . . expectations . . . contribute to the development of a social role for the lower class Negro man which includes patterns of irresponsible aggressive . . . behavior.⁵⁶

Because this study relied only upon information already available to the Acute Facility, the dynamics of the police decision cannot be discussed in any detail. Clearly more work needs to be done in this area. But one case was observed which supported the Baltimore study's conclusion that police may fail to present even seriously ill individuals.

ILLUSTRATION 5.

The patient believed that he was an F.B.I. agent, and he carried at least one weapon. He had accused his wife of being a "spy" and his mother-in-law of poisoning him. Three weeks before presentation he had been arrested for carrying a concealed weapon. Although it is extremely likely that he was exhibiting these symptoms at that time, he was not presented until several days before his preliminary hearing, when his wife called police and asked that they assist in presentation.

In interesting contrast to this general reluctance to present individuals encountered, however, was one admission which suggested that psychiatric hospitalization was being used by police to keep an individual believed dangerous "off the streets" when no other method was conveniently available.

ILLUSTRATION 6.

The patient reportedly drank one pint of whiskey and, becoming irritated at a group of children, shook one of them. Police were called and the child was taken to a hospital where it was determined that she had suffered no significant harm. The officers then took the patient to the Acute Facility and told the resident that if the patient were not admitted he would be released, as there were no charges against him. The patient exhibited no symptoms of present mental illness. When the decision to admit was made, one officer called his superior and reported in a relieved tone, "They'll take him."

The police decision to present, then, usually followed situations in which grossly bizarre behavior by the patient was observed. In addition to this symptomatic behavior, however, there was usually some

56. *Id.* at 215-16.

indication that the patient either endangered others or was unable to function in the community. Unlike the family decision to present (which will be discussed in the next section), the police decision to present apparently represented adherence to a "dangerousness" criteria. Although this meant that police agencies did probably forego opportunities to refer many mentally ill persons to psychiatric facilities, it conformed to the legal criteria set out in the statutory framework much more closely than did the family actions.

One other aspect of police presentations requires comment. The fact of police presentation created a strong pressure for admission without regard to the proposed patient's willingness to undergo hospitalization, since the Acute Facility recognized that the police seldom presented an individual unless he was a serious disruptive influence in the community and other resources had been exhausted. Nevertheless, as Table 1 shows, five of the nine police presentations admitted themselves on a voluntary basis. One was presented after a suicide attempt; it is probable that he recognized his "need" for treatment. In the other four cases, however, it is unlikely that the admission was voluntary in a realistic sense. In two cases, it was clear that the patients regarded hospitalization as the only alternative to jail. In the other two, the Acute Facility would have admitted the patients on a non-voluntary basis had they not admitted themselves. It is likely that if the patients did not believe that jail was the only alternative to admission, they were aware that they had no real choice to make and acted in response to this knowledge.

c. Family (and Police-Family) Presentations. In over half of the total number of admissions studied, the family was involved in the presentation. In 33 per cent of the total admissions, the presentation had been made by the family alone. When other categories are compared, it appears that the family was influential in the presentation of over half of the 46 patients whose admissions were examined.

Table 3 breaks down the 26 admissions in which the family participated in the presentation. In eight (slightly less than one third), presentation was apparently stimulated by the family's observation of what it interpreted as "symptoms" of an "illness" for which the patient needed "treatment." In those remaining, however, there was strong evidence that presentation was stimulated by something other than a simple conclusion on the part of the family that the patient was "sick" and "needed treatment."

In 13 cases presentation was stimulated by the patient's behavior

TABLE 3
SITUATIONS PRECIPITATING PRESENTATION: POLICE-FAMILY
AND FAMILY ONLY PRESENTATIONS (BY TYPE OF ADMISSION)

	Total	Police-Family Presentations		Family Only Presentations*	
		Nonvoluntary Admissions	Voluntary Admissions	Nonvoluntary Admissions	Voluntary Admissions
Situations Within Family Unit (21)					
suicide attempt	1	1	0	0	0
violent conduct	1	1	0	0	0
family fear of suicide	1	0	0	0	1
family fear of violent conduct	4	2	0	2	0
family disruption caused by patient's behavior	6	2	0	2	2
family observation of "symptoms of illness"					
depression	3	0	0	0	3
bizarre behavior	5	0	1	0	4
Situations Extending Beyond Family Unit (5)					
wandering	2	0	1	1	0
boisterous and disorderly behavior	1	1	0	0	0
other	2	1	1	0	0
Total	(26) 26	8	3	5	10

* For purposes of this table, Police-Family Presentations includes those cases designated in Table 1 as "Friend and Police" and "Family and Ambulance" Presentations.

within the family. In about half of these, there was evidence that the behavior was simply disruptive of family life and that this stimulated presentation.

ILLUSTRATION 7.

The family reported that for the last two months the patient had been sleeping poorly and his general level of activity had increased. He spent money freely and the family was consequently forced into debt. Recently he had attempted to open several new charge accounts. The family also complained of the patient's argumentativeness and "resentfulness" at home and repeated complaints of his irritability at work.

In only two of the 26 cases was there a specific act which indicated a

direct and serious danger of physical harm to the patient or others; in both of these cases the police assisted in presentation and the patient refused to admit himself. In five of the 26 cases, however, the family's fear of assaultive or suicidal actions appeared to have stimulated presentation.

In about one fifth of the 26 cases, the patient's symptomatic behavior became "public" in the sense that it could be observed by people other than the patient's immediate family and it appeared that the impact of this behavior on those outside the family unit was influential in stimulating admission. In these cases, the dynamics of the decision to present often differed significantly from those in which the entire matter was an internal family affair. In some of the "public behavior" cases those outside the family who were exposed to the patient's condition put strong pressure on the family to present the patient.

ILLUSTRATION 8.

A woman who had been discharged from psychiatric hospitalization during which she had been diagnosed as paranoid schizophrenic began to exhibit symptoms again. She was "abusive," paraded around her home in the nude in front of her children and charged her husband with drugging her and inviting neighbors to have sexual relations with her. She also accused her neighbors of "wanting to get rid of her." She was not presented to the Acute Facility, however, until the landlord, in response to complaints made by the neighbors, threatened to evict the family unless she was rehospitalized.

In other cases, the decision to present was made and effectuated in part at least by those nonfamily members who came into contact with the patient.

ILLUSTRATION 9.

The patient, a nineteen year old youth, had dropped out of high school because of a "nervous condition." He had been employed in a bakery but his employer called the family to take him home because he had been "acting strangely." The patient then became withdrawn and frequently paced the floor all night. Occasionally he would strike his brothers and sisters. Two days before presentation he swung at his mother with an iron bar and attempted to strangle his sister. No outside help was sought, however. On the day of presentation, he barricaded himself in the cellar and covered himself with soot and cobwebs. No attempt was made to obtain help until he left the cellar and ran out of the house. At this point, the police were called and the patient was apprehended

and presented by the mother and police officers to the Acute Facility.

In four of the five cases where the patient's symptomatic behavior was public, the police were involved in presentation. In only two of the five did the patient admit himself.

Most of the work that has been done on the dynamics of the decision to present has concerned the family decision to seek psychiatric help for one of its members.⁵⁷ These studies tend to agree with the results arrived at here. Polack, in his extensive examination of what he characterizes as the "crisis of admission"⁵⁸ suggests that the situation precipitating admission is frequently only the most recent in a series of crises involving the patient and his family. The series, he argues, is generally made up of common situations that confront most individuals and families in the course of life, such as separation, physical illness and death. Those families in which the crisis series is interrupted by the psychiatric hospitalization of one of the members have dealt with prior crises by simply denying the reality of the facts of the crisis, failing to use potential sources of help (sometimes because of reluctance to do so but frequently because the community has failed to make such resources readily available), and by failing to express negative feelings appropriate to the crisis. Hospitalization occurs when, during one of these crises, the family, frequently after exhausting other means of resolving the situation, attempts to relieve the crisis by labeling one of the members as "mentally ill" to secure this member's removal from the family.

[P]atients were admitted to the psychiatric hospital not primarily because they had the signs and symptoms of psychiatric illness, but usually because their behavior could no longer be tolerated by the people with whom they lived. . . . Most commonly . . . hospitalization became necessary either because the patient's behavior had changed in a direction which the members of his living group found more difficult to tolerate, or because the structure of the living group changed so that its members were less able to tolerate

57. See, e.g., Yarrow, Schwartz, Murphy & Deasy, *The Psychological Meaning of Mental Illness in the Family*, 11 J. Soc. ISSUES 12 (1955). See also Sampson, Messinger, Towne, Ross, Livson, Bowers, Cohen & Dorit, *The Mental Hospital and Marital Family Ties*, 9 Soc. PROB. 141 (1961). Cf. Blackwell, *Upper Middle Class Expectations About Entering the Sick Role for Physical and Psychiatric Dysfunctions*, 8 J. HEALTH & SOC. BEHAVIOR 83 (1967). For a general study of the process of identifying those "needing" hospitalization in England and some procedural implications, see A. LAWSON, *THE RECOGNITION OF MENTAL ILLNESS IN LONDON* (1966).

58. Polak, *The Crisis of Admission*, 2 Soc. PSYCHIATRY 150 (1967).

his behavior. This behavior may or may not have been related to the patient's psychiatric symptoms We agree with a number of other workers who have observed that the member of the family who is labeled the patient is not necessarily the individual with the greatest problem.⁵⁹

This is not to say, however, that hospitalization which results from family rejection or inability to tolerate the patient's behavior does not serve a function other than removal of the patient from the crisis situation. Frequently hospitalization provides an opportunity for "crisis remission," in which the family regroups itself and, sometimes with outside help, becomes able to again tolerate the patient. A recent study of married women psychiatric patients documented this function of the hospitalization process:

[A]n important if explicit function of mental hospitalization is to preserve and reinforce the patient's ties to a personal community. . . . [T]he immediate effect of hospitalization . . . is to define the wife as mentally ill and remove her from the family. These radical procedures initiate a personal and social moratorium. During the moratorium, the wife's role obligations are suspended without being abrogated; past and present expressions of alienation may be reinterpreted, isolated, and forgotten by the patient and her intimates; and critical relationships may be negotiated, modified, and resumed under conditions of limited contact and experimental tentativeness.⁶⁰

One half of those patients whose family was influential in the decision to present were admitted on a nonvoluntary basis. A significantly higher percentage of Police-Family presentations were nonvoluntary, probably reflecting a continuation of the patient's resistance that caused the family to summon the police to assist in presentation. But the fact that one third of the Family Only presentations were nonvoluntary suggests that even when informal family pressure was sufficient to cause an individual not to resist presentation, it was nevertheless sometimes not sufficient to cause him to admit himself. It is also clear that the patient's willingness to admit himself differed with the nature of the event precipitating presentation. Acts of violence within the family generally led the family to call for police assistance in presentation and ended with nonvoluntary admission; observations which the family interpreted simply as symptomatic of illness, however, were almost never followed by police participation in presentation and with-

59. *Id.* at 151, 153.

60. Sampson, et. al., *supra* note 57, at 154-55.

out exception ended in voluntary admissions. To the extent, then, that the family sought to use the psychiatric facility as a means of protection or of relieving itself of a disruptive influence, presentation and admission were likely to be nonvoluntary. When, on the other hand, the family invoked the psychiatric system to "help" an "ill" member, the patient almost invariably cooperated in presentation and admission.⁶¹

2. Analysis

a. The Dynamics of Community Selection. The observations described above make clear that there are two general types of participants in the community selection process. The first, the patient's primary group, is the family or those with whom the patient is in close everyday association. In some cases (about one-third, according to Table 3), the primary group's decision to seek medical help for one member follows the traditional model: behavior is observed which is interpreted as symptomatic of "mental illness," and when it progresses to a point where the individual is regarded as seriously in need of help, he is presented by the concerned family to a psychiatric facility. But in many cases the process is much more complex. The primary group is willing to tolerate extremely serious behavior until something—a "precipitating event"—makes it no longer feasible to tolerate the situation. This "precipitating event" is frequently fortuitous in the sense that it is not related to either progression of symptoms or seriousness of the patient's psychopathology.

ILLUSTRATION 10.

The patient had been depressed for a period of time and had considered attempting suicide for two weeks. He had specifically threatened to kill himself, but no attempt was made to present him to the Acute Facility until his wife happened to notice an apparatus apparently designed by the patient to hang himself.

61. For one of the only studies dealing with factors stimulating presentation of patients to acute psychiatric treatment facilities, see Smith, Pumphrey & Hall, *The "Last Straw": The Decisive Incident Resulting in the Request for Hospitalization in 100 Schizophrenic Patients*, 120 AM. J. PSYCHIATRY 228 (1963). After concluding that the family's fear of the patient and the patient's "general unmanageability" were more frequently factors stimulating presentation than the patient's actual assaultiveness, the study commented, "Nine types of events had been tolerated frequently [by the patient's family] without a request for hospitalization: suicidal threats, threats of harm to family members, destructiveness, shouting, obscene words, irrational talk, inexplicable behavior, wandering, and refusing to come out of a room. Suicidal attempts and actual harm to others were not tolerated." *Id.* at 230. For an excellent general discussion of the family and community aspects of acute psychiatric hospitalization as well as criticism of the manner in which the decision to hospitalize is made, see Knight, *Social and Medical Aspects of the Psychiatric Emergency*, in CRIME, LAW AND CORRECTIONS (R. Slovenko ed. 1966).

Sometimes the precipitating event is one that makes the patient's behavior apparent to those outside the family unit, thereby involving "secondary groups" in the decision to present. As Illustrations 8 and 9 indicate, the family is sometimes willing to tolerate even seriously dangerous behavior until the behavior extends outside the family. The "secondary group" may include the police and the neighbors; they may take direct action themselves to secure presentation or they may pressure the family into effecting presentation. This does not mean, however, that groups other than the patient's primary group demand presentation at the first sign of behavior symptomatic of "mental illness." If the behavior is not violent or otherwise seriously disruptive of everyday community life, the community is frequently willing to ignore even extremely bizarre symptomatic behavior. If the offensiveness becomes focused on one member of the community, however, his efforts are often enough to cause presentation.

ILLUSTRATION 11.

The patient had been observed by police officers for three weeks. He wandered through the downtown area with a picture of Christ around his neck and carried a wooden staff. No pressure to present existed, however, until the patient walked into a store, selected a suit of clothing, identified himself as Jesus Christ and asked that the clothing be charged to God. The store owner complained to police, who presented the patient to the Acute Facility.

Thus, the most significant characteristic of the community selection process is that it does not consistently operate on the basis of presenting to psychiatric facilities those whose illness has reached a given point on a continuum of increasingly serious psychopathology or symptomatic behavior. Rather, it frequently selects for presentation those whose symptomatic behavior becomes anti-social for reasons unrelated to the illness itself. The result is twofold. First, individuals are presented to the Acute Facility, sometimes under formal or informal coercion, who may not meet the criterion of "dangerousness." They may, as in Illustrations 7 and 8, have disrupted the lives of their families; or, as the patient in Illustration 11, they may have offended an influential member of the community; but as is discussed below, it is extremely doubtful whether these individuals can be regarded as dangerous. Second, even if an individual has exhibited behavior or symptoms that might arguably bring him within the "dangerous" criterion, this single characteristic may not have been the cause of his presentation. As Illustration 9 shows the most immediate factor in the process, and

the one stimulating presentation, may have no direct relationship to the symptoms that made the patient "dangerous."

b. Legal Significance of Community Selection. The only aspect of the community selection process that has received attention from the legal framework has been the criteria for the use of force to carry out the decision to present. In the vast majority of jurisdictions, the emergency detention power is, as a matter of formal law, limited to those situations where the individual constitutes a danger to himself or to others. But there is little case law helpful in determining what constitutes sufficient factual grounds for invoking the authority. Where the detention power has been flagrantly abused, damages have been awarded to the aggrieved party with little discussion.⁶² But in those situations in which the abuse is not obvious, the differences and inconsistencies in case analysis graphically reflect the difficulty in assessing whether "dangerousness" existed or whether there was sufficient basis to believe it did.⁶³

Some decisions reflect a willingness to construe the emergency power broadly, sometimes with the ultimate effect of deleting any effective requirement of "dangerousness" and other times apparently relieving the person invoking the power of any duty to evaluate the information which was received to indicate "dangerousness." The Supreme Court of Washington, over strong dissent, held that police officers had authority forcibly to enter an individual's home and seize him when his seventy-eight year old father reported to a police desk sergeant that the son "had" two guns and had threatened to kill the father. The officers, upon responding, observed the son sitting in the kitchen of the home wearing a beard, exhibiting disheveled hair and staring straight

62. *E.g.*, Crawford v. Brown, 321 Ill. 305, 151 N.E. 911 (1926), where the court reversed judgment for defendant and remanded for a new trial on the basis of evidence that the plaintiff had been detained in a private hospital for two weeks apparently because she had a fainting spell after caring for her physically ill husband over a long period of time. See generally Annot. 92 A.L.R.2d 570 (1963) regarding authority to detain a person believed to be mentally ill.

63. One of the reasons for lack of case law, of course, is the procedural difficulty of placing the issue before a court whose opinions are published. By the time the issue is reached, the matter of preliminary detention has frequently become moot. *See, e.g.*, *In re Perry*, 269 F. Supp. 729 (D.D.C. 1967) (denying a motion to dismiss a commitment proceeding on the ground that the respondent had been detained under emergency detention authority for longer than the statute authorized). *Cf.* *Application of Hoffman*, 281 P.2d 96 (Cal. Ct. App. 1955) (invalidating a commitment because the patient had been improperly detained under the emergency detention authority and as a result had been denied adequate notice and opportunity to consult with her attorney in regard to the subsequent commitment proceeding).

ahead. The subject refused to respond when officers knocked and called to him.⁶⁴

The California judiciary responded with equal sympathy to attempts to deal with self-appointed reformer Clarence E. Whaley.⁶⁵ Whaley was observed by police officers carrying a placard protesting denial of his driver's license, alleging corruption of public officials and "wanton sexual activity" of a woman employee of the Department of Motor Vehicles reporting that she had become infected with "a loathsome venereal disease"), and urging the local citizenry to take appropriate action. The officers, after talking with Whaley, forcibly took him to the psychiatric ward of a local hospital. Upon arrival at the facility, Whaley attempted to escape and struck the officer who restrained him. He was subsequently diagnosed as "paranoid condition," committed and retained for seven months. A year and a half after his release, he was again observed "campaigning," this time going from door to door outlining his grievances against public officials and asking residents to donate the use of their homes for neighborhood informational lectures. He also carried a variety of literature, among it a piece with the title, "A MOST APPALLING CONDITION, KIDNAPPED AND RAILROADED TO THE BUG HOUSE." He was arrested for vagrancy but taken again to a psychiatric facility. Within a week he was discharged (apparently no commitment proceedings were begun) and soon brought actions against numerous local officials for false arrest and false imprisonment. In affirming the trial court's dismissal of the complaints, the Court of Appeals held without detailed explanation that on both occasions the officers and the hospital officials had reasonable cause to believe that Whaley was "mentally ill" and dangerous to himself or others.

Other decisions have been less favorable to the exercise of the "emergency" power. In an action for wrongful death the New York Court of Claims held that there had been no justification for attempting to take one Marvin Titcomb into custody for purposes of observation and examination under the following facts: A police officer responded to complaints by a construction crew concerning broken windshields on parked cars. Titcomb's mother's home, which was near the site of the construction activity, had been condemned to make way for the project. His mother and brother, when questioned, denied knowl-

64. *Plancich v. Williamson*, 57 Wash. 2d 367, 357 P.2d 693 (1960).

65. *Whaley v. Kirby*, 208 Cal. App. 2d 232, 25 Cal. Rptr. 50 (Ct. App. 1962), *cert. denied*, 374 U.S. 856 (1963); *Whaley v. Jansen*, 208 Cal. App. 2d 222, 25 Cal. Rptr. 184 (Ct. App. 1962).

edge of the broken windshields but suggested that the subject might know something about them. Titcomb, however, refused to leave his room and talk with the officer, and his mother reported that he had been upset over the loss of the home and a newspaper route, had been locking himself in his room for hours at a time, refused to shave or have a haircut, and had tended to keep entirely to himself.⁶⁶

The New York Court of Appeals also held that a health officer was not justified in using summary detention powers when the patient's wife reported that her husband had been argumentative and irritable, believed his wife's hands "were poison," and felt that it was necessary to lock the doors against "thieves."⁶⁷ Responding to the suggestion that these symptoms evidenced an illness which might have caused the patient to become violent, the court stated:

Perhaps to one trained in psychiatry, the facts . . . might indicate that . . . Warner suffered from a paranoid condition It is undisputed that . . . the patient had committed no overt act forecasting danger to himself or others. . . . While a paranoid condition may sometimes erupt suddenly in some dangerous act, it may, on the other hand, slumber indefinitely; one who suffers from it may conduct himself for years, throughout life even, peaceably and quietly, with no symptoms other than a belief that he is being persecuted. [citing authorities]. There is a great difference between a case . . . where the condition may, at some future time, flare up . . . and one wherein there is imminent and immediate danger of harm unless the patient is summarily restrained.⁶⁸

The appellate case law, however, only reflects the frequent problems raised by strict application of the "dangerousness" criterion in the exercise of the emergency detention power for purposes of presentation. To what extent, for example, does the commission of acts of violence justify nonvoluntary presentation? Is it sufficient if the acts have been performed in response to what would be regarded by a "reasonable man" as insufficient provocation? Does knowledge of a prior history of "mental illness" justify presentation in such cases? To what extent must the reliability of informants be assessed? Is evidence of paranoid delusions sufficient to justify presentation? Is evidence of hallucinations? If not, what "overt acts" must be performed in response to these distortions of reality before presentation is justified? Nowhere does the

66. *Titcomb v. State*, 30 Misc. 2d 902, 22 N.Y.S.2d 596 (Ct. Cl. 1961).

67. *Warner v. State*, 297 N.Y. 395, 79 N.E.2d 459 (1948).

68. *Id.* at 402, 79 N.E.2d at 463.

law answer these questions which cannot be ignored in the day-to-day administration of the emergency detention power for purposes of presentation.⁶⁹

Apart from this attempt to regulate the use of coercion to effectuate the decision, the legal framework has ignored the community decision-making process. Arguably there is little reason why the law need be concerned with this. If the public psychiatric hospitalization system is to treat or control designated persons, the motivation of those bringing such persons to official attention should have no effect on the way in which the system handles such persons. It can also be argued that the decision to present is beyond the effective power of the law to control. The family, for example, is frequently influential in stimulating a demand for presentation. That the family considers the individual presented as "sick" and "in need of hospitalization" rather than "bad" and "deserving of punishment" or simply as a burden to be tolerated is the result of a variety of factors: the concept of "mental illness" held by the family's socioeconomic group, the attitude and economic situation of the family, the availability and anticipated effectiveness of alternative ways of dealing with the crisis, and the anticipated willingness and ability of the psychiatric facility to help alleviate the situation. It is true that many of these are probably beyond the power of the legal framework to control; they depend upon such diverse factors as the image of the "typical crazy man" presented by public communications media,⁷⁰ mental health information programs, ability and willingness of the police to invoke criminal procedures and availability of social service agencies to assist with such matters as school difficulties of children and obtaining public welfare payments. Some aspects, however, may be subject to influence by the legal framework. To the extent that the framework can control admission policies, it can affect the ultimate availability of the psychiatric facilities to deal with certain types of crises. To the extent that it can control police activity, it can limit the

69. Insofar as the dangerous criterion is offered to justify nonvoluntary presentation in the family crisis situation, it may ignore the actual dynamics of the decision to present. This is discussed in connection with the decision to admit; see text preceding note 85 *infra*. What is said there is equally applicable to the use of the criteria in the presentation situation.

