# ADMINISTRATIVE PSYCHIATRIC JUSTICE:

## Individual Rights v. Societal Rights in Involuntary Civil Commitment

by

Debra L. Martin

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First Reader Albert C. Price

Second Reader Charles J. Weber

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# Introduction

A musty file in Arizona's Greenlee County Courthouse reveals that on January 22, 1912, shortly before Arizona became a state, a 19-year-old Mexican-American woman was taken into custody and placed in the county jail by a deputy sheriff who, that same day, filed with the Probate Court the following commitment petition:

> Have known girl about one year. Last summer--July or Aug. 1911--commenced to act irrational. Has been under treatment of physicians past 4 months. They called me this A.M. and told me they were unable to treat her successfully--that she is crazy and I must arrest her.

The patient was apparently examined the next day by two physicians, who duly completed the required medical questionnaire. In addition to mentioning that the patient's physical health was good, that she was "cleanly" in her personal habits, that she did not use liquor, tobacco, or drugs, and that neither she nor any of her relatives had ever been mentally ill or hospitalized in the past, the doctors listed the following information on those portions of the form devoted to mental illness and dangerousness:

> Dangerousness:
> No threats or attempts to commit suicide or murder. Is of a very happy temperament. Has a tendency to laugh and sing.
>
> Facts indicating insanity:
> She wanted to dance. Most of conversation was fairly rational.
>
> Appearance and Activity of patient:
> Was in constant motion. Could not sit or stand still. Laughs at anything said or done.

Other facts:
The patient formerly was very quiet and retiring. Is now willing to talk with anyone.

Diagnosing her mental problems as being supposedly caused by "bathing in cold water at menstrual period" and as probably being "only temporary" in nature, the physicians nevertheless concluded that in their judgment, "the accused is insane, and it is dangerous to the accused and to the person and property of others by reason of such insanity that the accused go at large." On Janury 23, 1912, after a judicial hearing, the probate judge signed an order committing the patient to the "Territorial Asylum for the Insane, at Phoenix, Arizona, until sufficiently restored to reason, or otherwise discharged according to law."

But the 1912 commitment order does not complete the court file. It is followed by another order, requested by the hospital, permitting the institution to apply some of the patient's personal funds to pay the maintenance cost of her involuntary confinement. That order, however, was dated May 26, 1969. An investigation conducted during the 1970-71 academic year by David B. Wexler and his students confirmed the frightening fact that the patient, then 78 years of age, is still a resident at the hospital, the great bulk of her life reflected well by two drab documents resting back-to-back in a court file."[1]

Stories like this one began to accumulate and emerge from the dark back wards of mental institutions. Professionals and society alike were horrified when stories of individuals involuntarily confined to hospitals for seemingly little cause came to the harsh light of the era. Previously, societal rights had reigned supreme. However, in the context of newly defined individual civil rights the institutionalized were often seen as having been railroaded into the hospital without recourse. Lawyers began to address the abuses of the mental health system and as a result, "mental health law burst into

its own as an area of scholarly inquiry and of practical concern."[2]

The rights of the individual have been pitted against the rights of society since the birth of man. It is only natural that these value laden perspectives have confounded man, even in his simplest form. The complexity of society has increased many times over and is ever changing. As man and society evolve it follows that individuals and societal rights also evolve, defined and redefined time and again. The delineation of individual vs. societal rights is addressed informally through mores, culture, ethnicity and formally through legal mediums, courts, administrative agencies and regulations.

Sociologically a multitude of factors are involved in the melee of competing values and rights. Law was born early in the society's history. Preservation of man and the creation of order in the civilized world necessitated controls be placed on individuals. Laws protected the weak and the strong encouraging a satisfactory mode of living. Safeguards were placed into society so self-protection and defensiveness could be reduced. According to Alexander D. Brooks, "law is a product of the society in which it is formulated and enforced as well as being a derivative of antecedent societies."[3] The law is subjugated to continual pressure for alteration from society.

In mental health law the myriad of competing values is fostered by the involvement of a medical specialty, psychiatry. Comparatively, psychiatry is of recent origin, just in its infancy, as opposed to law. In contrast to law, the science of psychiatry can not provide absolute answers to many questions. Within psychiatry, due to the

lack of absolute certainty, several schools of thought have developed. Thus, the underpinnings of psychiatrists may ethically differ greatly. And as a result, the conclusions of mental status exams and treatment are based largely upon the school of thought to which the examiner ascribes. In other words, conclusions may vary although based on the same information.

Factors of uncertainty and differing psychiatric viewpoints cause obvious problems for law. Much to the consternation of many legal and mental health professionals, the exacting constraints of law interact with the imprecision of psychiatry. Sparks can fly.

Yet, psychiatric and psychological expertise influence the shape of the law and affect legal consequences in courts, legislatures and administrative agencies. In turn these mediums are pervasive in touching the lives of millions of people. There exists a "crucial interrelationship between the future of mental health law development and the future of multidisciplinary mental health law scholarship."[4] There are basic legal problems and therapeutic and ethical dilemmas caused by the influence of the law on the practice of mental health.

The care of mental health law safeguards the loss of liberty in the involuntary commitment procedure. Unconnected with the criminal justice system, the civil commitment process is utilized when a mentally ill person poses a danger to himself or to others and is confined to a mental hospital for treatment. Distinct from the criminal commitment system, which is an offshoot of the criminal justice system, civil commitment is paternalistic, and enumerates the

basis of public protection. Whereas, the criminal commitment system determines whether an individual is competent to stand criminal trial or the procedure may be instituted following a "successful" insanity defense.

A broad perspective of the civil commitment process and related issues will be explored through extensive literature review. The civil commitment process does not have its foundation in quantifiable data or even in well established, widely accepted terminology. Concepts of mental illness, civil liberty, right to treatment and right to refuse treatment are somewhat vague--not to mention perceived and interpreted in a highly individualistic manner. The terms are even suspect amongst some sectors of professionals and non-professionals.

Research revealed more issues than answered questions. Who can be involuntarily committed to a mental hospital for compulsory treatment?, for how long?, what are the judicial standards of treatment?, what type of treatment can be imposed without consent?, to what extent should involuntary intervention in the life of an individual be governed by due process when treatment is needed?, do law and mental health professionals work together effectively to meet the individual's needs?, do society's rights ever take precedence over the individual?

The age old struggle of individual vs. societal rights continues. Clearly, these issues engage the fundamental and overriding question of the balance between state power and individual rights. These

issues go far beyond the usual legal, medical and mental health concerns. They are issues of basic societal values and broad public policies. Moreover, they have profound moral and ethical implications. The solution to this struggle is obscure. Historically, the line of demarcation between individual and societal rights has shifted as though it were sand driven by the wind. The trajectory is sordid; the answer as difficult as ever. It is anticipated that the ferreting out of answers for this dilemma will remain with man.

## Introduction

### Notes

[1]David B. Wexler, Mental Health Law (New York: Plenum Press, 1981), pp. 1–2.

[2]Wexler, p. 2.

[3]Alexander D. Brooks, Law, Psychiatry and the Mental Health System (Boston: Little, Brown and Company, 1974), p. 605.

[4]Wexler, p. 7.

# Chapter I

## Sociological Antecedents

The care and treatment of the mentally disturbed has posed tantamount problems for the individual and for society for centuries. Historically, man's treatment of the mentally disturbed has followed a fascinating yet, blood curdling trajactory. A historical sociological understanding of the problem in the United States and knowledge of past governmental interventions is necessary for setting the tone for a fuller comprehension of the issues involved in the development of mental health law pertaining to the involuntary civil commitment process.

By the time of Colonial America, society had developed a unique way of viewing and treating disturbed people. Treatment varied according to the meaning that society attached to the particular form of deviant behavior. In some societies, deviants were highly valued; treated as prophets or "divine" beings with unusual powers to do good. In other societies, abnormal behavior was regarded as an evil threat to be suppressed. Mentally deviant individuals have been tortured and even put to death. In the United States before the 19th century the mentally disturbed were quartered in "mad houses" where they were often chained to the walls. Kept without regard in barren unsanitary

rooms the insane, beggars, and criminals mixed freely.[1] Children and adults were kept together and incurred multitudinous ridicule and harsh treatment. Squalid overcrowded buildings were the typical housing offered by local communities, who paid for the care of the disturbed on a per capita basis at a predetermined rate. If the wardens cared for them for less, they could pocket the remainder of the payment.[2]

By the end of the 18th century, with the development of interest in medical science, some of the more enlightened hospitals in Western Europe and America began to take a more humane attitude toward the insane. Physicians became scientifically interested in insanity, observing patients more systematically and listening to their utterings. Systems of classification for deviance began to develop from physician's observations; these were the forerunners of psychiatry. Physicians had little inkling that much of the behavior observed in the mad houses were side effects resulting from long periods of institutionalization.

Author William Tuke (1732 to 1822), a Quaker and founder of the notion of "Moral Treatment", espoused his theories in the infamous Treatis on the Moral Treatment of the Insane. Moral Treatment was first introduced in a hospital in Philadelphia. Moral Treatment involved rehabilitation, sanitary conditions, and a humane approach. During the first 20 years after instituting Moral Treatment of the patients admitted into the hospital who had been ill less than one year before admission, 70% were discharged "recovered", 5%

"improved".[3] Similar results were reported at many hospitals using this form of treatment. While Tuke's theories were far advanced of his time, they were costly to implement and at odds with the country undergoing population expansion and rapid urbanization. Local governments responsible for raising taxes for care of the insane consistently chose to give minimal support to the hospitals caring for the mentally ill. Therefore, hospitals grew in size becoming overcrowded. Frequently psychiatric patients mingled with the poor, disabled, and criminal. Finally, these institutions--poor houses--eventually became understaffed. Again patients were exploited by employment in hospital industries, provision of an inadequate diet, and squalid surroundings.

The first institution to be established specifically for the mentally ill was the Eastern State Hospital of Williamsburg, Virginia founded in 1773. A second community hospital for the mentally ill established ten years later was noted for a physician/reformer, Dr. Benjamin Rush. Dr. Rush later to be known as the "Father of American Psychiatry"[4] joined the staff of the Pennsylvania Hospital in Philadelphia. He insisted that mental patients should no longer be considered incapable of human reactions. He, like Tuke, advocated for humane treatment for insane patients rather than chaining them to the walls in cold, dark, windowless, dungeon-like basements and whipping them, if they became unruly. He introduced hot and cold baths, placed the patients in heated ventilated rooms, assigned them to simple work as occupational therapy and trained male and female attendants to

nurse patients with kindness. He differentiated between the sexes; the violent and the quiet patients; and the chronic and acute cases of mental illness. Dr. Rush changed the attitude of institutionalization from mere custodial care to giving active cure.[5] This was a highly innovative and startling treatment philosophy. Dr. Rush was one of the very first in the U.S.A. to recognize the crucial importance of physician/patient relationship as a unique tool in the treatment of mental disorders.[6]

Soon other hospitals for the mentally disturbed opened. In 1817 The Friends Asylum in Frankfurt, Pennsylvania was opened as a private institution. In 1824, the State of Kentucky opened the Eastern Lunatic Asylum at Lexington. Mental hospitals were only able to accommodate a small fraction of the mentally ill. Therefore, many feeble minded and dependent insane people remained neglected due to the great reluctance and ultimate failure to commit insane paupers to state hospitals that charged high county rates.[7] Local officials preferred to keep the insane who could not remain with their families in local jails, houses of correction and alms houses.

Another of the foremost pioneer/reformers for the care of the mentally ill was Dorothea Dix.[8] Significant reforms in the day to day care of mental patients was achieved through the effects of this reformer. Miss Dix toured every alms house, work house, jail and prison in Massachusetts and was deeply shocked to find mentally disturbed women in their cells--in bare, filthy, unheated quarters. After talking with inmates and wardens, she explored the potential for

improvement in her campaign. An outstanding feature of Miss Dix's crusade was that she took her cause to the Massachusetts State Legislature and in testimony described the shocking conditions which she had found--insane patients chained to the walls in cold cellars, beaten with rods, lashed and confined in cages and pens.[9] Examples she cited were one man was in a closed stall for seventeen years; a young girl naked in a barn was prey for the boys of village; and another patient had been chained in an outhouse in the winter and his feet had frozen. Great debate and political opposition initially arose in the Legislature and although some politicians tried to obstruct Miss Dix's survey, public indignation and outcry surpassed any political obstacle. The Legislature passed a bill providing immediate relief for the insane and provided for the enlargement of the State Lunatic Hospital at Worchester. Having met with success in Massachusetts, Miss Dix continued her investigations into the conditions of the insane and feeble minded in other New England states. She surveyed Rhode Island, New Jersey and eventually, in all, convinced eleven state legislatures of the necessity of constructing or increasing the capacity of mental hospitals.[10]

America was undergoing a radical change. Miss Dix believed that the growth of industrialization would have a causal effect and increase the incidence of mental illnesses. Motivated by her success on a state by state basis and propelled by her belief in the potential increase in mental illness she had the impetus to seek a Federal Grant from Congress for the future care of the insane. In 1848 she

submitted a memorial to Congress and pleaded that 5,000 acres of land be given to the state for the care of indigent insane.[11] Her proposal was rejected as were most efforts to allocate funds for internal improvement. Again she repeated her request in 1849 suggesting that the land grant should also be used for the blind and the deaf mute individuals. After considerable political maneuvering and much delay, Congress passed the bill in 1854. The bill provided for 10,000,000 acres of land for care of insane persons and 2,250,000 acres for maintenance and training of blind and deaf mutes. (Also known as the 12 1/4 million acre bill.) However, President Frankin Pierce vetoed the bill on constitutional grounds because "the power for the relief of the needy or otherwise unfortunate members of society was vested in the states and not confined on the Federal Government."[12] The Pierce veto, in essence, stated that the States had sole responsibility for the mentally insane not the Federal Government. Pierce further contended that if "Congress is to make provision for (paupers), the fountains of charity will be dried up at home, and the several states, instead of bestowing their own means on the social wants of their people, may themselves, through the strong temptations, which appears to States as individuals, become humble suppliants for the bounty of the Federal Government, reversing their true relation to the Union."[13] A bitter debate in Congress ensued; the veto was not overruled. The Pierce veto established for 80 years a principal of abstention by the Federal Government from the field of social welfare. This is the first instance of federal intergovernmental relations and grant

seeking for the mentally ill.

Yet, through Miss Dix's investigations, presentations to state legislatures, and garnering of public awareness and support, 32 new hospitals for the mentally disturbed were built in the United States.[14] (In contrast, today's national trend in the field of mental health is aimed at dissolving or transforming these institutions which are no longer seen as utilitarian.) Most of the 32 hospitals were located in rural settings.[15] Notably an important philosophical change had occurred, "care of the mentally ill had been removed from the local community, and the professional orientation toward the insane had been changed from seeing them as no different from paupers or criminals to seeing them as sick people in need of hospital care."[16] With mentally disturbed patients out of sight, States and communities took little interest in this issue.

The next wave of reform for the mentally disturbed was precipitated by Clifford Beers' book A Mind That Found Itself (1908). Beers recounted his emotional torture and recovery from mental illness in his book. Thus, it sensitized the public to the plight of mentally disordered people and the necessity for treatment. This surge of change was instrumental in the development of mental health associations. The mental health societies under Beers' leadership successfully demonstrated the prevalence of mental disorders and the need for increased and improved services. Under his influence the concept of outpatient treatment as a prevention for hospitalization became widespread.

With momentous efforts underway to improve hospital environments for the mentally disturbed some scientists and physicians were attempting to understand the etiology of mental illness and to effect a treatment or discover a cure. Sigmund Freud, founder of the Psychoanalytic theory, was the most significant figure in this development.[17] His influence imbued every phase of intellectual life from clinical treatment to political analysis. Freud's theories ranged from historical explanations as in The Civilization and Its Discontent and in Moses and Monotheism to the most precise and detailed studies of the individual psyche. "Unlike either the moral or the medical models, psychoanalysis did not place sole responsibility for abnormal behavior on either sinful man or diseased tissue, but assigned it to family, friends and physiology."[18] "Freud's influence was profound in the development of social work, the direction of casework techniques and in the rise of psychiatric casework in the 1920's and 30's."[19] His theory of neurosis has been an especially strong influence in shaping treatment modalities in small inpatient units and clinical settings but less utilized with psychotic patients in larger hospital settings. Another of Freud's contributions was his emphasis on outpatient treatment in community settings for the mentally disturbed. At this time, community treatment was a significant revelation and departure from past treatment modalities.

As explained by Freud in his stages of psycho-sexual development[20] from early infancy to adulthood, the realization that

emotional disorders result from childhood development led to the establishment of outpatient as well as inpatient psychological services for young people. In the initial decade of the 20th century, juvenile courts began to consider psychological reasons for disobedient behavior. Dr. Wm. Haley in 1909 founded the first Child Guidance Clinic in Chicago. In 1927 the commonwealth fund provided funds to establish demonstration children's guidance clinics in various areas of the country. "The goal of these clinics was prevention of psychological disorders but in actuality they came to deal mainly with the treatment of already identified behavior disorders."[21]

"Starting in the 1880's the number of patients admitted each year began to climb slowly, averaging about 600 per year between 1900 and 1950 . . . by 1950 there were 2,500 patients in the hospital. . . Thus, the average length of hospitalization had increased from one year in 1870 to nearly five years in 1950."[22] A crisis was building.

During the first 4 decades of the 20th century, care and treatment of the mentally disordered on an in-patient basis was undramatic. Only a few specific organic causes of mental illness were uncovered (general paresis, pallagra, and phenylkitornuria). Psychoanalytic explanations were being more widely accepted yet within certain medical circles there was a strong belief that most mental disorders were the result of genetic endowment, metabolic disorders, and infectious diseases. The concept that mental illness is related to other physical illnesses gave rise to the expectation that it could

be treated medically or even surgically. In the 18th century blood letting was widely used to treat the insane. But by the mid 20th century other forms of extreme treatment of the mentally ill was widely practiced; for example, electroconvulsive therapy (ECT), frontal lobotomy, and surgical alteration of a section of the brain to remove the illness from the patient. These physiological approaches were of little therapeutic value though they made it easier for patient control.

