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The Court of Last Resort: Mental Illness and the Law. By Carol A.B. Warren with essays by Stephen J. Morse and Jack Zusman (book review)

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BOOK REVIEW

THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW. By CAROL A. B. WARREN, with essays by STEPHEN J. MORSE and JACK ZUSMAN. Chicago: University of Chicago Press, 1982. xii + 265 pp., index. $25.00.

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In 1978, after a year of study, the President's Commission on Mental Health opened its final report with the observation that "a substantial number of Americans do not have access to mental health care of high quality . . . at a reasonable cost."[1] The Commission attributed this situation to the fact that mental health facilities were often at considerable distance from the persons in need of treatment and also to the influence of personal factors such as "race, age or sex"[2] on the nature and availability of mental health services. The Commission did not, however, limit its concern to the adequacy and delivery of mental health services, but also indicated concern about the institutional structure in which mental health laws are applied.

In its report, the Commission's concern with the legal environment in which the mental health system operates was reflected in several recommendations for protecting the basic rights of patients.[3] These rights specifically included the patient's right to select the best mental health services to meet his or her needs and

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1. PRESIDENT'S COMM'N ON MENTAL HEALTH, 1978 REPORT (1978). The report was accompanied by three volumes of appendices which contain a large number of task panel reports submitted to the Commission and covering a broad range of topics including mental health service delivery, specific mental health problems, and legal issues relating to mental health. *See generally*, 2-4 PRESIDENT'S COMM'N ON MENTAL HEALTH, TASK PANEL REPORTS (1978).

2. 2-4 PRESIDENT'S COMM'N ON MENTAL HEALTH, TASK PANEL REPORTS vii (1978).

3. *Id.* at 42-45.

the right to refuse treatment.[4] In addition, the Commission's general recommendations called for the establishment of a mental health advocacy system,[5] prohibition of all discrimination against mentally disabled persons,[6] limitation of legal guardianships to specific, demonstrated incapacities of individuals,[7] and application of confidentiality rules to mental health records.[8] With regard to reform of the laws governing commitment, the Commission made certain very specific suggestions, including statutory recognition of the following rights:

i) a right to treatment/right to habitation and to protection from harm for involuntarily confined mental patients and developmentally disabled individuals;

ii) a right to treatment in the least restrictive setting;

iii) a right to refuse treatment, with careful attention to the circumstances and procedures under which the right may be qualified; and

iv) a right to due process when community placement is being considered.[9]

These recommendations are consistent with much of what has come to be conventional wisdom in the field of mental health law and have, in fact, already been implemented to a great extent in those states which have adopted new comprehensive mental health codes, such as California and Illinois.[10]

While these recommendations do not seem startling today, it is important to note that these kinds of recommendations were, if considered at all, thought to be extremely radical only slightly over two decades ago. A sense of the timidity of those supporting mental health reform in the early sixties can be gleaned from the recommendations in the Final Report of the Joint Commission on

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4. *Id.* at 42.
5. *Id.*
6. *Id.* at 42-43.
7. *Id.* at 43.
8. *Id.* at 45.
9. *Id.* at 44.
10. The Lanterman-Petris-Short Act, California Health Act of 1967, CAL. WELF. & INST. CODE §§ 5000-5550 (West 1982) [hereinafter cited as LPS]; Mental Health Developmental Disabilities Code, ILL. REV. STAT. ch. 91 ½ §§ 1-100 to 6-107 (West 1982). *See also* GOVERNOR'S COMM'N FOR REVISION OF THE MENTAL HEALTH CODE OF ILLINOIS 1976 REPORT (1976); GOVERNOR'S COMM'N FOR REVISION OF THE MENTAL HEALTH CODE OF ILLINOIS 1977 REPORT (1977).

Mental Illness and Health issued in 1961.[11] Recommendations in that report, which emphasized the need for funding studies and the development of treatment programs, placed major stress on the need for public education as to the nature of mental illness and the provision of adequate institutional treatment.[12] The report did not consider, and did not even mention, the various issues addressed by the 1978 report which have come to be the focus of judicial concern with the mental health system, such as due process and procedural requirements for involuntary emergency hospitalization,[13] a requirement of least restrictive alternative treatment,[14] and concerns such as "right to treatment"[15] and the "right to refuse treatment."[16] The focus of concern in the 1961 report was to provide for involuntary commitment and emergency care.

Thus, to a great extent, the tone and content of the 1978 report reflects a great revolution within the past two decades in judicial recognition of the rights of persons subject to the mental health system. Similarly, although many states have yet to give se-

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11. JOINT COMM'N ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH, 1961 FINAL REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH (1961).

12. For mentally troubled people, the report recommended: "Persons who are emotionally disturbed—that is to say, under psychological stress that they cannot tolerate—should have skilled attention and helpful counseling available to them in their community if the development of more serious mental breakdowns is to be prevented." *Id.* at xii (emphasis deleted). For acutely disturbed mental patients, the recommendation for care explicitly recognized the lack of adequate provision of mental health services at the time of the report. The report provided that: "Immediate professional attention should be provided in the community for persons at the onset of acutely disturbed, socially disruptive, and sometimes personally catastrophic behavior—that is, for persons suffering a major breakdown. *The few pilot programs for immediate, or emergency, psychiatric care presently in existence should be expanded and extended* as rapidly as personnel becomes available." *Id.* at xiii (emphasis added). In other words, the concern in 1961 was for the provision for involuntary commitment and for emergency care.

13. *See, e.g.*, Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 421 U.S. 957 (1975) (minimal due process requirements should be met in cases of involuntary hospitalization, including notice and an opportunity to be heard, application of specified standards for commitment, provision of counsel, and application of the rules of evidence).

14. *See, e.g.*, Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) where the court construed the District of Columbia mental health code to require that the least drastic method of treatment be provided.

