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Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*

Donald H. J. Hermann**

I. INTRODUCTION

Anyone spending time in a major urban center in the United States must be shocked by the significant number of mentally ill persons living on the streets—the “bag people” who sleep in doorways, on steam grates, on subway stairs.¹ These people represent a

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1. See Hermann, *Mental Patient Release Program Leaves Many to Face Harsh Fate*, N.Y. Times, Nov. 18, 1979, at 1, col. 5. This column describes the human misery of a New York City men's shelter:

The fetid odor of unclean bodies and the gray-blue haze of cigarette smoke hang like smog about the destitute clientele of the Men's Shelter on the Bowery in Manhattan.

Nearly 1,300 men visit the shelter each day. By and large, they come from New York State's psychiatric hospitals, which have released 83,659 adult patients “to the community” over the last four years—nearly 40,000 of them to New York City.

On the first floor, ragged men with vacant eyes sit in the “Big Room” on plastic chairs attached in rows. As many as 250 men will sit all night if there are no beds available in the nearby flophouses.

Some men will wash themselves in the second floor shower, but many refuse. Others must be deloused or they cannot stay.

.....
The people in the Men's Shelter, the “shopping-bag ladies” at Pennsylvania Station, the disheveled characters outside the single-room-occupancy hotels on the west side—all have no contact with community mental-health centers or hospital outpatient clinics. If they were told about them, they do not know or have forgotten how to get there. Many do not realize they need care or are unwilling to go.

new lifestyle made possible in part by a policy of deinstitutionalization of the mentally ill, which has been motivated largely by economic considerations and rationalized as a matter of mental health law reform.² Another major factor contributing to the increasing denial of treatment to the mentally ill has been a revision of the mental health statutes. A number of jurisdictions now require, as a prerequisite to involuntary commitment, both a finding of dangerousness to self or others and that treatment be done in the least restrictive institutional setting.³ The policy of deinstitutionalization and these reforms of commitment law ignore the reality of mental illness—many mentally ill persons lack the ability to make rational decisions about their treatment needs.⁴

This Essay examines the efficacy of the procedural and substantive reforms in civil commitment law that courts and legislatures have made in the last decade and a half. In light of this examination, the Essay suggests some doctrinal revisions that are necessary to assure adequate treatment for mentally ill persons who lack the rational capacity to understand their own needs or how to meet those needs.

2. See C. WARREN, *THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW* 21-24 (1982). Warren maintains that the primary factor motivating political and legal authorities to adopt a policy of deinstitutionalization was fiscal. In Warren's view, the adoption of statutes such as that in California, which mandates the least restrictive alternative treatment, was motivated in large part by a desire to reduce the funding for mental health treatment. While the reformers urged the adoption of the least restrictive form of confinement consistent with patient needs on therapeutic and civil libertarian grounds, the legislature largely was moved by fiscal considerations. The state could thus replace costly hospitalization with less expensive alternatives such as nursing homes, day care centers, and community health clinics.

3. See Peele, *The Legal System and the Homeless*, in TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION: *THE HOMELESS MENTALLY ILL* 261 (H. Lamb ed. 1984) [hereinafter cited as Peele]. The author observes:

Over the past two decades many legislative and judicial actions have directly and adversely affected the homeless mentally ill. . . . [These include] current trends and philosophy in relation to advocacy, the principles of least restrictive alternative, malpractice and civil liability, commitment laws, the right to treatment, and the right to refuse treatment; we believe that many of these trends have contributed to homelessness.

Id.

4. See Arce, Tadlock, Vergare & Shapiro, *A Psychiatric Profile of Street People Admitted to an Emergency Shelter*, 34 *HOSP. & COMMUNITY PSYCHIATRY* 812, 812-17 (1983); Lipton, Sabatini & Katz, *Down and Out in the City: The Homeless Mentally Ill*, 34 *HOSP. & COMMUNITY PSYCHIATRY* 817, 817-18 (1983). These studies of the homeless in New York and Philadelphia both conclude that the vast majority of the homeless studied were mentally ill and had a history of psychiatric hospitalization. In Philadelphia, of the 193 persons studied, 84% were mentally ill, including 37% who were schizophrenic and 25% who were alcoholics or drug addicts. In New York, of 100 persons studied, almost all were mentally ill, with 72% diagnosed as schizophrenic.

The current law of civil commitment reflects the extensive reform of the last two decades.⁵ Historically, the process of involuntary civil commitment limited an individual's civil rights in favor of achieving social control by compelling treatment in conformity with the police power and a *parens patriae* policy.⁶ During the last two decades, however, this process has been challenged in the courts and subjected to legislative revision.⁷ This reassessment has produced three principal reforms: the imposition of procedural rights for those subjected to commitment proceedings,⁸ the restriction of substantive commitment criteria,⁹ and the adoption of

5. See generally Hermann, Book Review, 31 BUFFALO L. REV. 611, 611-14 (1983) (reviewing C. WARREN, *THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW* (1982)).

6. See R. REISNER, *LAW AND THE MENTAL HEALTH SYSTEM* 319-20 (1985) (discussing the difference between a state's police power and its *parens patriae* power). Together, the police power and the *parens patriae* power provide the legal foundation for state laws regarding civil commitment of the mentally disabled. When the state seeks to hospitalize a mentally disabled individual because he or she is dangerous to others, it is acting under its police power. When the state seeks to hospitalize a mentally disabled individual because he or she is dangerous to himself or herself, it is acting under its *parens patriae* power.

7. See S. HERR, S. ARONS & R. WALLACE, *LEGAL RIGHTS AND MENTAL-HEALTH CARE* 3 (1983). The authors observe:

Until recently, action to secure the enforceable legal rights of consumers of mental-health care was almost nonexistent. . . . In the wake of the civil-rights movement of the 1960s and the growth of public legal services in the 1970s, these patterns began to change.

. . . Legislative reforms and court decisions accelerated the release of patients from large mental institutions, tightened procedures for admission or commitment, and enunciated patients' rights by setting minimum standards of care and other remedies.

Id. (footnote omitted); see also PRESIDENT'S COMM'N ON MENTAL HEALTH, *REPORT TO THE PRESIDENT* 3-4 (1978).

8. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974), *redecided*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *redecided*, 413 F. Supp. 1318 (E.D. Wis. 1976) (minimal due process requirements should be met in cases of involuntary commitment, including notice and opportunity to be heard, application of specified standards for commitment, provision of counsel, and application of rules of evidence).

9. See, e.g., IDAHO CODE § 66-329(i) (1980) (restricting criteria for extended confinement of the mentally ill in terms of both evidentiary weight and substantive criteria: "If, upon completion of the hearing and consideration of the record, the court finds beyond a reasonable doubt that the proposed patient (1) is mentally ill or mentally retarded, and (2) is, because of his ailment, likely to injure himself or others, it shall order his commitment . . ."). *But see* N.Y. MENTAL HYG. LAW § 9.01 (McKinney 1978 & Supp. 1985) (providing in part: "'in need of involuntary care and treatment' means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment"); *id.* § 9.31 (providing involuntary hospitalization of persons in need of care and treatment without specifying an evidentiary standard to be applied in making such a determination); *cf. In re Rochman*, 104 Misc. 2d 218, 428 N.Y.S.2d 168 (N.Y. Sup. Ct. 1980) (holding that when psychiatric patient applied for a hearing to determine the need for involuntary care and treatment, he did not have the burden of proving by a fair

the least restrictive alternative disposition requirement.¹⁰ While the development of procedural rights raises obstacles to the imposition of effective treatment, this development, on the whole, has been desirable. On the other hand, the constriction of commitment criteria and the formulation and requirement of the least restrictive alternative for disposition have been mistaken: these developments raise inappropriate barriers to providing effective treatment to persons who are in need of such treatment.

