ARIZONA'S MENTAL HEALTH SERVICES ACT: AN OVERVIEW AND AN ANALYSIS OF PROPOSED AMENDMENTS

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INTRODUCTION

In 1971, the *Arizona Law Review* published a special project issue consisting exclusively of a comprehensive examination of the administration of psychiatric justice in Arizona.[1] The project examined in detail the 1958 version of Arizona's mental health law,[2] seriously criticized the law and its application, and made a number of recommendations for reform.

Because the 1971 study, and the publicity it generated,[3] sparked the interest of key legislators, the Arizona legislature responded by enacting, in 1974, the Mental Health Services Act,[4] a complete revision of Arizona statutory law regarding the civil commitment of the mentally disordered. The Mental Health Services Act is a progressive piece of legislation that is generally working well. Yet, it has its share of critics.

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1. *Special Project—The Administration of Psychiatric Justice: Theory and Practice in Arizona,* 13 ARIZ. L. REV. 1 (1971) [hereinafter cited as *Special Project*].

2. Act of Mar. 18, 1958, ch. 84, §§ 36-501 to -526, [1958] Ariz. Sess. Laws 158 (repealed 1974).

3. In large measure the project appears responsible for the content and passage of the Mental Health Services Act, ch. 185, § 2, [1974] Ariz. Sess. Laws 969 (codified at ARIZ. REV. STAT. ANN. §§ 36-501 to -548 (1974)). In 1972, the project received the American Psychiatric Association's Manfred S. Guttmacher Forensic Psychiatry Award. Arizona Daily Star, May 4, 1972, § A, at 13, col. 6. Don Bolles, the investigative reporter whose car-bomb death attracted national attention, published a two-part series discussing the project's findings. The Arizona Republic, Nov. 7, 1971, at 1, col. 4; *id.*, Nov. 8, 1971, at 19, col. 4.

4. Ch. 185, § 2, [1974] Ariz. Sess. Laws 969 (codified at ARIZ. REV. STAT. ANN. §§ 36-501 to -548 (1974)).

Some of its critics are disturbed over the rather stringent safeguards against commitment in the 1974 law.[5] Many of those critics, however, lack knowledge or appreciation of the extreme laxity of the "old" law and of the accompanying serious human rights problems that the Mental Health Services Act was designed to overcome. When assessed alongside the prior legal situation, many objections to the 1974 law evaporate.

Nonetheless, there is another category of critics—largely the recipients of the legislation's unforeseen or unintended effects—whose opposition to the Act is not so easily muted. Some of those critics, together with an occasional original opponent of the law, have advocated changes in the law that respond to their specific interests.[6]

With minor exceptions,[7] however, the concept of piecemeal amendment to the Mental Health Services Act has been rejected. Instead, as a prelude to a hoped-for single legislative effort, the Arizona Department of Health Services commissioned a comprehensive state-wide survey of the Act's effects.[8] The commissioned study was conducted during 1976,[9] and, with the authors' involvement in the study and its aftermath, the project's findings and recommendations have been shaped into specific proposals for legislative reform.[10] Principally, the proposed changes address pragmatic considerations noted in the functioning—or, rather, occasional malfunctioning—of the Act. To a certain extent, however, proposals deal also with refinements deemed appropriate to keep Arizona's Mental Health Services

5. *See Hearings Regarding Mental Health Act* (1976) (vols. 1-4 corresponding to cities in which hearings held) [hereinafter cited as *1976 Hearings*]; K. Hegland & D. Wexler, Report on the Mental Health Services Act 119-26 app. B (Aug. 4, 1976) (unpublished report in University of Arizona Law School Library) [hereinafter cited as Report].

6. *See 1976 Hearings* (Phoenix, Ariz. May 26), *supra* note 5, at 13-18.

7. The amendment pertaining to evaluation agencies and the additional statute pertaining to representation of the petitioner are the only changes in the Mental Health Services Act enacted thus far. Ch. 171, §§ 13, 14, [1976] Ariz. Sess. Laws 848-51 (codified at ARIZ. REV. STAT. ANN. §§ 36-501(8), 36-503.01 (Supp. 1976-77)).

8. See discussion note 9 *infra*.

9. During the spring semester, 1975-76, Professor Wexler and the students in his Law and Psychiatry Seminar identified many mental health law problems in Arizona and elsewhere, and the students prepared detailed papers on the problems. After the close of classes, Professors Hegland and Wexler arranged for four public hearings to receive input on the functioning of the 1974 Mental Health Services Act. Professor Hegland and law students Constance Trecartin, Edward Wong, and Mary Wisdom investigated the Act's functioning in all Arizona counties. Finally, a report was prepared synthesizing the findings and making legislative recommendations. Those recommendations formed the basis of discussion and review by Professor Shuman (then an Assistant Attorney General) and other interested legal and mental health professionals. The ultimate product of this entire process was H.R. 2326, 33d Legis., 1st Reg. Sess. (introduced Feb. 16, 1977), a bill based almost entirely on the 1976 study, together with some changes recommended by Professor Shuman. *See* discussion note 10 *infra*.

10. H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess. (introduced Feb. 16, 1977). The bill was an outgrowth of the study's recommendations as further refined by the Department of Health Services in joint meetings with representatives of the Arizona Psychiatric Society, Arizona Council of Mental Health Centers, Arizona State Association of Social Workers, Arizona League of Cities and Towns, Maricopa Legal Aid Society, Maricopa County Public Fiduciary, Arizona State Hospital, University of Arizona College of Law, State Senate, Central Arizona Health Systems Agency, Arizona Association of Counties, and the Attorney General of Arizona.

Editor's Note: Although H.R. 2326 was not enacted, *see* text & notes 112-113 *infra*, a similar bill is currently before the legislature. H.R. 2096, 33d Ariz. Legis., 2nd Reg. Sess. (introduced Jan. 12, 1978).

Act consistent with emerging case law defining the constitutional rights of the mentally disordered.[11]

The present Article was prepared to serve several objectives. First, the piece explains the major provisions of the Mental Health Services Act, an important piece of legislation not yet comprehensively discussed in the literature.[12] This task is accomplished by describing the Act against the backdrop of the previous law's defects revealed by the 1971 special project.

The second, and most important, objective of the article is to assess the functioning of the 1974 Mental Health Services Act, to pinpoint and discuss problems in its scope and operation, and to examine an array of proposed amendments designed to smooth some of the Act's rough edges. In the course of the examination of the proposed Arizona amendments, comparative reference will be made to provisions of the Mental Health Legislative Guide, the product of a mammoth undertaking by the Mental Health Law Project to prepare a model mental health act.[13] The Guide promises to be a highly influential document which will be consulted often by officials engaged in the legislative revamping of state mental health statutes.

THE 1971 PROJECT AND THE 1974 ACT

In 1970-1971, sixteen law students, working under the guidence of Professor David B. Wexler, conducted extensive library and field research on the workings of Arizona's mental health laws.[14] The field research consisted of interviews with judges, lawyers, physicians and other mental health professionals in each of Arizona's fourteen counties, observation of commitment hearings in Pima and Maricopa Counties, review of court files, and visits to facilities used for the confinement or care of the mentally ill.[15] Subsequently, with assistance from persons trained in psychiatry, psychology, sociology, and philosophy, the effort was synthesized in the publication of a 259-page special project entitled *The Administration of Psychiatric Justice: Theory and Practice in Arizona*.[16]

The publication began with a chilling but true tale worthy of Edgar Allen Poe's imaginative skills. A project participant reviewing court files in Greenlee County had discovered a 1912 commitment petition alleging that a

11. *See* text & notes 175-86 *infra*. *See generally Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974) [hereinafter cited as *Developments in the Law*].

12. The "post-commitment rights" provisions of the Act have been discussed in Note, *Protection Following Commitment: Enforcing the Rights of Persons Confined in Arizona Mental Health Facilities*, 17 ARIZ. L. REV. 1090 (1975).

13. *See* 2 MENTAL DISABILITY L. REP. 127 (1977) for the civil commitment section of the guide. The Mental Health Legislative Guide was prepared by the Mental Health Law Project under a cost sharing contract with the National Institute of Mental Health. The Mental Health Law Project is a private entity co-sponsored by the American Orthopsychiatric Association, the Center for Law and Social Policy, and the American Civil Liberties Union Foundation.

14. *Special Project*, *supra* note 1, at 3.

15. *Id.*

16. 13 ARIZ. L. REV. 1 (1971).

young woman suffered from a mental illness evidenced by "a tendency to laugh and cry" and by a desire to dance.[17] The illness was supposedly caused by "bathing in cold water at menstrual period."[18] The truly frightening fact of the incident is that the next document in the file is an order, dated May 26, 1969, permitting the Arizona State Hospital to apply some of the patient's funds toward the cost of her ongoing involuntary confinement. Rather than merely reciting such horror stories, however, the project identified specific flaws in Arizona's statutory scheme and its application to the commitment of the mentally ill.[19]

The 1971 project noted that then-existing law did not require commitment petitions to be screened by a mental health agency before being filed in court.[20] A petition for commitment was simply presented to a judge. If the petition was approved by the judge, a detention order would issue authorizing the deputy sheriff to apprehend and confine the subject. Even in the absence of an alleged emergency situation, no independent verification of the allegations in the petition was required prior to a deprivation of liberty.

A process of prepetition screening should involve, at a minimum, a review of the petition by a mental health professional and an interview, by that professional, of the petitioner. During the interview, information about pertinent community resources available as an alternative to commitment should be communicated to the petitioner, and the facts supporting the petition should be discussed. Frequently, the proposed patient can also be consulted. Through the practice of prepetition screening, inappropriate invocation of the commitment process is substantially reduced prior to a deprivation of liberty. In response to the deficiency in the old law, the 1974 Act requires screening, if at all possible, in nonemergency situations.[21]

In another area related to the absence of prepetition screening, the project's review of court files found a high incidence of conclusory petitions upon which detention orders had been issued.[22] When a detention order issued in response to a petition for civil commitment filed without prepetition screening, the judge relied, without independent factual verification, upon the allegations of a person whose credibility had not been evidenced and whose conclusory statement thwarted independent judicial scrutiny of the petition's factual and legal sufficiency.[23] This delegation of the judicial power to determine that the statutory standards for detention were met raised serious constitutional problems.[24] The 1974 Act's requirement of prepetition

17. *Special Project*, *supra* note 1, at 2.
18. *Id.*
19. The statutory scheme for civil commitment of the mentally ill in effect during 1971 and examined by the project was primarily the result of legislation passed in 1958. Act of March 18, 1958, ch. 84, § 1, [1958] Ariz. Sess. Laws 158 (repealed 1974).
20. *Special Project*, *supra* note 1, at 17-18.
21. ARIZ. REV. STAT. ANN. §§ 36-520 to -521 (1974).
22. *Special Project*, *supra* note 1, at 18.
23. *Id.*
24. *Id.* at 19.

screening and its specfic enumeration of factual items which must be included in the petition seek to correct the deficiencies noted in 1971.[25]

Under the statutory scheme examined by the project, once a detention order was issued and executed, no limit was placed upon the duration of confinement prior to a commitment hearing.[26] Moreover, no statutory or constitutional provision expressly conferred a right to a speedy hearing.[27] Coupled with the absence of prepetition screening and conclusory petitions, this deficiency aggravated the consequences of a legally insufficient petition upon which a detention order was issued. In sharp contrast to the law it replaced, the 1974 statutory scheme contains obligatory time requirements. As an example, within three to seven days after a petition for court-ordered treatment is filed, a full hearing must be conducted.[28]

The project also found in some counties that, once a detention order was issued, patients were detained pending hearing in the local county jail.[29] This practice was believed capable of producing serious deleterious consequences for an already disturbed person.[30] The 1974 law, on the other hand, provides that an inpatient evaluation shall occur at an "evaluation agency,"[31] which is defined as "a health care agency licensed by the department."[32] The statute thus prohibits prehearing detention in the local county jail and assigns licensure responsibility for permissible detention facilities to the same agency charged with licensure of health care institutions generally.[33] The 1974 Act therefore avoids the potential adverse effects of jail detention, and is certainly more consistent with the philosophy of commitment than was prior practice.[34]

Although Arizona has long provided a statutory right to counsel in commitment proceedings,[35] the project found substantial evidence indicat-

25. Under ARIZ. REV. STAT. ANN. § 36-523(A)(4) (1974), a petition for court-ordered evaluation may be accompanied by a prepetition screening report and, in any case, must contain a statement of the "facts upon which the allegations [of the petition] are based, including statements by the individual applying for the petition of the specific nature of the danger or grave disability." *Id.*

26. *Special Project*, *supra* note 1, at 23.