70. See Nunnally, *What the Mass Media Present*, in *POPULAR CONCEPTIONS OF MENTAL HEALTH* (1961), reprinted in *MENTAL ILLNESS AND SOCIAL PROCESSES* 60 (T. Scheff ed. 1967), concluding that "the causes, symptoms, methods of treatment, prognoses, and social effects of mental illness portrayed by the . . . [mass communications] media are far removed from what the experts advocate."

availability of the police to assist in effectuating the decision to present and thereby limit the number of situations in which that decision is a satisfactory way of dealing with the crisis.

Moreover, even if the legal framework cannot control the community decision to present, it nevertheless cannot ignore it. The decision to present is a primary factor in shaping later aspects of the hospitalization process that are perhaps more susceptible to such control. The public psychiatric treatment system, unlike other systems of social control such as the criminal justice system and programs of health and safety standards, has no field staff to seek out those properly included within the control of the system. It remains essentially passive and simply accepts or rejects those presented to it by individuals or agencies which have no formal relationship to the system itself. More than the other systems, then, the public psychiatric treatment system is molded by the attitudes and practices of the community. Some studies, in fact, have concluded that the decision to present is, as a practical matter, the controlling decision in the hospitalization process. As Scheff expresses it, the fact that hospitalization is sought raises a "presumption of illness" that is uncritically accepted by medical personnel and commitment courts.⁷¹ But even if the medical examination and the judicial hearing are not as nonfunctional as these studies suggest, the fact that an individual is regarded as in need of hospitalization by his family, neighbors, or other aspects of the community is nevertheless a significant factor in the decisions to hospitalize and commit. In view of its tremendous impact on the entire system of decision to present, this factor clearly cannot be ignored in fashioning a legal framework for the system.

C. *The Decision to Admit to Hospitalization*

Since only about one-third of those presented at the Acute Facility were admitted to full time hospitalization, it is clear that the admission procedure constituted a significantly selective decision-making process.⁷² The admission decision was made by a resident physician in the

71. Scheff, *The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State*, 11 Soc. PROB. 401 (1964).

72. Other studies have concluded that the admission procedure is *not* selective. Scheff, *supra* note 71, at 403-04. See also Mechanic, *Some Factors in Identifying and Defining Mental Illness*, 46 MENTAL HYGIENE 66, 70 (1962):

In the two mental hospitals studied over a period of three months . . . all persons who appeared at the hospital were absorbed into the patient population regardless of their ability to function adequately outside the hospital. It is almost certain, however, that these studies report results observed in traditional

Acute Facility's Emergency Room after about four minutes of observation and examination. Dissection of the decision is difficult because, like many clinical decisions, it is essentially a gestalt situation: the result of admission is the vector of numerous contributing forces and to designate one or two as determinative is often misleading. Nevertheless, it is possible to isolate at least some of the specific factors that enter into the decision.

1. *Factors Influencing the Decision to Admit*

a. *Patient's Desire.* Analysis of the admission decision is complicated by the fact that the formal designation of an admission as voluntary may not mean that the patient's entry was a free choice on his part. When the patient was presented by the police, for example, he may have believed or have been told that admission was the alternative to jail; this may or may not have been true.

ILLUSTRATION 12.

Police officers presented a 36 year old man to the Acute Facility and reported that he had become irritated at a group of children and had shaken a small girl. A medical examination of the girl revealed no significant harm, and the officers reported that they had no charges against the pre-patient. The resident, who wanted to admit the pre-patient because of the potential for violence on his part, indicated that the patient signed a voluntary admission because he believed this was the only alternative to jail.

A patient was sometimes advised by the admitting physician that if he did not sign a voluntary application he would be successfully "committed," that he should not "make things difficult." Family pressures also influenced some patients to admit themselves although they did not believe they needed hospitalization.

But it is also true that a patient hostile to hospitalization sometimes voluntarily admitted himself for reasons that were obscure and difficult to determine.

"State Hospital" systems rather than in the metropolitan acute treatment system with which this study is concerned. Other examinations of the admission stage of acute psychiatric hospitalization have established the selectivity of the process. Baxter, Chodorkoff & Underhill, *Psychiatric Emergencies: Dispositional Determinants and the Validity of the Decision to Admit*, 124 *AM. J. PSYCHIATRY* 1542 (1968) (which also attempts to isolate those factors influencing the decision to admit); Ungerleider, *The Psychiatric Emergency*, 3 *ARCHIVES OF GENERAL PSYCHIATRY* 593 (1960).

In part, at least, the selectivity of the facility studied here was caused by space shortages. The impression was inescapable that the facility would have preferred to admit more patients and retain many for longer periods of time but was prevented from both by lack of space.

ILLUSTRATION 13.

A woman diagnosed as paranoid schizophrenic was referred to the Acute Facility from another hospital. She was actively hostile but admitted herself. The resident believed that this was because the patient's sister was already hospitalized in the Acute Facility and the patient wanted to be near her and felt the facility was beneficial for her sister and therefore would also be for her.

In most cases, however, the decision to admit was made without regard to the patient's desire, and identical criteria were applied to voluntary and involuntary admissions. An interesting exception to this was the depressed patient who was not considered a suicidal risk; he was sometimes hospitalized only if he specifically requested it. But this attitude on the part of the Acute Facility seemed to be the exception rather than the rule.

b. Danger to Self. The decision to admit was influenced by a variety of factors which can be grouped together under danger to self. The most obvious was the admitting resident's conclusion that there was a substantial danger that the proposed patient would attempt to take his own life.

ILLUSTRATION 14.

A 24 year old unemployed musician presented himself at the Acute Facility. He reported that he had been depressed for a week, had experienced crying spells, and had observed an impairment in his ability to concentrate. He admitted having had suicidal thoughts and having specifically considered the use of sleeping pills as a means of taking his life. The resident admitted him.

"Dangerousness" to self in this sense is quite clearly not a readily identifiable clinical "symptom." The medical literature contains a number of studies of suicide potential, but all emphasize the variety of factors which must be considered and the ambiguity of each.⁷³ An im-

73. E.g., C. LEONARD, UNDERSTANDING AND PREVENTING SUICIDE (1967); Litman & Farberow, *Emergency Evaluation of Self-destructive Potentiality*, in THE CRY FOR HELP 48 (N. Farberow & E. Shneidman eds. 1961); Tabachnick & Farberow, *The Assessment of Self-destructive Potentiality*, in THE CRY FOR HELP *supra* at 60; Tuckman & Youngman, *Assessment of Suicide Risk in Attempted Suicides*, in SUICIDAL BEHAVIORS (H.L.P.) Resnik ed. 1968). Cf. Lessee, *Apparent Remissions in Depressed Suicidal Patients*, 144 J. NERVOUS AND MENTAL DISEASES 291 (1967).

The case law is equally ambiguous when invoked to determine what facts justify detention on grounds of danger of suicide. In *Jillson v. Caprio*, 181 F.2d 523 (D.C. Cir. 1950) the court reversed a directed verdict for defendant physician who had told police officers that he would not be responsible for what happened if the plaintiff (whom he described as "homicidal and suicidal") were not taken into immediate custody. Although the decision apparently rested on the failure to comply with a statutory requirement that the

portant problem, especially given the shortage of space in the facilities, is that of separating serious attempts to commit suicide which have a substantial likelihood of success from suicidal gestures which are intended only to cause someone else to respond in a desired way. The matter is complicated by the fact that the "intent" to perform only a "gesture" rather than to complete the action may not be conscious or the possibility that a gesture not intended to result in actual death may, for reasons not anticipated by the individual, be successful. In addition, it is established that an individual with suicidal intentions will frequently communicate these intentions to others before acting upon them, or at least will attempt to do so. But statements and actions which are subsequently identified as attempts to communicate suicidal intentions were often ambiguous at the time they were made even if the entire situation was understood, and if the individual's overall situation was not known the actions or statements would in many cases have been of no predictive value at all.⁷⁴ The literature also emphasizes the necessity for extensive knowledge of the individual's situation for other aspects of evaluating suicide potential. Some factors which have been established as relevant to suicidal potential, such as age and sex, are readily observable in the clinical context. Others, such as the nature of the fantasies the patient experiences and his impulsiveness and flexibility in adjusting to situations, require a more extensive clinical evaluation than is possible in the emergency room situation. Some cannot be evaluated without a detailed knowledge of the individual's social history; these include, for example, the patient's cultural and religious attitudes towards death, the availability of supporting resources in the community such as family members, friends, or coworkers and any recent decline in the patient's communication with others. It is not

certificates of two physicians be obtained before an insane person who was not in a public place could be taken into custody, the case was later distinguished by the same court on the ground that under the facts "there was no eminent danger." *Orvis v. Brickman*, 196 F.2d 762, 768 (D.C. Cir. 1952). In *Orvis* the court held that a police officer was justified in procuring the hospitalization of a woman who had cut an artery in her wrist, was bleeding profusely, and had refused medical help. Although she informed the officer that she had cut her wrist accidentally while removing a call from her foot, the officer could see no callus. *Id.* at 766-68.

74. Yessler, Gibbs & Becker, *On the Communication of Suicidal Ideas*, 3 ARCHIVES OF GENERAL PSYCHIATRY 612, 616 (1960) concluded that 30 per cent of successful suicides (and 25 per cent of those making unsuccessful attempts) had attempted to communicate their intention to others before acting. But included as an attempt to communicate were such statements as, "Some day I will have guts enough to kill myself" and, in the context of a conversation concerning the individual's approaching court martial, "I would rather be dead than restricted." *Id.* at 615.

difficult to see why the reliability of evaluations of suicide potential remains largely untested.⁷⁵ The matter is complicated further by the fact that, even if there is a significant danger of suicide, psychiatric hospitalization may be neither legally permissible nor medically desirable. Not all who attempt suicide are "mentally ill";⁷⁶ thus a potential suicide may not meet the basic criteria for psychiatric hospitalization. Moreover, while some individuals who have attempted suicide will welcome hospitalization, others will resist it,⁷⁷ and psychiatric hospitalization may, from the therapeutic point of view, aggravate those factors that gave rise to the suicidal desire.⁷⁸ In short, there is little scientific

75. For a recent study attempting to assess the effectiveness of such evaluations, see Cohen, Motto & Sieden, *An Instrument for Evaluating Suicide Potential: A Preliminary Study*, 122 AM. J. PSYCHIATRY 886 (1966). Using the traditional methods which attempt to classify those who have made attempts on the basis of the seriousness of their intentions, the study concluded that the resulting categories were of no predictive value whatsoever. The questionnaire developed by the authors, however, enabled them to divide those who had attempted suicide into three groups which were later established to contain suicidal and nonsuicidal individuals in the following ratios: 1 to 21, 1 to 2 and 1 to 1.

Piotrowski, *Psychological Test Prediction of Suicide*, in SUICIDAL BEHAVIOR 198 (H.L.P. Resnick ed. 1968) summarizes the success of the Rorschach inkblot and other psychological tests, and concludes that "There are no valid psychological test indicators capable of predicting with any degree of accuracy whether an individual will commit suicide in the foreseeable future." *Id.* at 198. Some studies have reported that at least eighty per cent of patients classified as "suicidal" (defined as "having suicidal trends") or as "nonsuicidal" were subsequently confirmed to have been correctly diagnosed. *Id.* at 199-200. But the defect in the research, Piotrowski argues, is that emphasis has been placed on discovering presently existing suicidal "intent" or "trends" rather than on predicting future specific behavior. Little attempt has been made to isolate signs which when present would reliably predict a suicide or an attempt. *Id.* at 202. Such signs would be invaluable for determining those for whom a serious risk of self-destructive behavior could be said to have been factually established, although the absence of the signs could not be said to affirmatively indicate the absence of any significant risk of self destruction. This characteristic of the research substantiates the difference in emphasis between legal and medical decisionmakers discussed in the text at note 137 *infra*; medical research has been concerned with establishing the potential need for treatment rather than with accurately predicting the probability that nontreatment will have specific adverse results.

76. C. LEONARD, UNDERSTANDING AND PREVENTING SUICIDE 273 (1967) concludes that about 35 per cent of suicides were "clearly mentally ill."

77. See C. LEONARD, *supra* note 76, at 23, 72, 135 (1967).

78. SUBCOMM. ON MENTAL HEALTH SERVICES, CALIFORNIA LEGISLATURE, ASSEMBLY INTERIM COMM. ON WAYS AND MEANS, THE DILEMMA OF MENTAL COMMITMENT IN CALIFORNIA 152-53 (1966) concluded that danger to self should not be a basis for nonvoluntary hospitalization:

There is good evidence that to assume responsibility for preserving the life of a suicidal person may be the worst possible therapy. Dr. Willard A. E. Larson . . . explains:

. . . orthodox suicidal precautions communicate to the patient that he is untrustworthy, indeed prone to overwhelming self destructive urges, and we give him our

support for the existence of a precise and reliable clinical ability to predict suicidal actions with any degree of accuracy, and the relationship among "mental illness," suicidal intention and the appropriateness of psychiatric hospitalization is far from settled.

But "dangerousness" to self, as the criteria was administered in the decision to admit, included more than the probability of self-inflicted violence. Danger of physical harm from sources other than the patient's own hand was also an important consideration in the decision to admit in some cases. For example, the patient's decreased ability to function normally in the community may have made him particularly susceptible to a danger that is regularly borne by many members of the community.

ILLUSTRATION 15.

The patient, a 44 year old woman, was brought to the Acute Facility by her husband who was 85 years old. He reported that she suffered from insomnia and sometimes locked herself in the bathroom. During the interview with the resident, the patient talked to the empty emergency room. Among the factors influencing the decision to admit her on an involuntary basis was the resident's observation that in her neighborhood "people were robbing and raping all the time" and that she would be particularly subject to such attacks.

c. Danger to Others. In some situations, the existence of serious mental disorder and danger to others was relatively simple and determinative; the patient in Illustration 3, for example, was admitted primarily because of her obvious loss of contact with reality and her assault upon the neighbor. But in other cases the information upon which a decision as to "dangerousness" had to be made depended on relatively vague reports from informants of untested reliability, and the inference of actual "dangerousness" was far from a necessary one given the truth of the factual assertions made by the informant.

ILLUSTRATION 16.

The patient, a 32 year old woman, was seen in the emergency on the 6th. She was given medication and the social service staff began to assist her in challenging the actions of the welfare office in terminating her AFDC payments. On the 23rd, the patient was returned to the facility by her sister. The sister reported that the

sanction to shed accountability for his own behavior in that we . . . are now ready to carry the full social burden of preventing his harming himself.

Cf. Harris & Myers, Hospital Management of the Suicidal Patient, in SUICIDAL BEHAVIOR, supra note 73, at 297 who argue the traditional position that treatment of a suicidal patient can be best provided in a psychiatric hospital.

patient had been depressed but had not taken her medication, had stated that she wished her children were dead and had given the children some unidentified medicine. The sister evidenced a great deal of concern over the safety of the children. The patient was admitted on a nonvoluntary basis; the admissions note stated that she could not be treated "safely" on an outpatient basis, principally because there was no adult member of the family to see that she took her medication and returned periodically to the clinic.

Moreover, a patient was sometimes admitted following violent conduct despite the absence of any "symptoms of mental abnormality" at the time of admission. The patient in Illustration 6, for example, was admitted despite the absence of any present symptoms of psychopathology because, according to the resident, "he should not be loose." The causal relationship between the demonstrated dangerousness and any mental illness was, of course, extremely tenuous in such cases.

In a few cases an important factor was not a fear on the part of the admitting resident that the patient would become violent, but the existence of such fear in others.

ILLUSTRATION 17.

The patient had been given a ride by a truck driver who found him hitchhiking along a highway. When the truck driver noticed that the patient had a gun, he took him to the police station. The police brought him to the Acute Facility where he refused to divulge anything other than the pronunciation of his name. He was admitted on a nonvoluntary basis.

One patient was admitted not because of a fear on the part of the admitting resident that the patient would actually engage in assaultive behavior, but rather because in the extremely unlikely event that the patient would cause harm to others, the facility would be placed in an awkward "public relations" position.

ILLUSTRATION 18.

A young man who had broken up with his girl friend became intoxicated and threatened to kill her. This threat was communicated to the police. The young man presented himself to the Acute Facility after release from jail on a peace disturbance charge. The resident indicated that he did not believe the patient had the "guts" to harm anyone but that he admitted him because the threats which the patient had made had been so widely dispersed.

"Dangerousness," then, cannot in any sense be regarded as a clinically observable symptom of a proposed patient. It is a complex evaluation of how the patient will react to what is anticipated will be his

future situation. In part, this turns upon conclusions drawn from clinically observable symptoms. But even this aspect of evaluating dangerousness is clouded with uncertainty; studies have shown that psychiatrists not only do not agree on the significance of given clinical observations, but that differences in interviewing techniques and skill result in widely different clinical observations.⁷⁹ Moreover, at least as important as clinical factors in evaluating dangerousness is the task of predicting whether the patient will encounter situations that might stimulate aggressive behavior.⁸⁰ In short, psychiatric predictions of "dangerousness" to others are at least as tenuous as predictions of serious self destructive tendencies. As one study of patients who had committed homicide concluded:

[I]n extremely few cases was there anything that would enable the psychiatrist to predict accurately the subsequent . . . offense . . . [T]he discipline of psychiatry has not yet developed valid criteria of sufficient degree of predictive reliability to justify hard and fast distinctions *before* the act between the . . . [mentally ill] individual who is likely to commit . . . violence, such as rape or homicide, and the one who will not translate his emotional conflicts into aggressive, destructive behavior.

. . . .

[M]entally ill people who have committed violent and serious offenses against society are not a group apart from other mentally ill persons who have not translated their emotional conflicts into overt assaults upon others. The psychotic patients who have committed homicide run the gamut of psychiatric disorders, and . . . are not clinically distinct from psychiatric patients in general. Some "mentally ill" patients who exhibit the most acutely dis-

79. Rosenzweig, Vandenberg, Moore & Dukay, *A Study of the Reliability of the Mental Status Examination*, 117 AM. J. PSYCHIATRY 1102 (1961). This study noted that there was "poor consistency" between examinations in regard to such matters as the patient's delusions, his use of the projection defense mechanism and even his orientation; these would normally be expected to remain fairly constant, which led to the conclusion that "different interviewers may tend to bring out different manifestations of psychopathology in the patient, . . ." *Id.* at 1108. In regard to the evaluation of observations the study noted that "some concepts in common clinical usage, which are usually taken for granted as being universally understood, are in fact unclear. This may be true for items . . . dealing with memory impairment, systematization of delusions, autistic *vs.* realistic concepts, symbolic thinking and autistic fantasy." *Id.* at 1107. See also Stoller & Geertsma, *The Consistency of Psychiatrists' Clinical Judgments*, 137 J NERVOUS AND MENTAL DISEASES 58 (1963).

80. Bychowski, *Dynamics and Predictability of Dangerous Psychotic Behavior*, in CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL (J. Rappeport ed. 1967) discusses the clinical aspects of such predictions. The inadequacy of a purely clinical approach is clear from the discussion.

turbed and destructive behavior have never demonstrated sufficiently directed and organized aggression to kill another, while others who are quite meek and inoffensive have on occasion killed suddenly.⁸¹

d. Degree of Illness. Another major consideration in the decision to admit was the degree of psychopathology which was diagnosed. In this context, psychopathology means the seriousness of the illness as determined by clinical symptoms such as hallucinations, disruption of thought process, loosening of association, etc. For example, a patient was frequently asked, "Name the last four presidents," "Start with the number one hundred and subtract seven, and then continue to subtract seven from each answer you get," or "Tell me why an apple is like a pear." Inability to recall matters regarded as common knowledge, to do simple mathematical calculations or to generalize (as by suggesting that an apple is like a pear because both are fruit) was regarded as symptomatic of impairment of mental facilities.

As Illustration 15 shows, serious psychopathology may have indicated danger to the patient or other situations which tended to encourage admission, but the degree of illness also operated as a pressure to admit, independent of its relationship to such other factors.

ILLUSTRATION 19.

A 26 year old woman had reportedly been "imagining things" since her marriage six months before presentation. She had accused her husband of spying on other men in public washrooms

81. Cruvant & Waldrop, *The Murderer in the Mental Institution*, 284 ANNALS 35, 36 (1952), reprinted in *STUDIES IN HOMICIDE* 167 (M. Wolfgang ed. 1967). See also M. Guttacher, *A Review of Cases Seen by a Court Psychiatrist* in *THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL* 17, 27 (J. Rappeport ed. 1967), who concludes, after a presentation of case studies of five patients who committed homicide, ". . . I am unable to decipher in these cases any symptoms which they presented in common that might act as warning signs of impending disaster. In large measure this is due to the fact that one cannot anticipate with accuracy social situations which the . . . patient will have to meet."

There appears to be growing recognition within psychiatry that dangerousness is too often being used as a basis for nonvoluntary hospitalization. See Mendell, *Brief Hospitalization Techniques*, 6 CURRENT PSYCHIATRIC THERAPIES 310, 314 (1966): "[The need to protect the patient from self destruction and from harming others] is too readily invoked. There are many and much better solutions to preventing a patient from committing suicide or inflicting harm on others than simply placing him in a hospital. The potential danger to others is frequently overestimated." Cf. Baxter, Chodorkoff & Underhill, *Psychiatric Emergencies: Dispositional Determinants and the Validity of the Decision to Admit*, 124 AM. J. PSYCHIATRY 1542 (1968), suggesting that admitting physicians tend to overestimate dangerousness and that this tendency was more pronounced in regard to patients of lower socioeconomic class and intellectual ability and those who had greater difficulty communicating with the physician.

and believed that he had holes in the wall of their home through which he spied on her. She was presented at the facility by her husband and police officers after she called police and reported that her husband, in an attempt to kill her, had filled the apartment with gas. When police arrived they observed no gas and found the husband asleep. When the patient returned to her home, she was taken to the Acute Facility. In explaining her non-voluntary admission, the resident emphasized her symptoms of psychosis.

e. Lack of Insight. The conclusion that a patient lacked "insight" is difficult to discuss in general terms, but such conclusions undoubtedly entered into the decision to admit. Insight, as used here, differs with the diagnosed psychopathology. If the patient was diagnosed as only neurotic or suffering from a personality disorder, insight was used by some medical personnel to refer to an understanding of the underlying psychic conflict that is viewed as causing the symptoms. But in other cases—especially when the patient was diagnosed as psychotic—insight was used to refer to an awareness that the symptoms were in fact symptoms of an illness. Thus a psychotic patient who exhibited disassociation of ideas or hallucinations but refused to acknowledge that he was "sick" was defined as lacking insight. Any substantial disagreement by the patient with the facility's diagnosis and plan of treatment was considered strong evidence of lack of insight. The ambiguity of this criterion is evident from the following illustration, which indicates that insight and judgment may for all practical purposes be defined in terms of the patient's willingness to accept moral, legal, or social norms.