II. PROCEDURAL REQUIREMENTS IN INVOLUNTARY CIVIL COMMITMENT

Through a series of cases the United States Supreme Court clearly has established that involuntary civil commitment in a state facility constitutes an invasion of an individual's constitutionally protected interests and therefore requires compliance with due process.¹¹ *Specht v. Patterson*,¹² decided in 1967, established that labeling state commitment proceedings as "civil" rather than "criminal" was constitutionally insignificant. The Court held that a convicted criminal defendant who faced indefinite "civil" commitment under a sex offender statute was entitled to the protections afforded by the due process clause¹³—notice, a full hearing, the right to be present at that hearing, and the right to be represented by counsel.

In 1972 the Court decided *Jackson v. Indiana*,¹⁴ which involved a commitment following a finding of incompetence to stand trial. Jackson's commitment was attacked on the ground that the State had violated his equal protection and due process rights by not providing the procedural protection otherwise available to

preponderance of evidence that he could be released safely; rather, the state had the burden of establishing by 'clear and convincing proof' that the patient was mentally ill and needed treatment). *But cf. In re Hurley*, 104 Misc. 2d 582, 428 N.Y.S.2d 604 (N.Y. Sup. Ct. 1980) (patient who, after a period of confinement, filed petition for a hearing to determine the need for involuntary care and treatment had the burden of proving by a fair preponderance of the evidence that he could be released safely).

10. *See, e.g., Lake v. Cameron*, 364 F.2d 657, 661 (D.C. Cir. 1966) (construing the District of Columbia mental health care law to require that the least drastic method of treatment be provided); *see also* ILL. ANN. STAT. ch. 91½, § 3-81 (Smith-Hurd Supp. 1985) (providing in part: "The court shall order the least restrictive alternative for treatment which is appropriate.").

11. *See infra* notes 12-30 and accompanying text.

12. 386 U.S. 605 (1967).

13. *Id.* at 608.

14. 406 U.S. 715 (1972).

those facing civil commitment in Indiana.¹⁵ The Court held that if a person charged with a criminal offense and adjudicated incompetent has no substantial probability of regaining competency in the foreseeable future, then the state must either institute customary civil commitment proceedings accompanied by the appropriate procedural protections or release the person.¹⁶

In *O'Connor v. Donaldson*,¹⁷ decided in 1975, the Court considered what state interests constitutionally would support involuntary commitment. The Court held that a state's interest in providing minimal living standards joined with the interest in protecting its citizens from exposure to the mentally ill were not sufficient grounds for involuntary commitment.¹⁸ *O'Connor v. Donaldson* thus suggests that the only constitutionally recognized grounds for involuntary commitment are preventing injury to the public, ensuring the mentally ill person's own survival or safety, or alleviating or curing the mental illness.

In *Addington v. Texas*,¹⁹ decided in 1979, the Court considered the burden of proof necessary for involuntary civil commitment. In reflecting on this issue, the Court noted that commitment constituted a significant deprivation of liberty and that adverse social consequences, such as enduring stigmatization, were likely to accompany any commitment of a person to a mental institution.²⁰ In light of these significant intrusions on a defendant's rights, the Court held that proof by a preponderance of the evidence was insufficient and that the heavier burden of proof by clear and convincing evidence was necessary to sustain an involuntary commitment.²¹ Nevertheless, the Court did distinguish civil commitment proceedings from criminal proceedings in ultimately concluding that proof beyond a reasonable doubt, the standard in criminal cases, was not constitutionally required in civil commitment proceedings.²²

In another 1979 case, *Parham v. J.R.*,²³ the Court continued to give attention to the procedural requirements for civil commitment. *Parham* concerned a Georgia statute that authorized parents

15. *Id.* at 723.

16. *Id.* at 738.

17. 422 U.S. 563 (1975).

18. *Id.* at 575-76.

19. 441 U.S. 418 (1979).

20. *Id.* at 426-27.

21. *Id.* at 432-33.

22. *Id.*

23. 442 U.S. 584 (1979).

or guardians to involuntarily commit minors to state hospitals upon an admitting physician's finding of mental illness following a careful examination and medical diagnosis.²⁴ The Court held that due process required inquiry by a neutral factfinder to insure that statutory commitment requirements were satisfied but did not require that the inquiry be conducted by a judicial officer or that the factfinder hold an adversary hearing.²⁵ Thus, a commitment decision following examination by the proper medical authority was sufficient to justify commitment.²⁶

In *Youngberg v. Romeo*,²⁷ decided in 1982, the Court again turned its attention to the due process requirements for treatment following civil commitment. The Court found that under the due process clause involuntarily committed retarded persons had constitutionally protected liberty interests in reasonably safe conditions, freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably may be required.²⁸ The Court held that the proper standard for determining whether a state adequately had protected such rights was whether professional judgment in fact had been exercised.²⁹ The Court found that qualified professional judgment was entitled to a presumption of correctness and that liability could be imposed only when a treatment decision represented such a substantial departure from accepted professional judgment as to demonstrate that the decision had not been based on professional judgment.³⁰

On the one hand, these decisions establish that not all of the procedural safeguards available to criminal defendants must be accorded to persons subject to commitment. One important difference between civil commitment and criminal prosecution is that the civil commitment process is concerned with predictions of dangerous or socially detrimental behavior rather than establishing a past criminal act that deserves punishment. On the other hand, the Supreme Court has established that some degree of procedural due process must be provided before the state may forcibly deprive a mentally ill person of his liberty. Although the Court has not definitively determined the type of hearing required for civil com-

24. *Id.* at 591.

25. *Id.* at 606-08.

26. *Id.* at 616.

27. 457 U.S. 307 (1982).

28. *Id.* at 324.

29. *Id.* at 323.

30. *Id.*

mitment under the due process clause, on the basis of the Court's lead state courts and legislatures have recognized a range of civil rights of persons who are subject to involuntary commitment; these include: prior notice,³¹ an opportunity to be heard,³² the right to counsel,³³ and the right to judicial review of an initial commitment order.³⁴

These precommitment procedural safeguards were enhanced from a concern more with accurately determining the factual basis of a commitment than with maximizing the liberty interest of the person subject to such a proceeding.³⁵ Consequently, after the factual basis for civil commitment is determined, attention is then

31. See, e.g., ILL. ANN. STAT. ch. 91½, § 3-206 (Smith-Hurd Supp. 1985); see also *Doremus v. Farrell*, 407 F. Supp. 509, 515 (D. Neb. 1975) (discussing the requirements of prior notice under Nebraska law).

32. See, e.g., ILL. ANN. STAT. ch. 91½, § 3-205 (Smith-Hurd Supp. 1985); see also *Stamus v. Leonhardt*, 414 F. Supp. 439, 447 (S.D. Iowa 1976) (holding that the restriction on the plaintiff's right to be present during her civil commitment hearing was an unconstitutional deprivation of her due process rights).

33. See, e.g., ILL. ANN. STAT. ch. 91½, §§ 3-205, 3-805 (Smith-Hurd Supp. 1980); see also *Lynch v. Baxley*, 386 F. Supp. 378, 389 (M.D. Ala. 1974) (noting that the subject of an involuntary civil commitment proceeding has a right to have counsel present during all significant stages of the commitment process), *rev'd on other grounds*, 651 F.2d 387 (5th Cir. 1981).

