I. INTRODUCTION

An underlying foundation of the United States Constitution is the protection of personal autonomy from unwarranted state intervention.
The Fifth and Fourteenth Amendments provide explicitly that "[n]o person shall . . . be deprived of life, liberty, or property, without due process of law." "Traditionally, the greatest insistence upon due process guarantees has been in the criminal realm, on the assumption that the citizen requires less protection against noncriminal governmental controls and intervention."2

In the mid-1960s and 1970s, scholarly3 and judicial4 scrutiny

1. U.S. CONST. amend. V and XIV. Due process of law deals with fundamental principles of fairness and requires that an individual be afforded the opportunity to challenge his or her accusers, Pointer v. Texas, 380 U.S. 400, 403 (1965), and the right of the accused to representation by counsel, Gideon v. Wainwright, 372 U.S. 335, 344 (1963). Essentially, there are two aspects of due process: procedural and substantive. Procedural due process pertains to the essentials for a fair trial, for example, the opportunity for a hearing. See Boddie v. Connecticut, 401 U.S. 371, 379 (1971). Substantive due process entails the concept of fundamental values such as liberty and privacy. See Roe v. Wade, 410 U.S. 113, 152 (1973).

2. NICHOLAS N. KITRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY 80 (1971). A premise of criminal law is that an individual should have free will and the ability to abide by the legal code before he or she can be morally blameworthy. See generally Henry M. Hart, The Aims of the Criminal Law, 23 LAW & CONTEMP. PROBS. 401 (1958). It is for this reason, therefore, that mentally ill individuals and juveniles are processed under different legal frameworks. The legal frameworks are civil commitment and the juvenile justice system where the professed goals for both are therapy, rehabilitation, and prevention. Note, Developments in the Law: Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1304-06 (1974); John J. Regan, Protective Services for the Elderly: Commitment, Guardianship, and Alternatives, 13 WM. & MARY L. REV. 569, 575 (1972). In essence, it is assumed that a "normal" person is capable of choosing to obey societal norms, while a mentally disabled individual or a child has little choice in deciding how to behave. As a result, mentally disabled persons are not generally to be punished but instead processed in the mental health system or the juvenile justice system under the auspices that such an intervention is benevolently motivated or in the best interests of the individual. Bruce J. Ennis, Civil Liberties and Mental Illness, 7 CRIM. L. BULL. 101, 103 (1971).


4. See Wyatt v. Adenholt, 503 F.2d 1305, 1310 (5th Cir. 1974) ("[P]atients with open wounds and inadequately treated skin diseases were in imminent danger of infection because of the unsanitary conditions existing in the wards, such as permitting urine and feces to remain on the floor . . . . [T]he United States described the food as "com[ing] closer to "punishment" by starvation' than nutrition."); In re Sealy, 218 So. 2d 765 (Fla. Dist. Ct. App. 1969) (doctors testified that a "hippie" who believed in a free life-style, nonviolence, and the use of drugs, was mentally ill); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966) (ruling that mentally disabled individuals have a right to treatment); see also Addington v.
paved the way for greater substantive and procedural safeguards in civil legal proceedings. Many of the due process safeguards afforded to persons in the criminal process were applied to juvenile delinquents and individuals facing civil commitment. For example, many states adopted civil commitment legislation which required, at a minimum, evidence of an overt recent act, attempt or threat of dangerous behavior before permitting the deprivation of liberty. Mental illness alone was no longer sufficient to justify the deprivation of individual autonomy. An additional change in civil commitment law was the adoption of a greater reliance on procedural formality. Decisionmakers were to place a greater emphasis on the assurance of procedural safeguards and shortening the length of detention. The rationale for these reforms came from a perspective that “people had a right to be different.” In Wisconsin, the adoption of a new civil commitment code in 1975 epitomized this civil commitment libertarian reform movement.

Texas, 441 U.S. 418 (1979) (raising the standard of proof in commitment proceedings from a “preponderance of the evidence” to a “clear and convincing” standard).

5. In re Gault, 387 U.S. 1, 50 (1967) (“[C]ommitment is a deprivation of liberty. It is incarceration against one’s will, whether it is called ‘criminal’ or ‘civil.’”). See also Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968); Saleem A. Shah, Legal and Mental Health Interactions: Major Developments and Research Needs, 4 INT’L J. L. & PSYCHIATRY 219 (1981) for an overview of the development in this area.


11. WIS. STAT. ANN. § 51 (West 1975); see generally Virginia A. Hiday & Stephen J. Markell, Components of Dangerousness: Legal Standards in Civil Commitment, 3 INT’L J. L. & PSYCHIATRY 405 (1980); Shah, supra note 5; Brooks, supra note 6. Some states have recently broadened their standards. See Mary L. Durham & John Q. La Fond, The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment, 3 YALE L. & POL’Y REV. 395, 398 (1985). However, most still adhere to restrictive
Many evaluation efforts have been conducted to assess the impact of reform efforts on commitment proceedings. Only a few studies have evaluated the changes in the civil commitment practices that may or may not have occurred as a result of reform in the State of Wisconsin. No study has assessed the extent to which the implementation of the 1975 reform law resulted in greater adherence to dangerousness and other legal factors in deciding case processing and case outcomes. The objective of the present research was to fill criteria and procedural formality.

Virginia A. Hiday, Dangerousness of Civil Commitment Candidates: A Six-Month Follow-up, 14 LAW & HUM. BEHAV. 551, 551-52 (1990) [hereinafter Hiday, Civil Commitment Candidates];


13. INGO KEILITZ & BRADLEY D. MGRAW, AN EVALUATION OF INVOLUNTARY CIVIL COMMITMENT IN MILWAUKEE COUNTY 71 (1983) (found that 25% to 60% of all involuntary commitment cases were diverted by means of "negotiated settlements"); Thomas Zander, Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt, 1976 WIS. L. REV. 503, 529-30 (1976) (finding that in Milwaukee courts, officials deferred to psychiatric judgment and relied on hearsay evidence—hospital records and nursing notes—which were in stark contrast to the proceedings at Dane County and the requirements set forth by the Lessard ruling); Walter Dickey, Incompetency and the Nondangerous Mentally Ill Client, 16 CRIM. L. BULL. 22, 30 (1980) (finding that persons who normally would have been subject to civil commitment were instead arrested and detained as incompetent to stand trial); Michael J. Leiber, Interaction Between Civil Commitment and Protective Services: A Case Study, 14 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 41, 64 (1988) [hereinafter Case Study] (finding through an examination of literature, reports, and legal cases that the process of protective placement may be used to bypass the more stringent proceedings of civil commitment); see generally Michael J. Leiber, Interactions Between Civil Commitment and Protective Placements: An Empirical Assessment, 15 INT'L J.L. & PSYCHIATRY 265 (1992) [hereinafter Empirical Assessment] (finding by means of empirical research that few differences existed between persons transferred to protective placement and those in civil commitment prior to the passage of the 1975 reform law); Michael J. Leiber, Civil Commitment in Dane County, Wisconsin: 1969 through 1984, J. PSYCHIATRY & L. (1992) [hereinafter Dane County] (finding that the implementation of reform is specific to certain areas and varies by the years assessed).

