

# Washington University Law Review

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Volume 1979

Issue 1 *Symposium: The Quest for Equality*

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1979

## Missouri's New Mental Health Act: The Problems with Progress

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### Recommended Citation

Valerie Hughes Staulcup, *Missouri's New Mental Health Act: The Problems with Progress*, 1979 WASH. U. L. Q. 209 (1979).

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## NOTE

### MISSOURI'S NEW MENTAL HEALTH ACT: THE PROBLEMS WITH PROGRESS

The Missouri legislature, after an aborted attempt in 1977,<sup>1</sup> succeeded in passing a comprehensive new act to govern civil commitment of the mentally ill.<sup>2</sup> The act, which repeals twenty-nine sections and enacts forty-seven new sections, represents Missouri's first major piece of legislation in the mental health area since 1953.<sup>3</sup> The definitions and the procedures became effective July 1, 1978, and January 2, 1979, respectively.<sup>4</sup>

The revision of the mental health code was prompted in part by court decisions in other states that declared unconstitutional under the due process clause of the fourteenth amendment<sup>5</sup> provisions similar to those in the old Missouri code.<sup>6</sup> Potential sources of constitutional infirmity included the vagueness and breadth of the definition of those persons subject to involuntary commitment,<sup>7</sup> the delay before a judicial

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1. Mo. S. 275, 79th General Assembly, 1st Sess. (1977).

2. Mentally Deficient and Mentally Ill Persons—Treatment and Involuntary Civil Commitment (Mo. REV. STAT. §§ 202.010- .225).

Civil commitment should be distinguished from criminal commitment. Criminal commitment refers to:

those proceedings under which a person, who has been charged with a criminal offense and who asserts he is not liable to criminal punishment because, at the time of the offense, he suffered from a mental disease or defect excluding responsibility, and who, after being acquitted upon that ground, is committed to the division of mental diseases.

*State v. Kee*, 510 S.W.2d 477, 480 (Mo. 1974). Mo. REV. STAT. §§ 552.010- .080 (1979) governs criminal commitment proceedings in Missouri.

3. The last major piece of legislation was entitled: Relating to Hospitalization of the Mentally Ill, ch. 202, 1953 Mo. Laws 647.

4. Mentally Deficient and Mentally Ill Persons—Treatment and Involuntary Civil Commitment, ch. 202, 1978 Mo. Legis. Serv. 83, 103 (Vernon).

5. U.S. CONST. amend. XIV ("nor shall any State deprive any person of life, liberty, or property, without due process of law").

6. *E.g.*, *Institutionalized Juveniles v. Secretary of Pub. Welfare*, 459 F. Supp. 30 (E.D. Pa.), *prob. juris. noted*, 437 U.S. 902 (1978) (No. 77-1715); *J.L. v. Parham*, 412 F. Supp. 112 (M.D. Ga. 1976), *prob. juris. noted*, 431 U.S. 936 (1977) (No. 76-1690); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972); *Dixon v. Attorney Gen.*, 325 F. Supp. 966 (M.D. Pa. 1971); *In re Roger S.*, 19 Cal. 3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977). *See also* *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

7. *Compare* Mo. REV. STAT. § 202.010(12) (1969) *and* Mo. REV. STAT. § 202.807.5 (Supp. 1975) *with* *Bell v. Wayne County Gen. Hosp.*, 384 F. Supp. 1085, 1095-96 (E.D. Mich. 1974) *and*

hearing,<sup>8</sup> the content of the notice of hearing received by a person alleged to be mentally ill,<sup>9</sup> the standard of proof required at the hearing,<sup>10</sup> and the power of a court to order hospitalization for an indeterminate period.<sup>11</sup>

The strong movement to protect the civil rights of the mentally ill also spurred the modernization of commitment standards and procedures.<sup>12</sup> Civil libertarians, analogizing the loss of liberty in civil commitment to that in criminal confinement, advocated that the procedural protections afforded to criminal offenders be provided to those subject

Dixon v. Attorney Gen., 325 F. Supp. 966, 971 (M.D. Pa. 1971) and Finken v. Roop, 234 Pa. Super. Ct. 155, 183, 339 A.2d 764, 778 (1975) (three judges) and Hawks v. Lazaro, 202 S.E.2d 109, 123 (W. Va. 1974). But see *In re Beverly*, 342 So. 2d 481, 485 (Fla. 1977); Fhagen v. Miller, 29 N.Y.2d 348, 354, 278 N.E.2d 615, 617, 328 N.Y.S.2d 393, 396-97, cert. denied, 409 U.S. 845 (1972).

8. Compare MO. REV. STAT. § 202.805 (1969) (full hearing within 25 days) with Lynch v. Baxley, 386 F. Supp. 378, 388 (M.D. Ala. 1974) (full hearing within 7 days) and Lessard v. Schmidt, 349 F. Supp. 1078, 1091-92 (E.D. Wis. 1972) (preliminary hearing within 48 hours and full hearing within 10 to 14 days). But see Logan v. Arafah, 349 F. Supp. 1265, 1268 (D. Conn. 1972) (full hearing within 45 days "not so baseless as to be unconstitutional"), *aff'd mem. sub nom.* Briggs v. Arafah, 411 U.S. 911 (1973).

9. The previous code provided that: "Upon receipt of an application [for involuntary hospitalization] the court shall give notice thereof, and of the time of hearing thereon, to the proposed patient, and to his legal guardian." MO. REV. STAT. § 202.807.2 (Supp. 1975). Cf. Lynch v. Baxley, 386 F. Supp. 378, 388 (M.D. Ala. 1974) ("Such notice should include the date, time, and place of the hearing; a clear statement of the purpose of the proceedings and the possible consequences to the subject thereof; the alleged factual basis for the proposed commitment; and a statement of the legal standard upon which commitment is authorized.") (footnote omitted); Lessard v. Schmidt, 349 F. Supp. 1078, 1092 (E.D. Wis. 1972) ("The patient should be informed of the basis for his detention, his right to jury trial, the standard upon which he may be detained, the names of the examining physicians and all other persons who may testify in favor of his continued detention, and the substance of their proposed testimony.") (footnote omitted).

10. The Missouri statute was silent on the degree of proof required, MO. REV. STAT. § 202.807.2 (Supp. 1975); thus courts applied the preponderance of evidence test used in civil cases. But see *In re Ballay*, 482 F.2d 648, 668 (D.C. Cir. 1973) (reasonable doubt standard); Lessard v. Schmidt, 349 F. Supp. 1078, 1095 (E.D. Wis. 1972) (same). Many courts have adopted the intermediate standard of clear and convincing proof. See, e.g., *Institutionalized Juveniles v. Secretary of Pub. Welfare*, 459 F. Supp. 30, 44 (E.D. Pa.), *prob. juris. noted*, 437 U.S. 902 (1978) (No. 77-1715); Lynch v. Baxley, 386 F. Supp. 378, 393 (M.D. Ala. 1974); Dixon v. Attorney Gen., 325 F. Supp. 966, 974 (M.D. Pa. 1971); *In re Beverly*, 342 So. 2d 481, 488 (Fla. 1977); *In re Stephenson*, 67 Ill. 2d 544, 556, 367 N.E.2d 1273, 1278 (1977); *State v. Valdez*, 88 N.M. 338, 343, 540 P.2d 818, 822 (1975); *In re Levias*, 83 Wash. 2d 253, 256, 517 P.2d 588, 590 (1973); Hawks v. Lazaro, 202 S.E.2d 109, 126 (W. Va. 1974).

11. Compare MO. REV. STAT. § 202.807.5 (Supp. 1975) with Dixon v. Attorney Gen., 325 F. Supp. 966, 974 (M.D. Pa. 1971) (6 months maximum commitment).

12. See B. ENNIS & L. SIEGEL, *THE RIGHTS OF MENTAL PATIENTS* (1973); T. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY* (1963); T. SZASZ, *PSYCHIATRIC SLAVERY* (1977); *1 LEGAL RIGHTS OF THE MENTALLY HANDICAPPED* (B. Ennis & P. Friedman eds. 1973).

to civil commitment laws.<sup>13</sup>

This Note summarizes key provisions of Missouri's revised mental health code, compares them with the repealed provisions, and discusses the difficulties the new code presents for the mentally ill, the medical and legal professions, and the judiciary.

### I. STANDARDS FOR COMMITMENT

Any person who has "symptoms of mental disorder, mental illness, alcoholism, or drug abuse"<sup>14</sup> may apply for admission as a voluntary patient to a public mental health facility.<sup>15</sup> The code defines "mental disorder," a term not used in the previous statute, as "any organic, mental or emotional impairment, including those induced by alcoholism or drug abuse, which has substantial adverse effects on a person's cognitive, volitional, or emotional functioning."<sup>16</sup> The definition of

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13. T. SZASZ, LAW, LIBERTY, AND PSYCHIATRY 182-90 (1963); Ennis, *Civil Liberties and Mental Illness*, 20 CRIM L. BULL. 101, 108 (1971). The drive to formalize the commitment process contrasts with the patient-rights movement of an earlier era, which advocated the informalization of commitment proceedings using the juvenile court as a model. See generally N. KITTRIE, *THE RIGHT TO BE DIFFERENT* 79-83 (1971).

