

1974

Some Interactions of Law and Mental Health in the Handling of Social Deviance

Saleem A. Shah

Follow this and additional works at: <https://scholarship.law.edu/lawreview>

Recommended Citation

Saleem A. Shah, *Some Interactions of Law and Mental Health in the Handling of Social Deviance*, 23 Cath. U. L. Rev. 674 (1974).

Available at: <https://scholarship.law.edu/lawreview/vol23/iss4/4>

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Catholic University Law Review by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

Some Interactions of Law and Mental Health in the Handling of Social Deviance

Saleem A. Shah*

There is a very long but perhaps not too distinguished history of interactions between the legal and mental health systems with respect to the handling of persons who have been officially defined as mentally ill. Such interactions have especially involved those who have been accused of law violations and who have also been considered to be mentally disturbed.

As Wootton¹ has pointed out, some of the most striking changes in public attitudes and policies towards social deviants² have very much been influenced during the past two centuries by medical and psychiatric concepts and by the development of the mental health movement. For example, in eighteenth century France no clear distinctions were drawn between criminals and the mentally ill. The mentally ill were regarded and treated much like criminals. Under the combined influence of the humanitarian and mental health movements these attitudes and practices in regard to the mentally ill underwent major changes. It appears also to have been found that the force of humanitarian arguments was appreciably increased if they were couched in the idiom of medicine and mental health. In more recent years, an increasingly wide range of social deviants (*e.g.*, sexual offenders, chronic alcoholics, drug users and abusers) have come to be regarded as suffering from mental disease. Indeed, it has been suggested that the growing encroachments of the "Therapeutic State" have very serious implications

* Chief, Center for Studies of Crime and Delinquency, National Institute of Mental Health, Rockville, Maryland; B.A. Allahabad University, India; M.S. (1955) and Ph.D. (1957), in Clinical Psychology, Pennsylvania State University.

This article is an expanded and revised version of a presentation made at the Conference on Mental Health and the Law, the School of Law, Catholic University, Washington, D.C., January 19-20, 1974. I would like to acknowledge the very helpful comments and suggestions received from Prof. Alexander Brooks and Mr. Herbert Silverberg.

1. B. WOOTTON, *SOCIAL SCIENCE AND SOCIAL PATHOLOGY* (1959).

2. The term social deviants is used in a broad sense to describe and to encompass persons whose behavior has deviated from major societal norms. For purposes of this discussion the term will be used to include those viewed and labelled as law violators, mentally ill, and delinquent, as well as persons variously labelled as sexual psychopaths, sexually dangerous persons, defective delinquents, etc.

for public policy in the handling of a wide range of socially deviant behavior.³

Despite the unquestionable social benefits which have resulted from the aforementioned humane and therapeutically oriented contributions to the handling of social deviants, the psychiatric and mental health ideologies and approaches appear to have also contributed a number of problems. In the main, these problems pertain to a gradual confusing and confounding of the social control and deterrent objectives of the criminal law with the therapeutic concerns and objectives of mental health.⁴

During the past century there have been increasing efforts to distinguish between those law violators who are handled under provisions of the police powers of the State via the *criminal* process, and those who are considered to be in need of care and treatment (e.g., juveniles, the mentally ill, sexual psychopaths, etc.), and whose handling has been premised on the *parens patriae* obligations of the State. The latter proceedings have been termed "civil." It is argued that since these "civil" proceedings are not designed to inflict sanctions, as in the "criminal" process, but rather to provide treatment and remediation, the usual due process and other procedural safeguards are not necessary. However, despite the repeated assertions of benign intentions as well as the idealistic rhetoric that have typified such "civil" proceedings in light of the actual consequences which typically follow there is good reason to believe that the asserted societal motives have undoubtedly been less than benign. In many instances the *parens patriae* justification appears to have been designed in large measure to avoid constitutional prohibitions against preventive detention and against the denial of other due process and related procedural safeguards which are required under the criminal process.⁵

There have been many criticisms of the manner in which societal handling of the mentally ill has been justified by invoking *parens patriae* functions. In its recent and very commendable report on the topic of pretrial incompetency, the Group for the Advancement of Psychiatry (hereinafter referred to as the GAP Report) was led to remark:

As one surveys the demeaning and degrading conditions which exist in hospitals for the criminally insane, the awful hypocrisy of our society and its system of criminal justice stands revealed in the harsh light of reality. American psychiatry, if for no other reason

3. See, e.g., N. KITTRIE, *THE RIGHT TO BE DIFFERENT* (1971).

4. See, e.g., Shah, *Crime and Mental Illness: Some Problems in Defying and Labeling Deviant Behavior*, 53 *MENTAL HYGIENE* 21 (1969).

5. See, e.g., A. Dershowitz, *Preventive Confinement: A Suggested Framework for Constitutional Analysis*, 51 *TEXAS L. REV.* 1277 (1973); N. KITTRIE, *supra* note 3; Shah, *supra* note 4.

that its passive complicity in this situation, must share the burden of social responsibility for it.⁶

The comments of the GAP Report with respect to facilities for the criminally insane are also equally relevant to most state and county mental hospitals and related facilities for sexual psychopaths and delinquent juveniles.

Most certainly, as several authorities have pointed out, there are many dangers which lurk when our society ostensibly sets out to deal with individuals in "remedial and therapeutic" fashion. For example, the U.S. Supreme Court was led to comment in *Minnesota ex rel. Pearson v. Probate Court*:⁷

We fully appreciate the danger of a deprivation of due process in proceedings dealing with persons charged with insanity or, as here, with a psychopathic personality as defined in the statute, and the special importance of maintaining the basic interests of liberty in a class of cases where the law though "fair on its face and impartial in appearance" may be open to serious abuses in administration and courts may be imposed upon if the substantial rights of the persons charged are not adequately safeguarded at every stage of the proceedings.⁸

The Scope of this Discussion

Given the voluminous literature that has accumulated on the topic to be addressed and the numerous and conflicting views and opinions to be encountered, perusal of the relevant literature reveals something close to the synopated chaos that one associates with the Tower of Babel.⁹

The topics and problems alluded to in the foregoing introductory statement will be the major concern of this presentation. The several issues to be addressed are organized under the following main headings: 1) The conceptualization of behavior and of social deviance; 2) The confusion of social control and therapeutic objectives; 3) The need for greater accountability in the social-legal handling of the mentally ill; 4) "dangerousness" and the mentally ill; and 5) the rights of mental patients and judicial default.

6. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, *Misuse of Psychiatry in the Criminal Courts: Competency to Stand Trial*, 8 COMM. ON PSYCHIATRY AND LAW 853, 861 (1974).

7. 309 U.S. 270 (1940).

8. *Id.* at 276-77.

9. See, e.g., E. Springer, *Law and Medicine: Reflections on a Metaphysical Misalliance*, 3 MILBANK MEMORIAL FUND QUARTERLY 255 (1972), where these sentiments have been expressed in describing the more general relationships between law and medicine; they appear equally applicable in this context.

The Conceptualization of Behavior and of Social Deviance

A major point of common concern to the law and to the mental health system, as well as to the behavioral and social sciences, pertains to efforts to better understand and to influence human behavior.¹⁰ Since the major societal concern with problems of deviance pertains to behavior, it is necessary to give careful thought to how behavior is conceptualized. A number of problems and misunderstandings seem to stem from the manner in which different people (as well as disciplines) view and understand behavior—be it prosocial, antisocial, deviant or conforming. Since many of these issues have been discussed at more length elsewhere,¹¹ only a few major points will be noted here.

The conceptualization of behavior. Behavior must be viewed and understood in reference to its social, environmental and situational context. In other words, behavior is properly conceptualized as involving an interaction between an individual and a particular physical and social environment. Behavior is neither fixed nor is it absolute and unvarying; rarely does behavior involve only the individual. For example, one does not behave on the job as he does at the New Year's party, the locker room of a gymnasium, or at a poker game. To varying degrees the physical and social environment influences and controls the kind of behavior displayed. Thus, even persons described in the community and in certain settings as quite erratic, impulsive and troublesome, may show very different behavior in a classroom or they may even be described as "model inmates" within a penal environment. Such observations about the variability of behavior are surprising only if one views behavior as a somewhat fixed and unchanging quality or characteristic residing entirely *within* the individual, or as a function entirely of one's personality. While there are undoubtedly fairly consistent behavioral characteristics (which are often referred to as an individual's *personality*), the particular behavior displayed will also be determined by various social and situational factors.

In essence, then, it is being suggested that efforts to understand, evaluate, predict, prevent and to treat an individual's behavior should not concentrate *solely* upon discovering or uncovering aspects of his or her personality and

10. While the law is also very much concerned about the motives and intentions of the actor, the individual typically comes to attention by virtue of his or her overt behavior, and it is this behavior that is subsequently sought to be changed through various deterrent, therapeutic, rehabilitative, and correctional methods.

11. See, e.g., H. BECKER, *OUTSIDERS: STUDIES IN THE SOCIOLOGY OF DEVIANCE* (1963); T. SCHEFF, *BEING MENTALLY ILL* (1966); L. ULLMAN & L. KRASNER, *A PSYCHOLOGICAL APPROACH TO ABNORMAL BEHAVIOR* (1969); J. Kitsuse, *Societal Reaction to Deviant Behavior: Problems of Theory and Method*, 9 *SOCIAL PROBLEMS* 247 (1962); Shah, *supra* note 4.

psychodynamics. It is also important to understand and to give careful attention to the particular physical and social environment and the situational contexts in which certain types of behavior were displayed, and the extent to which such environmental factors might increase the probability of such behaviors being displayed in the future.¹²

The conceptualization of social deviance. The discussion of social deviance (e.g., delinquency, crime and mental illness) appears often to be based upon the assumption that the deviant behavior indicates something inherently different about the individual, or that it reflects some special characteristic of the person, e.g., mental disorder or "dangerousness." We have already noted that, to varying degrees, the social and physical environment helps to influence the form and frequency of the behavior which is displayed.

Moreover, the determination of *deviance* obviously implies a set of values and standards in reference to which specific acts and/or the individuals who display such acts are judged to be deviant. Thus, the social values which establish the societal standards for judging deviance, and the power and influence which support particular values, are unquestionably rather integral and important aspects of the deviancy defining and labelling process. Likewise, since different groups tend to judge different things as deviant, the determination of deviance very much involves the persons or groups making the judgment, the particular processes by which such judgments are reached, the values and norms used by those responsible for evaluating the particular sample of behavior, and the situation or context in which the behavior occurred and also the context in which the evaluatory judgments are made. It follows, therefore, that deviance does *not* reflect only some special characteristic or quality residing within the individual.¹³

Behavior that may be labeled as deviant or abnormal should be studied as the interaction of at least three major variables: (1) the behavior itself; (2) the social context in which the behavior occurs; and (3) an observer who is in some position of power or influence.

To illustrate: An individual may *do something* (e.g., verbalize hallucinations or delusions, stare vacantly into space, or expose his genitals) under a *particular set of circumstances* often considered inappropriate (e.g., in a public place, in the presence of strangers, or in the middle of a busy street),

12. For further discussion of this view of behavior and personality, see R. BARKER, *ECOLOGICAL PSYCHOLOGY* (1968); W. MISCHEL, *PERSONALITY AND ASSESSMENT* (1968); R. MOOS, *Conceptualizations of Human Environments*, 28 *AM. PSYCHOLOGIST* 652 (1973).

13. See, e.g., H. BECKER, *supra* note 11; T. SCHEFF, *supra* note 11; Kitsuse, *supra* note 11.

which then *upsets, angers, or strongly disturbs somebody* (*viz.*, passersby, employers, relatives) to the extent that *some type of action is then taken* (*e.g.*, a policeman may be called, civil commitment proceedings initiated, or criminal charges preferred). At this point society's professional labelers (*viz.*, physicians, psychiatrists, prosecuting attorneys, judges and juries) come into contact with the individual and determine which of the applicable labels (*e.g.*, schizophrenic reaction, juvenile delinquent, sexual psychopath, com-mittably mentally disturbed, etc.) seems most appropriate in reference to the particular societal purposes to be served. Finally, there follow attempts to control and to change the individual and his disturbing behavior for purposes of social defense as well as for therapeutic and rehabilitative reasons; this may be done through involuntary hospitalization, through penal sentencing, or through the provision of rehabilitative and treatment services in the open community.¹⁴

It should be evident, therefore, that the behavior of a person may or may not be viewed as annoying depending upon who observes such behavior and who the actor happens to be. Indeed, the particular behavior displayed by an individual is often judged to be deviant primarily in terms of the social context in which the behavior occurs—rather than simply the characteristics of the behavior itself. For example, undressing is essential and typically a prerequisite to taking a bath, partial disrobing is considered necessary to go swimming, usually complete undressing is necessary to engage in "streaking," but the same partial or complete disrobing in a different social context or setting may bring criminal charges of indecent exposure.

Finally, just because an individual engages in some socially prohibited (deviant) act does not necessarily imply that the *individual* (and not simply a particular aspect of his *behavior*) is deviant. The assumption might at times be made that the samples of observed behavior (*viz.*, deviant and/or dangerous acts) are fairly representative or typical of the individual. Hence, through a conceptual short cut, not only are particular aspects of a person's behavior viewed as deviant or dangerous, but the *individual himself* comes to be viewed and officially labeled as dangerous. This in many instances may be misleading and even inaccurately stigmatizing since the deviant behavior may be a rare event and not very typical of the individual.