27. *Id.* at 31. During the year following the project, Professors Andrew Silverman and David Wexler, along with student Daniel Shuman, all of the University of Arizona College of Law, served as court-appointed counsel representing indigent persons involved in involuntary commitment proceedings in Pima County. It was then discovered that one local hospital often failed to notify the court of the need to schedule a hearing and thereby kept patients until the hospital determined they were appropriate candidates for release. Immediately after this discovery, the authors instituted frequent telephonic census checks of each local psychiatric ward's involuntary residents.

28. ARIZ. REV. STAT. ANN. §§ 36-535, -536 (1974). In addition, within twenty-four hours of an emergency admission, a petition for a court-ordered evaluation must be filed, or the patient must be released or converted to voluntary status. *Id.* § 36-527(A). Similarly, within 72 hours of the commencement of an inpatient evaluation, a petition for court-ordered treatment must be filed, or the patient must be released or converted to voluntary status. *Id.* § 36-531(A).

29. *Special Project*, *supra* note 1, at 27-28.

30. *Id.* at 29.

31. ARIZ. REV. STAT. ANN. § 36-529(B) (1974).

32. *Id.* § 36-501(9).

33. *See id.* §§ 36-401 to -491.07 (Supp. 1977-78).

34. *See Special Project*, *supra* note 1, at 29.

35. As early as 1928, Arizona law provided:

ing that counsel was often ineffective.[36] Frequently selected on the day of the hearing, the appointed attorney often had little familiarity with relevant law, psychiatry, or placement alternatives.[37] Additionally, counsel seldom objected to testimony or vigorously cross examined adverse witnesses.[38] Most disconcerting, the project observed instances when the patient's attorney actually assisted the court in adducing the evidence necessary to commit his client.[39]

To remedy this shocking deficiency, the project recommended the following:

> Effective representation requires at least the following activities on the part of counsel. The attorney should make a thorough study of the facts of the case, which should include court records, hospital records, and information available from social agencies. Communication with the patient is, in the ordinary case, a must. Where such communication is impossible for medical reasons, the family and friends of the patient should be contacted to ascertain the true facts behind the petition. It is essential that the attorney have a full understanding of the events preceding the filing of the petition. An investigation of the financial condition of the patient and his family—including hospitalization insurance—is necessary to determine if certain alternatives to hospitalization should be explored. Finally, the attorney should explore the treatment and custodial resources of the community. He should understand the various services offered by social agencies and the

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> The judge of the superior court, upon complaint under oath, setting forth that a person by reason of insanity is dangerous being at large, shall cause such person to be brought before him for hearing and examination, and in open court, inform him of the charge and of his rights to make a defense thereto, to secure witnesses and be represented by counsel. *If no counsel appear for such person, the court shall appoint counsel to represent him.*

Ariz. Rev. Code § 1769 (1928) (emphasis added).

36. *See Special Project*, *supra* note 1, at 51-60.

37. *Id.* at 52; *see 1976 Hearings* (Tucson, Ariz., May 18), *supra* note 5, at 5-7.

38. *Special Project*, *supra* note 1, at 52.

39. *Id.* at 53. Often the patient's attorney would, without more, ask the complaining witnesses if the petition against his client was true. *Id.* n.170. Thereafter, the attorney would ask these same questions of the lay witness. *Id.* On one particular occasion the attorney asked to be sworn and then testified that during their interview, the patient attempted to hit him. *Id.* n.172.

Another disturbing aspect of the system examined in 1971 was that the patient's presence at the hearing was occasionally waived by appointed counsel who had never met his client, let alone discussed with him the question of waiver of his presence at hearing. *Id.* at 73-74. Without prior investigation of the case or the client's presence at the hearing, little possibility existed that the patient's perspective would be presented. Moreover, the project discovered the very real possibility that, even when a patient's presence was not waived, the patient would be medicated to the extent of being physically unable to articulate relevant facts bearing upon either the veracity of the petition or the alternatives to commitment. *Id.* at 68. The 1974 Act responds to these problems by requiring the patient's presence at the hearing unless the court finds, upon clear and convincing evidence, that the patient is unable, for medical reasons, to be present and that the hearing cannot be conducted where the patient is. ARIZ. REV. STAT. ANN. § 36-539(B),(C) (1974). Medication is to be adjusted so as not to hamper the patient's participation in the hearing and the court must be given a record of "all drugs, medication or other treatment which the person has received during the seventy-two hours immediately prior to the hearing." *Id.* § 36-539(A).

> avenues by which these resources can be applied to meet the needs of his client as alternatives to involuntary commitment.
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> The attorney has a responsibility to consult with the examining physicians concerning the medical history of the patient, the diagnosis, the proposed treatment and the prognosis. While the lawyer is not expected to have a thorough understanding of psychiatry, he can insist that the doctor use lay language in explaining the patient's condition, and in giving reasons for his recommendations concerning the criteria for commitment.[40]

The 1974 Act responds to this recommendation by an unprecedented legislative articulation of minimum duties of counsel representing a patient in a proceeding for court-ordered treatment.[41] Compliance with these minimal duties is encouraged through the threat of a contempt citation for the attorney who fails to fulfill the duties.[42] Failure to perform those duties may well constitute per se ineffective assistance of counsel,[43] the constitutional equivalent of no counsel.[44] Because counsel is a jurisdictional requirement for commitment, noncompliance with the statutory list may void the commitment on both statutory[45] and constitutional grounds.[46]

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40. *Special Project*, *supra* note 1, at 56 (footnotes omitted).

41. ARIZ. REV. STAT. ANN. § 36-537 (1974) provides:

> A. The medical director of the agency which conducted the evaluation shall, at least seventy-two hours prior to the hearing, make available to the patient's attorney copies of the petition for evaluation, prepetition screening report, evaluation report and the patient's medical records.
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> B. The patient's attorney shall, for all hearings whether for evaluation or treatment, fulfill the following minimal duties:
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> 1. Within twenty-four hours of appointment, conduct an interview of the patient.
>
> 2. At least twenty-four hours prior to the hearing, review the petition for evaluation, prepetition screening report, evaluation report, petition for treatment and the patient's medical records.
>
> 3. At least twenty-four hours prior to the hearing, interview the petitioner, if available, and his supporting witness, if known and available.
>
> 4. At least twenty-four hours prior to the hearing, interview the physicians who will testify at the hearing, if available.
>
> 5. At the time of the hearing, submit to the court a written report on all placement alternatives for the care and treatment of the patient, stating whether they are feasible and the reasons why or why not. Failure of the attorney to fulfill at least the duties prescribed by paragraphs 1 through 5 of this subsection may be punished as contempt of court.

See also Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic and a Proposal*, 45 MISS. L.J. 43 (1974); Brunetti, *The Right to Counsel, Waiver Thereof, and Effective Assistance of Counsel in Civil Commitment Proceedings*, 29 SW. L.J. 684 (1975).

42. ARIZ. REV. STAT. ANN. § 36-537(B)(5) (1974).

43. *Cf.* State *ex rel.* Memmel v. Mundy, No. 441-417 (Milwaukee, Wisc., County Cir. Ct. Aug. 18, 1976) (passive legal representation as provided by a closed panel of attorneys held to violate the right to effective assistance of counsel of virtually all persons committed in Milwaukee County during a fifteen-month period). Borrowing from the doctrine of negligence per se, which presumes negligence upon the violation of an applicable statute establishing a standard of conduct, *see* Caldwell v. Tremper, 90 Ariz. 241, 367 P.2d 266 (1962), failure to satisfy the statutory duties designed to remedy the observed passive representation should result in a finding of ineffective assistance of counsel.

44. *See* Powell v. Alabama, 287 U.S. 45, 71 (1932).

45. *See In re* Burchett, 23 Ariz. App. 11, 530 P.2d 368 (1975), where the court of appeals, citing the special project, held that the statutory requirement for the testimony of two lay witnesses, ARIZ. REV. STAT. ANN. § 36-539(B) (1974) (original version at § 36-514(B) (1958) was jurisdictional, rendering void an order of commitment entered without compliance with the

As an inevitable consequence of the passive performance of counsel, the project found that commitment hearings were not only nonadversarial, but were also short and summary.[47] In Maricopa County, the observed hearings lasted an average of 4.7 minutes; in Pima County, the average duration was 27 minutes.[48] Coupled with passive legal representation, these terse hearings invariably resulted in judicial affirmation of the physician's conclusions. For example, an examination of cases in Pima County and Maricopa County found that the court followed the physician's recommendation in 96.1% and 97.9% of the cases, respectively.[49] These improprieties were magnified by the project's discovery that testifying physicians were often wrong in their conceptions of the applicable legal standards.[50] Without effective cross-examination or independent experts,[51] these conclusions formed the scant basis for an indefinite[52] order of confinement. While no existing statute seeks directly to establish minimum hearing lengths or to proscribe conclusory testimony by physicians, several sections of the current statutory scheme indirectly address this concern. The emphasis on preparedness of counsel,[53] on physician testimony based on a personal examination of the patient and not merely on a review of the chart or on a review of another physician's report,[54] on the availability of independent

requisite "two-witness" element. 23 Ariz. App. at 13, 530 P.2d at 370. That this deficiency renders the commitment void and not merely voidable is confirmed by the fact that in this convoluted prison-to-hospital transfer proceeding, the *Burchett* court found the commitment order void even though it was the patient who affirmatively sought to be committed to the hospital. *See id.* Certainly, effective counsel is the most critical right in these proceedings, for counsel is necessary to ensure that all other appropriate protections are observed. Therefore, if counsel is ineffective, the most elemental jurisdictional requisite is absent, rendering void any order for involuntary treatment.

46. *See, e.g.*, Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976); Coll v. Hyland, 411 F. Supp. 905 (D.N.J. 1976); Suzuki v. Quisenberry, 411 F. Supp. 1113 (D. Hawaii 1976); Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378, 389 (M.D. Ala. 1974); Bell v. Wayne County Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974); Lessard v. Schmidt, 349 F. Supp. 1078, 1097-1100 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1973), *modified on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), *aff'd on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976); Logan v. Arafeh, 346 F. Supp. 1265 (D. Conn. 1972), *aff'd sub nom.* Briggs v. Arafeh, 411 U.S. 911 (1973).

47. *Special Project*, *supra* note 1, at 53-54.

48. *Id.* at 42.

49. *Id.* at 60.

50. *See id.* at 64-66. This was aptly illustrated by the response of a psychiatrist who frequently testified at hearings in Maricopa County. When asked the requirements for civil commitment, the expert stated: "As you know, Arizona follows the *M'Naughton* test of incompetency." *Id.* at 65. The *M'Naughton* rule is, of course, a test which addresses legal responsibility for the commission of a criminal act. *See* A. GOLDSTEIN, THE INSANITY DEFENSE 111, 112n.8 (1967). Moreover, "incompetency" was itself not the appropriate criterion for commitment.

51. The statutory scheme examined by the project failed to provide for the appointment of independent expert witnesses for the patient. Given the recognized variance in psychiatric diagnosis, *see* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974), and the weight given expert testimony by the court, such independent testimony would be imperative in the effective representation of a patient. The 1974 Act provides for the right to an independent evaluator. ARIZ. REV. STAT. ANN. § 36-538 (1974).

52. *See* text & notes 74-78 *infra*.

