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Mental Illness and Danger to Self

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Mental Illness and Danger to Self

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I. RIGHTS V. TREATMENT: A CONFLICT BETWEEN LAW AND PSYCHOLOGY	258
II. LAW, PSYCHOLOGY, AND INVOLUNTARY COMMITMENT: SOME HISTORICAL BACKGROUND	264
A. <i>Anti-Psychiatry Meets the Due Process Revolution</i>	266
B. <i>Lessard and the Standard of Dangerousness</i>	268
C. <i>Revolt Against Process—the Pro-Treatment Side Rises Again</i>	275
III. REDEFINING “DANGER TO SELF”	280
A. <i>An Abolitionist Premise</i>	283
B. <i>Mental Illness As Grounds for Involuntary Commitment</i>	290
1. The Problem of Definition	290
2. In Search of a Legally Intelligible Standard	295
C. <i>Comparing Insanity</i>	305
1. The Battle Over Insanity, Or Why Psychiatry “Gifted” Insanity to the Law	307
2. Toward a Purely Legal Standard for Involuntary Commitment	312
IV. CONCLUSION	316

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The old way involves accepting a set of assumptions that are without factual basis Foremost on the list is the assumption that commitment for mental illness is a medical problem, not a legal problem. Therefore, since psychiatrists are the experts, their conclusions can be accepted without question. This fallacious assumption must be dispelled.

Judge P. Charles Jones¹

Michael is a single man in his forties. Sometimes Michael drinks too much alcohol and his alcohol consumption has landed him in a hospital detox unit twice before. During his third stay in detox Michael's family petitions the local district court to force him into a 30-day residential treatment program that takes place on the grounds of a local prison. Under order by the court, police bring Michael to the courthouse and place him in a holding cell while he awaits a hearing on his family's petition. At the hearing Michael is represented by an attorney. After four days in detox Michael is completely sober, and no one contends that he is unable to think clearly; that he has committed or is suspected of having committed a crime; or that he poses any sort of danger to other people. Michael tells the court that he opposes the commitment petition; that he does not want to be hospitalized; and that the hospital has provided him with the names and phone numbers of a substance-abuse counselor and a local contact from Alcoholics Anonymous if he wants help in controlling his alcohol consumption. Michael asks the court to release him so that he can go home. The judge calls the court psychologist to the stand and asks whether, under the terms of the state's involuntary commitment statute, Michael is an "alcoholic" whose use of alcohol is likely to cause "serious harm." She answers in the affirmative, whereupon the judge orders Michael to be committed for 30 days against his will. The police place Michael in handcuffs and take him away. Next case.

1. Thomas K. Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 WIS. L. REV. 503, 503 (1976) (quoting Dane County, Wisconsin Judge Jones).

This is not merely a hypothetical. In a number of states, a person can be committed to a psychiatric facility against his will on grounds of “danger” or “risk of harm” to self as evidenced purely by the person’s consumption of alcohol or other intoxicating drugs, and the risk that continuing to ingest such substances will cause harm to the person, whether intended or not.² And the example raises a large and fundamental question for the law: When may a court force someone into psychiatric treatment against her will, based purely on the judgment—with which the patient herself expressly and coherently disagrees—that she needs

2. See, e.g., MASS. GEN. LAWS ch. 123, § 35 (2013) (defining “alcoholic” as “a person who chronically or habitually consumes alcoholic beverages to the extent that (1) such use substantially injures his health or substantially interferes with his social or economic functioning; or (2) he has lost the power of self-control over the use of such beverages”). The statute provides:

Any police officer, physician, spouse, blood relative, guardian or court official may petition in writing any district court or any division of the juvenile court department for an order of commitment of a person whom he has reason to believe is an alcoholic or substance abuse In the event of the person’s failure to appear [at a court-ordered hearing in response to the petition], the court may issue a warrant for the person’s arrest If after a hearing and based upon competent testimony, which shall include, but not be limited to, medical testimony, the court finds that such person is an alcoholic . . . and there is a likelihood of serious harm as a result of the person’s alcoholism . . . the court may order such person to be committed for a period not to exceed ninety days [with intermittent reviews by the state health department at thirty, forty-five, sixty, and seventy-five days] The person may be committed to the Massachusetts correctional institution at Bridgewater, if a male, or at Framingham, if a female, if there are not suitable facilities available under said chapter 111B; provided, however, that the person so committed shall be housed and treated separately from convicted criminals.

Id. See also COLO. REV. STAT. ANN. § 27-81-102, 112 (West 2013) (defining “alcoholic” as a person who habitually lacks self-control as to the use of alcoholic beverages or uses alcoholic beverages to the extent that his or her health is substantially impaired or endangered or his or her social or economic function is substantially disrupted; providing for the involuntary commitment of alcoholics who have threatened harm to themselves or others, or are “incapacitated by alcohol.”).

care? The laws of involuntary commitment typically specify that courts may do this when the person is “mentally ill” and poses a “danger” or “risk of harm” to self or others. But if “mental illness” can be defined as the voluntary consumption of intoxicating substances, and “danger” as risk of harm to the patient’s own health, what boundaries constrain the law’s power to force resisting individuals into treatment?

Compassion may argue that mental illness should be treated. But for the law, compassion alone cannot dictate the answer. There *is* a Law of Compassion, which finds powerful expression in our positive law, establishing public programs that assist needy families, the unemployed, the elderly, the mentally ill. Such voluntary programs pose no threat to beneficiaries’ fundamental rights and freedoms. But when the law is asked, on grounds of compassion, to forcibly incarcerate a human being who poses no danger to others and has committed no crime, that is another matter entirely. In that situation the law’s first job is to act not as an agent of compassion but as an agent of respect for the individual. When it comes to involuntary commitment of the mentally ill, the law’s unique and vital role is to guard the rights of the person whose freedom is at stake. In our national conversation about mental illness and involuntary commitment, we have forgotten this fact. We must remember it again. When presented with a petition that would force an innocent person into psychiatric treatment against her will, the law’s presumptive role is to defend the perspective and the preferences of that person against society’s contrary preferences, including the contrary preferences of those who would offer treatment that the person does not want and has clearly said that she does not want.

In this context the law’s job is very different— from and is sometimes in conflict with—the treatment imperative which dominates the mental health profession. That is worrisome, but may be necessary. In guarding the rights of the mentally ill, as in guarding the rights of all persons, the law must ask its own questions, enforce its own standards, and stand its ground against unjustified (although often well-intentioned) efforts that deprive innocent persons of basic freedoms.

When a court forces an unwilling person into psychiatric treatment, the law deprives that person of two very important rights—the right to refuse medical treatment and (in the case of involuntary hospitalization) the right to liberty itself. In cases

where a psychologically disturbed respondent is believed to pose a serious danger to others, the state clearly has a legitimate interest in confining the respondent, and most discussion concerns the issue of dangerousness—how it is defined; how accurately it can be determined; how vulnerable it may be to bias or mistake.³ In cases involving risk of self-harm but not harm to others, the law more openly wrestles with the values of autonomy and respect for individual rights. Should we allow courts to commit a person involuntarily on the ground that he poses a serious risk of harm, not to others but to *himself*? If so, under what conditions is this permissible against the conceptual backdrop of the person's presumptive rights to refuse treatment and to retain personal liberty?

Psychiatry and Law have different perspectives, and inherently different roles, with respect to this issue. The contemporary standard for involuntary commitment—requiring both a “mental illness” and “danger to self”—attempts to marry those roles but has succeeded only in confusing the courts, too often causing them to convert what is fundamentally a legal question about legitimate grounds for overruling individual rights into a psychiatric question about the need for treatment. Reform efforts over the last three decades have not changed this reality. Indeed, today the loudest voices on the issue hail from the mental health profession, arguing that existing legal constraints on involuntary commitment are too stringent and that legal barriers should be dismantled so that more patients deemed mentally ill will be forcibly treated.⁴ This Article opposes that stance. The standard for involuntary commitment on grounds of danger to self should be articulated in non-medical terms and should be adjudicated as a purely legal matter. In making the case for that position, I hope to illuminate a core tension between law and psychiatry.

3. See *infra* p.7 and notes 15–16.

4. For example, see *Eliminating the Barriers to the Treatment of Mental Illness*, TREATMENT ADVOC. CTR., available at www.treatmentadvocacycenter.org (2011) [hereinafter *Eliminating the Barriers*], summarizing the content and the history of this argument.

I. RIGHTS V. TREATMENT: A CONFLICT BETWEEN LAW AND
PSYCHOLOGY

For most of U.S. history, the standard for involuntary commitment required only that mental health professionals certify the person was “mentally ill” and “in need of treatment.”⁵ That changed during the 1970s, when advocates for the mentally ill successfully championed a new standard which required both a *psychiatric* finding of “mental illness” and a *legal* finding of “danger to self or others” in order to hospitalize or treat a person against her will.⁶ Grounded in both the Due Process revolution which had significantly expanded the rights of criminal defendants,⁷ and the Civil Rights movement which had

5. See, e.g., Eric Turkheimer & Charles D. Parry, *Why the Gap? Practice and Policy in Civil Commitment Hearings*, 47 AM. PSYCHOLOGIST 646, 646 (1992) [hereinafter Turkheimer & Parry, *Why the Gap?*].

Until the late 1960s most state commitment processes were medical rather than judicial. Under the State’s *parens patriae* powers, physicians had the authority to confine and treat the mentally ill. The most common form of commitment was the two-physician certificate, whereby patients could be hospitalized on the statement of two physicians, without advice of counsel, a hearing, or any recourse other than a writ of habeas corpus.

Id.

6. In addition to this change in the substantive standard for involuntary commitment, a number of procedural changes were built into the standard during this period. See, e.g., *id.* at 646.

The civil commitment reforms were both procedural and substantive. Procedurally, most states mandated due process safeguards, including prior notice, authority for judicial officials over clinicians, legal counsel, the right to call and confront witnesses, more rigorous standards of proof, LRAs, limited commitment periods, right to appeal, and regular court review. Substantively, the standards for involuntary commitment were changed from simple requirements for mental illness and need for treatment to legal standards of dangerousness to self or others and, in some states, grave disability or inability to care for self.”)

Id. (citations omitted).

7. See, e.g., *In re Gault*, 387 U.S. 1 (1967) (holding that delinquency proceedings involving juvenile defendants must comply with procedural Due Process requirements under the Fourteenth Amendment of the Constitution).

successfully fought for legislation outlawing discrimination,⁸ the new standard for involuntary commitment was designed to give courts an independent role in the commitment decision, a role which would honor the patient's presumptive right to refuse medical treatment.⁹ Under the dangerousness element, judges were to be the guardians of individual liberty, allowing forcible commitment only under circumstances in which a mentally ill respondent posed a clear and immediate risk of harm.¹⁰

In a series of cases during the Seventies, both state and federal courts argued for the addition of a "dangerousness" prong to the traditional "need for treatment" standard. Many saw the traditional standard as too vague, overly biased toward medical (as opposed to rights-based) values, and discriminatory toward the mentally ill.¹¹ California took the lead on the legislative front, passing the Lanterman-Petris-Short (LPS) Act in 1967. The LPS

8. See, e.g., Stephen M. Crow et al., *Who is at Greatest Risk of Work-Related Discrimination – Women, Blacks, or Homosexuals?*, 11 EMP. RESP. & RTS. J. 15 (1998) (discussing civil rights paradigm as basis for expanding rights of women, gays, and lesbians). See generally Paul S. Miller, *Disability Civil Rights & a New Paradigm for the Twenty-First Century: The Expansion of Civil Rights Beyond Race, Gender, and Age*, 1 U. PA. J. LAB. & EMP. L. 512 (1998).

9. See, e.g., VA Hiday & SJ Markell, *Components of Dangerousness: Legal Standards in Civil Commitment*, 3 INT'L J. OF LAW & PSYCHIATRY 405, 405 (1980) [hereinafter Hiday & Markell, *Components of Dangerousness*] ("Dangerousness seemed to provide a legally enforceable test that would with one stroke protect the public's safety and limit involuntary hospitalization to those who truly required confinement, while simultaneously allowing the non-dangerous mentally ill to be treated in the community"); VA Hiday, *Court Decisions in Civil Commitment: Independence or Deference?*, 4 INT'L J. L. & PSYCHIATRY 159, 160 (1981) ("[B]y specifying due process rights and requiring court hearings the new legislation is moving to check perfunctory or no court review. Essentially it is declaring that medical opinion alone is not enough to confine a person to a mental hospital; and thus, it is defining the role of the court to be independent of psychiatry. The court may accept medical recommendation[s]; but to achieve the desired independence from psychiatric expertise, the court must refuse to accept psychiatric conclusory statements without supporting facts").

10. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078, 1087 (E.D. Wis. 1972) ("[U]nless constitutionally prescribed procedural due process requirements for involuntary civil commitment are met, no person should be subjected to 'treatment' against his will").

11. See, e.g., *id.* at 1086–104.

Act, which took full effect in 1972, required a finding of dangerousness specified as either (1) danger to others; (2) danger to self; or (3) grave disability (which the California courts defined as a form of “danger to self.”).¹² Other states followed suit, and by 1978 all but two states had built “dangerousness” into their standards for involuntary commitment.¹³

During the 1970s and 1980s, a sizeable literature in psychology analyzed the dangerousness-based standard in general, and its “danger to others” prong in particular. Abolitionists, some of whom had favored the reforms on grounds that they would restrict the power of the state to commit unwilling people for treatment, continued to fight for the abolishment or near-abolishment of such forced hospitalizations.¹⁴ Within the mental health profession, the new standard remained controversial among some psychologists and psychiatrists who worried that it prevented the mental-health system from helping patients who desperately needed (but sometimes opposed) hospitalization and treatment.¹⁵

12. See, e.g., SP Segal et al., *Civil Commitment in the Psychiatric Emergency Room*, 45 ARCH GEN. PSYCHIATRY 753 (1988); *Doe v. Gallinot*, 486 F. Supp. 983 (S.D. Cal. 1979), *aff'd* 657 F.2d 1017, (9th Cir. 1981) (grave disability element “implicitly requires a finding of harm to self”).

13. See, e.g., Hiday & Markell, *Components of Dangerousness*, *supra* note 9.

14. See generally RALPH SLOVENKO, *LAW IN PSYCHIATRY/ PSYCHIATRY IN LAW*, 433 (2009); BRUCE J. ENNIS, *PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS, AND THE LAW* (1972); *American Association for the Abolition of Involuntary Mental Hospitalization*, 127 AM. J. PSYCHIATRY 1698 (1971) (Letter to the Editor by AAAIMH founder Thomas Szasz); Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54 (1982) [hereinafter Morse, *A Preference for Liberty*].

15. E.g., Paul Chodoff, *The Case of Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976); Pauline Rabin & David Folks, *Dangerousness as the Criterion for Involuntary Hospitalization: A Time to Reassess*, 246 J. AM. MED. ASS'N 990 (1981); Donald A. Treffert, *Dying With Their Rights On*, 2 PRISM 49, 49–52 (1974). As I explore *infra* Part II.C., this view has acquired considerable momentum in the wake of deinstitutionalization. For more contemporary iterations, see, e.g., PS Appelbaum, *Almost a Revolution: An International Perspective on the Law of Involuntary Commitment*, 25 J. AM. ACAD. PSYCHIATRY L. 135 (1997); *Minds on the Edge: Facing Mental Illness: Fred Friendly Seminars*, Columbia University, New York (PBS television broadcast Oct. 2009) [hereinafter *Minds on the Edge*]. See also

Scholars analyzed various problems with implementing the new standard—for example, the difficulty of deciding which *kinds* of harm justified involuntary commitment; the difficulty of deciding what *degree* of risk justified forcibly committing someone against his will; and, the difficulty of assessing the *actual* risk that any particular respondent will inflict harm, particularly where the respondent had never in fact committed a violent harm and the fear was simply that he or she *might* do so in the future.¹⁶

Oddly, almost none of the discussion has specifically focused on the “danger to self” aspect of the modern test. Almost all states allow forcible commitment of a person on grounds of “danger” or “risk of harm” to self; yet most literature on the subject treats “danger to self or others” as a single concept and argues its virtues and vices in that manner.¹⁷

That is a mistake. Although there is sometimes significant overlap, the concept of “danger to self” is importantly different from that of “danger to others.” Even allowing for all the problems associated with forcibly confining someone on grounds of danger

Eliminating the Barriers, *supra* note 4, for a prominent voice in favor of involuntary commitment based on need for treatment (often referred to as “grave disability”) alone.