14. MO. REV. STAT. § 202.155 (1979). The code contains no definition of "alcoholism" or "drug abuse." The prior code also failed to define these terms. Compare Missouri's failure to define these terms with Wisconsin's efforts. "'Alcoholic' means a person who habitually lacks self-control as to the use of alcoholic beverages and uses alcoholic beverages to the extent that his or her health is substantially impaired or by reason of such use is deprived of his or her ability to support or care for himself or herself, or such person's family." WIS. STAT. ANN. § 51.01(1) (West Supp. 1978-1979). "'Drug dependent' means a person who uses one or more drugs to the extent that the person's health is substantially impaired or his or her social functioning is substantially disrupted." *Id.* § 51.08(8).

In addition to its failure to define these terms, the Missouri code lacks a declaration of legislative purpose. Compare other states' articulation of legislative intent. See, e.g., CAL. WELF. & INST. CODE § 5001 (Deering Supp. 1978); PA. STAT. ANN. tit. 50, § 7102 (Purdon Supp. 1978-1979); WASH. REV. CODE ANN. § 71.05.010 (1975); WIS. STAT. ANN. § 51.001 (West Supp. 1978-1979). A declaration of the policies intended to be pursued may be essential to proper judicial interpretation of statutory language.

The [state] legislatures provide administrators and courts nothing but the statutes themselves. Without legislative assistance in interpretation, courts have resorted to all the artificialities which make the rules of statutory construction an impenetrable tangle of waste words. . . . Legislatures must accept the responsibility of providing something more than journals recording motions made and lost, amendments offered, and final roll call votes and committee reports that consist of solemn recommendations that "the bill do (or do not) pass."

Horack, Jr., *Cooperative Action for Improved Statutory Interpretation*, 3 VAND. L. REV. 382, 387 (1950).

15. MO. REV. STAT. § 202.010 (16) (1979). The head of a private mental health facility may also accept voluntary and involuntary patients under the act. *Id.*

16. *Id.* § 202.010(3).

"mental illness"<sup>17</sup> is narrower in scope than "mental disorder;" it specifically excludes mental retardation, developmental disabilities, narcolepsy, simple intoxication, drug or alcohol dependence or addiction, and "any other disorders not of an actively psychotic nature, such as senility, unless such conditions are accompanied by a mental illness."<sup>18</sup>

The state may involuntarily commit for treatment<sup>19</sup> a mentally ill person who, as a result of his mental illness, presents a likelihood of serious physical harm to himself or others.<sup>20</sup> Likelihood of serious physical harm to oneself, under the code, requires a showing of a "substantial risk" that physical harm will be self-inflicted as evidenced by "recent threats or attempts to commit suicide or inflict physical harm on himself, or by failure or inability to provide for his essential human needs."<sup>21</sup> Likelihood of serious physical harm to others, on the other

17. MO. REV. STAT. § 202.010(4) (1979) defines "mental illness" as:

[A] state of impaired mental processes, which impairment results in a distortion of a person's capacity to recognize reality due to hallucinations or delusions or faulty perceptions or alterations of mood and interferes with an individual's ability to reason, understand or exercise conscious control over his actions, and may be manifested by instances of grossly impaired behavior.

This definition covers only schizophrenics, manic-depressives, paranoids, and psychotic-depressives. AMERICAN PSYCHIATRIC ASSOCIATION DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS §§ 295-98 (2d ed. 1968).

18. MO. REV. STAT. § 202.010(4)(a)-(d) (1979). Sections 202.187-.195 cover persons with mental retardation and developmental disabilities. Although these provisions are not discussed in this Note, the mentally retarded and developmentally disabled receive greater protection in some instances than the mentally ill. For example, a mentally retarded minor with voluntary status who requests discharge must be released unless dangerous; however, a mentally ill minor who requests discharge may be held for ninety-six hours while involuntary commitment proceedings are initiated on the mere ground that the head of the facility does not concur in his release. *Id.* §§ 202.187.2(3), .115.2(3), respectively.

19. A recent federal district court decision draws into question the right of a state to forcibly administer drugs to an involuntary mental patient. The court held that a mental patient's right of privacy entails a right to refuse treatment in nonemergency circumstances. The right, however, is not absolute. In a due process hearing the fact-finder must weigh the protection of hospital staff and other patients from harm along with the extent to which the refusal of treatment is based on the underlying mental illness against the patient's right to refuse treatment. During such a hearing, the patient is entitled to counsel and an outside psychiatrist of his choice. *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978).

20. MO. REV. STAT. §§ 202.135.5, .137.1, .143.3, .145.1 (1979). This standard comports with the view of the Supreme Court that a "finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement." There is "no constitutional basis for confining such persons if they are dangerous to no one and can live safely in freedom." *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

See note 44 *infra* for an analysis of the difficulties of predicting dangerousness.

21. MO. REV. STAT. § 202.010(5)(a) (1979). Compare Missouri's criteria with California's treatment of suicidal persons (patient may be held for a maximum of 14 days beyond the initial

hand, must be evidenced by "recent overt acts" that placed another in "reasonable fear of sustaining such harm."<sup>22</sup>

The present code makes three significant changes in civil commitment standards. First, the definition of mental illness covers a much smaller group of mental conditions.<sup>23</sup> Under prior Missouri law, "mental illness" meant "a state of impaired mental function [including] alcoholism or other drug abuse to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others."<sup>24</sup> The old code's definition of mental illness is comparable to the new code's definition of mental disorder.<sup>25</sup> Thus, while the group of persons eligible for voluntary treatment remains essentially the same, the revision eliminates some classes of persons eligible for involuntary commitment. No longer will the senile, alcoholic, drug addicted, or non-psychotic individual be subject to involuntary detention and treatment for their conditions.<sup>26</sup>

The reason for the deletion of alcoholics from the new definition of the mentally ill may be mere legislative oversight.<sup>27</sup> Section 202.177, however, seems to indicate a conscious exclusion.<sup>28</sup> Whatever the reason, persons previously within the ambit of the civil commitment statute can now be cared for in mental hospitals only if they seek treatment voluntarily,<sup>29</sup> or if a court declares them incompetent and subsequently

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72-hour detention period unless he is recommended for a conservatorship or is dangerous to others. CAL. WELF. & INST. CODE § 5264 (Deering Supp. 1978)).

22. MO. REV. STAT. § 202.010(5)(b) (1979). Pennsylvania law, unlike Missouri law, does not consider threats sufficient to justify commitment. A "clear and present danger to others" is shown by "establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated." PA. STAT. ANN. tit. 50, § 7301(b) (Purdon Supp. 1978-1979).

23. MO. REV. STAT. § 202.010(4) (1979).

24. *Id.* § 202.010(12) (1969).

25. *Id.* § 202.010(3) (1979).

26. *Id.* § 202.010(4). See text accompanying note 16 *supra*.

27. Missouri modeled its statute after Washington's mental health code, WASH. REV. CODE ANN. § 71.05.011-.930 (Supp. 1970), which provides for involuntary commitment of alcoholics through another enactment, The Uniform Alcoholism and Intoxication Treatment Act, WASH. REV. CODE ANN. § 70.96A.011-.930 (1975). Although Missouri adopted the majority of Washington's provisions, it did not enact Washington's accompanying alcoholism treatment act.

28. MO. REV. STAT. § 202.177 (1979) states that:

Persons who are mentally retarded, developmentally disabled, senile or impaired by alcoholism or drug abuse, shall not be committed judicially pursuant to the provisions of sections 202.121 through 202.147, unless they are also mentally ill and as a result present likelihood of serious physical harm to themselves or to others.

29. *Id.* § 202.115.1(1). See notes 50-51 *infra* and accompanying text.

approves the guardian's application for his ward's commitment.<sup>30</sup> These two routes hardly seem adequate in view of the physical danger the alcoholic often poses to himself or others.<sup>31</sup> Immediate danger may be avoided by emergency detention of the individual,<sup>32</sup> but after ninety-six hours the hospital must release the individual regardless of his dangerousness unless he falls within the act's narrow definition of mental illness.<sup>33</sup>

The second major revision in the new code relates to its creation of a "mentally disordered" category of persons.<sup>34</sup> The legislature recognized that differential diagnosis<sup>35</sup> cannot be made instantaneously.<sup>36</sup> A person may act in a bizarre manner for any number of reasons, only some of which are grounds for commitment. The state, therefore, may detain a mentally disordered individual who presents a likelihood of serious physical harm for a ninety-six hour period while hospital staff observes and examines him to determine whether involuntary commitment is appropriate.<sup>37</sup> The mental health facility must release the patient if he is mentally disordered, but not mentally ill.<sup>38</sup>

The third substantial change in the newly adopted standards is the requirement for involuntary commitment when there is a likelihood of

30. MO. REV. STAT. § 202.115.1(4) (1979). See note 53 *infra* and accompanying text.

31. "One half of all homicides and one third of all suicides are alcohol related, resulting in 11,700 deaths a year. Two-thirds of all assaults and felonies are committed by persons under the influence of alcohol." J. KINNEY & G. LEATON, LOOSENING THE GRIP 24 (1978).