34. See, e.g., ILL. ANN. STAT. ch. 91½, § 3-816 (Smith-Hurd Supp. 1985).

35. For an example of this type of reasoning, see *Moss v. State*, 539 S.W.2d 936 (Tex. Civ. App. 1976), in which the court held that the privilege against self-incrimination could not be invoked to preclude the admission of the testimony of examining experts. The court reasoned:

The Supreme Court's unwillingness to apply criminal due process requirements inflexibly to all proceedings involving involuntary incarceration is demonstrated in *McKeiver v. Pennsylvania*, in which the Court held that due process does not require trial by jury in a juvenile delinquency case. Likewise, in *Morrissey v. Brewer*, which involved the application of due process guarantees to proceedings for revocation of parole, the Court reaffirmed previous declarations that due process is flexible and calls for such procedural protection as the particular situation demands, and that a determination of what process is due requires a determination of the precise nature of the governmental function involved and the private interest affected.

. . . .

. . . So far as untrustworthiness is concerned, the opinion of a physician based on the patient's statement to him is likely to be more reliable than the opinion of the same physician if based on the statements of other witnesses who must rely on their own casual and untrained observation. Although an examination ordered by the court may be coercive to some extent, particularly if the patient is under detention, no particular answer is as likely to be coerced as when the inquiry is whether the person in question committed a particular criminal act. Consequently, we do not consider such a compelled examination inhumane or likely to produce an untrustworthy result to the same extent as a confession of crime elicited by interrogation of an accused person in custody of the police.

Id. at 945-46 (citations omitted).

properly directed at determining the proper treatment for the involuntarily committed patient.³⁶ Judicial attention on proper treatment is rooted in the view articulated in Chief Justice Burger's *Addington v. Texas* opinion in which he observed that "the state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves."³⁷ Significantly, the Supreme Court has deemed that the best way to protect the treatment rights of the patient is to defer the determination of proper and effective programs of treatment and training to the judgment of medical authorities.³⁸

On the whole, the Supreme Court's decisions evidence a bal-

36. See, for example, ILL. ANN. STAT. ch. 91½, § 3-811 (Smith-Hurd Supp. 1985), which provides:

If any person is found subject to involuntary admission, the court shall consider alternative mental health facilities which are appropriate for and available to the respondent, including but not limited to hospitalization. The court may order the respondent to undergo a program of hospitalization or alternative treatment in a mental health facility designated by the Department; in a licensed private hospital or private mental health facility if it agrees; or in a facility of the United States Veterans Administration if it agrees; or the court may place the respondent in the care and custody of a relative or other person willing and able to properly care for him. The court shall order the least restrictive alternative for treatment which is appropriate.

See also *id.* § 3-814, providing in part:

Not more than 30 days after admission under this Article, the facility director shall file a current treatment plan with the court which includes an evaluation of the patient's progress and the extent to which he is benefiting from treatment. The court shall review the treatment plan. . . . The patient or an interested person on his behalf may request a hearing or the court on its own motion may order a hearing to review the treatment plan. If the court is satisfied that the patient is benefiting from treatment, it may continue the original order for the remainder of the admission period. If the court is not so satisfied, it may modify its original order or it may order the patient discharged.

37. 441 U.S. at 426.

38. See *Youngberg v. Romeo*, 457 U.S. 307 (1982). Mr. Justice Powell, writing for the majority, observed:

In determining what is "reasonable"—in this and in any case presenting a claim for training by a State—we emphasize that courts must show deference to the judgment exercised by a qualified professional. By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized. Moreover, there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions. (Courts should not "second-guess the expert administrators on matters on which they are better informed"). For these reasons, the decision, if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.

Id. at 322-23 (citations and footnotes omitted).

anced judicial concern with patient rights.³⁹ The early civil commitment cases emphasized the civil rights of patients by requiring procedural safeguards and demanding that the state establish a proper basis for any restrictions on liberty.⁴⁰ Subsequent cases revealed an emerging concern with clinical or treatment rights.⁴¹ Establishing a burden of proof that lies between that used in civil cases and that used in criminal cases demonstrates the Court's sensitivity to the need for balancing the individual's interest in personal liberty against the state's interest in providing that person with needed treatment.⁴² The most recent cases reveal an even greater concern with the clinical needs of patients.⁴³ Deference to the judgment of admitting physicians as a basis for involuntary commitment of juveniles⁴⁴ and recognition of professional judgment in decisions on treatment modalities in civil commitment of retarded persons⁴⁵ suggest that the Court is concerned with maintaining a proper balance between protecting civil liberties and providing effective treatment.

39. Supreme Court decisions have established a series of due process rights that fall short of those provided to criminal suspects but that nonetheless are directed at guaranteeing the trustworthiness of the determinations needed to make a civil commitment decision. At the same time the Court has evidenced a concern with providing civilly committed persons with needed treatment; although here too the Court has taken care to avoid judicial control of clinical judgments and setting treatment standards that are not feasible given institutional and financial constraints. See generally Monahan, *Three Lingering Issues in Patient Rights*, in *PSYCHIATRIC PATIENT RIGHTS AND PATIENT ADVOCACY: ISSUES AND EVIDENCE* 264-65 (B. Bloom & S. Asher eds. 1982) (examining the differences both in nature and success in advocacy of procedural and treatment rights).

40. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974), *redecided*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *redecided*, 413 F. Supp. 1318 (E.D. Wis. 1976) (holding that minimal due process requirements must be met in cases of involuntary hospitalization).

41. See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563 (1975) (holding that custodial confinement without treatment was constitutionally deficient for nondangerous individuals capable of living in freedom by themselves or with the help of family and friends).

42. *Addington v. Texas*, 441 U.S. 418 (1979) (holding that in cases of involuntary civil commitment, the standard of proof required by the fourteenth amendment is clear and convincing evidence that the person is mentally ill).

43. See, e.g., *Youngberg v. Romeo*, 457 U.S. 307 (1982) (holding that mentally retarded residents of state institutions have constitutional rights to the basic necessities of life, reasonably safe living conditions, freedom from undue restraints, and the minimally adequate training needed to enhance or further their abilities to exercise other constitutional rights).

44. See *Parham v. J.R.*, 442 U.S. 584 (1979) (holding that parents have plenary authority, subject to independent medical judgment, to commit their children to a state mental hospital without a formal precommitment hearing).

45. See *Youngberg v. Romeo*, 457 U.S. 307 (1982) (holding that decisions made by mental health professionals are presumptively valid).

The judicial reform of commitment law has been limited largely to procedural matters with which the courts properly feel most qualified to deal. Courts have demonstrated a pronounced reluctance to alter the substantive basis for commitment, which has been viewed as essentially involving medical criteria. Instead, state legislatures have been the locus of change in the substantive criteria for commitment.

III. SUBSTANTIVE BASES FOR INVOLUNTARY CIVIL COMMITMENT

While commitment criteria vary from state to state, most states have adopted substantive standards for commitment that employ two elements. First, all states require that an individual must be found mentally ill as determined by medical authorities.⁴⁶ The second element varies in form and scope from state to state. Most states allow commitment upon a showing that an individual is dangerous to self or others.⁴⁷ For instance, in California a person may be certified for a one hundred and eighty day commitment period if "[t]he person had attempted, or inflicted physical harm upon the person of another, that act having resulted in his or her being taken into custody and who presents, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm upon others."⁴⁸ Some state legislatures and courts require that dangerousness be established by a recent overt act or threat.⁴⁹

A few states also allow commitment of those who are gravely disabled.⁵⁰ Several states do not use the term "gravely disabled"

46. See, e.g., ALA. CODE § 22-52-10(a)(1) (1984) (requiring a finding "that the person sought to be committed is mentally ill").

