Part I

THE CIVIL COMMITMENT PROCESS

MODELS OF CIVIL COMMITMENT

Because proper care and treatment of the mentally ill[1] often involves legal issues as well as the need for medical analysis, the administration of psychiatric justice is frequently plagued with conflict between the lawyer and the doctor. Unlike the normal requirements for treatment of a physical ailment, care for the mentally disturbed is often thought to necessitate incarceration of the individual against his will. Such a denial of liberty awakens the spirit of lawyers who have insisted, with increasing success, that the decision to detain a citizen not be left to the psychiatrist's therapeutic discretion. Instead, the cases have begun to hold that provision must be made for due process protections and judicial—instead of medical—decision making.[2] While the psychiatrist may continue to argue that detention of a mentally ill individual is a medical question to be decided by a doctor, the relevant point is that the courts have disagreed. Because denial of liberty is a concomitant of many current psychiatric treatment methods, due process considerations demand judicial and legal intervention in the therapeutic process. The real questions to be asked are (1) how much intervention is necessary, and (2) at what point in the process of detention should judicial intervention occur?

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1. We recognize that use of the term "mental illness" assumes the resolution of a current and important debate—whether those who demonstrate abnormal behavior can really be said to be "ill" in the medical sense or merely deviant in a normative sense. Nevertheless, we have chosen to accept common usage and to refer to individuals who find themselves in the "mental health" processes of our courts and hospitals as the "mentally ill," without expressing an opinion as to the value of that term.

Those wishing to pursue an analysis of the concept of "mental health" should begin with T. SZASZ, THE MYTH OF MENTAL ILLNESS (1961).

2. *See, e.g.*, Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968); Anderson v. Solomon, 315 F. Supp. 1192 (D. Md. 1970); State *ex rel.* Fuller v. Mullinax, 364 Mo. 858, 269 S.W.2d 72 (1954).

The theoretical limitations and requirements imposed on state civil commitment proceedings by the due process clause of the fourteenth amendment have been thoroughly discussed by many able commentators. *See* Kittrie, *Compulsory Mental*

ADMISSION OF PATIENTS INTO A MENTAL HOSPITAL: THEORETICAL BASES AND STATUTORY SCHEMES IN GENERAL

Before presenting an overview of the types of statutory schemes used by the various states to hospitalize the mentally ill, it is worth noting briefly the theoretical bases upon which those statutes rest. Other commentators have throughly examined the philosophical underpinnings of civil commitment,[3] which generally fall into one of two categories. The state is said to be entitled to detain a mentally ill person against his will as an exercise of its police power or as a function of its relationship to its citizens as *parens patriae*.[4]

When the justification for confinement stems from the police power, the proposed patient must be considered to be a danger to society. The readily apparent problems regarding the feasibility of identifying those who present a future danger to others are explored in detail later in this project.[5]

Under the power of *parens patriae*, "the sovereign has both the right and the duty to protect the persons and property of those who are unable to care [for] themselves because of minority or mental illness."[6] Accordingly, under a pure *parens patriae* statute, an individual need not be dangerous to be committable. Rather, incarceration is contigent upon a showing that the patient is mentally ill and in need of care and treatment.[7]

Of course, the police power and the doctrine of *parens patriae* are relevant only as justifications for the detention of persons alleged to be mentally ill. As might be expected, however, the manner by which one enters the mental health system may have an important impact on a patient's treatment and may as well raise serious legal questions of procedural due process.

The manner in which different jurisdictions have solved the disparity between the treatment goals of the medical profession and the due process

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Treatment and the Requirements of "Due Process," 21 OHIO ST. L.J. 28 (1960); Kutner, *The Illusion of Due Process in Commitment Proceedings*, 57 NW. U.L. REV. 383 (1962); Note, *Hospitalization of the Mentally Ill: Due Process and Equal Protection*, 35 BROOKLYN L. REV. 187 (1969); Comment, *The New Mental Health Codes: Safeguards in Compulsory Commitment and Release*, 61 NW. U.L. REV. 977 (1967); Project, *Civil Commitment of the Mentally Ill*, 14 U.C.L.A.L. REV. 822 (1967); Note, *Civil Commitment of the Mentally Ill*, 1969 U. PITT. L. REV. 752 (1969).

Although due process considerations may appear to have been safeguarded by the courts and legislatures, in actual practice the contemplated procedures may afford little protection. In the sections that follow, due process issues will be considered as they arise in the detailed discussion of Arizona's civil commitment scheme.

3. *See* Livermore, Malmquist and Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968); Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945 (1959).

4. *See* Ross, *supra* note 3, at 954-60.

5. See section on the determination of dangerousness, pp. 96-118 *infra.*

6. Ross, *supra* note 3, at 956-57.

7. *Id.* at 957.

goals of the law varies widely.[8] Furthermore, as concern for the mentally ill has mounted, new systems for detention have proliferated,[9] with substantial differences in the weight they give to medical or jural considerations.[10] Thus, every nonvoluntary admission in Arizona is culminated by judicial approval,[11] while California permits a patient to be medically certified without judicial intervention for a period of intensive treatment,[12] subject only to the patient challenging his confinement by habeas corpus.[13]

Any attempt at summary analysis of existing American statutory schemes becomes difficult not only because they are amorphous, but because specific systems are often in a state of flux.[14] Furthermore, it should be remembered that while different state statutes may be similar on their faces, they may vary widely in their application. In the mental health field,

> [w]hile there has been much borrowing of statutory provisions from state to state, and some efforts have been made toward establishing uniformity, it seems that local needs, conditions, and attitudes still determine the character of the state's regulations.[15]

Other commentators have throughly reviewed the various hospitalization procedures provided by statute for treatment of the mentally ill. Specifically we refer the reader to the work of Rock, Jacobson and Janopaul for the American Bar Foundation,[16] and the chapters by Professor Dix in a recently published casebook.[17]

The American Bar Foundation study rather neatly classifies hospitalization procedures by the level of patient cooperation required under each scheme. Thus, procedures are either (1) voluntary; (2) nonprotested; or (3) compulsory.[18] These categories are defined as follows:

> *Voluntary*—The potential patient himself initiates or actively participates in getting himself into a hospital.
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> *Non-protested*—The patient acquiesces to hospitalization, neither taking the initiative himself nor resisting the initiative of others.

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8. *See* F. LINDMAN & D. MCINTYRE, JR., THE MENTALLY DISABLED AND THE LAW (1961), for a definitive study of statutes existing at that time. (A revised edition is expected to be published in 1971.) *See also* R. ROCK, M. JACOBSON & R. JANOPAUL, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 7-20, 32 n.1 (1968) [hereinafter cited as R. ROCK ET AL.].

9. Thus, for example, the California code was substantially amended in 1965, 1967 and 1968. Ch. 391 [1965] 1 Cal. Stats. 1629; ch. 1667, [1967] 3 Cal. Stats. 4107; ch. 1374, [1968] 2 Cal. Stats. 2675.

10. R. ROCK ET AL., *supra* note 8, at 19.

11. *See* ARIZ. REV. STAT. ANN §§ 36-505, -507, -514 (Supp. 1970-71).

12. CAL. WELF. & INST'NS CODE § 5250 (West Supp. 1971).

13. *Id.* § 5275.

14. Attacks on the constitutionality of new statute schemes are frequent and may lead to further modification. *See, e.g.*, Fhagen v. Miller, 312 F. Supp. 323 (S.D.N.Y. 1970). The impact of this litigation on the New York statute is as yet unknown.

15. R. ROCK ET AL., *supra* note 8, at 19-20.

16. R. ROCK ET AL., *supra* note 8.

17. F. MILLER, R. DAWSON, G. DIX & R. PARNAS, CRIMINAL JUSTICE & RELATED PROCESSES (1971).

18. R. ROCK ET AL., *supra* note 8, at 33.

Compulsory—The patient at one stage or another, or in all stages, expresses reluctance or resistance to hospitalization.[19]

From the lawyer's point of view, it has been said that voluntary hospitalization, "because of the rights retained by the patient—presents the fewest civil rights problems in the hospitalization of the mentally ill."[20] Controversy regarding voluntary admission centers around the competency of a patient to admit himself voluntarily[21] and around the statutory authority delegated to the hospital to "detain" a voluntary patient against his will if the patient should decide that he wishes to leave the hospital.[22]

Despite its legal and therapeutic advantages, voluntary admission may prove inadequate in many cases precisely because it requires a certain amount of insight by the patient over a sufficiently sustained period to execute the necessary documents and move into a hospital. As such

19. *Id.* The study recognized, however, that no rigid dividing line separates the various categories. Thus, a patient may not be objecting to hospitalization, so much as he is responding to a delusional system, or a patient may be happy to seek treatment on a voluntary basis but may be so debilitated that compulsory admission may be required.

20. *Id.* at 38.

21. A question often arises over the competency of a mentally ill person to agree to whatever conditions and curtailment of liberty are incident to his admission. In states that deal with the problem, the hospital staff must use its judgment regarding the patient's competency before accepting the application. It has been suggested that the uneasiness felt by medical personnel making such a legal decision, for which they may incur liability, results in a reluctance to accept other than compulsory or at least non-protesting patients. R. ROCK ET AL., *supra* note 8, at 36-38.

22. If one were to admit himself to a medical hospital, presumably he would be released immediately upon his expressing a desire to leave. On the other hand, one who voluntarily admits himself to a state mental hospital might, upon his request to leave, be released "forthwith" or might be detained as long as 30 days. R. ROCK ET AL., *supra* note 8, at 35. Zigmond M. Lebensohn, M.D., clinic professor of psychiatry at Georgetown University School of Medicine, while representing the American Psychiatric Association before Senator Ervin's hearings on the constitutional rights of the mentally ill, spoke out against the authorization given hospital superintendents to detain "voluntary" patients. His comments are worth repeating.

> Certainly one of the soundest provisions incorporated into Public Law 88-597 (and it has many excellent, sound provisions), is that having to do with voluntary admissions wherein the admitted patient can sign himself out of the hospital shortly after giving the hospital due notice. We think this provision is virtually sacrosanct by way of protecting what is tantamount to a contract between the patient and the hospital.
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> It should not be qualified or diluted in any way, not even to accommodate the patient's physician who may, on occasion, feel that the patient lacks judgment about his condition and would be better served if he remained in the hospital.
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> Should the patient be considered dangerous to himself or others, there are other remedies for dealing with the situation. For example, the hospital can notify the patient's family or other authorities thus involving them rather than the hospital in any further proceedings that should be taken in the patient's interest.
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> I should like to say parenthetically that one of the therapeutic leverages that the hospital psychiatrist has in dealing with an involuntary patient may be demonstrated by the following comment of a hypothetical doctor to hypothetical patient:
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> > Sir, I have had nothing to do with your coming here to this hospital. I realize that you are not happy about it. But what I am interested in primarily is getting you well, finding out what it was that

insight and motivation may be lacking in many persons who would not object to hospitalization, a system is often provided for the admission of patients who have no objection to hospitalization.[23] The significance of non-protested admission procedures is that they result in hospitalization without the delay, expense and possible traumatic effects[24] of a full-blown commitment hearing.[25]

The status of non-protesting patients varies from scheme to scheme. In some states, they can be released on the same basis as voluntary patients; in others, they may be held an indeterminate period.[26] The legal validity of such a procedure

> would seem to depend on: whether recognition is given to the importance of noticing and responding to the patient's protest [or request for release], however informal its manner of expression, by those who administer the procedure; whether a patient is given a reasonable and practical opportunity to express his protest; the administrative and judicial consequences of his lodging such a protest; and the extent to which the non-protesting patient has an opportunity, as has the voluntarily admitted patient, to have the question of his release determined after stating his desire that hospitalization be terminated.[27]

The New York law[28] is essentially a non-protesting scheme. No judicial authority is required to admit a person to a mental hospital. Patients can be admitted and held up to 60 days on a petition and the certifications of two doctors, and no court becomes involved unless the patient, after confinement, asks for a hearing.

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brought you to this state, and seeing if we can rectify it. But I have had nothing to do with your coming here.

Now, if a patient enters a hospital on a voluntary basis, and wants to sign himself out, his treating doctor cannot tell him, 'No, you are not going to go out. I am going to see to it that you are going to stay here.' If he did this the doctor would lose his theropeutic [*sic*] leverage entirely, and this is a very important leverage. There are always emergencies, of course, but these can be handled in the way which I have suggested earlier. *Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st & 2d Sess. 18-19 (1970) [hereinafter cited as *1970 Hearings*].

23. *See* R. ROCK ET AL., *supra* note 8, at 39-40.

24. See "The Trauma of a Due Process Hearing," pp. 69-76 *infra*.

25. R. ROCK ET AL., *supra* note 8, at 38-39. The American Bar Foundation study also defines a non-protested admission as one where "no positive action, specifically the execution of a document requesting admission, is required on the part of the patient." R. ROCK ET AL., *supra* note 8, at 38. In some states, including Arizona, however, the certification procedure results in hospitalization upon the patient's signing of a consent form. ARIZ. REV. STAT. ANN. § 36-505 (Supp. 1970-71). Despite the requirement of an executed form, this procedure, which results in the hospitalization without a hearing of one who has not voluntarily sought admission, can rightfully be placed within a slightly broader definition of non-protested admission than that employed in the American Bar Foundation study.

26. R. ROCK ET AL., *supra* note 8, at 39-40.

27. *Id.* at 39.

28. N.Y. MENTAL HYGIENE LAW §§ 70 to 88 (McKinney 1971). The provisions are discussed in Comment, *Incarceration of the Mentally Ill—New York's New Law*, 17 SYRACUSE L. REV. 671 (1966).

California's Lanterman-Petris-Short Act,[29] provides that under some circumstances a person thought by a peace officer or staff member of a mental health facility or other designated professional to be a "danger to others, or to himself, or gravely disabled,"[30] may be held 72 hours in an evaluation unit[31] upon mere written application by an appropriate person. If in the opinion of the staff the person is indeed dangerous or gravely disabled and will not accept voluntary treatment, "he may be certified for not more than 14 days of involuntary intensive treatment."[32] The certification must be signed by the head of the facility and by a physician, preferably a board-qualified psychiatrist.[33]

Judicial review may be obtained at any time during the 14-day incarceration by writ of habeas corpus to the superior court—a right of more than passing substance, as the official presenting the certification notice to the patient must advise him of it,[34] and must, if asked to do so, provide the patient with a form requesting release.[35] A hearing must take place within 2 days after the habeas corpus petition is filed, and the patient is given the right to appointed counsel to assist him in preparing the necessary pleadings and represent him at the habeas corpus hearing.[36]

Non-protesting schemes have certain inherent due process difficulties, which have been well stated by the Supreme Court of California in *Thorn v. Superior Court.*[37] At the time of certification, a patient is likely to be in a confused state, under medication or in emotional distress. These factors indicate the difficulty a patient may face in trying to understand his rights and to choose to exercise them and demonstrate

> the problems of conveying to the patient a realistic notice that he has been certified . . . but that he has the right to counsel and to seek release on habeas corpus . . . . A problem may also be presented by the possibility of role conflict arising from the entrusting of the notice and explanation of rights function to the same agency which undertakes to perform the therapeutic function.
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> Accordingly, it is appropriate that in any certification . . ., procedures be established which will assure that the patient's rights receive meaningful protection. Respondent court's view that the fact of involuntary certification demonstrates that the patient has not consented to the treatment and . . . is tantamount to a request for release, . . . illustrates one possible procedure: that is, as respondent court ordered, upon certification

29. CALIF. WELF. & INST'NS CODE §§ 5000 *et seq.* (West Supp. 1971).
30. *Id.* § 5150.
31. *Id.* § 5151.
32. *Id.* § 5250. If the patient has attempted or threatened suicide, he can be held for a second 14-day period. *Id.* § 5260.
33. *Id.* § 5251.
34. *Id.* § 5252.1.
35. *Id.* § 5275.
36. *Id.* § 5276.
37. 1 Cal. 3d 666, 464 P.2d 56, 83 Cal. Rptr. 600 (1970).

> the patient shall promptly be visited by appointed counsel.[38] (footnotes omitted).

Even if the due process problems could be fully solved in the non-protesting admission context, there are, of course, some persons who would not submit to voluntary or non-protested admission. If society's interest demands that they be incarcerated nevertheless, a compulsory system is required.[39]

For a variety of reasons, most patients in American mental hospitals have been placed there through compulsory commitment procedures.[40] The courts have traditionally accounted "for more hospital admissions in this country than any other method of hospitalization, although between 1956 and 1961 the percentage of court-committed patients decreased from 50.9 to 39.6 percent of total admissions."[41]

Judicial commitment procedures have several characteristics in common. Each begins with a petition alleging the person to be mentally ill, along with such other allegations as are required by the statute, and requires an examination of the respondent prior to the judicial hearing. Typically, almost anyone may file the petition, and the detention is authorized either upon the petition alone, or when accompanied by a medical certificate.[42] During the detention period, an examination is made by two physicians, who present their findings at the hearing.

At the hearing, the patient is generally afforded counsel, and the testimony by lay witnesses and psychiatrists is usually informal and brief. While specific procedural safeguards that may be required by the due process clause are discussed in greater detail throughout the remainder of this project, it is important to note that the definition of due process in commitment hearings is becoming increasingly clear.[43]

Dealing with a situation somewhat analogous to compulsory hospitalization—the pronouncement of an indeterminate sentence on an habitual sex offender—the United States Supreme Court in *Specht v. Patterson*[44] held that in addition to notice,

> [d]ue process . . . requires that [the subject] be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and to offer evidence of his own. And there must be findings adequate to make meaningful any appeal that is allowed.[45]

38. *Id.* at 675, 464 P.2d at 62, 83 Cal. Rptr. at 606. *See also* cases cited *supra* note 2.
39. Compulsory detention may be resorted to for a short-term period (*e.g.*, emergency hospitalization) or for a longer or indefinite term of treatment. The focus of the present inquiry is on extended commitment.
40. R. ROCK ET AL., *supra* note 8, at 31-32, 42-43.
41. *Id.* at 41-42.
42. *Id.* at 43-44.
43. See commentary cited *supra* note 2.
44. 386 U.S. 605 (1967).
45. *Id.* at 610.

Moreover, the Court's opinion in the juvenile delinquency case of *In re Gault*[46] has already been read by the Tenth Circuit, in a case involving the commitment of mentally deficient persons, as holding that due process safeguards are not to be limited because the hearing is civil in nature:

> We do not have the distinction between the procedures used to commit juveniles and adults as in *Gault*. But, like *Gault*, and of utmost importance, we have a situation in which the liberty of an individual is at stake, and we think the reasoning in *Gault* emphatically applies. It matters not whether the proceedings be labeled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process. Where, as in both proceedings for juveniles and mentally deficient persons, the state undertakes to act in parens patriae, it has the inescapable duty to vouchsafe due process . . . .[47]

It should be apparent from this brief discussion of American statutory schemes that the aims of therapy and consitutional due process are difficult to mold into one statute. Certainly, the great variety of systems in use and their constant revision indicate an absence of agreement as to the best methods for achieving these goals. Arizona's last major attempt to grapple with the problem was in 1958, when its civil commitment law was revised.[48]

ARIZONA STATUTORY SCHEME

The current Arizona statutory scheme is the result of lengthy amendment[49] made in 1958. Under its terms, there are four separate methods by which a person may be admitted to the Arizona State Hospital: voluntary admission,[50] medical certification,[51] emergency certification,[52] and judicial commitment.[53]

Voluntary Admission

Consistent with its own rules and regulations, the state hospital is authorized by statute[54] to accept any mentally ill person who applies for admission. The state hospital board is to determine an amount which will

46. 387 U.S. 1 (1967).
47. Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968).
48. ARIZ. REV. STAT. ANN. §§ 36-501 to -526 (Supp. 1970-71).
49. *See* ch. 14, [1951] Ariz. Sess. Laws 38, for the previous provision.
50. ARIZ. REV. STAT. ANN. §§ 36-502 to -504 (Supp. 1970-71).
51. *Id.* §§ 36-505 to -506.
52. *Id.* §§ 36-507 to -508.
53. *Id.* §§ 36-509 to -516.
54. *Id.* § 36-502.

reimburse the state for the voluntary patient's hospitalization and treatment, and the patient is charged for hospital services based on that amount and upon his ability to pay.[55]

Use of the term "voluntary" may be a bit misleading in certain cases. Under the statute, a minor may be admitted "voluntarily" upon the petition of his parent, guardian or next of kin.[56] Moreover, the hospital can detain any voluntary patient for 5 days after he requests permission to leave.[57] If the superintendent believes the patient is dangerous to himself, others or property, he may, within the 5-day period, initiate a petition to have the patient civilly committed.[58]

Medical Certification

The Arizona provision for admission upon mere medical certification is unlike the normal non-protested admission, described in the previous section on commitment schemes in general, in that in Arizona, the patient must himself consent to hospitalization.[59] Under this procedure, a court can, without a hearing, commit a patient to the state hospital or other designated facility when certain conditions are met.

A friend, relative, guardian, public officer or head of an institution in which the proposed patient is located, must petition the superior court in writing, alleging that the proposed patient is mentally ill and specifying the grounds for such allegations. Two doctors must certify to the court that they have examined the proposed patient within 7 days of the date of the petition and that he is mentally ill and will benefit from care at the state hospital. The proposed patient is then to be served with copies of these documents along with notice of the release provision of the statute and a consent form.[60] If, by signing the consent form, he indicates his agreement to hospitalization, all the documents are to be filed with the superior court, and the court then has 15 days to decide if hospitalization would appear to be in the "best interest" of the patient. If that somewhat ambiguous test is met, the court is to approve the petition and authorize the transporting of the patient to the state hospital or other designated facility.

When he has recovered or is no longer benefiting from treatment and is not dangerous, a patient admitted by medical certification is to be discharged by the superintendent.[61] Such a patient should also be released within 72 hours of requesting release in writing, provided that the superin-

55. *Id.* § 36-503.
56. *Id.* § 36-502.
57. *Id.* § 36-504.
58. *Id.* This practice is criticized by the American Psychiatric Association. *See* note 22, *supra.*
59. ARIZ. REV. STAT. ANN. §§ 36-505 to 506 (Supp. 1970-71).
60. If the proposed patient is "under the age of twenty-one, his spouse, parent, guardian, or adult next of kin, shall be served with a copy of the petition and certification, together with a form of notice and consent." *Id.* § 36-505(B).
61. *Id.* § 36-506(A).

tendent does not believe the patient to be dangerous to himself, others or property.[62] If the patient is believed to be dangerous, the superintendent is once again empowered to postpone discharge by initiating proceedings for judicial commitment.

Emergency Certification

Upon a petition alleging that the respondent is both mentally ill and likely to cause immediate injury to himself or the person or property of others, and the certificate of only one physician, a court is authorized, under the emergency certification statute,[63] to order a patient detained for a maximum of 10 days.[64] And, like the medical certification provision, if the superintendent believes the patient is dangerous, he has the power to postpone release and to institute ordinary civil commitment proceedings.

It should be noted that under both medical and emergency certification, the proposed patient has neither a statutory right to counsel nor an opportunity to appear before a judge; the statute only provides a right to release at the end of the specified time period. The patient's only other recourse would appear to be habeas corpus—although the statute does not provide that the patient be informed of that right.

Judicial Commitment

Any person[65] may petition the court for the detention and examination of a respondent he believes to be "mentally ill and in need of supervision, care or treatment."[66] When the petition demonstrates to the court's satisfaction that the respondent is mentally ill and in need of supervision or care, the judge will issue a detention order and the respondent will be brought to the county hospital or other place for examination.[67]

At least 2 days before the scheduled hearing, the respondent must receive a copy of the petition and detention order, notice of time and place of hearing, notice of his right to retained or appointed counsel, and notice of his right to subpoena witnesses.[68] No limit, however, is set on the length of time he may be detained prior to hearing.

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62. *Id.* § 36-506(B).
63. *Id.* § 36-507.
64. *Id.* § 36-508(A). If a patient needs emergency hospitalization at a time when a superior court judge is not available to sign a detention order, *id.* § 36-512 permits an emergency apprehension without any legal formality and authorizes a facility—such as a county hospital—to detain such a person for 48 hours (and sometimes for 72 hours) on the authority of a petition alone.
65. *Id.* § 36-509. *Cf.* State v. Jordan, 80 Ariz. 193, 294 P.2d 677 (1956).
66. ARIZ. REV. STAT. ANN. § 36-509(A) (Supp. 1970-71).
67. *Id.* § 36-510(A).
68. *Id.* § 36-513(A). After providing carefully for notice to the patient, *id.* § 36-513(D) provides that notice to the patient may be dispensed with and given instead to the patient's guardian, spouse, next of kin, or person with whom the patient is living. The project found that in Arizona, on the average, 71 percent of commitments are initiated by these same people.

Two physicians—not necessarily psychiatrists[69]—must examine the respondent and appear at the hearing, along with two other witnesses who will testify to their knowledge of the proposed patient's behavior.[70] The testimony of those four persons is jurisdictional, so that in their absence the proposed patient should not be committed.[71] Upon hearing the testimony of the witnesses, and that of the doctors regarding the respondent's mental illness and the likelihood of his being dangerous, the judge may either commit him to a mental hospital or dismiss the petition.[72] Furthermore, at the time of commitment, the judge may make the additional finding that the patient is incompetent.[73] Thus, under the general civil commitment procedure, a person may be indefinitely incarcerated and may suffer the loss of civil rights.

While the Arizona legislature has made provision for medical and emergency certification, these procedures are seldom used. Instead, the vast majority of involuntary hospitalizations in this state are the result of petition, detention and a judicial order of civil commitment. It is to a detailed examination of that judicial system, in principal and practice, to which we now turn.

69. *Id.* § 36-501.
70. *Id.* § 36-514(A)&(B).
71. *Cf.* State v. De Vote, 87 Ariz. 179, 349 P.2d 189 (1960).
72. ARIZ. REV. STAT. ANN. § 36-514 (Supp. 1970-71). Patients are committed to the Arizona State Hospital in Phoenix, Veterans Administration hospitals, or facilities authorized under *id.* § 36-501(3). There is no appeal from the commitment order. At intervals of one year, the patient may obtain a rehearing. *Id.* § 36-516. While the judge may commit the patient for 30 days observation if he is not certain that the patient meets the criteria for indefinite confinement, *id.* § 36-515, this provision is seldom used.
73. *Id.* § 36-514(C).