15. *See, e.g.*, Wyatt v. Strickney, 344 F. Supp. 373 (M.D. Ala. 1972), *modified*, 503 F.2d 1305 (5th Cir. 1974), (upholding a right to treatment based on the United States Constitution and specified broad objective standards of adequacy of care to be established by quantitative determinations of personnel and consultations providing care and treatment).

16. *See, e.g.*, Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979) holding that patients have a right to refuse medication in certain circumstances.

rious attention to reform of the mental health laws, there has been a fundamental revision of much of the statutory law governing mental health to provide legal standards for commitment and to establish set procedures for dealing with persons who are brought within the control of mental health authorities.[17] Yet, as the legal realists so clearly showed a half-century ago, law on the books must be distinguished from law in practice.[18] In the words of one contemporary commentator: "Laws on paper are meaningless; they must be enforced or applied. At the cutting edge of law, rules devolve upon human operators not machines. In their hands rules may become a mockery."[19] There is a need, therefore, to make some assessment of the effect of reform legislation in the field of mental health.

In *The Court of Last Resort: Mental Illness and the Law*,[20] Carol A. B. Warren, a sociologist, provides just this type of study, thereby permitting those concerned with the law governing the mental health system to determine the extent to which the reform statutes and recent judicial precedents have given rise to "real" rules governing the mental health system, in particular the process of involuntary commitment, and the extent to which these reform laws are merely "paper rules" providing a ritual mask for official action. Moreover, Professor Warren's study affords an opportunity to assess the probable effect of the reform recommendations of the President's Commission on Mental Health on the field of mental health, at least to the extent that those recommendations are already incorporated into the law of California, the state in which Professor Warren conducted her study. By examining the experience in California, it is possible to determine whether the promise of reform is real or illusory.

The statutory background against which Professor Warren's empirical study is developed is provided by the Lanterman-Petris-

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17. *See supra* note 10.

18. This dichotomy was perhaps put best by Karl Llewellyn who distinguished between "real rules" and "paper rules." Particularly with respect to the judicial process, Llewellyn called for attention to the actual behavior of courts. He argued for the need to determine "how far the paper rule is real, how far *merely* paper." Llewellyn, *A Realistic Jurisprudence: The Next Step*, 30 COLUM. L. REV. 431, 450 (1930).

19. Friedman, *Legal Rules and the Process of Social Change*, 19 STAN. L. REV. 786, 790 (1967).

20. C. WARREN, THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW (1982).

Short Act (LPS),[21] the California statute first enacted in 1967. The principal reforms instituted by this statute were the elimination of indeterminate commitment and the removal of legal disabilities which formerly followed the adjudication of a person as mentally ill.[22] LPS provides for an initial involuntary detention of seventy-two hours at an approved facility for a person found to be mentally ill and evaluated to be a danger to himself, a danger to others, or gravely disabled.[23] This initial detention can be with or without a court order.[24] An allegedly mentally ill person can be committed without a court order by a peace officer or various mental health professionals.[25] It is important to note that this initial detention does not require judicial review nor appointment of counsel for the patient. The statute does provide, however, that any person taken into custody for examination must be informed of certain basic rights, including the right to phone family or friends, given notice of the nature and reason for detention, and informed that if they are to be held for longer then seventy-two hours they have a right to counsel and a right to a judicial hearing.[26]

Prior to the expiration of the initial seventy-two hour detention, the California statute requires the medical staff to examine

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21. CAL. WELF. & INST. CODE §§ 5000-5401 (West Supp. 1982).

22. Under previous code provisions involuntary and indefinite judicial commitment followed a 72 hour detention if a person was found by two physicians and a court to be mentally ill and dangerous to himself or others. CAL. WELF. & INST. CODE §§ 5550-5578 (West 1966) (repealed July 1, 1969). The legislative goal of eliminating involuntary commitment is specifically set forth in the current statute. CAL. WELF. & INST. CODE § 5001(a) (West Supp. 1972) provides that LPS should be construed to promote the legislature's intent: "To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons . . . and persons impaired by chronic alcoholism, and to eliminate legal disabilites." The California Supreme Court recognized the broad reform purposes of this legislation in Thorn v. Superior Court, 1 Cal. 3d 666, 464 P.2d 56, 83 Cal. Rptr. 600 (1970):

> The LPS act, as enacted in 1967 after a two-year legislative study, and thereafter amended, repealed the principal provisions for the civil commitment of mentally ill persons found in prior California law and replaced them by a new statutory scheme repealing the indeterminate commitment, removing the legal disabilities previously imposed upon persons adjudicated to be mentally ill, and enacting an extensive scheme of community-based services, emphasizing voluntary treatment and providing for periods of involuntary observation and crisis treatment for persons who are unable to care for themselves or whose condition makes them a danger to themselves or others.

Thorn v. Superior Court, 1 Cal. 3d at 668, 464 P.2d at 57, 83 Cal. Rptr. at 601.

23. LPS §§ 5150, 5170.

24. *Id.* § 5150.

