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Toward a Conceptual Framework for Assessing Police Power Commitment Legislation

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Abstract
Recent litigation and scholarship have begun to focus on the substantive limits of the state's power to use civil commitment as a social control tool. Courts and commentators describe civil commitment as grounded on two powers of the state: the parens patriae interest and the police power. This Article seeks an analytical framework for defining the boundaries of police power commitments in which justification rests on the interests of the public rather than on the interests of the committed individual.

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Toward a Conceptual Framework for Assessing Police Power Commitment Legislation: A Critique of Schopp's and Winick's Explications of Legal Mental Illness

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The author served as co-counsel for Linehan in *In re* Linehan, 518 N.W.2d 609 (Minn. 1994), and *In re* Linehan (II), 544 N.W.2d 308 (Minn. Ct. App. 1996), *aff'd*, 557 N.W.2d 171 (Minn. 1996). These cases involve the application and constitutionality of police power commitment statutes.

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I. INTRODUCTION

Recent litigation and scholarship have begun to focus on the substantive limits of the state's power to use civil commitment as a social control tool. Courts and commentators describe civil commitment as grounded on two powers of the state: the *parens patriae* interest and the police power. This Article seeks an analytical framework for defining the boundaries of police power commitments in which justification rests on the interests of the public rather than on the interests of the committed individual.

The state's general power to use civil commitment commonly is described as limited to individuals who have a mental disorder and who are dangerous to others or themselves.[1] The debate about the scope of civil commitment is often posed as a problem of defining the kind of mental disorder that is required to justify commitment. This question has proven much more intractable in the police power context than the analogous question in the *parens patriae* commitment context. The *parens patriae* interest is the state's power (and obligation) to care for those who are *unable* to care for themselves.[2] *Parens patriae* com-

1. *See* Foucha v. Louisiana, 504 U.S. 71 (1992); Jones v. United States, 463 U.S. 354 (1983); Addington v. Texas, 441 U.S. 418 (1978).
2. *See, e.g.*, Addington v. Texas, 441 U.S. 418, 426 (1978); Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988). *See generally* Lawrence B. Custer, *The Origins of the*

mitments are limited to persons with mental disorders that impair their ability to make decisions about their own lives and medical treatment.[3]

The boundaries of police power commitments, however, are more difficult to ascertain. The police power gives the state the right to protect the health and safety of the public.[4] Unlike the *parens patriae* interest, the police power is defined not explicitly in terms of the person's mental incapacity, but rather in terms of the danger the person poses to the community. Indeed, the police power clearly operates in circumstances, such as the criminal law, where there is no mental impairment. Thus, the limits on police power commitments and the role mental disorder plays in defining those limits are much more obscure.

Recently, two important scholarly articles contributed to defining these limits.[5] Writing in the inaugural issue of *Psychology, Public Policy, and Law*, Professor Robert Schopp's analysis argues that the bounds of police power commitments are to be found in the respect due to individuals who have the mental competency to act autonomously and to be held responsible for their choices.[6] Deploying massive behavioral science authority, Professor Bruce Winick argues that commitments are limited both to mental disorders that severely impair cognition or volition and, by the principle of "therapeutic appropriate-

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Doctrine of Parens Patriae, 27 EMORY L. J. 195 (1978); *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974)[hereinafter *Developments in the Law*].

3. *See* Addington v. Texas, 441 U.S. 418, 426 (1978)(holding that *parens patriae* power gives the state an interest "in providing care to its citizens who are unable because of emotional disorders to care for themselves"); Jarvis v. Levine 418 N.W.2d 139, 145 (Minn. 1988)(holding that "intrusive" treatment may not be forced on unconsenting, competent mental patients).

4. *See* United States v. Salerno, 481 U.S. 739, 748 (1987); Addington v. Texas, 441 U.S. 418, 426 (1978); Jacobson v. Massachusetts, 197 U.S. 11, 24 (1905); *Developments in the Law*, *supra* note 2, at 1233-34.

5. The boundaries of police power commitments only rarely have been the subject of careful study. Notable exceptions include ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 329, 332 (1989); *Developments in the Law*, *supra* note 2, at 1233-34; John Q. La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFF. L. REV. 499 (1981); Joseph M. Livermore et al., *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 86 (1968); Robert F. Schopp, *Sexual Predators and the Structure of the Mental Health System: Expanding the Normative Focus of Therapeutic Jurisprudence*, 1 PSYCHOL. PUB. POL'Y & L. 161, 181 (1995); Note, *Standards of Mental Illness in the Insanity Defense and Police Power Commitments: A Proposal for a Uniform Standard*, 60 MINN. L. REV. 1289, 1298 (1976)(arguing that police power commitments are justified by inability to control behavior). I have also addressed the issue in Eric S. Janus, *Preventing Sexual Violence: Setting Principled Constitutional Boundaries on Sex Offender Commitments*, 72 IND. L. J. 157, 208-12 (1996)[hereinafter Janus, *Preventing*].

6. Schopp, *supra* note 5.

ness," to mental disorders that are amenable to involuntary treatment.[7]

Litigation testing the constitutionality of sex offender commitment statutes has prompted the debate concerning the scope of police power commitments.[8] As this article goes to press, the United States Supreme Court has issued its decision in *Kansas v. Hendricks*, upholding the constitutionality of Kansas' Sexually Violent Predator Act. The precedential implications of the Court's decision will depend on careful analysis of the conceptual framework applied. Schopp's and Winick's articles are among the most comprehensive recent efforts to attempt to establish such frameworks. Schopp and Winick derive results similar to other's proposals. Roughly speaking, they propose that civil commitment is appropriate only when an individual's mental impairments render the person incompetent or unable to control his behavior.[9] I undertake a critique of Winick's and Schopp's articles because I believe that their results are substantially correct but are more sturdily supported through conceptual frameworks that differ in small but important ways.

II. CHOOSING A CONCEPTUAL FRAMEWORK

A conceptual framework sets forth the "givens" from which an analysis proceeds and often determines the results of the analysis and the generalizability of those results. In the present project, three "moves" establish the framework's essential structure. The first establishes the "explicandum," the concept that is to be explicated. This choice determines whether we will look for limits on police power commitments from within the civil commitment system itself or from a broader context, such as the criminal justice system. The second element resolves whether the framework will pursue an interest-based or a rights-based analysis. This determines whether the limits will arise from the variations in the rights of the individual or in the interests of the state. The third choice determines the role for medical or behavioral science in setting limits on civil commitment.

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7. Bruce J. Winick, *Ambiguities in the Legal Meaning and Significance of Mental Illness*, 1 PSYCHOL. PUB. POL'Y & L. 534 (1995).

8. *See* Garcetti v. Rasmussen, 57 Cal. Rptr. 2d 420 (Cal. Ct. App. 1996), *superseded by* 931 P.2d 262 (Cal. 1997); *In re* Hendricks, 912 P.2d 129 (Kan. 1996), *rev'd*, 117 S. Ct. 2072 (1997); *In re* Blodgett, 510 N.W.2d 910 (Minn. 1994), *cert. denied*, 513 U.S. 849 (1994); *In re* Linehan (II), 544 N.W.2d 308 (Minn. Ct. App. 1996), *aff'd*, 557 N.W.2d 171 (Minn. 1996); *In re* Young, 857 P.2d 989 (Wash. 1993), *habeas corpus granted*, Young v. Weston, 898 F. Supp. 744 (W.D. Wash. 1995); State v. Post, 541 N.W.2d 115, 122 (Wis. 1995).

9. For other similar proposals, see generally BUCHANAN & BROCK, *supra* note 5, at 327-28; *Developments in the Law*, *supra* note 2, at 1215; Janus, *Preventing*, *supra* note 5, at 208-12; Livermore et al., *supra* note 5, at 81, 86.

In the following sections, I introduce each of these variables and then propose a set of benchmarks or criteria for evaluating the explanatory power of the choices at each juncture.

A. Broad vs. Narrow Explicandum

The problem posed here can be seen as a problem of "explication," that is, taking an old concept, one whose "everyday" use has become inexact, and making it more exact.[10] The old concept, "civil commitment," has become inexact because social forces[11] demand the use of civil commitment in circumstances that teeter at or near traditional boundaries: states want to use civil commitment to continue confinement of sex offenders who previously have been criminally sentenced and have served their time. This trend requires states to stretch old ideas of what is required for civil commitment[12] and demands that the old concept be explicated or replaced by a new concept (perhaps retaining the same term as the old concept), and thereby clarifies the boundary conditions for the new concept.[13]

One common problem in debates about explication is that disagreements that appear to be about the explicatum (the new, more precisely defined concept) are really about the explicandum (the old concept to be explicated). That is, the discrepancy is traceable to different starting points—the disagreement arises because different concepts are being explicated.[14] Thus, a first step in the process of explication is to be as clear as possible about what "old" concept is the explicandum and to use that clarity to choose an explicandum that will yield the most useful explication.

Consider these three candidates for explicandum. The first and narrowest explicandum defines the limits of involuntary "psychiatric hospitalization." The second, slightly broader explicandum defines the limits of the state's "mental health" power. The third and broadest explicandum seeks the boundaries of the state's power to use a civil proceeding to indefinitely deprive an individual of liberty for purposes of social control. The first two candidates correspond

10. The old concept is called the "explicandum." Explication seeks to replace the explicandum with a new, more carefully defined concept, the "explicatum." *See* Rudolf Carnap, *The Two Concepts of Probability*, 5 PHIL. & PHENOMENOLOGICAL RES. 513, 513 (1945).
11. *See* Eric S. Janus, *The Practice of Sex Offender Commitments: Debunking the Official Narrative and Revealing Rules in Use*, 8 STAN. L. & POL'Y REV. (forthcoming 1997)(manuscript at 2-3, on file with the *Nebraska Law Review*)[hereinafter Janus, *The Practice of Sex Offender Commitments*]; John Q. La Fond, *Washington's Sexually Violent Predator Law: A Deliberate Misuse of the Therapeutic State for Social Control*, 15 U. PUGET SOUND L. REV. 655, 661 (1992).
12. Janus, *The Practice of Sex Offender Commitments*, *supra* note 11, at 2-3.
13. Carnap, *supra* note 10, at 520.
14. *Id.*

roughly to the frameworks chosen by Winick and Schopp. Elsewhere, I have suggested an analysis using the third.[15]

Their choices of explicandum lead Schopp and Winick to seek the boundaries of civil commitment through a method that is, at least in part, endogenous; that is, they seek to derive the limits from the essential nature of civil commitment itself. The third candidate for explicandum suggests a method that is exogenous. This method seeks to define civil commitment from without by understanding where civil commitment fits in the broader scheme of social control and police power.[16] Note that the third candidate does not appear to *assume* that mental disorder will play a limiting role. In contrast, the first two candidates logically and historically entail a role for mental disorder. Thus, only the third candidate allows exploration of the possibility of some forms of "civil commitment" without the presence of a "mental disorder."

B. Individual Rights/Status vs. State Interest Analysis

Any explication of the boundaries of civil commitment must offer a theory explaining why certain individuals with certain conditions are subject to civil commitment, while others are not.[17] Two theories are available. One focuses on the individual who is subject to commitment and asks whether the individual has the right or the "status" to avoid civil commitment. The presence or absence of "mental disorder" affects the individual's legal status and commitment rights. Under this "rights/status" theory, the presence of a mental disorder denotes a different status, and ultimately, diminished rights. For example, an individual's inability to act autonomously curtails her right to make medical care decisions.[18]

In the second theory, the interest-based theory, the variable is the state's interests, not an individual's rights. The individual's right to make his own decisions remains constant, but in certain circumstances, the state's interest reaches a level that justifies overriding the individual's rights. In the interest-based theory, in contrast to the

15. Janus, *Preventing*, *supra* note 5, at 208-12.
16. Schopp's analysis is a mixture of both methods, but, in the end, he appears to settle on an analysis in which the limits of civil commitment are derived from the ways in which civil commitment treats the individual, rather than from the proper role civil (as opposed to criminal) confinement plays in the vindication of the state's police power. *See* Schopp, *supra* note 5, at 167-68.
17. In Schopp and Sturgis' terminology, the boundary must not only discriminate among individuals, but also must provide a justification for the discrimination. *See* Robert F. Schopp & Barbara J. Sturgis, *Sexual Predators and Legal Mental Illness for Civil Commitment*, 13 BEHAV. SCI. & L. 437, 447, 450 (1995).
18. In Schopp's terminology, the impairment of an individual's "autonomous capacities" curtails his or her "sovereignty," or right to self-determination. Schopp, *supra* note 5, at 173.

rights/status theory, mental disorder does not create a classification of individuals with curtailed civil rights or a diminished civic personality.[19]

I suggest in this Article that both Winick and Schopp appear to rely on a rights/status approach, though they embrace such an approach ambiguously. The approach appears to be a product of their endogenous analysis, which seeks the boundaries of police power commitment by looking within its essential nature. The exogenous approach, on the other hand, factors in the analysis the state's interest in using the civil commitment system, rather than the criminal justice system, as a social control tool in particular circumstances.

C. The Role of Medical and Social Scientific Discourse

A third feature of the conceptual framework concerns the manner in which concepts, classifications, medical knowledge, and behavioral science developments enter into the analysis. Both Winick and Schopp adopt the perspective of therapeutic jurisprudence in their analyses. A central tenet of this approach is that "empirical information from the social sciences can inform legal decision-making and should indeed be taken into account in legal decision-making."[20] The choice at issue here is not whether, but how that information will enter into the legal analysis.

For Winick, who chooses psychiatric hospitalization as his explicandum, the domain of medicine, medical concepts, and medical advancements enter into the analysis at an early point and in a significant, highly normative role.[21] Schopp's analysis, in contrast, insists that medicine and the behavioral sciences play a much more descriptive role and enter late in the analytical process. While medical discourse appears central to Winick's derivation of his high level rules, behavioral and medical science for Schopp provide the facts that allow the rules (previously derived) to be applied to individuals.

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19. *See* CLIVE UNSWORTH, THE POLITICS OF MENTAL HEALTH LEGISLATION 36, 41 (1987). Persons with mental disorders are excluded from full participation in the benefits of a legal personality. "Freedom, responsibility and autonomy" characterize an individual's legal personality. *Id.*

20. Jeffrey A. Klotz et al., *Cognitive Restructuring Through Law: A Therapeutic Jurisprudence Approach to Sex Offenders and the Plea Process*, 15 U. PUGET SOUND L. REV. 579, 580 (1992).

21. Winick characterizes the role of medicine as less central. I argue below, however, that medicine plays a central role in setting the constitutional contours of Winick's explication in a number of ways. *See infra* notes 25-27 and accompanying text.

III. EVALUATING THE CONCEPTUAL FRAMEWORKS

The purpose of this Article is to build on the scholarly work of Schopp and Winick by evaluating the conceptual frameworks they employ to find the boundaries of civil commitment. In this section I set forth the criteria I have used to carry out this evaluation.