14. Of the research conducted, most studies are unable to provide an indication of the extent to which legal factors have an impact on decisionmaking. Zander examined the impact
this void. A "before and after" research design was employed to examine civil commitment practices in Dane County, Wisconsin. Dane County was the focus of the analyses because of its national reputation for having a model mental health program.¹⁵

The findings indicate significant advances to protect persons from the unjust deprivation of freedom, as well as the presence of significant gaps between intentions and implementation. In determining case outcome, the greatest slippage appears to be between the extent decisionmakers adhere to extralegal factors, such as age, gender, and social support, rather than legal factors such as dangerousness and mental illness. Mental health personnel appear to be still relying on the concept of parens patriae and possibly utilizing alternative means to provide treatment, absent due process of law available at the final hearing. These occurrences result in serious liberty violations that undermine the underlying and stated intentions of the 1975 reform law.

of Lessard v. Schmidt prior to its becoming state legislation. Yet, Zander's work says nothing about practices following the 1975 statutory reform. See generally Zander, supra note 13; see Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972). Dickey's research is noteworthy but the findings are limited to persons incompetent to stand trial and to the first three years after the law took effect (1976 through 1978). Dickey, supra note 13, at 30-31. The study by Keilitz and McGraw is interesting but it has shortcomings. The research was a nine month evaluation which employed only observations and interviews and ignored quantitative analyses of case records. KELlITZ & MCGRAW, supra note 13, at iii. Two of Leiber's studies focused on the relationship of protective placement with civil commitment. See generally Case Study, supra note 13; Empirical Assessment, supra note 13. The third assesses changes in civil commitment practices before and after reform. See generally Dane County, supra note 13. The weakness of Leiber's research is the failure to utilize multivariate analyses which control for the influence of more than one variable at a time on decisionmaking.

15. See generally DAVID GOODRICK, DANE COUNTY, WISCONSIN: PIONEER IN CREATING COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SERVICES (1988); E. FULLER TORREY & SIDNEY M. WOLFE, CARE OF THE SERIOUSLY MENTALLY ILL: A RATING OF STATE PROGRAMS (1986); Leonard I. Stein & Mary Ann Test, Alternative to Mental Hospital Treatment: I. Conceptual Model, Treatment Program and Clinical Evaluation, 37 ARCHIVES OF GEN. PSYCHIATRY 392 (1980). It is important to note that a debate has arisen in response to a number of tragic incidents involving mentally ill persons from Madison, Wisconsin. At the center of the controversy is the civil commitment statute itself, the availability of resources committed to community-based treatment, and the extent to which the ideological emphasis on community treatment "interferes with clinical judgment." Gary Maier, The Tyranny of Irresponsible Freedom, 40 HOSP. & COMM. PSYCHIATRY 453 (1989); Dianne Greenley, Advocacy in Wisconsin, 40 HOSP. & COMM. PSYCHIATRY 1198 (1989); Thomas Kuhlman, Unavoidable Tragedies in Dane County, Wisconsin: A Third View, 43 HOSP. & COMM. PSYCHIATRY 72 (1992).
II. WISCONSIN'S 1975 CIVIL COMMITMENT LAW

Wisconsin's pre-reform civil commitment law was typical of most states. The federal district court for the Eastern District of Wisconsin ruled in Lessard v. Schmidt in 1972 that the pre-reform law was for the most part unconstitutional. After four years of appeals and much collaboration, a new Mental Health Act took effect in the State of Wisconsin in 1976.

The Wisconsin legislature enacted most of the Lessard decision in a revised civil commitment code which called for greater procedural and substantive formality in commitment proceedings and the avoidance of involuntary commitment. The underlying judicial and legislative intent of the reform was to establish more restrictive criteria for involuntary commitment and to decrease medical prerogative.

A comparison of the statutory criteria of Wisconsin's pre-reform law and the 1975 reformed civil commitment law illustrates the extreme differences between the two laws in terms of who should be treated, how, and why. The pre-reform law justified commitment on the basis that a person was mentally ill and a proper subject for custody and treatment. An individual who was violent or threatened to behave violently and "who appear[ed] irresponsible and dangerous"


17. Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972). The most important holdings of the case are the following: (1) a preliminary hearing within 48 hours to determine probable cause; (2) 10 to 14 days is the maximum period during which a person can be detained without a full hearing on the necessity of commitment; (3) the state must prove that a person is both mentally ill and dangerous; (4) individuals subject to commitment have the right to counsel; (5) persons have a right to a jury trial; and (6) reexamination of the person is required six months after commitment. Id. at 1103.


19. Id.


could be taken into custody for purposes of emergency detention.\textsuperscript{22} For all purposes, commitment could be based solely on the diagnosis of mental illness since dangerousness was not defined. The court in \textit{Lessard v. Schmidt}\textsuperscript{23} did not rule that dangerousness was constitutionally required for commitment, but instead declared that "the statute can be interpreted to avoid a constitutional adjudication on the questions of vagueness, overbreadth and the availability of less restrictive alternatives."\textsuperscript{24}

The dangerousness criterion of the post-reform civil commitment law, on the other hand, is much more specific. As defined by state statute, "dangerousness" is behavior which is recent and involves acts or threats of homicide, suicide, or other violent behavior to oneself or others.\textsuperscript{25} An exception to the dangerous to self or others standard is when a person, as a result of impaired judgment manifested by evidence of recent acts or omissions, is likely to cause physical impairment or injury to oneself or is unable to satisfy basic needs.\textsuperscript{26} The fourth standard, the inability "to satisfy basic needs," was amended to the 1975 reform law in 1980.\textsuperscript{27} The addition of the fourth dangerousness standard was intended to "loosen the statutory commitment standards and strike a balance between making commitment too hard and too easy."\textsuperscript{28} Although the term never appears in the civil commitment code, the third and fourth standards could be labeled under the general "catchall" category of "gravely disabled."\textsuperscript{29}

Procedural discrepancies also exist between pre- and post-reform laws. The major distinction is the length of time before hearings must be held. The old civil commitment law allowed emergency detention for up to five days with the possibility of a court order extension of 145 days before a hearing.\textsuperscript{30} Since the enactment of the 1975 reform law, a probable cause hearing should be held within