The Confusion of Social Control and Therapeutic Objectives

Despite the many and even shrill warnings of persons like Thomas Szasz,¹⁵

14. See L.P. ULLMAN & L. KRASNER, *supra* note 11.

15. See T. SZASZ, *IDEOLOGY AND INSANITY* (1970); T. SZASZ, *PSYCHIATRIC JUSTICE* (1965); T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* (1953); T. Szasz, *Commitment of*

psychiatrists and other mental health professionals seem not to appreciate fully the manner and extent to which—in conjunction with the legal system—they function essentially as agents of social control. A major set of interactions between law and psychiatry pertains to the application, under the auspices of various deprivations of liberty (e.g., involuntary commitment under a variety of “criminal” and “civil” proceedings) to social deviants in the interests of the community. The imposition of such *sanction-equivalents* (whether for social defense, remediation, or treatment) in situations where the individual is in conflict with the community and where a collective societal response is being undertaken, involves a very different role and functions than the one typically reflected in the private relationship between a physician and his patient.¹⁶

Regrettably, our society has seriously blurred and confounded the important distinctions between situations where coercive actions of the state are primarily for purposes of social control and premised on the police powers of the state to protect the larger community, and the situations in which involuntary interventions in the lives of individuals are based upon truly humane and remedial concerns, viz., based upon the *parens patriae* responsibilities of the state. Since the legal handling of persons faced with various *parens patriae* motivated interventions is premised on the legal fact of their being adjudged in need of care and treatment because of mental illness, various medical and psychiatric sounding terms (“mental disease or defect,” “disease of the mind,” etc.) and medical, psychiatric and other mental health experts have come to play a critically important role in the official labelling of certain deviants. Thus, the law increasingly borrowed medical and psychiatric concepts, began to rely more heavily on such experts, and as a result has found a blurring and confusing of legal and psychiatric concepts and approaches. Indeed, in recent years there has been quite justified concern that physicians and psychiatrists have come to have an undue and inappropriate role and influence in the making of decisions which involve essentially matters of social policy and legal judgments.¹⁷

the Mentally Ill: "Treatment" or Social Restraint? 125 J. OF NERVOUS AND MENTAL DISEASES 293 (1957).

16. See, e.g., G. Dession, *Psychiatry and Public Policy*, 18 PSYCHIATRY 1 (1955).

17. It is the view of this writer that many of the problems pertaining to the blurring and confounding of fundamentally legal and social policy questions with psychiatric and mental health concerns have come about in large measure as the result of the very narrow and two way dialogue on these issues between law and psychiatry. The various groups and committees of the American Bar Association which have concerned themselves with these matters have typically—if not even invariably—involved lawyers and psychiatrists. Even the advisory committees of the American Bar Foundation which have pursued research projects concerned broadly with problems of the mentally disabled have consisted of lawyers and psychiatrists; see, e.g., A. MATTHEWS, MENTAL

The confounding of "expert witness" and judicial roles. In view of the gradual confusing and confounding of social control and therapeutic interventions, the roles and responsibilities associated with such societal interventions have also tended to become intertwined. Over the years the courts have periodically expressed concern about this situation but, until recently, the degree of such expressed concern has rather easily been over-matched by the willingness of judges to allow "experts" to testify on ultimate legal questions and to serve up ultimate conclusions and solutions for ready use by the triers of fact. In short, courts have rather typically failed in this area to undertake the careful *judicial* determinations required of them.

The U.S. Supreme Court has tried to make very clear that the ultimate decisions on legal questions are for the court or jury—not for expert witnesses. For example, in *United States v. Spaulding*,¹⁸ in a case involving medical opinions on an individual's total disability, the Court said:

The medical opinions that respondent became totally and permanently disabled before his policy lapsed are without weight. . . . [T]hat question is not to be resolved by opinion evidence. It was the ultimate issue to be decided by the jury upon all the evidence in obedience to the judge's instructions as to the meaning of the crucial phrase, and other questions of law. *The experts ought not to have been asked or allowed to state their conclusions on the whole case.*¹⁹

After eight years of experience with the decision in *Durham v. United States*²⁰ and its judicial definition of the terms "mental disease and defect," it was evident that jurors often were relying upon expert witnesses to define and to make decisions on the ultimate legal questions. Thus, in

DISABILITY AND THE CRIMINAL LAW (1970); R. ROCK, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL (1968). Behavioral and social scientists and persons representing the disciplines of psychology, social work, sociology, etc., have been conspicuous in their absence. Likewise, the wide range of issues concerning the interactions of the legal and mental health systems often have been discussed within the narrow context of psychiatry and law or even that of forensic psychiatry.

However, it must be noted that this situation has been changing, and increasingly such discussions are beginning to involve behavioral and social scientists and members of other disciplines in the mental health field. As a clear indication of this trend, the recently established American Bar Association Commission on the Mentally Disabled is multi-disciplinary in composition and also includes lay persons. Of the seven positions on the commission which had been set aside for various mental health disciplines, one is filled by a social worker, two by psychologists, and four by psychiatrists. Obviously, this proportion does not relate to the relative numerical strength of the membership of these professions; rather, it seems to reflect perceptions about their social and political power and influence. Nevertheless, this is most certainly a step in the right direction.

18. 293 U.S. 498 (1935).

19. *Id.* at 506 (emphasis added).

20. 214 F.2d 862 (D.C. Cir. 1954).

*McDonald v. United States*²¹ the United States Court of Appeals for the District of Columbia sought to correct this situation:

. . . Our purpose now is to make it very clear that neither the court nor the jury is bound by the *ad hoc* definitions or conclusions as to what experts state is a disease or defect. *What psychiatrists may consider a "mental disease or defect" for clinical purposes, where their concern is treatment, may or may not be the same as mental disease or defect for the jury's purpose in determining criminal responsibility.*²²

The fundamental importance of the distinctions between the role of psychiatric and other mental health experts and the role of the triers of fact was further emphasized by the same court in several other decisions. For example, in *Washington v. United States*²³ the court again sought to make clear the separate roles of the "expert" and the jury; the purpose was to ensure that the expert's conclusions would not be so heavily weighted in the minds of the jury in making the ultimate legal determination. Although noting that it had hoped that experts could separate their medical judgments from the legal and moral judgments which were for the court and jury, the court remarked that experts too often provided conclusory labels rather than the basic facts and analysis underlying such conclusions. Hence in *Washington* the court felt obliged to provide further clarification:

With the relevant information about the defendant, and guided by the legal principles enunciated by the court, the jury must decide, in effect, whether or not the defendant is blameworthy. Undoubtedly, the decision is often painfully difficult, and perhaps its very difficulty accounts for the readiness with which we have encouraged the expert to decide the question. *But our society has chosen not to give this decision to psychiatrists or to any other professional elite but rather to twelve lay representatives of the community.*²⁴

Also in *Washington* the court decided not to allow expert witnesses to testify on the issue of "productivity" in regard to the use of the insanity defense, *viz.*, whether the alleged crime was a "product" of a mental disease or defect, since this was the ultimate legal issue to be decided by the jury. The court also noted that:

It has often been argued that in the guise of an expert, the psychiatrist became the thirteenth juror, and unfortunately the most important one.²⁵

However, in its en banc decision in *United States v. Brawner*²⁶ the District

21. 312 F.2d 847 (D.C. Cir. 1962).

22. *Id.* at 850-51 (emphasis added).

23. 390 F.2d 444 (D.C. Cir. 1967).

24. *Id.* at 453-54 (emphasis added).

25. *Id.* at 451.

26. 471 F.2d 969 (D.C. Cir. 1972).

of Columbia Circuit shifted away somewhat from the earlier decisions to disallow expert testimony on the ultimate legal issue of "productivity" (*i.e.*, the causal relationship between the mental disease or defect and the alleged criminal act); it was there stated that such expert testimony may be offered. The decision did, nevertheless, very explicitly and repeatedly emphasize that experts cannot be allowed to offer conclusionary testimony on ultimate legal issues. For example, the court noted that jury decisions have been accorded "unusual deference" even when they have found responsibility in the face of a powerful record, with uncontradicted medical evidence, pointing to exculpation. It was pointed out that there was no departure from previous doctrines of the court built up over several years which assure "broad representation to the jury" concerning such issues; however, such testimony needed to "be accompanied by presentations of the facts and premises underlying the opinions and conclusions of the experts."²⁷

The foregoing points were further emphasized in *Browner* as follows:

It is the responsibility of all concerned—expert, counsel and judge—to see to it that the jury in an insanity case is informed of the expert's underlying reasons and approach, and is not confronted with ultimate opinions on a take-it-or-leave-it basis.²⁸

The above discussion is designed to indicate that the basic issue concerning the proper role of the expert and that of the court or jury seems rather

27. *Id.* at 994.

28. *Id.* at 1006. By retaining the *Washington* Appendix ("Court's Instructions to Expert Witness in Cases Involving the 'Insanity Defense,'" 390 F.2d at 457) with only a slight modification of one paragraph (471 F.2d at 1006 n.82), and by very explicit instructions to the jury on the insanity question (471 F.2d at 1008, app. B) using relevant language from *McDonald*, the en banc decision did indicate the court's concern that ultimate legal issues should *not* be dominated by expert witnesses. However, in his separate opinion Chief Judge Bazelon felt that the "albatross of the *Durham* decision" (*viz.*, the productivity requirement) was still very much alive and he feared that the shift away from the *Washington* prohibition against expert opinions on the ultimate legal issue of causality would not sufficiently prevent encroachment by the experts into the jury's function.

If there are clear and strong social policy and legal considerations which require that the roles of the "triers of fact" and "experts" *not* become confounded, then certainly there should be appropriate rules and guidelines to facilitate and maintain necessary distinctions. It appears to this writer that, given effective and competent functioning by expert witnesses, counsel, and the presiding judge, the relevant information pertaining to the ultimate legal questions could be elicited from the experts *without* having them offer their "expert opinion" on what are clearly social policy, ethical, moral and legal issues. By allowing expert witnesses to offer opinions on ultimate jury questions—even though supported by underlying reasons—the risk is certainly present that the triers of fact may allow the experts to make such difficult decisions for them.

As we shall discuss later in this article in reference to the roles of expert witness, counsel, and judge in the area of involuntary civil commitments of the mentally ill, the effective performance of these persons cannot be taken for granted. The available empirical evidence in regard to civil commitment proceedings points glaringly to rather inadequate role definition and judicial default in these situations.

clearly to have been stated in several key decisions. Hence, the continuing failure to put such rulings and directions into practice could hardly be said to be due to a lack of clarity about the basic legal issues involved. Nevertheless, this message does not seem to have affected many judges in their continued heavy reliance on expert witnesses for deciding ultimate legal questions. Nor do the aforementioned directions and instructions seem sufficiently clear to many psychiatrists and other mental health expert witnesses. The problem here does not appear to relate only to the presumptuous expansion of role by many expert witnesses; more importantly, it seems to reflect on the scope and seriousness of the judicial default apparent in such situations. We shall have more to say on this topic later in this discussion.

Consistent with the aforementioned U.S. Supreme Court and appellate opinions, the GAP Report on the issue of pretrial competency very cogently states the proper role of expert testimony on this legal issue:

The report should contain sufficient data to justify the conclusions reached and to indicate how they were reached. These conclusions should not set forth an opinion as to whether the defendant is legally competent. The data offered, however, will enable the Court to assume its *proper responsibility* and make an enlightened *legal judgment* as to the defendant's competency.²⁹

Immediately following this section of the report is a note which refers to a "minority opinion" of the GAP Committee which prepared the report. This minority opinion provides an excellent illustration of the problems discussed above, viz., the tendency of some psychiatrists to expand their roles and prerogatives into areas which are essentially and properly the responsibility of the triers of fact. It is summarized as follows:

A minority opinion of this committee holds that when the psychiatrist testifies in court his responsibility is to the social-legal system, and that he is the agent of society in this setting. Therefore, he must be familiar with the legal concepts of competency to stand trial; he must relate his clinical findings to the pertinent legal questions; and he should offer, on the basis of clinical findings, an opinion concerning the ultimate issue to be determined by the court.³⁰

Given the views already expressed by this writer, it need hardly be mentioned that the foregoing is precisely the type of opinion which has led to the confusing of legal and mental health issues and roles, and which practice has led to increasing encroachments by expert witnesses into areas which relate basically to social policy and legal issues and which have to be decided—not by medical or psychiatric concepts or experts, but by courts and juries.

29. GAP REPORT, *supra* note 6, at 898-99 (emphasis added).

30. *Id.* at 898.

The "minority opinion" in the GAP Report also illustrates some other serious difficulties. For one thing, it appears to imply that judges and juries will not be able to understand the clinical information provided by the experts, and to then relate this to the relevant socio-legal determinations. However, given the wide variety of complex issues that courts typically have to decide and the kinds of technical information which they have to absorb and understand, it seems somewhat arrogant to even imply that the triers of fact would not be able to make the necessary determinations on mental health related issues.

Secondly, when experts are allowed to testify on ultimate social policy and legal issues the impression may well be given to the jury that the legal issues are rather directly related to certain "scientific," "medical," or "psychiatric" facts known only to the experts, *e.g.*, that "dangerousness" may be related to certain psychiatric conditions and that psychiatrists are able both to diagnose and accurately predict such "dangerousness." However, what typically seems to happen in such situations is that the expert may be basing his decisions on his own values and preferences and, by couching such opinions in technical jargon, may well give the erroneous impression that something very "scientific" is being presented.

Finally, if indeed courts and juries are to assume their proper and socially prescribed and authorized roles in making certain social policy and legal decisions, the kind of "help" proffered by the "minority opinion" of the GAP Committee is precisely what is *not* needed.