16. See, e.g., Morse, *A Preference for Liberty*, *supra* note 14; Edward P. Mulvey & Charles W. Lidz, *Back to Basics: A Critical Analysis of Dangerousness Research in a New Legal Environment*, 9 L. & HUM. BEHAV. 209 (1985); J. C. Phelan & B.G. Link, *The Growing Belief That People With Mental Illnesses Are Violent: The Role of the Dangerousness Criterion for Civil Commitment*, 33 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY, S7 (1998); SP Segal et al., *Civil Commitment in the Psychiatric Emergency Room: The Assessment of Dangerousness by Emergency Room Clinicians*, 45 ARCHIVES GEN. PSYCHIATRY 748 (1988); SA Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 AM. PSYCHOL. 224 (1978); Carol A. B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California’s Lanterman-Petris-Short Act*, 11 L. & SOC’Y REV. 629 (1976).

17. A partial, but notable, exception is Alan M. Dershowitz, *Psychiatry in the Legal Process: “A Knife That Cuts Both Ways,”* 51 JUDICATURE 370 (1967). Although Dershowitz’s main point is that the insanity and commitment standards should be purely legal and not medicalized, he does raise the libertarian argument (a la John Stuart Mill) as to involuntary commitment on grounds of “danger to self,” and he explores some interesting hypotheticals which are meant to test out the premises of that standard.

to others,¹⁸ few doubt that preventing foreseeable violence inflicted upon innocent others is a legitimate concern of the state. Not so when the question is whether the state should be able to force treatment on someone in order to prevent him from inflicting harm on *himself*. As to that question, our intuitions are more libertarian:¹⁹ At least presumptively, the state should refuse to interfere with the clearly expressed preferences of adult persons (e.g., the preference not to receive psychiatric treatment) even if the state disagrees with the wisdom of those preferences.

Should the law of involuntary commitment instantiate the libertarian view? Two extremes define the spectrum of answers to this question. At one end are Abolitionists, according to whom involuntary civil commitment is always wrong no matter what the circumstances. Abolitionists argue that no justification exists for treating mentally ill persons differently from any others—that forcing such persons to undergo treatment or incarceration against their will is not justified unless and until they have committed a crime.²⁰ We do not permit the state to engage in preventive detention of non-mentally ill persons simply on the grounds that they may be dangerous. Suicide (for example) is not a crime. Thus, to authorize civil preventive detention of those deemed mentally ill and a “danger to self” is to invidiously discriminate against the mentally ill.²¹

18. See sources cited *supra* notes 15–16.

19. In the sense that we incline more toward the view of John Stuart Mill in this famous passage from *On Liberty*:

The only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because . . . to do so would be wise or even right . . .

J.S. MILL, ON LIBERTY 68 (Penguin Books 1974).

20. See, e.g., Chodoff, *supra* note 15 (describing, though not favoring, the abolitionist position).

21. See, e.g., *id.*; see also ENNIS, *supra* note 14; Morse, *A Preference for Liberty*, *supra* note 14; Jacob Sullum, *The Legal and Moral Problems of Involuntary Commitment, Mental Health and the Law*, CATO UNBOUND, Aug. 24, 2012, <http://www.cato-unbound.org/2012/08/24/Jacob-sullum/legal-moral-problems-involuntary-commitment>; Jeffrey Schaler, *Strategies of Psychiatric*

At the other extreme are Paternalists, who argue that courts should be able to forcibly commit a person if and when mental health professionals determine that the person is in serious need of treatment. Such treatment, presumptively at least, would continue until the experts determine that the patient no longer needs it. Paternalists argue that the contemporary rights-based standard of involuntary commitment denies treatment to desperately needy persons for whom a period of enforced hospitalization might significantly improve, or even save, their lives.²² For such pro-treatment advocates, the refusal to hospitalize (or force outpatient treatment upon) mentally ill patients who cannot responsibly care for themselves is cruel and inhumane, and a legal standard which makes it difficult or impossible to force such treatment has created a society in which mentally ill people are “dying with their rights on.”²³

Some understanding of history will be helpful here. Part II of this essay traces the victory of the rights-based standard for involuntary commitment, and also the push-back from Pro-Treatment forces. Part III engages the bedrock conceptual issues presented by involuntary civil commitment in cases of “danger to self”, using two paradigmatic cases of foreseeable self-harm to examine the justifications for forcing persons into psychiatric treatment. Part III more closely engages the core concepts of “mental illness” and “danger to self”—the medical and the legal prongs of the test for involuntary commitment—and forces an examination of each prong separately and of the test as a whole. Like other legal tests (such as the tests for insanity) which attempt to marry law and psychology, the test for involuntary civil commitment highlights an important and recurring conflict between the law’s focus on individual rights and psychiatry’s focus on treating illness. I argue that where state coercion on grounds of danger to self is the core issue, the involuntary commitment

Coercion, Mental Health and the Law, CATO UNBOUND, Aug. 6, 2012, <http://www.cato-unbound.org/2012/08/06/jeffrey-schaler/strategies-psychiatric-coercion>.

22. See, e.g., sources *supra* note 15.

23. Treffert, *Dying With Their Rights On*, *supra* note 15; *Minds on the Edge*, *supra* note 15.

decision should be wholly grounded in legal, and not medical, principles.

II. LAW, PSYCHOLOGY, AND INVOLUNTARY COMMITMENT: SOME HISTORICAL BACKGROUND

Less than a decade after the nationwide adoption of the “mentally ill and dangerous” standard for involuntary commitment, scholars and commentators identified a troublesome “gap” between the letter and spirit of the new commitment laws.²⁴ One author summed up the issue as follows:

The failure of civil commitment procedures to meet statutory requirements is one of the more reliable findings in the applied social sciences. Most states now require specific legal procedures and behavioral standards for involuntary hospitalization. Nonetheless, empirical studies have demonstrated that commitment hearings are rarely adversarial and clinical concerns continue to take precedence over legal issues.²⁵

Thus, while reformers had envisioned a system in which attorneys for patients adopted an adversarial role in zealous defense of their clients’ interests and courts operated as independent guardians of patients’ rights, the reality was that attorneys often failed to adopt an adversary role; judges frequently failed to make respondents’ rights known to them in court; and, in direct contradiction to the role assigned them by statute, judges continued to defer to the recommendations of mental health experts on *both* the questions of “mental illness” and “dangerousness” required to commit respondents against their will.²⁶ And while reformers had predicted that the dangerousness-based standard would shrink the

24. See, e.g., Roger Peters et al., *The Effects of Statutory Change on the Civil Commitment of the Mentally Ill*, 11 L. & HUM. BEHAV. 73 (1987); Warren, *Involuntary Commitment for Mental Disorder: The Application of California’s Lanterman-Petris-Short Act*, *supra* note 16.

25. Turkheimer & Parry, *supra* note 5, at 646.

26. *Id.* at 647.

number of involuntary commitments because it would offer greater respect and protection to a respondent's wish not to be treated, empirical research revealed that the new and supposedly stricter commitment statutes were having little if any effect on the rate of involuntary commitments across the country.²⁷ It seemed that the rights-based vision had succeeded in changing the language of state statutes but had failed to change the law on the ground, in court, where the fate of patients and commitment petitions was being decided under the supposedly new standard.

Why? What explains the emergence of a gap between the standards set out in commitment statutes and the courts' apparent failure to comply with those standards when faced with actual petitions for involuntary commitment? This Part re-examines the historical evolution of the dangerousness standard for involuntary commitment, looking for possible answers to these questions. I focus on three key participants in the legal and political debate which drove the passage of dangerousness-based statutes – (1) the anti-psychiatry movement, including lawyers and advocates for the rights of mentally ill people; ex-patients whose skepticism about psychiatry and psychiatric treatments fueled the abolitionist belief that involuntary civil commitment should simply not exist; and a relatively small number of renegade psychiatrists, the most prominent of whom was Thomas Szasz; (2) lawyers who viewed the old, “need for treatment” commitment procedures as a violation of patients' rights and sought to deploy the Due Process model of *In Re Gault* in order to change those procedures; and (3) the mainstream community of psychologists, psychiatrists, and other mental health professionals, many of whom opposed the incursion of procedural and substantive due process into involuntary commitment procedures on the ground that such procedures were bad for patients. On the surface, the nationwide move to a dangerousness-based commitment standard seemed to be a dramatic victory for the law and for the lawyer-driven fight to erase stigma and discrimination against the mentally ill. But beneath that surface

27. *Id.* See also James W. Luckey & John J. Berman, *Effects of a New Commitment Law on Involuntary Admissions and Service Utilization Patterns*, 3 L. & HUM. BEHAV. 149 (1979); J. Monahan et al., *Stone-Roth Model of Civil Commitment and the California Dangerousness Standard*, 39 ARCHIVES GEN. PSYCHIATRY 1267 (1982).

the debate between the rights-based dangerousness standard and the medical “need for treatment” standard played out in quite a different way.

A. Anti-Psychiatry Meets the Due Process Revolution

The anti-psychiatry movement took root in the widespread social and political unrest of the 1960s and 70s. Amid deepening skepticism and mistrust of social, religious, governmental, and military institutions, critics from both left and right depicted psychiatry – particularly its power to define mental illness and to justify and set in motion state coercion against those deemed mentally ill – as a tool of the oppressor state, a means of routing the different, the defiant, and the dissident into mental hospitals.²⁸ The voice linking psychiatry and justice was always implicit in this critique, but that voice became an open battle cry when four young lawyers – Bruce Ennis, Charles Halpern, Paul Friedman, and Margaret Ewing – formed the Mental Health Law Project (MHLP) in 1972. Drawing heavily on the views of libertarian psychiatrist Thomas Szasz, whose anti-psychiatry crusade caught fire in the United States about this time, Ennis and the MHLP took an abolitionist position on involuntary commitment. They sought not merely to constrain its availability or limit its effects, but to abolish it entirely. In a preface to Ennis’s book *Prisoners of Psychiatry: Mental Patients, Psychiatrists, and the Law*, Dr. Szasz praised Ennis for endorsing the abolitionist view “that individuals

28. This critique was highly ideological, from both ends of the political spectrum. See, e.g., Michel Foucault, *The Birth of the Asylum*, in THE FOUCAULT READER 141 (Rabinow ed., 1984); R. D. Laing, *The Schizophrenic Experience*, in THE POLITICS OF EXPERIENCE 100 (1967); ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961); DAVID J. ROTHMAN, THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC (1971); THOMAS S. SZASZ, THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT (1974); Andrew T. Scull, *Madness and Segregative Control: The Rise of the Insane Asylum*, 24 SOC. PROBS. 337 (1977). Perhaps the chief critic of psychiatry from the libertarian perspective was Thomas Szasz. See, e.g., THOMAS S. SZASZ, LAW, LIBERTY, AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES (1989); Thomas S. Szasz, *J’Accuse: Psychiatry and the Diminished American Capacity for Justice*, 2 POL. PSYCHOL. 106 (1980). See also, ENNIS, *supra* note 14; SLOVENKO, *supra* note 14.

incriminated as mentally ill do not need guarantees of treatment but protection against their enemies—the legislators, judges, and psychiatrists who persecute them in the name of mental health.”²⁹ And in a 1974 interview published in *Madness Network News*, Ennis declared: “My personal goal is either to abolish involuntary commitment or to set up so many procedural roadblocks and hurdles that it will be difficult, if not impossible, for the state to commit people against their will.”³⁰

Until abolition became politically possible, Due Process would have to do. Warren Court decisions such as *In Re Gault* offered the legal framework on which advocates for the mentally ill based a national campaign to make involuntary civil commitment more difficult, more time-limited, and less dependent on a psychiatric (and thus by definition oppressive and unjust) decision that the respondent “needs treatment.”³¹ In *Gault*, handed down in 1967, the United States Supreme Court decided that when a judgment of delinquency is at stake, states must offer juveniles the full panoply of procedures required under the Fourteenth Amendment Due Process Clause in adult criminal trials—including the right to timely notice of charges, the right against self-incrimination, the right to confront witnesses, and the right to defense counsel.³² The Court rejected the state’s argument that such due process protections should not apply to juveniles because the state acts as parent, not adversary, to juvenile defendants.

The Court’s decision in *Gault* offered an apt due process-based model for another legal setting involving the deprivation of liberty—involuntary commitment proceedings. As in *Gault*, states in commitment cases had long argued for a lower due process standard on the grounds that commitment is not a criminal adjudication, that the state acts not as an adversary to the respondent but instead as *parens patriae*.³³ In *Lessard v. Schmidt*, the court engaged, and rejected, the *parens patriae* argument,

29. *Id.*

30. SLOVENKO, *supra* note 14, at 433.

31. *In re Gault*, 387 U.S. 1; *see also supra* note 4 and accompanying text.

32. *Id.*

33. *See, e.g., Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wisc. 1972) (discussing and ultimately rejecting this argument).

expressly modeling its response on the High Court's opinion in *Gault*.³⁴

In *Lessard*, the Plaintiff, Alberta Lessard, was detained by police after what they believed was a suicide attempt. She was confined in a psychiatric hospital on a succession of petitions by police and medical personnel, was diagnosed as paranoid schizophrenic, and was repeatedly interviewed and examined without prior notice or opportunity to contest the various medical and legal judgments being made about her by the police, court personnel, judge, and psychiatrist involved in the case. Eventually Ms. Lessard hired her own attorney and was conditionally released under an ongoing 30-day commitment order. Ms. Lessard became the lead defendant in a class action suit against Wisconsin, alleging that the state's procedure for involuntary civil commitment denied her due process of law. In *Lessard*, the court agreed with her, holding that Wisconsin's statutory commitment procedure violated procedural due process in a number of respects that paralleled *Gault*. Like the statute invalidated in *Gault*, Wisconsin's commitment law failed to give detainees adequate notice of proceedings which could deprive them of the fundamental right of liberty; failed to mandate a hearing before commitment; failed to provide for the right to counsel or the right against self-incrimination; permitted involuntary commitment on an inadequate standard of proof; and failed to require that those petitioning for commitment consider less restrictive alternatives before seeking this drastic remedy.³⁵

B. *Lessard and the Standard of Dangerousness*

In addition to finding numerous procedural due process errors in the Wisconsin statute, the court in *Lessard* addressed and endorsed the need to add dangerousness to the substantive standard for involuntary civil commitment. The court traced the dangerousness standard back to the 1845 Massachusetts case, *Matter of Josiah Oakes*,³⁶ in which the state supreme court held:

34. *Id.*

35. *See generally id.*

36. *Matter of Josiah Oakes*, 8 Law Rep. 123 (Mass. 1845).

The right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others And the necessity which creates the law, creates the limitation of the law. The questions must then arise in each particular case, whether a patient's own safety, or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto. The restraint can continue as long as the necessity continues. This is the limitation, and the proper limitation.³⁷

The court in *Lessard* went on to make a point that would become crucial to the development and application of the dangerousness standard in the reformed commitment statutes passed during the seventies. “Unfortunately,” the court noted:

neither the Massachusetts court in *Oakes*, nor other courts to follow felt much concern for either a definition of ‘dangerousness’ or the effects of deprivations of liberty upon those committed The erosion of the common law of dangerousness continued . . . with the result that *many statutes today permit commitment based upon a wide range of showings of ‘mental illness.’*³⁸

It was this perceived defect—the fact that most statutes allowed involuntary commitment upon a finding of mental illness and need for treatment, without more and without defining either “dangerousness” or “mental illness” in ways which clearly limited such confinement—that the legal advocates for the mentally ill sought to change in the 1970s. By adding back a vigorous requirement of dangerousness, making that requirement a separate element of the commitment standard, and assigning courts the role of assessing dangerousness as a legally-grounded, rights-focused

37. *Id.* at 125, cited in *Lessard*, 349 F. Supp. at 1085.