PREHEARING PROCEDURE

PETITION AND DETENTION ORDER

Prepetition Screening

In order to set the commitment machinery in motion, a petition must be filed with the superior court asking that an examination be made into the mental health of the proposed patient. If the court at that stage approves the petition, a detention order will usually be issued, the proposed patient will be detained and examined by physicians or psychiatrists, and a judicial hearing exploring the propriety of commitment may be held.

In some counties, especially outside of Maricopa and Pima Counties, the filing of a petition is a markedly uncomplicated procedure: the prospective petitioner, with or without the assistance of the county attorney,[74] simply completes and files the pertinent form. Unless the county attorney participates in the process and serves as a buffer, no real screening of petitions takes place.[75]

Indeed, even in relatively populous Pima County, a process for screening has only recently been initiated. Until September 1970, it was possible for a petitioner to obtain the requisite petition form at several locations—including the county courthouse—and to file the petition without further ado. But since that time, when Pima County undertook, through an ambitious program of community mental health,[76] to reduce

74. According to ARIZ. REV. STAT. ANN. § 36-509(B) (Supp. 1970-71), "[t]he county attorney shall prepare the petition . . . when requested by a party who desires to file the petition . . . ." It appears that in the metropolitan communities the assistance of the county attorney is never sought, but in some of the rural counties the county attorney does participate in the pleading stage—and sometimes in the hearing itself.

75. But it has been shown in a study of midwestern commitment proceedings that rural procedures provide more screening, and stress rationality in decision making far more than do urban procedures. Some of the rural rationality is attributed to the fact that the proposed patient is often known to the decision-making officials. Scheff, *Social Conditions for Rationality: How Urban and Rural Courts Deal with the Mentally Ill*, 7 AMER. BEHAVIORAL SCIENTIST 21 (Mar. 1964). In some of Arizona's outlying counties, the county attorney will interview the petitioner and determine whether a physician has been contacted who concurs in the petition, and in one county the prior acquiescence of a physician seems to be insisted upon.

76. See section on community mental health, pp. 118-146 *infra*.

commitments to the state hospital, a screening process has been in operation. Under the new procedure, petition forms are available only at the Southern Arizona Mental Health Center (SAMHC) and at the county hospital emergency room. A screening and evaluation unit operates 5 days a week from 8 a.m. to 4 p.m. at SAMHC, and a staff member of that unit moves to the county hospital emergency room until 11:30 p.m. In addition, staff members are on call during weekends and early morning hours. Under such an arrangement, the staff seeks to dissuade the filing of unnecessary petitions and attempts to explore the propriety of non-commitment treatment alternatives.

In Maricopa County, although such a complete community mental health model is not yet in operation,[77] a screening system of sorts is administered by the Bureau of Mental Health Services of the County Department of Health (BMHS). Since BMHS is the sole facility in Maricopa County for receiving petitions, every prospective petitioner in Maricopa County is referred there for advice. Often BMHS will recommend that the petition be filed. It is troubling, however, that such a recommendation is almost always made solely on the basis of facts presented by the petitioner—the person who will, at any subsequent commitment hearing, be the principal witness against the proposed patient. Yet, after speaking with BMHS, 60 percent of potential petitioners decide against instituting commitment proceedings. Many do not file because they are convinced by BMHS that commitment is simply not in order. Often, they are referred instead to various social agencies, to community health clinics, and to other voluntary treatment programs. But, despite its existence, many petitions are filed which BMHS concedes are without merit. Apparently, BMHS personnel do not believe they have the power to refuse to accept and file a petition in superior court if the petitioner insists upon it, though BMHS sometimes submits its recommendations to the court in a memorandum accompanying the petition.[78]

Several of the screening problems existing in Arizona—and especially in Maricopa County—have been tackled head-on in California. There, prepetition screening is built into the statutory framework. Each county is required to designate a person or agency to be responsible for preparing and filing mental health petitions and an individual believing another person to be mentally ill—to the extent that a professional evaluation is in order[79]—is to apply to the designated agency for a petition. But before filing the petition, the designated agency is required to have another

77. See the section on Maricopa County facilities, pp. 26-27 *infra*.

78. See *infra* p. 21 for a copy of one such memorandum. *Cf.* CAL. WELF. & INST'NS CODE § 5202 (Supp. 1971): "If the petition is filed, it shall be accompanied by a report containing the findings of the person or agency designated by the county to provide prepetition screening."

79. Actually, the California standard requires the petition to allege the respondent to be mentally ill and gravely disabled or dangerous to himself or others. CAL. WELF. & INST'NS CODE § 5201 (Supp. 1971).

approved agency—the prepetition screening agency—"determine whether there is probable cause to believe the allegations" and "whether the person will agree voluntarily to receive crisis intervention services or an evaluation in his own home or in a [designated] facility."[80] When screening by the prepetition screening agency has been completed, the first designated agency "shall file the petition if satisfied that there is probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself, or gravely disabled, and that the person will not voluntarily receive evaluation or crisis intervention."[81]

Thus according to its theoretical design,[82] prepetition screening in California at least contemplates some sort of factual investigation to test the accuracy and veracity of the petitioner's allegations, contemplates the use of voluntary evaluation in lieu of the petition process whenever possible, and apparently gives the designated agency charged with filing petitions an absolute veto over filing nonmeritorious petitions. Clearly, the California screening approach is worthy of serious consideration in Arizona.

The Petition

Though Arizona law technically authorizes actual commitment only upon a showing of dangerousness,[83] a petition requesting that a proposed patient be detained for the purpose of examination need only allege that the proposed patient "is mentally ill and in need of supervision, care or treatment."[84] By contrast, the California provision discussed above requires that a petition for evaluation allege that the proposed patient, as a result of mental disorder, is "a danger to others, or to himself, or is gravely disabled."[85] Yet, notwithstanding the loose Arizona statutory standard, a great number of petitions are defectively drafted. Defective drafting is no surprise, of course, in those cases where the petitions are prepared by laymen. Inadequate lay pleading provides yet another reason why the law ought to insist that the commitment machinery be invoked by a county attorney or, better yet, by a professional mental health screening service.

The primary problem with defective petitions is the pleading of mere conclusions rather than underlying facts. It is quite a different thing to allege "he is violent" than it is to allege "he became angry and beat his brother with a stick on three occasions." Many of the petitions re-

80. *Id.* § 5202.
81. *Id.*
82. Empirical studies exploring the operation of the California law are not available.
83. ARIZ. REV. STAT. ANN. § 36-514(C) (Supp. 1970-71). *See also* "Dangerousness and Committability—The Standard in Arizona", pp. 96-117 *infra.*
84. ARIZ. REV. STAT. ANN. § 36-509(A) (Supp. 1970-71).
85. CAL. WELF. & INST'NS CODE § 5201 (Supp. 1971).

cite the magic words, "he is a danger to himself or others." That, of course, does not make it so.

Many petitions are a series of conclusory statements with one relevant or irrelevant fact alleged. The following is the entire text of a petition upon which a detention order was issued:

1. He has shown violent behavior several times.
2. He has memory lapses.
3. He might be harmful to himself and others.
4. Uses credit cards without usual restraint.

If courts issue detention orders on the basis of conclusory petitions, as they frequently do, they are actually improperly delegating to the petitioners the judicial task of determining the sufficiency of the petitions. The law authorizes a court to order a proposed patient detained for examination only "when it appears on a petition . . . *to the satisfaction of a judge* . . . that a person . . . is mentally ill and in need of supervision, treatment or care . . . ."[86] But if the petition speaks only in conclusions, it is, of course, impossible for the judge to decide independently that a proposed patient meets the statutory standard for detention. Judicial reliance on conclusory allegations has long been legally taboo where fourth amendment rights are involved,[87] and seems already to have been condemned in the civil commitment area as well—evidenced in one jurisdiction by a flurry of successful habeas corpus petitions.[88]

In reviewing court commitment files across the state, the project discovered many problematic petitions which did not, from the facts presented, adequately convince the project member that the proposed patient met even the broad Arizona standard of being mentally ill and in need of supervision, care or treatment, let alone a stricter standard such as being dangerous or gravely disabled. Nevertheless, in most of these cases, detention orders were issued, and commitment to the state hospital —perhaps for legally insufficient reasons—was not infrequent.

Some of the insufficient petitions can be categorized according to dominant themes in their allegations. Without in any way attempting to be exhaustive, the project has devised the following classification of troubling petitions.

The first group may be called *general eccentric.* In these, activi-

86. ARIZ. REV. STAT. ANN. § 36-510(A) (Supp. 1970-71) (emphasis added).
87. Aguilar v. Texas, 378 U.S. 108 (1964). *See also* Spinelli v. United States, 393 U.S. 410 (1969).
88. Pfrender, *Probate Court Attitudes Toward Involuntary Hospitalization: A Field Study,* 5 J. FAM. L. 139, 150 (1965):

> [O]f the 221 petitions for a writ from Kalamazoo State Hospital . . . only 23 were denied. This means that 198 of the 221 patients were released because of imperfections in the way they were orginally [*sic*] admitted. Sixty-one of these cases showed defects in the petition, chiefly due to insufficient facts cited by the petitioner. Nineteen cases involved improper petitioners, and in 127 cases the physicians' certificates were defective, the majority because of conclusions and hearsay evidence.

ties are described which are deviations from the community norm, and perhaps even from the person's particular segment of the community. Viewed objectively, the activity could not be called evidence of need for care and treatment. But if one were drawing inferences a little carelessly, a detention order might well issue, as it did in the case portrayed below. Recitals of previous mental illness are often a part of these petitions:

> She is again hyperactive and doing bizarre things. She wants to go take driving lessons thinking that she can get her license one day. She then wants to buy a new car. She talks very fast all the time. She dresses in a bizarre way also. She is not herself and I am sure she is ill again. She has had three previous hospitalizations.

A further step in the direction of judging individuals by their deviation from normative behavior in the community is found in those petitions based merely on the *life style* of the respondent. Consider the following case, where the respondent was detained for several days pending a hearing, at which time the examining psychiatrists testified that he exhibited no signs of mental illness, whereupon he was promptly released. The respondent is a young man whose pattern of living may be described as a blend of Christian simplicity and oriental philosophy. Many people would call him a "hippie." His father, who had not seen him in 4 years, arrived in town, met his son, and shortly thereafter filed a petition alleging the young man to be

> incapable of self-management. He is extremely dirty about himself and his living quarters. He has no utilities or sanitary requirements for daily personal use. He neglects his health, does not eat properly or nourishing food although he receives an ample disability pension from the VA each month. This pension, which should be used for [the respondent's] benefit, appears to be used by his associates, who even try to get his check from the post office. His behavior is inappropriate as he appears to be hallucinating, is extremely religious and identifies with Christ. He recently went on a "vinegar diet," is very thin and unkempt. While he is not dangerous to others, his present way of living and neglect to himself (he's deformed) creates a danger to himself.[89]

Another group of problematic petitions may be termed *aged*, whereby the petitioner seeks to commit a person of advancing years who may be developing senility or who may simply need physical care. Often, this group consists simply of old people in need of nursing care. The following petition, which led to a detention order and to an eventual commitment, was filed for the commitment of an elderly gentleman:

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89. See *In re* Sealy, 218 So. 2d 765 (Fla. App. 1969), for a similar case. *Sealy* also indicates that psychiatrists as well as laymen sometimes confuse matters of life style with matters of mental health, especially with respect to young people. It seems that certain time honored tools of psychiatric diagnosis—such as concern for appearance—clash head on with the youth culture.

> He is incapable of taking care of himself or of living alone at this time. He is confused. He has wandered away from home on several occasions and it has been necessary that he be admitted to a hospital for his own protection as he is a possible danger to himself in his confused state.

The first sentence is conclusory. No facts indicating a true danger are shown, nor is it probable, merely because he wanders away, that he is in need of psychiatric treatment or care. The petition should have described the length of the departures and in what way the departures put the respondent in danger or indicated a need for care.

A final type of petition that presents problems to the court and to the entire commitment process is not as easy to detect as those discussed above. The following petition was filed in Maricopa County Superior Court:

> My husband left the family on July 12th. He has disappeared for days on several occasions. He has exhibited a split personality for over 20 years. His attitude and his mood change frequently. He has been violent and threatening to family members, often explodes over nothing. He has often talked about killing himself. He has now been unemployed for three weeks. It has been said that he can no longer get along with people. He is failing to take care of his family and himself in his mental disturbance. I believe that he may be a danger to himself or his family if he gets under more pressure.

Although it contains some unexplained hearsay ("It has been said") many conclusory statements, and may appear somewhat jumbled to most readers, it is arguable that the petition, if true, creates a probability that the respondent is mentally ill and in need of care or treatment. But if a screening agency is doing its job, the judge need not rely on the petition alone. The Maricopa County Bureau of Mental Health Services submitted the following memorandum with this petition:

> The [respondent and petitioner] have been married almost 24 years. There have been many separations and much trouble. Mr. [Respondent] is currently living with . . . an alleged girl friend. Mrs. [Petitioner] has filed for divorce three times in the past three years. There is one minor child. Neither [the petitioner nor the respondent] have an attorney.

It now becomes apparent that the real charge here is not that the respondent is mentally ill, but that he is disregarding his marital duties. This is a *marital spite* petition, many of which are filed each year throughout the state. Despite the BMHS report, a detention order was issued, and the respondent in the above case was confined for examination and hearing. At the examination, the psychiatrist found him to be "[o]riented, affect appropriate to thought content—judgment and insight intact—no evidence of psychosis." Unfortunately, as a result of the action of his spite-

ful wife, the man was incarcerated in a psychiatric ward for 5 days. At the hearing, the petition was dismissed.[90]

Judges should learn to recognize the hallmarks of the types of petitions outlined above. Even if the screening agencies are not permitted to veto petitions, they can perform an invaluable service by providing background information which will aid the judge in deciding whether to issue a detention order. When the screening agency believes the facts are legally sufficient to warrant a professional evaluation of a patient, it should assist in drafting a petition that will satisfy the statutory standards.

Sufficient petitions, of course, should not contain conclusory statements. Instead, they should allege facts that show, or from which an inference may be clearly drawn, that the respondent is (1) mentally ill and (2) is in need of care and treatment. Examples of perfect petitions rarely exist. Some, however, sufficiently allege facts showing a need for care and treatment, if not dangerousness:

> Mrs. ——— has been a friend of ours for 38 years. Recently she has become very sick. She seemed accidentally to have set her house afire, although she says someone threw a smoke bomb into her house. She was wandering in the neighborhood nude, and drove her car through the wall of her carport so we brought her to our home for her protection. She has no control of bladder or bowel, wanders and puts lighted cigarettes on inflammable surfaces, so we placed her in St. Luke's Hospital to see if they could help. [After discharge from the hospital and a 2-day stay at a nursing home, they returned the respondent to their home.] Since she has been back in our home, she has been very agitated and disturbed. She can't sleep, she wants pain pills, she screams . . . and messes on the floor. She is often incoherent. Now she is stuck in the bath tub and we have been unable to get her out.

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90. Another example of a petition seemingly filed for improper motives was uncovered by the project in an interview with an examining physician. In this particular case, the petitioner was a social worker rather than a spouse, and the respondent was eventually committed. In a taped interview, the physician related the following:

> One time I can remember a lady who was alcoholic but not crazy. The fault was the social worker who was the child welfare worker. He was kind of a "go getter." He wanted to take the kids out of the house. Instead of presenting her as an unfit mother, which would have been the course to take, . . . he had her brought into court for alcoholism to be committed to the state hospital. . . .
>
> Well, she was an alcoholic but she was not endangering the kids in the sense that she even meant them harm or that she was insane by the legal definition of it. She was perfectly capable [and] put on a defense of herself in the court room. . . . [S]he was capable of giving a pretty strong defense of herself and she did. One of the complaints was that she believed in the supernatural and this and that. I think I made the statement in court that if they put up everyone that believes in the supernatural they are going to put up half the people in the room. That's no grounds for commitment. They found her drunk a couple of times. Fine, but that wasn't grounds for finding her insane. They should have brought her up under a different rule, unfit mother or something.

> I believe Mrs. ——— is so sick she is dangerous to herself and needs to be hospitalized immediately.

Perhaps the most common type of sufficient petition involves the recent attempt of suicide:

> My son has been emotionally disturbed since his return from Vietnam . . . .
>
> Today he cut his wrists. He has a violent temper, which is much worse when he has been drinking. Sometimes he says he is going to kill people and is very upset about his war experiences. At times he cries, says he needs help, but today refused to enter a hospital voluntarily.

The Detention Order

Once a petition has been filed and has been found sufficient by the court, the standard practice throughout most of Arizona is for the court to issue a detention order, whereupon the proposed patient is apprehended by a deputy sheriff and taken to the appropriate detention facility[91] for the purpose of undergoing an examination by psychiatrists or physicians. Sometimes, particularly when the examining physicians do not have their offices at the detention facility, a day or two may pass before the examination is conducted. If the patient is examined and found not to warrant hospitalization, he may, in some parts of Arizona, be released immediately,[92] although in many other areas of the state he will be detained until his hearing and will presumably be released at that time. Patients detained for commitment are held until the hearing and are then ordered committed, usually to the Arizona State Hospital. Hearings are held at least weekly, but on occasion a patient's hearing will be unduly deferred,[93] and Arizona law sets no statutory limit on the length of time a patient may be involuntarily detained pending a commitment hearing.

To evaluate the Arizona practice, it seems profitable once again to compare it with California's relatively recent progressive legislation. In California, as we have seen, even a person alleged to be mentally ill and dangerous or gravely disabled does not have a petition filed against him, let alone a detention order issued, unless the person refuses voluntarily to undergo mental evaluation.[94] Moreover, if the person refuses voluntary evaluation and a petition is filed, the court, instead of issuing an immediate detention order, issues a *conditional* order of detention, authorizing the apprehension and detention of the proposed patient only if the patient fails to appear for evaluation at a certain scheduled time and

91. This is usually a county hospital or a county jail. See "Detention Facilities," pp. 25-29 *infra.*

92. The prehearing discharge procedure of "dismissal by letter" is explained in detail in "Role of the Physicians," pp. 60-66 *infra.*

93. See the section on the right to a speedy hearing, pp. 31-32 *infra.*

94. CAL. WELF. & INST'NS CODE § 5202 (Supp. 1971).

place.[95] If possible, the "summons" is to be served by an official wearing plain clothes and driving an official vehicle other than a police car.[96] If the patient fails to appear for his scheduled appointment, he is to be apprehended in the same manner. Finally, if apprehension and detention are necessary, evaluation is to be had "as promptly as possible" and, except when Saturdays, Sundays and holidays intervene, detention shall in no event exceed 72 hours,[97] at the end of which the patient must either be released, referred for voluntary treatment, or, as a last resort, certified for a 14-day period of intensive treatment.[98] If a patient is certified for intensive treatment, he is entitled to a judicial hearing within 2 judicial days of requesting one.[99] California's scheme, then, more so than the prevalent Arizona practice, deemphasizes the analogy between the civil commitment process and the criminal process, particularly in the area of uniformed law enforcement officers making "arrests." Significantly, too, California seeks to encourage outpatient mental evaluations rather than resorting to apprehension and detention for that purpose.

Interestingly, although the prevailing practice in Arizona is for the superior court to issue a detention order so that the proposed patient will be confined pending examination and hearing, the project's field work revealed that in some outlying Arizona counties, respondents, unless violent or likely to flee, are seldom detained prior to hearing. One reason given for such a practice was the lack of adequate detention facilities, though generally it was thought the best interests of the proposed patient would be served by his being in his home surroundings.

Arizona law with respect to outpatient evaluation is actually far from clear, and perhaps a statutory revision patterned after California procedures is in order. Nevertheless, there is probably room under existing Arizona law for a superior court, in appropriate cases, to fashion its detention order in conditional terms, so that the proposed patient would actually be taken into custody only if he refused or failed to appear for a scheduled outpatient evaluation. Thus, the Arizona statute permits a judge, after a petition has been filed, to "make *orders* which are necessary to provide for examination into the mental health of the person and for his apprehension and safekeeping in the county hospital or other place . . . which will afford access to designated examiners . . . ."[100] This

95. *Id.* § 5206. In California, the court implements the evaluation procedure by issuing a single "Order for Evaluation or Detention." The appropriate form may be found in *id.* § 5207. In practice, a copy of the California order for evaluation is given to the designated examination facility, and if the proposed patient fails to appear at the scheduled time and place, the facility notifies the authorities, who then pick the patient up and bring him to the facility.

96. *Id.* § 5212.

97. *Id.* § 5206.

98. *Id.* § 5250.

99. *Id.* § 5276.

100. ARIZ. REV. STAT. ANN. § 36-510 (Supp. 1970-71) (emphasis added).

language can easily be read as providing not only for a traditional detention order, but also for other preliminary orders to submit to an evaluation which would result in apprehension and detention only in the event that the patient did not appear at the scheduled evaluation.[101]

There are, of course, certain potential dangers in the legal availability of outpatient evaluations, and the dangers flow in two different directions. First, the outpatient evaluation device might be mistakenly used in situations where persons are in need of immediate detention.[102] Second, the outpatient evaluation device might be used to accomplish the forced evaluation of persons who would be left alone if the more drastic device of detention were the only one available.[103] Nevertheless, sensible administration of an outpatient evaluation provision could quite probably be achieved and the above dangers minimized, particularly if the screening agencies are given an active role by recommending in each case whether an outpatient examination should be conducted.

THE DETENTION FACILITIES

Upon the issuance of a detention order by the court, the proposed patient is apprehended by an officer and transported to a place designated in the detention order.[104] At the detention facility, the patient is usually evaluated by those who will testify at his commitment hearing. The extent and techniques of treatment available during detention vary in the different counties, but generally the involuntary patient receives little psychiatric treatment other than medication and physical removal from his normal environment.[105]

In this section, the project will examine the types of detention facilities used in the 14 Arizona counties and the normal practices of those facilities, which involve limitations on the proposed patient's personal freedom.

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101. *Id.* Note that while Section 36-510 speaks of the court making various "orders," section 36-511 provides for an officer apprehending a proposed patient pursuant to an "order for detention." Reading the two sections together leads to the inference that section 36-510 provides for certain orders in addition to strict unconditional detention orders.

102. An obvious example might be the case of a recent serious suicide attempt.

103. Surprisingly, the project's research disclosed a possible third danger of outpatient evaluations. Apparently, in some communities, the fact that a member of the community has been detained pending a commitment hearing may operate in his favor to avoid a wrongful commitment. In one rural county, an attorney informed project interviewers that when neighbors or friends of a proposed patient think the person is being wronged, they will call the attorney or even the judge and inform him of the circumstances. Perhaps if outpatient evaluations become the rule, neighbors and friends of docile or distressed patients may never learn of the pending commitment until the patient departs with the sheriff for the Arizona State Hospital in Phoenix.

104. ARIZ. REV. STAT. ANN. § 36-511 (Supp. 1970-71).

105. It is possible that detention serves the additional purpose of extra-legal social control. A project team member who investigated mental health processes in one outlying county filed this report:

> Mention was made of a long-haired bearded 'hippie-type' person who

Maricopa County

In Maricopa County, patients are detained at the psychiatric ward of the recently constructed Maricopa County General Hospital. The present head of that ward is not satisfied with his new facility. In his words, it "was conceived and designed in the Dark Ages."[106] He indicated to the project that not only is the present facility already overcrowded, but its very design precludes the administration of modern community-oriented psychiatric services. Instead of an accessible center conducive to developing crisis intervention and day care programs, the county has provided the therapists with "a jail for the mentally and emotionally disturbed."

A brief tour of the Maricopa County psychiatric ward supports the doctor's assertions. The ward itself is situated on the third floor of the new hospital and the entrance is kept locked. To gain entry, one must identify himself over an intercom while he is viewed by an invisible doorkeep by closed circuit television. The halls are long, clean and barren except that, here and there, a patient may be found sitting on the tile floor by himself or with other patients. While the unit's rooms are larger than those of the old facility, they were intended to be occupied by only two patients. Because of overcrowding, three patients are already often assigned to each room.[107]

In keeping with the mythical notion that the mentally ill must be isolated from the civilized world, the ward windows are "pitted" and barely translucent, providing a greenish-grey lumination merely suggestive of the bright Arizona sun that shines outside.[108]

During detention, the patient at Maricopa County General Hospital apparently has ample opportunity for interaction with staff and other patients. There are two day rooms, although the size of one has been diminished by partitioning to create additional office space. Patients may receive visitors from 2 to 4 p.m. and from 6 to 8 p.m. In order to prevent the smuggling of illicit drugs into the ward, however, patients with a history of drug abuse are not allowed to receive guests.

While the new ward has the advantages of air conditioning and

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was confined for bizarre behavior thought to be drug induced. While he was detained he was given a haircut and a shave, but no mention was made as to the method of persuasion that was used to obtain such results. There was no hearing because the proposed patient escaped from the hospital early in his confinement. The interviewer's impression was that the patient was not given a choice about receiving a haircut. This interviewer also had a beard and long-hair and made his escape a few minutes later.

106. The new facility, designed in 1959, opened on February 27, 1971.

107. Full occupancy of the ward was to be 36 patients. During the project's examination of the facility, only 2 months after it opened, there were 47 patients on the ward.

108. Normal window glass is used throughout the rest of the hospital with the exception of the jail security ward on the fourth floor, where "pitted" glass is also utilized.

additional space, it is unfortunate that its design reflects an architectural assumption that the mentally ill must be removed from society and jailed for their own protection. Furthermore, the fact of its recent construction would seem to preclude politically the creation in the short run of additional facilities less restrictive and more community-oriented in nature.

Pima County

The neuro-psychiatric ward of Pima County General Hospital could best be described as an unsuccessful experiment in communal living. A total lack of privacy pervades the unit, which is internally separated by glass partitions into male and female sections. There is, however, interaction of males and females in the common areas. Indeed, there is interaction everywhere as nurses, orderlies and social workers work and patients live in cramped quarters, locked off from the rest of the hospital and the outside world.

Pima County General Hospital provides no exercise areas for its psychiatric patients, although one staff member told project interviewers that the hospital would perhaps provide a small outdoor area in the future. Involuntary patients are not allowed passes, while voluntary patients are allowed to leave the ward only for a "constructive or useful purpose," such as job hunting or family visitation. If the patient is merely tired of cramped quarters and desires to leave the ward for a short period, a request for a pass will presumably be denied.

The day room, which doubles as the courtroom for commitment hearings, is too small to permit any type of occupational or manual therapy, and is not so used. There is a television set as well as some reading matter for patient use. Each patient is allowed to keep his own toiletries and other personal items, except razors or potentially dangerous instruments. Violent patients are apparently quieted by the use of medication, mechanical restraints, or are placed in one of the ward's seclusion rooms.