A. How Well Does the Framework Focus on Police Power Commitments Rather Than *Parens Patriae* Commitments?

This Article seeks a conceptual framework that will help define the boundaries of police power commitments. This is a harder task than finding the boundaries for *parens patriae* commitments. Police power and *parens patriae* considerations are often intertwined in discussions of civil commitment. A conceptual framework must sort out the role for each.

It is possible that the *parens patriae* and police powers of the state are jointly necessary for the constitutional application of civil commitment.[22] If this is true, "pure" police power commitment is nonexistant. All commitments are mixed. The mental disorder limits of "police power" commitments would be exactly the same as those for "*parens patriae*" commitments. The problem of finding the mental disorder boundaries for police power commitments would translate into the much easier problem of finding boundaries for *parens patriae* commitments.

On the other hand, it is possible that "pure" police power commitments are permissible. These are commitments for which the state's *parens patriae* power, standing alone, provides insufficient support. In these cases, the state's *parens patriae* power either is not triggered at all (perhaps because the individual remains competent to choose her own health care) *or* the state's public protection interests require confinement that extends beyond the confinement required by the *parens patriae* interests.[23] In this Article, I will use the term "police

22. This was the position advocated by the American Psychiatric Association in its Amicus Brief in *Foucha v. Louisiana*, 504 U.S. 71 (1992). Identifying the *parens patriae* power as a "special power applicable to the mentally ill," the Association argued that "when dealing with the mentally ill the state may also rely on its *parens patriae* power, growing out of its historical role as 'guardian of all infants, idiots and lunatics.'" Amicus Brief for American Psychiatric Association at 8, 11, Foucha v. Louisiana, 504 U.S. 71 (1992)(No. 90-5844).

23. *See* BUCHANAN & BROCK, *supra* note 5, at 315. "Pure" police power commitments are permissible where, for example, treatment could be appropriately provided in a low-security or outpatient setting, but the risk posed by the patient is said to warrant a secure setting. Other examples might include a patient whose condition proves resistant to treatment, *see* Winick, *supra* note 7, at 574, or a patient for whom the risks (side effects) of treatment outweigh its benefits, or a patient who has an advanced health care directive that withholds consent for treatment.

power commitments" to refer to commitments inadequately supported by the *parens patriae* power standing alone.

A conceptual framework with strong explanatory power will accomplish one of two things: either it will help derive the boundaries for police power commitments, or it will help establish that "police power commitment" is an empty concept, i.e., that all commitments are *parens patriae* commitments.

B. Explaining Gaps and Overlaps

A second criterion for judging a conceptual framework is how well it answers questions about the relationship between civil commitment and the criminal justice system. There are two aspects to this important question. The "overlap" issue—can the same individual, or same set of circumstances, be addressed by both the criminal justice and civil commitment systems?—is central to the current litigation about sex offender commitments.[24] The "gap" issue—is there some dangerous behavior that cannot be addressed by either system?—is equally important in public policy debates about the insanity defense.[25]

Note that I will use the term "civil commitment" to mean all liberty deprivation that is "civil," and not "criminal." I do not intend to discuss at length the factors that constitute a criminal proceeding;[26] by "civil" I mean proceedings in which a state claims to be exempt from restrictions imposed on "criminal" proceedings.[27] Thus, in rough terms, I intend "civil commitment" to mean noncriminal deprivation of

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See MINN. STAT. § 253B.03, subd. 6c (1996)(setting forth procedures for an advanced declaration regarding mental health care).

24. *See, e.g., In re* Hendricks, 912 P.2d 129 (Kan. 1996), *rev'd*, 117 S. Ct. 2522 (1997); *In re* Blodgett, 510 N.W.2d 910 (Minn. 1994), *cert. denied*, 513 U.S. 849 (1994); *In re* Linehan (II), 544 N.W.2d 308 (Minn. Ct. App. 1996), *aff'd*, 557 N.W.2d 171 (Minn. 1996); *In re* Young, 857 P.2d 989 (Wash. 1993), *habeas corpus granted*, Young v. Weston, 898 F. Supp. 744 (W.D. Wash. 1995); State v. Post, 541 N.W.2d 115, 122 (Wis. 1995).

25. *See generally* HENRY J. STEADMAN ET AL., BEFORE AND AFTER HINCKLEY: EVALUATING INSANITY DEFENSE REFORM (1993); Winick, *supra* note 7, at 551 (discussing the public policy effects of *Foucha* and the "therapeutic appropriateness" principle).

26. *See, e.g.*, Stephen J. Schulhofer, *Two Systems of Social Protection: Comments on the Civil-Criminal Distinction, with Particular Reference to Sexually Violent Predator Laws*, 7 J. CONTEMP. LEGAL ISSUES 69 (1996).

27. Generally, states claim that civil commitment proceedings are exempt from the following requirements characteristic of the criminal law: prohibitions against double jeopardy and ex post facto laws; rights to juries as fact finders and to the highest standard of proof; and prohibitions against criminalizing a status and basing criminal conviction on predicted, rather than committed, crimes. *See* Janus, *Preventing*, *supra* note 5, at 188-89.

liberty by the state.[28] In this usage, "psychiatric commitment" and "mental health commitment" are subsets of civil commitment.

C. Evaluating the Role of Medical and Behavioral Science

The bounds of civil commitment historically have been a site of contention between medical and "moral" values, and between science and law.[29] A conceptual framework for civil commitment boundaries must help locate their respective realms. Schopp's and Winick's frameworks differ sharply on this question. Both Schopp and Winick emphasize the primacy of legal discourse. Their disagreement is translated, in large part, into their choices of the proper scale at which the interface among mental disorder and law and morality is to take place. Discussions about mental illness or disorder can proceed at a number of levels: physiological or biological pathology and etiology; psychological function or dysfunction; and clinical concepts of illness, disease, or disorder.[30] Schopp appears to settle at the intermediate level (dysfunction) in his linkage with the psychological discourse, whereas Winick's discussion is split between low level (biological etiology) and high level clinical concepts ("illness" and treatment). This Article offers a comparative evaluation of the two approaches. These are complex issues. I hope to set forth some basic considerations that are not intended to be exhaustive.

D. Tracing the Consequences of a Diminished Individual Rights/Status Approach vs. an Enhanced State Interests Approach

Historically, civil commitment has been justified on the grounds that those subjected to it are not whole civic persons because of their

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28. I intend for the term "civil commitment" to take up all of the space of the liberty-deprivation universe that criminal imprisonment does not occupy. It may be that there are forms of "civil" liberty-deprivation that would be usefully distinguished from what we think of as civil commitment. For example, imprisonment for civil contempt might be usefully thought of as a separate category. But, with such limited exceptions, I intend the term "civil commitment" to include all noncriminal confinement. Thus, if "preventive detention" is constitutional without a showing of mental disorder, that sort of confinement would be included. So would "quarantine," to the extent that this form of public health intervention involves involuntary, noncriminal confinement. My intent is that the term "civil commitment" should be broad enough to include all forms of confinement that are not criminal. Thus, if we know the limits of "civil commitment," then we will know the limits of all confinement that is not criminal.

29. *See generally* ANDREW SCULL, SOCIAL ORDER/MENTAL DISORDER 120-61 (1989)(discussing shift of responsibility for mentally ill from community to psychiatry).

30. *See, e.g.*, THEODORE MILLON, DISORDERS OF PERSONALITY DSM-III: AXIS II 12-14 (1981)(differentiating among levels of data used by classification systems).

mental impairments.[31] This approach seems dangerous, especially when used in the context of the state's police power. For example, in *Buck v. Bell*, the Supreme Court approved the sterilization of Carrie Buck; the stated rationale was the state's police power and Buck's "mental deficiency." *Buck* can be seen as a case in which the individual's mental impairment produced a diminished status, which in turn allowed the state to justify its exercise of police power on the basis of the medical nature of the sterilization procedure.[32]

As indicated above, I propose that one understanding of the conceptual frameworks advanced by both Schopp and Winick is that they rely, implicitly though not explicitly, on a diminished rights/status justification for police power commitments. Neither writer even remotely suggests that mental impairments entail a generalized diminution in civic personhood. But their frameworks, in conjunction with the law of unintended consequences, point to an expanded use of therapeutic benefits of medical care to justify social control for mentally impaired individuals. This approach invites justification based on impaired personhood.

IV. WINICK: THERAPEUTIC APPROPRIATENESS AND *PARENS PATRIAE*

A. Introduction

Professor Winick frames his inquiry as a search for the bounds of involuntary psychiatric hospitalization.[33] His analysis contains three critical steps. First, civil commitment is an "essentially medical" intervention. Second, a necessary (but insufficient) justification for civil commitment is that the intervention must be therapeutically appropriate. Third, civil commitment is limited to individuals with certain severe functional impairments of their mental functioning.

Applying these three principles to his impressive command of the psychiatric and behavioral science literature, Winick shows that only the "major mental illnesses"—schizophrenia and bipolar affective disorder—are appropriate predicates for civil commitment. In contrast, personality disorders and sexual paraphilias, the disorders commonly

31. *See, e.g.*, Addington v. Texas, 441 U.S. 418, 429 (holding that the subject, by reason of mental impairment, was not wholly free); UNSWORTH, *supra* note 19, at 36-42 (mental disorder produced a "subordinate legal status," not "fully human"); Jeffrey G. Murphy, *Moral Death: A Kantian Essay on Psychopathy, in* ETHICS AND PERSONALITY 217 (John Deigh ed., 1983)(arguing psychopaths are "morally dead" and hence not entitled "that special kind of respect" reserved for persons).

32. The connection between police power commitments and *Buck v. Bell*, 274 U.S. 200 (1927), was noted in the Brief for the State of Minnesota in Minnesota *ex rel.* Pearson v. Probate Court, 309 U.S. 270 (1940).

33. Winick, *supra* note 7, at 538.

underlying sex offender commitments, fall outside of the bounds for civil commitment.

Despite its weight, Winick's framework displays ambivalence that impairs its utility, especially in the context of police power commitments. In this Part, I trace these fuzzy spots in Winick's framework and their consequences.

Winick is ambivalent about two key aspects of his framework. First, it is unclear whether the "essentially medical" character of civil commitment is part of the explicandum (a given in the argument) or whether it is derived from other foundation principles. This ambivalence renders the principle of therapeutic appropriateness indeterminate. I will show that the principle has both a strong and a weak form and will then trace the consequences of each.

Winick is also ambivalent about the role the *parens patriae* power plays in his explication. It is unclear whether Winick *assumes* a central role for the *parens patriae* interest or *derives* some role for the interest, central or otherwise. This ambivalence in turn renders unclear Winick's functional impairment framework.

Because of these ambiguities, it is not at all apparent that Winick has undertaken the broader task of locating the limits of all mental health intervention. Thus, evaluation of his conceptual framework as a candidate for pinpointing the limits of police power commitments may unfairly broaden the intended context. That said, such an evaluation is worthwhile. Winick skillfully articulates a particular approach to the boundary-setting problem; critiquing his approach can only help achieve even greater clarity and explanatory power in a conceptual framework.

B. The Strong and Weak Versions of Winick's Therapeutic Appropriateness Principle

Winick's central argument proceeds in five steps. First, Winick identifies civil commitment with involuntary psychiatric hospitalization.[34] Second, he proposes that psychiatric hospitalization is an intervention that is "essentially medical."[35] Third, he suggests medical interventions are improper unless they are capable of rendering a therapeutic benefit.[36] Thus, the principle of therapeutic appropriate-

34. *Id.* Winick poses the issue as follows: what qualifies "as a mental illness for the purpose of commitment to a psychiatric hospital[?]" *Id.*

35. Winick characterizes contemporary psychiatric hospitals as offering essentially short-term medical intervention for acute, organically-based illnesses. The modern psychiatric hospital is a "short-term medical intervention facility that provides drug treatment and supportive therapy for patients' functional restoration." *Id.* at 539.

36. *Id.* "If the condition is not subject to hospital treatment that can produce beneficial clinical effects," then hospitalization should not be permitted. *Id.*

ness limits civil commitments. Fourth, Winick turns to the scientific literature to show that psychiatric hospitalization yields therapeutic benefits with respect to some, but not all, mental disorders.[37] Finally, he concludes that the "major mental illnesses," but not antisocial personality disorder or sexual paraphilias, are proper predicates for civil commitments.[38]

Let us examine parts of the argument more carefully. Winick's first step introduces important ambivalence into the argument. He is unclear about whether the identification of civil commitment and psychiatric hospitalization is a given, or rather a part of what he claims to have demonstrated. If it is part of the explicandum, then he is merely describing the bounds inherent in current psychiatric practice, leaving open the possibility that there are permissible forms for civil commitment outside of "psychiatric hospitalization."[39] This has little explanatory power for finding the bounds of police power commitments. In fact, one can precisely characterize the central question presented in the sex offender commitment cases as whether the state may act outside the bounds of traditional psychiatric hospitalization when designing civil commitment schemes and institutions.[40]

With this in mind, observe that Winick's argument, and the principle of therapeutic appropriateness he derives, can be understood in strong and weak forms. In the weak form, the identification of civil commitment with psychiatric hospitalization is assumed to be part of the explicandum, the "given" in the argument. The weak version defines where, but not whether, an individual may be committed. It simply stands for the proposition that a person who is committed must be placed in an appropriate institutional setting and afforded any available therapies that are at least *capable* of providing some beneficial effect for the individual. Winick's conclusion holds for psychiatric hospitalization, but his argument as a whole is silent about the constitutionality of forms of intervention outside of the traditional psychiatric

37. *Id.* According to Winick, psychiatric hospitals are inappropriate settings for those conditions that are not "amenable to organic treatment approaches." *Id.*

38. *Id.* at 539-40. Only the major mental illnesses are amenable to the organic treatment approaches used in modern psychiatric hospitals.

39. Winick's extensive focus on "psychiatric hospitalization" suggests that his inquiry is limited. On the other hand, he argues that the therapeutic appropriateness principle in *Foucha* applies *"[w]henever* the state seeks to invoke its mental health power to invade significant constitutionally protected liberty interests." *Id.* at 551 (emphasis added).

40. "It does not appear that the three categories mentioned in *Foucha* were meant to be exclusive. Minnesota, for example, provides for civil commitment without a finding of mental illness in three other situations." *In re* Blodgett, 510 N.W.2d 910, 914 n.6 (Minn. 1994). These situations are governed by Minn. Stat. § 253B.02, subd. 14 (1992)(mentally retarded); Minn. Stat. § 253B.02, subd. 2 (1992)(chemically dependent); and Minn. Stat. § 144.4172, subd. 8 (1992)(a health threat to others). *Id.*

intervention. In the strong form, Winick's argument asserts that psychiatric hospitalization is the only permissible form of civil commitment. The strong form of the principle allows only one form of civil commitment—psychiatric hospitalization—and consequently limits commitment to mental disorders appropriately treated with the "essentially medical" intervention of psychiatry.[41]

Applying the strong and weak forms to circumstances common in sex offender commitment cases demonstrates differences in the two forms. These cases most often involve the question of whether antisocial personality disorder and sexual paraphilias can be appropriately counted as mental disorder predicates for civil commitments.[42] Winick shows these forms of mental disorders are inappropriately treated using organic therapies of the modern psychiatric hospital.[43] Using the principle of therapeutic appropriateness (whether in its weak or strong form), persons with such disorders would be inappropriately committed to psychiatric hospitals.