53. ARIZ. REV. STAT. ANN. § 36-537 (1974).

54. *Id.* § 36-539(B).

evaluators,[55] and on the obligatory stenographic transcription of the hearing,[56] all indirectly seek to make the hearing a meaningful opportunity for the court to determine, based upon all the available facts, whether the person meets the relevant statutory criteria.[57]

Another problematic area noted by the project was the statutory standard for commitment—that the proposed patient is mentally ill to such a degree that he is in danger of injuring himself or the person or property of others if permitted to remain at liberty[58]—and its application in Arizona.[59] The project concluded that, apparently because of psychiatric inability to predict accurately future dangerous behavior, psychiatric evaluations tend toward overprediction of dangerousness.[60] The project suggested basing predictions of dangerousness upon a recent overt act, since a prior act is a logical, if not a constitutional, prerequisite to a prediction of dangerousness likely to lead to a deprivation of liberty.[61]

The 1958 Act also failed to define dangerousness with much particularity; it gave no indication of whether the danger contemplated need be imminent or merely remote, life threatening or only trivial. A detailed review of the manner in which dangerousness was defined in each county's superior court found wide variances throughout the state. The project found rural counties which, prompted by such factors as lack of expertise in predicting dangerousness, local intolerance of deviant behavior, and the absence of local treatment alternatives, ignored dangerousness, and instead substituted an "in need of treatment" standard.[62] Even when the court focused on the dangerousness criterion for commitment, it was observed "that many individuals are committed who are really not dangerous by any commonsense definition of the term. The project found that the decision to commit is commonly viewed as an undesirable—yet available—solution to human behavior problems."[63]

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55. *Id.* § 36-538.

56. *Id.* § 36-539(E). The absence of obligatory stenographic transcription was criticized by the project as hampering ongoing judicial review of an order of commitment. *See Special Project, supra* note 1, at 38 n.146.

57. Interestingly, a post-1974 amendment may ultimately precipitate the greatest change in the hearing process. Until 1976, no requirement existed for legal representation of the petitioner. That resulted in the court functioning both as judge and as prosecuting attorney. The hybrid role of the commitment court not only placed the judge in an awkward position, but also put the patient's attorney in an uncomfortable situation, since the latter's objection to the judge's examination of witnesses would be ruled on by the judge. This anomalous situation is corrected by requiring the county attorney or attorney general to represent the petitioner. ARIZ. REV. STAT. ANN. § 36-503.01 (Supp. 1976-77). This more traditional, adversarial framework may also assist the patient's counsel in sharpening his legal focus and role by substituting the county attorney as the proposed patient's "opponent" in place of the judge.

58. Act of March 18, 1958, ch. 84, § 1, [1958] Ariz. Sess. Laws 158 (repealed 1974).

59. *See Special Project, supra* note 1, at 100-17.

60. *See id.* at 96-97,98 n.352. *See also* Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 84 (1968).

61. *See Special Project, supra* note 1, at 99-100.

62. *Id.* at 100.

63. *Id.* at 111 (footnote omitted).

In response to the unearthed problems relating to the definition—or nondefinition—of dangerousness, a finding of "dangerous to others" under the 1974 Act must be predicated upon a recent overt act.[64] The requirement of a recent overt act does not, however, exist as a predicate to a finding of "danger to self."[65] The possibility, under the 1958 law, of commitment based upon danger to property was deleted from the statutory scheme.[66] In addition, the requisite degree of dangerousness was partially clarified by addition of the requirement that it be a "danger of inflicting substantial bodily harm" upon oneself or another.[67]

Under the procedures defined by the 1958 Act, once the court determined that the statutory standards for commitment were satisfied, it was empowered to commit the patient for inpatient psychiatric hospitalization regardless of the efficacy of treatment alternatives other than hospitalization.[68] The project noted that this failure of the statutory scheme to require consideration of alternatives less drastic than hospitalization not only raised serious constitutional questions,[69] but also probably resulted in more costly and less effective treatment.[70] The 1974 Act precludes involuntary commitment to a mental health treatment agency[71] if a "suitable alternative treatment" exists.[72] Moreover, even if no "suitable alternative exists," the patient must, unless presently in the state hospital, be hospitalized locally when the possibility of beneficial local treatment exists.[73]

In 1971, Arizona law provided for indefinite orders of confinement.[74] Moreover, no mandatory institutional or judicial review of ongoing confinement occurred with any fixed frequency. The possibility of a patient becoming forever lost in the back wards of a large public institution—such as the laughing lady from Greenlee County committed in 1912[75]—was thereby fostered by the system. Concomitantly, if the patient were successful in securing judicial review, the hospital would not bear the burden of proving that the patient continued to meet the standards for commitment; rather, the

64. ARIZ. REV. STAT. ANN. § 36-501(3) (1974).
65. *Id.* § 36-501; *see* text & notes 150-54 *infra*.
66. *Id.* § 36-540. This section limits court-ordered treatment to instances of danger to self or others. The exclusion of danger to property as a ground for commitment is consistent with recent trends in other jurisdictions. *See* Suzuki v. Yuen, 46 U.S.L.W. 2076 (D. Hawaii 1977) (holding that dangerousness to property is not a constitutionally valid basis for involuntary confinement); *Developments in the Law*, *supra* note 11, at 1205.
67. ARIZ. REV. STAT. ANN. § 36-501(3),(4) (1974). See also text & notes 123-35 *infra* for a discussion of proposals for further clarification of dangerousness.
68. Act of March 18, 1958, ch. 84, § 1, [1958] Ariz. Sess. Laws 158 (repealed 1974).
69. For a discussion of the due process and equal protection problems of the prior statutory scheme, see *Special Project*, *supra* note 1, at 140-46.
70. *Id.* at 146.
71. ARIZ. REV. STAT. ANN. § 36-501(19) (1974). This section defines "mental health treatment agency" as either the state hospital or a licensed health care agency approved for provision of treatment to civilly committed persons.
72. *See id.* § 36-540(A)-(D).
73. *See id.* § 36-541.
74. Act of March 18, 1958, ch. 84, § 1, [1958] Ariz. Sess. Laws 170 (repealed 1974).
75. *Special Project*, *supra* note 1, at 1-3. The "laughing lady" is discussed also at text & notes 17-18 *supra*.

patient bore the burden of proving that he no longer met the applicable standards.

These procedures were changed in 1974. Orders for hospitalization are now limited to a maximum of 180 days.[76] To continue involuntary hospitalization beyond the maximum period, new hearings must be conducted, at which all the requirements of the initial hearing must again be satisfied.[77] And, during the 180 day period, the patient is entitled to seek judicial review of his ongoing confinement, a right of which he must be specifically informed by the medical director of the treatment facility.[78]

The 1958 statutory scheme examined by the project provided for the possibility of an adjudication of civil incompetency as an adjunct to the order of commitment.[79] In practice, this resulted in confusion over applicable definitions and, in some counties, virtual equation of incompetency with commitment.[80] To remedy the problem, initial determinations of civil incompetency are now generally removed from the commitment hearing by the 1974 Act's specific statement that court-ordered evaluation or treatment is not a determination of incompetency.[81]

Once a patient was involuntarily hospitalized under the earlier scheme, his rights in the institution were delineated not by statute or regulation, but rather by institutional policy.[82] The legislature responded in 1974 by enumerating a panoply of patient rights in the institution pertaining to personal privacy,[83] compensation for work,[84] communication with third

76. ARIZ. REV. STAT. ANN. § 36-540 (1974). The pertinent language permits the court to "order [the patient] to undergo treatment for up to one hundred eighty days." *Id.* § 36-504(B). One hundred eighty days appears to be the maximum permissible duration of confinement, and would not prevent a judge, in an appropriate case, from ordering treatment for some lesser time.

77. *Id.* § 36-542(3). The present statute also permits involuntary confinement beyond 180 days if the director of the agency treating the patient recommends guardianship proceedings within 10 days prior to the release date. *Id.* § 36-542(a). Section 41 of H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess. (introduced Feb. 16, 1977) would delete this means of extending the duration of confinement. *See generally* Pima County Pub. Fiduciary v. Superior Court, 26 Ariz. App. 85, 87, 546 P.2d 354, 356 (1976) (use of guardian to commit ward avoids procedural requirements of mental health laws, and thus violates due process).

78. ARIZ. REV. STAT. ANN. § 36-546(B) (1974).

79. Act of March 18, 1958, ch. 84, § 1, [1958] Ariz. Sess. Laws 158 (repealed 1974). *See also Special Project, supra* note 1, at 88.

80. An examination of court files revealed that 90% of those committed in Maricopa County were simultaneously declared incompetent while only 10% of those committed in Pima County were found incompetent. *Special Project, supra* note 1, at 90.

81. ARIZ. REV. STAT. ANN. § 36-506 (1974).

82. *Special Project, supra* note 1, at 217. *See generally id.* at 206-27.

83. Ch. 185, § 2, [1974] Ariz. Sess. Laws 977-78 (codified at ARIZ. REV. STAT. ANN. § 36-507 (1974)) reads as follows:

> Every person undergoing evaluation or treatment pursuant to this chapter shall:
> 1. Not be fingerprinted except as regulations of the department may permit.
> 2. Not be photographed without consent of the person and his attorney or guardian, except that he may be photographed upon admission to an agency for identification and administrative purposes of the agency. All photographs shall be confidential and shall not be released by the agency except pursuant to court order.
> 3. Have access to individual storage space for his private use while undergoing evaluation or treatment.
> 4. Be permitted to wear his own clothing, to keep and use his own personal possessions including his toilet articles and to keep and be allowed to spend a reasonable sum of his own money for his own needs and comfort.

84. *Id.* at 979-80 (codified at § 36-510 (1974)) reads as follows:

persons,[85] and religious freedom.[86] In view of the identifiable correlation between hospital social conditions and the clinical status of patients,[87] the statutory rights granted in 1974 would appear to be desirable guides for dealing with patients in a consistent manner.

The societal decision to confine non-criminals to psychiatric hospitals is premised upon the assumption that beneficial treatment will be provided these persons.[88] In the absence of such treatment, commitment lapses into mere custodial confinement not even preceded by the procedural trappings of the criminal justice system. Yet, under Arizona's prior civil commitment scheme, any statutory right to treatment existed upon a precarious base.[89] The 1974 Act, however, requires the provision of "physical and psychiatric care and treatment for the full period [the patient] is detained."[90] Treatment must be administered pursuant to an individualized program which is to be coupled with periodic review of its effectiveness.[91]

From a legal and medical perspective, voluntary treatment is preferable to involuntary treatment.[92] When properly utilized, voluntary treatment involves a willing patient, knowledgeable of the alternatives and freely choosing to seek professional assistance. Voluntary treatment may avoid

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If a patient of the state hospital works, this work shall be in the patient's interest. If the primary purpose of this work is to benefit the state hospital or any agency of the state, the patient shall be employed and paid in accordance with law. If the purpose of the work is therapeutic, the patient may or may not be paid as circumstances indicate. This therapeutic work shall be part of a planned program of treatment described in the patient's record with the rationale for the work-treatment included. It shall be periodically reviewed by the appropriate hospital review procedures. The term "work" does not mean matters of personal housekeeping or personal maintenance.

85. *Id.* at 981-82 (codified at ARIZ. REV. STAT. ANN. § 36-514 (1974)) reads as follows:

Every person detained for evaluation or treatment pursuant to this chapter shall have the following additional rights:

1. To be visited by his personal physician, attorney and clergyman or any other person, subject to limitations as the individual in charge of the agency may direct.

2. To have reasonable access to telephones between the hours of nine a.m. and nine p.m. to make and receive confidential calls. Long distance calls shall be allowed if the patient can pay the agency for them or can properly charge them to another number. The agency may restrict the phone privileges of a patient when notified by the person receiving the calls that he is being harrassed by the calls and wishes them curtailed or halted.

3. To be furnished with reasonable amounts of stationery and postage and to be permitted to correspond by mail without censorship with any person, unless the person receiving the correspondence states that he is being harassed by the correspondence or objects to it and wishes it curtailed or halted, in which case the agency may restrict or halt the correspondence.

4. To enjoy religious freedom and the right to continue the practice of his religion in accordance with its tenets during the detainment, except that this right may not interfere with the operation of the agency.

86. *Id.*

87. *See Special Project, supra* note 1, at 207-08 (discussing Wing, *Evaluating Community Care for Schizophrenic Patients in the United Kingdom*, COMMUNITY PSYCHIATRY 138, 147-57 (Anchor ed. L. Roberts, S. Halleck & M. Loeb 1969)).

88. *Id.* at 228. *See also* Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 449 (1960).

89. *Special Project, supra* note 1, at 229 & n.64.

90. ARIZ. REV. STAT. ANN. § 36-511(A) (1974).

91. *See id.* § 36-511(B)(1), (2).