32. MO. REV. STAT. § 202.123.3 (1979). See text accompanying notes 87-88 *infra*.

33. MO. REV. STAT. § 202.127.1-.2 (1979). See note 17 *supra* and accompanying text.

34. MO. REV. STAT. § 202.010(3) (1979). "Mental disorder" is defined in text accompanying note 16 *supra*.

35. "Diagnosis," in its traditional sense, implies that:

there is some concrete thing, like an organ defect, an invading germ, or some definite psychic entity within the person, that exists internally and is the source of his behavioral troubles. The diagnostic search is to find the pathology so it can be treated. "Differential diagnosis" is the search for the exact disease responsible for the symptoms.

W. MISCHEL, PERSONALITY AND ASSESSMENT 194 (1968).

36. The patient is committed for treatment and care, and some knowledge of his mental condition can be gained by visual observation and diagnostic tests. This takes time. . . . [W]here a full blown court trial must be had . . . , additional time to undertake more elaborate testing of the patient's mental condition, and a more detailed probe into his relevant history, by both the hospital authorities and the expert witnesses who will testify in behalf of the patient is needed.

Logan v. Arafah, 346 F. Supp. 1265, 1269 (D. Conn. 1972) (footnotes omitted), *aff'd mem. sub nom.* Briggs v. Arafah, 411 U.S. 911 (1973).

37. MO. REV. STAT. § 202.123.2-.3 (1979).

38. *Id.* § 202.127.1-.2. "Mental disorder" and "mental illness" are defined in notes 16 and 17 *supra* and accompanying text.

serious physical harm to self or others. The old code demanded such a showing only for emergency detention.<sup>39</sup> For a court to order indeterminate involuntary hospitalization, the petitioning party needed only to establish that the respondent was "mentally ill and in need of custody, care, or treatment in a mental facility, and because of his mental condition lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization."<sup>40</sup> The new code limits involuntary commitment to actively psychotic persons whose psychosis renders them dangerous to themselves or others.<sup>41</sup>

This "dangerousness" standard in the new code probably will cause administrative problems. Many legislatures have recently narrowed the coverage of their civil commitment statutes to persons who have displayed overt dangerous behavior,<sup>42</sup> but have failed to take cognizance of the problems in predicting future dangerous behavior.<sup>43</sup> In addition, the Missouri Act offers no guidance to either the courts or expert witnesses charged with assessing dangerousness; that is, what magnitude, probability, or imminence of harms constitutes dangerousness and justifies deprivation of a person's liberty.<sup>44</sup>

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39. MO. REV. STAT. §§ 202.800.1(1), .803.1(1) (1969).

40. *Id.* § 202.807 (Supp. 1975).

41. *Id.* §§ 202.135.5, .137.1, .143.3, .145.1 (1979).

42. See 44 U. CHI. L. REV. 562 (1977) (listing Alabama, California, Hawaii, Massachusetts, Nebraska, Washington, and Wisconsin). For the view that the concept of dangerousness unnecessarily limits a psychiatrist who desires to help his patient, see Schwed, *Protecting the Rights of the Mentally Ill*, 64 A.B.A.J. 564 (1978).

43. See Levine, *The Concept of Dangerousness: Criticism & Compromise*, in *PSYCHOLOGY IN THE LEGAL PROCESS* 147 (B. Sales ed. 1977); Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439 (1974); Dix, *Civil Commitment of the Mentally Ill and the Need for Data on the Prediction of Dangerousness*, 19 AM. BEHAVIORAL SCIENTIST 318 (1976); Ennis & Latwick, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974); Monahan, *Strategies for an Empirical Analysis of the Reduction of Violence in Emergency Civil Commitment*, 1 LAW AND HUMAN BEHAVIOR 363 (1977).

44. MO. REV. STAT. § 202.010(5) (1979); see A. BROOKS, *LAW, PSYCHIATRY, AND THE MENTAL HEALTH SYSTEM* 680-82 (1974).

Definitions of what is "dangerous" tend to be as diverse as the views of individual judges, courts, and jurisdictions. It may be that persons committed on the basis that they are "dangerous" need not be, and would not be, if the term were more carefully defined and its component elements identified, even if those elements could not be evaluated with a high degree of accuracy or quantification. A more rigorous analysis, if not too cumbersome, might well result in more sophisticated judicial decision-making.

*Id.* at 680.

The failure of the legislature to grapple with the term "likelihood of serious physical harm" exemplifies the manner in which the new code fails to lend substance to its procedural protections. "Indeed, it may not be totally inaccurate to observe that the recent surge of interest in civil com-



The focus on dangerousness in the civil commitment statute also represents a departure from the state's reliance on its *parens patriae* role toward reliance on its police power as justification for commitment of the mentally ill.<sup>45</sup> Although likelihood of serious physical harm includes a person's "failure or inability to provide for his essential human needs,"<sup>46</sup> Missouri does not permit commitment of persons who other states label "gravely disabled," unless the individual is also mentally ill.<sup>47</sup> Perhaps the Missouri approach is preferable because placements in institutions such as nursing homes are generally more appropriate for those who are not mentally ill, but require some sort of custodial care. Under such a narrow definition of mental illness,<sup>48</sup> however, surely there are persons presently housed in mental institutions who, although not mentally ill according to the statutory definition, are too intractable for nursing homes to manage.

## II. PROCEDURES FOR VOLUNTARY ADMISSION AND DISCHARGE

The procedures for voluntary admission<sup>49</sup> to a mental health facility depend upon whether the applicant is an adult, a minor, or an incom-

mitment may occasionally focus on procedure to the ultimate detriment of substance." *In re Ballay*, 482 F.2d 648, 654 (D.C. Cir. 1973) (footnotes omitted).

Commentators, as well as judges, have noted the exaltation of procedure in the field of civil commitment. One group attributes this phenomenon to the reluctance of the judiciary and the mental health professionals to "scrutinize the medical-legal model of mental illness that forms the basis of their current relationship." Albers, Pasewark & Meyer, *Involuntary Hospitalization and Psychiatric Testimony: The Falibility of the Doctrine of Immaculate Perception*, 6 CAP. U.L. REV. 11, 12 (1977).

45. For a discussion of commitment under both powers, see generally *Developments in the Law—Civil Commitment*, 87 HARV. L. REV. 1190, 1207, 1245 (1974).

46. MO. REV. STAT. § 202.010(5)(a) (1979).

47. "[G]ravely disabled' means: . . . a condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter." CAL. WELF. & INST. CODE § 5008(h)(1) (Deering Supp. 1978). For a study of California's experience with the gravely disabled provision, see Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 LAW & SOC'Y REV. 629 (1977).

48. See note 17 *supra* and accompanying text.

49. One may question whether "voluntary" patients are really voluntary. The distinction "between willing and unwilling patients cuts across the legal one of voluntary and committed, since some persons who are glad to come to the mental hospital may be legally committed, and of those who come only because of strong family pressure, some may sign themselves in as voluntary patients." Goffman, *The Moral Career of the Mental Patient*, in *THE MAKING OF A MENTAL PATIENT* 156 n.10 (R. Price & B. Denner eds. 1973). See Gilboy & Schmidt, "*Voluntary*" *Hospitalization of the Mentally Ill*, 66 NW. U.L. REV. 429 (1971), for a study of voluntary admission procedures in Illinois. The authors found that individuals are "induced to voluntarily commit themselves with the threat of involuntary commitment as the principal means of persuasion, and

petent. When a person sixteen years of age or older applies for admission and meets the statutory standard outlined above,<sup>50</sup> the head of a public mental health facility must admit the applicant if he finds that admission is appropriate.<sup>51</sup> A public hospital must also accept a person under the age of eighteen upon his parent's application if the head of the facility believes that admission is appropriate. While such a minor is denominated a voluntary patient under the new code, the minor need not meet the statutory standard required for adult voluntary admission, *i.e.*, symptoms of mental disorder, mental illness, alcoholism, or drug abuse.<sup>52</sup> A third type of voluntary patient is the incompetent. Upon a court order, the public mental health facility must accept a judicially declared incompetent who meets the adult statutory standard and who, in the opinion of the head of the facility, is appropriate for admission.<sup>53</sup>

The discharge procedure for voluntary patients is straightforward. Adult voluntary patients may obtain their release by oral or written request.<sup>54</sup> Upon such request the hospital must immediately release the patient unless the head of the facility determines that the patient presents a likelihood of serious physical harm,<sup>55</sup> in which case the hospital may detain the patient for not longer than four days while it initiates involuntary commitment proceedings.<sup>56</sup> Release of a minor admitted on the application of his parent<sup>57</sup> is contingent upon the consent of the parent.<sup>58</sup> Similarly, release of a minor aged sixteen to eighteen admitted on his own application is contingent upon the minor's

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with little concern for the adequacy of the information on which the individual's decision is based or whether it is 'voluntary' at all." *Id.* at 430.