But this analysis invites an immediate retort: Could the state build a different sort of institution and then commit individuals with the appropriate mental disorders to the new institutions? For example, Minnesota has spent millions of dollars to construct facilities and

41. The American Psychiatric Association's *Model State Law on Civil Commitment* adopts the stronger version of the principle. *See* MODEL STATE LAW ON CIVIL COMMITMENT OF THE MENTALLY ILL (American Psychiatric Ass'n 1982), *reprinted in* Clifford D. Stromberg & Alan A. Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. LEGIS. 275 (1983). The article notes that the statute requires that "effective treatment will be provided. Many dangerous people cannot be treated effectively, so that present statutes confining them to mental hospitals merely achieve preventive detention under a therapeutic guise. This is both bad law and bad medicine." *Id.* at 281. *See generally* Mary L. Durham & John Q. La Fond, *"Thank you Dr. Stone": A Response to Dr. Alan Stone and Some Further Thoughts on the Wisdom of Broadening the Criteria for Involuntary Therapeutic Commitment of the Mentally Ill*, 40 RUTGERS L. REV. 865 (1988)(criticizing that aspect of the *Model Law*); Alan A. Stone, *Broadening the Statutory Criteria for Civil Commitment: A Reply to Durham and La Fond*, 5 YALE L. & POL'Y REV. 412 (1987)(defending the therapeutic orientation of the *Model Law*).

42. *See, e.g., In re* Hendricks, 912 P.2d 129 (Kan. 1996), *rev'd*, 117 S. Ct. 2522 (1997); *In re* Blodgett, 510 N.W.2d 910 (Minn. 1994), *cert. denied*, 115 S. Ct. 146 (1994); *In re* Linehan (II), 544 N.W.2d 308 (Minn. Ct. App. 1996), *aff'd*, 557 N.W.2d 171 (Minn. 1996); *In re* Young, 857 P.2d 989 (Wash. 1993), *habeas corpus granted*, Young v. Weston, 898 F. Supp. 744 (W.D. Wash. 1995); State v. Post, 541 N.W.2d 115, 122 (Wis. 1995); Schopp, *supra* note 5, at 171; Winick, *supra* note 7, at 554-55.

43. Winick shows that the "major mental illnesses"—schizophrenia and bipolar affective disorder, but not antisocial personality disorder—are appropriately treated using the organic therapies of the contemporary psychiatric hospital. Winick, *supra* note 7, at 572-75.

programs aimed at sex offenders.[44] Minnesota's sex offender commitment scheme centers around a newly built, special purpose facility with a "treatment program" designed specifically for sex offenders.[45] Such treatment programs are not always successful, but evidence demonstrates they are capable of providing some therapeutic benefit to at least some individuals.[46] Winick sets the potential-benefits bar quite low for his therapeutic appropriateness test,[47] so it is at least arguable that these newly established programs would be deemed therapeutically appropriate for sex offenders. Thus, the weak form of the therapeutic appropriateness principle would accommodate sex offender commitments, while the strong form would exclude them because they fall outside of the scope of traditional psychiatric intervention.

As noted, Winick seems ambivalent about whether he is advocating the strong or the weak version. His extensive focus on "psychiatric hospitalization" suggests that his inquiry is limited. Winick recognizes that the strong form of the principle would prohibit states from hospitalizing mentally ill individuals whose illnesses have proven to be "refractive to drug treatment" and who may be assaultive or other-

44. PROGRAM EVALUATION DIVISION, OFFICE OF THE LEGISLATIVE AUDITOR (MINNESOTA), PSYCHOPATHIC PERSONALITY COMMITMENT LAW 1 (Feb. 1994)(noting $28.55 million was appropriated for construction and improvement of facilities designated for psychopathic personality commitments); Conrad deFiebre, *Psychopathic Sex Offenders Get New Home*, STAR TRIB. (Minneapolis), Nov. 5, 1995, at 1B.

45. *Id. See* MINNESOTA PSYCHOPATHIC TREATMENT CTR., MINNESOTA SECURITY HOSP., SEX OFFENDER PROGRAM (rev. ed. 1993).

46. Gordon C. Nagayama Hall, *Sexual Offender Recidivism Revisited: A Meta-Analysis of Recent Treatment Studies*, 63 J. CONSULTING & CLINICAL PSYCHOL. 802 (1995).

Winick suggests organic therapy is the only form of therapy that can be therapeutic if it is coerced. Other forms of therapy, particularly the type used for sex offenders, depend on the individual's voluntary participation for therapeutic benefit. From this, Winick concludes only organic therapy can be therapeutic in the coerced setting of civil commitment. But Winick's argument appears to ignore that individuals may experience civil commitment at various places along the coerced-voluntary continuum. Sex offender treatment cannot be profitably "forced" on an unwilling individual in the same way as medical injections. Nonetheless, the prospect of facing a lengthy civil commitment may convince some individuals that cooperation with treatment may expedite their release. While such cooperation is not fully free, neither is it fully coerced. Winick recognizes the possibilty of this dynamic. *See* Winick, *supra* note 7, at 600 (possibility of release is incentive for treatment success). Some courts likewise recognize this possibility. *See* Call v. Gomez, 535 N.W.2d 312 (Minn. 1995).

47. Winick's article appears to set several standards for the therapeutic appropriateness principle. In places, he seems to set the bar quite low: "Unless a condition is *at least potentially amenable* to hospital treatment, it should not serve as a predicate for involuntary commitment." Winick, *supra* note 7, at 563 (emphasis added).

wise dangerous.[48] He reluctantly seems to acknowledge that states might be able to use "preventive detention" as a supplement to the "criminal sanction."[49] Preventive detention, he says, should not be in a psychiatric hospital, but rather in a "detention center."[50]

The strong version of the therapeutic appropriateness principle would not permit preventive detention. Under the strong version, civil commitment (understood in the broad sense as discussed above)[51] is essentially limited to medical intervention. Commitment to a "detention center" would be prohibited. The weak version determines where, but not whether, a dangerous person could be preventively detained. Thus, if Winick envisions the existence of such detention centers, he must embrace the weak version of the principle of therapeutic appropriateness.

There is additional reason to conclude Winick supports the weak version. For almost as long as madhouses have existed, reformers have feared they would be used inappropriately to confine those who are not truly mentally ill.[52] However, this concern was not a generalized concern about wrongful confinement, but rather a particular concern arising out of the particularly horrific nature of madhouses and insanity. This concern is reflected in the Supreme Court decision in *Addington v. Texas*,[53] in which the Court worries about the stigma that could attach to committed persons who are not "truly" mentally ill.[54] In *Foucha v. Louisiana*,[55] Justice Thomas seemed to recoil at the

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48. *Id.* at 582.
49. *Id.* at 583.
50. *Id.* It is unclear how seriously Winick advocates this proposition. The preventive detention, he argues, must be of the "narrowly focused" sort referred to by the *Foucha* Court. This style of preventive detention was applied in *United States v. Salerno*, where detention was limited to a brief and definite period prior to the criminal trial. *See* United States v. Salerno, 481 U.S. 739, 747 (1987). This form of preventive detention would not support police power commitments of untreatable though dangerous individuals.
51. *See supra* section IV.B and accompanying notes.
52. *See* SCULL, *supra* note 29, at 74.
53. 441 U.S. 418 (1978).
54. *See id.* at 427-28. The *Addington* Court, in the process of highlighting why the Constitution protects its citizens from unfettered government intrusion, made these observations:

> [A]t one time or another every person exhibits some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable. Obviously, such behavior is no basis for compelled treatment and surely none for confinement. However, there is the possible risk that a factfinder might decide to commit an individual based solely on a few isolated instances of unusual conduct. Loss of liberty calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior.

Id. at 426-27. *See generally* SCULL, *supra* note 29, at 57 (describing in vivid detail nineteenth century society's view that mental illness is "a condition that re-

idea of a "sane" person "forced to share a cell" with a truly insane person, though he saw no problem with keeping the noninsane Foucha confined until he could prove that he was no longer dangerous.[56] Justice Thomas' concern at most focused on where, not whether, Foucha was confined. Winick seems to reflect this historical concern about "psychiatric" hospitalization. He refers to the "massive deprivations and lasting stigmatization" as a particularly distinguishing feature of "mental hospitalization" that apparently is absent from "preventive detention."[57]

The weak version of the principle also seems consistent with aspects of the history of civil commitment, which reveals an evolving differentiation among confinees that expanded as the notions of treatment grew more sophisticated. Thus, the idea that there would be different sorts of institutions, or parts of institutions, for people with different forms of mental disorder and hence different treatment needs, is well established.[58] Nothing in the essential nature of mental institutions dictates that they retain a particular form. Civil commitment commonly is used for mental retardation, chemical dependency,[59] and mental illness. Following this line of thinking, it is

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quire[s] taming, as one might domesticate and thus render predictable the behavior of a wild beast . . . .").

55. 504 U.S. 71 (1992).

56. In his dissent in *Foucha*, Justice Thomas observed:

> *In particular circumstances*, of course, it may be unconstitutional for a State to confine in a mental institution a person who is no longer insane. This would be a different case had Foucha challenged specific conditions of confinement—for instance, being forced to share a cell with an insane person, or being involuntarily treated after recovering his sanity.

Id. at 125 n.18 (emphasis in original). But one of the main themes of his dissent was to attack the majority's apparent focus on the "psychiatric" nature of the institution to which Foucha was confined:

> Finally, I see no basis for holding that the Due Process Clause *per se* prohibits a State from continuing to confine in a "mental institution"—the federal constitutional definition of which remains unclear—an insanity acquittee who has recovered his sanity. . . .
>
> . . . I have no idea what facilities the Court or Justice O'Connor believe the Due Process Clause mandates for the confinement of sane-but-dangerous insanity acquittees. Presumably prisons will not do, since imprisonment is generally regarded as "punishment." May a State designate a wing of a mental institution or prison for sane insanity acquittees? May a State mix them with other detainees? Neither the Constitution nor our society's traditions provide any answer to these questions.

Id. at 124-25.

57. Winick, *supra* note 7, at 583. "[T]he massive deprivations and lasting stigmatization of mental hospitalization may make a humane form of preventative detention less restrictive than hospital confinement." *Id.*

58. SCULL, *supra* note 29, at 220 (discussing the pressures to differentiate among the institutionalized "mad").

59. *See, e.g.*, Robinson v. California, 370 U.S. 660 (1962)(acknowledging the possibility of civil commitment for persons who are addicted).

acceptable that additional forms of intervention ought to develop over time.

On the other hand, there is good evidence that Winick embraces the strong version of the principle of therapeutic appropriateness. He invokes a strong version when he argues that the therapeutic appropriateness principle applies *"[w]henever* the state seeks to invoke its mental health power to invade significant constitutionally protected liberty interests . . . ."[60] Although he mentions the idea of nonmedical "detention centers," he is reluctant about the idea and does not advocate it.[61] More importantly, he apparently has in mind the highly constrained form of preventive detention approved by the Supreme Court in *United States v. Salerno*.[62] Salerno involved pretrial confinement designed to prevent harm by a criminal defendant who was awaiting trial. In *Foucha*, the Court declined an invitation to extend *Salerno* to allow indefinite, dangerousness-based confinement.[63] Further, Winick is quite clear that disorders such as antisocial personality disorder and sexual paraphilias cannot support civil commitment.[64] As I have shown previously, Winick's framework for analysis seems to exclude these disorders only if the strong version of his theory is adopted.

Winick's derivation of the therapeutic appropriateness principle from *Foucha* sheds no additional light on this ambivalence. Winick frames the derivation as if he understands the principle to be of the strong variety, applicable not simply to "psychiatric hospitalization," but to all exercises of the state's mental health power.[65] But his derivation assumes, rather than demonstrates, that the civil commitment involved was essentially medical, a characterization consistent with the weak version of the principle.

In *Foucha*, the Court resolved the issue of whether Louisiana could continue to hold Foucha under civil commitment. Foucha was still "dangerous" and diagnosed with antisocial personality disorder, but he was no longer diagnosed with the "mental illness" that led to his initial commitment. The Court's decision, ordering Foucha's release, can be read in at least three ways. First, it can be read as rejecting

60. *See* Winick, *supra* note 7, at 551 (emphasis added).
61. *See id.* at 583.
62. *See id.* (citing United States v. Salerno, 481 U.S. 739, 747 (1987)).
63. I develop this theme at length in Janus, *Preventing*, *supra* note 5, at 162-77.
64. *See* Winick, *supra* note 7, at 572-74. According to Winick, "many of the 'personality disorders' do not seem to be 'illnesses' in an organic sense (although they do reflect maladaptive behavior patterns)." *Id.* at 572-73. Winick consequently concludes that "[u]nless the individual has a multiple diagnosis, these problems are not thought to be organic in nature and do not respond to organic treatment methods of the kind for which hospitalization is medically justified." *Id.* at 574 (citations omitted).
65. *See id.* at 554.

Louisiana's argument that commitments may be supported on the basis of dangerousness alone.[66] Second, the decision might have been based on the absence of a compelling interest, including Foucha's antisocial personality disorder, that could not be vindicated in the criminal justice system.[67] Third, the court might have rejected antisocial personality disorder as a predicate for commitment because, as Justice White observed, treatment for the condition is nonexistant.[68]

Clearly, only the third reading supports the therapeutic appropriateness principle. Winick chooses the third alalysis because he reads *Foucha* as the third case in a series, preceded by *Washington v. Harper*[69] and *Riggins v. Nevada*.[70] *Harper* and *Riggins* are cases dealing with the involuntary administration of psychotropic medications. *Foucha* is a case in the same series only if it also involves intervention that is "essentially medical." But others might read *Foucha* just as cogently in ways, represented by the first and second readings, that do not entail the notion that all civil commitment is essentially medical.

In sum, the strong version of the therapeutic appropriateness principle holds only if all civil commitment must be to a psychiatric hospital. Winick has not shown this to be the case. He is left with the weak version, a principle that offers little guidance in setting the boundaries of police power commitment.

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66. *See* Foucha v. Louisiana, 504 U.S. 71, 77 (1992).

67. *Id.* at 82. Justice White, writing for the majority, expressed the following:

> [T]he State does not explain why its interest would not be vindicated by the ordinary criminal processes involving charge and conviction, the use of enhanced sentences for recidivists, and other permissible ways of dealing with patterns of criminal conduct. These are the normal means of dealing with persistent criminal conduct. Had they been employed against Foucha when he assaulted other inmates, there is little doubt that if then sane he could have been convicted and incarcerated in the usual way.

Id.