92. *See Special Project, supra* note 1, at 58-59, 59 n.188.

perplexing issues raised by involuntary hospitalization. For example, voluntary treatment casts the facility and staff in the role of healer and not jailer. It was then ironic that the 1958 statutes militated against voluntary hospitalization of the indigent by declining to provide transportation to the state hospital in the case of voluntary admissions but providing such transportation for involuntary admissions.[93] The project noted instances where a patient desiring voluntary hospitalization was required to provide for the necessary transportation to the Arizona State Hospital.[94] The effect of requiring that a potential patient be involuntarily hospitalized as a prerequisite to obtaining transportation to the hospital might be far from minimal, since an order of involuntary confinement affects not only the right to release,[95] but also the hospital staff's willingness to render care and, as a consequence, the patient's chances for improvement.[96] The procedural wrinkle in the interpretation of Arizona's prior law was, therefore, not harmless. Responding to this deficiency even prior to the comprehensive 1974 Act, the legislature enacted an amendment that required transportation to the hospital for voluntary patients at county expense.[97] The 1974 law further encourages the use of voluntary admission.[98]

In summary, the 1974 revision of Arizona's civil commitment laws responded to many of the criticisms levied against them in the *Arizona Law Review* special project. It sought to implement early screening to divert as many cases as possible from the involuntary process, to tighten procedural and substantive standards for commitment, to enumerate specific patient rights, and to encourage the use of voluntary admission and community treatment as alternatives to commitment. By any estimation, the Mental Health Services Act was an ambitious effort to design a new system for involuntary treatment of the mentally ill. On the other hand, any comprehensive statutory revision will result in initial awkwardness of administration and in the creation of some unintended problems. Moreover, the risk always exists that the carefully considered blueprint to change the system will simply not accomplish its intended function. Because of the substantial interests involved—liberty, mental health, and the protection of society from harm—the importance of ascertaining the efficacy of the newly created system was considerable.

THE 1976 STUDY

After discussions with certain legislators, the Department of Health Services commissioned a study of the present law to ascertain whether the

93. Act of March 18, 1958, ch. 84, § 1, [1958] Ariz. Sess. Laws 158 (repealed 1974).
94. *Special Project*, *supra* note 1, at 58 n.186.
95. *Id.* at 13.
96. *Id.* at 58-59.
97. Act of May 9, 1972, ch. 119, § 1, [1972] Ariz. Sess. Laws 636 (repealed 1974).
98. Ch. 185, § 2, [1974] Ariz. Sess. Laws 984 (codified at ARIZ. REV. STAT. ANN. § 36-518(C) (1974)).

1974 Act was accomplishing its desired ends and to identify any problems created by the 1974 Act. The study was conducted by Professor Kenney Hegland, with Professor David Wexler serving as a consultant, and with three law students performing substantial investigatory and research tasks.[99] Public hearings to discuss the workings of the Act were held during the summer of 1976 in Bisbee, Tucson, Flagstaff, and Phoenix.[100] Additionally, interviews were conducted in each county with individuals who worked with the Act daily. The hearings, interviews and investigations conducted in the 1976 study culminated in the issuance of the *Report on the Mental Health Services Act*.[101]

The 1976 study found that two of the Act's major goals have been reasonably effectuated; prepetition screening is working well and the decision whether to order involuntary treatment has become a more meaningful judicial determination.[102] However, the study concluded that the encouragement of local treatment alternatives, in lieu of sending patients to the Arizona State Hospital, has generally failed.[103] At the core of the failure is an unresolved question of funding and the absence of a pragmatic distribution of the responsibility for care of the mentally ill between the counties and the state.[104] Rather than seeking to present panaceas for these complex problems, and rather than having these intractable problems thwart the completion of other needed reforms, the study recommended the creation of a task force on funding and local treatment to address this specific issue. Further, no effort was made in the study to delve into effectuation of the rights of institutionalized patients. Here again, the study recommended that a task force be appointed to investigate these issues.[105]

From a statistical perspective, the Act has increased the percentage of voluntary patients and has decreased the percentage of involuntary pa-

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99. *See* Report, *supra* note 5.
100. *Id.*
101. See discussion note 9 *supra*.
102. *See* Report, *supra* note 5, at 88.
103. *See id.* at 2-6. Although Mohave County has implemented the local treatment alternative, see ARIZ. REV. STAT. ANN. § 36-541 (1974), by providing court-ordered treatment in its county hospital if hospitalization of less than 25 days is anticipated, the local treatment requirement is circumvented in virtually every other county. This circumvention is the result of either an absence of local alternatives or a failure to utilize the existing local alternatives. For example, although Coconino County has a hospital, it continues to detain violent patients in the jail pending hearing.
104. *See* Report, *supra* note 5, at 2. The county obligation to care locally for the indigent mentally ill—created by ARIZ. REV. STAT. ANN. §§ 11-291 (1974) and interpreted in Opinion No. 61-22, 1961 OP. ARIZ. ATT'Y GEN. 38 — and the state obligation to maintain the state hospital results in a fragmentation of delivery of services and economic disincentives for either entity to provide a comprehensive spectrum of mental health care.
105. Report, *supra* note 5, at 115.

tients.[106] If these statistics are fully representative of patient desires,[107] the Act succeeded in accomplishing a desirable goal.[108]

The public hearings showed that the overwhelming response to the 1974 Act was favorable.[109] Those complaints that were received were primarily directed at specific facets of the Act and not at the major policy determinations upon which it was based.[110] The important issues brought to the fore by the public hearings and interviews include absence of a workable mechanism of emergency apprehension by peace officers, confusion over the definition of the term "substantial bodily harm," use of threats as a basis for commitment, confusion over "grave disability," and concern that there are certain categories of persons who need treatment and who are not receiving it.[111] In response to these and other problems identified by the Report, proposals for amendment of the 1974 Act were drafted and incorporated into H.R. 2326,[112] a bill introduced, but not enacted, in the last legislative session.[113] The following discussion will utilize the major amendments prepared in the bill as a focal point for analysis.

Emergency Apprehension By Peace Officers

One very practical problem in the existing statutory scheme is created by the requirement that peace officers apprehend mentally disordered persons on an emergency basis only after an application for emergency admission for evaluation has been filed.[114] Uniform objection was voiced to this

106. During the fiscal year 1971, 424 persons received care at the hospital on a voluntary basis and 844 persons were civilly committed. In the fiscal year immediately preceding the effective date of the 1974 Act, 587 persons sought and received voluntary hospitalization and 596 were civilly committed. During the 1976 fiscal year, 790 persons received care at the hospital on a voluntary basis and 273 persons were civilly committed. These statistical summaries of selected inpatient data were compiled by George Saravia, a statistician for the Arizona Department of Health Services.

107. The mere fact that an admission is labeled voluntary does not necessarily compel the conclusion that the patient himself chose to be admitted. *See* Gilboy & Schmidt, *"Voluntary" Hospitalization of the Mentally Ill*, 66 NW. U.L. REV. 429, 430, 452 (1971). A so-called voluntary hospitalization may indicate, for example, that the patient has "chosen" to be admitted in the face of a threatened involuntary commitment. *See also* Kremens v. Bartley, 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated as moot and remanded*, 45 U.S.L.W. 4451 (1977); J.L. v. Parham, 412 F. Supp. 112 (M.D. Ga. 1976) *prob. juris. noted*, 45 U.S.L.W. 3773 (1977); Pima County Pub. Fiduciary v. Superior Court, 26 Ariz. App. 85, 546 P.2d 354 (1976) (addressing the constitutional issues raised by the "voluntary" commitment of minors and incompetents by their parents and guardians).

108. *See* Wexler, *Mental Health Law and the Movement Toward Voluntary Treatment*, 62 CALIF. L. REV. 671, 691-92 (1974).

109. *See, e.g., 1976 Hearings* (Phoenix, Ariz., May 26), *supra* note 5, at 43; *id.* (Bisbee, Ariz., May 17), at 33; *id.* (Flagstaff, Ariz., May 24), at 24.

110. *See 1976 Hearings* (vols. 1-4), *supra* note 5; Report, *supra* note 5, at 119-41 apps. B-G.

111. *See 1976 Hearings* (Phoenix, Ariz., May 26), *supra* note 5, at 4-5, 20-21, 53-54; *id.* (Tucson, Ariz., May 18), at 13-14.

112. 33d Ariz. Legis., 1st Reg. Sess. (introduced Feb. 16, 1977).

113. Although this bill was not enacted into law, no major opposition to its passage was announced. It was reported out of one committee and merely died of inattention in another. Accordingly, no cause exists to conclude that the bill is tainted. Rather, the legislative session's focus on such other substantial legislation as the revision of the criminal code and the groundwater code and the bill's late introduction may have effectively excluded focus on revision of the Mental Health Services Act. It is perhaps relevant that it took two years for the 1974 Act to gain passage. See Editor's Note, *supra* note 10.

114. ARIZ. REV. STAT. ANN. § 36-525 (1974). Rather than a considered effort to protect

scheme which creates, particularly in rural areas, major logistical problems. For instance, if an officer observes a person whom he has probable cause to believe is acting dangerously as the result of a mental disorder, the officer is currently not permitted by the Act to apprehend the person until "an application for emergency admission for evaluation has been filed."[115] Because such an application must be made in writing to an evaluation agency,[116] the officer is faced with several unpalatable alternatives: He can remain with the person and send an eyewitness, if one is available, to make the required application and then return to inform the officer of its completion; he can make a sham arrest and then take the prisoner to the evaluation agency; or he might abandon the situation and make no attempt to render assistance. None of these alternatives is particularly satisfactory.

H.R. 2326 would permit a peace officer to apprehend a person when, based upon personal observations, the officer has probable cause to believe the person is mentally disordered and likely to suffer or inflict serious harm without immediate hospitalization.[117] However, so as not to circumvent the prepetition screening process completely, the proposed amendments create a telephonic application procedure: When the evaluation agency is open and the officer has access to a telephone, he would be required to screen the case with the agency before transporting the person to the evaluation agency.[118] On the other hand, when this telephonic application procedure is not available, the officer may apprehend the person, if the requisite probable cause is present.[119] Such a procedure seeks to maintain a delicate balance between the need for timely intervention in emergencies and professional screening prior to any deprivation of liberty.

The Mental Health Legislative Guide is more restrictive than is H.R. 2326 upon the peace officer's exercise of emergency apprehension authority.[120] Under the Guide's proposals, emergency apprehension by a peace officer is limited to those instances where a mentally ill person is subject to lawful arrest or has attempted suicide and where, in either instance, there is an ongoing likelihood of serious danger to self or others.[121] Restriction of the officer's powers to those situations seems likely either to induce sham

against specific abuses, this limitation appears to have been inadvertent. *See* Dr. Willis Bower, Proposals for Change in the Arizona Mental Health Services Act, *reprinted in* Report, *supra* note 5, at 127 app. C.

115. ARIZ. REV. STAT. ANN. § 36-525 (1974). *But see* Christensen v. Weston, 36 Ariz. 200, 284 P. 149 (1930), where the Supreme Court of Arizona concluded that a peace officer may arrest without prior issuance of process when a person is "dangerously insane, so that he is an immediate menace to himself or others, if allowed to be at large . . . ." *Id.* at 210, 284 P. at 153.

116. *See* ARIZ. REV. STAT. ANN. § 36-501(9) (1974).

117. H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess. § 24 (introduced Feb. 16, 1977).

118. *Id.*

119. *Id.* at § 24(B).

120. Mental Health Legislative Guide, *supra* note 13, § 2(d).

121. *Id.*

arrests or to prevent timely intervention in crises otherwise cognizable under the Act.

Substantial Bodily Harm

"Substantial bodily harm" is the Act's attempt to define the degree of dangerousness necessary to invoke the court-ordered treatment process.[122] This limitation on commitment has apparently been interpreted—or, rather, misinterpreted—by some screening agencies to require life-threatening danger, and thereby to be too strict.[123] One device suggested to remedy the effects of this interpretation was the simple deletion of the term "substantial."[124] That approach, however, would have been unsatisfactory, for it might have reopened the door to commitment predicated on danger of trivial harm. A finding of a danger of serious or substantial bodily harm has been wisely viewed by many courts as a constitutional condition precedent to commitment.[125] In reaching this conclusion, these courts have balanced the deprivations occasioned by commitment against the protection of society from harm, and have concluded that a proper balance between the interests of society and the individual requires a risk of substantial harm before the individual may be deprived of his liberty.[126] Accordingly, under emerging case law, the requirement of harm of some non-de minimus magnitude is mandatory and commitment based upon a danger of insignificant harm is proscribed.

