Civil Commitment and the "Great Confinement" Revisited: Straightjacketing Individual Rights, Stifling Culture

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NOTES

CIVIL COMMITMENT AND THE "GREAT CONFINEMENT" REVISITED: STRAIGHTJACKETING INDIVIDUAL RIGHTS, STIFLING CULTURE*

[M]adness comes from God, whereas sober sense is merely human.

-Socrates

In 1860, Reverend Packard committed his wife, Elizabeth, to a State public mental hospital where she remained for three years. Reverend Packard was driven to this decision because Mrs. Packard disagreed with his religious views. Although Mrs. Packard may have suffered a period of mental illness at some point in her life, her relative mental health or illness was unrelated to her forced hospitalization. Writing after her release, Mrs. Packard compared her commitment to the mistreatment of witches in an earlier era:

Had I lived in the sixteenth instead of the nineteenth century

* Dedicated to the special promise of Jordanna, born November 28, 1994.

4. Some confusion exists on this point. Deutsch notes that, as a girl, Mrs. Packard was hospitalized briefly in a psychiatric institution, and he also notes that it appears "established" that she experienced delusions. DEUTSCH, supra note 2, at 424-25. In particular, he refers to her reputed statement that she was the third person in the Holy Trinity. Id. at 425. Contra SAPINSLEY, supra note 2, at 25 (suggesting that Mrs. Packard's girlhood hospitalization was for delirium associated with unrecognized meningitis or encephalitis); id. at 15 (noting that her reference to herself as part of the Holy Trinity was metaphorical and consistent with existing theological doctrine).
my husband would have used the laws of the day to punish me as a heretic for this departure from the established creed. Much that is now called insanity will be looked upon by future ages with a feeling similar to what we feel toward those who suffered as witches in Salem, Massachusetts.\footnote{SZASZ, supra note 3, at 130-31 (quoting 1 E.P.W. PACKARD, MODERN PERSECUTION: OR INSANE ASYLUMS UNVEILED 95 (1873)). After her release, Mrs. Packard used her experiences to push for political reforms in commitment laws and the care of the institutionalized insane. SAPINSLEY, supra note 2, at 136-44, 180-81. But see DEUTSCH, supra note 2, at 426-27 (suggesting that Mrs. Packard’s reform efforts were ultimately counterproductive for the rights of the mentally ill).}

Mrs. Packard’s observations regarding the then-current standards of psychiatric diagnosis are chilling but accurate. Today, we understand that nineteenth-century psychiatry was about social control rather than medicine,\footnote{For representative critiques of nineteenth century psychiatry, see MICHEL FOUCAULT, MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON 241-78 (Richard Howard trans., 1988) (criticizing the putatively enlightened approaches of Turk and Pinel, fathers of nineteenth century psychiatry, as primarily a form of moral coercion that continues to infect modern psychiatry); JEFFREY M. MASSON, A DARK SCIENCE: WOMEN, SEXUALITY, AND PSYCHIATRY IN THE NINETEENTH CENTURY (1986) (criticizing nineteenth century psychiatry as misogynistic).} and we reassure ourselves that modern psychiatry is based firmly on science. We are convinced that Mrs. Packard’s commitment for, in effect, believing in the wrong gods is a relic of a dark past, an experience no longer possible given the modern scientific practice of psychiatry. Is our trust well placed?

In the early 1960s, a bright young man grew disillusioned with the hedonistic culture of his time. Rejecting an era of rampant drug use and wanton sexuality, Leonard Frank grew a beard, immersed himself in the study of orthodox Judaism, and adopted a vegetarian diet.\footnote{JUDI CHAMBERLIN, ON OUR OWN: PATIENT-CONTROLLED ALTERNATIVES TO THE MENTAL HEALTH SYSTEM 4 (1978).} His complete departure from their own casual Judaism and the developing mores of his generation alarmed his parents.\footnote{Id. Some critics charge that psychiatric diagnosis is little more than a pseudo-medical validation of an essentially political decision made by the family or others. James R. Greenley, Alternative Views of the Psychiatrist’s Role, in LABELING MADNESS 34, 43-46 (Thomas J. Scheff ed., 1975). Under this view, Leonard Frank’s parents, having already concluded that he was “sick,” consulted a psychiatrist, not for inde-}
ment on the grounds that he was a danger to himself and others. Leonard Frank's psychiatrists felt that he required involuntary psychiatric commitment because of his "religiosity," his "bizarre" dietary regimen, and his beard. These symptoms, along with Frank's refusal to accept being characterized as insane, justified a treatment regimen that ultimately included fifty insulin coma-convulsive and thirty-five electroconvulsive applications. After securing his release, Frank wrote and lectured about psychiatric abuses.

Independent investigation of the possibility that Frank was mentally ill, but rather for confirmation of the familial-political decision they already had reached. It is revealing that Frank, during an interview some years after his release, asserted that the doctor was not his doctor but his parents' JOHN FRIEDBERG, M.D., SHOCK TREATMENT IS NOT GOOD FOR YOUR BRAIN 61 (1976) (discussing interview with Leonard Roy Frank). "He was not my doctor. He was the one who was hired to deal with me." Id.

9. Frank remained hospitalized against his will for eight months. FRIEDBERG, supra note 8, at 58.

10. Frank was diagnosed as having a "Schizophrenic Reaction, Paranoid Type, Chronic, Severe." The Frank Papers, reprinted in FRIEDBERG, supra note 8, at 72 (letter from treating psychiatrist to Leonard Frank's parents). The Frank Papers are excerpts from Frank's actual hospital records while a patient. Schizophrenia, Paranoid Type, is a particularly onerous diagnostic label. Paranoid schizophrenia carries a public and professional aura of susceptibility to random and wanton violence. For example, the AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994) [hereinafter, DSM-IV], while acknowledging that there is conflicting evidence regarding whether the frequency of violent acts by schizophrenics is greater than in the general population, warns of violence as a feature associated with only paranoid schizophrenia. Id. at 280, 287.

11. CHAMBERLIN, supra note 7, at 5.

12. Id.

13. The Frank Papers, supra note 10, at 79. Although a psychiatrist may consider this "treatment," Leonard Frank, the recipient of these chemical and electric shock treatments, reasonably views them as "torture." See Leonard Frank, An End to Silence, in THE HISTORY OF SHOCK TREATMENT 104 (Leonard R. Frank ed., 1978). In a poem, Frank insists that:

we will call things
by their real names
its not shock treatment
its shock torture.

Id.

14. Frank never accepted the diagnosis that he was insane. Instead, he consciously and willfully lied to his therapists by adopting their perspective just long enough to secure his release. CHAMBERLIN, supra note 7, at 74 (citing personal interview with Leonard R. Frank, Dec. 7, 1976).

15. See generally THE HISTORY OF SHOCK TREATMENT, supra note 13 (a collection
These stories, although anecdotal and taken from history, raise a number of important questions regarding present-day commitment procedures. Upon what grounds will society sanction involuntary psychiatric commitment? What protection do citizens have from wrongful deprivation of their liberty pursuant to a finding of committable mental illness? Are these protections properly matched to the state of modern psychiatry? How is the balance between individual liberty and social welfare realized? Does this balance accurately reflect our constitutional principles? In short, how safe can we feel?

This Note will focus on the justifications for involuntary psychiatric commitment and the procedure by which such commitment is accomplished. This Note first will examine the constitutional standards that justify civil commitment and will consider contemporary critiques of these guidelines from two perspectives: the concerns of Pro-Treatment critics who believe that overemphasis on individual rights blocks access to treatment for people desperately in need, and the criticisms of Pro-Rights critics who assert that the constitutional safeguards are already too lax. This discussion will conclude with a hypothetical case for the reader to consider based on the preceding analysis.

This Note then will examine the evidentiary requirements for civil commitment and will mirror the previous discussion in structure. First, the evidentiary rules that guide the adjudicative process in involuntary commitment hearings will be explained in detail. Next, criticisms of these requirements from both the Pro-Treatment and Pro-Rights perspectives will be considered. This discussion concludes by expanding upon the hypothetical raised earlier, allowing the reader to consider the evidentiary requirements' impact on the hypothetical.

Next, this Note will present a limited case study of commitment hearings in a public mental hospital in Virginia. This discussion will begin by comparing Virginia's statutory guidelines for commitment and its evidentiary rules with those of other states in order to establish the relevance of a study based solely in Virginia for a national consideration of civil commitment. The
purpose of this case study is to examine how well the theoretical protection for those subjected to civil commitment hearings plays out in actual practice. The Virginia case study will provide insight into the relative strengths and weaknesses of the Pro-Treatment and Pro-Rights critiques presented earlier. Again, this discussion will close with a return to the hypothetical case to consider, in light of the findings of the case study, how modern courts might dispose of the issues raised in the hypothetical.

This Note concludes that an improper balance has been struck between the competing concerns at issue in the civil commitment context and will revisit the hypothetical in light of the hidden social cost of this improper balance.

THE CONSTITUTIONAL STANDARDS: GUIDELINES FOR INVOLUNTARY COMMITMENT

The Policy Rationales

Two compelling State interests justify involuntary psychiatric commitment: the police power to protect the general welfare and the parens patriae power to protect an individual who cannot protect himself. The Supreme Court attempted to define the extent and limit of these dual justifications for involuntary civil commitment in O'Connor v. Donaldson.

Kenneth Donaldson was confined in a Florida state mental hospital against his will for nearly fifteen years. The hospital's superintendent, Dr. J.B. O'Connor denied his repeated requests for release. Donaldson eventually sued for deprivation of his

18. Id. at 564.
19. Id. at 565. The record suggests that Dr. O'Connor was not a neutral arbiter of the merit of Donaldson's pleas for release. When an advocacy organization, Helping Hands, wrote asking that Donaldson be released to their care, Dr. O'Connor respond-
constitutional right to liberty. He claimed throughout his confinement that he was neither dangerous nor mentally ill, and that the hospital was not providing him with treatment. He was successful at trial and on appeal, and the Supreme Court accepted the jury's finding that Donaldson was not dangerous and, if mentally ill, had not received treatment during his hospitalization. The crucial question before the Court was whether a finding of mental illness alone could justify continued confinement. In deciding this question, the Court established the constitutional boundaries for civil commitment.

The Court held that an individual cannot be committed on the mere finding that he is mentally ill without proof of a further compelling need for confinement. In addition, the State may not commit a mentally ill person in order to raise his standard of living. The mere fact that a person can live more comfortably...
in an institution than elsewhere is not sufficient justification for civil commitment. Finally, the State cannot commit an otherwise harmless, mentally ill person in order to protect its citizenry from his eccentricity. In summary, "there is still no constitutional basis for confining such [mentally ill] persons involuntarily if they are dangerous to no one and can live safely in freedom." These holdings, establishing the permissible boundaries for civil commitment, have been challenged for relying upon untenable justifications for involuntary psychiatric commitment.

Criticisms

The Supreme Court's permissible justifications for involuntary psychiatric commitment are criticized from two perspectives, which this Note shall refer to as the Pro-Treatment and Pro-Rights positions. The Pro-Treatment critique argues that the standards for involuntary psychiatric commitment give too much protection to individual rights at the expense of providing necessary treatment and care to those suffering from mental illness. The Pro-Rights critique argues that the standards provide too little protection to individuals who find themselves at the mercy of the courts. Of course, the question confronting many mentally ill today is whether the courts will permit them to prefer life on the streets to life in an institution. So far, the answer appears to be no. See, e.g., Boggs v. New York City Health & Hosp. Corp., 523 N.Y.S.2d 71 (N.Y. App. Div. 1987) (involuntarily committing a homeless schizophrenic woman who the court said was not dangerous).