25. *Id.*

26. *Id.* § 5157.

and evaluate the subject for the purpose of making one of four recommendations: (1) that the patient be released without further treatment; (2) that the patient be referred for further care and treatment on a voluntary basis; (3) that the patient be certified for intensive treatment for not more than a fourteen day period; or (4) that a conservator or temporary conservator be appointed for the patient.[27]

Conservatorship requires the appointment of a person or agency to act as the subject's guardian and to protect his interests on the ground that the subject is unable to care for himself.[28] Such a conservator may make determinations of need and arrangements to the extent necessary for the subject's food, clothing, shelter, and treatment. The appointment of a conservator is accomplished by filing a petition with the court specifying the subject's disability and naming a suitable person or agency to serve as conservator. [29]

The basis for certification for the additional fourteen day period of involuntary treatment must be that the patient is mentally disabled and as a consequence of such disorder is either a danger to himself or others, or is gravely disabled.[30] The petition for an additional period must be filed by a professional in charge of the treating facility and must indicate that medical examinations show that the subject is mentally disabled, that he refuses to remain in the facility on a voluntary basis, and that the facility is capable of treating his disability.[31] Although a court hearing is not required as a matter of course to permit this additional fourteen day period of treatment, the subject must receive notice of the required certification[32] and must be informed of his right to counsel and to judicial review by petition for a writ of habeas corpus.[33] The patient must be granted a hearing in a trial court within two days after filing such a petition.[34] In order to authorize continued confinement, the court is required to determine that there has been no violation of the subject's rights and that the patient is not being held without

27. *Id.* §§ 5152, 5250.
28. *Id.* §§ 5350-5368.
29. *Id.* § 5350.
30. *Id.* § 5250.
31. *Id.* §§ 5250, 5251.
32. *Id.* §§ 5252, 5253.
33. *Id.* § 5252.1.
34. *Id.* §§ 5252.1, 5276.

good cause.[35] In addition to written notice of certification and a statement of his rights, the patient must receive an oral explanation of his rights to file a petition and to engage counsel or to have counsel appointed.[36]

At the conclusion of the fourteen day period of involuntary treatment further involuntary detention must be justified on one of three grounds: danger to others,[37] danger to self,[38] or grave disability and need of conservatorship.[39] Each of these grounds has its own statutory criteria which must be met to authorize additional treatment.[40]

LPS provides for a ninety day "postcertification hold" for a patient considered to be dangerous to others.[41] In order to qualify as dangerous to others, the patient must be shown to have threatened, attempted, or inflicted physical harm upon another person, either at the time of being taken into custody or while in custody, and must be evaluated as presenting an imminent threat of substantial harm to others as a result of mental disorder.[42] A court hearing is required before such a certification in order to determine whether or not the person should be detained for an additional ninety day period.[43] If the patient so requests, he is entitled to a jury trial on the issue of whether he is imminently dangerous. If a jury trial is requested, it must commence within ten days of the filing of the required certification petition, unless a continu-

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35. *Id.* § 5276.

36. *Id.* §§ 5252.1, 5276.

37. *See infra* text accompanying notes 41-46.

38. *See infra* text accompanying notes 47-56.

39. *See infra* text accompanying notes 51-58.

40. LPS § 5001(d) provides that one of the purposes of the statute is to safeguard individual rights through judicial review. It should be observed that a person involuntarily committed because of attempted or threatened suicide can be held for 31 days without judicial hearing unless one is specifically requested by the patient by filing a petition for a writ of habeas corpus. *See supra* text accompanying notes 26 & 33, and *infra* text accompanying note 50.

41. *Id.* § 5300. This provision provides for the most extensive form of involuntary treatment, since a patient can be committed for successive 90-day periods upon a certification of dangerousness to others. However, it is important to observe that this provision is seldom invoked. *See* ENKI RESEARCH INSTITUTE, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1971), at 154 (1972). The reason for the infrequent use of this provision, according to Professor Warren, is the difficulty in predicting dangerousness of a patient. C. WARREN, *supra* note 20, at 27.

42. LPS § 5304.

43. *Id.*

ance is requested by the patient's attorney.[44] If the patient elects not to have a jury, the court must proceed to hear the case within four days of the filing of the certification, again, unless a continuance is requested by the patient.[45] At the conclusion of the ninety day period, the patient must be released unless a new certificate is filed meeting all requirements set out above with the same procedural due process, including a judicial hearing.[46] Thus, a commitment based on dangerousness to others requires a judicial hearing every ninety days.

The second basis for extended involuntary treatment is a showing of dangerousness to self on the basis that the patient has threatened or attempted to take his own life during a previous holding period or was taken into custody following such a threat or attempt.[47] Satisfaction of this criterion will justify an additional fourteen day period of involuntary treatment, a significantly shorter period than the ninety day hold allowed where a showing is made of dangerousness to others.[48] Moreover, treatment and confinement beyond this fourteen day period cannot be justified by risk of suicide; rather, further detention requires the patient be reclassified as dangerous to others or as gravely disabled.[49] The additional fourteen day period of treatment does not require a court hearing. The patient must, however, be given notice of certification and informed of his right to petition for a writ of habeas corpus.[50]

The third basis for extended treatment requires establishing that the subject is gravely disabled by a showing that he is unable to provide for his basic personal needs for food, clothing, or shelter.[51] Upon such a showing, the court may appoint a conservator, which may be a person or an agency, to provide for the subject's basic needs.[52] During the period of the conservatorship, the subject may be permitted to reside outside a mental institution,[53] or may

44. *Id.* § 5303.
45. *Id.*
46. *Id.* § 5304.
47. *Id.* §§ 5260-5268.
48. *Id.* § 5260.
49. *Id.* § 5264.
50. *Id.* § 5263.
51. *Id.* §§ 5008(h)(1), 5350.
52. *Id.* § 5350.
53. *Id.* § 5352.

be committed to a mental institution for an indefinite period.[54] The subject has a right to judicial review of his status every six months,[55] and there is a mandatory judicial review each year[56] since the conservatorship automatically terminates at the end of one year and may be continued only by petition of the conservator. The subject also has the right to a jury trial on the issue of continuing mental disability and his gravely disabled status.[57]

This, then, in broad outline, is the statutory scheme governing involuntary commitment in California, and it is against this legislative background that Professor Warren provides an empirical evaluation of the operation of the institutional and judicial process of involuntary commitment. Two basic questions permeate the text of *The Court of Last Resort*: (1) what has been the effect of this legislation as measured by the decisions of a court administering the statute? and (2) what is the extent of compliance with the stated purpose[58] and formal requirements of this statutory scheme?