Although the term "substantial bodily harm" has not been the subject of additional judicial interpretation in these or other related cases, the Mental Health Legislative Guide[127] and certain state legislatures[128] have addressed the issue and their efforts can be compared to the Arizona proposal, which seeks to retain the notion of "substantial" harm but to embellish it with further definitional guideposts.

H.R. 2326 defines substantial bodily harm as follows:

> "SUBSTANTIAL BODILY HARM" MEANS UNJUSTIFIED PHYSICAL HARM OF SUCH A MAGNITUDE AS GIVES RISE TO APPREHENSION OF DANGER TO LIFE, HEALTH,

122. *See* ARIZ. REV. STAT. ANN. §§ 36-501(3), (4), -521(A), -532 (1974).

123. Interview with State Representative Richard Flynn by Kenney Hegland and David Wexler (May 1976) [hereinafter cited as Flynn interview]. *See also* ARIZ. REV. STAT. ANN. § 36-521(D) (1974) (screening agency must file petition for court ordered evaluation if prepetition screening indicates person is a danger to self or others).

124. Flynn interview, *supra* note 123. *See also* Report, *supra* note 5, at 20.

125. Doremus v. Farrell, 407 F. Supp. 509, 515 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378, 390 (M.D. Ala. 1974); Lessard v. Schmidt, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1973), *modified on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1957), *aff'd on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

126. *See* cases cited note 125 *supra*.

127. Mental Health Legislative Guide, *supra* note 13, § 1.

128. *See, e.g.*, CAL. WELF. & INST. CODE §§ 5260, 5310 (Deering 1969); MASS. GEN. LAWS ANN. ch. 123, §§ 1, 12 (West 1972); MICH. STAT. ANN. § 14.800 (Supp. 1976); W. VA. CODE ANN. §§ 25-5-2 to -5-7 (Supp. 1975).

OR LIMBS. IT INCLUDES GRAVE AS OPPOSED TO TRIVIAL INJURIES BUT IT IS NOT REQUIRED THAT THE INJURIES BE SUCH AS MAY RESULT IN DEATH.[129]

Several elements of the definition are significant. First, through the use of the word "unjustified," the definition incorporates certain defenses recognized by the criminal law. Where the law now tolerates the use of force, as in "self defense, or defense of another against unlawful violence,"[130] no cogent reason exists to proscribe the use of force in these circumstances by a person who is coincidentally mentally disordered. In short, where the harm is justified, the requisite danger to society is not present. Second, the definition is limited to physical as compared to mental or psychological harm to others. This rejects commitment based upon an offense to the sensibilities of some third person.[131] Third, this definition sheds more light on the question of just how substantial the harm must be by noting that it cannot be trivial, must threaten life, health or limb, but need not threaten death.[132]

The Mental Health Legislative Guide utilizes the term "serious harm" in conjunction with danger to self[133] or others.[134] The Guide's requirement

129. H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess. § 2 (introduced Feb. 16, 1977).

130. ARIZ. REV. STAT. ANN. § 13-246(A)(6) (1956) (self-defense). In Arizona, justified force is delineated in *id.* § 13-246 (1956) which provides:

A. Violence used to the person does not amount to assault or battery in the following cases:
1. In the exercise of the right of moderate restraint or correction given by law to the parent over the child, the guardian over the ward and the teacher over the scholar.
2. For preservation of order in a meeting for religious, political or other lawful purposes.
3. For preservation of the peace, or to prevent the commission of an offense.
4. In preventing or interrupting an intrusion upon the lawful possession of property.
5. In making a lawful arrest and detaining the party arrested when authorized by law, or in obedience to the lawful order of a magistrate or court, or in overcoming resistance to such lawful order.
6. In self-defense, or defense of another against unlawful violence to his person or property.

B. Only that degree of force may be used which is necessary to accomplish the lawful purpose.

Perhaps the "justified"—"unjustified" concept will be interpreted to transcend its criminal law exculpatory meaning and to embrace situations where a patient acts because of "reasonable provocation" and the like.

131. Commitment upon such a standard would compound the difficulty of predicting the proposed patient's behavior by adding the equally uncertain task of predicting the mental response of third persons should that behavior occur. Additionally, it treads precariously close to an impermissible use of the police power since "mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty." O'Connor v. Donaldson, 422 U.S. 563, 575 (1975).

132. This language was taken from an Arizona decision attempting to define "serious bodily harm" as used in the definition of aggravated battery. State v. Miller, 16 Ariz. App. 92, 491 P.2d 481, 483 (1972).

133. The Guide proposes the following meaning for "likelihood of serious bodily harm": "[I]t is more likely than not that in the near future the person will attempt to commit suicide or inflict serious bodily harm upon himself by violent or other actively self-destructive means."

134. Mental Health Legislative Guide, *supra* note 13, § 1. The term "serious harm" is defined by the Guide as follows: "[I]t is more likely than not that in the near future the person

of unjustified harm is similar to the proposal, but the Guide fails to delineate just how serious the serious harm must be. Rather, the Guide implicitly relies upon common understanding of the term or ultimate judicial interpretation. In that regard, the amendment proposed by H.R. 2326 should prove easier to understand and to administer than the Guide's recommendation.[135]

Experience in Arizona should demonstrate that adoption of the Guide's unembellished use of the term "serious or substantial bodily harm" by other states may be problematic.[136] Without further refinement, the definition may be thought to exclude, as some Arizona counties have concluded, certain types of serious harm for which commitment was intended legislatively.[137] It is evident that an articulated need for an embellished statutory definition of "substantial bodily harm" exists. Whatever the ultimate wording of the definition, at a minimum it should include only non-trivial harm and contain sufficient clarifying language to rectify the existing confusion over its specific parameters.

Threats

Closely related to the substantiality of the harm is the manner in which it must be manifested. The literature is replete with studies evidencing the inability of psychiatrists to predict dangerousness accurately.[138] Because a past act may enhance the accuracy of such predictions[139] and, at minimum, incorporates the notion that one should not suffer the loss of liberty without having "done something," the requirement of a recent overt act has, in

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will inflict serious, unjustified bodily harm on another person, as evidenced by behavior causing, attempting or threatening such harm."

135. *Id.* Similarly, neither California, Washington, Massachusetts, Michigan, or West Virginia, whose statutes require a finding of substantial or serious bodily harm as a condition of commitment, provide any legislative embellishment of this critical term. *See* CAL. WELF. & INST. CODE §§ 5260, 5310 (Deering 1969); MASS. GEN. LAWS. ANN. ch. 123, §§ 1, 12 (West 1972); MICH. STAT. ANN. § 14.800 (Supp. 1976); WASH. REV. CODE ANN. § 71.05 (1975); W. VA. CODE §§ 25-5-2 to -5-7 (Supp. 1975).

136. Moreover, adoption of the Guide's standard would constitute no significant change of Arizona's current law. ARIZ. REV. STAT. ANN. §36-532 (1974) authorizes involuntary confinement of an individual only when that person constitutes a danger to himself or others. The requisite danger is present when the individual presents a danger of inflicting "substantial bodily harm" upon himself or others. *See id.* § 36-501(3),(4). Arizona's standard is thus virtually indistinguishable from the "serious bodily harm" standard proposed in the Guide. *Compare* ARIZ. REV. STAT. ANN. § 36-501 (3),(4) (1974), *with* Mental Health Legislative Guide, *supra* note 13, § 1.

137. *See 1976 Hearings* (Phoenix, Ariz., May 26), *supra* note 5, at 56.

138. *See, e.g.*, Cocozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976); Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439 (1975); Ennis & Litwack, *supra* note 51. *But see* Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), where the California Supreme Court held that a psychotherapist may be liable for failure to warn his patient's threatened victim of a future violent act to be visited upon that person by his patient. The court reached its holding notwithstanding the amicus brief of the American Psychiatric Association which asserted "that therapists, in the present state of the art, are unable reliably to predict violent acts; their forecasts . . . tend consistently to overpredict violence, and indeed are more often wrong than right." *Id.* at 437-38, 551 P.2d at 344, 131 Cal. Rptr. at 24.

139. *See* Kozol, Boucher, & Garafola, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371, 378-88 (1972).

many jurisdictions, been found to be of constitutional dimension.[140] Current Arizona law requires, for a finding of danger to others, a recent overt act or attempt, but apparently excludes threats from consideration.[141] Much testimony at the public hearings claimed that if threats cannot be used as a basis for a finding of dangerousness, the intervention necessary to prevent pernicious problems is thwarted.[142] Sympathetic to the argument that a screening agency ought not to have to stamp "premature" on and discard an application alleging that a mentally disordered person is making serious threats against life, H.R. 2326 seeks to include threats in certain limited circumstances. It proposes to include within the definition of danger to others the following:

> HAVING SERIOUSLY THREATENED, WITHIN THIRTY DAYS PREVIOUS TO THE FILING OF THE PETITION FOR COURT-ORDERED TREATMENT, TO ENGAGE IN BEHAVIOR WHICH WILL LIKELY RESULT IN SUBSTANTIAL BODILY HARM TO ANOTHER PERSON, PROVIDED THAT THE THREAT BE SUCH THAT, WHEN CONSIDERED IN LIGHT OF ITS CONTEXT AND IN LIGHT OF THE INDIVIDUAL'S PREVIOUS ACTS, IS SUBSTANTIALLY SUPPORTIVE OF AN EXPECTATION THAT THE THREAT WILL BE CARRIED OUT . . . .[143]

A similar inclusion has been proposed for danger to self.[144]

The discharge of a firearm is clearly an act, as is the ingestion of an overdose of medication. Is a threat an act? If threats are to be included as a basis for finding dangerousness, it must be determined whether, as a matter of constitutional law, they satisfy the recent act requirement. Significantly, those courts that have struck down various state procedures for civil commitment and that have required the existence of a recent overt act as a predicate to a finding of dangerousness, have indicated that commitment

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140. Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976); Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378, 389 (M.D. Ala. 1974); Bell v. Wayne County Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974); Lessard v. Schmidt, 349 F. Supp. 1078, 1097-1100 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1973), *modified on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), *aff'd on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

141. *See* ARIZ. REV. STAT. ANN. § 36-501(3) (1974); text accompanying notes 144-46 *infra*.

142. *See 1976 Hearings* (Phoenix, Ariz., May 26), *supra* note 5, at 32-33.

143. H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess., § 2 (introduced Feb. 16, 1977). A typographical error in the 1976 study, see Report, *supra* note 5, at 155, carried over into H.R. 2326, renders the section a bit confusing. To correct the error and clarify the language, the word "it" should be inserted before the words "is substantially supportive." Alternatively, the words "be such that" could be deleted. Similar rewording is appropriate in the section of the bill relating to danger to self. See definition given in note 144 *infra*.

144. "Danger to self" means:

> (a) Behavior which constitutes a danger of PURPOSEFULLY inflicting substantial bodily harm upon oneself IN THE NEAR FUTURE, including attempted suicide OR THE SERIOUS THREAT THEREOF, PROVIDED THAT THE THREAT BE SUCH THAT, WHEN CONSIDERED IN THE LIGHT OF ITS CONTEXT AND IN LIGHT OF THE INDIVIDUAL'S PREVIOUS ACTS, IS SUBSTANTIALLY SUPPORTIVE OF AN EXPECTATION THAT THE THREAT WILL BE CARRIED OUT.

H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess., § 2 (introduced Feb. 16, 1977).

may be grounded upon a threat.[145] Implicit in these decisions, perhaps, is the conclusion that a threat is an objective historical event which may enhance the reliability of a prediction of future dangerousness. Further, even a threat seems to satisfy the requirement that the person have "done something." Additionally, the potential consequence, in the absence of authorized legal intervention, of a threatened person resorting to self-help provides some support for the legitimacy of society's intervention. Other recent state legislation apparently recognizes the need to include threats as part of a definition of dangerousness,[146] and Arizona's commitment laws should be amended to account for this need.

The paucity of literature on the predictive significance of threats reveals precious little.[147] Ultimately, then, a decision to permit commitment based upon threats is premised upon an intuitive belief that threats are predictive (or at least may be so viewed by potential victims) and that the menacing picture they present should not be ignored.[148] Accordingly, the amendment includes only serious threats to do substantial bodily harm. And the amendment requires that the threats be considered in context and in light of the individual's previous conduct.[149] Only where these two tests lead to "an expectation that the threat will be carried out" is commitment authorized.