Some communities have tried to resolve the plight of the homeless by building shelters and then threatening the homeless with arrest if they refuse to accept the city-supplied accommodations. See, e.g., Laura Irwin, Next Question: What If the Homeless Don't Want Shelter?, MIAMI TODAY, July 14, 1994, at 3. This issue raises the question whether a person has the right to refuse shelter, independent of relative mental health. Put another way, could Thoreau have been subject to arrest? Justice Stewart, writing for the majority in O'Connor, invited courts to deprive individuals of their liberty when he wrote that a person may be considered dangerous to himself if, for any reason, "he is helpless to avoid the hazards of freedom." O'Connor, 422 U.S. at 574 n.9. Those who would like to expand the permissible boundaries of involuntary commitment emphasize this language. See, e.g., Carney, supra note 25, at 190 (describing Stewart's phrase as loosening the "dangerousness" standard).

29. Id.
30. Id.
of the civil commitment process. A brief examination of each critique follows.

The Pro-Treatment Critique

Proponents of less stringent commitment procedures view the submission toward individual rights as standing needlessly in the way of access to treatment for those desperately in need of treatment. According to Pro-Treatment advocates, in mental illness the "diseased organ is the brain," and the mentally ill therefore are unable to make rational choices required to exercise effectively the freedom that the law permits.

From this perspective, any commitment standard that requires a prediction of dangerousness is unduly restrictive, in part because "dangerousness is the one characteristic of mental illness that doctors are unable to predict with reasonable scientific certainty," and in part because the official policy of the American Psychiatric Association is that considerations involved in characterizing mental disorders are not necessarily an appropriate basis for legal conclusions. Owing to the difficulties in predicting future behavior of any kind, the State often cannot meet this exacting standard. As a result, the mentally ill are "free" until they break the law, and the jails then become substitute insane asylums.

31. See infra notes 57-59 and accompanying text.
33. ISSAC & ARMAT, supra note 25, at 111.
34. Id., see also Carney, supra note 25, at 182 ("But what liberties are being protected [by strict commitment guidelines]? The freedom to be ill and have irrational thoughts?").
35. Carney, supra note 25, at 198; see also Edmund V Ludwig, The Mentally Ill Homeless: Evolving Involuntary Commitment Issues, 36 VILL. L. REV. 1085, 1099-1100 (1991) (stating that mental health expert testimony should be more limited because many times it exceeds the mental professional's sphere of expertise).
36. DSM-IV, supra note 10, at xxvii (cautionary statement).
37. Ludwig, supra note 35, at 1094. Ludwig notes that the reverse is also true. Mental hospital populations have grown increasingly dangerous, interfering with the functioning of the hospital. Id. at 1094-95; see also ALAN A. STONE, LAW, PSYCHIATRY, AND MORALITY 51 (1984) (noting that the "dangerousness" standard has bred a
Pro-Treatment proponents also criticize the dangerousness standard for failing to protect other interests. Ironically, the chronic but non-dangerous mentally ill may desire treatment yet be turned away because their pathologies do not rise to the level of the dangerousness threshold. Rejecting the non-dangerous mentally ill burdens the families of the mentally ill who are "forced to care for those they cannot treat." Finally, the rights of the larger society who desire minimal standards of behavior in public places are ignored in favor of the mentally ill individual's "right to be crazy."

Rather than a dangerousness standard, Pro-Treatment advocates insist that severity of illness should be the legal standard for civil commitment, whereby courts evaluate the competency of the mentally ill person to make rational choices regarding treatment. Such an evaluation would measure three characteristics of the individual under consideration: the individual's
awareness, the voluntariness of the individual's behavior and choices, and the individual's overall competency. Proponents argue that these criteria, unlike a dangerousness standard, would allow mental health professionals to do what they do best—diagnose mental illness rather than predict future dangerousness.

The Pro-Treatment position is mistaken in its philosophical anthropology; its supporters err in their fundamental understanding of the nature and essence of man. Emphasis on the brain as the seat of mind is a remnant of now-discredited Cartesian Dualism. Pro-Treatment advocates ignore current

43. Id.
44. Id. at 200.
45. Cartesian Dualism holds that "mind" is separate from all corporeal matter. The gulf between "mind" and "body," or "mind" and "world" is unbridgeable. Erwin W. Straus, Anesthesiology and Hallucinations, in EXISTENCE: A NEW DIMENSION IN PSYCHIATRY AND PSYCHOLOGY 139, 141-42 (Rollo May et al. eds., 1968) [collection as whole hereinafter EXISTENCE]. At its most fundamental level, this chasm divides subject and object. Rollo May, Contributions of Existential Psychotherapy, in EXISTENCE, supra, at 58.

Cartesian Dualism is named for, and arises out of, the philosophy of Rene Descartes. RENE DESCARTES, DISCOURSE ON METHOD AND MEDITATIONS, at x (Laurence J. Lafleur trans., 1960). Descartes set out to discover apodictic truth—absolute certainty. Id. His "first rule was never to accept anything as true unless certainly and evidently such." Id. at 15. He sought this indisputable truth in human experience rather than in the external world. Descartes proceeded from the proposition that "there is nothing certain in this world," id. at 81, and rejected even mathematical proofs, id. at 77-79.

Descartes found apodictic truth in his experience of himself as a thinking being. "I must finally conclude and maintain that this proposition: I am, I exist, is necessarily true every time that I pronounce it or conceive it in my mind." Id. at 82. This proof is known as the Cogito sum: I think, therefore I am. In defining truth as solely dependant upon subjective experience, Descartes makes problematic the connection of the thinker to the external world or even his own body. May, supra, at 61 ("Since Descartes the soul and nature have had nothing to do with each other.").

Cartesian Dualism is under attack in the twentieth century. See, e.g., MARTIN HEIDEGGER, BEING AND TIME 122-34 (John Macquarrie & Edward Robinson trans., 1962). In capsule form, Heidegger's critique of Cartesian Dualism may be summarized as follows: Cognition and perception originate as an experience of a human subject. Thought and sensation, therefore, are necessarily subjective in that they have no existence apart from the subject who thinks and perceives. The perception that a "thing" (for example, the chair in which you are sitting) is an "objective" entity separate from the perceiver (the reader who sees and feels the chair), is merely a subjective experience of the thing as being independent of the perceiver. "Objective" truth consists of widely held intersubjective experiences—virtually every subject would
trends in philosophy and science that understand the mind as enthused throughout and coterminous with corporeal matter. According to Dr. Richard Bergland, a highly respected neurosurgeon and scientist, modern neurology has discarded the old notion that the brain is distinct from the body because the former was driven by electricity and the latter by molecules. Modern science now understands that the brain, like other organs, is a gland—"the brain is one with the body." An interplay of hormones between the brain and other organs drives human thought. As Dr. Bergland observes, "the brain does not sing 'solos' to the body, but 'harmonies.'" Thinking occurs outside, as well as inside, the brain.

experience the chair as existing independently of one's experience of it. No "objective" proof of that belief is possible, however, because human subjects are incapable of adopting an objective perspective. Id.

The same analysis holds for the experience of a "split" between mind and body. The body qua object may be experienced as distinct from one's mind, but that experience is itself subjective because it is not susceptible of "objective" proof. Referring to the impossibility of proving a connection between Subject and Object (e.g., mind and body or human consciousness and world), a proof made necessary by Cartesian Dualism, Heidegger states that "the scandal of philosophy" is not that this proof has yet to be given, but that such proofs are expected and attempted again and again." Id. at 249. Heidegger reverses Descartes' cogito sum by recognizing that human beings already are caught up in the world. Id. at 254. Heidegger, then, replaces the cogito sum with his concept of "Being-in-the-world"—the idea that the Subject/Object duality is an illusion. Id. Mind and body, human consciousness and world, are unities. Id. at 78-86, 138-44.

In assessing the relative merits of Heidegger's and Descartes' philosophies, one must bear in mind that both were searching for apodictic truth and that both sought it in human experience rather than in the external world. MARTIN HEIDEGGER, MODERN SCIENCE, METAPHYSICS, AND MATHEMATICS, in BASIC WRITINGS 247, 278-82 (David F. Krell ed., 1977). Both understood that one can never be "wrong" about one's own experience even if one's experience of the world is mistaken. That is, one may mistakenly believe (from the standpoint of intersubjective validity) that the world is flat, but the fact that one so believes is absolutely true. Because Heidegger and Descartes both sought apodictic truth in experience, one can fairly conclude that Descartes, were he alive today, would concede to the truth of Heidegger's greater insight. "Cogito—sum is the fundamental axiom of all knowledge; but it is not the only fundamental axiom" Id. at 281.

47. BERGLAND, supra note 46, at 80.
48. Id. at 162.
49. Id. at 104.
50. Id. at 109 ("The mechanisms that drive thought are found all over the
From a more practical standpoint, the Pro-Treatment position severely undervalues individual rights and overvalues the curative powers of psychiatry. The Pro-Treatment camp acknowledges that mental illness—particularly those manifestations of psychopathology that are most likely to excite the state to seek commitment—probably is not curable given the current state of psychiatric medicine. Nonetheless, proponents argue that treatment can help the mentally ill “lead a comparatively normal life.” At best, this assertion is highly debatable. If Pro-Treatment proponents believe life in a mental hospital is “comparatively normal,” then they probably have not spent much time in a mental hospital setting. Those who have, either as patients, pseudo patients, or hospital observers, report a different picture of

body

51. Carney, supra note 25, at 183.
52. See, e.g., CHAMBERLAIN, supra note 7; VOICES FROM THE ASYLUM (M. Glenn ed., 1974); The Frank Papers, supra note 10, at 62. All three works are collections of writings from involuntary mental patients describing their experiences.
53. Pseudo patients are individuals who have faked their way into mental hospitals for the purpose of studying hospital life. See ANTHONY BRANDT, REALITY POLICE: THE EXPERIENCE OF INSANITY IN AMERICA 190 (1975) (“[S]omething happened to me at [the mental hospital], something nearly drove me crazy. Though I was not a ‘real’ mental patient I was under the control of the staff, I was living like a patient. My situation began to feel ambiguous. And I began to panic.”); D.L. Rosenhan, On Being Sane in Insane Places, 179 SCI. 250, 256 (1973) Rosenhan found the staff ignored patients to the point where the patients felt “invisible.” In one instance, a nurse unbuttoned her blouse to re-adjust her bra in full view of several male patients. In doing so, she acted in disregard of the patients rather than seductively. Id.

In both of these instances, researchers faked their way into the hospital by reporting a single instance of auditory hallucination. BRANDT, supra, at 162; Rosenhan, supra, at 251. It is not surprising that one can lie about one’s mental experience and be admitted to a hospital. Once in, however, the researchers behaved normally yet were never identified as sane. Rosenhan, supra, at 251. In Rosenhan’s words, “[t]he [n]ormal [a]re [n]ot [d]etectably [s]ane.” Id. at 252.