Prior to World War II the Federal government had played a very small role in the support of mental health services in the United States. In 1929 a narcotics division had been established within the United States Public Health Service. A year later the division was reorganized into Divison of Mental Hygiene and delegated more responsiblity and authority.[23] Several veteran's administration psychiatric hospitals were operating, the Public Health Service operated several hospitals for psychiatric patients and two federally supported hospitals for drug addicts were in existence.

During the years subsequent to World War II, "the enormous need for psychiatric services reached crisis proportion and forced Congress to establish a national health policy that increased psychiatric services."[24] The first piece of significant legislation, Mental Health Act, Public Law 79-487 in July 1946, was enacted after the war. By the end of World War II there were only a few psychiatric outpatient clinics. Most of these services were privately sponsored and mostly used by middle class patients. In major cities where

psychiatrists had opened private clinics "only the wealthy could afford the cost of treatment and the majority of people still depended upon the state mental hospitals for treatment."[25] Those with lesser forms of illnesses such as mild neurosis did not enter the hospitals. One of the most vital perciptants of the crisis revolved around the recruitment and return of servicemen. Pre-enlistment screening during World War II rejected about 5.7% of the enductees because of neuro-psychiatric disorders. "Among returning servicemen 39% of those discharged with service connected medical conditions were diagnosed as mentally ill."[26]

Congress to establish a national mental health policy involved the Veteran's Administration Hospital facilities. The VA psychiatric training program was a major step on a national level to increase the number of trained mental health professionals. This in turn increased the stature of psycho-dynamic theory as a basis of treating mental disorders. Another major advance was brought by PL 79-487 in the creation of the National Institute of Mental Health (NIMH). It established a national advisory mental health counsel, an agency which provided grants-in-aid for states to train personnel, fund research and encourage the development of local mental health services. NIMH was designed mainly to encourage preventive health measures and provide for an extensive mental health program by enabling the states and private institutions to obtain federal funds. In short, it authorized a broad national program to combat mental illness. During the ten years following its establishment, NIMH became both the

intellectual and financial source for much that was innovative in American mental health planning, research, practice, and training. PL 79-487 represents a clear repudiation of the position taken by President Pierce in his veto message in 1854. This development expressed an important change in intergovernmental policy indicative of political alteration.

The late 40's and 50's mark the expansion of psychiatric services to the community but the major facility for the treatment of mental disorders remained the state psychiatric hospital. "Most patients were released in less than 6 months time but yet there was a steady return of chronically mentally ill patients mostly diagnosed as schizophrenic and diseases of the aged."[27] Throughout the post war period dramatic reports of maltreatment and neglect of the mentally ill were published. Though hospitals had sufficient funds to provide high quality psychiatric care, most institutions suffered from under staffing, overcrowding and lack of leadership. During this time, expansion of services designed to prevent institutionalization had begun. Social therapeutic clubs, half way houses, rehabilitation workshops and therapeutic communities were aimed at shortening hospitalization and minimizing its negative features thereby speeding rehabilitation.

The advent of important "developments starting about 1950 in most innovative state hospitals set the stage for a major shift in mental health policy in the United States regarding institutional psychiatric care."[28] The development of psycho-active drugs was a basis for a

period of rapid growth in the field of psychopharmacology. Both tranquilizers and stimulants were found effective in controlling bizarre behavior and reducing anxiety so that many psychiatric patients were discharged from psychiatric hospitals on a rapid basis. These psychotherapeutic drugs modified emotional components of psychiatric disorders without impairing intellectual capabilities. Long term patients were returned to the community. Restrictive policies and procedures in the hospital environment were liberalized.

The second factor was the development of a therapeutic community philosophy. This orientation to psychiatric treatment grew out of the tenet that therapeutic potential resides in patients as well as staff. According to this theory the democratic community within hospitals would take advantage of therapeutic potentials and increase effectiveness of psychological treatment.

The third development was geographical decentralization in large state mental hospitals. Patients were placed in wards according to their place of residence prior to hospitalization. "This component which started to be simply an administrative reorganization policy rapidly developed into a mode of establishing working relationships between hospitals and the community that they served."[29] Prior to geographic decentralization, state mental hospitals were just as functionally isolated from their community as they were geographically isolated. Formerly, newly arriving patients would have had an initial diagnostic work-up and then be classified according to diagnosis and treatment needs. So that there were electric shock treatment wards,

insulin treatment wards, wards for patients who had dietary restrictions, wards for certain physical diseases, wards for elderly patients, wards for alcoholics, etc. Chronic and acute patients were mingled together in most "back wards". Also noteworthy was a growing accumulation of patients who were transferred to chronic treatment wards where they remained for years, decades, or even life.

These three developments: psychopharmacology advances, the therapeutic community, and geographic decentralization "worked together to democratize the clinical decision making process, establish working relationships between hospitals and the community to lower the hospital census.[30] The National Institute of Mental Health furthered these advances by funding a series of research studies designed to examine prevention of hospitalization. At this time, state hospitals were envisioned as being converted into community mental health centers. These complex innovations dramatically changed public policy regarding mental health services. Debate ensued over how to best utilize the mental health institution.

Federal role in mental health services has been one of vacillation. From the Pierce veto to the federally funded National Mental Health Act to today's standards mental health policy has been one of great flux. The three prong development subsequent to World War II set the stage of increased federal involvement in the planning and funding of mental health services throughout the country. Two distinct historical traditions--one based in mental institutions and the other based in the community--merged shortly after World War II.

States failed continually to appropriate enough funds to support high quality institutional mental health care. This inadequacy on the state's part was appraised and interpreted that the state run system needed to be replaced. The care of the mentally ill could be a viable alternative in the community. Federal funds and consultation were necessary for implementation of this plan.

Again, in 1955 Congress responded to growing political and public pressure for a general reassessment of the Mental Health Program in the United States by enacting the Mental Health Study Act (Public Law 84-182) to provide for a "objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness."[31] The Joint Commission on Mental Illness and Health was to make recommendations to Congress after seeking divergent viewpoints. The commission was to also measure the improvement, care and treatment of mental illness. The Congressional mandate of the Commission stated that "it should be ready to recommend a radical reconstruction of the present system, rather than advocating a patch on the present system."[32] The commission produced ten reports over the next six years, culminating in a report, "Action for Mental Health", submitted to Congress in 1961. The report acknowledged new treatment approaches in psychiatry, differentating them from the previous decade and also made recommendations for a major overhaul of the system of care for the mentally ill. The Commission further recommended that no hospital be larger than 1,000 beds (some hospitals at the time had over 10,000 patients). This recommendation also carried with it new ideologies,

practices, and systematic organization. The report stated that hospitals should be used for intensive treatment rather than the care of chronic patients; this meant revamping of the existing system for care giving. The National Mental Health Act suggested that each state and territory designate one agency to serve as the mental health authority of that state. The report recommended the beginning of a state grant-in-aid program to assist these mental health authorities in improving the quality of community based mental health services. The act established both research grant and training grant programs. Perhaps one of the most important recommendations was that psychiatric care should shift from state mental hospitals to newly created mental health centers in the community. "The Commission made a strong case for treating mentally ill patients in the community near their homes; avoiding the crippling effects of institutionalization."[33] These outpatient clinics were to be "created at the rate of one clinic per 50,000 population."[34] It recommended the establishment of a wide spectrum of community based services to provide continuous and comprehensive aid to the mentally disturbed and to meet the needs of all social classes. It further recommended that the federal government have a major role in financing the mental health system. The commission encouraged a commitment to long term basic and applied research on the etiology of mental illness, and funds were allocated. A more flexible use of available manpower through extensive training to serve the needs of those with emotional problems was advocated.

Other recommended components were improved and expanded: after care, partial hospitalization, rehabilitation services, and finally, expanded mental health education to inform the public about psychological disorders and reduce the public's tendency to reject the mentally ill. The report received criticism for its obvious bias in favor of improving the system of treatment for those already diagnosed as mentally ill, instead of a more balanced approach including primary prevention as well as secondary intersharing prevention.

In order to convert these reports into a coherent politically persuasive recommendation for a national mental health program, the President requested the Secretary of Labor; the Secretary of Health, Education, and Welfare; and the administrator of the Veteran's Affairs to join representatives of the Bureau of the Budget and Counsel of Economic Advisors and staff members of the National Institute for Mental Health in studying the documents and preparing recommendations. These recommendations were submitted to the President in December of 1962. When this report reached the desk of President John F. Kennedy, it found a very receptive audience. The role of the federal government in the planning and support of mental health services accelerated and culminated in President Kennedy's message to the United States Congress. The recommendations by the aforementioned group were given carful consideration by the President and transmitted to Congress on February 5, 1963 in a special message on mental health and retardation. This message was of historic importance because it represented the first time in American history that a message on the

topic of mental health and mental illness was delivered by a President. It was also important because it set the stage for the introduction of special legislation into the United States Congress that was enacted into law nine months later (PL 88-164). The President in his speech asserted that

> Mental illness and mental retardation are among our most critical health problems. They occur more frequently, effect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition.[35]

Kennedy then reviewed the conditions of mental hospitals and stated that time had come for a bold new approach. The bold new approach would involve working towards three objectives, he said:

> We must seek out the causes through mental illness and mental retardation and erradicate them . . . for prevention is far more desirable for all concerned. It is more economical and more likely to be successful. Second we must strengthen the underlying sources of knowledge and above all skilled manpower are necessary to mount and sustain our attack on mental disability for many years to come, and third we must strengthen and improve the programs and facilities serving the mentally ill.[36]

The President proposed a national mental health program to assist in inauguration of a wholly new emphasis and approach for the mentally ill.

> Central to a new mental health program is comprehensive community care. . . . We need a new type of health facility one which will return mental health care to the mainstream of American medicine, and at the same time upgrade mental health services. I recommend therefore that Congress (1) authorize grants for the

> states for the construction of comprehensive mental health centers, (2) authorize short term project grants for the initial staffing costs of comprehensive mental health centers, and (3) to facilitate the preparation of community plans for these facilities as necessary preliminary to any construction or staffing assistance appropriate for 4.2 million dollars for planning grants under the National Institute of Mental Health.[37]

The community mental health center concept combined the most forward looking aspects of the Joint Commission report into a single comprehensive program.[38] Underwritten in the President's message was his view that state mental hospitals as they existed in 1963 were virtually to be phased out and replaced by new Community Mental Health Centers.

> Some of the most distinguishing features of the community mental health orientation mentioned earlier . . .were the emphasis on community rather than institutional care, the focus on total community, prevention, and the emphasis on rational planning as a basis for center construction and staffing, and finally, a strong interest in the identification of stress reducing aspects in the community.[39]

Another innovative characteristic of the proposed Community Mental Health Center was to be its emphasis on comprehensiveness. Prior to this time most general mental health services were scattered and poorly coordinated and unavailable to all segments of the population. The new facilities were to provide continuity of care and to offer high quality care promptly to the total population.

As noted earlier complete services for care and treatment was one of the keys to the community mental health bold new approach. Federal monies were made available if states would met requirements aimed at establishing Community Mental Health Centers, improving existing

services delivery, and implementing new programs. Requirements, federally mandated initially, included five essential services: inpatient care, outpatient care, emergency services, partial hospitalization, consultation and education. Ultimately five additional services were also mandated: diagnostic services, rehabilitation services, pre-care and after-care, training, and research evaluation.[40] The original grant was financially designed so that states received 75% of the total cost of community programs from the federal government[41] with state and local units providing the remainder of the funding.

Legislation also called for a new basis of planning and organizing mental health services in political jurisdictions. In an effort to provide programs of optimum size it suggested that each center should serve a population of 75,000 to 200,000. The boundaries of the community were to be drawn so as to include areas having meaningful political, social, and economic interconnection. Some 1,500 catchment areas were created in the United States. This type of planning (catchment area planning) was to provide a sound basis for establishing preventive and treatment services and for monitoring changes in the incidents and prevalence of mental disorders.

In summary, the 1963 legislation proposed a well-rounded balanced program which would provide leadership and prevention, treatment and care of mentally ill, located in the community rather than in the hospital. The program would offer a comprehensive range of services linked together to provide community and individual attention.

Chapter I

Notes

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## Chapter II

## Development of Mental Health Law

John F. Kennedy's "Bold New Approach" to mental health services combined with the mood of America dramatically influenced the legal status of the mentally ill. The civil rights movement pricked the conscience of the country and interest in the constitutional rights of institutionalized people by public law attorneys gained momentum. The rights of the mentally ill gained a new political dimension. In the decade of expanded civil rights, "the mentally ill were afforded civil liberties of the first order."[1]

Progressive crusaders for the past century had argued that the mentally ill should be treated as patients rather than criminals. Movement from the classical method of determining justice for the mentally ill, grounded in the ideology of the criminal justice system, was slow. The classical scheme of the criminal justice system, fashioned on the psychology of free will, resulted in a series of consequences. That is to say, persons who "willingly flaunt legal commands are morally blameworthy and are proper candidates for the infliction of society's retributive wrath, which should be meted out by punishments proportionate to the crimes committed, but sufficient also to serve a deterrent function."[2] Developments in biology,

sociology and psychology began to erode the underpinnings of classical criminology's doctrine of free will. Enrico Ferri, an advocate of deterministic criminology called for abolishing criminal responsibility and moral guilt as the main stays of criminal law. Instead Ferri proposed, "when an individual has been found to have committed an act harmful to society, the law should not be concerned with questions of guilt or its degrees nor with measuring a fit punishment, but should humanely apply whatever measures are necessary to protect society from further transgressions by the same individual."[3] Ferri's ideas were a significant movement away from the classical approach toward deterministic practice.

Tailoring punishment to fit the criminal rather than the crime has since been reflected in determinate sentence statutues, the deemphasis of criminal responsiblity, expansion of insanity defense and commitment for the treatment of mentally ill persons. The major shift from retributive punishment of the offender in deterrence of others to the philosophy of offender rehabilitation with eventual return to society required a massive review of the traditional system of penalties. This review, influenced by the era, led to sweeping changes effecting the criminal justice system and the mental health system.

The much sought ideological principle of rehabilitation supported by Kennedy and translated into law expanded medical power in the commitment process for individuals deemed mentally ill. These changes gave way to a complex civil commitment system "which purported to

treat the mentally ill and relegated the courts to a supervisory role."[4] Statutory authority remained in the courts but under the new ideology "the decisions of psychiatrists were decisive and the court's imprimatur was a rubber stamp, abdicating authority."[5] This was a remarkable change.

Notably, one of the most important changes in the involuntary civil commitment of the mentally ill was the marked change from historically protecting societal rights to the recognition and protection of individual rights. During the 1960's, the Supreme Court's decisions in civil and criminal matters affirmed and protected the issues of due process, liberty and individual rights. This ideological shift also spilled into the issues surrounding the mentally ill. These changes mirrored the civil rights movement and society's awakening conscience and sensitivity to individual freedom.

The loss of freedom in the criminal justice and mental health systems is considered a grievous penalty in a democratic society. Therefore, citizens at risk must be afforded procedural protection, even if the State is required to pay the costs involved. Full safeguards for due process had traditionally been available to persons charged with crimes; however, such constitutional protections had not been seen as necessary for individuals subjected to "therapeutic" civil proceedings until the 1960's.

Precedents established for individuals involved in criminal proceedings led to the examination of loss of liberty in other contexts namely, the involuntary civil commitment procedure. The

Court's rationale had held constitutional protection was only essential when State power was exercised for punitive reasons. This did not include the exercise of power for benign concerns--care and remediation.

"The divestment of criminal justice and the coming of the therapeutic state"[6] was heralded in the United States Supreme Court 1962 case, Robinson v. California. In Robinson, the Court held that it was cruel and unusual punishment to punish a person criminally for the illness of addiction; however the Court also suggested it would be improper to confine addicts for the express purpose of treatment. In other words, the application of the criminal justice system to chronic alcoholics, drug addicts, sexual deviates, and to the mentally ill appeared to be unproductive. In these instances, the deviants were better served in a different legal framework. For example, the mentally ill were best served in the framework of civil commitment. Deviants, civilly committed, were turned over to behavioral experts for treatment. However, the therapeutic model was a mixed blessing.

Flaws abounded in this therapeutic medically dominated system; however, the problems were largely ignored. Psychiatry could not provide magical cures. It could not predict how patients would behave. Megainstitutions grew to unprecedented proportions due to civil involuntary commitment of the mentally ill, the aged, the young, the sexually deviant, and the mentally retarded. Warehoused, conditions were deplorable. By the late 1960's, the failed medical model had become a popular target of ridicule by lawyers and some

mental health professionals.

Critics suggested that "the entire mental health system was corrupt."[7] Thomas Szaz, a psychiatrist, gained international attention claiming mental illness was a myth, mental health professionals inquisitors, and the mentally ill were the scapegoats of society.[8] The criticism ballooned in a decade when psychotropic medications biological discoveries were changing the treatment course of the mentally ill. Yet, there were not enough mental health professionals nor enough public money to provide treatment. Legal airs of provocative condescension toward the mental health system continued to heighten the tension between the two specialties.

The demands for psychiatric care for the poor increased, costs skyrocketed and appropriate facilities became practically non-existent. "This situation created both reasons and rationale for attacking what passed as residental treatment services . . . legal advocates uncovered and challenged widespread abuses and the wretched quality of care rendered to the poor in mental hospitals, legislators and executives who passed laws and determined budgets focused on cutting costs."[9]

Whether as a result of fiscal restraints or in response to legal advocacy the psychiatric community established a more stringent hospitalization admission policy. New criteria enumerated grounds for admission: patients who were homicidal, suicidal or dangerous. Admittance based on the need to care for the mentally ill faded quickly. The "revolving door syndrome", as it is known today, was

born. Patients quickly sped through the mental health system. "No one accepted responsibility for following what happened to patients for residential care or whether outpatient care was available when it was recommended.