50. See notes 14-16 *supra* and accompanying text.

51. MO. REV. STAT. § 202.115.1(1) (1979). Admission depends on the availability of suitable accommodations. *Id.* § 202.115.1.

52. *Id.* § 202.115.1(2). Minors under the juvenile court's jurisdiction may be committed pursuant to § 211.201 of the Missouri Revised Statutes. *Id.* § 202.115.1(3).

53. *Id.* § 202.115.1(4). Thus, while incompetents are designated as "voluntary" patients, their entrance into the mental health system is not a voluntary act.

54. "A voluntary patient who is not a minor and who requests his release either orally or in writing to the head of the facility or his designee, shall be released forthwith." MO. REV. STAT. § 202.115.3 (1979). This provision appears to include incompetent adults. See text accompanying notes 75-76 *infra*.

55. Thus, it is more difficult for a voluntary patient to obtain release than an involuntary patient. See notes 77-80 *infra* and accompanying text.

56. MO. REV. STAT. § 202.115.3 (1979).

57. A minor admitted upon application of the juvenile court needs the court's consent to be released. *Id.* § 202.115.2(2).

58. *Id.*

concurrence in the request for release.<sup>59</sup> If the head of the facility does not concur in the minor's release and decides to initiate involuntary commitment proceedings, the child may be detained for an additional four days.<sup>60</sup>

These procedures for voluntary admission and discharge remain substantially unchanged from the prior statutory provisions, yet two important differences emerge. First, the new code reduces from twelve days<sup>61</sup> to four days<sup>62</sup> the time allowed for commencement of involuntary commitment proceedings once a voluntary patient requests release. Second, the hospital director may no longer discharge a voluntary patient on the ground that the discharge would "contribute to the most effective use of the hospital in the care and treatment of the mentally ill."<sup>63</sup> The hospital may only discharge voluntary patients when "continued care or treatment is no longer appropriate,"<sup>64</sup> not for reasons of administrative efficiency.<sup>65</sup>

The primary difficulty with the new code's voluntary procedures is its treatment of minors. A minor need not be mentally disordered, mentally ill, an alcoholic, or a drug abuser to be admitted to a hospital by his parent or guardian. The head of the mental health facility need only believe that the child's admission is "appropriate."<sup>66</sup> In light of *Institutionalized Juveniles v. Secretary of Public Welfare*,<sup>67</sup> such a proce-

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59. The code allows persons over age sixteen to apply for admission as adults, yet treats persons between the ages of sixteen and eighteen as minors for purposes of release. *Id.* §§ 202.115.1(1), .2(3).

60. *Id.* § 202.115.2(3). Compare the required showing of dangerousness for the continued confinement of an adult after release is requested, *id.* with the absence of any requirement (beyond the hospital director's approval) for confinement of a minor after release is requested, *id.* § 202.115.3.

61. *Id.* § 202.790 (Supp. 1975).

62. *Id.* §§ 202.115.2(3), .115.3 (1979).

63. *Id.* § 202.787 (1969).

64. *Id.* § 202.120(2) (1979).

65. A public hospital, however, may deny admission to a voluntary applicant if suitable accommodations are not available. *Id.* § 202.115.1.

66. *Id.* § 202.115.1(2). The procedure does not recognize the frequently disparate interests of a parent and child. See 15 DUQ. U.L. REV. 337 (1976-77).

67. 459 F. Supp. 30 (E.D. Pa.), *prob. juris. noted*, 437 U.S. 902 (1978) (No. 77-1715).

In 1975 the district court held unconstitutional under the fourteenth amendment certain provisions of the Pennsylvania Mental Health and Mental Retardation Act of 1966 that governed the commitment of children on the ground that Pennsylvania's procedures did not adequately guard against erroneous commitment of juveniles who are not mentally ill. *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975). The statute, similar to Missouri's, provided that a state mental hospital upon a parent's application could admit a person under eighteen years of age and could only

ture is probably unconstitutional. A three-judge federal district court in *Institutionalized Juveniles* found Pennsylvania's failure to provide minors less than fourteen years of age with a postcommitment hearing shortly after their admission denied them procedural due process under the fourteenth amendment.<sup>68</sup> The court reaffirmed its stance expressed in *Bartley v. Kremens*<sup>69</sup> that the child's liberty interest outweighs the state's interest in protecting the child and maintaining the family unit.<sup>70</sup> The court held that although a minor is not entitled to a precommitment hearing or trial by jury, he has a right to a probable cause hearing within seventy-two hours of admission and to a postcommitment hearing within two weeks of his admission. He may retain counsel, attend all hearings, offer testimony, and cross-examine witnesses to challenge his commitment.<sup>71</sup> The Missouri statute falls far short of these procedural protections.

The release standard for minors is also inadequate. When a minor requests release, the hospital may commence commitment proceedings and detain the child for ninety-six hours while processing the paperwork solely on the ground that the head of the facility does not concur in the release.<sup>72</sup> Further, the release provisions permit the hospital to keep a youth sixteen years or older who, over his parent's objec-

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release the child with the admitting parent's consent. Compare Mental Health and Mental Retardation Act of 1966, 1966 Pa. Laws 96, §§ 402, 403 (repealed except as to mental retardation by Mental Health Procedures Act of 1976, 1976 Pa. Laws 817, § 502) with MO. REV. STAT. §§ 202.115.1(2), .115.2(2) (1979).

After the United States Supreme Court noted probable jurisdiction, the Pennsylvania legislature enacted a new statute, which treated as adults persons fourteen years of age and over. PA. STAT. ANN. tit. 50, §§ 7101-7503 (Purdon Supp. 1978-1979). Under the 1976 act, therefore, parents could no longer admit a child fourteen years of age or older. Since the ages of the five appellees ranged between fifteen and eighteen when the complaint was filed, the Supreme Court held the claim moot. *Kremens v. Bartley*, 431 U.S. 119 (1977).

A group of mentally ill juveniles, age thirteen or younger, instituted a new class action challenging the constitutionality of the 1976 act. *Institutionalized Juveniles v. Secretary of Pub. Welfare*, 459 F. Supp. 30 (E.D. Pa. 1978), *prob. juris. noted*, 437 U.S. 902 (1978) (No. 77-1715).

68. 459 F. Supp. at 43-44. *Accord*, *J.L. v. Parham*, 412 F. Supp. 112, 138 (M.D. Ga. 1976) (neither parents nor psychiatrists can "statutorily be given the power to confine a child in a mental hospital without procedural safeguards being imposed to guard against errors in judgment and/or the arbitrariness that the best of us humans exhibit from time to time"), *prob. juris. noted*, 431 U.S. 936 (1977) (No. 75-1690).

69. 402 F. Supp. 1039, 1048 (E.D. Pa. 1975), *vacated as moot*, 431 U.S. 119 (1977).

70. 459 F. Supp. at 43.

71. *Id.* at 43-44.

72. MO. REV. STAT. § 202.115.2(3) (1979).

tions, wants to stay.<sup>73</sup> Such an interpretation may conflict with a parent's right to control his child's upbringing.<sup>74</sup>

Another significant problem with the code is its treatment of judicially declared incompetents. Although specially treated in the provisions for voluntary admission,<sup>75</sup> they are not mentioned in the provisions for release. The release procedures for adult voluntary patients, however, appear to include incompetent adults.<sup>76</sup> Surely the legislature did not intend a court-ordered placement of an incompetent in a mental health facility to be defeated by the incompetent's own request for release.

A third difficulty with the discharge procedures is the hospital's power to hold an adult voluntary patient for ninety-six hours after he requests release if he presents a likelihood of serious physical harm, and the staff intends to initiate commitment proceedings against him.<sup>77</sup> This standard makes it more difficult for a voluntary patient than an

73. *Id.* § 202.115.2(1) provides that:

A voluntary patient who is a minor . . . whose release is requested . . . by his parent . . . or person entitled to his custody, shall be released forthwith except that: [i]f the patient was admitted on his own application and the request for release is made by a person other than the patient, release shall be conditioned upon the agreement of the patient thereto.

74. *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975) (Broderick, J., dissenting), *vacated as moot*, 431 U.S. 119 (1977).