It appears that the Pima county detention facility is very much inferior to that of the Maricopa hospital, which at least provides semi-private rooms and more space. Both facilities, however, are woefully inadequate both in providing pleasant surroundings and therapeutic activities for those who have been detained against their will.

The Twelve Rural Counties

In the 12 less populous counties, patients are detained in either the available hospital facilities or the county jail. Use of the jail as the primary detention facility occurs in a few of the rural counties, although all counties use their jail facilities in certain circumstances. In the common situation, the limited number of psychiatric beds are filled to capacity, so that detention of an additional patient must be at the county jail. Of-

ten, violent patients will be incarcerated in the jail, although at least one county's sheriff prefers to transfer violent patients to the local hospital where they can receive tranquilizing medication.

It is worthy of note that in one of the most populous of the 12 "rural" counties, proposed patients are generally detained at the county jail, even though some hospital facilities are available. Project interviewers were told that the county jail is used because county officials were concerned about the additional expense represented by the hospitalization of proposed patients. In certain other counties, officials reported that local hospitals were simply not physically equipped to deal with mental patients and had insufficient staff trained in caring for the mentally ill.

Project members either visited the detention facilities in each county, interviewed officials about conditions in those institutions, or did both. The reports revealed the following information about detention under commitment petition in Arizona's 12 less populous counties.

1. DETENTION IN HOSPITAL FACILITIES. Where the local hospital facilities provide beds for psychiatric detention, the rooms are generally comparable to normal hospital rooms. The windows may be barred, however, and the rooms underfurnished. It is the normal practice in several counties to keep the door locked while a room is occupied by a proposed patient, although a private facility that is used for detention in one county is equipped with "half-door" rooms. That appellation refers to the fact that the top part of the door of these rooms may be left open while the bottom is latched from the outside. The proposed patient is thus provided with the impression of contact with the world beyond the locked door.

Although security facilities are available in one hospital, staff members informed project interviewers that, if at all possible, the proposed patients are kept on the general wards and, with certain limitations, are treated as ordinary hospital patients. In another county, however, patients awaiting commitment hearings are kept in the same detention unit as are inmates of the county jail who have been hospitalized for physical illness.

Most of the project interviewers reported that there is little opportunity for detained patients to exercise. Apparently, however, in at least one hospital a proposed patient is allowed to walk about the hospital if the doctor believes the patient would not abuse the privilege. Hospitalized patients are generally afforded the same rights and privileges as are other patients regarding visitation, mail and telephone use. In this regard hospitalized patients fare far better than those who are detained in county jails.

2. DETENTION IN THE COUNTY JAIL. While many counties regularly detain proposed patients in their county jails, there is little uniformity in the type of cell used for this purpose. The patient may be held in a normal single cell, an elaborate padded section of the jail, or merely

thrown in with the inebriates who occupy the "drunk tank." There is no therapy for those detained in jail facilities, and individual rights are considerably more restricted than they would have been had the patient been taken to a hospital.

As was previously mentioned, one fairly populous county uses its jail for the primary detention facility. In that county, patients are isolated in one of two padded cells. Both cells are adjacent to a central station, enabling deputy sheriffs to observe closely, through a slide-back, metal screen door, the patients' activities. If a patient manifests extreme dangerousness to himself, a strait jacket may be employed in addition to crisis level dosages of medication. Complete censorship of mail and phone use is the rule, together with prohibition of radio and television use. Visitors are generally not allowed, although a patient may receive members of his immediate family upon the doctor's recommendation. While the sheriff of this county has been described as "compassionate" and "overly cautious" toward those sequestered, it was the widespread view of interviewed officials that the local hospital should be used for detention purposes. Apparently, however, the county has been unwilling to accept the financial burden this would entail.[109]

The problems of additional expense and inconvenience to hospital staff notwithstanding, it is clearly unreasonable to maintain that jail detention for non-explosive patients is ever justified if hospitalization is an available alternative. Furthermore, even with patients who present some degree of dangerous behavior, it is difficult to accept the argument that the staff of a hospital in one county is incapable of dealing with such a problem, when the mentally ill are cared for, apparently without incident, in other county hospitals. However considerate and humane a sheriff's deputy may be when dealing with proposed patients, the fact remains that, under the guise of help and treatment, individuals are regularly being apprehended by law enforcement officers and detained in county jails. Obviously, jail incarceration may have a deleterious effect upon an already disturbed person and is thus at odds with the philosophical basis for commitment. It should be equally clear that this practice—which is probably a function of habituation—could be easily discontinued. At the very least, the judge issuing the detention order should, before authorizing jail detention, have to be convinced that hospitalization would be a grossly unsuitable detention alternative and that jail detention is an absolute necessity in the particular case.

PREHEARING RIGHTS

Notice

The Arizona statute dealing with notice provides that a copy of

109. Individuals who are able to afford the hospital costs, however, may be placed there upon a doctor's approval.

the petition, the order for detention and notice of the hearing shall be served on the proposed patient at least 2 days before the date of the hearing.[110] Upon affidavits of two physicians stating that, in their opinion, personal service will be "detrimental" to the patient, service may be dispensed with by order of the court and may be served instead "upon a guardian, spouse, adult next of kin, or a person in whose premises the proposed patient is living."[111] This notice procedure is in accord with the recommendation of the *Draft Act* model and has been adopted in most other jurisdictions.[112]

Some psychiatrists, however, have criticized the requirement of formal notice. One psychiatrist has termed formal notice "the most infuriating of the legal features of commitment."[113] His rationale is that a paranoid given formal notice that he is about to be committed may be prompted to violence or seek to escape, and a person in severe depression may attempt suicide or may retreat mentally, worsening his condition. One answer to these critics is that the experience of detention in a mental ward is no less traumatic than the formal notice sought to be avoided.[114] Another answer is that most jurisdictions, Arizona included, provide for waiver of notice when the detrimental effects are apparent to the physician. Such a provision is not a complete solution to the problem, however, since detention orders and notice are usually served at the "pick-up stage"—before the individual is examined. Thus, the dispensation provision would seem fully applicable and beneficial only where the patient is already under detention, is in a psychiatric hospital, or is otherwise under psychiatric care.[115]

An examination of actual practice in Arizona indicates that formal notice is normally served with the detention order at the time the proposed patient is picked up for examination. The notice is read to the in-

110. ARIZ. REV. STAT. ANN. § 36-513 (Supp. 1970-71).

111. ARIZ. REV. STAT. ANN. § 36-513(D) Supp. (1970-71). Actually, the technical language of the statute permits dispensation of notice and then states that notice "may" be served instead on a substitute individual. Hopefully, the substitute notice rule will be read as mandatory rather than discretionary when personal notice is dispensed with. Yet, commitment file checks in Pima and Maricopa Counties indicated that, if the files are accurate, notice was not served on anyone at all in 2 percent of Pima County cases and in 10 percent of Maricopa County cases.

112. NATIONAL INSTITUTE OF MENTAL HEALTH, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL § 9(b) at 26 (Public Health Service Pub. No. 51, 1951) [hereinafter cited as DRAFT ACT] (reprinted in F. LINDMAN & D. McINTYRE, THE MENTALLY DISABLED AND THE LAW 397, 402 (1961).

113. H. DAVIDSON, FORENSIC PSYCHIATRY (1965).

114. *See* Comment, *The New Mental Health Codes: Safeguards in Compulsory Commitment and Release*, 61 NW. U.L. REV. 977, 999-1000 (1967).

115. Omission of notice "in the best interest of the patient" has been held not to violate due process if notice is given to individuals who represent the interest of the patient, and statutes allowing notice to others on behalf of the patient have been upheld. See the discussion in Weihofen & Overholser, *Commitment of the Mentally Ill*, 24 TEX. L. REV. 307, 341 n.113 (1946).

dividual by the deputy. In Pima County, if the patient is already in detention, the notice is termed a "reader" by the Pima County Sheriff's Department, and a deputy is sent to the county hospital to read the notice to the patient. The mental picture of a deputy reading the formal notice of hearing to a highly distraught patient under detention in a psychiatric ward may seem somewhat bizarre, but according to one interviewed official, such is the local interpretation of the requirements of the statute.

The effectiveness of notice to the individual in such circumstances, or in any circumstances when the mental state of the individual is in issue, can be seriously questioned. This objection is overcome in a Washington statute which provides that the patient must be given notice unless a guardian *ad litem* is appointed.[116] Perhaps the only way to insure effective notice in commitment proceedings would be to require the immediate appointment of a guardian *ad litem*, which could be the court-appointed attorney, and to serve him and, in the ordinary case, the patient as well. Such a statutory requirement would hardly place a heavy burden on appointed counsel and would effectively protect the individual's rights as intended by the present statutory requirement of notice.

Right To A Speedy Hearing

The right to a speedy hearing is of the utmost importance in commitments since no right to bail exists for one detained for mental examination prior to a commitment hearing. In Arizona, this has not usually been a significant problem since commitment hearings are regularly held twice a week in Maricopa County and weekly in Pima County. The rural counties, dealing with fewer commitment cases, almost always hold hearings within 48 hours after the petition is filed. One county judge related an instance where the commitment hearing was held within 2 hours of the filing of the petition, in an ambulance parked outside the courthouse.[117] Since due process would allow a reasonable time for medical examination and for the scheduling of hearings, this right seems seldom infringed in Arizona. One possible exception might be in those instances, primarily in the metropolitan areas, where the examining doctors seek an excessive number of continuances in order to see how the patient progresses while on the county hospital psychiatric ward. Continuances for that purpose may, of course, be in the patient's best interests, but excessive continuances should not be permitted over the objection of the patient or his counsel. Another abuse involves the use of a continuance to postpone a hearing when crucial witnesses fail to attend. In one instance, for example, an Ari-

116. WASH. REV. CODE § 71.02.140 (1962).
117. Although the proposed patient was afforded a speedy hearing, it is possible that in this case justice might have moved somewhat more rapidly than the circumstances required.

zona Civil Liberties Union observer reported to the project a case he observed where the commitment case of a woman in her late sixties was continued because her daughter—a central witness—did not appear and could not be reached. Perhaps a speedy hearing could be insured if Arizona adopted a statute establishing a maximum length of time a proposed patient could be held pursuant to a petition and detention order. In California, for example, a patient can be confined pursuant to a detention order for no longer than 72 hours, at the end of which the patient must either be released or formally proceeded against.[118]

Right to Counsel

The right to counsel in commitment proceedings has traditionally been premised on legislative policy rather than on constitutional right. But the legislative policy has been rather widespread: in a study conducted 5 years ago, only eight states had no provision for counsel at commitment proceedings.[119] In fact, there has of late been a growing recognition that appointed counsel in a commitment proceeding is a constitutional right. The langauge used in the Supreme Court opinion of *In re Gault*,[120] concerning procedural safeguards—including the assignment of counsel—in juvenile commitment, may be readily extended to any type of proceeding involving the potential loss of liberty. The Tenth Circuit in *Heryford v. Parker*,[121] relying on *Gault*, found a constitutional right to counsel in commitment hearings involving the mentally deficient. There, the court stated:

> We do not have the distinction between the procedures used to commit juveniles and adults as in *Gault*. But, like *Gault*, and of utmost importance, we have a situation in which the liberty of an individual is at stake, and we think the reasoning in *Gault* emphatically applies. It matters not whether the proceedings be labeled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process. Where, as in both proceedings for juveniles and mentally deficient persons, the state undertakes to act in parens patriae, it has the inescapable duty to vouchsafe due process, and this necessarily includes the duty to see that *a subject of an involuntary commitment proceedings*

118. CAL. WELF. & INST'NS CODE § 5206 (Supp. 1971).
119. Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424, 437 (1966). In Appendix A, Cohen lists 42 jurisdictions with some provision for appearance of counsel at commitment proceedings. *Id.* at 460-66.
120. 387 U.S. 1 (1967). *See also The Supreme Court 1966 Term*, 81 HARV. L. REV. 69, 174-76 (1967).
121. 396 F.2d 393 (10th Cir. 1968).

> [*sic*] *is afforded the opportunity to the guiding hand of legal counsel* at every step of the proceedings, unless effectively waived by one authorized to act in his behalf.[122] (emphasis added).

In Arizona there is a statutory right to counsel. The statute provides: "At the time of apprehension or during detention, but before the hearing, the proposed patient apprehended shall be permitted to consult an attorney to represent him at the hearing. If he is not represented by an attorney, the court shall, before the hearing, appoint an attorney to represent him."[123] The statute is quiet as to the role of counsel, a matter to be dealt with later. Since Arizona has a definite right to counsel, the existence of a constitutional right to counsel would seem of secondary importance were it not for the line of cases starting with *Powell v. Alabama*,[124] where the Supreme Court held that the duty to appoint counsel "is not discharged by an assignment at such a time or under such circumstances as to preclude the giving of *effective aid* in the preparation and trial of the case."[125] Presumably a constitutional right to appointed counsel would, even more than a statutory right, require "effective assistance of counsel" —a matter of extreme importance when consideration is given to the actual performance of appointed counsel in Arizona.[126]

Under the terms of the Arizona statute, appointment of counsel must be made "before the hearing." In actual practice, appointment of counsel may be made the same day as the hearing. Unless the patient has retained his own counsel, his interview with appointed counsel may at best be of short duration and take place a few minutes before the hearing.

In Maricopa and Pima Counties, one attorney is usually appointed to represent all of the indigent cases on the docket for the same day. In Maricopa County, hearings are scheduled in the afternoon and lawyers usually try to interview patients the previous evening or the morning before the hearing. In Pima County, during hearings observed by the project, a public defender was appointed *at* the hearing and had no opportunity to pre-interview the patients.

While it might appear that the practice of first appointing counsel at the hearing itself is the lowest standard by which any "right to counsel" could be enforced, a project interview did uncover, in one of the counties where Indians sometimes come before the civil commitment court, an even graver deprivation of the right to counsel:

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122. *Id.* at 396.
123. ARIZ. REV. STAT. ANN. § 36-514(A) (Supp. 1970-71).
124. 287 U.S. 45 (1932).
125. *Id.* at 71 (emphasis added).
126. For an analysis of the potential effect of counsel on commitment hearings, *see* Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. HEALTH AND SOC. BEH. 66 (Mar. 1969).

JUDGE: I have absolutely no jurisdiction over an Indian to commit him to the State Hospital. But I do it anyway—I do it all the time. It's illegal *ab initio*. So why appoint an attorney?
PROJECT: So commitment is for his benefit?
JUDGE: Yes, it's for his benefit, but if I have no jurisdiction, I see no point in appointing an attorney, because its' all illegal anyway.[127]

Project interviews of court-appointed attorneys disclosed that many felt more time should be permitted to allow adequate investigation of the facts. But those attorneys also agreed that even if time did permit, the stipend offered for such services would not cover the expenses of even the most cursory of investigations. Before the use of the Public Defender in Pima County, appointed counsel were paid $5 per case. In Maricopa County, appointed counsel are paid $10 per case (with a $50 minimum for the afternoon). These fees should be contrasted with the recent experience in Allegheny County, Pennsylvania, where a proposed fee schedule, already accepted by the State Commissioner of Mental Health but not yet implemented, would pay assigned counsel $200 per commitment case.[128]

Even if the attorney in his brief interview with the patient were to be convinced of the lack of need for commitment, he, like the court, is very apt to be swayed by the psychiatric examination and recommendation. Lacking medical expertise, the attorney will usually rely on the psychiatric report more than on his own intuitive reaction or the unsupported word of his client. Bruce J. Ennis, appearing before the Senate Subcommittee on Constitutional Rights, made the following statement concerning appointed counsel at commitment hearings:

> One thing that is clear is that assigned lawyers are frequently worthless. Mental hygiene law and practice is extraordinarily intricate. It requires as much specialization as tax law or securities law. Furthermore, effective cross-examination of psychiatrists requires a good working knowledge of psychiatric terms and intra-discipline disputes. Inexperienced attorneys cannot adequately represent mental patients.[129]

If the attorney decides that his client is not in need of treatment, he has had no opportunity to ascertain the facts nor to prepare a case. His only course of action would be to ask for a continuance, which would automatically remand his client back to confinement in the psychiatric ward. On the other hand, when the patient, in the eyes of the attorney, needs

127. The entire question of Indian mental health and the legal process is an important and intriguing one, but is beyond the scope of the current project. *Cf.* Kelly, *Indian Adjustment and the History of Indian Affairs*, 10 ARIZ. L. REV. 559 (1968); Comment, *Indian Legal Services Programs: The Key to Red Power?*, 12 ARIZ. L. REV. 599 (1970).

128. Interview with David M. Janavitz, Esq., former member of the Task Force on Mental Commitments, Office of Mental Health, Pennsylvania State Department of Welfare, in Tucson, Arizona, March 24, 1971.

129. *1970 Hearings, supra* note 22, at 286.

treatment or confinement, an awkward and uncomfortable situation arises. Unlike a criminal action where an attorney generally seems untroubled by zealously seeking his client's acquittal despite a personal belief in the client's guilt and dangerous character, attorneys representing patients in commitment hearings usually do little or nothing to obtain the client's release, regardless of the client's wishes, when the attorney feels commitment is in order. This apparent conflict will be discussed later in the section on the role of counsel.[130]

If appointed counsel is to be effective at all, he must be appointed far enough in advance of the hearing to permit investigation of the facts and of possible alternative dispositions to commitment. Also, adequate funds must be made available to compensate counsel for his efforts and to reimburse counsel for conducting any necessary investigations.

Self-Incrimination

The goal of a civil commitment hearing is an adjudication of the respondent's *susceptibility*, under the statutory standards, for involuntary psychiatric treatment. Towards this end, a thorough mental examination of the patient is necessary if a medically sound decision is to be reached. If the disposition calls for involuntary commitment, however, the patient may be subject to stringent deprivations of liberty. Thus, the patient's own active participation in the hearing and psychiatric interview may cause him to be an agent in his own demise. Requiring a patient to "incriminate" himself in this manner may well violate the fifth amendment to the United States Constitution.

Evaluating the applicability of the fifth amendment protection against self-incrimination to a civil commitment proceeding,[131] one is initially dissuaded by the amendment's reference to "criminal" matters,[132] but recent Supreme Court decisions serve to dispel such a limited application.[133] The Court has of late avoided limiting the scope of constitutional protections according to a simplistic labeling process, and has instead looked to the possible loss of liberty to be incurred. The Court's position is succinctly stated in *In re Winship*:[134] "[we] made it clear in [*Gault*] that civil labels and good intentions do not themselves obviate the need for

130. *See* pp. 53-60 *infra.*

131. Strictly speaking, the privilege is "applicable" to *all* proceedings in the sense that a witness in any criminal, civil or administrative proceeding can always refuse to answer a question on the ground that the answer might be used against him in a later *criminal* prosecution. In the present discussion, however, the matter at issue is whether the privilege should protect an individual from making testimonial or communicative assertions that could later be used not in a criminal case but in a "civil" proceeding which may result in the deprivation of his liberty.

132. "In any criminal case". U.S. CONST. amend. V.

133. *In re* Winship, 397 U.S. 358 (1970); *In re* Gault, 387 U.S. 1 (1967); Specht v. Patterson, 386 U.S. 605 (1965).

134. 397 U.S. 358 (1970).

criminal due process safeguards . . . ."[135] Indeed, in *Gault,* referring to the fifth amendment privilege, the Court expressly noted: "It is incarceration against one's will, whether it is called 'criminal' or 'civil'. And our Constitution guarantees that no person shall be 'compelled' to be a witness against himself when he is threatened with deprivation of his liberty—a command which this Court has broadly applied and generously implemented . . . ."[136]

The traditional argument against application of the privilege is premised upon the assumption that proceedings for the commitment of the mentally ill are for therapeutic and not punitive purposes.[137] Yet, particularly when active treatment does not necessarily follow commitment[138] and when commitment results in institutionalization and in the loss of many privileges,[139] it is inconceivable that the rationale of the fifth amendment in criminal proceedings should not similarly apply to civil commitment proceedings.[140] It should, of course, be made clear that even if a prospective patient can avail himself of the privilege, it by no means always follows that he ought to do so. If, as is beginning to be the case in Pima County, the court or the examining physicians are in the habit of closely guarding the patient's liberty by authorizing hospital commitment only where no less drastic alternatives are suitable or available, then a thorough psychiatric examination is necessary so that the feasibility of all the alternative modes of treatment can be exhaustively explored. In the absence of this information, the patient may well be institutionalized because of a judicial or medical error in over-prediction of dangerous tendencies—an error which might well be avoided by a thorough and open psychiatric interview.[141] In short, where the mental health system operates within

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135. *Id.* at 365-66.

136. 387 U.S. 1, 50 (1966).

137. *See* People v. Lipscomb, 263 Cal. App. 2d 59, 69 Cal. Rptr. 127 (1968); People v. Fuller, 24 N.Y.2d 292, 248 N.E.2d 17, 300 N.Y.S.2d 102 (1969). *See also* Note, *Civil Restraint, Mental Illness and the Right to Treatment,* 77 YALE L.J 87 (1967).

138. "The Right to Treatment," pp. 228-36 *infra.*

139. *See* "Rights of Patients," pp. 207-27 *infra.*

140. Heryford v. Parker, 396 F.2d 393, 397 (10th Cir. 1968); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1967); People v. Potter, 85 Ill. App. 2d 151, 228 N.E.2d 238 (1967); Hasket v. State, — Ind. —, 263 N.E.2d 529 (1970). More elaborate legal discussions of the self-incrimination clause in the commitment context can be found in Ennis, *Mental Illness,* 1969-70 ANN'L SURV. AM. L. 29, 33-37 (1970); Note, *Due Process for the Narcotic Addict? The New York Compulsory Commitment Procedures,* 43 N.Y.U.L. REV. 1172, 1181-83 (1968).

Arizona has not, by statute or case law, faced the issue of self-incrimination in a civil commitment hearing. The privilege contained in ARIZONA CONST. art. II, § 10 has, however, been extended to those situations in which the claimant has shown " 'that the answer is likely to be dangerous to him.' " Thoresen v. Superior Court, 11 Ariz. App. 62, 66, 461 P.2d 706, 710 (1970), *quoting* United States v. Weismann, 111 F.2d 260, 262 (2nd Cir. 1940) (Hand, J.). Although this language may provide a touchstone for extending the privilege into the civil area, the Arizona courts have not given any other positive indication that they are receptive to such an extension.

141. It is assumed that assertion by the defendant of his fifth amendment

the contours of the community psychiatry model,[142] strict reliance on the constitutional privilege against self-incrimination may, in many cases, not serve the best interests of the patients.[143]

privilege will severely restrict the psychiatric interview and thereby limit the psychiatrist's personal knowledge of the patient's mental disorder.

142. *See* "Community Mental Health; Social Impact and Legal Implications," pp. 118-46 *infra.*

143. Whether or not the patient has the right to refuse to speak with a psychiatrist, some commentators, invoking the "critical stage" and cross-examination doctrines of United States v. Wade, 388 U.S. 218 (1967), have argued persuasively that the patient should have the constitutional right to the presence of counsel during the psychiatric interview (or at least to a tape recording of that interview) in order to insure a meaningful cross-examination of the psychiatrist at a later commitment hearing. For a full and thoughtful analysis of this legal proposition, see Ennis, *supra,* note 140, at 37-42. Ennis notes, too, that California by statute permits a prospective patient to be accompanied to a psychiatric evaluation by a friend, relative, attorney, religious advisor, etc. *Id.* at 40. *See also* Lee v. County Court, 27 N.Y.2d 432, 260 N.E.2d 869 (1971).

THE HEARING

AN OVERVIEW

After detention and psychiatric examination, the next step in the commitment process is the judicial hearing. The hearings in all Arizona counties comply at least superficially with the broad statutory requirements: a hearing is always held, the requisite number of witnesses always attend to testify, and the doctors or psychiatrists are always present to make their recommendations. But, as will be seen, superficial compliance hardly insures adequate protection to the proposed patient. Interestingly, the atmosphere of the hearing seems to differ in the various counties.

Maricopa County

Hearings in Maricopa county are conducted before the probate judge[144] twice a week, on Mondays and Thursdays. A large number of cases are commonly heard on each day. On one occasion, for instance, the project observed the processing of 18 cases during a single afternoon sitting.[145]

The hearings, which are not transcribed,[146] progress in rapid fire fashion, averaging 4.7 minutes each, with some consuming not more

144. In Maricopa County, a single judge hears all civil commitment cases. The practice differs in Pima County, where the judge who happens to be the assignment judge for a particular month, pursuant to a rotation schedule, also hears all commitment cases during that month.

145. While holding all commitment hearings on certain days has obvious advantages, such as the efficient use of the testifying psychiatrists' time, the clear-cut pressure to process all current cases by the end of the court day must inevitably work against the contemplative exploration of pertinent legal, factual and medical issues. Where deprivation of liberty is at stake, it seems in order to follow the model of the criminal process and to depart from a rigorous time schedule.

146. The right to a transcript of the hearing has been raised by some advocates of patients' rights. In the District of Columbia, Mental Health Commission hearings are now transcribed and a copy of the transcript is made available to the patient and his counsel. *1970 Hearings, supra* note 22, at 796 (letter from Robert J. Golten, Chief, Mental Health Division, District of Columbia Public Defender Service, to Larry Baskir, Esq., Chief Counsel, Senate Subcommittee on Constitutional Rights, Aug. 24, 1970). In Arizona, however, the proceedings are not transcribed and only minute entries are made in the file record of the court.

It might be thought that since the hearing determines committability at the

than 3 minutes. They begin with the judge announcing the name and case number of the first patient and then the calling and swearing of the witnesses.[147] Next, the patient is ushered into the hearing room—a small room on the psychiatric ward of the county hospital.[148] On some occasions the patient may not be present.[149]

After the patient is seated, the patient's court-appointed attorney asks the witnesses if they have read the petition, whether they feel it is "substantially" true, and whether they wish to amend or change anything in it. The witnesses almost invariably answer that the petition is substantially true and that they have nothing to add.

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time of the proceeding rather than guilt or innocence of a past act, a transcript is probably not as crucial in mental health proceedings as it would be in criminal proceedings: If the patient is committed and later petitions for a periodic re-examination and release hearing pursuant to ARIZ. REV. STAT. ANN. § 36-516 (Supp. 1970-71), it will be his mental condition *at the time release is sought* that will be crucial, not his past mental state. Indeed, facts relating to the patient's mental state at the time of his original commitment hearing, even if recorded in a verbatim transcript, might seem remote and irrelevant if the courts take advantage of section 36-516's provision that re-examination by petition "shall not be required to be conducted if the petition is filed sooner than one year after the issuance of the order of commitment."