47. See, e.g., N.M. STAT. ANN. § 43-1-11(c) (1984) (providing for involuntary commitment upon a finding by clear and convincing evidence that: "(1) as a result of mental disorder, the client presents a likelihood of serious harm to himself or others; (2) the client needs and is likely to benefit from the proposed treatment; and (3) the proposed commitment is consistent with the treatment needs of the client and with the least drastic means principle").

48. CAL. WELF. & INST. CODE § 5-300(h) (West 1984).

49. See, e.g., ALA. CODE § 22-52-10(3) (1984) (requiring "that the threat of substantial harm has been evidenced by a recent overt act"); see also ARIZ. REV. STAT. ANN. § 36-501(3)(Supp. 1984) (providing that danger to others must be "based upon a history of either: (a) [h]aving seriously threatened, in the recent past by verbal or nonverbal acts or both, to engage in behavior which will likely result in serious physical harm to another person, . . . [or] (b) [h]aving inflicted or having attempted to inflict serious physical harm upon another person within one hundred eighty days preceding the fixing of the petition").

50. See, e.g., CONN. GEN. STAT. ANN. § 17-178(c) (West Supp. 1985) (providing in part: "If, on such hearing, the court finds by clear and convincing evidence that the person complained of is mentally ill and dangerous to himself or herself or others or *gravely disabled*, it

when setting forth substantive commitment criteria but nevertheless set forth descriptions of conditions that may fairly be considered equivalent to a standard of "grave disability."⁵¹ For instance, Florida permits commitment of a person if "[h]e is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, he is likely to suffer from neglect or refuse to care for himself, and such neglect or refusal poses a real and present threat of substantial harm to his well-being."⁵² Illinois permits commitment of a "person who is mentally ill and who because of his illness is unable to provide for his basic physical needs so as to guard himself from serious harm."⁵³ Finally, some states, such as New Jersey⁵⁴ and New York,⁵⁵ merely require a showing that an individual is in need of treatment.

Many of the present civil commitment criteria are the products of a twenty year reform effort.⁵⁶ The statutory reform was

shall make an order for his or her commitment, considering whether or not a less restrictive placement is available, to a hospital for mental illness to be named in such order, there to be confined for the period of the duration of such mental illness or until he or she is discharged in due course of law") (emphasis added).

51. See, e.g., VT. STAT. ANN. tit. 18, § 7101(17)(B)(ii) (Supp. 1985) (providing that a person may be shown to pose a danger to himself by establishing that "he has behaved in such a manner as to indicate that he is unable, without supervision and the assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration or serious physical debilitation or disease will ensue unless adequate treatment is afforded").

52. FLA. STAT. ANN. § 394.467(1)(b)(1)(b)(I) (Supp. 1985).

53. ILL. ANN. STAT. ch. 91½, § 1-119(2) (Smith-Hurd Supp. 1985).

54. N.J. STAT. ANN. §§ 30:4-44, 30:4-45 (West 1977) (providing that the court shall determine whether the respondent is suffering from mental illness). The Code provides: "'Mental illness' shall mean mental disease to such an extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community." *Id.* § 30:4-23.

55. N.Y. MENTAL HYG. LAW § 9.32 (McKinney 1978 & Supp. 1985) (providing for a "hearing on the question of need for involuntary care and treatment"). The Code provides: "'in need of care and treatment' means that a person has a mental illness for which inpatient care and treatment in a hospital is appropriate." *Id.* § 9.01.

56. See generally Peele, *supra* note 3, at 285. The report states:

Because of renewed concern about the civil rights of the mentally ill, the pendulum swung again in the early 1960's to more extensive procedures and narrow admission criteria. Standards emphasizing that for commitment a patient must be dangerous as well as mentally ill, limitations on the loss of rights of patient, mandatory times of judicial review, and an increase in procedural safeguards became prominent in the standards legislated in the 1960's and 1970's. While some states still consider the need for psychiatric treatment an adequate criterion for involuntary treatment, by and large state legislation requires that the individual be not only mentally ill but also likely to harm others, likely to harm himself, or likely to be harmed if not hospitalized.

Id.

prompted by an increase in concern for civil liberties⁵⁷ and by empirical studies providing evidence of poor diagnosis and treatment.⁵⁸ Legislatures increasingly have restricted their reliance on *parens patriae* as a justification for commitment and have substituted instead a greater reliance on police power.⁵⁹ Thus, there has been a general movement away from a concern for a person's treatment needs and toward a concern for a person's dangerousness.⁶⁰ By placing stress on the legal concept of dangerousness rather than on the medical concept of need for treatment, legislatures have chosen a legal rather than a medical or psychiatric model of commitment.⁶¹ This narrow legal analytical framework results in a substantial rejection of and insensitivity to psychiatric concerns and ignores the basic needs of the mentally ill.⁶² Thus, while procedural

57. See, e.g., Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968); see also Ennhis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101 (1971).

58. See, e.g., Dix, *Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 WASH. U.L.Q. 485, 503-21 (1968); see also Wexler & Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1 (1971).

59. See *supra* notes 47-49 and accompanying text.

60. States limiting involuntary commitment to those mentally ill persons who are dangerous to themselves or others include: ALA. CODE § 22-52-37(a)(7) (1984) (adopted in 1975); D.C. CODE ANN. § 21-545(b) (1981) (adopted in 1965); HAWAII REV. STAT. § 334-602 (Supp. 1984) (adopted in 1984); KY. REV. STAT. ANN. § 202A.026 (Baldwin 1982) (adopted in 1982); ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(E) (Supp. 1985) (adopted in 1983); MD. HEALTH-GENERAL CODE ANN. § 10-617(a) (Supp. 1985) (adopted in 1982); N.H. REV. STAT. ANN. § 135-B:26 (1977) (adopted in 1973); N.M. STAT. ANN. § 43-1-11(c) (1984) (adopted in 1977); N.C. GEN. STAT. § 122-58.7(i) (Supp. 1983) (adopted in 1973); PA. CONS. STAT. § 4405 (1969 & Supp. 1985) (adopted in 1966); TENN. CODE ANN. §§ 33-6-103, -104 (Supp. 1985) (adopted in 1965); W. VA. CODE § 27-5-4(d) (Supp. 1985) (adopted in 1955).

61. See Dershowitz, *Psychiatry in the Legal Process: A Knife That Cuts Both Ways*, in *THE PATH OF THE LAW FROM 1967*, 82-83 (A. Sutherland ed. 1968). The author urges the adoption of a legal rather than a medical model for development of the civil commitment law; Professor Dershowitz argues that "no legal rule should ever be phrased in medical terms; that no legal decision should ever be turned over to the psychiatrist; that there is no such thing as a legal problem which cannot—and should not—be phrased in terms familiar to lawyers. And civil commitment of the mentally ill is a legal problem; whenever compulsion is used or freedom denied—whether by the state, the church, the union, the university, or the psychiatrist—the issue becomes a legal one; and lawyers must be quick to immerse themselves in it." *Id.* But see Stone, *Comment*, 132 AM. J. PSYCHIATRY 829-31 (1975) (maintaining that the purpose of civil commitment is not for legal control but for treatment; for example, hospitalization in the case of suicidal or homicidal behavior is not for the purpose of preventing that behavior but for the purpose of treating the underlying disorder).