68. *Id.* at 82-83. Winick's position is as follows:

> Arguably, *Foucha* should be read to apply a newly crystallized due process principle: Whenever the state seeks to invoke its mental health power to invade significant constitutionally protected liberty interests, its proposed intervention must be therapeutically justified. *Foucha* demonstrates that this condition will not be satisfied unless the individual in question is mentally ill. Although Foucha's continued hospitalization would have accomplished the state's compelling police power interest in protecting community safety, it would not have been therapeutically appropriate to confine an individual in a psychiatric hospital who no longer suffered from a treatable mental illness.

Winick, *supra* note 7, at 551.

69. 494 U.S. 210 (1990).

70. 504 U.S. 127 (1992).

C. Functional Impairment Criteria and *Parens Patriae* Commitments

In addition to the principle of therapeutic appropriateness, Winick posits that commitments are limited to mental disorders that impair the individual's mental functioning in particular and severe ways.[71] In this section I suggest that Winick's discussion of these functional impairment criteria reflects an important ambivalence about whether the state's *parens patriae* power is a necessary condition for civil commitments. I alluded to this issue at the beginning of this paper, framing the question in terms of whether "pure" police power commitments (those that extend beyond the state's *parens patriae* power) are possible. Winick's explication fails to provide a clear answer in part because he appears to assume as a given (but only in an ambivalent way) that all commitments must reflect the *parens patriae* power.

For Winick, as for many others, mental disorders are adequate predicates for civil commitment only if the disorders entail severe impairments of cognitive and/or volitional functioning.[72] Further, like others, Winick asserts that the nature of the required impairments is related to "justifications for involuntary hospitalization."[73]

Winick's statement of the functional impairment criteria strongly suggests that he views all commitments as *parens patriae* commitments. At one point he asserts that "[c]onditions should not be considered mental illness sufficient to justify intervention unless they render individuals incompetent to make rational decisions about hospitalization or treatment or unable to control their conduct in ways that may endanger themselves."[74] Later in the article he characterizes the necessary impairment as "significant functional impairment in ways that prevent the individual from exercising autonomy," which similarly suggests a relationship to the *parens patriae* powers of the state.[75] Winick is a bit inconsistent, however. In at least one articulation of the condition, he includes impairments of control that cause harm to others.[76]

This discussion of the functional impairment criteria helps us understand that the state's *parens patriae* power and the principle of therapeutic appropriateness are closely related. The strong version of the therapeutic appropriateness principle makes the most sense if all

71. Winick, *supra* note 7, at 538. Winick does not specify whether, or under what circumstances, the functional impairment condition would be sufficient for commitment. He clearly asserts, however, that it is necessary for commitment. *Id.*
72. *See* BUCHANAN & BROCK, *supra* note 5, at 319; *Developments in the Law*, *supra* note 2, at 1217; Winick, *supra* note 7, at 578-79.
73. Winick, *supra* note 7, at 568.
74. *Id.* at 539-40.
75. *Id.* at 567.
76. *Id.* at 568, 570.

commitments are *parens patriae* commitments. Recall that the strong version of the principle entails the notion that civil commitment is an "essentially medical" intervention. The imposition of involuntary health care is justified only if it serves the therapeutic interests of the individual. The only condition under which medical intervention could be "therapeutic" for a nonconsenting individual is if the individual lacks the competency to give consent.[77] A competent individual's nonconsent *defines* the "benefits" of therapy as outside of his or her "good."[78] Both the therapeutic appropriateness principle and the functional impairment requirement derive centrally from the medical nature of the intervention. Under this derivation, incompetence is a necessary condition for therapeutic appropriateness. An involuntary medical intervention can be therapeutically appropriate only if the disorder of the individual renders him incompetent.

Reversing the argument, one could also derive the strong version of the therapeutic appropriateness principle from the premise that all commitment is *parens patriae* commitment. *Parens patriae* commitment is appropriate only when the individual is incompetent and the intervention is in her therapeutic interests. Only the major mental illnesses impair functioning in such a manner as to render individuals incompetent. Only psychiatric hospitalization provides therapeutic benefit for major mental illnesses. Thus, all (*parens patriae*) commitment must be "essentially medical."

Note, however, that if the therapeutic appropriateness principle is understood in its weak form, Winick's derivation of the functional impairment criteria becomes more problematic. If some forms of commitment are not "essentially medical," then the argument for incompetence as a necessary condition for commitment significantly weakens. For example, the psycho-social treatment programs addressed to sex offenders may be effective (and hence therapeutically appropriate) only when the patient renders some form of consent to participate.[79] For this sort of commitment, incompetence and lack of autonomy would probably negate, rather than produce, therapeutic appropriateness. Further, if we posit a form of civil commitment in which the main purpose is social control rather than medical care, then Winick's functional impairment requirement looks quite different. Because protecting the public from violence is the purpose of

77. I discuss a variation of this argument below. *See infra* section IV.E and accompanying notes pertaining to "objective" and "subjective" benefit.

78. *See* Schopp, *supra* note 5, at 172-73. *See generally* Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1711 (1992)(discussing the place of individual autonomy in the legal system).

79. Winick, *supra* note 7, at 575. Minnesota's sex offender commitment treatment program identifies the "voluntary" participation of the individual as a measure of treatment effectiveness. MINNESOTA PSYCHOPATHIC TREATMENT CTR., MINNESOTA SECURITY HOSP., SEX OFFENDER PROGRAM 1 (rev. ed. 1993).

these commitments, disorders such as antisocial personality disorder or paraphilias, which arguably "predispose" the individual to violence, would be sufficient since they produce "functional impairment in a way that relates to the justifications for involuntary hospitalization."[80]

I do not wish to be misunderstood here. I agree with Winick that antisocial personality disorders or paraphilias are inadequate predicates for commitment.[81] My point here is simply that the ambivalence in Winick's framework seems to allow for the opposite conclusion.

D. The Strong Version Entails the High Level Adoption of Medical Discourse

Historically, physicians (more specifically, psychiatrists) have fought for dominance in the treatment of the mentally ill.[82] Winick's characterization of the modern psychiatric hospital as "essentially medical" is a recognition that the medical profession has achieved that dominance.[83] His extensive reliance on medical and scientific knowledge invites the question whether Winick has granted medicine and science a privileged or dominant role in defining the legal boundaries of civil commitment.

As noted above, science can appear in the explication at an early stage (providing concepts and values that shape the rules) or at a later stage (providing the "facts" to which the rules are applied).[84] Winick claims that his use of medicine falls into the latter category. Winick's "medical model" is coincidental, rather than essential, in the derivation of the constitutional limits of civil commitment.

> [A] medical model of mental illness may . . . be useful as a rough basis for thinking about how mental illness should be defined for purposes of involuntary hospitalization. This may be so not because the Constitution requires a medical model, but because other considerations that seem to be constitutionally relevant appear to be present for conditions meeting the medical model but not for conditions that seem to be only psychosocial in nature.[85]

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80. This is one theory that apparently underlies contemporary sex offender commitment statutes. The Washington sex offender commitment act, and those modeled after it, define one of the requisite mental conditions, "mental abnormality," as "a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts . . . ." WASH. REV. CODE § 71.09.020(2) (1992). The Minnesota Court of Appeals pointed to the "nexus" between a mental disorder and violence as a key factor legitimating that state's Sexually Violent Persons Act. *In re* Linehan (II), 544 N.W.2d 308, 317-18 (Minn. Ct. App. 1996), *aff'd*, 557 N.W.2d 171 (Minn. 1996).
81. *See* Janus, *Preventing*, *supra* note 5, at 194.
82. *See* SCULL, *supra* note 29, at 118-23 (examining how "medicine first 'captured' insanity").
83. *See id.*
84. *See supra* section III.C and accompanying notes.
85. Winick, *supra* note 7, at 563.

Despite this disclaimer, in some places in his argument Winick appears to rely on medical discourse to shape, rather than to apply, the rules. For example, Winick uses the medical concept of illness to demonstrate that antisocial personality disorder does not meet the definition of legal mental illness.[86] He begins this argument by stating a thoroughly legal definition of "mental illness": "Involuntary confinement in a hospital should be possible only when that illness threatens public health or produces significant functional impairment in ways that prevent the individual from exercising autonomy."[87] Using behavioral science literature, Winick shows that antisocial personality disorder fails to satisfy the second prong of this rule because it does not produce autonomy impairment.[88] By utilizing science at the latter stages of analysis, Winick applies the rule to the "facts." Trouble ensues, however, when science is applied in the first prong of the rule because it is possible to argue that antisocial personality disorder *does* threaten the public health.[89] The conclusion of Winick's syllogism—that antisocial personality disorder does not support commitment—can be achieved only if antisocial personality disorder is not an "illness." But to show this, Winick relies on the medical definition of illness to deomonstrate that antisocial personality disorder lacks the features of an "illness in the traditional sense."[90] It is not "organic in nature" and does not respond to organic interventions "that characterize the modern psychiatry hospital."[91] Here, the "medical model" has been used not to apply the rule defining illness, but rather to shape the rule itself.

The analytical placement of the medical model is a function of Winick's choice of explicandum. If he starts with the premise that civil commitment is essentially medical and derives from that premise his functional impairment criteria, then the medical model enters his analysis at the very beginning. That which is "essentially medical"

86. In this analysis, antisocial personality disorder is not an illness in large measure because it is not organic in etiology and does not respond to organic therapy. For a contrary view arguing that personality disorders and psychotic illnesses ought to be classified together, see MILLON, *supra* note 30, at 3 (arguing that "[p]ersonality disorders reflect pathogenic processes that are identical to those seen in classical 'neurotic' and 'psychotic' states"). *See generally* SCULL, *supra* note 29, at 123 ("Psychiatrists' labels stick in a way lay ones don't, not least because they are backed by the police power of the state. The psychiatrist can 'transform his judgment into social reality.'" (citation omitted)).

87. Winick, *supra* note 7, at 567.

88. *Id.* at 570.

89. *See* Alan Wertheimer, *A Philosophical Examination of Coercion for Mental Health Issues*, 11 BEHAV. SCI. & L. 239, 256 (1993). *See also* Maura Lerner, *AMA Diagnoses a Health Threat to Children: Media Violence*, STAR TRIB. (Minneapolis), Sept. 10, 1996, at A1 (describing an "epidemic of violence" that "poses a serious health threat, especially to children").

90. Winick, *supra* note 7, at 559.

91. *Id.* at 570.

becomes the touchstone for defining the scope of commitment. On the other hand, if he starts with the premise that all commitments are *parens patriae* commitments, the role of medicine appears only later in the analysis when the legal rules are applied.

There is danger in either approach. Science provides an unstable foundation for defining central legal categories. Winick relies on a medical definition of "illness" to solidify his argument about antisocial personality disorder. But there is no stable medical or scientific consensus for the definition of "illness."[92] Winick suggests that both organic etiology and organic treatment are important factors in the classification of a condition as an illness. But, consider the following: There is research tending to show that violence is associated with low levels of serotonin;[93] some physicians use organic therapies to treat some forms of sexual violence;[94] conditions caused by trauma, environmental factors, and an individual's own behavior qualify for treatment in medical hospitals; and some forms of antisocial personality may be hereditary.[95] Further, some scholars claim that at least some forms of personality disorders are legitimate disorders in some strongly meaningful ways.[96]

In short, we may learn more about sexual violence and violence in general. As we learn more about violence or patterns of violence, it may become apparent that such behavior may constitute organically treatable "illnesses." Will, or should, those developments impact the legal system's treatment of violence? It clearly should be relevant.

But the legal issues are addressed at a different scale of meaning.[97] The question should be whether medicine and science inform our thinking on the moral and political judgments that underlie the law. To do this, we must first have a firm understanding of the moral and political structure of those judgments. Thus, it seems the medical

92. *See* Jerome Wakefield, *The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values*, 47 AM. PSYCHOLOGIST 373 (1992).

93. Robert Wright, *The Biology of Violence*, NEW YORKER, Mar. 13, 1995, at 68, 74 (emphasizing, however, that the existence and direction of any causal arrow between violence and serotonin levels is unclear).

94. *See generally* John McD. Bradford, *Treatment of Sexual Offenders*, 39 HOSP. & COMMUNITY PSYCHIATRY 152 (1988)(discussing treatment of sexual offenders with various chemical agents).

95. *See* DAVID LYKKEN, THE ANTISOCIAL PERSONALITIES 108-09 (1995).

96. *See, e.g.*, Grant T. Harris et al., *Psychopathy as a Taxon: Evidence that Psychopaths Are a Discrete Class*, 62 J. CONSULTING & CLINICAL PSYCHOL. 387, 396 (1994); Vernon L. Quinsey, *The Prediction and Explanation of Criminal Violence*, 18 INT'L J.L. & PSYCHIATRY 117, 122 (1995)(suggesting that Hare's concept of psychopathy may be a "taxon" or a "categorical variable").

97. Charles Kester, *The Language of Law, the Sociology of Science and the Troubles of Translation: Defining the Proper Role for Scientific Evidence of Causation*, 74 NEB. L. REV. 529, 562 (1995)(arguing that "[i]t becomes impossible to tell whether the same concepts are used by both [scientific and legal] paradigms").

discourse must enter the analysis after the main legal limitations have been established.[98]

E. Therapeutic Appropriateness, *Parens Patriae*, and the Bounds of Police Power Commitments

Recall that the theme of this Article is to develop a conceptual framework that will allow us to discover the boundaries of police power commitments. Here, I explore the ways in which Winick's framework operates in that project. I suggest that the weak version of the principle of therapeutic appropriateness sets too few boundaries on police power commitments. The strong version may be too limiting and introduces the problematic principle that social control may be justified by way of the "therapeutic interests" of the individual.

I have suggested above that Winick appears to adopt the strong version of the principle of therapeutic appropriateness in part because the weak version appears not to limit commitments at all. Indeed, the only element the weak version controls is where, not whether, an individual is civilly committed. This version would insist that police power commitments provide treatment that is appropriate to the individual's condition and that the condition have functional impairments relating to the state's purpose in the commitment. But, as shown above, these concerns set few, if any, limits on the state's power.[99]

The strong version of the principle, on the other hand, either limits police power commitments very severely or establishes a questionable linkage between social control and therapeutic interests. Police power commitments, as I have defined them, are those supported by the state's interests in public safety, but not by the state's *parens patriae* interests. The state's *parens patriae* interests can fail in two distinct ways: the individual might be competent to make treatment decisions or the proposed hospitalization might not be in the individual's therapeutic interest.[100] In their strong forms, Winick's limiting conditions for commitment (therapeutic appropriateness plus functional impairments) seem to insure that both conditions for *parens patriae* commitments will always be met. Thus, it appears that Winick's framework may allow no room for police power commitments.

As Winick acknowledges, this result produces a gap in the social control system.[101] It is entirely plausible that an individual could be unreachable by criminal prosecution and also uncommitable under

98. *See generally id.* ("Ignorance of these difficulties in the translation of scientific evidence has dramatically increased the risk that scientific evidence will be accidentally misused, or 'mistranslated,' by the fact finder.").

99. *See supra* section IV.B.

100. Ignore for a moment the question of how unconsented treatment could ever be in the therapeutic interests of a competent adult.