The Supreme Court has repeatedly recognized and afforded great weight to the rights of parental control and custody of their children and has given due respect to the powerful role of the familial relationship in our democratic society. This substantial interest of parents undeniably warrants deference and, absent a powerful countervailing interest, warrants protection. It is plain that the interest of family integrity and the interests of parents in the care, custody and nurture of their children come to the court with a momentum deserving of respect.

402 F. Supp. at 1056. *See Wisconsin v. Yoder*, 406 U.S. 205 (1972).

Consider Pennsylvania's solution to the problem of parental right to control:

Upon the acceptance of an application for examination and treatment by a minor 14 years or over but less than 18 years of age, the director of the facility shall promptly notify the minor's parents, guardian, or person standing in loco parentis, and shall inform them of the right to be heard upon the filing of an objection. Whenever such objection is filed, a hearing shall be held within 72 hours by a judge or mental health review officer, who shall determine whether or not the voluntary treatment is in the best interest of the minor.

PA. STAT. ANN. tit. 50, § 7204 (Purdon Supp. 1978-1979).

75. MO. REV. STAT. § 202.115.1(4) (1979).

76. *Id.* § 202.115.3. For text of this statute see note 54 *supra*.

77. MO. REV. STAT. § 202.115.3 (1979). *Cf.* CAL. WELF. & INST. CODE § 6005 (Deering 1969) (a "voluntary adult patient may leave the hospital or institution at any time by giving notice of his desire to leave to any member of the hospital staff and completing normal hospitalization departure procedures.").

involuntary patient to obtain his release. While a voluntary patient must be nondangerous to secure immediate release, an involuntary patient, even if dangerous, must be released if no longer mentally ill.<sup>78</sup> This discrepancy between release for voluntary and involuntary patients could be challenged on equal protection grounds.<sup>79</sup> Furthermore, compulsory confinement of a voluntary patient after a request for release may discourage voluntary admissions altogether.<sup>80</sup>

### III. PROCEDURES FOR INVOLUNTARY ADMISSION AND DISCHARGE

The procedural protections for involuntary patients<sup>81</sup> are considerably greater than those for voluntary patients. The new code establishes the position of a mental health coordinator, appointed by the director of the department of mental health to serve a particular geographic region.<sup>82</sup> The mental health coordinator must conduct an investigation when he receives information alleging that a person, as a result of mental disorder, presents a likelihood of serious physical harm to himself or others.<sup>83</sup>

Any adult person, including the mental health coordinator, may file an application for evaluation and detention of a person who may be mentally disordered and presents a likelihood of serious physical harm

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78. MO. REV. STAT. § 202.183.1 (1979).

79. *Cf. In re Buttonow*, 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968) (statute, which did not provide for periodic judicial review of retention of voluntary patients or for compulsory involvement of Mental Health Information Service for voluntary patients, held constitutional by reading into the law the same protections afforded involuntary patients); Reisner, *Psychiatric Hospitalization and the Constitution: Some Observations on Emerging Trends*, 1973 U. ILL. L.F. 9, 19 (equal protection argument advanced in favor of a right to treatment for voluntary patients).

80. See Note, *Pennsylvania's New Mental Health Procedures Act: Due Process and the Right to Treatment for the Mentally Ill*, 81 DICK. L. REV. 627, 635 (1977). Although the voluntary patient "at the time of admission" receives information concerning release procedures, MO. REV. STAT. § 202.215.5 (1979), it is unclear whether he receives such information before or after he signs in.

81. Involuntary patients may include patients who were initially voluntary, but were subsequently committed when they requested release.

82. MO. REV. STAT. §§ 202.110, .010(11) (1979). The coordinator must be a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker with knowledge of the civil commitment laws. *Id.* § 202.010(10)-(11). Psychiatric residents—*i.e.*, M.D.'s training to become psychiatrists—who often staff the hospitals at night do not fall within the definition. Their exclusion will require additional expenditures for evening staff because the new law mandates that a mental health professional examine the patient within three hours after arrival at the facility. *Id.* § 202.123.4(1).

83. *Id.* § 202.121.1(1).

to himself or others.<sup>84</sup> A probate judge then must hold an *ex parte* hearing in a county where the respondent may be found to determine whether "there is probable cause . . . to believe that the respondent may be suffering from a mental disorder and presents a likelihood of serious physical harm to himself or others . . ." <sup>85</sup> On a finding of probable cause, the court will order the respondent taken into custody for evaluation and treatment.<sup>86</sup>

The code also contains emergency admission procedures. If the mental health coordinator or a peace officer has reasonable cause to believe that a person suffering from a mental disorder presents an "imminent"<sup>87</sup> likelihood of serious physical harm, the person may be taken into custody without even an *ex parte* hearing before a probate court.<sup>88</sup>

The new statute guarantees certain rights to an involuntary patient. Within three hours of the patient's arrival, a mental health professional<sup>89</sup> must examine the patient and the hospital must supply the patient with a copy of the application for his initial detention, a notice of his rights, and the name and address of his appointed attorney,<sup>90</sup> as well as assistance in contacting the attorney, if requested.<sup>91</sup> Within a reasonable period of time, a physician must examine the involuntary patient.<sup>92</sup> As soon as possible after the patient's admission, the hospital staff or mental health coordinator must notify a responsible member of the patient's immediate family of the enumerated rights, provided that the patient consents to the notification.<sup>93</sup> The involuntary patient's

84. *Id.* § 202.123.1-.2.

85. *Id.* § 202.123.2. Only mental disorder, not mental illness, is necessary for initial detention. At this stage, the mental disorder need not be causally related to the likelihood of serious physical harm that the individual poses to himself or others. All hearings subsequent to the probable cause hearing require that the dangerousness of the individual be linked to mental illness.

86. *Id.*

87. The act does not define "imminent."

88. MO. REV. STAT. § 202.123.3 (1979). See note 122 *infra* for a proposed amendment to this provision.

89. MO. REV. STAT. § 202.010(10) (1979).

90. While the statute does not specify whether responsibility for appointment of attorneys rests in the hospital or the probate court, the three-hour restriction for appointment, as a practical matter, results in appointment by the hospital because hospitals, unlike probate courts, never close. It is questionable whether courts can and should delegate their appointment power to hospital personnel.

91. MO. REV. STAT. § 202.123.4(1)-(3) (1979).

92. This examination normally should occur within 24 hours of the patient's arrival at the facility. *Id.* § 202.123.5.

93. *Id.* § 202.130. In addition, § 202.195 indicates that the fact of admission may not be revealed whether the patient is voluntary or involuntary. These provisions give rise to a number

[https://openscholarship.wustl.edu/law\\_lawreview/vol1979/iss1/23](https://openscholarship.wustl.edu/law_lawreview/vol1979/iss1/23)

rights<sup>94</sup> include: a judicial hearing within ninety-six hours to determine whether there is a probable cause to detain him;<sup>95</sup> an attorney to represent him with whom he may communicate at all reasonable times, or the right to a private attorney at his own expense;<sup>96</sup> notice of the purpose of the evaluation and notice that whatever he says may be used against him at the court hearing;<sup>97</sup> the right to present evidence and cross-examine witnesses at the hearing;<sup>98</sup> and the right to refuse medication twenty-four hours before the probable cause hearing.<sup>99</sup>

of troublesome questions. If the patient refuses to give consent, can the hospital hold him without notice to the family? May families of voluntary patients be notified? What action should the hospital take if the voluntary patient is a self-admitted minor?

94. The rights enumerated in the text accompanying notes 95-99 *infra* reveal the striking resemblance between the civil commitment process and the criminal process. Compare a mental patient's rights with the following state criminal defendant's rights: *Klopfer v. North Carolina*, 386 U.S. 213 (1967) (right to speedy trial); *Miranda v. Arizona*, 384 U.S. 436 (1966) (safeguards in the questioning of suspects); *Pointer v. Texas*, 380 U.S. 400 (1965) (confrontation of opposing witnesses); *Gideon v. Wainwright*, 372 U.S. 335 (1963) (right to counsel). See note 9 *supra*.

95. MO. REV. STAT. § 202.130(1) (1979). *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), mandated a probable cause hearing within 48 hours. See notes 100-07 *infra* and accompanying text.

96. MO. REV. STAT. § 202.130(2)-(3) (1979).

It is regrettable that the legislature failed to provide specialized legal services for involuntary patients, particularly in light of empirical evidence that court-appointed attorneys in St. Louis do not adequately represent their clients in civil commitment proceedings. See *Dix, Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 WASH. U.L.Q. 485, 544. The author concludes 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." *Id.* at 573.

In fact, as recently as 1975, the St. Louis Post-Dispatch disclosed that the court-appointed attorney for nearly all commitment cases in the city, Alderman Frank C. Boland, routinely failed to "discuss his cases with medical personnel, examine medical records or spend appreciable time with his clients." He succeeded in obtaining release for only one of 375 clients over a six-year period and never appealed an order of involuntary hospitalization. *St. Louis Post-Dispatch*, Sept. 28, 1975, at 1, col. 5. Cf. *Schmidt, Illinois' Proposed New Mental Health Code: The Need for Advocacy*, 66 ILL. B.J. 402 (1978) (arguing for the existing code, with all its deficiencies, plus effective advocacy through a specialized legal service agency for the mentally ill, over the proposed code without specialized legal services). See generally *Cohen, The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424 (1966).