38. *Id.* at 1086 (emphasis added).

element of the standard, advocates hoped to make courts less deferential to psychiatric findings of “mental illness” and more attuned to the serious deprivations of liberty inherent in the act of committing a person to a mental institution against his will.

Three years after the landmark opinion in *Lessard*, the United States Supreme Court seemed to drive this point home. In *O'Connor v. Donaldson*,³⁹ the Court held that the Due Process Clause of the Fourteenth Amendment prohibits states from forcibly confining non-dangerous persons who are capable of surviving “safely” by themselves or with the aid of family and friends.⁴⁰ In the decades since that holding, discussion of *Donaldson* has focused heavily on the psychology side of the conversation, for example on the question of what (if anything) the *Donaldson* Court said about committed patients’ right to treatment, or what (if anything) it said about committing mentally ill persons who are not dangerous but who are deemed “in need of treatment”—for instance, whose condition may deteriorate if untreated; or who are mentally ill and lack family and friends to help them maintain a treatment regimen.⁴¹ Here, we look at *Donaldson* from a rights-focused perspective.

In January 1957, respondent Kenneth Donaldson was diagnosed paranoid schizophrenic and was committed to the Florida State Hospital at Chattahoochee. For the next fifteen years, Donaldson was held at the hospital against his will, despite his repeated attempts to secure release on the grounds that he was not dangerous to himself or others; that he was not mentally ill; and

39. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

40. *Id.* at 576 (“In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends”). The Court vacated and remanded the judgment of the lower court on other grounds. *Id.*

41. *See, e.g.*, Daniel Baldwin, *O'Connor v. Donaldson: Involuntary Civil Commitment and the Right to Treatment*, 7 COLUM. HUM. RTS. L. REV. 573 (1975); L. E. Kopolow, *A Review of Major Implications of the O'Connor v. Donaldson Decision*, 133 AM. J. PSYCHIATRY 379 (1976); Loren H. Roth, *Mental Health Commitment: The State of the Debate*, 31 HOSP. & CMTY. PSYCHIATRY 385 (1980); *O'Connor v. Donaldson*, TREATMENT ADVOC. CTR., available at <http://www.treatmentadvocacycenter.org/component/content/article/341> (calling the Court’s opinion in *Donaldson* “probably the single most important decision in mental health law”).

that he was not receiving treatment at the hospital.⁴² In 1971, Donaldson brought suit under 42 U.S.C.A. § 1983 (West 1996), alleging that hospital superintendent Dr. J.B. O'Connor, and others, had “intentionally and maliciously deprived him of his constitutional right to liberty.”⁴³ The jury agreed, awarding Donaldson both compensatory and punitive damages, after being instructed by the trial judge that it should award punitive damages only if “the act or omission of the Defendant or Defendants which proximately caused injury to the Plaintiff was maliciously or wantonly or oppressively done.”⁴⁴

The facts of the case powerfully reinforced the dangers of forcible commitment under a “grave need for treatment” standard.⁴⁵ Donaldson was hospitalized under a provision of the Florida law that then allowed such commitment for the purpose of “care, maintenance, and treatment.”⁴⁶ Testimony at the trial proved that Donaldson had never—either before or after he was committed—posed a danger to himself or others.⁴⁷ Dr. O'Connor himself acknowledged that he had neither personal nor second-hand knowledge of any dangerous act ever committed by Donaldson.⁴⁸ No evidence showed that Donaldson had ever been a suicide risk, and one of O'Connor's codefendants conceded that Donaldson had earned his own living outside the hospital for fourteen years before his commitment and that he was capable of supporting himself outside the hospital. Indeed, immediately after his release from the hospital in 1971, Donaldson got a responsible job in hospital administration.⁴⁹ Further, under the law and regulations at the time,

42. 422 U.S. at 564–65.

43. *Id.* at 565.

44. *Id.* at 571 n.7.

45. It is assuredly no coincidence that Bruce Ennis, a leader in the move to introduce Due Process protections into civil commitment proceedings, argued the case for Donaldson. *Id.* at 564. *See also supra* text accompanying notes 28–30 (summarizing Ennis's role in the civil commitment reforms of the 1970s and 1980s).

46. *Donaldson*, 422 U.S. at 565–66 n.2.

47. *Id.* at 563.

48. *Id.* at 568.

49. *Id.* Dr. O'Connor had resigned as hospital superintendent by the time of trial. Shortly after that resignation, Donaldson—with the help of the hospital staff—successfully secured his release from the hospital—again, after a confinement of almost fifteen years.

the hospital staff had the power to release a mentally ill patient who was not dangerous to self or others. Apparently displeased with Donaldson's attempts to be released and his refusal to cooperate with hospital staff, Dr. O'Connor denied Donaldson's requests for such release, even when those requests were supplemented by a halfway house, Helping Hands, which offered to care for Donaldson, and by a letter from the respected Minneapolis Clinic of Psychiatry and Neurology, which supported Donaldson's release.⁵⁰ According to the Supreme Court's opinion:

O'Connor rejected the offer, replying that Donaldson could be released only to his parents. That rule was apparently of O'Connor's own making. At the time, Donaldson was 55 years old, and, as O'Connor knew, Donaldson's parents were too elderly and infirm to take responsibility for him. Moreover, in his continuing correspondence with Donaldson's parents, O'Connor never informed them of the Helping Hands offer.⁵¹

O'Connor also rejected an offer of help from a college classmate and longtime family friend of Donaldson's, John Lembcke, who petitioned for Donaldson to be released into his care.⁵² Dr. O'Connor testified that he rejected all these requests on the grounds of his conviction that Donaldson would not have made a "successful adjustment outside the institution"—but at trial O'Connor could not remember the basis for that conclusion.⁵³ Dr. O'Connor characterized Donaldson's care at the hospital as "milieu therapy"—custodial care that is not geared toward improving or

50. *Id.* ("The [halfway house] request was accompanied by a supporting letter from the Minneapolis Clinic of Psychiatry and Neurology, which a codefendant conceded was a 'good clinic'").

51. *Id.* at 568–69.

52. *Id.* at 569. The Court adds here: "The [trial] record shows that Lembcke was a serious and responsible person, who was willing and able to assume responsibility for Donaldson's welfare."

53. *Id.* at 568.

curing the patient's mental illness.⁵⁴ The conditions on the ward were hardly conducive to good care: Donaldson was frequently housed in a large room with 60 other patients, some of whom had been criminally committed.⁵⁵ Finally, shortly after Dr. O'Connor resigned as superintendent of the hospital, Donaldson—with the help of the hospital staff—successfully petitioned for restoration of his competency and for his release from involuntary care.⁵⁶

The facts in *Donaldson* gave credence to the abolitionist argument that the law should not permit forcible commitment based only on the discretionary judgments of mental health professionals.⁵⁷ Even assuming that Kenneth Donaldson had been correctly diagnosed with a serious “mental illness”—about which the Supreme Court expressed skepticism⁵⁸—the use of legal

54. *Id.* at 569 (“[W]itnesses from the hospital staff conceded that, in the context of this case, ‘milieu therapy’ was a euphemism for confinement in the ‘milieu’ of a mental hospital”).

55. *Id.*

56. *Id.* at 568.

57. *See, e.g., supra* main body text accompanying notes 20–21.

58. *Donaldson*, 422 U.S. at 584 (“There can be little responsible debate regarding ‘the uncertainty of diagnosis in this field and the tentativeness of professional judgment.’”) (quoting *Greenwood v. United States*, 350 U.S. 366, 375 (1956)). The Court’s view echoed a high degree of public skepticism about the reliability of psychiatric diagnosis at the time. Only two years before the Court’s decision in *Donaldson*, psychiatry had been greatly embarrassed by the publication in *Science* magazine of the now-famous Rosenhan experiment. David L. Rosenhan, *On Being Sane in Insane Places*, 179 *SCI.* 250 (1973). Rosenhan sent a group of healthy associates to twelve different mental hospitals in five states. *Id.* These pseudo-patients attempted to gain admission to the hospitals as patients by falsely claiming to suffer from auditory hallucinations. All were admitted and diagnosed with psychiatric disorders. *Id.* While in the hospital, all the patients behaved normally and informed the staff that they felt fine and were not experiencing any more hallucinations. *Id.* Nonetheless, Rosenhan’s pseudopatients spent an average of nineteen days in the hospital. *Id.* In order to gain release all were forced to agree to take antipsychotic medications, and all except one were diagnosed with schizophrenia “in remission.” *Id.* The uproar over the Rosenhan experiment was a significant factor in psychiatry’s subsequent turn toward diagnostic verifiability and reliability, a move which took center stage in the profession with the publication of the DSM III in 1980. *Id.*; *see, e.g.,* Mitchell Wilson, *DSM-III and the Transformation of American Psychiatry: A History*, 150 *AM. J. PSYCHIATRY* 399 (1993).

coercion to enforce the judgment of a psychiatrist, without giving courts an independent basis on which to question those judgments and guard the patient's presumptive right to refuse treatment, put vulnerable patients at the mercy of psychiatric professionals like O'Connor, whose judgments could be influenced by personal pique, personal dislike of a patient, or other reasons not relevant to the patient's welfare or legal rights. The hope of reformers was to give the law an independent basis—the “dangerousness” standard—upon which to ensure that involuntary commitment was confined to those mentally ill patients who really posed a serious risk of harm to themselves or others.

But the apparent victory of legal advocates for the mentally ill, whose arguments persuaded legislatures across the land to adopt dangerousness-based standards for involuntary commitment, has been replaced by a growing sense of failure. Whatever the statutes said, it soon became clear that in actual court proceedings, “dangerousness” was often treated either as synonymous with “mental illness,” or at least as primarily the concern of mental health professionals. In short, the courts were not using dangerousness as a way of limiting the reach of involuntary commitment or of staking the law's independence from psychiatric judgments.⁵⁹

In explaining this failure we should look to the crucial role played by those in the mainstream clinical community, especially (1) mental health professionals who evaluate detainees and testify in court as to their mental health and dangerousness; and (2) judges who, although charged with the statutory duty of making a final judgment about whether the law should force someone into treatment, frequently short-circuited the required legal judgment by deferring to the medical one.⁶⁰

59. See, e.g., Joel Haycock et al., *Mediating the Gap: Thinking About Alternatives to the Current Practice of Civil Commitment*, 20 NEW ENG. J. CRIM. & CIV. CONFINEMENT 265 (1994) [hereinafter *Mediating the Gap*] (discussing “vast formal expansion of procedural and substantive rights [in involuntary commitment proceedings, which] has led to continually disappointing results”).

60. See, e.g., Zander, *supra* note 1, at 503 (quoting a post-*Lessard* dialogue, at an involuntary commitment hearing, between a Milwaukee judge and defense attorney: *Defense attorney*: “But I just wonder if we are dealing with just family emotional-type problems. And, it's a little difficult for me to

C. *Revolt Against Process—the Pro-Treatment Side Rises Again*

Even in the 1970s, not everyone agreed with lawyer and ex-patient advocates that involuntary commitment was more evil than good. The pro-treatment voices were there, though subdued for a while by the reforms of that era. By the 1980s, however, pro-treatment forces were on their way back. In 1981, in their editorial *Dangerousness as the Criterion for Involuntary Hospitalization: A Time to Reassess*,⁶¹ Pauline Rabin and David Folks passionately argued for the loosening of the involuntary commitment standard on the ground that the “dangerousness” criterion prevented doctors from treating desperately suffering patients:

The present emphasis on dangerousness to self or others as the sole criterion on which a psychiatrist can enforce hospitalization of the mentally ill has been challenged by the physician who is confronted with an acutely psychotic patient and the social worker and community agencies on whom the burden of handling this group now falls Our dilemma as physicians is that we are forced to overlook the acute symptoms of mental illness and to intervene only if the patient’s behavior can be characterized as dangerous. The decision to hospitalize a patient involuntarily for evaluation, treatment, or both is a legal rather than a medical determination Is it not time to reassess the criteria for emergency involuntary hospitalization? How can we withhold treatment from an acutely ill patient? Whose freedom is compromised by the current standards? Should we not reintroduce broader options for emergency

understand how full-time inpatient hospitalization at this time would be the cure” *Court*: “I have the same feeling. However, I’m not expert in psychiatric matters. The experts have testified. My feelings are the same as yours, but I can’t disregard the expert testimony”).

61. Rabin & Folks, *supra* note 15.

commitment? We strongly urge that a comprehensive review of these questions be undertaken, directed toward reframing the standards for involuntary commitment while safeguarding the patient's fundamental civil rights.⁶²

Considering the subsequent empirical research indicating that the dangerousness standard had not, in fact, made significant changes in the rate or substantive proceedings in involuntary commitment cases, Rabin and Folks' concerns may seem a bit overheated. The real significance of these concerns, however, lies not in their factual accuracy but in the attitude and orientation they reveal—that of the psychiatrist on the ground, in the emergency room or in the courtroom, faced with a suffering patient who, in the professional's opinion, is in desperate “need of treatment.” While the law and the legal standard have remained focused on rights and procedures, many mental health professionals charged with implementing those standards continue to perceive involuntary commitment through a “need for treatment” lens. The pro-treatment voice became even more vocal in the 1980s and 1990s amid the controversies over deinstitutionalization⁶³ and homelessness, which eventually generated calls for expanded rights to treatment for the mentally ill.⁶⁴ As one author characterized the literature in 1994:

62. *Id.* at 980.

63. Deinstitutionalization refers to a set of government policies, during the mid-late twentieth century, which led to the downsizing or closure of most psychiatric hospitals nationwide and shrank the number of patients hospitalized for mental illness from more than 500,000 in 1955 to under 50,000 by 2002. *See, e.g.,* Tom Jackman, *Commitment Rule is Key to Changing the System: Interpretation of Criteria Varies Among Counties*, WASH. POST, Nov. 28, 2007, at A01, <http://www.washingtonpost.com/wp-dyn/content/story/2007/11/27/ST2007112702512.html> (“In 1955, 558,239 patients were in public psychiatric hospitals. By the mid-1990s, the number had dropped to fewer than 72,000. By 2002, the total had fallen below 50,000”).

64. *See, e.g.,* Haycock et al., *supra* note 59; Luis R. Marcos, *Taking the Mentally Ill Off the Streets: The Case of Joyce Brown*, 20 INT'L J. MENTAL HEALTH 7, 7 (1991) (“Hardly a section of the country, urban or rural, has escaped the ubiquitous presence of ragged, ill, and hallucinating human beings, wandering through our streets, huddled in alleyways, or sleeping over vents. . . . It now is apparent that a substantial portion of the homeless are chronically and

Reports on the failure of courts to abide by procedural and substantive standards, and regular criticism of that failure from mental health and legal scholars, have not appreciably advanced the practice of rights-based civil commitment . . . a number of practicing clinicians experience substantive and procedural guarantees as destructive of patients' treatment needs, and as misguided, one-sided interference with the treatment of persons with debilitating mental disorders. The simple reiteration of patients' substantive and procedural rights during a civil commitment hearing has neither ensured those rights, nor arguably advanced durable treatment relationships necessary to prevent rehospitalization.⁶⁵

It seems that the new standard made no one happy: It failed to invigorate the legal rights of mentally troubled patients, and it also raised a substantial obstacle to the effective treatment of patients who may need, but not want, psychiatric care.