62. See Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496, 498 (1976). The author argues: "Despite the revisionist efforts of the anti-psychiatrist, mental illness *does* exist . . . [I]t does encompass those few desperately sick people for whom involuntary commitment must be considered." *Id.* (emphasis added).

safeguards are necessary to prevent abuse of involuntary commitment, medical criteria other than dangerousness are necessary to provide a means for meeting the treatment needs of the mentally ill, particularly those who are incompetent to make treatment decisions.⁶³

Civil commitment traditionally has been justified on the grounds that it protects the mentally ill from harming themselves or others and provides them with care, custody, and treatment.⁶⁴ The use of state power to prevent harm to others is clearly an exercise of police power,⁶⁵ while state enforced treatment is an exercise of *parens patriae* power.⁶⁶ Preventing harm to self involves both police power and *parens patriae* power. The revisions of civil com-

According to Chordoff, the criteria for involuntary treatment should include: (1) the presence of a mental illness, (2) a serious disruption of functioning together with an impairment of judgment of such a degree that the individual is incapable of considering his condition and making decisions about it in his own interest, and (3) the need for care and treatment. *Id.* at 498-99; see also Stone, *supra* note 61, at 830. Stone maintains that psychiatry involves the identification of the presence of clinical states and of the appropriate interventions or treatment to remedy those conditions.

63. See Klein, *Legal Doctrine at the Crossroads, Mental Health Law Project Summary of Activities* 7, 8 (Mar. 1976). The author provides examples of the type of nondangerous persons who need treatment but who are not likely to be voluntary patients:

For example, some depressed people believe they are unworthy of help. There are also paranoids who reject treatment on such grounds as that the psychiatrist "is a CIA agent who will plant a tape recorder in my head." And, perhaps most significantly, there are numerous extremely passive people, including many elderly, who simply will not seek treatment on their own. If they are not treated involuntarily and here I think the concept of "involuntariness" is largely metaphysical—we know by recent experience that many of them will wander aimlessly through our blighted inner cities, subject to a host of dangers.

Id.; see also Peele, *supra* note 3, at 270-71 (noting that the legal system needs to reconsider the commitment law reforms of the last two decades, which have contributed to the plight of the homeless mentally ill and have made it too easy for those who need help to refuse treatment).

It should be noted that the Supreme Court in *O'Connor v. Donaldson* explicitly declined to address the question "whether the [s]tate may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment." 422 U.S. 563, 573 (1975). So at present, there is no constitutional barrier to involuntarily committing the nondangerous mentally ill.

64. See, e.g., *Jones v. United States*, 463 U.S. 354, 368 (1983) ("The purpose . . . of civil commitment, is to treat the individual's mental illness and protect him and society from his potential dangerousness.").

65. See, e.g., *Rogers v. Okin*, 634 F.2d 650, 654 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982) (noting that under its police power, "the state has a legitimate interest in protecting persons from physical harm at the hands of the mentally ill").

66. *Id.* at 657 (observing that [t]here is no doubt that [t]he state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable to care for themselves'") (quoting *Addington v. Texas*, 441 U.S. 418, 426 (1979)).

mitment law in the direction of a single standard of dangerousness⁶⁷ therefore reflect a determination that *parens patriae* standing alone is an insufficient basis for commitment of the incompetent mentally ill.⁶⁸

The grounds for rejecting the *parens patriae* standards of "grave disability" and "need of mental treatment" include an asserted unreliability of medical diagnosis;⁶⁹ a failure of statutes and regulations to define mental illness adequately;⁷⁰ a judgment that treatment often is not provided or not successful;⁷¹ and a concern with loss of liberty, stigmatization, and invasion of privacy.⁷² The United States District Court for the District of Nebraska applied this rationale in *Doremus v. Farrell*,⁷³ decided in 1975. The court reasoned as follows:

Considering the fundamental rights involved in civil commitment, the *parens patriae* power must require a compelling interest of the state to justify the deprivation of liberty. In the mental health field, where diagnosis and treatment are uncertain, the need for treatment without some degree of imminent harm to the person or dangerousness to society is not a compelling justification To permit involuntary commitment upon finding of "mental illness" and the need for treatment alone would be tantamount to condoning the State's commitment of persons deemed socially undesirable for the purpose of indoctrination or conforming the individual's beliefs to the beliefs of the State. Due process and equal protection require that the Standards for

67. See, e.g., *State ex rel Hawks v. Lazaro*, 202 S.E.2d 109, 123 (W. Va. 1974) (stating that "[s]ociety is entitled to protect itself against predatory acts on the part of the anti-social people, regardless of the cause of their anti-social actions. Therefore, if the state can prove that an individual is likely to injure others if left at liberty, it may hospitalize him. The state is also entitled to prevent a person from injuring himself in the very specific sense of doing physical damage to himself, either actively or passively.").

68. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093-94 (E.D. Wis.), *vacated*, 414 U.S. 473 (1974) (holding that a finding of dangerousness was required for a constitutionally valid civil commitment).

69. See, e.g., *Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 707 (1974) (concluding that the empirical data revealed that psychiatrists could not reliably make judgments about the need for hospitalization and treatment, and the effects of hospitalization and treatment).

70. See, e.g., *Livermore, Malmquist & Meehl, On the Justification for Civil Commitment*, 117 U. PA. L. REV. 75, 80 (1968) (concluding that the definition of "mental illness" was dependent on the norms of adjustment applied by the mental health professional, effectively masked the actual norms being applied and was thus expandable to include anyone the case worker chose to so classify.)

71. See, e.g., *Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide*, 49 N.Y.U. L. REV. 227, 256 (1974) (reporting that few controlled studies of the effectiveness of treatment measures had been reported and concluding that these results had been either inconsistent or negative).

72. See, e.g., T. SZASZ, *LAW LIBERTY AND PSYCHIATRY* 40-41 (1963) (arguing against compulsory hospitalization of mentally ill persons because of the extensive deprivations of civil rights that commitment entails).

73. 407 F. Supp. 509 (D. Neb. 1975).

commitment must be (a) that the person is mentally ill and poses a serious threat of substantial harm to himself or to others; and (b) that this threat of harm has been evidenced by a recent overt act or threat. The threat of harm to oneself may be through neglect or inability to care for oneself.⁷⁴

At one level this reasoning fails to recognize the reality of mental illness, which can be debilitating to the person and provide a real source of social disruption.⁷⁵ The view expressed by the *Doremus* court—particularly its labeling of mental health treatment as a process of “indoctrination”—demonstrates a hostility toward and lack of understanding of mental health treatment. On another level this reasoning is simply inconsistent with the scope of the dangerousness standard. To the extent that the dangerousness standard includes “threat of harm to oneself,” it is broad enough to permit commitment on exactly the same basis as a “need of treatment” or “incompetence” standard. Ironically, those courts and legislatures that have adopted reasoning similar to the *Doremus* court’s and explicitly have rejected need of treatment as a grounds for commitment nevertheless implicitly have recognized incompetence as a basis for *parens patriae* commitments.⁷⁶ They manifest this recog-

74. *Id.* at 514-15.

75. See Treffert, *Dying with Their Rights On*, 130 AM. J. PSYCHIATRY 1041, 1041 (1973) (reporting that under a law that provided commitment only upon a showing of “‘extreme likelihood that if the person is not confined he will do immediate harm to himself or others’ . . . a 49-year-old anorexic woman starved herself to death; a 70-year-old man died a self-perpetuating, metabolic, toxic death; and a 19-year-old student, while unable to qualify for commitment under the new guidelines, was able to hang herself. Each of these patients needed commitment; none qualified. Each outcome was entirely predictable. Each of these patients went to his or her grave with his rights entirely intact.”) (emphasis in original).

76. See, e.g., TEX. REV. CIV. STAT. ANN. art. 5547-50(b) (Vernon Supp. 1984-85). The statute provides:

Upon the hearing, the judge or the jury, if one has been requested, shall determine that the person requires court-ordered mental health services only if it finds, on a basis of clear and convincing evidence, that: (1) the person is mentally ill; and (2) as a result of that mental illness the person: (i) is likely to cause serious harm to himself; or (ii) is likely to cause serious harm to others; or (iii) will, if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress and will continue to experience deterioration of his ability to function independently and is unable to make a rational and informed decision as to whether or not to submit to treatment.