101. Winick, *supra* note 7, at 582-83.

Winick's framework. This is possible because the impairments that relieve a person of criminal responsibility are not always sufficient to render a person incompetent to make health care decisions.[102] Further, even if an individual's mental disorder impaired both criminal responsibility and health-care competence, Winick's therapeutic appropriateness principle might prohibit the commitment. This would happen if the individual's illness was resistant to the usual treatments or if the individual's therapeutic interests dictated a more open, community-based treatment setting or shorter institutional stay than was compatible with the community's safety interests. Such divergence of community interests from individual interests is not a rare occurrence. Statistics from Minnesota show that "forensic" civil commitments last much longer than nonforensic commitments, suggesting that public safety considerations often prolong confinement well beyond what is necessary for therapeutic benefit.[103]

Winick's framework can deal with this "gap" in three ways, none of which is very satisfactory. First, his framework can simply posit some form of "preventive detention." But this seems dangerous because the limits for such detention are unclear. Second, his framework could dilute the meaning of *parens patriae*. Third, it could argue that the state's *parens patriae* interests provide the justification for police power commitments. I examine the latter two possibilities in this section.

One way of closing the "gap" is to stretch the meaning of the state's *parens patriae* interest to include not only those who cannot make health care decisions, but also those who are incompetent in the criminal context. Further, the meaning of "therapeutic benefit" could be extended to include not only the "subjective" interests of the individual, but also his or her "objective" interests.

Let us define two senses of the term "therapeutic interests." Objectively, a person's therapeutic interests are measured against an ideal of proper functioning. Thus, if an individual's cognition is impaired, it would be in the individual's objective therapeutic interests to restore her cognition as nearly as possible to its unimpaired or ideal functioning. Because the ideal of proper functioning is more or less the same for all humans, the individual's desires or values do not determine her objective therapeutic interests. Interests in this sense are often referred to as a person's "best interests."[104]

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102. Schopp develops this point at length. *See* Schopp, *supra* note 5, at 179.

103. In Minnesota, "forensic" patients are institutionalized much longer than nonforensic, though mentally ill, patients. MINNESOTA DEPARTMENT OF HUMAN SERVICES, A SURVEY OF ADULTS WITH MENTAL ILLNESS IN MINNESOTA'S REGIONAL TREATMENT CENTERS 141 (1991).

104. *See* David Luban, *Paternalism and the Legal Profession*, 1981 WIS. L. REV. 454, 472.

Contrast a second sense of the term, which I will label the person's therapeutic interests in the *subjective* sense. These are the therapeutic goals or effects that the competent person actually chooses for himself. Some people might choose abnormal functioning for its own sake; some might settle for abnormal functioning because the price to be paid to achieve normal functioning is too high.

In either case, the subjective therapeutic interests of the individual would not coincide with the objective. Arguably the state's *parens patriae* obligation is to assist incompetent individuals to attain their *subjective* therapeutic interests.[105] But suppose *parens patriae* is redefined so it refers to the *objective* therapeutic interests of the individual.[106] Under the redefined terms, it is possible for the state to recast its own public safety concerns as the "needs" of the individual. Lengthy confinement is justified on this (newly defined) *parens patriae* grounds because the individual "needs" more treatment before he is ready for release.[107] This version of the *parens patriae* doctrine should be rejected because it blurs the critical distinction between the interests of the state and the individual.

The other way to close the gap respects the core meaning of the *parens patriae* interest, but argues that this interest provides at least part of the justification for police power commitments. The *parens patriae* power could be used to justify police power commitments in two ways, both of which yield undesirable results. First, it may be argued that the therapeutic benefit to the individual justifies, or offsets, the intrusion on the individual's liberty. In Winick's framework, for example, amenability to treatment transforms commitment from an unconstitutional state intervention into a constitutional state intervention.[108] This formula works well in *parens patriae* commitments because the intrusion on liberty is calibrated to be proportionate to the benefit derived by the patient. But in police power commitments, the intrusion is tied to the public's interests, not to the individual's.

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105. *See* BUCHANAN & BROCK, *supra* note 5, at 317-18.

106. For example, Winick in some places suggests that the measure of therapeutic appropriateness is whether the individual's "psychiatric condition would benefit" from treatment. Winick, *supra* note 7, at 585.

107. Courts often resort to this sort of discourse in commitments that are clearly police-power based. *See, e.g., In re* Bieganowski, 520 N.W.2d 525, 531 (Minn. Ct. App. 1994)(reasoning that "[t]he trial court found that the security hospital was the least restrictive alternative available. Appellant needs long-term treatment in a group therapy setting. He has not participated in sex offender treatment on a voluntary basis, and if released would likely fail to participate in treatment."); *In re* Stofferahn, No. C5-93-768, 1993 WL 276857, at *1 (Minn. Ct. App. Jul. 27, 1993)(reasoning that "[t]he security hospital did not consider voluntary treatment appropriate, because appellant needs to be in a secure facility").

108. *See* Winick, *supra* note 7, at 585 (arguing that a "therapeutic basis for their hospitalization might justify their involuntary commitment").

The principle inherent in this argument is that "therapeutic" medical procedures can justify intrusive state ends.[109] In *Buck v. Bell*, the Supreme Court relied upon this very theory, approving the use of a medical procedure, sterilization, thereby vindicating a "scientific" theory of individual and public health.[110] As *Buck* illustrates, this theory allows for limitless intrusion so long as some arguable therapeutic benefit results.

Second, it might be argued that the individual's incompetence justifies the public-oriented intrusion. The theory underlying this claim is that the very fact of having a severe mental disorder diminishes the individual's interest in, and hence right to, liberty. This, too, is a way of understanding how the Supreme Court justified imposing an intrusive medical procedure on the "feebleminded" Carrie Buck to advance the public interest.

In no way do I imply that Winick would endorse the reasoning, results, or anything else about *Buck*. My only point is that there is danger in using therapeutic benefit or diminished mental competence as a justification for intrusive social control measures. As I have indicated above, it may be that Winick does not advocate this sort of justification. Using therapeutic benefit to justify a *parens patriae* commitment is not controversial. Winick may intend to limit civil commitment to those circumstances that trigger the state's *parens patriae* interest. It is only if the theory extends beyond that benign[111] form of intervention that the dangers of a *Buck*-type analysis arise.

Nevertheless, it seems clear that a principle of therapeutic appropriateness has a place in a police power commitment framework. It must function, however, as a limitation on, rather than a partial justification for, commitment.[112] If the principle of therapeutic appropri-

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109. Paul A. Lombardo, *Three Generations, No Imbeciles: New Light on* Buck v. Bell, 60 N.Y.U. L. REV. 30, 33 (1985).

110. *See* Buck v. Bell, 274 U.S. 200, 207 (1927); Lombardo, *supra* note 109, at 33.

111. There is no doubt that the benign intentions of *parens patriae* intervention often result in less than benign consequences. *See* SCULL, *supra* note 29, at 264. But in *Buck*, the Supreme Court relied solely upon an analysis that measured the benefit to society:

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.

Buck v. Bell, 274 U.S. 200, 207 (1927)(citation omitted).

112. In contrast, in *parens patriae* commitments, therapeutic benefit is one of the central justifications for commitment.

ateness justifies commitments, police power commitments are unconstitutional unless therapeutically appropriate treatment is provided. If no such treatment is available, the commitment is unconstitutional.[113] When the principle is used as a limitation, otherwise constitutional[114] police power commitments become impermissible if the state fails to provide available therapeutically appropriate treatment. Use of the principle as a limitation is based on the notion that state deprivations of liberty must be narrowly tailored or focused. Use of the principle as a justification is based on the theory that the provision of treatment to the individual enhances the state's right to intrude on the individual's liberty. It is this enhancement theory that leads to difficulties.

F. Conclusion

Winick's framework provides a valuable focus on the medical and behavioral science context in which the boundaries of civil commitment will be established. His framework, however, is ambivalent about the role of the state's *parens patriae* interests in commitments and about the level at which medical discourse enters his analysis. If the *parens patriae* power plays a central role, then Winick has difficulty explaining the social control role for the mental health system. Winick's framework helps expose the danger in using a *parens patriae* explanation to justify social control intrusions on liberty.

I suggest that the major error in Winick's framework is that it uses an endogenous approach to seek limits on police power commitments. A more profitable approach seeks those limits by examining the role the civil commitment system plays in broader institutions of social control. Elsewhere I have suggested that police power commitments are justified, as well as limited, by an analysis of the state's interest in vindicating its police power. The basic limiting principle requires the state to show a compelling reason to justify its abandonment of the primary system for social control (the criminal justice system) for the alternate system (the civil commitment system). Mental impairment

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113. This does indeed seem to be the position that Winick is advocating.

> Under this requirement [therapeutic appropriateness], which seems implicit in *Foucha*, [police power] civil commitment would be impermissible for individuals who would realize no therapeutic benefit from hospitalization. . . . For mentally ill people who are dangerous to others and whose psychiatric condition would benefit from hospitalization, the therapeutic basis for their hospitalization might justify their involuntary commitment, even though nonmentally ill people predicted to be dangerous are generally not subject to this intervention.

Winick, *supra* note 7, at 585.

114. For my explication of what the other constraints on police power commitments ought to be, see Janus, *Preventing*, *supra* note 5, at 208-12.

that removes an individual beyond the reach of the criminal system provides just that sort of interest-enhancing reason for the state.[115]

V. SCHOPP: DERIVING POLICE POWER LIMITS FROM MENTAL STATUS

Where Winick's analysis has as its core the premise that civil commitment is essentially medical, Schopp's analysis rests on the way in which civil commitment impairs the status of mentally competent individuals. I will comment on four aspects of Schopp's analysis. First, I will examine Schopp's choice of explicandum. I will suggest that Schopp is ambivalent about whether police power commitment is essentially medical and about whether the limits of police power commitments should be derived either endogenously from such an essence or exogenously from its relationship to the broader institutions of social control.

Second, I will examine Schopp's discussion of the proper level at which medical and behavioral science discourse should be linked with the legal analysis. Schopp relegates the discourse of medicine and science to a descriptive level in an effort to insure that the bounds of civil commitment are derived from legal, rather than medical, principles. I suggest some cautions about Schopp's analysis.

Third, I discuss how Schopp's framework deals with the relationship between the social control and health care aspects of the mental health system. In this context I explore Schopp's ambivalence about the medical nature of police power commitments. Finally, I look at the way in which Schopp addresses the critical step of locating the limits of police power commitments. It is here that Schopp most clearly relies on a rights/status analysis. I argue that this sort of analysis does not provide for well limited police power commitments.

A. Schopp's Choice of Explicandum

As set out above,[116] the choice of explicandum—that which is "given" and in need of clarification—is a critical step in the task of defining the boundaries of civil commitment. Winick's focus on "psychiatric institutionalization" led him to an explication that relied heavily on medical discourse and left unanswered the question, posed by contemporary sex offender commitment legislation, of whether commitments outside the limits of psychiatric treatment are permissible.

Schopp frames his inquiry in broader terms. He chooses to explicate the "mental health" power of the state. The question left open by

115. *See id.*
116. *See supra* section II.A and accompanying notes.

this explicandum, perhaps foreclosed by Winick's analysis, is whether "legal mental illness" can properly be expanded beyond psychiatric illnesses. Schopp's analysis focuses on both the extension and the limitation of police power commitments. Schopp shifts the nature of his explicandum in a small but important way by moving from one topic to the other. In determining the extension (what conditions are *included*), Schopp adopts an exogenous approach to the explication; that is, police power commitments complement the criminal justice system and the scope of the latter defines the breadth of the former. In discussing the limits on police power commitments, however, he switches to an endogenous approach, seeking the limits through an analysis of the essence of the mental health power itself. As I show below, this switch reflects an ambivalence about the role that health care plays in police power commitments.

A complete discussion of the switched context for explication requires a fuller understanding of Schopp's conceptual framework, to which this Article now turns.

B. Levels of Discourse and the Law-Science Linkage

Schopp's framework for finding the boundaries of civil commitment sorts out the roles played by law, on the one hand, and by medicine and science on the other. His framework is designed to elevate the role of law in the boundary setting. The role of science and medicine is intended to be descriptive rather than normative.

Schopp analyzes "mental illness" as three separate concepts: psychological dysfunction; psychological disorder or diagnosis; and legal mental illness. The first, psychological dysfunction, is a component part of the second and third concepts. "Dysfunctions" are "impairments" of "particular psychological processes."[117] "Diagnoses," the second category, are "names for clinically recognizable and significant patterns of impaired processes that occur relatively frequently."[118] In other words, "diagnoses" are clinically (medically) useful patterns of "dysfunctions." The third category, "legal mental illness," refers to "any pattern or type of psychological impairment that meets the legal standard."[119] Thus, "legal mental illness" means legally significant patterns of "dysfunctions."

This analysis provides a useful tool for explication because it minimizes any *a priori* connection between concepts defined in medical terms (diagnoses) and those defined in legal terms ("legal mental illness"). Schopp's analysis facilitates legal control in the boundary set-

117. Schopp, *supra* note 5, at 171.
118. *Id.*
119. *Id.*

ting by acknowledging that legal categories may differ from medical categories. "[D]iagnosis," for Schopp, "carries no legal significance."[120]

The reason for this is that medical diagnostic categories are developed in a different context and for a different purpose than the categories of "legal mental illness." Medical diagnostic schemes are generally categorical.[121] All categorization distorts the complete picture because it discards potentially significant information.[122] Medical categorization cuts along lines that arguably are useful for clinical and research purposes, but not necessarily for legal ones.[123]

Dysfunction is a logically simpler concept than diagnosis. Dysfunction entails neither the notion of pattern nor the thresholds necessary for clinical categorization. Dysfunctions can be expressed dimensionally, thus preserving some of the information lost in diagnosis.[124] The information lost in medical diagnosis may well be precisely the information that is critical for legal purposes.[125] The dimensional descriptions of dysfunction can be fit more accurately into the relevant legal categories. For these reasons, use of a discourse of dysfunction rather than diagnosis allows a greater level of legal control.

Schopp's insistence on a discourse of dysfunction should allow for greater legal control in a second way. Expert testimony of mental health professionals is likely to be distorted not only by the categories of medicine and science, but also by their own "social preferences."[126]

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120. *Id.* at 172.

121. MILLON, *supra* note 30, at 14-16.

122. *See* JACOB BRONOWSKI, THE ORIGINS OF KNOWLEDGE AND IMAGINATION 79-80 (1979)(discussing the loss of knowledge that arises from the inevitable cutting of the universe into categories); Thomas A. Widiger et al., *The DSM-III-R Personality Disorders: An Overview*, 145 AM. J. PSYCHIATRY 786 (1988); Thomas A. Widiger & Timothy J. Trull, *Personality Disorders and Violence, in* VIOLENCE AND MENTAL DISORDERS: DEVELOPMENTS IN RISK ASSESSMENT 216 (John Monahan & Henry J. Steadman eds., 1994)(discussing how diagnostic classifications may discard information critical for prediction of violence).