ILLUSTRATION 20.

A medical report submitted to the probate court contained the following assertion offered to support the conclusion that the patient's judgment and insight were "poor": "He still sees no harm in the fact that he lived with a sixteen year old girl as husband and wife. . . [H]is reasoning at the present time is that his wife was not satisfactory at that time so why not have the girl . . ."

f. Control for Treatment Purposes. It is doubtful whether hospitalization was ever effected for "pure" treatment purposes in the sense that the "therapy" indicated required full time hospitalization.⁸²

⁸² Hospitalization on a short term basis may be used to remove an individual from a stressful situation that is believed to have "caused" his acute episode. Mendel, *Brief Hospitalization Techniques*, 6 CURRENT PSYCHIATRIC THERAPIES 310, 315 (1966). And, in theory, full time hospitalization can be "therapeutic" in the sense that forced contact

Neither medication nor electroshock can be administered only during hospitalization. But there were frequently factors of a quasi-therapeutic nature that influenced the decision to admit. The resident's judgment as to whether the patient would faithfully take medication prescribed on an outpatient basis and return periodically to the outpatient clinic was an important determinative; the patient in Illustration 16 was admitted in part because of the anticipation that she would not take medication on an outpatient basis. Moreover, there is a significant period of time before medication actually alleviates symptoms;⁸³ during this period, hospitalization was sometimes used simply to control the patient while the medication took effect. Electroshock treatments are considered to have a somewhat longer lasting effect than a period of intensive drug therapy, but they must be administered over a significant period of time. The choice of a therapeutic program, especially the choice between drug therapy and electroshock treatments, was sometimes a difficult one dependent upon a variety of nonmedical factors, and the choice may have had a significant effect upon the extent to which the patient's liberty was restricted.

ILLUSTRATION 21.

The patient was presented to the Acute Facility after he had caused an auto accident while responding to hallucinations. He was diagnosed as a schizophrenic, paranoid type. The staff concluded on the basis of their experience with him after earlier hospitalizations that he would not continue to take medication after his release. The alternative course of treatment was seen as retaining him for about a week while a series of electroshock treatments were administered. But the staff also concluded that if his employer discovered that this was the reason for his absence from his job, he would be discharged. The tentative decision was

with people in an institutional setting can encourage a withdrawn patient to "reach out" and reestablish interpersonal contacts. Thus it may be theoretically beneficial for schizophrenics who frequently withdraw severely. A. CHAPMAN, *TEXTBOOK OF CLINICAL PSYCHIATRY* 237-38 (1967). Insofar as such institutionalization constitutes therapy, the treatment is in fact administered primarily by aids and others with extended daily contact with the patients. Programs relying heavily on such personnel (rather than trained therapists) have offered encouraging results. See N. COLARELLI & S. SIEGAL, *WARD H.* (1966). But in the acute system, the process is too rushed for this to be an important part of the program, although specific attempts are made to keep patients active and to encourage personal interaction.

83. The time required for "drug therapy" to become effective varies. For example, when phenothiazine is used to treat a schizophrenic, improvement may occur within a few days but "it usually requires from ten days to a few weeks for decisive improvement to be evident." A. CHAPMAN, *TEXTBOOK OF CLINICAL PSYCHIATRY* 239 (1967). The variations in time are about the same when the drug is an antidepressant. *Id.* at 405-08.

to retain him in the facility but to give him a daily gate pass to go to his job; medication would be administered during this time and its effectiveness would be later evaluated.

In a few cases, hospitalization was used for therapeutic purposes not directly related to the psychiatric illness of the patient.

ILLUSTRATION 22.

An 18 year old youth was admitted after being in an auto accident while under the influence of a drug. He denied taking amphetamines in addition to the drug which he had taken prior to the accident, but the staff psychiatrist indicated that he would be retained, involuntarily if necessary, for a week, because it was believed that he was in fact taking amphetamines and the psychiatrist expected withdrawal symptoms to develop.

g. Observation for Diagnostic Purposes. The limited period of time available during the emergency room procedure was sometimes considered to provide inadequate opportunity for diagnosis, and an accurate diagnosis was seen as important for purposes of prescribing a treatment program. Thus the need to observe the patient in a less pressured situation and over a longer period of time influenced the decision to admit.

ILLUSTRATION 23.

The patient, a 32 year old woman, was presented by her husband because he had returned after a week away to find that she had wandered to the home of an occasional acquaintance six miles away. The husband also reported that the patient had not been eating or sleeping properly and had gone to taverns alone the past three weekends. The patient reportedly told her husband that she had relations with another man and informed the resident that she was under the spell of a "wise old man." The resident indicated that a major factor in his decision to admit her as an involuntary patient was the fact that this was her first psychotic episode and that he desired an opportunity to diagnose her psychopathology.

h. Community Disruption. The decision to admit was sometimes strongly influenced by the fact that the patient's symptomatic behavior offended or irritated a portion of the community.

ILLUSTRATION 24.

The patient, a 61 year old woman, lived alone. She had a history of persecutory delusions extending back over fifteen years. On a number of previous occasions, she had screamed at the neighbors; they finally responded by calling the police. On the

occasion preceding her presentation, the neighbors specifically demanded that the police secure the patient's hospitalization. When examined at the Acute Facility, the patient indicated that she believed spirits came to her home and attempted to have "spiritual sex" with her. The resident, who admitted her on a nonvoluntary basis, indicated that a major factor in his decision was that he was not certain "how much the neighbors could take."

Patients were sometimes admitted because they disrupted the emergency room of the Acute Facility by repeated appearances there. As a rule of thumb, the Acute Facility admitted patients who appeared at the emergency room three times within a period of two weeks. Sometimes, however, the sequence of events was more complex.

ILLUSTRATION 25.

The patient, a 33 year old man, had a history of amphetamine abuse and for two years had exhibited paranoid ideas. He had reportedly made certain threats, but his family did not believe he was capable of carrying them out. He had been seen several times in the emergency room and an administrative official of the Acute Facility suggested that the next time he was seen in the emergency room he be admitted. Subsequently, the patient's car was stopped by police and he was discovered to be driving without a license. The officers found an out-patient clinic card in the patient's wallet, and they then called the Acute Facility. They were instructed to bring him to the emergency room; upon arrival, he represented himself as an Internal Revenue Agent and showed significant thought disorder. He was admitted.

i. Family Disruption or Rejection. When there was available a family which was considered able and willing to care for the patient despite his symptomatic behavior, he would frequently be released despite the existence of symptoms that would otherwise result in hospitalization. The opposite was also true, however; a patient was hospitalized when he exhibited relatively minor symptoms but there was no family able or willing to assume responsibility for him. Ambiguity of available information concerning the family situation was itself influential in the decision to admit.

ILLUSTRATION 26.

The patient, a 53 year old woman, was brought to the Acute Facility as a referral from another facility. She exhibited significant thought disassociation, a classical symptom of schizophrenia. The admitting resident indicated she had no insight at all, citing her statement, "If you take a drive in the city, you'll find lots of

people crazier than I am." Curiously, the patient had functioned in her employment up to the time of admission. Little information was available as to the patient's home situation. The patient maintained that she had to return home to take care of her daughters, but the admitting resident believed that three of her daughters were married and the fourth was engaged. She was admitted despite her objections. The resident indicated that he felt she might well have been able to remain in the community if some supporting person had been available, but he had concluded that no one was available.

Supporting resources, such as this patient lacked, may have been available in the community; but the patient may nevertheless have been admitted because these resources were disrupted or disturbed—in some cases by the patient's symptomatic behavior, although in others the relationship between the patient's illness and the disruption of the family was much less direct.

ILLUSTRATION 27.

The patient was a 38 year old woman who had been having severe marital difficulties. After receiving unexpected doctor bills, she took an overdose of sleeping medication and immediately informed her husband of what she had done. When, at the emergency room of a general hospital, she became abusive, she was taken to the Acute Facility. The resident, after determining that the dosage taken was not enough to be dangerous, was about to release her to "sleep it off." He indicated that he hospitalized her because the family was disrupted by the patient's insistence that she was unhappy with her marriage and desired to terminate it, and had been particularly shaken by the events of the evening. One son, the resident related, had been reported at home hiding in the bathroom from fright.

In these cases hospitalization of the patient was essentially a means of "treating" the family. The objective sought was not so much improvement of the patient's psychopathology as giving the family an opportunity to resolve as far as possible the temporary crisis that preceded the patient's presentation and to regroup itself in preparation for taking the patient back.

2. *The Decision to Retain*

Although the initial decision to admit was made by a resident in the emergency room, each patient's case was reviewed by an experienced staff psychiatrist within several days of admission. This process—the "staffing"—involved a discussion of the patient by the staff

psychiatrist, the ward social worker, a clinical psychologist, and frequently the admitting resident. The patient was usually interviewed during the staffing, which lasted up to two hours per patient. In no observed case⁸⁴ did the staffing result in a determination that the patient had been erroneously admitted. In fact, in no observed case was any consideration given to the facility's legal right to admit or retain the patient; sole emphasis was placed on determining the appropriate program of treatment (which, of course, influenced the duration of full-time hospitalization).

ILLUSTRATION 27 (continued).

The patient whose admission was discussed in Illustration 27 was staffed the morning following her admission. During the staffing she was belligerent but revealed no thought disorganization or loss of contact with reality. She maintained that she was unhappy with her husband and wanted to leave him but that he would not "let her go." She avoided responding to questions directed at determining why she did not simply leave. The staff concluded that her actions in taking the pills had not been a serious attempt to end her life; the fact that she called her husband's attention to her actions immediately after taking the pills suggested that she was using this as a weapon against him. No significant depression was observed, and it was agreed that the action was impulsive rather than symptomatic of serious depression. She was diagnosed as having "personality disorder" and it was decided to retain her for about eight days and then reevaluate her situation. During this time, she was to be given no medication but would be seen by the staff psychologist and an attempt to smooth out her marital discord would be made. It was also agreed that the possibility of a divorce would be raised.

3. *Analysis*

It is difficult to generalize concerning the decisions to admit and retain because psychiatric hospitalization serves a number of different functions and the criteria applied at admission differ with the function to be performed. As a result, the relationship between admission practice and the legal framework presents an especially difficult problem.

All initial nonvoluntary admissions were made pursuant to the emergency certification authority which required that the admitting physician certify that the proposed patient was dangerous to himself or others. The ambiguity of "dangerousness" is no less apparent here

84. No attempt was made to observe staffings of all patients whose admissions were examined. This comment is based on a relatively small number of randomly selected staffings.

than it is in the presentation situation. But in some ways the issue becomes more sharply focused here; nonvoluntary admission is inevitably an easily isolated legal step, whereas nonvoluntary presentation is frequently so informally accomplished that it is difficult to isolate the point at which the criteria should be applied.

Perhaps the most troublesome aspect of the admission decision is the use of emergency psychiatric hospitalization for purposes of resolving temporary family crises. As this study indicated, a family frequently tolerates a "mentally ill" member until a crisis develops; this crisis is often caused by fortuitous factors which may or may not be related to the "mentally ill" person or his affliction. At this point the family demands immediate removal of the patient to the psychiatric facility. In many cases there is no indication that failure on the part of the facility to accept the patient would create a physical danger to any member of the family. In a number of cases, however, it can be argued that failure to remove the patient would result in severe discomfort for the other family members and might affect their ability to cope with the other problems presented by their situation. Illustration 27 is an excellent example. Insofar as postponing hospitalization would result in decreasing the ability of the system to perform the function sought to be performed, it is clear in the family crisis situation that if action is appropriate, there is a need for immediate action. But it is not clear whether nonvoluntary hospitalization is justified at all. There is, of course, a substantial question whether the "danger" against which the legal framework offers protection extends as far as disruption of the family unit. In addition, is it proper when a family is disrupted by the total impact of a number of factors, many of longstanding duration, to single out the apparent psychopathology of one member and designate this as "the cause" of the threat to the family and then to use this as justification for confining that member to a psychiatric facility?⁸⁵

85. Knight, *Social and Medical Aspects of the Psychiatric Emergency*, in *CRIME, LAW AND CORRECTIONS* 497-98 (R. Slovenko ed. 1966) suggests:

Properly speaking a family crisis situation should be considered psychiatric only when an individual's illness is the major evocative influence. Other situations of family or social crisis are not essentially eligible for, or liable to, the peculiar and unique prerogatives of medical intervention. Therefore the special immunities and extreme measures allowable in handling medical emergencies will not be necessary in matters of routine treatment or preventative health measures. The critical pressures and stresses that threaten a geographically or economically dislocated family may require precautionary mental health measures but not medical advice.

This criteria—whether the proposed patient's psychiatric illness is "the major evocative influence" in the family crisis—is far from easy of application. Consider, for example, the

While the problem occurs most frequently in the family context, as Illustration 24 shows, community disruption also may serve as a basis for admission. It is likely that community and family demand hospitalization for reasons more far-reaching than those contemplated by the legal framework. If so, it is clear that the hospitalization system is under a strong pressure to meet these demands. This study suggests that one such system does in fact respond by admitting on a nonvoluntary basis even those patients who do not meet the relatively narrow legal criteria.

There are other problems. For example, the legal framework contains little guidance as to the scope of the facility's duty to assess the reliability of the information it receives and on which it bases the decision to admit. There is a hint in the case law that, although the community members are subject to the same criteria for nonvoluntary presentation as the facility must apply for admission purposes, the community members have more leeway in determining whether that criteria have been met.⁸⁶ But the decisions do not carry this distinction through. The *Whaley* cases,⁸⁷ for example, contain no indication that what might have been an adequate factual basis for the police to take Whaley to a psychiatric facility might not have been sufficient to justify his retention by that facility. Nor did the New York court consider the possibility that facts indicating a "paranoid condition" might justify a wife in presenting her husband to a psychiatric facility, but would not, without more, justify the facility in retaining him.⁸⁸ In

woman in Illustration 27. Assuming that she was "mentally ill" and that this was causally related to her actions in taking the medication, the immediate cause of the family crisis existing at the time of her presentation, can it be said in light of her longstanding dissatisfaction with her marriage that her mental illness was "the major evocative influence" in the crisis?

86. See *Babb v. Carson*, 116 Kan. 690, 693, 229 P. 76, 77-78 (1924):

An insane person is liable to become dangerous at any moment. Must a sheriff who sees an insane person, before taking him into custody, wait until that person shows dangerous tendencies by attacking another? . . . The law has a higher regard for the protection of the insane person and of all others. Such a person may be taken into custody until it is known that he is not dangerous

87. See text accompanying note 65 *supra*.

88. See text accompanying notes 67 and 68 *supra*. But cf. *Brecka v. State*, 179 N.Y.S.2d 469 (Ct. Cl. 1958). Brecka had been admitted to a psychiatric facility pursuant to an emergency procedure authorizing admission upon the certification of a local health officer. The health officer, in response to the question on the form asking what characterized the attack, wrote, "arson—excitement—is tractive." There was a factual showing that Brecka had been taken into custody while she had been burning old lumber on her own property. In dismissing the action, the court held that because the certificate was valid on its face the state incurred no liability by reason of the action of the facility. This suggests that the facility itself had no duty to investigate the reliability of the factual assertions underlying

any case, the time pressures of the admission decision in the emergency room of a metropolitan acute facility are so intense that no real assessment of offered information could be made. This does not mean, however, that at the first opportunity the facility need not consider whether the legal criteria for nonvoluntary hospitalization have been met by reliable information.

In practice, then, it appeared that the legal criteria had almost no effect in limiting those who were admitted on a nonvoluntary basis. Although a patient who was considered a threat to himself or others may have been admitted for that reason, no attempt was made to limit nonvoluntary admissions to such situations. As Illustrations 19 and 24 show, patients who cannot be considered to meet the "dangerousness" criteria (under any reasonable definition of the meaning of that criteria) were nevertheless admitted. As Illustrations 23 and 27 demonstrate, even where an argument that the patient is within the criteria could have been made, it was frequently true that the reason for admission was not that the patient may have met the criteria.

D. *The Decision to Commit*

For a relatively small number of individuals, public psychiatric hospitalization also involved a decision by the probate court as to the justification for hospitalization. Procedurally, there are three ways in which an individual may come before the probate court: (1) having entered a hospital as a voluntary patient, he may give notice of intent to leave and the facility may then apply for his commitment as a nonvoluntary patient; (2) he may, after having been served with the notice required by the Missouri version of the standard nonjudicial procedure, request a judicial hearing; or, (3) direct application may simply have been made to the probate court for his commitment.

Table 4 shows the frequency with which the various procedural routes have been used since 1954.⁸⁹ The standard nonjudicial proce-

a certification. But where, as in certifications by resident physicians of the facility itself, the certifying physician is an agent of the facility, it seems impossible to separate his duty and that of the facility.

89. Because of the method of filing in the probate court, these tables do not accurately indicate the exact number of hearings held in each year. If an application is filed in regard to a patient who had been before the court in an earlier case, the newly filed case is placed with the earlier proceeding file. For this study only those files under the years indicated were examined; those files for nonexamined years, then, contained some cases that were in fact heard during the years studied. Of the 185 cases examined for 1967, for example, nine were found in files under the years 1955, 1957, 1959, 1961, 1963 and 1965. There is no reason to believe that the cases not considered were other than randomly distributed throughout the categories.

TABLE 4
JUDICIAL HEARINGS BY YEAR AND TYPE OF PROCEDURE

Year	Total Hearings	Direct Applications		Patient Request —Standard Nonjudicial Procedure		Application to Retain Voluntary Patient	
		No.	%	No.	%	No.	%
1955	71	70	99	1	1	0	0
1957	180	173	96	2	1	5	3
1959	328	315	95	5	2	8	3
1961	382	371	97	3	1	8	2
1963	410	397	97	2	1	10	2
1965	232	225	97	4	2	2	1
1967	185	168	91	1	.5	16	8.5

dures, it appears, has been a relatively minor part of the process.⁹⁰ The most common procedural route to the court has been the direct application. But this designation is misleading insofar as it implies that it is a judicial proceeding brought to hospitalize an individual who is at the time in the community. Table 5 breaks down direct applications for the years studied by location of the respondents at the time notice of the proceeding was served. Never more than 2.7 per cent of the proceedings were begun before the patient had been hospitalized;⁹¹ the overwhelming majority had already been hospitalized in the Acute Facility.

The primary function of the probate court, then, has been to au-

90. Extensive records were not available, but figures obtained from the Welfare Department indicated that in 1967 notices were served pursuant to the standard nonjudicial procedure in 104 cases. The location of the respondents at the time they were served was as follows:

public acute facility	73
private hospitals	24
State Hospital	6
at patient's home	1
Total	104

Apparently the general policy of the Acute Facility is to use the standard nonjudicial procedure only for those patients initially admitted on a voluntary basis but for whom longer term care is desired with a right to retain if necessary. Careful screening results in the use of this procedure only for those patients who are almost certain not to request a judicial hearing.

It is significant that, as the above figures show, even in the use of this procedure legal steps towards securing nonvoluntary hospitalization are almost never taken until hospitalization has already been effected. This strongly suggests that the basic dynamics of the process do not differ with the procedural route chosen to effectuate the decisions.

91. Most of those cases where legal action was taken before the individual was hospitalized involved either children living at home or elderly relatives.

TABLE 5
PATIENT STATUS PRIOR TO HEARING AND HEARING DISPOSITION, BY YEAR (DIRECT APPLICATIONS ONLY)

Year	Total Hearings	Patient Status (% of total)						Disposition (% of total)						
		Hospitalized			Home Other			Patient discharged	Dismissed by Petitioner	Other reasons	Dismissed by court on merits	Committed		
		Acute Fac.	Other Public Fac.	Private Fac.	Home	Other	Public Fac.					Veteran Fac.	Private Fac.	
1955	70	94	1.5	1.5	0.0	3.0	56.0	4.0	4.0	0.0	40.0	0.0	0.0	0.0
1957	173	94	0.0	3.0	2.0	1.0	35.8	4.6	4.6	0.0	59.6	0.6	1.2	1.2
1959	315	91.4	7.0	1.6	0.0	0.0	15.2	1.0	1.0	0.0	83.8	1.3	0.0	0.0
1961	371	96.8	1.6	0.8	0.8	0.0	11.9	1.9	1.9	0.0	86.3	1.9	0.8	0.8
1963	397	95.2	3.3	1.0	0.5	0.0	17.7	2.0	2.0	0.0	80.3	2.0	0.5	0.5
1965	225	89.4	5.3	1.8	2.7	0.9	26.6	3.1	3.1	0.0	70.3	3.1	0.5	0.5
1967	168	89.0	6.5	2.0	2.0	0.5	22.0	7.1	7.1	1.2	69.7	66.6	1.2	1.2

thorize continued retention of patients hospitalized pursuant to the emergency detention power. This function, moreover, has not been performed until after a significant period of hospitalization has already elapsed. Usually the hearing was held about three weeks after the patient's admission to the Acute Facility, although continuances (sometimes at the request of the Acute Facility itself, but more often on the motion of the court when witnesses failed to appear for a scheduled hearing) frequently lengthened this period.

Because of this time lapse between admission and hearing, the opportunity for a judicial hearing was as a practical matter extended to only about one-half of all patients admitted on a nonvoluntary basis. In 1967, there were approximately 500 patients admitted on a nonvoluntary basis. (This excludes those committed for pretrial study by criminal courts.) Yet, as Table 5 shows, hearings on applications submitted by the Acute Facility for commitment of patients already detained in the hospital amounted to less than half this number.

Table 5 also indicates that the number of cases in which applications for commitment have been filed has decreased from a peak of 397 in 1963 to 168 in 1967. This probably represents an increased emphasis on initial voluntary admissions as well as a more rapid turnover of patients stimulated by space pressures as well as a desire to minimize duration of hospitalization for therapeutic purposes.

