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CIVIL COMMITMENT OF THE MENTALLY ILL IN CALIFORNIA: THE LANTERMAN- PETRIS-SHORT ACT

A possible conversation between an "enlightened" man and his son in the Middle Ages:

Q. What is a madman?

A. A madman is a person possessed by devils.

Q. What happens to a madman?

A. The evil spirit must be exorcised from him. This is accomplished by beating or burning the madman. Sometimes it is even necessary to drill a hole in his skull to permit the demon to escape.

Q. Where does this exorcism take place?

A. In a jail or dungeon. Since the demon might leave the madman and contaminate others, it is necessary to confine the madman and to chain him securely.

Q. But aren't jails and dungeons places where criminals are locked up?

A. Yes.

Q. Then what is the difference in the way we handle madmen from criminals?

A. Ask your mother.¹

I. INTRODUCTION

Each year several hundred thousand people are admitted to mental institutions,² mostly on an involuntary basis.³ One out of every two

1. Morris, "Criminality" and the Right to Treatment, in *THE MENTALLY ILL AND THE RIGHT TO TREATMENT* 109 (G. Morris ed. 1970) [hereinafter cited as Morris].

2. Estimates of the number of individuals committed through civil proceedings each year range from 250,000 to 500,000. See T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* 40 (1963) [hereinafter cited as SZASZ]; Comment, *Compulsory Commitment: The Rights of the Incarcerated Mentally Ill*, 1969 *DUKE L.J.* 677, 681.

3. About 90% of the individuals in mental hospitals have been admitted involuntarily. Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 *HARV. L. REV.* 1288 (1966) [hereinafter cited as *Civil Commitment*]. Actually, this figure may be misleadingly low. The term "voluntary" is often used as an euphemism for a process, which as Dr. Thomas Szasz of the State University of New York has explained, is actually coercive:

This so-called voluntary admission to a mental hospital is a procedure, which more often than not could be paraphrased as follows. It is as if the patient were told: "If you don't go to the hospital by signing this piece of paper, then we'll get you in by having someone else sign another piece of paper."

KATZ, GOLDSTEIN, & DERSHOWITZ, *PSYCHOANALYSIS, PSYCHIATRY AND LAW* 475 (1967).

hospital beds in this country contains a mental patient,⁴ and one out of every twelve Americans will spend at least a few days of his or her life in a mental institution.⁵ Yet, the process of civil commitment too often operates as a system that would shock common ideas of fair play and justice if applied in the criminal courts. When the individuals involved are not criminals, but those who have been declared "mentally ill," the cry for due process suddenly grows faint.⁶ While almost every racial, ethnic, political, and sexual group in the American culture is achieving new levels of success in the area of basic human rights, involuntarily admitted mental patients remain close to legal impotency. They are possibly the most disadvantaged people in our society.⁷

The musty files of the institutions to which these persons are committed contain many case histories as disturbing as the following:

In Chicago a Polish immigrant discovered a sum of money missing from her apartment. Since the building janitor was the only person other than her husband who had a key to the apartment, she suspected him of taking the money and confronted him with an accusation of theft. The janitor telephoned the police and, upon their arrival, stated that the woman and her husband were insane. The police took the couple in handcuffs to the Cook County Mental Health Clinic. A "hearing" was held. The immigrants had but a rudimentary knowledge of English and were not provided with counsel. They were pronounced mentally ill and committed to the Chicago State Hospital. Bewildered, frightened, and confused by his sudden inexplicable imprisonment, the husband, who had spent time in a concentration camp during World War II, hanged himself during the sixth week of his confinement.⁸

4. See Morris, *Introduction*, in *THE MENTALLY ILL AND THE RIGHT TO TREATMENT* at vii (G. Morris ed. 1970) [hereinafter cited as *Introduction*].

5. See Comment, *Civil Commitment of the Mentally Ill in Nebraska*, 48 NEB. L. REV. 255 (1968).

6. See *Introduction*, *supra* note 4, at vii.

7. *Id.*

8. Johnson, *Due Process in Involuntary Civil Commitment and Incompetency Adjudication Proceedings: Where Does Colorado Stand?*, 46 DENVER L.J. 516, 521-22 (1969) (footnote omitted). Other cases might be illustrative:

[T]he plaintiff had been a patient in the Allentown State Hospital for the Insane for 10 years. He had been diagnosed as a manic depressive. In the words of the court, he was a "raving maniac" at the zenith of his anxiety. Part of the prescribed psychiatric therapy . . . was the application of wet packs. This treatment supposedly rendered extremely agitated patients calm by the soothing effects of warm water. . . . After extensive use of the wet packs, the patient developed severe blisters on his hands. The blisters were opened by a doctor, using an unsterilized pocketknife. [The patient then] developed severe infections in both hands. . . .

The court denied any recovery for a 60 percent impairment in the use of his hands following the infection.

This example, while admittedly an extreme case, reflects some of the disturbing features that have characterized the administration of American psychiatric justice. In an attempt to achieve what is basically a medical goal, *i.e.*, providing treatment to those who may be mentally ill, personal liberty is taken with far fewer safeguards than would be found in the criminal justice system.⁹ Civil commitment has often been characterized as one of concern only to the medical profession and therefore not of interest to the law.¹⁰ Commenting on this unfortunate

Comment, *The Expanding Role of the Lawyer and the Court in Securing Psychiatric Treatment for Patients Confined Pursuant to Civil Commitment Procedures*, 6 HOUSTON L. REV. 519, 525 (1969) (footnote omitted). In the case from which this example was taken, *Powell v. Risser*, 99 A.2d 454 (Pa. 1953), Justice Musmanno, in a dissenting opinion, commented on the "snake-pit" atmosphere then existing in the mental health field:

The assumed therapeutics administered to the plaintiff in this case read like the chronicle of a medieval torture. . . . [T]he unnecessary or reckless use of violent measures which steal away physical assets from one already robbed of the treasures of a sound mind constitutes a misdeed which humanity abhors, justice condemns and the law should correct.

Id. at 458. Still another example is given in Wexler & Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1 (1971) [hereinafter cited as ARIZONA PROJECT]. They describe the case of a Mexican-American woman taken into custody on January 22, 1912, for a mental condition purportedly caused by "bathing in cold water at menstrual period." She was still confined to the state hospital 59 years later. *Id.* at 1-2.

9. See Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, in THE MENTALLY ILL AND THE RIGHT TO TREATMENT 3 (G. Morris ed. 1970) [hereinafter cited at Katz]; Kaplan, *Civil Commitment "As You Like It,"* 49 B.U.L. REV. 14 (1969). Kaplan writes: "'Mental Illness' is the triggering conclusionary phrase which allows the state to legally remove an individual involuntarily to an institution for treatment despite the fact that he has not violated a criminal statute." *Id.* at 16.

Medical and legal aspects of civil commitment tend to conflict, thus compelling legislatures to forge a compromise between the medical goal of treatment without delay and the legal requirement of due process. The latter, of course, often results in delay. See *Thorn v. Superior Court*, 1 Cal. 3d 666, 673, 464 P.2d 56, 61, 83 Cal. Rptr. 600, 605 (1970).

10. See Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. HEALTH & SOCIAL BEHAVIOR 66 (1969) [hereinafter cited as Wenger & Fletcher]:

"It is the official position of the American Psychiatric Association that physicians should have unrestricted power to commit." The medical profession believes "provisions should be made for involuntary hospitalization without the necessity of court proceedings." . . .

Lawyers, on the other hand, argue that the situation is not that simple. They state that the problem is basically a legal one due to the loss of civil liberties which results from commitment. The legal profession appears to view the mental hospital as a "corrective institution," similar to a prison, whose main functions are incarceration, custodial care, and rehabilitation. The due process of law must be served if anyone is committed to such an institution.

Id. at 67 (citations and footnotes omitted), quoting SZASZ, *supra* note 2, at 61 and H. DAVIDSON, *FORENSIC PSYCHIATRY* 282 (1965). This quotation seems to imply that due process is required only when a person is committed to an institution which is the

approach, Professor Alan Dershowitz of Harvard Law School noted that:

Civil commitment of the mentally ill is a legal problem; whenever compulsion is used or freedom denied—whether by the state, the church, the union, the university, or the psychiatrist—the issue becomes a legal one, and lawyers must be quick to immerse themselves in it. But the issue is not for lawyers alone: The average person can predict with some confidence that he will never stand accused of committing some serious crime. Can he be as confident that he will never confront the process of commitment?¹¹

The history of civil commitment in California has generally paralleled that of other jurisdictions,¹² although some early attempts at defining and safeguarding the rights of mental patients were made. For instance, in 1901, the California supreme court, in *Matter of Lambert*,¹³ held certain provisions of the Insanity Law of 1897 unconstitutional on due process grounds. As the statute was written, the first notice the person had of the proceedings was provided when the person was taken into custody by the sheriff for delivery to the institution to which he or she was being committed.¹⁴ As a result of this case, California law at least incorporated the element of notice to the individual being committed, but it still retained many characteristics which could be considered fundamentally unfair, the most important of which was the provision for indeterminate commitment.¹⁵

The past decade has been a period when interest in the plight of the mentally ill has begun to increase in the legal community.¹⁶ The

functional equivalent of a jail, *i.e.*, an institution whose main functions are "incarceration, custodial care, and rehabilitation." It is submitted that most attorneys would argue, if asked, that due process is required whenever a person is deprived of liberty irrespective of the reason for the deprivation or the function of the institution to which the person is sent.

11. Dershowitz, *Two Models of Commitment: The Medical and the Legal*, THE HUMANIST, July-Aug. 1971, at 19, 23 [hereinafter cited as Dershowitz]. It should be noted that, despite its use by many authors (*see, e.g.*, the titles of the articles cited in notes 2 & 8 *supra*), the term "involuntary commitment" is an unnecessary redundancy: People never voluntarily "commit" themselves to hospitals.

12. *See Projects—Civil Commitment of the Mentally Ill*, 14 U.C.L.A.L. REV. 822 (1967) [hereinafter cited as *Projects*].

13. 134 Cal. 626, 66 P. 851 (1901).

14. *Id.* at 627, 66 P. at 851-52.

15. *See Abramson, The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 102 (1972) [hereinafter cited as Abramson].

16. *Introduction, supra* note 4, at viii. The use of the term "mentally ill" presupposes resolution of the controversy as to whether or not those who deviate from society's norms can really be classified as "ill" in the medical sense. *See text accompanying notes 74-80 infra.* Likewise, referring to these individuals as "patients," "de-

trend is reflected in California by the Lanterman-Petris-Short Act,¹⁷ which became operative as part of California's Community Mental Health Services Law¹⁸ on July 1, 1969.¹⁹ This Act (hereinafter LPS)

fendants," and "inmates" may seem confusing and, at times, inappropriate. For the purposes of this discussion, however, the words are to be used interchangeably to refer to individuals caught in the processes of psychiatric justice.

17. CAL. WELF. & INST'NS CODE ANN. §§ 5000-01 (West 1972).

18. Division 5 of the California Welfare and Institutions Code titled Community Mental Health Services, was added by the California Mental Health Act of 1967, ch. 1667, § 36, [1967] Cal. Stat. Reg. Sess. 4074. Part 1 is the Lanterman-Petris-Short Act (CAL. WELF. & INST'NS CODE ANN. §§ 5000 *et seq.* (West 1972)). It became operative as amended by ch. 1374, § 13, [1968] Cal. Stat. Reg. Sess. 2640 on July 1, 1969. Part 2 is a modification of the Short-Doyle Act of 1957 (CAL. WELF. & INST'NS CODE ANN. §§ 5600 *et seq.* (West 1972)). It became operative as amended by ch. 989, § 2, [1968] Cal. Stat. Reg. Sess. 1912 on July 1, 1969; except for §§ 5604, 5650, 5658, 5659, 5756, 5760, and 5763, which became operative on the 61st day after final adjournment of the 1968 Regular Session. The Short-Doyle Act functions as enabling legislation for the Lanterman-Petris-Short Act. It is designed:

[T]o organize and finance community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. It is furthermore intended to better utilize existing resources at both the state and local levels in order to improve the effectiveness of necessary mental health services; to integrate state-operated and community mental health programs into a unified mental health system; to ensure that all mental health professions be appropriately represented and utilized in such mental health programs; to provide a means for participation by local governments in the determination of the need for and the allocation of mental health resources; to establish a uniform ratio of local and state government responsibility for financing mental health services; and to provide a means of allocating state mental health funds according to community needs. It is furthermore intended to provide a means of reimbursing local governments for certain services to the mentally retarded and persons afflicted with alcoholism which counties may elect to provide.

CAL. WELF. & INST'NS CODE ANN. § 5600 (West 1972).

19. Judge Hugo Fisher declared LPS unconstitutional in *San Diego v. Superior Court*, Civ. No. 1276 (Super. Ct., San Diego County, July 3, 1969), just two days after the Act went into effect. On appeal to the California supreme court (*County of San Diego v. Superior Court*, 1 Cal. 3d 677, 464 P.2d 63, 83 Cal. Rptr. 607 (1970)), Justice Burke, in a memorandum opinion handed down the same day as *Thorn v. Superior Court*, 1 Cal. 3d 666, 464 P.2d 56, 83 Cal. Rptr. 600 (1970), wrote:

[Eugene Callahan sought habeas corpus relief] on the ground that provisions of the act permitting him to be detained for 14 days on certificate of a physician without prior notice, court hearing, or advice as to right to counsel or appointment of counsel, deprived him of due process. . . .

However, as noted in *Thorn v. Superior Court*, the act has now been amended to require that a certified patient be informed of his right to counsel including court-appointed counsel; and the relevant issues are discussed in *Thorn*. Additionally, it appears that Callahan has long since been released, and that no useful purpose would be served by further proceedings with respect to his certification.