123. *See* AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III-R 8 (3rd ed. 1987)(noting that the "use of this manual for nonclinical purposes, such as determination of legal responsibility . . . must be critically examined in each instance within the appropriate institutional context").

124. *See* MILLON, *supra* note 30, at 14-16; Allen Frances, M.D., *The DSM III Personality Disorders Section: A Commentary*, 137 AM. J. PSYCHIATRY 1050, 1051 (1980)(discussing advantages of a dimensional system); Paul E. Meehl, *Bootstraps Taxonometrics*, 50 AM. PSYCHOL. 266, 266 (1995)(noting the loss of information in the use of categorical discourse and questioning whether the "payoff in ease of communication makes up for the disadvantages").

125. W.M. Grove, *When Is a Diagnosis Worth Making? A Comparison of Two Statistical Prediction Strategies*, 68 PSYCHOL. REP. 3, 17 (1991).

126. Michael Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625, 643-44 (1993).

> Experts' testimony is premised on individual value systems (i.e., the expert "knows" what's "really best" for the patient), or on cognitive distor-

"Dysfunction" is a more factual, less conceptualized level of discourse than diagnosis. The factual aspect of dysfunction testimony is amenable to challenge by standard advocacy tools available to "lay" lawyers and judges, such as cross-examination based on documentary evidence. In the end, the expert must be able to point to the behaviors of the individual that justify finding a dysfunction. The witness' "social preferences" are much more difficult to ferret out of the higher level diagnosis discourse because diagnostic "impressions" come from the clinician's "judgment," a process with no stable anchor in the observable world of behavior.

Winick and Schopp apparently disagree about the appropriate level of discourse. Winick's analysis, as discussed above, turns heavily on etiology and treatability, both of which are the kinds of information reflected in medical diagnostic categories.[127] The medical notion of "illness" also plays into Winick's analysis.[128] Winick's adoption of such a high level of medical discourse is a corollary of his premise that commitment is an "essentially medical" intervention. Schopp's insistence on using science at a simpler, more descriptive level is evidence that he sees the medical nature of commitment as less central than does Winick. I return to this aspect of Schopp's analysis below.[129]

Here I want to raise three notes of caution about Schopp's basically sound plan to limit science and medicine to a descriptive role.[130] First, it would be a mistake to assume that the discourse of dysfunction is itself free of normative conceptualization. While dysfunction is a logically less complex notion than diagnosis, even dysfunction necessarily entails judgments that are, or may be, of important legal signifi-

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> tions (i.e., the last time that the expert recommended release at an involuntary civil commitment review hearing, the patient subsequently was found homeless in the town's rail station, and the local press coverage focused on the hapless expert's trial testimony as the dispositive antecedent 'cause' of the subsequent event), and, as a result, one of the most basic and important linchpins of the forensic mental health system comes seriously loose from its moorings.

Id. at 640-41.

127. Common etiology and common response to treatment are two factors that may be reflected in the classification of a set of conditions as a disease or illness entity. *See* STUART A. KIRK & HERB KUTCHINS, THE SELLING OF DSM: THE RHETORIC OF SCIENCE IN PSYCHIATRY 21, 235 (1992); R. Rogers & K. L. Dion, *Rethinking the* DSM III-*R Diagnosis of Antisocial Personality Disorder*, 19 BULL. AM. ACAD. PSYCHIATRY L. 21, 23 (1991)(arguing that diagnoses should predict outcomes).

128. *See supra* section IV.D and accompanying notes.

129. *See infra* section V.D.

130. Schopp's views about the irrelevance of diagnosis echo a position set forth in Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978). Morse's views are criticized in Richard Bonnie & Christopher Slobogin, *The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation*, 66 VA. L. REV. 427, 466-73 (1980), which foreshadows some of the cautions articulated here.

cance. For example, there is a debate about whether psychopathy, and the constellation of psychological characteristics that it describes, is a "normal" evolutionary response to certain environmental conditions.[131] If dysfunction is defined (as it often is) as the failure of a psychological mechanism to function as it is "supposed" to function,[132] then psychopathy would not count as a dysfunction.

Further, the notion of psychological "function" is itself a construction. There is, for example, a debate about the meaning of "volition."[133] Psychological testimony about impairment of volition[134] sounds like description, but actually encodes complex categorical constructions. Finally, the notion of dysfunction often entails a judgment about "capacity" or "incapacity."[135] These terms, in some circumstances, stand for controversial resolutions of complex conceptual and value problems.[136] Thus, it would be wrong to assume that reliance on "dysfunction" discourse removes all concern about subsurface distortion of legal concepts.

There is a second set of concerns about the focus on dysfunction and the claim that diagnosis is irrelevant to legal mental illness. These are perhaps more fundamental than those just alluded to, which can be overcome simply by moving along the axis of complexity until one reaches the level of descriptiveness that reveals the information that is relevant to legal determinations. The second set of issues is this: there may be a medical concept of "illness" or "disorder" that is central to the limits of civil commitment.

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131. *See* ROBERT WRIGHT, THE MORAL ANIMAL 273-74 (1994); Quinsey, *supra* note 96, at 117; Wakefield, *supra* note 92, at 383.

132. *See* Wakefield, *supra* note 92, at 383.

133. *Compare* GILBERT RYLE, THE CONCEPT OF MIND 62 (1949)(volition is a concept with no utility), *and* ROBERT F. SCHOPP, AUTOMATISM, INSANITY, AND THE PSYCHOLOGY OF CRIMINAL RESPONSIBILITY 202 (1991)(defining volition), *and* Stephen J. Morse, *Causation, Compulsion, and Involuntariness*, 22 BULL. AM. ACAD. PSYCHIATRY L. 159, 171 (1994)(summarizing various views on volition and will), *with* MICHAEL S. MOORE, ACT & CRIME 134 (Tony Honore & Joseph Raz eds., 1993), *and* Julius Kuhl and Jürgen Beckmann, *Historical Perspectives in the Study of Action Control*, *in* ACTION CONTROL: FROM COGNITION TO BEHAVIOR 89, 89-90 (Julius Kuhl & Jürgen Beckmann eds., 1985)(noting that some authors define volition in terms of the psychological processes mediating decisions; others define volition in terms of processes that "mediate the maintenance and enactment of decisions"). *See also* Charles M. Culver & Bernard Gert, *Volitional Disabilities*, *in* PHILOSOPHY IN MEDICINE: CONCEPTUAL AND ETHICAL ISSUES IN MEDICINE AND PSYCHIATRY, at 109, 110 (1982)(defining "volitional abilities").

134. *See In re* Blodgett, 510 N.W.2d 910, 915 (Minn. 1994)(defining legal mental illness as entailing a "volitional dysfunction").

135. *See* Schopp, *supra* note 5, at 174.

136. *See, e.g.*, DANIEL C. DENNETT, ELBOW ROOM: THE VARIETIES OF FREE WILL WORTH WANTING 133 (1984); Culver & Gert, *supra* note 133, at 110; Timothy Duggan & Bernard Gert, *Voluntary Abilities*, 4 AM. PHIL. Q. 127, 127-28 (1967).

Let me provide two examples. Winick's analysis strongly focused on the "traditional notion of illness." This is unsurprising in light of his principle of therapeutic appropriateness. By insisting that proper subjects for commitment exhibit only conditions for which there is appropriate treatment, Winick wants to capture one of the pieces of information that makes a diagnosis clinically useful (and perhaps valid)—information about treatment.[137] Thus, for Winick, it appears to matter whether a condition is really a *medical illness*.[138]

Further, it may matter at some rather deep level of our jurisprudence whether the condition suffered by the individual is simply a bit more or less of some characteristic shared by all humans, or, in contrast, represents some "real" categorical difference in kind from the rest of the species.[139] A number of courts upholding sex offender commitment statutes have emphasized that the condition identified in sex offender commitment statutes is a real, diagnosable condition.[140] Is this but the surface manifestation of some deep notion in our jurisprudence that allows us to treat individuals with "real differences" less well than those who, while possessing various characteristics in varying degrees, are nonetheless of the "normal type"?[141] This topic deserves further study. The only point here is to raise the issue so that the adoption of a dysfunction discourse does not further bury it.

There is a third way in which diagnostic categories quite legitimately may be relevant to legal proceedings. Expert testimony by mental health professionals in legal proceedings often involves predic-

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137. KIRK & KUTCHINS, *supra* note 127, at 235 ("The ostensible clinical purpose for making a formal psychiatric diagnosis is to guide the choice of therapeutic intervention.").

138. Kirk and Kutchins describe the "credo" that guided the development of modern psychiatric nosologies. Under this "credo," "[p]sychiatry is a branch of medicine .... Psychiatry treats people who are sick .... There is a boundary between the normal and the sick." *Id.* at 50 tbl.3.1.

139. Quinsey, *supra* note 96, at 122. *Cf.* MILLON, *supra* note 30, at 5. Millon criticizes the view that

> syndromes of psychopathology [are] one or another variant of a disease, that is, some 'foreign' entity or lesion that intrudes insidiously within the person to undermine his or her so-called normal functions. The archaic notion that all mental disorders represent external intrusions or internal disease processes is an offshoot of prescientific ideas such as demons or spirits ....

Id.

140. *See, e.g., In re* Blodgett, 510 N.W.2d, 910, 915 (Minn. 1994)(holding that "the 'psychopathic personality' is an identifiable and documentable violent sexually deviant condition or disorder"); *In re* Young, 857 P.2d 989, 1017 (Wash. 1993)(holding that "[t]he sexually violent predator condition is not only recognized, but treatable and capable of diagnosis").

141. In *State ex rel. Pearson v. Probate Court*, the Minnesota Supreme Court referred to the sex offenders subject to civil commitment as a "type[ ] of 'unnaturals.'" *State ex rel.* Pearson v. Probate Court, 287 N.W. 297, 299 (Minn. 1939), *aff'd*, 309 U.S. 270 (1940).

tion and postdiction—inferences, drawn from the current observations of an individual concerning her past or future behaviors and mental capacities. Inferences of this sort lead to a process of reasoning that goes up and down the "arch of knowledge,"[142] i.e., from specific observations about this individual (that would probably correspond to Schopp's "dysfunctions"), to general principles (often statements about diagnostic categories), and then back down to the specifics (predictions or postdictions about the individual's condition or behavior at some other point in time).[143]

Diagnoses are one of the major repositories for the accumulation of clinical knowledge.[144] Indeed, one measure of the "validity" of diagnostic categories concerns how useful they are in predicting or inferring the unknown aspects of the individual from the observed aspects.[145] Strictly speaking, the specifics, not the general principles, are matched with the legal standards. But it would be a mistake to hold that diagnosis is "irrelevant" since it seems to have a large, if only intermediate, role in ascertaining legally relevant facts. Given this role in prediction and postdiction, it might be prudent for a legis-

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142. DAVID OLDROYD, THE ARCH OF KNOWLEDGE 13 (1986).

143. *See* Barbara D. Underwood, *Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment*, 88 YALE L.J. 1408, 1427 (1979)(noting that even decisions that make use of individualized "clinical" judgment rely on categorical information about the "class" to which the individual is thought to belong).

144. *See* Paul E. Meehl & Robert R. Golden, *Taxometric Methods, in* HANDBOOK OF RESEARCH METHODS IN CLINICAL PSYCHOLOGY 127, 130 (Philip C. Kendall & James N. Butcher eds., 1982). Meehl and Golden argue that "taxons" or diagnoses are used to

> summarize a great deal of our knowledge, including low probability or highly problematic conjectural knowledge about a patient . . . . It is doubtful that clinicians could talk with each other if they were strictly forbidden to employ such summarizing rubrics as this, although the dangers of reification when the entity has no existence, as well as premature diagnostic closure by one's adoption of the semantics, are well known.

Id. At least in certain circumstances, it is knowledge of active symptoms (dysfunctions?) rather than diagnoses that allows for prediction. *See* Edward P. Mulvey, *Assessing the Evidence of a Link Between Mental Illness and Violence*, 45 HOSP. & COMMUNITY PSYCHIATRY 663, 665 (1994). In some circumstances, moreover, diagnostic thinking impairs, rather than assists, prediction. *See generally* W.M. Grove, *When Is a Diagnosis Worth Making? A Comparison of Two Statistical Prediction Strategies*, 69 PSYCHOL. REP. 3, 3-17 (1991).

145. KIRK & KUTCHINS, *supra* note 127, at 29. *See also* Edgar F. Borgatta & Marie L. Borgatta, *Validity, in* 4 ENCYCLOPEDIA OF SOCIOLOGY 2217, 2219 (Edgar F. Borgotta & Marie L. Borgotta eds., 1992)(defining predictive validity); Grant T. Harris et al., *Violent Recidivism of Mentally Disordered Offenders: The Development of a Statistical Prediction Instrument*, 20 CRIM. JUST. & BEHAV. 315, 325 (1993)(noting that predictive validity is a crucial psychometric issue); Robert A. Prentky et al., *Predictive Validity of Lifestyle Impulsivity for Rapists*, 22 CRIM. JUST. & BEHAV. 106, 128 (1995).

lature to require the presence of a "valid" (medically recognized) disorder as a necessary condition for commitment.[146]

C. Legal Mental Illness as Incompetence in a Particular Context

Schopp's method is to provide a usable interface between law and psychology by expressing legal standards in the language of dysfunction or impairment. At the heart of his explication, Schopp derives these legal standards from the internal logic of the two legal contexts—the criminal justice system and the mental health system.

Schopp demonstrates that the fundamental nature of the criminal justice system entails the notions of responsibility and competency to stand trial, and that these can be expressed as sets of mental competencies. Dysfunctions that impair these mental competencies render a person "ineligible" for the criminal justice system.[147] I shall refer to

146. It seems quite clear that courts operate heuristically in the mental health area. That is, they use "shortcuts" to manipulate the complexities of mental health law and social science that underlies it. *See* Michael L. Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning*, 69 NEB. L. REV. 3 (1990). Laws need to be written with that propensity in mind. In civil commitments, predictions of future harmful behavior play a central role, but the measurement of the validity of predictions is somewhat complex and likely to be overshadowed by more vivid evidence. *See* Eric S. Janus & Paul E. Meehl, *Assessing the Legal Standard for Predictions of Dangerousness in Sex Offender Commitment Proceedings*, 2 PSYCHOL., PUB. POL'Y & L. (forthcoming 1997)(manuscript at 2-7, on file with the author)(describing methods for measuring validity of predictions); Laurens Walker & John Monahan, *Social Frameworks: A New Use Of Social Science in Law*, 73 VA. L. REV. 559, 576 (1987)(discussing use of statistics in litigation).

Requiring a medically recognized diagnosis as a condition for commitment may be a shorthand, or heuristic, for predictive validity that courts can use and understand. Though flawed as a tool for predictions, it may be a more effective legislative strategy for obtaining valid predictions than a naked statutory provision mandating validity in prediction.