Tension increased between the two systems. Three developments became startling clear: 1) megainstitutions were recognized as disasters, 2) Community Mental Health Centers were not the panacea envisioned, and 3) the widespread distrust of coercive psychiatry in the mental health system was recognized. Acknowledgement of these issues led to litigation attacking megainstitutions, giving recognition to unmet needs and thrusting ideological questions into the forefront. The practice of mental health law, as a discipline, originated about 1970, give or take a year or two. Recurring tension between the legal and mental health systems continued, especially flaring when governmental budget cuts caused decline in services. "Five years into the decade of the seventies there was enough evidence to suggest that the United States was engaged in an all out legal war over the fate of the mentally ill."[10] The accelerated rate at which litigation and change in the mental health system took place led the Honorable Justine Wise Polier, Judge of the New York State Family Court, to remark, it had "the speed and lack of staying power of a man on a flying trapeze."[11]

David B. Wexler, J.D., a noted specialist in mental health law, noted during the 1970's, "the U.S. Supreme Court and numerous appellate courts have held repeatedly that where involuntary

deprivation of liberty are involved, the traditinal distinctions between 'civil' and 'criminal' proceedings provide insufficient justification for the denial of certain constitutional safeguards."[12] Landmark decisions in this area of judicial scrutiny speak to the same underlying principle of freedom. Indeed, such cases as Rouse v. Cameron, Wyatt v. Stickney, Humphrey v. Cady, Dixon v. Attorney General, Johnson v. Indiana and O'Conner v. Donaldsen have held prominence in American legal and mental health history. The decisions are almost unanimous in concluding that the loss of freedom in civil commitment is at least as grievous as in criminal confinement. "Some courts have decided that civil commitment is considerably more injurious in its effects"[13] than criminal confinement.

Legal regulation of psychiatric practice has dramatically increased over the past decade. Before 1975 the Supreme Court had "never issued a substantive opinion dealing with the practice of psychiatry in a civil setting."[14] Since entering this area of legal opinion in O'Connor v. Donaldson (1975) there have been a number of summary dispositions with direct impact onto civil commitments in mental health.

"The visibility and impact of the Court's decisions make them a widely watched barometer of popular and legal sentiment toward psychiatry."[15] Interest generated is not only in the legal rulings and subsequent action but in important supporting arguments. Appelbaum states, "these 'dicta' although technically lacking in precedential value, often find their way into subsequent opinion at

all levels of the judiciary."[16] These arguments function as a window to the Court's attitudes toward issues. Although an imperfect indicator, it is a means of predicting the direction of future Supreme Court decisions. A brief analysis of the Court's attitude is useful in understanding the legal forces affecting the practice of mental health.

In O'Conner v. Donaldson (1975), the Court denied states the right to hospitalize without treatment persons who are capable of living in the community. Later in Addington v. Texas (1979) "Clear and convincing evidence" would be the minimum standard of proof to be met in civil commitment proceedings and Parham v. J.R. (1979) upheld the rights of parents to hospitalize minor children without judicial review.

The Supreme Court rulings have been riddled with inconsistent remarks against mental institutions and psychiatry. A 1980 case, Vitek v. Jones revealed the majority opinion compared mental hospitals unfavorably with prisons. A transfer from prison to a mental hospital was considered "adverse reaction". In an earlier case, Humphrey v. Cady, stated, "the loss of liberty produced by involuntary commitment is more than a loss of freedom from confinement (in a prison)"[17] due to the stigma. Stigmatization of the mentally ill results from the symptomatology of mental illness. People needing but not receiving medical care may incur greater ostracism because of the untreated disorder.

Having repeatedly compared the results of civil commitment and criminal punishment, the Court at other times denied the connection. In the Addington opinion, Justice Burger argued "in a civil commitment state power is not exercised in a punitive sense . . . a civil commitment proceeding can in no sense be equaled to a criminal prosecution."[18] He continued, "It is not true that the release of a genuinely mentally ill person is no worse than failing to convict the guilty. . . . Since freedom for the mentally ill person would be purchased at a higher price."

One of the areas of "greatest activities for federal district court judges has been considering the alleged violations of constitutional rights in state-run institutions."[19] This area includes prisons, school systems, public housing, prisons and mental institutions. The direct role of the courts in institutional administration has engendered much debate. Paul Appelbaum in the American Journal of Psychiatry submits that the primary interest of the Supreme Court in mental health law cases with which it has dealt has been to limit the role of the judiciary in the day-to-day administration of mental health facilities.[20] As suspicious as the Court may be of psychiatric expertise, the judges are even more reluctant to have judges rather than pyschiatrists, managing the mental health system. For all its ambivalence, "the Court ultimately prefers to let psychiatrists carry on with the task with which they have historically involved themselves," according to Appelbaum.[21]

Trends similar to these can be seen in recent decisions on prisoner's rights and school desegregation. As expansive notions of individual rights in mental health law cases are promulgated, the Court limits the rights through procedures it establishes. Newly defined rights are sacrificed for the sake of efficient, nonjudicial administration.[22] The justices have expressed a clear aversion to judicial involvement in professional decision-making.

With the aforementioned developments in the area of mental health law, the courts increasingly began to reject the long held view that the loss of freedom for purposes of treatment, rehabilitation or custodial care is different than the loss of freedom for punitive purposes. Whether the etiology of this suddenly changed conclusion lies in judicial sensitivity to individual freedom or in the growing dissatisfaction with psychiatry and the recognition of inadequate institutional treatment is unclear. Affording mentally ill persons constitutional safeguards came of age.

Statutory and judicial definitions of commitability were vague and very loosely applied. Some statutes required little more than the declaration that the person being considered for commitment was "mentally ill" and "in need of care and treatment." Other statutes required that the person have "impaired judgement." With "mental illness" rarely defined psychiatrists had minimal difficulty certifying their patients as mentally ill but also in need of in-patient care or treatment. Patients resisting hospitalization obviously showed "impaired judgement."

The broad legal framework facilitated psychiatric hospitalization by permitting psychiatrists ease in hospitalizing anyone whom they wished and giving virtually no guidance to judges in distinguishing between appropriate and inappropriate commitments. The net result was psychiatrists and judges were given excessive discretion. In retrospect, these conditions led to railroading persons into hospitals. However in the more recent past, Courts have begun to strike down such provisions as unconstitutional in being "void for vagueness."

Legal challenges were mounted against all standards of commitment as attitudes changed. The United States Supreme Court (1972) suggested that the Wisconsin civil commitment statute which allowed for the involuntary commitment of persons deemed mentally ill and needing treatment for their own welfare or the welfare of others was inadequate. The U.S. Supreme Court countered that the law should be interpreted as requiring "a social and legal judgement that (the person's) potential for doing harm to himself or to others is great enough to justify such a massive curtailment of liberty."

Armed with this decision, lawyers brought litigation against the State of Wisconsin questioning the constitutionality of the law. Out of the litigation a landmark mental health law case, Lessard v. Schmidt,[23] set a milestone for the future. A Wisconsin federal court interpreted the Supreme Court language as requiring a finding of "dangerousness" for civil commitment. David B. Wexler describes, "Lessard as a far-reaching decision dealing with the commitment of the

mentally ill, but probably pertinent to the entire gambit of therapeutic justice."[24]

Lessard invalidated the provisions of commitment laws in virtually all states. The Wisconsin federal court interpreted the Supreme Court statement as "implying a balancing test in which the state must bear the burden of providing that there is an extreme likelihood that if the person is not confined he will do immediate harm to hmself or to others." The lower court also required a recent overt act in a determination of dangerousness. Nonetheless, the court did not define harm as precluding physical, property or emotions. Harm to self could also include not only suicide but also death or injury resulting from failure to eat, cloth, or house oneself adequately.[25]

Lessard did clearly form another new standard ruling out committing mentally ill persons who solely acted bizarrely, irrationally, peculiarly, annoyingly, or even with offensive behaviors. While these behaviors are undesirable, they are not dangerous thus, not included in the other defined standard of commitment.

"Lessard also served as a catalogue" of procedural safeguards in the mental health system. Boldly, Lessard provided the right to an independent medical or behavioral science expert, the right to be provided with a transcript of the proceedings, the right to an expedited appellate review with commitment determination, to periodic judicial review (with counsel and independent experts, and with the

state carrying the burden of proof) of the need for continued commitment or treatment.[26]

Dangerousness and nothing less was the only cause for commitment. The new standard, while at first limited to state "police power" was expanded to include "parens patriae" as well. Inclusion of persons characterized as severely ill was added to the dangerous concept. In the late 1960's the "California legislature in the Lanterman-Petris-Short Law (LPS) had pioneered providing commitment for "gravely disabled" persons defined as a condition in which a person, as a result of a mental disorder is unable to provide for his basic personal needs, clothing or shelter."[27] "LPS was the result of legislative distrust of the decisionmaking process in commitment."[28] These standards joined together are the basis for current legislation effecting the mentally ill.

In Lynch v. Baxley,[29] the court stated that while "dangerous to self" and "dangerous to others" are often considered together, the standards represent two different state interests. "Parens patrie" power is applicable to danger to self in that the State assumes authority to become the ultimate guardian to the individual. Police power implies the person is dangerous to others. This specific power is invoked to protect society from harm, aside from protecting the individual who is incapable of caring for his or her welfare, presumably, self harm. Noted earlier in Lynch even though an individual does not threaten violence against himself there are other instances when a person may be commitable: 1) mental illness

manifests itself in neglect or refusal to administer self-care, 2) neglect or refusal poses a real and present threat of substantial harm to well being, and 3) the person is incompetent to determine whether or not he needs treatment.[30]

In State ex rel. Hanks, the Court ruled against a commitment standard that solely relied upon "need of custody, care or treatment" and a lack of capacity to understand need for treatment.[31] However, the Court did uphold commitment when it was determined that an individual was "likely to injure himself."[32] The Hanks Court further stated that if an individual possesses a self-destructive tendency of self violence or is severely mentally ill that by "sheer inactivity" the person will allow death to occur by starvation or lack of care, the State is entitled to require hospitalization. Similar cases are: Bell v. Wayne County General Hospital (1974), Dixon v. Attorney General of the Commonwealth of Pennsylvania (1971), Humphrey v. Cady (1972), Lessard v. Schmidt (1972), Lynch v. Baxley (1974), and O'Conner v. Donaldson.

A brief summary of the principle Court holdings for commitment due to being a danger to others follows:

> Bell: "The basis for confinement must lie in threatened or actual behavior stemming from the mental disorder, acts of a nature which the State may legitimately control; vis., that causing harm to self or others." (384 F.Supp. at 1096).
>
> Dixon: "Manifests indications that the subject poses a threat of serious physical harm to other persons or to himself." (325 F.Supp. at 374).

> Humphrey: "A social and legal judgment that the mentally ill individual's potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty." (405 U.S. 504,509).
>
> Lessard: "Mental illness and imminent dangerousness to self or others beyond a reasonable doubt based at a minimum upon a recent act, attempt, or threat to do substantial harm." (379 F.Supp. at 1380).
>
> Lynch: "Minimum findings (that) the person to be committed in mentally ill . . . and a real and present threat of substantial harm to himself or to others." (386 F.Supp. at 390).
>
> O'Connor: "Mental illness alone cannot justify . . . locking a person up against his will and keeping him indefinitely . . . . There is . . . no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom." (422 U.S. 563).

It is easy to see why the generic concept of dangerousness, as found in Lessard, quickly transcended all other commitment criteria and emerged as the paramount consideration in the law--mental health system in the 1970's. Alan A. Stone, Professor of Law and Psychiatry at Harvard University explains, "the assumption is that all sides will agree on dangerousness, violence, or harmful conduct as valid criteria for State intervention."[33] In retrospect dangerousness is not a concept easily separated from one's politics or belief system. Dangerousness, in the eye of the beholder, poses problems that have not been surmounted in the search for an agreed upon standard of commitment. "Although the concept of dangerousness may initially appear to be specific and provide a focal point for much agreement in the areas of law and mental health, in point of fact, it has led to a number of complex issues evoking differing practices and points of

view."[34]

The emerging legal war transformed psychiatry from an esoteric specialty into a more pragmatic discipline. Since the mid-seventies there has been increased "legal interest and activity with respect to the commitment, treatment, and handling of the mentally ill. . ."[35] Litigation has had a dramatic effect on the provision of mental health care, institutional treatment and mental health planning and policies. Litigation has seemingly embodied the social and legal trends in our society, the growing concern to safeguard the rights of various categories of socially deviant individuals when involuntary deprivations of liberty may be involved.[36]

During the past twenty years the civil commitment process has experienced a period of challenge and change from a process emphasizing state rights. As a result of court rulings, a much greater emphasis on due process and individual liberty interests has evolved. Subsequently many states, including Michigan, developed new statutory procedures to reflect these gains.

Despite these promising developments in mental health law, many problems remain. Alan A. Stone, Professor of Law and Psychiatry at Harvard University, states, "Simply put, the distinction is between those who attack involuntary civil commitment as a dangerous and potentially repressive force in a free society and those who endorse involuntary confinement and proper treatment of the mentally ill as a moral responsibility of the State."[37]

Out of improvements, another problem developed. "State courts must now effectuate these new statutes so that individual due process and liberty interests are protected while allowing speedy and effective treatment to those who need it."[38] The Institute on Mental Disability and also the Law and the National Center for State Courts have undertaken a multi-year study to develop resolutions for this second generation problem.

The general nature of the changes has been to impose the procedural safeguards of the criminal law system on the various types of civil commitment. The result may be good law whether it is good social policy remains to be seen. The American criminal justice system's effectiveness in dealing with the problem of crime is limited. Superimposing this same method on the civil commitment system has left nagging doubts about its productivity as well.

# Chapter II

## Notes

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[14]Paul A. Appelbaum, "The Supreme Court Looks at Psychiatry," American Journal of Psychiatry, 141 (1984): 827.

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[16]Appelbaum, p. 827.

[17]Appelbaum, p. 829.

[18]Addington v. Texas, 441 US 418 (1979).

[19]Appelbaum, p. 830.

[20]Appelbaum, p. 831.

[21]Appelbaum, p. 834.

[22]Rennie v. Klein, 653 F 2d 836 (3rd Cir 1981).

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[25]Saul Feldman, The Administration of Mental Health Services (Springfield, Illinois: Thomas, 1980), pp. 333-334.

[26]Wexler, p. 34.

[27]California Welfare and Institution Code Sec. 5000 et seq. 5150.

[28]Stone, p. 60.

[29]Lynch v. Baxley, 386 F. Supp. 378, 1974.

[30]Calvin J. Frederick, Dangerous Behavior: A Problem in Law and Mental Health. U.S. Department of Health, Education and Welfare. National Institute of Mental Health (Washington, D.C.: GPO, 1978), p. 9.

[31]Frederick, p. 9.

[32]Frederick, p. 9.

[33]Stone, p. 25.

[34]Frederick, p. 3.

[35]Shah, p. V.

[36]Shah, p. V.

[37]Stone, p. 3.

[38]Ingo Keilitz and Robert F. Roach, "A Study of Defense Counsel and the Involuntary Civil Commitment System in Columbus, Ohio," Capital University Law Review, 13 (1983): 176.

# Chapter III

## Standards of Commitment

The pendulum has swung once again. Currently, involuntary civil commitment is declining. Voluntary admissions have come to outnumber involuntary commitments. A trend resulting from the legal agitation of the past 20 years shows no signs of slowing or changing. Psychiatrists who once committed people with much ease are showing restraint. Courts have become more knowledgeable and scrupulous in reaching their decisions; lawyers have evidenced more involvement in prevention of confinement and hospitals are more conscious about their role.

Data reflecting how many persons entered hospitals voluntarily only because of the threat of commitment is not available. As a social conscience for the mentally ill emerged, mental health services have been upgraded, psychiatrists have become sensitive to the legal issues, and involuntary commitment has become a rarer event. Avoiding wholesale involuntary confinement is an important aspect of acknowledging and respecting the legal rights of patients. In some areas such conditions do not readily exist and the result is a battle over legal standards and procedures for involuntary admittance. Such battles accomplish little.

Traditionally, civil commitment of the mentally ill person has had four social goals: 1) providing care and treatment to those needing it, 2) providing protection for irresponsible people from themselves, 3) relieving society and the family of these bothersome people, 4) protecting society from anticipated dangerous acts.[1] Whatever the goals of civil commitment may be, the historian "can document that confinement of bothersome, obnoxious or worrisome persons for no reason but convenience has been a steady and perhaps proliferating, if ignoble history."[2]

Implementation of the therapeutic model while recognizing civil liberties has posed difficulties. According to David B. Wexler, "the multitude of problems associated with the therapeutic model, the great bulk can be summarized under a single unifying theme: that the therapeutic approach knows no bounds."[3] It is as though the cure of deviants is an elevated statute superceding all other traditional factors. The therapeutic premise implicates, "the law should not be concerned with questions of guilt and its degree nor with measuring fit punishment, but should humanely apply whatever measures are necessary to protect society from further transgressions by the same individual."[4] This broad premise includes therapeutic prevention, as well as correction and would apply to the elimination of self-dangerous and society dangerous behavior. Thus, a limitless premise, one in which opportunities for abuse abound.

Who shall be subject to involuntary civil commitment? During the seventies, "Commitment was accomplished through the medical model

which is contrasted to the legal or civil libertarian model,"[5] according to Saul Feldman. The medical/therapeutic model, as reviewed earlier, focused on ease and simplicity of commitment, untangled by legal red tape.

Commitment may be sought under "parens patriae" and under the police power doctrine. First the issues surrounding "parens patriae" will be explored. "The true essence of the therapeutic state is its paternalistic or "parens patriae" jurisdiction[6] . . . allowing "the state power to institutionalize persons for their own benefit, as the state perceives that benefit."[7] A guiding classic premise has been provided by John Stuart Mill in "On Liberty" in Harvard Classics, "that society ought to interfere with an individual against his or her will only to protect others, not to protect the individually personally."