1 Cal. 3d at 678, 464 P.2d at 64, 83 Cal. Rptr. at 608 (citation omitted). In *Thorn*, Justice Burke, writing for a unanimous court, held that the superior court acted within its jurisdiction in ordering the hospital to permit the legal staff of a non-profit corporation to visit patients detained for 14-day intensive treatment under LPS, and that the superior court was justified in directing the staff to act as attorney for such detained persons. A psychiatric foundation, devoted to the care and treatment of such patients had sought to nullify the superior court order. 1 Cal. 3d at 676, 464 P.2d at 63, 83 Cal. Rptr. at 607.

was the culmination of a two-year legislative study, and was designed to establish new procedures for the civil commitment of mentally ill persons and to safeguard their legal rights after commitment.²⁰ The specific goals the legislature was trying to achieve are outlined in section 5001 of the California Welfare and Institutions Code:

- (a) To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons and persons impaired by chronic alcoholism, and to eliminate legal disabilities;
- (b) To provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism;
- (c) To guarantee and protect public safety;
- (d) To safeguard individual rights through judicial review;
- (e) To provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons;
- (f) To encourage the full use of all existing agencies, professional personnel and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures.²¹

20. See CALIFORNIA ASSEMBLY INTERIM COMMITTEE ON WAYS AND MEANS, SUB-COMMITTEE ON MENTAL HEALTH SERVICES, *THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA: A BACKGROUND DOCUMENT* (1966) [hereinafter cited as *DILEMMA OF MENTAL COMMITMENTS*]. In *Thorn v. Superior Court*, 1 Cal. 3d 666, 464 P.2d 56, 83 Cal. Rptr. 600 (1970), the court stated:

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

Id. at 668, 464 P.2d at 57, 83 Cal. Rptr. at 601. The legislative study which eventually led to the enactment of LPS was based on information obtained from public hearings, interviews, and a survey of more than 300 hospitals. Data was gathered on 83% of all the hospitalized psychiatric patients in California. ENKI RESEARCH INSTITUTE, *A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW 12 (1969-1971)* [hereinafter cited as *ENKI REPORT*]. For a summary of the legislative committee findings, see *id.* at 12-14.

See generally, Abramson, *supra* note 15; Bazelon, *Implementing the Right to Treatment*, in *THE MENTALLY ILL AND THE RIGHT TO TREATMENT* 108 (G. Morris ed. 1970) [hereinafter cited as *Bazelon*]; Fuller, *Civil Commitment of the Mentally Ill in California: 1969 Style*, 10 SANTA CLARA LAW. 74 (1969) [hereinafter cited as *Fuller*].

It should be noted that LPS does not use the term "commitment." See CAL. WELF. & INST'NS CODE ANN. § 5008.1 (West Supp. 1973), where the term "judicial commitment" is limited to non-LPS procedures. Instead, "evaluation" and "certification" are the terms of art selected by the legislature. See text accompanying notes 25-54 *infra*. Despite this semantic shuffling, individuals are still "committed" as that term is normally understood, and it will be used throughout this Comment.

21. CAL. WELF. & INST'NS CODE ANN. § 5001 (West 1972). All textual references

This Comment will attempt to evaluate the legislature's success in fulfilling these commendable goals. Analytically, this evaluation will proceed by studying five areas: (1) commitment standards; (2) right to treatment; (3) release from hospitalization; (4) role of the psychiatrist; and (5) role of counsel.²² Prerequisite to an assessment of the impact of LPS on each of these areas, however, is an understanding of its procedural aspects.

II. PROCEDURAL ASPECTS OF LPS

The Act in general applies to persons who are dangerous to themselves or others or "gravely disabled" due to "mental disorder," although it explicitly does not cover sex offenders, criminal offenders, or those suffering from chronic alcoholism.²³ The statute also excludes from its coverage epileptics and the mentally retarded.²⁴

A mentally disordered person subject to the provisions of the Act can enter the LPS scheme in several ways. Under section 5150, he or she may, for reasonable cause, be taken into custody by a peace officer, a member of the staff of a designated "evaluation facility," *i.e.*, the mental hospital or institution in the county to which persons are civilly committed, or by a professional person otherwise designated by the county.²⁵ This section was apparently designed to give police officers the power to take a person into custody when the person's behavior indicates to the police that he or she may be in need of psychiatric help. It thus makes no provision for a hearing prior to the detention. After the person is in custody, a written application is made to an appropriate facility, where the person is then detained for evaluation and treatment.²⁶ Section 5170 also allows police officers and professionals to commit persons for a short period of time if they are mentally disabled because of inebriation.

Sections 5200-5206 provide a method by which a person may be "given an evaluation," *i.e.*, committed for a short term, at the request of someone other than a police officer or professional. In this case, the

to sections are to the California Welfare and Institutions Code Annotated unless otherwise noted.

22. To be sure, the five categories overlap considerably, but these divisions, nevertheless, provide a workable conceptual framework with which to examine the process of civil commitment.

23. CAL. WELF. & INST'NS CODE ANN. § 5002 (West 1972).

24. *Id.*

25. *Id.* § 5150 (West Supp. 1973).

26. *Id.*

person desiring the mentally disordered person to be committed²⁷ requests a county-designated agency²⁸ to prepare a petition for evaluation.²⁹ This petition is screened by another agency³⁰ to assure that there is probable cause to believe the allegations.³¹ Upon approval by this second agency, the petition is filed in superior court, and, assuming the judge of that court is satisfied that the person being committed is in fact mentally disabled, an order is issued requiring the person to be evaluated.³²

Although section 5002 explicitly states that LPS does not modify any law relating to the commitment of mentally disordered criminal offenders, section 5225 allows a judge to commit a criminal defendant in a manner similar to that countenanced by sections 5200-5206, if the defendant is believed to be mentally disordered because of alcoholism or use of drugs.

Finally, section 6551 (not part of LPS) allows wards of the juvenile court to be committed according to the procedures outlined in section 5150; section 4011.6 of the Penal Code allows persons in charge of jails to commit prisoners pursuant to section 5150;³³ and section 1370 of the Penal Code provides that persons charged with a crime, but unable to stand trial because of their insanity, shall be "subject to the provisions" of LPS in the event the criminal charges against them are dropped before they regain their sanity.³⁴

In all these cases, the "evaluation" period is 72 hours.³⁵ If, in the opinion of the staff, the patient does not require further evaluation or treatment, he or she may be released before or at the end of the 72 hours. The professional in charge of the facility, however, may certify the person for further detention, if the medical staff feels the patient is still mentally disabled, the patient refuses to remain on a voluntary basis, and the facility is properly equipped to treat that type of disability.³⁶ Notice of the certification for the continued detention must be given to the patient,³⁷ who also must be informed of the right to counsel and to

27. The person requesting the petition, of course, would normally be a relative.

28. The code does not further specify the agency which will perform this function.

29. CAL. WELF. & INST'NS CODE ANN. § 5201 (West 1972).

30. The screening agency is selected by the county and the State Department of Health. *Id.* § 5202 (West Supp. 1973).

31. *Id.*

32. *Id.* § 5206 (West 1972).

33. CAL. PENAL CODE § 4011.6 (West 1972).

34. *Id.* § 1370.

35. CAL. WELF. & INST'NS CODE ANN. §§ 5151, 5206, 5230 (West 1972).

36. *Id.* § 5250.

37. *Id.* §§ 5251, 5253 (West Supp. 1973).

judicial review by habeas corpus.³⁸ The detention period under this certification is fourteen days.³⁹

At the end of this initial 17 days, the procedures which must be followed in order to retain the person in custody depend on the particular category of mental disability into which the patient has been placed. If the person has threatened or has attempted to cause actual physical harm to others and presents "an imminent threat of substantial physical harm to others," then the professional in charge may petition the court for a judicial commitment.⁴⁰ A hearing is held to determine whether or not the person should be further detained, with the right to a jury being provided.⁴¹ If the trier of fact determines that further detention is necessary, the person is committed for 90 days.⁴² At the end of this period, the patient must be released unless he or she has again been demonstrably assaultive during the confinement.⁴³ If the patient has engaged in dangerous conduct, a new petition for treatment may be filed.⁴⁴ Thus, a person who is dangerous to others and who has been committed will receive automatic judicial review (with the right to a jury trial) every 90 days until released.⁴⁵

Persons who are dangerous to themselves may be committed for an additional 14 days after the initial 17 day period, but further confinement is predicated on reclassifying them as either "dangerous to others" or "gravely disabled."⁴⁶

38. *Id.* § 5252.1 (West 1972).

39. *Id.* § 5250.

40. *Id.* § 5304.

41. *Id.* § 5303.

42. *Id.* § 5304.

43. *Id.*

44. *Id.*

45. This leaves open the possibility of a person having a jury trial every three months for years on end. This result, however, is highly unlikely, since the provisions for 90 day commitments have been seldom used. See ENKI REPORT, *supra* note 20, at 154. According to Dr. Victor G. Haddox, Assistant Professor of Psychiatry, Institute of Psychiatry, Law and Behavioral Science, School of Medicine, University of Southern California, none of the approximately 3000 LPS hearings in which he has testified involved a person who was being certified for a 90 day detention. Interview with Dr. Victor G. Haddox, Nov. 5, 1973 [hereinafter cited as Interview].

46. CAL. WELF. & INST'NS CODE ANN. §§ 5260-68 (West 1972). The involuntary reclassification provision is found in § 5264, which states that suicidal persons must be released after the second 14 day period *unless* they can be recommended for a conservatorship or unless "Article 6" of the Act, relating to the continued detention of persons dangerous to others, is applicable to the person. In order for the first exception to apply, the person must, by the terms of the Act, be gravely disabled. The second exception obviously requires that the person be found to be dangerous to others. Despite this straight-forward construction of the statutory scheme, some courts have

If the person in charge of the evaluation facility determines that a patient is "gravely disabled"⁴⁷ and in need of further aid, he or she may petition the court for the appointment of a conservator.⁴⁸ Under the conservatorship program, the patient may either be allowed to live outside the hospital,⁴⁹ with the power in the conservator to commit if the conservator deems it necessary,⁵⁰ or the person may be indefinitely hospitalized. During the entire course of the conservatorship, the patient has the right to judicial review of his or her status (although no more often than once every six months)⁵¹ with automatic judicial review being required once per year.⁵² Again, the right to a jury trial on the issue of the patient's continuing mental disability is guaranteed by LPS.

Irrespective of the category of mental disability into which they are placed, committed individuals retain certain rights under the California legislative scheme, including the right to wear their own clothes, keep

apparently not permitted reclassification of persons initially detained as being a danger to themselves. Interview, *supra* note 45.

47. See notes 90-92 *infra* and accompanying text.

48. CAL. WELF. & INST'NS CODE ANN. § 5352 (West Supp. 1973).

49. *Id.*

50. *Id.* § 5358. The conservator usually is a public agency, rather than an individual. In addition, the qualifications of a conservator are applied differently throughout the state:

In practice the conservatorship procedure requires two phases: a temporary conservatorship obtained by the hospital at the end of the certification period to allow time for conservatorship investigation, and the court hearing to grant the conservatorship. The request for a temporary conservatorship is usually approved by courts without any hearing or review.

In California there is a distinction between conservatorship and guardianship. Both apply to responsibility for the person and estate, but conservatorship allows for involuntary placement of the conservatee, and is limited to one year with annual review possible. Because of the one year time limitation in conservatorship, the individual's property may not be liquidated as readily as under guardianship. The legal authorities involved—usually a Public Guardian's Office—utilize a staff whose members have experience in real estate, stocks, bonds, etc.

The qualifications of public conservator differ in some counties. In Los Angeles a deputy public guardian was required to have one year of social service experience. Previously, staff had been divided into those handling conservatorship and those handling guardianship, but in March, 1970 these functions were combined for each worker. This allowed the worker to follow through on each case, regardless of whether it developed into a guardianship or conservatorship situation.

In San Francisco the roles of public guardian and conservator, by contrast, were separated. If a patient was in need of care or placement, the conservator provided services. If a patient was in need of financial management, the public guardian handled this. If both services were needed, the patient was served by both.

In San Mateo, investigation for conservatorship was done by the mental health system (contracted by the public guardian) to make the initial critical determination as to whether conservatorship was indicated. The public guardian then followed-up on the case.

ENKI REPORT, *supra* note 20, at 156-57.

51. CAL. WELF. & INST'NS CODE ANN. § 5364 (West 1972).

52. *Id.* § 5361.

their own possessions, spend their own money, have space to store possessions, see visitors, make telephone calls, and mail and receive unopened correspondence.⁵³ Even these rights, however, may be denied for "good cause" by the professional in charge of the facility, and the statute requires neither hearing nor notice before such a decision is implemented. LPS gives the patient a qualified right to refuse electric shock treatment and an absolute right to refuse a lobotomy.⁵⁴

This, then, is a capsulized description of the LPS procedural apparatus. The potential problems with the system are apparent: What do "dangerous to others," "gravely disabled," and "dangerous to self" mean? Is informing a mentally disabled person of the right to counsel and review by habeas corpus an effective method of protecting those rights? What are the attitudes and roles of the psychiatrists and lawyers in this scheme? What should they be?

III. LPS: ARE THE SAFEGUARDS SUFFICIENT?

A. Commitment Standards

The statutes of virtually every state define potential candidates for civil commitment in terms of one or both of two general classifications:⁵⁵ "dangerous"⁵⁶ and "need for treatment."⁵⁷ The particular justification employed is important since it has a bearing in subsequent stages of the process.⁵⁸

53. *Id.* § 5325 (West Supp. 1973).

54. *Id.* It should be noted that "good cause" is nowhere defined in the Act. Also, until the passage of Assembly Bill 47 (ch. 959 CAL. STATS. [September 30, 1973]), the psychiatrist could deny the patient's request to refuse a lobotomy. The bill, however, grants the patient an absolute right to refuse that form of treatment.

55. See generally *Projects, supra* note 12; *ARIZONA PROJECT, supra* note 8.

56. This uniformity may be a reflection of the traditional definition of "insanity" as "a disease or discord of the mind which renders its victim dangerous to himself or to others." *Apunkte v. State*, 153 A.2d 665, 669 (N.J. 1959). See also Marschall, *A Critique of the "Right to Treatment" Approach*, in *THE MENTALLY ILL AND THE RIGHT TO TREATMENT* 37, 40 (G. Morris ed. 1970) [hereinafter cited as Marschall].