It must, however, be recognized that a transcript of the commitment proceeding might prove extremely helpful to a patient preparing for a section 36-516 judicial re-examination by enabling him to compare his current mental condition—and his possible improvement—with the very points that were in issue at the time of his earlier commitment. Such a comparison, if favorable, should no doubt carry considerable weight with the re-examining court. Moreover, an involuntarily confined patient might seek release not through a section 36-516 re-examination proceeding, but via habeas corpus—contending, for example, that the committing court failed to ventilate the issue of possible treatment alternatives less drastic than full-time compulsory state hospitalization. *See* the section on less drastic means, pp. 140-46 *infra*. To litigate such a contention, the commitment proceeding transcript would seem highly advantageous if not essential.

Because a confined patient's opportunities for release can rest heavily on the availability of a transcript, Arizona commitment proceedings should be recorded. Precedent for recording state-initiated actions possibly leading to the loss of liberty can be found in Arizona's new Juvenile Code, calling for a court reporter in most juvenile hearings. ARIZ. REV. STAT. ANN. § 8-234 (Supp. 1970-71).

Under the doctrine of *Gardner v. California*, 393 U.S. 367 (1969), transcripts of the proceedings should be made available free of charge to indigent patients who are committed. In *Gardner*, which dealt with an equal protection claim to transcripts in a post-conviction context, the Court rejected a state argument that hte petitioner, having been present at his superior court hearing, could draw on his memory in preparing an application for further judicial review. Considering that patients at commitment hearings are usually under sedation and are mentally troubled, *Gardner* would seem to govern *a fortiori* in a commitment context.

147. In one observed hearing, a witness failed to appear. Another "interested" party was present and volunteered to testify. The volunteer was asked if he was familiar with the case, and when an affirmative answer was given, he was sworn.

In some Pima County cases observed by one project member prior to the project's actual inception, ward attendants were sometimes called as witnesses to satisfy the statutory two witness rule, ARIZ. REV. STAT. ANN. § 36-514(B) (Supp. 1970-71), when one of the two required lay witnesses failed to appear. Similar cases in Maricopa County are frequent.

148. Hearings are also held at the county hospital in Pima County, though in many of the outlying counties they are held in courtrooms, in chambers, or in courthouse libraries.

149. The right to be present is discussed in "The Trauma of a Due Process Hearing," pp. 69-76 *infra*.

After the testimony of the witnesses is given, the appointed attorney asks one of the psychiatrists for his opinion of the patient. The standard answer of the first psychiatrist is approximately the following: "Patient is suffering from a major psychiatric disorder," followed by other conclusory statements such as "he is psychotic, depressed and demonstrates inappropriate affect. I recommend that he be committed to Arizona State Hospital as an incompetent."[150] Very seldom is any evidence given concerning the factual basis of the conclusions. In the hearings observed by the project a history was given only if the patient had been previously hospitalized.

The attorney then asks the second psychiatrist, "Do you agree and concur with Dr. ———?" The usual answer of the other psychiatrist is, "Yes, I concur completely with Dr. ———," followed by the second psychiatrist generally repeating some of the same conclusions about the patient's mental disability.

Ordinarily, the judge then says to the patient, "That's all,"[151] and the patient is removed from the hearing room without being asked to give a statement. In some cases, however, the patient asks to be heard, in which case permission is always given.

After the patient has left the room, the judge enters an order, ordinarily to "commit to Arizona State Hospital as an incompetent." And the next case is called.

In order to better demonstrate the summary procedures that exist in Maricopa County, the following chronologies[152] of observed hearings are offered. They are representative of the typical hearing.

Case 1

ATTORNEY: Are you the petitioner?

SOCIAL WORKER: Yes.

ATTORNEY: Is the petition true?

SOCIAL WORKER: Yes, to the best of my knowledge.

ATTORNEY (to patient's wife): Have you read the petition?

WIFE: Yes.

150. By this statement the psychiatrist is actually recommending that the judge take two actions: (1) that he commit the patient and (2) declare him to be civilly incompetent. It appears, however, that in some cases the psychiatrist confuses the separate legal requirements for the two judicial actions. See "The Role of the Physician," pp. 60-66 *infra*; discussion of physicians' concept of legal definitions, pp. 64-65, 90 & n.312 *infra*.

151. Or, more often, the bailiff merely taps the respondent on the shoulder and ushers him from the room.

152. The chronologies were taken by having two project members observe each hearing. The observers rapidly took notes, which they compared for accuracy after the hearings. The chronologies are believed to be virtually verbatim replicas of the observed hearings.

ATTORNEY: Is it true?

WIFE: Yes.

ATTORNEY: Doctor, have you had a chance to examine the patient?

PSYCHIATRIST I: Yes, this patient is hallucinatory, judgment markedly impaired. He would be dangerous to others and should be committed as an incompetent.

PSYCHIATRIST II: I concur. He has poor impulse control. He suffers from a major psychiatric illness and would be dangerous to others.

COURT: It is ordered that the patient be committed to Arizona State Hospital or the Veterans Hospital as an incompetent. No costs;[153] maintenance as VA may provide.

Case 2

ATTORNEY (to patient's father): Did you sign the petition?

FATHER: Yes.

ATTORNEY: Is the petition true?

FATHER: True and correct.

ATTORNEY (to patient's mother): Is the petition true?

MOTHER: Yes.

ATTORNEY (to doctor): Dr. ———, would you give us your findings?

PSYCHIATRIST I: Patient shows all the symptoms of a major psychiatric disturbance. He may be dangerous to himself and others.

PSYCHIATRIST II: He is suffering from a major psychiatric illness and may be dangerous to himself and others.

[Patient is removed from hearing room.]

COURT: Is he a veteran?

PSYCHIATRIST II: Yes.

COURT: The patient is ordered committed to Arizona State Hospital or VA as an incompetent; no costs; maintenance as VA may provide.

Case 3

ATTORNEY (to patient's mother): Is the petition true?

MOTHER: Yes, it is true.

ATTORNEY (to patient's stepfather): Is the petition true?

STEPFATHER: Yes, it is true.

PSYCHIATRIST I: The patient demonstrates poor impulse control; is suspicious, evasive, hostile and has poor judgment. The patient is a danger to himself and to others. I recommend commitment to

153. For a discussion of the assessment of costs of the proceedings and of maintenance costs, see the section on assessment of costs, pp. 80-88 *infra.*

Arizona State Hospital as an incompetent.

PSYCHIATRIST II: [Gave similar statement.]

[Patient is removed from hearing room.]

COURT: It is ordered that the patient be committed to Arizona State Hospital as an incompetent.[154]

Pima County

Not long ago, hearings in Pima County, which have long been held only once a week, closely approximated the Maricopa model.[155] But since September 1970, when Pima County initiated a community mental health model and drastically reduced commitments to the Arizona State Hospital,[156] the nature of the hearings have changed considerably. Now, with 2 to 3 hearings per week, instead of the previous 15 to 20, speed is not nearly as essential as before. Consequently, the hearings observed by the project in Pima County averaged 27 minutes each, while the average duration of hearings observed in Maricopa County was 4.7 minutes. And the Office of the Public Defender, which now represents patients in Pima County, participates in the hearing to a considerably greater extent than do the court-appointed attorneys in Maricopa County. Nonetheless, the preparation and participation provided by the public defenders does not begin to approximate acceptable standards of advocacy as proposed by the project.[157]

The Pima County hearing procedure as observed by the project is described below. It should be noted, however, that since Pima County superior court judges rotate in taking responsibility for commitment hearings,[158] the nature of the hearing may well differ from judge to judge.

Hearings in Pima County are held in a small recreation room at the county hospital once a week on Thursdays. The hearing begins with the patient present. If the patient is without counsel, which is usually the case, a public defender is appointed.[159]

After appointment of counsel, the court asks the lay witnesses their names and asks them to be sworn. The court ordinarily then proceeds to describe the prospective hearing:

The purpose of this hearing is to determine whether John Doe suffers from a mental illness that makes him dangerous to

154. This entire hearing, including the time taken to remove the patient from the hearing room, consumed three minutes.

155. Mental Health Committee, Pima County Board of Health & Hospital Services, Final Report to Board of Supervisors (Feb. 24, 1970) [copy on file with the *Arizona Law Review*].

156. See the section on Pima County mental health programs and their impact on the legal process, pp. 132-40 *infra*.

157. See "The Role of Counsel," pp. 51-60 *infra*.

158. See note 144 *supra*.

159. Sometimes, but by no means always, the public defender will have already conferred with his client prior to his formal appointment at the hearing.

self, others, or property. The doctors will testify and then the patient's attorney will examine the doctors.

After the lay witnesses are sworn, the psychiatrists are asked to testify. Their testimony is presented in greater depth than in Maricopa County. A history of the patient is usually given, and factual support for the diagnosis and recommendation is much more common.

After the testimony of the psychiatrists, the court usually asks the public defender if he has any questions. In the hearings observed, the public defender ordinarily did have a few questions going to the basis of the diagnosis and the recommendations. The fact that some questions were addressed to the psychiatrists represents a significant departure from the Maricopa model, where in none of the observed hearings did the attorneys ask the psychiatrists for anything more than their recommendations.

Following the cross examination of the psychiatrists, the lay witnesses give their testimony.[160] Their statements are not simply that the petition is true or correct as in Maricopa County, but are usually narrative of the behavior they have seen in the day-to-day activity of the proposed patient.

The public defender is not the only participant in the hearings to question the lay witnesses; the judge often asks questions also. In fact, in Pima County, the judge often proved to be a rather active participant in the hearings.

After the attorney finishes his cross examination of the witnesses, the judge will ask the patient if he has anything he wishes to say. If no statement is offered, or after a statement is given, the judge makes his determination and order.

In the case of Maricopa County, it was relatively easy to give examples of typical hearings. The summary nature of the proceedings made selection a simple process. In Pima County, however, each hearing is rather unique. Therefore, the following chronologies are not typical in the sense of being recurring, but they are satisfactorily representative of Pima County hearings.

Case 4

COURT: Do you have an attorney?

PATIENT: No.

COURT: The law requires that you have an attorney. His purpose is to

160. Note that this chronological sequence is violative of the statute, which requires the testifying physicians to base their opinions not only on the psychiatric examination, but also on the testimony presented at the hearing. ARIZ. REV. STAT. ANN. § 36-514(B) (Supp. 1970-71). Accordingly, the physicians should testify last.

see to it that your rights and interests are protected. Do you understand this?

PATIENT: Yes.

[Court appoints public defender.]

COURT: Who will testify?

MOTHER OF PATIENT: I am her mother, we will testify.

[Father and mother sworn.]

COURT: The hearing is to determine if ——— suffers from a mental illness that makes her dangerous to herself, others or property.

PSYCHIATRIST I: Patient is 19 years old. She was previously committed in September with an acute psychotic illness. At the time of commitment ——— was pregnant. On October 10th she left Arizona State Hospital unauthorized and went to New Mexico with her father for an abortion. Patient was discharged while she was in New Mexico. The characteristics of her disease: she was under pressure, she had uncontrolled behavior, bizarre behavior, belligerent, auditory hallucinations, no suicide attempt. She was confused, thought process disorganized. She has been fighting, setting fires. When at home, she manifested uncontrolled behavior. Diagnosed as schizophrenic.

PSYCHIATRIST II: I have examined her and concur.

PUBLIC DEFENDER: Dr. ———, was there any improvement [since her previous commitment]?

PSYCHIATRIST I: Under large doses of medication there was improvement. But treatment was interrupted by the abortion.

PUBLIC DEFENDER: What kinds of acts constituted uncontrollable behavior?

PSYCHIATRIST I: Frequent arguments, fighting, running out of the house. She was found by the police in a confused state.

COURT: [Asked the patient's mother to testify.]

MOTHER: She has been spending nights with me and days with her father. We were giving her Thorazine. The abortion upset her. The Thorazine tended to confuse her. Whatever medicine they are giving her now seems to help.

COURT: Without medication how did she act?

MOTHER: She had flashbacks, she was nervous. Her problems are related to drugs that she took at college. She was very nervous or sensitive but she didn't throw temper tantrums.

COURT: Has she thrown temper tantrums?

MOTHER: No.

COURT: Would she get violent?

MOTHER: No, she resented being taken to the gynecologist; she tried to run away.

COURT: What do you mean upset?

MOTHER: She wanted to get away. She refused to let the doctor examine her. That day I did not give her any medication. She seemed good. I told her to take a bath and set her hair. She said, "I will take a bath, but I won't set my hair." I said, "If you don't set your hair, I'll set it for you."

COURT: Did you bring her to the hospital?

MOTHER: No, the police found her in a vacant house and brought her here.

COURT (to public defender): Do you have any questions?

PUBLIC DEFENDER: Mrs. ———, was there any marked improvement on medication? Could you control her on medication?

MOTHER: Yes.

PUBLIC DEFENDER: Do you think it is natural to be upset by an abortion?

MOTHER: Yes, I would be.

COURT (to father): Mr. ———, I understand [the patient] spent days with you?

FATHER: Yes, I helped her go to New Mexico. She seemed confused, but only after the abortion did she seem confused. She seemed confused from the transition from days at my house and nights at her mother's. She has been a problem ever since.

COURT: How did she act?

FATHER: Once she stepped off a high place and fell down. She was erratic with her speech.

COURT: Could she carry on normal conversation?

FATHER: Yes, but sometimes erratic. She couldn't be trusted. She jumped in a truck and drove down the street and ran a stop sign.

COURT: Do you feel that if she were not hospitalized she would need someone to take care of her at all times?

FATHER: Absolutely. Someone would have to watch her constantly. She was very unpredictable.

COURT: Behavior unpredictable?

FATHER: Yes.

MOTHER: She was unpredictable before the abortion.

PUBLIC DEFENDER: Are you two separated?

MOTHER & FATHER: Yes.

PUBLIC DEFENDER: Have you ever seen your daughter set fires, as Dr. ——— stated?

MOTHER & FATHER: No.

PUBLIC DEFENDER: Would the patient be OK if she were at home?

MOTHER: Yes, if she were on medication.

PUBLIC DEFENDER: Do you feel you could care for her?

MOTHER: Yes, I am a home nurse. I am experienced. I could take care of her. I think it would be better for [the patient].

COURT: Do you feel you can do a better job than the Arizona State Hospital?

MOTHER: Yes.

COURT: Who will take care of her medicine? Who will prescribe it? A doctor should be on call.

MOTHER: I can administer the medicine, I can't prescribe it.

COURT (to social worker): You signed the petition, didn't you?

SOCIAL WORKER: Yes. I filed on the advice of a physician. I have seen her. She remains withdrawn. She seems a *little* confused, a *little* hostile, unpredictable. I am aware of the fire she set.

COURT: Doctor ———, you heard Mrs. ——— [mother] say she could take adequate care of [the patient]?

PSYCHIATRIST I: I don't think at this time she has completed her treatment. She gets most upset when she interacts with her mother or her mother comes to see her. There is a definite conflict between the mother and the girl.

PSYCHIATRIST II: [The patient] told me she would rather live with her friend than her mother.

MOTHER: That couldn't be because she doesn't have any friends.

PUBLIC DEFENDER (to patient): Do you think commitment to Arizona State Hospital a couple of months ago was beneficial?

PATIENT: Yes, it did help me. But there are certain things that go on at the state hospital that push my ideals too far. They allow an open ward for therapeutic reasons. A lot of times the therapeutic ward does not function therapeutically.[161] At times like that I become disgusted and explode.

PUBLIC DEFENDER: Do you think their facilities would be more beneficial than if you went home to your mother?

PATIENT: No, my mother is an experienced nurse. I feel with the help of a doctor on call and with the help of the health care program at the mental health center—I think that would be more beneficial than Arizona State Hospital, with the possibility of going to the mental

161. The patient's use of the term "therapeutic ward" is probably a reference to the system of ward government characterized by patient participation in decision-making. See "After Commitment: The Arizona State Hospital," pp. 189-236 *infra*.

health center at times of friction with my mother. Hospital is no better than home.

MOTHER: She has been an outpatient at the mental health center and has done very well.

COURT: Apparently not well enough.

PSYCHIATRIST I: This is actually her third hospitalization. The past few days she has looked better. But she still looks withdrawn and preoccupied. It is my own personal feeling that treatment out of the hospital would not be good. I would strongly recommend Arizona State Hospital.

MOTHER: How do you propose to keep my daughter at the hospital? She can walk out any time she wants.

PSYCHIATRIST II: The same thing can be said when she lives at your house.

COURT: In many respects Arizona State Hospital leaves a lot to be desired. But they are trying to do the best they can with the personnel and funds available. This is the only institution we have in this case. There is no doubt in my mind that your daughter needs care and treatment. At least until she functions on her own. Experience is all we have to go on.

Let the record show that the patient suffers from a mental illness and if left at liberty is likely to be dangerous to herself and/or others or property. It is ordered that the patient be committed to Arizona State Hospital .

Case 5

COURT: Do you have an attorney?

PATIENT: Yes, Mrs. ——— [a staff member] called him but he never called back.

COURT: Do you know who she called?

PATIENT: He didn't call back. She left a message. I thought he would be here, that he would call her in the evening. But he is not here.

COURT: Apparently he doesn't want to represent you.

PATIENT: No, he has other . . . .

COURT: Cases?

PATIENT: Yes, cases.

COURT: The court will appoint the public defender to represent you and protect your interests.

PATIENT: Fine.

[The lay witnesses are identified and sworn.]

PSYCHIATRIST I: Where is the patient's husband? He is the petitioner.

SOCIAL WORKER: He is not coming. He was not subpoenaed.

COURT (to patient): Where is your husband?

PATIENT: Where is he? He didn't come? He told me he would come later on, that there would be other hearings before mine and that they take a long time, but that he would be here for mine.

COURT: He was mistaken.

PSYCHIATRIST I: I can clarify this with my testimony.

COURT: Well, let's have it.

PSYCHIATRIST I: Patient is 24, married, and well known to this service, as well as to Arizona State Hospital. She has five children, including two sets of twins. She has had 13 hospitalizations since 1964. In January 1970, she was released. All five children are in foster homes. Her husband brought her to the walk-in clinic. He said she demonstrated bizarre behavior. He was unable to leave her alone. He said they were not living together. Their relationship is stormy, but he doesn't want her to go to Arizona State Hospital. Welfare said it has no plans to return her children to her. She was cooperative but agitated and tangential. Affect constricted and inappropriately argumentative. She struck a lab technician who was going to take a blood sample . . .

PATIENT: [Interrupting.] I've apologized to her, Doctor. I've seen her before. She is a cousin of my husband or the cousin of a friend. I've seen her.

PSYCHIATRIST I: She could be quite volatile. There is no evidence of organic brain disease. She is suffering from a chronic psychosis but she needs to be committed to Arizona State Hospital.

PATIENT: The welfare people said I would get my children back. They gave me a paper to get them back. They didn't think I was crazy.

PSYCHIATRIST I: The attorney she speaks of represented her when she broke her foot at Arizona State Hospital and sued them.

PATIENT: ——— represented me when I broke my foot.

COURT: We will get back to you.

PATIENT: Excuse me. My brother says that you shouldn't send me to Arizona State Hospital because they gave me money for my foot.

COURT: We will get back to that.

PSYCHIATRIST II: She is quite anxious. She told me to get in touch with her husband, but I couldn't reach him at the number she gave me.

She indicates that she could get her children, which is quite contrary to fact. She can't take care of herself at this time.

COURT: Left to her own devices, would she cause trouble for herself?

PSYCHIATRIST II: She would be a nuisance to others.

COURT: Her behavior is unpredictable?

PSYCHIATRIST II: Yes.

PATIENT: I did say to my husband and the nurse that I'd give up my children, rather than go to Arizona State Hospital. That is why they took my children away. Give me a chance. I've never harmed anyone. I've never cut my wrists. Look at my wrists. I had my boy for a year. I washed clothes by hand. I used to take in laundry and iron white shirts. I used to make corn bread. I didn't fight him. I just left him at my mother-in-law's.

COURT: Let me interrupt. This has nothing to do . . .

PATIENT: [Begins to speak unintelligibly.]

COURT: I've heard all I want to hear. Be quiet.

PATIENT: I'm sorry.

COURT: When I tell you to be quiet, be quiet.

COURT (to mother): Mrs. ———, prior to the time she was hospitalized, was she in your house?

MOTHER: Yes.

COURT: How did she happen to be sent to the hospital?

MOTHER: She was nervous, she wanted to argue.

PATIENT: I . . .

COURT: She doesn't want to shut up?

MOTHER: Yes, she doesn't want to do much of anything.

COURT: If left alone, could she take care of herself?

MOTHER: I think so. She stayed by herself all while I worked.

COURT: Why is she here?

MOTHER: I don't know.

PSYCHIATRIST I: She was brought to the walk-in clinic by her husband.

COURT (to witness): Mrs. ———, when was the first time you saw the patient?

WITNESS: About 3 weeks ago.

COURT: How was she acting?

WITNESS: I don't know anything about her. You shouldn't ask me. She seemed normal to me. I don't know.

COURT (to public defender): Any questions?

PUBLIC DEFENDER: I don't think so.

COURT (to nurse): You have observed her on the ward?

NURSE: Yes.

COURT: Will you be sworn?

[Nurse is sworn.]

COURT: You are familiar with [the patient's] prior visits?

NURSE: Yes, and I helped admit her this time.

COURT: How was she different?

NURSE: Well, she thinks she is changing into a man and was highly agitated.

PUBLIC DEFENDER (to nurse): Was she agitated when she talked about turning into a man?

NURSE: No, . . . well she is agitated all the time.

PUBLIC DEFENDER: Is she agitated now?

NURSE: Well, she is talking; yes, she is agitated.

PUBLIC DEFENDER: Have you known anyone else on the ward to strike anyone?

NURSE: Yes, they've struck me, but that doesn't have anything to do with this.

PUBLIC DEFENDER: Is there any pain associated with taking blood?

NURSE: Yes, sometimes.

COURT (to psychiatrist): Do you think she needs Arizona State Hospital?

PSYCHIATRIST I: In view of her lack of support at home, I would be concerned with her taking medication and taking care of herself. We need to resolve her situational problems. If there was proper supervision and control . . .

PATIENT: What do you mean proper supervision and control?

PSYCHIATRIST I: She is on Thorazine four times per day.

PUBLIC DEFENDER: What does that do?

PSYCHIATRIST I: It decreases agitation and organizes behavior.

PATIENT: I won't hurt anyone.

COURT: With the amount of medication you are taking now, you are still upset. I find that without supervision or control you would be a danger to yourself.

PATIENT: No.

COURT: The patient is ordered committed to Arizona State Hospital.
PATIENT: There is a mental health center here. I could get help there.
COURT: You must not have been following their treatment.
PATIENT: Yes, I have.
[Patient is helped from the room.][162]

THE ROLE OF COUNSEL

Having discussed the right to counsel, constitutional and statutory, we deal here only with the role of counsel in the commitment context. Arizona's statute provides: "At the time of apprehension or during detention, but before the hearing, the proposed patient apprehended shall be permitted to consult an attorney to represent him at the hearing. If he is not represented by an attorney, the court shall, before the hearing, appoint an attorney to represent him".[163] A literal interpretation of the statute has led most Arizona judges to the conclusion that mere appointment of an attorney "before the hearing" meets all of the necessary statutory requirements, although it is worthy of note that in Pima County, during the hearings observed by the project, the public defender was actually appointed *during* the court proceedings.

Not surprisingly, the statute is silent concerning the role of the attorney before or during the hearing. The legislature has served its function by providing for legal representation, leaving the development of the functions to be performed to the expertise of the Bar, guided by its own code of ethics and professional responsibility. But, unlike its performance in the criminal arena, the Bar has not comfortably defined its role in the area of mental commitments.

While both criminal trials and commitment hearings have accusatory elements and may result in the deprivation of liberty, the attorney in the criminal setting seems to step more easily into his role as an advocate for his client (guilty or innocent) and zealously prepare a defense to support his client's cause. In the area of civil commitment proceedings, although the petitioner may be present, observations have shown that the state is seldom represented at the hearing;[164] thus the traditional ad-

162. The project was unable to observe hearings in the outlying counties, but the principal participants in the rural commitment process were interviewed. By and large, commitment hearings in the outlying counties are not markedly different from the metropolitan hearings, though they are generally more formal and legalistic. Hearings are frequently conducted in the courthouse and the county attorney often presents the case against the proposed patient. Average hearing lengths seem to vary widely from county to county, ranging from a low of 3 to 4 minutes to a high in some counties of 30 to 40 minutes, or over an hour.

163. ARIZ. REV. STAT. ANN. § 36-514(A) (Supp. 1970-71).

164. A survey of Arizona counties indicated that the county attorney's office is only represented at commitment hearings in six rural counties where commitment hearings average fewer than 25 per year. The judge of one outlying county, apparently unaware of the practice of six of his brethren, indicated that he wished the county attorney *could* be allowed to participate in commitment hearings.

versary (the prosecution) is absent. In addition, the lawyer may have limited experience in the civil commitment area and little or no professional training in the medical and psychological areas involved. While the testimony of two physicians or psychiatrists was presented, in more than 50 hearings observed by the project the patient's counsel seldom presented any such testimony or actively cross-examined the testifying doctors. It is difficult to imagine a competent attorney representing a client in a personal injury action or in any other case involving medical or technical questions without at least consulting his own professional experts and cross-examining the adverse experts. Indeed, it is disheartening to realize that when we deal not with the liberty-threatening situation of commitment, but deal instead with lucrative cases such as will contests and traumatic neurosis personal injury matters, lawyers hardly seem unduly deferential to—or bewildered by—the damning pronouncements of adverse psychiatrists.