In retrospect, this tension between the legal and psychiatric perspectives on the standard for involuntary commitment seems obvious, even inevitable. The two professions—reflected in the two parts of the standard—come to the policy problem with very different fears, very different nightmare scenarios. Nightmare #1,

severely mentally ill men and women who in years past would have been long-term residents of state hospitals”).

65. Haycock et al., *supra* note 59, at 266:

By far the largest body of literature consists of both professional and mass media material criticizing the impact of stringent commitment criteria on the care of the seriously mentally ill Distressed at the inability of clinicians to force treatment on thousands of severely mentally disabled persons, a number of clinicians and researchers have proposed modifications of procedural standards [that were] modeled on criminal due process, [and] a shift away from adversarial hearings, stringent due process requirements, and strict evidentiary standards.

Id.

represented by the facts in *Donaldson*,⁶⁶ envisions innocent patients forcibly incarcerated in a mental institution and held there by the ignorance, arrogance, or personal pique of the staff. By defending patients' presumptive right to refuse treatment and subjecting requests for forcible commitment to vigorous examination by attorneys and judges, reformers sought to prevent such injustices. Nightmare #2, expressed in Donald Trefferts's powerful phrase *Dying With Their Rights On*,⁶⁷ envisions seriously disturbed (even if not "dangerous") patients, helpless, unable to feed, clothe, or care for themselves, and left to languish on the streets because the law is so focused on protecting their rights that it turns away from their suffering. Both scenarios suggest real risks for the law. Under a "need for treatment" standard that relies solely on the judgment of mental health professionals, the risk is that the standard will give rise to more Kenneth Donaldsons—patients held in mental hospitals, for years, against their will while the doctor supposedly caring for them acts against, rather than for, their interests.⁶⁸ On the

66. And in fiction by such characters as Nurse Mildred Ratched in Ken Kesey's famous novel, *One Flew Over the Cuckoo's Nest*, KEN KASEY, *ONE FLEW OVER THE CUCKOO'S NEST* (1962), and Nurse Davis in the 1948 film *THE SNAKE PIT* (Twentieth Century Fox 1948).

67. Treffert, *supra*, note 15.

68. Reports of cases which confirming this fear are not difficult to find. See, e.g., Alicia Curtis, *Involuntary Commitment*, *BAD SUBJECTS*, Dec. 2001, <http://psychrights.org/states/Maine/InvoluntaryCommitmentbyAliciaCurtis.htm> (Curtis, a psychiatric social worker, reports that "[h]usbands ridding themselves of wives via the psychiatric institution was still enough of a problem in the 1930s that the first woman in Maine's legislature, Gail Laughlin, authorized a bill penalizing husbands for bringing false testimony in the involuntary commitment hearings of their wives"). More recently Curtis recalls:

I worked with a patient who in the 1960s had been brought to the hospital by her husband. The chief complaint listed on the admitting record was: 'Patient does not do her housework.' I think she did actually have a recurrent depression, a symptom of which was her inability to care for herself and her home, but here was obviously a large overlap conceptually between mental illness and not functioning in a prescribed social role. There is also a large history of the forced treatment of homosexuality as mental 'illness.' One gay man I know has a familiar story. He was brought, as a teenager, to a psychiatric hospital in the Midwest by his parents, when they found out he

other hand, under a vigorous standard which seeks to protect the presumptive rights of patients to refuse commitment even if doctors or court personnel see a “need for treatment” or “grave disability,” the risk is that seriously ill patients, unable to care for themselves but unwilling to be medicated or hospitalized, will be abandoned on the streets to be arrested, victimized, or even killed.

For the law, the core issue is which risk to take—or, alternatively, how to arrange the relevant legal architecture into a standard that minimizes both risks. The law’s options are limited, because law in our society is closely bound to the protection of individual rights. It is the law’s foundational job to protect those rights and, in the context of involuntary commitment, to treat the rights of the mentally ill with the same respect as the rights of others. The law *must* care about the flawed legal standard which allowed Kenneth Donaldson to be held against his will for fifteen years although he had committed no crime and presented no danger. For the law, any inquiry into involuntary commitment must begin there. Forcing a person into treatment against her will flies directly in the face of the individual’s right to refuse medical or psychiatric treatment whether or not medical professionals agree.⁶⁹ And where no harm to others is foreseeable or expected, the right of a respondent to refuse treatment is especially compelling. Further, once we embark on a course which allows the state to incarcerate a person against her will on grounds of “danger to self,”

was having gay sex. He was involuntarily committed to the institutional and treated for his homosexuality.

Id. (The treatment didn’t work). See also Mike Riggs, *Lost in the Madhouse: Three Stories of Involuntary Confinement*, THE DAILY CALLER, Jan. 21, 2011, <http://dailycaller.com/2011/01/21/lost-in-the-madhouse-three-stories-of-involuntary-confinement> (recounting the story of “Eric,” a Florida college student who in 2008 was involuntarily committed, or “Baker Acted” under Florida’s forcible commitment statutes, apparently on extremely flimsy grounds).

69. See, e.g., *O’Connor v. Donaldson*, 422 U.S. 563, 575 (1975) (“A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the ‘mentally ill’ can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom”). See also A. Stone, *The Right to Refuse Treatment: Why Psychiatrists Should and Can Make it Work*, 38(3) ARCH. GEN. PSYCHIATRY 358 (1981).

the definitional question—what constitutes an actionable danger under the standard—becomes both vitally important, and enormously difficult, to resolve coherently.

Can the reigning conceptions of “mental illness” and “dangerousness” resolve this issue? If we define “danger to self” in the usual way—as “posing a significant risk of serious physical harm” to oneself—then adventurers like Steve Fossett, who engage in risky activities because they love to confront and overcome the risk, are just as committable as the depressed person who drinks poison with the express purpose of ending his life. But should the concept be defined so expansively? And if not, does the “mental illness” prong of the test establish a rationally defensible boundary line?

III. REDEFINING “DANGER TO SELF”

Consider the following three scenarios. Scenario One: Alice has decided to kill herself and proceeds to the roof of her twenty-story apartment building, intending to jump off. Alarmed bystanders grab Alice just as she jumps, pull her to safety, and phone the police who deliver her to the psychiatric wing of a nearby hospital. Despite Alice’s clearly expressed wish to be released from the hospital so that she can accomplish her own death, her concerned family petitions the court to have her forcibly committed on grounds of danger to self.

Scenario Two: Bruce⁷⁰ is a senior partner at a large urban law firm. Bruce works seven-day, eighty-hour weeks, and has always believed that his life is his work. Bruce suffers a major heart attack and is informed by his doctors that unless he dramatically reduces his workload and stress level, he will almost certainly suffer a second and fatal heart attack in the near future. Despite Bruce’s clearly expressed preference to return to work at his normal pace, his concerned family petitions the court to have him committed on grounds of danger to self.

Scenario Three: Christopher⁷⁰ suffers from atherosclerotic dementia, a condition that causes periods of confusion interspersed

70. The characters of “Bruce” and “Christopher” are renamed versions of cases described in Alan Dershowitz, *Psychiatry in the Legal Process: “A Knife that Cuts Both Ways,”* 51 JUDICATURE 370, 375 (1968) (discussing the cases of “Mrs. Lake” and of Supreme Court Justice Robert Jackson).

with periods of rationality. Christopher is neither suicidal nor dangerous to others. He has no close family or friends, and lives alone. One night the police find him wandering the streets, confused but not endangering anyone. They bring Christopher to the psychiatric wing of the local hospital and petition the court to have him committed for treatment. At the commitment hearing Christopher petitions for release and coherently testifies that he knows about his illness, understands its risks, but that he has spent time in a psychiatric facility before and prefers to take the risk of living on his own rather than be hospitalized again.

First, consider Scenario Three. Should the law grant the petition and commit Christopher for treatment against his will? In more than half the states the law permits forcible commitment not only in cases where a court finds a mentally ill respondent to be dangerousness to self or others, but also in cases involving mental illness and grave disability or need for treatment.⁷¹ But what should “count” as a grave disability? The law must have a role in deciding this because the answer determines when courts may overrule the express preference of a respondent not to be hospitalized (or forcibly treated, for example with drugs, on an outpatient basis).

By hypothesis, Christopher is not “dangerous” in the sense that he intends to do violence either to other people or himself. But the answer to the “grave disability” question must nonetheless depend on a concept, which is closely related to dangerousness—the concept of harm, or risk of harm, to self. Christopher’s dementia, while not disposing him toward violent behavior, risks self-harm in the sense that he might, in a confused state, be unable to provide for his own basic needs or wander into a dangerous situation where he is vulnerable to assault by violent others. Should that kind of risk be a proper basis on which to overrule Christopher’s clearly expressed desire not to be treated for his dementia?

71. See, e.g., *Legal Resources in Your State: Maine*, TREATMENT ADVOC. CTR., http://www.treatmentadvocacycenter.org/index.php?option=com_content&view=article&id=215&Itemid=150 (last visited Jan. 15, 2014) (noting that Maine is one of twenty-three states whose involuntary treatment standard is based on a person’s “need for treatment” rather than only the person’s likelihood of being dangerous to self or others).

To answer that, we need to know what risk of harm means in the involuntary commitment context; what kinds of risk, and of risked harm, should “count” for purposes of evaluating someone under the standard;⁷² and what degree of harm, or risk of harm, justifies a court in acting against a respondent’s desire not to be treated. “Grave disability,” in this sense, is another name for “danger to self.”⁷³ Assessing such disability necessarily involves assessing the degree of harm, or risk of harm, to the self if the respondent is not hospitalized/forcibly treated. In this important sense, investigating the content of the “danger to self” standard is conceptually prior to defining the boundaries of the “grave disability” one.

How, then, should the law of involuntary commitment view the two “danger to self” cases of Alice and Bruce? Should the law treat those two cases the same, or differently? If the same, should a court force both Alice and Bruce into treatment, or neither? If the two cases call for different legal dispositions, what would justify that result, and which way should the relevant differences cut? By analyzing the range of possible answers to these questions, this Part illuminates some problems with the “danger to self” rule and articulates the basis for a fairer, more just standard, one which holds true to the *legal* values which necessarily arise when a person is forced into treatment against his will.

In the cases of Alice and Bruce, four resolutions are possible. First, the court could grant both commitment petitions, forcing both respondents into treatment. Second, the court could deny both petitions, refusing to force either respondent into treatment. In choosing either of these two options, the court would be treating Bruce and Alice the same for purposes of involuntary commitment.

Alternatively, the two petitions should be decided differently, an option that offers the third and fourth possible resolutions. Thus, the petition for involuntary commitment could be

72. For example, what about alcohol abuse? Consider the case of “Dan” that opened this Article. *See supra* text accompanying note 2.

73. And some courts have expressly defined grave disability in those terms. *See, e.g., Doe v. Gallinot*, 486 F. Supp. 983, 991 (S.D. Cal. 1979) (grave disability “implicitly requires a finding of harm to self”).

granted as to Alice but not as to Bruce, or it could be granted as to Bruce but not as to Alice.

The next Section considers these four options.

A. *An Abolitionist Premise*

Again: In a legal system that takes individual rights seriously, the law must always have good reason to overrule a person's desire to be left alone. Thus, we begin with the premise that unless there is good reason to force Alice, Bob, or both into treatment, neither one should be committed against their will. Further discussion becomes necessary only if we determine that the abolitionist position is wrong—only if there are in fact cases where the law clearly *should* order someone to be committed despite their contrary preference.

Against that conceptual backdrop, what should happen to Alice and Bruce? The abolitionist premise would dictate that neither respondent should be forced into treatment. Should the court, then, deny both petitions?

Consider this response: The cases of Alice and Bruce are not similarly situated; in fact they are polar opposites. Alice, who attempted suicide, represents the paradigm case in which a respondent *should* be forcibly committed, while Bruce, the workaholic, represents an equally obvious case in which the law should respect the respondent's preference *not* to receive treatment—in which the family's petition for commitment should be denied. What might justify this view? To answer we need to think more deeply about what the commitment standard is, and to what factual situations it applies.

Three core elements animate the “danger to self” standard: that, absent intervention: (1) There is a risk of serious harm to the self, (2) there is a high degree of likelihood that the harm will occur, and (3) the threatened harm is imminent, will occur within a very short time. Alice's case satisfies all three elements. There is a risk of serious self-harm from failing to hospitalize Alice—if she is not forcibly hospitalized she will probably die by her own hand. Second, Alice's behavior on the roof demonstrated a firm determination to kill herself, and she continues to demand that she be released so that she can try again. Thus, there is a high degree of likelihood that the serious harm in question—Alice's death by suicide—will occur if Alice is not forcibly committed. And third,

Alice's recent behavior indicates that this serious and likely harm is imminent—if she is not hospitalized Alice will try to kill herself again very soon.

It seems to follow that Alice is among the most compelling cases for forcible confinement of a person on grounds of “danger to self.” Such cases involve respondents who are likely to inflict imminent death or serious bodily harm upon themselves in the absence of intervention. In this context the phrase “danger to self” is a summary way of describing the factors of (1) threatened serious harm, (2) high probability of such harm, and (3) imminence of such harm.

If this is correct, then the three criteria are *sufficient* to justify hospitalization against the respondent's will. Are these criteria also *necessary* to justify such commitment? Would dropping any one of the three elements sink the case for involuntary commitment below the normative threshold at which the law is justified in overriding a person's presumptive right *not* to be incarcerated against her will?

A brief thought experiment will test this out. First consider element (1), and suppose that the imminent threatened harm from *not* hospitalizing a respondent is far less serious than the person's death. If the respondent was captured not while attempting to kill herself but while lying on a summer beach without sunscreen, few would feel comfortable incarcerating her against her will for attempting to inflict such “harm” on herself. The harm must be serious, amounting to a threat of death or serious self-injury.

The same is true for element (2). Even a person who has threatened to do serious and imminent harm to herself will not be forcibly committed if the *likelihood* he will actually do the harm is not very high. In fact mental health professionals make this kind of judgment all the time. Does a depressed client who says he wants to die really mean to kill himself, or is he merely using references to death as a means of expressing the sadness, emptiness, and hopelessness he feels while experiencing a very black mood? If the former, presumably the person is a candidate for hospitalization; if the latter, presumably not. The degree of likelihood that the serious and imminent harm will occur is an indispensable element of the calculus.

Finally, the case for forcible commitment would fall below the requisite threshold if the threatened danger to self is admittedly serious and credible, but is not *imminent*—not about to happen in

the immediate future. Consider the case of a forty-year-old person who has an inordinate fear of aging. The person believes that life has no meaning after age fifty, and she tells her therapist that she intends to kill herself on the night before her fiftieth birthday. Even if the client's intent is real and the therapist believes her, the therapist lacks adequate cause to have the patient forcibly committed now, because although the client may very well follow through on the threat at the time she indicates, the ten-year delay between threat and time of harm would, and should, defeat any effort to have the person hospitalized against her will. The factor of imminence, in this sense, is a way of assuring that the threatened danger to self is almost certain to occur, right now, unless the person is hospitalized. Understood in this way, the imminence requirement can be seen as an adjunct to the likelihood element—both seek to limit the law of involuntary commitment to cases in which failing to commit someone involuntarily will almost certainly lead to serious injury or death of that person.