57. See generally Marschall, *supra* note 56. The distinction between the "need for treatment" and the "right to treatment" doctrine (see text accompanying notes 107-53 *infra*), must be kept clearly in mind. The former is a commitment standard. The "right to treatment" doctrine, on the other hand, involves the patient's rights *after* commitment, whether it be based on a need for treatment, dangerousness, or a criminal standard.

58. When the justification for commitment is the individual's need of treatment, the decision as to whether or not confinement should continue may depend on whether or not treatment is in fact provided. When a person is committed on a prediction of dangerousness, courts may qualify the "right to treatment" approach in an effort to protect the community.

The prediction that a person is a danger to himself or others constitutes one of the more often cited reasons for the issuance of a commitment order,⁵⁹ the theory being that both the community and the patient need protection.⁶⁰ There are those who maintain that this is an unjustifiable standard because the mentally ill persons, on balance, are no more dangerous than the rest of the population.⁶¹ But assuming the state has a valid interest in isolating and confining dangerous persons, whether mentally ill or perfectly sane, the question becomes one of identifying which persons actually pose a threat to themselves or to the other members of society.⁶² This, of course, requires that a prediction of the person's future behavior be made. Since the result of a prediction of dangerousness is the deprivation of the person's liberty, *i.e.*, commitment, the due process requirements of the fifth and fourteenth amendments must be satisfied.⁶³ If in criminal law, those requirements are met only by proof "beyond a reasonable doubt,"⁶⁴ by analogy, a mental patient should be committed only when the trier of fact⁶⁵ believes that the prediction that a patient will be dangerous has been shown to be true "beyond a reasonable doubt."⁶⁶ Even a psychiatrist

59. See ENKI REPORT, *supra* note 20, at 116. That study shows that, depending on the city and time period selected, between 31 and 55 percent of admissions are based on dangerousness. Approximately 60 percent of those admitted on this basis are dangerous to themselves, and only 40 percent are dangerous to others.

60. See generally Marschall, *supra* note 56.

61. "[T]here is no evidence that the ones who are mentally ill are any more dangerous than ones who are mentally healthy." Statement of Thomas Szasz in *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 87th Cong., 1st Sess. 270 (1961) [hereinafter cited as *1961 Hearings*]. See also Swan, *A New Emancipation: Toward an End to Involuntary Civil Commitments*, NOTRE DAME LAW. 1334, 1339 (1973) [hereinafter cited as *Swan*].

62. Predictability is the key word. Rather than lock up every person who is suspected of being dangerous, it is necessary to make a psychiatric prediction of who actually is dangerous; thus the psychiatrists are placed in the position of having to predict the individual's future conduct.

63. U.S. CONST. amends. V & XIV.

64. *In re Winship*, 397 U.S. 358, 364 (1969).

65. Under the California scheme, the trier of fact may be either the judge or the jury, depending on the type of hearing. See text accompanying notes 41, 52 *supra*.

66. See *Murel v. Baltimore Criminal Court*, 407 U.S. 355, 359 (1972) (Douglas, J., dissenting); Statement of Bruce J. Ennis in *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st & 2nd Sess. 275 (1969-1970) [hereinafter cited as *1969-70 Hearings*].

Professors Livermore, Malmquist, and Meehl present a statistical argument which they claim demonstrates the inadequacies of any prediction technique, even one that is highly accurate:

Assume that one person out of a thousand will kill. Assume that an exception-

would be willing to admit, however, that a great many of those individuals committed on the basis of a psychiatric prediction of danger-

ally accurate test is created which differentiates with ninety-five percent effectiveness those who will kill from those who will not. If 100,000 people were tested, out of the 100 who would kill, 95 would be isolated. Unfortunately, out of the 99,900 who would not kill, 4,995 people would also be isolated as potential killers. In these circumstances, it is clear that we could not justify incarcerating all 5,090 people. If, in the criminal law, it is better that ten guilty men go free than that one innocent man suffer, how can we say in the civil commitment area that it is better that fifty-four harmless people be incarcerated lest one dangerous man be free?

Livermore, Malmquist, Meehl, *Justifications for Civil Commitment*, 117 U. PA. L. REV. 85, 94 (1968) [hereinafter cited as Livermore]. In *People v. Collins*, 68 Cal. 2d 319, 438 P.2d 33, 66 Cal. Rptr. 497 (1968), the California supreme court rejected the use of mathematical probabilities to show the likelihood that a particular individual committed a particular crime. In doing so, the court, in an appendix to the opinion, convincingly demonstrated the type of fallacy into which a person untrained in statistical analysis can fall when attempting to use probability theory. *Id.* at 333-35. Prof. Livermore's argument is one of the same fallacious mold as the court rejected in *Collins*. As noted in *Collins*, "[m]athematics, a veritable sorcerer to our computerized society, while assisting the trier of fact in the search for truth, must not [be allowed to] cast a spell over him." *Id.* at 320.

The prediction of the dangerousness of an individual is a problem in "detection theory." In this discipline, the basic problem is as follows: A universe of "inputs" is assumed, some of which are "signals" which carry desired information while others are "noise" which carry no information. A combination of the signals and noise (neither of which are known to the observer) is "input" to a "detection device." The device is supposed to indicate that a "signal" is present only when desired information is in fact present at the input, and indicate no signal when only noise is present at the input. Since all detection devices have some error in them, and since with purely random noise, some noise will "look like" signal, the detection device will occasionally output an erroneous indication. The measure of the performance of the device is then based on the number of errors it makes. These can be of two types. First, the device may not output an indication of signal when a signal is in fact present. The measure of this kind of error is called the "probability of detection," or "P(D)." If the device indicates the presence of a signal in 95% of the cases where a signal is actually present, then the P(D) of that device is 95%. The other type of error occurs when the device indicates the presence of a signal when in fact no signal is present. The measure of this kind of error is called the "probability of false alarm," or "P(FA)." Thus, if the system indicates the presence of signal in 5% of the cases where no such signal is actually present, then the P(FA) of the system is 5%. The relation between these two parameters is, in general, quite complicated, and depends on the signal characteristics, the noise characteristics, the "strength" of the signal relative to the noise, and the characteristics of the detection device itself. See generally, W. DAVENPORT & W. ROOT, AN INTRODUCTION TO THE THEORY OF RANDOM SIGNALS AND NOISE (1958).

Applying this analysis to the problem set out by Livermore, et. al., the "universe of inputs" includes all persons subjected to the test; "signal" are those persons who will actually kill; "noise" consists of those persons who will not kill, and the "detection device" is the psychiatrist who makes the prediction. Prof. Livermore's analysis then assumes a P(D) of 95%, i.e., that 95% of all persons who are actually dangerous will be so classified by the psychiatrist. His argument also assumes a P(FA) of 5%, i.e., that 5% of all persons who are not killers will be so classified. Prof. Livermore claims that this is "an exceptionally accurate test." The difficulty with the argument lies in

ousness are not actually dangerous,⁶⁷ and, therefore, could not be involuntarily confined if criminal law standards were applied.

the assumption that the relation between P(D) and P(FA) is:

$$P(FA) = 100\% - P(D)$$

This assumption is completely unjustified both in logic and mathematics. Conceptually, it would be possible to design a test which has a P(FA) of 0%, *i.e.*, it never misclassifies a non-killer, but which has a P(D) of 95%. Equally conceivable is a system where $P(D) = P(FA) = 95\%$. The point is that the accuracy of a test cannot be determined only by reference to its P(D).

In designing any detection system, whether it be a psychiatric test or a radar receiver, the ultimate goal is to maximize the P(D) while minimizing the P(FA). But in performing the inevitable "trade-off" between P(D) and P(FA), one must always keep in mind which parameter is more important. In engineering terms, the parameters must be "weighted" according to their relative importance when doing the trade-off. In the problem at hand, the emphasis should be, as it is in criminal law, on minimizing the P(FA), even at the expense of lowering the P(D) below the ultimate possible. (The importance of weighting the parameters properly can be shown by the following example: Suppose that it is of overwhelming importance to incarcerate all killers, and keeping non-killers free is of no importance. Then the obvious solution is to lock up everyone, *i.e.*, design a system with $P(D) = P(FA) = 100\%$.) When viewed in this light, Prof. Livermore's test, with its P(FA) of 5%, is an extremely poor detector—not the "exceptionally accurate" one he assumes it to be.

In terms of the result which is desired, a much more acceptable test would be, *e.g.*, one which had a P(D) of 50%, or even 25%, and a P(FA) of 0.005%. But whatever performance criteria are ultimately determined to be acceptable, it is clear that, at least theoretically, a prediction system can be designed which meets those goals. In other words, contrary to the implications of Prof. Livermore's argument, "prediction" does not inherently mean that large numbers of innocent people must be locked up in order to protect society from a large percentage of those who are dangerously ill.

67. *See, e.g.*, Jessup, *Civil Commitment of the Mentally Ill*, 30 U. PRR. L. REV. 752 (1969):

The Council of the American Psychiatric Association has approved the following statement: "on the basis of long experience, psychiatrists estimate that about 90 percent of all mental hospital patients are harmless and in no way threaten the community in which they reside." It has also been estimated that for every dangerous mental patient there are one thousand perfectly harmless patients in institutions.

Id. at 765 (citations and footnotes omitted). *See also* 1961 Hearings, *supra* note 61, pt. 1, at 43.

From the viewpoint of a psychiatric professional, the fact that most mental patients are not really dangerous (even though most may have been committed under this criterion) would not justify their release for two reasons: (1) If the individual were in need of treatment, the standard used to bring the individual into a mental hospital might not concern the psychiatrist; (2) A psychiatrist, primarily concerned with medical matters rather than civil liberties, might be inclined to keep an individual locked up as long as any real possibility of dangerousness were present:

In the uncertain case, the doctor faces a dilemma. Aware of his own inability to make accurate predictions, he may either be solicitous of individual freedom and refuse to categorize the patient as dangerous, or he may be concerned more with the protection of society and recommend commitment.

ARIZONA PROJECT, *supra* note 8, at 98. Basically one is faced with a conflict involving essentially medical goals operating within the context of legal criteria. *See* notes 74-81 *infra* and accompanying text.

The difficulties with the "dangerousness" standard are threefold. First, psychiatrists subject themselves to public censure if they release patients who later prove to be actually dangerous. Professor Dershowitz⁶⁸ has written:

[A] psychiatrist almost never learns of his erroneous predictions of violence. For predicted assailants are generally incarcerated and have little opportunity to prove or disprove the prediction. But he always learns about his erroneous predictions of non-violence, often from newspaper headlines announcing the crime.⁶⁹

(Of course, this statement is directed to the standards for *release* from commitment, rather than the initial commitment itself, but the argument is still applicable in the latter case.) As a consequence, committing psychiatrists tend to overpredict dangerous behavior,⁷⁰ and a great many individuals are institutionalized on the basis of these erroneous predictions.⁷¹

68. See note 71 *infra*.

69. Dershowitz, *supra* note 11, at 23.

70. "There is a natural inclination of institutional psychiatrists and committing courts to protect themselves against possible censure by retaining patients until any possibility of danger has passed." Livermore, *supra* note 66, at 85.

71. Psychiatric predictions of dangerous behavior are generally inaccurate. One study by Professor Alan Dershowitz, of Harvard Law School, concluded:

Psychiatrists are rather inaccurate predictors—inaccurate in an absolute sense—and even less accurate when compared with other professionals. . . . For every correct psychiatric prediction of violence, there are only a few who would and many more who would not actually engage in such conduct if released.

A. Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways*, PSYCHOLOGY TODAY, Feb. 1969, at 43. Two specific case studies are illustrative. A study of Maryland's Patuxent Institution for "defective delinquents" shows that of 432 inmates who were released judicially over the objections of the institution, only 137 (32%) committed new offenses. All of these patients were considered dangerous by the hospital staff upon release. Yet 295 (68%) of them showed no overt indication of dangerousness upon release. Schreiber, *Indeterminate Therapeutic Incarceration of Dangerous Criminals: Perspectives and Problems*, 56 VA. L. REV. 602, 619 (1970). One might be inclined to think that the release of even 137 dangerous individuals out of 432 poses a threat to the community, and indeed it does. But should this be a justification for the incarceration of all 432? Note that these were all individuals who had previously committed some overt act which could be classified as dangerous, but that in the case of civil commitments that are independent of criminal proceedings, the individual frequently has committed no prior dangerous or criminal act upon which the dangerousness prediction can be based.

The second case study involves the United States Supreme Court decision of *Baxstrom v. Herold*, 383 U.S. 107 (1966). In New York, convicts who become mentally ill while serving in prison are transferred to Dannemora State Hospital, a maximum security institution. If the patient is still considered mentally ill when the sentence expires, he or she is transferred to the Commissioner of Mental Hygiene for placement in an appropriate institution. If the ex-convict is still considered dangerous, he or she is returned to a maximum security institution administered by the Department of Correction. See Morris, *supra* note 1, at 119; N.Y. CORREC. LAW § 383 (McKinney 1968),

A second difficulty with the dangerousness criterion is its definitional vagueness. This is, of course, closely intertwined with the difficulty of prediction, but even if the predictions of the psychiatrists were 100 percent accurate, how dangerous would persons have to be?