In an effort to develop a response to these questions, Professor Warren has provided a text which is broadly divided into conceptual and empirical analyses of the operation of the mental health system. The first part provides an overview of the conceptual framework in which mental health decisions are made; here the focus is on legal standards, psychiatric theory, and sociological presuppositions which provide the framework for mental health decision making.[59] The second part provides an account of the operation of a court involved in mental health decision making, and an account of the activity of other important participants in the decision making process including attorneys, medical personnel, and the subjects of commitment themselves.[60]

Warren's study is supplemented by two independently authored papers on the issue of the desirability of maintaining a pro-

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54. *Id.* § 5358.

55. *Id.* § 5364.

56. *Id.* § 5361.

57. *Id.* § 5350(d). California courts have held that the due process clause of the United States Constitution requires the standard of proof in conservatorship proceedings for persons with grave disability, to be proof beyond a reasonable doubt. Furthermore, any jury proceedings conducted under these provisions require a unanimous verdict for commitment. *See* Estate of Roulet, 23 Cal. 3d 219, 590 P.2d 1, 152 Cal. Rptr. 425 (1979).

58. C. WARREN, *supra* note 20, at 39-42.

59. *Id.* at 19-68.

60. *Id.* at 135-213.

gram of involuntary commitment. The first paper is by a legal scholar, Stephen Morse, who argues against continuing a program of involuntary commitment on two principal grounds: 1) the inadequacy of medical diagnosis and treatment, and 2) a preference for individual autonomy and responsibility over state intervention on any paternalistic basis.[61] The second paper is by Jack Zusman, a medical doctor, who argues for retention of a program of involuntary commitment based on the reality of mental disorder, the occurrence of dysfunctional behavior which is destructive and dangerous, and the inability of the critically mentally ill to act freely and rationally.[62] Additionally, Warren includes a significant appendix describing her methodology and, more importantly, suggesting the ways in which her study is likely affected by her own values, biases, and conflicts with the personnel and institutions which are the focus of her study.[63]

Professor Warren identifies three elements which provide the legal framework for decision making in the involuntary commitment procedure: first, the institutional setting—Warren's primary focus is on the court and the personnel involved in the processing of individual cases;[64] second, the legal framework provided not only by express statutory provisions, but also by broad jurisprudential limits such as the stated purpose of the legislation being

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61. *Id.* at 69-109. Professor Morse's paper is entitled *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered* (presented at the 6th International Symposium on Law and Psychiatry, Charlottesville, Va., June 1981). An expanded version of this paper has been published, under the same title, in the California Law Review. 70 CALIF. L. REV. 54 (1982). Professor Morse has contributed a significant number of articles to the legal literature of the subject of mental illness and the question of involuntary commitment. *See generally* Morse, *Failed Explanations and Criminal Responsibility: Experts and the Unconscious*, 68 VA. L. REV. 971 (1982); Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978); Morse, *The Twilight of Welfare Criminology: A Reply to Judge Bazelon*, 49 S. CAL. L. REV. 1247 (1976); *The Twilight of Welfare Criminology: A Final Word*, 49 S. CAL. L. REV. 1275 (1976).

62. C. WARREN, *supra* note 20, at 110-33. Doctor Zusman's paper is entitled *The Need for Intervention: The Reasons for State Control of the Mentally Disabled.*

63. C. WARREN, *supra* note 20, at 215-39. This "Appendix on Methods" has significance beyond the subject of this study itself. This highly personal statement suggests inherent limits on the sociological study of law, as well as providing those who are subject to or who might use such studies with significant observations about their limits and their necessarily subjective cast.

64. *See id.*, where the author states: "This study is about decision making in a court of law. . . . The purpose of the research is to examine the individual, interpersonal, organizational, and interorganizational elements which enter into decision making." *Id.* at 1.

applied;[65] and third, conceptual notions as well as shared understandings about the nature of mental illness.[66] Throughout this study, the author stresses a tension between what she identifies as the "ideal" and the "material," by which she means a tension between the language and stated policy of mental health laws and the actual decision making processes, which are influenced by unacknowledged social and economic factors and by the relationships between the various persons involved in decision making.[67]

In considering the first element of the legal framework for mental health decision making, the institutional setting, Warren devotes particular attention to the interests, motivations, and effects of the personalities of the persons participating in involuntary commitment hearings. The participants include not only the judge and the petitioner, but also counsel and psychiatric witnesses.[68] The author stresses the "middle class" values of official personnel and the probably "lower class," and most certainly "eccentric," status of the petitioner.[69]

Warren further observes that the commitment hearing, and for that matter the mental health system generally, is affected by what she denominates the "labelling" process.[70] According to labelling theory, designations of mental illness result not from the existence of objectively determined disability, but from the identification by authorities of certain persons as deviant. Once made, this identification has a reflexive effect on the persons labelled, who are then viewed as deviant not only by others but also by themselves. According to the theory, this effect in turn influences how these persons are treated by medical personnel and how they themselves

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65. Chapter 2 of THE COURT OF LAST RESORT provides a broad overview of the statute with attention to the social setting in which the enactment was adopted and an account of some of the problematic features of the involuntary commitment law. *See id.*, at 21-43. The account of the statute is brief and somewhat impressionistic. This review has as one of its goals the presentation of a more systematic account of these statutory provisions, against which the observations and empirical data of Professor Warren can be measured. *See supra* text and accompanying notes 21-57.

66. *See* C. WARREN, *supra* note 20, at 44-68.

67. *Id.* at 1-2.

68. *Id.* at 8.

69. *Id.* at 14.

70. *Id.* at 5. *See generally* Gove, *Societal Reaction as an Explanation of Mental Illness: An Evaluation*, 35 AM. SOC. REV. 873, 873-84 (1970). *But see* Murphy, *Psychiatric Labeling in Cross-Cultural Perspective*, 191 SCI. 1019, 1019-28 (1976).

act in the hospital setting.[71] Middle class values, then, lead the participants in the commitment decision to view eccentric behavior as deviant, dangerous, and as evidence of mental illness; labelling leads to the designation of persons as deviant and the treatment of these persons as ill or dangerous, causing a reaction which can become a confirmation of the designation.