It is understandable that such conditions prompted one writer who examined the function of counsel at commitment hearings to describe the average attorney as "a stranger in a strange land without benefit of guidebook, map or dictionary."[165] Contending that "any decision concerning a deprivation of liberty, perhaps for life, must be made openly with full exploration of all the issues,"[166] the same author concludes: "The perfunctory performance of the 'roleless' attorney is a major factor in the sterility of the commitment hearings, and it is the competent attorney who must be responsible for the development of meaningful prehearing and hearing procedures."[167]

Another commentator has noted that

> [m]ost of the 'breakthrough' cases of the past decade have been handled by a rather small group of attorneys. In fact, most attorneys appointed to represent mental patients are remarkably unclear about their role. Few are aware of the technical complexity of mental hygiene laws, and most know little or nothing about psychiatry or psychiatric terms.[168]

The conclusion of this author is that "widespread reform will not come until there is an available body of lawyers with specialized training in this area."[169]

A full understanding of the conditions which prompt such descriptive terms as "roleless" and "sterile" requires a knowledge of the dynamics of the commitment process. It requires, too, an examination of the functions of the judge and the factors which he considers in making a final determina-

165. Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424 (1966).
166. *Id.* at 425.
167. *Id.*
168. Ennis, *Mental Illness*, ANNUAL SURVEY OF AMERICAN LAW 29 (1970).
169. *Id.*

tion. Also necessary is an examination of the role of the psychiatrist and the administrative decisions made by various mental health authorities. But in exploring these areas, one should keep in mind that the decision-making process raises important legal considerations which can assist in delineating an effective role for the attorney, so that instead of being a passive guardian of the patient's rights, he can become an active advocate representing his client's interests.

Observation of commitment hearings in Maricopa and Pima Counties, combined with extensive interviews in all counties with judges, county attorneys, patients' attorneys and doctors involved in prehearing examination and courtroom testimony, has disclosed some disquieting data concerning the commitment process in Arizona. Probably the most significant conclusions which can be drawn from the data concern the role of counsel and the general lack of any adversity to the proceedings. Most debasing to the adversary role is the procedure followed in Maricopa County, where the appointed counsel assists the court by virtually presenting the case *against* the patient.[170] Indeed, in those outlying counties where the county attorney participates in the proceedings on behalf of the *petitioner*, his performance is indistinguishable from the performance of the *patient's* attorney in Maricopa County.

Interviews with attorneys who represent patients at commitment hearings throughout Arizona disclosed that most saw their role as one of guarding the procedural rights of the patient. One attorney expressed the common view that his role was to see that "only those patients needing commitment were committed." Interestingly, a committee appointed by the Pima County Board of Supervisors to study local commitments rightly noted that a lawyer's role surely should extend beyond simply insuring fairness, for such a limited function would be a superfluous duplication of the role of the judge.[171]

Another attorney similarly felt that a lawyer should become an advocate only when the patient was not actually in need of treatment. When questioned concerning how such determinations were made, he, like his colleagues, disclosed that he relies on the examining doctors' recommendations. When the doctors recommended commitment, attorneys felt they should do nothing to interfere with the patient's opportunity to receive "needed treatment." In one hearing observed in Maricopa County, the attorney actually requested that he be sworn, whereupon he proceeded to testify against his client.[172]

170. The questions most frequently asked by the patient's appointed counsel consisted of asking the petitioner if the facts stated in the petition were true and whether the petitioner had anything to add. These same questions were also asked of the lay witnesses. *See* the hearing transcripts, pp. 38-42 *supra.*

171. Mental Health Committee, Pima County Board of Health & Hospital Services, Final Report to Board of Supervisors (Feb. 24, 1970) [copy on file with *Arizona Law Review*] [hereinafter cited as Pima County Report].

172. The attorney testified that during his interview with the proposed patient, the

The limited concept of the role of counsel in the commitment process helps to explain, but cannot justify, other data collected. Attorneys are often appointed the morning of the trial and have, at best, only a few minutes before the hearing to meet with the patient. In many instances, the attorney may never meet with the patient until the case is called. In some rural counties and in Maricopa County, appointment is made sufficiently in advance to permit the attorney to meet with the patient the evening before the hearing. In either case, however, the patient may be heavily tranquillized and may be unable to contribute effectively to his own defense. In one observed instance, counsel was appointed the morning of the trial, and the doctors testified that the patient was too ill to attend, whereupon the attorney promptly waived his unseen and unknown client's right to be present at the hearing. In another observed instance, where a statutorily required witness failed to attend, the patient's counsel attempted to waive the witness requirement, but was admonished by the court that the requirement was jurisdictional and thus could not be waived.

The length of hearings in the more populous counties is an indicator of the "sterility" of most commitment hearings. In the hearings observed in Maricopa County, the average length was less than 5 minutes, during which an average of slightly over four questions were asked by the patient's counsel. The questions most frequently asked were: of the petitioner, (1) "Are the facts which you have stated in this petition correct to the best of your knowledge?" (2) "Do you have anything to add?"; of the witness, (1) "Do you know the facts in the petition to be true?" (2) "Do you have anything to add?" In Pima County, the average hearing took considerably longer (27 minutes) and the average number of questions asked by patients' counsel was 6.3 per hearing. Interviews with judges in the rural counties indicated that the average commitment hearing lasted from 45 minutes to an hour and a half (but such estimates were not substantiated by observation).

It appears from the data that not even the most elementary legal questions are explored, such as (1) whether the decision to commit is to be based on dangerousness to self or to the person or property of others; (2) whether there is any real factual basis for such a conclusion; (3) whether possible alternatives to involuntary commitment exist or have even been explored; (4) whether medical examinations were thorough (this could be of particular significance in rural counties where examining physicians are usually not psychiatrists); and (5) whether the doctor's recommendation is based on factual or conclusory data.

Under the current system in Arizona, the conclusion is inescapable that counsel at commitment hearings are generally ineffective. Professor Fred Cohen would lay the responsibility for such ineffectiveness right at the

latter had attempted to hit the attorney. In the attorney's opinion, the patient was dangerous.

feet of the practicing attorney.[173] "The attorney who represents the proposed patient and fails to investigate and prepare a case for presentation at the hearing bears the heaviest responsibility for the ineffectiveness of the hearing."[174]

The effectiveness of counsel at a commitment hearing will depend heavily on his efforts prior to the proceeding. But compensation for appointed counsel in Arizona is so grossly inadequate that attorneys are unquestionably discouraged from investigating facts, preparing a defense, exploring possible alternatives to commitment, and seeking outside psychiatric opinions. For example, Maricopa County allows $10 per case. Pima County, which previously allowed $5 per case, now uses the services of the public defender.[175] Significantly, some states have begun to recognize that patients at commitment hearings deserve to receive effective representation, and that quality services are far more readily obtained when attorneys are compensated adequately. One county in Pennsylvania, for example, has devised a payment plan, approved but not yet implemented by the relevant state agency, to compensate counsel $200 per commitment case.[176]

Actually, the sort of payment scheme most likely to provide patients with meaningful legal representation would compensate counsel by the hour, rather than by the case. When counsel is compensated a certain amount per client, he may not have as much incentive to labor over the case as he would if his compensation were tied to time expended in preparation.[177] Since Arizona's counsel compensation statute specifies that appointed attorneys may receive "such amount as the court in its discretion deems reasonable, considering the services performed,"[178] an hourly fee schedule could easily be achieved in this state simply by judicial implementation of the existing legislation.

The minimal compensation now available for appointed attorneys in commitment cases is indicative of a lack of understanding of the true role of counsel, and represents a most perfunctory compliance with the statutory requirement to provide counsel. It is incumbent upon the legal profession to make society aware that an individual's right to freedom in the face of possible lifelong deprivation is worth far more than the pittance provided to furnish a ritualistic conformance to the letter of the law.

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173. Cohen, *supra* note 165.
174. *Id.* at 434.
175. By statute, the public defender is required to represent patients at commitment hearings, at least where appointed by the court to do so. ARIZ. REV. STAT. ANN. § 11-584(2) (Supp. 1970-71). But this statute has not been implemented in Maricopa County, where private attorneys continue to be appointed to represent proposed patients.
176. See text & note 128, *supra* p. 34.
177. *Cf.* Tumey v. Ohio, 273 U.S. 510, 532 (1927) (judicial payment scheme unconstitutional when it runs counter to defendant's interest in a fair trial). *See also* Ison v. Western Veg. Distrib., 48 Ariz. 104, 59 P.2d 649 (1936).
178. ARIZ. REV. STAT. ANN. § 13-1673 (1956).

The legal profession has a grave responsibility to prevent society from salving its conscience so cheaply.

Effective representation requires at least the following activities on the part of counsel.[179] 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 their 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 avenues by which these resources can be applied to meet the needs of his client as alternatives to involuntary commitment.[180]

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. In many of the rural counties in Arizona, interviews of examining physicians disclosed that many of them have only the vaguest comprehension of the standard of dangerousness required by the statute.

As will be demonstrated in the following section, crucial decisions in the commitment process are made by the physician, and his recommendations carry more than considerable weight with both judges and patients' counsel. The decisions made in the medical area are largely responsible for the mechanical processing aspects of the commitment hearing. If the attorney becomes an active advocate, the doctor will be faced with the necessity of justifying his recommendation to commit.[181] This could result in a reduction of the tendency of doctors to recommend commitment whenever they are in doubt.[182] Active advocacy on behalf of the patient

179. A manual for attorneys handling commitment proceedings in the District of Columbia has been prepared by the Legal Aid Agency (now the Public Defender Service) and is reprinted in *1970 Hearings, supra* note 22, at 975 *et seq.*

180. See "Community Mental Health in Arizona," pp. 127-40 *infra.*

181. Lawyers timid of cross-examining psychiatrists should view as a godsend a new book authored by a lawyer-psychologist. J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY (1970).

182. *1970 Hearings, supra* note 22, at 32 (statement of Bruce J. Ennis): "The psychiatric rule of thumb is: when in doubt, commit." *See also* Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways,* PSYCHOLOGY TODAY 43 (Feb. 1969).

will also force doctors to explore alternatives to commitment or at least to lengthen the observation period in marginal cases to insure a proper diagnosis.

Functioning as an active advocate, the attorney may well provide the missing link between the medical role and the legal role in commitment proceedings. The attorney

> can and should perform the functions lawyers often perform in this mediational role: Interpret specialized information to the client and other participants; advocate and negotiate on behalf of his client; clarify, anticipate, and communicate effects of alternative courses of action; and design and clarify policy.[183]

Richard Janopaul's observations, based on field studies of the commitment process, offer additional guidance as to the functions which effective counsel could provide:

> It is not adequate to have a public attorney or a public defender appear merely at the court hearings. From our observations, this type of legal representation proves ineffectual in practice. I feel that the patient needs a much different type of representation. He needs someone to 'listen to his case'; someone who can give him advice about the legal consequences of hospitalization. The task of the lawyer would not be to 'get the patient off' whenever possible. Instead, he would objectively weigh the medical, social, and legal aspects of the proposed commitment, and then advise and assist the patient accordingly. Lawyers are accustomed to performing this type of counseling service and they can be very effective at it. I am sure that, in most cases, the attorney would advise the patient that hospitalization will be the best thing for him. The attorney would then be in an excellent position to help the patient with any legal problems which might arise from the hospitalization, such as guardianships, possible foreclosures on installment purchase contracts, pending legal actions, the protection of his personal property, and so on.[184]

As Janopaul suggests, there is much that concerned, competent counsel can do short of seeking the release of his client. Even if the propriety of hospitalization seems beyond question, counsel can press for the most favorable type of commitment and can play an important role in the determination of civil legal competency that, in some counties, usually accompanies a determination of committability.[185]

With respect to counsel's possible role regarding the type of commitment, consider the following observed example.

"Jim," the 15-year-old son of relatively wealthy parents, was suffering from organic brain damage. Because he was exceptionally hard

183. Cohen, *supra* note 165, at 455.
184. JANOPAUL, PROBLEMS IN HOSPITALIZING THE MENTALLY ILL, 13-14 (American Bar Foundation Res. Mem. Series No. 31, 1962).
185. See the discussion, pp. 88-96 *infra*.

to handle at home, Jim had been placed in a foster home, where he resided until a member of the foster family became ill, necessitating Jim's departure. To the parents, the prospect of Jim's returning home seemed out of the question. His father testified that "the family couldn't function as a unit with him around," that he upset the normal routine, and that his presence at home was particularly taxing on the mother.

According to the doctor, Jim wanted *voluntarily* to go to the state hospital, but no one was available to transport Jim there and, in the absence of a court commitment, the sheriff's department felt it lacked the statutory authority to transport the patient.[186] Jim's lawyer then asked him whether he thought it would help him to go to the hospital, and when Jim responded affirmatively, the court promptly ordered Jim involuntarily committed and the hearing terminated—to everyone's apparent satisfaction.

Jim's lawyer must obviously have been relieved to hear Jim say he desired hospitalization, for that must have plainly altered the lawyer's conception of his role. Yet, with only a mild assertiveness, the lawyer could have markedly helped his client.

He could have inquired, for example, into the suitability of another foster placement, thereby possibly short-circuiting hospitalization altogether. But even if hospitalization seemed inevitable, there was much for the lawyer to do. He could, for instance, have challenged the sheriff's interpretation of the transportation statute and might have persuaded the court to issue an order directing the sheriff's department to transport Jim as a voluntary patient. Or he might have asked Jim's parents whether they would either provide or arrange for the necessary transportation. Indeed, he could have provided the transportation himself. Moreover, since the doctors felt hospitalization was warranted and Jim and his parents concurred, Jim seemed clearly eligible for commitment under Arizona's "non-protesting" admission statute,[187] which is in many principal respects similar to voluntary admission, but which is included in the county-provided transportation statute.

Had the attorney truly represented his client, therefore, he could seemingly have arranged for an admission to the hospital pursuant to statutory provisions far less threatening to liberty than the ordinary involuntary civil commitment provision. Further, voluntary admission may in many cases be desirable simply because available evidence indicates that nurses and attendants find voluntary patients "more attractive" than

186. *See* ARIZ. REV. STAT. ANN. § 36-518, (Supp. 1970-71) (providing for transportation for persons committed under sections 36-505, -507, & -514, but not under the voluntary admission procedure of section 36-502). If county-provided transportation for voluntary patients cannot be arranged informally or administratively, statutory revision seems clearly in order.

187. *Id.* § 36-505 (Supp. 1970-71).

committed patients, and such attitudes may be perceived by the voluntary patients and may play a role in their self-concept and eventual recovery.[188]

As suggested earlier, counsel can, in some counties, perform an important function—even for clearly committable clients—when civil legal competency is put in issue at the commitment hearing. Arizona's statute properly recognizes that the standards for commitment should differ from those of competency, and that a determination of committability should not in itself result in a finding of incompetency.[189] In some counties, such as Pima, the statute is closely adhered to. In fact, patients committed from Pima County are virtually never declared incompetent and deprived of their civil rights.[190] But in Maricopa County and some of the outlying counties, the situation is otherwise: nearly all committed patients are declared incompetent. In those counties, counsel should strive to persuade the courts to separate these two determinations.

Thus, even if commitment seems inevitable, the lawyer should investigate and argue the question of competence. In so doing, the following factors are relevant: How much and what type of property does the patient possess? A patient may well be capable of handling a small and simple estate even though he would be incapable of handling a large and complex one. How much control and guidance are provided by other members of the patient's family? Despite a physician's opinion of incapacity, how has the patient *actually* performed in handling his own affairs? Would it be psychologically detrimental to deprive him of that right? What assumptions has the doctor made in finding that spending patterns have not been in the patient's best interests? Is it more in the interest of an elderly person to increase his spending and to enjoy his last years or to keep his estate intact for his heirs?[191] These issues could and should be explored in Arizona proceedings, but they are not being aired at present.

Although the bleak Arizona situation is not markedly different from the situation in many other jurisdictions, some jurisdictions have already begun to provide true legal services for the mentally ill. In New York, for example, the American Civil Liberties Union has undertaken a law re-

188. Denzen & Spitzer, *Patient Entry Patterns in Varied Psychiatric Settings*, 50 MENTAL HYGIENE 257 (1966). Unfortunately, the judge of one Arizona county discourages voluntary admissions because he feels they "hamper the proper care of the patient". Accordingly, he tells prospective petitioners that if they want to explore the voluntary admission route, they will have to "go through the routine themselves" and would have to make their own arrangements to transport the proposed patient to the state hospital.

189. ARIZ. REV. STAT. ANN. § 36-514(D) (Supp. 1970-71). See the section on civil incompetency, pp. 88-96 *infra*.

190. See the discussion of civil incompetency in the commitment process, pp. 90-96 *infra*. The few incompetency determinations in Pima County were usually cases where a single elderly person required a guardian to care for substantial real and personal property.

191. See ALLEN, FERSTER & WEIHOFEN, MENTAL IMPAIRMENT AND LEGAL INCOMPETENCY 118-19, 133-35 (1968).

form project on behalf of the mentally ill,[192] and the Mental Health Information Service has undertaken an effective servicing role.[193] And in the District of Columbia, the Public Defender's Service has a separate Mental Health Division which seemingly represents patients at hearings with competence and vigor, and continues to represent the patients even after they are hospitalized.[194] Arizona must strive to provide comparable legal services.

THE ROLE OF THE PHYSICIAN

The judge who signs the commitment order is the most significant figure in the commitment process by only a small margin. The physician's recommendation is probably the most important single factor in the commitment decision. In Arizona's rural counties, judges have indicated that they almost always follow the doctor's recommendation. Of 396 cases studied in Maricopa County, the physician's recommendation was followed in 97.9 percent of the cases. A similar study in Pima County of 367 cases indicated that action taken by the court conformed with the physician's recommendation in 96.1 percent of the cases.[195] This extraordinary correlation, coupled with data gleaned from interviews with judges throughout the state, can lead to only one conclusion—nearly total reliance is placed on the recommendation of the physician.[196]

The power of the medical profession becomes especially significant in view of the vagueness of the Arizona statutes. Provision for examination prior to a commitment hearing is found in the following statutory language:

> The judge shall also appoint and require two or more designated examiners [physicians] to be present at the examination [hearing]. On the basis of the testimony and a personal examination of the proposed patient, the designated examiners shall make a written statement under oath stating their opinion as to the mental health of the proposed patient, whether he has a mental illness likely to be dangerous to himself or to the person or prop-

192. Ennis, *supra* note 168.

193. *1970 Hearings, supra* note 22, at 801 (letter from M.H.I.S. staff attorney). *See also* Note, *The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill*, 67 COLUM. L. REV. 672 (1967); discussion at pp. 32-35 *supra*.

194. *1970 Hearings, supra* note 22, at 796 (letter from Chief, Mental Health Division, D.C. Public Defender Service).

195. Also, the two examining physicians virtually always agree with each other with regard to recommendations. In many cases, this may be attributable to the fact that only one physician actually examines the patient, and that physician then "briefs" his colleague before the hearing. It should be noted that often in those cases where the doctors' recommendation was not followed, the judge was precluded from doing so because the doctor had recommended a type of disposition not provided for by the statute. See Appendix B.

196. At one observed hearing, a patient questioned the correctness of a diagnosis, which prompted the following revealing retort by the judge: "I don't guess you want to put your judgment over these doctors. I don't like to do it myself."

erty of others if he is permitted to be at large, and whether the mental illness is likely to be temporary or permanent.[197]

"Designated examiner" is defined as "a licensed physician selected by the superior court. Whenever possible, the designated examiner shall be a licensed physician experienced in the diagnosis, treatment and care of mental illness."[198]

One apparent flaw in the implementation of the statute is attributable to the shortage of trained psychiatrists in Arizona.[199] Psychiatrists are actually used only in Arizona's four most populous counties. Most counties use ordinary physicians who, although conscientious, are for the most part lacking in the psychiatric training necessary for an accurate diagnosis and recommendation.

In two rural counties using physicians, no actual examination of the proposed patient is made. In direct contravention of the statutory "personal examination" requirement, the doctors, acting much like jurors, merely attend the hearing and form their recommendations based on observations made at that time.[200] They apparently feel, too, that they should not ask any questions at the hearing, which is in sharp contrast with the practice in another county, where the examining doctors sit with the county attorney during the hearing and actively participate in questioning witnesses. In many other rural counties, well-meaning physicians indicated during interviews that their decision was most often based on whether the patient needed treatment rather than the criterion of "dangerousness" required by the statute. In one instance, a general surgeon, used frequently by the court to examine proposed patients, indicated that his actual decision was based on whether the patient needed psychiatric evaluation. It was his feeling that by recommending commitment, he was merely sending the patient to the Arizona State Hospital for psychiatric evaluation by qualified psychiatrists who could release the patient if treatment was not needed.

Even in the more populous counties, where psychiatrists are used, a study of 342 medical reports submitted in commitment cases indicated that 154 or 45 percent were based on conclusory information taken from the petition relative to allegedly "dangerous conduct" of the patient.

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197. ARIZ. REV. STAT. ANN. § 36-514(B) (Supp. 1970-71).
198. *Id.* § 36-501.
199. Arizona has only 75 to 80 psychiatrists, with all except three or four located in either Phoenix or Tucson. It is ironic that psychologists are excluded as qualified examiners since, in many cases, they may be better qualified than a physician specialist in some other area of medicine. The shortage of psychologists, however, is equally acute in Arizona's rural counties.
200. One of those doctors made the following comments in a taped interview:

> I am supposed to form an opinion on only what I hear in the courtroom. Sometimes I feel I am the jury and the judge both. I don't examine the patient. I only listen to testimony in the court room unless it happens to be a patient of mine. There have been several times when I have said I don't have enough information [to have an opinion] but the judge sent them up anyway.

Since the psychiatrist who is called upon to testify as a witness at commitment hearings is, in some of the more populous counties, also involved in many of the community-based outpatient treatment programs, problems may arise which are similar to Dr. Szasz's vision of the "dual role" of institutional psychiatrists—therapist for the patient and agent for the state.[201] A committed patient may be released from the hospital and, immediately or after a while, desire or need outpatient or supportive psychiatric services in his home community. When he looks into the availability of those services, however, he may find that his proposed therapist is the very person who, as agent of the state and protector of society, testified in the past as to his mental illness, dangerousness, and need for total confinement. Under such circumstances, the patient may forego the community-based treatment, as much as he may require it, for fear that his therapist will betray him.[202]

Another significant problem concerning the role of the psychiatrist was uncovered by extensive research performed by Professor Dershowitz on the prediction of anti-social behavior.[203] His conclusion, discussed in detail in the later section on dangerousness,[204] is that since failure to commit a patient who later becomes violent and dangerous usually makes the headlines, psychiatrists are, in commitment recommendations, particularly prone to overprediction of the need for hospitalization. Nevertheless, there are many instances where examining physicians will conclude that a proposed patient is not mentally ill or in need of hospitalization. Such a diagnosis seems to lead to differing prehearing responses in Arizona's two most populous counties.

In Pima County, a system has been informally devised to permit the immediate release of patients who have been medically determined not to be in need of hospitalization. Upon reaching such a diagnosis, the examining doctor asks a county psychiatric social worker to contact the court, to inform the court of the medical finding, and to request that the petition be immediately dismissed. The petition is then dismissed, the patient is released, and a form letter is transmitted from the doctor to the court for insertion in the patient's legal file.[205] Although the doctors in

201. Szasz, *Hospital Refusal to Release Mental Patients*, 9 CLEV.-MAR. L. REV. 220 (1960).

202. *Cf. id. See also* Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 964 (1959).

203. Dershowitz, *supra* note 182, at 47. Dershowitz explains that overprediction is the result of the seriousness of an erroneous prediction of nonviolence. *See also* T. SCHEFF, BEING MENTALLY ILL (1966).

204. "Dangerousness and Commitability—The Standard in Arizona," pp. 96-117 *infra*.

205. The letter reads as follows:

Dear Judge ———:

The above-named person was admitted to the psychiatric service of the Pima County General Hospital on ————, 197— (date) by petition of ————.

We have examined the patient, and do not feel that he (she) meets

Pima County seek to have the petitioner acquiesce in the dismissal of the petition, the petitioner's consent is by no means considered a necessary prerequisite to the operation of their prehearing discharge procedure.

In Maricopa County, there also exists a procedure for releasing patients prior to hearing who, in the opinion of the doctors, are not in need of hospitalization. But the procedure is more limited than in Pima County because, as learned in interviews with the judge and with a testifying psychiatrist, a Maricopa County petition will not be dismissed without the petitioner's consent unless it is completely frivolous. Accordingly, a recalcitrant petitioner can block the prehearing dismissal of a Maricopa County commitment petition—thereby necessitating the continued custody of the patient on the county hospital psychiatric ward until the date of the hearing—even though both examining psychiatrists feel hospitalization is not in order. That impediment to release seems particularly curious in view of the fact that, at the commitment hearing, the doctors will no doubt testify against involuntary hospitalization, and the petition will invariably be dismissed at that time.

Unfortunately, some psychiatrists apparently do not practice any sort of prehearing release procedure, as evidenced by a commitment hearing observed in one of the state's Veterans Administration Hospitals.[206] In that case, the patient had been in custody against his will for several days awaiting his hearing. At the hearing, however, the psychiatrists asked if they could testify first, and both concluded that the patient showed no signs of mental illness, whereupon he was promptly released by the court.

It is apparent that there is a need for the development of effective prehearing discharge procedures in many parts of Arizona. Such procedures would not only result in speedier justice for persons not needing hospitalization, but would also enable the examining physicians to play a role more in keeping with medical theory: they would be permitted to release—rather than be required to hold and treat—"patients" not needing hospital treatment.

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the statutory requirements for commitment at this time. The patient is not considered psychotic nor dangerous to himself (herself) or to others. We feel the patient has received maximum benefits from hospitalization, and recommend that the patient be released from the hospital and the petition dismissed at this time. Thank you for your cooperation.

Sincerely yours,

_____, M.D.

_____, M.D.

Note that this procedure is in some ways similar to the proposal of the Center for the Study of Responsive Law that a board of doctors be established to determine the presence of mental disorder, and that a patient found not to be suffering from a mental disorder be immediately discharged. *1970 Hearings, supra* note 22, at 393, 395-96. The Pima County letter, however, addresses itself—perhaps improperly—not only to the question of mental illness and need for treatment but also to the more legal question of whether the statutory requirements for commitment are met.

206. Eligible persons may be committed by state courts to the Veteran's Administration. *See* ARIZ. REV. STAT. ANN. § 36-514(C) (Supp. 1970-71).

But, with respect to the many patients who would not be released even under a fully developed prehearing discharge procedure, the physician will be called to testify at the commitment hearing. It is important, therefore, to discuss his appropriate role at that stage of the proceedings as well.

If commitment is truly viewed as a legal rather than as a medical determination, it would seem logical to limit the psychiatrist's role in the commitment hearing to merely presenting evidence.[207] The psychiatrist might be required only to delineate the various factors which are determinative of the commitment question, and not be asked specifically whether or not the patient meets the legal criteria for commitment. Rather, the court, after consideration of the various factors presented by the psychiatrist and other relevant evidence, would, as it should in any case, determine whether the patient meets the legal standards for commitment. To insure independent and reasonable judicial decision-making, it would be helpful to require the court to make findings of fact and conclusions of law for each case.