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{22} \textit{Id.}
\item \textsuperscript{23} 349 F. Supp. 1078 (E.D. Wis. 1972).
\item \textsuperscript{24} \textit{Id.} at 1093. See generally Paul Applebaum, \textit{Is the Need for Treatment Constitutionally Acceptable as a Basis for Civil Commitment?} 12 LAW, MED. \& HEALTH CARE 144 (1984).
\item \textsuperscript{25} WIS. STAT. ANN. § 51.20(1)(a)(1), 2(a), (b) (West 1984-1985).
\item \textsuperscript{26} WIS. STAT. ANN. § 51.20(1)(a)(1), 2(c), (d) (West 1984-1985).
\item \textsuperscript{27} WIS. STAT. ANN. §§ 51.15(1)(a)(1)-(4), 51.20(1)(a)(1)-(2)(d) (West 1984-1985).
\item \textsuperscript{28} KEILITZ \& McGRAW, supra note 13, at 31 n.32.
\item \textsuperscript{29} See generally CAROL A.B. WARREN, COURT OF LAST RESORT: JUDICIAL REVIEW OF INVOLUNTARY CIVIL COMMITMENT IN CALIFORNIA (1982).
\item \textsuperscript{30} WIS. STAT. ANN. § 51.04(1)-(3) (West 1971).
\end{itemize}
\end{footnotesize}
seventy-two hours.\textsuperscript{31} A final hearing must be held within fourteen to twenty-one days for a person in custody and thirty days if the individual has been released while awaiting further proceedings.\textsuperscript{32}

The rationale for requiring hearings within specified time periods rested on the recognition that "even a short detention in a mental facility may have long lasting effects on the individual's ability to function in the outside world due to the stigma attached to mental illness."\textsuperscript{33} Concomitantly, the first section of the 1975 reform act states: "To protect personal liberties, no person who can be treated adequately outside of a hospital, institution or other inpatient facility may be involuntarily treated in such a facility."\textsuperscript{34} The emphasis on the minimization of state intervention on individual liberty through procedural time limits and hearings was not explicitly expressed or believed to have been practiced prior to the enactment of the 1975 reformed civil commitment law.\textsuperscript{35}


\textsuperscript{34} Wis. Stat. Ann. § 51.001(2) (West 1984-1985).

\textsuperscript{35} See generally Michael J. Remington, Lessard v. Schmidt and Its Implications for Involuntary Civil Commitment in Wisconsin, 57 Marq. L. Rev. 65 (1973). Changes in the mental health system and funding for the delivery of mental health services also occurred during this time, if not before the enactment of the 1975 reform law. Thompson and associates indicated that Dane County's community mental health network was well underway to improve hospital care and provide intensive post-discharge follow-up care in the community as early as 1965. By 1972, an emphasis was also placed on teaching skills in the community and limiting hospitalization for dangerous and severely mentally ill persons. Kenneth S. Thompson et al., A Historical Review of the Madison Model of Community Care, 41 Hosp. & Comm. Psychiatry 625 (1990). In 1973, the state legislature shifted the responsibility for the delivery of mental health services from the state to each individual county. Leonard I. Stein & Leonard J. Ganser, Wisconsin's System for Funding Mental Health Services, in Unified Mental Health Systems: Utopia Unrealized 25, 26-27 (John A. Talbott ed., 1983). Each individual county has a community health board which is solely responsible for the development and monitoring of mental health care. Wis. Stat. Ann. § 51.42(3) (West 1984-1985). The state legislature appropriates money to each county on the basis of an annual county budget proposal and guidelines set forth by statute. Id. Financial incentives encourage the use of community-based alternatives: it is less costly for the county to place persons in community programs than it is to provide inpatient hospitalization. See generally Sari Gilman & Ronald J. Diamon, Economic Analysis in Community Treatment of the Chronically Mentally Ill (unpublished manuscript, on file with Department of Sociology and Psychiatry, University of Wisconsin); Dane County, supra note 13.
III. IMPLICATIONS FOR THE PRESENT STUDY

If the stated and underlying intentions of the 1975 reform law were implemented in practice, we could expect a number of changes in the degree and importance of dangerousness and mental illness in justifying civil commitment; therefore, more final hearings should be held.\(^6\) In addition, after the 1975 reform law, persons should exhibit more dangerousness and mental illness.\(^7\) These factors should be of greater importance in determining case processing and outcome than extralegal factors such as gender or age.\(^8\) In addition, individuals subjected to civil commitment should also be detained for shorter lengths of time than those similarly situated prior to the 1975 reform.\(^9\) The goal of the present study is to assess the validity of these assumptions. Findings to the contrary would raise questions regarding a decisionmaker’s ability to conform to the mandate of the 1975 reform law: the preservation of individual liberty.\(^40\)

IV. THE PRESENT STUDY

A. Sample Description and Research Design

The data for the current research was collected from case files at the Mendota Mental Health Institute in Dane County, Wisconsin. The


\(^38\) As noted by Hiday, “[r]ecent statutory and judicial reforms of civil commitment suggest some dissatisfaction with the image of psychiatric dominance, for they mandate procedural and substantive changes designed to reduce reliance on psychiatric expertise and to increase the importance of the ‘facts’ . . . [such as an emphasis on] due process rights of . . . confrontation . . . [and] dangerousness.” Hiday, Judicial Decisions, supra note 8, at 517-18; see generally Keilitz & McGraw, supra note 13.

\(^39\) “[E]ven a short detention in a mental facility may have long lasting effects on the individual’s ability to function in the outside world due to the stigma attached to mental illness.” Lessard, 349 F. Supp. at 1091.

\(^40\) A principle legislative author of the civil commitment law noted that “[t]he principle of the ‘least restrictive alternative’ reflects our belief that most persons in need of mental health treatment are best served in their own communities.” Dickey, supra note 13, at 28. The court in Lessard also noted that “[p]erhaps the most basic and fundamental right is the right to be free from unwanted restraint. It seems clear, then, that persons suffering from the condition of being mentally ill, but who are not alleged to have committed any crime, cannot be totally deprived of their liberty if there are less drastic means for achieving the same goal.” Lessard, 349 F. Supp. at 1096.
Mendota Mental Health Institute is the primary detention facility and commitment institution for mentally ill persons in Dane County. Information on demographics, mental health histories, court processing, and case outcomes comprised the database for the present analysis. Only those cases initiated as emergency detentions were examined. A random sample of 600 cases was used for the study. Persons aged seventeen and younger were excluded from the research, as were individuals committed for alcoholism or drug addiction. The rationale for excluding these populations was that they were subject to different commitment standards than those discussed here.41

A random sample of 200 cases was collected prior to 1975 and 400 cases were selected in the longer time period following passage of the new law. The years 1969 through 1974 represent the period previous to legislative reform, while the years 1977 through 1979 and 1982 through 1984 comprise the period of post-reform legislation.

