Critique of the American Psychiatric Association’s Guidelines for State Legislation on Civil Commitment of the Mentally Ill

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I. INTRODUCTION

“Civil commitment” is a form of non-criminal confinement for persons who are judicially found mentally ill.¹

The average daily census of the people committed in state and county mental hospitals, has decreased from 560,000 in 1955 to 276,000 in 1972, to 138,000 in 1981.² There are estimates that three³ to five⁴ million people in the United States suffer severe mental disorders.

The American Psychiatric Association (APA) began work on a proposal concerning civil commitment in the mid-1970’s.⁵ This task was apparently renewed in 1980 through the effort of the APA’s Council on

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1. See BLACK'S LAW DICTIONARY 222-23 (5th ed. 1979). See also T. SzaSZ, LAW, LIBERTY AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES 39 (1963). (“Commitment is compulsory or involuntary detention of a person in an institution designated as a mental hospital.”).


Governmental Policy and Law. Acceptance of the *Guidelines for Legislation on the Psychiatric Hospitalization of Adults* [hereinafter the *Guidelines*] by the APA's Assembly occurred on October 31, 1982, while the APA's Board of Trustees indicated its approval on December 4, 1982. A commentary to these *Guidelines* written by Stromberg and Stone, has been published, as well as a brief and disapproving summary analysis written by Rubenstein. Stromberg and Stone suggest that the *Guidelines* represent "the views of our nation's psychiatrists." They conclude somewhat defensively: "But [the *Guidelines*]
should not be dismissed as an effort simply to advance the narrow interests of psychiatrists. [The Guidelines do] not seek to return complete discretion to psychiatrists or to dispense with countervailing legal safeguards."'11

Stromberg and Stone observe that civil commitment of the mentally disabled has been the target for "unceasing" legislative and judicial activity in the past ten years.12 "Lax" involuntary commitment processes, and warehousing of persons in large "total institutions"13 for extensive periods of time without effective treatment, are identified as first generation problems.14 The answers to these problems have included reforms in conditions of institutions, deinstitutionalization to community services, and the limiting of legal commitment to the more dangerous patients. The issues driving the metamorphosis in state commitment laws have included: individual mental patient rights to treatment,15 to refuse (to consent to) treatment,16 and to the least restrictive alterna-

11. Stromberg & Stone, supra note 2, at 279.
12. Id. at 277.
15. See Youngberg v. Romeo, 457 U.S. 307, 325 (Blackmun, J., concurring) (if the question of whether an involuntarily committed mentally disabled person has a constitutional right to treatment was properly presented to the Court, "there would be a serious issue whether, as a matter of due process, the State could so refuse"); W. Schmid, The Right to Treatment in Mental Health Law (1976); Spece, Justifying Invigorated Scrutiny in the Least Restrictive Alternative as a Superior Form of Intermediate Review: Civil Commitment and the Right to Treatment as a Case Study, 21 ARIZ. L. REV. 1049 (1979); Spece, Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories, 20 ARIZ. L. REV. 1 (1978). But see Youngberg, 457 U.S. at 330 n* (Burger, C.J., concurring) (characterizing respondent's substantive due process claim that a state right to treatment creates a federal right as "obviously frivolous"); O'Connor v. Donaldson, 422 U.S. 563, 588-89 (Burger, C.J., concurring) (1975) ("few things would be more fraught with peril than to irrevocably condition a State's power to protect the mentally ill upon the providing of [a right to treatment]"); Katz, The Right to Treatment—An Enchanting Legal Fiction?, 36 U. CHI. L. REV. 755 (1969).
tive (placement and treatment). Stromberg and Stone suggest that these necessary reforms have stimulated a second generation of similarly formidable problems. The new problems are: “abandonment of severely ill persons, custodial care without treatment for patients who refuse treatment, conversion of mental hospitals into jails, failure to protect society, frequent lawsuits against mental health professionals, and continuing confusion about the goals of civil commitment.”

Involuntary civil commitment has served three recognized social functions: the police power function of protecting society, the parens patriae function of individual protection and guardianship, and custodia


18. Stromberg & Stone, supra note 2, at 275.

19. Id.

20. Parens patriae refers to the alleged authority of a sovereign to act as “the general guardian of all infants, idiots and lunatics.” Hawaii v. Standard Oil Co. of California, 405 U.S. 251, 257 (1972) (quoting 3 W. BLACKSTONE, COMMENTARIES *47). According to one commentator, “[a]lthough the doctrine could easily have stemmed from simple necessity and been justified by legal logic, English judges, wedded to the concept of stare decisis, chose instead to find their precedent in a seventeenth-century printer’s error.” Custer, The Origins of the Doctrine of “Parens Patriae”, 27 Emory L.J. 195 (1978). Another commentator concludes:

The concept of parens patriae has exhibited a remarkable staying power. Rebuked in one branch of the law, it makes its appearance in another; even when circumscribed, it remains actively viable within its new limits. Because it is uninhibited by a strict conceptual of precedential definition, this theory imparts an extensive discretionary power to the court, agency, or government which is able to justify its usage.


The Latin phrase [parens patriae] proved to be great help to those who sought to rationalize the exclusion of juveniles from the constitutional scheme; but its meaning is murky and its historic credentials are of dubious relevance. The phrase was taken from chancery practice, where, however, it was used to describe the power of the state to act in loco parentis for pro-
todial confinement. As of 1975, custodial confinement alone is no longer a constitutionally permissible function of civil commitment. The Guidelines suggest an approach to civil commitment that increases the parens patriae function while limiting the police power function.

This critique will review the improvements contained in the Guidelines; assess the most significant and problematic recommendations, note several additional deficiencies, gauge the likely outcomes, effects, and impacts should the Guidelines be implemented, briefly note alternative civil commitment models, and conclude with personal recommendations concerning civil commitment.

II. IMPROVEMENTS

A. Definition of “severe mental disorder”

The Guidelines limit the threshold criterion for involuntary commitment to “severe mental disorder,” defined as an illness, disease, organic brain disorder, or other condition that (1) substantially impairs the person’s thought, perception of reality, emotional process, or judg-

22. O’Connor, 422 U.S. at 576 (“a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends”). The respondent, Kenneth Donaldson, was confined in Florida State Hospital for 15 years with no more than custodial care.
23. Stromberg & Stone, supra note 2, at 280-81.
ment or (2) substantially impairs behavior as manifested by recent disturbed behavior. Mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder.”24 (emphasis added). Stromberg and Stone suggest that “severe

24. Guidelines, supra note 5, at 673; Stromberg & Stone, supra note 2, at 312. Cf. Mental Health Law Project, supra note 7, at 133:

'Severe Mental Disorder' means a severe impairment of emotional processes, ability to exercise conscious control of one's actions or ability to perceive reality or to reason or understand, which impairment is manifested by instances of grossly disturbed behavior or faulty perceptions; it does not include (a) epilepsy; (b) mental retardation; (c) brief periods of intoxication caused by substances such as alcohol or drugs; (d) dependence upon or addiction to any substances such as alcohol or drugs. (emphasis added)

The Mental Health Law Project, supra note 7, at 127. This suggested statute on civil commitment represents a "legal model" of involuntary commitment and provides a good context and comparison for the "medical model" in the APA Guidelines. Note the requirement of both "severe" impairment and gross behavior or perceptions. But see Morse, supra note 4, at 59-67 (arguing that mentally disordered persons should not be legally distinguishable from normal persons); Note, Mental Illness: A Suspect Classification?, 83 YALE L.J. 1237 (1974). The suspect class theory was apparently adopted in Town Court Nursing Center, Inc. v. Beal, 586 F.2d 280, 283, 289 (3d Cir. 1978) (en banc) (Adams, J., concurring).