N.Y. Laws ch. 540, § 4 (1965) (repealed N.Y. Laws ch. 891, § 1 (1966)). Johnnie K. Baxstrom was one such patient who was held in maximum confinement after the expiration of his sentence. He sought a writ of habeas corpus and the Supreme Court, with Chief Justice Warren writing for the majority, held that Baxstrom had been denied equal protection of the law under the fourteenth amendment. The Court found that, although the procedure in question was civil in nature, people in Baxstrom's position were denied the possibility of jury review, a right granted to all other persons who were civilly committed in New York. The Court also held that Baxstrom was entitled to a judicial hearing to determine if he was dangerous. 383 U.S. at 110. As a result of this decision "Operation Baxstrom" came into being. Nearly a thousand individuals, all of whom were considered too dangerous to be released from maximum confinement, had to be transferred into minimum security civil state hospitals. Within three months, 173 patients were retained as "voluntary" patients, meaning that they could discharge themselves by giving ten days notice. Eighteen patients were given "informal patient" status, meaning that they could leave the hospital at any time. Only four of the original group of patients were transferred to maximum security institutions. After six months, it was found that only six-tenths of one percent of the "Baxstrom" patients were too dangerous to be treated in civil hospitals. Morris, *supra* note 1, at 118-24. Johnnie Baxstrom himself was transferred to a minimum security hospital, and later a jury found that he was not mentally ill. He was released on May 24, 1966. He died of an epileptic seizure on June 7, 1966. *Id.* at 120 n.51. The report of the Department of Mental Hygiene after one year of "Operation Baxstrom" stated: "The most striking news is that there is no news. None of the hospitals has any particular problems to report." Hunt & Wiley, *Operation Baxstrom After One Year*, 124 AM. J. PSYCHIATRY 974, 976 (1968). Bruce Ennis, of the New York Civil Liberties Union, concluded: "To use an analogy, the so-called dangerous patients turned out to be purer than Ivory Snow. They were, in fact 99.54% non-dangerous." B. ENNIS, THE RIGHTS OF AMERICANS 487 (1967).

The results of Operation Baxstrom and the Maryland experience prove that psychiatric predictions of dangerous behavior are inaccurate in the direction of overprediction of danger. Furthermore, other studies indicate that presently there are no accurate tests to predict dangerous behavior. Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways*, PSYCHOLOGY TODAY, Feb. 1969, at 43, 47. On psychiatric predictions of danger, see generally ARIZONA PROJECT, *supra* note 8, at 96-100.

This same inaccuracy exists when the psychiatrist is attempting to predict if individuals will be dangerous to themselves. In those jurisdictions where the standard of dangerousness includes danger to self, such as California (see note 46 *supra*), suicidal patients would naturally come under that criterion. Yet some maintain that such irresponsible behavior among mental patients is even more difficult to predict than is behavior that would be dangerous to others. Livermore, *supra* note 66, at 86.

With respect to suicide specifically, not only are there no accurate tests for predicting the likelihood of a given individual attempting it, but there is good reason to believe that trying to assume responsibility for preserving the life of a suicidal person may be the worst possible therapy. Protrowski, *Psychological Test Prediction of Suicide*, SUICIDAL BEHAVIOR 198 (1968). See also DILEMMA OF MENTAL COMMITMENTS, *supra* note 20, at 152-53.

Would they have to be the type who inflicts pain for mere pleasure, or would a short and violent temper suffice? Should a person who merely threatens violence, but only on the most rare occasion actually indulges in physical contact, be considered dangerous? Where, in other words, is the line to be drawn between those who are "dangerous" in the sense that they should be committed and those who are not? This question apparently does not even appear as a problem to be resolved in the literature on this subject,⁷² perhaps because it is one which is presently beyond solution.⁷³

A third difficulty with the dangerousness criterion is its basic irrelevance to any medical standard of mental illness. From a psychiatrist's point of view, the only issue of consequence is whether or not the individual is in need of treatment, the second of the common statutory commitment standards.⁷⁴ Yet even this purely medical standard can be as vague and difficult to apply as the dangerousness criterion.⁷⁵ Mental

72. See N. Morris, *Psychiatry and the Dangerous Criminal*, 41 S. CAL. L. REV. 514 (1968). Writing in the context of criminal insanity, this article comes close to a discussion of the question of where the cut-off should be before the label of "dangerous" is placed on an individual. Professor Morris writes:

Such an approach to predicting dangerousness does not, of course, define the types of criminal behavior which are and are not "dangerous"—the *types of risk* which the community should and should not have to bear. But adequate prediction does lead us to the central policy issue after this definition: What *degree of risk* should the community bear in relation to the countervailing values of individual freedom? That is, how many "false positive" predictions [one is predicted to be a danger, but does not prove to be] are justified for the social benefits derived from the "true positive" predictions? This is a socio-legal question, not within the psychiatrist's particular competence.

Id. at 535-36.

73. Dangerousness, in light of the available empirical data (see note 71 *supra*) and the definitional problem, might seem to be a constitutionally inadequate criterion when used as a basis for civil commitment. Nonetheless, the United States Supreme Court, in *Minnesota ex rel. Pearson v. Probate Court of Ramsey County*, 309 U.S. 270 (1940), held that while due process of law is required in judicial proceedings that involve the mentally ill, it is permissible to commit individuals because they are "dangerous" as long as evidence of the individuals' habitual conduct is shown. *Id.* at 274-75. This may be provided by the testimony of examining psychiatrists or by lay testimony. In addressing the equal protection issue implicated by a process which singles out a particular group for possible incarceration unconnected with the commission of a crime, the Court stated:

[T]he legislature is free to recognize degrees of harm, and it may confine its restrictions to those classes of cases where the need is deemed to be clearest. If the law presumably hits the evil where it is most felt, it is not to be overthrown because there are other instances to which it might have been applied.

Id. at 275.

74. See note 57 *supra* and accompanying text.

75. "The fact that competent psychiatrists disagree as to diagnostic labels . . . does raise questions as to the accuracy of predictability and assessment of results based in part on these labels." Fuller, *supra* note 20, at 87. Some psychiatrists maintain that, as difficult as mental illness is to define, they "know it when they see it." *Id.*

health is defined in terms of a community norm,⁷⁶ and, conversely, those persons needing treatment are so categorized because they deviate too greatly from the norm. By definition then, a determination that a person is mentally ill is highly dependent on the community in which the determination is made. In Salem, Massachusetts, during colonial times, the burning of witches was considered "therapeutic"; it was good therapy for the eternal souls of the "witches," and it was good therapy for the community, which was able to purge itself of individuals who did not conform to societal norms.⁷⁷ Today, the concept of mental illness, while more "scientific," is still defined in terms of norms, although these norms are expressed in terms of psycho-social, ethical, and legal concepts.⁷⁸ Because such concepts are inherently vague, it is difficult to identify which individuals should be institutionalized on the basis of need for treatment, *i.e.*, needing to be brought back to some point reasonably close to the norm.⁷⁹ The Senate Subcommittee on Constitutional Rights of the Mentally Ill heard testimony that a number of studies show "psychiatric diagnosis . . . so unreliable as to merit very serious question when classifying, treating, and studying patient behavior and outcome."⁸⁰

While part of the problem with the concept "need for treatment" thus lies in the absence of an objective definition of mental illness,⁸¹ part lies in the considerable fragmentation within the psychiatric community

at 87 n.49. Compare *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964) (Stewart, J., concurring).

76. See Wegner & Fletcher, *supra* note 10, at 67 ("Mental illness is not a fact in the same sense as a broken leg: . . . It is a legal theory to explain deviant behavior."); 1969-70 Hearings, *supra* note 66, at 419 ("The great bulk of mental illness is defined and measured in terms of behavioral deviance."); Duhl, *The Changing Face of Mental Health*, THE URBAN CONDITION 59, 63 (L. Duhl ed. 1963) ("[T]he concept of normality has become the criterion of mental health. But since the middle class is most often the source of what is considered 'normal,' we are in peril of utilizing 'mental health' to perpetuate middle-class values."); Szasz, *Involuntary Commitment: A Form of Slavery*, THE HUMANIST, July-Aug. 1971 at 12 [hereinafter cited as *A Form of Slavery*] ("Mental illness is a metaphor. If by disease we mean a disorder of the physiochemical machinery of the body, then we can assert that what we call 'functional mental diseases' are not diseases at all. Persons said to be suffering from such disorders are socially deviant or inept, or in conflict with individuals, groups, or institutions. Since they do not suffer from disease, it is impossible to 'treat' them for any sickness.").

77. See generally A. MILLER, THE CRUCIBLE (1952).

78. LEIFER, SOCIAL PROBLEMS 22 (1966); SZASZ, *supra* note 2, at 14.

79. See generally Wenger & Fletcher, *supra* note 10.

80. 1969-70 Hearings, *supra* note 66, at 420, quoting CENTER FOR THE STUDY OF RESPONSIVE LAW, TOWARDS AN ENLIGHTENED COMMITMENT LAW (1970).

81. See SZASZ, *supra* note 2, at 99-100.

regarding the application of whatever criteria the profession should decide to follow.⁸² The entire diagnostic process allows the examining doctor to view the patient in almost any light desired.⁸³ If the physician is so predisposed, he or she has the ability to "shoehorn" almost anyone into the "mentally ill" classification for almost any reason.⁸⁴ The fate of the patient is thus almost entirely dependent on the personal views of the diagnostician as to how to interpret and apply the various psychiatric criteria.⁸⁵

As vague as the criteria for civil commitment may seem to be in reality, when they are placed in the context of the commitment hearing, they may appear perfectly definite to the committing court. This is due to a breakdown in communication between the legal and medical professions.⁸⁶ The physician may recognize the limits of the diagnosis and predictions, but is forced by statute to place the patient in categories which the physician may feel are entirely unsatisfactory.⁸⁷ From the point of view of the court, however, once a person is so categorized, a definite and meaningful result has been reached, and the court feels

82. T. CAINE & J. SMALL, *THE TREATMENT OF MENTAL ILLNESS* 7 (1969). Assuming that a behavioral norm of some sort could be established, the professionals still disagree as to the use of therapeutic techniques. Cf. Mechanic, *Therapeutic Intervention: Issues in the Care of the Mentally Ill*, AM. J. ORTHOPSYCHIATRY, July 1967, at 703; Schatzman & Strauss, *A Sociology of Psychiatry: A Perspective and Some Organizing Foci*, SOCIAL PROBLEMS, Summer 1966, at 7. In addition, none of the techniques used have enough evidential support to justify any assertions about their effectiveness. Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 105 (1967) [hereinafter cited as *Civil Restraint*]. One comparison of diagnoses among eight residents of the same psychiatric institution showed an overall percentage of agreement of only 42%. Beck, *Reliability of Psychiatric Diagnoses: I. A Critique of Systematic Studies*, AM. J. PSYCHIATRY, Sept. 1962, at 210, 212. The number of categories and subcategories of mental disorders that are listed in psychiatric manuals are numerous enough to include almost any type of personality in the insanity class. Note, *The Need for Reform in the California Civil Commitment Procedure*, 19 STAN. L. REV. 992, 999 (1967). The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (1952) lists fourteen different categories and within these over 75 subcategories of mental disorders.

83. Livermore, *supra* note 66, at 80.

84. *Id.*

85. See Manis, *The Sociology of Knowledge and Community Mental Health Research*, 15 SOCIAL PROBLEMS 498 (1968); JOINT INFORMATION SERVICE OF THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE NATIONAL ASSOCIATION OF MENTAL HEALTH, STUDY, (Nov. 1962).

86. "When we try to answer the court's questions we implicitly assent to their validity. We thereby reinforce the confusion of the judge, jury and public, while perpetuating an absurd dilemma for the legal system and forensic psychiatrist." Dr. Kaufman, Adjunct Professor of Law and Psychiatry, Georgetown Law Center, in *1969-70 Hearings*, *supra* note 66, at 401.

87. Interview, *supra* note 45.

it can proceed on firm ground. It thus appears that the two professions may be operating under two different standards, using the same terms to convey each profession's distinct meaning.

The California statutory commitment scheme appears to set forth a more specific standard for who may be committed than the laws of most jurisdictions.⁸⁸ Persons who are classified simply as "mentally disordered" may no longer be involuntarily hospitalized under the provisions of LPS.⁸⁹ Individuals who are considered dangerous to themselves or to others, however, and persons defined as "gravely disabled" may still be taken into custody if "reasonable cause" is shown.⁹⁰ The Act does not define the terms "dangerous," "mentally disordered," or "reasonable cause,"⁹¹ although it does define "gravely disabled" as "a condition in which a person, as a result of mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter."⁹² Further, the California State Department of Health has, by regulation, adopted the American Psychiatric Association's definitions of "mental disorder."⁹³

Since the "gravely disabled" standard has not yet been litigated at the appellate level, it is difficult to predict how narrowly or broadly the courts will interpret it. On its face, the statutory definition seems clear and comparatively easy to apply. It may even be that it can be applied by lay triers of fact without the intervention of psychiatric testimony. On the other hand, it is possible that the term could be interpreted to be a "need for treatment" standard. Apparently some psychiatrists have so interpreted the statute, although the indications are that this has happened only in limited areas on an occasional basis.⁹⁴

Similarly, the meaning of "reasonable cause" has not been litigated at the appellate level, and there is a dearth of information concerning

88. CAL. WELF. & INST'NS CODE ANN. § 5150 (West 1972). Included within LPS are new time limits and commitment procedures for the hospitalization of mentally ill individuals, a "Bill of Rights" for the patient in the hospital, and a conservatorship program for those who are gravely disabled. See notes 24-54 *supra* and accompanying text.

89. *Id.* § 5002.

90. *Id.* § 5150. See ENKI REPORT, *supra* note 20, at 12-13. Most of the residents of California's mental hospitals at the time of the adoption of LPS were not "dangerous to others."

91. See *Thorn v. Superior Court*, 1 Cal. 3d 666, 669, 464 P.2d 56, 58, 83 Cal. Rptr. 600, 602 (1970).

92. CAL. WELF. & INST'NS CODE ANN. § 5008(h) (West 1972).

93. 9 CAL. AD. CODE § 813.

94. See ENKI REPORT, *supra* note 20, at 158.

the standards actually employed. Hopefully, the courts will interpret the phrase to contain the same meaning as "probable cause" in the criminal law context. It would seem that any other standard would be subject to attack on the ground that the person being committed was being deprived of liberty without due process of law.