The idealistic rhetoric and the sorry reality. Whether in reference to the to the handling of juveniles, mentally ill persons, or certain law-violators given quasi-psychiatric legal labels such as "sexual psychopaths," our society has demonstrated a truly remarkable capacity for a veritable torrent of idealistic rhetoric to justify such coercive interventions. Given the glaring lack of adequate resources to *implement* the stated societal objectives, one may well wonder about the reasons for the exuberance of the lofty rhetoric.

Legislators seem quite willing, even eager, to enact laws which state that "the individual dignity of the patient shall be respected at all times and all occasions . . .;"³¹ or, "the policy of the state is that no person shall be denied care and treatment for mental disorder . . .,"³² or, "each patient . . . shall receive care and treatment that is suited to his needs and such care and treatment shall be administered skillfully, safely, and humanely with full respect for his dignity and personal integrity."³³ However, as these

31. GA. CODE ANN. § 88-502.1 (1969).

32. *Id.* § 88-502.2 (1969).

33. *Id.* § 88-502.3 (1969).

legislative bodies know only too well, it is only the appropriation of adequate funds and resources that can give real meaning to their lofty phrases and also reflect a genuine and honest societal intent. Given the enormous gulf which typically separates the idealism of the stated intentions and the actual reality to which the recipients of the benevolence are actually exposed, it could be said with little possibility of exaggeration that ours is indeed a remarkably hypocritical society. It seems not to be realized that the targets of such efforts cannot be helped by the good that was only intended, but they are hurt by the reality that they actually experience.

The above discrepancies are best illustrated in the handling of persons under the *parens patriae* responsibilities of the state through proceedings labeled as "civil." As Dershowitz has recently pointed out, the primary object of the "civil-criminal labeling game" is simply that the court must determine whether certain procedural safeguards required by the constitution in "all criminal prosecutions," apply to various other legal proceedings.³⁴ Stated rather simply, the individual whose liberty is restricted by a particular statute, e.g., a juvenile ward, a mental patient, or a sexual psychopath, must try to convince the courts that the proceedings through which his liberty is being infringed is much like a criminal prosecution. In opposition, the state must show that the proceeding is really "civil" in that the results and objectives are designed to help rather than to hurt the individual.³⁵

Regrettably, for the most part courts have shown a remarkable insensitivity to the glaring discrepancies between the stated societal aims (expressed in very idealistic and benevolent terms) and the harsh realities which have actually been experienced by the recipients of help and remediation. Indeed, often the social deviants end up spending years of involuntary confinement for an act which under criminal proceedings would have brought a few months penal sentence for a misdemeanor. Moreover, the promised care and treatment resources have typically been most inadequate. Even when reasonably adequate, the demonstrated *effectiveness* of such treatment for many persons (e.g., sexual psychopaths) is quite lacking. Most certainly one could hardly expect an individual to be helped by adequate—or even abundant—amounts of treatment which may happen to be quite ineffective.³⁶

However, courts have often demonstrated remarkable skills as intellectual contortionists in finding constitutional and justified various practices which

34. See Dershowitz, *supra* note 5.

35. See, e.g., T. Baynes, *Continuing Conjectural Concepts Concerning Civil Commitment Criteria*, 26 AM. PSYCHOLOGIST 489 (1971).

36. See, e.g., Schwitzgebel, *Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria*, 8 HARV. CIV. RIGHTS—CIV. LIB. L. REV. 513 (1973).

even on their face reflect massive social control and preventive detention as well as a glaring lack of the promised care and treatment—upon which promise the “civil” proceedings were originally justified.

As Dershowitz points out, “There is hardly a proceeding that has not been deemed civil because of its similarity to another proceeding that had in turn been deemed civil because of its similarity to the proceeding at issue.”³⁷ Moreover, as remarkable as it may seem, state legislatures appear to have learned that the “best way to assure that courts will uphold a criminal statute against a charge that it fails to provide *every* safeguard is to eliminate enough of the existing safeguards so that the statute will be deemed civil” in nature.³⁸ In fact, in *Hyser v. Reed*,³⁹ then Judge Burger was able to find that parole revocation proceedings which could culminate in incarceration for the parolee were not an “adversary proceeding in the usual sense,” because there was a “genuine identity of interest if not purpose” between the parolee and the parole board, viz., that the parolee be rehabilitated.⁴⁰ Hence, such proceedings were felt to be related to a *parens patriae* situation.

In more recent years, however, courts have begun increasingly to question and challenge the aforementioned legal word games of “criminal-civil,” and have repeatedly held that involuntary commitment “is a deprivation of liberty. It is incarceration against one’s will, whether it is called ‘criminal’ or ‘civil.’”⁴¹ In the last few years the number of cases has increased significantly in which liberty-depriving practices premised on *parens patriae* notions have been questioned and due process and other constitutional safeguards have been provided.⁴²

The Need for Greater Accountability in the Social-Legal Handling of the Mentally Ill

In many of the interactions between the legal and mental health systems in the handling of persons believed to be mentally disordered our societal practices display a rather astonishing discrepancy between the asserted goal values and stated policy objectives and the actual reality which such indi-

37. Dershowitz, *supra* note 5, at 1298.

38. *Id.* at 1300-01.

39. 318 F.2d 225 (D.C. Cir.), *cert. denied*, 375 U.S. 957 (1963).

40. 318 F.2d at 237.

41. *In re Gault*, 387 U.S. 1, 50 (1967).

42. *Jackson v. Indiana*, 406 U.S. 715 (1972); *In re Winship*, 397 U.S. 358 (1970); *In re Gault*, 387 U.S. 1 (1967); *Specht v. Patterson*, 386 U.S. 605 (1967); *Kent v. United States*, 383 U.S. 541 (1966); *Baxstrom v. Herold*, 383 U.S. 107 (1966); *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973); *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972); *Dixon v. Commonwealth*, 325 F. Supp. 966 (M.D. Pa. 1971).

viduals experience. Quite obviously, there are many deviations and discrepancies between the initial statements of societal values and policies, the manner in which such policy objectives are formulated into rules and guidelines, and the extent to which adequate resources are provided in order meaningfully to achieve the stated objectives.

Elsewhere this writer has suggested a simple analytic model for facilitating greater social accountability in reference to the aforementioned problems.⁴³ The issue of pretrial competency was used to illustrate the several departures and discrepancies at various levels of policy formulation and practices.

The four basic considerations and questions involved in the analytic model are as follows:

I. *What are the fundamental societal values to be protected, the major goals to be attained, and the social harms to be avoided?* These basic values may be reflected in broad policy statements, constitutional provisions, and related proclamations, e.g., the Bill of Rights and the fourteenth amendment.

II. *How clearly and how well have the goal values and policies been articulated into rules for the implementation of policy objectives?* At this level of analysis it is necessary to ascertain the extent to which the rules provide an accurate and meaningful reflection of the broad goal values, whether they facilitate proper understanding of the underlying policy objectives, and also whether they are capable of being implemented.

III. *Have appropriate and necessary resources been allocated to allow attainment of the proclaimed goal values and policy objectives?* The real importance of the professed values and the sincerity of the stated policy objectives can better be assessed by the resources actually provided than by the exuberance and abundance of the idealistic rhetoric. When resources required for policy implementation are substantially lacking, the professed policy objectives, as well as other practices contingent upon such policies, need to be questioned and even challenged.⁴⁴

IV. *Have appropriate and effective provisions been made to monitor and to evaluate actual compliance with the asserted policy objectives, rules and*

43. Lecture by Saleem A. Shah, *Law and Mental Health Interactions: Some Recent Trends and Policy Implications*, Third Annual Institute on Law, Psychiatry, and the Mentally Disordered Offender, Southern Illinois University, Nov. 1972, to appear in 3 LAW, PSYCHIATRY, AND THE MENTALLY DISORDERED OFFENDER (L.M. Irvine & T.B. Brelje eds.).

44. An important and related policy might well be to place strict limits on the extent to which hypocritical practices are allowed to become institutionalized—a situation which tends to weaken and to distort the professed values and their importance, and to create feelings of cynicism about other societal values and policies.

associated practices? Such evaluation and accountability are essential to ensure that serious discrepancies do not develop between stated policy objectives and their actual implementation. Such assessment mechanisms need to be built into policy enactments and administrative guidelines, along with appropriate contingencies to encourage compliance and to provide sanctions for noncompliance.

Expert opinions and ultimate legal determinations. If a major societal purpose is to ensure that, within stated policy guidelines, specifically designated societal institutions and agents must determine the proper balance between societal interests and individual rights, then clearer distinctions must be made between the role of expert witnesses on issues of mental disorder, and the role of the court and jury.

It has been noted, for example, that the greater the statutory ambiguity, the greater is the discretion of the decisionmaker who operates under the law.⁴⁵ Quite typically, given the rather vague and ambiguous statutory language of most laws pertaining to the mentally ill and other status offenders handled via "civil" proceedings, the psychiatric expert is often the effective decisionmaker—the very important "thirteenth juror." Such a role is only possible, of course, as a result largely of judicial default.

However, if decisions pertaining to civil commitment of the mentally ill, the sexual psychopaths, defective delinquents, and juvenile delinquents, are fundamentally legal rather than medical or psychiatric in nature, it seems obvious that the role of the mental health expert must be limited in such judicial proceedings to the presentation of clear, detailed and relevant evidence on the basis of which the triers of fact can make the ultimate legal decision. Blurring and confusing these roles can and does have many serious consequences. For example, one article has pointed out:

The greatest danger of permitting a psychiatrist to testify in conclusory fashion about legal criteria is that the doctor may have his own notion of the substantive legal standards required for commitment. And that notion may differ markedly from that of the court, but the difference may easily go unnoticed and unexplored at the hearing—particularly if neither the court nor the patient's lawyer vigorously questions the doctor.⁴⁶

In order to achieve this objective and to enable the triers of fact to make the decisions for which they alone have been given responsibility, expert witnesses should be prevented from giving conclusory opinions and answers to

45. See F. Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEXAS L. REV. 424 (1966).

46. D. Wexler, et al., *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 64 (1971).

the ultimate questions in the various proceedings involving mentally disordered persons. It is the view of this writer that the logic of *Spaulding*⁴⁷ and *McDonald*⁴⁸ should be followed in prohibiting expert opinion on various ultimate legal questions. Moreover, consistent with this logic, experts should also not be allowed to state (in the context of the insanity defense and in certain other such situations) whether or not the individual is suffering from what *the law has defined* as a "mental disease."⁴⁹ Since mental health professionals use the term mental disease in reference to various clinical and related concerns, this is *not* what the term means when used in certain legal contexts. Hence, it would be confusing to the triers of fact to have the very same terms used with quite different meanings and decisional implications.

Thus, even though the experts may be asked whether or not the nature and degree of psychopathology ascertained may be classified and diagnosed in reference to *psychiatric* nomenclature, the court should very explicitly instruct the jury that such psychiatric or psychological uses of the terms "mental disease and defect" are *not* the same as the legal meaning of the terms. Also, that in its final determination the jury should give strict attention to the *legal* definitions of these and other terms as explained by the court in its instructions.

Similar logic should prevail regarding the role of mental health experts and the making of the ultimate legal decisions in reference to issues such as pretrial competency, sexual psychopathy, defective delinquency, and judicial commitments of the mentally ill.

More effective legal roles. Several recent decisions have emphasized that individuals whose liberty may be affected via "civil" proceedings must receive due process and other procedural protections, including the assistance of legal counsel. For example, in its landmark decision in *In re Gault*,⁵⁰ the Supreme Court concluded that the due process clause of the fourteenth amendment required representation by counsel in delinquency adjudications which can result in curtailment of the individual's freedom. Similarly, in *Heryford v. Parker*⁵¹ it was held:

Where, as in both proceedings for juveniles and mentally deficient

47. See p. 681 *supra*.

48. See p. 682 *supra*.

49. One of the likely disadvantages of having gradually eliminated older and obviously legal sounding terms such as "insanity" and substituted more current psychiatric terms such as "mental disease and defect" (which as alluded to above can be ascribed at least in part to the *Durham* decision) is that the clear distinctions which are warranted with respect to legal and expert opinion determinations have been blurred and even lost to some extent. See, e.g., J. Livermore & P. Meehl, *The Virtues of M'Naghten*, 51 MINN. L. REV. 789 (1967).

50. 387 U.S. 1 (1967).

51. 396 F.2d 393 (10th Cir. 1968).

persons, the state undertakes to act in *parens patriae*, it has the inescapable duty to vouchsafe due process, and this necessarily includes the duty to see that a subject of an [*sic*] involuntary commitment proceedings is afforded the opportunity to the guiding hand of legal counsel at every step of the proceedings, unless effectively waived by one authorized to act in his behalf.⁵²

Given the usual practice in regard to both the availability of legal counsel as well as its actual effectiveness, it would be safe to say that the prescribed due process and related protections are often not vouchsafed such subjects; the "guiding hand of legal counsel" seems quite often distinctly to be missing, at other times even though present it may offer little guidance.

Based on his studies in Texas some years ago, Cohen was led to observe that:

The lawyer representing a prospective patient in a typical civil commitment proceeding is a stranger in a strange land without benefit of guidebook, map, or dictionary. Too often he shows no interest and makes no effort to learn his way about his foreign environment. As a result, free citizens of a free country are frequently deprived of their liberty for an indefinite duration.⁵³

Cohen found that commitment hearings were held in very rapid and even perfunctory fashion. It took all of seventy-five minutes to conduct "hearings" of forty proposed patients—all of whom were involuntarily committed and also found to be mentally incompetent. However, the judge and attorney *ad litem* actually observed only two of these forty patients. Such observations led Cohen to conclude that "[t]he complexity of the decision to deprive a person of his liberty and adjudicate him incompetent was obscured by the passivity of the participants in the hearing."⁵⁴

Like many others who have studied civil commitment hearings, in their field studies conducted in Arizona, Wexler and his associates found that in one county civil commitments were held in "rapid fire fashion," averaging 4.7 minutes each, with some consuming no more than three minutes. In many instances the patient was not even present. In another county the hearings averaged twenty-seven minutes each and with much greater participation of the public defender.⁵⁵

52. *Id.* at 396.