54. See ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961). Goffman was not only an observer, but an actual hospital employee. He spent a year as a recreation counsellor at St. Elizabeth’s Hospital in Washington, D.C., to observe the social situation of mental patients. The hospital administration granted Goffman permission to work and observe for the purposes of his study. ROBERT PERRUCCI, CIRCLE OF MADNESS: ON BEING INSANE AND INSTITUTIONALIZED IN AMERICA (1974) (reporting results of a year-long field study at a mental hospital in the midwest).
hospital life. Further, the Supreme Court has expressly rejected the idea that the *parens patriae* power of the State authorizes forcible confinement of the mentally ill merely to improve their living conditions.\(^5\) Justifying the deprivation of liberty imposed by civil commitment requires something more than a desire to help those diagnosed as mentally ill.\(^6\)

*The Pro-Rights Critique*

On the opposite end of the spectrum, Pro-Rights proponents argue that statutes allowing confinement on the basis of a foreseeable likelihood that the accused\(^5\) will be dangerous are unconstitutional and place excessive reliance on the power of psychiatrists to predict future dangerousness.\(^5\) This standard for confinement permits discrimination against the homeless, among others.\(^5\)

According to Pro-Rights critics, statutes that allow the forced confinement of individuals who have not actually committed any violent acts but whose behavior is seen as “dangerous in the reasonably foreseeable future” are unconstitutionally vague and overbroad.\(^6\) These statutes necessarily fail to forewarn citizens of the conduct that would justify their confinement. By permitting a complete curtailment of liberty when less restrictive means are available,\(^6\) the state readily can use such statutes to discrimi-


\(^{56}\) Id.

\(^{57}\) Admittedly, a psychiatric commitment hearing is not a criminal trial. See Addington v. Texas, 441 U.S. 418, 423-24 (1979). However, the person whose sanity is tested by such a hearing risks loss of liberty. The term “accused,” therefore, is an apt description of the defendant in such a hearing.

\(^{58}\) See Kaufman, *supra* note 16.

\(^{59}\) Id.

\(^{60}\) Id. at 344-45. In the 1980s, New York considered language permitting commitment based on a standard of “dangerous in the reasonably foreseeable future,” but the legislature repeatedly rejected this standard precisely because it is vague and overbroad. Ludwig, *supra* note 35, at 1107.

\(^{61}\) One less restrictive option is commitment to outpatient treatment. Virginia allows outpatient commitment as a less restrictive alternative to institutional confinement even after a finding of dangerousness if “deemed suitable” by the judge. VA. CODE ANN. § 37.1-67.3 (Michie Supp. 1994). As a practical matter, it is highly unlikely that a judge, after finding a person to be an imminent danger to himself or others, will then release that person back into the community.
nate against the homeless mentally ill or the homeless in general. Pro-Rightists also fear that the lack of clearly defined standards in civil commitment statutes leads judges to apply an excessively loose construction to these statutes. Judges may avoid strict construction of civil commitment statutes because of either their fears for the untreated mentally ill or their fears of the untreated mentally ill. The problem of loose statutory construction is particularly acute because judges are already unduly dependant upon the opinions of expert witnesses who tend to overpredict dangerousness and the severity of mental illness. The relaxed standard of appellate review further exacerbates this problem. Courts rarely overturn commitment decisions because they need only be based on "substantial professional judgement."

Statutes authorizing the involuntary commitment of persons whose dangerous behavior is a future assumption rather than a

North Carolina was the first State to allow outpatient commitment upon a lower standard than dangerousness, ISSAC & ARMAT, supra note 25, at 314, thus solving the practical inconsistency of finding a person dangerous yet releasing that person back into the community, but raising the issue of the State's right to commit. Although outpatient commitment is less onerous than institutional confinement, it remains an interference with individual liberty. See Susan Stefan, Preventive Commitment: The Concept and Its Pitfalls, 11 MENTAL & PHYSICAL DISABILITY L. REP 288, 292 (1987) (stating that "the scheme creates extended deprivations of liberty with little or no financial savings for the State"); see also KANTER, supra note 38, at 12-13.

63. See Michael L. Perlin, On "Sanism," 46 SMU L. REV. 373, 402-03 (1992) (arguing that only the most arbitrary and baseless decisions can be challenged).
64. Id. at 401-02 (stating that release might lead to homelessness).
65. Id. at 402 (arguing that judges are susceptible to "sanism" myths of the mentally ill, including the myth that the mentally ill are almost always prone to violence).
67. Expert predictions of future dangerousness are so inaccurate that one commentator concludes that "professional judgment is simply judgment made by a professional, not a judgment that has any special validity and is often no better than lay judgment." Bersoff, supra note 66, at 362. For a discussion of research regarding limitations on the powers of psychiatrists to predict dangerousness, see infra, note 70.
68. Perlin, supra note 63, at 402.
present fact also bypass the Supreme Court’s restrictions on confinement. The Supreme Court has rejected confinement based solely on a finding of mental illness, imposed solely to improve living conditions of the mentally ill, or imposed solely to protect the citizenry from idiosyncratic behavior. Nonetheless, a person who has done no harm to himself or others, but who lives in squalor and whose beliefs and behavior violate the broad band of socially-accepted reality and mores, can suffer confinement based upon a highly unreliable prediction that the person will be dangerous in the future. Such a person is not confined by society because of dangerousness but because of a mixture of paternalism and repulsion.


70. For a critique of the accuracy of psychiatric predictions of future dangerousness, see Bersoff, supra note 66, at 355-57 (discussing studies that demonstrate between a 65% to 66% false positive rate for psychiatric predictions of violence); Bruce J. Enns & Thomas R. Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 CAL. L. REV. 693, 711-16 (1974) (arguing that psychiatric predictions of violence are no more accurate than a coin flip); David Faust & Jay Ziskin, The Expert Witness in Psychology and Psychiatry, 241 SCI. 31, 32 (1988) (citing studies which indicate that psychiatrists may be wrong in over two of every three cases); Alan M. Dershowitz, The Psychiatrist’s Power in Civil Commitment: A Knife That Cuts Both Ways, PSYCHOL. TODAY, Feb., 1969, at 43, 47 (noting that of those “confined on the basis of psychiatric predictions of violence there are only a few who would, and many more who would not, actually engage in such conduct if released”).

But see Joseph E. Jacoby, Dangerousness of the Mentally Ill—A Methodological Reconsideration, in DANGEROUS BEHAVIOR: A PROBLEM IN LAW & MENTAL HEALTH 20, 31-32 (Calvin J. Frederick ed., 1978) (stating that better methods of data collection may reveal that psychiatric predictions of dangerousness may be substantially more accurate than believed); Joseph M. Livermore et al., On the Justifications for Civil Commitment, 117 U. PA. L. REV. 75, 84 (1968) (arguing that low frequency events are inevitably overpredicted).

71. See Addington v. Texas, 441 U.S. 418, 426 (1979) (noting that a “State has a legitimate interest under its parens patriae powers”). At least one commentator appears to advocate a paternalistic role for lawyers. See David B. Wexler, Therapeutic Jurisprudence and the Criminal Courts, 35 WM. & MARY L. REV. 279, 284-86 (1993) ("[D]efense lawyers would need to coax more actively those clients who lack plausible defenses to admit guilt and accept the bargain."). For a detailed review and critique of Wexler’s “therapeutic jurisprudence” proposal, see infra notes 95-120 and accompanying text. Most of the lawyers representing civil commitment defendants in the case study presented in this Note, see infra notes 181-215 and accompanying text, do not mount vigorous defenses because of a paternalistic belief that the defendant needs psychiatric treatment.

72. See Ludwig, supra note 35, at 1096 (describing the “counterdeinstitutionalizing effect” of the mentally ill homeless whose mere presence incited “complaints stirred
Hypothetical

Having discussed the policy considerations implicated in the involuntary commitment debate, this Note will describe a hypothetical situation in which the protagonist’s arguably unusual behavior encourages his family to seek involuntary commitment. This hypothetical provides a context through which the discussion can weigh the merits of the State’s interests in confining its citizens.

Paul is a successful stockbroker, married with three children, who takes up song-writing in his late twenties as a hobby Possessing scant musical experience, Paul soon begins to view himself as a musical genius. He believes that the wider society does not properly appreciate his talents, although limited segments of the music-loving population find Paul to be a competent songsmith. Convinced of his own genius and before making any profit from his music, Paul quits his job to devote himself full time to his songwriting. He informs his wife of his decision to quit work only after it is a fact accompli. Paul’s wife understandably is upset, not the least because he was the family’s sole means of support. She petitions to have him committed to involuntary psychiatric treatment.

Is Paul mentally ill? If so, should he be committed? Pro-Treatment advocates might argue that this case illustrates the need for a legal standard for civil commitment that focuses on illness rather than dangerousness. Paul poses no immediate danger to himself or his family, but his actions appear so manifestly irrational as to suggest a compelling need for treatment. A social policy that interferes with treatment, by barring commitment without a showing of dangerousness or grave inability to care for self, serves neither Paul nor his family.

Conversely, Pro-Rights enthusiasts might argue that this case demonstrates the importance of establishing high standards for civil commitment. Although Paul’s decisions are unusual, they

by feelings of fear, anger, resentment and guilt); see also Perlin, supra note 63, at 388-98 (describing “samist” biases and myths).

73. See supra notes 16-30 and accompanying text.
74. See supra notes 32-56 and accompanying text.
75. See supra notes 57-72 and accompanying text.
are not criminal, and no reason exists to fear that he is about to harm anyone. Instead, he has exercised his right to self-determination, even if his choice is misguided. If his wife is sufficiently upset, she has the right to leave him. However, society ought not to confine him because she is disturbed.

**The Constitutional Standards: The Evidentiary Guidelines**

*Standard of Proof and Evidentiary Requirements*

*The Standard of Proof*

Inasmuch as an individual's liberty is at stake in a commitment hearing, one would expect, incorrectly, that the necessary standard of proof of dangerousness or of an inability to care for oneself would be the same as in a criminal trial—"beyond a reasonable doubt." In *Addington v. Texas*, the Supreme Court distinguished the psychiatric commitment hearing from a criminal trial and held that the former requires only a standard of proof greater than the mere "preponderance of the evidence" standard used in ordinary civil proceedings.

The Supreme Court distinguishes between civil commitment hearings and criminal trials—permitting a lower standard of proof in the former—based upon the State’s motive for initiating each proceeding and the relative costs of error in each setting. In *Addington*, the Court found it noteworthy that the State, in seeking psychiatric commitment, does not exercise its power "in a punitive fashion." In other words, the benevolent motive of the actor who deprives one of liberty makes that deprivation less

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76. Marcy H. Speiser, *Indigents and the Denial of Due Process at Involuntary Treatment Hearings: The Need for Independent Psychiatric Assistance*, 8 TOURO L. REV. 141, 143 n.14 (1991) (arguing that "the due process concerns in both the criminal judicial proceeding and the civil involuntary treatment hearing are similar in nature").

77. 441 U.S. 418 (1979).

78. *Id.* at 432-33. ("To meet due process demands, the standard [of proof] has to inform the fact finder that the proof must be greater than the preponderance-of-the-evidence standard applicable to other categories of civil cases.").

79. *Id.* at 428-29.

80. *Id.* at 428.
onoruous.