'Mentally ill' means an impairment of the emotional processes, of the ability to exercise conscious control of one's actions, or of the ability to perceive
mental disorder” corresponds to a psychotic disorder, although “other disorders” might meet the definition “[u]nder exacerbating circumstances.”

The Guidelines' definition of “severe mental disorder” raises the threshold for state involvement to serious mental conditions, avoids unsuitable vagueness, and describes mental dysfunctioning by several components (emotion, volition, cognition) that should be more understandable to lay persons.

B. Required criterion of “lacks capacity to make an informed decision concerning treatment”

The Guidelines make lack of “capacity to make an informed decision concerning treatment” a specific criterion for both parens patriae and police power commitments. While Stromberg and Stone characterize this across-the-board requirement as “somewhat novel,” at least five legislatures, an earlier model statute, and other commentators

reality or to understand, which impairment substantially interferes with a person’s ability to meet the ordinary demands of living, regardless of etiology; except that, for the purposes of this act, the term does not include retardation or developmental disability as defined in chapter 393, simple intoxication, or conditions manifested only by antisocial behavior or drug addiction.


'Mentally ill' means any person afflicted with mental disease to such extent that for his own welfare or the welfare of others, he requires care and treatment; provided that, for the purposes of Chapter 2 (§ 37.1-63 et. seq.) of this title, the term 'mentally ill' shall be deemed to include any person who is a drug addict or alcoholic.

25. Guidelines, supra note 5, at 674; Stromberg & Stone, supra note 2, at 330.

26. Stromberg & Stone, supra note 2, at 333.


28. Mental Health Law Project, supra note 7, at 141, 144 (provisions of suggested statute).

29. E.g., Livermore, Malmquist & Meehl, On the Justifications for Civil Commitment, 117 U. Pa. L. Rev. 75, 88-89 (1968); Mental Health Law Project, supra note 7, at 89-93 (incompetency may be a constitutionally required threshold criterion for parens patriae commitments); Roth, A Commitment Law for Patients, Doctors, and Lawyers, 136 Am. J. Psychiatry 1121 (1979); Schmidt, supra note 7, at 402-05, 429, 432-35; Note, Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation, 64
have suggested this requirement. Stromberg and Stone cite three federal courts (Alabama, Utah, Wisconsin), a state court (Pennsylvania), and five state statutes (Colorado, Hawaii, Kansas, Utah, Wyoming) that require lack of capacity for at least *parens patriae* commitments. A recent survey of the state involuntary commitment statutes reveals at least four additional states (Connecticut, Delaware, South Carolina, West Virginia) with such a lack of capacity criterion.

A lack of capacity criterion is necessary because, as Stromberg and Stone observe, "[m]any mental disorders do not impair a person's ability to assess his desire for hospitalization." Further, mentally disordered persons are probably not generally any more incompetent than normal persons. In sum:

> [T]he assertion that the crazy behavior of mentally disordered persons is compelled, in contrast to the freely chosen behavior of normal persons, is a belief that rests on common sense intuitions and not on scientific evidence. Indeed, the degree of lack of behavioral control necessary to justify involuntary commitment is fundamentally a moral, social, and legal question—not a scientific one. Social and behavioral scientists can only provide information about the pressures affecting an actor's freedom of choice. The law must determine for itself when the actor is no longer to be treated as autonomous.(citations omitted)

This is not to suggest ignoring the reality of some incapacity in some mentally disordered persons. Rather, "because the capability for rationality and self-control is distributed along a continuum, most men-

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30. Stromberg and Stone, supra note 2, at 333 nn. 193-94.
31. Beis, supra note 27.
34. Morse, supra note 4, at 60-61.
tally disordered persons meet the low threshold in these capacities necessary for freedom from involuntary state intrusion in a society that so highly values liberty.\textsuperscript{35}

The \textit{Guidelines} incapacity criterion heeds such policy concerns on its face.\textsuperscript{36} A difficulty is that the real motive for such a criterion seems to be the desire to abrogate the emerging right to refuse treatment.\textsuperscript{37} Such an annulment is manifest in the \textit{Guidelines} definition for "lacks capacity."\textsuperscript{38}

C. Required criterion of treatability

For a person to be involuntarily committed under the \textit{Guidelines}, the court must determine that "there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed."\textsuperscript{39} Treatability reflects both legal\textsuperscript{40} and policy\textsuperscript{41} considerations.

\begin{quote}
\textsuperscript{35} \textit{Id.} at 62 n.29. The constitutional threshold is the survival standard announced in \textit{O'Connor}, 422 U.S. at 576.
\textsuperscript{36} Rubenstein, \textit{supra} note 9, at 559.
\textsuperscript{38} Rubenstein, \textit{supra} note 9, at 560. The \textit{Guidelines} definition is:

\begin{quote}
Lacks capacity to make an informed decision concerning treatment means that the person, by reason of his mental disorder or condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decision-making process regarding such hospitalization or treatment, as evidenced by inability to weigh the possible risks and benefits.
\end{quote}

\textit{Guidelines, supra} note 5, at 673.
\textsuperscript{39} \textit{Guidelines, supra} note 5, at 674. \textit{Cf. Mental Health Law Project, supra} note 7, at 93-94, 143-44, 146 ("there is a substantial probability that treatment to be provided the respondent will significantly improve his mental condition").

Stromberg and Stone maintain that "all treatment facilities should meet the standards of the Joint Commission on Accreditation of Hospitals (JCAH)," and "that if a treatment facility cannot meet accreditation standards, there is serious doubt as to whether it can provide the quality of treatment needed to justify \textit{parens patriae} confinement 'for the patient's own good.'" Stromberg \& Stone, \textit{supra} note 2, at 315 n.129. Accord B. \textit{Ennis} \& R. \textit{Emery}, \textit{The Rights of Mental Patients} 167 n.98 (1978) [hereinafter cited as B. \textit{Ennis} \& R. \textit{Emery}].

A recommitment criterion is "that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment." \textit{Guidelines, supra} note 5, at 677.
\textsuperscript{40} \textit{See In re} Ballay, 482 F.2d 648, 659 (D.C. Cir. 1973) ("Without some form of treatment[,] the state[s]' justification for acting as \textit{parens patriae} becomes a nullity."); Wyatt v. \textit{Stickney}, 325 F. Supp. 781, 784 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373, 387 (M.D. Ala. 1972), \textit{aff'd sub nom.} Wyatt v. \textit{Aderholt}, 503 F.2d 1305, 1308 (5th Cir. 1974) (involuntary patient has a right to treatment that affords "a realistic opportunity to be cured or to improve his or her mental condition"). \textit{Cf. Jackson} \& \textit{Indiana}, 406 U.S. 715 (1972) (confinement of nontreatable person as incompetent to stand
A criterion of treatability for involuntary commitment is theoretically noncontroversial, yet only a few states have such a criterion for commitment. To prevent commitment for treatment from being a "charade," or "quasi-medical window-dressing" for criminal preventive detention, a treatability criterion is imperative.