Id. (emphasis added); see also *Colyar v. Third Judicial Dist. Ct.*, 469 F. Supp. 424 (D. Utah 1979). The *Colyar* court held:

Given that in order to be involuntarily committed a mentally-ill person must be shown to be a danger to himself or others, and that such danger may include the incapacity to provide the basic necessities of life, the court feels constrained to hold that the state must also show that the individual is incapable of making a rational choice regarding the acceptance of care or treatment.

. . . .
 . . . [T]he involuntary commitment of the mentally ill under the *parens patriae* power must reflect the following considerations: The committing authority must find,

nition whenever they permit commitment on a showing that a person is "unable to provide for his basic personal needs and is not receiving such care as is necessary for his health or safety,"⁷⁷ which on its face should include an inability to understand one's need for mental health treatment or an inability to obtain such treatment. What is needed is further statutory reform that will give explicit recognition to incompetence as a basis for commitment.

Courts and legislatures must recognize that the dangerousness criteria for civil commitment has serious problems. Empirical studies reveal that psychiatrists and sociologists are notoriously inaccurate at predicting dangerousness and in fact have a pronounced tendency to overpredict.⁷⁸ The most effective predictive criteria yield a sixty to seventy percent false positive rate—persons incorrectly predicted as dangerous.⁷⁹ Moreover, psychiatrists rarely claim to be able to treat dangerousness.⁸⁰ The assertion that dangerousness results from mental illness and will be eliminated by treatment is simply unsubstantiated. By making dangerousness the principal substantive criterion, legislatures have chosen to base civil commitment on the very criterion that the mental health system is least able to diagnose and treat.⁸¹ At a minimum, courts and legislatures should supplement the dangerousness standard by requiring a finding that the person is likely to respond to available treatment. Otherwise, civil commitment becomes merely a form of preventive detention.⁸² Furthermore, if nontreatable, dangerous

as a threshold requirement, that the proposed patient is incapable of making a rational treatment decision. The purpose of this requirement is to require the committing court to "distinguish between those persons whose decisions to refuse treatment must be accepted as final from those whose choices may be validly overridden through *parens patriae* commitment."

Id. at 431, 434 (quoting *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1216 (1974)).

77. OR. REV. STAT. § 426.005(2) (1983).

78. See Coccozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084, 1085 (1976).

79. See Ennis & Litwack, *supra* note 69, at 714.

80. See B. ENNIS & R. EMORY, *THE RIGHTS OF MENTAL PATIENTS* 46-47 (1978) (reporting that no method of treatment, including behavioral conditioning, has been shown to be successful in reducing dangerous behavior in mentally ill persons).

81. See A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 36-37 (1975) (suggesting that there is little evidence that mental disorders and the dangerous behaviors that supposedly ensue from them are particularly ameliorable through mental health treatments).

82. See, e.g., *People v. Sansone*, 18 Ill. App. 3d 315, 323-24, 309 N.E.2d 733, 739, *leave to appeal denied*, 56 Ill. 2d 584 (1974) (holding that a person committed as mentally ill and dangerous to self or others was entitled to treatment to alleviate his condition). See generally Dershowitz, *Preventive Confinement*, 51 TEX. L. REV. 1277 (1973).

persons are to be civilly committed, the reliability of prediction should be increased by requiring the finding of a recent overt dangerous act,⁸³ and confinement should be for a limited fixed period under a rubric of crisis intervention.⁸⁴ Better yet, the criminal justice system should deal with nontreatable, dangerous persons by explicitly adopting a scheme of preventive detention.⁸⁵ Once courts and legislatures recognize the inherent problems of a civil commitment system based on dangerousness criteria, they can begin to develop further the standards for therapeutic commitment.

The elimination of the "need of treatment" standard standing alone may be necessary to avoid imposition of treatment when a person is competent to make treatment decisions.⁸⁶ There is a need, however, to create a statutory basis for providing treatment for those who are mentally ill and not capable of evaluating their own condition and making an appropriate treatment decision.⁸⁷

83. See generally Comment, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562 (1977). Various state statutes now include provisions requiring an overt act to establish dangerousness. See ALA. CODE § 22-52-10(a)(3) (1984) (providing "that the threat of substantial harm has been evidenced by a recent overt act"); see also MICH. COMP. LAWS ANN. § 330.1401(a) (West 1980) (providing for commitment of "[a] person who is mentally ill, and as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or made significant threats that are substantially supportive of the expectation").

84. See generally Peszke, *Is Dangerousness an Issue for Physicians in Emergency Commitment?*, 132 AM. J. PSYCHIATRY 825 (1975).

85. See Note, *Mental Illness: A Suspect Classification?*, 83 YALE L.J. 1237, 1261-62 (1974) (suggesting that the dangerous mentally ill are no more dangerous than the dangerous nonmentally ill, so that the grounds for involuntary institutionalization creates a grossly underinclusive class). See generally Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54, 67 (1982) (arguing for the abolition of involuntary civil commitment but acknowledging the need to confine those people who have demonstrated dangerous behavior).

86. See *Commonwealth ex rel. Finken v. Roop*, 234 Pa. Super. 155, 339 A.2d 764 (1975), cert. denied, 424 U.S. 960 (1976) (holding that an involuntary commitment requirement that a person be "in need of care at a [mental health] facility" was overbroad and vague); see also *Colyar v. Third Judicial Dist. Ct.*, 469 F. Supp. 424 (D. Utah 1979) (invalidating as unconstitutionally vague a statute that authorized civil commitment of a mentally ill individual in need of custodial care and treatment in a mental health facility and lacking insight to make responsible decisions about his need for care and treatment; the statute failed to require the committing authority to determine whether the person's refusal was rational).

87. Recent studies establish that a large percentage of current mental patients lack capacity to make informed decisions concerning treatment. See Appelbaum, Murkin & Bateman, *Empirical Assessment of Competency to Consent to Psychiatric Hospitalization*, 138 AM. J. PSYCHIATRY 1170 (1981); Olin & Olin, *Informed Consent in Voluntary Hospital Admissions*, 132 AM. J. PSYCHIATRY 938 (1975); Pryce, *Clinical Research upon Mentally Ill Subjects Who Cannot Give Informed Consent*, 133 BRIT. J. PSYCHIATRY 366 (1978).

This *parens patriae* concern may be met by an additional or alternative standard other than "dangerousness." The commitment criteria should be enlarged to provide that those mentally ill persons who need treatment and who are incapable of exercising a rational choice between seeking treatment or continuing in their present situation can be involuntarily treated.⁸⁸ While it makes no sense to presume incompetence from the fact of mental illness alone,⁸⁹ it also does not make sense to presume that all mentally ill persons are competent to make a rational treatment decision.⁹⁰ Insuring that its citizens have a minimal opportunity to assert their human autonomy and freedom in a rational fashion should be recognized as a compelling state interest justifying the use of the state's coercive power.⁹¹

A standard that would satisfy this treatment need might be formulated as follows: Commitment is permitted for a person who is mentally ill and in need of care or treatment in a mental hospital but because of illness lacks sufficient insight or capacity to make a rational decision concerning treatment.⁹² This standard

88. See Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275, 302 (1983) (reporting that individuals afflicted with severe mental disorders may be unable to pay attention or assimilate information, or disorganized thoughts may preclude them from engaging in anything resembling a rational thinking process).