The greatest danger of permitting a psychiatrist to testify in conclusory fashion about legal criteria is that the doctor may have his own notion of the substantive legal standards required for commitment. And that notion may differ markedly from that of the court, but the difference may easily go unnoticed and unexplored at the hearing—particularly if neither the court nor the patient's lawyer vigorously questions the doctor. Consider the following hypothetical: A patient, the subject of a commitment hearing, is suffering from depression and has, because of his depression, stayed home from work rather frequently. If the doctor is permitted to testify in legal conclusory terms, and if the doctor believes that endangering one's employment is equivalent to "injuring oneself," the doctor could easily testify that "this patient is very depressed, is a danger to himself, and should be committed." Such perfunctory testimony—by no means atypical in Arizona commitment proceedings—could readily lead to the involuntary hospitalization of the patient even by a judge who believes that the statutory requirement of danger to self contemplates some risk of suicide. The court, in light of the psychiatrist's testimony, might simply assume that he and the doctor are using the legal standard similarly, and might, without probing and without giving the matter a great deal of thought, routinely order commitment.

The confusion is compounded even further when the testifying physicians are completely bewildered, as they often are, by the various legal concepts of committability, competency, and the insanity defense. For

207. Ross, *supra* note 202. *Cf.* Washington v. United States, 390 F.2d 444 (D.C. Cir. 1967) (doctors prohibited from testifying whether an offense was a "product" of a mental illness under the *Durham* rule, for otherwise the jury's function would be usurped).

example, one psychiatrist who regularly examines proposed patients and testifies as to their committability at weekly Maricopa County hearings, demonstrated complete confusion as to the various concepts. In an interview with project members, he repeatedly used the terms "competency" and "committability" interchangeably. When pressed as to the requirements of committability, he responded, "As you know, Arizona follows the *M'Naghten* test of incompetency. That is, he [the proposed patient] must be so mentally ill as to be a danger to the person or property of others." Perhaps confusing civil incompetency standards with the name of the ancient test of criminal responsibility is pardonable. But the belief that competency is a function of the commitment test surely is not, particularly when this very psychiatrist often testifies in conclusory terms that "the patient should be committed as incompetent."[208]

The role of the psychiatrist at the hearing should consist simply of providing information on which the court would base its decision. Such a procedure could be defended based on the tendency of psychiatrists to overpredict dangerousness and the need for hospitalization,[209] and on the possibility that the doctor may otherwise usurp judicial functions. The procedure would also be consistent with the underlying assumption that indeterminate commitment should be, in the final analysis, a legal and not a medical determination.

Probably the greatest weakness in the statutory role prescribed for the physician is the lack of psychiatric training required on the part of the examining physician.[210] This is especially apparent when one considers the strides which have been made in recent years in mental health theory and practice. Today, psychologists, if they were qualified as statutory designated examiners, would probably be far more competent to examine and to testify than would average physicians. Available psychiatric knowledge raises serious doubts concerning the qualifications of the average physician to make any kind of accurate diagnosis and prognosis of mental illness in all but the most typical cases.

In that regard, it is noteworthy that physicians in some of the outlying counties mentioned that although they testified as experts in civil commitment hearings, they declined to do so in criminal cases (where competency

208. It would be unfortunate enough if the doctor had confused two concepts—civil commitment and civil incompetency—but he clearly has confused four: the two civil standards, and the criminal standards for competency to stand trial and not guilty by reason of insanity. *See* the discussion of these standards, pp. 149-54, 162-65 *infra*. See the section on civil incompetency pp. 88-96 *infra*, for a discussion of the extent to which patients committed in Maricopa County are also declared legally incompetent.

209. Dershowitz, *supra* note 182.

210. It would be interesting to determine empirically whether their lack of behavioral knowledge leads non-psychiatrist physicians to "overpredict" mental illness to an even greater extent than do psychiatrists. From the interview data gathered in Arizona's rural counties, greater overprediction on the part of physicians would be anticipated. *Cf.* Appendices B, C.

to stand trial or the insanity defense is at issue), necessitating the appearance of out-of-town psychiatrists. Because civil commitment, like criminal cases, entails the loss of liberty, the physicians should perhaps hesitate to involve themselves in commitment hearings as well. Even recognizing the shortage of qualified psychiatrists in Arizona, and the total absence in some counties, it seems incongruous that in an age where men walk on the moon, transportation for less than 200 miles to obtain qualified psychiatric assistance should be such an insurmountable obstacle—particularly when the deprivation of an individual's freedom is at stake.

THE PATIENT AND THE COMMITMENT PROCEDURE

Effect of Drugs on Will to Resist

The drug revolution in psychopharmacology began with the synthesis of chlorpromazine (Thorazine) in 1951.[211] Introduction of chlorpromazine into the state hospital systems in 1954 drastically changed the mode of hospital psychiatric treatment and within several years it functioned along with other anti-depressant and tranquilizing drugs to reduce the populations in state hospitals.[212] With the advent of tranquilizers, new hope was given to the mentally ill.

> Tranquilizers, while apparently not a specific . . . cure for mental disturbance, eased some of the worst and most savage symptoms of the mentally ill and opened the way for more personal treatment. A quiet patient can get help: the doctors can talk to him; nurses and attendants can give him small responsibilities and a feeling of contact with the world. Everyday tasks, such as eating, working in the garden, reading, and going to the movies, are now an integral part of the patient's treatment.[213]

Yet, the patient's right to present his case against commitment or for release from it with all of his available mental faculties—perhaps free from the influence of medication—is put into issue through the widespread use of drugs upon mental patients. The commitment hearing must be conducted in a manner consistent with due process, although necessity would, at times, seem to require that the patient be medicated either to calm him down, or to enable him to participate in the hearing.[214]

Some maintain that the mental patient has the absolute right to present his defense at a commitment hearing free from the influence of tran-

211. Tourney, *Therapeutic Fashions in Psychiatry*, 124 AM. J. PSYCHIATRY 784, 790 (1968).

212. Tourney, *supra* note 211; Comment, *Civil Commitment of the Mentally Ill in California: 1969 Style*, 10 SANTA CLARA LAW. 74 (1969).

213. SPECIAL COMMITTEE TO STUDY COMMITMENT PROCEDURES, THE BAR OF THE CITY OF NEW YORK, MENTAL ILLNESS AND DUE PROCESS 3 (1962).

214. Davidson, *Mental Hospitals and the Civil Liberties Dilemma*, 51 MENTAL HYGIENE 371, 372-73 (1967); *cf.* Illinois v. Allen, 397 U.S. 337 (1970).

quilizers or medications.[215] In at least some instances, the patient is at a disadvantage if he is under the influence of medication at the commitment hearing. His attorney, if appointed, will probably not be able to present the patient's case effectively without the patient's assistance, and considering that the court hearing may be the last step before a serious loss of liberty occurs, the need for the patient's total awareness is great. The possibility of the patient being subjected to some type of treatment prior to his commitment hearing is significant, and often, the argument continues, the effect of this treatment is to destroy the patient's will to resist,[216] as drugs given to the patient as treatment may also have the effect of temporarily incapacitating him.[217]

Conversely, one hospital administrator, speaking for the medical community, answered that the civil libertarian approach fails to consider the practical result of prohibiting medication of all patients before their commitment hearings:

> Here is a bedridden old woman who has had a stroke, who is utterly confused and unresponsive . . . . The only way she can participate in the hearing is by giving her a mood stimulant. Are we forbidden to do that because the medication is a drug? Or suppose we have an extremely disturbing, noisy, shouting, obscene, tear-clothing [*sic*] manic. Do you insist that we bring him to court in this condition because, if we try to tranquilize him, we will be violating one of his constitutional rights?[218]

This "dilemma," however, may be more apparent than real: perhaps doctors should be authorized to medicate a patient prior to the proceeding if, after consultation with the doctor, it is the attorney's opinion

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215. Kutner, *The Illusion of Due Process in Commitment Proceedings*, 57 NW. U.L. REV. 383 (1962). Kutner, illustrating the dichotomy between actual commitment procedures and statutory standards, describes the Cook County Mental Clinic in operation:

> It appears that in practice the alleged mentally-ill is presumed to be insane and bears the burden of proving his sanity in the few minutes allotted him. A person's last opportunity to demonstrate his sanity is at the court hearing, yet doctors at the Mental Health Clinic keep all the "patients" under such heavy sedation that many of them appear stuporous at their hearings and are unable to intelligently defend themselves for that reason alone. *Id.* at 385 (footnotes omitted).

Kutner goes on to insist that due process at commitment hearings must be absolute, minimally requiring notice and a "fair hearing" (inferentially one at which the patient is not controlled by sedation). *Id.* at 398. *Compare*, Davidson, *supra* note 214, at 372.

216. Bruce J. Ennis, the Director of the New York Civil Liberties Union project on Civil Liberties and Mental Illness, states that in New York the patient admitted by medical certification without prior judicial approval is immediately subject to "treatment"—such as massive doses of tranquilizers or electro-shock therapy. The undisputed effect of this "treatment" is to deprive "the patient of initiative and the will to resist." *1970 Hearings*, *supra* note 22, at 267. *Cf.* SPECIAL COMMITTEE TO STUDY COMMITMENT PROCEDURES, THE BAR OF THE CITY OF NEW YORK, MENTAL ILLNESS AND DUE PROCESS 26 (1962).

217. Note, *The New York Mental Health Information Service: A New Approach to the Hospitalization of the Mentally Ill*, 67 COLUM. L. REV. 672, 677 (1967).

218. Davidson, *supra* note 214.

that medication would seem likely to *enhance* the patient's ability to participate effectively at the hearing.

It would seem, then, that the only sensible approach to take at present is to "avoid a callous doctrinairism, a rigid uncompromising insistence on a single rule applicable to everybody at all times,"[219] and to concentrate on the individual patient and his situation. The goal we must hope to achieve for each patient is to strike a balance by administering drugs, if required, to remove psychotic, disabling and disruptive symptoms without impairing the patient's right to converse with his attorney and to carry out his defense effectively. The patient's attorney should play an active part in helping to strike the appropriate balance.

ARIZONA DRUG PRACTICE. No Arizona statute expressly prohibits the use of drugs in treatment of the mentally ill, nor is there a prohibition against the medication of prospective patients immediately prior to the commitment hearing.[220] The state of the law is best illustrated by an exchange excerpted from a hearing observed by the project.

> [Discussion in which patient claims he is being held incommunicado.]
>
> PATIENT: [Requested judge to order doctors to cease medicating him, as he was currently under medication and could not function.]
>
> COURT: I have no authority to make such an order, [but asked doctors to see if they could handle the patient with less medication].

In addition to suggesting that all power relating to medication lies with the doctor, the above excerpt suggests that the effect of drugs may not be entirely harmless—or at least that the prospective patient may not regard the medication as harmless. An even more serious pronouncement from a patient regarding medication is provided by the following abstract of an observed hearing:

> . . . .
>
> ATTORNEY: Is the petition true?
>
> WITNESS: Yes.
>
> PATIENT: They have misconstrued. I am under tremendous sedation. It is really not fair.
>
> ATTORNEY: Just wait.
>
> PSYCHIATRIST I: Patient suffers from paranoid schizophrenia, is a danger to herself or others, and I recommend she be committed as an incompetent.
>
> PATIENT (throughout doctors' testimony): Oh my God, oh my goodness!

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219. *Id.* at 373.

220. In fact, ARIZ. REV. STAT. ANN. § 36-510(B) (Supp. 70-71), states:
> The county hospital shall accept the proposed patient as a county

PSYCHIATRIST II: She is suffering from a major psychiatric disorder, is dangerous to herself or others, and should be committed as an incompetent.

PATIENT: [Gets up and walks around.] I can't stand this, I have to walk. (to deputy) Don't worry, I'm not going to leave. I just can't stand this. I am under heavy sedation and it's not fair to have me appear in court this way. I can't think because of this heavy sedation. A lot of those things are just not true.

COURT: Have you been in before?

PATIENT: I have been in some. I'm just human. These things they say aren't true.

DEPUTY: You'll have to sit down.

PATIENT: How long will it be for?

COURT: That is up to the doctors.

PATIENT: This medication is driving me nuts . . . .

In the final analysis, whether the above patient's claim is real or imagined is beside the point. So long as the patient sincerely believes that forced medication has impaired his ability to avoid involuntary commitment, the hearing will be traumatic to him, and he may well view his institutionalization as unjust or worse.[221] Under these circumstances, his lawyer might well have inquired into the propriety of deferring the hearing and reducing the medication dosage.

Lawyers engaged in the representation of prospective patients should seek to avoid these real or imagined effects of drugs. Perhaps what is needed is an insistence, framed in some legally enforceable terms, that even if medication is necessary for treatment or for permitting the patient to participate in the hearing, only the minimum required dosage should be administered.

The Trauma of a Due Process Hearing

As the due process safeguards applied to civil commitment hearings[222] have led to more formalized procedures, medical authorities have voiced fears concerning the traumatic affect the "due process hearing" may have on the patient.[223] Some of the various factors related to the

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charge and take reasonable measures, including provision for medical care necessary to assure proper and humane care of the proposed patient . . . .

221. *See* the immediately following discussion of traumatic procedures, pp. 69-76 *infra.*

222. *Cf.* Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968).

223. *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 87th Cong., 1st Sess. pt. 1, at 22 (1961) [hereinafter cited as *1961 Hearings*] (statement of Dr. Winfred Overholser); H. DAVIDSON, FORENSIC PSYCHIATRY 282 (1965). *But see 1961 Hearings, supra*, pt. 1 at 266-267, (statement of Dr. Thomas Szasz); Kutner, *The Illusion of Due Process in Commitment Proceedings*, 57 NW. U.L. REV. 383, 396 (1962).

hearing which have been challenged as traumatic to the patient are the requirement of formal notice,[224] the confrontation of witnesses,[225] the requirement of the patient's presence,[226] the "punitive aura" of the courtroom,[227] the use of "archaic legal terminology,"[228] and the inquiries into the financial status of the patient,[229] and into his need for treatment.[230]

To a large extent, these assertions reflect a lack of understanding of what due process requires in a given situation and an inability to distinguish the requirement from the means used to implement it. Although

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224. *1961 Hearings, supra* note 223, pt. 1, at 71 (statement of Dr. Francis J., Braceland). Braceland deplores notice as one of the most damaging features of commitment laws:

> [W]hen they [patients] come and we have convinced them that they are to be treated and that they are in the hands of people who are genuinely interested in them, and not interested in some of the persecutory ideas which they have, but in them, and interested to know why they have those, everything is settled down when in comes a notice, frequently couched in terms that has horrendous language, saying, 'insane' or 'mentally weak person,' 'incompetent' and so forth. And off they go and our chances for treatment are nil for a while. *Id.* at 72.

See also H. DAVIDSON, *supra* note 223, at 229, characterizing notice as "perhaps the most infuriating of the legal features of commitment."

225. *1961 Hearings, supra* note 223, at 22 (statement of Dr. Winfred Overholser). Overholser states that witnesses are summoned to appear at the hearing and they testify in the presence of the patient. He describes this procedure as "an extremely traumatic thing both for the patient and for his family." Overholser contends further that this resulting traumatic effect "tends to make families hesitate greatly about sending a patient or proceeding for his commitment." Such an observation, however, cuts both ways. The negative effects of due process procedures may discourage those who are in a position to invoke the commitment process for one who is properly confinable under current treatment standards. On the other hand, the trauma of legal entanglements might also stay the hand of those who might otherwise cause the unwarranted or unjustified detention of a friend or relative.

Though Overholser concedes the necessity of confrontation where it is demanded by patients "who feel they are victims of a persecution," he criticizes subjecting patients "who feel very unworthy or, feel they have committed the unpardonable sin" to a confrontation. He suggests the confrontation merely impresses upon the patients that their ideas of unworthiness are correct.

226. *Id.* at 26. Insisting on having the patient present is said to result in having his problems exposed to the public. *Id.* at 81 (testimony on behalf of the American Psychiatric Association by Dr. Francis J. Braceland and Dr. Jack R. Ewalt). *Compare* Curran, *Hospitalization of the Mentally Ill,* 31 N.C.L. REV. 274, 282 (1953), *with* Kutner, *supra* note 223, at 396.

227. H. DAVIDSON, *supra* note 223, at 283. *See also 1961 Hearings, supra* note 223, pt. 1 at 63-84 (testimony on behalf of the American Psychiatric Association by Dr. Francis J. Braceland and Dr. Jack R. Ewalt), where it is contended that mental illness is frequently identified with criminality as a result of court procedures.

228. *1961 Hearings, supra* note 223, pt. 1 at 81, where the employment of antiquated and traumatic terms such as "insane," "of unsound mind," "idiot," "feeblemindedness," are challenged as "conveying a legal, rather than a medical, meaning."

229. See "The Assessment of Costs," pp. 80-88 *infra.*

230. Birnbaum, *A Rationale for the Right,* 57 GEO. L.J. 752, 762 (1969). Birnbaum discusses the inquiries that may be made into adequacy of treatment:

> Thus, while the inmate is still under the institution's care, he may be sitting in a courtroom and participating in, or at least observing, the speculative contentions regarding the adequacy of his therapy made in his behalf during the adversary litigation. There can be little doubt that further damage is often inescapable; the treatment which the institution will thereafter be able to offer will be limited.

due process is by definition a vague legal concept,[231] it appears that due process is minimally satisfied upon notice and a fair hearing. If a legal hearing is traumatic, the trauma results not from observance of formal due process, but rather from the development of the commitment system itself.

Henry A. Davidson, a forensic psychiatrist and hospital administrator, maintains that a due process hearing provides the opportunity for paranoids to engage in endless harassment upon being told that they may protest and raises the possibility that a depressed person, upon hearing himself labeled as insane, will be driven to suicide.[232] He constructs hypothetical cases of the effect of the "day in court" upon various patients with results including humiliation, anguish, and self-deprecation.[233] Davidson concludes that

> [w]e cannot have it both ways. Either the compulsory hospitalization of the patient is a medical problem to be disposed of without the flavor of courts, without sheriffs, due process, subpoenas, judges, juries, and charges. Or is it a legal problem, in which case the patient is entitled to due process down to the last iota.[234]

It is precisely this type of dogmatic generalization which must be avoided if mental patients are to enjoy their constitutional rights without being subjected to unnecessary trauma. The recently established New York Mental Health Information Service is illustrative of an attempt to avoid the harshness and formality of the courtroom. The commitment

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231. *See* Ratner, *The Function of the Due Process Clause*, 116 U. PA. L. REV. 1048 (1968). *See also* Graham, *Poverty and Substantive Due Process*, 12 ARIZ. L. REV. 1 (1970).

232. H. DAVIDSON, *supra* note 223, at 281-82. In *Mental Hospitals and the Civil Liberties Dilemma*, 51 MENTAL HYGIENE 371 (1967), Davidson related the gruesome outcome of one due process hearing he attended:

> Some years ago, I was in the courtroom while a depressed patient was, at his own insistence, getting his day in court, to contest his commitment. His family and his doctor correctly feared that, unless he were restrained by being hospitalized, he would kill himself. This man heard his wife, his daughter, and his beloved family doctor testify about his deep depression and their concern. The patient softly excused himself and went to the men's room. A few minutes later, an alarmed bailiff called a court attendant and me into that room. The patient's head was over the toilet bowl, blood pumping out of a severed carotid artery. To this day I can hear the gurgle as some of the blood was sucked into the cut larynx.
>
> The newly made widow cried, "Why did we have to do this to him?" And the judge gently explained that, to protect her husband's civil rights, he had to be confronted with the evidence that might lead to his hospitalization. Thus, we could all take satisfaction in the fact that the man died with his civil liberties carefully guarded.

233. H. DAVIDSON, *supra* note 223, at 282.

234. *Id.* Compare the views of Weihofen & Overholser, *Commitment of the Mentally Ill*, 24 TEXAS L. REV. 307, 339-340 (1946):

> [T]he concept of due process is not so inflexible as to prevent special procedures to meet special needs. On the contrary, due process contemplates a process which is appropriate to the case and just to the parties to be affected, and which is adapted to the end to be attained. (footnote omitted).

proceedings are held in hospital "courtrooms" specially prepared for that purpose.[235] As to the nature of the proceeding, "[a]lthough appropriate decorum is expected, rigid trial formalities do not prevail."[236]

Informality, however, must not permit the hearing to degenerate into a sham. Authority from the area of juvenile delinquency indicates that overly informal procedures may be detrimental to future rehabilitation.

> [T]here is increasing evidence that the informal procedures, contrary to the original expectation, may themselves constitute a further obstacle to effective treatment of the delinquent to the extent that they engender in the child a sense of injustice provoked by seemingly all-powerful and challengeless exercise of authority by judges and probation officers.[237]

Several writers have taken the position that although a hearing may be traumatic, it is even more traumatic for the patient to be confined in an institution without an explanation as to the reason or the duration.[238] Consider the frightening analogy to the tactics of the Gestapo during World War II. The entering of a home and taking of an individual without explanation—without opportunity for the individual to challenge the basis of his confinement—is undoubtedly a horrifying experience, capable of rebirth in the mental health setting by depriving an individual of a hearing or of his right to be present there.

Proposals have been presented to provide protection to the patient without subjecting him to the traditional due process hearing. It has been suggested that a scientific procedure be employed basing commitment decisions on impartial investigations by administrators after exhaustive research into the patient's situation, with minimal use of the elements of the adversary process.[239] But, particularly in view of the infancy of the discipline of psychiatry,[240] the implementation of such a system, with no

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235. Note, *The New York Mental Health Information Service: A New Approach to the Hospitalization of the Mentally Ill*, 67 COLUM. L. REV. 672, 679 (1967) [hereinafter cited as *New York MHIS*]. *See 1961 Hearings, supra* note 223, at 132 (statement of Hon. John Biggs, Jr.).

236. *New York MHIS, supra* note 235.

237. WHEELER AND CONTRELL, JUVENILE DELINQUENCY: ITS PREVENTION AND CONTROL 85 (1966). *Cf.* Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968), which discusses the similarity of juvenile and civil commitment proceedings.

238. *1961 Hearings, supra* note 223, at 266 (statement of Dr. Thomas Szasz); Kittrie, *Compulsory Mental Treatment and the Requirements of Due Process*, 21 OHIO ST. L.J. 28 (1960). Szasz takes the position that the hearing might be highly therapeutic.

> [I]t is very beneficial for a human being to be told why other people object to him. This is what the hearing is all about in my opinion. For example, a person might be told that he is not taking the garbage out, it is accumulating in the garage and he had better do something about it. I think that if such a person is going to become better, he had better be told. If he is going to be committed without a hearing, without proper explanation, that will only make it worse. *Id.* at 47.

239. Kittrie, *supra* note 238.

240. See the discussion of psychiatric prediction in the section on the dangerousness standard, pp. 96-100 *infra*. *Cf.* Appendices B, C.

provision for judicial safeguards, could easily deteriorate into a process of commitment by arbitrary administrative discretion. The lesson for civil commitment is obvious: if procedural safeguards are informalized to the point of becoming non-existent, the hearing may be more traumatic than any formal adherence to procedural safeguards could possibly be.

THE SITUATION IN ARIZONA. The statutorily created procedural safeguards applicable in Arizona commitment hearings do not, ipso facto, create the possibility of a hearing becoming traumatic. Initially, although notice is required to be served on the proposed patient, it may be dispensed with where the effects of service would be harmful to the patient, in which case it "may" be served on the patient's guardian, spouse, adult next of kin, or a person with whom the proposed patient is living.[241] Notwithstanding the possibility that notice might be detrimental in some situations, any decision to forego notice should take into consideration the increased fear of the unknown the patient might have as a result of the dispensation of notice. And, if personal notice is dispensed with, surely substitute notice ought to be given, though that does not always appear to happen in Arizona.[242]

Oddly enough, the current Arizona statutes make no specific mention of the patient's presence or nonpresence at the hearing.[243] But since presence is integrally tied to the right of confrontation,[244] a patient's right to be present (including the right to be *truly* present—without excessive medication) at his hearing ought to receive constitutional recognition, although there seems to be no valid reason for compelling a patient's presence against his will.

The argument that requiring the patient to be present at the commitment hearing may be injurious to him has been challenged as being circular insofar as it is based on the faulty presumption that "all persons who are the subject of the commitment proceedings are in fact insane."[245] The more reasonable presumption, of course, is that the "commitment machinery" is not infallible; that some of its victims will be members of society who, though possibly mentally troubled, are not proper subjects for involuntary commitment under the applicable statute.[246] It seems that

241. ARIZ. REV. STAT. ANN. § 36-513(A), (D) (Supp. 1970-71). See section on notice and other rights, pp. 29-37 *supra.*

242. See "Notice," pp. 29-31 *supra.*

243. The earlier Arizona statute specifically required the patient's presence at the hearing. Ariz. Code 1939 § 8-301. *See* ch. 14, [1951] Ariz. Sess. Laws 38. The current statute simply provides that the patient shall have the right to "contest" the petition. ARIZ. REV. STAT. ANN. § 36-513(C) (Supp. 1970-71). In addition, one statutory provision empowers the court to exclude persons "not necessary or appropriate to the conduct of the proceedings." *Id.* § 36-513(B). Presumably, however, that statutory provision refers simply to the power to exclude the public, if the proposed patient does not object. *Id.* § 36-513(E).

244. Illinois v. Allen, 397 U.S. 337 (1970).

245. Kutner, *supra* note 223, at 396.

246. *Id. See also* Weihofen & Overholser, *supra* note 234, at 339.

those who decry the due process hearing as traumatic are presuming as fact that element which it is the very purpose of the hearing to ascertain.

In practice, absent exigent circumstances, commitment hearings in Arizona seem generally to be conducted in the presence of the proposed patients. Yet, there is some cause for concern. Project observations of commitment hearings in Pima and Maricopa Counties disclosed that the patient was present at every Pima County hearing but was sometimes absent at Maricopa County hearings.[247] In Maricopa County, counsel occasionally waives the presence of his client—sometimes even in situations when counsel and client have never met.