147. Punishment is limited to those who deserve it, and "a retributive system reaffirms the moral force of the criminal law." Schopp, *supra* note 5, at 178. Thus, criminal punishment "applies uniquely to those who possess the capacities necessary to function within such a rule-based system. The system expresses respect for these persons by presenting them with the rules and allowing them to guide their own conduct by exercising their capacities for practical reasoning." *Id.* Legal mental illness in this context is "psychological impairment that undermines these capacities, preventing the person from guiding his or her conduct according to the rules through the capacities ordinarily available to the competent practical reasoner." *Id.* at 179.

Note that "competent moral agents" are those who

> have the ability to comprehend and conform to a system of rules and punishments without having to actually experience the consequences. Competent moral agents are those who have the capacities needed to direct their conduct in conformity with a legal or moral standard by engaging in a process of practical reasoning and deliberation.

this set of competencies as CL-competencies ("criminal law competencies"), and those who lack them as CL-incompetent. People who are CL-incompetent have "legal mental illness" in the criminal justice context.

Schopp then turns to the mental health system, correctly pointing out that the mental health system has dual functions in our society (as well as in our history). These functions are social control and health care. He suggests that this duality corresponds to the two powers supporting mental health commitment—the police power and the *parens patriae* power.[148] Schopp observes that the characteristics (including boundaries and criteria) of health care commitments (supported by the *parens patriae* power) may be different from those of social-control commitments (supported by the police power).[149]

Schopp argues that a fundamental value underlying our health care system (including the health care aspect of the mental health system) is the right to act autonomously, which he calls "sovereignty."[150] The area of sovereignty extends only to "self-regarding life decisions."[151] In general, health care decisions fall within the area of sovereignty, and people have the right to informed consent about their own health care.[152]

Some people do not have the ability to exercise their "autonomous capacities." Thus, they lack the "necessary condition for sovereignty."[153] Schopp argues that "[a] legal standard of competence that deprives these individuals of the right to informed consent and the concomitant right to refuse treatment does not violate the principle of autonomy."[154] I will refer to the competencies that are a precondition to the exercise of autonomy, and thus of sovereignty, as S-competencies. S-incompetence is a condition for legal mental illness in the context of *parens patriae* commitments for the involuntary provision of mental health care.[155]

Three points should be emphasized. First, note the differences between CL-competency and S-competency. The former refers to mental capacities needed for an individual to be held responsible for criminal actions. The latter refers to the capacities needed for an individual to

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Id. at 178.

148. *Id.* at 183.

149. Buchanan and Brock also expressed this insight. *See* BUCHANAN & BROCK, *supra* note 5, at 312.

150. Schopp, *supra* note 5, at 173.

151. *Id.*

152. *See id.* at 172. "The moral principle of autonomy as a right to self-determination within a sphere of personal sovereignty supports the right to informed consent." *Id.*

153. *Id.* at 174.

154. *Id.*

155. *Id.* at 183.

exercise control in a sphere that is self-regarding. Second, the two standards for competency may well be different. Thus, conditions that render an individual CL-incompetent may not affect the capacities that are necessary for the exercise of sovereignty in self-regarding areas and so do not render the person S-incompetent.[156]

Third, the principles of sovereignty and autonomy do not reach behavior that is outside of the area of self-regard. In particular, "sovereignty" does not give an individual the right to threaten or harm others. As Schopp points out, legal institutions can "monitor and intervene in conduct that threatens harm to others. . . . Such behavior does not constitute the exercise of sovereignty because it extends beyond the essentially self-regarding domain."[157]

Having established this framework, Schopp's analysis now turns to the central problem of finding the boundaries of police power commitments. It is clear enough where Schopp wants to end up on this question. It is to be CL-incompetence that distributes individuals to the two branches of the social control system, criminal and mental health. Harmful behavior of CL-competent individuals is addressed in the criminal system and harmful behavior of CL-incompetent individuals is addressed in the police power commitment system. Schopp's analysis contemplates a nonoverlapping, gapless boundary between the two systems of social control.[158]

Schopp's analysis must answer two questions. The first is why *all* CL-incompetent individuals are properly subject to social control commitment. The second is why *only* CL-incompetent individuals are subject to this form of commitment. The first of these questions (the "gap" question) is easier; the second ("overlap") is more difficult.

Schopp addresses the "gap" problem in three steps. First, legal mental illness renders the individual "inappropriate" for the criminal justice system because subjecting those who are CL-incompetent to the criminal justice system would "dilute the moral force of the criminal law by punishing those for whom punishment is not justified."[159] Second, he asserts that the system of social control must be comprehensive.[160] That is, there must be an "alternative institution" to address dangerous behavior left unaddressed through the criminal justice system. Third, Schopp prescribes that the mental health system complements the criminal justice system. In other words, the

156. *Id.* at 182-83.

157. *Id.* at 175 n.49.

158. "The mental health component of the institution of social control, rather than the criminal justice component, applies to *all and only those* who suffer legal mental illness undermining the capacity to direct their conduct [i.e., to CL-incompetent individuals]. . . ." *Id.* at 181 (emphasis added).

159. *Id.* at 179.

160. *Id.*

mental health system addresses all social control confinements that are outside the scope of the criminal system.

Each of these three steps is necessary to Schopp's conclusion, which is that all CL-incompetent individuals are properly addressed by the mental health power of the state. Note that Winick almost certainly rejects that conclusion, and with it, the third of Schopp's steps. Winick's analysis contemplates the possible existence of individuals who are criminally excused, yet not committable because their conditions are untreatable. Further, Winick only reluctantly and ambiguously embraces the second step of Schopp's analysis by postulating some form of nonmental health preventive detention for those who fall between the criminal justice and mental health systems.[161]

This discussion illustrates the difference between Schopp's and Winick's frameworks for explicating legal mental illness. Schopp's observation that social control civil commitment should be viewed as analytically related more to the criminal justice system than to *parens patriae* commitments[162] emphasizes two key distinctions: (1) the criteria for social control commitments might differ from the criteria for *parens patriae* commitments[163] and (2) the criteria for police power commitments complement those in the criminal system.[164]

Note that in this explication, the "mental health" aspect of police power commitments is a dependent variable (a result of the explication) rather than one of the independent variables (a "given" in the argument). Under this explication, police power commitments are "mental health" commitments because criminal-excuse conditions are based on mental incapacities. This explication results in a "gapless" boundary between the criminal and mental health systems.

In contrast, Winick's explication provides that the essentially medical nature of civil commitment appears to be part of the explicandum (a given). Winick's explication is entirely endogenous, deriving the boundaries of civil commitment from the essential nature of commitment as a medical intervention.

This distinction between the frameworks of the two writers, however, blurs as Schopp turns to his discussion of the limits on police power commitments. When Schopp argues that *only* those who are CL-incompetent may be committed under the police power, he appears

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161. *See supra* Part IV and Winick's discussion about preventive detention.

162. Schopp writes:

> [C]riminal incarceration and police power commitment serve as complimentary institutions within the police power category, serving the social control function for those who are (criminal incarceration) or are not (police power commitment) eligible to participate in the criminal justice system.

Schopp, *supra* note 5, at 183.

163. *Id.* at 182.

164. *Id.*

to argue that the limits of police power commitments arise from the health care aspect of commitments.

D. The Health Care/Social Control Distinction: What Is Their Relationship?

As mentioned above, Schopp's conceptual framework distinguishes between two aspects of civil commitment, social control, and health care. Schopp never explicitly states what he considers to be the relationship of the two. As I shall show below, the nature of this relationship is critical, so it is worth contemplating how the two aspects might be related and how Schopp's framework appears to arrange them.

Since this Article focuses on police power commitments, the key question is whether, and in what sense, health care is a necessary component of civil commitments. This question was addressed above at some length in connection with the discussion of Winick's principle of therapeutic appropriateness.[165] Winick's position that civil commitment is "essentially medical," translated into Schopp's terms, states that all commitments must exhibit the health care aspect. Winick's conception of the health care aspect of civil commitment, at least in its strong version,[166] further characterizes civil commitment health care as that which is (and therapeutically can be) *involuntarily* administered. As I argued above, other possible conceptions of civil commitment are available. For example, we can imagine civil commitment in which health care, conceived quite broadly as including nonmedical forms of treatment, is offered to, but not forced on, those who are committed.[167] Thus, we can contemplate at least three ways in which the social control and health care functions might combine in police power commitments. In the strongest form, health care is a necessary condition and is forced involuntarily. In the weak form, health care is an unnecessary component of commitments. In the intermediate combination, health care is necessary in the sense that it must be offered, but commitments without health care are permissible

165. *See supra* section IV.B and accompanying text.

166. *See supra* note 41 and accompanying text.

167. Treatment for persons committed under Minnesota's sex offender commitment laws is not "forced" provided the committed individual consents. *See* MINNESOTA SECURITY HOSP., SEX OFFENDER TREATMENT PROGRAM: PLAN, CONTENT AND SEQUENCE 7-8 ("Residents sign a consent form each trimester acknowledging their awareness of limits to confidentiality and either consenting to, or refusing, treatment in the program."). The Minnesota treatment program contemplates that committed individuals will "voluntarily cooperate" with the program. *See generally* ST. PETER REG'L TREATMENT CTR., MINNESOTA SECURITY HOSP., PSYCHOPATHIC PERSONALITY SEX OFFENDER PROGRAM 1 (July 1993). Schopp acknowledges that civil commitment may involve a "broad range of interventions," apparently not limited to the organic treatments prescribed by Winick. Schopp, *supra* note 5, at 180.

where the individual refuses the health care or where no appropriate health care is available.

Now let us pinpoint where on this continuum Schopp's analysis lands. Recall that Schopp defines legal mental illness for police power commitments in terms of the criminal justice system. CL-incompetence, rather than S-incompetence, is the standard for police power commitments. CL-competence and S-competence are not identical. Some CL-incompetent individuals are S-competent. Thus, under Schopp's analysis, some individuals who are S-competent—able to exercise the capacities to act autonomously—will be committed to the mental health system.

This result strongly suggests that Schopp rejects the strong position on health care (that forced medical treatment is an "essential" feature of commitment). Schopp instead would endorse, at most, the intermediate position. The strong position would suggest that some S-competent persons would be subjected to forced health care. This position would clearly violate the basic principles of autonomy that Schopp sets forth. Schopp rejects the notion that his framework will result in the violation of the principles of autonomy: "The state can respect individual sovereignty, yet retain legitimate authority to *prevent acts* that extend beyond the sphere of sovereignty to harm others."[168] Here, Schopp is saying that "prevention," i.e., social control, can be exercised without violating sovereignty, an area that protects the individual's right to make autonomous decisions about health care.

This analysis suggests that Schopp rejects Winick's position that commitment is essentially medical. If commitment is essentially medical, then the mere commitment of an S-competent individual would amount to the autonomy-violating involuntary imposition of health care. At a key point in his analysis, however, Schopp appears to fall back on an argument that is much closer to Winick's position. It is to that portion of the argument that I now turn.

E. Autonomy, Mental Competency, and the Limits on Social Control: Do Some People Have a Diminished Right to Be Treated as Persons?

Schopp seeks to establish that CL-competent and S-competent individuals ought not be addressed in the mental health system. Put another way, Schopp argues that an individual whose criminal responsibility is not impaired and who is competent to decide about his own health care should not be civilly committed. I wish to make three points about Schopp's argument. First, I will suggest that Schopp relies on a rights/status approach to make this argument. Second, I will

168. Schopp, *supra* note 5, at 175 n.49 (emphasis added).

argue that Schopp's argument may contradict his earlier rejection of the premise that civil commitment is essentially medical. Third, I will argue that Schopp's rights/status-based approach fails to provide a solid limitation for police power commitments.

The central force behind Schopp's limitations argument is that commitment is inconsistent with the status or "standing" properly accorded to competent individuals. Schopp argues that "[c]onsistent respect for the principle of autonomy requires that those who qualify for sovereignty be treated in a manner appropriate to that standing in all social institutions."[169] The corollary of this proposition is that those who are incompetent lack such "standing" or status and thus may be properly committed. This argument ties the limits of police power commitments directly to the "status" of the individual. Those with a particular status "qualify" for certain rights; those who lack that status do not.

Contrast this argument with Schopp's argument about the extension of commitments. In the extension argument, he focuses on the interests of the state and the functioning of the criminal justice system. It is the state's inability to apply criminal sanctions to CL-incompetent individuals that justifies the use of civil commitment as a social control mechanism. Schopp then changes focus from the state's interests to the individual's right to be treated in a particular manner. Those with the requisite mental capacities have the right to be treated as responsible persons in the criminal justice system; those without such capacities have a diminished set of rights and are "relegated" to the mental health system.

The cornerstone of Schopp's limitations argument is that committing competent individuals is inconsistent with their standing as autonomous individuals who qualify for sovereignty. Let us examine what this claim means and entails. Recall first the definitions of autonomy and sovereignty. Autonomy has several meanings for Schopp. Here, he appears to be referring to "autonomous capacities,"[170] by which he means the psychological capacities necessary to "qualify for sovereignty."[171] "Sovereignty" is the right to act in the context of self-regarding decisions, such as decisions about one's own health care. Individuals are not sovereign with respect to the other-regarding decisions involved in the system of social control. In Schopp's framework,

169. *Id.* at 181.

170. Schopp argues that subjecting CL-competent individuals to the mental health system would "sacrifice the value of autonomy by treating those who are eligible to participate in the criminal justice component as if they lacked the autonomous capacities they actually possess." *Id.* at 182.

171. *Id.* at 174.

states have the right to prevent actions that harm or threaten harm to others,[172] and such prevention does not violate the value of autonomy.

Given this framework, civil commitment is inconsistent with autonomy only to the extent that its intervention extends to areas, such as health care, that are self-regarding. If the health care aspect of civil commitment is not imposed, then commitment, at least in this analysis, does not violate the value of autonomy. Conversely, Schopp's assertion that the principle of autonomy is violated suggests he contemplates that civil commitment always entails forced health care.[173] In short, the autonomy argument appears to entail, at its base, a reliance on an "essentially medical" conception of civil commitment. As suggested above, this appears inconsistent with other aspects of Schopp's framework.[174]

Perhaps my critique reads Schopp too narrowly. Perhaps he really intends to argue that social-control commitment treats CL-competent individuals as CL-incompetent, i.e., as if they lacked the competencies to be treated as responsible individuals in the criminal law system.

It might be shown, for example, that social-control civil commitments characterize criminal behavior as "caused" by a mental disorder rather than chosen, and thereby treat individuals as objects for examination rather than as moral actors.[175] But this argument appears to be based on the accident of the current conceptualization of civil commitment. While it is true that civil commitment laws often are framed in terms of the psychological causation of behavior, a sophisticated understanding of such causation shows that it is not necessarily inconsistent with CL-competence. All behavior is psychologically caused; causal explanations are not inconsistent with explanations of behavior based on the exercise of choice.[176] Civil commitment laws could be

172. *Id.* at 175. "The state can respect individual sovereignty, yet retain legitimate authority to prevent acts that extend beyond the sphere of sovereignty to harm others." *Id.* at 175 n.49.

173. *Cf.* Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988)(contemplating a system in which the confinement decision and the forced treatment decision are made independently and on different grounds).