The most difficult standard to apply is "dangerousness." Much has been written on this subject,⁹⁵ but the legislature carefully avoided defining it in LPS. There are some indications that this was done in order to allow some flexibility in the commitment standards,⁹⁶ but in practice, "dangerousness" has been interpreted in a very narrow and strict manner. The *ENKI Report*⁹⁷ states that some people associated with LPS claim that before a person's detention can be continued on the basis that the person is a danger to others, not only must the patient commit a specific overt act toward someone, but that act must be witnessed by either a psychiatrist or a police officer.⁹⁸ Such an interpretation is surely not required by the language of the statute. According to the District Attorney's office in Los Angeles, which acts as a "prosecutor" in civil commitment hearings in Los Angeles, the criterion used for the initial detention is not quite so strictly interpreted, and a person can be committed without the necessity of showing a specific example of dangerous behavior.⁹⁹ Nevertheless, fewer persons are being committed,¹⁰⁰ and they have been committed under standards which from the available data, seem more closely to satisfy due process requirements than those used in the past.¹⁰¹ Furthermore, this result has apparently been accomplished without increasing the public's exposure to dangerous behavior on the part of mentally disordered persons.¹⁰² Thus, in terms of protection of civil liberties, it would appear that LPS's approach to the "dangerousness" problem has been fairly successful.

But improvements are needed. While the California courts have been interpreting the dangerousness criterion strictly, it appears that psychiatrists themselves have not changed their basic approach to com-

95. See notes 59-76 *supra*.

96. See ENKI REPORT, *supra* note 20, at 154.

97. ENKI REPORT, *supra* note 20.

98. *Id.* at 155.

99. Interview with Mel Thale, Head of the Psychiatric Division, District Attorney's Office, Los Angeles County, Nov. 2, 1973.

100. Interview, *supra* note 45.

101. The standards on their face appear vague; as applied, they seem to be satisfactory.

102. ENKI REPORT, *supra* note 20, at 155.

mitment.¹⁰³ This places a considerable burden on the courts, since the psychiatrist, who is still the primary witness at commitment proceedings, is still basing the prediction of dangerousness on poorly defined, subjective criteria which apparently correlate only with the psychiatrist's feeling that the person needs custodial treatment.¹⁰⁴ The court must then rely on the testimony of someone who is speaking a different language than that used by the court, even though the words employed may sound the same.¹⁰⁵ It is doubtful that changes in the statutory criteria will solve this problem, however, since any standard adopted can be subverted in the same way as the present dangerousness standard.¹⁰⁶

B. *The Right to Treatment*

For many years state hospitals have been dumping grounds for individuals who are unwanted or undesirable,¹⁰⁷ with hospitalization amounting to little more than another form of incarceration.¹⁰⁸ When persons are found not guilty of a crime by reason of insanity,¹⁰⁹ such incarceration seems almost paradoxical: They cannot be imprisoned, for they are not guilty, but they are deprived of liberty for no other reason than their undesirable nature.¹¹⁰ The contrast is even more stark in civil commitments: Individuals are "dumped" into a "hospital" where they receive no treatment even though they, unlike acquitted criminal defendants, have committed no act which society deems worthy of the label of "crime."

In 1966, the United States Court of Appeals for the District of Columbia became the first court to accept the principle of a "right to treatment" for individuals involuntarily detained in mental institutions. In

103. *Id.* at 116.

104. See notes 71-84 *supra* and accompanying text.

105. See notes 71-84 *supra*.

106. The solution probably lies in clearly defining the role of the lawyer in civil commitment proceedings. See notes 258-60 *infra* and accompanying text. And, of course, the mere adoption of certain standards by the legislature cannot change the medical standards by which a psychiatrist will personally determine whether or not a person should be hospitalized.

107. See Fuller, *supra* note 20, at 75.

108. "[A]n institution that involuntarily institutionalizes the mentally ill without giving them adequate medical treatment for their mental illness is a mental prison and not a mental hospital." Statement of Morton Birnbaum in 1969-70 *Hearings*, *supra* note 66, at 363. See also Marschall, *supra* note 56, at 39.

109. See, e.g., *In re Franklin*, 7 Cal. 3d 126, 496 P.2d 465, 101 Cal. Rptr. 553 (1972).

110. See Abramson, *supra* note 15, at 103; *Rouse v. Cameron*, 373 F.2d 451, 452 (D.C. Cir. 1966).

Rouse v. Cameron,¹¹¹ Chief Judge David Bazelon, writing for the majority, held that the purpose of such hospitalization is to provide treatment, not punishment,¹¹² and that a mental patient who is not receiving treatment may obtain habeas corpus relief.¹¹³ The supposition which runs throughout the *Rouse* decision is that individuals are committed because they are in need of treatment,¹¹⁴ and, as Judge Bazelon has noted elsewhere, "If society confines a man for the benevolent purpose of helping him—'for his own good'— . . . then its right to so withhold his freedom depends entirely upon whether help is in fact provided."¹¹⁵

Despite this rather appealing statement, the impact of *Rouse* is severely curtailed by the qualification that the treatment need not be effective. That is, the hospital is not required to show that the treatment will cure the patient, but only that "there is a bona fide effort to do so."¹¹⁶ In *Tribby v. Cameron*,¹¹⁷ the same court that decided *Rouse* held that the psychiatrist's decision as to the type of treatment to be given is subject to judicial review, but that the court's role is similar to that it plays when reviewing the decisions of administrative agencies.¹¹⁸ Therefore, the court is limited to determining if the psychiatrist's decisions are "permissible and reasonable in view of the relevant information and within a broad range of discretion."¹¹⁹

This case is indicative of the reluctance of many jurists to carefully scrutinize psychiatric decisions. Another example is Chief Justice (then

111. 373 F.2d 451 (D.C. Cir. 1966).

112. *Id.* at 452. The right to treatment in *Rouse* was justified in terms of statutory language, but the court also stated: "Absence of treatment 'might draw into question the constitutionality of [this] mandatory commitment section' as applied." *Id.* at 453. For a discussion of the constitutional arguments, see *Civil Restraint*, *supra* note 82, at 97-104. See also *Nason v. Superintendent of Bridgewater State Hosp.*, 233 N.E.2d 908, 913 (Mass. 1968), in which the Massachusetts Supreme Judicial Court based the right to treatment on due process and equal protection grounds.

113. 373 F.2d at 458. It should be noted that *Rouse* and many of the other cases in this area involve persons *criminally* committed to mental institutions. As has been noted, however, (see note 57 *supra*) the "right to treatment" doctrine is applicable irrespective of the initial reason for commitment. Therefore, the rationale of these cases is applicable to both civil and criminal commitment situations.

114. "The purpose of involuntary hospitalization is treatment. . . . Absent treatment the hospital is transformed . . . into a penitentiary where one could be held indefinitely." *Id.* at 452-53.

115. Bazelon, *supra* note 20, at 102.

116. 373 F.2d at 456.

117. 379 F.2d 104 (D.C. Cir. 1967).

118. *Id.* at 105.

119. *Id.*

Judge) Burger's concurring opinion in *Dobson v. Cameron*,¹²⁰ where he stated that he had "grave doubts that we are qualified to oversee mental hospitals in cases of civil commitment."¹²¹ He viewed the role the court should play as being "largely limited to determining whether the choice of therapy was a conscious medical decision rather than neglect; obviously judges have no competence to evaluate the *quality* of a given choice of treatment."¹²² Superficially this argument might seem to have some validity, but when one considers the role the courts play in medical malpractice cases, it becomes difficult to defend. In such cases, the courts not only are called on to determine if the particular choice of treatment was correct, but whether the initial diagnosis was correct and whether the treatment given, even if correct, was properly executed.¹²³ If courts are qualified to oversee physical medicine to this degree, certainly they must also be qualified to oversee the treatment given to mental patients. Nonetheless, Chief Justice Burger's comments are by no means unique and are an indication of the extent to which the courts have abdicated their responsibilities to the psychiatric profession.¹²⁴

Other courts, while affirming the right to treatment concept, have greatly diluted its utility by predicating its application on other criteria, including the availability of staff and the protection of the community (a semantic variation of the dangerousness standard).¹²⁵ This conforms to the attitude taken toward the right to treatment approach by many within the psychiatric field. When the *Rouse* decision was handed down, the Council of the American Psychiatric Association responded by stating:

It is the responsibility of the physician to determine the appropriate treatment techniques. . . . Further, this determination must be made realistically in relation to the facilities, personnel, and objectives of the institutions, clinics, or agencies that are at hand.¹²⁶

120. 383 F.2d 519 (D.C. Cir. 1967).

121. *Id.* at 523.

122. *Id.* at 524 n.2.

123. See, e.g., *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969) (reversing nonsuit in malpractice action based on theory that a myelogram had been negligently performed).

124. See notes 196-99 *infra* and accompanying text. A classic example of such abdication is found in *Burnham v. Department of Pub. Health*, 349 F. Supp. 1335 (N.D. Ga. 1972), *appeal docketed*, No. 72-3110, 5th Cir., Oct. 4, 1972.

125. Some states have adopted the Draft Act Governing the Hospitalization of the Mentally Ill (Public Health Service Publication No. 51, Sept. 1962) which states: "Every patient shall be entitled to humane care and treatment . . . to the extent that facilities, equipment, and personnel are available." *Id.* at 19.

126. 123 AM. J. PSYCHIATRY 1458, 1459 (1967). *But see* *Wyatt v. Stickney*, 344

Another difficulty is that the criteria established in the right to treatment doctrine, as it has been applied in the *Tribby* and *Dobson* decisions, are sufficiently vague as to allow the courts to take as active or as passive a role as they wish in the supervision of the treatment of mental patients.¹²⁷ For this reason, the doctrine has been dismissed as "an enchanting legal fiction."¹²⁸

To some extent, the discussion of treatment and involuntary hospitalization in the same context is internally inconsistent. One of the conclusions arrived at by many psychiatrists is that the coercion inherent in the civil commitment process has a negative effect on mental patients¹²⁹ in that involuntary institutionalization not only fails to help many individuals, but, in some cases, exacerbates the patient's illness.¹³⁰ Dr. Werner M. Mendel, of the University of Southern California School of Medicine, after studying nearly 3,000 schizophrenic patients, concluded:

F. Supp. 387 (M.D. Ala. 1972); 344 F. Supp. 373 (M.D. Ala. 1971), *enforcing* 325 F. Supp. 781 (M.D. Ala. 1971), *appeal docketed sub nom. Wyatt v. Aderholt*, No. 72-2634, 5th Cir., Aug. 1, 1972, *noted in* 86 HARV. L. REV. 1282 (1973), in which the court ordered that the Alabama Mental Health Board implement minimal treatment standards designed to give mental patients a "realistic opportunity" to improve or be cured.

127. See Katz, *supra* note 9, at 32-34.

128. *Id.* at 3.

129. Some claim that the principal motivating factor underlying the reactions of mental hospital staffs is fear of patients. This leads them to adopt policies aimed at custody, rather than therapy. RUBIN, *PSYCHIATRY AND CRIMINAL LAW* 83 (1965). In *Ward 7*, Valeriy Tarsis presents this statement by a patient to a hospital physician: "This is the position. I don't regard you as a doctor. You call this a hospital, I call it a prison. . . . I am your prisoner, you are my jailer, and there isn't going to be any nonsense about my health . . . or treatment." *Quoted in, A Form of Slavery, supra* note 76, at 13.

130. Dr. Philip Deutsch testified before the Senate Subcommittee on Constitutional Rights that "freedom is a therapeutic tool" when dealing with mentally ill individuals. *1961 Hearings, supra* note 61, at 45. This theory was empirically supported by a study of 7,000 mental cases in the 1950's. The subjects were divided into two equal groups. One group received treatment in a mental hospital, while the other group did not receive any treatment at all. A greater number of the group not treated recovered sooner, apparently spontaneously. Kimmel, *Patterns and Consequences of Psychiatric Hospital Treatment*, 21 BROOKLYN BARRISTER 186, 190 (1970).

One tends to wonder about a system of treatment where the patients improve faster when they are left untreated. Dr. Szasz sums up the loss of liberty experienced by the mental patient:

A psychiatrist who accepts as his "client" a person who does not wish to be his client, defines him as a "mentally ill" person, then incarcerates him in an institution, bars his escape from the institution and from the role of mental patient, and proceeds to "treat" him against his will—such a psychiatrist, I maintain, creates "mental illness" and "mental patients."

A Form of Slavery, supra note 76, at 14.

"The chronic, deteriorated schizophrenic patient who vegetates in the back wards of our many state hospitals is the final outcome of an iatrogenic (doctor caused) condition resulting from long hospitalization superimposed on the schizophrenic illness."¹³¹

It may be that the loss of liberty is itself counter-therapeutic.¹³² Data is, as yet, inconclusive, but there is evidence to suggest that patients who are not hospitalized recover more rapidly than those who are hospitalized, even though the non-hospitalized individuals receive no treatment at all and would have been classified in the same category of mental illness as those who were confined.¹³³

These types of problems led Judge Bazelon, commenting on his own right to treatment doctrine, to admit the possibility that the *Rouse* decision may have created an unenforceable right:

If psychiatric standards for adequate treatment are uncertain among experts and incomprehensible to mere judges, then perhaps we must admit, however reluctantly, that *Rouse* discovered the fabled right without a remedy.¹³⁴

Yet, Judge Bazelon did find hope in the California statutory scheme: "If its [LPS] goals are achieved, the necessity for a right to treatment in its present form will wither away."¹³⁵

To the extent that LPS allows greater freedom of choice for the civilly committed individual, it would appear to remove the impairment to adequate treatment caused by the coercion inherent in most involuntary civil commitment procedures.¹³⁶ In addition, a form of the right to treatment doctrine is written into the legislation. LPS requires that incarcerated patients receive "such treatment and care" as their condition requires during the period of confinement.¹³⁷ The overall legislative scheme, as indicated in the section on intent, is designed to provide the best possible atmosphere for the patient within the confines of the institution.¹³⁸ For example, the patient is given a choice of physician within the limits of available staff,¹³⁹ and the bill establishes the legislative intent that mentally and physically handicapped persons

131. *Projects, supra* note 12, at 862 n.216, quoting unpublished paper on file at the University of Southern California School of Medicine.

132. *See* note 130 *supra*.

133. *See* note 130 *supra*; FRAZIER & CARR, INTRODUCTION TO PSYCHOPATHOLOGY 124 (1964).

134. Bazelon, *supra* note 20, at 96.

135. *Id.* at 108.

136. *See* notes 129-33 *supra* and accompanying text.

137. CAL. WELF. & INST'NS CODE ANN. § 5152 (West 1972).

138. *Id.* § 5001.