Obviously, without detailed and accurate pre- and post-hearing psychiatric reports, no specific findings can be made concerning whether a hearing was a traumatic experience for a particular patient. Yet, there were instances observed where the hearing surely did seem to have a traumatic impact on the patient:

> COURT: Is it your feeling, Doctor, that the patient is a danger to self as suicidal?
>
> PSYCHIATRIST I: Yes, he has committed a suicidal act. [The patient asks to talk.]
>
> PATIENT: I've been released since September 15th from Arizona State Hospital—things are the same now as when I went in. Could I have a 10-day continuation? I didn't know any better—I know what happened—it's happened before—I will take medication and somehow I lose . . . I become depressed and I try to commit suicide. Could I have a continuation for a week to be able to talk to a psychiatrist? I was at Arizona State Hospital for 11 months. They wouldn't even let me come back for help. To me hospital is not for rehabilitation—they are no help, they didn't want me there, they wanted me to make it outside, to make outside friends. I don't know anybody on the outside. The doctors felt this way. Out of the last 5 years, I've been in the state hospital for three. Each time I get out, it's the same situation. I take some pills, they do some good . . . but soon I'm taking too much. Every time I'm released the same thing happens again.
>
> Last time I tried to really commit suicide, I was at Arizona State Hospital. I had over 1000 stitches in my arm. [The judge later confirmed that the patient came close to cutting his arm off.—EDS.]
>
> I had confidence that last time—until they told me I couldn't come back for rehabilitation. What's the sense of spending my life in a little room? [The judge later indicated that the state hospital does have an out-pa-

247. During the observation period, seven hearings were observed in Pima County and 59 in Maricopa County. In Maricopa County, patients were not present at 11 of the hearings, but only three of these 11 cases led to commitment (the remaining cases were dismissed or continued).

tient program and that the patient's story as to the hospital's refusal to treat him on that status was simply not true, but the court was not prepared to argue with this severely depressed patient.—EDS.]

COURT: Do you have a driver's license?

PATIENT: It's expired. I need some answers. If I am going to be committed as incompetent, could I have some sessions of therapy before I go back? There is booze, razor blades on the wards, also drugs. If I go back like this, well it's too much . . . you might as well take a gun and shoot me right now.

COURT (to doctors): Does this change your recommendation?

PSYCHIATRISTS I & II: No.

ATTORNEY: Our facilities are inadequate. This man has just about cut his arm off, Your Honor. This simply points up our unfortunate situation. He cries out for help, and how much are we able to help him? Can the doctors' recommendations be different? Regrettably, they cannot be—there is our inadequacy.

PATIENT (sobbing): Can't I talk to somebody before I go?

[The judge shook his head and indicated to the orderly that it was time to take the patient from the room.]

Indeed, hearings can be traumatic, but our basic notions of fair play demand that the patient be given an opportunity to contest his confinement.[248] The real problem is to design a type of proceeding which will satisfy the notions of procedural fairness while still evidencing compassion for the patient. In Arizona, the nature of the hearings seems to vary substantially from county to county. In Maricopa and Pima Counties, hearings are held in informal quarters at the respective county hospitals. In the outlying counties, some hearings are held in courthouses while others are held in the available detention facility. Since the project observed hearings in Maricopa and Pima Counties, a comparative discussion of the hearings in those two counties, as related to trauma, seems in order.

Hearings in Maricopa County are relatively stiff and formalized when compared to Pima County. For example, the patient in Pima County, as opposed to his counterpart in Maricopa County,[249] is told in friendly terms, by the judge, the nature of the inquest, who will be speaking, and that he will be able to express his own thoughts to the court if he wishes. This procedure apparently mitigates against the fear of an official doing something to the patient without his comprehension. Instead of having the patient brought into the hearing by an unknown sheriff's deputy as in

248. The notion, however, ought not to be extended to require the patient to be present and to contest in those cases where the patient does not desire to challenge the propriety of commitment. In such situations it would be preferable to arrange, if possible, for the patient's voluntary admission to the hospital.

249. For examples of Maricopa County procedure, see pp. 38-42 *supra*.

Maricopa County, in Pima County the ward attendant, with whom the patient presumably has some familiarity, brings the patient into the hearing and sits by his side.

Because, in comparative terms, the patient's attorney takes a somewhat more active role in defending the patient's rights in Pima County, the patient in Pima County might subjectively view the hearing in a less conspiratorial light than might his counterpart in Maricopa County. It must be emphasized, however, that in neither county does the attorney function in a fashion to convince the patient that the hearing is an honest and fair inquest into his committability.

Additionally, unlike the situation in Maricopa County, the doctors in Pima County testify fully and not in conclusory terms; the patient, therefore, is made aware of why he is the subject of a commitment hearing. Finally, in the hearings observed in Pima County, the judge, after ordering commitment, explained to the patient that the doctors and the court felt the patient was in need of help and that they would try to make that help available. In Maricopa County, however, the patient was removed from the hearing prior to the disposition. The judge did not tell the patient what was happening to him and he lacked the chance to voice acceptance or rejection to the court.[250]

This comparative analysis suggests that compassion for the patient need not be inversely correlated with legal protection, and that, in fact, a hearing in which the patient is actually accorded his legal rights may, if properly conducted, be far less traumatic than a mere pro forma proceeding which seeks to cut corners on traditional legal paraphernalia.

SOME ELEMENTS OF THE JUDICIAL DECISION-MAKING PROCESS AND THEIR IMPLICATIONS

During the hearing, the commitment court is called upon to make several decisions, many of which will produce long term reverberations. For instance, the judge, together with counsel and with the physicians, ought to inquire whether a mentally ill patient can suitably be treated outside the setting of a state hospital. Whether the patient should be assessed the costs of the proceeding and whether he should be assessed the costs of his maintenance at the hospital are other issues that constantly confront the commitment court. Furthermore, the court, particularly if it finds the patient committable, is often required to determine whether the patient should be declared legally incompetent—an action that may be felt by the patient even after his discharge from the hospital.

250. According to the hearing judge the justification for the Maricopa County procedure is that the commitment order may shock the patient into commission of a violent act. To the project's knowledge, no patient in Pima County has ever acted in a violent manner when he heard the court's disposition.

Each of these issues will be discussed in the order set forth above in this portion of the project. The most basic judicial decision made at the hearing—whether the proposed patient is committable in the first place—will be thoroughly discussed in the next section which deals with the judicial inquiry into the proposed patient's potential for dangerous behavior. The topics in the present section will be presented not simply from the narrow perspective of judicial decision making, but will include, where appropriate, an analysis of the aftermath of the decision-making process and, in some cases, a discussion of pertinent antecedents.

The Exploration of Alternatives to Hospitalization

The constitutional doctrine of less drastic means refers to the obligation of the state, in pursuing a valid goal, to refrain, whenever possible, from infringement upon protected freedoms in the process of attaining that goal. As applied to civil commitment of the mentally ill, the doctrine would preclude institutionalization of any patient who, although statutorily committable, was susceptible to a form of treatment which involved less stringent deprivations of liberty.[251]

In Arizona, less drastic treatment schemes can be explored both at the screening stage, discussed previously,[252] and at the hearing itself. Though the Arizona statute does not require and might not even technically permit the court to enter an order other than for total hospitalization or for outright release,[253] Arizona courts have often in effect required patients to undergo less drastic treatment—such as nursing home care, outpatient treatment, and Alcoholics Anonymous participation—by "continuing" or dismissing the case "on the condition" that the patient avail himself of such care.[254]

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251. See "The Constitutional Doctrine of Less Drastic Means," pp. 140-46 *infra*.

252. See section on prepetition screening, pp. 16-18 *supra*, and section on community mental health, pp. 118-27 *infra*.

253. ARIZ. REV. STAT. ANN. § 36-514(C) (Supp. 1970-71). To comport with emerging constitutional notions, as well as to keep pace with the burgeoning community mental health movement, the statute should be amended to require judicial ventilation of treatment alternatives short of state hospitalization.

It is clear that in some instances commitment is unquestionably ordered simply because the court lacks the authority to compel a patient to undergo less restrictive treatment. In one case, reported to the project by an observer from the Arizona Civil Liberties Union, a girl was committed solely because the doctor testified that the patient failed in two attempts at outpatient treatment because she did not voluntarily take her medication. He noted that if she were hospitalized, her stay would probably last only 2 to 4 weeks, after which she could receive a conditional discharge requiring her to submit to involuntary outpatient care. Under a conditional release arrangement, the authorities would possess the legal clout to revoke the patient's release and reinstitutionalize her if she failed to comply with the medication condition. Presumably, her hospitalization could have been avoided if the court felt capable of placing her initially on a legally enforceable "probationary" status, sometimes accomplished informally by the "continued petition" route. Under the circumstances, her lawyer might well have suggested that alternative route.

254. In one observed case, for example, the court dismissed the petition but

A study of court commitment files in Maricopa and Pima Counties revealed numerous instances where deferred or dismissed cases resulted in some type of community care. Nevertheless, the issue of treatment alternatives less restrictive than hospital commitment is not aired nearly as often as it ought to be. In over 50 hearings observed by the project in Maricopa County, for example, counsel explored the less drastic means avenue in only one case. There are several plausible explanations for the failure of a patient's attorney to take the initiative on this issue: he may be unaware that there are alternatives, he may feel it improper to question the doctors' opinions,[255] he may not be terribly interested in the result,[256] or there may be no less restrictive alternatives available for the particular case. But counsel's marked inactivity in this important area underscores the need for breathing life into the lawyer's commitment hearing role.[257]

In the observed Maricopa County hearings, the doctors played a relatively more active role in considering alternatives. Less drastic means were discussed by them in 12 of the cases, and, perhaps significantly, 10 of those 12 cases were either deferred or dismissed. On the other hand, of the 35 cases resulting in hospital commitment, alternatives were discussed in only two cases. It may be, of course, that the doctors did not mention alternatives in the committed cases simply because those were the very cases where alternatives were impractical. But even if that were the case, the hearings would presumably seem far more fair if the issue had at least been raised. Moreover, considering the impact of reducing the number of communities that a recent aggressive community psychiatry effort in Pima County has had,[258] it is difficult to believe that none of the 33 committed patients about whom no alternatives were discussed could have been properly dealt with in a less restrictive manner. In any event, the following hearing chronology, selected as representative of many similar instances, may leave the reader with an uncomfortable feeling.

ATTORNEY: Has your son been committed before?

WITNESS: He committed himself, in 1967, for a week. St. Luke's [Hospital]; was voluntary.

PSYCHIATRIST I: He has no impulse control, poor judgment. He is suffering from a major psychiatric illness, and is a danger to himself. I recommend that he be committed as incompetent.

PSYCHIATRIST II: I concur.

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said to the patient, "I'll sign, and you understand you are to go to the Southern Arizona Mental Health Center and take your medication."

255. See "The Role of Counsel", pp. 51-60 *supra.*

256. See discussion of payment of counsel, pp. 55-56 *supra.*

257. See "The Role of Counsel", pp. 51-60 *supra.*

258. See section on community mental health, pp. 127-40 *infra.*

PATIENT: I want to go to the rehabilitation center and get a job. I have no intention to do danger to myself. I won't spend money foolishly. I have no intention of hurting myself or anyone. I will continue on outpatient care.

[Patient removed from the hearing room.]

COURT: He was in Arizona State Hospital in 1966, is that right?

WITNESS: He volunteered.

COURT: He got treatment at St. Luke's as an outpatient? When did that start?

WITNESS: In the spring, April.

COURT: Has he been living with you?

WITNESS: Most of the time. Some of the time with some others, but most of the time with me.

COURT: On the basis of the Doctor's testimony, don't you think he needs treatment? Don't you think commitment is best?

WITNESS: Whatever they say, I guess.

COURT: He will be better off there; he will have a source of treatment. Later on he will be out on passes. I want to send him there to the hospital so he will respond. Paranoid schizophrenia is a progressive disease as I understand it, is that right, Doctor?

PSYCHIATRIST I: Without treatment.

COURT: Yes, without treatment, so he needs treatment . . . . [Patient committed to Arizona State Hospital and adjudged incompetent.]

On the basis of this hearing alone, it would of course be impossible to select the best and most appropriate disposition in accordance with the less drastic means rationale, but it seems striking that at no point during the hearing were any alternatives to commitment expressed by anyone except the patient.[259] Notwithstanding the possibility that treatment in an institutional setting might have been necessary for this particular patient, it was counsel's obligation to his client to ask the doctor about the availability of other forms of treatment, and the doctor's medical obligation in the absence of counsel's effective participation to explain to the court why alternative treatment was or was not practical.[260] In this

259. Perhaps significantly, empirical evidence now exists to support the conclusion that many schizophrenics are amenable to treatment outside a mental hospital. *See* B. PASAMANICK, F. SCARPITTI & S. DINITZ, SCHIZOPHRENICS IN THE COMMUNITY (1967). *See also* G. FAIRWEATHER, D. SANDERS, H. MAYNARD & D. CRESSLER WITH D. BLECK, COMMUNITY LIFE FOR THE MENTALLY ILL (1969).

Actually, although a patient may be in need of treatment, that treatment can often best be provided away from a hospital—so that the patient can try to adjust and to live in society and so that the "secondary" effects of hospitalization (such as dependence and a diminished self-image) can be avoided. *See* E. GOFFMAN, ASYLUMS (1961).

260. Unfortunately, the Maricopa hearing set forth in text was not atypical. Too many hearings are conducted with only two possible alternatives in mind—

case, as in many others, the default of the court, the counsel and the physicians, may have led to the unnecessary hospitalization of the patient.

Assessment of Costs

As we have seen, commitment hearings are employed to require an individual to submit to treatment and confinement against his will. Perhaps even more offensive, however, is that the unwilling patient may then be asked to contribute financially to his unwanted hospitalization. Every state has created a statutory obligation rendering the patient liable for that portion of his hospitalization expenses which he is financially able to bear.[261] Additionally, in some states, the costs may be assessed to the patient's relatives, and even if the patient is not committed, he may be liable for the costs of the proceedings.[262]

These statutes, called "support" or "pay-patient" statutes, have been attacked on numerous constitutional grounds, but generally their validity has been upheld.[263] The rationales relied upon to justify such statutes are numerous—the statute transforms "the imperfect moral duty to support one's relatives into a statutory and legal liability";[264] it is both unnecessary and unreasonable to extend charity to those who are able to support themselves;[265] and that the state's initial voluntary undertaking does not create an estoppel to preclude the state from requiring reimbursement from the estate of the person.[266]

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commit or release. Although no specific figures are available as to consideration of alternatives less drastic than commitment in the outlying counties, our investigation revealed that except for Coconino, Pinal and Mohave Counties, no care outside of commitment seems to be considered unless the patient does not meet the statutory standards for commitment.

261. *See* Comment, *Compulsory Contribution to Support of State Mental Patients Held Deprivation of Equal Protection*, 39 N.Y.U.L. REV. 858 (1964).

262. *See, e.g.*, CAL. WELF. & INST'NS CODE § 7275 (West Supp. 1971). Arizona law may be read to require relatives of the patient to bear the costs of his hospitalization when the patient is in a designated facility other than the state hospital. ARIZ. REV. STAT. ANN. § 36-520(H) (Supp. 1970-71) (For the text of this subsection and a discussion of the Arizona legislation and its possible meanings, see text accompanying notes 289-92 *infra*). *See also* N.Y. MENTAL HYGIENE LAW § 77 (McKinney 1971). *Compare id. with* ARIZ. REV. STAT. ANN. § 36-520(B) (Supp. 1970-71), which also appears to provide that the patient need not be found mentally ill in order to be assessed with the costs of the proceedings:

> If the patient or proposed patient is able to pay all or any portion of the charges from money or property owned by him, the court shall order the payment of such amount of the charges as the patient or proposed patient can afford for examination, detention, commitment and delivery. The court shall also order the payment of the maintenance charge while hospitalized at as much as the patient or proposed patient can afford of the monthly per capita cost for treatment and maintenance as estimated by the superintendent.

263. *See* Annot., 20 A.L.R.3d 363 (1968).

264. People v. Hill, 163 Ill. 186, 191, 46 N.E. 796, 798 (1896) (statute requiring contribution by relatives). *See also* State v. Bateman, 110 Kan. 546, 204 P. 682 (1922); *In re* Idleman's Commitment, 146 Ore. 13, 27 P.2d 305 (1933); Commonwealth v. Zommick, 362 Pa. 299, 66 A.2d 237 (1949).

265. *In re* Yturburru's Estate, 134 Cal. 567, 66 P. 729 (1901). *See also* Rice v. State, 14 Ohio App. 9, 30 Ohio Ct. App. 188 (1918).

266. State v. Romme, 93 Conn. 571, 107 A. 519 (1919).

Although challenges of support statutes on due process and equal protection grounds have been largely unsuccessful,[267] some successful attacks have been maintained. For example, an early Illinois case held that state's support statute, which authorized a state board, at its discretion, to modify the patient's support payments, violated the due process clause of the state constitution.[268] That case seems to rest, however, upon the absence of standardized procedure and not upon the absolute violation of a constitutional right where payment is sought by any means.

The attempted application of the California support statute[269] to a parent, whose son was charged with murder and committed for incompetency to stand trial, was found to deprive the parent of due process. In *Department of Mental Hygiene v. Hawley*,[270] the Supreme Court of California reasoned that the detention of the son was for the protection of the public pursuant to the administration of the criminal law, and hence the cost of such detention should be borne by the state.[271]

One year later, in *Department of Mental Hygiene v. Kirchner*,[272] the California court held that the same support statute[273] was violative of equal protection.[274] Liability in *Kirchner* was sought to be imposed upon the estate of an adult daughter for the costs of maintenance and

267. *See, e.g.*, Beach v. District of Columbia, 320 F.2d 790 (D.C. Cir.), *cert. denied*, 375 U.S. 943 (1963) (statute imposing liability on father for cost of maintenance and treatment of insane child not violative of due process); Kough v. Hoehler, 413 Ill. 409, 109 N.E.2d 177 (1952) (statute imposing liability on patient's estate or on relatives, but exempting mentally ill persons in custody on a criminal charge, not violative of due process or equal protection); State v. Estate of Raseman, 18 Mich. App. 91, 170 N.W.2d 503 (1969) (parent of mental patient not deprived of equal protection when he was required to contribute his share of taxes to the state institution in addition to his statutory responsibility to reimburse the state for care and maintenance).

268. Board of Admin. v. Miles, 278 Ill. 174, 115 N.E. 841 (1917).

269. Ch. 1797, § 31, [1965] 3 Cal. Stats. 4155 (previous Cal. Welf. & Inst'ns Code § 6650) provided in part: "The husband, wife, father, mother or children of a mentally ill person . . . shall be liable for his care, support and maintenance in a state institution of which he is a patient." Section 6650 has been amended and the present California support statute is CAL. WELF. & INST'NS CODE § 7275 (West Supp. 1971).

270. 59 Cal. 2d 247, 379 P.2d 22, 28 Cal. Rptr. 718 (1963).

271. *Id.* Interestingly enough, many state civil commitment statutes provide that one ground for commitment is a showing that, because of the patient's mental illness, he will be a danger to others if left at large. *Cf.* ARIZ. REV. STAT. ANN. § 36-514 (C) (Supp. 1970-71). Commitment based upon this ground is obviously for the protection of the public—treatment of the individual in such cases is necessary because non-treatment will present a threat to society, much the same as incarceration of a convicted felon is justified because non-incarceration represents a threat to society.

272. 60 Cal. 2d 716, 388 P.2d 720, 36 Cal. Rptr. 488 (1964), *cert. granted*, 379 U.S. 811 (1965), *vacated on other grounds & remanded*, 380 U.S. 194 (1965), *on remand*, 62 Cal. 2d 586, 400 P.2d 321, 43 Cal. Rptr. 329 (1965).

273. *See* note 269 *supra*.

274. The Supreme Court remanded to the Supreme Court of California for clarification as to whether the latter court's decision rested on the equal protection clause of the Federal Constitution or on the equal protection clause in the California Constitution. The Supreme Court of California, in a memorandum opinion, replied that though it believed the same result would obtain under federal law, its decision was based on the state constitution clause.

care of her mother, who had been civilly committed. The court, however, found no rational basis to support the statute's classification which imposed liability upon one person for the support of another who was in a state institution. The decision immediately drew numerous comments, most critical of the court's reasoning and conclusion.[275] *Kirchner* was soon distinguished and held not to be determinative in subsequent California cases dealing with the same[276] or similar statutes.[277]

Challenges against the constitutionality of the support statutes have also been founded upon theories that the statutes constitute class legislation, double taxation, impairments of the obligation of contracts, taking of property without just compensation, and undue delegation of legislative power to administrators.[278] Among the variety of reasons why courts have tended not to be receptive to such arguments, perhaps the most compelling consideration is simply that of economics.

> [M]ost states cannot afford to neglect a possible source of non-tax revenue. The state suffers a double loss during the period in which a mentally ill person is institutionalized: the cost of his care falls heavily upon the state, and his loss of earning capacity not only affects tax revenues, but may also require governmental support for his dependents. . . . [I]t is abundantly clear that without additional sources of revenue many states will be unable to continue existing mental health programs and certainly will be unable to institute new ones. Until and unless some radical revolution occurs in state financing, the continuation of the principle of private responsibility can be justified on the same basis as the special tax on gasoline, used for highway construction and maintenance, that those who receive the primary benefits from the facilities should bear the primary burden of paying for them.[279] (footnote omitted).

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275. *See* Note, *Constitutional Law: Domestic Relations: Family Responsibility Statutes: Department of Mental Hygiene v. Kirchner*, 49 CORNELL L.Q. 516 (1964); Note, *Liability of Relatives for Support of the Mentally Ill in State Institutions*, 16 HASTINGS L.J. 129 (1964); Comment, *Compulsory Contribution to Support of State Mental Patients Held Deprivation of Equal Protection*, 39 N.Y.U.L. REV. 858 (1964); Note, *Constitutional Law: Equal Protection: Financial Responsibility for Relatives Confined in State Mental Hospitals*, 12 U.C.L.A.L. REV. 605 (1965); 77 HARV. L. REV. 1523 (1964); 63 MICH. L. REV. 562 (1965).

276. Department of Mental Hygiene v. O'Connor, 246 Cal. App. 2d 24, 54 Cal. Rptr. 432 (1966); Department of Mental Hygiene v. Kolts, 247 Cal. App. 2d 154, 55 Cal. Rptr. 437 (1967). In both cases, the relationship was spousal, and the court relied on the common law duty of spouses to support each other to overcome the equal protection argument based on *Kirchner*.

277. *In re* Dudly, 239 Cal. App. 2d 401, 48 Cal. Rptr. 790 (1966), *hearing denied*, 64 Adv. Cal. Minutes 2 (Mar. 16, 1966). The statute sought to be enforced was the previous section 5260 [now CAL. WELF. & INST'NS CODE § 5250 (West Supp. 1971)], which dealt with support of mentally deficient persons. Ch. 1797, § 31, [1965] 3 Cal. Stats. 4155; *see* note 269 *supra*. *Kirchner* was distinguished in that it dealt with the relationship between a parent and an adult child in which there was no common law duty to support), while in *Dudly* the relation was that of parent and minor child (in which there was a common law duty to support).

278. For a general analysis of cases based on these and other theories, see Annot., 20 A.L.R.3d 363 (1968).

279. Mernitz, *Private Responsibility for the Costs of Care in Public Mental Institutions*, 36 IND. L.J. 443, 470 (1961). Mernitz, in his comprehensive article,

A secondary consideration favoring support statutes is the deterrent effect they may have upon the filing of frivolous petitions. Conceivably, absent a bona fide need for involuntary treatment, a wife or mother might be disinclined to commit her husband or daughter where the petitioner may be held liable for support payments or where assessment of the patient might diminish the estate from which the petitioner expects to inherit. Conversely, the same fear may preclude patients and their relatives from seeking needed treatment, based upon the fear of a financial strain. And although a mentally ill indigent can in fact receive care without personal expense, a support statute may deter people from seeking treatment for a patient until he is in a highly distressed state.

The policies upon which the cost of commitment are assessed to the patient essentially rely on the proposition that commitment is for the patient's benefit—a premise so open to question that some even doubt the more basic power of society to involuntarily commit anyone.[280] But even if the power to commit is not undermined, surely the state should have the obligation to use the patient's money most efficiently in his treatment. This observation suggests, of course, still another reason why the use of "less drastic means" ought to be compelled in civil commitment.[281]

COST ASSESSMENT IN ARIZONA. The Arizona support statute requires an involuntarily committed mental patient to pay the cost of the commitment and maintenance if he is so able.[282] And the Arizona Constitution provides:

> Reformatory and penal institutions, and institutions for the benefit of the insane, blind, deaf and mute, and such other institutions as the public good may require, shall be established and supported by the State in such manner as may be prescribed by law.[283]

An Arizona case construing the support statute ruled that the con-

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discusses the historical aspects of state procedures for the determination and enforcement of private responsibility, and proposes various guidelines for a modern state reimbursement program. The Arizona statutes are subject to various criticism under the proposals made by Mernitz. Arizona imposes liability only on the patient or the guardian of his estate under ARIZ. REV. STAT. ANN. § 36-520(B) & (C) (Supp. 1970-71). This is not inconsistent with Mernitz's proposal that liability be limited to the patient, his spouse, parents and children. But Arizona requires, under section 36-520(B), that non-indigent patients pay maintenance expenses based on a monthly per capita average, while Mernitz, tying responsibility to a notion of reimbursement, recommends that payment be based on the actual cost to the state of care and treatment. Moreover, section 36-520(A) does not, as Mernitz suggests, delineate factors to be taken into consideration in determining the patient's ability to pay. Rather, the statute merely authorizes the court to "direct a discreet person to inquire into the ability" of the proposed patient to bear the expenses of the proceedings and hospitalization from the initial examination through commitment and maintenance.

280. *1970 Hearings, supra* note 22, at 272-76 (statement of Bruce J. Ennis).

281. See the section on less drastic means, pp. 140-46 *infra.*

282. *See* text accompanying note 291 *infra.*

283. ARIZ. CONST. art. XXII, § 15.

stitutional provision did not preclude the state from requiring a mental patient to pay for his care. In *State v. Glenn*,[284] the court relied on the provision that the institution should be supported "in such a manner as prescribed by law," and proceeded to reason that the state, by requiring the patient to pay, had prescribed one manner by which the institution should be supported.

The same constitutional provision has not been applied similarly with respect to penal institutions, as prisoners at the Arizona State Prison are not charged with the costs of their confinement. This classification arguably violates equal protection, at least when applied to those mental patients who are committed to the state hospital because they are believed dangerous.