The three elements—serious harm to self, high likelihood/probability of such harm in the absence of hospitalization, and imminence of the harm—are thus both necessary and sufficient to commit a person involuntarily on grounds of danger to self. In the case of Alice, all three exist, and this explains the intuition that Alice is a proper candidate for forcible commitment on grounds of danger to self.⁷⁴

But consider that the above test may come out exactly the same way in Bruce's case as it does in Alice's. As to element (1), risk of serious harm to self, Bruce's case is quite similar to Alice's. Like Alice, Bruce's choice to refuse treatment carries the serious and foreseeable (actually foreseen) risk of his own death. As for element (2), the likelihood element, there may be a difference between Alice and Bruce—on the other hand, there may not. People sometimes live much longer than their doctors expect them to. But severely depressed people sometimes behave in unpredicted ways. Statistics indicate, for example, that between eighty-five and ninety-five percent of people who attempt suicide are still alive

74. Some state statutes also contain requirements that (1) treatment be available and/or that (2) the patient is likely to benefit from such treatment. *See, e.g.,* N.Y. MENTAL HYG. LAW 9.60(C).

fifteen years later.⁷⁵ Statistics also indicate that the five-year survival rate from congestive heart failure is only fifty percent—half of those who suffer massive heart attacks die of heart failure within five years of diagnosis.⁷⁶ The difference in likelihood of serious and imminent harm between Alice and Bruce may be negligible, or even non-existent. Further, even if there is some difference here, we can't know that Bruce's case falls below the likelihood threshold unless and until we know what that threshold is.⁷⁷ Just how likely must the threat of serious and imminent harm to self be in order to justify involuntary commitment? On its face the “danger to self” standard offers no answer to this. It should.

Finally, with respect to element (3), the imminence criterion, again no necessary difference divides the cases of Alice and Bruce. In the real-life scenario on which Bruce's hypothetical case is based—that of Supreme Court Justice Robert Jackson—the patient (Justice Jackson) suffered a serious heart attack; was warned that if he continued his demanding work schedule that he risked a fatal heart attack at any time; and in fact suffered a fatal heart attack shortly after he rejected the advice of his doctors and returned to his pre-illness schedule.⁷⁸ The harm to self was in fact imminent, as Jackson's doctors had warned him. Once again, even if this were not clear, we can't know whether the threatened self-harm in Bruce's case is imminent *enough* to justify forcing him into treatment until we know what the threshold level of imminence actually is.

75. Catherine E. Bonn, *Suicide and the State: The Ethics of Involuntary Hospitalization for Suicidal Patients*, 3 INTERSECT 40, 44 (2010), available at <http://ojs.stanford.edu/ojs/index.php/intersect/article/view/197/101> [hereinafter Bonn, *Suicide and the State*].

76. See, e.g., *Statistics: Heart Failure*, HEART AND STROKE FOUNDATION OF CANADA, <http://www.heartandstroke.com/site/c.ikiQLcMWJtE/b.3483991/k.34A8/Statistic.htm> (last visited Jan. 15, 2104).

77. In his perceptive article *Psychiatry in the Legal Process*, Alan M. Dershowitz made this point in 1968. Dershowitz, *supra* note 17, at 376 (discussing an “important question which rarely gets asked in the civil commitment process: how likely should the predicted event have to be to justify preventive incarceration? Even if it is agreed, for example, that preventing a serious physical assault would justify incarceration, an important question still remains: how likely should it have to be that the person will assault before incarceration is justified?”).

78. *Id.* at 375.

Thus, if the three-pronged “dangerousness” test justifies the involuntary commitment of Alice, then forcing Bruce into treatment too may be at least equally legitimate.

But consider a second intuition, which seems to distinguish the cases of Alice and Bruce: a difference in their intent. One factual difference between Alice’s case and Bruce’s is that at the time her family petitions the court to have her forcibly committed, Alice has the conscious purpose and the primary intent of causing the serious, likely, and imminent harm in question—her own death. On the other hand Bruce’s course of action, although in fact it poses a high *risk* of his death and Bruce knows of that risk, was chosen despite that risk, not because of it. Is the presence of conscious purpose in Alice’s case, and its absence in Bruce’s, a valid basis on which to grant the family’s petition for commitment as to Alice and deny it as to Bruce?

The answer must be no. To the extent that Alice’s intent to cause her own death makes it more *likely* that she will accomplish that result, or makes the result more *imminent*, perhaps such intent should be relevant to the court’s decision in her case (and, by reference, perhaps the absence of such intent should count as one factor in favor of denying the family’s petition in Bruce’s case) under the three prongs of the dangerousness standard. But intent alone is *not* a valid basis for distinguishing between Alice and Bruce. A moment’s thought makes this clear and also moves the discussion in an important new direction.

The fundamental question in “danger to self” cases is whether the state has adequate reason to override the person’s preference not to seek treatment. Intent to cause harm to oneself, even a drastic harm like one’s own death, does not offer adequate reason to override that preference. The reason is that we can easily imagine situations in which a person’s choice to end her own life is rational; makes sense; is supported by reasons we can understand and with which we can sympathize (though of course we might ultimately disagree with it on religious or moral grounds). In Alice’s case, for example, what we need to know is not merely that she intends to kill herself, but *why*. If Alice intends to end her life because she believes that Martians have invaded her town and are

planning to kidnap and transport her to another planet,⁷⁹ a fate worse than death, then (for all except abolitionists) Alice's delusional motive for wanting to kill herself might give the state adequate reason to step in and prevent her from carrying out her suicide plan. On the other hand, if Alice wants to end her own life because she is in the end-stage of an incurable and excruciatingly painful form of cancer and has been told by her doctors that there is nothing they can do either to prolong her life or to diminish the suffering she will experience as the disease progresses further, then this is a rational and understandable motive which might merit respect from the state and the courts—*whatever* the nature of the contemplated self-harm, its likelihood, and/or its imminence.⁸⁰

79. Unfortunately, such cases do happen. For example, in 1998 Russell Weston shot and killed two Capitol Hill police officers in the United States Capitol. Weston, who had been diagnosed with paranoid schizophrenia some years before the killings, shot the officers because he believed they were blocking access to a device which would stop the United States from being annihilated by cannibals. *See, e.g.*, Bill Miller, *Capitol Shooter's Mind-Set Detailed*, WASH. POST, Apr. 23, 1999, at A1, available at <http://www.washingtonpost.com/wp-srv/national/longterm/shooting/stories/weston042399.htm> (“Russell Eugene Weston Jr. told a court-appointed psychiatrist that he stormed the U.S. Capitol last summer, killing two police officers, to prevent the United States from being annihilated by disease and legions of cannibals. ‘He described his belief that time was running out and that if he did not come to Washington, D.C., he would become infected with Black Heva,’ wrote Sally C. Johnson, the psychiatrist who examined Weston last fall. Weston called this imaginary ailment the ‘most deadliest disease known to mankind’ and said it was spread by the rotting corpses of cannibals’ victims, Johnson wrote. Weston told Johnson he went to the Capitol to gain access to what he called ‘the ruby satellite,’ a device he said was kept in a Senate safe. That satellite, he insisted, was the key to putting a stop to cannibalism”). *See also* Clark v. Arizona, 548 U.S. 735, 743 (2006) (discussing defendant Eric Clark’s “undisputed paranoid schizophrenia” at the time he shot and killed a police officer). Witnesses testified that paranoid delusions led Clark to rig a fishing line with beads and wind chimes at home to alert him to intrusion by invaders, and to keep a bird in his automobile to warn of airborne poison. There was lay and expert testimony that Clark thought Flagstaff was populated with ‘aliens’ (some impersonating government agents), the ‘aliens’ were trying to kill him, and bullets were the only way to stop them.

Id. at 745.

80. *See, e.g.*, Bonn, *Suicide and the State*, *supra* note 75.

Notice that the same analysis applies to Bruce. If Bruce chooses to continue working at his pre-heart attack pace because he delusionally believes that his doctors and his family are plotting his murder and his only chance of escape is to remain at the office,⁸¹ that irrational motive might justify state intervention and forced treatment. But if Bruce's choice to reject his doctors' advice and continue to work is based on his belief that work is the most valuable thing in his life—or even (is this a closer case?) that all doctors are quacks and his own judgment about his health is more reliable than theirs—then, while we might personally disagree with his decision, the motive behind it is comprehensible and not irrational in the same sense as it would be in the first scenario. In that instance, perhaps, the state should respect Bruce's decision.

But if this analysis is correct, it dramatically shifts the argument. What now becomes crucial to the legal standard of involuntary commitment is not the three elements of dangerousness, but the *reasons* offered by the respondent for wanting to harm himself. The nature and coherence of those reasons—not merely the characteristics of the harm—emerge as

81. Again, such events do occur. For example, seventeen-year-old Eric Clark murdered a police officer and then challenged Arizona's insanity defense on constitutional grounds in *Clark v. Arizona*. *Clark*, 548 U.S. 735. Clark had previously been diagnosed as paranoid schizophrenic and had come to believe that his own parents were aliens and that he was in constant danger of being attacked or killed. See, e.g., *Was Eric Clark Insane or Just Troubled?*, CNN, April 15, 2008, available at http://sentencing.nj.gov/downloads/pdf/articles/2006/0426_14_cnn.pdf; John Gibeaut, *A Matter Over Mind*, A.B.A. J., Apr. 22, 2006, available at http://www.abajournal.com/magazine/article/a_matter_over_mind (“‘It started with the water,’ David [Clark, Eric's father] says. Terry [Clark, Eric's mother] explains:

He thought it contained lead. He thought he was going to be poisoned, and we couldn't convince him otherwise.’ Then came the aliens. Clark believed that Flagstaff had been invaded by them, and that he and the city were in danger. Though he still recognized David and Terry as his parents, he also believed they were aliens. ‘But he couldn't tell us who they were or why we would be in danger,’ David says. He recalls his son's matter-of-fact response when he asked Eric how he knew his parents were aliens: He said, ‘Bring me some tools and I'll show you.’

Id.

central to the legitimacy of state coercion. Thus, in addition to a dangerousness component consisting of the three-pronged analysis outlined above, a defensible involuntary commitment standard contains a “rational motive” or “rational capacity” requirement commanding the state to uphold a respondent’s decision to forego psychiatric treatment unless and until the state affirmatively concludes that the respondent lacks the capacity to rationally deliberate about his own situation and to articulate reality-based reasons for his decision not to seek treatment.

But the current standard for involuntary commitment does not require that the respondent fail a rational motive/capacity test. Instead, (in addition to a finding of dangerousness) it requires that a respondent suffer from “mental illness.”⁸² Is the presence of “mental illness” an accurate proxy for the lack of reasoning and deliberative capacity that could justify committing someone against their will? Section B engages that question.

B. Mental Illness As Grounds for Involuntary Commitment

If the term “mental illness” refers only to cases in which a respondent’s thinking is so disordered that (s)he is unable to assess the risks and benefits of hospitalization, and/or to articulate a rational basis for declining treatment, then there is no gap between the actual standard and the rational basis one. Thus, clarifying the relevant meaning of “mental illness” is a crucial step in the analysis.

1. The Problem of Definition

How, then, is “mental illness” defined for purposes of involuntary commitment? A first response is to consult psychiatry and psychology and to borrow their conception of the term. But this turns out to be quite difficult, in large part because psychiatric and

82. See, e.g., *State Standards for Assisted Treatment: Civil Commitment Criteria for Inpatient or Outpatient Psychiatric Treatment*, TREATMENT ADVOC. CTR., Jan. 2013, http://www.treatmentcenter.org/storage/documents/Standards_The_Text_June_2011.pdf (“All states and the District of Columbia have laws governing court-ordered hospital (inpatient) commitment of individuals with severe mental illness . . .”).

psychological terms are formed for very different purposes than are legal ones.

As a first try, we might refer the concept of mental illness to the “bible” of psychiatric diagnosis—the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).⁸³ The DSM is produced by the American Psychiatric Association and is the most widely accepted diagnostic instrument among clinicians in the United States of America.⁸⁴ DSM-5 defines “mental disorder” as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.”⁸⁵ DSM-IV-TR and DSM-5 include more than 300 possible diagnoses, ranging from psychological conditions which are universally viewed as serious (such as major depression, bipolar disorder, and schizophrenia) to conditions (for example, “impairment in written expression,”⁸⁶

83. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5]. The most recent version of the manual, DSM-5, took effect in May 2013. Most of the statutes and cases discussed in this Article were enacted during earlier versions of DSM. *See, e.g.*, AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000) [hereinafter, DSM-IV-TR]; *see also* Allen Frances, Op-Ed., *Diagnosing the DSM*, N.Y. TIMES, May 11, 2012, available at http://www.nytimes.com/2012/05/12/opinion/break-up-the-psychiatric-monopoly.html?_r=0 (evaluating “revisions to what is often called the ‘bible of psychiatry’—the Diagnostic and Statistical Manual of Mental Disorders, or D.S.M.”).

84. *See, e.g.*, Marcia C. Peck & Richard M. Scheffler, *An Analysis of the Definitions of Mental Illness Used in State Parity Laws*, 53 PSYCHIATRIC SERVICES 1089 (Sept. 2002).

85. DSM-5, *supra* note 83, at 20.

86. *Id.* at 67 (a form of “Specific Learning Disorder” characterized by problems in spelling accuracy, grammar and punctuation accuracy, and clarity or organization of written expression). In DSM-IV-TR, “Disorder of Written Expression” defined as follows:

- A. Writing skills, as measured by individually administered standardized tests (or functional assessments of writing skills), are substantially below those expected given the person’s chronological age, measured intelligence, and age-appropriate education.
- B. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living

“impairment in mathematics”⁸⁷ and “caffeine intoxication”⁸⁸) which seem much less disabling to the threshold capacities for deliberation and reason that are at issue here. In short, the range of conditions to which DSM attaches the word “disorder” is quite wide, including at one end of the spectrum the schizophrenic person who suffers from psychotic delusions and hallucinations,⁸⁹

that require the composition of written texts (e.g., writing grammatically correct sentences and organized paragraphs).

DSM-IV-TR, *supra* note 83, at 56.

87. *Id.* (a form of Specific Learning Disorder characterized by problems with memorization of arithmetic facts, accurate or fluent calculation, number sense, and accurate math reasoning). In DSM-IV-TR, “Mathematics Disorder” is defined as follows:

- A. Mathematical ability, as measured by individually administered standardized tests, is substantially below that expected given the person’s chronological age, measured intelligence, and age-appropriate education.
- B. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living that require mathematical ability.

DSM-IV-TR, *supra* note 83, at 54.

88. *Id.* at 503 (recent consumption of high dose caffeine which is accompanied or followed by signs/symptoms, such as restlessness, nervousness, excitement, insomnia, psychomotor agitation.) *See also* DSM-IV-TR, *supra* note 83, at 232 (defining “Caffeine-induced Sleep Disorder”). A Caffeine-Induced Sleep Disorder is a variant of Substance-Induced Sleep Disorder characterized by the following:

- A. A prominent disturbance in sleep that is sufficiently severe to warrant independent clinical attention.
- B. There is evidence from the history, physical examination, or laboratory findings of (1) or (2): (1) the symptoms in Criterion A developed during, or within a month of, [Caffeine] Intoxication or Withdrawal
- C. The disturbance is not better accounted for by a Sleep Disorder that is not [caffeine] induced.

DSM-IV-TR, *supra* note 83, at 660.

89. *See, e.g.*, DSM-5, *supra* note 83, at 87–88 (Schizophrenia Spectrum and Other Psychotic Disorders characterized by “key features” including delusions, hallucinations, and disorganized thinking). *See also* DSM-IV-TR, *supra* note 83 (Defining schizophrenia). Schizophrenia in relevant part, is defined as follows:

- A. *Characteristic symptoms:* Two (or more) of the following,

and at the other end the person whose over-consumption of coffee or soda interferes with his sleep. Indeed, recent research suggests that almost half the U.S. population will meet the criteria for a DSM diagnosis during their lifetimes.⁹⁰ Although DSM explicitly cautions that its diagnostic categories “may not be wholly relevant to legal judgments,”⁹¹ many states and the federal government have

each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these should include 1, 2, or 3. (1) delusions; (2) hallucinations; (3) disorganized speech; (4) grossly abnormal psychomotor behavior, including catatonia; (5) negative symptoms, e.g., diminished emotional expression or avolition.

DSM-IV-TR, *supra* note 83, at 312.