B. Measurement of Variables

The task guiding the present research is to examine the extent to which legal factors are adhered to in determining case processing. One of the most important factors associated with the 1975 reform effort is the reduction of the length of the involuntary intrusion.42 Thus, the length of stay was used here to represent this concept or goal. Length of stay is operationalized as the time, measured in days, an individual was under the authority of the Mendota Mental Health Facility. Preliminary examination of the distribution of the variable length of stay revealed skewness or abnormal variance because a few cases evidenced longer lengths of stay than the sample as a whole. To induce normality, the natural log of the length of the stay was created.43

The independent variables examined in this study include social characteristics, measures of dangerousness, indices of behavior in detention, mental illness, and the holding of final hearings. The social characteristics are age and gender. Another variable is environmental stability which is a proxy for the type of support an individual may

41. See Lessard, 349 F. Supp. at 1093. For discussion of differing state commitment standards, see supra note 11.
42. Lessard, F. Supp. at 1091, 1096; See supra notes 39 and 40 and accompanying text.
43. This is a critical procedure in which log transformations are used to stabilize the error variance, that is, to make the error variance constant for all observations. See generally SAMPRIT CHATTERJEE & BERTRAM PRICE, REGRESSION ANALYSIS BY EXAMPLE (1977).
have received at the time of the emergency referral; the higher the score, the greater the level of support. The influence of these variables on length of stay should be minimal following the 1975 reform.\(^44\)

Individuals referred to involuntary civil commitment are expected to evidence a greater number of prior hospitalizations following reform. The impact of this variable on predicting length of stay is also anticipated to increase in its significance.\(^45\)

In addition to changes in the number of prior hospitalizations, differences should also be apparent in the type of mental illnesses persons exhibit following reform.\(^46\) For example, individuals detained in civil commitment post-1975 should be more likely to be labeled as having an affective disorder or suffering from a schizophrenic disorder than those in civil commitment pre-reform. The variable "diagnosis" is differentiated by "other" and "affective disorder/schizophrenic."\(^47\)

Virginia Hiday, a researcher in the area of mental illness and dangerousness, argued that most researchers in their assessment of the concept of dangerousness have failed to (1) determine the degree of danger in the assaults of threats, and (2) distinguish between threats of assaults and actual assaults.\(^48\) The dangerousness that led to the emergency detention was measured in this study to reflect Hiday's suggestions in the context of the assumed and stated intentions of the 1975 reform law. Two indices of dangerousness were recorded, the object of the behavior and the potential or actual seriousness of the

\(^{44}\) See supra note 39 and accompanying text.

\(^{45}\) It needs to be noted that some scholars view the use of prior hospitalization as a legal criterion as inappropriate. James W. Luckey & John J. Berman, Effects of a New Commitment Law on Involuntary Admission and Service Utilization Patterns, 3 LAW & HUM. BEHAV. 149 (1979). The underlying justification for their concern rests on the belief that evidence of prior hospitalization "may have little to do with the person's present condition." Id. at 159-60. Past research has shown that an individual's history of mental hospitalizations is most often the determining factor in deciding commitment. Warren, supra note 12, at 629. In short, it is believed by many that the introduction of prior hospitalization as a legal variable amounts to an institutional stigmatization. Compare Luckey & Berman, supra at 160, with Hiday, Judicial Decisions, supra note 8, at 527.

\(^{46}\) See generally Mills, supra note 10.

\(^{47}\) The category of 'other' consists of organic and mental retardation, personality disorder, anxiety disorder, disorder of impulse, psychosexual disorder and adjustment disorder. For a discussion of the appropriateness of this categorization, see JAMES C. COLEMAN ET AL., ABNORMAL PSYCHOLOGY AND MODERN LIFE (1980).

\(^{48}\) Hiday, Civil Commitment, supra note 6, at 20-21.
act. Information was collected for the most serious incident leading to the emergency mental health detention. Of all the variables included in the analysis, the indices representing the dangerousness leading to the emergency detention should be strongest following the 1975 legislative reform.

Because the length of stay may be confounded by behavior within the hospital setting, information on whether restraint was practiced, and why, was incorporated into the analyses. Behavior within the hospital setting was defined as “cooperative,” “eccentric,” and “defiant.” Restraint is either the “strapping” or “tying” down of persons to a bed or a chair, or the placing of individuals in an isolation room within one month following the emergency detention.

One additional factor that may influence an individual’s length of stay is the use of the final hearing. After the 1975 reform, it is anti-

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49. Cases regarding an act involving property were joined together with an act directed at oneself. Although each involves a different behavior, only 12 cases involved property (2% of 600). The potential for death, or actual death, was collapsed into the cuts or harm category. In the pre-reform period 39 cases (5% of 200) fell into the death classification compared to 115 cases (29% of 400) during the post-reform period. Thus, a proportional increase in this kind of behavior occurred following the 1975 reform, a finding which is consistent with the stated and underlying intentions of the reform effort.

50. As the former governor of Wisconsin stated:

'The new law should guarantee that no one is unjustly taken advantage of because of mental impairment or a belief a mental impairment exists . . . . No one should have to fear that he or she can be institutionalized at the whims of local officials or simply because his or her behavior appears unusual."


51. Michael J. Lieber et al., The Practice of Restraint Within a Hospital Setting Before and After Civil Commitment Reform, 29 WIS. SOCIOLOGIST 4, 7 (1992). “The eccentric category consists of an incident evidenced by confusion, trembling, poor hygiene, hallucinations, delusioned, noncommunicative, or the like. Verbal [sic] threats with no action, resistant [sic] to instructions, and failure to do something (e.g., failure to enter one’s room when told to do so) comprise the category of defiant.” Id. An act involving physical aggression was collapsed into this category because behavior that represents defiance of authority is assumed to elicit a similar response on the part of hospital staff.

52. Past studies have revealed a negative association between the degree of dangerous behavior exhibited in the hospital and the length of the detention. Hiday, Civil Commitment, supra note 6, at 24. Most studies have also indicated that dangerousness occurs within 7-10 days of admission. Id.; see generally Dale E. McNiel & Renee L. Binder, Predictive Validity of Judgments of Dangerousness in Emergency Civil Commitment, 144 AM. J. PSYCHIATRY 197 (1987). In light of these findings, a one month period is believed to be a reasonable amount of time to determine the extent to which restraint may or may not have been exercised. Statutory law indicates that “restraint may be used only when less restrictive measures are ineffective or not feasible . . . .” WIS. STAT. ANN. § 51.61(1)(i)(1) (West 1985).
anticipated that final hearings should be held with greater frequency and become more important in the decisionmaking process.

V. RESULTS

The distributions and significance of differences between each of the variables before and after the 1975 reform law are presented in Table 1 and Table 2 below. As anticipated, persons referred to emergency civil commitment spent a shorter length of time under the authority of the facility after the legislative reform than before the reform (mean = 11, compared to mean = 23).