53. Cohen, *supra* note 45, at 466.

54. *Id.* at 470.

55. See, e.g., L. Kutner, *The Illusion of Due Process in Commitment Proceedings*, 57 NW. U.L. REV. 383 (1962); R. Maisel, *Decision-Making in a Commitment Court*, 33 PSYCHIATRY 352 (1970); D. Miller & M. Schwartz, *County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital*, 14 SOCIAL PROBLEMS 26 (1966); T. Scheff, *The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State*, 11 SOCIAL PROBLEMS 401 (1964).

Given the speed with which most of these hearings tend to be conducted, it is understandable—indeed almost self-evident—that very seldom is any evidence given concerning the factual bases underlying the conclusions. Conclusory statements by the medical and psychiatric experts predominate, commitment recommendations are offered to the court, and very typically the court routinely follows such medical recommendations. In one of the counties studied, the physician's recommendations were followed by the court in 97.9 per cent of the cases; the percentage in another county was 96.1.

On the basis of their studies Wexler and his associates were moved to remark:

Indeed, it is disheartening to realize that when we deal not with the liberty-threatening situation of commitment, but deal instead with lucrative cases such as will contests and traumatic neurosis personal injury matters, lawyers hardly seem unduly deferential to—or bewildered by—the damning pronouncements of adverse psychiatrists.⁵⁶

Yet in the aforementioned involuntary commitment proceedings the role and functioning of legal counsel often is perfunctory, uninformed, and hardly a reflection of the “guiding hand” that the court in *Heryford* felt was so essential to protect the interests and rights of patients. As remarkable—even bizarre—as it may seem, Wexler found instances in which appointed counsel sought to assist the court by virtually presenting the case *against* the patient. In some outlying counties where the county attorney participates in the proceedings on behalf of the petitioner, his performance was indistinguishable from that of the *patient's* attorney in one of the other counties!

Wexler's group notes several ways in which the role of counsel can be made more effective. Among these they suggest that payment to court appointed lawyers should be by the hour, rather than by the case, in order to provide more incentive—even on the very low fees typically paid—for working harder on preparation of the case and providing the range of services needed for effective legal representation.

Unquestionably, a major and even critical need in this field is that the availability of legal counsel also be accompanied by the kind of knowledge, skill, and active participation in the proceedings as is typically to be found in other trial situations. In view of the relative recency of case law providing due process and other procedural protections, but especially because of the lack of economic incentives, there is at present a relatively limited development of a mental health bar. However, much activity is currently under way via the efforts of the American Civil Liberties Union, the Mental Health

56. Wexler, *supra* note 46, at 52.

Law Project in Washington, D.C., and many other groups across the country.

An impressive development in regard to the training of lawyers for effective legal roles in regard to the mentally disabled has been the series of institutes held recently under the joint sponsorship of the Practicing Law Institute and the Mental Health Law Project. A very comprehensive and impressive three volume course handbook entitled *Legal Rights of the Mentally Handicapped*⁵⁷ has also been produced and should be a most valuable item for lawyers as well as for others interested in this general area.

Greater attention to the use of "least restrictive alternatives." Consistent with the notion of enhancing greater accountability and candor in the use of the state's role as *parens patriae*, and consistent also with the stated remedial and therapeutic purposes which underly such interventions, increasing attention has been given in recent years to the doctrine of using the "least restrictive alternative." In *Shelton v. Tucker*⁵⁸ the Supreme Court provided a clear rationale for this doctrine:

In a series of decisions this Court has held that, 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.⁵⁹

It would appear, therefore, that given the legitimacy and rationality of governmental purposes, more drastic methods should not be used to attain ends and objectives that could readily be accomplished through less restrictive means. The implications of this legal doctrine seem to have rather obvious relevance to the many situations in which involuntary commitments are used under the *parens patriae* rationale. Most particularly the principle would appear to have very direct application for the handling of mentally disabled persons who do *not* pose a serious threat to themselves or to others, but who require the care, supervision and treatment that could be provided outside of state mental hospitals.

A case which illustrates the point rather well is that of Mrs. Catherine Lake,⁶⁰ a sixty-four year old woman who was found to be suffering from senile brain disease and who had involuntarily been committed to Saint Elizabeth's Hospital in Washington, D.C. As Chief Judge Bazelon noted in speaking for the majority, the trial court had a duty to explore less restric-

57. LEGAL RIGHTS OF THE MENTALLY HANDICAPPED (B.J. Ennis & P.R. Friedman eds. 1973).

58. 364 U.S. 479 (1960).

59. *Id.* at 488 (emphasis added).

60. *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966) (en banc).

tive alternatives for providing the care and supervision Mrs. Lake needed. In such a case the court's duty "related also to the obligation of the state to bear the burden of exploration of possible alternatives an indigent cannot bear."⁶¹

The same principle was again enunciated and emphasized by the United States Court of Appeals for the District of Columbia in reviewing a habeas corpus petition for transfer from a maximum security ward at Saint Elizabeth's Hospital to a less restrictive ward:

[T]he principle of the least restrictive alternative consistent with the legitimate purpose of a commitment inheres in the very nature of civil commitment, which entails an extraordinary deprivation of liberty justifiable only when the respondent is 'mentally ill to the extent that he is likely to injure himself or other persons if allowed to remain at liberty.' *A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law.*⁶²

The Court went on to indicate that the principle was equally applicable to alternative disposition *within* a mental hospital.

Recent mental health statistics indicate that over the past several decades there has been an increasing movement toward providing psychiatric care in

61. *Id.* at 660. For purposes of noting the stance of the various judges on the fundamental social policy objectives inherent in "civil" proceedings which are meant to provide treatment and care "in the best interests of the person or the public," the views of the minority merit attention. Writing for himself as well as for Circuit Judges Danaher and Tamm, then Circuit Judge Burger noted that the only issue before the court was the legality of Mrs. Lake's confinement in Saint Elizabeth's Hospital. The minority opinion also stated:

Although proceedings for commitment of mentally ill persons are not strictly adversary, a United States court in our legal system is not set up to initiate inquiries and direct studies of social welfare facilities or other social problems.

Id. at 663.

Given the fact that involuntary civil commitment proceedings are premised on the *parens patriae* role of the state acting through the court, it is interesting to note this minority view. It appears that these judges completely forgot about the excellent probation services typically available to the federal district courts. Indeed, in their presentence and related investigations, as well as in the supervision of their clients, probation officers usually develop considerable familiarity with, and knowledge of, the range of rehabilitative, therapeutic, vocational, and various social services available in the community. Most certainly, these trained and knowledgeable probation officers could easily investigate the availability of "less restrictive alternatives" for an indigent elderly lady being handled under the *parens patriae* obligations of the state, just as they do on behalf of those who are being subjected to the sanctions of the criminal process.

It would seem that, like other professionals who get caught up in the day-to-day routine of processing a voluminous stream of cases, judges also can get so preoccupied with specific legal technicalities that they tend to lose sight of the larger social objectives.

62. *Covington v. Harris*, 410 F.2d 617, 623 (D.C. Cir. 1969) (emphasis added). See also *Williams v. Illinois*, 399 U.S. 635, 259 (1970).

the community as opposed to inpatient treatment. For example, inpatient care accounted for 77 percent of all psychiatric patient care episodes in 1955.⁶³ However, in 1971 inpatient episodes had decreased to 42 percent, with outpatient episodes accounting for 55 percent of total psychiatric episodes. It should be emphasized that this estimate does *not* include the large number of patients treated by psychiatrists and other mental health therapists in private offices. In addition, the relatively brief length of stay for patients admitted to hospitals and the large number of readmissions tend to strengthen further the indication that the locus of treatment for the *largest number of psychiatric patients* today is the community; the inpatient stays are relatively brief episodes in the continuum of care.⁶⁴

It seems obvious that, given the further development and increased use of alternative facilities, many persons presently committed to mental hospitals could be provided both appropriate and effective care in less restrictive settings. Not only would such community-oriented treatment generally be less expensive than the cost of total hospitalization,⁶⁵ but it would not entail the disruption of family and community ties and maintenance of healthy areas of functioning. Moreover, it would avoid the regressive features often associated with long term and "total" hospitalization. Most importantly, and in regard to *involuntary* commitments, the various community oriented treatment alternatives would *not* infringe so drastically on the individual's liberty.

Further empirical support for greater implementation of "least restrictive alternatives" for the treatment of the mentally ill has been provided by a variety of research and demonstration studies. These studies indicate that a wide range of ambulatory services can be as effective as total hospitalization in helping the mentally disabled persons to maintain a level of functioning quite adequate to permit their residing in the community. Such services include outpatient and follow-up care, partial hospitalization (*e.g.*, day hospital services), half-way houses, and various other types of sheltered living

63. Patient care episodes are defined as the number of residents in inpatient facilities at the beginning of the year, or the number of persons on the rolls of non-inpatient facilities, plus the total additions of patients during the year. Patient care episodes are thus to some degree a duplicative count of the number of persons actually under care.

64. See L. Ozarin & C. Taube, *Psychiatric Inpatients: Who, Where, and Future*, 131 AM. J. OF PSYCHIATRY 98, 100 (1974).

65. In fiscal year 1973 the average daily expenditures per resident patient for inpatient services at state and county mental hospitals was \$25.20. In twenty-four states the daily expenditure per resident patient was higher than this average figure, with seven states reporting costs of \$40.00 or more per day. (See DIVISION OF BIOMETRY, NATIONAL INSTITUTE OF MENTAL HEALTH, *Statistical Note 106, Provisional Patient Movement and Administrative Data—State and County Mental Hospital Inpatient Services, July 1, 1972-June 30, 1973* (1974)).

arrangements.⁶⁶ One such study will very briefly be described.

Herz, *et al.* conducted a controlled study to compare the efficacy of day versus inpatient hospitalization for patients for whom both treatments were judged to be equally feasible clinically.⁶⁷ The 90 patients were randomly assigned to day hospital and inpatient hospitalization, and both groups of patients were treated on the same fifty-five bed inpatient ward. The day patients started their treatment by spending the full eight hours during the day at the hospital on weekdays. The result showed that by virtually every measure used to evaluate progress and outcome there was clear indication of the superiority of day treatment. The day patients returned to full time life in the community and resumed their occupational roles sooner, and they were more apt to remain in the community without subsequent readmission to the hospital. Moreover, more day patients were in the community on a full time basis and the more striking differences in improved functioning were in favor of the day patients. In other words, the shorter initial hospital stay associated with day hospital treatment was *not* followed by a higher readmission rate, as might possibly have been expected.⁶⁸

Similarly, Wilder, *et al.* found that in a two year follow-up of acute psychotics who had been treated in a day hospital, the subsequent adjustment of these patients was as good as that for patients who had received total hospitalization.⁶⁹ Michaux, *et al.* have reported similar findings.⁷⁰

In short, the evidence to date would seem to corroborate Wilder's statement:

A patient should be able to enter the treatment continuum at any point, move to any point, and exit at any point. The aim of any

66. See Ozarin & Taube, *supra* note 64, at 100.

67. M. Herz, J. Endicott, R. Spitzer & A. Mesnikoff, *Day Versus Inpatient Hospitalization: A Controlled Study*, 127 AM. J. OF PSYCHIATRY 1371 (1968).

68. In this particular study, the investigators saw all new admissions to the inpatient service over a period of fourteen months in order to screen them for inclusion in the study. A total of 424 patients were evaluated. While 134 of these patients were rejected as "too ill" (*viz.*, suicidal, possibly violent, too disorganized), fully eighty-five (*i.e.*, 20%) were rejected for inclusion as "too healthy." It is interesting to note the relatively large number of patients seeking admission to the inpatient service who could be sent home almost immediately. Of the eighty-five patients in this group, sixty-one were discharged immediately, while fourteen were placed on day care and ten on night care only.

One might well wonder, therefore, about the number of persons brought for involuntary commitment who, given good screening techniques and an adequate range of treatment services (*i.e.*, a continuum of care), could also appropriately be helped through less than total hospitalization.

69. J. Wilder, G. Levin & I. Zwerling, *A Two-Year Follow-up Evaluation of Acute Psychotic Patients Treated in a Day Hospital*, 122 AM. J. OF PSYCHIATRY 1095 (1966).

70. See M. Michaux, M. Chelst, S. Foster & R. Pruim, *Day and Full-Time Psychiatric Treatment: A Controlled Comparison*, 14 CURRENT THERAPEUTIC RESEARCH 279

mental health intervention is to preserve and enhance the patient's personal autonomy. All other things being equal, it is better for a patient to receive care in a hospital where he spends the night at home than in a hospital where he spends the night in the hospital.⁷¹

Determinate periods of involuntary confinement. We have noted that a basic guide to societal actions in regard to interventions in the lives and liberty of individuals should be the major goal values of the society and the stated policy objectives to be attained. In essence, our values require that a very careful balancing be undertaken between the interests of individual liberty and the needs for collective security. Frankel has very nicely expressed the point:

Whether the deprivation of liberty be justified primarily as punishment, as a necessary condition of treatment, or as the means for preventing future dangerously deviant behavior, it inevitably involves some mix of punitive, restorative and preventive motives.⁷²

Therefore, in regard to the involuntary confinement of persons—whether premised on their presumed dangerousness or because of their grave disablement—there should be a major concern with minimizing as much as possible the severity of the confinement as well as its duration. Moreover, even when total confinement is deemed necessary the duration of such severe restrictions on liberty should be definite and limited, rather than indeterminate as is generally the case.