Also central to the Court's distinction between civil commitment and criminal trials were the consequences of error in each setting. In the context of a criminal trial, an erroneous finding of innocence has no negative consequences for the individual whereas, in the Court's words:

\[\text{[I]t is not true that the release of a genuinely mentally ill person is no worse for the individual than the failure to convict the guilty. One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma. It cannot be said, therefore, that it is much better for a mentally ill person to "go free" than for a mentally normal person to be committed.}\]

The Court has reduced drastically the liberty interests of all citizens by implying that the opportunity to receive psychiatric treatment is of a higher value than liberty because the Justices seem to be willing to allow the mentally normal to be wrongly committed rather than allow the mentally ill to be wrongly released. Moreover, the Court underestimates the supreme value individuals and cultures place on liberty. The proposition that the mentally ill person would prefer treatment consequent to involuntary commitment over no commitment and no treatment is not axiomatic given the high esteem in which liberty has

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81. Id. at 428-29.
82. Id. at 429 (citations omitted). With this holding, the Court turns a fundamental principle of the common law on its head. The burden of proof serves to protect the wrongly accused, not to ensure appropriate handling of an accurately charged defendant. Coffin v. United States, 156 U.S. 432, 456 (1895) ("[T]he law holds that it is better that ten guilty persons escape than that one innocent suffer.") (quoting 2 WILLIAM BLACKSTONE, COMMENTARIES *358). The Court in Addington should have shown greater concern with preventing wrongful commitment.
84. The Jews at Masada are an example of a people preferring liberty to life itself. See, e.g., YIGAEL YADIN, MASADA: HEROD'S FORTRESS AND THE ZEALOTS' LAST STAND 232-37 (1966); see also R. M. Hare, Liberty and Equality: How Politics Masquerades as Philosophy, 2 SOC. PHIL. & POL'Y 1, 1-2 (1984) (discussing liberty as a universal value and providing historical examples of individuals and cultures choosing a worse condition of their own making over a better condition imposed from without).
85. As a logical matter, those who are subjected to involuntary commitment hearings do not prefer treatment to liberty. This preference is not evidence of a rational
been held throughout time and across cultures. Because the Court permits a burden of proof below “beyond a reasonable doubt,” evidentiary rules become particularly important.

The Evidentiary Requirements

The question of whether the accused presents a danger to himself or others typically turns on the expert testimony of psychiatrists. Although variations exist among the States, the foundation upon which the testifying psychiatrist bases his opinion typically must meet a comparatively low threshold. Only five States require evidence of recent overt conduct that caused or threatened to cause harm before the state can involuntarily commit an individual. Moreover, the testifying psychiatrist need not be in an ongoing treatment relationship with the accused in order to render an opinion as to the accused’s potential
deficiency. As no less a man of reason than Benjamin Franklin said: “They that can give up essential liberty to obtain a little temporary safety deserve neither liberty nor safety.”


86. Hare, supra note 84, at 1-2.
88. Id. at 429.
89. See, e.g., In re Melton, 597 A.2d 892, 894-95 (D.C. 1991) (approving commitment based on the testimony of psychiatrist relying almost exclusively on hearsay information supplied by family members to support his prediction of dangerousness).
90. Memorandum from Kelley O’Brien to Thomas L. Hafemeister, Senior Research Associate, Institute on Mental Disability and the Law, National Center for State Courts (Mar. 1993) (on file with the author) (used with permission of Thomas L. Hafemeister) [hereinafter O’Brien Memorandum]. The O’Brien Memorandum is a working document prepared for the internal use of IMDL and is intended as a complete State-by-State review of commitment statutes. See also Project Release v. Prevost, 722 F.2d 960, 973-74 (2d Cir. 1983) (holding that commitment of an individual without evidence of overt conduct showing substantial risk of serious harm does not violate substantive due process); In re Albright, 836 P.2d 1, 5-6 (Kan. Ct. App. 1992) (upholding constitutionality of Kansas statute permitting commitment in the absence of a recent, overtly dangerous act); Hatcher v. Wachtel, 269 S.E.2d 849, 852 (W. Va. 1980) (holding that commitment did not require a showing of imminent or substantial danger). But see Wyatt v. King, 781 F. Supp. 750, 753 (M.D. Ala. 1991) (applying Alabama law and requiring evidence of a recent overt act to continue a commitment predicated on dangerousness); Doremus v. Farrell, 407 F. Supp. 509, 514-15 (D. Neb. 1975) (requiring evidence of a recent overt “dangerous” act, and other due process protection, before ordering involuntary commitment); In re Harris, 654 P.2d 109, 113 (Wash. 1982) (en banc) (requiring evidence of a recent overt act showing a substantial risk of harm).
for future violence. A single examination, conducted immediately before and pursuant to the commitment hearing, provides a sufficient basis for the expert prediction of dangerousness. The pre-commitment hearing interview need not be a full-fledged mental status exam. The Court even may accept expert prediction of the accused's potential for future dangerousness when the testifying psychiatrist has never examined nor spoken to the accused, and the sole ground for forming the expert opinion is hypothetical questions posed to her by the prosecutor.

93. Id. at 450 (stating that the fact that the exam is short in duration is not, by itself, grounds to regard the resulting examination as deficient). A mental status examination is the standard method of assessing relative mental health and proper diagnosis. A full fledged mental status examination can take three hours or more to complete. By contrast, the average pre-commitment examination in the present case study, see infra tbl. A, was less than twenty minutes, a figure consistent with that reported elsewhere; see Thomas J. Scheff, Social Conditions for Rationality: How Urban and Rural Courts Deal with the Mentally Ill, in MENTAL ILLNESS AND SOCIAL PROCESSES 109, 112 (Thomas J. Scheff ed., 1967) (finding average psychiatric assessment interview in one urban court lasted 9.2 minutes). For a full description of a mental status exam, see EKKEHARD OTHMER & SIEGLINDE OTHMER, THE CLINICAL INTERVIEW USING DSM-III-R 109-74 (1989).
94. Cf. Barefoot v. Estelle, 463 U.S. 880, 903-05 (1983). Barefoot concerned expert testimony offered in support of the death penalty. If the Supreme Court was willing to allow diagnosis by hypothetical in the context of the ultimate punishment, the Court likely would permit such a basis for expert psychiatric testimony in a civil commitment hearing.

Because this Note includes a case study of commitment hearings in Virginia, see infra notes 181-215 and accompanying text, it is noteworthy that Virginia also allows expert opinion based on hypothetical questions posed to the expert during direct examination subject to minimal restrictions, see CHARLES E. FRIEND, THE LAW OF EVIDENCE IN VIRGINIA § 218 (3d ed. 1988). For a discussion of the Virginia Rules of Evidence as they relate to expert testimony in an involuntary commitment hearing, see infra notes 177-80 and accompanying text.

The tolerance for expert predictions based upon hypothetical questions is consistent with the Federal Rules of Evidence. Rule 703 governs the permissible bases of expert opinion testimony. See FED. R. EVID. 703. The rule is permissive, allowing opinion to be formed in any manner an expert might reasonably form an opinion in his practice. Id. The advisory committee note specifically includes hypothetical questions as a permissible basis of opinion at trial. Id. cmt.
CIVIL COMMITMENT AND INDIVIDUAL RIGHTS

Criticisms

Both Pro-Treatment and Pro-Rights critics have criticized the guidelines, rules, and processes by which civil commitment hearings are conducted, as well as the legal standards specifying the permissible boundaries of commitment. Pro-Treatment activists see the current process as hopelessly misguided in approach. Pro-Rights are concerned that the present rules are based on a fundamental misunderstanding of the doctor-patient relationship at play in a pre-commitment examination, which, in turn, creates an unfair playing field.

The Pro-Treatment Critique

Pro-Treatment proponents believe that the law should be restructured, in virtually every field, to capitalize on its opportunity to serve as a therapeutic force. This approach focuses on the therapeutic or anti-therapeutic effect of existing legal rules, roles, and procedures. Advocates of "therapeutic jurisprudence" seek to revolutionize the law so that lawyers as well as judges would act as therapeutic agents. "The psychological perspective highlights the importance of conducting judicial hearings in ways that will have positive psychological consequences on those who undergo commitment hearings."

Under a therapeutic jurisprudence approach, judges would require those pleading guilty to take the stand and give a detailed recital of their crime or other transgression. This recitation would constitute a first step toward the cognitive restructuring

95. Wexler, supra note 71, at 280. The therapeutic jurisprudence approach arose from mental health law. Wexler believes the approach would be of value in a wide range of fields of law, including criminal law, health law, and family law. Id. at 281; see also Tom R. Tyler, The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings, 46 SMU L. REV. 433 (1992) (discussing the therapeutic effects of the commitment process); David B. Wexler & Bruce J. Winick, Therapeutic Jurisprudence and Criminal Justice Mental Health Issues, 16 MENTAL & PHYSICAL DISABILITY L. REP 225 (1992) (explaining how therapeutic jurisprudence can be applied to criminal justice and mental health issues).

96. Wexler & Winick, supra note 95, at 225.
97. Wexler, supra note 71, at 285-89.
98. Tyler, supra note 95, at 444.
99. Wexler, supra note 71, at 286-87. The judge could ask the defendant questions about the crime or allow the defendant to make his own statement.
process of psychotherapy. Defendants who admit every aspect of their guilt would receive a more lenient sentence than those who attempt to excuse their own behavior. Those who contest the government's case could be subject to even harsher sentencing upon a finding of guilt.

Professor Wexler's suggestion is fraught with problems. First, despite the author's conclusory denial, therapeutic jurisprudence represents the ultimate victory of the therapeutic state. Every defendant, regardless of the strength of the case against him, would be subject to this therapeutic approach. The threat of harsher punishment upon a finding of guilt after trial would significantly curtail the right to defend.

Wexler either overestimates the skills of judges or underestimates the skills of therapists when he suggests that judges can, in effect, perform therapy in the courtroom. Psychotherapeutic techniques are not parlor tricks to be used indiscriminately by the mildly informed. Wexler actually recognizes the critique that "judges make lousy social workers." In response, he stresses that because judges impact defendants in a manner similar to social workers, the system should recognize and capitalize on this

100. Id. at 290 (asserting the potential for judges to employ cognitive restructuring as a first step in the rehabilitative process).

101. Id. at 287. Harsher sentencing after trial would require that the judge find the defense perjurious. Wexler offers no guidelines to restrain a judge from so finding.

102. "Therapeutic jurisprudence in no way advocates coercion, paternalism, or a 'therapeutic State.'" Id. at 280.

103. This curtailment implicates possible constitutional violations under Blackledge v. Perry, 417 U.S. 21 (1974) and North Carolina v. Pearce, 395 U.S. 711 (1969); see infra notes 111-20 and accompanying text.

104. "'[N]o great amount of specialized training' is required to use the recommended [therapy] techniques." Wexler, supra note 71, at 298 (quoting DONALD MEICHERNBAUM & DENNIS C. TURK, FACILITATING TREATMENT ADHERENCE: A PRACTITIONER'S GUIDEBOOK 261 (1987)). Note that Meichenbaum and Turk's book addresses skilled practitioners in the helping professions, not laypeople. "Helping professionals" are considered to include physicians, psychologists and psychiatrists, social workers, nurses, and, possibly, mental health paraprofessionals such as alcoholism counselors. Frederick H. Kanfer & Arnold P Goldstein, Introduction, in HELPING PEOPLE CHANGE 2 (Frederick H. Kanfer & Arnold P. Goldstein eds., 1986). Judges and lawyers are conspicuously absent from this list.

aspect of the judge’s role. Wexler fails to appreciate the therapeutic effect of being held accountable for the consequences of one’s own behavior without condescending attempts at paternalism.

Further, under his plan, the reach of therapeutic jurisprudence would extend past trial and intrude into the treatment of the convicted defendant. The detailed admission of guilt required to receive the most lenient sentence could be used against the defendant after trial. Wexler specifically recommends that trial transcripts be used to confront the offender if he tries to deny guilt after placement in a treatment program. In addition to constituting a serious denial of privacy within the treatment setting, this use of the admission of guilt would also jeopardize the defendant’s rights in future trials.

Therapeutic jurisprudence is more than just a bad idea. It is probably unconstitutional as well. If the severity of a defendant’s sentence is correlated with the defendant’s willingness to forfeit his right to defend and take the stand to make a detailed confession of guilt, as Wexler suggests, then the defendant faces a Hobson’s choice: should he exercise his constitutional right to defend at the risk of a significantly enhanced sentence?

106. Wexler, supra note 71, at 298-99; see also Tyler, supra note 95, at 439 (“If people leave commitment hearings with favorable views about the legitimacy of legal authorities, such views are likely to facilitate the subsequent therapeutic process.”).