D. Criterion of admission refusal

An improvement specifically unremarked upon by either Rubenstein or the other principal model statutes is another Guidelines criterion for commitment that "the person either refuses or is unable to consent to voluntary admission for treatment." Stromberg and Stone suggest that "the practical and therapeutic advantages to voluntary admission make consent to admission a meaningful patient right." Chief Justice Burger has observed that "it is universally recognized as fundamental to effective therapy that the patient acknowledge his illness and cooperate with those attempting to give treatment." At least seven state legislatures and the courts of three states are in accord with such an involuntary admission requirement.

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41. See Morse, supra note 4, at 79-87 ("The State Will Not Provide Adequate Care and Treatment to Involuntarily Committed Persons"; "Hospitalization Is Not Necessary for the Efficacious Treatment of the Vast Majority of Involuntarily Committed Patients"); Stromberg & Stone, supra note 2, at 281, 334 ("preventive detention under a therapeutic guise . . . is both bad law and bad medicine"; "If a violent person is not severely mentally ill or if treatment will not help him, the person should be dealt with by the criminal justice system or by other social institutions (e.g., guardianship); "The criminal justice system should bear the primary responsibility for protecting society against dangerous but competent persons; such people do not usually belong in mental hospitals.")

42. The practical difficulty, of course, is financial. Morse, supra note 4, at 79-84.
44. Stromberg & Stone, supra note 2, at 336 n.201.
45. Id. at 281.
46. Rubenstein, supra note 9.
47. Mental Health Law Project, supra note 7.
48. Guidelines, supra note 5, at 674.
49. Stromberg & Stone, supra note 2, at 333.
50. O'Connor, 422 U.S. at 584 (Burger, C.J., concurring). Chief Justice Burger adds that "the failure of a large proportion of mentally ill persons to do so [acknowledge and cooperate] is a common phenomenon." Id.
One author notes that treatment will be enhanced if it is voluntary, that there is a nationwide preference for voluntary services, and that a purely voluntary scheme will result in more efficient use of limited mental health resources.52

Providing refusal of voluntary commitment as a criterion for involuntary commitment should provide an incentive to voluntary admission for treatment. Attorneys for persons facing involuntary commitment might also use this criterion as one of the easier means to avoid inappropriate involuntary commitment for their clients.53

refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment”). See also Fla. Stat. Ann. § 394.463(1)(b) (West 1983) (criterion for involuntary examination: “He has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination”).

52. Morse, supra note 4, at 102-03, citing, e.g., Wexler, Foreward: Mental Health Law and the Movement Toward Voluntary Treatment, 62 Calif. L. Rev. 671, 675-92 (1974); Steinglass, Grantham & Hertzman, Predicting Which Patients Will Be Discharged Against Medical Advice: A Pilot Study, 137 Am. J. Psychiatry 1385 (1980) (patient and staff differences about “therapeutic contract” is valid predictor of patients discharged against medical advice). Morse concludes:

If the treating professional is entirely the patient’s agent and is not perceived also as an agent of the state, the therapeutic alliance and the ameliorative influence of the therapist’s authority will surely be strengthened. If treatments are offered in a respectful and caring fashion and costs (e.g., side effects?) are explained clearly and patiently to the disordered person, one can expect much less resistance to treatment and the optimum chance for therapeutic gain. This type of behavior may take a lot of time, but it is nothing more than the preferred, traditional, voluntary, contractual mode of treatment initiation.

Morse, supra note 4, at 102-03.

53. See A. Brooks, Law, Psychiatry and the Mental Health System 115-16 (1980 Supp.) (citing a public defender who prevents involuntary commitment in 98% of cases, 17% becoming voluntary patients). But see In re Byrd, 68 Ill. App. 3d 849, 854, 386 N.E. 2d 385, 389 (1979) (“voluntary” admission not approved if a ruse to permit discharge at any time). In most states, even a “voluntary” patient can be involuntarily held for purposes of initiating involuntary commitment, and the like. Beis, State Voluntary Civil Commitment Statutes, 7 Mental Disability L. Rep. 430 (1983) (13 states do not have some provision for continuing to hold “voluntary” patients after request for discharge: Alabama, California, Colorado, Indiana, Kentucky, Maine, Nevada, New Hampshire, New York, North Dakota, Ohio, South Carolina, West Virginia). Accord Guidelines, supra note 5, at 674 (must be discharged within five business days of request).

Concerning the right to effective counsel in civil commitment, see, e.g., State ex rel. Memmel v. Mundy, 75 Wis. 2d 276, 249 N.W.2d 573 (1977); Andalman & Chambers, Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic and a Proposal, 45 Miss. L.J. 43 (1974); Litwack, The Role of Counsel in Civil Commitment Proceedings: Emerging Problems, 62 Calif. L. Rev. 816 (1974); Preparation and Trial of a Civil Commitment Case, 5 Mental Disability L. Rep. 201-10, 224, 281-95 (1981); Note, The Role of Counsel in the Civil Commitment Process: A Theoretical Framework, 84
E. Rejection of open-ended commitment duration

The Guidelines provide that a person may be involuntarily committed on an emergency evaluation and treatment basis for up to fourteen days, with successive thirty and sixty-day commitment periods preceding a potentially indefinite number of 180-day recommitments. While a majority in the assembly of the APA endorsed this proposal, Stromberg and Stone believe it "unwise." Stromberg and Stone believe that parens patriae commitments should end after about 104-days (fourteen day evaluation and treatment, thirty and sixty-day commitment). They cite clinical research showing effective treatment within such a limit "for the vast majority of committed patients who can be treated." Their conclusion is that society should give patients a chance on their own at some point.

F. Right to jury trial

Stromberg and Stone also differ with the assembly of the APA on the issue of a jury trial for people facing involuntary commitment.


54. Guidelines, supra note 5, at 674-75, 677. But cf. Mental Health Law Project, supra note 7, at 147:

[N]o person may be civilly committed for a continuous period of more than 197 days on grounds of danger to others (72 hours of evaluation, 14-day commitment, a 90-day period of extended commitment and a 90-day period of further extended commitment) or 31 days on grounds of danger to self (72-hour evaluation plus two 14-day commitments, assuming the optional section for renewals of 14-day commitments is enacted.)

California's experience with its 1969 law, providing the shorter period of 72-hours evaluation and two 14-day commitments for suicidal persons, showed over two years that less than one percent of the cases required the second commitment, and that no one committed suicide during six months after release compared with three percent under the old law. ENKI, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1971) 152 (1972). There is a lack of substantial evidence that mental health services successfully prevent suicides. Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide, 49 N.Y.U. L. Rev. 227, 256 (1974); Light, Treating Suicide: The Illusions of a Professional Movement, 25 Int'l Soc. Sci. J. 475, 482-84 (1973). There is some evidence that involuntary treatment may increase the rate of suicide attempts. Greenberg, supra at 236, 250, 256-59. The President's Commission on Mental Health suggests a 48-hour commitment for suicide attempts. See Report of the Task Panel on Legal and Ethical Issues, supra note 7.

55. Stromberg & Stone, supra note 2, at 380.

56. Id.

57. Id. (citing Klerman, National Trends in Hospitalization, 30 Hosp. & Community Psychiatry 110 (1979)).

58. Id.
Stromberg and Stone believe jury trials are proper. While the constitutional question has not been resolved by the Supreme Court, Stromberg and Stone argue that juries inject community values into the decision making process, and that jury trials provide a better perception of citizen protection than the "credulously accepted...[public] view that psychiatrists coerce normal citizens into civil commitment, with the complicity of the courts." There are at least eighteen jurisdictions with a statutory right to a jury trial in civil commitment.