89. See *Winters v. Miller*, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971). The court observed that:

[T]he law is quite clear in New York that a finding of "mental illness" even by a judge or jury, and commitment to a hospital, does not raise even a presumption that the patient is "incompetent" or unable adequately to manage his own affairs. Absent a specific finding of incompetence, the mental patient retains the right to sue or defend in his own name, to sell or dispose of his property, to marry, draft a will, and, in general to manage his own affairs.

Id. at 68.

90. See *Colyar v. Third Judicial Dist. Ct.*, 469 F. Supp. 424, 431 (D. Utah 1979) (holding that a finding of mental illness did not create a presumption of lack of capacity to make rational decisions, but noting that the committing authority could find in an appropriate case that a mentally ill patient was incapable of making a rational treatment decision).

91. See *Jacobson v. Massachusetts*, 197 U.S. 11, 20 (1905) (recognizing the authority of the state in its sovereign capacity to enact laws that protect the public's health, safety, morals, and welfare); see also *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972) (observing that *parens patriae* power was predicated upon the state acting in a protective role to assure the health, welfare, and well-being of individual citizens who could not care for themselves).

92. State statutes currently containing provisions that could be fairly construed to provide for commitment of the mentally disabled who are unable to make rational treatment decisions include: CGLO. REV. STAT. §§ 27-10-102, -106 (1982) (providing for commitment of the "gravely disabled," which "means a condition in which a person, as a result of mental illness, is unable to take care of his basic personal needs or is making irrational or grossly irresponsible decisions concerning his person and lacks the capacity to understand

would require a mental health professional to ascertain an individual's competency to make a rational treatment choice.⁹³ Involuntary commitment would not be permitted under this standard unless the professional could demonstrate to the committing authority the specific manner in which a patient lacked relevant insight or capacity for rational choice.

Under the above standard, psychotic individuals who are out of touch with reality usually would qualify since they generally are not aware of their mental illness, usually are not aware of treatment alternatives available to them, and frequently are not able to provide for their basic needs or deal reasonably within the context of their daily lives.⁹⁴ Persons not subject to commitment under this standard would include those who are aware of their mental disor-

this is so,"); CONN. GEN. STAT. ANN. §§ 17-176, -177 (West Supp. 1985) (providing in part that "'gravely disabled' means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital treatment is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his mental illness"); DEL. CODE ANN. tit. 16, §§ 5001, 5010 (1983) (providing in part: "'Mentally ill person' means a person suffering from a mental disease or condition which requires such person to be observed and treated at a mental hospital for his own welfare and which . . . renders such person unable to make responsible decisions with respect to his hospitalization"); FLA. STAT. ANN. § 394.467 (West Supp. 1985) (providing for involuntary commitment of person found mentally ill and unable to determine for himself whether treatment is necessary and who without treatment is unable to care for himself); MO. ANN. STAT. §§ 632.005 - .335 (Vernon Supp. 1985) (providing for commitment of persons who, as a result of mental illness, present likelihood of serious physical harm, which is defined as "a substantial risk that serious physical harm to a person will result because of impairment in his capacity . . . and need for treatment as evidenced by his inability to provide for his own basic necessities of food, clothing, shelter, safety or medical care"); S.C. CODE ANN. § 44-17-580 (Law. Co-op. 1984) (providing for commitment of a mentally ill person who "lacks sufficient insight or capacity to make responsible decisions with respect to his treatment"); S.D. CODIFIED LAWS §§ 27A-1-1, -9-18 (1984) (providing for commitment of persons mentally ill and in need of treatment and defining "mentally ill" to include persons who lack "sufficient understanding or capacity to make responsible decisions concerning his person so as to interfere grossly with his capacity to meet the ordinary demands of life"); UTAH CODE ANN. § 64-7-36(10)(c) (Supp. 1985) (providing for hospitalization of mentally ill person when "[t]he patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible costs and benefits of treatment").

93. See Stomberg & Stone, *supra* note 88, at 299-300 (suggesting that the treatment team conscientiously try to explain to a patient the nature and effects of proposed hospitalization or treatment before attempting to make a specific assessment of a patients' capacity for making a treatment decision).

94. See, e.g., AMERICAN PSYCHIATRIC ASS'N, TASK FORCE ON NOMENCLATURE AND STATISTICS, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 367-68 (3d ed. 1980) (describing "psychotic" behavior as inaccurately drawing inferences concerning external reality despite evidence to the contrary).

der and the effect their illness may have on their daily lives and also are aware of treatment alternatives, including the risks and benefits of those alternatives.⁹⁵ Because such persons have sufficient insight into their condition and into ways to change it if they so desire, their autonomy should be respected.

For commitment to be upheld under this standard, the state also should be required to demonstrate that appropriate and effective treatment is available and will be offered.⁹⁶ In fact the criteria for treatment under any standard should require the state to make a showing that effective treatment will be made available to any persons whom the state seeks to involuntarily commit.⁹⁷ Furthermore, under an incompetence standard, the treatment objective should be limited to restoring the individual's capacity for making rational treatment decisions.⁹⁸ This limitation would insure that the nature and duration of the commitment is consistent with the legitimate purposes of *parens patriae* commitment. Thus, commitment under such a standard would have as its objective not the complete restoration to full mental health of the patient but the restoration of the patient's capacity to engage in rational choice. Under this scheme, once competence is restored, a patient would be free to terminate hospitalization or, if he chooses, to continue treatment as a voluntary patient.

Parens patriae commitment on the basis of incompetence is

95. See, e.g., *Rogers v. Commissioner*, 390 Mass. 489, —, 458 N.E.2d 308, 313 (1983) ("[A] finding [of incompetence], apart from evidence as to mental illness, should consist of facts showing a proposed ward's inability to think or act for himself as to matters concerning his personal health, safety, and general welfare." (quoting *Fazio v. Fazio*, 375 Mass. 394, 403, 378 N.E.2d 951, 957 (1978))).

96. See, e.g., UTAH CODE ANN. § 64-7-36(10)(e) (Supp. 1983) (providing the following requirement for hospitalization of a patient lacking rational decisionmaking ability: "The hospital or mental health facility in which the individual is to be hospitalized pursuant to this act can provide the individual with treatment that is adequate and appropriate to the individual's conditions and needs. In the absence of required findings of the court after the hearing, the court shall forthwith dismiss the proceedings.").

97. See *Wyatt v. Stickney*, 325 F. Supp. 781, 784, *reh'g granted*, 334 F. Supp. 1341, 1342 (M.D. Ala. 1971), *redecided*, 344 F. Supp. 373 (M.D. Ala. 1972), *redecided*, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part and remanded in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305, 1312 (5th Cir. 1974) (reasoning that absent the opportunity to receive treatment, mentally disabled persons in an institution were not patients but mere residents with indefinite sentences; treatment and not custodial care was found to be the purpose of involuntary commitment).

98. The standard for release in civil commitment logically should be the same as the standard for initial commitment of the mentally ill. See Note, *Due Process for All-Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633, 658 (1967); Comment, *The New Mental Health Codes: Safeguards in Compulsory Commitment and Release*, 61 NW. U.L. REV. 977, 1007-08 (1967).

an appropriate and limited state response to the factual reality of a person's condition and disability. Unlike the current standards for commitment, which limit commitment to those found to be dangerous, an incompetence standard is not a state response to a mere prediction of dangerous future conduct. Moreover, under an incompetence standard, psychiatric expertise is used in an appropriate manner by the legal system. Rather than predicting future conduct, the medical authority must determine the extent to which a mental disorder has affected a person's capacity for rational choice. This use of the medical authority is thus in accord with the essential expertise of psychiatrists, which consists of diagnosing and treating mental illness—not of predicting future dangerous behavior.⁹⁹ Courts have recognized the legitimacy of professional medical judgments within the procedural context;¹⁰⁰ legislatures similarly should recognize the proper scope of medical judgment in establishing substantive standards for commitment.