In addition to the effect of class-related values and labelling, Warren notes the inherent potential conflict between legal authorities and medical personnel[72] and its failure to actually materialize. While there is a deep philosophical conflict between legal theory, with its emphasis on free choice, and psychiatric-medical theory, which is rooted in notions of determinism,[73] Professor Warren suggests that the potential conflict in the decision making process is largely averted by a pragmatic orientation by all personnel, both medical and legal, who are involved in the process of commitment.[74]

The second element of the framework for decision making in involuntary commitment cases, the mental health law itself, provides an important part of the framework, albeit only a part. Warren emphasizes the need to consider the policy commitments underlying the statute's enactment and their effect on the administration of the statute as well as the statute itself. To this end, she points out the shift from major emphasis on paternalism in the earlier mental health law to a new emphasis on the liberty

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71. C. WARREN, *supra* note 20, at 19.

72. *Id.* at 16-17.

73. *See*, C. WARREN, note 20, *supra* at 190. *See also*, Roberts, *Some Observations on the Problem of the Forensic Psychiatrist*, 1965 WIS. L. REV. 240, where it is observed:

> The inter-professional differences become clear when one looks at criminal law. This segment of law focuses primarily on the crime with emphasis on intent and with lessor regard for motivation. On the other hand, psychiatry remains concerned with the criminal rather than the crime. The psychiatrist considers criminal intent as a manifestation of the underlying motivation of the criminal. The legal concept, which appears to separate the actor from the act, the criminal from the crime, is at variance with the view of the psychiatrist.

Id. at 242.

74. Warren suggests that the potential for conflict is avoided by all parties subscribing to common sense notions of mental illness, responsibility, and autonomy. *See* C. WARREN, *supra* note 20, at 140, where the author observes: "Although the medical and legal frames may appear to conflict on the surface, there is an underlying commonsense and a taken-for-granted perspective on mental illness." This results, it is asserted, in the meshing of "the roles of the participants into a neatly functioning unit." *Id.* at 140.

and rights of persons subjected to the mental health law.[75] At the same time, Warren stresses that considerable effect is given to the police function through the administration of the mental health law, not only in terms of providing protection from dangerous persons, but also in providing relief from socially disruptive persons, particularly where there is a showing of impaired functioning of the family unit which can be remedied by commitment.[76]

Warren shows that the administration of the mental health law is further affected by social and economic considerations not explicitly recognized in the statutory provisions. Primary among these factors is the fiscal. In Warren's view, the adoption of the California statute itself, with its emphasis on less restrictive alternative treatment, was in part a consequence of reduced funding for mental health treatment. While reformers urged the adoption of the least restrictive form of confinement consistent with patient needs on therapeutic and civil libertarian grounds, it is important to note that the legislature was largely moved by fiscal considerations. Costly hospitalization was to be replaced with less expensive alternatives such as nursing homes, day-care centers, and community health clinics.[77]

A third aspect of the legal framework is created by decisions and practices of the courts applying the mental health laws. The practical influence of the courts has led to supplementation of the statutory provisions by a developing case law which has given increased recognition to such matters as the right to treatment, right to refuse treatment, and a right to the least restrictive treatment

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75. *Id.* at 23-24.

76. *Id.* at 24, 175. Warren concludes "that considerations of individual rights and the protection of society are displaced in this court by considerations of the relief of family tensions and the smooth functioning of the mental health system." *Id.* at 175.

77. *Id.* at 22. Warren argues that this has not necessarily resulted in a more benign mental health system, since in her experience these alternatives have largely been relegated to the private sector where the profit motive has undermined the provision of adequate treatment. *Id.* at 203-07. The author's evaluation of this "transinstitutionalism" is expressed in strongly critical terms:

> [D]ata from New York, Hawaii, California, and other states mainly concern the fate of those poor and/or elderly mental patients who have been de-institutionalized from the state mental hospitals. However, the poor and the elderly are not the only "social junk" who can be transformed "into a commodity from which various 'professionals' and entrepreneurs can extract a profit." Adolescents—both from poor families and from the not-so-poor—can also be socially problematic and candidates for social control.

Id. at 205 (citations omitted).

setting.[78] As importantly, the explicit legal framework of the statute has been limited by various procedural and evidentiary rules adopted by the courts administering the statute. These include lack of a right to counsel at psychiatric examinations and use of the "clear and convincing evidence" standard for issues decided under the mental health law.[79] Most important, however, is the *treatment* of problematic concepts in the statute in a manner that subjects the process of commitment to less rigorous proof and procedure than was intended by the legislature in adopting the statute. The major difficulties stem from the standards for commitment which require proof of dangerousness. Warren observes that not only is the definition and prediction of dangerousness difficult, but psychiatrists tend to overpredict dangerousness.[80] Moreover, Warren finds that in practice the problematic features of showing the continued dangerousness of persons originally confined on an unlitigated determination of dangerousness to self or others are in fact avoided by a shift in the basis for continued confinement from "dangerous" to "gravely disabled."[81]

The legal context of involuntary commitment is complemented by the third element of the decision making framework cited by Warren, the theoretical orientations of the various participants in the mental health system toward mental illness, as well as the effect of diagnosis of mental illness itself. Warren identifies two competing theoretical orientations. The first is labelling theory which emphasizes the use of the designation of madness to identify certain unacceptable social behavior without any implication that there is any "real" underlying disorder.[82] The second is the medical model which asserts the existence of a physiological or psychological condition which results in impaired personal functioning.[83] While these competing perspectives are hotly debated in the literature, Warren reports that this debate has little effect on the actual

78. *Id.* at 31-35.