The rationale for determining more definite durations of involuntary confinement for the seriously mentally disabled can be based upon the kind of actuarial data used by insurance companies in determining the usual periods of hospital stay for specified medical conditions. Some relevant mental health statistics will be provided to indicate the clear feasibility of shorter and determinate periods of involuntary hospitalization.

There has generally been a very marked decrease in the number and proportion of involuntary commitments to mental hospitals. In 1933, based upon

(1972); M. Michaux, M. Chelst, S. Foster, R. Pruim & E. Dasinger, *Postrelease Adjustment of Day and Full-Time Psychiatric Patients*, 29 ARCHIVES OF GENERAL PSYCHIATRY 647 (1973); M. Michaux, K. Garmize, J. Rossi, L. Schoolman & G. Gross, *A Controlled Comparison of Psychiatric Day Center Treatment With Full-Time Hospitalization: Special Report*, 11 CURRENT THERAPEUTIC RESEARCH 190 (1969). See also J. MELTZOFF & R. BLUMENTHAL, *THE DAY TREATMENT CENTER* (1966); M. Craft, *Psychiatric Day Hospitals*, 116 AM. J. OF PSYCHIATRY 251 (1959); S. Smith & E. Cross, *Review of 1000 Patients Treated at a Psychiatric Day Hospital*, 2 INT'L J. OF SOCIAL PSYCHIATRY 292 (1957); I. Zwerling & J. Wilder, *An Evaluation of the Applicability of the Day Hospital in Treatment of Acutely Disturbed Patients*, 2 ISRAEL ANNALS OF PSYCHIATRY AND RELATED DISCIPLINES 162 (1964).

71. J. Wilder, 127 AM. J. OF PSYCHIATRY 1381, 1382 (1971).

72. Frankel, *Preventive Restraints and Just Compensation: Toward a Sanction Law of the Future*, 78 YALE L.J. 229, 234 (1968).

United States Bureau of the Census data, fully 90 percent of admissions to state mental hospitals were court commitments and only five percent were voluntary.⁷³ However, in 1972 only 41.8 percent of all inpatient admissions to State and county mental hospitals were involuntary and almost 49 percent were voluntary.⁷⁴

Of the estimated 407,640 admissions to state and county mental hospitals during fiscal 1971, 86.8 percent were released and 3.0 percent died within six months of admission, while 10.1 percent were retained continuously in the hospital for six months or longer.⁷⁵ Using cumulative percentages, of the total admissions, 61 percent were released (alive) within two months, about 75 percent were released within ninety days, and slightly over 85 percent were released within six months (183 days) following admission. The median length of stay was about forty days.⁷⁶

Looking again at the fiscal 1971 data on the release of patients from state and county mental hospitals, relevant information has been selected for the four most frequent diagnostic categories of such admissions (Alcohol Disorders, Organic Brain Syndromes, Depressive Disorders, and Schizophrenia). The cumulative percent of patients released alive within sixty-one to ninety days differed, as one would expect, according to diagnostic category as indicated below; the median days of stay have been provided in each instance:⁷⁷

| | |
|------------------------------|--------------------------|
| Alcohol Disorders | 85.2 percent (31.8 days) |
| Organic Brain Syndrome | 41.2 percent (70.2 days) |
| Depressive Disorders | 83.7 percent (36.1 days) |
| Schizophrenia | 68.4 percent (60.4 days) |

Except for elderly patients suffering from chronic brain syndromes, the great majority of patients in the other three major categories noted above are released from mental hospitals within ninety days. In light of the foregoing information, and considering also the relevant policy objectives, it seems evident that—for the great majority of involuntary admissions to state and county mental hospitals—determinate periods of treatment should be specified for no more than ninety days. Additional periods of continued treatment in the hospital should be based upon the presentation of clear and convincing indications for continued hospitalization.

73. NATIONAL INSTITUTE OF MENTAL HEALTH, *Statistical Note 105, Legal Status of Inpatient Admissions to State and County Mental Hospitals, United States, 1972* (1974).

74. *Id.* at 2, Table A.

75. NATIONAL INSTITUTE OF MENTAL HEALTH, *Statistical Note 74, Length of Stay of Admissions to State and County Mental Hospitals, United States, 1971* at 2 (1973).

76. *Id.* at 5, Table 1.

77. *Id.* at 8, Table 4.

It must be recognized, however, that there will be a category of chronically ill and gravely disabled patients who will undoubtedly require long term care and supervision. Special provisions will have to be made to ensure that such patients receive the care which they require but, whenever possible, in less restrictive facilities.

Legal rights and societal duties. This discussion has tended to focus upon the serious and longstanding deprivations of civil rights and liberty suffered by the mentally ill in this country. In view of this history and even the present situation, it is indeed necessary that due emphasis be given to the rights of the mentally ill when they are subjected to involuntary and indeterminate periods of commitment.

However, when one speaks of "rights" in a legal context there is immediately the implication of correlative duties and responsibilities which must also be considered. Thus, if the courts find that there is a *right*—whether provided under the Constitution or through interpretation of legislative language—then somebody also has a responsibility and obligation to provide that to which the mentally ill are entitled. Clearly, we are referring here to societal and legislative responsibilities to provide adequate and necessary resources commensurate with the rights that have been guaranteed when an individual's liberty is infringed under the *parens patriae* doctrine.

This point needs to be emphasized for the benefit of lawyers who may tend to focus their efforts primarily on winning major class action suits. Such litigation is certainly an important step and often provides essential leverage for seeking social change. However, the provision of adequate care and treatment resources will have to be obtained through related but somewhat different efforts directed primarily at the legislatures, though it is possible that in the absence of other economic incentives the relevant career contingencies for many lawyers might relate to the professional rewards and recognition obtained through winning major court battles, rather than from the long and difficult efforts to influence legislatures to provide more resources. Chambers has emphasized this point to his legal colleagues:

Class actions that succeed may produce hastily devised alternative placements or the release of institutional residents with nothing to support them in the community. When lawyers seek to persuade courts to do what legislatures ought to have done, they bear a weighty burden to do what legislatures ought to do before they act—that is, to avoid being propelled along by high sounding slogans like the principle of least restrictive alternative or even by their anger at the vile conditions at an institution. Rather, they must first become well-informed about the problem they seek to cure.⁷⁸

78. D. Chambers, *Right to the Least Restrictive Alternative Setting for Treatment*, in 2 LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 991, 1009 (B.J. Ennis & P.R. Friedman eds. 1973).

What may happen when seriously disabled patients gain their liberty but little else? Reich and Siegel have described in vivid detail some of the consequences of a policy to reduce commitments to state mental hospitals in New York.⁷⁹ This policy led to the refusal to admit many chronically ill patients. As a result, these patients were turned back into the community—where many did not have any families or were too disturbed for normal family living. These individuals became wards of the welfare system. The Department of Social Services was forced to make markedly increased use of its foster home program—in which, however, boarders are expected to be fairly independent and to look after themselves. Although several thousand chronically ill patients were placed in this program, according to Reich and Siegel the results in many instances were disastrous.

The quality of care provided by many of the proprietary homes is described by these authors as very inadequate; many of these homes have in effect become “unsupervised state hospitals.” If the patients deteriorated in these facilities, often they have been turned out onto the street when the state hospital did not admit them. Thus, in New York’s traditional skid row, the alcoholics are being replaced by the severely mentally disturbed discharges from state hospitals. Unable to function anywhere else these patients often “live on the streets of the Bowery, sleeping in doorways and begging money from passersby.”⁸⁰ In sum, according to these authors, “. . . a large body of patients, formerly the responsibility of state hospitals, has been abandoned to an unprepared, unequipped, and unready society.”⁸¹

Attention must certainly be devoted to safeguarding the civil rights of the many mental patients who do not need the long term confinement in state hospitals via involuntary commitments. However, it must also be remembered that the patients described by Reich and Siegel, as well as others in similar situations, are entitled to their treatment rights; they are entitled to receive from society the care and supervision which they need and which the *parens patriae* responsibility of the state requires be provided to them.

“Dangerousness” and the Mentally Ill

This section will focus attention upon what appear to this writer to be some major problems pertaining to societal and legal handling of the topic;

79. R. Reich & L. Siegel, *Psychiatry Under Siege: The Chronically Mentally Ill Shuffle to Oblivion*, 3 PSYCHIATRIC ANNALS 35 (1973).

80. *Id.* at 47.

81. *Id.* at 55. See also U. Aviram & S. Segal, *Exclusion of the Mentally Ill*, 29 ARCHIVES OF GENERAL PSYCHIATRY 126 (1973); H. Lamb & V. Goertzel, *Discharged Mental Patients: Are they Really in the Community?* 24 ARCHIVES OF GENERAL PSYCHIATRY 29 (1971); D. Treffert, *Dying With Their Rights On*, 26 PRISM 49 (1974).

some related issues have been discussed elsewhere.⁸²

Concern about the alleged "dangerousness" of an individual is raised in a variety of contexts, including references to involuntary civil commitment, sexual psychopathy and related "civil" proceedings, and to the confinement and release of persons acquitted by reason of insanity, and determinations of the sentencing and release of "dangerous" offenders.⁸³ The focus of this discussion, however, will be on some of the uses and misuses of the notion of "dangerousness" in regard to the mentally ill.

There are fourteen states with civil commitment statutes which explicitly refer to the likelihood of danger to self or others. However, if we also include the criteria used for the issuance of hospitalization orders, for involuntary hospitalization via medical certification, and for emergency detention, the issue of dangerousness to self or others appears in the laws of fully forty-four states and the District of Columbia.⁸⁴

The initial and fundamental question which must be asked when the state wishes to intervene coercively with the liberty of an individual is: Which harms to society are sufficiently serious and so likely to occur that infringements of liberty are justified?⁸⁵

It appears self-evident that the above question involves social policy, socio-political, and legal considerations. It certainly is *not* a medical, psychiatric, psychological or mental health question. The legal process is assigned the important task of sorting out and evaluating the medical-psychiatric and social judgments that are fused together in the officially designated label of "mentally ill" when making a determination that the individual needs involuntarily to be hospitalized—either for the safety (good) of the community (*viz.*, dangerous to others), or for the safety and welfare of the person himself (*viz.*, dangerous to self or gravely disabled). To reiterate, the legal-judicial role is of critical importance as the intervening (regulating or balancing) judgment between the problematic behavior of an individual and the specific social action being contemplated.

Despite the fundamental importance of the judicial role in the above social judgments, quite typically the actual determinations are left to physicians

82. Presentation by Saleem A. Shah, *Dangerousness and Considerations of Social Policy*, Annual Meeting of the American Psychiatric Association, Detroit, Mich., May 6, 1974.

83. See NATIONAL COUNCIL ON CRIME AND DELINQUENCY, COUNCIL OF JUDGES, MODEL SENTENCING ACT: SECOND EDITION, 18 CRIME AND DELINQUENCY 335 (1972).

84. See S. BRAKEL & R. ROCK, THE MENTALLY DISABLED AND THE LAW (rev. ed. 1971).

85. See, e.g., J. Goldstein & J. Katz, *Dangerousness and Mental Illness*, 70 YALE L.J. 225 (1960); J. Livermore, C. Malmquist & P. Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968); N. Morris, *Psychiatry and the Dangerous Criminal*, 41 S. CAL. L. REV. 514 (1968).

and psychiatrists, in large part because of the remarkably vague, imprecise and even circular definitions of "mental illness" and "dangerous," and also as a result of rather obvious judicial default in such judicial proceedings. Given the usual brevity of the commitment hearings, the frequent absence of convincing evidence relevant to the legal criteria, and the perfunctory manner of these proceedings, the very high rate of agreement (around 90 percent) between the court and the experts might more accurately be described as a judicial "rubber-stamping" of the recommendations of the experts.⁸⁶

To intervene coercively in the life of an individual on the assumption, or even very real expectation, that he might in the future display dangerous behavior, raises very serious constitutional issues and appears to run afoul of very basic societal values pertaining to the primary importance of personal liberty and the general prohibition against preventive detention.

For example, the societal and judicial concern about preventive detention for anticipated dangerous behavior was nicely expressed in the case of *In re Williams*:⁸⁷

However commendable was the court's purpose to protect the public from the release to society of a man "potentially dangerous to others," there is no District of Columbia statute or inherent equity power permitting commitment to any institution upon that showing alone. Many persons who are released to society upon completing the service of sentences in criminal cases are just as surely potential menaces to society as this petitioner, having a similar pattern of anti-social behavior, lack of occupational adjustment, and absence of remorse or anxiety; yet the courts have no legal basis of ordering their continued confinement on mere apprehension of future unlawful acts, and must wait until another crime against society is committed or they are found insane in proper mental health proceedings before confinement may again be ordered.⁸⁸

And again,

This court is conscious, as was the United States Attorney, of the need for protection not only of the community but also of individuals in need of psychiatric care and treatment. *But these laudable purposes, under our form of government, must be accompanied by*

86. See, e.g., Baynes, *supra* note 35; Cohen, *supra* note 45; A. Dershowitz, *The Psychiatrist's Power in Civil Commitment*, 2 *PSYCHOLOGY TODAY* 43 (1969); A. Dershowitz, *When in Doubt, Don't Let Them Out*, N.Y. Times, April 25, 1971, § 4, at 8, col. 1; Kutner, *supra* note 55; Maisel, *supra* note 55; Miller & Schwartz, *supra* note 55; Scheff, *supra* note 55; T. SCHEFF, *supra* note 11; H. Steadman, *Implications from the Baxstrom Experience*, 1 *BULL. OF THE AM. ACADEMY OF PSYCHIATRY AND LAW* 189 (1973); Wexler, *supra* note 46.