In extremely few cases did the court dismiss applications on their merits. Only two of the 1,700 cases examined resulted in the patient's release. This suggests that further examination of the court proceedings may be fruitless. If applications for indeterminate commitment submitted by the Acute Facility were granted simply as a matter of course, the judicial hearing process was essentially nonfunctional. But observation of a number of hearings revealed that their form was much less perfunctory than the hearing observed in some other studies⁹² and less than would be expected if the hearing was regarded by all concerned as merely a matter of form. This contrast between the form

92. Scheff, *Social Conditions for Rationality: How Urban and Rural Courts Deal with the Mentally Ill*, 7 BEHAVIORAL SCIENTIST 21 (1964), in MENTAL ILLNESS AND SOCIAL PROCESSES (T. Scheff ed. 1967), studied four urban courts in an unidentified state. Even in the one court in which Scheff felt some attempt was made during the hearing to ascertain the circumstances of the patient, he concluded that the court did not use the information gathered to make a meaningful decision as to disposition. This was based largely on his observation that in all 43 cases observed in this court (including some where there seemed to be a significant question whether the legal criteria was met) the court ordered hospitalization. Cf. Miller & Schwartz, *County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital*, 14 Soc. PROB. 26 (1966).

of the hearing and its apparently minimal role in the overall process justifies a more detailed examination of the judicial hearing step, if only for the purpose of explaining this apparent discrepancy.

The following discussion is based on first hand observation of seventeen hearings. The basic observations are summarized in Table 6. The first column breaks the hearings down according to the source and nature of the principal demand for hospitalization. A case was characterized as "Family Demand Based on Desire for Treatment" if it appeared that the family desired the patient's hospitalization, had acted on that desire and the desire was based primarily upon a sincere concern for the patient's welfare. A case was characterized as "Family Demand Based on Rejection of Patient" if it appeared that the family had actively sought hospitalization of the patient primarily as a means of relieving itself of a disruptive influence. "Acute Facility Demand for Hospitalization" was used where no family had been actively involved in the hospitalization process, and consequently the primary demand for continued hospitalization came from the Acute Facility.

This breakdown suggests that families played a smaller role (quantitatively speaking) in obtaining long term hospitalization than they did in obtaining short term institutionalization. The family was influential in the presentation of about 75 per cent of the nonvoluntary admissions studied. Table 6, however, suggests that they were influential in only about 50 per cent of commitments. This can be explained in part at least by the successful performance of the "crisis solving" function by the Acute Facility; during a short period of hospitalization, the crisis situation that caused the family to seek the hospitalization of one of its members can often be resolved, thereby dissipating the demand for continued hospitalization. It is not surprising, therefore, that those patients for whom longer periods of hospitalization were sought were more frequently patients without a family group who could reabsorb them and for whom the demand for removal from the community came from "official" community agencies, initially the police in many cases and subsequently the Acute Facility.

Only about one-third of the patients actively appeared and protested their continued hospitalization. In most of these "resisters" cases the demand for hospitalization was made by the Acute Facility. This indicates that where a patient was a member of a family group and the family actively sought his hospitalization (either from concern for his welfare or for their own convenience), the patient frequently did not actively resist continued hospitalization, although he may have refused initially to admit himself on a voluntary basis.

TABLE 6
SEVENTEEN OBSERVED COMMITMENT HEARINGS

	Symptoms Present			Diagnosis*				Patient Attitude		Disposition			
	danger of suicide	tender-ness	wandering tendencies	psychosis	neurosis	personality disorder	chronic brain syndrome	alcoholism	resistive		not present		
Primary Demand for Continued Hospitalization	Total Cases	1	2	0	2	0	0	1	0	1	2	3	0
By Family—		0	3	3	1	0	1	2	0	1	2	3	0
based on desire for treatment		0	2	0	5	0	1	1	2	2	5	7	1
based on rejection of patient		1	7	3	8	0	2	4	1	4	7	6	1
By Acute Facility													
Total		17	17	17	17	17	17	17	17	17	17	16	1

* In two cases no diagnosis was offered.

Almost half of the patients were diagnosed as psychotic; all were either schizophrenic or manic depressive affective reaction. The psychotics tended to be patients where the demand for hospitalization was made by the Acute Facility. Where a family group was actively involved, this suggests, the demand for hospitalization was likely to arise from factors other than the degree of psychopathology; where, however, the decision was left largely to medical personnel, degree of psychopathology apparently played a more important role.

As both the court files and the firsthand observations indicated, dismissals were extremely rare. No meaningful statistical comparison can be made, therefore, between those cases resulting in commitment and those resulting in dismissals. But it is feasible to discuss in some detail the mechanics of the hearing procedure and the basic dispositional alternatives for the purposes of analyzing existing practice and investigating the potential for more active judicial involvement.

1. *The Hearing Mechanics*

The hearings were held in the probate court's regular courtroom on Monday and Thursday. Court was not convened until 10:00 a.m., but the patients usually arrived (accompanied by hospital attendants) about 9:30 a.m. Patients were not required to attend; they were notified by formal service at the hospital and on the morning of the hearing they were asked whether they desired to attend. Although in six out of the seventeen observed cases the patient did not attend, in only one case was any inquiry made into the reason for the patient's non-attendance.⁹³

Also present prior to the opening of court was a local practicing attorney who by agreement with the court was assigned as counsel for all patients who did not have a privately retained attorney. He received ten dollars per case which was added to court costs. In only one observed case was a privately retained attorney present.⁹⁴ The repre-

93. In this case the inquiry was stimulated by the judge's recollection that when the patient had appeared in court a week earlier (at which time his hearing had been continued because a witness had failed to appear) he had indicated a desire to protest hospitalization. The inquiry revealed that the patient had not appeared because the Acute Facility, unaware of the continuance, had assumed that the patient had been committed and had not offered him the opportunity to leave the facility and appear in court.

94. This case provided no basis for confidence that involvement of privately retained counsel would make the judicial process more meaningful. The patient involved is described in Illustration 30, *infra*; whether she met the legal criteria is an extremely close question. At the first hearing date, counsel appeared but the case was continued because the patient's father did not appear. At the second hearing date (at which the father was

sentative of the city attorney's office, who presented the "case" for hospitalization, arrived about the same time. He brought with him the medical report, which was given to defense counsel for examination. The report was in the form of a deposition typed in a mimeographed form. On the front was a blank for the attorney for the patient to sign a waiver of personal appearance by the physician; in all cases it was routinely signed.

Between 9:30 and 10:00 the appointed attorney interviewed the patients. He generally asked them about events leading to their hospitalization and whether they desired to testify. When asked—and sometimes when no inquiry was made—he advised them that the court was unlikely to release them and that little good would probably be done by their testimony. There were usually two to five hearings per session; the attorney-patient interviews took about five minutes each. Sometimes the attorney would speak with family or friends who were present in the courtroom; the city attorney's representative almost always did.

At ten o'clock court was formally opened and the judge entered. He sat at the bench but did not wear a robe. As each case was called, the city attorney's representative called his witness.⁹⁵ When, as sometimes happened, a witness failed to respond to the subpoena the case was continued and the city attorney's representative directed to secure the witness's presence. During the continuance, of course, the patients remained hospitalized.

The witness, after being formally sworn by the judge, was initially questioned by the city attorney's representative. Questions were usually asked about the patient's life, his residence, events leading to his hospitalization and factual matters alluded to in the medical report (such as violent conduct by the patient). Frequently the witness was asked if he believed the patient needed further treatment or if he was willing for the patient to remain in the hospital. Counsel for the patient had an opportunity to cross-examine but this was seldom done. The court itself also usually questioned the witness; in many cases,

present), counsel did not appear and the case was again continued. At the third date, both counsel and the patient's father appeared. Counsel was shown the medical report (which he had not seen before) and spent about five minutes reading it. During the testimony he asked a few questions of no significance. This was the extent of his participation.

95. The court usually required one witness in each case. If the patient had a local family or close friend, a member of the family or the friend was usually called. If the patient was a transient, a member of the facility staff (usually a social worker) was called. A shorthand transcript of the proceeding was always taken.

most of the detailed information was elicited by the court rather than by counsel. The same procedure was used by defense counsel in calling the patient. In none of the observed cases was any witness other than the patient himself called on the patient's behalf, nor was any other evidence submitted in support of the patient's case. The hearings lasted from ten to forty minutes.

At the end of the hearings, the judge took one of three steps: he indicated to the patient that he would order him discharged; he indicated that he would enter an order committing the patient; or, he took the case under submission, indicating that he would seek further information from the hospital. Each of these deserves special examination.

2. Results of Hearings

a. Commitment. Sixteen of the seventeen observed cases resulted in indeterminate commitment of the patient. According to the statutory criteria, such a disposition required factual showings of mental illness and that by reason of this illness the patient was dangerous to himself or others or lacked the insight or capacity to make responsible decisions with respect to his hospitalization. In the cases observed, however, these did not appear to be the governing factors.

Relatively little attention was directed towards dangerousness. As Table 6 shows, in only one case was there any indication of potential for self-inflicted violence; in this case, the patient's mother had found him almost entirely out of an eleventh story window. Six cases contained some indication that there was a danger of assaultive conduct; in all six, this was based upon the past acts or threats of the patient. There was, however, little detailed investigation of the factual allegations. In one case, for example, the medical report contained the mere assertion that the patient had "threatened hospital personnel"; the patient did not appear at the hearing and no investigation as to the truth of the assertion or its seriousness was made. In another case, the minimal factual investigation revealed a significant dispute as to the factual basis for the allegation of dangerousness.

ILLUSTRATION 28.

The medical report asserted that the patient had "jumped on his sister's son with intention to do great bodily harm." The patient's mother (who agreed that her son was sick and needed hospitalization) denied that the patient had ever assaulted or even threatened her grandchild. (The medical report also stated, "He

remains withdrawn, suspicious, guarded, antisocial, hostile, defiant and it seems he is dangerous to himself or others.”)

It is doubtful whether past acts of an assaultive nature or threats of such actions were controlling in the decision to commit even in those cases in which they existed. In some, the assaultive actions seemed to be more disruptive of family harmony than such as to create a danger of serious physical injury.

ILLUSTRATION 29.

The patient, who lived with her sister's family, reportedly threatened the members of the family. On the morning of her presentation to the Acute Facility, she threw a cup of hot coffee on her sister; this stimulated her presentation.

The relatively minor impact of assaultive tendencies which have not had serious results can be easily seen in the following illustration. Although both acts of violence and threats had occurred, they played only a minimal role in the patient's presentation, admission, and commitment.

ILLUSTRATION 30.

The patient was a young woman who had voluntarily entered the Acute Facility but subsequently demanded her release. The medical report stated:

The patient came to the emergency room . . . and was diagnosed as Anxiety Reaction. The patient went to New York . . . and lived there for three years. Her father went after her because he stated the patient had a nervous breakdown. No other factors are known. The patient was [previously] in . . . [a local private hospital] and received shock treatments. After her discharge she refused to go to the clinic and returned to New York. She called her father for money to pay her hotel bills while in New York. . . . [S]he came back to St. Louis but did not work. She made trips to Chicago and Detroit and kept calling her father for money. She lived in [an apartment hotel] . . . and when asked to pay the rent would cry. The patient had threatened to kill her sister and her brother-in-law. She had been moody, having nightmares, will sit and stare, will not talk and says she hates everybody.

The patient . . . refused to answer any questions and showed poor insight into her problems. Her affect was shallow but there was no evidence of hallucinations and no evidence of delusions could be brought out The patient remains hostile, unfriendly and uncooperative.

At the hearing the patient's father testified. He indicated obvious

concern over the inconvenience and expense of getting the patient back to St. Louis after her trips. He also testified that he "had been told" that the patient had threatened to take her brother-in-law's gun and shoot his family (with whom she lived at the time) and to burn their house down. He also stated that she had once violently resisted the family's attempts to force her into a car to go to a psychiatric outpatient clinic. The patient's employment history was irregular; the father testified that he had been told that there were few hospitals in New York City where the patient had not worked.

The patient herself testified that she felt that she did not need further full time hospitalization and that she could—and would—take outpatient treatment. She emphatically indicated that she did not want additional electroshock treatments. When asked about her plans regarding what she would do if released, she was vague. She was not asked about the alleged threats to her brother-in-law's family, nor was any inquiry into her employment history made. The court ordered her committed.

In three of the six cases, the patient had at least once left the family and subsequently requested help when difficulties arose; the patient in Illustration 30 was one example. All three were cases where the family had rejected the patient; the "wandering" tendency was undoubtedly a factor in the rejection. This graphically illustrates the extent to which the "need" for hospitalization depended on factors external to the patient: the tendency to wander can be realistically said to create a danger only if the family is or becomes unwilling to lend assistance.

In five of the sixteen cases in which commitment was ordered, there was no specific indication of "dangerousness" within any reasonable definition of that criteria. Some contained evidence of serious psychopathology which might have so distorted the patients' mental processes as to bring them within the category of those lacking sufficient insight or capacity to make responsible decisions with regard to hospitalization.

ILLUSTRATION 31.

The patient, diagnosed as manic depressive (depressed type) had exhibited auditory hallucinations and was treated on an outpatient basis. The medical report indicated that on her last appointment it was decided to hospitalize her "in an effort to speed her recovery"; no details or explanation were given. The "voices" spoke against hospitalization and the patient refused to admit herself. She was admitted on a nonvoluntary basis. At the staffing, three days after admission, it was concluded that she had lost her insight. (She at that time believed she was another Christ risen

from the dead.) But at the time of the application for commitment, the report indicated, she had "begun to develop insight again." The patient's sister testified that she did not believe the patient needed hospitalization. The patient herself (who was classified as a "resister") testified that she went to the clinic because she was sick and wanted to get well but she felt she received no real treatment in the hospital. She indicated that she considered herself ready to go home and, if this were permitted, would take medication on an outpatient basis.

There was, therefore, at the time of the hearing no indication that the patient did not acknowledge that she was "sick" and that she would faithfully make use of outpatient facilities. (This, of course, was strong evidence of "insight.") On the other hand, it seemed clear that she had made a rational decision to accept treatment only on an outpatient basis and there was no proof that this would be either unsuccessful (or even less successful than hospitalization) or dangerous to the patient or others. No effort was made at the hearing to resolve these problems.

In some cases commitment was ordered where there was neither evidence of dangerousness nor a diagnosis of serious psychopathology. Apparently the basis for commitment was that even the minor degree of psychopathology diagnosed had caused the patient significant difficulty in adjustment to the inevitable problems of everyday living.

ILLUSTRATION 32.

The patient, a woman in her early thirties, had been deserted by her husband and left without support for herself and her eleven year old child. She had, however, been receiving welfare payments. About three and one-half years ago, according to the medical report, she "became ill in a major way as she became increasingly suspicious, interrupted her employer, lived a life of a recluse and severed all family contacts." Admitted at this time to the Acute Facility, she was given electroshock treatments and discharged.

The present crisis occurred when the patient went to see her son's teacher and "something happened." The patient testified that because of her recent shock treatment she could not remember the event; apparently neither the family nor hospital personnel had investigated. The patient's mother testified that following the "event" school authorities took the child and gave it to the father, while the patient's sisters took the patient to a local private hospital. (The medical report, however, stated that she was admitted to the private hospital because "she was given to wandering, neglecting her child and relating to her family in a very markedly paranoid way.") Her legal status at the private hospital

was unclear; she was, however, given electroshock treatments there. Because of the cost of the private facility, she was transferred to State Hospital. She refused to sign an application for voluntary admission "on the ground that she was not sick." The State Hospital applied for her commitment.

The medical report diagnosed her as "personality pattern disturbance, paranoid personality" and noted a history of psychopathology in her mother's family. The report concluded, "All of the facilities of the hospital were used in order to rehabilitate her, but it became evident that the patient was not going to be mobilized in a short period of time." A social history report filed with the court indicated that the patient's husband had left her to live with another woman and that the patient's attitude towards her family arose from the fact that the patient resented the fact that she was illegitimate and feared that this would be disclosed.

The testimony of the patient's mother added little. She suggested that the prior admission to the Acute Facility followed a criminal charge of assault which arose out of a dispute the patient had with neighbors over a clothesline. The patient herself testified that she felt capable of leaving the hospital and could get along if she could find a job. She was questioned by the court as to whether she had many close friends (which she indicated she did not) and the amounts she had received from welfare payments. There was no indication of disorientation or disruption of the patient's mental processes. She was ordered committed.⁹⁶

b. Dismissals. In only one of the observed cases did the court dismiss on its merits an application for hospitalization. In this case, it was clear that the patient had sustained organic brain damage but it was equally clear that this affected his behavior only to a minimal extent.

ILLUSTRATION 33.

The patient, according to the medical report, had been brought to the Acute Facility by the police because "a confusional state was suspected." While at the Acute Facility he had several seizures

96. Whitmore, *Comments on a Draft Act for the Hospitalization of the Mentally Ill*, 19 GEO. WASH. L. REV. 512, 522-23 (1951) criticized the Draft Act's criteria on the basis that patients diagnosed as neurotics would be subject to hospitalization under the "sufficient insight" criteria. Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 959 (1959) responded that the "sufficient insight" criteria was meant for psychotic individuals whose condition had not yet created a danger to the patient or others but which would in the future; neurotic individuals, he asserted, would be subject to hospitalization only if they met the dangerousness criteria. This study indicates, however, that as the Draft Act criteria is applied in St. Louis, individuals suffering from only a personality disorder (a lesser degree of psychopathology than neurosis or psychosis) who do not meet the dangerousness criteria are in fact subjected to nonvoluntary hospitalization.

and was treated with phenobarbital. Diagnosis was chronic brain syndrome, "chronic alcoholism (by history)" and "convulsive disorder (etiology unknown)." In the medical report the patient was described as

cooperative and friendly. He has dull facial expression, his mood was well modulated, with no thought disorder, no delusions, or hallucinations . . . He was oriented to place and person but disoriented to time. His memory for past events was . . . [*sic*] with marked fluctuation and was fair for recent events, attention and concentration were poor. Patient was poor in arithmetic and general information, highly concrete on proverbs; insight and judgment fair.

At the hearing the patient testified that he lived with his cousin and his wife. He could not remember being taken to the hospital but attributed this to one of the "fits" he had experienced. These "fits," he testified, had not interfered with his work and his car washing job (which he had held for a number of years) was being held open for him. The patient admitted an earlier "drinking problem" but maintained that he had stopped drinking two years ago because of his health. The other witness was the patient's cousin's wife who confirmed the patient's work history and indicated that there was no objection to the patient returning to her home if he were released.

Commenting that "There is no reason to hold this man," the court indicated that it would order him released.

c. Submissions. In three of the observed cases no disposition was made at the time of the hearing. Rather, the case was taken "under submission" and the court took informal steps to secure additional information. Commitment was ultimately ordered in all three cases. Nevertheless, all three represented situations where the court recognized that the hearing procedure did not disclose sufficient information on which to base a disposition and where specific attempts to engage in further fact-finding were made.

ILLUSTRATION 34.

The patient, an elderly but large man, had been taken to the Acute Facility by police upon the request of his wife. He was diagnosed as "highly suspected chronic brain syndrome, mild" and the medical report indicated:

The patient's wife states that her husband would accuse her of dating a man and then he would beat her. She stated that this had been happening for about a year. We are still unable to determine whether the patient is delusional in regard to his wife or whether she is really being unfaithful to him. Social Service is in the process of investigation

At the hearing the patient's wife testified that she knew nothing about the men that the patient had accused her of dating. She also reported that the patient had exhibited other abnormal behavior; he had refused to sleep with the lights off and accused her of leaving the house door open so that "someone" could get in to kill him so she could collect his insurance and he occasionally "saw things." The patient testified that he had observed his wife with other men, had merely left the television lamp on on several occasions and denied any hallucinations. Upon being questioned by the court, he admitted striking his wife once on each of two occasions; the first, he testified, involved her failure to prepare a meal for the children and was unrelated to her unfaithfulness. The court indicated to the patient that unless the hospital had some evidence that his beliefs were not factually true, release would be ordered.

The court phoned the Acute Facility resident in charge of the patient's ward and also spoke with the supervising staff psychiatrist. Nine days after the hearing, a supplemental medical report containing the following was filed:

The ministers, neighbors and children were approached by the facility's social service staff. No definite information could be obtained that the wife was stepping out of the home with other men.

. . . .

The patient could be dangerous to his wife due to the fact that he responds to his delusions, which are highly systematized and fixed. The patient is being treated with Thorazine . . . and Stelazin . . . So far there has been no change in the patient's belief. After a certain period on the drugs, electroshock therapy might be considered and if there is no change there is a possibility of the patient being transferred to State because the patient will be a risk to his wife's safety and well-being if released.

Ten days later, according to a note in the case file, the court again phoned the supervising staff psychiatrist and was assured that "it is not simply the protection of the wife that motivates them to retain the patient, but that the patient actually needs custodial treatment for a mental condition." On that date, an order committing the patient was entered.⁹⁷

97. A similar informal method of gathering information was condemned in *In re Leary's Appeal*, 272 Minn. 34, 136 N.W.2d 552 (1965). After the hearing on an application for commitment, the superintendent of the facility visited the trial judge in chambers and related "some information as to the day to day observations of the patient during the time that she was in the institution." Although it concluded that this was not sufficient basis to reverse the commitment, the Minnesota Supreme Court commented that it was "convinced that it was not proper to consult with . . . [the superintendent] in the absence

3. *Analysis*

Several general observations can be made regarding the judicial commitment process. A great deal of emphasis was placed upon forms of procedural fairness: assignment of counsel, availability of witnesses, direct and cross examination of witnesses, and even, to a lesser extent, the rules of evidence. But far from all of those involuntarily hospitalized were ever afforded whatever opportunity to avoid hospitalization this provided. Because of the three week delay between admission and hearing, many patients had, by the time scheduled for the hearing, been released. In addition, if a patient was still detained at the time of the hearing, the judicial procedure offered him little substantive protection. The criteria applied by the court was not that laboriously set out in the statute. Commitment was ordered if the court believed, on the basis of assertions in the medical report, that the Acute Facility had some basis for concluding that the patient was "mentally ill" (as the facility chose to define that term) and that as a result of this illness the patient had experienced some difficulty in living.⁹⁸ No attempt was made to resolve many of the factual issues that arose, even where these appeared to be determinative.

The implications of these observations, when considered in light of

of appellant or her counsel. Appellant had a right to cross examine the doctor on any information conveyed to the court that might influence his determination." 272 Minn. at 44, 136 N.W.2d at 558. *See also* Holm v. State, 404 P.2d 740 (1965), holding that the trial court in a commitment proceeding erred in permitting the jury to inspect the court file which contained a medical report. A statutory provision (adopted from the Draft Act) relied upon by the appellee provided that the court in a commitment proceeding "shall not be bound by the rules of evidence"; this was held unconstitutional as a violation of the judiciary's inherent power to control the course of litigation as well as the appellant's right to hear and controvert all evidence upon which factual determinations are to be made. *Cf.* People v. Dykema, 89 Ill. App. 2d 409, 232 N.E.2d 471 (1967).