107. Stanton Peele, a critic of the ever-expanding definition of, and treatment for, alcoholism, cites research finding that drunk drivers who suffer criminal penalties fare better than their counterparts who receive therapy rather than punishment. STANTON PEELE, DISEASING OF AMERICA: ADDICTION TREATMENT OUT OF CONTROL 57 (1989); see also Daniel W. Shuman, Therapeutic Jurisprudence and Tort Law: A Limited Subjective Standard of Care, 46 SMU L. REV. 409, 409 n.4 (1992) (citing research indicating better outcomes for patients following voluntary rather than involuntary mental hospitalization).


109. Because the court transcripts are a matter of public record, they can be used against the defendant/patient without special permission. Currently, privacy laws protect the patient’s history.

110. For example, his testimony could be impugned in any future trial in which he participates. Moreover, he could be subjected to harsher penalties after future convictions for similar offenses based on a possibly strategic admission of guilt at an earlier trial.

111. Wexler, supra note 71, at 289-87.

112. Indeed, under a therapeutic jurisprudence procedure, the defendant would re-
This issue raises the specter of vindictive sentencing. Under the holdings of North Carolina v. Pearce and Blackledge v. Perry, a defendant may not be subjected to greater penalties for vigorous use of his constitutional rights. Although the Supreme Court has limited Pearce and Blackledge, and "the Due Process Clause is not offended by all possibilities of increased punishment, but only by those that pose a realistic likelihood of 'vindictiveness','" the prohibition against vindictive sentencing continues to apply whenever "the government, in response to a defendant's exercise of legally-protected rights, brings additional or more severe [punishment] based on the same underlying offense." Because the fear of possible vindictive action tends to chill seriously a defendant's exercise of his constitutional rights, the Court will apply vindictive sentencing analysis even in the absence of actual retaliatory motivation. The Supreme Court likely would find that a defendant subjected to harsher sentencing because he had chosen to mount a defense demonstrates a "realistic likelihood of 'vindictiveness.'"

113. Vindictive sentencing occurs when sentencing is enhanced in response to the defendant's exercise of his constitutional rights. See generally Michael P Doss, Comment, Resentencing Defendants and the Protection Against Multiple Punishment, 133 U. PA. L. REV. 1409 (1985).

114. 395 U.S. 711 (1969) (finding a Fourteenth Amendment due process violation when a judge increases the sentence upon reconviction after retrial following a successful appeal).

115. 417 U.S. 21 (1974) (holding that the Due Process Clause of the Fourteenth Amendment is violated if there is a reasonable likelihood of prosecutorial vindictiveness toward a defendant who successfully exercised his constitutional rights).


117. Perry, 417 U.S. at 27.


120. Id. at 27.
The Pro-Rights Critique

Pro-Rights proponents disagree with the evidentiary standards for civil commitment on philosophical, constitutional, and practical grounds. First, they argue that the Supreme Court places too much reliance on expert psychiatric testimony because of a fundamental misunderstanding of the psychiatrist-patient relationship at play in a pre-commitment hearing. Second, Pro-Rights critics charge that the statutorily mandated, independent expert evaluation insufficiently protects the defendant's due process rights. Third, Pro-Rights advocates complain that current evidentiary rules create an unfair playing field, disadvantaging the accused.

Philosophically, Pro-Rights proponents object to the Supreme Court's overreliance on expert psychiatric testimony because the Court misunderstands the nature of the doctor-patient relationship upon which that testimony is based. The Court understands the psychiatrist-client relationship as a voluntary and cooperative professional-client interaction focused on the client's best interests. This description does not capture the psychiatrist-patient relationship in the context of civil commitment. Far from voluntarily consulting the physician of his choice, the typical defendant is poor and cannot choose who will examine him. During the

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121. See Stefan, supra note 66, at 644.
122. Speiser, supra note 76, at 141-43.
123. See, e.g., Enns & Litwack, supra note 70, at 734-51.
124. Stefan, supra note 66, at 659.
125. Perhaps the clearest statement of the modern Court's image of the doctor/patient relationship is Justice Blackmun's description in his dissent in Rust v. Sullivan, 500 U.S. 173 (1991). Blackmun describes it as: "A unique relationship of trust. [P]atients place their complete confidence, and often their very lives, in the hands of medical professionals. One seeks a physician's aid not only for medication or diagnosis, but also for guidance, professional judgement, and vital emotional support." Id. at 218 (Blackmun, J., dissenting). Obviously, this model does not apply to a doctor/patient interaction in which the patient wants only to be left alone and has chosen neither the specific doctor nor any doctor at all.
126. Stefan, supra note 66, at 649.
127. Id. at 644.
pre-commitment examination, the examining psychiatrist assesses the accused's appropriateness for involuntary commitment—a deprivation of liberty—but the accused has no right to remain silent. In fact, the accused receives only minimal information regarding the future use of the examination. When a


Defendants in civil commitment hearings apparently have few due process protections. The California Supreme Court recently held the exclusionary rule inapplicable in a civil conservatorship proceeding. Lake County Mental Health Dep't v. Susan T., 8 Cal. 4th 1005, 1010, 1014 (1994) (refusing to bar evidence obtained by "a government official" who entered the defendant's home without a warrant while the defendant was in state custody and "in the absence of any demonstrable exigent circumstances").

129. The information supplied by Eastern State Hospital in Williamsburg, Virginia, to those temporarily detained and awaiting a civil commitment hearing is typical. Its complete text reads as follows:

DETECTION ORDER
You were sent here for an evaluation to determine whether or not you need psychiatric treatment. You will be seen by a psychologist and. On at there will be a civil hearing to make the decision on your need for treatment. You will be seen by an attorney prior to the hearing. The attorney is appointed to ensure that your rights are protected. You have a right to have witnesses present and the social worker will assist you in contacting them.

The hearing is informal. The judge will hear the doctor's evaluation and then he/she will hear from any community representatives and any witnesses present. Your attorney will be able to question the doctor and witnesses. You will then be given an opportunity to respond with your attorney's assistance.

The judge will make one of three decisions:
1) you may be released
   -or-
2) you may be allowed to sign yourself into the hospital as a voluntary patient if the doctor and the judge feel you are competent to do so
   -or-
3) you may be ordered to stay at the hospital. You have the right to appeal this decision. Just let your attorney know if you desire to appeal.

If you have any questions, please ask the staff.
representative of the State, who will later testify for the State at the accused’s commitment hearing, forces the accused to submit to an examination, the Supreme Court’s model of a doctor-patient relationship “involving the highest level of intimacy and trust” is not applicable. Given the true nature of the doctor-patient relationship in the civil commitment context, the Court errs by putting more faith in the psychiatric expert’s testimony than the client puts into the expert’s examination.

Moreover, in the civil commitment setting, the psychiatrist-patient connection is in fact a captive relationship in which the psychiatrist has an inescapable conflict of interest. This conflict has several sources. At its most basic level, psychiatrists are typically male, white, and reasonably affluent. Civil commitment defendants typically are not. Although the mere fact of a cultural gap between doctor and patient, standing alone, should not receive excessive emphasis, the patently personal nature of the assessment heightens the importance of this gap in psychiatric assessment. In psychiatric assessment, psychiatrists explicitly are taught to use their own (culturally derived) understanding of normal behavior as a baseline against which to assess the normality of the examinee.

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This document is of little use to a person awaiting a civil commitment hearing. A better, more protective, and complete informational packet would inform the accused of the exact grounds on which he could be involuntarily committed.

130. Stefan, supra note 66, at 649.
131. Id. at 644, 655-67.
132. Id. at 643 n.12 (noting that men compose 76.2% of all psychiatrists).
133. Id. at 658.
134. Id. at 659.
135. Medical training stresses the personal nature of the assessment and the doctor’s personal view of normality. See, e.g., RONALD S. KRUG & ALVAH R. CASS, OKLAHOMA NOTES: BEHAVIORAL SCIENCES (2d ed. 1989) (a widely used study guide for medical students). This study guide suggests the following guideline for assessing the proper psychotropic medication to be used:

b. Put yourself in the patient’s shoes:
   (1) If given the same circumstances, you would feel the same way—don’t use anything.
   (2) If you conclude you would feel differently, but understand how the patient feels—minor tranquilizers.
   (3) If you conclude that you don’t know what the hell is
The nature of psychiatric diagnostic categories themselves compounds this unavoidable cultural bias. Classifications of psychopathology tend to reinforce the cultural norms of those making the diagnoses. Ultimately, the classifications themselves are reached, not via scientific advancement, but through consensus or actual vote. Thus, both the individualized assessment and the established classifications of psychopathology defining abnormality are highly dependant on cultural norms.

Finally, the psychiatrist's goal of treating the defendant is in direct conflict with the defendant's desire to be left alone. The defendant inevitably loses when these goals conflict: psychiatrists tend to suspect the competence and judgement of those who disagree with their recommendations. In sum, the testifying psychiatrist may be decidedly less neutral than the Supreme Court imagines.

Id. at 183.

In addition to learning an established scoring system, psychiatrists are taught to use their own projections to ascertain the appropriateness of an examinee's responses to projective stimuli such as Rorschach Tests and Thematic Apperception Tests. Some projective tests, such as Sentence Completion, rely exclusively on the psychiatrist's personal assessment for scoring. Id. at 98.

136. Stefan, supra note 66, at 661-62 (stating that psychiatric diagnostic categories are created by consensus; the race, gender and socioeconomic status of those making the determination is relevant to their views on the dividing line between normality and abnormality); see Perlin, supra note 63, at 397 (noting that even mental health professionals are susceptible to sanist myths); see also THOMAS J. SCHEFF, BEING MENTALLY ILL 159 (1984) ("The separation of members of society along the axis of sanity and insanity is largely a product of social rather than medical or scientific selection."); cf. SEYMOUR SARASON, PSYCHOLOGY MISDIRECTED (1981) (arguing that psychologists must first examine their own biases and assumptions about what constitutes normal and abnormal behavior before taking aim at society). But see DSM-IV, supra note 10, at xxiv (stressing the difficulty in applying Personality Disorder criteria across cultural settings).

137. DSM-IV, supra note 10, at xix (noting that a review of the empirical literature had limited utility for some issues).

138. See id. at xviii-xx (describing the process for revision of DSM-IV).

139. Stefan, supra note 66, at 656-57.

140. Id. at 657. For a more detailed discussion of therapist reaction to patient disagreement, see WILLIAM H. PINCUS, THE PROBLEM OF GAUGUIN'S THERAPIST: LANGUAGE, MADNESS AND THERAPY 51-53 (1994) (noting that patient disagreement typically results in the upgrading of the psychiatric diagnosis and/or an increase in the length of hospitalization).

141. Stefan, supra note 66, at 655-67.
Apart from these problems in the relationship between doctor and patient, the decision at issue in a commitment hearing is constitutional, not clinical. An expert's assurance that a particular course of action is in the best treatment interests of the accused implicates the issue of whether that course of action is constitutionally permissible. Historically, psychiatric experts have ordered unconscionable treatment such as the use of cattle prods on mentally ill patients to reduce aggressive behavior. Because the question of the clinical effectiveness of a particular course of action is independent of the question of its constitutionality, the latter question is properly reserved for the trier of fact.

Ignoring the distinction between the clinical efficacy and constitutional validity of a particular course of treatment, the Supreme Court justifies the rather lax foundation for expert predictions of dangerousness by noting that the accused has the opportunity for cross-examination and for calling his own expert witnesses to dispute the testimony of the State's experts. Although these opportunities may exist in theory, as a practical matter, they are rarely utilized. One obstacle to implementing these defenses is the lack of zeal on the part of the attorneys defending in the civil commitment context.