Passive Danger to Self

Some critics of the 1974 Act complain that it does not reach people who are passively dangerous to self but who are not actively suicidal.[150]

145. See cases cited note 140 *supra*. The decisions do not, however, provide a specific analysis supporting the use of threats as a basis for commitment.

146. *See* CAL. WELF. & INST. CODE § 5300 (Deering 1969); MICH. STAT. ANN. § 14.800 (401)(a) (1976).

147. *See* McDonald, *The Threat to Kill*, 120 AM. J. PSYCH. 125 (1963). Although the predictability of threats remains unresolved, the criminal law permits incarceration of people who, for example, make telephonic threats to inflict injury upon another. ARIZ. REV. STAT. ANN. § 13-895 (Supp. 1973). *See also* Scales v. United States, 367 U.S. 203 (1961); Dennis v. United States, 341 U.S. 494 (1951), representative of the line of cases permitting punishment of otherwise protected speech when it presents a "clear and present danger" of imminent harm.

148. Illustrative are two situations presented at the statewide hearings held to review the Mental Health Services Act. One person described an incident where a person approached two peace officers, displayed a hacksaw blade, and threatened to cut up the officers. This petition was rejected by the evaluation agency. *See 1976 Hearings* (Flagstaff, Ariz. May 24), *supra* note 5, at 19-20. At the Phoenix hearing, a local psychiatrist described another sequence of events:

> I had an occasion to participate in a very dramatic episode, being called in the middle of the night by the Scottsdale Police to try to talk a man with a gun out of a house. That man had purchased a pistol after threatening to kill himself and after shooting out some windows in a business establishment that he had just recently lost, holed himself up in this house and occupied three squad cars of police, an ambulance, a fire department, city councilman and a doc for three hours, from 1:00 to 4:00 a.m. He was subsequently apprehended, fortunately. We had no beds available. He would not accept treatment voluntarily, at that time. The proper people were informed at County Hospital that this man had been apprehended under those circumstances, and upon evaluation at the County Hospital it was their interpretation that since he had not hurt anyone, under the provisions of the law that [sic] he could not be admitted involuntarily.

1976 Hearings, (Phoenix, Ariz. May 26), *supra* note 5, at 32-33.

149. H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess. § 2 (introduced Feb. 16, 1977).

150. Report, *supra* note 5, at 38-39.

Although many of the passively dangerous are encompassed within the category of "gravely disabled,"[151] those who are suddenly[152] and acutely disordered but not purposefully self-destructive are not included within the Act. Consequently, H.R. 2326 proposes a new category of danger to self defined as:

> BEHAVIOR WHICH WILL, WITHOUT HOSPITALIZATION, RESULT IN GRAVE PHYSICAL HARM OR SERIOUS ILLNESS TO THE PERSON IN THE NEAR FUTURE. IF THE DANGEROUS BEHAVIOR IS RESTRICTED TO THE CONDITIONS DEFINED UNDER GRAVE DISABILITY THIS DEFINITION OF DANGER TO SELF DOES NOT APPLY.[153]

This proposal would require a risk of serious harm in the near future. So long as the harm sought to be averted is of the requisite magnitude and is predicated upon an historical event, the proposal is consistent with emerging case law;[154] no court has restricted commitment based upon danger to self to suicidal or purposeful self-destructive behavior.

In contrast to the Arizona proposal, the Mental Health Legislative Guide has restricted its definition of harm to oneself to suicide or "other actively self-destructive means."[155] The Guide provision is based upon the assumption that a guardianship is a more appropriate response to passive dangerousness. However, under the Arizona proposal, commitment is prohibited where the use of a less drastic alternative, such as a guardianship, would provide sufficient protection;[156] the inclusion of commitment for passive dangerousness is a narrowly tailored means to protect against behavior which may be no less harmful than that contemplated by purposefully self-destructive conduct.

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151. *See id.* at 38. "Gravely disabled" is defined in ARIZ. REV. STAT. ANN. § 36-501(11) (1974) as follows:

> 'Gravely disabled' means a condition in which a person is unable to provide for his basic personal needs for food, clothing and shelter as a result of a mental disorder of a type which has:
> (a) Developed over a long period of time and has been of long duration; or,
> (b) Developed as a manifestation of degenerative brain disease during old age; or,
> (c) Developed as a manifestation of some other degenerative physical illness of long duration.

152. *See* Report, *supra* note 5, at 38-39. The Arizona statute applies only to persons whose disability has developed over a long period of time, and thus does not reach the suddenly disabled person. ARIZ. REV. STAT. ANN. § 36-501(11)(a)-(c) (1976). Similarly, the section on danger to self, *id.* § 36-501(4), may not encompass the sudden, yet passive disability, as the section may require a self-destructive desire. *See* Report, *supra* note 5, at 39.

153. H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess., § 2 (introduced Feb. 16, 1977).

154. The court in Lynch v. Baxley, 386 F. Supp. 378, 391 (M.D. Ala. 1974) specifically recognized that commitment may be predicated not only on a person's threat to do actual violence to himself, but also upon a neglect or refusal to care for himself—that is, upon a passive danger to self.

155. Mental Health Legislative Guide, *supra* note 13, § 1.

156. ARIZ. REV. STAT. ANN. § 36-540 (1974), which describes judicial options, proscribes court-ordered treatment when "suitable alternative treatment exists." This phraseology should be interpreted to include consideration of guardianship as well. *See generally* Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107 (1972).

In Arizona, the distinction between the proposals in the Guide and H.R. 2326 may rise to constitutional dimensions. The Guide simply assumes that the guardian may exercise the power necessary to effectuate treatment alternatives in the ward's best interest, and assumes that if the guardian determines it necessary, he may volunteer the passively dangerous ward for inpatient psychiatric hospitalization. The Guide thus assumes the availability of an unconstitutional procedure, since in the case of *Pima County Public Fiduciary v. Superior Court*,[157] the Arizona Court of Appeals held that the guardian's extra-judicial commitment of his ward would violate the ward's constitutional guarantee of procedural due process.[158] The Arizona proposal, on the other hand, permits commitment only if guardianship, or some other alternative, is not adequate; use of the guardian to circumvent the procedural protections would not be permitted under H.R. 2326. The logic of the bill is preferable to the Guide's proposal not only on constitutional grounds but on policy grounds as well: It is not sensible to create a system of strict procedural safeguards for commitment of the mentally ill only to permit circumvention of those safeguards through the appointment of a guardian who could, in turn, consent to the involuntary confinement of the ward pursuant to a loose procedural path.[159]

Perhaps the greatest potential for abuse under the passive dangerousness standard is that the proximity of danger sought to be averted may become so remote as to devolve into an unsanctioned "in need of treatment" standard. If physicians are permitted to speculate about nonimminent danger, the door may be inadvertently opened to consideration of more remote and speculative harm. This conceptual difficulty should be avoided by the proposal's requirement that the harm sought to be averted be grave and that it be about to occur in the near future.[160]

An In-Need-of-Treatment Standard?

Some persons who spoke at the public hearings called for the adoption of an "in need of treatment" standard.[161] The first question raised by the proposed adoption of such a standard is whether it would survive constitutional scrutiny. Relying on Justice Burger's concurring opinion in *O'Connor v. Donaldson*[162] and the result of the Court's majority opinion, one formula-

157. 26 Ariz. App. 85, 546 P.2d 354 (1976).
158. *Id.* at 87, 546 P.2d at 356.
159. *See* Wexler, *supra* note 108, at 676 n.17, describing a review of the California experience under stricter commitment procedures. The review suggested that less rigorous procedures for the appointment of conservators were utilized with greater frequency to sign wards into mental health treatment facilities.
160. *See* H.R. 2326, 33d Ariz. Legis., 1st Sess., § 2 (introduced Feb. 16, 1977). H.R. 2326 similarly recommends an "in the near future" time frame for predicted danger to others and suicidal behavior. *See id.*
161. *1976 Hearings*, *supra* note 5; Report, *supra* note 5, at 48. *See also* A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION (1975).
162. 422 U.S. 563 (1974). Chief Justice Burger stated that:

tion of the argument recites: If confinement of a nondangerous mentally ill person without "more" is impermissible,[163] the effective provision of "more" (in the form of treatment) to a person unable to act for himself serves to legitimate the confinement of the nondangerous mentally ill under the state's parens patriae power.[164] It has been argued that to survive constitutional scrutiny, a paternalistically-premised commitment statute must require a finding of debilitating mental illness, a showing that treatment is in the best interests of the person, incapacity on the part of the person to decide about matters of treatment, and convincing evidence that readily available treatment will be effective.[165]

Notwithstanding that analysis, several courts have recently voided "in need of treatment" laws on constitutional grounds.[166] Illustrative of these courts' reasoning is the recent decision of the federal district court in *Doremus v. Farrell*,[167] where it was stated:

> In the mental health field, where diagnosis and treatment are uncertain, the "need for treatment" without some degree of imminent harm to the person or dangerousness to society is not a compelling justification.[168]

Doremus' articulated basis for rejecting the "need for treatment" standards is the current state of the art. However, even assuming that the requisite skill

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> [T]he States are vested with the historic parens patriae power, including the duty to protect 'persons under legal disabilities to act for themselves' . . . .
> . . . At a minimum, a particular scheme for protection of the mentally ill must rest upon a legislative determination that is compatible with the best interests of the affected class and that its members are unable to act for themselves.

Id. at 583. A critical requirement for the exercise of paternalism in civil commitment, according to the Chief Justice, is the inability of a patient to act for himself. *See id.* Under that standard, a statute which permitted the commitment of a competent but mentally ill person in need of treatment would not survive constitutional scrutiny. But even with a criterion of incapacity, there is of course a danger of circumvention through a circular, constitutionally engendered "Catch 22": the patient is obviously incompetent because he rejects suggested care (though if he accepted the care, he would not be incompetent).

163. *See id.* at 576. Technically, the Court merely held unconstitutional the involuntary confinement, without treatment, of a nondangerous mentally ill person capable of surviving in the community alone or with the assistance of willing others. *See id.* at 576. It did not squarely address the question of whether providing needed treatment would have rendered the confinement constitutional. See discussion note 164 *infra*.

164. Of course, any argument that *Donaldson* permits or proscribes such purely paternalistically motivated confinement must take cognizance of the Court's disclaimer: "Specifically, there is no reason to now decide . . . whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment." *Id.* at 573. Likewise, in view of Chief Justice Burger's statement that a state cannot constitutionally confine an individual thought to be in need of treatment, and justify the confinement by providing some treatment, reliance on his view of parens patriae as support for an "in need of treatment" standard may be misplaced. *See id.* at 589.

165. *See* A. STONE, *supra* note 161; *Developments in the Law*, *supra* note 11, at 1205.

166. *See, e.g.*, Suzuki v. Quisenberry, 411 F. Supp. 1113, 1124-25 (D. Hawaii 1976); Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Kendall v. True, 391 F. Supp. 413, 417-18 (W.D. Ky. 1975); Lynch v. Baxley, 386 F. Supp. 378, 389 (M.D. Ala. 1974); Bell v. Wayne County Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974); Lessard v. Schmidt, 349 F. Supp. 1078, 1097-1100 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 437 (1973), *modified on remand*, 379 F. Supp. 137 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), *aff'd on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976). *But see* Fhagen v. Miller, 29 N.Y.2d 348, 356, 278 N.E.2d 615, 618, 328 N.Y.S.2d 393, 398, *cert. denied*, 409 U.S. 845 (1972).

167. 407 F. Supp. 509 (D. Neb. 1975).

168. *Id.* at 514.

now exists in regard to the diagnosis and treatment of all or some mental illnesses,[169] a major policy question would remain regarding whether the state should, in the absence of a likelihood of serious harm, involuntarily confine persons in need of treatment.