87. 157 F. Supp. 871 (D.D.C. 1958).

88. *Id.* at 876.

*proceedings which are legal and not at the cost of disregarding constitutional safeguards by deprivation of liberty without due process of law.*⁸⁹

It must be emphasized that the particular case being discussed involved a man with a rather long and serious criminal record. Hence, to a large degree, it could have been said that "dangerous" (*i.e.*, serious criminal) behavior had already been demonstrated.

However, despite the disputes and arguments about the nature, scope and proper use of preventive detention,⁹⁰ it is clear that the so-called mentally ill have been singled out by our society for use of preventive detention often on the basis of their assumed "dangerousness" to others (which seems to relate to the police power and social control functions), as well as for assumed or demonstrated danger to themselves or because they appear to be gravely disabled (*parens patriae* rationale). A reading of some of the relevant statutes indicates that, in many instances, there is a clear presumption that persons defined as "mentally ill" are, as a group, more likely to be dangerous than so-called "normals" (*i.e.*, those not labeled as mentally ill).

Why link mental illness and dangerousness? A very troublesome aspect of involuntary civil commitment statutes and proceedings pertains to the presumptions about the "dangerousness" of the mentally ill. As indicated above, the issue is not the person's dangerousness alone; rather, there first has to be a judicial determination of "mental illness." The implicit, if not very explicit, assumption is that by virtue of this condition the person is more likely to engage in dangerous behavior.

In view of the presumed link between mental illness and dangerous behavior which is embedded in statutes and also present in the judicial hearings on involuntary commitments, one would expect that such major social policies—which allow for deprivation of liberty and which run counter to usual practices pertaining to preventive detention—must surely be based on very sound and impressive empirical evidence.

This expectation would be false. In fact, one can look long and hard in the relevant literature but will *not be able to find any clear or convincing empirical evidence that the mentally ill, as a class, are more likely to be dangerous than so-called "normals" (i.e., persons not labelled as mentally ill)*. Indeed, the empirical evidence that is available suggests the contrary: the mentally ill *do not* appear to be more dangerous than other groups, and most certainly are not if one compares them with an analogous group of

89. *Id.* (emphasis added).

90. See, *e.g.*, Dershowitz, *supra* note 5.

convicted offenders, or even with those having records of criminal arrests.⁹¹

Even when so-called "dangerous mentally ill" persons have been studied during the course of their transfer from security hospitals to civil mental hospitals and the community, following the decision in *Baxstrom v. Herold*,⁹² the anticipated dangerous behavior was infrequent. For example, only three percent of the transferred patients proved sufficiently dangerous to be returned to a hospital for the criminally insane.⁹³ And, among the 121 transferred patients who were released to the community, only nine were convicted of a crime during thirty months of freedom (twenty-one had been arrested); three of these convictions were for felonies (*i.e.*, grand larceny, possession of a dangerous weapon, and robbery).⁹⁴ Even minimal familiarity with criminal recidivism data would be sufficient to indicate that these so-called "dangerous" patients had a much better community record than is typically to be found for released offenders.

Given the nature and consistency of the aforementioned empirical evidence, one must indeed wonder about the nature and intensity of the societal feelings and beliefs which have led to the policies and practices in question. Considering the lack of empirical evidence, the preventive detention which typically follows, and the difficulties and errors of predicting dangerous behavior, one must surely marvel at the strength and persistence of the false belief about the dangerousness of the mentally ill. Indeed, it would be accurate to say that the above belief rather closely fits at least one definition of a delusion.⁹⁵

Predictions of dangerous behavior. Since the involuntary confinement of mentally ill persons is often premised upon the likelihood of their dangerousness, the predictions of such anticipated behavior would seem to play a very key role in the commitment process. The medical and psychiatric ex-

91. See, e.g., J. Giovannoni & L. Gurel, *Socially Disruptive Behavior of Ex-Mental Patients*, 17 *ARCHIVES OF GENERAL PSYCHIATRY* 146 (1967); G. Gulevich & P. Bourne, *Mental Illness and Violence*, in *VIOLENCE AND THE STRUGGLE FOR EXISTENCE* 309 (D. Daniels, M. Gilula & F. Ochberg eds. 1970); J. Rappeport & G. Lassen, *Dangerousness—Arrest Rate Comparisons of Discharged Patients and the General Population*, 121 *AM. J. OF PSYCHIATRY* 776 (1965); J. Rappeport, G. Lassen & N. Hay, *A Review of the Literature on Dangerousness of the Mentally Ill*, in *THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL* 72 (J. Rappeport ed. 1967); B. Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 *ARCHIVES OF GENERAL PSYCHIATRY* 397 (1972).

92. 383 U.S. 107 (1966).

93. H. Steadman & A. Halfon, *The Baxstrom Patients: Backgrounds and Outcomes*, 3 *SEMINARS IN PSYCHIATRY* 376 (1971).

94. H. Steadman & G. Keveles, *The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-1970*, 129 *AM. J. OF PSYCHIATRY* 304 (1972).

95. *Delusion*: "n. a belief held in the face of evidence normally sufficient to destroy the belief." H. ENGLISH & A. ENGLISH, *A COMPREHENSIVE DICTIONARY OF PSYCHOLOGICAL AND PSYCHOANALYTIC TERMS* 143 (1958).

perts are expected to predict the likelihood of dangerousness. However, problems are immediately posed since the term "dangerous" is rarely defined in reference to the specific behaviors to be so classified. This allows experts to substitute their own notions about what kinds of expected or possible behaviors may be classified as "dangerous." There is also the problem, as Steadman has found, that the reasons for arriving at conclusions about the individual's dangerousness are either difficult to discern or tend to be tautological.⁹⁶ Steadman notes that the links most often drawn in the reports of the psychiatrists are that the defendant (mentally disordered law-violator) has done something violent (typically referring to the criminal charges) and/or the person is *apt* to become violent (because he is delusional, unpredictable, and/or impulsive and therefore potentially assaultive), and therefore he is *dangerous* (i.e., some time in the future he may display violent behavior). Thus, Steadman points out that the typical references to "dangerousness" are *not* synonymous with dangerous behavior. Rather, "dangerousness" seems to refer to the perception of the "expert" that an individual may some time in the future display dangerous (presumably assaultive and violent) behavior.

One might reasonably assume that the medical and psychiatric experts who typically make predictions about "dangerousness" must have some demonstrated skills in this regard. Once again the assumption is false. The studies which are available indicate quite clearly and consistently that psychiatrists and other clinicians uniformly *over-predict* dangerousness, i.e., the great majority of the persons predicted to be dangerous turn out to be "false positives" (persons predicted as likely to be dangerous but who in fact will *not* display such behavior).⁹⁷

Ironically, it is a statistical truism and *most predictable* that predictions about events which have very low rates of occurrence in a given population (i.e., low *baserates*)—e.g., violent and other dangerous behavior by various groups—will tend to have a very high rate of "false positive" errors.⁹⁸ This issue has been discussed in the literature for at least the past

96. H. Steadman, *The Psychiatrist as a Conservative Agent of Social Control*, 20 SOCIAL PROBLEMS 263 (1972); Steadman, *supra* note 86.

97. See, e.g., Dershowitz, 1969, *supra* note 86; R. Hunt & E. Wiley, *Operation Baxstrom After One Year*, 124 AM. J. OF PSYCHIATRY 974 (1968); L. White, W. Krumholz & L. Fink, *The Adjustment of Criminally Insane Patients to a Civil Mental Hospital*, 53 MENTAL HYGIENE 34 (1969); Livermore, Malmquist & Meehl, *supra* note 85; E. Wenk, J. Robison & G.W. Smith, *Can Violence Be Predicted?* 18 CRIME AND DELINQUENCY 393 (1972); see also H. Kozol, R. Boucher & R. Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME AND DELINQUENCY 371 (1972); J. Monahan, *Dangerous Offenders: A Critique of Kozol, et al.*, 19 CRIME AND DELINQUENCY 418 (1973).

98. A. Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events*, 18 J. OF CONSULTING PSYCHOLOGY 397 (1954),

twenty years.⁹⁹ Yet, it would seem accurate to say that a large majority of the physicians and psychiatrists who testify on issues of dangerousness very probably are not familiar with this literature nor with its obvious implications. As a matter of fact, it is fairly well known in the field of prediction research that actuarial predictions rather consistently are superior to clinical judgments.¹⁰⁰

The clear policy implication of these research findings and the high rate of "false positives" is this: for every person who may accurately be detained on a preventive basis as dangerous (*viz.*, a true positive), we would have to also confine anywhere from five to even 99 or more non-dangerous (false positive) individuals—depending upon the particular *baserates* in the population for the predicted behavior and the accuracy of the predictive instrument or judgments.¹⁰¹

The foregoing material raises a number of perplexing questions about the knowledge and expertise that the "experts" actually contribute on the issues discussed. Even though lay people might well continue to maintain a stereotyped and inaccurate view of the mentally ill as more likely to be dangerous, surely one would expect the *experts* to be more familiar with the relevant empirical evidence. Likewise, given the available literature on the topic of prediction of rare events, one would also expect the *experts* to be aware of the technical limitations and other evidence. We shall return to these questions.

Societal values and dangerous behavior. We have noted that the statutes do not provide any clear or specific definition of the kinds of behavior to be considered "dangerous" in regard to the involuntary commitment of the men-

has provided a theoretical discussion of the problem of the high rates of "false positives" in attempting to predict low frequency events. Taking suicide as an example, and using a suicide rate of about .0033 among a group of 3000 psychiatric inpatients, he provides a table showing the rate of correct predictions (true positives) and false positive errors for various cutting scores. *Id.* at 319, Table 1. Thus, with the above suicide rate there would be approximately forty suicides within the group. Assuming that a suicide index was developed which could correctly predict 75% of both the suicide and non-suicide groups, thirty of the forty suicide patients could correctly be predicted, but there would be 2990 patients in the non-suicide group incorrectly identified (*viz.*, the false positives.) This would give a ratio of one correct prediction for every ninety-nine false positives. Suppose the policy decision was made to reduce the false positives among the non-suicide group to 10%; we would then have reduced the false positives to 1196, but would also have decreased to twenty-four the number of correct predictions among the suicide group. This would give a ratio of about one correct prediction for every fifty false positives.

99. See, e.g., Rosen, *supra* note 98; P. Meehl & A. Rosen, *Antecedent Probability and the Efficiency of Psychometric Signs, Patterns, or Cutting Scores*, 52 PSYCHOLOGICAL BULLETIN 194 (1955).

100. See, e.g., Meehl & Rosen, *supra* note 99. See also Livermore, Malmquist & Meehl, *supra* note 85, at 76-77 n.4.

101. See, e.g., Rosen, *supra* note 98.

tally ill. Reference has also been made to several empirical studies which indicate that the ascription of "dangerousness" is often made by experts without providing any clear evidence that such behavior is very likely.

It is quite evident, however, that our society is not equally concerned about all forms of dangerous behavior, *viz.*, behavior which leads to serious injury and/or loss of life to others or to the individual himself. The basic problem is not simply whether or not a person is viewed as dangerous; rather, it depends on *who* the person is, *in what ways* he is dangerous, the social context of his behavior, and the *value judgments* of influential and powerful social groups in regard to the particular perceived harms to be officially designated as "dangerous."

Thus, many persons are allowed by the community to be dangerous; others may be allowed to be dangerous in some ways but not in others; and some forms of dangerous behavior are legally allowed and socially reinforced, *e.g.*, "death-defying" circus acts, automobile track racing, sky diving, etc.¹⁰² Similarly, in other instances (*e.g.*, the mentally ill), even in the absence of clear indication of dangerousness, the concept of "danger" may be invoked and the label applied (or rather often misapplied), and actions taken to restrict the liberty of certain individuals and groups.

Interestingly, however, some of the most dangerous as well as more easily predictable and preventable forms of dangerous behavior do *not* seem to arouse strong societal concern or actions. Drunken drivers, for example, are dangerous to themselves as well as to others. In his report to Congress in 1968 the Secretary of Transportation noted:

The use of alcohol by drivers and pedestrians leads to some 25,000 deaths and a total of at least 800,000 crashes in the United States each year. Especially tragic is the fact that much of the loss of life, limb, and property damage involves completely innocent parties.¹⁰³

Numerous other studies have indicated with rather marked consistency that *at least* 50 percent of all fatal traffic crashes involve drunken drivers. Also, that less than 10 percent of the driving population (*viz.*, those with *serious drinking problems*) account for almost two-thirds of all alcohol-related traffic fatalities.¹⁰⁴

It could be estimated that approximately 25,000 persons have been killed annually during the past six or seven years in traffic crashes involving drunken

102. See, *e.g.*, T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* (1953).

103. U.S. DEP'T OF TRANSPORTATION, *ALCOHOL AND HIGHWAY SAFETY, A REPORT TO THE CONGRESS FROM THE SECRETARY OF TRANSPORTATION*, i (1968).