142. Id. at 715-16. Interestingly, Pro-Treatment advocates also recognize this distinction. "Many of the issues at the heart of mental health law are legal, not clinical." Wexler & Winuck, supra note 95, at 226.
143. Tyler, supra note 95, at 434 n.7.
144. Stefan, supra note 66, at 715-16.
The determination of dangerousness involves a delicate balancing of Society's interest in protection from harmful conduct against the individual's interest in personal liberty and autonomy. This decision, while requiring the court to make use of the assistance which medical testimony may provide, is ultimately a legal one, not a medical one. Id. at 302.
147. See supra notes 67-70 and accompanying text.
149. See Perlin, supra note 63, at 404-05 (1992). Perlin cites studies finding that
A second obstacle to an effective defense is the poverty of the typical defendant in psychiatric commitment hearings, coupled with the State's refusal to pay for an examination by a psychiatrist of the accused's choosing. Pro-Rights critics charge that this refusal is an affront to defendant's due process rights.

The denial of a right to an independent psychiatrist at the State's expense in the civil commitment context prohibits an indigent defendant from mounting an adequate defense. Although State statutes typically provide for an examination by a presumably neutral psychiatrist, this provision is not the equivalent of providing legal representation. The public defender may be paid by the State, but his role, if not his actual performance, is to zealously defend his client. By contrast, State-appointed psychiatric experts typically identify with the State's interests and are far from neutral.

Yet even absolute neutrality would be insufficient to guard the indigent defendant's due process rights. A defense psychiatrist is representation by counsel in commitment hearings is so ineffective that when public defender organizations represent the accused, his outcome is likely to be more favorable than if he retains private counsel. Id. at 405 n.243. Perlin cites another study finding that the accused was more likely to be released if he appeared pro se than if he paid for private representation. Id. at 404-05. The case study discussed in this Note, infra notes 181-215 and accompanying text, also found the attitude of defense attorneys to be less than zealous, see infra notes 204-09 and accompanying text.


151. Spenser, supra note 76, at 143. The court in Goetz failed to reach this question in granting summary judgment.

152. Id.

153. Virginia's commitment statute is representative. Section 37.1-67.3 of the Virginia Code requires the judge to order a psychological examination prior to the hearing. VA. CODE ANN. § 37.1-67.3 (Michie Supp. 1994). The statute also permits the defendant to arrange for an independent psychological evaluation at private expense. Id.

154. The meaning of "zealous" defense in the civil commitment context is an open question. See supra note 149 and accompanying text; infra notes 204-09 and accompanying text.

155. Stefan, supra note 66, at 655-67; see also supra notes 131-41 and accompanying text.
an absolute necessity in civil commitment hearings. "No matter how brilliant the lawyer may be, he is in no position to effectively contest the commitment proceedings because he has no way to rebut the testimony of the psychiatrist from the institution who has already certified to the patient’s insanity."156 As the Supreme Court has noted, psychiatrists can assist defense counsel in a variety of important ways: "psychiatrists gather facts [to] share with the judge, they analyze the information gathered and from it draw plausible conclusions about the defendant’s mental condition They know the probative questions to ask of the opposing party’s psychiatrists and how to interpret their answers."157

There are two weaknesses with the Pro-Rights emphasis on the need for an independent psychiatrist to buttress the defense in a civil commitment hearing. As a practical matter, even if the accused was provided with an independent psychiatric examination, given the relative costs of error, a defense psychiatrist is unlikely to testify that the accused is not dangerous.158 Thus, the fact-finder would be left to decide between one expert who says the defendant is dangerous and one who will say only that dangerousness is unpredictable.159 In addition, defense counsel in civil commitment hearings typically assume a paternalistic rather than a zealous approach to defending the rights of the

156. Speiser, supra note 76, at 190 (quoting In re Gannon, 301 A.2d 493, 496 (N.J. Super. 1973)).

157. Ake v. Oklahoma, 470 U.S. 68, 80 (1985). Although Ake concerned the importance of a defense psychiatrist to a defense based on the insanity plea, the Court’s description of the possible contributions of a defense psychiatrist is readily transferable to the civil commitment context. The plaintiffs in Goetz, citing Ake, asked for expert assistance both for testimonial purposes and for consultation with defense counsel. Goetz v. Crosson, 967 F.2d 29, 33 (2d Cir. 1992).

158. Barefoot v. Estelle, 463 U.S. 880, 934 (1983) (Blackmun, J., dissenting) (noting that no responsible psychiatric expert would testify that the accused is not dangerous, only that dangerousness is impossible to predict, leaving the jury to choose between an expert who confidently predicts future violence and one who hedges his bet regarding the probable future behavior of the accused); see also PINCUS, supra note 140, at 87-88 (discussing the pressures that work against anyone in the spectrum of authorities involved with a civil detainee—expert witnesses, judges, juries, and, after detention has been ordered, the treating psychiatrist with the power to discharge—who reach the conclusion that the individual is not dangerous).

159. See Barefoot, 463 U.S. at 934 (Blackmun, J., dissenting).
An independent psychiatrist’s advice, therefore, would fall on unenthusiastic ears.\footnote{Possibly, counsel would defend more zealously if they had the reassurance of an “expert” that the defendant did not require confinement.}

\textit{Hypothetical}

Returning to the hypothetical case described earlier,\footnote{See \textit{supra} text accompanying notes 73-75.} imagine that Paul, our songwriting ex-stockbroker, and his family have exhausted all their funds in pursuit of his “being discovered” after he quit his job. During this time, he had arranged a genuine opportunity for significant public exposure, but the public flatly rejected his work. Paul still can return to his old job with the brokerage house, and his wife begs him to do so. He refuses, suspecting his wife of sabotaging his big chance. More certain than ever of his own musical genius, he tells her he has decided to leave her and the children in order to pursue his “art.” She has him temporarily committed to a mental hospital to await a civil commitment hearing.

From a Pro-Treatment perspective, Paul’s commitment is long overdue. The evidence of his dramatic decline is clear and convincing. A psychiatrist likely would find that his abrupt change of careers and his decision to leave his family are signs of depression. His persistent belief in his own “genius,” despite empirical evidence to the contrary—the public rejection of his work—may further suggest a Delusional Disorder, Grandiose Type. Failure to commit the ex-stockbroker would, in effect, make society complicitous in his self-destruction and the destruction of his family.

Pro-Right advocates might accept, arguendo, the psychiatric diagnosis and still maintain that no compelling case has been established explaining why the State must forcefully commit Paul. He may be depressed and even delusional; clearly he has made a series of poor choices. However, there is still no showing that Paul is a danger to anyone nor that he is unable to meet his basic needs. A Pro-Rightist might believe, from a personal perspective, that the ex-stockbroker is acting irrationally and against his own interests and those of his family yet maintain that the

\footnote{Perlin, \textit{supra} note 63, at 404-05.}
State has no right to interfere.

LIMITED CASE STUDY OF ACTUAL COMMITMENT HEARINGS: WEIGHING THE THEORETICAL CRITIQUES AGAINST ACTUAL PRACTICE

In order better to assess the relative merits of the contemporary criticisms of the civil commitment process,163 this Note will discuss a case study. This study consisted of observing ten commitment hearings in a Virginia State mental hospital for the purpose of assessing both how the current laws governing commitment are applied and the relative merits of the diametrically opposed critiques discussed throughout this Note. Before discussing the results of this case study, it is necessary to address the Virginia commitment statute and Virginia laws of evidence relative to other approaches nationwide.

Relevance

The Similarities and Differences Between Virginia and Other States’ Statutory Authorizations of Involuntary Commitment Proceedings

States employ varying standards for involuntary commitment.164 These standards tend to fall into four categories: (1) Physical Danger—requiring serious harm involving physical injury,165 (2) Imminent Danger—requiring the likelihood of a substantial risk of danger in the near future,166 (3) Overt Conduct—requiring that the finding of dangerousness to self or others be supported by a “recent overt act,”167 and (4) Gravely Dis-

163. See supra notes 32-72, 95-161 and accompanying text.
167. Kaufman, supra note 16, at 351-52. Kaufman does not cite any state that has adopted this criteria by statute but refers to a West Virginia case, Hatcher v. Wachtel, 269 S.E.2d 849 (W. Va. 1980), in which the court rejected commitment
abled—allowing for commitment of persons whom the State regards as unable to meet their most basic needs. Under the fourth standard, the court must find that the self-neglect would eventually lead to such personal deterioration that the person would become a danger to himself.\footnote{168}

Approximately one-third of the states restrict commitment to those who are adjudged dangerous, using one of the three definitions discussed above, whereas the majority of states also permit commitment of the gravely disabled.\footnote{169} The gravely disabled standard is considered the more lenient commitment criteria\footnote{170} because it is more discretionary.

In Virginia, the involuntary commitment of persons to psychiatric hospitals is governed by section 37.1-67.3 of the Code of Virginia. This statute authorizes involuntary detention when the judge finds either that the person is mentally ill and presents an imminent danger to himself or others, or is so mentally impaired as to be "substantially unable to care for himself."\footnote{171} In addition, the judge must determine that no less restrictive treatment setting would be satisfactory.\footnote{172} Thus, Virginia's criteria for commitment is identical, in whole or in part, to the criterion most other states employ.\footnote{173}

The judge's findings typically are based upon the testimony of expert witnesses, usually psychiatric experts who have examined the accused. Virginia, like most other states, mandates that the state provide such an examination prior to the commitment process.\footnote{174} Also consistent with the approach taken by other states,
Virginia allows the accused to rebut with testimony from a private examiner but will not provide indigent defendants with funds for this independent evaluation. In Virginia, the examiner must determine whether probable cause exists to believe that the person is mentally ill, that the person is imminently dangerous to self or others, and that involuntary hospitalization is required.

The Similarities and Differences in the Rules of Evidence Employed by Virginia and States Adopting the Federal Rules

Although Virginia has not adopted the Federal Rules of Evidence, recent changes to the Virginia Code have brought its rules regarding expert testimony into accord with the Federal Rules. Both Virginia and the Federal Rules allow experts to base their opinions on inadmissible hearsay evidence if it is the type of evidence upon which experts in the field normally rely—including hearsay evidence such as reports from family members regarding the behavior of the accused. The expert need not lay the foundation for his opinion, but opposing counsel may inquire into the basis of the opinion on cross examination. In

This requirement is similar to that mandated by other states. See, e.g., Speiser, supra note 76, at 151 & n.46.

175. The Virginia Code provides in relevant part that the defendant may “obtain independent evaluation and expert opinion at his own expense.” VA. CODE ANN. § 37.1-67.3; see also Speiser, supra note 76, at 151-56 (discussing New York’s refusal to provide an indigent defendant with a psychological expert for the defense).

176. VA. CODE ANN. § 37.1-67.3. Note that although the Virginia Code allows for forced hospitalization of a person deemed substantially unable to care for himself, the psychiatric evaluation ordered pursuant to the commitment hearing does not mandate a finding on this issue. Id. Although the examiner must determine if the person is mentally ill, the requisite incapacity to care for self clearly exceeds the mere existence of mental illness. The statute, therefore, contradicts the Supreme Court’s holding that the State may not confine an individual solely on the basis of a finding of mental illness. See O’Connor v. Donaldson, 422 U.S. 563, 575 (1975).

177. VA. CODE ANN. § 8.01-401.1 (Michie Supp. 1994) was amended in 1982 to bring the rules governing opinion testimony by expert witnesses in accord with FED. R. EVID. 703.