98. *Cf.* the conclusions of Miller & Schwartz, *County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital*, 14 Soc. PROB. 26 (1966), 58 hearings, averaging 4.4 minutes each, were observed; thirteen resulted in release of the patient. As to the decisional criteria, the study concluded:

[T]hose persons who were able to approach the judge in a controlled manner, use proper eye contact, sentence structure, posture, etc., and who presented their stories without excessive emotional response or blandness and with proper demeanor, were able to obtain the decision they wanted . . . despite any "psychiatric symptomatology." *Id.* at 34. Yet, the study suggests, this criteria was not altogether inappropriate: it can be argued that those patients who were unable to present the appearance demanded by the court lacked "social acumen and awareness" and that this (whether or not it was technically a symptom of their illness) demonstrated that they would encounter difficulty living in the community. Assuming this to be true, however, neither the criteria applied in St. Louis nor that apparently applied in the hearings observed in the Miller-Schwartz study had any relationship to the formal legal criteria for nonvoluntary hospitalization.

the preceding steps in the hospitalization process, are clear. Although the statutory framework assumed that the operation of the system would be controlled by the legal criteria and that the criteria would be applied by a judicial body, this has not been the case. The criteria actually used has been much broader than that set out in the statute and has been applied by the Acute Facility itself (subject to very limited review by the probate court *if* the facility decided to retain a patient longer than three weeks). Despite the strict observance of the form of effectiveness, the judicial commitment procedure was in reality practically functionless in the hospitalization process.

E. *The Hospitalization Process: An Overall Analysis*

This study had demonstrated that nonvoluntary hospitalization in the St. Louis public Acute Facility is the result of decisions by a series of decision-makers: the community's decision to present, the facility's decision to admit, and, in a few cases, the probate court's decision to commit. Each decision influences the next—the fact of presentation influences the facility to admit, and the fact of admission influences the court to commit. The procedural sequence of events is far different from that anticipated by the legal framework. In almost none of the cases is the initial decision to coerce the patient for treatment purposes made by the court. In almost all the initial decision is made in the community; the next decision is frequently that by the facility to admit and retain. Only after these decisions have been made and effectuated does the court have the opportunity to decide whether or not to authorize continued nonvoluntary detention.

But the fact that all (or the most important) decisions are not made judicially does not mean that they are made in violation of the criteria set out in the legal framework. Even if the criteria actually applied at a given stage does not correspond to that in the legal framework, this does not necessarily mean that the system is at that point exceeding its theoretical authority. It is possible that from among those who meet the general criteria of the legal framework, the system, its capacity limited by facility and personnel shortages, selects only a limited number for inclusion within its program. This would be the situation if the criteria actually applied was included within that proscribed by the framework or if it was applied only to those who also meet the statutory criteria, i.e., if the actual criteria included the requisites of the statutory criteria or if prior to the application of the actual criteria all those not meeting the statutory criteria had been screened out. If either is

the situation, the legal framework could be considered as establishing an outer boundary defining those who *may* be subjected to the system. As among those within this boundary, the system can be considered free to select for actual inclusion on some basis other than the criteria set out in the legal framework.

The study, however, suggests that not only does the criteria applied at all three decision-making points not correspond to that set out in the legal framework, but also that the criteria actually applied is *broader* than that proscribed by the legal framework. Nor is there any preliminary screening process assuring that this broad criteria is applied only to those who meet the statutory criteria. The techniques used in the study are not sufficiently precise to permit a reliable estimate as to the total number of patients presented, admitted or committed who did not come within the boundary defined by the statutory criteria. There is no doubt, however, but that on a day-to-day basis the acute psychiatric treatment system exceeds its legal authority to detain individuals for treatment purposes.⁹⁹

99. A breakdown of admissions by race and sex also permits some interesting speculation. At the time of the 1960 census the city was 28.8 per cent Negro; as Table A indicates, the

TABLE A
ADMISSIONS BY TYPE, RACE AND SEX

	Race			Sex	
	White	Negro	Unidentified	Male	Female
All Admissions	67%	20%	13%	53%	47%
Voluntary Admissions					
Only	75	14	11	57	43
Nonvoluntary Admissions					
only	53	29	18	47	53

admissions studied were 23 per cent Negro. This provides some—but little—support for the assertion that public mental health facilities underserve the nonwhite population. Although female patients tended more than male patients to have been nonvoluntary admissions, the variation was not large.

A more significant difference is apparent when admissions are considered by type and race. Voluntary admissions were significantly more often White patients than were nonvoluntary admissions; nonvoluntary admissions contained more than its proportionate share of Negro patients. Several factors may account for this. The city's Negroes may, as a group, have less "psychiatric sophistication" than Whites and consequently they may voluntarily seek help less frequently for what they regard as illness. Or, psychiatric hospitalization may be more frequently invoked by others as a control device.

Both hypotheses are supported by Table B, which breaks down types of presentations by race. Identified Negro patients tended more than White patients to have been Police Presentations. *None* of the identified Negro patients had presented themselves. This

Why is the legal framework such a minor determinative of the actual operations of the system, both in terms of the content of the substantive criteria and the procedure by which it is applied? The most effective decision-making point was quite clearly the Acute Facility. Why had the court such a minor role in the overall process? Cause and effect are difficult to separate. Several possible explanations are more likely effects than causes of the minor role of the court.¹⁰⁰ For example, the court was not presented with a decision as to whether "to treat or not," but rather whether to authorize continuation of a course of treatment that has already been administered for several weeks. Thus the alternatives were unequally weighted. Release, which meant reversing a prior decision by the Acute Facility and discarding the potential value of three weeks of "therapy," was much less attractive than its alternative, especially in view of the general shortage of public psychiatric services. But this does not explain why the court did not attempt to become active at an earlier point in the process and thus minimize this factor. Consider also the obvious difficulty that the court encountered in obtaining factual information on which to make decisions which might be offered to explain its role. But this does not explain why the court did

TABLE B
PRESENTATIONS BY TYPE AND RACE

	White	Negro	Unidentified	Total
All Admissions	67%	20%	13%	100%
Self Presentations	90	0	10	100
Police Only Presentations	44	44	12	100
Family and Police Presentations	62	25	13	100
Family Only Presentations	60	20	20	100

suggests, then, that Negro patients were not presented because they recognized in themselves symptoms of illness but rather tended to have been presented under coercion and following precipitating situations that disrupted either the family or the community.

100. Scheff, *Social Conditions for Rationality: How Urban and Rural Courts Deal with the Mentally Ill*, 7 AMERICAN BEHAVIORAL SCIENTIST 21 (1964), MENTAL ILLNESS AND SOCIAL PROCESSES (T. Scheff ed. 1967), reported that court commitment procedures tended to be more functional in rural than in urban courts. He attributed this to several factors: (1) the high volume of cases in urban courts, (2) stronger "political" pressures on urban judges to retain persons whom subsequent events might prove should have been retained (as, for example, newspaper coverage of a crime committed by a released patient), (3) the greater personal familiarity of the rural judges with the situations brought before them, (4) the greater psychiatric sophistication of the urban judges, which tended to encourage them to seek "treatment" and to rely on the facilities to determine "need for treatment," and (5) the tendency of the rural patient to be more articulate and to have a greater awareness of his legal rights.

not take steps to obtain more information, such as requiring personal appearances of medical personnel in close cases.

Most likely, the distribution of effective decision-making authority was the result of general acceptance of what might be called a clinical concept of mental illness and the need for hospitalization. This approach holds that the "need" for psychiatric hospitalization is based upon the severity of clinical symptoms; existence of such need, it follows, is best determined by medical experts. But, as this study has shown, the clinical approach frequently does not correspond to the actual dynamics of the process. A symptom's significance lies largely in how it affects the patient's relationship to his environment. "Dangerousness," for example, is a combination of predictions as to how the patient will respond to certain situations (based to some extent on clinical symptoms), the likelihood of those situations arising and such other factors as the probability that specific persons may be present when they arise. There is some indication that a judicial decision maker may even be able to make a *more* accurate determination as to the need for hospitalization, even when the "need" is defined in terms of the patient's ability to live adequately in the community.¹⁰¹ Nevertheless, the court with jurisdiction over the system examined here seems to have accepted the "clinical approach" and it appears that this is the most important determinative of the allocation of real authority in the hospitalization process.

While this may help to explain the failure of the court to take a more active part in the decision-making process, it does not explain why the legal criteria was not more closely followed by whoever exercised the actual authority. The answer to this question probably lies in the wide gap between the role envisioned for the psychiatric hospitalization system in the legal framework and that actually demanded of it by the community. The attempt to impose upon the system the criteria carefully set out in the legal framework constituted an attempt

101. Rappeport, Lassen & Gruenwald, *Evaluation and Followup of Hospital Patients Who Had Sanity Hearings*, 118 AM. J. PSYCHIATRY 1078 (1962), in *THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL* 81 (J. Rappeport ed. 1967), reports a study of 73 patients who had court hearings (at their own request) to determine the appropriateness of their continued hospitalization. Twenty-six were released by the court; of the remaining 47, ten were later discharged by the hospital and eleven escaped. A followup study of the 47 patients released by the three methods showed that although 44 per cent of those discharged by the court had a "satisfactory adjustment" to the community, only 30 per cent of those discharged by the hospital had adjusted satisfactorily. 42 per cent of the escapees had adjusted satisfactorily. The implication, as the study recognizes, is that "the hospital is unable to prognosticate significantly better than the court." *Id.* at 88.

to define the role that the psychiatric hospitalization system would perform in the overall business of keeping society in operation. If the prescribed criteria were effectively implemented, the psychiatric hospitalization system would serve the relatively limited functions of protecting the community from reasonably imminent physical assaults by the mentally ill, of protecting the mentally ill from self-inflicted harm or from situations which, because of their affliction, created a risk to their physical safety that was greatly in excess of that normally endured by members of the community, and of making the decision to obtain treatment for those mentally ill persons whose thought processes had been severely impaired by their illness. The fundamental error in this approach, of course, was in making the underlying assumption that this function could be controlled by legal fiat, i.e., the assumption that the psychiatric hospitalization system was controlled by the legal framework within which it in theory operated, and consequently that the operation of the system could be altered by simple manipulation of the legal framework.

The criminal justice system has been compared to the natural system of a biological cell;¹⁰² the same comparison can be made with regard to the psychiatric hospitalization system. As is true of a single cell composing one part of a multi-cellular organism, the psychiatric hospitalization's internal operation is determined largely by its relationship to other aspects of the entire social organization of which it is a part. Specific aspects of the system's internal processes, in other words, are determined by the system's function as one part of a larger system, which in turn is determined by demands made upon the system by other parts of the larger system. In the case of the psychiatric hospitalization system, the legal framework is only one of those demands. Other demands from other sources are often of a more pressing nature in the day to day operation of the system: disrupted families demand hospitalization of one member as a means of "crisis remission"; neighbors demand hospitalization of irritating neighborhood "nuts"; police (and other participants in the criminal justice system) demand hospitalization of those considered dangerous or troublesome but who for some reason are deemed inappropriate subjects for the criminal system; physicians demand hospitalization when this is seen as a means of alleviating the suffering of an individual or family. Where there is no readily available alternative means of satisfying these demands, those upon whom the demands are made will, if possible, use the flexibility

102. D. OAKS & W. LEHMAN, *A CRIMINAL JUSTICE SYSTEM AND THE INDIGENT* 185-88 (1968).

in the resources available to them to satisfy the demands as best they can. Attempted revisions which neither eliminate the flexibility (which is probably impossible) nor alter the demands are unlikely to have significant effects. As a recent study of changes in juvenile court procedure observed, "Formal structure and procedure can be changed . . . but . . . old ends persist and continue to be satisfied."¹⁰³ An attempt to alter the function of a system such as the psychiatric hospitalization system by simply enacting a restrictive criteria and inserting in the system a judicial officer with directions to apply that criteria was destined in advance to failure.

III. JUDICIAL INVOLVEMENT IN THE PSYCHIATRIC HOSPITALIZATION PROCESS

The empirical examination of the operations of a public acute psychiatric hospitalization system in Part II raises a variety of issues, including the scope of the substantive criteria for defining those subject to nonvoluntary treatment, the relationship of the legal framework to community demands upon the system, the extent to which medical authorities should or may be granted initial or final authority to determine whether a specific individual meets the criteria for nonvoluntary treatment, the necessity for outside supervision or control of medical authorities, and the ability of a judicial officer to supervise the operation of the system or to take an active role in the hospitalization process. All, however, are interrelated; a discussion of one necessarily involves consideration of all.

To the extent that systems such as that studied here permit deprivation of personal liberty by administrative authorities of the psychiatric hospitalization system, they raise significant problems under the Fourth and Fourteenth Amendments. The purpose of Part III is to discuss these problems as a vehicle for demonstrating the interrelationship of the issues raised by the observations reported in Part II.

A. *Right to Judicial Participation in the Hospitalization Process*

1. *Theoretical Framework*

Although the system described in Part II may to some extent have developed in response to factors unique to St. Louis, there are indications that in other jurisdictions, and especially in urban areas, early judicial involvement in the hospitalization process is the exception

103. Lemert, *Legislating Change in the Juvenile Court*, 1967 WIS. L. REV. 421, 447.

rather than the rule.¹⁰⁴ Despite this, however, there has been a surprising lack of theoretical development of the constitutionally required function of the judiciary in this area. This section suggests a basic approach towards the issue.

When a state acts to deprive a specific individual of his liberty, whatever the justification asserted for doing so, the function of determining whether the action is justified under the general standard has traditionally been a judicial one. Attempts to transfer this function to administrative agencies have been regarded as violations of constitutionally required separation of powers and, apparently on the theory that due process embodies to some extent the requirement of separation of powers, denials of due process of law.¹⁰⁵ Underlying these holdings has

104. H. GRACE, *et al.*, SCREENING THE MENTALLY ILL BEFORE COURT COMMITMENT, 16 (California Department of Mental Hygiene 1965) (California); Dix, *Hospitalization of the Mentally Ill in Wisconsin: A Need for a Reexamination*, 51 MARQ. L. REV. 1, 15 (1967) (Wisconsin); Note, *Hospitalization of the Mentally Ill in Utah: A Practical and Legal Analysis*, 1966 UTAH L. REV. 223, 229 (Utah).

105. See generally, Note, *Constitutionality of Nonjudicial Confinement*, 3 STAN. L. REV. 109, 115-17 (1950). As a general rule, separation of powers is required only by state constitutions and, unless due process under the Fourteenth Amendment is thereby violated, a state is free to distribute governmental functions as it sees fit. *Id.* at 111. Nevertheless, the separation of powers policy and the assumptions underlying it have been an important factor in determining the contents of the due process requirement. See, e.g., the comment in *ICC v. Brimson*, 154 U.S. 447, 485 (1894): "[The Interstate Commerce Commission] could not, under our system of government, and consistently with due process of law, be invested with authority to compel obedience to its orders by a judgment of fine or conviction." See also *Wong Wing v. United States*, 163 U.S. 228 (1896) (discussed in note 106 *infra*) in which the decision was apparently based on due process, and *Underwood v. People*, 32 Mich. 1 (1875), holding unconstitutional a procedure which provided for a veto by the hospital superintendent of judicially ordered release of patients committed to the hospital following a verdict in a criminal trial or not guilty by reason of insanity. Consider the question whether an individual condemned to death has a right to a judicial determination of his sanity prior to execution. *Ex parte Phyle*, 30 Cal. 2d 838, 186 P.2d 134 (1947), *cert. granted*, 333 U.S. 841, *petition for cert. dismissed*, 334 U.S. 431 (1948); *Phyle v. Duffy*, 34 Cal. 2d 144, 208 P.2d 668, *cert. denied*, 338 U.S. 895 (1949) (subsequently overruled in *Caritativo v. Teets*, 47 Cal. 2d 304, 303 P.2d 339 (1956)). Cf. *City of Portland v. City of Bangor*, 65 Me. 120 (1876), holding invalid under the due process clause of the Fourteenth Amendment a statute authorizing commitment to the poorhouse by two overseers of the poor. "The objection," declared the court, "does not lie in the fact that the persons named may be restrained of their liberty, but in allowing it to be done without first having a judicial investigation to ascertain whether the charges made against them are true." *Id.* at 121.

The question has also been raised in regard to procedures for detention or quarantine of those believed afflicted with physical disease. In *Ex parte Lewis*, 328 Mo. 843, 42 S.W.2d 21 (1931) a statute authorizing quarantine of individuals believed by the Division of Health to be suffering from venereal disease was challenged on the ground that it conferred judicial power upon an administrative officer in violation of the state constitution. Upholding the statute, the court held that the authority of the health officer to determine

been a fear that only a judicial tribunal could assure compliance with those procedural safeguards which the seriousness of the outcome demanded.¹⁰⁶ As the volume of judicial business has grown, and as the criminal system has begun serious attempts to effectuate rehabilitation programs, it has become clear that even in the criminal system non-judicial authorities must be empowered to make decisions significantly affecting individual liberty.¹⁰⁷ Nevertheless, courts for the most part

whether or not a proposed patient was suffering from a venereal disease in an infectious stage was administrative and not judicial. *See also* *Huffman v. District of Columbia*, 39 A.2d 558 (D.C. Mun. Ct. App. 1944), upholding a similar regulation of the Commissioners of the District of Columbia on the ground that the function of the health officer was administrative rather than "penal"; emphasis was also placed on the danger posed by the situation to the public health. *But cf.* *Wragg v. Griffin*, 185 Iowa 234, 170 N.W. 400 (1919), refusing to interpret a similar statute to authorize administrative detention. Some quarantine statutes did provide for judicial involvement in the process; *see* *People v. Johnson*, 252 N.Y. 387, 169 N.E. 619 (1930), applying a statute providing an opportunity prior to the medical examination for a detained person to obtain a judicial determination of the justification for compelling the examination.

106. I K. DAVIS, *ADMINISTRATIVE LAW TREATISE* § 2.13 (1958). The issue is generally put as whether the obligation imposed by the agency is a criminal penalty or a "civil or remedial" penalty, on the assumption that only pursuant to a judicial proceeding can a criminal penalty be imposed. The controversy generally is generated by imposition of a duty to pay money; a restriction of liberty is usually assumed to be beyond the authority of an administrative agency. *Id.* The difficult problem comes when the authority of an agency to impose deprivation of liberty for contempt is questioned. *Compare Ex parte Victor*, 220 Cal. 729, 32 P.2d 608 (1934) with *People v. Swena*, 88 Colo. 337, 296 P. 271 (1931). *Cf.* *Davis v. Britt*, 243 Ark. 556, 420 S.W.2d 863 (1967), holding that a statute delegating to psychiatric hospitalization authorities the power to determine whether a defendant was "sane" so as to be competent to stand trial was a violation of separation of powers.

One area where the general rule has been compromised is that of action against aliens. The United States Supreme Court has held that the federal government may, consistent with due process of law, entrust exclusion and expulsion of aliens to administrative officials and may authorize a temporary detention by these officials pursuant to their duty of exclusion and expulsion. It may not, however, authorize the administrative officials to impose upon an alien a prison sentence which must be served before he is expelled. *Wong Wing v. United States*, 163 U.S. 228 (1896). And, except when the alien has not arrived on American soil (and therefore is being excluded rather than expelled), the administrative procedure must itself comply with basic due process requirements. *The Japanese Immigration Case*, 189 U.S. 86 (1903); *cf.* *Kennedy v. Mendoza-Martinez*, 372 U.S. 144 (1963).

Several courts have also held that the authority to issue warrants, admittedly a judicial function, may be delegated to prosecuting attorneys. *State v. Furrage*, 250 N.C. 616, 109 S.E.2d 563 (1959); *see* *State ex rel. Sahley*, — W. Va. —, 151 S.E.2d 870 (1966). *But cf.* *State ex rel. White v. Simpson*, 28 Wis. 2d 590, 137 N.W.2d 391 (1965).

107. For example, under Sex Offender Acts the judicially imposed sentence may be for "between one day and life." But correctional authorities have the right to release prior to the expiration of the sentence. *E.g.*, *Trueblood v. Tinsley*, 158 Cal. 503, 366 P.2d 655 (1961), *cert. denied*, 370 U.S. 929 (1962); *Sims v. Rives*, 84 F.2d 871 (D.C. Cir.), *cert.*

have continued to insist that imposing deprivation of liberty upon an individual remained a judicial function which cannot constitutionally be assigned elsewhere. Respect for this proposition has led to decisions whose analysis clearly shows the wide discrepancy between the theoretical requirement and demands of the everyday world, with the result that the case law contains no realistic criteria for distinguishing "judicial" from "nonjudicial" functions.¹⁰⁸

As the issue of judicial participation in the public hospitalization process is now presented it is essentially the same as that traditionally analyzed under the constitutionally permitted extent of delegation of authority to administrative agencies. Public psychiatric facilities constitute a well developed administrative organization and the issue is basically whether (or to what extent) authority can be delegated to them to determine whether specific individuals meet the criteria for nonvoluntary psychiatric hospitalization.

This, however, has not been the approach of most of the limited case law on the subject. Early cases upholding nonjudicial hospitalization procedures often emphasized the availability of a judicial hearing after hospitalization had been effected and vaguely referred to the community's right to take immediate action to protect its members and the patient's need for immediate restraint as a justification for postponing the judicial proceeding. A 1907 Rhode Island case, for example, explained:

[I]nsanity is a disease, and the state has the right to treat one who has the misfortune to suffer from it, as it does one who has a contagious malady. The exercise of this right of self-protection must be regulated by the circumstances of the case. If it is dangerous to the community that a citizen should go at large, whether because he is liable to spread contagion, or to commit some act of violence, public safety demands that he be immediately confined . . . and the extent of his personal right can only be to test by judicial process,

denied, 298 U.S. 682 (1936); *State ex rel. Volden v. Haas*, 264 Wis. 127, 58 N.W.2d 577 (1953).

108. See, e.g., the analysis of the California Supreme Court in upholding an indeterminate sentence statute:

[T]he Adult Authority is empowered to determine as an administrative matter "what length of time" a person sentenced to prison shall serve . . . but the actual *imposition* of that sentence for the term prescribed by law remains a judicial function which can be performed only by a court. . . . The Adult Authority's determination of the length of term is no part of the imposition of sentence, and "if it were so regarded it would be the exercise of a judicial function by an executive board, and void under section 1, article 3, of the Constitution [i.e., guaranteeing the separation of powers].

In re Sandel, 50 Cal. Rptr. 462, 465, 412 P.2d 806, 809 (1966).

at a time when it may safely be done, the propriety of his restraint.¹⁰⁹

The language and analysis of the cases were often so terse as to be unclear; postponement of judicial participation in the hospitalization process, however, apparently has been upheld on the ground that when hospitalization is sought immediate restraint is generally necessary for the protection of the community and the mentally ill person and this necessity makes initial judicial involvement impracticable.