G. Immunity

The Guidelines provide that treatment facility employees will not be held liable for acts relating to the commitment process, unless such a person is responsible for "willful misconduct or gross negligence."
Stromberg and Stone suggest that the proposed standard is in accord with existing judicial and statutory provisions, assuming it is interpreted to include conduct that the psychiatrist should have known violated patient rights. This provision should militate against the otherwise inherent tendency to limit patient freedom by conservatively overpredicting rare dangerousness.

The Guidelines also recommend immunity for failure to warn potential victims concerning the admission or discharge status of a patient. While there should be policy to counteract a decision that holds therapists liable for predicting that which they cannot (i.e., future dangerousness), the debate seems unresolved and non-comprehensive.

In the absence of willful misconduct or gross negligence, no officer, director, staff member, or employee of a treatment facility shall be liable for acts or omissions within the scope of his employment related to admission, evaluation, care, treatment, nonadmission, transfer, removal or restrictions upon, or discharge of a person, pursuant to this Act.


65. E.g., O'Connor, 422 U.S. at 577 (whether a person “knew or reasonably should have known that the action he took within his sphere of official responsibility would violate the constitutional rights of . . . [the patient], or if he took the action with the malicious intention to cause a deprivation of constitutional rights or other injury to . . . [the patient]”). Id. (quoting Wood v. Stickland, 420 U.S. 308, 322 (1975)).

66. E.g., CAL. WELF. & INST. CODE §§ 5113, 5154, 5173, 5275, 5276, 5278, 5306 (West 1972); FLA. STAT. ANN. § 768.28(9) (West Supp. 1983).

67. Stromberg & Stone, supra note 2, at 393.

68. Mental Health Law Project, supra note 7, at 152.

69. Guidelines, supra note 5, at 678.


72. The Supreme Court has ruled that psychiatric predictions of future dangerousness, although empirically no more than 33% accurate, are admissible evidence at sentencing hearings in capital cases. Barefoot v. Estelle, 463 U.S. 880 (1983). While the APA filed an amicus brief opposing the eventual outcome in Barefoot, such acknowledgement of a lack of prediction expertise did not become organizationally widespread until psychia-
munity may be a poor prophylactic for a practice in which psychiatrists and psychologists at least ethically should not engage in any context. 73

III. ASSESSMENT AND CRITIQUE OF MOST SIGNIFICANT RECOMMENDED GUIDELINES

While the Guidelines (and if not the Guidelines, then Stromberg and Stone) make some positive recommendations for the general civil commitment process, it is evident that the APA is most interested in a more limited number of issues. An addendum to the Guidelines offers the opportunity “for states that do not wish to undertake a comprehensive revision of their civil commitment laws” 74 to add provisions allowing commitment of persons “likely to suffer substantial mental or physical deterioration.” 75 The issues highlighted in the addendum are more problematic than the comprehensive Guidelines. 76

A. Definition of “consistent with the least restrictive alternative principle”

The second part of the Guidelines treatability criterion for commitment specifies that any such commitment must be “consistent with the least restrictive alternative principle.” 77 The principle has been applied in a variety of constitutional contexts, 78 as well as to issues in civil

74. Guidelines, supra note 5, at 678.
75. Id.
76. Morse, though disagreeing, characterizes the Stone and Roth analyses, which evidently provide the bases for the Guidelines, as “marked by wisdom, honesty, compassion, and restraint.” Morse, supra note 4, at 88. Cf. A. Stone, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 65-69 (1975); Roth, supra note 29.
77. Guidelines, supra note 5, at 674. One of the earlier announcements of the least restrictive alternative principle came in Shelton v. Tucker, 364 U.S. 479 (1960):
[Even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.

364 U.S. at 488.

commitment.\textsuperscript{79}


But see, e.g., Pennhurst v. Halderman, 451 U.S. 1 (1981) (Federal Developmentally Disabled Assistance Program and Bill of Rights Act of 1975, 42 U.S.C. § 6000 et seq., does not create substantive rights to appropriate treatment in the least restrictive environment); State v. Sanchez, 80 N.M. 438, 457 P.2d 370 (1969), appeal dismissed for want of a substantial federal question, 396 U.S. 276 (1970). Pennhurst is essentially a narrowly decided statutory interpretation case, and has been criticized elsewhere, e.g., Schmidt, Deinstitutionalization Following "Pennhurst State School v. Halderman", 5 J. HEALTH & HUM. RESOURCES AD. 481 (1983). Until Pennhurst, 451 U.S. at 16 n.12 (citing Sanchez for the proposition that the Court has never found a constitutional right to treatment), Sanchez had been ignored by lower federal courts. Hoffman & Foust, supra note 17, at 1102 n.2 (citing Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974), and Welsch v. Likins, 373 F. Supp. 53 (E.D. Tex. 1974)). Sanchez had also been significantly ignored by the Supreme Court. See O'Connor, 422 U.S. at 575 ("while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends," citing Shelton v. Tucker, 364 U.S. at 488-90); accord B. ENNIS & R. EMERY, supra note 39, at 59-60 citing W. SCHMIDT, supra note 15, at 54 (Ennis argued O'Connor v. Donaldson for respondent Donaldson). Hoffman & Foust, supra note 17, at 1102 n.2, citing Burnham v. Depart-
The Guidelines definition is:

'Consistent with the least restrictive alternative principle' means that 1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, a setting in which treatment provides the patient with a realistic opportunity to improve and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient, and 2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.80

Stromberg and Stone suggest that the traditional (legal) least restrictive alternative principle ignores patient interests in getting well.81 This poses an alleged dilemma between restrictiveness and treatment effectiveness.82 What the Guidelines, and Stromberg and Stone, do not seem to appreciate is a person's opportunity to choose "preferring his home to the comforts of an institution"83 in analogous fashion to choosing medication over surgery, or walk-in surgery to in-patient care and convalescence, or dying over extraordinary treatment measures, even when legally incompetent.84 While Stromberg and Stone are sincerely concerned with the second generation problem of patient abandonment to "welfare hotels and alleys,"85 they seem to confuse their...
perceived psychiatrist's duty to treat effectively with a person's right to claim treatment in the least restrictive, but perhaps less effective, alternative. The Guidelines least restrictive alternative means "the most effective treatment," which, because the judge cannot order outpatient treatment, is a contemporary social choice of in-patient treatment. This renders the claimable right to effective mental treatment meaningless.

The Guidelines approach to the least restrictive alternative requires maximum effectiveness first, then less restrictiveness as behavior seems to merit. The correct approach is to make the most appropriate least restrictive placement first, and only become more restrictive as behavior warrants. Therefore, an alternative statutory definition is:

'Consistent with Least Drastic Means Principle' means that the mental health treatments and conditions of treatment for the respondent, separately and in combination, are (a) no more harsh, hazardous or intrusive than necessary to achieve acceptable treatment objectives for such client and (b) involve no restrictions on physical movement nor supervised residence or in-patient care except as reasonably necessary for the administration of treatment or for the protection of the client or others from physical injury. At least 10 studies, involving random assignment of seriously disordered patients to inpatient care or outpatient treatment, suggest that alternative outpatient care is more effective in promoting adaptation (employment, school attendance) in the community, and substantially less expense. Kiesler, Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients, 37 AM. PSYCHOLOGIST 349 (1982).