90. According to Ronald Kessler, Professor of Health Care Policy at Harvard Medical School, almost half the United States population becomes “eligible” for a DSM-IV diagnosis at some point in their lives. *See, e.g.*, Wynne Parry, “Normal or Not? New Psychiatric Manual Stirs Controversy,” *LIVESCIENCE.COM*, May 19, 2013, www.livescience.com/34496-psychiatric-manual-stirs-controversy (“More than 46 percent of the U.S. population will meet the criteria for at least one DSM-IV diagnosis during their lifetimes, according to research published by [Kessler and his colleague Philip Wang]”).

91. The phrase is from the Cautionary Statement in DSM-IV-TR, *supra* note 83, at xxxvii.

The Cautionary Statement’s purpose is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.

Id. DSM-5, *supra* note 83 at 25 also contains a “Cautionary Statement for Forensic Use of DSM-5,” which states in relevant part:

Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental

used the manual as the definitional referent in legislation relevant to “mental illness” in a variety of contexts.⁹²

Of course DSM categories are primarily designed to detect mental disorders for the purpose of treating them. And in that context—a context in which there is no question of weighing the costs of rights violations against the benefits of psychological treatment—they make perfect sense. If diagnosis and treatment are the goals, then defining “mental illness” should be about identifying treatable conditions whether or not they involve dangerous or risky behavior.

That changes radically, however, in a legal setting where a respondent’s very freedom may depend on the presence or absence of a diagnosable “mental illness.” The problem is made more acute by the ambiguity surrounding causation in those state commitment statutes which set out the two elements—“dangerous to self or others” and “mental illness”—without specifying any particular causal relationship between them.⁹³ Must the diagnosed “mental illness” or “mental disorder” be the primary *cause* of the

disorders. As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals.

Id. The statement goes on to say that DSM-5 diagnostic categories can be useful to courts and legislatures, “[f]or example, when the presence of a mental disorder is the predicate for a subsequent legal determination (*e.g.*, involuntary civil commitment).” *Id.* Of course the question addressed here is whether the legal standard for involuntary commitment should contain a predicate that renders the law dependent on the conception of “mental disorder” developed by the mental health profession. I argue that it should not.

92. *See, e.g.*, Peck & Scheffler, *supra* note 84, at 1090 (making the point that in federal legislation the phrase “mental illness” has been interpreted to include all disorders in the D.S.M.).

93. *See, e.g.*, CONN. GEN. STAT. ANN. § 17a-498(c) (West 2009)(stating “. . . If, on such hearing, the court finds by clear and convincing evidence that the person complained of has psychiatric disabilities and is dangerous to himself or herself or others . . . it shall make an order for his or her commitment, considering whether or not a less restrictive placement is available, to a hospital for psychiatric disabilities”). *See also id.* § 17a-495(a) (stating that “dangerous to himself or herself or others” means there is a substantial risk that physical harm will be inflicted by an individual upon his or her own person or upon another person. . .).

respondent's dangerous behavior? If not, then courts, perhaps convinced of a respondent's dangerousness, might be tempted to force the person into treatment as long as *any* mental illness can be identified by the court psychologist or psychologist. Suppose, for example, the respondent threatens to harm himself, and also happens to suffer from mathematics disorder or disorder of written expression. Can the court commit him for treatment whether or not the disorder is a causal factor in the respondent's behavior or treatment preferences? Or suppose the respondent undoubtedly has a serious mental illness—suffers from schizophrenia and is actively psychotic at the time of the petition. Should the presence of an active psychosis suffice to satisfy not only the mental illness requirement but also the requirement of dangerousness?⁹⁴ These are core questions for the law, questions that the treatment-focused diagnostic categories of psychiatry cannot (and were not intended to) answer.

2. In Search of a Legally Intelligible Standard

On two variants of the abolitionist view, either (1) there is no such thing as “mental illness” and those who defend involuntary commitment based on that concept are agents of social oppression

94. See, e.g., Dershowitz, *supra* note 17, at 374. The involuntary commitment statutes

authorize preventive incarceration of mentally ill persons who are likely to injure themselves or others. Generally, ‘injure’ is not further defined in the statutes or in the case law, and the critical decision—whether a predicted pattern of behavior is sufficiently injurious [in today's terms, “dangerous”] to warrant incarceration—is relegated to the psychiatrist's unarticulated judgments. Some psychiatrists are perfectly willing to provide their own personal opinions—often falsely disguised as expert opinions—about which harms are sufficiently serious. One psychiatrist recently told a meeting of the American Psychiatric Association that ‘you’—the psychiatrist—have to define for yourself the word danger, and then having decided that in your mind. . . look for it with every conceivable means. . .

Id. The Dershowitz article was published in the late 1960s. Has the reformed “dangerousness” standard that took hold in the 1970s and 1980s sufficiently strengthened the rights of patients since then? This Article suggests that the answer is “no.”

against the different and the powerless;⁹⁵ or (2) even if “mental illness” *does* exist, the mentally ill should be treated in exactly the same manner as others for purposes of involuntary commitment.⁹⁶ Absent a previous or impending criminal charge, civil preventive detention on grounds of dangerousness alone is strongly disfavored in the law.⁹⁷ Abolitionists believe that the preferences of mentally disordered people should be accorded equal respect—that their choice to refuse psychiatric treatment should be as dispositive as it would be for any person.⁹⁸ Thus, abolitionists would argue that even a severely depressed respondent who is openly suicidal should *not* be forced into treatment despite her continuing and clearly serious wish to kill herself. If that suicidal person is released without treatment and then kills herself, a true abolitionist argues

95. See generally, from opposite ends of the political spectrum: (1) the views of Thomas Szasz, SZASZ, *supra* note 28; and (2) the views of R.D. Laing, R.D. LAING, *THE POLITICS OF EXPERIENCE* 1, 118–40 (1967).

96. See, e.g., Rabin & Folks, *supra* note 15, at 990 (describing this abolitionist view).

97. See, e.g., Stephen J. Morse, *Blame and Danger: An Essay on Preventive Detention*, 76 B.U.L REV. 113, 114 (1996) (“The strong presumption against preventive detention and the relatively limited means to accomplish it ensure that, in absolute terms, the dangerous undetainables are vastly greater in number than the dangerous detainables . . .”). The state’s power of preventive detention has greatly expanded when founded upon a pre-existing criminal charge, or prior criminal history of a defendant. See, e.g., Paul H. Robinson, *Punishing Dangerousness: Cloaking Preventive Detention as Criminal Justice*, 114 HARV. L. REV. 1429, 1429–30 (2001). Laypersons have traditionally thought of the criminal justice system as being in the business of doing justice: punishing offenders for the crimes they commit. Yet during the past several decades, the justice system’s focus has shifted from punishing past crimes to preventing future violations through the incarceration and control of dangerous offenders. Habitual-offender laws, such as “three strikes” laws, authorize life sentences for repeat offenders . . . “Sexual predator” statutes provide for the civil detention of sexual offenders who remain dangerous at the conclusion of their criminal commitment. New sentencing guidelines increase the sentence of offenders with criminal histories because these offenders are seen as the most likely to commit future crimes. These reforms boast as their common denominator greater official control over dangerous persons, a rationale readily apparent from each reform’s legislative history. *Id.* (citations omitted).

98. See, e.g., Paul Chodoff, *Involuntary Hospitalization of the Mentally Ill as a Moral Issue*, 141 AM. J. PSYCHIATRY 384 (1984) (contrasting the stance of “medical model” with that of civil libertarians on the issue of involuntary commitment).

that this potential consequence must be accepted as a cost of respecting the civil rights of the mentally disordered—just as we ought to respect the right of Justice Jackson to continue a stressful work schedule despite the knowledge that doing so risks his demise, or the right of adventurers such as Steve Fossett who choose to go solo ballooning around the world because they love and embrace the risk.

To be sure, even some who are generally sympathetic to the abolitionist perspective balk at the prospect of releasing an actively psychotic respondent (for example, a delusional schizophrenic who plans to jump from a building because he believes he will sprout wings and fly) without treatment. In his perceptive essay *What is So Special About Mental Illness?*,⁹⁹ the philosopher Joel Feinberg articulated a quasi-abolitionist position, which incorporates this exception. According to Feinberg, when a person's mental illness "so affect[s] the cognitive processes that [s]he is unable to make inferences or decisions,"¹⁰⁰ the state may exercise its "sovereign power of guardianship"¹⁰¹ in the person's behalf and force the person into treatment.

On its face, Feinberg's standard—which would make only those mental disorders which render the person "unable to make inferences or decisions" a proper basis for involuntary commitment—sounds a lot like the rational motive standard articulated above. But Feinberg then further defines the standard in a way that draws a bright, but inaccurate, line between cognitive disorders, which he argues *can* serve as psychological predicates for state intervention against a person's preferences, and "emotional" or "volitional" disorders, which should not. Feinberg states:

By no means all mentally ill persons . . . suffer from defects of reason. Many or most of them suffer from emotional or volitional disorders that leave their cognitive faculties quite unimpaired. To impose compulsory therapy on such persons *would be as objectionably paternalistic as imposing*

99. Joel Feinberg, *What Is So Special About Mental Illness?*, in *DOING AND DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY* 272 (1970).

100. *Id.* at 279.

101. *Id.*

*involuntary cures for warts or headaches or tooth decay.*¹⁰²

Thus, for purposes of forcible commitment Feinberg conceptualizes two clearly distinct groups of mental illnesses: (1) those which deprive the person of his or her rational faculties and can justify involuntary commitment when such commitment is in the rational best interest of the patient, and (2) those—“many or most”—which involve “emotional or volitional disorders that leave [the person’s] cognitive faculties quite unimpaired” and thus render involuntary commitment unjustifiably coercive in the same way that forcing a person into treatment for warts or tooth decay would be coercive.

Feinberg’s position implies that a respondent who suffers from a severe mood disorder (without psychotic features) should be treated as autonomous and rational for purposes of the commitment statutes. The state should respect that person’s preference not to be hospitalized, since in such cases the person’s disorder is “emotional” rather than “cognitive.” Thus, a person who is severely depressed and thinks constantly of killing himself suffers merely from an “emotional” problem and should be treated as fully rational and competent for the purposes of involuntary commitment. A court would have no legitimate cause to interfere with such a person’s decision to reject hospitalization so that he may kill himself.

Feinberg’s model rests upon a background dichotomy between the cognitive and the emotional, between mind and mood. And for the law this model has great intuitive appeal. It adopts a generally rights-oriented, abolitionist stance while also carving out a category of serious, cleanly defined mental disorders which disable the core cognitive capacities that merit respect and deference from the liberal state.

Further, the Feinberg standard would easily adjudicate some involuntary commitment cases, those at the extremes. Thus, suppose that Alice wants to jump off a building because her internal voices are telling her she can fly; or that Bob works all the time because he delusionally believes that his family are Martians

102. *Id.* (emphasis added).

in disguise and if he goes home they will kill him.¹⁰³ Both cases involve psychotic disorders that interfere with the patients' thinking and ability to make reality-based inferences and decisions. Under the Feinberg model, the state could justifiably intervene, in the rational best interest of respondents, and force both Alice and Bruce into psychiatric treatment. On the other hand, if Alice wants to jump in order to end the excruciating, escalating, and unavoidable pain from her terminal illness; or Bob continues his full-tilt work schedule because work is the most important thing in his life and he would rather be able to work all the time for a few months than live for years without the work he loves; those desires (although many might disagree with them) are rationally comprehensible and coherent. Thus, the courts in such cases should respect respondents' preferences to refuse treatment and deny the commitment petitions.

If all mental disorders did clearly fall into distinct and separate "cognitive" and "emotional" categories, Feinberg's quasi-abolitionist model would be a natural solution to the problem of balancing need for treatment with respect for individual rights. But reality is much messier than this. Contemporary psychological science convincingly argues that no firm boundary divides the cognitive from the emotional, nor does such a clean separation divide normality from mental illness.¹⁰⁴ Even schizophrenia, the mental disorder most closely associated (at least in the public mind) with impairment of a person's cognitive abilities, does not neatly fit this paradigm. For one thing, schizophrenia has an important emotional component. The so-called "negative" symptoms of the disorder, characterized by depression, low energy, and flat emotional affect, can be extremely disabling, and may be more resistant to treatment, than the "positive" or cognition-disabling symptoms such as hallucinations and delusions.¹⁰⁵ And when we

103. Again, such events do occur in ways that affect legal rights. *See, e.g., supra* notes 79, 81 (describing cases of Russell Weston and Eric Clark).

104. *See, e.g.,* Jeffrey A. Gray, *Brain Systems That Mediate Both Emotion and Cognition*, 4 *COGNITION AND EMOTION* 269 (1990). *See generally* Mick Power & Tim Dalgleish, *COGNITION AND EMOTION: FROM ORDER TO DISORDER* (2d ed. 2008).

105. *See, e.g.,* S.M. Stahl & Peter F. Buckley, *Negative Symptoms of Schizophrenia: A Problem That Will Not Go Away*, 115 *ACTA PSYCHIATRICA SCANDINAVICA* 4 (2007); Stephen M. Erhart et al., *Treatment of Schizophrenia*

begin to consider the most serious emotional disorders such as major depression,¹⁰⁶ Feinberg's dichotomy completely breaks down. Like schizophrenia, major depression is defined *both* by cognitive and emotional symptoms—by thoughts and by moods. The DSM-IV-TR defined “major depressive episode”, the basis for a diagnosis of Major Depressive Disorder, to include a variety of physical and cognitive symptoms—the former including emotions such as sadness, insomnia, significant weight changes; the latter including “feelings of worthlessness or excessive or inappropriate guilt . . . nearly every day,” “diminished ability to think or concentrate, or indecisiveness, nearly every day,” and “recurrent thoughts of death . . . recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.”¹⁰⁷ At another end of the mood spectrum, DSM also

Negative Symptoms: Future Prospects, 32 SCHIZOPHR BULL 234 (2006); P.F. Liddle, *The Symptoms of Chronic Schizophrenia: A Re-examination of the Positive-negative Dichotomy*, 151 BRIT. J. PSYCHIATRY 145 (1987). See also DSM-5, *supra* note 83, at 87–88 (Schizophrenia Spectrum and Other Psychotic Disorders characterized by “key features” including “negative symptoms” such as “diminished emotional expression”).

106. DSM-IV-TR categorized the Depressive and Bipolar Disorders as “mood disorders.” DSM-IV-TR, *supra* note 83, at 382, 369. DSM-5 categorizes the two types of disorder separately: “Depressive Disorders” and “Bipolar and Related Disorders.” DSM-V, *supra* note 83, at 155, 123.

107. DSM-IV-TR, *supra* note 83, at 160–61. For purposes here, DSM-5 closely parallels DSM-IV-TR in this respect. DSM-5 defines “major depressive disorder” in distinctly (though not exclusively) emotional terms:

Diagnostic Criteria [:]

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

defines Generalized Anxiety Disorder as a mixture of emotional and cognitive symptoms (e.g., “Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance.”).¹⁰⁸

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3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
 4. Insomnia or hypersomnia nearly every day.
 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 6. Fatigue or loss of energy nearly every day.
 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Id. at 160–61.

108. DSM-IV-TR, *supra* note 83. Similarly, among the Anxiety Disorders in DSM-5, Generalized Anxiety Disorder is defined as follows:

Diagnostic Criteria 300.02 (F41.1) [:]

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The individual finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going

The DSM definitions of these two paradigmatic “emotional” disorders reflect a foundational belief in modern psychology and psychiatry: That mental disorders are not cleanly separable into “emotional” and “cognitive” categories, and (by implication) that rules grounded in such a separation do not reflect current thinking or the best science in the mental health professions.¹⁰⁹

blank.

4. Irritability.

5. Muscle tension.

6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

- D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

DSM-IV-TR, *supra* note 83, at 222.