In contrast, in an article in The American Journal of Psychiatry (1979), Dr. Loren Roth affirmed paternalism once safeguards were in place. Recognizing that many mental patients prefer to be left alone, Roth contends that in the absence of incompetency or an emergency, mental patients should not be treated involuntarily. Clashes with mental health lawyers keen to advocate for clients (and to protect civil rights) have shown lawyers are reluctant to recognize the legitimate role of paternalism in society. Thus, people can be degraded by taking care of them and people can be degraded by not taking care of them. There are no simple answers. Roth proposes brief periods of mental health commitment be permitted based on

"parens patriae." In other words, a period of temporary guardianship for the incompetent person would be provided in the patient's best interest. The purpose of "parens patriae" treatment would be to restore the patient to competency using commonly accepted therapy. Once a person is restored to functioning, he can then decide whether he has been helped by interventions initially provided against his objections. Roth stresses, "a parens patriae" commitment would make explicit and legally sanctioned what is now implicit and only questionably legally sanctioned under the law of commitment."[8]

Yet, there are reasons for the general philosophical resistance to paternalistic interferences, even to those proposed by Roth. The state may not know what is best for the individual, it may not have the ability to improve the individual's condition and "it offends one's dignity to have the state meddling in his or her affairs."[9] The antipaternalism premise has been adhered to in law and in practice. Society does not typically impose restraint on others who may be dangerous until a violation of the law occurs.[10] Generally, "society does not intervene to prevent self-harming conduct."[11] Law does not mandate diets, abstinence from alcohol, refraining from smoking or seeking treatment for health problems. Nor, does society intervene to prevent bizarre risk taking. It is not clear why the disparity in expectations for the mentally ill differs from the general population.

The question is not only whether paternalism intervention is in the person's best interest but whether the state has the right to

decide for him. The state has been given the right when there is clear evidence that the person is mentally incompetent. However, the older view that all mentally ill persons are incompetent per se has been shown to be false. It has been clearly demonstrated "that many persons who are mentally ill are entirely competent to make rational decisions . . . including to accept or reject hospital treatment.[12] Therefore, prior to exercising paternalistic intervention convincing evidence showing the person to be incompetent would be required. It must be strongly advised that the mere refusal of a patient to accept hospitalization or treatment does not esablish mental incompetence. Of course, refusals must be based on a true test of a client's mental capability.

A patient's "wrong" decision to refuse treatment may, on close analysis, prove "correct".

> To begin with, the choice of liberty rather than treatment might not be "wrong." Some types of mental illness are not treatable at all. And even for those types that are treatable, the probability that a given patient will permanently be cured, or even improved, because of the treatment, is discouragingly low. Of course, a good number of patients committed to mental hospitals are released "as improved" within a matter of months, but most of them return. Also, there is very little hard evidence that even temporary improvement is the result of the treatment and is not, instead, a spontaneous remission.
>
> In determining whether it is necessarily "wrong" for a mentally ill person to choose liberty rather than hospitalization, it should also be noted that even short-term hospitalization can, of itself, reinforce and exacerbate some types of mental illness, and that long-term hospitalization is particularly anti-therapeutic. In that event, the choice is not between liberty and health, but between functioning at

> an impaired level or getting worse. More precisely, the choice is the risk of getting worse on the outside, compared with the risk of getting worse in the hospital. We must also remember that treatment in a mental hospital is often degrading and occasionally brutal, and . . . even voluntary hospitalization creates a terrible and lasting stigma. Finally, most state hospitals provide only custodial welfare, not treatment.[13]

In addition to the finding of incompetence, a social judgement must be made whether we ought to override a patient's desires. To do this, objective evidence must be sought.

Chief Justice Burger expressed the view of the Superme Court regarding the "parens patriae" doctrine when he wrote the opinion for O'Connor v Donaldson.[14] Reacting to a lower court's premise that a state could confine a mentally ill person for the purpose of treatment, even if that person was not dangerous, Burger outright rejected the theory.

The "parens patrias" doctrine should not be relied upon as an opportunity for confining an individual to provide treatment. If a physically ill person is able to decide whether he will seek treatment, the same opportunity should be available to the mentally ill person who has the capacity to make his own decisions.

One of the two traditional justifications for civil commitment is the doctrine of police power. The doctrine embodies the state's interest in preventing dangerous behavior. However, the doctrine does not include preventive detention unless predicated on evidence of mental illness and violent behavior. A central question in police power civil commitment is the degree to which those committed are actually

dangerous.

It is significant to note that a "police officer's participation in the commitment procedure often arises out of a frantic call for assistance from the patient's family."[15] The officer's judgement is often based on third party reports. If the person about who the complaint is lodged has not committed a criminal act, the officer's task becomes even more difficult. An option often chosen is the removal of the offender from the home for the family's relief. This is at the expense of the offender's liberty. A viable solution is to present the person for a psychiatric evaluation because the doctor is the final arbiter. It is noted however in an article by Bonovitz and Bonovitz, "In general, police were reluctant to arrest even assaultive mentally ill individuals who were resistant to treatment."[16] On two occasions the officers went to great lengths to talk relatives into seeking involuntary civil commitment rather than pressing criminal charges.[17]

Commitment justified on the grounds of dangerousness of mentally ill persons by the exercise of police power is an important second alternative. In an article by Miller and Fiddleman, the authors investigated the use of emergency hospitalization in North Carolina and found that the majority of petitions executed by police officers did not provide adequate evidence for the required criteria.[18] While problems remain inherent in this police power approach, it is the only method of emergency commitment.

> Power power commitments . . . are based on potential dangerousness but do not necessarily require a level of mental disability amounting to incompetency. Police power patients, therefore may be in a position to refuse intrusive treatment. Although . . . their continuing confinement while dangerous may, for public protection purposes be constitutionally affirmed.[19]

An issue surrounding imminent danger vs. "dangerousness" over the long term or the potential for dangerous behavior is hotly debated. "Under police power there is no doubt as to society's right to restrain dangerous persons and to prevent the continuation of violent behavior."[20] But it is difficult to predict dangerous behavior.

Criminal law has maintained a system of preventive confinement under which confinement or restriction of freedom is based. That is to say, a determination of whether the individual is dangerous or if danger is done is made. Then legal devices such as hands, bail, incarceration are used. In all legal situations, the measure of freedom denied is based upon a prediction of future events rather than solely upon past acts. Questions abound. How valid are predictions? How is the seriousness of danger calculated? How are dangerous events ranked? A standard for predictive, preventive confinement is difficult, at best, to develop. There are few instances in which specific dangerous events can be reliably predicted with confidence by judges, mental health experts or anyone else.

Statistical research into the dangerousness of the mentally ill has provided a pattern which has changed through the years. A review of literature conducted by Gulevich and Bourne in their book, Violence and the Struggle for Existence (1970), concluded that "the base rate

of violent behavior (except for suicide) by those labelled as mentally ill is no different than the general population."[21] Prior to 1950, statistics revealed that ex-mental patients had a lower crime rate than the general population.[22] However, due to dramatic changes in the treatment and legal rights of the mentally ill over time an appreciable change took place.

For years it was argued that the mentally ill are no more dangerous to others than nonmentally ill persons. Huber, Roth, Appelbaum and Orr cite recent reevaluations of this position. Studies have "found that the arrest rate of ex-mental patients is now greater than the general population."[23] A 1978 study by Steadman, Cocozza and Melick found that "ex-mental patients were about three times more likely than the general population to be arrested for crimes of violence."[24] The American Psychiatric Association's Task Force (1978), revealed that the great majority of mentally ill pesons do not behave violently toward others, but a minority do.[25] Steadman found following discharge from psychiatric institutions, 1.7% of patients were arrested for violent crimes over a 19 month period."[26]

The need and justification for emergency involuntary psychiatric hospitalization is currently a much debated subject amongst lawyers, psychiatrists and those in allied fields. There has been ardent discussion on the ability of psychiatrists to predict dangerousness. "There exists considerable commentary on the issues of dangerousness."[27] Predictability of such behavior is problematic for lawyers and psychiatrists alike. The psychiatrist often evaluates a

client who has been perceived as dangerous by associates. Many times an individual is brought involuntarily for an emergency psychiatric assessment because he has threatened persons who have sought police intervention. It is then expected that " a relatively prompt judgement about the mental condition of the individual. . ."[28] will be conducted. Furthermore, it is this decision which determines whether a person should be confined. In the event there is no history of aggressive behavior, then the issue of dangerousness is based solely on recent events or an isolated incident. "The physician dilemma centers on his concern that failure to identify as dangerous may return to haunt him if the patient is released and thereafter reacts violently"[29], according to Elwin and Ezra Griffiths in California Western Law Review. According to noted legal expert, Alan Dershowitz, as a matter of precaution, psychiatrists tend to over predict[30] to lessen a vulnerable situation. Overprediction usually increases at night when client files are inaccessible and student psychiatrists are staffing the facility.

Numerous studies of psychiatrist's ability to predict dangerous behavior have generally reached the same conclusion. Prediction of the dangerousness of the mentally ill is difficult and inaccurate. Society's conceptual approach to mental illness enhances the difficulties in predicting dangerousness. If a person is perceived as dangerous, an overt act is required and then the person can be detained under a penal statute. It is believed that the detention is justified by the criminal act. "If the same person is both dangerous

and mentally ill, it is considered sufficient for him to be confined without requiring any criminal act as a basis for confinement."[31] Psychiatric opinion becomes increasingly important as society weights him to a heavier burden, forcing him to proceed with increased caution. "The burden is imposed upon the evaluator despite weighty evidence that his powers of prediction are unimpressive."[32] Legal decisions all questions the psychiatrist's ability to forecast dangerousness and call for further study of the circumstances which might permit at least, some predictive accuracy under special conditions.[33]

"False-positive predictions consistently outnumber true positive ones."[34] Statistically, overprediction stems from the low base rate of violent behavior,[35] biases in psychiatrist's assessment and the lack of corrective feedback to psychiatrists and the Courts. Moreover, state laws governing involuntary hospitalization vary widely in defining mental illness, standards for commitment and legal safeguards in the commitment process. Research on the issue of dangerousness is plentiful; very little is conclusive. State laws and recent findings will be discussed.

"Dangerousness: In the eye of the beholder" is a concept asserted by Loren H. Roth, M.D., M.P.H. in the American Journal of Psychiatry. Roth states dangerousness is not predictable within the context of emergency civil commitment. Noting methodological problems in studies of this nature, Roth contends that "to clearly show mental health professionals are able to predict dangerousness one would have to study individuals, who although considered by psychiatrists to be

eligible for emergency commitment, are not committed and who then go on to complete violent acts."[36] Difficulty to justify ethically, the necessary empirical data has not been generated. It is one of the reasons why controversies in this area continue.

A 1980 research project was undertaken by Dr. Ethan S. Rofman, M.D., et al. in response to comments made by an Illinois federal appeals Court three member panel of judges in the Mathew v. Nelson case. The judges found only a limited number of statistical studies in the area of dangerousness prediction. They stated,

> No study has attempted to measure the extent to which the predictability of dangerousness is enhanced by a history of a recent overt act . . . no study called to our attention attempts to measure the incidence of violent behavior in a sample population of persons civilly committed for dangerousness.[37]

In this case the judges upheld the Illinois standards for emergency commitment, which do not require an overt act or threat of dangerousness to self or others for involuntary civil commitment. This decision diverges from rulings by federal courts in other states. In Hawaii, for example, for emergency commitment to be constitutional, the threat of danger to others must be imminent and substantial (i.e., a recent overt act, attempt or threat). At least one state maintains that threat alone does not constitute grounds for commitment.

Rofman reviewed records of all psychiatric patients admitted to a Massachusetts hospital under emergency involuntary commitment for 1 1/2 years. Rofman found that "the occurrence of an actual act of battery before admission did not predict assault in the hospital to a

greater degree than did verbal threat."[38] The author concluded "that short-term clinical predictions of dangerousness predict assaultiveness in the hospital to a significant degree."[39]

In "Short Term Civil Commitment and the Violent Patient" (1982) Jerome Yesavage, M.D., et al., published the results of an examination between civil commitment for dangerousness to others under the California Civil Commitment Statute (the Lanterman-Petris-Short Act) and violent acts and behavioral ratings made immediately after commitment. The hypothesis, "involuntary admission to a mental hospital on the basis of dangerousness to others is unassociated with dangerous behavior in the hospital"[40] was not rejected. "Similarities between patients considered dangerous to others and those not considered dangerous to others were found in the number of violent acts and violence-related events as well as in demographic characteristics such as age and diagnosis."[41]

A 1983 study by Lee Rubin and Mark Mills retrospectively examined the prehospitalization behavior of 66 voluntary and involuntary psychiatric patients to determine precipitating factors in each person's hospitalization. "Involuntary patients had engaged in dangerous acts more frequently than had voluntary patients."[42] However, Rubin and Mills found "very little significant harm was caused by members of either group."[43]

Dr. Douglas Levinson wrote "The value of Clinical Predictions of Dangerousness" in which he maintained, "the kinds of threatening, agitated, labile or provocative behavior that led a community to seek

hospitalization of an individual for dangerousness also led psychiatrists to apply this label"[44] and frequently place the individual "in seclusion in the hospital."[45] Levinson stresses the community decision making role and responsibility in the issue of dangerousness.

Griffith and Griffith state, "there should be no reliance on a professional standard concerning prediction of dangerousness because the accuracy of such predictions has been seriously impinged."[46] In Tarasoff v. Regents of University of California, the Court held that "a duty to exercise reasonable care to protect the foreseeable victim" exists. Yet, this finding may cover a broad spectrum of alternatives. The Court in Tarasoff did not delineate all the nuances of the duty. Therefore, the duty may include a simple warning. Certainly discharge of the duty will vary according to each case. Again, another vague finding to follow.

Like the duty to warn the method for prediction of dangerousness is murky, the studies noted above clearly show the psychiatrist is in an unenviable position. On one side the courts rely upon the psychiatrists to comment on the danger posed by the clients. Conversely, others tell him that he can not predict dangerousness. Psychiatrists are placed in a "Catch-22". The psychiatrist's plight to protect the public and the individual may be eased when there has been a recent overt act of violence by the individual.

Controversy rages in the psychiatric and legal communities. How good must predictions of dangerousness be to justify civil commitment?

"Prediction of violent behavior is a matter of considerable empirical, political, professional and moral controversy on which people of equal intelligence will differ."[47] Yesavage poses several questions,

> If I can predict with 90% accuracy that someone will
> commi90 events? What if I could predict with 70%, 80% or
> predi99% accuracy?[48]
> should be committed inaccurately to prevent the other
> 90 events? What if I could predict with 70%, 80% or
> 99% accuracy?[48]

Acceptable levels of certainty are social and moral decisions on which differing viewpoints will exist.

In a related issue, "the confinement of the mentally ill should not be tolerated on a mere possibility of future danger."[49] "To the extent that persons are committed because they are potentially dangerous, there is an element of preventive detention," according to Dershowitz.[50] Non-tolerance of preventive detention respects psychiatric limitations and the constitutional mandate that no man shall be "deprived of life, liberty, or property, without due process of law."[51] Continued confinement then would be founded "not on the mere possibility of a violent occurrence, but on the establishment of mental illness and the present dangerousness of the individual."[52] Those persons who pose a clear and present danger of harm to others or to themselves need to be considered for involuntary civil commitment. The "clear and present danger" test has been defined in terms of the occurrence of certain acts within the last 30 days, such as an infliction of or an attempt to inflict serious bodily harm."[53]

Given the social cost of a brief deprivation of liberty for those not fully dangerous (because dangerousness is not an all-or-nothing variable) versus the social cost of death or injury to victims of people not committed . . . the use of brief emergency commitment[54] is appropriate. Patients are likely to harm others until their psychosis is diagnosed, treated and brought under control.

A full range of behavior potentially falls under state control and correction. For civil involuntary commitment, mental illness is "an undisputed first criterion."[55] While involuntary hospital admission is often predicated on the severity of illness, there is no uniformity to the application. In some instances, the only definition of mental illness has been a condition that substantially impairs mental health. The concept of mental illness is elastic. That is to say, it ranges from functional characteristics to massive dysfunction along the psychopathological continuum. The concept of mental illness is interpreted by the user and is dependent upon the user's norms.

The vagueness of the term "mental illness" is not assisted by the requirement of dangerousness for commitment. Standard tests employed for involuntary civil commitment are: "mentally ill and dangerous to oneself or others" or "mentally ill and in need of care, custody, or treatment" are ambiguous and can serve as general guidelines, at best.

Although the symptoms of mental illness are the same the world over, for any one form of mental illness the manifestation of symptoms in any one individual are unique to him or her, dependent upon such factors as intellect, religion and total life experiences. Because

the manifestations of each illness vary from individual to individual and no one individual will exhibit all the possible symptoms of that illness at any one point in time. The symptoms vary in a given individual based on such factors as age, length of illness and treatment.

Mental illness, for the purpose of this research, will be defined in Michigan's Mental Health Code, Act 258 of Public Acts of 1974, "A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life." This definition is equated with the psychotic disorders. In the glossary found in the appendix, psychosis is defined as "a severe mental disorder characterized by changes in the form and/or content of thought, exhilaration or depression of mood and behavior related to the altered thought/mood." Mental illness, as defined in Michigan's Mental Health Code, does not include personality disorders classified as psychopathic or neurotic. For example, conversion reactions or obsessive compulsive reactions are not covered by the definition.

Psychotic disorders can be divided into two broad categories. The first category, organic psychosis is caused by structural or physiological alterations of the brain. "Injuries, disease, and various chemicals can affect the central nervous system and give rise to abnormal behavior."[56] Causal factors in organic psychosis include infection of the brain (i.e., syphillis, meningitis and encephalitis), trauma (i.e., penetrating wounds, closed injuries resulting from blows

to the head), toxins or poisons (i.e., alcohol intoxication, psychodelic and illicit drug use or drug abuse), degenerative disorders (i.e., senility, parkinsons disease), tumors of the brain, metabolic or nutrition disorders (i.e., hyperthroidism, pernicous anemia), and general body infections (i.e., pneumonia, rheutmatic fever).

By contrast functional psychosis is a result of environmental influences and other unknown factors. Three factors--heredity (i.e., genetic predisposition), chemical alterations (i.e., protein molecules changed or a missing chemical agent), environmental (i.e., severe traumatic events)--either singly or in combination may precipitate mental illness characterized by psychosis. Functional disorders have been divided into two categories and outlined below.

Schizophrenia is a group of psychoses best described by a specific type of alteration-withdrawal from social interaction, disorganization and fragmentation--in the psychic functions of thinking, feeling, affect, motor and behavior.[57] Schizophrenia is usually characterized by delusions (two of which are ideas of grandeur or persecution) and hallucinations (i.e., auditory, visual, olfactory, qustation, and tactal). Three of the schizophrenias will be mentioned. "Paranoid type patients show growing suspiciousness. . ."[58] The individual's behavior becomes centered around delusions and hallucinations. Catatonic symptoms are characterized by a decrease or increase of psychic and physical energy. Schizo-affective type is usually manifested by severe alterations of thought

and mood.