For proposed scales of intrusiveness and coerciveness, see Shapiro, Legislating the Control of Behavior Control: Autonomy and Coercive Use of Organic Therapies, 47 S. CAL. L. REV. 237 (1974); Note, Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients, 45 S. CAL. L. REV. 616, 619-33 (1972). See also Comment, supra note 82.
B. Involuntary commitment criterion of "likely to cause harm to himself or to suffer substantial mental or physical deterioration"

The Guidelines criteria for involuntary commitment longer than fourteen days includes clear and convincing evidence of: (1) severe mental disorder, (2) treatability and commitment "consistent with the least restrictive alternative principle," (3) refusal or inability to consent to admission, (4) incapacity "to make an informed decision concerning treatment," and (5) "as a result of the severe mental disorder, the person is (a) likely to cause harm to himself or to suffer substantial mental or physical deterioration or (b) likely to cause harm to others." The Guidelines definition for criterion (5)(a) is as follows:

'Likely to cause harm to himself or to suffer substantial mental or physical deterioration' means that, as evidenced by recent behavior, the person 1) is likely in the near future to inflict substantial physical injury upon himself, or 2) is substantially unable to provide for some of his basic needs, such as food, clothing, shelter, health, or safety or 3) will if not treated suffer or continue to suffer severe mental and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own."

The "distress and deterioration" criterion would likely have the greatest impact of the proposed criteria on existing civil commitment practices. It is aimed at the second generation of "large numbers of 'new chronic' patients who live in the community, but constantly face 'readmission,' alcohol abuse, suicidal propensities and ineffective treated schizophrenia. In every city, many severely impaired mentally ill people live in welfare hotels, flop houses, abandoned buildings, and alleys." The criterion is in many ways an ultimate manifestation of,

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92. See Addington v. Texas, 441 U.S. 418 (1978) (due process requires that the standard of proof to civilly commit a person to a state hospital for an indefinite period must be at least "clear and convincing"; the standard must functionally "inform the factfinder that the proof must be greater than the preponderance of the evidence standard applicable to other categories of civil cases"). According to Addington, three states have adopted the higher standard of "clear, cogent, and convincing" evidence, two states the higher standard of "clear, unequivocal, and convincing" evidence, and 14 states have adopted "beyond a reasonable doubt" as the standard of proof in civil commitment; 15 states, adding California, Conservatorship of Roulet, 23 Cal. 3d 219, 590 P.2d 1, 152 Cal. Rptr. 425 (1979).

93. Guidelines, supra note 5, at 674, 677.

94. Id. at 673.

95. The preoccupation with readmissions has been difficult to understand. There is a connotation of recidivism analogous to the criminal justice system, but little analogy to medicine where readmission lacks such stigma.

96. Stromberg & Stone, supra note 2, at 278.
and response to, the paternalistic rhetorical question directed to libertarian critics of involuntary commitment: "How real is the promise of individual autonomy for a confused person set adrift in a hostile world?"

The criterion will clearly result in more commitments, including improper commitments. Moreover, the important test of deterioration in previous functioning is relative rather than specific, and amounts to any mentally disabled person suffering "abnormal . . . distress" being committable "whenever a psychiatrist thinks a patient needs treatment" and can state, as evidenced by recent behavior, "that the person is not functioning as well as before."

Stromberg and Stone give several examples of cases eligible for commitment under the new criterion. "For example, a severely mentally ill 'bag lady' who scrounces sufficient food and clothes for her needs but who sleeps in city alleys and doorways might be committable because she cannot provide for her health or safety." Also, "[p]hysical distress caused by a mental illness (for example, intractable pain, or delirium tremens (D'Ts) associated with an alcoholic brain syndrome) could

97. Id. citing Bazelon, Institutionalization, Deinstitutionalization and the Adversary Process, 75 COLUM. L. REV. 897, 907 (1975). This mentally-unfree-to-be-free argument was also used in Addington v. Texas:

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

Id. at 429. The argument apparently ignores the fundamental legal presumption of competence (sanity).

But see O'Connor, 422 U.S. at 575 ("A finding of 'mental illness' alone cannot justify a State's locking up a person against his will and keeping him indefinitely in simple custodial confinement.").

98. See Durham & Pierce, Beyond Deinstitutionalization: A Commitment Law in Evolution, 33 Hosp. & COMMUNITY PSYCHIATRY 216 (1982) (involuntary commitment in Washington initially up 56.4%, i.e. by 412, total admissions up 12.2%, i.e. by 247, with addition of criterion providing for community dysfunctioning or deterioration); Rubenstein, supra note 9, at 560; Stromberg & Stone, supra note 2, at 278 n.12, 280-81, 335 (e.g., New York City's estimated 40,000 homeless mental patients); Durham, Pierce & Fisher, Legislative Policy and Resource Allocation in Involuntary Civil Commitment (unpublished manuscript) (voluntary admissions in Washington initially down 19.9%, i.e by 170, budget up $4,523,000, with addition of criterion).

99. Morse, supra note 4, at 90, 93 (discretionary and "dishonest" application; unacceptable and needless overcommitment).

100. Rubenstein, supra note 9, at 560. See Morse, supra note 4, at 89.

101. Stromberg & Stone, supra note 2, at 304.
It should be doubtful that such cases, or the proposed criterion, satisfy the survival standard for constitutional confinement of nondangerous persons established by the Supreme Court in O'Connor v. Donaldson, in the absence of meaningful implementation of the conjunctive treatability criterion.

As for the mentally-unfree-to-be-free argument, "[t]o claim that we care about the 'effective' liberty of crazy people but to be willing to ignore its lack in the lives of 'normals' simply exposes the hypocrisy of the involuntary commitment system." Why should the mentally disordered be singled out as a special class deserving attention, and treatment, for their illusory liberty? That many disabled people live in scandalous conditions is undeniable, but that civil commitment should therefore be used more "is both a breathtaking non-sequitur and cynical." The "distress and deterioration" criterion does not seem to be premised on the reality of public institutional services that are "considerably less than what is available in private institutions and no more than what is available in a community setting." This imprecise criterion returns discretion in involuntary commitment to individual psychiatrists, thus usurping what "is fundamentally a moral, social, and legal question—not a scientific one."

The "distress and deterioration" criterion "is theoretically unjustified and practically unworkable." An alternative should be considered.108

102. Id. at 305.

[M]anifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative state services, and without treatment, he is likely to suffer from neglect or refuse to care for himself and such neglect or refusal poses a real and present threat of substantial harm to his well-being.

104. Morse, supra note 4, at 96.
105. Id. at 88-89. See Note, Mental Illness: A Suspect Classification?, 83 YALE L.J. 1237 (1974).
106. Morse, supra note 4, at 96.
107. Id. at 92.
108. Id. at 60.
109. See id. at 92.

The solution to scandalous conditions "lies in the provision of resources in the community to insure decent food, clothing, shelter, and treatment services for those who need them." Id. at 96, 103.