109. See, e.g., Alice M. Isen, *Some Perspectives on Positive Feelings and Emotions: Positive Affect Facilitates Thinking and Problem-Solving*, in FEELINGS AND EMOTIONS: THE AMSTERDAM SYMPOSIUM 263 (Antony Manstead, Nico Frijda, & Agnetta Fischer eds., 2004):

The work reviewed in this chapter indicates that positive affect facilitates careful, thorough thinking and problem solving, and promotes a flexible, responsive approach to situations that fosters new learning as well as utilization of existing knowledge. Evidence indicates that these processes also

For the law of involuntary commitment, this matters. It matters because once we acknowledge the impossibility of separating “cognitive” from “emotional” disorders—that mental disorder almost always involves both cognitive and mood-related components and the two are intricately bound up with each other—then we are forced to admit that a very wide range of disorders could form the psychological predicate for a finding of “mental illness” in the involuntary commitment context. Someone suffering from a serious mood disorder—say, Major Depression—may be prey to mental confusion, a slowing of cognitive processes generally, and/or constant thoughts of suicide, thoughts which are as integral a part of her disorder as the sad mood which accompanies them.¹¹⁰ Such thoughts can interfere with normal cognitive functioning in serious and dramatic ways, and it is hard to see how the law would be any more justified in ignoring such cognitive deficits than it would be in ignoring the disabled mental processing of the schizophrenic whose cognitive abilities are distorted by delusions. Of course, confusion, sadness, and other symptoms of depression can be more or less severe depending on the case. But that is also true with schizophrenia, whose sufferers may display a wide variety of positive and negative symptoms and who possess varying levels of ability to cope with such symptoms.¹¹¹ If schizophrenia “qualifies” under the mental illness

facilitate pro-social behavior and flexibility in social perception Thus, the chapter argues for a conceptualization that integrates affect, cognition, and behavior/motivation (the traditional trichotomy of mind) and recognizes the fact that they mutually influence one another. The chapter argues against the common assumption that affect and cognition are separate, competing systems or approaches, and shows, instead, that they have mutual influence and are subject to similar processes.

Id.

110. See *supra*, note 107 (DSM description of Major Depressive Disorder).

111. DSM-5, in fact, speaks of a “schizophrenia spectrum,” reflecting a current belief in psychiatry that many mental disorders are best conceptualized along a continuum as opposed to the “there or not there” categorization featured in the previous editions of DSM. DSM-5, *supra* note 83, at 87–88 (defining Schizophrenia Spectrum). Further, recent research suggests that some schizophrenic patients can benefit from Cognitive Behavioral Therapy, which

criterion of the forcible commitment standard, then so should any illness which can potentially disable the patient's normal cognitive functioning. Thus, the person suffering from Major Depression, who is tormented by convictions of worthlessness as well as constant thoughts of killing himself, and eventually tries to act on those thoughts, is potentially of as much concern as the person who decides to jump off a building because she is delusional and convinced that, even if the fall kills her, she will immediately come back to life.

This realization helps greatly to focus the argument because it confirms the importance of the rational capacity theory suggested above. What should concern the law of involuntary commitment is not the presence or absence of a "mental illness," but (1) the presence or absence of the threshold capacities to deliberate about options and choose a rational course of action; and (2) the clear presence of a causal link between the lack of such threshold capacities, on the one hand, and the state's justification for overriding the person's refusal of treatment on the other. Persons whose behavior presents a risk of serious self-harm and who lack the capacity to make rational choices about whether or not to accept treatment may be committed against their will for the purpose of restoring such capacities and returning the decision about further treatment back to them. Testimony from mental health professionals—for example, as to the respondent's actual level of cognitive functioning and ability to deliberate and reason, or the availability of treatments which could alleviate or cure any cognitive deficits—may be helpful to the law in such cases. But no formal finding of "mental illness" should be required since "mental illness," by itself, is not what the law should care about; the capacity to reason and deliberate is.

can help them learn to control their hallucinations and delusions and the behavior results therefrom. *See, e.g.*, Douglas Turkington, David Kingdon & Peter J. Weiden, *Cognitive Behavior Therapy for Schizophrenia*, 163 *AM. J. PSYCHIATRY* 365 (2006) (reporting that "[a] growing body of evidence supports the use of cognitive behavior therapy for the treatment of schizophrenia" and concluding: "The strength of the evidence supporting cognitive behavior therapy for schizophrenia suggests that this technique should have more attention and support in the United States."). *See generally* DAVID KINGDON & DOUGLAS TURKINGTON, *COGNITIVE-BEHAVIORAL THERAPY OF SCHIZOPHRENIA* (1994).

One significant potential benefit of changing the rules in this way is that it promises to end the subliminal tug-of-war between the legal (rights-focused) and psychiatric/psychological (treatment-focused) halves of the commitment standard as it exists today. In the 1970s, lawyers led the reform effort which created the two-pronged “danger and mental illness” standard that still dominates state commitment statutes across the nation. The idea was to give courts a doctrinal basis (through the dangerousness prong) on which to guard the rights of respondents who chose not to receive hospitalization or psychiatric treatment. But the standard’s “mental illness” prong seems to command the input of the mental health profession, whose conception of mental disorder has been formed with the primary goal of treating patients, not of assessing their ability to decide matters relevant to their legal status. Although in particular cases the application of the commitment standard can be informed by testimony from mental health professionals, the standard must ultimately speak in terms that are wholly accessible to legal, rather than medical, judgments.

What we need, in short, is a purely legal standard which contains (1) a *dangerousness element*; (2) a *cognitive capacity element* designed to gauge the respondent’s ability to exercise autonomous judgment on the question of hospitalization or other psychiatric treatment; and (3) a *causal element* explicitly linking the legitimacy of state intervention to the respondent’s deliberative and reasoning capacities.

This might seem to be an alien idea—the search for a purely legal standard whose fundamental purpose is to assess a defendant’s cognitive abilities. But to find an instructive analogy we need only look across the border from the civil to the criminal law, to the criminal law’s defense of insanity. In Part C, I pursue such an analogy.

C. *Comparing Insanity*

The criminal law applies a strong presumption that defendants are responsible—that they possess the threshold capacities necessary in order to obey the law and to deserve blame (and therefore punishment) if they do not.¹¹² The law admits a

112. See, e.g., Julian N. Eule, *The Presumption of Sanity: Bursting the Bubble*, 25 UCLA L. REV. 637, 637 (1977–78) (“It was Lord Chief Justice

small number of affirmative defenses—defenses that might excuse or justify what would otherwise be a crime—on grounds either (1) that the defendant did the right thing under the circumstances (*e.g.*, self-defense and necessity) or (2) that the defendant did the wrong thing but could not help it because, for example, at the time of the otherwise criminal act the defendant suffered from a mental disease or defect which rendered her unable to understand what she was doing, to know it was wrong, or to control her impulse to do it (*e.g.*, insanity).¹¹³ Thus, in insanity cases the law admits the possibility that a person might not be responsible if her mental defect was such that it caused her to lack threshold cognitive or moral capacities at the time of the act.¹¹⁴

“Insanity” is now considered a purely legal term; both lawyers and psychologists are taught this, and it is repeated so often on both sides as to be a cliché.¹¹⁵ But for most of its long life,

Tindal, responding to the questions posed by the House of Lords in *Daniel M’Naghten’s Case*, who first popularized the principle that ‘every man is presumed to be sane and to possess a sufficient degree of reason to be responsible for his crimes.’ This so-called presumption of sanity is operative and unquestioned in every American jurisdiction today.”)

113. See, *e.g.*, the so-called M’Naghten test for insanity (which follows the standard laid down by Justice Tindal in M’Naghten’s Case, (1843) 8 Eng. Rep. 718 (H.L.) (“[T]o establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.”); and the American Law Institute (ALI) insanity test, according to which “A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law.” MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962). Most American jurisdictions have adopted one or another of these tests in some version. See, *e.g.*, *Clark v. Arizona*, 548 U.S. 735, 749–52 (Souter, J., for the majority) (discussing the various incarnations of the insanity defense among the states).

114. See, *e.g.*, the M’Naghten test for insanity (which follows the standard laid down by Justice Tindal in M’Naghten’s Case, (1843) 8 Eng. Rep. 718 (H.L.); see also MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962).

115. See, *e.g.*, Ryan Howes, *The Definition of Insanity is...*, PSYCHOLOGY TODAY (July 27, 2009), <http://www.psychologytod-ay.com/blog/in-therapy/200907/the-definition-insanity-is> (“To be clear, insanity is a legal term pertaining to

insanity was a medical term—one that defined the realm of mental illness and was proudly worn by those who sought to treat it. Some facts about insanity’s journey from medicine to law will inform the attempt to articulate the proper civil standard for involuntary commitment.

1. The Battle Over Insanity, or Why Psychiatry “Gifted” Insanity to the Law

In a fascinating article, *What’s in a Name? A Brief Foray into the History of Insanity in England and the United States*, historian Janet Tighe details the early twentieth-century battle between law and psychiatry over the concept of insanity.¹¹⁶ Tighe attempts to put this struggle in historical perspective, arguing that “[u]ntil well into the [nineteenth] century the word insanity was ubiquitous, not only in medical writing but in that of the legal and lay world as well. It was the general term used by both professions and the public to refer, in the words of the 1851 *Webster’s Dictionary*, to the ‘state of being unsound in mind’ and ‘applicable to any degree of mental derangement from slight delirium or wandering, to distraction.’”¹¹⁷ Medical texts, law texts, and court opinions freely used the word,¹¹⁸ as did the organizations and publications of those who treated the mentally ill.¹¹⁹ Both the

a defendant’s ability to determine right from wrong when a crime is committed.”).

116. Janet Tighe, *What’s in a Name? A Brief Foray into the History of Insanity in England and the United States* 33 J. AM. ACAD. PSYCHIATRY & LAW 252 (2005) [hereinafter Tighe, *What’s in a Name?*].

117. *Id.* at 253.

118. M’Naghten’s case, (1843) 8 Eng. Rep. 718, is only one famous example.

119. See, e.g., Tighe, *What’s in a Name?*, *supra* note 116, at 253 (“Use of the term [“insanity”] appears to have been relatively unproblematic for members of the legal and medical profession. Law texts, legislation, and cases are littered with it, as are medical texts in which the term is used interchangeably with unsound mind, deranged, crazy, *non compos mentis*, lunacy, madness, and alienation Even the first bodies of nationally organized medical professionals in the United States and Great Britain, the asylum superintendents, proudly used the word . . . in the name of their organizations (e.g., the Association of Medical Superintendents of American Institutions for the Insane)

medical and legal professions shared a sense that, if they did not always agree about the meaning of insanity, it was nonetheless important to share the term and to have a common language by which to understand and articulate the nature of mental illness in both the asylum and the courtroom.¹²⁰

That began to change in the late nineteenth century, partly as a result of growing rifts within what would become the professions of psychiatry and forensic psychology, and partly as a result of substantive debates over particular concepts, particularly the idea of “moral insanity,” which highlighted the varying needs and approaches toward mental illness of medical professionals on the one hand and the law on the other. The emerging field of neurology, which sought dominance of psychiatry around this time, viewed insanity as an unscientific concept that belonged to a receding era of failed asylum treatments.¹²¹ In 1909, the American Institute of Criminal Law and Criminology deputized its committee on Insanity and Criminal Responsibility—which included prominent medical figures such as William A. White and Adolf Meyer—to create and propose a joint vision of the insanity defense. “Over and over again, their efforts broke down as the lawyers . . . and the physicians tried to explain to each other what they meant by insanity. Ultimately agreeing to disagree, the committee drafted model legislation, which all the physicians felt was woefully inadequate.”¹²² The failure to agree on common language to describe mental illness foreshadowed the ejection of the term “insanity” from the psychiatric realm—the outright “gifting” of insanity to the law:

and in their journal titles, such as the *American Journal of Insanity* (which is the parent of the *American Journal of Psychiatry*) (citations omitted).

120. *Id.* at 254 (“Initially taking for granted the shared language of insanity, [American Physician Isaac] Ray and many others interested in the topic, including legal scholars, such as Frances Wharton, saw this sharing as a good thing. The first versions of Ray’s text and Wharton’s . . . underlined the need to have the law, medicine, and the public all speaking the same language. That they could find situations in which this was not the case, particularly in the courtroom, dismayed both of them and inspired their efforts to educate and reform the insanity defense.”) (citation omitted).

121. *Id.* at 254–55.

122. *Id.* at 255.

By the 1930s, their dream of a shared medical-legal language and a common object of analysis was nothing more than ceremonial rhetoric. Embedded in their very word choice was the belief that law and psychiatry were focusing on very different things. The law was developing mechanisms by which knowledge about mental illness could be introduced into a legal proceeding and used with other relevant information to make decisions about such legal categories as responsibility and competence. Psychiatry, on the other hand, was developing mechanisms for diagnosing and treating illness and disease. To confuse the two would only spell disaster or at least more years of . . . the pointless wrangling in the courtroom that psychiatrists like White and Meyer so abhorred.¹²³

Unlike insanity, involuntary commitment is not a criminal concept or process, and that substantive distinction should not be forgotten. But speaking structurally rather than substantively, the history of insanity is enormously instructive here, for at least two reasons. First, it illuminates a problem that lies at the core of the law-and-psychiatry dialogue not only in the insanity context but also in the civil commitment one: the difficulty of marrying concepts of mental disorder and disease that are formed for the purpose of diagnosis and treatment, with the conceptions of individual rights and responsibility that animate our law. This is a problem that eventually proved unsolvable in the insanity context, with the result that insanity came to be viewed as a legal and *not* a psychiatric concept. The criminal law, of course, calls on mental health professionals for their assessments and expert testimony in cases where the insanity defense is at issue. But both professions now understand that although psychiatric assessment and input can be helpful, the ultimate judgment as to a defendant's insanity is a legal decision that can, and should, be made in terms intelligible and responsive to the law's central concerns about blameworthiness and responsibility, not to psychiatry's concern about treatment or cure.

123. *Id.* at 256.

Second, the terms and the structure of the criminal insanity defense ought to inform the legal-psychiatric conversation about involuntary civil commitment. Both the *M’Naghten* and the American Law Institute (ALI) versions of the insanity defense¹²⁴ contain three fundamental requirements: (1) the presence of a mental disease or defect; (2) a causal link between such disease or defect and the defendant’s mental state at the time of the crime; and (3) a description of the mental capacities at issue in assessing the defendant’s responsibility for the act (s)he committed. Thus, the M’Naghten Rule prescribes:

[T]o establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know what he was doing was wrong.¹²⁵

And, the ALI version states:

A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.¹²⁶

Important differences exist between the two formulations. Again, I focus here on three structural requirements they share: (1) presence of a mental disease/defect; (2) which has caused psychological disabilities¹²⁷ that (3) deprived the accused of relevant threshold

124. See *M’Naghten’s Case*, (1843) 8 Eng. Rep. 718 (H.L.); see also MODEL PENAL CODE § 4.01(Proposed Official Draft 1962).

125. *Id.*

126. *Id.*

127. In a sense the insanity standard contains *two* causal elements: (1) a requirement that the defendant’s incapacities were caused by “mental disease or defect,” and (2) a requirement that it is those incapacities which deprived the defendant of the relevant knowledge/appreciation of what he or she was doing

knowledge (or, under the ALI test, “appreciation”)—such as the knowledge that the defendant was squeezing someone’s neck, not a lemon, or the knowledge that (s)he was doing something that is considered morally wrong; or of threshold capacities such as the capacity to control his/her impulse to break the law.