Major affective disorders include involutional melancholia, depression and mania. Involutional melancholia, usually occurs after 40 years of age is most often described by feelings of guilt and complaints of physical disturbance for which no cause can be found. Sometimes the concern is greatly exaggerated so it is inappropriate to the seriousness of the problem.

Manic-depression or bi-polar affective disorder is characterized by two distinguishing features. With mania the individual is excited, euphoric, happy and talkative with accelerated speech and motor activity. The depressed type is characterized by the appearance of dejection (furrowed brow, corners of the mouth turned down, shoulders sloped, slowed speech and gait) and the expression of morbid ideas such as worthlessness and a need to die.

Treatment varies with the disorder. In organic psychosis, most often once causative factors have been identified specific remedial agents can be applied. Unfortunately, this is not true for all organic disorders, the exceptions being senility and parkinsons disease. The treatment of functional disorders is handicapped by the speculative nature of identifying causal factors.

Excerbation of psychotic symptoms leading the severely mentally ill individual to become dangerous to himself or to others requires mandatory treatment, involuntary civil commitment. A person requiring treatment is carefully defined in Michigan's Mental Health Code

section 401. Criteria for "a person requiring treatment" in this chapter means (a), (b) or (c).

(a) A person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

(b) A person who is mentally ill, and who as a result of that mental illness is unable to attend to those of his basic physical needs such as food, clothing, or shelter that must be attended to in order for him to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.

(c) A person who is mentally ill, whose judgment is so impaired that he is unable to understand his need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to himself or others. This person shall be hospitalized only under the provisions of sections 434 through 438 of this act.

330.1402 "Person requiring treatment"; exceptions

Sec. 402. (A person whose mental processes have simply been weakened or impaired by reason of advanced years, a person with epilepsy, or a person with alcoholism or other drug dependence shall not be deemed to be a person requiring treatment under this chapter unless the person also meets the criteria specified in section 401). However, the person may be hospitalized under the informal or formal voluntary hospitalization provisions of this chapter if he is deemed clinically suitable for hospitalization by the director.

In pre-screening individuals desiring to file petitions two initital questions should be asked: 1) Who is the person on whom you

are filing? 2) What has the person done in the past few days? Subsequent to these preliminary questions, the above criteria for filing a petition should be explained. Once it has been determined through pre-screening that the individual meets the criteria established in the Mental Health Code, a petition may be taken. Guidelines which assist in establishing when a petition is appropriate follow:

1. Mental illness evidence as defined by the Mental Health Code, AND
2. Acts by the respondent indicate he is a danger to himself or others, AND
3. Overt acts indicating he will carry out the threats, AND
4. He is unable to understand his need for treatment.

Petitions must be written in factual statements. A series of descriptions giving examples of current behavior as defined above could include:

1. He is not eating and sleeping. He paces the floor at night and the family is afraid to sleep. He has lost 25 pounds in the last month or two.
2. He smokes and drops cigarettes, causing burns around the house. The family is afraid he will set the house on fire.
3. He leaves pots and pans on the stove and forgets them.
4. She turns the furnace up very high or to the other extreme, down very low.

5. She thinks television is telling her what to do or it is emitting dangerous rays.
6. He doesn't take a bath or keep himself clean. He is dirty and disheveled.
7. She wanders outside in cold weather (20 ) without proper clothing (no coat, pants; etc.).
8. Subject has prescribed medication from doctor for his mental illness which he now refuses to take.
9. He is afraid to eat because the food is poisoned and the subject has lost considerable weight (10 pounds in 2 weeks).
10. He destroyed all his furniture because God told him to do so.

A partial list of guidelines giving descriptive situations when petitions are <u>not</u> appropriate are below:

1. There is no immediate danger to himself or others. The Mental Health Code says subject can be mentally ill but unless he is a danger to himself or others he should <u>not</u> be hospitalized.
2. If the subject of the petition is able to work each day and has no problems in the workplace, a petition may be indicative of a family argument. Because someone will not work is not sufficient reason to take a petition. It must be shown he cannot work because of mental illness and dangerous.

3. Do not take a petition on an individual if he can care for his needs and is not hurting himself or anyone else, even though you may feel he is mentally ill.
4. If a patient is in a medical hospital and is physically ill a petition need not be taken. A doctor will have to determine need for petition when the subject is physically well. The doctor can then determine if he needs mental treatment and can make out a certificate.
5. Only take the petition if the facts indicate the subject needs immediate hospitalization because of mental illness.

Any individual over 18 years of age is able to file a petition alleging another's mental illness, dangerousness and inability to care for himself. The involuntary civil commitment process has been useful in gaining treatment for people who are a clear, present danger and refusing treatment. The process is useful and accessible to adults. Thus, the involuntary civil commitment system also experiences abuse through "grudge" or "spite" petitions. There are several scenarios below that illustrate circumstances when petitions are commonly sought inappropriately.

1) A petitioner tells about incidents that happened two years ago or six months ago. A petitioner must have actually witnessed an overt act in the past few days. Heresay is not admissible as the sole basis for a petition.
2) A petitioner says he has not seen his spouse in the last couple of weeks because he had to leave. A divorce may be

pending. A petition should be scrutinized because credibility is lacking. However, if another relative has observed the mentally ill person's behavior, the relative should file the petition.

3) If relatives of the mentally ill person do not live in state, the subject of the petition should be evaluated by a doctor or the police can file a petition if they have witnessed significant behavior and overt acts.

4) If the subject of the petition is under the influence of alcohol or drugs when he made the threats, it is essential to inquire what the person is like when not under the influence of substances. The substance abuser can not be psychiatrically evaluated while under the influence of alcohol or drugs. Alcoholics and other substance abusers are inappropriate for the mental health system.

5) Neighbors filing petitions on each other is a touchy proposition. Other alternatives need to be explored (i.e., a family or police officer petition). If a police officer witnesses an incident he can take the person directly to a Community Mental Health Center or hospital.

Filing a petition with the court is the first step in a multi-step in the involuntary civil commitment non-emergency procedure. The petitioner then goes before a Probate Judge to swear that the facts are true. The judge then decides if he'll accept the petition based on his discussion with the petitioner and the document itself. He

issues orders of examination and transport (see Appendix). Section 330.1435 of Michigan's Mental Health Code specifically deals with the issuance of these orders.

> Sec. 435. (1) If the petition is accompanied by one certificate, the court shall order the individual to be examined by a psychiatrist.
>
> (2) If the petition is not accompanied by a certificate, and if the court is satisfied a reasonable effort was made to secure an examination, the court shall order the individual to be examined by 2 physicians, at least one of whom shall be a psychiatrist.
>
> (3) The individual may be received and detained at the place of examination as long as necessary to complete the examination or examinations, but in no event longer than 24 hours.
>
> (4) After any examination order under this section, the examining physical shall either transmit a certificate to the court or report to the court that execution of a certificate is not warranted.
>
> (5) If one examination was ordered and the examining physician reports that execution of a certificate is not warranted, or if 2 examinations were ordered and one of the examining physicians reports that execution of a certificate is not warranted, the court shall dismiss the petition or order the individual to be examined by another physician who shall be a psychiatrist if a psychiatrist is available. If the third physician reports that execution of a certificate is not warranted, the court shall dismiss the petition.

There are occasions when patients under a Judge's Order of Examination and Transport are taken for evaluation at a Community Mental Health Center or designated hospital, the first doctor examining the patient certifies he is mentally ill and in need of inpatient treatment. Then, the second doctor, a psychiatrist, certifies he is not mentally ill but can go as an out-patient to a

clinic. If this happens, the court requires a third doctor's (psychistrist) certificate. Two out of three doctors must agree whether the individual needs in-patient treatment or is not mentally ill or is mentally ill but does not need immediate hospitalization. (Section 435.5)

There are other points of entry into the mental health involuntary civil commitment process. The variety of entry points require differing documentation. The State of Michigan has enumerated specific procedures and documentation that must be completed for involuntary admission to a psychiatric hospital. Pertinent sections of the Mental Health Code have been noted. Admission by Medical Certification and petition are governed by these requirements:

I. The individual is accompanied by a properly completed "Application for Hospitalization" (PCM 201) and Physician's Certificate (PCM 208) (Sec. 423), completed before transfer to psychiatric hospital, or

II. An "Application for Hospitalization (PCM 201) is properly completed in the Admissions Office of the psychiatric hospital by a person over 18 and a "Physician's Certificate" is properly completed by a State of Michigan physician (Sec. 425), both are completed at the psychiatric hospital, or

III. If a peace officer who observes an individual conducting himself in a matter which causes the peace officer to reasonably believe the individual is "a person requiring treatment" and who properly completes an "Application for Hospitalization" (PCM 201) (Sec. 424), or

IV. If a person over the age of 18 properly completed a "Petition for Admission" (PCM 201) but was unable to secure an examination of the individual to be examined at a hospital. (In this case, the Court will execute the "Petition and Order for Examination" (PCM 209). The Court will order the individual to be examined and may also order a peace officer to take the individual into protective custody and transport him/her immediately to the indicated place of examination.

An individual may be admitted to a State of Michigan Psychiatric Hospital on a Petition if the requirements under IV are met and in addition it appeared to the Court that the individual required immediate hospitalization in order to prevent physical harm to self or others, the Court may order the individual hospitalized (PCM 210) (Secs. 434-438). The Court may also order a peace officer to take the individual into protective custody and transport him/her to the hospital.

Specific examples of completed documentation are enclosed in the appendices. Each method of involuntary commitment and the appropriate documentation has been included for review.

Michigan's Mental Health Code was revised in 1978 following a series of crucial Supreme Court, State and Federal Court decisions effecting a mentally ill individual's civil liberties. Outlined below are highlights of the Code as they pertain to mental health proceedings in Probate Court.

I. A "Quick" Review of Normal Procedures

A. Admission by Medical Certificate

1. An individual can be hospitalized if an individual is presented to the hospital accompanied by a petition and physician's certificate. (Sec. 423)
2. The physician's certificate must have been executed within 72 hours of the filing at the hospital and after personal examination of the individual. (Sec. 425)
3. If a petition and physician's certificate are given to a peace officer, he shall take the individual into custody and take him to the hospital.

B. Admission by Petition

1. An individual can be hospitalized if a petition is filed with the Probate Court asserting that the subject meets the criteria of Section 401.
2. If the court is satisfied that the individual will not comply with an order for examination, it may order that a peace officer take the individual into custody and transport him to a hospital for the examination.

II. Venue

A. Venue is sometimes a problem. The question is simply put: what is the appropriate county to hold the hearing?

B. "Court" is defined in Section 400(g) as ". . .the probate court of the county of residenceof the subject of a

petition, or of the county in which the subject of a petition was found.

C. On occasion, a non-resident of a county will be hospitalized out of a county not of his residence. Some counties will automatically change venue to the county of residence, pursuant to PCR 401.

D. No real guidance is offered beyond the statute and court rules as to which county has precedence or priority.

E. The only real solution rests with informal agreements and understandings of the respective courts as to the circumstances when and how each court will accept venue.

III. The Court Appointed Attorney

A. Section 454(1) states "Every individual who is the subject of a petition is entitled to be represented by legal counsel." Section 454(2) states that the counsel shall be appointed within 24 hours of the hospitalization.

B. Procedures for appointing counsel

1. Some counties contract with a local attorney or attorneys to provide counsel at a given rate or fee.
2. Other counties appoint those attorneys who have requested appointment.
3. Counsel is now required to certify in writing that they visited with their client at least 24 hours before the time and date set for the hearing.

Failure to do this can cause a problem at the time of the hearing. The statute sets forth no guidance as to procedures for the failure to visit. Some judges have dismissed the case, while others have adjourned it for one or more days.

4. One distinct problem is that there is no provision that provides for the reimbursement of counsel fees to the county. Some courts issue orders for repayment, while others send a bill to the respondent, hoping to get what they can.

IV. The Hearing within 7 Days

A. The Mental Health Code requires that the hearing be held within 7 days after the court receives the petition and the two physician's certificates. (Sec. 452)

B. The Mental Health Code and the Probate Court Rules make no specific provisions for any extension of time.

C. Despite the language of Section 452, there are circumstances when a hearing may have to be scheduled beyond the 7 days. Two factors that should be looked for are:

1. Good cause shown for the delay/adjournment.
2. Consent, if possible, of the respondent and his counsel.

D. Another cause for a delay is when there is a demand for a jury trial, the court may grant a continuance for not

more than seven days from the court's receipts of the demand. In some counties, at some time, it may be difficult to bring a jury panel in with that time constraint. While there is a difference of opinion, it is generally agreed that the hearing can be delayed beyond the seven days for such extra days as might be reasonable under the circumstances.

V. Other Roles of the Probate Court for "Troubled People".

As a point of discussion, not every trouble person is suitable for admission under the Mental Health Code. For them, alternative procedures under the Probate Code might be more suitable.

A. The "Temporary Guardian" Under Emergency Circumstances

1. PCR 714 permits a Temporary Guardian to be appointed with less notice than would be required for the normal proceeding. For cause shown, the court may even dispense with notice to the respondent.
2. The circumstances for the dispensing of notice should be substantive in the extreme. For instance, the court might wish to be fully satisfied that the condition of the individual is life threatening before it will dispense with notice.
3. The hearing must be held at the county courthouse.
4. Some courts feel that when notice is dispensed with, the treating person (who is often the instigator of

the petition) should be required to attend the hearing.

5. The court may wish to appoint a Guardian Ad Litem to investigate the circumstances and report to the court on the status of the individual.

6. As this can often be a very sensitive issue (often the emergency arises out of religious convictions), the court should be satisfied as to the need for guardianship and the degree to which the condition in life threatening and the competency of the individual.

7. If the condition of the individual needs long-term protection, then a regular hearing should be held for the appointment of a full guardian under the procedures of the Revised Probate Code, Chapter 4.

B. Conservatorships and Protective Orders

Under some circumstances, the problems that the individual may have are as a result of problems with finances, or if unsuitable for admission under the Mental Health Code, they still need management of their finances. Under these circumstances, sometimes gaining control of the financial situation will result in benefit to the individual.

VI. Chapter 4 of the Revised Probate Court provides very broad powers to the Probate Court to empower conservators and gives those conservators broad powers.

A. Protective Orders as Short Term Solutions

1. If the protection that is needed is suitable for a single action or would be complete in a very short period of time, a Protective Order might well be considered as opposed to a conservatorship.

2. The Protective Order can be framed to specifically address itself to the single action and by the terms of the order can be terminated. This saves the court from having to have long-term supervision of the conservatorship.

B. Revised Probate Code, Section 468, provides the court or a conservator broad powers to use to protect the estate of the individual.

1. Most courts are reluctant to actually exercise the powers granted to the court.

2. Most courts would rather appoint a fiduciary and authorize the fiduciary to exercise the powers granted.

# Chapter III

## Notes

[1]Alan A. Stone, Mental Health Law: A System in Transition. U.S. Department of Health, Education and Welfare. National Institute of Mental Health (Washington, D.C.: GPO, 1976), p. 45.

[2]Stone, p. 46.

[3]David B. Wexler, Mental Health Law (New York: Pleunum, 1981), p. 14.

[4]Wexler, p. 15.

[5]Saul Feldman, The Administration of Mental Health Services (Springfield, Illinois: Thomas, 1980), p. 332.

[6]Wexler, p. 39.

[7]Feldman, p. 332.

[8]Loren H. Roth, "A Commitment Law for Patients, Doctors, and Lawyers," American Journal of Psychiatry, 136 (1979), p. 1123.

[9]Wexler, p. 39.

[10]Elwin J. Griffith and Ezra E.H. Griffith, "Duty to Third Parties, Dangerousness and the Right to Refuse Treatment: Problematic Concepts for Psychiatrist and Lawyer," California Western Law Review 14 (1978): 259.

[11]Wexler, p. 39.

[12]Wexler, p. 40.

[13]J. Ennis, "Civil Liberties and Mental Illness," Criminal 101, 104 (1971): 105-106.

[14]Griffith, p. 260.

[15]Griffith, p. 262.

[16]Jennifer Caldwell Bonovitz and Jay S. Bonovitz, "Diversion of the Mentally Ill into the Criminal Justice System: The Police Intervention Perspective," American Journal of Psychiatry, 138 (1981): 974.

[17]George Huber et al., "Hospitalization, Arrest or Discharge: Important Legal and Criminal Issues in the Emergency Evaluation of Persons Believed Dangerous to Others," Law and Contemporary Problems, 45 (1982): 101.

[18]Robert D. Miller and Paul B. Fiddleman, "Emergency Involuntary Commitment: A Look at the Decision-Making Process," Hospital and Community Psychiatry, 34 (1983): 249.

[19]Roth, p. 1124.

[20]Roth, p. 1124.

[21]Stone, p. 27.

[22]Stone, p. 27.

[23]Huber, p. 99.

[24]Huber, p. 100.

[25]Huber, p. 100.

[26]Huber, p. 100.

[27]Griffith, p. 257.

[28]Griffith, p. 257.

[29]Griffith, p. 257.

[30]Griffith, p. 255.

[31]Griffith, p. 258.

[32]Griffith, p. 258.

[33]Ethan S. Rofman et al., "The Prediction of Dangerous Beahvior in Emergency Civil Commitment," American Journal of Psychiatry, 137 (1980): 1061.

[34]Lee C. Rubin and Mark Mills, "Behavioral Percipitants to Civil Commitment," American Journal of Psychiatry, 140 (1983): 603.

[35]Rubin, p. 603.

[36]Roth, p. 995.

[37]Rofman, p. 1061.

[38]Rofman, p. 1061.

[39]Rofman, p. 1061.

[40]Jerome Yesavage et al., "Short Term Civil Commitment and the Violent Patient," American Journal of Psychiatry, 139 (1982): 1147.

[41]Yesavage, p. 1147.

[42]Rubin, p. 603.

[43]Rubin, p. 603.

[44]Douglas F. Levinson, "The Value of Clinical Predictions of Dangerous," American Journal of Psychiatry, 140 (1983): 657.

[45]Levinson, p. 657.

[46]Griffith, p. 272.

[47]Yesavage, p. 657.

[48]Yesavage, p. 657.