79. *Id.* at 29-31. *See* Addington v. Texas, 441 U.S. 418 (1979) (Supreme Court holding that in a civil commitment hearing the state must bear the burden of proof by clear and convincing evidence).

80. *Id.* at 35-36. *See generally* NATIONAL INSTITUTE OF MENTAL HEALTH, DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH (1978).

81. C. WARREN, *supra* note 20, at 37, 39-42.

82. *Id.* at 45-48. *See, e.g.*, T. SZASZ, THE MYTH OF MENTAL ILLNESS (rev. ed. 1974).

83. C. WARREN, *supra* note 20, at 45, 48-49. *See, e.g.*, P. CONRAD & J. SCHNEIDER, DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS (1980).

functioning of the mental health courts since participants adopt what she calls a "topos or commonsense model of mental illness."[84] Rather than employing one of the two models, attorneys and court personnel tend to refer to subjects as "sick, crazy, weird, different or hopeless."[85] In response to the questions asked by Warren of one psychiatrist: "What type of people come here?" the elicited response was: "Crazy ones."[86] Everyday notions of craziness thus become the basis of involuntary commitment.

In addition to the tendency toward the use of a common sense notion of mental illness in the mental health decision making process, the author identifies two other operational features of the system. The first, and perhaps most important, is that the diagnosis of a person as mentally ill goes largely unchallenged in the commitment process.[87] Adversary presentation and argument are limited to the issue of dangerousness or the establishment of grave disability.[88] Secondly, the fact that someone has been labelled mentally ill or merely brought within the mental health system affects not only how the person is treated by medical personnel, but also how the person is viewed by legal authorities, and may additionally affect the self-view and behavior of the subject himself with direct consequences for any judicial proceeding in which the person may be included.[89] These two factors can obviously have a tremendous effect on the outcome of the decision making process of the mental health tribunal. In a sense, they create effective presumptions that certainly are not intended by the statute.

This account of the framework for decision making in cases of involuntary commitment already suggests that the bare bones rules of the mental health law do not alone determine case outcomes. However, only by consideration of actual decisions can one assess the effectiveness of the mental health law. Such an assessment is the focus of the second part of *The Court of Last Resort*, which involves an examination of one hundred and thirty cases before a

84. C. WARREN, *supra* note 20, at 138-39.

85. *Id.* at 140.

86. *Id.*

87. *Id.* at 164, where Warren reports: "[T]he finding of mental disorder was routine and illustrated the accepted practice of using psychiatric testimony to establish mental disorder in law. . . . In practice, district attorneys and public defenders rarely challenged psychiatric diagnosis. . . ." *Id.* at 164.

88. *Id.* at 164-65.

89. *Id.* at 50-67.

mental health court in Los Angeles County in 1979 involving petitions for habeas corpus filed by persons involuntarily committed to the mental health system and an observational study of one hundred persons found mentally disordered and gravely disabled, dangerous to self, or dangerous to others.[90]

In setting out to evaluate empirically the operation of the mental health court, Warren identifies four hypotheses which she undertakes to test: (1) an organizational perspective which predicts that outcomes will be a product of court organization; (2) the legal perspective which suggests that outcomes will be based on the terms of the law; (3) the conflict perspective which maintains that outcomes will be based on qualities of the subject of the proceedings; and (4) the individual perspective which holds that outcomes will be determined by qualities of the decision making judge.[91] The most important finding Warren reports is that the statutory criteria for civil commitment, which she judges to be vague, are not strictly applied.[92]

Warren finds that the stated intent of the statute being applied, as well as its explicit language, is blunted by several factors. Chief among these is the use of "common sense" notions of mental illness rather than the legal categories established in the statute.[93] A second factor is the adoption of an informal relationship of cooperation rather than maintenance of strong adversarial stances in the courtroom. She observes that the attorneys who represented mental health clients, whether they were public defenders or private attorneys, did not make aggressive advocacy presentations but rather gave the impression of uncritically accepting the psychiatrist's testimony.[94] Psychiatrists were generally treated as " 'unimpeachable witnesses.' "[95] More importantly, Warren finds that a ju-

90. Warren reports that in 1979 in Los Angeles County 9,778 persons were involuntarily confined on 14-day writs. Of those involuntarily committed, 2,796 filed petitions for writs of habeas corpus. Of those who filed petitions, 298 were released by the hospitals, 282 were changed to voluntary status, 40 escaped, 628 were discharged after the writ was issued, 620 were released on stipulation from the court, and 972 proceeded to a hearing. Of the 972 writs which were heard, 255 were released and 660 were not released. Of the 130 cases studied by Warren, 49.9% had their petitions granted and were released, 47.7% had their writs denied. *Id.* at 155-56.

91. *Id.* at 157.

92. *Id.* at 175.

93. *Id.* at 153.

94. *Id.* at 139.

95. *Id.*

dicial informality and a sometimes "joking" demeanor intrudes into the process[96] and that the proceedings themselves are characterized by a ritual quality manifested in stock questions and responses.[97] All of these influences are viewed by Warren as obstructing justice, rendering the process "vulnerable to charges of lack of justice, cynicism, or even corruption."[98]

In the examination of the habeas corpus proceedings which were a major focus of this study, and about half of which resulted in denial of relief, Warren reaches a number of significant conclusions. The greatest attention to statutory criteria occurred in petitions where commitment was based on danger to self.[99] Yet even here great emphasis was placed on the willingness or lack of willingness of family members to take charge of the patient, rather than simple consideration of evidence showing future danger of suicide. Generally, there was little evidence of future danger presented in any of the cases.[100] As noted above, the category of dangerousness to others was usually avoided, with the adoption in most cases of the gravely disabled standard as the basis for further confinement.[101] Again, under the gravely disabled category, great stress was placed on whether family members were willing to take charge of the patient. As to the initial requirement of mental disorder, few patients were not labelled mentally disordered, and the most common diagnosis was schizophrenia, either paranoid or undifferentiated.[102]