179. FED. R. EVID. 703; VA. CODE ANN. § 8.01-401.1.

all important respects, the Virginia rules of evidence mirror the federal rules regarding the admission of expert testimony in a psychiatric commitment hearing. Thus, a case study of civil commitment hearings in Virginia provides a fair platform for reflection on the merits of current commitment standards and rules.

The Case Study

Purpose

The purpose of this case study was to observe the application of the law in actual practice and to assess the relative merits of the Pro-Treatment and Pro-Rights critiques. The sample size is too small to reach any statistically significant conclusions. However, Table A summarizes the results.

Methodology

At each hearing, I focused on the following questions: (1) What behavior brought the subject of the hearings to the attention of the civil authorities? (2) By what methods did the examining psychiatric expert assess the mental condition and putative dangerousness or incapacity of the subject and how much time was spent in the assessment? (3) What did the examining psychiatric expert recommend? (4) What evidence supported the recommendation? (5) What evidence was presented in rebuttal, and what was the defense attorney's attitude toward defending a court-assigned client in a civil commitment hearing? (6) What did the judge order?

181. For a discussion and critique of the justifications, guidelines, and evidentiary requirements for civil commitment, see supra notes 16-161 and accompanying text.
182. In Virginia, as in virtually every state, a state-licensed psychiatrist or clinical psychologist must first examine the person whose possible commitment is to be weighed, or, if unavailable, a state-licensed physician or psychologist qualified in the diagnosis of mental illness must conduct the examination. VA. CODE ANN. § 37.1-67.3 (Michie Supp. 1994).
183. In every case, the attorney appeared pro bono as assigned by the court. In every case, the attorney had no prior relationship with the defendant and did not anticipate any future relationship.
184. In Virginia, a "special justice," often another lawyer, conducts civil commitment hearings. For purposes of this Note, the word "judge" will be employed.
Findings

Observation of actual commitment hearings suggests the following findings:

*Society is adequately protected by present commitment law* When the defendant in a civil commitment hearing had physically assaulted someone, as did Patients 5\(^\text{185}\) and 6, or when the patient had made serious threats of injury, as did Patient 9, they were properly committed pursuant to the State's police power to protect the general welfare.\(^\text{186}\)

\(^{185}\) Patient 5 voluntarily entered the hospital after assaulting his wife. *See supra* tbl. A. Although he was not ordered into the hospital, his voluntary entry was strategic and responsive to both civil commitment law and criminal law concerns.

\(^{186}\) *See supra* notes 16-30 and accompanying text.
<table>
<thead>
<tr>
<th>PATIENT NUMBER</th>
<th>RACE</th>
<th>SEX</th>
<th>TRIGGERING EVENT</th>
<th>ASSESSMENT (TIME)**</th>
<th>OPINION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BF</td>
<td></td>
<td>prior commitment order expired; hospital seeks recommitment</td>
<td>not done; psychologist's opinion based on in-hospital observations</td>
<td>recommit as grave disabled</td>
</tr>
<tr>
<td>2</td>
<td>WM</td>
<td></td>
<td>presently-hospitalized, voluntary patient requests release</td>
<td>in-hospital observation</td>
<td>commit as dement and deteriorating</td>
</tr>
<tr>
<td>3</td>
<td>WM</td>
<td></td>
<td>drunk in public (non-student on college campus) had left hospital AMA*** 3 days earlier</td>
<td>interview (15 min.)</td>
<td>commit as danger to self and others</td>
</tr>
<tr>
<td>4</td>
<td>BM</td>
<td></td>
<td>left hospital AMA picked up by police wearing only his underwear</td>
<td>refused to cooperate</td>
<td>commit as gravely disabled</td>
</tr>
<tr>
<td>5</td>
<td>BM</td>
<td></td>
<td>beat wife</td>
<td>interview (&lt;20 min.)</td>
<td>n/a</td>
</tr>
<tr>
<td>6</td>
<td>BM</td>
<td></td>
<td>assaultive behavior in jail</td>
<td>could not be done***</td>
<td>commit as gravely disabled</td>
</tr>
<tr>
<td>7</td>
<td>WF</td>
<td></td>
<td>suicidal gesture*** during alcohol binge</td>
<td>interview (&lt;20 min.)</td>
<td>release</td>
</tr>
<tr>
<td>8</td>
<td>BM</td>
<td></td>
<td>prior commitment order expired; hospital seeks re-commitment</td>
<td>in-hospital observations</td>
<td>recommit as grave disabled</td>
</tr>
<tr>
<td>9</td>
<td>BM</td>
<td></td>
<td>discovered running in traffic, shouting homicidal and suicidal threats, in possession of a box cutter</td>
<td>interview (&lt;20 min.)</td>
<td>commit as mental and dangerous</td>
</tr>
<tr>
<td>10</td>
<td>WF</td>
<td></td>
<td>overdosed on prescription drugs and alcohol</td>
<td>interview (&lt;20 min.)</td>
<td>commit as danger self</td>
</tr>
</tbody>
</table>

187. Where indicated, Assessment Time is based on Examiner's estimate.
188. AMA stands for “Against Medical Advice.”
189. Patient 6 was transferred from jail to hospital in four-point restraints. The only notation on his transfer papers read: “Assaultive behavior in jail.” He was agitated upon arrival at the hospital and the hospital staff administered Haldol, an antipsychotic. No assessment was attempted until the following morning. However, in the morning, the patient was only semi-conscious and unable to carry on conversation. He was also found to be suffering from a potentially fatal staph infection.
190. Suicide threats and/or attempts are highly successful manipulative devices. Some personality types, such as Borderline Personalities, are masters of the unsuccessful suicide attempt. Indeed, “recurrent suicidal behavior, gestures, or threats” is a diagnostic criteria of Borderline Personality Disorder. DSM-IV, supra note 10, at 651. Thus, it is not uncommon for a Borderline patient to have a history of six or more “attempted suicides.” However, it is equally common for these attempts to be highly superficial. DSM-IV describes typical Borderline Personality Type behavior, in this regard, as “frantic efforts to avoid abandonment such as self-mutilating.” Id. at 650.
Each Attorney was asked about his or her approach to defense in civil commitment cases. "Social Welfare" indicates that the attorney was generally willing to follow whatever the hospital recommended. "Zealous Defense" indicates that the attorney intended to fulfill his or her normal institutional role. For a discussion of these two models of attorney participation in civil commitment proceedings, see DONALD H.J. HERMANN, REPRESENTING THE RESPONDENT IN CIVIL COMMITMENT PROCEEDINGS 2-10 (1985).

Although the defense attorney acquiesced in hospital recommendation, the presiding judge refused to commit in the absence of any supporting evidence.

The State cannot commit a patient who agrees to enter voluntarily. A voluntary patient may sign out of the hospital at any time although the State may seek commitment if the patient expresses an intention to leave.
Pro-Rightists will note that these defendants committed recent overt acts\textsuperscript{194} demonstrating their dangerousness. A statute requiring that commitment pursuant to a finding of dangerousness be based on a recent overt act would have resulted in their commitment. Such a statute, however, would have properly permitted Patient 3,\textsuperscript{195} whose dangerousness had to be inferred from his drinking and non-compliant behavior, to go free. Patient 3 provides a clear example of the danger to personal freedom posed by a commitment standard requiring less than a recent overt act.

Pro-Treatment advocates counter that a recent overt act standard would include only the most dangerous among the mentally ill in need of confinement, frustrating social efforts to intervene and help those mentally unstable individuals who, although they have yet to commit an overtly dangerous act, are close to the breaking point. Pro-Treatment advocates might point to Patient 4\textsuperscript{196} as an example of such a person. Moreover, Pro-Treatment advocates will note, the recent overt act standard necessarily means that society can respond only after a menacing act by a mentally ill individual. Obviously, some of these acts will result in serious injury and even death to innocent victims.

The commitment statute is loosely construed. Even this limited case study reveals multiple instances in which commitment was ordered on the basis of a highly attenuated connection between the defendant's behavior and either dangerousness or grave inability to meet one's own needs. For example, a young man\textsuperscript{197} was committed after being found drunk on the campus of a college he did not attend. One might safely assume that he was not the only person drinking on campus. But this behavior, coupled with the fact that he had three days earlier exercised his option as a voluntary patient to leave the hospital against medical advice\textsuperscript{198} and with his adamant refusal to cooperate with any outpatient treatment order, was sufficient to have him involuntarily committed.

\textsuperscript{194} See \textit{supra} note 167 and accompanying text.
\textsuperscript{195} See \textit{supra} tbl. A.
\textsuperscript{196} See \textit{supra} tbl. A.
\textsuperscript{197} Patient 3, see \textit{supra} tbl. A.
\textsuperscript{198} The patient said he had entered the hospital to escape pressure at home and left when it seemed safe to return home.
A second example of loose statutory construction is provided by Patient 2. The hospital sought involuntary commitment when this voluntary patient asked to leave. The testifying psychologist opined that Patient 2 was demented and deteriorating and should be committed as gravely disabled because he was unable to attend to his basic needs. However, the only evidence offered in support of this opinion was testimony that, in the preceding month, the patient had twice wandered off during group activities and that the patient was occasionally incontinent. Although the testifying psychologist interpreted Patient 2's wandering away from group activities as a sign of dementia, this behavior is also perfectly consistent with the goal-directed behavior of a person who no longer wishes to be part of any hospital group. Nevertheless, the judge ordered involuntary commitment.

These examples support the Pro-Rights critique that the lack of clearly defined standards—a requirement of a recent, overtly dangerous act, or a patent inability to care for self—allows judges to apply an overly loose construction of commitment statutes. Judges apply such loose standards, Pro-Rightists contend, because they are themselves susceptible to “sanist myths” of the dangerousness and extreme disability of the mentally ill.

However, Pro-Treatment advocates argue that loose construction is necessary because the dangerousness or grave incapacity standard is too high a burden to meet. Patient 2, they would probably concede, is neither dangerous nor wholly lacking in ability to care for himself. Yet in his dementia, he can be cared for best in a hospital setting. To release this person would be akin to failing our social obligation to protect him.

Pro-Treatment proponents would likely make the same argument with regard to Patient 4. This man was found wandering around in his underwear and was observed drinking water from a toilet bowl. Although he may have some minimal capacity

199. See supra tbl. A.
200. See supra notes 63-68 and accompanying text.
201. See supra notes 64-65.
202. For the Pro-Treatment critique that dangerousness is an inappropriate standard to determine the need for psychiatric hospitalization, see supra notes 32-44 and accompanying text.
203. See supra tbl. A.
to attend to his own basic needs, his behavior clearly indicates that both he and the community would be better off if he received in-patient psychiatric care.

*Lawyers are failing their professional role.* Six different attorneys represented these ten defendants. Only two, when asked prior to the hearings about their attitudes toward their professional obligations in the civil commitment context, expressed an intention to zealously defend.204 One of these two attorneys added that although prepared to represent her client’s expressed interest, she personally believed that the client’s expressed interest was not consistent with his best interests.

Each of the other four attorneys stated that they were prepared to follow whatever the psychologist recommended, although emphasizing that they would not allow their clients to be committed without any showing of need.205 These attorneys saw their compliance as serving the best interests of the community and the client.

Although Pro-Treatment advocates might argue that these attorneys’ attitudes represent the common-sense view of the community, the findings lend strong support to the Pro-Rights critique that attorneys are failing their professional roles in the context of commitment hearings.206 In this limited case study, four of six attorneys abandoned their professional, adversarial roles at the door of the commitment hearing.207 These attorneys deferred to expert psychological judgment in the context of a commitment hearing in a manner they certainly would not imitate in any other context. This abdication of the professional role

204. One of these two attorneys represented Patient 6 who was so incapacitated as to be unable to communicate. The attorney, therefore, was unable to mount any defense. The finding that defense counsel in civil commitment hearings take a passive, non-adversarial role is consistent with the results of other studies. See HERMANN, supra note 187, at 25 (literature review reveals that the “passive best interest approach” is most prevalent).