[49]Griffith, p. 273.

[50]Griffith, p. 273.

[51]U.S. Constitution, Amendment V.

[52]Griffith, p. 273.

[53]Griffith, p. 273.

[54]Rofman, p. 1064.

[55]Calvin J. Frederick, Dangerous Behavior: A Problem in Law and Mental Health. U.S. Department of Health, Education and Welfare. National Institute of Mental Health (Washington, D.C.: GPO, 1978): 8.

[56]James Coleman, Abnormal Psychology and Modern Life (Glenview, Illinois: Scott, Foresman and Company, 1976), p. 292.

[57]Coleman, p. 292.

[58]Coleman, p. 300.

## Chapter IV

## The Actors

Mental health law is fully multidisciplinary. It is influenced--and contributed to--by professionals in the fields of law, psychology, psychiatry, sociology, criminal justice and other related fields. The complexity of mental health issues daily confronting professionals from the allied fields need to be appreciated. All concerned actors in the system must emphasize global concerns and resist rigid boundaries. Only the primary actors and disciplines will be examined.

General descriptions are easy to form; however, none is truly adequate. Generally speaking, the "law seeks to order and control the conduct and affairs of men."[1] By contrast the emphasis in mental health is to understand why man behaves the way he does, "to instill insight, self-understanding, and greater self control of feelings and actions."[2] Thus, the inherent conflict for actors practicing the disciplines of psychology and law.

As noted earlier, the interaction between mental health and law has not always been mutually productive. Historically, distrust and value conflict between the two professions has led to volatile debates regarding mental health issues. At the heart of the conflict are issues of theory, value and practice. Lawyers bring legal doctrines,

skills, ideologies and values that sharply contrast with those traditionally accepted in the psychiatric medical model.

Most often the law is regarded as "the establishment through which society decrees what one may do, what is forbidden, how property is safeguarded, and in what interpersonal relations the state may be involved."[3] Law is logical and precise, and often rigid. Upon closer look, law represents all aspects of the human condition and sways in its reflection. Law is an expression of the collective human will. Exact codes for conduct have been subject to interpretation and reinterpretation throughout history.

In the courtroom, differences in orientation and practice between mental health and law professionals co-exist. While lawyers tend to stress physical liberty, individual autonomy, freedom of movement and community residence as opposed to institutionalization, the psychiatric model on the other hand, focuses on the importance of treatment and the value of hospitalization with physical liberty being a lesser value than restoration to normal functioning.[4] "For the Psychiatrist, achieving freedom from mental illness justifies the deprivation of physical freedom,"[5] according to Saul Feldman. The medical model is traditionally paternal and authoritarian. In summary, each institution, law and mental health, view individual deviance and mediation differently.

Law and mental health professionals look at each other warily. Viewpoints may include wild caricatures (i.e., mental health professionals are unpredictable, swingers; "flat foot" law enforcement

officers are hardened) that may influence daily interaction. Beyond stereotypes influencing some behavior misunderstanding may exist. The psychiatrist whom society treats with much deference may be hesitant to enter the lawyers' arena where he may anticipate what he perceives as criticism and humiliation. Meanwhile, many lawyers and judges may not have a solid grasp of the complex, somewhat imprecise, concepts of mental health. This working environment hinders understanding and can promote skepticism and cynicism in the mental health justice system.

Are lawyers enemies of psychiatrists? Virginia A. Hiday, The American Journal of Psychiatry, responded to a number of psychiatric articles discussing recent changes in civil commitment procedures and standards which portrayed psychiatrists as being under assault from patients' lawyers.[6] More extreme articles depicted benevolent psychiatrists seeking help for severely distressed mental patients encountering lawyers blinded by the concept of individual liberties preventing psychiatric intervention. In essence, allowing the mentally ill "to die with their rights on."[7] Hiday explored a number of issues. Answers to two pertinent questions: 1) What attitudes do lawyers hold toward psychiatrists? and 2) Do they view psychiatrists positively, giving them an honored place in society similar to that conferred on other physicians, or do they relegate psychiatrists to a discipline with unreliable and invalid tools and remedies will be utilized? Results gathered from a survey of 101 lawyers and judges who participate in involuntary civil commitment and a review of 1,000 civil commitment cases follows. Hiday found that "like the general

public, these lawyers and judges tended to view psychiatrists in favorable terms" and there was "little difference between counsel and judges in mean attitudes toward psychiatrists."[8] A total of 91% of both groups gave positive ratings. Furthermore, "those surveyed tended to respect psychiatrists as professionals in the area of mental health and to regard them as having valid tools and remedies to aid the mentally ill."[9]

Setting aside wild caricatures can lead to mutual regard. In spite of differences in orientation and practice, law and mental health professionals have learned to co-exist and mutually work toward the client's benefit. Hiday (1983) found that lawyers and judges "tended to view the ill as sick people who can be helped by psychiatrists and by hospitalization."[10] Acceptance of the illness with relative sympathy for the individual implies understanding for an illness which the individuals can not control. This expression is in accordance with the medical model which does not blame the mentally ill, it further implies that nonspecialists can not make judgements about or treat illness--only a psychiatrist can do so. As a result, counsel tends to defer to psychiatrists' opinions and recommendations for involuntary hospitalization.

An interview with an assistant prosecuting attorney, formerly responsible for mental hearings, in Genesee County had some interesting revelations. "Most lawyers have a strong sense of ambiguity about their role in commitment hearings."[11] Oftentimes attorneys lack expertise in medicine, specifically, mental illness and

its treatment. In addition to medical knowledge, commitment hearings also require the lawyer's expertise in legal principles preventing their client's loss of freedom. It is here that the sense of ambiguity deepens. Arguing against commitment may lead to the client's failure to receive necessary medical treatment. Not fighting commitment may lead to a loss of the client's freedom. "A real Catch-22!"[12] Fighting for release of dangerous mentally ill persons further endangers society and eliminates the opportunity for the ill to get much needed treatment.

The ambiguity deepens and may be manifest in a variety of ways, specifically in the quality of legal representation. Reluctant to discuss colleagues, the assistant prosecutor did confirm, "lawyers representing mentally ill clients usually make little preparation for the hearing."[13] This author's courtroom observations provide this further evidence. Seldom do lawyers speak with clients, petitioners, psychiatrists or other witnesses before the day of the hearing. Rarely do lawyers take an adversarial role to obtain their clients' release. Instead lawyers tend to defer to the psychiatrist's opinions and recommendations after reading the client's legal records and two short certification/affidavits. (See Appendix)

Deference or independence? An examination of the defense counsel in the involuntary civil commitment system was undertaken by Ingo Keilitz and Robert F. Roach. As noted earlier the defense counsel is often less than effective in representing client's rights. "It seems that most professionals involved in civil commitment became absorbed

in the process itself and lose sight of the fact that a person's liberty and dignity are at stake . . . the 'best interests' approach denies individuals their right to participate in and control their destiny. . ."[14] Thus, independence is compromised. Keitlitz and Roach emphasize,"the justification for something other than a zealous advocate approach seems to grow out of a benevolent veneer of paternalism."[15]

The role of defense counsel in the involuntary civil commitment process has generated heated debate, ambivalence, and confusion. Should the defense attorney act as an advocate or guardian? Professionals who endorse the guardian ad litem role allow the attorney to determine and assist the client in seeking what is in his best interests, independent of the client's wishes. Best interests and client's wishes may be incongruous. Critics say, the guardian ad litem "role does not effectively satisfy the requirement of the right to effective assistance of counsel because of the potential conflict between strict adherence and zealous advocacy of a (client's) expressed desires and the guardian's perception of the 'best interests' of the (client)."[16]

The role of defense attorneys promulgating either a best interest or advocacy approach becomes even more complicated. Delineating a mentally ill client's desires can be difficult. Oftentimes clients do not truly understand what is happening to them. Futuristic concerns, legal parameters and treatment options may seem equally obscure to the client. The effects of mental illness combined with the confusion of

the judicial system limits participation by the client. At times rational thought and communication by the client may be impossible. Advocacy based on client wishes at this point is hollow.

Active advocacy in civil commitment hearings has never had the same impetus as in the criminal justice system which is "always haunted by the ghost of the innocent man convicted."[17] However in Quesnell v. State, the Quesnell decision held, "the use of beneficient, self-serving labels such as 'civil', 'clinical' and 'treatment' as a means of supporting procedural aberation in the mental illness hearing constitutes an intolerable abuse of the duty to ensure stringent protection of constitution and statutory rights."[18] The Court has pointed to the need for sufficient, enthusiastic defense representation for the mentally ill in order to guard against unwarranted loss of liberty. In the Quesnell case, the Court warns against a rubber stamp hearing for 'treatment'.

A State's mental health--justice system may not always act in what an individual may consider his best interests. Acknowledgement of individual risk encountered in the mental health system has led to a review of legal practices. "The nature, conduct, and consequence of this review of involuntary civil commitment proceedings depends largely on the performance of the attorney representing the person who faces possible involuntary hospitalization."[19]

A judge's role in the civil commitment process is important. The general view of adjudication is that it is a process whereby judges, perhaps influenced by their attitudes and values, apply the law to the

facts of a case. However, when the question is involuntary civil commitment to a mental hospital, research shows that the model does not hold. Virginia Hiday (1983) applied regression analysis to civil commitment decisions. In Law and Society Review, Hiday argues that "judges often abdicate their roles as neutral fact finders and defer to expert psychiatric opinion."[20] Judges like lawyers tended to defer to psychiatrists, accepting diagnosis and treatment recommendations.

In other research also published in 1983 by Hiday it was found that, "Judges' positive attitudes toward psychiatrists and mental hospitals . . . the medical model were manifest in the respect shown toward psychiatry and its practitioners who participated in the involuntary civil commitment process."[21] "Where judges did not defer to psychiatrists was in demanding testimony about dangerous acts, a criterion for evidence mandated by law before ordering commitment."[22]

Judges, lawyers, and legislators, many of whom have been unfamiliar with the mental health system, have been required to play significant roles in fashioning and implementing the law. Some public law lawyers moved swiftly to address historic neglect of the legal rights of the mentally ill and develop legal doctrines and remedies. Many of the remedies are controversial and challenge long-held views and attitudes. As a result, resistance to change is found in many areas by numerous actors. It has been argued boisterously that the remedies do not account for the realities in the mental health system. The changes have been viewed as excessively burdensome and not beneficial to the mentally disabled. The controversy and the

resistance by actors rages onward.

Despite shared conflict, overlapping interests and ambivalence, law and mental health can not be separated. Each needs the other. Professionals from both disciplines are concerned with the impetuous compelling man's thoughts, actions, ideals and societal needs. In addition, law and mental health confront the realities that restrict achievement. Both are committed in principle to "processes and programs that lead toward entry or reentry of citizens into the productive sector of society."[23] These are mutual global concerns.

Actors in mental health and law may hold similar goals. Yet, the process defining individuals requiring remediation needs further refinement in implementation. Ultimately the involuntary civil commitment process requires "difficult decisions between liberty and state intervention in the lives of allegedly mentally disturbed persons,"[24] both which are strong, competing societal values. In the final analysis, judgements based on values and morals rather than facts and logic may be best decided by the public and legislators.

# Chapter IV

## Notes

[1]Justine Wise Polier, "Law and Mental Health," American Journal of Orthopsychiatry, 50 (1980): 394.

[2]Polier, p. 394.

[3]Polier, p. 395.

[4]Saul Feldman, The Adminstration of Mental Health Services (Springfield, Illinois: Thomas, 1980), p. 331.

[5]Feldman, p. 332.

[6]Virginia A. Hiday, "Are Lawyers Enemies of Psychiatrists? A Survey of Civil Commitment Counsel and Judges," American Journal of Psychiatry, 140 (1983): 323.

[7]D.A. Treffert and R.A. Krojeck, "In Search of a Sane Commitment Statute," in Psychiatrists and the Legal Process: Diagnosis and Debate (New York: Insight Communications, 1977).

[8]Hiday, p. 324.

[9]Hiday, p. 324.

[10]Hiday, p. 326.

[11]Assistant Prosecutor, personal interview, 3 October 1986.

[12]Assistant Prosecutor, 3 October 1986.

[13]Assistant Prosecutor, 3 October 1986.

[14]Ingo Keilitz and Robert F. Roach, "A Study of Defense Counsel and the Involuntary Civil Commitment System in Columbus, Ohio," Capital University Law Review, 13 (1983): 174.

[15]Keilitz, p. 174.

[16]Keilitz, p. 194.

[17]U.S. v. Garsson, 291 F. 646, 649 (S.D. N.Y. 1923).

[18]Keilitz, p. 174.

[19]Keilitz, p. 198.

[20]Virginia A. Hiday, "Judicial Decisions in Civil Commitment: Facts, Attitudes and Psychiatric Recommendations," Law and Society Review, 17 (1983): 517.

[21]Hiday, "Are Lawyers," p. 326.

[22]Hiday, "Are Lawyers," p. 326.

[23]Alan A. Stone, Mental Health Law: A System in Transition. Department of Health, Education and Welfare. National Institute of Mental Health (Washington, D.C.: GPO, 1976), p. 9.

[24]Keilitz, p. 178.

## Conclusion

Does the greater good of the whole society override individual rights? Lawmaking has occurred in the legislative and regulatory spheres to address this perennial question. Even so, courts have been "the primary forum for this activity and have often prodded the legislatures and regulatory agencies into action."[1] While it seems unlikely that the Supreme Court will "through constitutional construction mandate major changes in mental health law . . . state courts have begun to interpret state laws and state constitutional provisions as requiring greater than the minimal protections required by the Burger Court. . ."[2]

The "considerable permanent and change in the way our society provides care and treatment for the mentally disabled"[3] can be seen. The emergence of a full blown "body of mental health law is still in a rapidly expanding and volatile state."[4] This relatively new segment of law encompasses the mental health system, impacting hundreds of thousands of patients and mental health professionals.

Rapid progress in mental health law has occurred on several fronts: legislative, judicial and administrative. Reconstruction of mental health statutes has been undertaken by many state legislatures in recent years. In part this legislative review has been undertaken

due to the proliferation of state and federal litigations of a personal nature and class-action suits. As a result a host of new legal controls over mental health practices can be found in substantial administrative regulations. Many controls and practices are changing due to frequent new interpretations of the law.

Overall, mental health legislation recently enacted has improved on older laws by recognizing procedural rights for patients. Stricter commitment standards, procedures and durational limits have resulted in fewer people being committed for shorter periods of time than in the past. "Along with increased procedural rights for patients have come changes in the relationships among social workers, lawyers and psychiatrists, the three groups involved in the commitment process."[5] Strained relations have accompanied legal changes paradoxically, at a time when interdependence has grown. It is a tendency for each group to be ignorant of the other's specialized area. Members of all three professions have sizeable gaps in their knowledge about either mental health or the law. Society has outgrown its simple faith in psychiatry. The relevant professions must cooperate to provide better treatment for persons who need help.

Vicious circles in the involuntary civil commitment process have evolved. The first generation established procedural safeguards and addressed the abuses of the mental health system. Competing values were redefined and established individual rights for the mentally ill. However, the second generation has formulated multiple vital, yet unanswered questions. Some of which focus on the viability of the

mandated legal reforms.

There exists a dark side of mental health litigation. The picture is real and evidence is mounting. Lawyers need to look carefully at the often unexamined assumptions behind the new laws. Is it really the patients who have had their day in court? "When the shortcomings of the deinstitutionalization movement are combined with the exceedingly strict standards of the current generation of involuntary commitment statutes, the result is a critical failure to provide essential mental health services to a large and growing number of seriously impaired people."[6] Legal solutions secured in the court room have established an impressive fortress of due process. ". . . beyond the legal structure human suffering continues unabated and its relief is more difficult to achieve,"[7] according to Alan Stone.

One of the proudest claims of our American legal system is that we are a government of laws and not men. Not surprising the implementation of the law is less than perfect since it is in the hands of men and women. Important landmark decisions won over the past 15 years "will constitute mere paper victories unless creative monitoring and implementation efforts are continually undertaken."[8] An inadequacy, the narrow standards of commitment, are often not implemented uniformly. Some professionals opt for 'business as usual' and are reluctant to conform to legislative reform. However, noncompliance may be in part due to the lack of alternatives especially since the community demands that "something must be done

for these people." Promulgation of standards without accurate application, supporting alternatives, or review may be the worst of all possible worlds.[9] "If the legal standard is impractical those administering the system day to day . . . may encourage the development of an essentially lawless system of justice."[10] It is not clear that the narrow theory of commitment criteria satisfies daily practical needs. "Despite extraordinary recent activity in the area of mental health law, there has been relatively little attempt to study the actual impact of these events on the policy and programmatic changes sought."[11] So the debate continues.

The conflicts are real. Issues require decision making based on sound principles and pragmatic options, often the two are irreconcilable. How deep is the disillusionment about government intervention lowering treatment services and how far has a loss of will to correct abuses and denials of service affected mental health professionals? These second generational questions carry "the unspoken concerns of the courts for how far they should go in seeking remedies that expend tax dollars."[12] Neither law or mental health can close its eyes to old abuses or new needs.

The time has arrived for the mental health and legal professions to work cooperatively toward improving the system "by which society affords involuntary psychiatric treatment to the seriously mentally ill."[13] The new system needs to be improved so that it is responsive to community treatment alternatives. Furthermore, these alternatives need to be adequately funded so as to afford effective treatment with

the least possible restriction of personal liberty and autonomy.

"Like psychotropic medications, which drastically altered the nature of mental health care, the law will leave significantly changed contours of the mental health system."[14] Mental health law forged new rights and rectified old wrongs for the mentally ill. The law has had a dramatic impact on the mental health system and has left it sensitized. The mental health system subsequently remains in a state of legal flux. Lawyers have pivotal roles in determining policy. An area of the law primarily limited to insanity defense cases has burgeoned and "has entered the mainstream of American legal activity."[15]

Clearly, these many issues engage the fundamental question of the balance of power between the state and the individual. These questions go beyond the usual legal, medical and mental health concerns. They relate to issues of basic societal values and widespread public policies. Policies with such strongly held moral and ethical beliefs are much too critical to be left to lawyers and mental health professionals. The burden of social responsibility must be shared by all, including society which allows these conditions to exist.