139. *Id.* § 5009. According to Dr. Victor Haddox (*see* note 45 *supra*), the practical realities of mental hospital administration prevent any patient from actually exercising the choice given him by this section.

should be allowed to live in "normal residential surroundings" where possible.¹⁴⁰ Even the patient's religious inclinations are provided for in a section allowing treatment by prayer.¹⁴¹

To some extent, however, the enactment of LPS has worked against the concept of the right to treatment. The community has, in the past, tended to view civil commitment as a means of social control.¹⁴² LPS, with its emphasis on early release of committed individuals, runs counter to this attitude,¹⁴³ with the result that criminalization of the mentally ill seems to be more common than it was in the pre-LPS period.¹⁴⁴

Quite often candidates for civil commitment enter the system following an arrest for such offenses as public drunkenness, malicious mischief, or possession of drugs.¹⁴⁵ Criminal charges are dropped in favor of commitment to a mental institution, which is generally considered better for the individual who will then be able to receive treatment not always available in state prisons.¹⁴⁶ Under LPS, with its more stringent limitations on confinement, the criminal justice system has gone searching for a better way to insure that these individuals will remain in custody.¹⁴⁷ The result is that, in many cases, the criminal conviction is replacing hospitalization for mentally ill individuals.¹⁴⁸ Marc Abramson, a psychiatric consultant to the San Mateo County, California jail system, observes:

Police seem to be aware of the more stringent criteria under which mental health professionals are now accepting responsibility for involuntary detention and treatment, and thus regard arrest and booking into jail as a more reliable way of securing involuntary detention of mentally disordered persons.¹⁴⁹

140. CAL. WELF. & INST'NS CODE ANN. § 5115 (West 1972).

141. The provisions of this part shall not be construed to deny treatment by spiritual means through prayer in accordance with the tenets and practices of a recognized church or denomination for any person detained for evaluation or treatment who desires such treatment, or to a minor if his parent, guardian, or conservator desires such treatment.

Id. § 5006.

142. See Abramson, *supra* note 15, at 102; Fuller, *supra* note 20, at 80-81.

143. But see Fuller, *supra* note 20, at 80-81.

144. Abramson, *supra* note 15, at 103.

145. *Id.*

146. *Id.* There is only one psychiatrist per 2,000 to 3,000 federal prisoners and one for every 12,000 state prisoners. 1969-70 Hearings, *supra* note 66, at 562. One authority, however, contends that some California prisons have better care available for the treatment of mentally ill persons than the mental hospitals. Interview, *supra* note 45.

147. Abramson, *supra* note 15, at 103.

148. *Id.*

149. *Id.*

Because of the exclusions in LPS, long-term commitment is still possible if the person is found to be a user of hard drugs or to be a mentally disordered sex offender.¹⁵⁰ In hearings to determine the competence of an individual to stand trial, the standards (non-LPS) are such that the psychiatrist may be able to base the decision concerning the person's competence on a "need for treatment" standard without the necessity for showing either dangerousness or grave disability in the LPS sense.¹⁵¹ Since these standards have been rigorously applied in civil proceedings, psychiatrists will find that they have more "success," *i.e.*, more of the persons they feel need treatment will be committed, under the criminal standards than the civil.¹⁵² Thus, the correctional system, which in general offers little in the way of rehabilitative services for the mentally ill,¹⁵³ becomes an alternate form of social control which results in the person being unable to obtain the type of treatment guaranteed by LPS.

C. Release From Hospitalization

The writ of habeas corpus is considered a writ of right and is constitutionally guaranteed in our legal system.¹⁵⁴ Nevertheless, the availability of the remedy does not necessarily solve the problem of gaining release for a mental patient who may no longer be in need of confine-

150. California statutes still permit long-term civil commitment for users of hard narcotics; however, this procedure is usually invoked only after criminal conviction, prior to sentencing. Abusers of habit-forming nonnarcotic drugs are no longer vulnerable since provision for their civil commitment was repealed about one year after LPS went into effect.

The only completely indeterminate commitments still existing in California are those for mentally disordered sex offenders (again applicable only after criminal conviction), and penal-code commitments that follow adjudication of mental incompetency to stand trial or of being not guilty by reason of insanity.

Id. It should be noted that some psychiatrists strongly disagree with this statement, citing the statutory requirements and case law interpreting those requirements. Interview, *supra* note 45.

151. Raising the question of mental incompetency to stand trial sometimes permits psychiatric examiners to reintroduce covertly the old need-for-hospitalization criterion to secure involuntary treatment of the mentally disordered person for an adequate length of time, beyond the LPS time limits.

Abramson, *supra* note 15, at 103.

152. *Id.* at 104.

153. A California prison psychiatrist said in a recent newspaper interview, "We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds of men continue to deteriorate psychiatrically before our eyes into serious psychoses. . . . The crisis stems from recent changes in the mental health laws allowing more mentally sick patients to be shifted away from the mental health department into the department of corrections. . . . Many more men are being sent to prison who have serious mental problems."

Id., quoting Sacramento Bee, Feb. 13, 1971, at A4.

154. U.S. CONST. art. I, § 9; *Fay v. Noia*, 372 U.S. 391, 401-02 (1963).

ment. When patients wish to challenge their continued detention through this writ, it is their burden to persuade the court that they are sane or will pose no more threat to the community than the average person.¹⁵⁵ In *Overholser v. O'Beirne*,¹⁵⁶ a criminal commitment case, the United States Court of Appeals for the District of Columbia held that patients must demonstrate that they are so recovered that there no longer exists an abnormal mental condition.¹⁵⁷ As a result of this type of decision, it is difficult for mental patients in some jurisdictions to avail themselves of habeas corpus.

The first problem facing patients seeking release in habeas corpus proceedings is the difficult level of proof required to demonstrate improper detention.¹⁵⁸ This becomes especially difficult if the commitment order conforms with all the procedural requirements. As Dr. Thomas Szasz, Professor of Psychiatry at the State University of New York, indicates, "[I]f the commitment forms are properly executed, the plaintiff has no valid claim."¹⁵⁹

Since courts usually follow the recommendation of the psychiatrist, the decision to release a mental patient was,¹⁶⁰ prior to LPS, almost exclusively in the hands of the hospital staff.¹⁶¹ From the doctor's point of view, the mere fact that the patient seeks release may be evidence that the patient is in need of further hospitalization.¹⁶² After all, recognition that one is sick is a necessary step toward recovery. That is the "Catch 22"¹⁶³ of involuntary hospitalization. Commitment thus becomes, for some, tantamount to a life sentence.¹⁶⁴ Even for

155. See, e.g., *In re Riddle*, 57 Cal. 2d 848, 852, 372 P.2d 304, 306, 22 Cal. Rptr. 472, 474 (1962).

156. 302 F.2d 852 (D.C. Cir. 1962).

157. *Id.* See also SZASZ, *supra* note 2, at 67.

158. This is, of course, the burden placed on any petitioner seeking a writ of habeas corpus. See note 155 *supra*. Dr. Haddox (see note 45 *supra*) indicates, however, that in his experience the state seems to assume the actual burden in habeas corpus hearings under LPS. The statute itself is silent on the question.

159. SZASZ, *supra* note 2, at 65.

160. *Id.* at 69.

161. See notes 193-219 *infra* and accompanying text.

162. Swan, *supra* note 61, at 1343; SZASZ, *supra* note 2, at 63.

163. There was only one catch and that was Catch-22, which specified that a concern for one's own safety in the face of dangers that were real and immediate was the process of a rational mind. Orr was crazy and could be grounded. All he had to do was ask; and as soon as he did, he would no longer be crazy and would have to fly more missions. Orr would be crazy to fly more missions and sane if he didn't, but if he was sane he had to fly them. If he flew them he was crazy and didn't have to; but if he didn't want to he was sane and had to. Yossarian was moved very deeply by the absolute simplicity of this clause of Catch-22 and let out a respectful whistle.

J. HELLER, CATCH-22, at 47 (1961).

164. See Statement of Raymond Chasen in 1961 Hearings, *supra* note 61, at 220-21.

rational individuals, clearly no longer in need of confinement, the struggle to gain release can take years.¹⁶⁵ Patients may vegetate for years in hospital wards before being able to secure legal assistance.¹⁶⁶

Under the provisions of LPS, an attempt is made to correct this situation by placing the right to habeas corpus relief into the legislative scheme.¹⁶⁷ The patient, however, may not be able to make effective use of this writ if he or she does not make a formal request for release.¹⁶⁸ A question immediately arises as to what constitutes a request for release. It would seem that, by definition, the very fact that a person is confined involuntarily demonstrates a lack of consent to treatment. Is such lack of consent a request for release? Likewise, would other conduct, such as an escape attempt, constitute a request for release? The California supreme court, in *Thorn v. Superior Court*,¹⁶⁹ raised these questions but provided no answer.¹⁷⁰ The *Thorn* court did decide, however, that procedures must be provided so that a patient who does not specifically request release may invoke the judicial machinery that LPS has created to review the legality of continued detention.¹⁷¹ Accordingly, it is necessary to insure that every individual has counsel to provide proper assistance in obtaining habeas corpus relief.¹⁷² No mandatory procedures for invoking the legal process were established in the *Thorn* decision.¹⁷³

The habeas corpus provisions were treated more directly in *In re Gonzales*.¹⁷⁴ There the court denied a writ of habeas corpus to an individual who was committed prior to enactment of LPS¹⁷⁵ and suggested instead that the petitioner be accorded the benefits of a conservatorship.¹⁷⁶ If no conservatorship petition had been filed for him by a

165. *Id.*

166. *Id.*

167. CAL. WELF. & INST'NS CODE ANN. §§ 5252.1, 5275. Prior to the enactment of LPS, the writ was seldom used by committed individuals, although it was theoretically available. ENKI REPORT, *supra* note 20, at 179.

168. See generally *Thorn v. Superior Court*, 1 Cal. 3d 666, 675, 464 P.2d 56, 62, 83 Cal. Rptr. 600, 606 (1970).

169. 1 Cal. 3d 666, 464 P.2d 56, 83 Cal. Rptr. 600 (1970).

170. *Id.* at 675 n.9, 464 P.2d at 62 n.9, 83 Cal. Rptr. at 606 n.9.

171. The court did suggest some possible procedures. *Id.* at 675, 464 P.2d at 62, 83 Cal. Rptr. at 606.

172. *Id.*

173. See note 171 *supra*.

174. 6 Cal. 3d 346, 491 P.2d 809, 99 Cal. Rptr. 17 (1971).

175. *Id.* at 347, 491 P.2d at 809, 99 Cal. Rptr. at 17.

176. *Id.* at 351, 491 P.2d at 812-13, 99 Cal. Rptr. at 20-21.

specified date, he could again seek relief by habeas corpus.¹⁷⁷ Expressing the unanimous view of the court, Justice Burke stated:

We are persuaded that the Legislature intended that one committed as dangerously mentally ill under former section 5567, as was petitioner, should neither be automatically released under provisions of the new LPS act, nor should he be deprived of the medication he needs to control his violence, in order to provide a basis for continued detention for his own safety and that of the public. Instead, he is to be accorded the benefits of the conservatorship proceedings under the new act.¹⁷⁸

This approach might indicate more than a reluctance to apply automatic release procedures to persons committed before LPS; it can also be interpreted as showing that the attitude of the California judiciary toward habeas corpus relief for mentally ill individuals is similar to that of other jurisdictions, *i.e.*, that a considerable burden will still be placed on the individual seeking release to show that he or she is no longer in need of confinement.¹⁷⁹ Such an interpretation of this decision is questionable, however, because of the unusual factual situation presented by the case. Gonzales' psychiatrist characterized him as "one of the most dangerous men I have ever examined."¹⁸⁰ The patient was continually kept under heavy sedation, since when he was not drugged he was extremely violent.¹⁸¹ The psychiatrist in charge of his case was thus faced with a perplexing dilemma. In order to keep Gonzales confined as being a "danger to others," the doctor had to be able to report to the court every ninety days that the patient had at least threatened violence to someone in the hospital. To have such a threat materialize, the doctor would have had to take Gonzales off the calming drugs, but if this course of action were to be followed, the patient could seriously injure someone on the staff. On the other hand, the doctor could keep the patient on drugs for the entire ninety days, during which time the patient would not, of course, commit any violent acts. At the end of the ninety day period, the doctor would have to release Gonzales knowing that he would injure someone on the outside within a few days.¹⁸² The

177. *Id.*

178. *Id.* The conservatorship in *Gonzales* was available under the terms of CAL. WELF. & INST'NS CODE ANN. § 5367 (West 1972) which states that such conservatorships are available to persons committed prior to the effective date of the Act. The section is not limited in its operation to those who were committed as being what LPS would call "gravely disabled."

179. *See Overholser v. O'Beirne*, 302 F.2d 852 (D.C. Cir. 1962).

180. 6 Cal. 3d at 350, 491 P.2d at 812, 99 Cal. Rptr. at 20.

181. *Id.*

182. *Id.* at 350 n.9, 491 P.2d at 812 n.9, 99 Cal. Rptr. at 20 n.9.

case vividly demonstrates the inadequacies of the definitional standards set up by the LPS.¹⁸³ It also indicates one reason psychiatrists might tend to make overly cautious predictions of future violence by their patients.¹⁸⁴ And, of course, the factual situation in *Gonzales* destroys any value the case might have in predicting the future course of judicial decisions under LPS: The court was clearly concerned with keeping such a dangerous individual calmly and safely sedated within the confines of an institution.