110. Cf. Mental Health Law Project, supra note 7, at 132:

"Likelihood of Serious Harm to Oneself" means that it is more likely than not that in the near future the person will attempt to commit suicide or inflict serious bodily harm upon himself by violent or other actively self-destructive means, as evidenced by behavior causing or attempting the in-
C. Emergency psychiatric evaluation, and other procedures

Another issue emphasized in the addendum of the Guidelines is emergency psychiatric evaluation. The Guidelines specify several alternative means by which a person can be involuntarily detained for emergency evaluation and treatment. A person may be detained and transported to a treatment facility by a police officer: (1) if the person is otherwise subject to criminal arrest and the officer believes the person needs emergency treatment, (2) if the officer has probable cause to believe the person has attempted suicide in the preceding forty-eight hours, (3) if the officer has probable cause, based on his investigation, or the petition of "any interested adult" and any "necessary" corroboration, that the person suffers a severe mental disorder which causes likelihood of harm to self or others, "or is manifestly unable to care for some of his basic needs," and "immediate hospitalization" is necessary to prevent such harm, or (4) if the officer "is acting upon the certification of a licensed physician."1

1 Physician certification involves written certification of examination within the past seventy-two hours, or ongoing medical responsibility for the person and current knowledge, and probable cause that the person suffers severe mental disorder causing: (1) lack of capacity "to make an informed decision concerning treatment," and (2) likelihood to cause harm to self "or to suffer substantial mental or physical deterioration," or likelihood to cause harm to others, and (3) immediate hospitalization is necessary to prevent such harm.112 "Any interested adult" may petition or present someone for evaluation based on the same probable cause criteria used by the police officer.113 At the treatment facility, the person "shall" be admitted if the examining psychiatrist determines there is probable cause that the person meets the same criteria used in the certification by a licensed physician.114

Inability to meet one's basic needs is better addressed through guardianship than civil commitment. Id. at 64, 89.

111. Guidelines, supra note 5, at 673. Only provision (3) is kept in the addendum for states not wishing comprehensive revision of their commitment law. Id. at 678.

112. Id. at 673. Physician certification does not necessarily require dangerousness to self or others, only substantial deterioration. See supra discussion beginning with the text accompanying note 92. Contra, e.g., FLA. STAT. ANN. § 394.463(1) (West Supp. 1983) (criteria for involuntary examination up to 72 hours include: mental illness; examination refusal; incapacity; and likely substantial harm to self, or recent, overt danger to another).

113. Guidelines, supra note 5, at 673. This provision is not included in the addendum. Id. at 678-79.

114. Id. at 673. See supra text accompanying note 112.
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The Guidelines provisions for emergency psychiatric evaluation do not require a preliminary judicial hearing until five business days after admission; that hearing "shall be informal" and subject only "to such rules as the court sets consistent with fundamental fairness;" there is no specified right to counsel; and, while thirty-day commitment requires petition within two business days of a thirty-day\textsuperscript{116} probable cause determination by the court, the duration of involuntary "emergency" evaluation and treatment may last up to fourteen days.\textsuperscript{116}

Stromberg and Stone suggest that the Guidelines' provisions embody "the belief that care and treatment should be made available to severely mentally ill persons without unnecessary procedural hurdles."\textsuperscript{117} Rubenstein identifies the problem of the examiner also being the initial decisionmaker, the incentive for the psychiatrist to commit for the week until the judicial hearing, and the factual predicaments of personal disputes or family conflicts in such situations which magistrates are more trained and experienced at resolving than physicians.\textsuperscript{118}

The Guidelines approach at this preliminary stage puts the psychiatrist in the self-aggrandizing position of being able to recruit one's own involuntary clients. The psychiatrist's dual role of judge and therapist is the kind of conflict of interest that legal procedural theory suggests is amenable to arbitration involving a third-party decisionmaker.\textsuperscript{119} The adversary system may be inefficient for the "autocratic decision-making" that facilitates both "process" and "decision control" for psychiatrists, but persons facing commitment are more likely to have a favorable reaction to the outcome of an adversary procedure than a nonadversary procedure.\textsuperscript{120}

\begin{itemize}
  \item[115.] See supra text accompanying note 93.
  \item[116.] Guidelines, supra note 5, at 674. That provisions for advising of rights and the preliminary hearing are not included in the addendum could reflect either their comparative unimportance to the APA, or the extent to which state law (some blanks in the addendum contain the bracketed language, "as in state law") is perceived to be at least as stringent, and probably more so.
  \item[117.] Stromberg & Stone, supra note 2, at 320.
  \item[118.] Rubenstein, supra note 9, at 559.
  \item[119.] See Thibaut & Walker, A Theory of Procedure, 66 Calif. L. Rev. 541 (1978). There is a "maximum conflict of interest" between decisionmaker psychiatrist and person facing involuntary evaluation and treatment. Id. Tracking Thibaut and Walker's theory, if the issue is the truth of someone's illness without the sanction of involuntariness, then non-adversarial "bilateral bargaining" would be procedurally appropriate. Id.
The suggested procedure for thirty-day commitment is not included in the addendum to the *Guidelines*. "[A]ny interested adult" may begin the process toward a hearing within three to five days; the simple filing of a petition triggers a compulsory outpatient psychiatric examination that may be avoided only by submitting a report of examination by one's own psychiatrist.  

Rubenstein asserts that the Supreme Court has required "more due process than this . . . to repossess a refrigerator."  

The thirty-day hearing is also informal, hearsay is admissible. There is no specified right to subpoena or cross-examine witnesses, and there is only an optional provision for a right to an independent psychiatric examination. The doctor-patient privilege and any fifth amendment privilege are eliminated, and hearings are closed unless opened by request and a showing of good cause. There is a requirement to keep a

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122. Rubenstein, supra note 9, at 559. *Compare In re Harris*, 98 Wash. 2d 276, 654 P.2d 109 (1982) (en banc) (procedure empowering mental health professional to summon appearance for evaluation and treatment or be involuntarily committed is deficient).  

record but no right to appeal. There is no right to a jury, and there is a right to counsel but no realistic opportunity to prepare, while at the same time there is an optional provision for state reimbursed petitioner's representation if the District Attorney or County Counsel fails to prosecute the commitment.

In sum, persons accused of crime have more legal protections than would people facing civil commitment under the Guidelines.

D. Informed consent of involuntary patients to treatment

The final issue in the Guidelines addendum for states not undertaking a comprehensive revision of civil commitment is the informed consent of involuntary patients to medication or other treatment. The Guidelines addendum suggests the following:

Since it is a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatments, the treatment facility shall be authorized to administer medications or other treatment to such persons consistent with good medical practice without their consent, except insofar as particular laws or regulations require consent for special therapies. Although consent to treatment is not required, during the course of treatment the responsible psychiatrist (optional provision: 'the responsible physician') shall consult with the patient and his next of kin or guardian and give consideration to the views they express concerning treatment and any alternatives.

While the more comprehensive Guidelines would require staff to explain the "purposes, nature, and effects of treatment" to the patient during emergency evaluation, and limit such special therapies as aversive therapy, experimental treatment psychosurgery, and electroconvulsive therapy to the extent permitted by state law, the Guidelines otherwise eliminate any right to refuse treatment in emergency or non-emergency situations during involuntary evaluation and subsequent involuntary commitments.