104. See *id.*; D. MULVIHILL AND M. TUMIN, *12 CRIMES OF VIOLENCE, A STAFF REPORT TO THE NATIONAL COMMISSION ON THE CAUSES AND PREVENTION OF VIOLENCE* 649

drivers. This is a number considerably higher than the approximately 17,000 criminal homicides our society has averaged during each of these same years. However, given the societal and legal handling of drunken driving, it must be said that we seem to have a truly astonishing—it might even be called bizarre—tolerance for this category of *demonstrably dangerous persons*. Indeed, although no precise estimates are available on this point, it would appear safe to say that in all probability more persons are killed and seriously injured by drunken drivers during the course of a *single week*, than could be attributed to all combined categories of psychotics over a period of several years!¹⁰⁵

What are we to conclude then about our society's handling of the problem

(1969); E. Voas, *Alcohol as an Underlying Factor in Behavior Leading to Fatal Highway Crashes*, in RESEARCH ON ALCOHOLISM: CLINICAL PROBLEMS AND SPECIAL POPULATIONS—PROCEEDINGS OF THE FIRST ANNUAL ALCOHOLISM CONFERENCE OF THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM 324 (M.E. Chafetz ed. 1973). Voas provides data on the percentage of fatally injured drivers in single-vehicle crashes who were drunk, *i.e.*, they had blood alcohol concentration levels at or above .10%. The percentage of drunken drivers involved in fatal crashes ranged from a low of 48% to a high of 71%. Of the eleven studies cited, only one had a drunken driver percentage below 50, in five studies the percentage exceeded 60. *See id.* at 327-28.

In a section entitled, "The Drinking Driver—Public Menace No. 1," a U.S. Department of Transportation report indicates that of the 27,000 persons who died in highway crashes in 1971 in which alcohol played a part, an estimated 18,000 "perished on the highways in traffic crashes which involved drivers who were abusive, problem drinkers." NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION & FEDERAL HIGHWAY ADMINISTRATION, U.S. DEP'T OF TRANSPORTATION, TRAFFIC SAFETY—'72, AN ACTIVITIES REPORT 10 (1973).

We also find roughly the same statistics in regard to the nature of the drinking drivers most often involved in fatal traffic crashes. "Problem drinkers"—not social drinkers—account for fully two-thirds of all alcohol-related fatalities in motor vehicle crashes. Voas, *supra* at 329; NATIONAL HIGHWAY TRAFFIC SAFETY DIVISION, U.S. DEP'T OF TRANSPORTATION, ALCOHOL SAFETY ACTION PROJECTS, 1 EVALUATION OF OPERATIONS—1972, SUMMARY, 3 (1972). This type of dismal statistic does not change if the most recent available data are examined. In 1972, there were 56,000 fatalities in motor vehicle crashes, 2,100,000 disabling injuries, property damage estimated at \$6 billion, accidental injury costs totalling \$23.5 billion, and combined total "accident costs" of \$37 billion. *See* THE NATIONAL SAFETY COUNCIL, ACCIDENT FACTS (1973). This report also notes that "Drinking is indicated to be a factor in at least half of the fatal motor-vehicle accidents." *Id.* at 52. If we compare motor-vehicle deaths with war deaths, we learn from this source that from 1900 through 1972 the estimated automobile fatalities totalled 1.9 million. The total deaths in all wars (from the Revolutionary War to the Viet Nam War) totalled 1.155 million. *Id.* at 49.

Finally, in a study of newspaper coverage of traffic crashes, Waller and Worden report the following: ". . . alcohol is mentioned in only 11% of the fatal crashes and 2% of the non-fatal ones, although it is known to be a factor in at least five times as many fatal crashes and about eight times as many non-fatal ones." Paper presented by J. Waller and J. Worden, *Application of Baseline Data for Public Education About Alcohol and Highway Safety*, Conference on Evaluation of Alcohol Safety Action Projects, Office of Alcohol Countermeasures, U.S. Dep't of Transportation, Bethesda, Md., Sept. 1973.

105. For a discussion of some of the more "subtle" forms of violence in our society, see G. Geis & J. Monohan, *The Social Ecology of Violence*, in MAN AND MORALITY

of dangerous behavior? How dangerous have been the thousands of mentally ill who are involuntarily committed each year on this basis?

Considering the indeterminate loss of liberty which invariably follows involuntary commitment of the mentally ill, the fact that the mentally ill as a class are *not* more dangerous than various other groups, the erroneous predictions of "experts" in this regard, as well as the perfunctory judicial proceedings which lead to involuntary loss of liberty for the mentally ill, it would be accurate to say that the decisions regarding the mentally ill made by "experts" and courts have been themselves rather *dangerous* acts.

Why does this situation exist? Why is it that even in the presence of contradictory evidence our society seems to scapegoat the mentally ill?

It seems likely that societal attitudes concerning mental illness and the mentally ill still retain the characteristics which Nunnally found several years ago.¹⁰⁶ Even though the *information* held by the public about mental illness was not bad in the sense of being gross misinformation, the *attitudes* certainly were "bad." People tended to regard the mentally ill as relatively dangerous, dirty, and unpredictable. Also, feelings of anxiousness and apprehension were associated with the mentally ill. The stereotyped pictures often conveyed of the mentally ill and the unusual media publicity given to the occasional bizarre and violent acts of the mentally ill seem sufficient to maintain and to even reinforce the foregoing attitudes.

Indeed, Nunnally also found that general practitioners of medicine, who often act as key "gatekeepers" between the public and the mental health specialist and who in many instances are the "experts" involved in commitment hearings, also tended to hold negative attitudes about the mentally ill. This was more typically the case with older practitioners.¹⁰⁷

The rule of law and the role of the "experts." The foregoing discussion raises a number of perplexing questions about the kind of knowledge and expertise that the "experts" actually contribute to the issues discussed. There are also questions about the particular role and social function of experts in regard to the handling of the mentally ill. For example, one might reasonably wonder why the "experts" are not better informed about the erroneous and stereotyped aspects of the supposed dangerousness of the mentally ill as a class. Likewise, it would seem entirely reasonable to expect that the "experts" on the subject of predicting behavior should be quite familiar with the available empirical evidence on the subject and also with some of the technical problems in undertaking predictions of low base rate events.

(T. Lickona ed. 1974).

106. J. NUNNALLY, *POPULAR CONCEPTIONS OF MENTAL HEALTH* (1961).

107. *Id.*

We might consider, therefore, some possibilities as to why the current situation seems to prevail. First, it seems likely that many of the "experts" who testify on issues of mental disorder and "dangerousness" might not actually be very knowledgeable in the sense of having demonstrable and reliable knowledge in the specific areas in which they are asked to—and obviously are willing to—testify. There should also be very real questions about the substantive knowledge of mental disorders, and of the prediction of dangerous behavior and related matters on the part of non-psychiatric physicians whom the statutes often authorize and the courts accept as "experts" on these matters. Indeed, it is puzzling to know why the use of non-psychiatric physicians has not been questioned and challenged in the courts. Clearly, the ascription of "expert" status to these physicians is based more upon the social power and status of medicine than upon their substantive knowledge on issues of mental disorder. In terms of substantive expertise, it would be safe to say that trained clinical psychologists would bring more knowledge to bear on the subject than do these "experts."¹⁰⁸

Second, it is possible that the "experts" actually are familiar with the fact that the mentally ill are not very dangerous as a class and therefore that the *great majority* are not really dangerous. However, they may find themselves placed in a social role in which society *expects* them to assist in the labelling and social control of persons who are perceived by the community as disturbing, discomfoting, and threatening. Assuming this to be the case in many instances, the "experts" might be responding to what they *perceive* is socially expected of them rather than in response to the specific legal questions and processes designed to attain the desired societal objectives.

Finally, and closely related to that possibility, the experts may also find themselves in a social role (*viz.*, of knowledgeable and skilled "experts") which *requires* that they not jeopardize this ascribed expertise—and thus the associated status, prestige and power. Given the particular social context in which the "experts" operate in regard to the determination and prediction of "dangerousness," it is entirely predictable that they function as they do. It is not surprising that psychiatrists and other experts turn to medical decision rules which state: "When in doubt, suspect illness;" "When in doubt, suspect dangerousness;" "When in doubt, commit;" and "When in doubt, don't let them out."¹⁰⁹

Using medical decision rules, and also in order to safeguard their "expert"

108. See, *e.g.*, *Jenkins v. United States*, 307 F.2d 637 (D.C. Cir. 1962); *State v. Padilla*, 66 N.M. 289, 347 P.2d 312 (1959).

109. See, *e.g.*, T. SCHEFF, *supra* note 11; Dershowitz, 1971, *supra* note 86; T. Scheff, *Decision Rules, Types of Error, and Their Consequences in Medical Diagnosis*, 8 BEHAVIORAL SCIENCE 97 (1963).

role and status, experts are much more willing in such cases to make Type 1 errors (*i.e.*, have a very high number of false positives), than Type 2 errors (*i.e.*, have even a few false negatives—releasing persons as “not dangerous” only to have them commit some dangerous acts).

While the very-cautious approach might be understandable, it nevertheless raises quite serious social policy and legal questions. After all, these decisions are *not* medical in nature; the decisions have to be made by courts and juries in accordance with stated policy and in adherence to legal rules and requirements. Indeed, it appears that not even the “preponderance of evidence” rule is strictly adhered to in these “civil” proceedings. In essence, then, the experts are allowed to use their own values and perceptions of what is right and desirable, and they typically function in the involuntary commitment situations to wrongfully and unnecessarily deprive persons of their liberty.

One is reminded here of Freidson’s admonition concerning the role and authority of the expert in making essentially normative decisions:

[T]he profession’s role in a free society should be limited to contributing the technical information men need to make their own decisions on the basis of their own values. When he preempts the authority to direct, even constrain men’s decisions on the basis of his own values, the professional is no longer an expert but rather a member of a new privileged class disguised as expert.¹¹⁰

It would be correct to say, therefore, that psychiatrists and other experts involved in decisions about the involuntary commitment and release of the mentally ill very often appear to function as “conservative agents of social control.”¹¹¹ However, it would have to be added that courts and judges *also* function as rather “conservative agents of social control.” Likewise, in regard to the willingness of legislatures to enact measures which speak of “treatment” but seem designed to facilitate social control, we would also have to say that legislatures play a most important role in bringing about such policies and practices.

The role of courts and judges is especially disturbing. They have been designated by society as the institutions and agents charged with the responsibility to protect and safeguard individual liberty against improper use of state power; to implement the rule of law (as contrasted, perhaps, to the authority and power of the state or even the “experts”); to carefully balance the rights of the individual and those of the community; and to ensure that any deprivations of liberty are carried out in accordance with due process of

110. E. FREIDSON, *PROFESSION OF MEDICINE: A STUDY IN THE SOCIOLOGY OF APPLIED KNOWLEDGE* 382 (1970).

111. Steadman, *supra* note 96.

law. In view of these critically important social responsibilities, the judicial default reflected in the legal handling of the mentally ill is certainly most egregious and should be a cause for much concern.

The Rights of the Mentally Ill and Judicial Default

Although considerable attention has been given by lawyers and others to the infringements of the civil rights and liberty of the mentally ill as a result of various institutional psychiatric practices, there has been a remarkable degree of silence about the even greater infringements which appear to result from the failure of courts to give careful attention to the various liberty-depriving judicial proceedings over which they preside. Physicians, psychiatrists and other mental health professionals lack the legal training and sensitivity to related social policy issues. But this cannot be said for lawyers and judges.

The reality of fundamental importance is simply this: the mentally ill need *equally* to be protected against improper and unlawful infringements of their liberty whether affected by uninformed mental health professionals or by judicial default.

The foregoing discussion has already referred to the perfunctory nature of the legal hearings pertaining to involuntary civil commitment, the inadequate legal and judicial performance in such proceedings, and the failure of courts to adhere to evidentiary requirements.¹¹² Two very specific illustrations will be provided to indicate more clearly the kinds of practices which have been described here as "judicial default."

Continued involuntary confinement of pretrial incompetents even though charges dropped. The first illustration is provided in the report based upon comprehensive research on pretrial competency in Massachusetts.¹¹³ Following *Commonwealth v. Druken*¹¹⁴ which established unequivocally the full panoply of civil safeguards for defendants committed as incompetent to stand trial, a variety of reform efforts were undertaken. It was the interpretation of the legal counsel for the Department of Mental Health that the decision applied retroactively to patient-defendants who were awaiting trial in facilities of the department.

As of May 1, 1970, there were 496 pretrial incompetents whose status was

112. See pages 691-92 *supra*.

113. A. MCGARRY, W. CURRAN, P. LIPSITT, D. LELOS, R. SCHWITZGEBEL & A. ROSENBERG, COMPETENCY TO STAND TRIAL AND MENTAL ILLNESS, FINAL REPORT TO CENTER FOR STUDIES OF CRIME AND DELINQUENCY, NATIONAL INSTITUTE OF MENTAL HEALTH (1973).

114. 356 Mass. 503, 254 N.E.2d 779 (1969).

that of indefinite commitment. When the various courts in the commonwealth were surveyed, the investigators were astonished to learn that in *over 90 percent* of such cases *the criminal charges against these individuals were no longer standing*. By the fall of 1970 only forty-six persons still faced pending criminal charges out of the 496 committed patients who were supposed to be "awaiting trial." Fully 176 of these patients had been hospitalized for more than five years, in a criminal status, without home visitation privileges, for charges that for the most part simply did not exist!

This, however, was not the entire story. During the course of the survey the researchers also came across one court which "routinely" dismissed the charges against the individuals *while at the same time* committing them indefinitely to the hospital—in the category of incompetents awaiting trial!

Even this does not capture the strange and almost "Alice in Wonderland" quality of some of these judicial dispositions. The study's authors state:

We were not prepared for the remarkable fact that 212 out of the 496 had had their charges dismissed *on the same day* that they were committed "awaiting trial."¹¹⁵

One might well wonder about the travesty of justice and fundamental fairness that the patient-defendants received at the hands of the courts. Remember, these persons were still presumed innocent of the charges against them.