Some decisions insisted that nonjudicial restraint be available only in situations where there was specific evidence of "dangerousness" or that judicial involvement be postponed only to the extent required by the danger.¹¹⁰ Most, however, accepted uncritically the assumption that existence of "mental illness" necessarily meant a sufficiently high probability of dangerousness to justify postponing judicial intervention.¹¹¹

109. *In re Crosswell's Petition*, 28 R.I. 137, 144, 66 A. 55, 58 (1907). *Cf.* cases upholding procedures whereby imprisoned convicts were transferred to psychiatric facilities at the expiration of their sentences without a prior hearing but the opportunity for a later hearing procedure was held to save the entire procedure: *Hiatt v. Soucek*, 240 Iowa 300, 36 N.W.2d 432 (1949); *In re Le Donne*, 173 Mass. 550, 54 N.E. 244 (1899). *See also* *Hammon v. Hill*, 228 F. 999 (W.D. Penn. 1915); *Payne v. Arkebauer*, 190 Ark. 614, 80 S.W.2d 76 (1935); *In re Bryant*, 214 La. 573, 38 So. 2d 245 (1948); *In re Dowdell*, 169 Mass. 387, 47 N.E. 1033 (1897); *Ex Parte Dagley*, 35 Okla. 180, 128 P. 699 (1912). The court in *Moses v. Tarwater*, 257 Ala. 361, 58 So. 2d 757 (1952) declined over strong dissent to reach the issue.

110. In *Appeal of Sleeper*, 147 Me. 302, 87 A.2d 115 (1952) a statute permitting thirty-five days hospitalization upon the certificate of one physician with the endorsement of a local official was held unconstitutional on the ground that it was neither restricted to situations where emergency restraint was necessary for the comfort or safety of the patient or for the safety of the public nor was it ancillary to proceedings for indeterminate judicial commitment. Two years later, in *In re Opinion of the Justices*, 151 Me. 1, 117 A.2d 53 (1955) the court in an advisory opinion indicated that a proposed substitute, although it was limited to those cases where a certification of dangerousness had been made, failed to meet constitutional requirements because it had no specific provision for an individual held pursuant to it to test the validity of his confinement by recourse to the courts. A proposal with such a provision was approved by the court two weeks later. *Id.* at 24, 117 A.2d at 57.

In *In re Cornell*, 111 Vt. 525, 18 A.2d 304 (1941) the Vermont Supreme Court held that authorization for nonvoluntary hospitalization could not be permanent without judicial proceedings. And in *Petition of Doyle*, 16 R.I. 537, 18 A. 159 (1889) the court, holding a certification proceeding unconstitutional, commented, "We are not prepared to say that . . . the sections would be void, if they were intended simply for temporary detention, preliminary to or pending a proper judicial inquiry." *Id.* at 538-39, 18 A. at 160. *Cf.* the discussion in *Petition of Rohrer*, — Mass. —, —, 230 N.E.2d 915, 1919 (1967).

111. *See, e.g.*, the comment of the Oklahoma Supreme Court in *Ex Parte Dagley*, 35 Okla. 180, 183, 128 P. 699, 700 (1912): "For the purpose of [nonjudicial] committal in an

A broader rationale for nonjudicial hospitalization was accepted by the New York Court of Appeals in *In re Coates*,¹¹² decided in 1961. Upholding a statute that permitted indeterminate hospitalization without judicial proceedings of one certified "mentally ill" and "in need of care and treatment," the court explained:

[T]he exact meaning and scope of the phrase "due process of law" cannot be defined with precision . . . [but] . . . *a hearing or an opportunity to be heard is absolutely essential*. . . . Due process does not, however, "guarantee to the citizen of a state any particular form or method of state procedure."

[A]mple provision is made in Section 76 for a complete rehearing and review *ab initio* [T]his provision saves the constitutionality of [the statutory procedure].

Appellant contends that Section 76 does not cure the defect . . . because the hearing it provides for is *after*, rather than before, the order of certification has become final. . . . [T]he Supreme Court of the United States, in somewhat analagous situations, has made it clear that the provisions of an act authorizing the seizure of property without a prior judicial hearing are "rescued from constitutional invalidity" by provisions affording the claimant a subsequent judicial hearing as to the propriety of the seizure This principle has been extended to commitment cases . . . and *ex parte* commitment for an indefinite time has been upheld where the statute made adequate provision for the allegedly mentally ill person to test the legality of his confinement after his admission¹¹³

Coates, then, stands for the proposition that by reason of a later opportunity for a judicial proceeding, hospitalization upon certification is constitutionally permissible without regard to danger to the community or need for immediate restraint for therapeutic or protective purposes, and despite mechanical feasibility of holding judicial proceedings prior to hospitalization. This is a proposition of doubtful validity. It arguably has, however, some support in U.S. Supreme Court cases dealing with property rights. In *Anderson National Bank v. Lockett*,¹¹⁴ for example, the court upheld a state statute requiring a

asylum, it is not necessary that, in addition to insanity, there should be evidence of danger to the lunatic or others beyond what is implied in the insanity itself."

112. 9 N.Y.2d 242, 173 N.E.2d 797, 213 N.Y.S.2d 74, *appeal dismissed for want of a substantial federal question*, 368 U.S. 34 (1961).

113. *Id.* at 249-251, 173 N.E.2d at 801-02, 213 N.Y.S.2d at 79-81 (emphasis in original).

114. 321 U.S. 233 (1944).

bank to transfer to the state accounts that had been inactive for a number of years; the depositor (or any other claimant) could subsequently assert through a judicial proceedings rights in the funds. Holding that due process requirements were met, the Court declared:

The fundamental requirement of due process is an opportunity to be heard upon such notice and proceedings as are adequate to safeguard the right for which the constitutional protection is invoked. . . .

For this reason . . . it is not an indispensable requirement of due process that every procedure affecting the ownership and disposition of property be exclusively by judicial proceedings. Statutory proceedings affecting property rights, which, by later resort to the courts, secure to adverse parties an opportunity to be heard, suitable to the occasion, do not deny due process. . . . The mere fact that the state or its authorities acquire possession or control of property as a preliminary step to the judicial determination of asserted rights in the property is not a denial of due process.¹¹⁵

Despite the broad language of the decisions, however, each contained facts upon which a strong practical argument could be made for the necessity of transfer of possession prior to judicial proceedings. In *Anderson*, for example, the problems of locating potential claimants made postponing the transfer until they were available clearly impracticable. The cases upholding the Trading with the Enemy Act,¹¹⁶ specifically relied upon in *Coates*,¹¹⁷ show that the Supreme Court regarded the Act (which applies only during a period of war or national emergency) as an exercise of the emergency war powers and that the seizure authorized by the Act was upheld on the theory that it gave the government only a limited right to possession pending a judicial determination of rights in the property.¹¹⁸ Despite the court's failure to em-

115. *Id.* at 246-47.

116. 50 U.S.C.A. APP. § 1 (1968).

117. *In re Coates*, 9 N.Y.2d 242, 251, 173 N.E.2d 797, 802, 213 N.Y.S.2d 74, 81 (1961). The court specifically cited *Société Internationale v. Rogers*, 357 U.S. 197 (1958).

118. *Central Union Trust Co. v. Garvan*, 254 U.S. 554 (1921). *See also* *Société Internationale v. Rogers*, 357 U.S. 197 (1958); *Stoehr v. Wallace*, 255 U.S. 239 (1921). The same is true of *Falbo v. United States*, 320 U.S. 549 (1943), also relied upon in *Coates*. In *Falbo*, the Court considered the availability of judicial review of a selective service board's classification of a registrant under the Selective Service and Training Act of 1940. Before holding that Congress had not intended to make judicial review of classifications available in criminal prosecutions for failure to report for an assignment to work of national importance, the Court—without citing authority—commented, "Even if there were as the petitioner argued, a constitutional requirement that judicial review must be available to test the validity of the decision of the local board, it is certain that Congress was not required to provide for judicial intervention before final acceptance of an indi-

phasize this, the cases upon which *Coates* relied were cases in which the postponement of judicial involvement was made necessary by the situation in which the case arose.

Insofar as *Coates* rested upon a general rule that a subsequent opportunity to obtain a judicial hearing will, even in the absence of any showing of special necessity for delaying judicial proceedings, justify administrative action affecting possession of property, it is without impressive support in the case law. Moreover, in view of the current emphasis upon personal rights, the use of a rule developed in the context of rights in property for the purpose of upholding an administrative procedure affecting liberty of individuals was extremely questionable; note the court's care in *Anderson National Bank* to emphasize that the case was one in which *property* rights were at issue.

But the most important oversimplification of the *Coates* analysis was its restriction of constitutional considerations to general aspects of the Fourteenth Amendment's guarantee of procedural due process. The Fourteenth Amendment also makes applicable to the states the Fourth Amendment's "right of the people to be secure in their persons, houses, papers and effects against unreasonable searches and seizures." It seems clear that nonvoluntary detention for purposes of psychiatric hospitalization is a "seizure" of the "person" within the meaning of the Fourth Amendment, and it is under this amendment's guarantees that the right to judicial participation in and supervision over the operation of agencies of social control has been developed. The case law has large gaps, but there are several basic principles that can be regarded as settled in the criminal context. A search, to be reasonable, must (with the exception of certain emergency situations) be conducted pursuant to a warrant.¹¹⁹ The warrant must be issued only upon the determination of a judicial officer that the situation meets the legal criteria justifying the search.¹²⁰ The same is true of a warrant authorizing an arrest

vidual for national service." 320 U.S. at 554. It is not entirely clear whether the Court equated "final acceptance . . . for national service" with actual deprivation of liberty. But in any case, it is certain that the Court regarded the Act as an exercise of the general emergency war power. 320 U.S. at 551, 554-55. In *Clark v. Gabriel*, 89 S. Ct. 424 (1968), the Court—citing only *Falbo* and *Esteps v. United States*, 327 U.S. 114 (1946)—upheld Sec. 10(b)(3) of the Military Selective Service Act of 1967, 50 U.S.C.A. App. § 460(b)(3) (1968), which prohibited any judicial review of a classification except as a defense to a criminal prosecution following a registrant's refusal to comply with an order based upon that classification. Cf. *Ostereich v. Selective Service System Local Board No. 11*, 89 S. Ct. 414 (1968).

119. E.g., *Mancusi v. De Forte*, 392 U.S. 364, —, 88 S. Ct. 2120, 2125 (1968) and cases cited at n.7.

120. *Aguilar v. Texas*, 378 U.S. 108 (1964).

—it may issue only after a judicial determination that there is justification for the arrest.¹²¹

The case law does not go further with any degree of clarity. For example, it is unclear whether arrests without warrants are subject to the same restrictions as searches without warrants, i.e., whether such arrests may only be made when use of a warrant procedure is not feasible.¹²² Nor is it clear whether once an arrest without a warrant has been made it is constitutionally necessary to take the subject before a judicial officer within a reasonable time so that a disinterested determination of the justification for his continued retention may be made.¹²³ If constitutional limitations on police activity are to be logically consistent, the answer to both questions must be affirmative, although there is as yet little specific case support for such a response. Nevertheless, the case development of the Fourth Amendment has tended to interject wherever reasonably feasible a judicial officer between the administrative police decision to invade personal liberty and those potentially subject to these invasions. The underlying policy of this line of decisions was succinctly stated by Mr. Justice Jackson in *Johnson v. United States*:¹²⁴

The point of the Fourth Amendment . . . is not that it denies

121. *Giordenello v. United States*, 357 U.S. 480 (1958).

122. *McCray v. Illinois*, 386 U.S. 300, 314 (1967) (Mr. Justice Douglas, dissenting): "[N]ormally an arrest should be made only on a warrant issued by a magistrate on a showing of 'probable cause, supported by Oath or affirmation,' as required by the Fourth Amendment."

123. The language in the case law indicates that there is no federal constitutional right to a preliminary hearing. *E.g.*, *Butterwood v. United States*, 365 F.2d 380, 384 (10th Cir. 1966), *cert. denied*, 386 U.S. 937 (1967). *Cf.* *Rivera v. Virgin Islands*, 375 F.2d 988 (3d Cir. 1967). Most cases, however, present the issue as whether denial of a preliminary hearing will itself vitiate a subsequent conviction. A holding that it will not does not, of course, necessarily mean that if an individual being held sought to obtain a preliminary hearing the courts would reach the same result. The same holds true of right to counsel. A number of federal courts have held that the federal right to counsel does not extend to state preliminary hearing; these cases, however, are generally those where the issue is whether failure to provide counsel is sufficient to vitiate a subsequent conviction where no plea was entered at the preliminary hearing. *Atkins v. Kansas*, 386 F.2d 819 (10th Cir. 1967); *Allen v. Wilson*, 365 F.2d 881 (9th Cir. 1966). *But cf.* *Pece v. Cox*, 354 F.2d 913 (10th Cir. 1965), *cert. denied*, 384 U.S. 1020 (1966); *Blue v. United States*, 342 F.2d 894 (D.C. Cir. 1964), *cert. denied*, 380 U.S. 944 (1965). The courts have not faced (nor have most considered in making general statements concerning constitutional requirements for the preliminary hearing) the situation where an individual being held on the basis of police conclusions that he should be detained for trial asserts a federal constitutional right to a judicial determination of that matter and counsel's assistance in presenting his case.

124. 333 U.S. 10 (1948).

law enforcement the support of the usual inferences which reasonable men draw from evidence. Its protection consists in requiring that those inferences be drawn by a neutral and detached magistrate instead of being judged by the officer engaged in the often competitive enterprise of ferreting out crime.¹²⁵

Recently the Supreme Court made clear that the Fourth Amendment protections are not restricted to these invasions of personal liberties that are part of the criminal justice system. In *Camara v. Municipal Court*,¹²⁶ the Court overruled *Frank v. Maryland*¹²⁷ and held that the Fourth Amendment required a search warrant be obtained prior to the search of a private home for the purpose of determining whether local health regulations had been observed. The holding and the Court's analysis establish several propositions of importance in the psychiatric hospitalization context. First, the noncriminal purpose for which a personal right is invaded does not automatically justify failure to apply traditionally "criminal" procedural safeguards.¹²⁸ Second, the general policy favoring placing a disinterested judicial officer between an administrative officer with authority to invade personal rights and the holder of those rights encompasses noncriminal systems of social control as well as the criminal system where the policy was developed. Third, the traditional functions of the disinterested judicial officer may be modified to meet exigencies encountered when his function is exercised in noncriminal systems. Finally, in determining whether it is constitutionally required that the intervention of a disinterested judicial officer be extended into a noncriminal system it is necessary to consider (a) the nature and purpose of the system's invasion of personal liberty, (b) the extent to which the system, without judicial intervention, protects the substantive rights of those potentially subject to de-

125. *Id.* at 13-14. The procedural right to early judicial involvement in a process infringing on a substantive right has been emphasized where the substantive right is one of First Amendment nature. See *Freedman v. Maryland*, 380 U.S. 51, 59 (1965), making clear that any restraint on the showing of a purportedly obscene film prior to a final judicial determination of the merits of the restraint must be "limited to preservation of the status quo for the shortest fixed period compatible with sound judicial resolution [of the merits]." See also *Wolff v. Selective Service Board No. 16*, 372 F.2d 817 (2d Cir. 1967).

126. 387 U.S. 523 (1967). See also *See v. City of Seattle*, 387 U.S. 541 (1967). Both cases are discussed in La Fave, *Administrative Searches and the Fourth Amendment: The Camara and See Cases*, 1967 SUP. CT. REV. 1.

127. 359 U.S. 360 (1959). See also *Ohio ex rel. Eaton v. Price*, 360 U.S. 246 (1959).

128. In *State ex rel. White v. Simpson*, 28 Wis. 2d 590, 137 N.W.2d 391 (1965), the Wisconsin Supreme Court held that a prosecuting attorney could not constitutionally issue a warrant for the detention of the defendant in a *civil* paternity suit. *Cf. Schmeier v. Gagnon*, 276 F. Supp. 4 (W.D. Wis. 1967), *rev'd*, 396 F.2d 786 (7th Cir. 1968).

privation of liberty, (c) the effect upon the attainment of the system's objectives which the insertion of the judicial officer will have, and (d) the extent to which the judicial officer can act effectively within practical limits imposed by the everyday operation of the system.

The issue of the constitutionally required extent of judicial participation in the hospitalization process is closely analogous to the question presented in *Camara*; both raise essentially the extent to which a "disinterested magistrate" must be interposed between the citizen and an administrative organization attempting to enforce a social objective. Certainly the psychiatric hospitalization system presents an equivalent danger to that underlying the Fourth Amendment cases; the probability of inaccurate drawing of inferences on the part of personnel of a psychiatric facility devoted to providing medical care to those regarded as "ill" is not likely to be less than similar actions on the part of a police officer enthusiastically "engaged in . . . ferreting out crime" or a building inspector in search of nonconformity with health and safety regulations. Perhaps the most effective way to discuss the problem, then, is to consider the hospitalization issue in terms of the analysis in *Camara*. Such an approach is certain to be more satisfactory than the "delegation of power-due process" analysis.

2. *Fourth-Fourteenth Amendment Analysis*

The delegation of power—due process analysis assumes that due process embodies the basic policy of separation of powers and that it consequently requires that "judicial" functions be performed only by a judicial officer. Whether nonjudicial psychiatric hospitalization is constitutionally valid, therefore, depends upon whether hospitalization is a "judicial" function. Underlying this has been the assumption that only a judicial officer can assure compliance with the necessary procedural safeguards. The basic assumption, of course, is subject to challenge, especially in light of general acceptance of administrative organizations with broad powers. Moreover, the case law, as the result of desperate attempts to make the delegation of power doctrine coincide with reality, has become a completely unsatisfactory basis for distinguishing judicial from non-judicial functions. Even if the theoretical reliability of the analysis is accepted, its application presents an impossible task.

A Fourth-Fourteenth Amendment approach, based on the *Camara* analysis, would begin anew with two premises. First, individuals are entitled to protection against unreasonable seizures of their persons.

Second, those directly involved in the administration of a system of social control are likely to be unable to make an impartial evaluation of the strength of "their" case for depriving a specific individual of his liberty and consequently there is a strong constitutional policy in favor of assuring reasonableness by inserting a judicial officer between administrative officials seeking to deprive an individual of his liberty and the right to do so. But whether in any specific noncriminal context a judicial officer must make the decision depends upon consideration of four factors.

a. Nature and Extent of Invasion of Liberty. The line between "criminal" and "noncriminal" systems of social control, once drawn for the purpose of determining the extent to which traditionally "criminal" procedural requirements applied, is no longer clear, if indeed it exists at all. Recent Supreme Court decisions concerning these procedural rights have discounted differences between the objective of systems seeking to invade personal liberty for purposes other than "punishment" and the criminal system itself. After observing that "the constitutional basis for [the juvenile] system is—to say the least—debatable" and that in practice the system has "not been entirely satisfactory," the Court in *In re Gault*¹²⁹ held that the therapeutic objectives of the system did not justify relaxing traditionally criminal procedural safeguards as much as has been regarded by many as permissible. In *Specht v. Patterson*,¹³⁰ stringent procedural safeguards were imposed on Sexual Psychopath systems despite the Court's acknowledgement that the systems were "designed not so much as retribution as . . . to keep individuals from inflicting future harm."¹³¹ Neither

129. 387 U.S. 1, 17-18 (1967).

130. 386 U.S. 605 (1967).

131. *Id.* at 608-09. This ambiguity is part of a problem that pervades all systems of social control, in part at least because of the rise of what Allen has called the "rehabilitative ideal." Allen, *Criminal Justice, Legal Values and the Rehabilitative Ideal*, 50 J. CRIM. L.C. & P.S. 226 (1959). The present system of psychiatric hospitalization, like all systems that have been effected by recent scientific innovations that purportedly make effective "therapy" available to those who pass through them, represents the imposition of a "treatment oriented" program upon the framework of an old system designed almost exclusively to protect society. Perhaps in part from a sense of guilt over the long years of emphasis upon control and protection, today's emphasis on treatment tends to detract from the fact that these systems—including psychiatric hospitalization—still serve protective functions. More disturbingly, the protective function is frequently clothed in the language of therapy so that its "non-therapeutic" or control aspects are hidden from casual view. But, as Allen points out, no complex social institution serves a single function. *Id.* at 227. The psychiatric hospitalization system can no more accurately be characterized as entirely "therapeutic" than it can be painted as entirely "protective"; like the juvenile justice system, it serves both functions.

therapeutic nor protective objectives, then, are automatic grounds for exemption of a system from traditionally criminal procedural requirement. But the extent to which a system of social control resembles the criminal system in its objectives and the means adopted to achieve those objectives probably remains a substantial determinant of the extent to which the system may relax procedural requirements which must be strictly observed in the criminal system.

This study suggests that although the acute psychiatric hospitalization system is not oriented towards imposing retributive punishment for its own sake, its objectives and methods resemble in several ways the corresponding aspects of the criminal system. An important objective of the psychiatric hospitalization system, for example, is protection. Protection, moreover, is extended not only against physical assault upon members of the community but also against community irritation and inconvenience and family disturbance and disruption. The analysis of the dynamics of family presentation suggested that when the primary motive for presentation was the family's desire to invoke the system for these protective purposes, the likelihood that the patient's entry into the system would be nonvoluntary was much greater. Much like the juvenile correctional system, the public acute psychiatric hospitalization system has "therapeutic" objectives, but those who are given "therapy" are frequently selected by reason of their antisocial (and sometimes illegal) behavior.

In addition, however, it is by no means clear that the dynamics of psychiatric "therapy" is always significantly different than that of the

For the views of a psychiatrist who regards the protective functions as more significant than the therapeutic functions, see T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* (1963). See also Leifer, *Involuntary Psychiatric Hospitalization and Social Control*, 13 *INT'L J. Soc. PSYCHIATRY* 53 (1967), who argues that classifying psychiatric hospitalization as a "medical" program rather than as a system of social control enables society to convey the impression of being governed by laws which are neither harsh nor restrictive. Conveying this impression, he suggests, serves the function of encouraging society to be more respectful of individual liberty in other contexts. But openly recognizing that psychiatric hospitalization is in fact a system of social control of deviant behavior

would confront us with the agonizing alternatives of either devising laws to cover the forms of deviance from which protection is demanded or of increasing our tolerance for certain varieties of human behavior. In the first case, the gleam of our free society would be tarnished and in the second case we would be presented with a challenge for which there is little evidence of our capacity or our willingness to overcome.

Id. at 58.