Stromberg and Stone acknowledge the legal presumption of competence not to consent and the advent of judicial recognition for the right to refuse treatment. They consider the right to refuse treat-

124. See Rubenstein, supra note 9, at 560. Cf. Preparation and Trial of a Civil Commitment Case, supra note 53.
125. Guidelines, supra note 5, at 674-75.
126. Id. at 679.
127. See Stromberg & Stone, supra note 2, at 358, n.293.
128. Guidelines, supra note 5, at 675.
129. Stromberg & Stone, supra note 2, at 348-49.
130. See, e.g., Rogers and Rennie, supra note 16. Accord Jamison v. Farabee, 7 MENTAL DISABILITY L. REP. 436 (N.D. Cal. April 26, 1983) (consent decree recognizing
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ment, however, to be "perhaps the most incendiary issue in all of mental health law." Stromberg and Stone suggest that the legal trend should be compared with certain research findings: (1) antipsychotic medications help many patients and allow earlier discharge, (2) involuntary medication is infrequently necessary and about two-thirds of involuntary committees continue voluntary treatment after involuntary confinement, (3) many committed patients cannot make reasoned treatment decisions and are subsequently grateful ("thank-you theory"), (4) few drug treatment side effects develop within three months with most occurring after drug therapy lasting over two years, and (5) more right to refuse antipsychotic medication for involuntary and incompetent patients, except in emergency to preserve life or prevent serious bodily harm, and in some cases where patient is "substantially deteriorating").

131. Stromberg & Stone, supra note 2, at 349.

"The criticism from the medical profession that the legal profession is not properly trained to make medical decisions should not be dismissed, although the concerns that the medical profession is not adequately trained to protect the civil rights of patients also must not go unheeded. (citations omitted.)" Comment, Medication and Adjudication: Extending In re Richard Roe III to Institutionalized Psychiatric Patients, 17 New Eng. L. Rev. 1029, 1041-42 (1982).
133. Stromberg & Stone, supra note 2, at 353-56.
134. Contrast this with the position that whether a patient should enjoy the benefit of treatment and secure earlier release should be up to the patient, the patient's guardian, or the court applying a substituted judgment standard.
135. If involuntary medication is needed infrequently, the debate may really be about other issues.

That involuntary committees continue voluntary treatment later can reflect: the overbearing of their will; the fostering of dependency; the exacerbation of, or failure to cure or improve their mental condition; the ease of non-confinement treatment; or other factors distinct from any inherent attraction or benefit of treatment.
136. Contra notes 32 and 33 supra. See Bloom, Shore & Treliever, Oregon's Civil Commitment Statute: Stone's "Thank You Theory"—A Judicial Survey, 7 Bull. Am. Acad. Psychiatry & L. 381 (1979). A person's gratitude may be relevant within the context of the substituted judgment doctrine, but it would set a poor precedent to premise the legal acceptability of involuntary state action on the assurance that "many" are appreciative.
137. Side effects are a factor in the calculus of the decision about whether to consent to treatment. How much solace is it to the individual being treated, to the many patients...
than half of persistent treatment refusers in one study (eighty-nine of one hundred fifty-nine) deteriorated, and other frequent refusal "raises markedly the level of tension between staff and patients, and degrades the therapeutic environment." While such research might be readily dismissed in some discussions of legal issues, the proposed comparison should be accompanied by a discussion of the legal perspective.

Hornbook tort law states that "the absence of lawful consent is part of the definition of an assault." Consent can be implied "in an emergency which threatens death or serious bodily harm, but the mere desirability of treatment cannot justify . . . going ahead without the consent of the patient, or at least of a near relative." Furthermore, "if the plaintiff is known to be incapable of giving consent because of . . . mental incompetence, his failure to object, or even his active manifestation of consent will not protect the defendant." An other court concludes: "There is no support in common law for the proposition that treatment, medical or psychiatric, constitutes a legal irreversible medical decision . . . In a society ruled by laws, social actions that infringe or control individual freedoms must be judged by legal standards.

In addition to a common law basis for refusing treatment, there are constitutional bases. These include: privacy and personal autonomy, including the ninth amendment, first amendment protection of hospitalized for far more than two years, and to the law, that "medical means to avoid and to treat such effects are improving?" Stromberg & Stone, supra note 2, at 354.

138. This is a state of art wherein 70 of 159 treatment refusers in one small study do not deteriorate. Should the law protect against error and abuse, or facilitate the unchecked discretion within which it occurs? The Guidelines can seem preoccupied with staff-patient tension, disruption of environment, "constant fear of lawsuits," and allocation of power between physicians and patients. Id. at 350, 356.


141. PROSSER, supra note 140, at 114.


144. See, e.g., Rogers and Rennie supra note 16.

145. E.g., Kaimowitz v. Dep't of Mental Health, 1 MENTAL DISABILITY L. REP. 147 (No. 73-19434-AW Wayne County Cir. Ct., Michigan, July 10, 1973); Developments in the
thought processes or religious beliefs, \textsuperscript{146} eighth amendment cruel and unusual punishment protection prohibiting use of drugs for control or aversive conditioning, procedural and substantive due process, \textsuperscript{147} equal protection, \textsuperscript{148} and the least restrictive alternative principle. \textsuperscript{149}

The Supreme Court recently faced the issue of "whether involuntarily committed mental patients have a constitutional right to refuse treatment with antipsychotic drugs,"\textsuperscript{150} but remanded the case for a consideration of Guardianship of Roe.\textsuperscript{161} The Court noted agreement by the parties that there is a constitutionally recognized liberty interest in shunning unwanted antipsychotic drugs that raises both substantive and procedural issues.\textsuperscript{162}

In Roe, the Massachusetts Supreme Judicial Court held that a noninstitutionalized incompetent with a guardian has a right to refuse antipsychotic drugs and the guardian must seek judicial determination of substituted judgment concerning the patient's choice if he were competent.\textsuperscript{163} Medical experts, advice, and opinion are to be used only to the same extent as if the person were competent.\textsuperscript{164} The court based its holding on: the intrusiveness of proposed treatment (forcible injection of antipsychotic medication), the possibility of adverse side effects, the absence of an emergency,\textsuperscript{165} the nature and extent of prior

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\textsuperscript{146} Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973); Winters v. Miller, 446 F.2d 65 (2nd Cir. 1971), cert. den., 404 U.S. 985 (1971); Shapiro, Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies, 47 S. Cal. L. Rev. 237, 255-56 (1974).


\textsuperscript{148} Brief for Amici, Okin v. Rogers, 2 MENTAL DISABILITY L. REP. at 50.

\textsuperscript{149} See, e.g., Dubose, Of the Pares Patr\'ae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?, 60 Minn. L. Rev. 1149 (1976); Plotkin, supra note 16; Comment, Madness and Medicine: The Forcible Administration of Psychotropic Drugs, 1980 Wis. L. Rev. 497.

\textsuperscript{150} Mills v. Rogers, 457 U.S. 291, 298 (1982).


\textsuperscript{152} 457 U.S. 291. But cf. Guidelines, supra note 5; Stromberg & Stone, supra note 2, suggesting elimination of any right to refuse treatment and making no attempt to develop procedures concerning the issue.

\textsuperscript{153} 383 Mass. at 433-36, 421 N.E.2d at 51-52.

\textsuperscript{154} 383 Mass. at 435-36, 421 N.E.2d at 52.