## Conclusion

### Notes

[1]Alan Meisel, "The Rights of the Mentally Ill Under State Constitutions," Law and Contemporary Problems, 45 (1982): 7.

[2]David B. Wexler, Mental Health Law (New York: Plenum Press, 1981), p. 260.

[3]R. Kirkland Schwitzgebel, Legal Aspects of the Enforced Treatment of Offenders. U.S. Department of Health, Education and Welfare. National Institute of Mental Health (Washington, D.C.: GPO, 1979), III.

[4]Saul Feldman, The Administration of Mental Health Services (Springfield, Illinois: Thomas, 1980), p. 329.

[5]Richard Gaskins and Mona Wosow, "Vicious Circles in Civil Commitment," Social Work, 24 (1979): 129.

[6]John E.B. Myers, "Involuntary Civil Commitment of the Mentally Ill: A System in Needs of Change," Villanova Law Review, 29 (1983-84): 412.

[7]Alan A. Stone, "Recent Mental Health Litigation: A Critical Perspective," American Journal of Psychiatry, 134 (1977): 278.

[8]Wexler, p. 258.

[9]George E. Dix, "Major Current Issues Concerning Civil Commitment Criteria," Law and Contemporary Issues 45 (1982): 159.

[10]Dix, p. 159.

[11]United States Department of Health and Human Services, National Institute of Mental Health. Civil Commitment and Social Policy (Washington, D.C.: GPO, 1981), p. 1.

[12]Justine Wise Polier, "Law and Mental Health," American Journal of Orthopsychiatry, 50 (1980): 398.

[13] Myers, p. 433.

[14] Feldman, p. 330.

[15] Feldman, p. 329.

# Glossary

| | |
|---|---|
| Affect (Mood) | The predominant feeling state. |
| Ambivalence | The inability to choose between two opposite drives. |
| Anergia | Loss of initiative and purpose and the development of a state of inaction. |
| Autism | Absorption or preoccupation with fanciful or imagery ideas to the exclusion of real things. |
| Blocking of Thought | The arrest of thought followed by a resumption of ideas having little or no relationship to the previously expressed ideas. |
| Catatonia | A severe state of tension manifested by stupor or excitement. |
| Clang Associations | The direction of the thought processes being governed by the similarity of the sound of words in totally unrelated ideas. |
| Clear and Present Danger Test | The occurrence of the act of dangerousness has taken place within the last 30 days. |
| Condensations | The contraction of many ideas into a single idea. |
| Dangerousness | Significant infliction or attempt to inflict seriously bodily harm. |
| Delusion | A false belief out of keeping with the individual's knowledge and cultural group. The belief is maintained against logical argument and despite objective contradictory evidence. |
| Delusion of Grandeur | Exaggerated ideas of one's importance and identity. |

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| Delusion of Persecution | Ideas that one has been singled out for persecution. |
| Delusion of Reference | Incorrect assumption that certain casual or unrelated remarks or the behavior of others applies to oneself. |
| Delusion of Influence | Incorrect assumption that casual or unrelated remarks or behavior permits one to influence the behaviors, or one to be influenced by the remarks or behavior of others. |
| Delusion of Hypochondriasis | Belief that certain physical or emotional disease states exist without demonstrable organic pathology. |
| Dissocation of Thought | The haphazard interjection of ideas into a train of thought so that the resultant product is illogical or bizarre. |
| Echolalia and Echopraxia | Acting out, copying, imitating what is heard and seen. |
| Fantasy | An imaginary idea. |
| Functional Disorder | A disorder which is the product of adverse environmental factors. |
| Hallucination | False sensory perceptions--without actual external stimuli. |
| Auditory | "Hearing things"--the most common, usually voices. |
| Visual | "Seeing things." |
| Gustatory | "Tasting things." |
| Olfactory | "Smelling things." |
| Illusion | Distorted true sensory perception. |
| Indifference | The lack of feeling for what is going on outside and frequently inside of oneself as well. |

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|---|---|
| Inappropriateness of Affect | Mood that is inconsistent with the ideas or thoughts expressed. |
| Insight | Understanding of the factors causing the emotional upheaval. |
| Involuntary Civil Commitment | Process used by the state to provide care and treatment to mentally ill individuals who are incapable, unwilling to provide care and treatment for themselves and who are dangerous to self and/pr others. |
| Liability of Affect | Sudden shifts in mood, often without discernible external stimulus. |
| Manic-Depressive Illness | A mental disorder characterized by a predominant mood of euphoria or depression or alternating between the two. |
| Monoiedeism | The domination or impoverishment of thought to a single idea. |
| Negativism | Opposition to the wishes of others manifested by stupor, mutism, rejection of food, waste retention, etc. |
| Neologisms | Creating new words, sometimes from parts of words currently in use. |
| Organic Disorder | A mental disorder due to a structural or physiological alteration of the brain. |
| Paren Patriae | Paternalistic exercise of state intervention assumed to serve the best interests of the deviant subject. |
| Psychosis | A severe mental disorder characterized by changes in the form and/or content of thought, exhilaration or depression of mood and behavior related to the altered thought/mood. |
| Pressure of Thought | A compulsive, accelerated flow of ideas. |
| Reality | An awareness of, and an interest in the substantial things in one's external and internal environment. |

| | |
|---|---|
| Schizophrenia | A group of psychoses characterized by a specific type of alteration in the psychic functions of thinking, feeling or affectivity and behavior. |
| Somatic | Referring to the physical body as opposed to the mental or psychic. |
| Stereotypy | A fixation to the same circle of ideas, the same words, the same sentences, structure or returning to them again and again without any logical needs. |
| Sufficient Petition | Allege facts that show or from which an inference can be drawn. Must show that the respondent is mentally ill and in need of care and treatment. Petitions should not contain conclusory statements. |
| World Destruction Fantasies | The dissolution of one's personal world. |
| World Reconstruction Fantasies | Those constructions of one's personal world in which hallucinations and delusions often play a prominent part. |

APPENDIX I

ADMISSION BY MEDICAL CERTIFICATION:

1. A properly completed application.

2. A properly completed Physician's Certificate.

Both completed before arrival at the Psychiatric Hospital.

| STATE OF MICHIGAN<br>PROBATE COURT<br>COUNTY OF Genesee | PETITION/APPLICATION<br>FOR HOSPITALIZATION | FILE NO. |
|---|---|---|

In the matter of John Doe Social Security Number: 123-45-6789

1. I, Mary Doe (Name), an adult, make this petition/application as wife (Relative, neighbor, peace officer, etc.).

2. The alleged mentally ill person who is the subject of this petition was born 1-1-38 (Date), lives in Genesee County at 1020 Bay Drive (Street address) Flint (City) MI (State) 48502 (Zip)

and can presently be found at: 1020 Bay Drive (Street address) Flint (City) MI (State) 48502 (Zip).

3. The subject of this petition is mentally ill, and:

(a.) as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or another person, and has engaged in an act or acts or made significant threats that are substantially supportive of the expectation;

and/or

b. as a result of that mental illness is unable to attend to those personal basic physical needs such as food, clothing, or shelter that must be attended to in order to avoid serious harm to self in the near future, and has demonstrated that by failing to attend to those basic physical needs;

and/or

(c.) his/her judgment is so impaired that (s)he is unable to understand the need for treatment and his/her continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to self or others.

4. This conclusion is based upon:

a. My personal observation of the person doing the following acts and saying the following things:

His conversation makes no sense. He may begin to talk about one thing and in the middle of a sentence he starts to talk about something else. He claims the Mafia is after him because he has 58 million dollars in a Swiss bank that he stole from them. In reality, he has never had more than a few hundred dollars in his possession at one time. He has on 3 occasions this past week hit me causing bruises and a bloody nose because he thinks I am helping the Mafia to get him. He said he would kill himself before the Mafia could get him. He is so afraid the Mafia is watching our house that he has not gone to work for the last five weeks.

; and/or

(PLEASE SEE OTHER SIDE)

Do not write below - For court use only

b. Conduct and statements I have been informed that others have seen or heard:

I saw John Doe coming running out of the house with a .38 revolver in his hand, hollering "I know you're out there watching me. Come on out and I'll shoot you. You'll never take me alive." There was no one near the house at the time.

By: Dorothy Smith — 1024 Bay Drive, Flint, MI — 343-5555
Witness name — Complete address — Telephone no.

By: ______
Witness name — Complete address — Telephone no.

5. Persons interested in these proceedings are:

| NAME | RELATIONSHIP | ADDRESS | TELEPHONE |
|---|---|---|---|
| Mary Doe | Spouse | 1020 Bay Drive, Flint, MI | 343-4444 |
| | Guardian | | |
| Charles Doe | Son | 1113 Elm Street, Flint, MI | 345-9507 |
| | | | |

6. The subject of this petition/application ☐ is ☒ is not a Veteran.

7. I therefore request that the subject of this petition be determined by the Court to be a person requiring treatment and that until the hearing the individual be hospitalized.

I declare under penalty of contempt of court that this petition has been examined by me and that its contents are true to the best of my information, knowledge and belief.

December 1, 1986
Date

Signature

Attorney name — Bar no.

1020 Bay Drive
Address

Address

Flint, MI 48502
City, state, zip

City, state, zip — Telephone no.

343-4444 — None
Home telephone no. — Work telephone no.

This petition is accompanied by
☒ Certificate of Physician.
☐ Certificate of Psychiatrist.
☐ Petition for examination.

FOR HOSPITAL USE ONLY: This application for admission was filed with the hospital on December 1, 1986 (Date) at 12:30 p.m. (Time)

Dorothy A. Gerity
Signature of hospital representative

STATE OF MICHIGAN
PROBATE COURT
COUNTY OF Genesee

110
PHYSICIAN'S CERTIFICATE

FILE NO.

In the matter of John Doe

1. TO THE EXAMINER: The following is a statement that must be read to the individual before proceeding with any questions.

I am authorized by law to examine you for the purpose of advising the probate court if you have a mental condition which needs treatment and whether such treatment should take place in a hospital or in some other place. I am also here to determine if you should be hospitalized, or remain hospitalized, before a court hearing is held. I may be required to tell the court what I observe and what you tell me.

I certify that on this date I read the above statement to the individual before asking any questions or conducting any examination.

2. I further certify that I, William R. Kavanaugh, M.D. (Print or type name of examiner), personally examined John Doe (Patient)
at Martin Hospital Emergency Room, Flint, MI (Name of hospital and address).
on December 1, 1986 (Date) commencing at 10:30 a (Time) m. and continuing for 30 minutes.

INSTRUCTIONS: In answering describe in detail the specific actions, statements, demeanor and appearance of the individual, together with other information in reasonable detail, which underlie your conclusion. INDICATE THE SOURCE OF ANY INFORMATION NOT PERSONALLY KNOWN OR OBSERVED. If this certificate is to accompany a petition for discharge, also state why the individual continues to be or is no longer a person requiring treatment or in need of hospitalization.

3. My determination is that the person is:
- ☒ Mentally ill (has a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life).
- ☐ Mentally retarded (has a significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior).
- ☐ Not mentally ill or mentally retarded.

4. (if applicable) The person has:
- ☐ developmental disability
- ☐ convulsive disorder
- ☐ alcoholism
- ☐ other drug dependence
- ☐ mental processes weakened by reason of advanced years
- ☐ other (specify):

5. My diagnosis is: Schizophrenia, paranoid type

6. Facts serving as the basis for my determination are: Mr. Doe claims that 2 years ago he was approached by a man who asked him to keep some money for him. He says he took the money, 58 million, and deposited it in a Swiss bank. He says that now the man believes that Mr. Doe intended to keep the money for himself and that this man is a member of the Mafia and that members

(CONTINUE ON OTHER SIDE)

Do not write below this line - For court use only

6. (continued)



of the Mafia have been spying on him and have surrounded his house. He believes that the Mafia members are planning to rush his house to kill him and his wife.

7. Set forth in the space below the facts which lead to the belief that future conduct may result in: (check applicable box)

a. ☒ Likelihood of injury to others. Facts: Mr. Doe told me that he believed that the Mafia had been watching his house and following him everywhere he went if he left the house. He said that he had armed himself with a .38 revolver and that he had a hunting knife strapped to his leg. He said that if the "gang" rushed his house that he would kill a few of them before they got him. I believe he might misidentify someone coming to his house and shoot them believing them to be a member of the Maifa trying to kill him.

**Therefore, I believe the person can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure another person.**

b. ☒ Likelihood of injury to self. Facts: Mr. Doe told me that he is so discouraged because nobody will believe him or help him and has thought of killing himself.

Therefore, I believe the person can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self.

c. ☒ Inability to attend to basic physical needs. Facts: Because Mr. Doe believes that members of the Mafia are surrounding his house, he has not left the house for the past five weeks to go to work. Relatives and friends have to bring foodstuffs into the house for he and his wife.

Therefore, I believe that as a result of mental illness the examined person is unable to attend to those basic physical needs (such as food, clothing or shelter) that must be attended to in order to avoid serious harm in the near future.

d. ☐ Inability to understand need for treatment. Facts:

Therefore, I believe that as a result of mental illness the examined person is unable to understand the need for treatment, and continued behavior can reasonably be expected to result in significant physical harm to self or others.

8. I therefore conclude that the individual ☒ is ☐ is not a person requiring treatment or that the individual ☒ is ☐ is not an individual who meets the criteria for judicial admission.

9. I further certify that I am a person authorized by law to certify as to the individuals's mental condition. I am not related by blood or marriage either to the person about whom this certificate is concerned or to any person who has filed, or whom I know to be planning to file, a petition in this proceeding. I declare that this certificate has been examined by me and that its contents are true to the best of my information, knowledge and belief.

| December 1, 1986 | ____ m. | William R. Cavanaugh M.D. |
|---|---|---|
| Date | Time | Signature |
| Physician | | William R. Kavanaugh, M.D. |
| Title (Physician, Psychiatrist, etc.) | | Print or type name and business telephone no. |

# APPENDIX II

## ADMISSION BY MEDICAL CERTIFICATION:

1. A properly completed application.
2. A properly completed Physician's Certificate.

Both completed at the Psychiatric Hospital.

| STATE OF MICHIGAN<br>PROBATE COURT<br>COUNTY OF Genesee | PETITION/APPLICATION<br>FOR HOSPITALIZATION | FILE NO. |
|---|---|---|

In the matter of John Doe Social Security Number: 123-45-6789

1. I, Mary Doe (Name), an adult, make this petition/application as wife (Relative, neighbor, peace officer, etc.).

2. The alleged mentally ill person who is the subject of this petition was born 1-1-38 (Date), lives in Genesee County at 1020 Bay Drive (Street address) Flint (City) MI (State) 48502 (Zip)

and can presently be found at: 1020 Bay Drive (Street address) Flint (City) MI (State) 48502 (Zip).

3. The subject of this petition is mentally ill, and:

(a.) as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or another person, and has engaged in an act or acts or made significant threats that are substantially supportive of the expectation;

and/or

b. as a result of that mental illness is unable to attend to those personal basic physical needs such as food, clothing, or shelter that must be attended to in order to avoid serious harm to self in the near future, and has demonstrated that by failing to attend to those basic physical needs;

and/or

(c.) his/her judgment is so impaired that (s)he is unable to understand the need for treatment and his/her continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to self or others.

4. This conclusion is based upon:

a. My personal observation of the person doing the following acts and saying the following things:

His conversation makes no sense. He may begin to talk about one thing and in the middle of a sentence he starts to talk about something else. He claims the Mafia is after him because he has 58 million dollars in a Swiss bank that he stole from them. In reality, he has never had more than a few hundred dollars in his possession at one time. He has on 3 occasions this past week hit me causing bruises and a bloody nose because he thinks I am helping the Mafia to get him. He said he would kill himself before the Mafia could get him. He is so afraid the Mafia is watching our house that he has not gone to work for the last five weeks.

; and/or

(PLEASE SEE OTHER SIDE)

Do not write below - For court use only

b. Conduct and statements I have been informed that others have seen or heard:

I saw John Doe coming running out of the house with a .38 revolver in his hand, hollering "I know you're out there watching me. Come on out and I'll shoot you. You'll never take me alive." There was no one near the house at the time.

By: Dorothy Smith — 1024 Bay Drive, Flint, MI — 343-5555

Witness name — Complete address — Telephone no.

By:

Witness name — Complete address — Telephone no.

5. Persons interested in these proceedings are:

| NAME | RELATIONSHIP | ADDRESS | TELEPHONE |
|---|---|---|---|
| Mary Doe | Spouse | 1020 Bay Drive, Flint, MI | 343-4444 |
| | Guardian | | |
| Charles Doe | Son | 1113 Elm Street, Flint, MI | 345-9507 |
| | | | |

6. The subject of this petition/application ☐ is ☒ is not a Veteran.

7. I therefore request that the subject of this petition be determined by the Court to be a person requiring treatment and that until the hearing the individual be hospitalized.

I declare under penalty of contempt of court that this petition has been examined by me and that its contents are true to the best of my information, knowledge and belief.

December 1, 1986
Date

Signature

Attorney name — Bar no.

1020 Bay Drive
Address

Address

Flint, MI 48502
City, state, zip

City, state, zip — Telephone no.

343-4444
Home telephone no.

None
Work telephone no.

This petition is accompanied by ☒ Certificate of Physician. ☐ Certificate of Psychiatrist. ☐ Petition for examination.

FOR HOSPITAL USE ONLY: This application for admission was filed with the hospital on December 1, 1986 (Date) at 12:30 p .m. (Time)

Dorothy A. Gerisitz [signature]
Signature of hospital representative

| STATE OF MICHIGAN<br>PROBATE COURT<br>COUNTY OF Genesee | 115<br>PHYSICIAN'S CERTIFICATE | FILE NO. |
|---|---|---|

In the matter of John Doe

1. TO THE EXAMINER: The following is a statement that must be read to the individual before proceeding with any questions.

I am authorized by law to examine you for the purpose of advising the probate court if you have a mental condition which needs treatment and whether such treatment should take place in a hospital or in some other place. I am also here to determine if you should be hospitalized, or remain hospitalized, before a court hearing is held. I may be required to tell the court what I observe and what you tell me.

I certify that on this date I read the above statement to the individual before asking any questions or conducting any examination.