**TABLE ONE**

**DIFFERENCES BETWEEN CONTINUOUS VARIABLES BEFORE AND AFTER PASSAGE OF THE LAW OF 1975 (ANOVA).**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Reform (N=200)</th>
<th>Post-Reform (N=400)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Logged Length of Stay</strong>* (range=0-6.48)</td>
<td>Mean=3.15 Std.Dev.=1.6</td>
<td>Mean=2.43* Std.Dev.=1.66</td>
<td>F=25.07*</td>
</tr>
<tr>
<td>Age (range=18-93)</td>
<td>Mean=38.91 Std.Dev.=18.61</td>
<td>Mean=36.24 Std.Dev.=15.34</td>
<td>F=3.50</td>
</tr>
</tbody>
</table>

* Unlogged mean for length of stay during pre-reform and post-reform periods is 23.33 and 11.35, respectively.
* Significant below .05
TABLE TWO

DIFFERENCES BETWEEN CATEGORICAL VARIABLES BEFORE AND AFTER PASSAGE OF THE LAW OF 1975 (CROSSTABS)

<table>
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<tr>
<th>Variables</th>
<th>Value</th>
<th>Pre-Reform (1975) (N=200)</th>
<th>Post-Reform (1975) (N=400)</th>
<th>Chi-Square</th>
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<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
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<td>Gender</td>
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<td>Male</td>
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<td>131 (66)</td>
<td>240 (60)</td>
<td>1.70</td>
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<tr>
<td>Female</td>
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<td>69 (34)</td>
<td>160 (40)</td>
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</tr>
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<td>Environmental Stability</td>
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</tr>
<tr>
<td>Alone</td>
<td>0</td>
<td>44 (22)</td>
<td>134 (34)</td>
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<tr>
<td>Facility</td>
<td>1</td>
<td>42 (21)</td>
<td>84 (21)</td>
<td></td>
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<tr>
<td>Acquaintance</td>
<td>2</td>
<td>114 (57)</td>
<td>182 (45)</td>
<td>9.52*</td>
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<tr>
<td>Prior Hospitalization</td>
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<tr>
<td>Zero</td>
<td>0</td>
<td>63 (32)</td>
<td>129 (32)</td>
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<tr>
<td>One</td>
<td>1</td>
<td>41 (20)</td>
<td>69 (17)</td>
<td></td>
</tr>
<tr>
<td>Two +</td>
<td>2</td>
<td>96 (48)</td>
<td>202 (51)</td>
<td>.96</td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>103 (52)</td>
<td>125 (31)</td>
<td>20.68*</td>
</tr>
<tr>
<td>Affect/Schizo</td>
<td>1</td>
<td>93 (47)</td>
<td>254 (64)</td>
<td></td>
</tr>
<tr>
<td>Object of Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property/Self</td>
<td>0</td>
<td>122 (61)</td>
<td>232 (58)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>78 (39)</td>
<td>168 (42)</td>
<td>.50</td>
</tr>
<tr>
<td>Seriousness of Harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Harm</td>
<td>0</td>
<td>118 (59)</td>
<td>160 (40)</td>
<td>19.36*</td>
</tr>
<tr>
<td>Cuts-Harm</td>
<td>1</td>
<td>82 (41)</td>
<td>240 (60)</td>
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</tr>
<tr>
<td>Behavior in Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooperative</td>
<td>0</td>
<td>58 (29)</td>
<td>111 (28)</td>
<td></td>
</tr>
<tr>
<td>Eccentric</td>
<td>1</td>
<td>107 (54)</td>
<td>178 (44)</td>
<td></td>
</tr>
<tr>
<td>Defiant</td>
<td>2</td>
<td>35 (17)</td>
<td>111 (28)</td>
<td>8.10*</td>
</tr>
<tr>
<td>Restraint</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td>147 (74)</td>
<td>170 (43)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>53 (26)</td>
<td>230 (57)</td>
<td>51.42*</td>
</tr>
<tr>
<td>Final Hearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td>120 (60)</td>
<td>149 (37)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>80 (40)</td>
<td>251 (63)</td>
<td>27.90*</td>
</tr>
</tbody>
</table>

* Due to missing cases in the pre-reform and post-reform periods, percentages do not equal 100.

b The “other” category consists of the following diagnoses: organic/mental retarded, personality disorder, anxiety disorder, disorder of impulse, psychosexual disorder, and adjustment disorder.

* Significant below .05
Following 1975, a substantial decrease exists in the category representing living with an acquaintance (-11%). During the same period, a significant increase occurred in the percentage of those living alone (+12%).

No observable changes were exhibited in the number of prior hospitalizations. Most individuals evidence two or more prior contacts with the system. A large percentage of people labeled as having an affective/schizophrenic disorder were present in the post-reform period in contrast to the pre-reform period. Persons most often referred during both time frames were those who engaged in an act against property or oneself. An increase in the severity of the potential or actual harm was evident following the 1975 reform (60% compared to 41%). Increases in deviant behavior within the hospital setting were also present after 1975. A similar increase in the use of restraint also existed. Contrary to expectations, final hearings did not occur with greater frequency following reform.

Up to this point in the analysis, shorter lengths of stay and greater indices of a need for treatment are evident after the 1975 reform effort. Increases in the degree of mental illness and the potential or actual harm caused by the behavior leading to the emergency civil commitment provide support for this belief. The rise in problematic behavior within the institution and in the practice of restraint also suggests the detention of a more dangerous inpatient population.53 With the exception of the unexpected reduction in the use of final hearings, the underlying and stated intentions of the 1975 reform law54 appear to have been implemented in Dane County, Wisconsin. To further test the validity of this claim, multivariate analyses were employed to simultaneously control the effects of each of the independent variables with logged length of stay. If adherence to the

53. An increase in a more dangerous hospital population and concomitant increase in the use of restraint does not alone mean an association exists between the two. A study of the use of restraint within a hospital setting in Dane County, Wisconsin, for example, revealed that the likelihood of this practice was most frequent for aggressive (45%) and defiant behavior (61%) prior to the 1975 reform. Leiber, supra note 51, at 10.

Following 1975, the figures rose to 84 percent and 76 percent, [for aggressive and defiant behavior] respectively. These findings indicate compliance with the intentions of the [1975] reform law. On the other hand, noncompliance [was] also evident as 61 percent of the individuals engaging in eccentric behavior were restrained after reform compared to just 25 percent before reform.

Id.

1975 reform occurred, mental illness and the severity of harm should be the stronger predictors of length of stay than age, gender, or possibly, prior hospitalization.

Results from regressing length of stay on the independent variables are shown in Table 3 below. The model for the pre-reform period (1969-1974) explained twenty-three percent (23%) of the variance in the number of days individuals were detained (p<.01 F=6.59). Forty-four percent (44%) of the variance in the number of days individuals were detained was explained by the same model for the period following reform (1977-1979; 1982-1984). This model was also significant (p<.01 F=29.04).

**TABLE THREE**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Reform (1975)</th>
<th>Post-Reform (1975)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beta</td>
<td>SE</td>
</tr>
<tr>
<td>Age</td>
<td>.02</td>
<td>.00</td>
</tr>
<tr>
<td>Gender</td>
<td>.19</td>
<td>.19</td>
</tr>
<tr>
<td>Environmental Stability</td>
<td>-.00</td>
<td>.11</td>
</tr>
<tr>
<td>Prior Hospitalization</td>
<td>.12</td>
<td>.11</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>.14</td>
<td>.18</td>
</tr>
<tr>
<td>Object of Behavior</td>
<td>.22</td>
<td>.19</td>
</tr>
<tr>
<td>Seriousness of Harm</td>
<td>-.08</td>
<td>.09</td>
</tr>
<tr>
<td>Behavior in Hospital</td>
<td>.23</td>
<td>.13</td>
</tr>
<tr>
<td>Restraint</td>
<td>.50</td>
<td>.20</td>
</tr>
<tr>
<td>Final Hearing</td>
<td>.93</td>
<td>.18</td>
</tr>
<tr>
<td>R²</td>
<td>.236</td>
<td></td>
</tr>
<tr>
<td>F=</td>
<td>6.59</td>
<td></td>
</tr>
<tr>
<td>N=</td>
<td>200</td>
<td></td>
</tr>
</tbody>
</table>

*Beta=Standardized Coefficient; SE=Standard Error; B=Unstandardized Coefficient.