\textsuperscript{155} Emergency is defined as "an unforeseen combination of circumstances or the resulting state that calls for immediate action," i.e., "a possibility of immediate, substan-
\end{footnotesize}
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judicial involvement (e.g., guardianship proceedings already initiated), and the likelihood of conflicting interests (e.g., parent as guardian). 156 In making the substituted judgment decision of what the ward would do if competent, the court requires consideration of six relevant factors: (1) the ward’s expressed preferences regarding the treatment, (2) the ward’s religious beliefs, (3) impact on the ward’s family, (4) probability of adverse side effects, (5) consequences of refusing treatment, and (6) prognosis with treatment. 157 If a determination is made that the ward would not accept treatment, this decision stands unless the state can prove beyond a reasonable doubt that there is an overriding state interest in preserving life, protecting innocent third party interests, preventing suicide, or maintaining the medical profession’s ethical integrity. 158

Roe is in line with the modern development of the substituted judgment doctrine. 159 Given the fundamental nature of a right not to consent to treatment, at least one commentator encourages the specific extension of Roe to institutionalized psychiatric patients. 160

Civil commitment can be viewed as a bifurcated process in which there may be legitimate parens patriae or police power interests in confining a person, yet persons retain their own interests in the further question of what is done during confinement. Psychiatrists are no more enthusiastic about a guardianship approach than they are about legalization generally. 161 Guardianship, especially for indigents, is not necessarily a panacea, 162 nevertheless, the inherent parens patriae responsibility of the state to provide a guardian for those it must involuntarily commit 163 may indeed be “the key to the courthouse door” 164—the only

tial, and irreversible deterioration of a serious mental illness.” 383 Mass. at 441, 421 N.E.2d at 55.

156. 383 Mass. at 435-43, 421 N.E.2d at 52-56.
159. Comment, supra note 132 (citing Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977)).
163. See Vecchione v. Wohlgemuth, 426 F. Supp. 1297 (state must return appropriated Social Security checks through creation of autonomous guardian offices in each
fair way to resolve the key issue of allocating decisionmaking power between mental patients and psychiatrists,168 and the means to salvage the viability of involuntary commitment. Florida, for example, has an incapacity criterion for both short-term involuntary examination and long-term involuntary placement,166 but there are also provisions for a distinct determination of competence to consent to treatment,167 and if incompetent, then the mandatory appointment of a "guardian advocate" as substitute treatment decision-maker.168

The Task Panel on Legal and Ethical Issues of the President's Commission on Mental Health169 generally endorsed a right to refuse treatment for voluntary and involuntary competent and incompetent patients, with provision for a due process hearing that would address factors similar to those in Roe.170 There are many psychiatrists who consider forced treatment to be unethical.171

Most telling, perhaps, is that many organized recipients of mental health services continue to "regard involuntary hospitalization and forced medication as policies to which they are fundamentally and unalterably opposed."172

IV. CONCLUSION

Doctors and lawyers have difficulty agreeing about civil commitment policy not because each profession does not encourage interdisciplinary effort and multidisciplinary consideration, but because their values are generally different. Physicians live in a deterministic world requiring more and better science. Attorneys live in a world of free will and responsibility, or at least a world that must function as if there is free will and responsibility; they require more and better fictions. The noblest scientific experiment, however, may be making the fictions work

mental hospital); In re Gamble, 118 N.H. 771, 394 A.2d 308 (1978).
165. Stromberg & Stone, supra note 2, at 350.
170. Id.
The APA's Guidelines for State Legislation on Civil Commitment of the Mentally Ill are a commendable and comprehensive effort. Managing a mentally disordered person, and making a civil commitment policy, are formidable tasks. This critique has been a preliminary and noncomprehensive review that only begins to consider some of the issues raised by the Guidelines.

Implementation of the Guidelines would increase the number of people subjected to involuntary commitment. Mental health system costs would rise, deviance would be further medicalized and legal regulation of mental health care, in the short-run, would diminish. There would also be opportunity costs to medicine because of judicial challenges to such a statute, as well as opportunity costs to the legal system of statutory alternatives that the law could be addressing if it were not dealing with such provisions. The legal opportunity costs may be the most important consideration.

The first generation civil commitment problems of lax criteria and procedures, and patient warehousing without effective treatment, were alleviated within a legal framework of rights: to treatment, to refuse treatment, to the least restrictive alternative, and to more specific and behavioral commitment criteria and procedures. Institutional conditions improved, and patients were transferred to community facilities. Stromberg and Stone, for example, note the thirty right to treatment consent decrees entered in the last decade directly governing care in fifteen states, and indirectly in most others.173

No state statute in and of itself is going to solve the alleged second generation commitment problems of patient abandonment, custodial care of treatment refusers, conversion of mental hospitals into jails, a less protected society, frequent lawsuits against mental health personnel, and confusion about commitment goals. The principle difficulty with the Guidelines is that they would not provide the legal framework within which these problems could be alleviated.

The Guidelines would enhance psychiatric discretion. The insidious aspect to this enhancement, and to what psychiatric discretion the Supreme Court is recognizing,174 is the responsibility (and liability) that accompany it. Psychiatrists allowed themselves to be used in the charade of predicting dangerousness before discovering the inherent liabil-

ity identified in Tarasoff. Now the horse is out of the barn, and psychiatric pleas of non-competence are too late.

Psychiatrists alone were politically incapable of reforming the first generation problems until galvanized by legal reformers. The second generation problems are similarly remediable through incremental attention to individual and class legal actions. The cumulative inefficiency of the legal process is, nevertheless, inexorable as an avenue of reform.

Some provisions of the Guidelines offer vehicles for the avenue: more specifically and behaviorally defining eligibility, requiring incapacity as a threshold criterion for involuntary confinement, requiring treatability, requiring admission refusal, limiting the duration of confinement, and immunizing prediction and release decisions. But gutting the least restrictive alternative principle, introducing vague deterioration as a criterion, opening involuntary evaluation, eliminating procedures, and subjecting involuntary clients to unilateral treatment contracts, would revive first generation problems of institutionalization and commitment laxity while exacerbating second generation problems of frequent lawsuits and confusion concerning civil commitment goals.

The alternative models for involuntary civil commitment are arrayed on a continuum from high medical discretion, through various due process models, to abolition. A leading abolitionist, Professor Morse, concludes:

[T]hat if involuntary commitment of only the mentally disordered can be justified at all, it should be limited to cases of persons who, first, are so clearly crazy that all reasonable persons would agree that their capability for self-control or rationality fails to pass even the lowest of legal thresholds (whether the person's thoughts, feelings, and actions are so crazy that the assumption about lack of capacity is clearly reasonable); second, are so dangerous or incompetent, as demonstrated by objective acts, that preventive confinement is clearly and absolutely necessary to prevent grave harm; and, third, are clearly and only treatable on an in-patient basis.

My own conclusion is that incapacity (or incompetence) as a threshold criterion is best addressed in probate court as a guardianship issue. While no panacea, and certainly problematic, guardianship is a model to which both physicians and attorneys are accustomed, and about

175. Supra note 70.
177. E.g., Mental Health Law Project, supra note 7.
178. See Mosher, Italy's Revolutionary Mental Health Law: An Assessment, 139 AM J. PSYCHIATRY 199 (1982) (favorable observation of Italy's effort to stop state hospital admissions, phase-out state hospitals, and not involuntarily commit to these facilities).
179. Morse, supra note 4, at 66.
which there is less confusion concerning goals. Psychiatrists should be free to practice medicine wherein the absence of lawful consent by the patient, or duly appointed surrogate, is a tort.