For an interesting discussion of the relationship among such factors as views regarding accountability of mentally ill individuals for their behavior, willingness to invoke the treatment processes, and social class, see Fletcher, *Social Class Variations in Psychiatric Referral of Withdrawn and Aggressive Case Descriptions*, 16 *Soc. PROB.* 227 (1968).

correctionally-oriented imprisonment that society imposes on individuals convicted of antisocial behavior which has been designated as "criminal." During this study, at least one situation was observed in which a patient was straightforwardly told that if her behavior did not change she would be hospitalized on a long-term basis; this action, obviously designed to deter her from future symptomatic behavior, was referred to as a "therapeutic threat" by the psychiatrist who had administered it. Several patients indicated clearly that they regarded their hospitalization as having been imposed because of their commission of what they believed was illegal conduct. There is also some evidence that there may be a substantial similarity between criminal sanctions and forms of psychiatric treatment that on the surface appear to be purely "therapeutic." While there is little agreement on the dynamics of electroshock therapy, one theoretical explanation holds that it achieves its results by "punishing" the patient for exhibiting symptomatic behavior and thereby deters him from resorting to such behavior in the future as a means of responding to a stress situation.¹³² Insofar as psychiatric "treatment" achieves its results by imposing unpleasant experiences upon patients (or threatening to do so) for purposes of deterring antisocial behavior, it differs much less from the criminal justice system's correctional programs than is often supposed.

The extent of the deprivation of liberty might arguably distinguish the psychiatric hospitalization system from the criminal system. Average duration of stay in the system studied here was about thirty days; many patients were discharged after less than ten days of full-time hospitalization. Yet this, as the search in *Camara*, is not an insignificant

132. Dies, *Electroconvulsive Therapy: A Social Learning Theory Interpretation*, 146 J. NERVOUS AND MENTAL DISEASES 334 (1968). Dies subscribes to a theory that holds that behavior regarded as symptomatic of mental illness is learned behavior little different in terms of the dynamics of formation than any other learned behavior; see note 42 *supra*. A hospitalized person, he argues, is clearly informed that electroshock "treatment" is administered because he has exhibited behavior which is not approved. The fear of the therapy and the unpleasant aftereffects make his symptomatic behavior a much less satisfactory way of meeting stress situations. Consequently, the patient is motivated to develop other responses. In part, Dies indicates, this is an unconscious process, but in part, he believes, the patient consciously makes efforts to avoid the behavior that experience has shown will result in the administration of "treatment." There is, however, experimental evidence tending to show that the convulsion caused by electroshock rather than the patient's anticipation of the unpleasant experience is responsible for the observed improvement in symptoms. Ulett, Smith & Gleser, *Evaluation of Convulsive and Subconvulsive Shock Therapies Utilizing a Control Group*, 112 AM. J. PSYCHIATRY 795 (1956). See also Crumpton, Brill, Eidusion & Geller, *The Role of Fear in Electroconvulsive Treatment*, 136 J. NERVOUS AND MENTAL DISEASES 29 (1963).

deprivation of liberty, and without judicial participation in the process the choice between overnight hospitalization and much longer detention is entirely within the control of the system itself. Moreover, as additional facilities become available, duration of hospitalization may increase, although some jurisdictions report success with much shorter periods of time.¹³³

An opportunity for judicial "review" of the administrative decision to detain affects the extent of nonjudicial detention. If the patient is presented before a judicial officer soon after presentation, perhaps the short nonjudicial detention is within constitutionally acceptable limits. But it is necessary to distinguish between presentation which is in fact "soon after" admission and the delayed review observed in this study. Delayed review not only removes many patients from whatever protection judicial proceedings provide, but also tends to diminish the court's willingness to overturn the facility's decision to admit and retain, thereby minimizing the protection afforded by the judicial process in those cases where it is invoked. The constitutionality of pre-hearing judicial hospitalization depends not only on its duration but also upon the effectiveness of the subsequent judicial proceeding as a meaningful decision-making process.

b. Protection of Substantive Rights Without Judicial Participation. The basic argument made here underlies the validity of most administrative action affecting the rights of individuals: notice and opportunity to protest invasions of liberty can be effectively afforded by the hospitalization system itself with less disruption to the system, the patient, and the family than a judicial procedure involves.¹³⁴ To equate "due process" with "judicial process," the argument goes, is to adopt a naive approach towards protection of substantive rights.¹³⁵

133. See Guido & Payne, *72 Hour Psychiatric Detention*, 16 ARCHIVES OF GENERAL PSYCHIATRY 233 (1967) describing a study of the use of 72 hour emergency detention in California. This short period, the study concluded, was sufficient in 76 per cent of the over 8,000 admissions to permit relieving the patient's immediate distress with medication, "personality reintegration" of the patient, "family reorganization" and planning for the future. Often, the study asserted, the 72 hour period was better than sixty to ninety day short term treatment because it avoided the dependency reaction to institutionalization that might occur even during relatively short periods of hospitalization.

134. See generally 1 K. DAVIS, ADMINISTRATIVE LAW § 1.07 (1958).

135. In two recent decisions dealing with the mental health field, the United States Supreme Court has emphasized the importance of procedural rights. In *Baxtrom v. Herold*, 383 U.S. 107 (1966) New York's procedure for administratively committing to psychiatric facilities prison inmates whose sentences expire was held to violate the Equal Protection clause of the Fourteenth Amendment because, in contrast to the general procedure for civil commitment of those not under prison sentence, it extended no right to

The validity of this position, however, turns to a large extent upon the factual conclusion as to whether the administrative process does protect the substantive rights of those who pass through the system. Little attempt was made in the internal administration of the hospital system which was the subject of this study to apply the *legal* criteria to those offered for admission or those retained. In part, this was undoubtedly because of the wide gap between the legal criteria and the demands upon the system; the experience reported here may not be a reliable indicator of how the system would operate if the criteria coincided more closely with general community demands. But it is clear that under existing practice, the patient is accorded no real opportunity to present a "case" to hospital authorities for nonhospitalization and almost no attempt is made to protect legally defined substantive rights of those processed through the system.¹³⁶

It has also been suggested that the basic orientation of medically trained persons is such that they are less likely to effectively administer procedural devices designed to protect legal substantive rights. When the need for "treatment" is in doubt, the medical tendency is to assume the need exists, on the premise that no chance should be taken with the patient's well being. Although a somewhat different matter is involved when "treatment" means "detention,"¹³⁷ it is likely that the

a jury or court determination that the criteria for commitment was met. And in *Specht v. Patterson*, 386 U.S. 605 (1967) the Court held that before a convicted defendant could be sentenced under a Sexual Psychopath program he must receive reasonable notice and a variety of procedural rights, including a hearing, the right to be present at that hearing, and to confront and cross examine witnesses. In neither case did the Court hold specifically that the procedure was constitutionally required to be a judicial one; but the language of the decisions leaves little doubt that the Court had a judicial procedure in mind.

136. The right to counsel may have some effect upon the constitutionality of some procedures. Several recent decisions suggest that respondent in a commitment may have a constitutional right to counsel. *People ex rel. Rodgers v. Stanley*, 17 N.Y.2d 256, 217 N.E.2d 636, 270 N.Y.S.2d 573 (1966); *People ex rel. Woodall v. Bigelow*, 20 N.Y.2d 852, 231 N.E.2d 777 (1967). Cf. *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968) (holding that a right to counsel existed in a proceeding to commit an individual to an institution for the mentally deficient, and applying the rule retroactively). See generally *Cohen, The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEXAS L. REV. 424 (1966); Note, 40 TEMP. L.Q. 381 (1967). If the respondent has a right to counsel, does he have a concomitant right to a procedure whereby counsel can effectively resist hospitalization, i.e., a judicial proceeding? But, on the other hand, could not the right to counsel be defined so as to attach only if the individual indicated a desire to actively oppose hospitalization, i.e., if he demanded a judicial hearing? Moreover, does this argument not involve a naive view of counsel's role? Might not, for example, counsel function effectively in a system of administrative hospitalization (as lawyers have in other administrative environments)?

137. See S. HALLECK, *PSYCHIATRY AND THE DILEMMAS OF CRIME*, 230-32 (1967).

treatment-orientation of medical decision-makers carries through into this context. The legal orientation, on the other hand, is to reject non-voluntary control for whatever purpose until the justification for it has been established.¹³⁸ Insofar as the basic approach to the need for hospitalization is concerned, then, medically trained decision-makers can be expected to be less sympathetic to the legal requirement that justification for commitment be established as a matter of fact before hospitalization is effected. Moreover, there may be other influences that bear upon medical personnel that encourage them to be less solicitous of legally defined rights than a non-medical person might be. For example, one psychiatric journal has taken the editorial position that short-term hospitalization is undesirable because it interferes with the hospitals' ability to maintain a large and stable patient population for research and training purposes.¹³⁹ Insofar as this influences admission and retention, of course, it necessarily involves a blatant sacrifice of the patients' legally defined substantive rights.

c. Effect Upon the System's Objectives. One objective of the public psychiatric hospitalization system is the protection of the community from disruptive influences by "treating" those who cause the disruptions, although treatment of those experiencing discomfort for the purpose of relieving the discomfort is also an objective in itself. Perhaps the most appealing arguments against judicial involvement in the process are those asserting that such involvement would impede the system's ability to achieve these goals. For purposes of evaluation, however, the dual objectives of the system must be carefully separated.

i. Protection of the community. An argument against judicial involvement that apparently was heavily relied upon by the early judicial

138. This difference in the orientation of legal and medical decision-makers is developed in T. SCHEFF, *BEING MENTALLY ILL* 105-27 (1966).

139. See *Editorial Comment, Law's Labor Lost*, 40 *PSYCHIATRIC Q.* 150, 156-57 (1966), criticizing the recently enacted New York statutory scheme:

Perhaps . . . the most calamitous effect of the new law and procedures will fall on research and training. . . .

Research in psychiatry depends upon enough hospital population to provide statistical validity with matched subjects, controlled in a variety of ways, over a *fully adequate time of close follow-up*. The new system will not allow this. Patients will not be around long enough for . . . adequate research study. . . . The practical research on tranquilizing and antidepressant drugs . . . was done at state hospitals under the old system [of long term hospitalization].

All of this equally applies to the training of doctors in psychiatry. In order to learn they need to see a representative selection of patients from a very large admission group over a long enough time in which to verify diagnosis and to justify treatment choice. This they cannot get in a . . . [facility] with selective admission rules, small capacity and rapid turnover. . . .

The argument was repeated in *Editorial Comment, Mental Hygiene Law—1967*, 41 *PSYCHIATRIC Q.* 766, 768-69 (1967).

decisions was the assertion that nonjudicial hospitalization is necessary to safeguard both the community and the patient himself from his violent acts.¹⁴⁰ The difficulty of predicting dangerousness lends some support to this. Insofar as the dangerous "mentally ill" cannot be separated on the basis of clinical examination from those who are not dangerous,¹⁴¹ this suggests that immediate detention be used for all "mentally ill" until a determination of "non-dangerousness" can be made. But there is a clear lack of support for the underlying assumption that the "mentally ill," as a group, contain a sufficiently high percentage of dangerous individuals to justify the wholesale deprivation of liberty this argument suggests.¹⁴² Nor does the argument explain why this justification can suffice for more than the brief nonjudicial hospitalization necessary to make presentation before a judicial officer practicable.

There is a more basic problem with the "dangerousness" rationale, however. Assuming that at some point a distinction can be made between those "mentally ill" persons who are "dangerous" and those who are not, this criteria does not correspond to the reasons for which the community demands hospitalization. Any attempt to limit immediate hospitalization to those who are dangerous means that the facilities would be unable to meet community demands. The result, as this study shows, is that the legal criteria is ignored and the legal framework has almost no function in determining who is subjected to non-voluntary hospitalization and for how long.

ii. *Therapeutic needs of the patient.* Professor Kadish, in one of the few attempts to develop a coherent theoretical foundation for nonjudicial hospitalization on more than an emergency basis, has asserted that a requirement of judicial proceedings prior to hospitalization would "undermine the important societal objective of therapeutic

140. See cases cited at note 108 *supra*.

141. See text at note 81 *supra*.

142. For obvious reasons, the dangerousness of the mentally ill as a group has not been subjected to much study. Examinations of arrest and conviction records of formerly hospitalized individuals have been carried out, however, and most of the studies suggest that mental patients have been less involved in criminal activity than the general population. Rappeport and Lassen, *Dangerousness—Arrest Rate Comparisons of Discharged Patients and the General Population*, 121 AM. J. PSYCHIATRY 776 (1965) summarizes the literature. But the study conducted by Rappeport and Lassen themselves indicated that the former psychiatric patients had been as involved as the general population in murder, negligent manslaughter and aggravated assault. More surprisingly, the study indicated that the former patients were *more* frequently involved in robbery than the general population, and probably more often involved in rape. In addition, this held true after hospitalization

treatment.”¹⁴³ If this disruptive impact of judicial proceedings is weighed against the relatively less significant impact of an improper hospitalization (as compared to the impact of erroneous conviction of a criminal offense), he concludes, the balance justifies modifying traditional due process rules to the extent of permitting nonjudicial hospitalization for a limited period, if the patient has available after hospitalization an opportunity to invoke the judicial process. Underlying this analysis, of course, is the factual conclusion that judicial proceedings significantly impede effective treatment of the “mentally ill.” Each of the several ways in which Kadish asserted that judicial involvement has this effect deserves specific attention.

First, Kadish asserted that judicial proceedings arouse a feeling of “public shame” and constitute a “publically humiliating experience” for the family. The result, he argued, is that the prospect of a hearing discourages the family from seeking help for the patient during the early stages of the “illness” when the patient’s prognosis may be most favorable.¹⁴⁴ It might also be argued that if the patient is in fact publically shamed, this may decrease his desire to return to the community and thereby minimize his receptiveness to therapy. But this study suggests that in neither way need the judicial process be detrimental. Help is frequently not sought soon after symptoms are observed, but this is for reasons bearing no relationship to the anticipated procedure necessary for nonvoluntary hospitalization. When help is sought, it is often not because of the degree of psychopathology but because of a crisis situation precipitated by fortuitous circumstances. It is, then, doubtful whether the prospect of a judicial hearing is a significant factor in the decision to seek help. Even if it is a factor, however, it is at most only one of numerous “nontherapeutic” factors that determine time of presentation and it is doubtful whether minimizing this factor would have any appreciable effect on the timing of presentation. Kadish’s argument also assumed that the hearing affects the status or the “reputation” of the patient and the family in the community. This is doubtful. The hearings are unlikely to be either publicized or widely attended; thus a hearing is unlikely to publicize the fact of

as well as before, when arrest records for period before and after hospitalization were examined. *Id.* at 779. Psychiatric patients are not only more dangerous in some ways than “normal” individuals, this suggests, but formal therapy does little to lessen this dangerousness.

143. Kadish, *A Case Study in the Significance of Procedural Due Process—Institutionalizing the Mentally Ill*, 9 W. POL. Q. 93 (1956).

144. *Id.* at 96.

hospitalization or the details of family problems much more than does the fact of hospitalization. Some family members who participated in the hearings observed for this study, found the hearing a disturbing and difficult experience; the prospect of undergoing such an experience might deter some individuals from taking action. But this does not mean the hearing had an effect on the regard in which the community held the family. Kadish, it seems clear, exaggerated the extent to which a hearing adversely affects the family. Finally, even if it were true that the prospect of a hearing did in fact delay the decision to present the patient, this would not be as serious as might be supposed. There is little evidence that treatment of the sort administered by the public hospitalization system is significantly less effective if delayed. While delay in hospitalization may prolong the discomfort of the patient and his family, it is unlikely to have any significant effect on his subsequent susceptibility to treatment.

Second, Kadish asserted that judicial proceedings create "an anti-therapeutic condition of maximum excitement and confusion."¹⁴⁵ The observations made during this study suggest that although judicial proceedings may cause patients some discomfort both before and during the actual hearing, this is of only a temporary nature and has no effect upon the therapeutic objectives of the system. Closely related is Kadish's third argument that the patient's attendance at the hearing may be antitherapeutic. It may, Kadish asserted, feed a persecution delusion "with objective evidence a therapist would be hard put to refute."¹⁴⁶ To this might be added the danger that hearing a detailed analysis of his psychopathology might convince a patient that he is in fact hopelessly ill and thereby minimize his motivation to take medication or engage in other forms of treatment. To the extent that these assertions are offered to support nonjudicial hospitalization, they fall somewhat short. If, in a specific case, a patient's attendance at a hearing would be detrimental, his presence might be prevented; as is provided for by the statutes of many states. The danger, of course, is in routine *ex parte* hearings even when there is no factual basis for concluding that the patient's participation would have any long term unfortunate effects.

But the basic arguments, in the public hospitalization context, are open to significant challenge. If the patient's family was influential in hospitalizing him, he is likely to know this and to be aware of the

145. *Id.*

146. *Id.*

underlying crisis that precipitated admission. The hearing is likely to add little to this. Nor is a patient hospitalized in a locked ward likely to be unaware of the fact that he is regarded as seriously ill. More important, however, these arguments rest largely on questionable assumptions regarding the nature of the therapy administered in the public hospitalization system. Kadish apparently assumed that the hearing would decrease the patient's susceptibility to "insight therapy" designed to gradually bring the patient to an awareness of the unconscious conflicts underlying his symptomatic behavior. But this type of treatment is a minimal part of public acute therapy. There is no evidence that there would be any equivalent impact on the effectiveness of drug or electroshock therapy, the methods of treatment almost exclusively administered.

Another argument advanced in favor of administrative hospitalization is that judicial involvement places a foreign agency between the patient and the therapist with the result that the close relationship essential to treatment is destroyed. A discussion of recent New York legislation argued:

The primary effect . . . has been to orient the patient away from his doctor. Now he looks to the court . . . for release rather than to his doctor. After counting treatment in days rather than in improvement, he . . . can request a hearing . . . and a *judge* will determine whether his treatment shall end. This is antitherapeutic.

. . . . [I]nstead of replacing legalistic machinery with a medical approach to the problem of admission and retention, the . . . new law has . . . emphasize[d] the court and legal ritual.¹⁴⁷

This again, however, assumes a much closer patient-physician relationship than this study suggests actually exists in the acute treatment system. In addition, there is little less logic in the alternative argument that unless a nonvoluntary patient is convinced that he has been treated fairly, he will not be susceptible to suggestions that he conform to the desires of his "captors" on other than a superficial basis. As of yet, there is simply no reliable evidence as to the actual effect of court procedures on the therapeutic relationship in those limited situations where such a relationship can be said to exist.

d. Effectiveness of judicial participation. Camara makes clear that in determining the constitutionally-necessary role of the judiciary, the extent to which a judicial function can be performed effectively in the

147. *Editorial Comment, Law's Labor Lost*, 40 *PSYCHIATRIC Q.* 150 (1966).

specific context is a necessary consideration. A strong case can be made for the position that at the time admission is indicated, a psychiatric facility cannot reasonably be expected to prove by a preponderance of the evidence that the proposed patient meets the criteria for non-voluntary hospitalization. For example, the patient's home situation is extremely important in admission and retention, yet it may be several days before a realistic evaluation can be made of this.

But *Camara* also leaves no doubt but that the function of the judicial officer may be adjusted to the situation. The effectiveness of a judicial decision-maker inserted at an early stage of the hospitalization process may well depend on a realistic definition of his function. There are two basic alternatives. The court may perform a "review" function, assuring that no one not within the legal criteria is subjected to hospitalization. Under this view, the task of selecting those within this boundary who are to be subjected to the system is delegated primarily to medical personnel. On the other hand, the court may be viewed as having the function of determining in each case whether the individual before it is to be subjected to the system.¹⁴⁸

As the system has developed in St. Louis, the actual role performed by the court is that of review. Only where it appears to the court that medical authorities have hospitalized a patient who falls without a very broadly defined category, does the court consider denying the commitment application. The Court of Appeals for the District of Columbia has, however, taken the position that the District of Columbia Hospitalization of the Mentally Ill Act imposes on the courts of that jurisdiction a much more active function. The Act authorizes the

148. Similar disputes over the role of the court have arisen in the juvenile court context. See generally U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, STANDARDS FOR JUVENILE AND FAMILY COURTS 9-15 (1966). The analagous problem in the juvenile court area is complicated by the fact that the "treatment" is frequently administered by agencies which are themselves within the organizational control of the court. Decisions made by workers in these agencies are sometimes considered "quasi-judicial." It has generally been felt, however, that the basic dispositional decision *must* be made by the court itself although the initial decision as to whether to detain the child prior to adjudication and disposition may be made by a court-designated administrative official. *Id.* at 12, 61 (1967). But there has been a great deal of emphasis on providing a standard procedure—essentially an administrative hearing—at which the child or his parents have a right to "make a case" for release and to have the *legal* criteria applied to the situation. *E.g.*, NATIONAL COUNCIL ON CRIME AND DELINQUENCY, STANDARD JUVENILE COURT ACT § 17, at 38-40 (1959). Most psychiatric hospitalization statutes do not provide for this administrative due process nor is there any evidence that the facilities have developed this themselves; the staffing, described in the text at note 84 *supra*, served no purpose in the facility observed here insofar as application of the *legal* criteria was concerned.

court, if it finds that the pre-patient is "mentally ill and, because of that illness, is likely to injure himself or others if allowed to remain at liberty," to order whether commitment or "any other alternative course of treatment which the court believes will be in the best interests of the person or of the public."¹⁴⁹ In *Lake v. Cameron*,¹⁵⁰ the Court of Appeals remanded the habeas corpus appeal of an elderly woman (with a proven tendency to "wander about the streets") for a consideration of alternative courses of treatment. Before commitment could be ordered, the court indicated, those seeking commitment would have to carry the burden of proving *to the court* that alternative courses of treatment would not in each specific case sufficiently protect the patient and the public.

To a significant extent the view of the court as having the function in each case of initially determining the appropriate form of "treatment" rests on the assumption that the court will be the first official agency approached by those seeking hospitalization of an individual. The statutory procedures for hospitalization by court order, for example, almost uniformly assume that when the community decision to seek medical attention is made, the court will be approached, the procedure put into motion and the applicant and the prospective patient will remain in the community, awaiting the results of a judicial inquiry. But, as this study illustrates, such a view does not correspond to the actual dynamics of the community decision; hospitalization is frequently not sought until a crisis situation develops, and when this occurs a strong demand is made for rapid hospitalization. Immediate help is sought directly from public psychiatric facilities. By the time of judicial involvement in the process, a program of treatment has already been determined by the facility which has accepted the patient; the existence of such a determination by a professional staff works strongly against the court going again over the same ground. To the extent that the court will make a *de novo* determination of the course of treatment in each case assumes that it will be presented with somewhat equally balanced alternatives, it is an unrealistic expectation.