The experience in the superior courts indicates that habeas corpus petitions are in fact an effective means by which an individual may secure release. According to Dr. Victor Haddox, approximately 90 percent of such petitions result in the release of the patient;¹⁸⁵ the Los Angeles County District Attorney's office estimates that approximately 75 percent of all petitions result in release.¹⁸⁶ If these figures are reflective of the state as a whole, it would appear that the inclusion of the right to habeas corpus within the commitment statute itself has indeed produced a prophylactic effect on the patient's ability to obtain release.¹⁸⁷

Outside the possibility of habeas corpus, LPS attempted to assure as early a release from hospitalization as possible by placing finite limits on the duration of permissible detention.¹⁸⁸ The critics of the bill argued that such limits would have a negative effect on the patients,¹⁸⁹ but those whose major concern was the rights of the individual felt that such a requirement was necessary to protect those rights.¹⁹⁰ The *ENKI Report* indicates, however, that in practice, the limits have had essentially no effect on the average duration of detention.¹⁹¹ Therefore, it appears that the major impact of LPS has been through the habeas corpus proceedings and not because of the limited periods of commitment specified in the Act.¹⁹²

183. See text accompanying notes 55-102 *supra*.

184. See text accompanying notes 68-71 *supra*.

185. See note 45 *supra*.

186. See note 99 *supra*.

187. The ENKI REPORT, *supra* note 20, indicates that the usefulness of habeas corpus might be dependent on the county in which the patient is committed. *Id.* at 179-83.

188. See text accompanying notes 35-39, 42-46, 51-52 *supra*.

189. See ENKI REPORT, *supra* note 20, at 142.

190. See generally Bazelon, *supra* note 20.

191. ENKI REPORT, *supra* note 20, at 142.

192. In terms of the number of patients in mental facilities, however, the strict interpretation the courts have given the dangerousness criteria has probably had a larger impact. See note 100 *supra* and accompanying text.

D. Role of the Psychiatrist

As previously noted, some psychiatrists believe that incarceration of the mentally ill is entirely a medical problem,¹⁹³ and that they should have unrestricted power to commit.¹⁹⁴ As a result, psychiatrists do not generally regard the commitment hearing as a true adversary proceeding but rather as a judicial certification of a previously made medical judgment.¹⁹⁵

The courts have acquiesced in the psychiatrists' approach: Several studies outside of California show that the recommendation of the committing physician is adopted in a very large majority of the cases.¹⁹⁶ The psychiatrist thus assumes the role of an "unimpeachable witness,"¹⁹⁷ whose conclusions are seldom questioned, and even less often rejected.¹⁹⁸ The psychiatrist has therefore become the most significant participant in the commitment hearings, with the courts sitting merely to review, then ratify, psychiatric decisions.¹⁹⁹

Under the California statute, it is the psychiatrist who is primarily responsible for advocating the confinement of the mentally ill individual.²⁰⁰ The responsibility to petition the court for continued confinement lies with the person in charge of the mental health facility where the patient is confined, although admittedly this is not the exclusive responsibility of this individual.²⁰¹ Furthermore, the basic role of the physician in the commitment hearing has not been changed by LPS. The physician now has different terms to use when classifying the

193. See text accompanying notes 10-11 *supra*. Some psychiatrists do prefer voluntary admissions over the involuntary procedure, but others appear to be indifferent as long as the patient receives needed hospitalization. Wenger & Fletcher, *supra* note 10, at 66-67.

194. *Id.* Compare Brandeis, J., dissenting in *Olmstead v. United States*, 277 U.S. 438 (1928): "Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding . . ." *id.* at 479, with statement of Zigmond Lebensohn, M.D., 1969-70 *Hearings*, *supra* note 66, at 14: "[I]t may be that our zeal for protecting the rights of the patient has to some extent, already hampered a desirable expedition in getting some patients into treatment promptly."

195. See note 10 *supra*.

196. See generally ARIZONA PROJECT, *supra* note 8; Wenger & Fletcher, *supra* note 10.

197. See Dershowitz, *supra* note 11, at 23.

198. See text accompanying note 86 *supra*.

199. ARIZONA PROJECT, *supra* note 8, at 60.

200. Normally the professional in charge of the mental health facility is expected to take the initiative and petition to have those individuals who require incarceration to remain so incarcerated. See Fuller, *supra* note 20, at 77-79 n.13.

201. *Id.*

patients, and the physician must phrase classifications so that they conform to the criteria in the bill.²⁰² Thus, a physician who wishes to classify a patient as dangerous or gravely disabled in order that the patient may be treated, can still manipulate the terms to reach the desired result.²⁰³

LPS does, however, change the role of the physician in some respects. First, the bill removes civil liability from the medical staff for anything a patient may do after release.²⁰⁴ If the possibility of public censure causes physicians to "play it safe" when predicting dangerous behavior, the removal of legal responsibility may reduce this tendency.²⁰⁵ A physician, however, is as much a part of the public as a lay person, and as such, may feel that "moral" or "ethical" responsibility attaches to an erroneous prediction of non-danger. Thus, the same community attitudes that existed prior to LPS may partially influence psychiatric predictions.²⁰⁶

The provision of LPS which allows a patient to select his or her own physician within the limits of the staff may also change the role of the physician to some extent.²⁰⁷ The coercive nature of mental institutions often creates a great deal of resentment in the patients, and they commonly tend to look upon the physician as a jailer,²⁰⁸ but post-LPS studies indicate that increased patient involvement in controlling at least some aspects of the confinement has led to greater acceptance of hospitalization.²⁰⁹

Despite these minor improvements, LPS procedures still tend to place the psychiatrist in an untouchable position. Some commentators

202. CAL. WELF. & INST'NS CODE ANN. § 5008(h) (West 1972).

203. See notes 83-85 *supra* and accompanying text. Under LPS, this apparently does not frequently occur. See note 260 *infra*.

204. CAL. WELF. & INST'NS CODE ANN. § 5267 (West 1972).

205. See notes 68-71 *supra* and accompanying text.

206. See generally Abramson, *supra* note 15, at 101.

207. CAL. WELF. & INST'NS CODE ANN. § 5009 (West 1972). But see note 139 *supra*.

208. See, *A Form of Slavery*, *supra* note 76, at 14.

209. One of the intentions of the L-P-S legislation was that there would be more patient involvement in individual hospitalization, and a greater awareness of events. This goal appeared to have been reached in that pre L-P-S 50% of the patients were aware they were being hospitalized, while post L-P-S there was a significant increase in the percent of patients who were aware of the process. . . .

One can hypothesize that patients' greater awareness of the fact that they were being hospitalized led to greater acceptance of the hospitalization. The greater acceptance may also have been influenced by patient awareness of the 14-day limitation on commitments. The important factor is that post L-P-S there was more acceptance of the hospitalization, which, theoretically, facilitates treatment. ENKI REPORT, *supra* note 20, at 119.

have suggested that doctors enjoy this enviable status because they are not required to explain the reasons upon which they base the ultimate conclusion of "dangerous" or "gravely disabled";²¹⁰ instead, the psychiatrist is usually asked no more than whether or not a given harm is likely, and the answer is usually confined to a mere "yes" or "no."²¹¹ The clear implication of these contentions is that if someone were to delve into the reasons upon which the expert based an opinion, then the court could make a better judgment as to the validity of the conclusions reached. Presumably, the attorney for the patient would, on cross examination, be the one to perform the actual feat of eliciting such information from the doctor.

Such an analysis, however, leaves much to be desired. It seems to assume that the court, the attorney, and the jury (if there is one), can understand the doctor's reasoning better than the ultimate conclusion. Yet any time an expert is testifying in a legal action, whether it be an engineer testifying as to the cause of an automobile accident or a physician testifying as to the standard of treatment in a medical malpractice case, the point of the testimony is to have someone take a collection of facts which anyone can comprehend and draw from those facts a conclusion which can be reached only by having the expert's special training and background.²¹² For instance, in the case of an automobile accident, the engineer may use the length of a skid mark, the distance the automobile frame is crushed, and the final position in which the automobile stopped as the basic facts,²¹³ all of which are perfectly understandable by the lay person. But the engineer, using these facts, will then proceed to determine the speed at which the automobile was traveling when the accident occurred, a step in the deductive chain of reasoning beyond the capabilities of the typical lay person. Similarly, the psychiatrist will use as basic facts certain behavior on the part of the patient, response to certain stimuli, etc., each of which is again comprehensible to the lay person.²¹⁴ Nevertheless, it takes training in psychiatry to fit these facts together before one can reach a conclusion as to "mental illness." The triers of fact are not in a position to determine whether or not the psychiatrist has used all relevant data available,

210. See, e.g., Dershowitz, *supra* note 11, at 23.

211. *Id.*

212. See, e.g., CAL. EVID. CODE § 801 (West 1968).

213. See, e.g., Garcia v. Hoffman, 212 Cal. App. 2d 530, 534, 28 Cal. Rptr. 98, 101 (1963).

214. See generally J. BENTLEY, GENERAL PSYCHOLOGY, PRINCIPLES & PRACTICE (1947).

whether or not all necessary data was made available, or whether or not the doctor's reasoning process was correct, simply because they do not know what data is required to make such a judgment or what the proper steps in such an analysis are. Thus, a knowledge of the facts and logic upon which the doctor bases a conclusion is highly unlikely to change the result of a commitment hearing.

It would seem obvious, then, that the proper way to attack the problem arising from the "unimpeachable" position of psychiatrists is to attack their credibility in the same manner that expert witnesses are "impeached" in other types of legal proceedings, namely, through use of opposing experts.²¹⁵ As in all cases involving the "battle of experts," the trier of fact would simply determine which expert is the more credible. Such an approach resolves a number of other problems often cited as stumbling blocks to fair hearings on the questions of "dangerousness" and disability. First, it alleviates, to a great extent, difficulties of communication.²¹⁶ Attorneys no longer have to be the equivalents of practicing psychiatrists,²¹⁷ since they have experts of their own to guide them to the proper lines of questioning and to indicate areas where the opposing witness is weak or wrong. Analogies to automobile accident cases and medical malpractice actions are particularly appropriate here. Comparatively few attorneys are knowledgeable as engineers or as physicians, yet many are quite competent to try such actions. They are competent because they know how to *use* experts, not because they know what their experts know. Certainly, if attorneys can effectively confront neurosurgeons and automotive engineers, they should also be able to effectively impeach psychiatrists.

If this analysis is correct, then the basic conclusion must be that the role of the psychiatrist in a commitment hearing should be no different than the role played by any physician in any other type of legal proceeding. And if this is true, it is up to the attorney representing the patient to insure that the committing physician plays no role in excess of this. The only modification to LPS required to obtain this result in all cases is a provision which allows indigent patients to obtain psychiatric experts who will testify on the patient's behalf.²¹⁸ The

215. See, e.g., *Culpepper v. Volkswagon of America, Inc.*, 33 Cal. App. 3d 510, 109 Cal. Rptr. 110 (1973).

216. See text accompanying note 87 *supra*.

217. See note 255 *infra* and accompanying text.

218. LPS does not itself provide for the appointment of psychiatrists. There are, however, provisions in various parts of the California codes which could possibly be used for this purpose. See, e.g., CAL. EVID. CODE §§ 730-32 (West 1972), which allow courts to appoint expert witnesses.

rest of the solution is up to the patient's attorney.²¹⁹

E. Role of Counsel

The right to counsel in civil commitment proceedings is a statutory guarantee in most jurisdictions.²²⁰ In addition, there is a growing recognition that this legislative policy should be elevated to a constitutional right.²²¹ For example, in *Heryford v. Parker*²²² the Tenth Circuit relied on the Supreme Court's analysis in *In re Gault*²²³ to find a constitutional right to counsel in civil commitment hearings.²²⁴ *Gault* extended the right to counsel,²²⁵ the privilege against self-incrimination,²²⁶ the right to a judicial hearing,²²⁷ and the right to cross-examine witnesses²²⁸ to juveniles in delinquency proceedings. These rights were accorded even though such proceedings are deemed civil rather than criminal in nature.²²⁹ The *Heryford* court recognized that, like *Gault*, civil commitment involves a situation in which an individual's liberty is at stake.²³⁰ "It matters not whether the proceedings be labeled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency."²³¹

The right to be represented by counsel is included within the California commitment statute²³² and the patient must be informed of this right.²³³ In *Thorn v. Superior Court*,²³⁴ the California supreme court

219. See notes 220-60 *infra* and accompanying text.

220. ARIZONA PROJECT, *supra* note 8, at 32.

221. *Id.* See also *People ex rel. Woodall v. Bigelow*, 285 N.Y.S.2d 85, 231 N.E.2d 777 (1967).

222. 396 F.2d 393 (10th Cir. 1968).

223. 387 U.S. 1 (1966).

224. It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process. Where, as in both proceedings for juveniles and mentally deficient persons, the state undertakes to act in *parens patriae*, it has the inescapable duty to vouchsafe due process, and this necessarily includes the duty to see that a subject of an involuntary commitment proceeding is afforded the opportunity to the guiding hand of legal counsel at every step of the proceeding, unless effectively waived by one authorized to act in his behalf.

396 F.2d at 396.

225. 387 U.S. at 41.

226. *Id.* at 55.

227. *Id.* at 33.

228. *Id.* at 56-57.

229. *Id.* at 30.

230. 396 F.2d at 396.

231. *Id.*

232. CAL. WELF. & INST'NS CODE ANN. § 5276 (West 1972).

233. *Id.* § 5252.1

upheld a superior court order that the legal staff of a nonprofit corporation, established to provide legal services to indigents in San Diego County, visit all persons detained for intensive psychiatric treatment under the provisions of the LPS.²³⁵ The right to counsel was thus extended to patients even if they had not specifically requested counsel. Noting that the circumstances of confinement create difficult problems, the court stressed the importance of assuring "that the patient's rights receive meaningful protection."²³⁶ Many of these individuals lack the capacity to understand the rights that are provided them, and as a result, it is necessary for the courts to set forth particular procedures to guard these rights.²³⁷ In approving the procedure used by the superior court in *Thorn*, the court did not establish any specific requirements for other courts to follow.²³⁸ The court did note, however, some suggestions offered by the Citizens Advisory Council created by the Short-Doyle Act:²³⁹

(1) that the certificated person be provided with counsel at the time he receives written notice of certification under section 5252; (2) that counsel or some other third person not connected with the treatment facility be present at the time the patient's right to a hearing is explained to him; (3) that a third party—the patient's attorney, the public defender, or the mental health counselor—visit the patient immediately after the notice of certification is submitted to the court and other parties as required by section 5253.²⁴⁰

The court concluded that any of the suggested procedures would provide the patient with adequate protection, but declined to establish any rigid rules.²⁴¹

234. 1 Cal. 3d 666, 464 P.2d 56, 83 Cal. Rptr. 600 (1970).