Consistent with an emerging national trend of courts and legislatures restricting involuntary commitment to the dangerous mentally ill,[170] the 1974 Mental Health Services Act represents a decided rejection of the "in need of treatment" standard. Before discarding the 1974 approach, it seems far more prudent to consider the impact on the commitment scheme of the proposed amendments' inclusion of threats and of passive danger to self as bases for commitment. After the effects of those amendments have been ascertained, it may be found that many of those persons whom the act's critics believe should be confinable under an "in need of treatment" standard, and who are excluded by the 1974 Act's present phraseology, will be included within its grasp on the basis of their threats, their passive dangerousness, or their danger of inflicting substantial (though not fatal) bodily harm on themselves or others. Given the legislature's decisive stand in 1974, the burden of persuasion surely now rests with the Act's critics to demonstrate that the law operates too narrowly. Additionally, it may be an appropriate policy decision to utilize limited fiscal resources only where people actually seek help or where intervention is necessary either to protect society from dangerousness or to protect an individual from the physical danger he presents to himself. Moreover, whatever the ultimate scope of the constitutional right to treatment, it is clear from *Donaldson* that ongoing confinement of the nondangerous mentally ill requires the provision of something more than mere custodial confinement.[171] In addition, the limitations imposed by the lower federal courts on the state's power to confine mentally ill persons[172] suggest that, if confinement solely for treatment is at all permissible, the right to treatment during confinement should be most broadly interpreted where commitment is justified by nothing more than the need for such treatment. Accordingly, a legislative decision to adopt such a standard concomitantly binds that legislature to whatever appropriations may be necessary to fulfill the promise of truly beneficial treatment.[173]

169. *But see* Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936 (1974).

170. *See Developments in the Law*, *supra* note 11, at 1205. In Arizona, the requirement of insanity plus consequent dangerousness predates admission to the Union in 1912. The statutes of the Arizona Territory permitted confinement in the territorial insane asylum only where the court found "that by reason of his or her insanity he or she be in danger, if at liberty, of injuring himself or herself, or the person or property of others . . . ." Ariz. Rev. Stat., Penal § 2768 (1901).

171. 422 U.S. at 576. "In short, a state cannot constitutionally confine *without more* a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *Id.* (emphasis added).

172. See text & notes 166-68 *supra*.

173. This issue raises interesting questions with regard to private psychiatric facilities. Private psychiatric hospitals have generally provided more individual care in less onerous settings than have public institutions. Assuming that greater individual attention results in more

Whether for fiscal, libertarian, or pragmatic considerations, it is now premature to consider adoption of an "in need of treatment" test in Arizona.[174]

Relevant Time Frames

H.R. 2326 proposes several changes in the relevant time frames contemplated by the existing Act. As noted previously, many courts have concluded that a "recent overt act, attempt or threat" is a necessary predicate to commitment.[175] Arizona currently permits a finding of danger

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efficacious care, would short term "in need of treatment" commitments to private, but not to public institutions then be justifiable? On the other hand, it is quite possible that a private psychiatrist, far more than a public psychiatrist, may feel an obligation not only to a particular mentally disordered patient, but also to that patient's entire family. That feeling of obligation may lead a private psychiatrist to attempt to commit a patient more for the benefit of the family than for the patient. If that is the case, private hospitals may abuse the rather easily satisfied "need for treatment" standard more than would public hospitals.

174. Similarly, both the 1976 study, *see* Report, *supra* note 5, at 63-65 and H.R. 2326 reject the proposals of some to expand the current Act's definition of "mental disorder" so as to permit the commitment of persons—principally alcoholics and sociopaths (including "sexual psychopaths")—who now generally fall outside the scope of the statute's classification of committable persons. The current restrictiveness is attributable to ARIZ. REV. STAT. ANN. §36-501(18) (Supp. 1977-78), which states that "mental disorder" (a necessary precondition for commitment) is *distinguished* from:

> (a) Conditions which are primarily those of drug abuse, alcoholism or mental retardation.
> (b) The declining mental abilities that directly accompany impending death.
> (c) Character and personality disorders characterized by lifelong and deeply ingrained anti-social behavior patterns, including sexual behaviors which are abnormal and prohibited by statute unless the behavior results from a mental disorder.

Id. Most of the criticism aimed at the above provision involved its exclusion of alcoholism. Part of the problem, however, may be that the Act is being misinterpreted by some: the statute does not automatically exclude all alcoholics. If an individual has a mental disorder in addition to alcoholism, or if the individual's alcoholism has led to a mental disorder, then the person would properly fall within the statutorily specified definition of "mental disorder." What the Act attempts to do is simply exclude the commitment of alcoholics *as alcoholics* (similarly with drug addicts and the mentally retarded). The burden of proving the desirability of expanding the current restrictive definition ought to rest on those who would forceably treat alcoholics. After all, the legislative decision to exclude them was made as recently as 1974. Moreover, a very similar decision was made when the Local Alcoholic Reception Center ("LARC") legislation was passed in 1972. (Ch.162, § 1-3, [1972] Ariz. Sess. Laws 1170 (codified at ARIZ. REV. STAT. ANN. §§ 36-2021 to -2031 (1972)). Under that legislation, except for 24 hour detention, no forced treatment of alcoholism is authorized.

Indeed, policy and constitutional considerations cut against detention much in excess of a 24 hour period. Under the parens patriae rationale, intervention is not justified because alcoholics, at least when sober, have sufficient capacity to decide whether or not they wish treatment. Similarly, since alcoholics are not typically of real danger to others, intervention under the police power does not seem warranted. Finally, given the incidence of alcoholism, the state should think twice before embracing alcoholism within the legislative definition of "mental disorder." If alcoholics are included in the definition, the state hospital would be obliged to accept them upon court order. ARIZ. REV. STAT. ANN. §§ 36-2021 to -2031 (1972). Perhaps significantly, some of the persons criticizing the Act's exclusion of alcoholism seemed unaware of the 24 hour detention period authorized by the LARC legislation.

The Act's exclusion of "character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behavior," seems to be the Arizona State Hospital's victory in part of a continuing battle between the hospital and the Arizona State Prison. *See generally Special Project, supra* note 1, at 176-80. As this group appears by definition to be both dangerous and not terribly receptive to treatment, it seems best to retain the exclusion and to attempt to upgrade psychiatric services at the prison. One final point is in order. The exclusions go only to those persons who can be *committed*; they do not prevent the state hospital from accepting persons as voluntary patients. *See* ARIZ. REV. STAT. ANN. § 36-518(A) (1974). That is, alcoholics and those with antisocial or sexual disorders can seek help at the state hospital, and the hospital can accept such persons if, given space and resource limitations, it believes it can be of help to them.

175. Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976); Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378, 389 (M.D. Ala. 1974); Lessard v.

to others based upon an act which has occurred within the preceding twelve months.[176] On its face, this time frame may be too broad to survive constitutional scrutiny.[177] However, a review of the practice under the Act suggested no evidence of "stale" claims; most persons are committed based upon events occurring in the immediate past.[178] Accordingly, while a reduced time frame will eliminate some possible stale claims, no change in present practice should thereby be necessitated. The Mental Health Legislative Guide limits the relevant time frame to twenty days prior to the commencement of the petition process.[179] At a minimum, a tightening of the outer limits to six months is desirable, which would be accomplished by the language of H.R. 2326.[181]

Another time frame relates to the duration of court-ordered treatment. With respect to commitments for danger to self, H.R. 2326 proposes to reduce the commitment period from 180 to 60 days.[182] This proposal is based upon the literature that reveals that attempted suicidal behavior is an episodic phenomenon and is not repetitive.[183] Illustrative is the suicide rate of persons who were prevented from leaping off the Golden Gate and San Francisco-Oakland Bay Bridges. Only four percent of these people subsequently committed suicide.[184] Moreover, California's experience suggests that lengthy involuntary detention of such persons is not required to avert subsequent attempts at suicide.[185]

An amendment to California's law provided for an initial three-day evaluation of suicidal persons with two subsequent 14-day confinements. A

Schmidt, 349 F. Supp. 1078, 1097-1100 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1973), *modified on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), *aff'd on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976)..

176. ARIZ. REV. STAT. ANN. § 36-501(3) (1974). While not the subject of judicial consideration in other jurisdictions, the Arizona law embodies two exceptions to the time frame requirement—where restraint has deterred dangerous conduct or where the original act was grievous or horrendous. *See* Wexler, *Foreword: Current Currents in Institutionalization*, 14 SAN DIEGO L. REV. 979, 999-1000 (1977).

177. Whether it is so would seem to be a question of the extent to which past behavior is predictive of future dangerousness; if the predictive character of the past overt act diminishes over time, a long interval between the act and the evaluation or commitment proceeding will vitiate the constitutionality of using the act as a basis for commitment. As for Arizona's present 12 month time limit, see ARIZ. REV. STAT. ANN. § 36-501(3)(1974), it seems reasonable to doubt the accuracy of using a single overt act occurring one year prior to a commitment proceeding as a basis for a finding of future dangerousness.

178. Report, *supra* note 5, at 27-28 & n.61.

179. Mental Health Legislative Guide, *supra* note 13, § 1.

180. Report, *supra* note 5, at 27.

181. *See* H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess., § 2 (introduced Feb. 16, 1977).

182. *Id.* § 39.

183. *See* Greenberg, *Involuntary Psychiatric Commitments to Prevent Suicide*, 49 N.Y.U.L. REV. 227, 238-39 (1974), containing a review of existing studies of the efficacy of treatment in preventing suicide.

184. Seiden, *Suicide, Preventable Death*, Public Affairs Report, Bulletin of the Institute of Governmental Studies, Vol. 15, No. 4 (Aug. 1974). Therefore, if all persons attempting suicide are hospitalized, substantial and unnecessary confinement would occur. As one commentator notes, *see* Greenberg, *supra* note 183, at 243-44, even using a predictive test which is 80% efficient, if 10 of 1000 suicide attempters will attempt suicide a second time, we must commit 206 to save the 8 out of the 10.

185. ENKI RESEARCH INSTITUTE, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW 152 (1972).

study of two years operation of this scheme revealed that the second 14-day confinement was utilized in only one percent of the cases. Follow-up revealed that of 300 persons released within weeks, none had committed suicide within six months. The author of the follow-up report noted that three percent of those who had been committed under prior law committed suicide within six weeks of discharge.[186] Based upon California experience, it is evident that commitment for a period of time much less than 180 days will permit amelioration of the danger sought to be averted.

The Gravely Disabled

The greatest confusion created by the 1974 Act—confusion that remains unresolved notwithstanding increased familiarity with the Act—arises out of the sections pertaining to the gravely disabled.[187] One section of the Act implies that court-ordered treatment may not be predicated upon a finding of grave disability,[188] but the section enumerating court options at a hearing on court-ordered treatment obfuscates that interpretation by ambiguous language from which an inference can be drawn that court-ordered treatment may be based upon a finding of grave disability.[189] Even assuming commitment for grave disability is permissible, the definition of the term presents other difficulties.

Under the Mental Health Services Act a person is gravely disabled if, inter alia, he is "unable to provide for his basic personal needs for food, clothing, and shelter."[190] This conjunctive enumeration technically necessitates a judicial finding of inability to provide all of these necessary elements for survival before a finding of grave disability may be made. Yet, the

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186. *Id.*

187. ARIZ. REV. STAT. ANN. § 36-501(11) (Supp. 1977-78) (definition of "gravely disabled"). Other sections implicate the grave disability standard. *Id.* §§ 36-520(A), -521(D), -529(A), -531(A), (B), -540(C), -547 to -547.08 (1974).

188. ARIZ. REV. STAT. ANN. § 36-532 (1974) purports to list those circumstances under which a person "may be ordered confined for treatment." Because this provision lists only danger to others and danger to self (which specifically excludes "conditions defined under grave disability," *see id.* § 36-501(4)), principles of statutory construction suggest that the enumeration is exclusive, thereby proscribing court-ordered treatment based solely upon a finding of grave disability. *See* State v. Allred, 102 Ariz. 102, 103, 425 P.2d 572, 573 (1967).

189. ARIZ. REV. STAT. ANN. § 36-540(C) (1974) provides:

> If the court finds that the proposed patient is, as a result of mental disorder, gravely disabled the court shall in lieu of making orders as in subsection A of this section, or the court may in addition to or in lieu of making orders as in subsection B of this section establish guardianship for the person or conservatorship for the estate of the person or both pursuant to article 8 of this chapter and pursuant to title 14.

In Pima County, the superior court interprets this language not to permit commitment upon a finding of grave disability, whereas the superior court in Maricopa County concludes the opposite.

190. ARIZ. REV. STAT. ANN. § 36-501(11) (1974). The complete definition provides:

> 'Gravely disabled' means a condition in which a person is unable to provide his basic personal needs for food, clothing and shelter as a result of a mental disorder of a type which has:
>
> (a) Developed over a long period of time and has been of long duration; or
>
> (b) Developed as a manifestation of degenerative brain disease during old age; or
>
> (c) Developed as a manifestation of some other degenerative physical illness of long duration.

inability to meet any one of these needs can result in serious harm or death. Therefore, if timely intervention is intended to prevent serious harm to those suffering from a mental disorder developed as a manifestation of a degenerative process,[191] the requirement of a conjunctive finding is unnecessary.