Apart from the application of medical and legal criteria, Warren makes a number of additional significant observations. There appeared to be little significance given to race or ethnicity in the decision to commit, nor did sex or age seem to affect the decision.[103] In addition to the willingness of the family to assume responsibility for the petitioner,[104] factors favoring release included: willingness of the patient to take medication, lack of prior hospitalization, lack of delusions or hallucinations, and the fact that no

96. *Id.* at 153.
97. *Id.* at 153-54.
98. *Id.* at 154.
99. *Id.* at 174-75.
100. *Id.* at 173.
101. *Id.* at 165-68. *See supra* note 81 and accompanying text.
102. C. WARREN, *supra* note 20, at 164-65.
103. *Id.* at 162.
104. *Id.* at 161.

conservatorship petition was pending.[105] Another factor which played an important role in the decision to release was the absence of physical threats or attacks by the subject.[106] Warren questions the appropriateness and relevance to the legal basis for commitment of some of these factors, particularly prior hospitalization and absence of a pending conservatorship petition.

The willingness of family members to take responsibility for the petitioner is also questioned as to its appropriateness and relevance as a factor in the decision to discharge.[107] Warren argues that the emphasis on family care reflects the class orientation of the judicial decision maker. The petitioner, who is likely to be, according to Warren, a "socially marginal" person, is just that type of person who is unlikely to have available extended family support.[108] Further, Warren suggests that this emphasis on availability of "sponsorship of family members" threatens the integrity of the mental health law by transforming it from a scheme to provide care for the mentally disordered who are dangerous or disabled to a mechanism serving "as a kind of safety valve for families of mentally disordered persons" seeking relief from the stress and tension created by the presence of the mentally disordered person.[109]

Beyond the legal criteria and the behavioral and social factors which influence decisions of the mental health court, Warren identifies various organizational features of the mental health system which influence decisions (she prefers the term "network" to "system" since it suggests a greater degree of openness to external influences).[110] Three principal factors are identified: resource availability, number of subjects or clients, and personnel needs and loyalties.[111] Warren maintains that availability of resources, including financial resources, has a direct outcome on commitment decisions. She suggests that a lack of financial resources might lead hospitals to encourage filing of petitions, or lead a court to release in order to give relief to "beleaguered" hospitals.[112] The need for patients and overcrowding are also conditions which can affect hos-

105. *Id.*
106. *Id.* at 171.
107. *Id.* at 176.
108. *Id.*
109. *Id.* at 168.
110. *Id.* at 178.
111. *Id.* at 180-81.
112. *Id.*

pitals' release decisions. According to Warren, "Clients are resources, as well as money. . . . A working, adequate number of clients is a desirable resource; none, and the organization might not exist, too many, and it might be overwhelmed."[113] The working relationship based on these concerns and needs between the hospital and the court and attorneys has an influence on case outcomes. Warren observes that an amicable, routine relationship existed between the court and the state mental hospitals, while a degree of hostility existed between the court and private and federal hospitals.[114] The degree of hostility was measured in terms of required testimony from treating psychiatrists. Some private hospitals were required to provide such testimony, while reports were accepted from general hospital staff in the case of state hospitals.[115] The use of the "gravely disabled" standard in place of a "dangerous" standard is itself judged by Warren to be the result of inter-organizational cooperation aimed at "a de facto continuation of the more psychiatric and less legal involuntary commitment standard that prevailed in California" prior to adoption of the reform statute.[116] Warren is led to the conclusion that official self-interest and inter-organizational needs have led to a significant erosion of the intended legal reforms embodied in LPS and to a compromise of justice in decision making. Warren concludes: "The idiosyncratic and organizational features of decision making in the [mental health] court are obvious to the long-term observer to [sic] the court. . . . [They] add to the sense of justice not done, . . . to the topos and informal ritual of the court, and to the particularism of decision making."[117]

Based on her empirical and observational study, Warren comes to view the decisions of the mental health court as too "particularistic, situational, and arbitrary."[118] To a great extent she sees this situation as following in part from medical diagnosis being accepted as proven fact, and partly from personnel and organizational needs taking precedence over legal and psychiatric re-

113. *Id.* at 180.
114. *Id.* at 183-84.
115. *Id.* at 185-87.
116. *Id.* at 193.
117. *Id.* at 199.
118. *Id.* at 211.

quirements.[119] Her evaluation is that "[j]ustice is not done in involuntary civil commitment."[120] Nevertheless, two principal convictions lead her to argue for the continuation of the present process. First, she views mental illness as a reality in which there is an obvious loss of control and dysfunctional behavior.[121] Second, she views the available alternatives of de-institutionalization and use of nursing homes as inadequate.[122] These alternatives, which utilize the private sector, are viewed as primarily operated for profit without any effective provision of social support and treatment for the persons relegated to them.[123]

As to further reform, Warren does not believe it desirable to provide greater judicial control of commitment by requiring judicial review of all temporary commitments (in California this could include the seventy-two hour holds, or at least all fourteen day holds).[124] She argues that there is already too much legal and psychiatric expertise in the system. Rather, she suggests the desirability of more administrative and lay-dominated control of the involuntary commitment system.[125] While favoring a system of voluntary commitment, Warren suggests that a halfway reform should be directed at reducing organizational control of the system, with greater challenge to what she views as the "pseudoscientific rhetoric" of an expert dominated system.[126] She suggests more frequent rotation of judges and attorneys in the mental health court and efforts at reducing the "assembly line justice" quality of current proceedings as immediate reforms.[127] Her concern is less with the actual decisions the courts have rendered than with what she considers the apparent injustice of the present system. Thus she does not, in the end, object to the use of common sense notions of mental illness, since for her they are no less legitimate than the legal and psychiatric concepts used in the present statutory framework.[128]

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119. *Id.*
120. *Id.* at 212.
121. *Id.* at 202.
122. *Id.* at 204-07.
123. *Id.* at 211.
124. *Id.* at 212.
125. *Id.*
126. *Id.*
127. *Id.*
128. *Id.* at 213.