Since the involuntary confinement of these individuals without proper civil commitment was illegal after the criminal charges had been dropped, and since these individuals had wrongfully and improperly been deprived of their liberty for up to and even longer than five years, should they not have legal recourse to seek redress against the courts? On the basis of even the most elementary notions of fundamental fairness and justice the answer for this legal layman would clearly be in the affirmative.

It appears, however, that the doctrine of judicial immunity effectively prevents—or at least makes extremely difficult—suits against judges for malpractice and damages. Even if it could be said that the responsibility for the failure to inform pretrial incompetents or the hospital that the criminal charges have been dropped is that of various court personnel under the principal of *respondeat superior*,¹¹⁶ could the judges be held responsible for such failure?¹¹⁷

115. A. McGARRY, W. CURRAN, P. LIPSITT, D. LELoS, R. SCHWITZGEBEL & A. ROSENBERG, *supra* note 113, at 55-56.

116. *See, e.g.,* Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

117. It is, of course, arguable whether in these situations the primary responsibility for informing the patients (or the hospital) that the criminal charges had been dropped was the prosecutor's. Given the nature of the situation described (*viz.*, several hundred

Wrongful involuntary civil commitments. We have already referred to the criteria for involuntary civil commitment of the mentally ill and the requirement (in several states) of a showing of danger to self or to others. It has also been abundantly documented in the literature that such commitment hearings typically take place in "rapid fire fashion" and with very perfunctory attention to both substantive and procedural legal requirements.¹¹⁸ Most certainly this is not what is meant when reference is made to the right of persons to a "speedy hearing."

The major point is that courts often do *not* seem to determine that the prescribed legal requirements for "danger to self or to others" have in fact been met (in states providing such criteria) prior to decisions to involuntarily commit the individuals.

Thus, the relevant Arizona statute for involuntary judicial commitment requires that there be a showing that the mentally ill person is likely to be dangerous.¹¹⁹ However, in two rural counties using physicians for the mental examinations, the doctors are reported to act much like jurors in that they merely attend the hearings and form their recommendations based on observations at these times. This, however, is in direct contravention of the statutory requirement of "personal examinations."¹²⁰ Similarly, in other rural counties well meaning physicians indicated during interviews with the researchers that their decisions pertaining to involuntary commitment were often based on whether the patients needed treatment, rather than on the criterion of "dangerousness" required by the statute. It might be noted, once again, that in about 96 percent of the cases the judges simply accept the recommendations of the experts, *i.e.*, they "rubber-stamp" these recommendations.

The basic issue then, as this writer understands it, seems to be this: If the statutes require that involuntary commitments be based upon a *judicial* finding of mental illness and on the additional *judicial* finding that the person is likely to be dangerous, then commitments that are *not* based upon an explicit and proper judicial determination of "dangerousness," or

cases were involved and some courts were evidently "routinely" dismissing charges while at the same time committing the persons as pretrial incompetents), it appears to this non-lawyer that some judicial responsibility might also be involved.

The problems described may possibly relate to the issues of: 1) "wrongful imprisonment" (the logic should also include other involuntary confinement situations); and 2) "abuse of process." See *Maniaci v. Marquette University*, 50 Wis. 2d 287, 184 N.W. 2d 168 (1971).

118. See, *e.g.*, Cohen, *supra* note 45; Kutner, *supra* note 55; Maisel, *supra* note 55; Miller & Schwartz, *supra* note 55; Scheff, *supra* note 55; Wexler, *supra* note 46.

119. ARIZ. REV. STAT. ANN. § 36-514 (Supp. 1973).

120. Wexler, *supra* note 46, at 61.

commitments ordered in the *absence* of any competent and convincing evidence of "dangerousness," are illegal.

Thus, given the fact that persons are illegally committed to mental hospitals in the aforementioned manner, we find again what seems to be a fairly common type of "judicial default." What recourse might an individual have in these situations—not only to seek release from such illegal confinement, but also to seek compensation as well as damages for the wrongful deprivations of liberty which have been suffered?¹²¹

How to hold judges accountable? In order to prevent the kinds of problems revealed by one study, its author have urged that the psychiatrist's role in commitment hearings should be limited to merely presenting the relevant evidence. The court would more specifically and explicitly be asked to determine whether the patient in fact meets the legal criteria for involuntary commitment. This, of course, is already known to be the proper and expected role and responsibility of the courts, but it needs to be emphasized further. However, it was also recommended that, after consideration of all the evidence and factors in the case, and to ensure "independent and reasonable judicial decision-making," the courts should be required to make findings of fact and conclusions of law for each case.¹²² This would seem to be most essential.

Recording the findings of fact and conclusions of law should help to make judges more self-conscious and alert to their responsibilities; it should also facilitate greater accountability.

However, being aware of the professional and institutional practices which serve to protect members of a professional group against actions that might be embarrassing to the entire profession, the writer believes that additional

121. See note 117 *supra*. The reason for raising these issues is certainly not to attempt to advise lawyers about how they should proceed to seek redress of such problems. Rather, the concern is with the broad social policy issues as they relate to the improper (and possibly illegal) deprivation of liberty for a certain class of persons. The fact that such deprivations result from judicial or prosecutorial carelessness, or from a lack of sufficient attention to certain legal requirements, does not alter nor even detract from the fact that improper deprivations of liberty nevertheless appear to be involved. These seem to be lacunae in the law that clearly indicate avenues for legal research and necessary corrective actions.

It also appears to this writer that there are many professional and institutional contingencies which may tend to militate against the bringing of complaints and other legal actions by lawyers against judges for the misuse of process or related reasons. See note 117 *supra*. Attorneys concerned about adequately representing future clients would typically be very diffident about bringing complaints against judges. It might be feared that such actions *may* result in subsequent unfavorable judicial rulings and related actions. If these impressions are reasonably correct, it raises the question of whether the enormous discretionary power of judges warrants further scrutiny in an effort to establish a greater judicial social accountability.

122. Wexler, *supra* note 46, at 64.

measures are required if the courts are to discharge more conscientiously the awesome responsibility assigned to them. A more powerful, visible, and persuasive oversight and corrective mechanism seems very much to be needed.

One such mechanism that already exists and which reflects the views and ideas of the United States Congress is the District of Columbia Commission on Judicial Disabilities and Tenure.¹²³ This Commission is empowered to suspend, retire, or to remove judges of a District of Columbia court as provided in the various subchapters. Of special interest to us for the purposes noted above are sections 11-1526(a)(2)(B) and (C), entitled, "Removal; involuntary retirement; proceedings."

Section 2 states:

A judge of a District of Columbia court shall also be removed from office upon affirmance of an appeal from an order of removal filed in the District of Columbia Court of Appeals by the Commission (or upon expiration of the time within which such an appeal may be taken) after a determination by the Commission of—

- (A) willful misconduct in office,
- (B) willful and persistent failure to perform judicial duties, or
- (C) any other conduct which is prejudicial to the administration of justice or which brings the judicial office into disrepute."

Of special relevance in regard to prevention and remediation of the problems discussed above would be subsections (B) and (C), since what has been described earlier would pertain to "willful and persistent failure to perform judicial duties," and to conduct which is "prejudicial to the administration of justice."

Undoubtedly, knowledgeable lawyers could think of other effective means to prevent and to correct the kinds of problems which have been discussed in this section. It goes without saying, but is consistent with various problems and issues discussed earlier in this article, that similar notions of ensuring accountability should apply equally to mental health experts as well as to attorneys who are responsible for representing mentally ill persons in various legal proceedings.

Finally, there is also a need for appropriate mechanisms for correcting poorly conceived legislative measures. When legislative or executive bodies enact measures or undertake actions that appear to run counter to established societal rules and safeguards, courts are expected to intervene. These are problems with which courts have much experience. However, as Frankel points out, whenever a court seeks to strike down a governmental restraint on

123. D.C. CODE ANN. §§ 11-1521-30 (1973).

personal liberty on the grounds that a legislatively determined rationale does not warrant such a deprivation "the court is at the outermost border of judicial authority."¹²⁴ There is, moreover, the traditional tendency for courts to defer to legislative findings of danger and legislative choices of appropriate means for dealing with it. This is especially true when public sentiments are running high on a particular issue.

This, again, seems to be a problem which requires some adjustments in the system of checks and balances to ensure greater protection of fundamental societal values and objectives. Possibly, greater attention should be devoted to the constitutionality of legislation that may be premised upon erroneous beliefs or assumptions (*e.g.*, the presumption that the mentally ill, as a class, are more likely than others to be dangerous). Also, it appears quite obvious that a wider range of relevant expertise should be sought on such issues by lawmakers and courts. That is, more empirically based information should be provided by behavioral and social scientists, rather than continuing the heavy reliance on physicians and psychiatrists. The confusion of ascribed social status and influence with demonstrated substantive expertise on particular issues must be put to an end.¹²⁵

Conclusion

This discussion has highlighted some of the problems which continue to be evident in the interactions of the legal and mental health systems in regard to the handling of the mentally ill. While a number of fairly specific issues have been the focus of attention, the major purpose has been to emphasize broad social policy considerations and their relevance and implications for legal and mental health practices.

The overall picture one gets is not reflective of the benign, remedial, non-punitive, and treatment objectives suggested by the legal doctrine of *parens patriae*, nor even those suggested by the *therapeutic* concerns of the mental health movement. When it comes to the use of involuntary legal processes for the commitment and handling of persons labelled as mentally ill, the clear and glaring picture that most typically emerges is that of *social control*. Very serious and even unnecessary infringements of the liberty of the mentally ill continue to take place because of the societal failure to provide the necessary resources to develop the full continuum of treatment and care facilities. Lacking suitable alternatives, ready recourse to total hospitalization seems often the most available choice.

124. Frankel, *supra* note 72, at 244.

125. For an excellent discussion of these matters, see E. FREIDSON, *supra* note 110.

There continues to be a serious, confusing and confounding of legal and medical models in the articulation of policies, as well as in the actual practices pertaining to the involuntary handling of the mentally ill. Moreover, despite the fact that loss of liberty is involved and that social policy and legal questions are fundamentally at issue, *medical*—rather than *legal*—decision-making typically comes into play.

The conceptualization of behavior and of deviance continues to focus on the characteristics (psychopathologies) of the individual, while neglecting to consider the social, environmental, and situational contexts in which the behavior occurs, and the social conditions that may give rise to and which also sustain and maintain certain types of social deviance. This preoccupation with psychopathology leads to a neglect of broader social factors relevant to the understanding of etiology as well as of prevention and treatment. The use—rather, the frequent misuse—of the concept of “dangerousness” and its false attribution to the mentally ill as a class serves to illustrate the manner in which social and legal policies have in some instances been premised upon incorrect information and beliefs. Thus, unjustified societal fears and apprehensions provide the basis for unstated social control efforts, even though benign and benevolent rhetoric is used to offer the explicit rationale—rather, the rationalization—for such practices.

It has been suggested that a grave social harm results when hypocritical policies and practices become institutionalized. A sound approach to the correction and prevention of such practices is to bring about and to *enforce* greater accountability. Such accountability is needed in regard to legislative, legal, and judicial processes, as well as in reference to mental health practices. And, even though the discussion has tended to emphasize the wrongful (and even illegal) involuntary confinement of the mentally ill, attention has also been drawn to the very real and very serious needs for proper care and treatment of the thousands of mentally ill persons who often have rather precipitously been removed from mental hospitals—only to be allowed in many instances to “shuffle to oblivion.” These latter situations do at least serve to bring the problems more clearly and starkly into the open.

The role of lawyers in helping to bring about a more honest and genuine societal effort to provide proper care and treatment under the *parens patriae* responsibilities of the state seems very much to have been neglected. This is as important an area for legal concern and social reform as the problem of unnecessary and improper involuntary commitments.

Since the topic of this discussion pertains to both mental health and legal issues, the writer has made numerous references to very specific legal matters. For one who is not a lawyer this poses very real hazards. It is likely

that in many instances the complexities and nuances of the legal issues have not fully been understood or adequately appreciated. However, it has very explicitly been noted that the major concern of this discussion has been to focus on the broad social policy aspects and implications of the problems described. Such policy issues, of course, are neither the sole concern of lawyers, nor of mental health professionals; they require wide public participation. The legal reader is reminded, therefore, to consider primarily the broader social policy implications of the problems which have been highlighted, and to only then translate them into more specific legal issues and complexities.

There is also an advantage that a layperson may have vis-a-vis the trained professionals in a specialized field. It is possible that the academic and professional training we receive in our respective fields tends in some degree to bring about a "trained incapacity" to perceive and to conceptualize problems in a manner unconstrained by the concepts and frames of reference of the particular discipline. Thus, it may also be possible (although it could simply be this writer's hope) that the discussion of these issues may indicate some novel ways of viewing both policy and legal problems. The perplexities which have been noted might even raise some questions about the "Emperor's clothes."

In the final analysis, it has been urged that we need much more clearly to recognize that societal hypocrisies are not in any way changed simply by clothing them in idealistic rhetoric, a *parens patriae* doctrine, legal technicalities, nor even by resorting to mental health labels. In situations where involuntary losses of liberty are involved, a paraphrasing of some sentiments expressed by C. S. Lewis¹²⁶ seems quite pertinent: Treatments, when detached from fundamental notions of justice and fairness, may indeed be viewed as most untherapeutic.

126. C. Lewis, *The Humanitarian Theory of Punishment*, in *PSYCHOANALYSIS, PSYCHIATRY AND LAW* 626, 628 (J. Katz, J. Goldstein & A. Dershowitz eds. 1967).