The current definition of gravely disabled requires no finding that the inability to satisfy the enumerated need occur within a specific future time frame.[192] Thus, the definition is subject to the same criticism levied against the definitions of danger to self and others: It is overly broad, permits unsupportable speculation, and thereby threatens to lapse into an "in need of treatment" standard.[193]

In addition to the possibility of court-ordered treatment,[194] a finding of grave disability may result in the appointment of a guardian.[195] The requirements for appointment include the satisfaction of all the procedures set forth in the probate code for guardianship of an incapacitated person,[196] plus additional requirements with respect to notice, hearing, and appointment of counsel,[197] as well as a finding of grave disability.[198] Upon appointment, this guardian has the responsibility for finding placement for the ward according to statutory priorities that reflect a scheme of less drastic alternatives.[199] If alternate placement is not available, the court, after notice and hearing, may order placement in a mental health treatment agency.[200] Such an order constitutes civil commitment.[201]

Although this statutory scheme would apparently avoid the constitutional infirmities of a guardian's extrajudicial consent to the "voluntary" hospitalization of his ward,[202] the ambiguity in the statutes providing for use

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191. *Id.*
192. *Id.*
193. *Id.*
194. *Id.* § 36-540(C).
195. *Id.* §§ 36-540(C), -547 to -547.08.
196. *See id.* § 36-547(A) to -547.04(3) (1974). The guardianship procedures of Arizona's probate code are set forth in *id.* §§ 14-5301 to -5314.
197. *See id.* § 36-547.03(1), (2), (4).
198. *See id.* §§ 36-540(C), -547(A).
199. *Id.* § 36-547.04. This section sets forth the obligations of a title 36 guardian:

> In addition to the duties of a guardian provided in § 14-5312, the guardian of a gravely disabled person shall be required in the provision of the care, comfort and maintenance of his ward to comply with these preferences:
>
> 1. First preference is to allow the ward to return to his home, family or friends.
>
> 2. Second preference is for arrangements which provide for placement in an agency, other than a mental health treatment agency, as close to his home or the home of a relative as possible.
>
> 3. Final preference is for arrangements which provide for placement in a mental health treatment agency after notice and hearing in the court which appointed the guardian and a finding of the court that alternative placement is not available. The hearing required in this paragraph shall comply with the provisions of all hearings under title 14 and the provisions of this article.

200. *Id.*
201. *See id.* § 36-540(A)-(C).
202. Such a procedure was invalidated in Pima County Pub. Fiduciary v. Superior Court, 26 Ariz. App. 85, 87, 546 P.2d 354, 356 (1976), where the court held that the use of a guardian to consent to the commitment of his ward avoids the procedural protections of the Mental Health Services Act, and thus violates due process.

of guardianships for the gravely disabled left room for some inconsistent constructions. For instance, the 1974 Act authorizes the guardian to arrange for placement of the ward in a mental health treatment agency only after a court finding that less restrictive placement is unavailable.[203] This section has been construed to permit the court to authorize the guardian to commit the ward regardless of the ward's consent,[204] and, in conflict with this interpretation, as permitting the guardian to sign the ward into the Arizona State Hospital only if the ward consents.[205] In the face of other unclear language, Maricopa County commissioners interpreted section 36-540,[206] in apparent conflict with an equally reasonable construction of its terms, as allowing the court to order a 180-day commitment of a gravely disabled person, even without a finding of danger to others.[207] These problematic constructions exemplify a larger problem: Not only are the sections of title 36 dealing with guardianship ambiguous; the precise interrelationship between the guardianship procedures of titles 14 and 36 is also unclear.[208] These difficulties indicate the need for a change in current mental health laws; the ambiguity of the guardianship rules applicable to the gravely disabled—due at least in part to the requirement that cross references be made between Arizona's probate and mental health statutes to determine required procedures[209]—demands that specialized mental health problems be dealt with under a statutory scheme designed to deal with such problems.

In response to this plethora of problems, H.R. 2326 proposes, inter alia, to make the requirements for grave disability disjunctive, to delete the article of the Act pertaining to guardianship of the gravely disabled, to permit placement of a gravely disabled person in a mental health treatment agency only upon compliance with the procedures for court-ordered treatment and only after a finding that no other alternatives (such as ordinary

203. *See* ARIZ. REV. STAT. ANN. § 36-547.04(3) (1974).

204. E. Schocket, The Gravely Disabled and the Relationship of Grave Disability to the Mental Health and Probate Codes 37 (April 26, 1976) (unpublished seminar thesis on file with Professor David B. Wexler, University of Arizona College of Law). This interpretation may be unconstitutional. *See* Pima County Pub. Fiduciary v. Superior Court, 26 Ariz. App. 85, 87, 546 P.2d 354, 356 (1976).

205. E. Shocket, *supra* note 204.

206. ARIZ. REV. STAT. ANN. § 36-540(A)-(C) (1974).

207. E. Schocket, *supra* note 204, at 11. Another logical interpretation of this section is that ARIZ. REV. STAT. ANN. § 36-540(C) (1974) precludes involuntary confinement of a gravely disabled person unless he is dangerous to others or has been committed after a finding that less restrictive alternative forms of treatment are not available. *See id.* § 36-547.04(3).

208. Under the guardianship article of title 36, ARIZ. REV. STAT. ANN. §§ 36-547 to -547.08 (1974), the ward may be involuntarily confined in the same setting as if he were civilly committed. *See id.* § 36-547.04(3) (authorizing confinement of ward in mental health treatment agency); *id.* § 36-540(A), (B). However, certain of the procedural safeguards afforded civil committees under ARIZ. REV. STAT. ANN. §§ 36-532 to -544 (1974) (court-ordered treatment) may not be available to a gravely disabled person under the guardianship article. For instance, a gravely disabled person may not be entitled to a stenographic transcript of his placement hearing, as would other committees. *See id.* § 36-539(E) (1974). Similarly, the burden on the petitioner to prove by "clear and convincing evidence" that the proposed patient is a danger to himself or others, *see id.* § 36-540(A), (B), may not be applicable to the guardianship or commitment. *Id.* § 36-547.04(3). *See generally* E. Schocket, *supra* note 204, at 12-48.

209. ARIZ. REV. STAT. ANN. § 36-547.04(3) (1974) (last sentence).

guardianship) are appropriate.[210] The thrust of these proposals is to provide a viable standard and practical but constitutionally sufficient procedures for the treatment of the gravely disabled. Although judicial intervention is necessary prior to confinement of the ward in a mental health treatment agency,[211] the proposal recognizes that the prognosis for this class of persons is often not optimistic. Accordingly, it provides that after the expiration of the initial 180 day commitment, the court may order the patient recommitted for treatment for a period up to 1 year.[212]

CONCLUSION

The amendments contained in H.R. 2326 represent necessary refinements in the Mental Health Services Act to maintain the precarious balance between the conflicting interests expressed by the operation of laws for civil commitment of the mentally ill in Arizona and elsewhere. The authors recommend legislative adoption of those amendments, with the recognition that the amendments are not the final solution to all of the remaining problems. Critical to the operation of the entire system is the issue of funding and responsibility for delivery of mental health services. The present division of responsibility between the state and the counties has proved unsatisfactory; comprehensive analysis of this problem and viable proposals for reform are needed.

Even if the amendments are enacted and if a satisfactory mental health financing system is constructed, much activity will lie ahead for those interested in mental health law. Recommitment of those who have not performed a recent dangerous act while hospitalized raises perplexing constitutional problems. If accurate predictions of dangerousness require recent acts, should society be penalized when it has successfully prevented the occurrence of a dangerous act during the hospitalization? Does this provide support for requiring less restrictive placement within the hospital? Is prediction otherwise enhanced because of the opportunity for 24-hour observation during hospitalization? Does the performance of a "grievous or horrendous" act[213] obviate the constitutional necessity of a recent act? All of these issues are legitimate concerns requiring future consideration.

Recently, federal district courts in Pennsylvania[214] and Georgia[215] concluded that procedures for the "voluntary" hospitalization of minors by their parents or guardians violated the children's constitutional rights. Both

210. H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess., §§ 2(11), 32(2) (introduced Feb. 16, 1977). The alternatives required to be considered include such options as a return to home, family, or friends, guardianship, and utilitization of welfare services.
211. *Id.*
212. *Id.*
213. *See* discussion note 176 *supra*.
214. Kremans v. Bartley, 420 F. Supp. 1039 (E.D. Pa. 1975), *vacated as moot and remanded*, 97 S. Ct. 1709 (1977).
215. J.L. v. Parham, 412 F. Supp. 112 (M.D. Ga. 1976), *prob. juris. noted*, 431 U.S. 936 (1977).

cases have been brought before the United States Supreme Court. The Pennsylvania case was deemed moot because of legislation passed to resolve the problem; the Court has noted probable jurisdiction in the Georgia case. If, as a matter of federal or state constitutional law, such "involuntary admissions" are proscribed in Arizona,[216] further questions are raised. Does the proscription apply only to public hospitals or to private hospitals as well? Should the same standard for adult commitment apply? Is "in need of treatment" intervention more appropriate in the case of juveniles? Are juveniles more amenable to treatment? If so, what bearing should this have on the procedures for their hospitalization? Again, these are important issues for future debate and resolution.

H.R. 2326 cursorily addresses court-ordered treatment of Arizona residents in veterans administration hospitals and proposes to limit out-of-state transfer within the veterans system to instances where the patient consents.[217] Another alternative might be to authorize out-of-state transfer only after a court finding of informed consent. Out-of-state transfers within the veterans systems raise serious problems. The Mental Health Services Act embodies a strong Arizona policy determination concerning the rights to be accorded the mentally ill. Although out-of-state transfer within the veterans system does not deprive the committing court of jurisdiction,[218] it is difficult, if not impossible for Arizona courts to scrutinize the ongoing conditions of a patient transferred to a veterans psychiatric hospital in Ft. Lyon, Colorado or Sheridan, Wyoming. In light of these considerations and other recent proposals concerning the veterans hospital system,[219] the relation of Arizona's court-ordered treatment system to the veteran's administration should be reexamined.[220]

One of the major advances of the Mental Health Services Act was its limitation upon commitment where less restrictive alternatives were found to exist.[221] Curiously, the Act does not permit the court to order the proposed patient to accept these alternatives; rather the court's power to order commitment simply abates when they exist. The solution to this problem is not readily apparent: Ordering such alternatives in the absence of a comprehensive state system for the mentally ill raises perplexing questions. For example, the private alternative may refuse to accept the patient, or the patient may be unable to pay for the private alternative's service.[222]

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216. *See* Pima County Pub. Fiduciary v. Superior Court, 26 Ariz. App. 85, 87, 546 P.2d 354, 356 (1976).

217. H.R. 2326, 33d Ariz. Legis., 1st Reg. Sess. § 44 (introduced Feb. 16, 1977).

218. ARIZ. REV. STAT. ANN. § 36-548(A) (1974) (last sentence).

219. *See* R. Burt, Admission and Release Processes of Veterans Administration Psychiatric Hospitals (January 1973) (unpublished manuscript on file in the *Arizona Law Review* office).

220. For a recent detailed discussion of the Veterans Administration transfer problem, see Wexler, *supra* note 176, at 992-97.

221. *See* ARIZ. REV. STAT. ANN. § 36-540(A),(B), (D) (1974).

222. The Mental Health Services Act authorizes payment by the state or county of the cost of hospitalization in a private facility in certain very limited circumstances. *See* ARIZ. REV. STAT. ANN. §§ 36-545.03, -545.05 (1974).

How can the patient's compliance with the order be policed? What procedures are required where the patient abandons the alternative or it is otherwise unsuccessful?

These are some of the difficult and subtle problems not addressed in the progressive Mental Health Services Act or in the amendments proposed by H.R. 2326. On the other hand, H.R. 2326 contains important refinements which are necessary responses to the practical problems in ongoing application of the Act, and to the evolving legal doctrines against which the Act's constitutionality must be measured. The enactment of H.R. 2326 seems to be a necessary precondition to the proper, contemplative, and efficient resolution of the next generation of issues.