* p<.10
** p<.05
*** p<.01
An examination of the results for the pre-reform period reveals four variables that are statistically significant. The model final hearing was the most powerful indicator of an individual's length of stay (Beta=.34). Net of all other independent variables, an individual who has a final hearing subsequently spends a longer amount of time under the authority of the institution. While behavior within the hospital and restraint also influence length of stay, the second strongest determinant is age (Beta=.23); older individuals experience longer periods of confinement.

During the post-reform period, the Ordinary Least Squares Regression estimates demonstrate that seven variables in the model significantly influence an individual's length of stay. Similar to the pre-reform results, final hearing, restraint, and age were also important determinants of the dependent variable. Behavior within the hospital is no longer a significant predictor of length of stay after the 1975 reform. Gender, environmental stability, and prior hospitalization, however, have an impact on the dependent variable. Females, those with less support in the community, and persons with more prior contact with the system increase the probability of longer lengths of stay. Of the observed relationships following reform, final hearing (Beta=.54), followed by restraint (Beta=.15) and age (Beta=.10) have the strongest effects on decision-making.

Because the variable final hearing was a significant factor in influencing an individual's length of stay, and became even more important after the 1975 reform, logistic regression was performed to assess the factors associated with this procedural right.\(^5\) The results from this analysis are provided in Table 4.

---

\(^5\) Since final hearing is a dichotomous variable, Logistic Regression is required rather than Ordinary Least Squares Regression. See generally ERIC A. HANUSHEK & JOHN E. JACKSON, STATISTICAL METHODS FOR SOCIAL SCIENTISTS (1977).
#### TABLE FOUR

**LOGISTIC REGRESSION RESULTS FOR FINAL HEARING ON ALL EXOGENOUS VARIABLES BEFORE AND AFTER LAW OF 1975**

<table>
<thead>
<tr>
<th>Variables</th>
<th>R</th>
<th>SE</th>
<th>B</th>
<th>R</th>
<th>SE</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.01</td>
<td>.01</td>
<td>.00</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Sex</td>
<td>.69</td>
<td>.34</td>
<td>.09**</td>
<td>-.31</td>
<td>.24</td>
<td>.00</td>
</tr>
<tr>
<td>Environmental Stabilityb</td>
<td>.00</td>
<td></td>
<td></td>
<td>.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility (1)</td>
<td>.15</td>
<td>.47</td>
<td>.00</td>
<td>-.02</td>
<td>.33</td>
<td>.00</td>
</tr>
<tr>
<td>Acquaintance (2)</td>
<td>.36</td>
<td>.39</td>
<td>.00</td>
<td>.36</td>
<td>.27</td>
<td>.00</td>
</tr>
<tr>
<td>Prior Hospitalizationb</td>
<td>.00</td>
<td></td>
<td></td>
<td>.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One (1)</td>
<td>.36</td>
<td>.39</td>
<td>.00</td>
<td>-.64</td>
<td>.27</td>
<td>-.08**</td>
</tr>
<tr>
<td>Two+ (2)</td>
<td>.14</td>
<td>.40</td>
<td>.00</td>
<td>.08</td>
<td>.31</td>
<td>.00</td>
</tr>
<tr>
<td>Mental Illness</td>
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<td>.33</td>
<td>.00</td>
<td>.06</td>
<td>.27</td>
<td>.00</td>
</tr>
<tr>
<td>Object of Behavior</td>
<td>.57</td>
<td>.35</td>
<td>-.05*</td>
<td>-.16</td>
<td>.24</td>
<td>.00</td>
</tr>
<tr>
<td>Seriousness of Harm</td>
<td>.04</td>
<td>.33</td>
<td>.00</td>
<td>-.44</td>
<td>.24</td>
<td>-.05*</td>
</tr>
<tr>
<td>Behavior in Hospitalb</td>
<td>.00</td>
<td></td>
<td></td>
<td>.13***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEH (1)</td>
<td>.26</td>
<td>.36</td>
<td>.00</td>
<td>1.06</td>
<td>.34</td>
<td>.13***</td>
</tr>
<tr>
<td>BEH (2)</td>
<td>.50</td>
<td>.49</td>
<td>.00</td>
<td>1.16</td>
<td>.36</td>
<td>.13***</td>
</tr>
<tr>
<td>Restraint</td>
<td>.28</td>
<td>.36</td>
<td>.00</td>
<td>-.83</td>
<td>.26</td>
<td>-.13***</td>
</tr>
</tbody>
</table>

-2 Log Likelihood           | 250.40***|      | 448.36***|
Degree of Freedom           | 183      |      | 336    |

*R=Standardized Coefficient; SE=Standard Error; B=Unstandardized Coefficient

b The reference category for environmental stability is being alone; for prior hospitalization the reference category is none; for behavior in hospital the reference group is cooperative.

* p<.10
** p<.05
*** p<.01

Contrary to the patterns found when regressing length of stay with the independent variables, very few significant associations exist with final hearing. During the pre-reform period, only gender and the object of the behavior leading to the emergency detention have statistically significant effects. Being female and directing certain types of behavior toward others increased the likelihood of having a final hearing. After the 1975 reform, these effects disappeared. Prior hospitalization, the severity of the harm, behavior within the hospital, and restraint are all associated with the probability of a final hearing. Persons with a history of one prior hospitalization, behavior resulting in cuts or harm, behavior within the hospital reflective of eccentricity...
and defiance, and restraint increase the likelihood of a final hearing. Of these effects, the strongest are restraint (R=-.13) and behavior within the hospital (R=.13).

VI. DISCUSSION

An important underlying objective of the 1975 reform law was the protection of personal autonomy from unnecessary state intervention. We hypothesized that if this objective was to be accomplished, noticeable differences should be more evident after reform, rather than before it, in the following respects: (1) characteristics of those referred for emergency civil commitment; (2) extent to which legal factors impact decisionmaking; and (3) amount of time an individual is subject to involuntary state intrusion. Therefore, the primary impetus for evaluating the 1975 reform law was to discern the extent to which these anticipated changes occurred in commitment practices in Dane County, Wisconsin.

Legal reform should be assessed along various dimensions rather than in absolute terms. Thus, the findings suggest both significant advances to protect persons from unnecessary intrusive interventions, as well as the presence of significant gaps between intentions and implementation of the 1975 reform effort.