Consider the first requirement, that defendant suffer from a “mental disease or defect.” On its face this seems to raise the same problem that we saw with the involuntary commitment standard—it seems to call for a medical judgment rather than a legal one. But appearances are deceiving in this instance. At least in part, the “mental disease or defect” requirement is a hangover from bygone days when insanity was widely used in both the medical and legal worlds.¹²⁸ But a second fact is even more important. To the extent it inescapably refers to the medical understanding of psychological disorder, the insanity test’s mental disease/defect element continues to cause the same problems which led to psychiatry’s “gifting” of insanity to law a century ago—the problems of disagreement and confusion over whose conception of “mental disease” should govern, and over the precise meaning of “mental disease or defect” in the context of each particular case.¹²⁹ In fact, the mental disease element is best understood structurally rather than substantively—that is, it functions simply to rule out insanity claims by certain defendants, such as those whose mental disabilities at the time of the criminal act were self-inflicted by intoxication or other means.

when he or she did the act. It is not clear that these two conceptions of cause are identical. At the very least, the second formulation seems crucial to construction of a purely legal commitment standard. *Id.*

128. For example, M’Naghten’s Case was published in 1843. M’Naghten’s Case, (1843) 8 Eng. Rep. 718 (H.L.).

129. See *State v. Guido*, 191 A.2d 45 (N.J. 1963) (court-appointed psychiatrists examined defendant and found her to be legally sane. After meeting with defendant’s attorney the psychiatrists changed their opinion, finding defendant insane. On appeal, the New Jersey Supreme Court found that the change was thoroughly consistent with honesty however mistaken it might be. . . . Specifically, the doctors originally understood that the “disease of the mind” required by [M’Naghten] means a *psychosis* and not some lesser illness or functional aberration. As the result of their pretrial debate with [the defense attorney], the doctors concluded that they had too narrow a view of M’Naghten and that the “anxiety neurosis” they had found did qualify as a “disease” within the legal rule, and hence . . . defendant did not know right from wrong and she did not know what she was doing was wrong because of that “disease.” *Id.*

On that interpretation, the requirement of mental disease or defect may be the law's way of restricting the defense to those persons who suffer relevant psychological incapacities through no fault of their own. Read in this way, the element remains entirely explicable in law language, focusing on blameworthiness and responsibility.

It is the remaining two elements of the insanity tests that are most illuminating for the civil commitment standard. Those two elements (2) articulate the incapacities that may excuse a defendant from responsibility, and (3) require that those incapacities be the *cause* of defendant's lack of threshold knowledge or self-control at the time of the act. In the next section I argue that these two prongs offer a compelling model for involuntary civil commitment.

2. Toward a Purely Legal Standard for Involuntary Commitment

Consider, again, the basic structural elements of such a standard – elements that, if satisfied, justify the state in overruling a respondent's preference not to be hospitalized or receive psychiatric treatment. Those elements are: (1) danger/risk of harm to self; (2) the presence of cognitive and deliberative incapacity that (3) deprives the respondent of the capacity to make a rational decision about treatment. *Contra* Feinberg, any mental illness, mental disorder, or mental condition could be the basis for these disabilities—but mental illness or disorder *per se* is not required.

The elements can be translated into a civil standard that, like the criminal insanity defense, refers the involuntary commitment decision entirely to the law and thus ends the tug of war between rights and treatment that has characterized the standard for decades.

A standard crafted along these lines would require two primary findings: that the respondent poses a serious, likely, and imminent risk of harm to self, and that he or she lacks the capacities to understand his/her difficulties; deliberate about the benefits and costs of treatment; and make a rational decision in his/her own best interests. Such incapacity would justify state intervention to force treatment over the respondent's objection. Thus, a model statute might provide:

A person shall be eligible for involuntary hospitalization if the court finds based upon clear and convincing evidence, that:

- (1) the respondent is unable to make a rational and informed decision as to whether or not treatment would be desirable, and
- (2) the respondent poses a serious and imminent risk of harm to self¹³⁰

The clear and convincing standard of proof would require a persuasive demonstration (not merely more likely than not, as a preponderance standard would allow) of the respondent's lack of capacity, thus offering some protection against the possibility that the mere refusal to be treated would be taken as proof of the respondent's lack of ability to make a rational decision. And, the "danger to self" criterion would filter out cases in which the defendant's incapacity does not pose a serious threat to his or her well-being or that of others. Psychiatric/psychological testimony could of course be relevant to proving either or both elements, but no explicit finding of "mental illness" or "mental disorder" would be necessary. The ultimate judgment about whether to confine someone against their will would reside where it belongs: with the law, attuned to the language of rights and accustomed to assessing the harm and the cognitive capacities of persons who come before it.

130. Compare this hypothetical model statute with ALA. CODE § 22-52-10.4 (1975), which contains the "rational and informed decision" language above, but also mandates a finding of mental illness:

- (a). A respondent may be committed to inpatient treatment if the probate court finds, based on clear and convincing evidence that (i) the respondent is mentally ill; (ii) as a result of the mental illness the respondent poses a real and present threat of substantial harm to self and/or others; the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and (iv) the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable.

Id.

The proposed standard honors core intuitions that inform our law. One is that the state should not forcibly incarcerate someone only because he or she is mentally ill; there should be a strong presumption that mentally disordered persons, as persons, are generally able to make their own decisions and act in their own best interests. Under the proposed standard, before being committed against her will a person must lack certain cognitive and deliberative capacities to make a rational and informed decision about treatment.¹³¹

A second intuition is that the law should not lock people up only for doing things that pose a “danger to self”—things that risk self-harm or even risk life. Only if the respondent poses such a risk *and* lacks the capacity to make his/her own decisions about treatment would the law be justified in stepping in. Thus, the standard could not force Dan the heavy drinker into treatment. It could not force adventurers like Steve Fossett into treatment. It could not force Justice Jackson, who continued working against medical advice, into treatment. And, it could not force Bruce or Alice into treatment as long as they possessed capacity to make rational decisions about whether or not to receive psychiatric care.¹³²

Third, the proposed standard steps away from the requirement of “mental illness” and focuses the inquiry squarely on the capacities, which ought to determine the limits of state intervention.

Finally, the proposed standard clarifies the cases of Alice and Bruce in ways that match our intuitions about the role of law both as the guardian of individual rights and as *parens patriae*—again, without reference to the presence or absence of “mental

131. Compare the insanity defense, which operates in a similar way. Everyone acknowledged, for example, that Eric Clark, the defendant in *Clark v. Arizona* (discussing defendant Eric Clark’s “undisputed paranoid schizophrenia” at the time he shot and killed a police officer), was mentally ill and actively psychotic at time of the crime. *Clark v. Arizona*, 548 U.S. 735, 743 (2006). Yet, the trial court determined Clark was not insane, but was mentally ill and was aware of what he was doing and that it was wrong. *Id.*

132. What counts as a “rational decision” is, of course, fundamental in this context. What the law tries to gauge is a respondent’s threshold capacity to make decisions, not whether his or her particular decision about treatment is approved by, or dovetails nicely with, the intuition of the court.

illness.” Thus, if Alice (a) refuses treatment because she fears an imminent Martian invasion and wants to die before it occurs, the state may intervene on the grounds that her delusional thinking demonstrates a lack of capacity for making a rational choice about treatment. But if (b) Alice chooses to take her own life because she can no longer bear the pain of her terminal disease and there is, in fact, no chance she will get better or that her pain level will drop significantly, then the state should not intervene—even if most people, including the court, believe they would choose differently in her place. If Bruce (a) decides to shorten his life by working because he delusionally believes he cannot go home since his family is plotting to kill him, the commitment petition could be granted. But if Bruce, like Justice Jackson, simply (b) values his work above everything else in life and chooses to take the risk that his work schedule will hasten his death, the state would not intervene—even if most people, including Bruce’s family and the court, believe that his values are wrong and that he should choose differently.¹³³ Decisions (a) demonstrate the lack of capacities to

133. A potential problem arises when courts focus on assessing the content of a respondent’s reasons in order to gauge their capacity to make choices about treatment. In the examples above, content seems obviously relevant in assessing capacity. But, the standard should prevent courts from conflating reasons with capacity in the sense that disagreement with a respondent’s reasons proves respondent’s lack of capacity. Reasons are relevant to, but not dispositive of, capacity and the commitment standard must clearly establish that distinction. But in many cases it would seem quite possible to do this. See Dershowitz, *supra* note 17, at 375. Dershowitz discusses the case of sixty-two-year-old Mrs. Lake, who “suffers from arteriosclerosis which causes periods of confusion interspersed with periods of relative rationality.” *Id.* One day she was found wandering around downtown Washington looking confused but bothering no one, whereupon she was committed to a mental hospital. She petitioned for release and at her trial testified, during a period of apparent rationality, that she was aware of her problem, that she knew that her periods of confusion endangered her health and even her life, but that she had experienced the mental hospital and preferred to assume the risk of living—and perhaps dying—outside its walls. *Id.* Mrs. Lake’s petition for release was denied. *Id.* Under the standard articulated in this context, the petition for release would have been granted on the grounds that although her illness produced confusion and clearly interfered with her cognitive capacities generally—and although the courts and most people might disagree with her decision to refuse hospitalization—the reasons she gave for refusing treatment demonstrate a capacity to think clearly about her illness and its potential consequences and to

deliberate and choose in a rational way; decisions (b) demonstrate the presence of such capacities although the actual choice produced may be unusual or unpopular. The proposed standard achieves the appropriate goals and according to the right (legal) values—protecting rights; guarding individual autonomy; and showing strong respect for a respondent’s capacity to act in his or her own best interest.

IV. CONCLUSION

In the decades since legal advocates for the mentally ill successfully fought for a rights-based dangerousness element in the standard for involuntary commitment, that success has come under continuous attack from the treatment-focused side of the conversation. From the perspective of the mental health profession, whose primary concern is that mentally disordered people get the treatment they need, a rights-based standard for involuntary commitment threatens to leave vulnerable patients unprotected.¹³⁴ And, as deinstitutionalization emptied state psychiatric hospitals in the mid-to-late twentieth century, that fear seemed to become reality. Deinstitutionalization generated a fierce debate not only about the relationship between mental illness and homelessness but more generally, about the availability of treatment for persons with serious mental illness.¹³⁵ This, in turn, has led to a significant shift in focus, in both the scholarly and popular media, away from the need to win legal rights for the mentally ill and toward getting them treated.¹³⁶ State statutes have shifted focus accordingly; most now allow a person to be committed for inpatient treatment against

weigh the costs and benefits of inpatient treatment against those of living outside the hospital.

134. Thus, the phrase “dying with their rights on.” Treffert, *supra* note 15.

135. See H. Richard Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899 (1984).

136. See, e.g., *Minds on the Edge*, *supra* note 15; “Frontline: The New Asylums,” www.pbs.org/wgbh/pages/frontline/shows/asylums (2005) (jails and prisons have become “the new asylums” for mentally-ill persons who commit crimes); FRONTLINE: THE RELEASED, www.pbs.org/wgbh/pages/frontline/shows/released (2009) (tracing the experiences of mentally ill inmates released into the community). See generally, *Eliminating the Barriers*, *supra* note 4 (advocating legal rules that would make it easier to commit mentally ill persons involuntarily).

his/her will on grounds of “grave need for treatment” or something similar—the standard that predated the reforms of the 1970s.¹³⁷ Further, more than half the states now allow involuntary *outpatient* treatment, permitting courts to order compliance with an out-of-hospital psychiatric treatment regime that the patient does not want.¹³⁸ The widespread adoption of involuntary outpatient commitment potentially expands the reach of forced treatment regimes to cover a much larger group of mentally ill persons than would be reachable under the standard for involuntary inpatient treatment.¹³⁹

137. See, e.g., Treatment Advocacy Center, *Improved Treatment Standards*, TREATMENT ADVOC. CTR., www.treatmentadvocacycenter.org/solution/improved-treatment-standards (majority of states allow commitment on grounds of need for treatment such as “grave disability”).

138. See *supra*, note 82.

139. See, e.g., ALA. CODE § 22-52-10.2 (1975). The Alabama statute states that:

A respondent may be committed to outpatient treatment if the probate court finds, based upon clear and convincing evidence that: (1) the respondent is mentally ill; (ii) as a result of the mental illness the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and (iii) the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable.

Id.; GA. CODE ANN. § 37-3-61(2) (West 2013) (“Any person may file with the court a petition executed under oath alleging that a person within the county is a mentally ill person requiring involuntary treatment.”); GA. CODE ANN. § 37-3-1(12.1) (West 2013). The Georgia statute states that:

‘Outpatient’ means a person who is mentally ill and: (A) who is not an inpatient but who, based on the person’s treatment history or current mental status, will require outpatient treatment in order to avoid predictable and imminently becoming an inpatient; (B) Who because of the person’s current mental status, mental history, or nature of the person’s mental illness is unable voluntarily to seek or comply with outpatient treatment; and (C) who is in need of involuntary treatment.

Id.; N.Y. MENTAL HYG. LAW § 9.60(C) (McKinney 2013). The New York statute states that:

A person may be ordered to receive assisted outpatient treatment if the court finds that such person: (1) is eighteen

This Article, therefore, bucks the winds of current opinion by arguing for a renewed focus on rights rather than treatment. But that change in focus is necessary. It is time to end the tug of war between psychiatry and law that underlies the “mental illness and danger to self” standard. Forcible commitment is a legal decision that must be fully articulated in legally relevant language and justified by a legally comprehensible rationale.

For the law, such a rationale must be grounded in respect for individual autonomy, including the autonomy of those who may suffer from mental disorder. The argument for a purely legal commitment standard must rid itself of the more extravagant anti-psychiatry claims which characterized this debate in the 1960s and 1970s—for example, the claim that psychiatry is shilling for the capitalist establishment by forcing people into hospitals in order to maintain a docile and compliant proletariat;¹⁴⁰ that involuntary commitment is a method society uses to enforce bourgeois values and silence the creative, the diverse, and the different by labeling them as “deviant”;¹⁴¹ or that mental illness itself is a myth created

years of age or older; and (2) is suffering from a mental illness; and (3) is unlikely to survive safely in the community without supervision, based on a clinical determination; and (4) has a history of lack of compliance with treatment for mental illness. . . . and (5) is, as a result of his or her mental illness, unlikely to voluntarily participate in the outpatient treatment that would enable him or her to live safely in the community; and (6) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others as defined in section 9.01 of this article; and (7) is likely to benefit from assisted outpatient treatment.

Id.

140. See *id.* at 150 (“The asylum reduces differences, represses vice, eliminates irregularities. It denounces everything that opposes the essential virtues of society . . .”). See, e.g., Foucault, *supra* note 28; Andrew T. Scull, *Madness and Segregative Control: the Rise of the Insane Asylum*, 24 SOC. PROBS. 337 (1976) (rise of the insane asylum as social control mechanism to enforce capitalist social order); GOFFMAN, *supra* note 28 (psychiatric labels subject the “deviant” to depersonalizing and stigmatizing practices).

141. See, e.g., Rael Jean Isaac & Virginia C. Armat, *The Origins of Anti-Psychiatry*, in *MADNESS IN THE STREETS: HOW PSYCHIATRY AND LAW ABANDONED THE MENTALLY ILL* (1990).

by psychiatry to increase its own power and influence in society at the expense of the most vulnerable.¹⁴²

Shed of over-heated political rhetoric, fundamental principles reveal themselves. There *is* such a thing as mental disorder. Mental disorder can be disabling and can involve such severe distortions of thought and reality perception that a person might not be able to know his or her own best interest. There is no clean line dividing cognitive from emotional disorder; mental disorder may involve cognitive impairment accompanied by emotional deprivations, as in schizophrenia, or disturbances of thought and cognition that originate in mood or emotional disruption, as in major depression. In a small number of cases a person's psychological disorder can be so severe, and can be accompanied by such substantial risk of self-harm, as to deprive the person of the capacity to make rational choices about treatment. In such cases, the state may hospitalize a person against his will. But forced hospitalization cannot be justified by a mere diagnosis of mental illness; of behavior that poses risk of harm to self; or of both together. Only where a person poses a serious risk of self-harm *and* is unable to make a rational and informed decision about whether or not to receive treatment, may the law force him or her into psychiatric care.

142. See, e.g., *supra* note 28. For an argument that the theoretical innovations brought to DSM-III were in part a reaction to these anti-psychiatry critics, see Wilson, *supra* note 58, at 402–03.