174. *See infra* Part VI.

175. Schopp argues that addressing CL-competent persons within the mental health system "distorts the conventional public morality by misrepresenting the standards of competence and culpability. This distortion denigrates the defendants, misleads the public, and undermines the moral force of the larger institution of social control." Schopp, *supra* note 5, at 181. *See also*, Janus, *Preventing*, *supra* note 5, at 212; John Q. La Fond, *Washington's Sexually Violent Predators Statute: Law or Lottery? A Response to Professor Brooks*, 15 U. PUGET SOUND L. REV. 755, 767 (1992)(arguing that legal mental illness "assumes there is a causative defect in cognitive, emotional, or volitional processes that can be diagnosed and, in most cases, treated").

176. *See* Morse, *supra* note 133, at 162. *See generally* Icek Ajzen, *From Intentions to Actions: A Theory of Planned Behavior*, *in* HISTORICAL PERSPECTIVES IN THE STUDY OF ACTION CONTROL 12 (Julius Kuhl et al. eds., 1985)(discussing the pre-

rewritten, it might be argued, to emphasize the coexistence of pathological cause and free choice.[177] The design of the social control aspect of the mental heath system is contingent and changeable. It is not inevitable that this function should emphasize psychological causality rather than moral responsibility. A design could clearly deliver the messages of *both* responsibility *and* psychological dysfunction.[178] The task here is to explicate the role of mental disorder, not describe how it currently functions in civil commitment. The accidents of current commitment schemes should not govern the constitutional boundaries of the state's police power. To merely say that social-control commitment treats competent people as incompetent is an oversimplification since it treats them as "incompetent" only if we say it does.

One could suggest a deeper way in which CL-competent individual's capacities—the capacities to deliberate and follow rules—are "sacrificed" if those individuals are addressed by the mental health system. This argument does not stem from the labels of the mental health system, but rather from its structure. As Professor Underwood observed, confining people on the basis of predictions of their bad behavior violates the principle of autonomy because it "denies [them] the opportunity to choose to avoid those crimes."[179] According to this argument, the structure of the mental health system is incompatible with responsibility because it deprives individuals the "choice" to follow the rules. The system is essentially preventive and forward looking, rather than punitive and backward looking.[180]

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diction of volitional behavior through an understanding of its "psychological determinants").

177. Even under current law, the language of "choice" figures prominently in sex offender commitments. For example, in *Rydberg v. Gomez*, the Minnesota Court of Appeals cited the individual's "refusal to participate in sex offender treatment" as one of the grounds for denying his petition for discharge. Rydberg v. Gomez, No. C7-96-883, 1996 LEXIS 1086 at *5 (Minn. Ct. App. 1996). And consider the following description of persons who are subject to Minnesota sex offender commitment law: "They may choose to commit harmful acts even if they know that the acts are wrong because their mental disorder causes them to act." Brief for Respondent Ramsey County at 13, *In re* Linehan (II), 577 N.W.2d 171 (Minn. 1996)(No. C1-95-2022). The Minnesota Attorney General's Brief in *Linehan II* characterized the state's Sexually Dangerous Persons Act as aimed at mentally disordered sexual predators "whose mental disorders cause them to 'choose' to commit sexual assaults." Brief for Respondent State of Minnesota at 15, *In re* Linehan (II), 557 N.W.2d 171 (Minn. 1996)(No. C1-95-2022).

178. Sex offender treatment programs often emphasize the personal accountability of the patient. *See, e.g.*, MINNESOTA SECURITY HOSP., SEX OFFENDER TREATMENT PROGRAM: PLAN, CONTENT AND SEQUENCE, *supra* note 167, at 4. The first of 12 listed "treatment goals" is "[a]ccepting responsibility for sexual behavior without cognitive distortion." *Id.*

179. Underwood, *supra* note 143, at 1414.

180. *See id.*

This is, of course, an accurate characterization of civil commitment. Further, it is not simply an accident of the current incarnation of commitment laws. At its essence, commitment is preventive. The bite in this argument arises from the comparison to the criminal law. The criminal justice system, it is argued, gives competent rule-followers the opportunity to follow or break the rule and provides negative consequences when the decision is to break the rule. This is the paradigm that gives meaning to the notion of criminal responsibility.

But this argument proves too much. Many structures in our society remove the opportunity to break the rules. The government erects fences, locks doors, screens for guns and bombs, bans imports, and in many other ways restricts the choices of individuals. Like civil commitment, these restrictions prevent, rather than punish, harmful behaviors. The criminal justice system itself is highly preventive. Many criminal punishment systems are designed to calibrate the period of incapacitation to future dangerousness, rather than to the magnitude of the crime.[181] Schopp would have to explain how civil commitment incapacitation is less consistent with responsibility than criminal law incapacitation.[182]

It might be argued that prevention in the criminal justice system differs from prevention in the civil commitment system because criminal preventive confinement is *deserved*, whereas the confinement in civil commitments is not based on a desert justification.[183] The criminal system, based on desert, treats people as ends in themselves, rather than a means to an end.[184] The mental health system is not

181. *See* Michael Tonry, *Prediction and Classification: Legal and Ethical Issues*, 9 CRIME & JUST. 367, 373 (1987). There appears to be nothing unconstitutional in basing pre- or post-trial decisions in criminal cases on predictions of dangerousness.

182. Indeed, Underwood recites arguments that prevention strategies in the criminal law are inconsistent with "autonomy." Underwood, *supra* note 143, at 1418.

183. *See, e.g., In re* Young, 857 P.2d 989, 998 (Wash. 1993)("Although the scheme here does involve an affirmative restraint, the civil commitment goals of incapacitation and treatment are distinct from punishment, and have been so regarded historically."). *See also* State *ex. rel.* Pearson v. Probate Court, 287 N.W. 297, 300 (Minn. 1939), *aff'd*, 309 U.S. 270 (1940)("In the interest of humanity and for the protection of the public, persons [with psychopathic personalities] should be given treatment and confined for that purpose rather than for the purpose of punishment.").

184. See Tonry, *supra* note 181, at 385, for a more sophisticated discussion of this issue. Not all theorists would agree that the severity or length of punishment must be based on a retributivist theory of desert. Tonry describes H.L.A. Hart's "middle way" as allowing a utilitarian calculus to measure the severity of punishment, while insisting on a retributivist desert-based theory in the determination of "liability" for punishment. *Id.* Schopp appears to adopt Hart's approach: "[A] theory qualifies as retributive in this minimal sense if it limits punishment to those who are culpable by requiring desert as a constraint on the manner in which society pursues its deterrent purposes through punishment." Schopp, *supra* note 5, at 177. *See generally* John Monahan, *The Case for Prediction in the*

based on desert. The deprivation of liberty in police power commitments is based on the utilitarian justification that confining the individual is a means to achieve greater safety for society as a whole.[185] Treating people as means to an end is generally seen as improper and inconsistent with the full humanity of an individual.[186]

The question Schopp must answer is this: What is the theory underlying the conclusion that it is permissible for CL-incompetent, but not CL-competent, individuals to be treated as means to an end rather than ends in themselves? Why is it permissible for incompetent people to be confined when they do not "deserve" the confinement, whereas competent people may not be?

Schopp, as I have suggested above, frames his theory in terms of rights and status. Under this theory, diminished mental capacity means diminished rights and status. Those who are CL-incompetent are not entitled to be treated as full moral agents in the criminal system; they are "relegated" to the civil system. Treating them as means to an end is permissible because their rights are diminished and their status as persons (or as diminished persons) is not insulted by this treatment.[187]

The alternate theory is an interest-based theory.[188] Under this theory, the rights of the individual and her status remain unaffected by mental impairment. The state's interests, in contrast, are differentially affected by the mental competency of the individual. If, for example, the individual's mental impairment forecloses criminal prosecution, the state's interest in using the alternate system of social control (civil commitment) is heightened. The state cannot use the alternate system for individuals without the requisite impairment because the state's interest is not heightened.

The first analysis, rights-based, is dangerous because it lacks principled limitations. If mentally impaired individuals are entitled to less and have fewer rights, they are in a sense only partial citizens. If

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Modified Desert Model of Criminal Sentencing, 5 INT'L J.L. & PSYCHIATRY 103 (1982)(discussing the use of prediction in sentencing).

185. *Parens patriae* commitments do not suffer from the same characteristic. In *parens patriae* commitments, the confinement is a means to ends that are (at least in theory) the individual's own, rather than the society's.

186. *See* Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1715 (1992). According to Winick,

> Kant's theory asserts that individuals must be treated as persons capable of rational choices, as ends in themselves, rather than merely as means to the achievement of others' ends. According to this view, there is a natural, inalienable right to be treated as a person, as one whose individual autonomy is respected.

Id.

187. *See, e.g.*, SCULL, *supra* note 29, at 1 (quoting Lord Shaftesbury, *Diaries*, Sept. 5, 1851: "Madness constitutes a right, as it were, to treat people as vermin").

188. I develop this theory more fully in Janus, *Preventing*, *supra* note 5, at 208-12.

their diminished status allows them to be treated as means to social ends for some purposes, why not others? On the other hand, the interest-based analysis is self-limiting. The state's interests are enhanced only to the extent that its police power, otherwise exercisable in the criminal law, is thwarted by the mental impairment.

As suggested above, Schopp's autonomy argument relies on the rights/status approach. Schopp's discussion of "values convergence" shows that the limits of police power commitments cannot be firmly founded on this sort of approach. Schopp hopes to show that the mental-status-based argument works for police power commitments by analogizing it to *parens patriae* commitments. In the latter context, Schopp convincingly shows that autonomy and well-being are convergent when the civil commitment system is invoked involuntarily only for S-incompetent individuals, i.e., those who lack the capacity to engage in autonomous action. This convergence arises because well-being in this context is self-referential, and for that reason, the concepts of autonomy and well-being are tied together. An individual's well-being consists in what he competently chooses for himself.[189] Nonintervention in the lives of competent individuals thus respects both autonomy and well-being. *Parens patriae* intervention, on the other hand, respects autonomy because the individual is incompetent to exercise autonomy. Further, it enhances well-being because its surrogate decisions are aimed at replacing the incompetent choices about health care and other self-regarding matters. Note that the values of autonomy and well-being pull in the same direction. Intervention increases well-being only to the extent that it respects the value of autonomy.

Schopp hopes to show that social control commitments operate in a parallel fashion. He argues that autonomy and well-being are values that converge if CL-competence is the test that distributes individuals to the criminal or mental health systems of social control. Here, of course, he means *societal* well-being, not self-referential well-being. Further, I take it he does not precisely mean "autonomy," but rather the value of respecting responsibility for ones actions. The argument works, but only if Schopp assumes as a premise the very conclusion that is said to flow from the autonomy argument: the criminal law and mental health systems must be nonoverlapping, i.e., any given set of psychological impairments can justify the invocation of, at most, one of them. If one makes this assumption, then the values of responsibility and public well-being not only converge, but are maximized by making CL-competency the sorting principle. One receives a maxi-

189. As Schopp states this point: "By exercising sovereignty, each competent person defines and pursues those aspects of well-being that are central to the life he or she has chosen." Schopp, *supra* note 5, at 175.

mum amount of social control, and the respect for responsibility is maximized.[190]

But now proceed without the assumption about nonoverlapping systems. Let us assume, rather, that the question of the relationship between the criminal and mental health system is to proceed from the explication, not as a part of the explicandum. Under these circumstances, one could argue that the aggregate value would be maximized through the use of the two systems *seriatim*. *Seriatim* use maximizes the value of criminal responsibility by holding the CL-competent individual responsible and then maximizes societal well-being by confining the individual in the mental health system until he is no longer "dangerous."

This analysis shows that the use of the individual's diminished status to justify the enhancement of *society's* well-being in police power commitments is not a self-limiting system. There will be many circumstances in which society can maximize the well-being/autonomy function by enhancing its own well-being, even at the expense of further imposition on the individual.[191]

In short, an analysis that looks only to the individual's status will not result in limits on police power commitments. Such limits will come only from an analysis founded upon an analysis of the state's interests.

VI. CONCLUSION

Schopp, Winick, and many others are in basic agreement about the limits on the state's power to use civil commitment for social control. Mental disorder supports civil commitment only when it impairs fundamental psychological capacities like cognition and volition. Schopp and Winick offer conceptual frameworks that incorporate philosophical and behavioral science principles into the fabric of this legal in-

190. Note that the synergistic effect is not as strong because the concepts of responsibility (CL-competence) and societal well-being are not connected in the same way that autonomy and self-regarding well-being are. At most, there is a contingent connection in the sense that the mental health system may make choices for the individual that enhance her CL-competence; but such enhancement does not necessarily translate into societal well-being.

191. In contrast, the *parens patriae* analysis produces a closed and self-limiting system. The individual's diminished status (S-incompetence) justifies state intervention aimed at enhancement of her own well-being. Intervention is adjusted to maximize the individual's benefit, a formula that ought to limit the imposition on the individual. Thus, in the *parens patriae* context, a rights/status analysis for civil commitment produces limited intervention. *But see* SCULL, *supra* note 29, at 313 (showing that such benign calculi rarely perform as promised). *See also* Mary L. Durham & John Q. La Fond, *supra* note 41, at 887 (claiming to show that therapeutically-derived criteria for commitment can have an outcome that is detrimental to individuals with mental illness).

quiry. Their differences highlight the importance of choosing a conceptual framework.

Winick chooses psychiatric hospitalization as his explicandum. He seeks the limits of civil commitment from within itself. Psychiatric hospitals are medical facilities, and from this observation the principle of therapeutic appropriateness follows. Canvassing the medical and behavioral science literature, Winick shows that the modern psychiatric hospital is simply therapeutically inappropriate for individuals with disorders, such as antisocial personality disorder, that are not medically treatable. But his analysis cannot determine whether the state might establish other sorts of institutions, and in so doing, expand the reach of its civil commitment power beyond psychiatric illnesses. Winick's mastery of the medical discourse is a valuable contribution. In the end, however, the structure of his explication relies too much on science and not enough on law to set the limits on the state's police power.

Schopp deploys philosophical analysis as masterfully as Winick makes use of science. Schopp observes that civil commitment has two aspects. He offers the insight that police power commitments and the criminal law ought to be seen as two components of a comprehensive system of social control. This helps us see that the bounds of police power commitments may be derived from understanding its place in the broader system. But Schopp applies a rights/status analysis to derive the limits on the state's power to use civil commitment for social control. This analysis cannot, by itself, generate stable limits on police power commitments.

I have proposed a third framework for analysis. As in Schopp's analysis, police power civil commitment is defined in relation to the criminal law. In my analysis, the "moral force" of the criminal justice system depends on that system being the primary means for the state to vindicate its social control interests. Civil commitment is limited because it may fill only the interstices of the criminal law. Incompetent individuals are subject to the civil commitment power not because their mental impairments diminish their personhood or their rights, but because the state's social control interests can be vindicated in no other way. Subjecting competent individuals to police power commitments would destroy the primacy, and thus the moral force, of the criminal law.