Evidence was present which indicated persons referred for emergency civil commitment exhibited more severe forms of mental illness and degrees of dangerousness. The results also revealed that the legal factors of final hearing, prior commitment, and restraint were related to decisionmaking following reform. Individuals who had a final hearing, were previously hospitalized or subject to restraint evidenced longer lengths of stay than those who had no hearing, no prior commitments or restraint. In addition, persons most likely to have a final hearing were those who exhibited problematic behavior. Individuals also spent less time under the auspices of the Mendota Mental Health Facility after the 1975 reform than before its enactment. These findings, for the most part, are consistent with the "spir-

56. See supra note 11.
57. In general, it is practical to assume and expect that formal and informal legal norms, political events, organizational necessities, and psychological motives will effect the implementation of legal mandates. Stephen Vago, Law & Society (1981); see generally David B. Wexler, The Structure of Civil Commitment: Patterns, Pressures, and Intentions in Mental Health Legislation, 7 Law & Hum. Behav. 1 (1983).
it” of the 1975 reform law.58

Contrary to expectations and the underlying intentions of the reform effort,59 a significant proportion of detainees still evidenced behavior leading to the emergency detention that involved no actual harm.60 In addition, the expected increase in the use of the final hearing was not evident. Likewise, the importance of the detainee's degree of dangerousness and mental illness seemed to have no impact on the determination of the length of stay or the probability of a final hearing. Although a patient's behavior within the hospital setting influenced the use of a final hearing, there is no evidence of such an effect upon the length of stay. Age, gender, and environmental stability, however, influenced the decisionmaking process.

On the basis of these findings, concerns arise that mental health decisionmakers may not be acting in the best interests of the client. This may account for the lack of a substantial increase in the degree of dangerousness justifying the emergency detention and the non-effects of this variable, as well as other legal factors which have an impact on commitment proceedings. Adherence to this principle may

58. Lessard, 344 F. Supp. at 1096; Dickey, supra note 13, at 28. For discussion of the underlying concerns of the 1975 reform law, see supra note 40 and accompanying text.


60. It was believed that reforms in civil commitment legislation aimed at reducing medical prerogative and increasing observable dangerousness as the criterion for involuntary intervention would lead to a reduction in admission rates and the detention of more persons exhibiting greater dangerousness. See Hiday, Civil Commitment, supra note 6, at 15-16. Most studies have failed to provide support for such a view. Bagby and Atkinson, for example, provide a comprehensive overview of the past research conducted assessing changes in admission rates following the implementation of reform intended to limit civil commitment. See generally Bagby & Atkinson, supra note 12. In their review of 17 independent data sets addressing this issue, findings from 15 of those studies suggest short-term decreases in civil commitment rates followed by post-reform increases. Id. See also Virginia A. Hiday, New Involuntary Commitment Legislation: Impact on State Mental Hospitals (1979) (unpublished manuscript, on file with the Department of Psychiatry, Duke University); Bick Wanck, Two Decades of Involuntary Hospitalization Legislation, 141 Am. J. Psychiatry 33 (1984). Most studies have also found less evidence of dangerousness than would be expected under restrictive standards of dangerousness. See Hiday, Civil Commitment supra note 6, at 37. A large proportion of persons are still defined as dangerous by inclusion in the broad category of “gravely disabled.” See Durham & La Fond, supra note 11, at 409-10. McNiel and Binder did find an increase in the number of persons detained as dangerous to others following reform, though no significant differences were observed in violence. See McNiel & Binder, supra note 52, at 199. Likewise, Peters and associates in their assessment of the impact of reform in Florida discovered greater evidence of dangerousness. However, threats accounted for 58% of the dangerousness. See Peters et al., supra note 12, at 90.
also explain why older persons, females, and those that lack support in the community received longer lengths of stay than younger individuals, males, and those who have a support network.  

Benevolent intentions that provide little protection from unnecessary loss of rights and liberty are not sufficient. Courts, legislators, and scholars have recognized that adherence to the principle of *parens patriae* is an invitation to arbitrariness. The stated and underlying intentions of the 1975 reform effort, and the *Lessard* decision in particular, reject the notion of “good” intentions on these grounds. Both of these reform efforts insist upon evidence of dangerousness and mental illness as justification for intervention.

61. It appears that age, gender, and the degree of social support may condition decisionmakers' views of a need for treatment in Dane County, Wisconsin. In their assessment of reform in Nebraska, Luckey and Berman also discovered differential treatment. James W. Luckey & John J. Berman, *Effects of a New Commitment Law on Involuntary Admissions and Service Utilization Patterns*, 3 Law & Hum. Behav. 149, 154-57 (1979). For example, males were found to be more likely than females to be committed. *Id.* at 154. Luckey and Berman believed this discrepancy was the result of actual behavioral differences and the reaction of decisionmakers to those behavioral tendencies. *Id.* at 160. Males were believed to be more likely to engage in acts against others, while females were thought of as more likely to participate in suicidal behavior or threats of suicide. *Id.* It was their contention that the former criterion was viewed by others as more dangerous than the latter. *Id.* at 149. Some have also argued that, compared to males, females often lack social support and, therefore, are less likely to prevent commitment. Carol A.B. Warren, *The Court of Last Resort: Mental Illness and the Law* (1982). See generally James A. Holstein, *Producing Gender Effects on Involuntary Mental Hospitalization*, 34 Soc. Probs. 141 (1997); James A. Holstein, *Court-Ordered Insanity: Interpretive Practice and Involuntary Commitment* (1993).

62. The fact that a deprivation of liberty was benevolently motivated provides little justification or comfort to the individual. "The rationale neither minimizes the deprivation nor eliminates the need for procedural safeguards." David S. Douglas et al., *RX for the Elderly: Legal Rights (and Wrongs) Within the Health Care System*, 20 Harv. C.R.-C.L. L. Rev. 425, 442 n.103 (1985) (citing Roger B. Sherman, *Guardianship: Time for a Reassessment*, 49 Fordham L. Rev. 350, 362 (1980)).

63. For discussion of due process and its application, see *supra* notes 1, 4 & 5 and accompanying text.


65. See *supra* notes 3, 38.


67. See generally Leiber, *supra* note 16.

Persons suspected of a need for treatment may also be treated by means that lack constitutional safeguards. This may account for the failure to find the expected increase in the use of the final hearing following the reform. One alternative method for dealing with the needs of dangerous and mentally ill persons exists within the 1975 reform law itself. Contained within the law is a procedure that states, if probable cause has been found, an individual may be released if he or she agrees to abide by certain conditions as determined by the court. If acceptance of treatment, for example, is made a condition of such a release, a person may elect to accept the condition or choose detention pending the final hearing. A final hearing must be held within fourteen to twenty-one days for a person in custody and thirty days if the person has been released while awaiting further proceedings. If a person has abided by all the conditions of the "negotiated settlement," the proceedings typically conclude at the end of the thirty-day period as does the need for a final hearing.