97. MO. REV. STAT. § 202.130(4) (1979). Such a warning exemplifies the adversary nature of the entire commitment process.

98. *Id.* § 202.130(5).

99. *Id.* § 202.130(6). In the words of one court:

The right to be present at the hearing necessarily includes the right to participate therein to the extent of the subject's ability. Due process is not accorded by a hearing in which the individual, though physically present, has no meaningful opportunity to participate because of incapacity caused by excessive or inappropriate medication.

*Lynch v. Baxley*, 386 F. Supp. 378, 389 (M.D. Ala. 1974).



The probable cause hearing, which must be held within ninety-six hours of the involuntary patient's detention,<sup>100</sup> is primarily designed to prevent groundless confinements for extended periods of time. During the four-day evaluation period, the head of the facility or the mental health coordinator may file a petition for a fourteen-day involuntary detention.<sup>101</sup> Upon such petition the probate court must hold an informal hearing to determine whether there is probable cause for further confinement.<sup>102</sup> The rules of evidence applicable to civil judicial proceedings govern the hearing,<sup>103</sup> except affidavits may be received into evidence if neither party objects.<sup>104</sup> The standard of proof is "clear, cogent, and convincing evidence."<sup>105</sup> If the probate court finds the respondent "as a result of mental illness, presents a likelihood of serious

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Presumably, legislators thought the right to refuse medication would eliminate possible side effects such as slurred speech or dazed expression, which may detract from the respondent's appearance in court. Twenty-four hours, however, is not long enough to eradicate the long-lasting effects of many psychotropic drugs. See Jarvik, *Drugs Used in the Treatment of Psychiatric Disorders*, in *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 171-72 (1965).

The patient may also present a poorer image without medication, *i.e.*, rapid speech, flight of ideas, and manic look. In addition, the provision creates administrative uncertainties. The court can schedule the probable cause hearing any time within 96 hours of the patient's admission. The hospital may not know when to cease administration of drugs.

100. MO. REV. STAT. § 202.135.1 (1979). The judge may grant continuances upon a good cause showing and release the patient pending the hearing. *Id.* In rural Missouri where judges still ride circuit, the four-day time frame may be impossible to meet.

101. *Id.* § 202.133.2. Subsections (1) through (5) list the allegations petitioner must make: that respondent, by reason of mental illness, presents a likelihood of serious physical harm; that respondent needs detention and treatment; that a mental health facility has agreed to accept respondent; and, that the specific behavior of respondent supports the petition. The attorney served with the petition must also be provided with the names of petitioner's prospective witnesses. *Id.*

102. *Id.* § 202.135.2. The patient may be present unless his conduct "is so disruptive that the proceedings cannot reasonably continue with him present," or "his physical condition is such that his presence would entail too great a risk of serious physical harm." *Id.* § 202.135.2(7), (10). Although the latter determination is made by the court, there is no requirement that the judge personally view the patient. A respondent may waive his right to be present if his attorney has explained to him the "nature, purpose, and import of the hearing." *Id.* § 202.135.2(9).

103. *Id.* § 202.135.2(8).

104. *Id.* § 202.135.3-.4.

105. *Id.* § 202.135.5.

[C]lear and convincing proof is a standard frequently imposed in civil cases where the wisdom of experience has demonstrated the need for greater certainty, as where this high standard is required to sustain claims which have serious social consequences or harsh or far-reaching effects on individuals, to prove willful, wrongful, and unlawful acts, to justify an exceptional judicial remedy, or to circumvent established legal safeguards, or in the case of claims evidenced merely by the oral testimony of interested witnesses as to events long past.

32A C.J.S. *Evidence* § 1023 (1964) (footnotes omitted).

physical harm to himself or others," the court must order involuntary treatment for fourteen days.<sup>106</sup> The court, in the best interests of the patient, may order detention in "a less restrictive environment which is reasonably available."<sup>107</sup>

Upon expiration of the fourteen-day period, the court, in accordance with the procedures used at a probable cause hearing,<sup>108</sup> may commit the patient for an additional ninety-day period<sup>109</sup> and successive one-year periods.<sup>110</sup>

An involuntarily committed patient has three routes to discharge. First, if the state fails to carry its burden of proof at any judicial hearing, the court must order the patient's release.<sup>111</sup> Second, the patient may appeal the court commitment or apply for a writ of habeas corpus.<sup>112</sup> Finally, the new code imposes a duty upon the head of the facility to review every six months the status of each involuntarily committed patient, and to discharge the patient when he no longer is mentally ill or presents a likelihood of serious physical harm.<sup>113</sup>

Comparisons of involuntary commitment procedures in the old code with those in the revised code are difficult because the entire thrust of the statute has changed. One major difference is the time frame within which the commitment process operates. Previously, thirty days could elapse before a court determined whether a patient's mental condition

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106. MO. REV. STAT. § 202.135.5 (1979).

107. *Id.*

108. See notes 100-07 *supra* and accompanying text. At the hearing to determine these longer periods, the patient may request a jury trial, MO. REV. STAT. §§ 202.137.1(2), .145.1(2) (1979), and the appointment of a licensed physician to testify in his behalf. *Id.* §§ 202.140.2, .145.2.

109. *Id.* §§ 202.137, .140, .143.

110. *Id.* §§ 202.145, .147, .149.

111. *Id.* §§ 202.135.5, .143.3, .145.3.

112. *Id.* §§ 202.170.1, .173. Habeas corpus is "the privilege of an imprisoned or detained person, of being bailed, tried, or discharged without arbitrary delay." H. BINNEY, *THE PRIVILEGE OF THE WRIT OF HABEAS CORPUS UNDER THE CONSTITUTION* 10 (1862). The patient has the burden of proving the illegality of his confinement. See *Thompson v. Sanders*, 334 Mo. 1100, 1103-04, 70 S.W.2d 1051, 1053 (1934). Habeas corpus is also available in cases in which the petitioner was properly committed in the first instance, but no longer meets the criteria for commitment. See *De Marcos v. Overholser*, 137 F.2d 698, 699 (D.C. Cir.), *cert. denied*, 320 U.S. 785 (1943).

113. MO. REV. STAT. §§ 202.153.1, .183.1 (1979). The mental health coordinator and the committing court receive a copy of the semiannual evaluation. The court, upon its own motion or motion of the patient, must order a hearing to determine the continued need for detention and involuntary treatment. Thereafter, the court may discharge the patient, order a less restrictive course of detention and treatment, or remand the patient to the mental hospital. *Id.* § 202.153.1-2.

warranted involuntary hospitalization.<sup>114</sup> Today, the time from initial detention to judgment must not exceed four days.<sup>115</sup> Prior law mandated that hospital staff examine every involuntary patient as soon as practicable after admission;<sup>116</sup> the new law, however, dictates which staff members shall see the patient and sets stricter time guidelines.<sup>117</sup> The new statute also replaces indeterminate commitments,<sup>118</sup> which required hospitals to reexamine as frequently as practicable the appropriateness of a patient's hospitalization,<sup>119</sup> with determinate yearly commitments under which hospitals must reevaluate every six months the propriety of each patient's detention and treatment.<sup>120</sup>

Another significant variation from the prior statute is the withdrawal from physicians of the authority to act in emergency situations. Formerly, certification by one licensed physician of an individual's mental illness and consequent dangerousness plus application by anyone alleging the individual's dangerousness permitted confinement of the individual for fifteen days if the head of the facility notified the probate court of the patient's admission.<sup>121</sup> Present law authorizes only the mental health coordinator and peace officers to take a person into custody in an emergency situation.<sup>122</sup>

The involuntary procedures present a number of potential problems. First, the legislature considerably weakened the role of the coordinator as originally proposed in the 1977 bill.<sup>123</sup> The 1977 bill required that the coordinator file all petitions for initial detention,<sup>124</sup> but under the adopted act any adult person may file for initial detention.<sup>125</sup> The sole

114. *Id.* § 202.805 (1969).

115. *Id.* § 202.133.1 (1979). *See* note 8 *supra*.

116. MO. REV. STAT. § 202.820 (1969).

117. *Id.* § 202.123.4-.5 (1979).

118. *Id.* § 202.790.5 (Supp. 1975). *See* note 11 *supra*.

119. MO. REV. STAT. § 202.827 (1969).

120. *Id.* § 202.153.1 (1979).

121. *Id.* §§ 202.800.1, .805.1-.2 (1969).