The value of *The Court of Last Resort* lies in the empirical and observational information it provides about the actual operation of the procedure of involuntary commitment under a reform mental health statute. Warren's study makes it clear that the policies and explicit terms of the statute are blunted by the influence of a number of factors. Nevertheless, one must seriously question some of the evaluative conclusions which are reached in *The Court of Last Resort*. A court that gives serious consideration to whether the family of a petitioner is willing to provide care or whether a conservatorship proceeding is pending is going beyond the criteria in the statute. Yet these considerations seem to be proper for a court which must take some responsibility for the welfare of mentally disabled and non-functioning persons. Moreover, the evaluative conclusions of *The Court of Last Resort* seem tainted by what appears to be an excessive hostility on the part of the author toward legal and medical expertise. This hostility leads the author to prefer lay decision making over expert determination in this area of law. For those, like the present reviewer, who accept that there is a medical basis for mental disorder and who view legal decision makers more capable of evaluating the applicability of a complex legal-medical standard than lay persons, the author's conclusions appear to a large degree unfounded.

Perhaps one of the gravest deficiencies in the evaluative stance of the author is either a misunderstanding or rejection of the notion of judicial discretion. Warren seems to believe that a court should operate within the statutory framework in a somewhat mechanistic manner producing determinate decisions when the evidence before it is evaluated against the standards of the statute. Throughout *The Court of Last Resort* there is a current of criticism which finds decisions, to the extent that they are "particularistic" rather than "universalistic," to be tainted by the appearance of injustice.[129] But justice requires an effort to reconcile the general requirements of the law with the individual features of the case before the court. Principled judicial discretion, by which I mean decisions based on articulated reasons, provides a needed supplement to the explicit terms of a statute such as a mental health code.

While the legal realists argued for a need to differentiate be-

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129. *See, e.g., id.* at 154, 199.

tween law on the books and law in practice, they did not take the position that law in practice was unjust to the extent that it varied from the law on the books. In relation to involuntary commitment, one may object to the disregard of the statutory framework and the apparently manipulative use of categories, such as "gravely disabled," for continued hospitalization. Moreover, one may fault counsel for not providing effective representation if they fail to properly examine psychiatric witnesses or challenge adverse evidence. It is quite another thing to see as objectionable consideration of factors such as family care or rationing of scarce hospital resources in the face of overwhelming demand. It seems quite appropriate for a court to make hospital utilization determinations based on the relative needs of various persons subject to involuntary hospitalization where all subjects cannot be accommodated.

Finally, I would like to differ with Professor Warren's suggestions for further reform of the involuntary commitment law. Warren rejects increased judicial supervision of involuntary commitment by requiring court review of all seventy-two hour or fourteen day holds under LPS. In part, this rejection stems from an admitted hostility to judicial expertise. Nevertheless, involuntary hospitalization involves a significant deprivation of liberty, potential stigmatization, and limitation of personal autonomy. Given these costs to the person hospitalized, it would seem that family members, police, or even intake medical personnel are not the proper parties to make the commitment decision, no matter how short the period of involuntary confinement. Whenever possible, independent judicial evaluation of the propriety of commitment should be made by a magistrate.

Warren suggests that reform should lead to rotation of legal personnel and utilization of lay decision making. However, the process of commitment is to be governed by legal standards and based on medical diagnosis of mental disorder. While application of these criteria may always be tempered by common sense notions, it is quite a long step to suggest that legal and medical criteria should be replaced with lay common sense opinions of what is crazy or bizarre. To the extent that formal legal standards are involved and medical diagnosis required, the more expertise which can be brought to bear on a case, the more likely that a proper decision will be reached. One of the reasons that there has been such poor representation of those brought within the mental health system in

the past is that attorneys very often lack familiarity with the system and are ignorant of the nature of mental disease itself.[130] More, not less, expertise would seem appropriate.

Warren's defense of continuation of the present process of involuntary hospitalization stems in part from her judgment of the inadequacy of institutional alternatives, especially for-profit nursing homes, day-care centers, and outpatient clinics. Certainly Warren is correct in her assessment of the inadequacy of the present operation of these facilities in providing adequate care and shelter. But her critical view of capitalist enterprise leads her to reject outright the possibility of these institutional alternatives ever providing adequate care. However, rather than rejecting a program of alternative institutionalization which requires the use of least restrictive alternatives, it would seem prudent to urge more effective state regulation of these facilities. Such alternative institutions continue to offer a greater promise of autonomy and appropriate care and treatment for a large number of mentally disabled persons than the overcrowded wards of state hospitals or a program of premature and irresponsible release of persons unable to provide effectively for themselves.[131]

The concerns identified in the report of the President's Commission on Mental Health in 1978 with the availability and quality of treatment for the mentally ill and with the recognition of a wide array of rights for mental health patients are well-founded. *The Court of Last Resort* shows that these concerns cannot be met by statutory reform alone. Adequate funding, trained legal personnel, and individualization, rather than routine diagnosis by medical personnel, will be required to give effect to statutory reform. Most important, however, is an understanding of, and commitment to, the needs of the mentally ill by all those involved in the administration of reform mental health legislation.

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130. *See generally* 4 PRESIDENT'S COMM'N ON MENTAL HEALTH, REPORT OF THE TASK PANEL ON LEGAL AND ETHICAL ISSUES, in IV 1978 TASK PANEL REPORTS app. (1978).

131. *See generally* Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107 (1972).