On its face, the utilization of this procedure may be reflective of the least restrictive treatment alternative in civil commitment proceed-

incorporation of variables present within hospital setting into the definition of dangerousness, see supra note 51.

69. Stier and Stoebe's examination of Iowa's civil commitment process and Warren's study of California law, for example, suggest that in both states public defenders acted in the "best interests" of their clients rather than in an adversarial defense as required by legislative standards. See Stier & Stoebe, supra note 12, at 1343. Accordingly, defense attorneys rarely called witnesses, used cross examination, or mounted an aggressive defense. As a result, individuals were often confined on the basis of mental illness alone. Id.; Warren, supra note 12, at 633. The filing of temporary conservatorships as a means to prolong confinement, the relabeling of persons on 72-hour detentions as "gravely disabled," and the use of conservatorship proceedings in general were all methods used in California to circumvent legislative intentions to protect individual rights. H. Richard Lamb et al., Legislating the Control of the Mentally Ill in California, 138 AM. J. PSYCHIATRY 334-37 (1981); Warren, supra note 12, at 40; Grant H. Morris, Conservatorship For the "Gravely Disabled": California's Nondeclaration of Nonindependence, 15 SAN DIEGO L. REV. 201 (1977-1978). A recent study also indicates mentally ill persons may end up in the criminal justice system. Robert D. Miller, Economic Factors Leading to Diversion of the Mentally Disordered From the Civil to the Criminal Commitment System, 15 INT'L J.L. & PSYCHIATRY 1, 8-12 (1992); Dickey, supra note 13, at 22, 35-36.

70. WIS. STAT. ANN. § 51.20(7)(a)-(e) (West 1984-1985).

71. Id.

72. Id.

73. Id.

74. Id.

75. See generally KELLITZ & MCGRAW, supra note 13; Leiber, supra note 16.
The problem with this method of providing treatment, however, is that persons are subject to state control, often without the benefit of the final hearing, to determine the necessity for such an intrusion. Without the final hearing, many of the procedural safeguards afforded to individuals are lost. For example, access to a hearing by one's peers is forsaken as is a finding of mental illness, dangerousness, and the need for continuing intervention upon a standard of clear and convincing evidence. The Lessard Court clearly stated that "[t]he resulting burden on the state to justify civil commitment must be correspondingly high." This sentiment should apply with equal vigor whether a person is facing inpatient hospitalization, psychiatric therapy or medication while living in the community. In either situation, personal liberty is intruded upon without due process of law.

76. Lessard v. Schmidt, 349 F. Supp. 1078, 1095-98 (E.D. Wis. 1972). Although somewhat of an elusive concept, the traditional interpretation of the least restrictive treatment alternative suggests that government intervention should not intrude upon individual autonomy and other constitutional rights to a greater degree than is necessary to achieve a legitimate purpose. Shelton v. Tucker, 364 U.S. 479, 488 (1960); Lake v. Cameron, 364 F.2d 657, 660 (D.C. Cir. 1966). There is some disagreement, however, as to the doctrine's meaning and purpose as it applies to civil commitment. See P. Browning Hoffman & Lawrence L. Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses, 14 SAN DIEGO L. REV. 1100 (1977). "As administration of the doctrine varies among jurisdictions, so does opinion about its scope." Id. at 1119.

79. Lessard, 349 F. Supp. at 1090.
80. In a recent Wisconsin Court of Appeals decision, the court ruled that a guardian did not have the authority to enter a ward's home, detain her, and forcibly administer psychotropic drugs. State ex rel. Roberta S. v. Waukesha County Human Services Dep't., 491 N.W.2d 114, 118 (Wis. 1992) (To allow such practices would run contrary to "the type of paternalistic intervention that the legislature and the courts have sought to minimize in their dealings with mentally ill individuals.").
81. An argument could be made that an individual still has the right to a probable cause hearing. Wis. Stat. Ann. § 51.20(7)(a) (West 1975). Still, the procedural safeguards are less than that at the final hearing. In addition, the argument could be made that persons "voluntarily" agree to the settlement. The problem with this position is that it assumes individuals are making an informed decision and/or are allowed to make their choice freely. It assumes individuals will not be intimidated by the environment in which they have been involuntarily institutionalized. It assumes individuals will make their decision without the employment of coercive tactics on the part of interested parties. Several studies indicate that court procedures (continuances or stays) and professional persuasion are often used to coerce persons into "voluntary" admissions to avoid the time-consuming court proceedings associated with involuntary commitment. See Dan A. Lewis et al., The Negotiation of Involuntary Civil Commitment, 18 LAW & SOC'Y REV. 629, 639-40 (1984); Janet A. Gilboy & John R. Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429, 429-31,
VII. CONCLUSION

Although the findings from this study are important, further research is needed to elaborate on the present research and extend the questions raised beyond Dane County, Wisconsin to commitment practices elsewhere. The task of this further research should be to determine if the observed findings portray current decisionmaking on commitment practices. Future research, for example, should focus more specifically on the use of "negotiated settlements" and the increasing importance of final hearings in commitment proceedings. Ethnographic methodologies, observational techniques, or interviews should also be used to account for historical effects and the social context in which decisionmaking occurs. Until this happens, the findings reported here suggest the partial attainment of a balance between protecting individual liberty and preserving society's moral.

436-37 (1971); Virginia A. Hiday, Court Discretion: Application of the Dangerousness Standard in Civil Commitment, 5 LAW & HUM. BEHAV. 275, 275 (1981). A compromise needs to be reached between those who are concerned with treating mentally ill persons and those who want people to be assured greater due process protections. Samuel J. Bra kel et al., The Mentally Disabled and the Law 378-79 (3d ed. 1985). One means to accomplish both, as this issue relates to the use of the negotiated settlement, is to eliminate the probable cause hearing and have the final hearing held within 10 days of the initial detention. The option of conditional release would not be available until a final hearing was held. If the individual is found to be mentally ill and dangerous to oneself and/or others the court could: (1) involuntarily institutionalize the person; and/or (2) order an outpatient commitment that could not exceed the length of an order for involuntary commitment. The adoption of this method would still assure the court authority over the person once he or she was released into the community. However, this would be done only after an individual has been assured due process of law by a final hearing.

82. An important consideration in any empirical study is the quality of the data analyzed. The data used for this study relied upon official records and in some instances data which contained allegations and conclusory statements which have not necessarily been substantiated by fact (e.g., police reports). Therefore, it is uncertain whether the behavior reported is reflective of the persons detained or of the individuals or organizations doing the reporting. See Richard McCleary et al., Uniform Crime Reports as Organizational Outcomes: Three Time Series Experiments, 29 SOC. PROBS. 361 (1982). It is possible, for example, that police officers and mental health officials simply wrote more or less specific information detailing behavior. At this point, the extent to which the data used were contaminated by such effects lies in the realm of conjecture, and rests strongly on arguments for their "face validity." Frank E. Hagan, Research Methods in Criminal Justice and Criminology 182 (1982).
obligation to provide needed treatment.†††

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