122. *Id.* § 202.123.3 (1979). A proposed amendment to the new act would restore the physician's authority to detain a person whom he has "reasonable cause to believe . . . is mentally disordered and presents an imminent likelihood of serious physical harm to himself or others unless he is accepted for detention." Mo. S.243, 80th General Assembly, 1st Sess. § 202.123.4 (1979).

123. Mo. S.275, 79th General Assembly, 1st Sess. (1977).

124. *Id.* § 202.129.6(1). *Cf.* WASH. REV. CODE ANN. § 71.05.150(1)(c) (Supp. 1977) (granting the designated mental health professional exclusive authority to file all petitions for initial detention).

125. MO. REV. STAT. § 202.123.1-.2 (1979).

purpose of the coordinator in the mental health system is to investigate and evaluate allegations that a person needs detention and treatment.<sup>126</sup> The coordinator, through his advocacy and "gate-keeping" functions, serves to eliminate unjustified detention of those not subject to the act and to promote judicial economy by removing the need for an ex parte hearing before taking a person into custody.<sup>127</sup> Missouri's failure to retain the coordinator's exclusive power to file applications renders nugatory the purpose of the position.

The legislature's treatment of the coordinator position also gives rise to a potential conflict of interest. The 1977 bill stipulated that the mental health coordinator could not be a staff member of a mental health facility that accepts involuntary patients.<sup>128</sup> The absence of this restriction in the enacted bill creates a danger that the mental health coordinator's desire to help the alleged mentally disordered person at his facility may interfere with his judgment about whether the individual meets the statutory criteria for confinement.<sup>129</sup>

Another problem with the involuntary procedures stems from the class of persons who may file an application for nonemergency detention. The new statute increases the possibilities for harrassment by enlarging the group of people who may file an application to include any adult person.<sup>130</sup> The problem is compounded by the new statute's deletion of the requirement that an application for commitment be accompanied by a certificate of a licensed physician, which states that on the basis of his examination he believes the individual to be mentally ill.<sup>131</sup> The present statute takes the position that a judge, in a hearing at which the alleged mentally disordered person is not present, is better able to determine the need for detention than a licensed physician who

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126. *Id.* § 202.121.1.

127. *Id.* § 202.121.3.

128. Mo. S.275, 79th General Assembly, 1st Sess. § 202.125.2 (1977).

129. MO. REV. STAT. § 202.140.2 (1979) recognizes that this conflict of interest may arise and allows appointment of an independent physician to testify on the patient's behalf. *See also In re Gannon*, 123 N.J. Super. 104, 301 A.2d 493 (Somerset County Ct. 1973) (right to independent psychiatrist); T. SCHEFF, BEING MENTALLY ILL 105-21 (1966) (norm in medical diagnosis is to err on the side of judging a well person to be sick rather than judging a sick person to be well).

130. MO. REV. STAT. § 202.123.1 (1979). The prior Missouri statute permitted only a friend, relative, spouse, county sheriff, guardian, health officer, or head of the institution where the individual is located to file an application for involuntary commitment. *Id.* § 202.807.1 (Supp. 1975). *See also* Peters, Teply, Wunsch & Zimmerman, *Administrative Civil Commitment*, 10 CREIGHTON L. REV. 243, 272 (1976).

131. MO. REV. STAT. § 202.807.1 (Supp. 1975).

has examined the person.<sup>132</sup> A better solution would be to require judge and physician to collaborate on the question.<sup>133</sup>

The new statute also contains a serious ambiguity concerning the right of physicians to treat patients detained for the initial ninety-six hour period.<sup>134</sup> Certain provisions of the code refer to the ninety-six hour period as a time for detention and evaluation,<sup>135</sup> other provisions designate the period as a time for evaluation and treatment.<sup>136</sup> In light of the act's emphasis on individual liberties, one could argue that hospital staff should impose no involuntary medical treatment upon a patient until a court orders his commitment. On the other hand, few hospitals have the facilities to contain a hostile, aggressive patient for four days without the use of medication. In addition, courts may view the patient's right to refuse medication twenty-four hours prior to his probable cause hearing<sup>137</sup> as implying legislative approval of treatment before then.

The new statute adopts "clear, cogent, and convincing evidence" as the standard of proof,<sup>138</sup> and therefore comports with the Supreme Court's ruling this term that the due process clause of the fourteenth amendment requires states to use a "clear and convincing" standard of proof in civil commitment proceedings.<sup>139</sup> Given the difficulty of predicting dangerousness<sup>140</sup> and the poor reliability of psychiatric diagnosis,<sup>141</sup> this standard is arguably appropriate. The individual's liberty

132. *Id.* § 202.123.2 (1979).

133. In nonemergency detentions there are no time pressures to prevent effective collaboration between a judge and a physician. While the law should not abdicate to medical judgment, it should recognize the profession's expertise. *See generally* Poythress, *Mental Health Expert Testimony*, 5 J. PSYCH. & L. 201 (1977).

134. *Cf.* CAL. WELF. & INST. CODE § 5172 (Deering Supp. 1978) ("Each person admitted to a facility for 72-hour treatment and evaluation . . . shall receive such treatment and care as his condition requires for the full period that he is held."); WASH. REV. CODE ANN. § 71.05.210 (Supp. 1977) ("Each person involuntarily admitted to an evaluation and treatment facility . . . shall receive such treatment and care as his condition requires for the period that he is detained, except that, beginning twenty-four hours prior to a court proceeding, the individual may refuse all but emergency life-saving treatment . . .").

135. MO. REV. STAT. §§ 202.123.3, .123.4(2), .125.1, .127.1-.2 (1979).

136. *Id.* §§ 202.123.2-.3, .127.4, .130.

137. *Id.* § 202.130(6).

138. *Id.* §§ 202.135.5, .143.2. *See* note 10 *supra*.

139. *Addington v. Texas*, 47 U.S.L.W. 4473 (1979). Although the Constitution requires only clear and convincing evidence, states may dictate a more stringent standard of proof. *Id.* at 4476-77.

140. *See* authorities cited at note 44 *supra*.

141. A. BUSS, *PSYCHOPATHOLOGY* 39-42 (1966).

interest, however, may so strongly outweigh the state's interest in protecting the patient and others that states should employ the stricter "beyond a reasonable doubt" standard of proof.<sup>142</sup> Perhaps the state should require proof beyond a reasonable doubt of factual allegations on which commitment is based, and clear and convincing evidence of dangerousness and mental illness.<sup>143</sup>

A final problem in the statute's procedures for involuntary detention relates to the provision for less restrictive alternative courses of treatment. At any hearing beyond the probable cause hearing, the court may order a "less restrictive course of detention and involuntary treatment,"<sup>144</sup> if in the best interest of the respondent. Furthermore, the head of the mental health facility must conclude every six months that each patient is receiving treatment in the least restrictive environment consistent with his needs,<sup>145</sup> and the director may release a patient to a less restrictive environment when in the patient's best interests.<sup>146</sup> The language of the statute, however, is permissive, not mandatory; thus the statute imposes no duty upon a court or hospital director to order a less restrictive course of treatment even when a patient's best interests warrant such treatment. The wide discretion of the court and hospital director in ordering less restrictive treatment may render meaningless the promising language.<sup>147</sup> In addition, the director of the department of mental health may override both the court's and the hospital director's decisions, thus further emasculating the provision.<sup>148</sup> The statute's failure to require alternatives to hospitalization supports such conjecture.<sup>149</sup>

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142. See *United States ex rel. Stachulak v. Coughlin*, 520 F.2d 931 (7th Cir. 1975); *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972); *In re Pickles' Petition*, 170 So. 2d 603 (Fla. Ct. App. 1965); *Denton v. Commonwealth*, 383 S.W.2d 681 (Ky. 1964).

143. This standard is suggested by Peters, Teply, Wunsch & Zimmerman in *Administrative Civil Commitment*, 10 CREIGHTON L. REV. 243, 269 (1976).

144. MO. REV. STAT. §§ 202.143.3, .145.3, .153.2(2) (1979).

145. *Id.* § 202.120(1).

146. *Id.* § 202.180.1.

147. The 1977 proposal required the probate court to find that a less restrictive alternative was not appropriate before it could order detention. Mo. S.275, 79th General Assembly, 1st Sess. §§ 202.150.3, .157.2, .159.3, .160.3 (1977).

148. MO. REV. STAT. § 202.150 (1979). The director shall "notwithstanding any provision . . . to the contrary . . . determine where detention and involuntary treatment shall take place." *Id.*

149. *Id.* § 202.205.