2. I further certify that I, William R. Kavanaugh, M.D. (Print or type name of examiner), personally examined John Doe (Patient)

at Martin Hospital Emergency Room, Flint, MI (Name of hospital and address).

on December 1, 1986 (Date) commencing at 10:30 a m. (Time) and continuing for 30 minutes.

INSTRUCTIONS: In answering describe in detail the specific actions, statements, demeanor and appearance of the individual, together with other information in reasonable detail, which underlie your conclusion. INDICATE THE SOURCE OF ANY INFORMATION NOT PERSONALLY KNOWN OR OBSERVED. If this certificate is to accompany a petition for discharge, also state why the individual continues to be or is no longer a person requiring treatment or in need of hospitalization.

3. My determination that the person is:
- ☒ Mentally ill (has a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life).
- ☐ Mentally retarded (has a significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior).
- ☐ Not mentally ill or mentally retarded.

4. (if applicable) The person has:
- ☐ developmental disability
- ☐ convulsive disorder
- ☐ alcoholism
- ☐ other drug dependence
- ☐ mental processes weakened by reason of advanced years
- ☐ other (specify): ______

5. My diagnosis is: Schizophrenia, paranoid type

6. Facts serving as the basis for my determination are: Mr. Doe claims that 2 years ago he was approached by a man who asked him to keep some money for him. He says he took the money, 58 million, and deposited it in a Swiss bank. He says that now the man believes that Mr. Doe intended to keep the money for himself and that this man is a member of the Mafia and that members

(CONTINUE ON OTHER SIDE)

Do not write below this line - For court use only

6. (continued)

of the Mafia have been spying on him and have surrounded his house. He believes that the Mafia members are planning to rush his house to kill him and his wife.

7. Set forth in the space below the facts which lead to the belief that future conduct may result in: (check applicable box)

a. ☒ Likelihood of injury to others. Facts: Mr. Doe told me that he believed that the Mafia had been watching his house and following him everywhere he went if he left the house. He said that he had armed himself with a .38 revolver and that he had a hunting knife strapped to his leg. He said that if the "gang" rushed his house that he would kill a few of them before they got him. I believe he might misidentify someone coming to his house and shoot them believing them to be a member of the Maifa trying to kill him.

Therefore, I believe the person can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure another person.

b. ☒ Likelihood of injury to self. Facts: Mr. Doe told me that he is so discouraged because nobody will believe him or help him and has thought of killing himself.

Therefore, I believe the person can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self.

c. ☒ Inability to attend to basic physical needs. Facts: Because Mr. Doe believes that members of the Mafia are surrounding his house, he has not left the house for the past five weeks to go to work. Relatives and friends have to bring foodstuffs into the house for he and his wife.

Therefore, I believe that as a result of mental illness the examined person is unable to attend to those basic physical needs (such as food, clothing or shelter) that must be attended to in order to avoid serious harm in the near future.

d. ☐ Inability to understand need for treatment. Facts:

Therefore, I believe that as a result of mental illness the examined person is unable to understand the need for treatment, and continued behavior can reasonably be expected to result in significant physical harm to self or others.

8. I therefore conclude that the individual ☒ is ☐ is not a person requiring treatment or that the individual ☒ is ☐ is not an individual who meets the criteria for judicial admission.

9. I further certify that I am a person authorized by law to certify as to the individuals's mental condition. I am not related by blood or marriage either to the person about whom this certificate is concerned or to any person who has filed, or whom I know to be planning to file, a petition in this proceeding. I declare that this certificate has been examined by me and that its contents are true to the best of my information, knowledge and belief.

December 1, 1986
Date

______ m.
Time

William R. Kavanaugh MD
Signature

Physician
Title (Physician, Psychiatrist, etc.)

William R. Kavanaugh, M.D.
Print or type name and business telephone no.

## APPENDIX III

### ADMISSION BY ORDER FOR EXAMINATION:

1. A properly completed application which was filed with the Probate Court because the subject of the application would not submit to an examination. An order for examination and transport are completed by the Court.

| STATE OF MICHIGAN<br>PROBATE COURT<br>COUNTY OF Genesee | PETITION/APPLICATION<br>FOR HOSPITALIZATION | FILE NO. |
|---|---|---|

In the matter of John Doe Social Security Number: 123-45-6789

1. I, Mary Doe (Name), an adult, make this petition/application as wife (Relative, neighbor, peace officer, etc.).

2. The alleged mentally ill person who is the subject of this petition was born 1-1-38 (Date), lives in Genesee County at 1020 Bay Drive (Street address) Flint (City) MI (State) 48502 (Zip)

and can presently be found at: 1020 Bay Drive (Street address) Flint (City) MI (State) 48502 (Zip)

3. The subject of this petition is mentally ill, and:

(a.) as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or another person, and has engaged in an act or acts or made significant threats that are substantially supportive of the expectation;

and/or

b. as a result of that mental illness is unable to attend to those personal basic physical needs such as food, clothing, or shelter that must be attended to in order to avoid serious harm to self in the near future, and has demonstrated that by failing to attend to those basic physical needs;

and/or

(c.) his/her judgment is so impaired that (s)he is unable to understand the need for treatment and his/her continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to self or others.

4. This conclusion is based upon:

a. My personal observation of the person doing the following acts and saying the following things:

His conversation makes no sense. He may begin to talk about one thing and in the middle of a sentence he starts to talk about something else. He claims the Mafia is after him because he has 58 million dollars in a Swiss bank that he stole from them. In reality, he has never had more than a few hundred dollars in his possession at one time. He has on 3 occasions this past week hit me causing bruises and a bloody nose because he thinks I am helping the Mafia to get him. He said he would kill himself before the Mafia could get him. He is so afraid the Mafia is watching our house that he has not gone to work for the last five weeks.

; and/or

(PLEASE SEE OTHER SIDE)

Do not write below - For court use only

b. Conduct and statements I have been informed that others have seen or heard:

I saw John Doe coming running out of the house with a .38 revolver in his hand, hollering "I know you're out there watching me. Come on out and I'll shoot you. You'll never take me alive." There was no one near the house at the time.

By: Dorothy Smith — 1024 Bay Drive, Flint, MI — 343-5555
Witness name — Complete address — Telephone no.

By:
Witness name — Complete address — Telephone no.

. Persons interested in these proceedings are:

| NAME | RELATIONSHIP | ADDRESS | TELEPHONE |
|---|---|---|---|
| Mary Doe | Spouse | 1020 Bay Drive, Flint, MI | 343-4444 |
| | Guardian | | |
| Charles Doe | Son | 1113 Elm Street, Flint, MI | 345-9507 |
| | | | |

6. The subject of this petition/application ☐ is ☒ is not a Veteran.

7. I therefore request that the subject of this petition be determined by the Court to be a person requiring treatment and that until the hearing the individual be hospitalized.

I declare under penalty of contempt of court that this petition has been examined by me and that its contents are true to the best of my information, knowledge and belief.

December 1, 1986
Date

Signature

Attorney name — Bar no.

1020 Bay Drive
Address

Address

Flint, MI 48502
City, state, zip

City, state, zip — Telephone no.

343-4444 — None
Home telephone no. — Work telephone no.

This petition is accompanied by
☒ Certificate of Physician.
☐ Certificate of Psychiatrist.
☐ Petition for examination.

FOR HOSPITAL USE ONLY: This application for admission was filed with the hospital on December 1, 1986 (Date) at 12:30 p.m. (Time)

Dorothy A. Gerrity
Signature of hospital representative

Approved by the Michigan State Court Administrator and the Department of Mental Health

JDC CODE:

| STATE OF MICHIGAN PROBATE COURT COUNTY OF Genesee | PETITION AND ORDER FOR EXAMINATION | FILE NO. |
|---|---|---|

In the matter of JOHN DOE

1. I represent that I executed the attached petition/application and:
   - ☐ there is attached a certificate, and I request that the court order the individual to be examined by a psychiat
   - ☑ no certificate is attached and no examination could be secured, although reasonable effort was made, beca
     - ☑ subject of the petition refused to be examined.
     - ☐ other reason: ______

2. I request that the court order the individual to be examined.

I declare, under penalty of contempt of court, that this petition has been examined by me and that its contents are to the best of my information, knowledge and belief.

December 1, 1986
Date

[signature]
Signature

## ORDER

THE COURT FINDS that:

1. The application/petition is reasonable and is in full compliance with section 424 of the Mental Health Code.
2. A reasonable effort was made to secure an examination.
3. ☑ The individual will not comply with an order of examination.

IT IS ORDERED that:

4. The individual be examined at Ypsilanti Psychiatric Hospital
5. ☑ A peace officer take the individual into protective custody and transport him/her immediately to the ind place of examination provided that the individual be presented for examination by December 1, 1986 which is within 10 days of the date of execution of the petition/application.

December 1, 1986
Date

[signature]
Probate Judge
Donald A. Burge

Do not write below this line - For court use only

APPENDIX IV

ADMISSION BY MEDICAL CERTIFICATION:

1. A properly completed application by a peace officer.

| STATE OF MICHIGAN<br>PROBATE COURT<br>COUNTY OF Genesee | PETITION/APPLICATION<br>FOR HOSPITALIZATION | FILE NO. |
|---|---|---|

In the matter of John Doe Social Security Number: 123-45-6789

1. Frederick Taylor (Name), an adult, make this petition/application as peace officer (Relative, neighbor, peace officer, etc.).

2. The alleged mentally ill person who is the subject of this petition was born 1-1-38 (Date), lives in Genesee County at 1020 Bay (Street address) Flint (City) MI (State) 48502 (Zip)

and can presently be found at: 1020 Bay (Street address) Flint (City) MI (State) 48502 (Zip).

3. The subject of this petition is mentally ill, and:

a. as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or another person, and has engaged in an act or acts or made significant threats that are substantially supportive of the expectation;

and/or

b. as a result of that mental illness is unable to attend to those personal basic physical needs such as food, clothing, or shelter that must be attended to in order to avoid serious harm to self in the near future, and has demonstrated that by failing to attend to those basic physical needs;

and/or

c. his/her judgment is so impaired that (s)he is unable to understand the need for treatment and his/her continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to self or others.

4. This conclusion is based upon:

a. My personal observation of the person doing the following acts and saying the following things:

I was called to the home of the above named individual at 1020 Bay because he said that there were six members of the Mafia outside of his home and that they were preparing to rush the house and break in and kill him and his wife. When I arrived at his home, he repeatedly kept pointing to members of the gang on his lawn, but I could see no one. When I told him that I could see no one, he became angry and tried to get my gun. At first he said he was going to shoot me but then he said he was going to shoot himself.

; and/or

(PLEASE SEE OTHER SIDE)

Do not write below - For court use only

b. Conduct and statements I have been informed that others have seen or heard:

His wife reports that he has not left the house for five weeks to go to work or for any other reason because he believes the Mafia are watching him and are going to kill him.

By: Mary Doe — 1020 Bay Flint, MI — 343-444
Witness name — Complete address — Telephone no.

By:
Witness name — Complete address — Telephone no.

5. Persons interested in these proceedings are:

| NAME | RELATIONSHIP | ADDRESS | TELEPHONE |
|---|---|---|---|
| Mary Doe | Spouse | 1020 Bay, Flint, MI | 343-4444 |
| | Guardian | | |
| | | | |
| | | | |

6. The subject of this petition/application ☐ is ☐ is not a Veteran.

. I therefore request that the subject of this petition be determined by the Court to be a person requiring treatment and that until the hearing the individual be hospitalized.

declare under penalty of contempt of court that this petition has been examined by me and that its contents are true o the best of my information, knowledge and belief.

ecember 1, 1986
ate

Signature: Frederick Taylor
Flint Police Department, 310 E. Fifth
Address
Flint, MI 48502
City, state, zip
385-8241
Home telephone no. — Work telephone no.

ttorney name — Bar no.

ddress

ty, state, zip — Telephone no.

his petition is accompanied by ☐ Certificate of Physician. ☐ Certificate of Psychiatrist. ☐ Petition for examination.

FOR HOSPITAL USE ONLY: This application for admission was filed with the hospital on December 1, 1986 (Date) at 12:30 p.m. (Time)

Dorothy A. [illegible]
Signature of hospital representative

# APPENDIX V

## ADMISSION BY PETITION

Approved by the Michigan State Court Administrator
and the Department of Mental Health

JDC CODE: ORC

| STATE OF MICHIGAN<br>PROBATE COURT<br>COUNTY OF Genesee | ORDER FOR IMMEDIATE ADMISSION AND TRANSPORT TO HOSPITAL OR FACILITY | FILE NO. |
|---|---|---|

In the matter of John Doe

1. Date of ~~Hearing~~ December 1, 1986 Judge of Probate: John Smith

2. A petition has been filed alleging that the above named individual is a person requiring treatment or a person meeting the criteria for judicial admission, and requesting that the person be admitted to a hospital or a facility.

3. It appears to the court that the subject of the petition requires immediate ☒ hospitalization ☒ admission to a facility to prevent physical harm to self or others for the following reasons: see attached petition

IT IS ORDERED that:

4. The above named individual be immediately admitted to Ypsilanti Psychiatric Hospital
Name of hospital or facility
pending a preliminary or full hearing.

5. ☒ A peace officer take the above named individual into protective custody and transport him or her to the hospital or facility named above.

NOTE: If the individual is not found within 30 (thirty) days of this order, this order shall be void and of no effect.

December 1, 1986
Date

[signature]
Probate Judge

Do not write below this line - For court use only

Approved by the Michigan State Court Administrator
and the Department of Mental Health

JDC CODE:

| STATE OF MICHIGAN<br>PROBATE COURT<br>COUNTY OF Genesee | PETITION AND ORDER<br>FOR EXAMINATION | FILE NO. |
|---|---|---|

In the matter of JOHN DOE

1. I represent that I executed the attached petition/application and:
   - ☐ there is attached a certificate, and I request that the court order the individual to be examined by a psychiat
   - ☒ no certificate is attached and no examination could be secured, although reasonable effort was made, becs
     - ☒ subject of the petition refused to be examined.
     - ☐ other reason: ______

2. I request that the court order the individual to be examined.

I declare, under penalty of contempt of court, that this petition has been examined by me and that its contents are to the best of my information, knowledge and belief.

December 1, 1986
Date

Signature

## ORDER

THE COURT FINDS that:

1. The application/petition is reasonable and is in full compliance with section 424 of the Mental Health Code.
2. A reasonable effort was made to secure an examination.
3. ☒ The individual will not comply with an order of examination.

IT IS ORDERED that:

4. The individual be examined at Ypsilanti Psychiatric Hospital
5. ☒ A peace officer take the individual into protective custody and transport him/her immediately to the ind place of examination provided that the individual be presented for examination by December 1, 1986 (Date) which is within 10 days of the date of execution of the petition/application.

December 1, 1986
Date

Probate Judge
Donald A. Burge

Do not write below this line - For court use only

| STATE OF MICHIGAN PROBATE COURT COUNTY OF Genesee | PETITION/APPLICATION FOR HOSPITALIZATION | FILE NO. |
|---|---|---|

the matter of John Doe Social Security Number: 123-45-6789

Mary Doe, an adult, make this petition/application as wife.
Name (Relative, neighbor, peace officer, etc.)

The alleged mentally ill person who is the subject of this petition was born 1-1-38 (Date), lives in Genesee County at 1020 Bay Drive (Street address) Flint (City) MI (State) 48502 (Zip)

and can presently be found at: 1020 Bay Drive (Street address) Flint (City) MI (State) 48502 (Zip).

The subject of this petition is mentally ill, and:

(a) as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or another person, and has engaged in an act or acts or made significant threats that are substantially supportive of the expectation;

and/or

b. as a result of that mental illness is unable to attend to those personal basic physical needs such as food, clothing, or shelter that must be attended to in order to avoid serious harm to self in the near future, and has demonstrated that by failing to attend to those basic physical needs;

and/or

(c.) his/her judgment is so impaired that (s)he is unable to understand the need for treatment and his/her continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to self or others.

This conclusion is based upon:

a. My personal observation of the person doing the following acts and saying the following things:

His conversation makes no sense. He may begin to talk about one thing and in the middle of a sentence he starts to talk about something else. He claims the Mafia is after him because he has 58 million dollars in a Swiss bank that he stole from them. In reality, he has never had more than a few hundred dollars in his possession at one time. He has on 3 occasions this past week hit me causing bruises and a bloody nose because he thinks I am helping the Mafia to get him. He said he would kill himself before the Mafia could get him. He is so afraid the Mafia is watching our house that he has not gone to work for the last five weeks.

; and/or

(PLEASE SEE OTHER SIDE)

Do not write below - For court use only

b. Conduct and statements I have been informed that others have seen or heard:

I saw John Doe coming running out of the house with a .38 revolver in his hand, hollering "I know you're out there watching me. Come on out and I'll shoot you. You'll never take me alive." There was no one near the house at the time.

By: Dorothy Smith — 1024 Bay Drive, Flint, MI — 343-5555
Witness name — Complete address — Telephone no.

By:
Witness name — Complete address — Telephone no.

5. Persons interested in these proceedings are:

| NAME | RELATIONSHIP | ADDRESS | TELEPHONE |
|---|---|---|---|
| Mary Doe | Spouse | 1020 Bay Drive, Flint, MI | 343-4444 |
| | Guardian | | |
| Charles Doe | Son | 1113 Elm Street, Flint, MI | 345-9507 |
| | | | |

6. The subject of this petition/application ☐ is ☒ is not a Veteran.

7. I therefore request that the subject of this petition be determined by the Court to be a person requiring treatment and that until the hearing the individual be hospitalized.

I declare under penalty of contempt of court that this petition has been examined by me and that its contents are true to the best of my information, knowledge and belief.

December 1, 1986
Date

Attorney name — Bar no.

Address

City, state, zip — Telephone no.

Signature

1020 Bay Drive
Address

Flint, MI 48502
City, state, zip

343-4444 — None
Home telephone no. — Work telephone no.

This petition is accompanied by ☒ Certificate of Physician.
☐ Certificate of Psychiatrist.
☐ Petition for examination.

FOR HOSPITAL USE ONLY: This application for admission was filed with the hospital on December 1, 1986 (Date) at 12:30 p.m. (Time)

Dorothy A. Gevirtz
Signature of hospital representative

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