IV. LEAST RESTRICTIVE ALTERNATIVE VERSUS MOST EFFECTIVE TREATMENT ALTERNATIVE

One consequence of the adoption of a dangerousness standard for civil commitment has been the imposition of a dispositional requirement that the patient be provided with the least restrictive treatment alternative.¹⁰¹ This requirement represents a balancing of the liberty interests of the patient with the requirements of social protection.¹⁰² This balancing reflects the fact that civil com-

99. See *Stone, supra* note 61, at 830 (maintaining that psychiatry has the ability to concern itself with the presence of clinical states and to identify those that require drastic intervention for appropriate treatment rather than predicting future events or dangerous acts).

100. See *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982) (recognizing presumptive validity of decisions of mental health professionals).

101. See *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966) (finding that "[d]eprivations of liberty solely because of dangerousness to the ill persons themselves should not go beyond what is necessary for their protection"). Several state statutes specifically require committing courts to consider less restrictive alternatives. See, e.g., ALA. CODE § 22-52-10(a)(5) (1984); ARIZ. REV. STAT. ANN. § 36-540 (Supp. 1983); ILL. ANN. STAT. ch. 91½, § 3-812 (Smith-Hurd Supp. 1985); MICH. COMP. LAWS ANN. § 330.1468(2)(c) (West Supp. 1985); VA. CODE § 37.1-84.1(6) (1984); WASH. REV. CODE ANN. § 71.05.320(1) (West 1986).

102. See, e.g., *Lessard v. Smith*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974). The court reasoned:

[E]ven if the standard for an adjudication of mental illness and potential dangerousness are satisfied, a court should order full-time involuntary hospitalization only as a last resort. A basic concept in American Justice is the principle that "even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued

mitment under a dangerousness standard is an exercise of police power resulting in a form of preventive detention.¹⁰³ A standard for commitment that is based on a finding of lack of competence and need of treatment demands instead that a patient be provided the *most effective* treatment alternative rather than the *least restrictive* alternative. A dangerousness standard leads to concern that the mentally ill will not be unnecessarily deprived of liberty; it thus has little to do with the treatment concerns of the mentally ill. An incompetence standard focuses solely on the need for the treatment. In this sense, the move toward a dangerousness standard for commitment has entailed an abdication of responsibility for treatment and care of those who are incompetent. Adoption of an incompetence standard reflects the view that beneficial treatment, though involuntarily received, ultimately may increase personal welfare, freedom, and autonomy.

It should be pointed out that the least restrictive alternative concept was first developed in cases involving the curtailment of civil liberties. In the 1960 *Sheldon v. Tucker*¹⁰⁴ decision, the Supreme Court ruled that a state was constitutionally compelled to achieve its goal of combatting subversion by choosing the means that least interfered with individuals' basic civil rights.¹⁰⁵ The Court observed:

[T]his Court has held that, even though the government's purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same purpose.¹⁰⁶

This concept of the least restrictive alternative was first applied in the mental health area by the United States Court of Appeals for the District of Columbia in 1966 in *Lake v. Cameron*.¹⁰⁷ The court held:

"[T]he court may order . . . hospitalization for an indeterminate period, or order any other alternative course of treatment which the court believes will be in the best interests of the person or the public." . . . Deprivations of

by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose."

Id. at 1096 (quoting *Shelton v. Tucker*, 364 U.S. 479, 488 (1960)).

103. See generally Dershowitz, *supra* note 82, at 1286; Hermann, *Preventive Detention, A Scientific View of Man, and State Power*, 1973 U. ILL. L.F. 673, 682.

104. 364 U.S. 479 (1960).

105. *Id.* at 490.

106. *Id.* at 488.

107. 364 F.2d 657 (D.C. Cir. 1966).

liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.¹⁰⁸

It is clear from this opinion that the least restrictive alternative is required because of the application of a dangerousness standard for commitment. The least restrictive alternative is applied because of the need to balance the liberty interest of the patient against the danger posed by his behavior.

Lake v. Cameron ultimately suggests that the standard of the least restrictive alternative favors community placement over involuntary hospitalization.¹⁰⁹ Observers, however, have suggested that some patients experience more freedom in the setting of a mental hospital than in available community placements.¹¹⁰ More significantly, some mental health professionals have maintained that the goal of placement should not be the least restrictive alternative but the most optimal setting for the patient.¹¹¹

The adoption of the least restrictive alternative reflects a view that equates the degree of governmental involvement with the degree of restriction. This approach makes sense only as long as intervention is permitted to further the governmental interests of providing protection from dangerous behavior at the cost of individual liberty. If, however, the intervention is aimed at developing mental competence by providing needed treatment, the standard for appropriate dispositional alternatives changes. Instead of the least restrictive alternative, the committing authority should aim at identifying the most effective treatment alternative. Under such a standard, the judgment of medical authorities should determine the most efficacious treatment modality that will satisfy the treatment needs of the patient. Legal support for this view can be found in the Supreme Court's *Youngberg v. Romeo*¹¹² opinion in which the Court observed that "[i]t is not appropriate for courts to specify which of several professionally acceptable choices should have been made."¹¹³ Rather, the proper dispositional alternative should be one that adopts the most effective treatment alternative as determined by medical authorities based on a professional diagnosis and a professional determination of the efficacy and availa-

108. *Id.* at 659-60 (quoting D.C. CODE ANN. § 21-545(b) (Supp. V 1966)).

109. *Id.* at 661.

110. See, e.g., Bachrach, *Is the Least Restrictive Environment Always the Best? Sociological and Terapeutic Implications*, 31 HOSP. COMMUNITY PSYCHIATRY 97-103 (1980).

111. See, e.g., Perr, *The Most Beneficial Alternative: A Counterpoint to the Least Restrictive Alternative*, 6 BULL. AM. ACAD. PSYCHIATRY L. iv, iv-vii (1978).

112. 457 U.S. 307 (1982).

113. *Id.* at 321.

bility of a particular treatment plan.

V. CONCLUSION

The Supreme Court in its more recent procedural decisions has revived the *parens patriae* doctrine as a justification for involuntary civil commitment. This development is clear from a reading of *Addington v. Texas*,¹¹⁴ *Parham v. J.R.*,¹¹⁵ and *Youngberg v. Romeo*.¹¹⁶ While the Court has recognized a range of procedural requirements that protect the civil liberty interests of persons subject to civil commitment, it has at the same time increasingly given recognition to treatment and clinical rights of persons involuntarily committed to mental health facilities. On the other hand, many legislatures and courts have focused only on the civil liberty interests of persons subject to involuntary civil commitment. These courts and legislatures thus have limited commitment to cases of mentally ill and dangerous persons and have required a disposition that is the least restrictive alternative. There is, however, a need to provide commitment criteria that will permit the state to meet the treatment needs of the mentally ill who are not capable of making rational decisions about their treatment needs. By adopting a standard that requires a finding of lack of competence, the state is best able to satisfy the needs of citizens afflicted with serious mental illness and who are otherwise condemned to a life of suffering. Statutory revision, therefore, should focus on satisfying the needs of the mentally ill because their needs cannot and are not being met under statutes that limit commitment under a dangerousness standard and require the least restrictive dispositional alternative. To meet these needs, commitment statutes should be revised to require proof of incompetence, a showing of susceptibility to and availability of treatment, and provision of the most effective treatment.

114. 441 U.S. 418 (1979).

115. 442 U.S. 584 (1979).

116. 457 U.S. 307 (1982).