But early judicial involvement in the hospitalization process need not require the court to perform the dispositional function. A limited function, arguably more appropriate to the situation, has been given the court in the Illinois statutory structure. Within five days of admission, each patient admitted pursuant to the certification of one physi-

149. D.C. Code § 21-545(b) (1967).

150. 364 F.2d 657 (D.C. Cir. 1966), *cert. denied*, 382 U.S. 863 (1967).

cian must have an informal consultation with a judicial officer.¹⁵¹ At this consultation, the judicial officer is directed to identify himself, explain to the patient his legal rights and inquire whether the patient desires a full judicial hearing.¹⁵² He is to determine at this time only whether there is "reasonable doubt as to whether the patient should be detained" as meeting the criteria for nonvoluntary hospitalization.¹⁵³ "If the patient indicates in any manner that he desires such a hearing" or if the judge entertains reasonable doubt as to the propriety of the confinement, a full hearing is to be held within five days.¹⁵⁴

Routine judicial participation, it has also been argued, will frequently be ineffective because the proposed patients will often not actively take part in the procedure. The St. Louis study lends some support to this; less than one-third of the patients appeared to take part in the commitment hearing. But it does not necessarily follow from this that even in these cases the hearing must be functionless. If the argument assumes that failure to participate in the hearing means that the patient no longer opposes continued hospitalization or that he accurately realizes he is properly hospitalized (and in either case a hearing is consequently unnecessary), it can be effectively questioned. A number of patients observed in the court hearings took the position that they did not desire hospitalization but had resigned themselves to the fact that the "medical determination" of their need for hospitalization would be carried out. It is reasonable to assume that some of those who did not appear at the hearings failed to do so because of the same belief in the futility of opposition. Moreover, the court files suggested that there was often significant doubt whether the nonresisters met the criteria for nonvoluntary hospitalization. Family and medical pressure, it seems clear, can stifle opposition to nonvoluntary hospitalization in cases where there is serious doubt that the patient meets the legal criteria.

Insofar as the argument assumes that active participation by the proposed patient is necessary to the effective functioning of the judicial process, it is also open to challenge. But in these cases (as well as in many where the patient actively opposes institutionalization), the effectiveness of judicial participation will probably depend upon the availability of an ancillary staff to assure that adequate factual in-

151. ILL. STAT. ANN. ch. 91½, § 7-2 (Smith-Hurd Supp. 1969).

152. *Id.*

153. *Id.*

154. *Id.*

formation is placed before the court. Pro forma representation by counsel such as was observed in this study will not suffice. Probably the only realistic answer is a professional staff assigned to hospitalization matters. New York's Mental Health Information Service is the best developed example.¹⁵⁵ Only such a staff, with detailed knowledge of technical medical matters and with time to investigate and prepare cases, can make the hearing procedure an effective fact-finding process.

But perhaps most important is the need to recognize that judicial involvement can be effective only if the judiciary enforces realistic substantive criteria. Insofar as the legal framework, through the judiciary, attempts to impose upon a psychiatric hospitalization system a function that is significantly at variance with that demanded by the community, the entire legal framework is unlikely to be an effective determinant of the system's operation. This study suggests that the substantive criteria must recognize that in practice, medical help is frequently sought in a crisis situation after the family or community has exhausted its patience with the symptomatic behavior of the patient. Those criteria that consider only what purport to be characteristics of the patient—such as lack of insight or ability to make responsible decisions—ignore the basic reality of "mental illness"; the significance of a symptom is determined by factors external to the patient, such as community or family resources or attitudes. Non-voluntary hospitalization is demanded not because of the *existence* of symptoms, but because of the *effect* which the patient's symptoms have on others. Unless the legal criteria take into account the actual dynamics of the underlying problem, the legal framework and the judiciary are almost certain to be largely ignored and therefore ineffective in practice.

155. New York's Mental Health Information Service is an exciting innovation made in response to a recommendation by a Special Committee of the New York City Bar Association in cooperation with Cornell Law School. See SPECIAL COMMITTEE TO STUDY COMMITMENT PROCEDURES, ASS'N OF BAR OF THE CITY OF NEW YORK, MENTAL ILLNESS AND DUE PROCESS (1962). Note, *The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill*, 67 COLUM. L. REV. 672 (1967), describes the operation of the Service. Composed of individuals with a variety of backgrounds (most are either attorneys or social workers), the Service attempts to make hearing procedures meaningful and, when no formal hearing is held, to assist the patient through the administrative procedure. Members explain to admitted patients their legal rights, compile information for adjudication and disposition in those cases in which a hearing is held and, in some cases, even act as counsel for the patient. Although it is questionable whether such an agency should—or constitutionally could—replace representation by counsel, the existence of such an agency makes protection of the legal rights of patients a more attainable goal.

3. *Waiver of Right to Initial Judicial Involvement*

Even if the right to a prior or early judicial determination of the justification for hospitalization is a constitutional right, it is nevertheless clear that it may be waived, not only by the individual himself but also by someone acting for him. As the issue arises in the mental hospitalization context, it raises the question of the extent to which subsequent judicial involvement in the continued detention of an individual admitted pursuant to a nonjudicial procedure may be made to depend on continued and active assertion of objections to the hospitalization or specific demand for judicial involvement. The issue is essentially one of waiver; by failing to affirmatively and actively oppose hospitalization by demanding a judicial hearing, the individual is considered to have waived his right to a judicial determination of the justification for that hospitalization. There is no apparent reason why the matter should not be tested by the Supreme Court's traditional definition of waiver as "an intentional relinquishment or abandonment of a known right or privilege"¹⁵⁶ as this has been developed in case law.

*Henry v. State of Mississippi*¹⁵⁷ suggests that the constitutional validity of a waiver procedure may depend in part upon whether the procedure serves a "legitimate state interest" and upon the importance of that interest. It seems realistic to say that effective judicial participation in the hospitalization process requires some preliminary screening of the cases that are brought before the court. If all cases, regardless of the attitude of the hospitalized individual or the merits of his opposition to hospitalization, are taken through the same procedure, there is strong pressure for that procedure to become little more than form. In addition, the strong time pressure on the court as well as counsel and the psychiatric facilities suggests that the time and effort necessary to the reliable resolution of the difficult issues posed by the close cases may not be available if significant time and effort must be spent on even the "clear" cases. The unavoidable impact of inertia must also be considered; a patient with an arguably meritorious case who is presented before a court immediately after the court has heard twenty cases with no merit whatsoever probably has an initial task of significant difficulty in directing the court's full and neutral attention to his own situation. The state, then, has an identifiable and impor-

156. *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938).

157. 379 U.S. 443 (1965).

tant interest in providing for waiver by nonassertion of the right to a judicial determination.

But existence of a state interest is not enough. The waiver must also meet basic minimum standards, usually summarized by the statement that waiver of a right requires knowledge and understanding of that right in addition to a clear and voluntary intention to relinquish it.¹⁵⁸ In the criminal context, it has been suggested that to assure that the waiver meets these requirements, a waiver of an important right must be made before the court itself whenever feasible:

[W]here the defendant is available, "the serious and weighty responsibility" of determining whether he wants to waive a constitutional right requires that he be brought before the court, advised of that right and then permitted to make "an intelligent and competent waiver."¹⁵⁹

The implementation of this position has been attempted by the hospitalization procedure adopted in Illinois which requires that each nonvoluntary patient be interviewed by the court and informed of his right to a judicial determination of the justification of his detention; the patient's response in the presence of the court determines whether the right has been waived.¹⁶⁰

In the hospitalization context, as in the criminal context, without the advice of someone trained and experienced in the law, most patients cannot have either the knowledge or intent that is required for waiver of their right to a judicial proceeding. Nor would appointment of routinely ineffective counsel fill the need. By far the most promising answer seems to be the development of a professional staff devoted to assuring that patients are aware of their rights. This is essentially the task which has been undertaken in New York by the Mental Health Information Service. Such a program, however, raises a difficult question: to what extent may a legal advisor (such as a member of the Mental Health Information Service) waive for a patient the right to a judicial determination? *Henry* made clear that even in the criminal area counsel could, by a choice of trial tactics, legitimately waive for a defendant a constitutional right. But only one year later, in *Brookhart v. Janis*,¹⁶¹ the Court emphasized that this did not permit counsel

158. *E.g.*, *Dupes v. Johnson*, 353 F.2d 103, 105 (6th Cir. 1965) ("Constitutional rights cannot be waived without a knowledge and understanding of them and without a clear and voluntary intention to waive them."). *See also* *Brookhart v. Janis*, 384 U.S. 1 (1966).

159. *Gross v. United States*, 325 F.2d 629, 631 (D.C. Cir. 1961).

160. *See* text at notes 151-53 *supra*.

161. 384 U.S. 1 (1966).

to override a defendant's expressed desire to assert a specific right. If counsel is to perform a valuable screening function, it is inevitable that he will be confronted with extremely difficult *Henry-Brookhart* problems: to what extent should—and must—he assist a patient in the presentation of opposition to hospitalization when the patient insists on a full scale judicial hearing despite the lack of any merit whatsoever to his objections? To what extent should—and must—counsel advise and assist a patient in obtaining a judicial determination where the patient's resistance is very mild and it is likely that he does not meet the criteria, yet his release would cause both the patient and his family severe discomfort? These difficult problems of ethics and counseling technique are beyond the scope of this discussion.¹⁶² But any successful resolution of the issues which are of primary concern here must anticipate that difficulties of this nature will arise in practice.¹⁶³

162. The problem of waiver is one on which there is little helpful law. In *Dooling v. Overholser*, 243 F.2d 825 (D.C. Cir. 1957), the court, interpreting a statute extending to a respondent in a commitment proceeding the "right to be represented by counsel" in all hearings, invalidated a commitment because the respondent had not been represented by counsel at a hearing before the Commission on Mental Health. An attorney had been appointed but had been discharged at the specific request of the respondent. The court carefully indicated, however, that its ruling did not require appointment of an attorney but only the appointment of a responsible person to act as guardian ad litem. Apparently this guardian ad litem would have been empowered to waive for the respondent such rights as that to be represented by counsel as well as such procedural rights as putting the state to its proof on the issue of whether the criteria for nonvoluntary hospitalization were met. *But cf.* *Rees v. Peyton*, 384 U.S. 312 (1966), remanding for a judicial determination of the competency of a state prisoner under sentence of death who attempted to withdraw his petition for certiorari in which he challenged the constitutional validity of his conviction.

Even in the criminal context there is little consistency in the approaches taken by courts to waiver questions. In *Cross v. United States*, 325 F.2d 629 (D.C. Cir. 1961) (*see* text at note 158 *supra*), for example, it was held that the defendant had not waived his right to be present at this trial by telling his attorney specifically that he did not want to return to the courtroom after a recess. *But cf.* *Hatcher v. United States*, 352 F.2d 364 (D.C. Cir. 1965), *cert. denied*, 382 U.S. 1030 (1966), in which the same court upheld a purported waiver of jury trial despite the lack of any direct communication between the defendant and the court because there was "no suggestion that [the] waiver was not intentional or without actual knowledge of . . . [the] right." *Id.* at 365. There is even some suggestion that defective counsel may increase the likelihood that a waiver will be found. In *Kuhl v. United States*, 370 F.2d 20 (9th Cir. 1966), counsel's failure to demand exclusion of evidence because he felt the basis for the exclusion was "arguable" was held to constitute a waiver by the client of the right to have the evidence excluded. The court commented, "The law does not . . . make the fact of waiver stand or fall upon such tenuous matters as the extent or accuracy of the lawyer's knowledge of the facts or the law or the sufficiency of the reasons for his actions." *Id.* at 26. *Compare* *United States v. Banmiller*, 310 F.2d 720 (3d Cir. 1962), *cert. denied*, 374 U.S. 828 (1963).

163. Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*,

B. *A Proposal*

The Fourth-Fourteenth Amendment analysis strongly suggests that it is constitutionally necessary that a "neutral and detached magistrate" be inserted at an early point in the psychiatric hospitalization process. There is, however, room within the constitutional directive to accommodate his function to the practical problems presented by the process. Moreover, if care is taken to assure that the hospitalized individual is provided with effective legal counseling, it is constitutionally permissible to limit, on the basis of failure to demand a full review of the situation, full judicial inquiry to those cases where it can serve a valuable function.

The following proposal is geared to a large metropolitan area served by acute psychiatric facilities offering emergency room services. It assumes that community members will frequently approach the acute facility rather than any other official agency when a crisis situation develops. It also assumes that in many cases it would be mechanically impracticable to obtain judicial authorization prior to the time of hospitalization. This, together with the reliability of psychiatric facility personnel, the proposal concludes, justifies postponing judicial intervention in all cases to a limited extent. In defining the judicial function, it assumes that more flexibility must be granted to community and facility medical personnel early in the process than is accorded them after they have had an opportunity to investigate the situation. Consequently, the function of the court develops from a screening

44 TEXAS L. REV. 424 (1966), considers in detail the role of an attorney assigned to (or engaged by) a patient. He concludes that if a patient desires to resist commitment, "the attorney must seek to further that desire, attempt to convince the client that hospitalization or some other treatment plan appears to be in his best interest, or withdraw." *Id.* at 451-52. This oversimplifies the problem. No consideration is given to the difficult question of the extent to which the attorney should attempt to convince a patient out of his expressed desires. This is especially important given the inherently coercive atmosphere surrounding a hospitalized individual. Nor does Cohen suggest the attitude counsel should take towards the "nonprotesting" patient, the "nonresisters" of this study. Undoubtedly counsel's general attitude, the manner in which various alternatives are described, and the enthusiasm with which they are presented as well as counsel's own evaluation of their desirability all influence the patient's actions. In approaching this, to what extent should counsel be influenced by family desires or by his own evaluation of the family's best interests? These are the real problems.

Nor does Cohen's analysis provide much help for the professional staff member of an agency who does not have the option of withdrawal. It is almost certain that members of staffs such as the New York Mental Health Information Service will have to allocate their efforts among patients. To what extent should or may staff members effectuate this allocation by waiving the rights of those patients whose invoking of the rights would lead to what the staff believes are undesirable results?

role at the initial stage to a *de novo* consideration of the merits of alternative disposition at the indeterminate commitment stage. The criteria for nonvoluntary hospitalization also become increasingly restrictive as the consequences of hospitalization become more serious. The short-term criterion is broader than most existing statutory provisions but it probably represents what is generally used in actual practice; it recognizes that patients are presented for a variety of "non-therapeutic" reasons and that relatively short-term hospitalization is frequently effective in relieving the "nonmedical" crisis that precipitated presentation. The criteria for indeterminate commitment is much more restrictive. Family and community disruption, as well as danger to property, may be a sufficient basis to demand that "something be done." But if the only recourse is indeterminate custodial detention, the social objective does not justify the means required to achieve it. Moreover, a broader criteria may run afoul of patients' "right to treatment"; its constitutional validity may be saved if it is used for the limited purpose of "crisis remission."¹⁶⁴

164. Whether a "right to treatment" exists on a constitutional level is far from clear. The leading case is undoubtedly *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), enforcing a statutory right to treatment of a patient hospitalized pursuant to a finding of not guilty by reason of insanity in a criminal trial. See generally, Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134 (1967).

The rationale asserted for the right is simple: the justification for depriving the patient of his liberty is that by requiring him to submit to treatment, his condition can be improved. If, however, there is no reasonable expectation of improving the individual's "illness," the rationale for his detention fails and he is entitled to release. This, of course, ignores potential reliance upon social interests other than the patient's cure. Dangerousness without regard to curability is a reasonable justification for continued detention, and the danger of family disruption as well as the social interest in preserving the ability of people to carry out their everyday affairs without serious inconvenience can be offered to justify detention. But this creates additional problems. Insofar as interests other than the patient's improvement for its own sake are relied upon to justify detention, less relaxation of traditionally criminal procedural safeguards can be tolerated. And if some individuals who commit antisocial acts are imprisoned while others are hospitalized for longer periods after (and because) they committed the same acts, does this violate Equal Protection? If the concept of "mental illness" is vague or unreliable, the answer must be affirmative. Moreover, if the danger or disruption of affairs is small or its potentiality low, long-term preventative detention may constitute a denial of substantive due process or an imposition of cruel and unusual punishment. Cf. *Powell v. Texas*, 392 U.S. 651 (1968), in which the Court held that the constitutional prohibition against cruel and unusual punishments did not require that the states forsake the criminal process as a means of dealing with the chronic alcoholic. The Court was obviously influenced by its conclusion that "medical" knowledge of the nature and treatment of alcoholism was scant and that to restrict states to a "treatment" approach "might subject indigent alcoholics to the risk that they may be locked up for an indefinite period . . . with no more hope

1. *Initial Admission*

The acute facility should be authorized to admit upon the certification of a staff physician of the acute facility that he believes an individual meets the criteria for short-term hospitalization. The criteria applied should be those set out in the next paragraph. Brief, informal hearings should be conducted by a judicial officer at the facility on the morning of each weekday, a patient, whether a voluntary or a non-voluntary admission, should be required to appear at the first hearing following his admission. The judicial officer should have available the report of the admitting physician and should attempt to elicit from the patient his understanding of the circumstances of his presentation and admission. The patient should be informed by the judicial officer of his legal status and of his right to a full judicial hearing. Release should be ordered only if the judicial officer finds that there is not substantial reason to believe that the patient meets the criteria for nonvoluntary short-term hospitalization or (in the event that the patient is a voluntary admission) that the admission was not a free exercise of the patient's will.

2. *Short-term Treatment*

The initial certification by the admitting physician should be a sufficient basis for a thirty-day period of hospitalization unless a judicial hearing is requested. If, either at the time of the initial informal hearing or at any subsequent time, the patient or the legal service re-

than before of receiving effective treatment and no prospect of periodic 'freedom.'" 392 U.S. at —.

Nor is the scope of the right, if it exists, at all clear. In *Rouse*, the court recognized that "milieu therapy" would in some cases meet the requirement; 373 F.2d 451, 456 (D.C. Cir. 1966). In *Lake v. Cameron*, 364 F.2d 657, 659 (D.C. Cir. 1966), the court hinted that full time hospitalization where a lesser degree of control would be adequate might violate constitutional norms. Yet in *Collins v. Cameron*, 377 F.2d 945 (D.C. Cir. 1967), the court held that the right to treatment did not prohibit the full time hospitalization of the petitioner while he was taking tranquilizing drugs for the purpose of denying him access to alcohol. The testimony was that the petitioner was not dangerous while taking medication, but that if he discontinued his medication and resorted to alcohol (as he had done in the past), he would become dangerous. Moreover, in *Rouse* the court apparently held that "the hospital need not show that the treatment will cure or improve . . . [the patient] but only that there is a bona fide effort to do so." While expressly disclaiming consideration of the "untreatable patient," the court quoted expert opinion that *no* patients are untreatable. Cf. *Nason v. Commissioner of Mental Health*, 351 Mass. 94, 217 N.E.2d 733 (1966).

In any case, both a realistic evaluation of the reliability of the illness concept as well as constitutional considerations indicate that use of the "convenience" justifications be limited to relatively short term hospitalization.

quests a hearing, such a proceeding should be held within three days. At this hearing, the facility should have the burden of establishing that the patient meets the criteria for nonvoluntary hospitalization. The court should be directed to order hospitalization for thirty days from the date of initial admission in all cases where it is found that the patient is (1) "mentally ill," and (2) by reason of that "mental illness," (a) there is a significant danger that the patient will engage in violent conduct and thereby create a serious danger of immediate physical harm to himself or others, or will create a substantial danger of serious damage to property belonging to others, or (b) the patient's ability to function normally in the community is so impaired that there is a substantial probability that he will be seriously harmed or that he will repeatedly and seriously disrupt the ordinary affairs of others, or (c) the patient's living situation has been so disrupted as to create a significant threat to the family's stability or the emotional or physical health of its members.

3. *Authorization for Indeterminate Hospitalization*

Since this is a much more significant deprivation of liberty, judicial investigation of alternatives should occur in each case and the criteria should be significantly more restrictive. A thirty-day short-term period of hospitalization should precede the application for indeterminate hospitalization. This would give the facility adequate opportunity to diagnose and prepare the factual foundation for the application. In each case, the court should be required to consider alternatives to full-time hospitalization and should be directed to order hospitalization only if no other disposition will prevent the adverse results anticipated by the criteria. Commitment should be authorized only after a factual finding that the patient is (1) "mentally ill," and (2) by reason of that "mental illness" either (a) there is a significant danger that the patient will engage in violent conduct and thereby create a serious danger of immediate physical harm to himself or others, or (b) the ability of the patient to function normally in the community is so impaired that there is substantial probability that, if not hospitalized, he will be subjected to serious physical harm.

* * *

This study concerned itself with only a few of the many problems that arise in the relationship between nonvoluntary psychiatric treatment and the law. Many others deserve far more attention than they

receive in current literature. For example, few legal frameworks make any attempt to accommodate nonvoluntary outpatient treatment, an increasingly important part of public psychiatric care.¹⁶⁵ The wide variety of problems raised by hospitalization of those accused or convicted of criminal offenses is beginning to attract attention, but the issues are far from resolved.¹⁶⁶

The proposal in Part III represents no more than a summary of subjective conclusions regarding the issues raised throughout the paper. Insofar as it is inconsistent with existing practices, there is no assurance that it would be any more successful in changing those practices than was the Missouri legal framework in affecting the system that was the subject of this study. The problem is not one of legal research or draftsmanship. Oaks and Lehman were probably correct when they concluded:

The surest way to solve systemic problems is the slowest: to advocate ideals rather than to institute them. Ideals that are absorbed by the participants in, and by the clients of, a system are likely to find expression in the system¹⁶⁷

Insofar as many of the problems discussed here are caused by what are probably misconceptions as to the nature and dynamics of the affliction with which the psychiatric hospitalization system must deal, their solution depends more on a better understanding of the affliction than on legal directives. Families who "solve" a crisis by labeling one member "mentally ill" and securing his hospitalization and courts which operate on the assumption that "need for hospitalization" is a medical judgment based upon clinical observations will probably be little affected by changes in the legal framework or will only find other

165. In *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966), the Court of Appeals ordered the lower courts to consider in each case court-ordered outpatient treatment as an alternative to full time hospitalization. But see the problems raised by the lower court judge who was faced with the *Lake* case on remand. *Lake v. Cameron*, 267 F. Supp. 155 (D.D.C. 1967). For a general discussion of the need for supervised treatment other than full time hospitalization and a proposal for structuring such a program, see Bleicher, *Compulsory Community Care for the Mentally Ill*, 16 CLEV.-MAR. L. REV. 93 (1967). For an encouraging report on the possibilities of nonhospital care of even those seriously ill, see B. PASAMANIC, F. SCARPITTI & S. DINITZ, *SCHIZOPHRENICS IN THE COMMUNITY* (1967).

166. See Lewin, *Disposition of the Irresponsible: Protection Following Commitment*, 66 MICH. L. REV. 721 (1968); Matthews, *Mental Illness and the Criminal Law: Is Community Mental Health an Answer?*, 57 AM. J. PUB. HEALTH 1571 (1967); Hess & Thomas, *Incompetency to Stand Trial: Procedures, Results and Problems*, 119 AM. J. PSYCHIATRY 713 (1963).

167. D. OAKES & W. LEHMAN, *A CRIMINAL JUSTICE SYSTEM AND THE INDIGENT* 195 (1968).

equally effective methods of implementing their beliefs. The problems raised by this study, like most problems raised by critical examination of legal rules and systems of social control, are not legal ones. They involve difficult factual questions and a variety of people acting in accord with their own answers to these questions. Reform must take into account not only the factual issues but also the resolutions of these questions arrived at by the participants in the process.