#### IV. NONPROCEDURAL PATIENT RIGHTS

Perhaps the most pressing concerns of a patient are those that relate to his treatment. Missouri's revised statute provides that all patients shall be "entitled to humane care and treatment" and to "freedom from verbal and physical abuse."<sup>150</sup> Every patient must receive, subject to the availability of equipment and personnel, "medical care and treatment in accordance with the highest standards accepted in medical practice."<sup>151</sup> Patients treated by prayer may refuse medical treatment on religious grounds.<sup>152</sup> Further, any patient may refuse electroshock treatment.<sup>153</sup>

The code also provides rights designed to make daily life in the hospital less oppressive for the patient and to allow him continuous contact with the outside world. The mental health facility must provide patients with a brochure enumerating these rights, and, if necessary, hospital staff must explain them.<sup>154</sup>

Finally, the code safeguards the patient's right to confidentiality of records. The fact of admission and all information and records compiled by the mental health coordinator or hospital may be released only in a few limited situations<sup>155</sup> or upon the patient's authorization.<sup>156</sup>

The state may no longer deny the implementation of these non-procedural rights on the basis of prohibitive cost. Because humane

150. *Id.*

151. *Id.* The qualification of this entitlement renders the promise an empty one.

152. *Id.* § 202.207.1.

153. *Id.* § 202.213. A court order is needed to administer electroshock without the patient's consent, and then only after a full evidentiary hearing. The order is not necessary if, absent treatment, the patient would die within 48 hours. *Id.*

154. *Id.* § 202.215.5.

The patient "bill of rights" includes the right: to wear one's own clothing and keep personal possessions; to keep and spend a reasonable sum of one's own money; to communicate by sealed mail; to receive visitors at reasonable times; to have reasonable access to a telephone to make and receive confidential calls; to be served a nourishing well-balanced diet; to have an opportunity for physical exercise and outdoor recreation; and to have reasonably prompt access to current newspapers, magazines, and television programming. Any of these rights may be curtailed at the recommendation of the head of the facility in the interest of the patient's medical welfare. *Id.* § 202.215(1)-(8). The patient has an absolute right, however, to communicate by sealed mail with the mental health department and committing court, as well as a right to receive private visits from his attorney, physician, or clergyman at reasonable times. *Id.* § 202.215.3- 4.

155. Information and records may be disclosed to health care providers, insurance companies, welfare officials, courts, law enforcement officers, the patient's and petitioner's attorneys, and the mental health coordinator. *Id.* § 202.195.1(2)-(9).

156. *Id.* § 202.195.1.

care and treatment for the mentally ill under the new code are not contingent upon the availability of resources,<sup>157</sup> courts may order physical improvements in state mental institutions and may release patients who have not received humane care and treatment.<sup>158</sup>

The legislature, however, failed to imbue the term "treatment" with much substance. The legislature defined the term as "any effort to accomplish a significant change in the mental or emotional conditions or the behavior of the patient."<sup>159</sup> Although the United States Supreme Court has not yet recognized a constitutional "right to treatment,"<sup>160</sup> some lower courts have ordered hospitals to make a "bona fide effort" to cure or improve an involuntary patient's mental condition as evidenced by "initial and periodic inquiries . . . into the needs and conditions of the patient with a view to providing suitable treatment," and by provision of a program suited to the patient's particular needs.<sup>161</sup> Legislatures in other states have responded to these cases with elaborate enactments that describe what constitutes treatment.<sup>162</sup> Missouri

157. Compare MO. REV. STAT. § 202.840 (1969) with MO. REV. STAT. § 202.205 (1979).

158. See 44 U.M.K.C. L. REV. 23 (1975).

159. MO. REV. STAT. § 202.010(27) (1979).

160. O'Connor v. Donaldson, 422 U.S. 563, 573 (1975).

161. Rouse v. Cameron, 373 F.2d 451, 456 (1966). See Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974) (mentally retarded); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971) (mentally ill). See generally Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Katz, *The Right to Treatment—An Enchanting Legal Fiction*, 36 U. CHI. L. REV. 775 (1969).

162. See, e.g., MINN. STAT. ANN. § 253A.17, subd. 9 (West Supp. 1979):

Every person hospitalized or otherwise receiving services . . . shall be entitled to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further custody, institutionalization, or other services unnecessary. To this end the head of the hospital shall devise or cause to be devised for each person so hospitalized a written program plan which shall describe in behavioral terms the case problems, and the precise goals, including the expected period of time for hospitalization, and the specific measures to be employed in the solution or easement of said problems. Each plan shall be reviewed at not less than quarterly intervals to determine progress toward the goals, and to modify the program plan as necessary. The program plan shall be devised and reviewed in each instance with the appropriate county welfare department, and with the patient. The hospital record shall attest to the program plan review. If the county welfare department or the patient does not so participate in the planning and review, the hospital record shall include reasons for non-participation and the plans for future involvement.

The department of public welfare shall monitor the aforementioned program plan and review process to insure compliance with the provisions of this subdivision.

PA. STAT. ANN. tit. 50, § 7104 (Purdon Supp. 1978-1979):

Adequate treatment means a course of treatment designed and administered to alleviate a person's pain and distress and to maximize the probability of his recovery from mental illness. It shall be provided to all persons in treatment who are subject to this act. It may include inpatient treatment, partial hospitalization, or outpatient treatment. Adequate inpatient treatment shall include such accommodations, diet, heat, light, sanitary



should have followed that lead. While such statutes limit the prerogative of hospitals and physicians to provide what each deems to be appropriate treatment, these enactments guard against the provision of mere custodial care.

The new statute also allows the courts to order involuntary treatment of the mentally ill,<sup>163</sup> previously, the court could order only hospitalization.<sup>164</sup> This change in the law is unfortunate because the act, while authorizing treatment, fails to specify what treatment is permissible. The statute does prohibit electroshock treatment without the informed and voluntary written consent of the patient, except under extreme circumstances.<sup>165</sup> Psychosurgery, however, apparently may be performed under the present statute without the patient's consent.<sup>166</sup>

Finally, patients lost their right under the new act to criminally prosecute persons who caused their unwarranted hospitalization or otherwise violated their rights.<sup>167</sup> The legislature eliminated both civil and criminal liability of public hospital staff and other public officials "performing functions necessary for administration of chapter 202 . . . provided that such duties were performed in good faith and without gross negligence."<sup>168</sup> While qualified immunity may promote fearless enforcement of the act's provisions, it will leave without an adequate remedy those patients who feel they have been "railroaded."<sup>169</sup>

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facilities, clothing, recreation, education and medical care as are necessary to maintain decent, safe and healthful living conditions.

Treatment shall include diagnosis, evaluation, therapy, or rehabilitation needed to alleviate pain and distress and to facilitate the recovery of a person from mental illness and shall also include care and other services that supplement treatment and aid or promote such recovery.

163. MO. REV. STAT. §§ 202.123.2-.3, .135.5, .143.3, .145.3 (1979).

164. *Id.* § 202.807.5 (Supp. 1975). At least one probate judge under prior law refused to require a patient to submit to a program of involuntary medical treatment. Sullivan, *Judicially-Ordered Involuntary Treatment of the Mentally Ill*, 31 J. Mo. B. 254 (1975). The statutory language now permits forced medical treatment.

165. MO. REV. STAT. § 202.213 (1979). See note 152 *supra* and accompanying text.

166. The earlier Senate bill prohibited psychosurgery without the written consent of the patient. Mo. S.275, 79th General Assembly, 1st Sess. § 202.183 (1977).

167. MO. REV. STAT. § 202.870 (Supp. 1975).

168. *Id.* § 202.200 (1979). Persons making and filing applications for detention are also protected from the imposition of liability if they acted in good faith.

A proposed amendment to the new act would bestow the same immunity on the staff of private hospitals. Mo. S.243, 80th General Assembly, 1st Sess. § 202.200 (1979).

169. See T. SZASZ, LAW, LIBERTY, AND PSYCHIATRY 66-70, 217-18 (1963).

## V. CONCLUSION

The Missouri legislature should be commended for its revision of the laws regarding civil commitment of the mentally ill. The standards for commitment set forth in the new act<sup>170</sup> more precisely define those persons subject to civil commitment and thus should enable the statute to better withstand constitutional challenges of vagueness or overbreadth to which the prior statute was susceptible. In addition, the revised code offers significantly greater procedural protections for the admission and discharge of both voluntary<sup>171</sup> and involuntary<sup>172</sup> patients. Finally, the new statute guarantees to patients in mental health facilities certain nonprocedural rights designed to make daily life in hospitals less oppressive.<sup>173</sup>

Despite these improvements, however, the new code fails to adequately secure for mental patients in Missouri certain rights that other jurisdictions have recognized, such as the right of a minor to contest his parent's application for his admission,<sup>174</sup> the right to adequate treatment,<sup>175</sup> and the right to treatment in the least restrictive environment.<sup>176</sup> The legislature should act to alleviate these deficiencies before they give rise to judicial declarations of the statute's unconstitutionality.

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170. See notes 14-48 *supra* and accompanying text.

171. See notes 49-80 *supra* and accompanying text.

172. See notes 81-149 *supra* and accompanying text.

173. See notes 150-69 *supra* and accompanying text.

174. See notes 66-71 *supra* and accompanying text.

175. See notes 159-66 *supra* and accompanying text.

176. See notes 144-49 *supra* and accompanying text.