205. Note, however, that at least one attorney (representing Patient 1) accepted a psychologist’s conclusory opinion that his client was gravely disabled without any evidentiary support. This patient was released only because the judge conducted his own cross-examination to clarify that the psychologist was offering no evidence other than her own unsupported opinion.

206. For the Pro-Rights critique of legal representation in civil commitment hearings, see supra note 149.

207. See supra tbl. A, column 7.
appears attributable to attorneys’ unfamiliarity—and perhaps discomfort—with the mentally ill and their lack of an informational base upon which to challenge professional opinion.

A “recent overt act or patent inability to care for self” commitment standard, coupled with zealous representation, would provide the best balance between social welfare and individual rights. More stringent criteria for commitment would constrain judicial interpretation and defuse the problem of overly loose construction of commitment statutes. Moreover, a “recent overt act or patent inability to care for self” standard would force the State to present additional evidence to corroborate the expert psychological opinion. Statutes should require corroboration of expert opinion because the empirical research strongly supports the conclusion that expert opinion, standing alone, never properly can be considered clear and convincing. However, no evidentiary requirement or statutory criteria can provide sufficient protection for the defendant in a civil commitment hearing without zealous representation on the part of legal counsel.

The present case study demonstrates multiple instances in which clearer commitment criteria coupled with more zealous legal representation would have led to a fairer result. Patients 2 and 8 were both committed under a finding of grave disability. At Patient 8’s hearing, no concrete disability was alleged. The testifying psychologist merely discussed the patient’s behavior and mental condition upon admission four years earlier and added that the patient had not improved. The attorney did not attempt rebuttal. Even assuming that the hospital had sufficient

208. This unfamiliarity is an example of the “sanist” influence on attorneys. See Perlin, supra note 63, at 404-06.
209. For the importance of a defense psychiatrist in helping counsel prepare to defend a civil commitment hearing, see Speiser, supra note 76, at 148-49.
210. For the empirical critique of expert prediction of dangerousness, see supra notes 67-70 and accompanying text.
211. For criticism of the ineffective role currently played by legal counsel, see supra note 149.
212. See supra tbl. A.
213. Patient 8 had been continuously hospitalized for four years prior to the observed commitment hearing. A commitment order is effective for up to 180 days. VA. CODE ANN. § 37.1-67.3 (Michie Supp. 1994). The court may extend the commitment after a recommitment hearing. Id.
grounds for continuing this patient's commitment, such grounds never surfaced. A patient who sought rehabilitation to prepare for release would have no guidance as to the standard of normalcy he must meet in order to gain his liberty. Moreover, the waiver of cross examination theoretically allows the commitment to continue, unchallenged, ad infinitum.

The psychologist testifying at Patient 2's hearing did point to specific behavior—wandering and incontinence—suggestive of dementia and an inability to care for self. As noted, however, the wandering behavior admits of competing interpretations, and incontinence alone cannot constitute grounds for commitment. However, no rebuttal was offered and, with only one interpretation of the facts before him, the judge ordered commitment.

In contrast to these cases, Patient 9 provides an example of how stricter commitment criteria and zealous defense result in social protection and due consideration of individual rights. Although this patient had not actually attacked anyone, he had threatened to kill randomly while clearly emotionally distressed and in possession of a weapon. This episode would satisfy a "recent overt act" standard were one in place. Defense counsel, in this instance, conducted a vigorous cross examination under which the testifying psychologist admitted that the defendant presently denied any suicidal or homicidal ideation. With a full airing of the evidence, the judge, as fact-finder, exercised his prerogative to believe the expert's testimony that the defendant was lying about his present intentions over the defendant's testimony that his dangerous impulse had passed. The judge ordered commitment. He may well have declined to do so absent a recent overt act. This case illustrates that more stringent commitment criteria and active legal representation could better balance the competing interests at stake in a civil commitment hearing.

Hypothetical

Returning to our hypothetical case presented earlier, the lessons learned from our case study strongly suggest that Paul

214. See supra text accompanying and following note 199.
215. See supra tbl. A.
216. See supra text accompanying notes 73-75, 162-63.
would be committed involuntarily

Recalling the pertinent facts, Paul, a successful stockbroker, abruptly quits his job to pursue a career as a songwriter. He has had only minimal prior musical experience, yet believes himself a musical genius. He persists in this belief even after public rejection of his work and blames his wife for sabotaging his opportunity. When his wife begs him to return to his former job, Paul announces his decision to leave her and the children in order to pursue his musical career. She seeks to have him committed.

Although he has done nothing to indicate that he is dangerous or incapable of caring for himself, a psychiatrist is likely to recommend involuntary commitment. Paul’s downward spiral, financially and vocationally, likely would be interpreted as signs of depression. His abrupt decision to leave his family and his delusional belief in his talent suggest a declining capacity to care for himself and an imminent future dangerousness to either himself or his family.

Although the psychologist’s opinion could be challenged by vigorous cross examination, demonstrating that Paul’s desire to leave his wife or the decision to change careers is not inherently irrational or dangerous, the present case study suggests that the psychologist likely would not be cross examined at all. Further, given the loose statutory interpretations typically applied by judges in commitment hearings, the psychologist’s opinion supported by the behavioral evidence contained in this hypothetical would certainly be sufficient for the judge to order Paul’s commitment.

CONCLUSION

The Wrong Balance Has Been Struck

The present review of commitment standards and competing criticisms highlights the essential principles at stake: individual liberty versus social welfare. Consistency with our constitutional philosophy of elevating individual rights over state concerns demands that we either err on the side of allowing too much liberty or demonstrate a substantial reason for curtailing the rights of

217. See supra notes 204-09 and accompanying text.
the mentally ill. The burden must be on those seeking to curtail individual rights to demonstrate the necessity of so doing.

Those who support even broader civil commitment authority ground their argument in two main points. First, Pro-Treatment advocates assert that broad civil commitment power is necessary to protect the wider society from the dangers posed by the mentally ill. Second, they maintain that civil commitment is not punishment; rather it is a humane approach to caring for those who cannot care for themselves.

These arguments are not sufficient to carry the burden of demonstrating a substantial need for curtailing the individual rights of the mentally ill. First, psychological experts vastly overpredict the dangerousness of the mentally ill. Empirical research suggests that experts may overpredict dangerousness in as many as eight of ten cases, and the most favorable estimates credit expert prediction with no more than fifty percent accuracy. Such speculation should never be equated with "clear and convincing" evidence.

As to the argument that commitment is necessary to protect the mentally ill, the State may offer treatment to those who seek it, but the idea of the State humanely mandating treatment for those who resist is belied by the historical evidence. The State has committed a woman for exercising independent religious thought and a man for practicing vegetarianism. It was not until 1972 that homosexuality ceased to be classified as mental illness and, hence, potential grounds for commitment. These examples are more than artifacts of the past; they are cautionary statements about the future. On what primitive grounds do we justify commitment today?

218. See ISAAC & ARMAT, supra note 25, at 340 (describing the needs of families to protect themselves).
219. See supra notes 32-44 and accompanying text.
220. See supra note 70.
221. See supra notes 2-5 and accompanying text.
222. See supra notes 7-15 and accompanying text.
The Past is Prologue

In his history of Western Society's treatment of irrationality, *Madness and Civilization*, Foucault explores the forces—political, social, economic, and religious—that led to the "Great Confinement" of the insane, the unemployed, the idle, and the disabled in the seventeenth century. Confine-ment was, for classical man, a solution to the problem of the unpro-ductive citizen:

[P]urely negative measures of exclusion were replaced by a measure of confinement; the [unproductive] person was no longer driven away or punished; he was taken in charge, at the expense of the nation but at the cost of his individual liberty. Between him and society, an implicit system of obligation was established: he had the right to be fed, but he must accept the physical and moral constraint of confinement.

In the classical era, the State rationalized widespread confinement of the socially-undesirable as moral rehabilitation. Today we call it medical treatment. In the classical era, as now, confinement of the insane (and others) was seen as both necessary and benign. Yet regardless of the rhetoric by which we justify confinement, the trade-off is the same: food and shelter at the cost of personal freedom.

Such is the individual cost of social intolerance for irrationality. Is there a social cost as well?

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224. FOUCAULT, supra note 6.
225. Id. at 38-64.
226. Id. at 48.
227. Id. at 59 (noting that institutions of confinement had an "ethical status" and were "moral institution[s]"). Forced labor, as an institutional requirement was "an exercise in moral reform which reveal[ed], if not the ultimate meaning, at least the essential justification of confinement." Id. at 60.
Hypothetical Unveiled

The hypothetical discussed throughout this Note is loosely based on the life of Paul Gauguin, the great post-impressionist painter. Gauguin was himself a wealthy and successful stockbroker who took up not songwriting but painting in his mid-twenties. As with our hypothetical stockbroker, Gauguin became so obsessed with painting and with a belief in his own genius, despite the lack of popular acceptance, that he abruptly quit his job to devote himself exclusively to his art. After more than a year of failure, Gauguin was able to arrange a major public exhibition of his work. The exhibition not only failed miserably, but his work was denounced as mad and immoral. Blaming his wife's family for his failure, he permanently left her. Gauguin lived the remainder of his life unknown and impoverished, but his work, and his genius, was discovered

228. See supra text accompanying notes 73-75, 162-63, 216-17.
230. Jean de Rotonchamp, On Gauguin as a Young Man, in GAUGUIN: A RETROSPECTIVE, supra note 229, at 37 (Gauguin "made a veritable fortune" in the stock market).
231. Most researchers estimate that Gauguin began painting at age 25. ALFRED WERNER, PAUL GAUGUIN 6 (1967). But see GAUGUIN: A RETROSPECTIVE, supra note 229, at 11 (estimating that he may have begun sketching as early as 23).
232. See HANSON & HANSON, supra note 229, at 48 (noting that Gauguin's decision to quit work came as a complete shock to his wife).
233. Id. at 49-58 (describing Gauguin's life in the year after quitting his job and moving to Rouen).
234. Gauguin's Copenhagen exhibition, the first solo display of his art, closed just three days after opening. GAUGUIN: A RETROSPECTIVE, supra note 229, at 12.
235. Gauguin was so distraught by the failure of his show that he considered suicide. See id. at 52-53 (quoting letter from Gauguin to Camille Pissarro, May, 1885).
236. WERNER, supra note 231, at 6. The utter scorn that accompanied the rejection of Gauguin's work is a powerful indicator of how grossly incongruent was his vision of art with the prevailing aesthetics of his time.
237. HANSON & HANSON, supra note 229, at 61-64.
238. Within two years of abandoning his family, Gauguin was reduced to poverty.
What if Gauguin's wife had sought involuntary hospitalization for her husband under modern commitment laws? As the analysis of the hypothetical suggests, Gauguin likely would have been hospitalized. His life certainly would have been different—perhaps easier—but at the cost of realizing his genius. Society itself would be poorer.

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Id. at 69. The legacy of his final years is one of suffering. Id. at 248-81; see also DANIELSSON, supra note 229 (recounting Gauguin's later years).

239. HANSON & HANSON, supra note 229, at 282-83. After Gauguin's death, both his commercial and artistic stock rose. Id. at 282. His paintings began to sell at ever inflating prices, and the most renowned artists of his day began to acknowledge his influence. Id. Gauguin is now considered, along with Vincent Van Gogh, to be one of the fathers of Post-Impressionism. Id. at 282-83.