235. *Id.* at 676, 464 P.2d at 61, 83 Cal. Rptr. at 605.

236. *Id.* at 675, 464 P.2d at 62, 83 Cal. Rptr. at 606.

237. *Id.*

238. [I]t would appear that any one of the suggested procedures [see text accompanying notes 169-74 *supra*] would provide adequate protection to the patient in any particular case, and that this court should not undertake to lay down rigid rules on the subject, but instead should only suggest ground rules which . . . will provide guidelines to those charged with carrying out the provisions of the LPS Act.

Id. at 676, 464 P.2d at 63, 83 Cal. Rptr. at 607.

239. CAL. WELF. & INST'NS CODE ANN. § 5763 (West 1972) creates a Citizens Advisory Council of 15 citizens, including mental health professionals, who are appointed by the Governor, the President of the Senate, the Chairman of the Senate Rules Committee, and the Speaker of the Assembly. The Council filed an amicus brief in *Thorn*. 1 Cal. 3d at 674 n.8, 464 P.2d at 62 n.8, 83 Cal. Rptr. at 606 n.8.

240. 1 Cal. 3d at 675-76, 464 P.2d at 62-63, 83 Cal. Rptr. at 606-07 (footnotes omitted).

241. *Id.* at 676, 464 P.2d at 63, 83 Cal. Rptr. at 607.

While the "right to counsel" is thus firmly established both in California and other jurisdictions, the question of the role to be played by counsel is unresolved. Regrettably, the simple presence of counsel cannot be equated with "effective" counsel. Bruce J. Ennis, of the New York Civil Liberties Union, told the Senate Subcommittee on Constitutional Rights that "assigned lawyers [for mental patients] are frequently worthless."²⁴²

The role attorneys actually play in the commitment hearing is indeed disturbing.²⁴³ Most people would expect an attorney to take an active part in any legal proceeding, but this is not always the case in the civil commitment process.²⁴⁴ Many hearings give the impression of being merely a "rubber stamp" of the psychiatrist's decision, and not a true adversary process.²⁴⁵ One indicator of this is the length of the proceedings. The shorter the hearing, the less time spent questioning the medical recommendation.²⁴⁶ From the psychiatrist's point of view this procedure is less harmful to the patient than a long judicial proceeding which could be anti-therapeutic.²⁴⁷

242. Statement of Bruce Ennis in 1969-70 *Hearings, supra* note 66, at 286. *But see* Wenger & Fletcher, *supra* note 10. These authors indicate that there is evidence that the simple presence of an attorney at the hearing may be an asset to the patient. One study of one hundred admissions at a midwestern state hospital showed a high correlation (.942) between the presence of an attorney and the decision not to commit a person to the hospital. This is inconclusive, as it is possible, in light of other evidence on the role of counsel, that the mere presence of counsel was not the only variable. It is conceivable that individuals who would normally be judged legally sane would be more likely to secure the assistance of legal counsel. This is very probable when one considers the fact that the court went along with the psychiatrist's recommendation in virtually all cases, thus seeming to indicate that the lawyer had little real effect on the outcome. *Id.* at 66-72.

243. Of course, the attorney may also play an interesting and important role outside the hearing room in terms of counseling the client and in terms of investigation. *See* ARIZONA PROJECT, *supra* note 8, at 55.

244. A study of commitment hearings in Arizona indicates the following conclusions about court appointed lawyers functioning in this area of the law:

It appears from the data that not even the most elementary legal questions are explored, such as (1) whether the decision to commit is to be based on dangerousness to self or to the person or property of others; (2) whether there is any real factual basis for such a conclusion; (3) whether possible alternatives to involuntary commitment exist or have ever been explored; (4) whether medical examinations were thorough . . .; and (5) whether the doctor's recommendation is based on factual or conclusory data.

Id. at 54.

245. *Id.* at 38-60.

246. In a case study made in Travis County, Texas, the attorney asked no questions of the psychiatrists. He did not study the court files to determine if proper notice had been given. Forty patients were committed at a hearing where the role of the attorney was largely ceremonial. Taylor, *A Critical Look Into the Involuntary Civil Commitment Procedure*, 10 WASHBURN L.J. 237, 256-57 (1971).

247. *See* Wegner & Fletcher, *supra* note 10, at 66.

Often the psychiatrist is asked to state an opinion, and the defendant is pronounced mentally ill without additional questioning. After a few minutes in court, the patient is taken away to an institution. In one study of commitments before a mental health commission, the average length of the hearings was 4.7 minutes, with some being less than three.²⁴⁸ Another study showed the average length at 8.13 minutes, the median at 5.3 minutes, and the range from 0.45 minutes to almost 45 minutes.²⁴⁹ One patient had not even been examined by a psychiatrist prior to his hearing, yet the proceeding lasted only 4.5 minutes.²⁵⁰

Various explanations for this situation have been advanced by commentators on the subject. One is that attorneys worry that their position as leaders in the courtroom might become subordinate to that of the psychiatrists.²⁵¹ Psychiatrists in turn tend to feel that this is essentially a medical area and dislike the intrusion of the law into the psychiatric field.²⁵² The conflict between the two professions is then negotiated into an uneasy peace where lawyers appear to play the major role in the courtroom while the actual show is being directed by the psychiatrists.²⁵³ This trade-off between the two professions allows the hearing to go smoothly, with the appearance of all the legal safeguards, and still nothing prevents the patient from receiving "necessary" hospitalization.

This explanation is unsatisfying. If it is true, civil commitment is the only area where attorneys ever allow another profession to control courtroom proceedings. Again, analogies to medical malpractice actions and tort cases involving automobile accident reconstruction are instructive.²⁵⁴ That the physician and engineer feel that they are better equipped to decide an issue does not seem to inhibit attorneys from completely dominating trial proceedings.

Another explanation which has been advanced is that lawyers are just beginning to receive adequate training in this area of the law,²⁵⁵ perhaps because it is still considered by many to be primarily a medical problem. Often the phrasing of the issues in medical terms will

248. ARIZONA PROJECT, *supra* note 8, at 38-39.

249. Wenger & Fletcher, *supra* note 10, at 69.

250. *Id.* at 68 n.5.

251. "Psychiatric and legal professions compete in their claims to expertise and decision-making authority regarding hospital commitment." *Id.* at 67.

252. *Id.* at 66-68.

253. *Id.* at 68.

254. See text accompanying note 212 *supra*.

255. See ARIZONA PROJECT, *supra* note 8, at 34; Dershowitz, *supra* note 11, at 21.

"frighten—or bore—lawyers away."²⁵⁶ This contention is as unacceptable as the "protection of identity" argument, and for similar reasons. Few attorneys have training in neurosurgery, internal medicine, automotive engineering, or a host of other subjects which are the bases of actions brought and prosecuted daily by scores of lawyers. There is no obvious reason why psychiatric medicine should be any more "frightening" or require any more "training" than the other areas with which attorneys constantly grapple.

The only explanation which seems to fit the available data is that attorneys most often agree with the psychiatrist that the person should be committed and therefore do not offer the type of "defense" one would expect in a normal legal proceeding. This is strikingly demonstrated by a case in which the attorney for the client took the stand during the commitment hearing and testified that his client should be committed.²⁵⁷ If attorneys in fact acquiesce to psychiatric judgments because the attorneys agree with them, then the underlying problem in all civil commitment proceedings is basically to define the duties an attorney owes to the client. Should attorneys "roll over and play dead" when they agree with the psychiatrist? Or should they, as in criminal cases, assume that it is their duty to force the "prosecution" to prove its case irrespective of the persons' actual mental condition or the attorneys' personal conclusions about the merits of the psychiatric conclusions? Or is there perhaps some more neutral ground which should be taken, such as simply ensuring that the psychiatrist's suggested treatment is the least restrictive but still useful alternative? For instance, the attorney might believe that a conservator should be appointed, but that commitment is not necessary,²⁵⁸ and would then oppose commitment, but would accede to the appointment of a conservator without argument.

It would seem that if the object of civil commitment is to insure that only those persons who actually need institutionalization are in fact committed, then the only real choice is for the attorney to approach a civil commitment proceeding as one would approach a criminal proceeding. The attorney must force the persons who are trying to commit the client to *prove* their case, as that term is understood in other proceedings, or one is simply not fulfilling necessary obligations to the

256. Dershowitz, *supra* note 11, at 21.

257. ARIZONA PROJECT, *supra* note 8, at 53.

258. See notes 48-50 *supra* and accompanying text. See also *In re Basso*, 299 F.2d 933 (D.C. Cir. 1962); *Mazza v. Pechacek*, 233 F.2d 666 (D.C. Cir. 1956); *Prochaska v. Brinegan*, 102 N.W.2d 870 (Iowa 1960); *Hussman v. Hursh*, 92 N.W.2d 673 (Minn. 1958); *In re Moynihan*, 62 S.W.2d 410 (Mo. 1933).

client; instead of representing them, the lawyer has become a mere adjunct to the client's adversaries.

As might be expected, LPS does not address itself to this problem, nor is it likely that it is a problem which lends itself to statutory solution. While it would be possible to add some statement of the lawyer's duties to the Code of Professional Responsibility,²⁵⁹ the only satisfactory method of remedying the situation would appear to be widespread educational efforts to inculcate attorneys with the same feeling toward the mentally ill that they presently have toward those accused of crimes.²⁶⁰ For the present, one can only conclude that the attitude of the bar toward mental commitment hearings reflects a disquieting lack of confidence in the effectiveness of the adversary system.

CONCLUSION

When it first became law, LPS was both hailed and criticized.²⁶¹ Some marked it as a breakthrough that would guarantee the mentally ill much deserved constitutional rights; others regarded it as an impediment to needed treatment and a threat to the safety of the community. In the area of providing treatment, the conclusions of the *ENKI Report* indicate that the legislation has not had the negative effect on therapy forecast by critics. Nevertheless, LPS in some ways has failed to live up to the predictions that it would provide effective guarantees of constitutional rights. Specific procedures are still lacking to insure that involuntarily incarcerated individuals receive the guiding hand of effective counsel; the definitional standards, while certainly more specific than those of other jurisdictions, are still so vague that the psychiatrist can manipulate them to assure that the individual will receive the benefits of "needed hospitalization"; and prevailing community attitudes cause people to resort to the criminal justice system as an alternative to civil commitment.

In the area of the right to treatment, there is considerable question as to whether hospitalization is the best alternative for most mentally ill individuals. Case law, as well as medical research, is still inconclusive as to the nature of adequate treatment. Nevertheless, attorneys

259. ABA CODE OF PROFESSIONAL RESPONSIBILITY (1969).

260. Recent evidence indicates that some attorneys are developing this attitude. See *ENKI REPORT*, *supra* note 20: "In many cases the writ [of habeas corpus] was granted because public defenders began requiring that treatment staff testify in court. . . ." *Id.* at 181.

261. See generally Bazelon, *supra* note 20 (in support of LPS); Fuller, *supra* note 20 (questioning LPS); Abramson, *supra* note 15 (highly critical of LPS).

for the mentally ill should be prepared to explore alternatives to hospitalization where such alternatives are realistic.

Civil commitment in California continues to be a confrontation between the legal and medical professions. To be sure, society may have an obligation to insure that every individual receive necessary medical treatment, and it certainly has a right to protect itself from dangerous individuals. But whenever individuals face the possibility of being deprived of their liberty, society should assume the responsibility to provide a truly adversary proceeding with all of the due process protections inherent in the criminal justice system.²⁶² The psychiatrist must not be allowed to remain in the position of an "unimpeachable expert." As long as the law considers commitment to be a legal proceeding, the issues raised are ultimately legal, not medical. It is for the bar to develop a body of attorneys who are trained in this area of the law and who are capable of providing effective legal assistance to mentally ill individuals.

But most importantly, the bar must develop an approach to the commitment of the mentally ill similar to that taken in the criminal area. Attorneys must treat the mentally ill as clients whose rights are endangered by the process of commitment, and who deserve the best possible defense. This would automatically lessen the impact of other weaknesses in LPS and other problems associated with civil commitment in general. First, it would force the committing psychiatrist back into the role normally played by physicians testifying in lawsuits, *i.e.*, they would become mere expert witnesses, whose testimony is to be impeached not only through cross examination, but also through rebuttal testimony from other psychiatrists. The vagueness of the definitional standards becomes less important also, since careful rebuttal testimony should be able to point out this very vagueness to the trier of fact, who would then become aware, as is apparently not the case at present, that the committing psychiatrist may be manipulating the standards to reach what is believed to be a desirable result.

The California experiment does provide a good working model for other jurisdictions to emulate and perhaps improve upon. As Judge

262. *But see* Statement of William J. Curran, Professor of Law, Boston University, in *1969-70 Hearings*, *supra* note 66, at 26:

In the past 100 years mental illness has been far the most legally regulated sickness in the United States. In spite of all this, there is little evidence that this legal attention has done mental patients much good. Law and government have played "Big Brother is watching you" with the mentally ill for a century. Another approach may now be advisable. Less law rather than more may be the answer for the future.

Bazelon indicates, however, "Only experience will reveal whether California can truly end involuntary commitments as a principal response to mental illness, and avoid the potential sequelae of voluntary commitments which are the product of subtle coercion."²⁶³ If nothing else, California has abandoned attempts to resolve the problem of the mental patient by telling the inquiring mind to "Ask your mother."

*The surest test if a man be sane
Is if he accepts life whole, as it is,
Without needing by measure or touch to understand
The measureless untouchable source
Of its images,
The measureless untouchable source
Of its substances,
The source which, while it appears dark emptiness,
Brims with a quick force
Farthest away
And yet nearest at Hand
From oldest time unto this day,
Changing its images with origin:
What more need I know of the origin
Than this?*

—Lao Tzu²⁶⁴

Mark Alan Hart

263. Bazelon, *supra* note 20, at 108.

264. LAO TZU, *THE WAY OF LIFE* 37 (W. Bynner trans. 1962).