Though the Arizona support statute has never been specifically challenged on equal protection grounds, there is an Arizona case which suggests what the result of such an attack in state court might be. In *Maricopa County v. Douglas*,[285] an equal protection attack against the Old Age Assistance Act[286] was rejected by the court. The defendants (husband and wife) refused to reimburse the state, as required by the statute, for aid the state had given to the mother of the defendant wife. The defendants contended they were subject to discrimination and double taxation since they also paid income taxes, part of which is used to maintain the social welfare programs, while relatives of blind persons are not required to reimburse the state for care of the blind. The court, however, found the contention without merit: "Everyone who spends money pays taxes directly or indirectly. The number of needy blind receiving assistance is insignificant compared to the number receiving old age assistance. It therefore resolves itself into the question of a reasonable classification."[287] The court went on to find that the classification made by the legislature was neither arbitrary nor unreasonable. Although *Douglas* is not of recent vintage, it is probable that any challenge to the Arizona support statute would be dealt with similarly, especially in light of the dilemma of institutional funding faced by most states.[288]

Notably, the Arizona statute does not provide that costs may be assessed to a relative if the patient is committed to the Arizona State Hospital.[289] But the law is far less certain where the patient is committed not

284. 60 Ariz. 22, 121 P.2d 363 (1942).
285. 69 Ariz. 35, 208 P.2d 646 (1949).
286. Ch. 32, [1941] Ariz. Sess. Laws 58.
287. 69 Ariz. at 40, 208 P.2d at 649.
288. See text accompanying note 279 *supra*. A decision denying an equal protection violation could be expected despite the fact that prisoners in Arizona hardly constitute an "insignificant" number when compared with mental patients. Regardless of the actual facts, the state courts would probably uphold as reasonable a financial responsibility distinction between prisoners and patients based on the notion that hospitalization is of more benefit to an individual than is imprisonment.
289. Even though it does not extend liability beyond the patient, many would find the Arizona statute objectionable on the ground that it forces an involuntarily

to the state hospital, but to a "designated facility"[290] that is a private institution. In such a case, the statute provides that:

> All costs in connection with a patient hospitalized in a designated facility other than the state hospital shall be borne by the patient, his parents, spouse, guardian or estate. In the event the patient, his parents, spouse or guardian ceases or refuses to pay the costs of hospitalization of the patient at a designated facility, the patient shall forthwith be transferred to the state hospital.[291]

The meaning of the above statute is unclear. On the one hand, it can be read as creating non-consensual statutory liability on the part of relatives (beyond spousal liability imposed by community property law[292] and parental liability for minors imposed by principles of domestic relations law) for the mental hospitalization expenses of the patient. But an alternative—and equally plausible—interpretation is that the statute simply negates state liability for private mental hospitalization and specifies that a patient committed to a private facility should be transferred to the state hospital in the event he or his relatives are unable or unwilling to pay the costs of private care.

With regard to public hospitalization, the assessment decision in practice follows a different pattern in each of Arizona's two most populous counties. Arizona's support statute requires "a discreet person to inquire into the ability of a person proposed to be hospitalized . . . to bear the charges and expenses of his examination, detention, commitment, delivery, and maintenance."[293] In Maricopa County, this task is accomplished by a court appointed mental health investigator, who, prior to the hearing, speaks with the patient and his family, discovering assets and assessing ability to pay costs.[294] This information is transmitted to the judge at the time of the hearing, and if the patient is committed, costs are generally assessed to the patient or to his immediate family, based upon the investigator's recommendation.

In Pima County, the practice is to file a statement of the patient's financial status concurrently with the petition. If the petitioner has no knowledge of the patient's financial status, the form is left blank and, if commitment is ordered, the assessment of maintenance costs is deferred.[295] The assessment task is, in such a case, then taken over by

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confined patient to help pay the cost of his unwanted confinement. *1970 Hearings, supra* note 22, at 397 (proposed commitment law precludes charging a patient for the costs of an involuntary commitment).

290. ARIZ. REV. STAT. ANN. § 36-501(3) (Supp. 1970-71).

291. *Id.* § 36-520(H).

292. *Id.* §§ 25-211 *et seq.* (1956).

293. *Id.* § 36-520(A) (Supp. 1970-71).

294. Telephone conversation with Mrs. Pascal, Mental Health Investigator for Maricopa Co., Ariz., March 7, 1971.

295. Telephone conversation with Mrs. Michael, Clerk of the Probate Court, Pima Co., Ariz., March 7, 1971.

the business administration office of Arizona State Hospital, whose interest in securing payment would presumably be greater than the county's. If, upon investigation by the hospital, assets are revealed, a subsequent judicial order assessing costs is obtained.

One interesting—but distressing—facet of the Arizona cost assessment and reimbursement statutes is that, in the case of a patient likely to be hospitalized indefinitely, the statute authorizes the sale at public auction of articles of the patient's personal property "which are on the premises of the state hospital and which are of little value and cannot be used by the patient at the institution, with the exception of jewelry, watches and items of sentimental value . . . ."[296] Although the hospital is permitted to retain only that portion of the proceeds which constitutes reimbursement for expenses incurred, the statute is objectionable on many grounds. In addition to creating nearly insurmountable problems in determining what constitutes "sentimental value" to a particular disturbed patient, the statute unwisely presupposes a fixed state of medical knowledge. Though the prognosis for a particular patient may appear very dim, liquidating that patient's estate suggests that the hospital is almost certain that no future medical innovation could markedly improve the patient's condition. And since liquidation is an irreversible action carrying considerable symbolic significance, this statute should be invoked, at best, only in the most extreme cases. Indeed, the "little value" which could accrue to the institution is probably so outweighed by the anti-therapeutic and dehumanizing effect of the dim hospital pronouncement that the statute seems deserving of repeal.[297]

A file check made by the project indicated that less than half of those patients committed from Pima County and only 20 percent of those from Maricopa County are self-supporting. As would be expected from these figures, costs are generally not assessed to the patients, and thus a substantial burden is placed upon the state in providing adequate services to the mentally ill.

Possibly in recognition of the financial burden that could be placed upon the state by non-resident indigents requiring hospitalization while in Arizona, the Arizona legislature enacted a statute which permits the superintendent of the Arizona State Hospital to return to his home state any non-resident admitted to the hospital.[298] "Non-resident" is statutorily defined as "a person who has not resided in this state continuously for at least one year immediately preceding his admittance to the

296. ARIZ. REV. STAT. ANN. § 36-520.01 (Supp. 1970-71).
297. Conceivably, the statute could, in some cases, work in the reverse of the manner intended; that is, a patient with a sizable estate might find himself labeled incurable, and the labeling process could itself serve as a catalyst for his further deterioration.
298. ARIZ. REV. STAT. ANN. § 36-522 (Supp. 1970-71).

state hospital."[299] At one time, the hospital actively returned to their home states patients who did not meet the one-year residency requirement. But a suit by the Pima County Legal Aid Society, grounded on the *Shapiro v. Thompson*[300] right to travel theory, culminated in the *Vaughan v. Bower*[301] decision, which held that the one-year waiting rule was unconstitutional.

Vaughan apparently settles the question of the right to treatment in Arizona of indigent patients who are Arizona residents but who have not been so for at least a year. But *Vaughan* does not deal specifically with the appropriate place of treatment for patients who are concededly non-residents but who happen to require mental hospitalization while temporarily in Arizona. Presumably, they may still be subject to return to their home states, although such a course may not always be in the patient's best interest—as when a New York widow without family in the East requires institutional care while visiting in Phoenix with her only child. Several states, adopting the Council on State Governments Interstate Compact on Mental Health,[302] have statutorily vowed to resolve such questions clinically rather than on the basis of costs. The compact, which seems quite superior to current Arizona law, permits transfer only when it would be in the best interest of the patient and only if the receiving state, after reviewing the pertinent medical records, agrees to accept the patient. Experience at the state hospital following *Vaughan*, indicates that fears

299. *Id.* § 36-522(B).
300. 394 U.S. 618 (1969).
301. 313 F. Supp. 37 (D. Ariz. 1970), *aff'd*, 400 U.S. 884 (1970).
302. *E.g.*, N.Y. MENTAL HYGIENE LAW § 141 (McKinney Supp. 1968). Adoption of the compact in the District of Columbia has recently been urged by witnesses appearing before Senator Ervin's Senate Subcommittee hearings on the constitutional rights of the mentally ill. *See 1970 Hearings, supra* note 22, at 25-26 (testimony of Dr. Zigmund Lebensohn, representing the American Psychiatric Association). *See also id.* 157-58 (testimony of Mrs. Patricia Wald, staff attorney, District of Columbia Neighborhood Legal Services program).

File checks in Maricopa and Pima Counties of persons against whom commitment petitions were filed reveals the following regarding the length of time spent by the patient in Arizona before the petition was filed: *See also* Appendix B.

TIME IN ARIZONA

	Patients	*Percent*
Maricopa County (436 files checked)		
Less than 1 month	22	5.0
1-3 months	16	3.6
4-7 months	16	3.6
8-11 months	6	1.3
1 year or more	376	86.2
Pima County (332 files checked)		
Less than 1 month	23	6.9
1-3 months	12	3.6
4-7 months	11	3.3
8-11 months	7	2.1
1 year or more	279	84.3

of an increased hospital population were unfounded.[303] Thus in order to facilitate the best and most convenient care for all patients committed to the state hospital, this further statutory revision seems to be in order.

Civil Incompetency—A Concomitant of Commitment?

1. DETERMINATION OF INCOMPETENCY. Civil incompetency in Arizona is characterized by statutory confusion. First of all, there are two routes by which a finding of civil incompetency may be reached: pursuant to an ordinary Title 14 guardianship proceeding,[304] and as an adjunct to a Title 36 civil commitment proceeding.[305] Only the latter will be considered in detail here.

The Arizona civil commitment statute follows the progressive trend of separating determinations of committability and competency, recognizing that a person may be committed but may nevertheless be competent to handle his affairs and to perform various jural functions.[306] The statute provides that:

> If upon completion of the hearing and consideration of the examination and the record, the court, in addition to committing the proposed patient . . . , shall also adjudge the proposed patient as incompetent, it may appoint a guardian for the estate of the proposed patient at the time of the judgment of incompetency. However, unless adjudged incompetent, the proposed patient shall be considered competent and retain his civil rights. In the event a guardian is appointed, the court shall file with the clerk of the court a certificate so stating. And thereafter all proceedings relating to such guardianship shall be had as provided by law for guardians of estates.[307]

Although legal incompetency is undefined in Title 36, that statute presumably incorporates the Title 14 substantive standards, which require a finding that "the person is incapable of taking care of himself or managing his property."[308] A more troubling question of statutory interpretation is whether a determination of committability is a necessary prerequisite for a Title 36 adjudication of incompetency. Though no dis-

303. Interview with Dr. Willis H. Bower, Superintendent, Arizona State Hospital.

304. ARIZ. REV. STAT. ANN. § 14-861 *et seq.* (1956). For an in-depth discussion of this and other areas of civil incompetency see R. ALLEN, E. FERSTER & H. WEIHOFEN, MENTAL IMPAIRMENT AND LEGAL INCOMPETENCY (1968).

305. ARIZ. REV. STAT. ANN. § 36-514(D) (Supp. 1970-71). For an indication of the complex interaction between Titles 14 and 36 regarding restoration to competency, see Swartz v. Superior Court, 105 Ariz. 404, 466 P.2d 9 (1970).

306. For a discussion of the lawyer's role in insuring that these determinations remain separate, see "The Role of Counsel," pp. 51-60 *supra.*

307. ARIZ. REV. STAT. ANN. § 36-514(D) (Supp. 1970-71).

308. *Id.* § 14-863 (1956). Actually, the use in Title 36 of the term "incompetent" is somewhat misleading since, in Title 14, one can have a guardian appointed if he meets the statutory test either by reason of "insanity" *or* "incompetency" (which is defined in ARIZ. REV. STAT. ANN. § 14-861 (1956), as something *less than* insanity). Perhaps the confusion would be dispelled if section 14-861 were amended to define as "incompetent" anyone mentally incapable of managing his affairs—without regard to whether or not he is also "insane."

cernible policy reasons support the result, the statutory language seems to suggest in two respects that a Title 36 proceeding could not properly result in a finding of incompetency without a concurrent commitment of the proposed patient. First, the pertinent section specifies that "[i]f . . . the court, *in addition to committing the proposed patient* . . . , shall also adjudge the proposed patient as incompetent, it may appoint a guardian for the estate of the proposed patient . . . ."[309] Thus, the statute seems to permit an inquiry into competency only if a determination requiring hospitalization has already been made. Second, a Title 14 adjudication of incompetency can result in the appointment of a guardian of the person as well as of the estate,[310] whereas a Title 36 adjudication of incompetency can lead only to the appointment of a guardian of the estate. That distinction presumably reflects a legislative assumption that persons found incompetent in a Title 36 proceeding would be hospitalized, rendering unnecessary a guardian of the person.

The above construction is apparently adhered to in Maricopa County. There, the project learned of no instance where an adjudication of incompetency in a Title 36 proceeding was unaccompanied by an order civilly committing the patient.[311] In Pima County, however, a file check disclosed three instances—involving three different judges—where Title 36 commitment proceedings resulted in dispositions other than commitment, but where the patients were adjudicated incompetent.

Since the substantive standards of incompetency appear to be the same for Titles 14 and 36, and since Title 14 incompetency adjudications can properly be made irrespective of the ward's need for hospitalization, there seems to be no valid reason for legislatively precluding an incompetency adjudication in a Title 36 proceeding not resulting in commitment. In fact, if an incompetency ruling were permissible under Title 36 even in the absence of a commitment order, conscientious lawyers might in many cases successfully argue that an incompetency adjudication and the appointment of a guardian would suffice as a "less drastic alternative" to involuntary hospitalization. It seems evident, then, that Title 36 should be amended to permit an incompetency adjudication—and the appointment of a guardian of the person as well as of the estate—regardless of whether civil commitment is ordered.

As mentioned earlier, modern psychiatric theory favors disassociating the question of one's need for hospitalization from the question of one's capacity to exercise various jural functions, and Arizona's commitment and competency legislation conforms to the notion of separability.

309. *Id.* § 36-514(D) (Supp. 1970-71) (emphasis added).
310. *Id.* § 14-863 (1956).
311. The reverse was also true, however. In almost all commitments, the patient was adjudged incompetent, which leads to the conclusion that insufficient distinction is made in Maricopa County between commitment and incompetency standards.

Nevertheless, the project found the administration of the law to be exceptionally uneven—with many counties adhering in practice to the more dated view that incompetency ought to accompany hospitalization virtually as an a fortiori proposition.

The dichotomous administration of the law is perhaps best illustrated by the results of the project's legal file checks in Pima and Maricopa Counties. In Maricopa County, 197 of 219 people commited (90 percent) were found incompetent, whereas in Pima County only 10 of the 121 committed (8.2 percent) were found incompetent.[312] Interviews in the remaining counties disclosed that five tend to follow the Maricopa model, while the rest seem to conform to the Pima model—requiring a truly distinct finding of incompetency in the individual case before a declaration to that effect is entered.

2. RESTORATION TO COMPETENCY. Restoration, like a finding of incompetency pursuant to civil commitment, is governed by statute in Arizona.

> Any person adjudicated incompetent receiving a *complete* discharge from the state hospital or other designated facility, who, in the opinion of the superintendent, has been restored to competency and able to manage his own affairs, shall be furnished by the superintendent with a certificate to that effect. A certified copy of the certificate shall be sent by the superintendent to the superior court under whose order the patient was hospitalized. Thereupon the court shall enter an order that the person has been restored to full competency and to full civil rights. The person may present the certificate to any superior court and the court shall enter an order that the person has been restored to full competency and to full civil rights.[313] (emphasis added).

The statute seems to bar restoration absent an unconditional discharge and has been so interpreted by the hospital and the courts. Thus, patients declared incompetent cannot be restored while they are in the hospital or, far more importantly, even when they are conditionally released.[314] Considering the disabilities—such as loss of the franchise and suspension of a driver's license—which attach to a finding of incompetency, readjustment to normal life may be seriously hampered by such a

312. In a project interview, one Maricopa County psychiatrist, who regularly testifies at commitment hearings, repeatedly used interchangeably the terms "competency" and "committability." Marked judicial confusion was evident in another county, where a judge noted that he never made a separate determination of competency, since he believed that the statute automatically rendered incompetent anyone sent to the state hospital. *See* text accompanying notes 207-09 *supra*; Appendix B.

313. ARIZ. REV. STAT. ANN. § 36-524(G) (Supp. 1970-71).

314. A Maricopa County legal file check disclosed that, of 208 persons committed and declared incompetent over a certain period of time, none of the 98 persons still in the hospital had been restored to competency, and only one of the 55 persons conditionally released had been restored. No explanation is available for the single non-conforming case. *See* note 319 *infra*.

rule. These restrictions, which may impair the use of conditional discharge as a halfway measure,[315] have led Judge Thurston[316] to call for a statutory amendment permitting restoration in the absence of unconditional discharge.[317] The suggested amendment is clearly needed. Indeed, considering that the Arizona commitment legislation separates commitment and competency determinations, it is curious that the current restoration provision was ever enacted.

Many problems exist, however, even with respect to unconditional discharges—where the current competency provision unquestionably permits restoration. In November and December of 1970, the project checked court files in Maricopa County of patients who had been committed as incompetent earlier that year. At the time of the file check, 55 of these patients had been released unconditionally, but only 12 of them had been restored to competency, and many of the unrestored patients had at that time already been released for 5 or 6 months.[318] To a large extent, then, the Maricopa model of incompetency restoration is worse than automatically equating hospitalization with competency, for in that county an adjudication of incompetency ordinarily accompanies hospitalization, but an order of restoration does not ordinarily accompany release. This entire practice is troubling, particularly in light of the Pima County experience, which has demonstrated that almost all committed patients can, without adverse incident, be permitted to retain their civil rights.

3. CONSEQUENCES OF A DETERMINATION OF INCOMPETENCY: TOWARD A THEORY OF SELECTIVE INCOMPETENCY. In Arizona, as elsewhere,

315. Nevertheless, conditional discharge accounted for over 50 percent of all the discharges from the two Maricopa County units at the state hospital, though they account for only 11 percent of the discharges from the Pima County Unit. Arizona State Hospital, 1969-70 Annual Report 24 (Aug. 24, 1970). Some prefer conditional releases not only because of their "halfway" qualities, but also because, if rehospitalization is in order, they can be revoked easily, without the necessity of going through a formal commitment hearing, which Judge Thurston estimates cost the county $1,800 to $2,000 each. Phoenix Gazette, Mar. 18, 1971, at 23.

Dr. Bower, the Hospital superintendent, dislikes lengthy conditional discharges—and often uses instead a 2-week "home pass" followed by a complete discharge. He did note that, in certain circumstances, conditional releases are very important, and their abolition would result in the unnecessary retention of several patients at the state hospital. Specifically, the hospital has a practice of discharging many chronic patients to boarding homes within the vicinity of the hospital. But many of those homes would not accept such patients if the hospital did not retain some legal control over them.

316. The Honorable Edwin Thurston, Maricopa County Superior Court judge. Judge Thurston sat as probate judge and regularly heard civil commitment cases during the period of the project's study.

317. Phoenix Gazette, Mar. 18, 1971, at 23.

318. Indeed, in some of the cases, the hospital superintendent had issued a certificate of restoration, and under ARIZ. REV. STAT. ANN. § 35-524(G) (Supp. 1970-71) and Swartz v. Superior Court, 105 Ariz. 404, 466 P.2d 9 (1970), the court order of restoration should have followed as a matter of course but, in fact, months passed before such a court order was entered.

an indication of incompetency results in the loss of many rights.[319] Moreover, despite the advanced legislative thinking which resulted in Arizona's commitment law separating hospitalization and competency, certain other state statutes in effect merge those two concepts, thus depriving committed patients of many rights solely because of their hospitalization.

Voting is a case in point. The Arizona Constitution provides, "No person under guardianship, non compos mentis, or insane, shall be qualified to vote at any election . . . unless restored to civil rights."[320] These general categories are redefined by statute to include "insane person[s] or person[s] under guardianship."[321] And the voter registration statutes provide for cancellation of registration, a prerequisite to the right to vote,[322] upon the appointment of a guardian or upon civil commitment.[323] Interestingly enough, despite the statutory and constitutional mandates, the voter registration form[324] does not inquire into these matters, though the registration cancellation provision is enforced when a court clerk forwards notification of commitment and incompetency adjudications to the county recorder.[325] Since the need for hospitalization should not per se

319. As Professors Allen, Ferster and Weihofen have ably demonstrated, a detailed discussion of the various rights affected by an incompetency adjudication—such as the right to contract and to convey—could nearly fill a volume. R. ALLEN, E. FERSTER & H. WEIHOFEN, *supra* note 304. *See also* F. LINDMAN & D. MCINTYRE, THE MENTALLY DISABLED AND THE LAW (1961). Consequently, we deal here with only some of the legal consequences of incompetency, and refer the reader to the above cited works for complete coverage of incompetency and guardianship.

In Arizona, licenses to practice some occupations can be revoked for reasons relating to mental health. ARIZ. REV. STAT. ANN. § 32-267 (1956), ARIZ. SUP. COURT R. 42-44 (Supp. 1970-71) (attorneys) ("Judicially declared incompetent" or "commit[ment] to an institution"); ARIZ. REV. STAT. ANN. § 32-1263 (1956) (dentistry) ("physical or mental incompetency to practice his profession"); *id.* § 32-1451 (Supp. 1970-71) (medicine and surgery) ("mentally or physically unable to safely engage in the practice of medicine"); *id.* § 32-1663 (nursing) ("mentally incompetent"); *id.* § 32-1855 (osteopathic physicians and surgeons) ("mentally or physically unable to safely engage in the practice of medicine"); *id.* § 32-1927 (pharmacy) ("found by psychiatric examination to be mentally unfit to practice the profession of pharmacy"); *id.* § 32-2042 (1956) (physical therapy) ("is under a declaration of insanity by a court of competent jurisdiction"); *id.* § 32-2081 (Supp. 1970-71) (psychologists) ("is under commitment or under medical certification to an institute for the mentally ill").

320. ARIZ. CONST. art. VII § 2 (Supp. 1970-71).

321. ARIZ. REV. STAT. ANN. § 16-101(C) (Supp. 1970-71). *But see* Anderson v. State, 54 Ariz. 387, 96 P.2d 281 (1939), where the Supreme Court of Arizona, drawing a distinction between insane persons and persons merely under guardianship, held that the latter evidenced simply an inability to manage property and hence ought not to be incompetent to serve as a juror. *See also* State v. Brown, 102 Ariz. 87, 425 P.2d 112 (1967) (commitment does not per se render one incompetent to be a witness under ARIZ. REV. STAT. ANN. § 12-2202 (1956)).

322. ARIZ. REV. STAT. ANN. § 16-102 (Supp. 1970-71).

323. *Id.* § 16-150(B). The guardianship portion of the statute is peculiarly worded, and might well be read to suggest that voting registration shall be cancelled only when a guardian of the person as well as of the estate is appointed, and not merely when the latter is appointed to manage the ward's property.

324. *Id.* § 16-143. Note, however, that the form does inquire into whether the elector suffers from a *physical* disability or whether his civil rights have been lost because of a felony *conviction.* Closely allied to the right to vote is jury service. *See id.* § 21-201. *See also* note 321, *supra.*

325. Interview with Pima County Probate Clerk, in Tucson, Arizona (Apr. 2,

be determinative of one's capability to exercise the franchise, and since voting may serve to encourage hospital patients to keep abreast of current events in the outside community,[326] these aspects of Arizona voting law are clearly in need of revision—perhaps entailing a constitutional amendment in addition to a legislative overhaul.[327]

Another Arizona statute which confuses and blends mental illness and mental competency is the motor vehicle licensing provision, which specifies:

> The department shall not issue a license:
>
> . . . .
>
> (5) To a person, as an operator or chauffeur, who has previously been adjudged to be afflicted with or suffering from a *mental disability or disease* and who has not at the time of application been *restored to competency* by the methods provided by law.[328] (emphasis added).

The wording of the statute leaves open the possibility for the Motor Vehicle Division of the Highway Department to refuse to license a person simply because he had been committed to a hospital, though never declared incompetent. It might also require such a person, in order to obtain a license, to seek a judicial "restoration" to a status of legal competency of which he has never been actually deprived.[329] In practice, however, the law seems to be more sensibly administered.

In Tucson—the only city in which this issue was investigated by the project—the right to hold a driver's license is tied to an adjudication of incompetency rather than to mental illness per se. Although the application form for a license inquires whether the applicant had ever been committed to a mental hospital rather than whether he had ever been adjudicated incompetent, the inquiry is so formulated because, in the experience of the Motor Vehicle Division, many applicants were confused by "incompetency" terminology used on prior forms.[330] When an applicant

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1971). Notice of pertinent legal findings are also forwarded to the Motor Vehicle Division of the Arizona Highway Department and to jury service personnel.

326. Voting practices of mental hospital patients vary from state to state. *See 1970 Hearings, supra* note 22, at 666 *et seq.* In Minnesota, the League of Women Voters has encouraged patients to vote. *Id.* at 673.

327. ARIZ. CONST. art. VII, § 22 (Supp. 1970-71), also seems to require restoration before an "insane" person may be permitted to vote. This may lead to the peculiar result that a person who has been committed but who has never been declared incompetent may be required to seek a court order "restoring" him to competency. In this regard, the project noted instances in Pima County commitment files where persons never declared incompetent were judicially restored to competency. This sort of anomaly is not unique to Arizona. Fred Cohen has noted that "although Texas law is clear that incompetency can be determined only in an indefinite commitment case, some title insurance companies insist that *voluntary* patients secure evidence of 'restoration' before issuing a policy." Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424, 453 (1966).

328. ARIZ. REV. STAT. ANN. § 28-413(A)(5) (Supp. 1970-71).

329. See note 327 *supra*.

330. This and other information relating to the Tucson practice was ascertained

answers the "commitment" question affirmatively, the more crucial question of whether he had also been adjudicated incompetent is then explored,[331] and the applicant is often asked, in that regard, to supply the office with a copy of his commitment order to aid in ascertaining that fact. In the typical case, a license will be issued if the commitment order does not reflect an adjudication of incompetency, and a license will be denied, absent a subsequent restoration order,[332] if the applicant had been declared incompetent. In some cases, however, the "typical" outcome is not reached: licenses are occasionally denied persons who were committed but not declared incompetent and licenses are sometimes granted persons despite their technical legal incompetence.

If a person has been committed, though not declared incompetent, and has only recently been discharged from the hospital, he might be asked, particularly if he is currently an outpatient, to supply the Motor Vehicle Division with a letter from a psychiatrist offering a professional opinion on the applicant's mental ability to drive a vehicle. Presumably, the division would then follow the doctor's recommendation. This practice is analogous to the division's precautionary practice of sometimes requiring diabetics, heart attack victims and epileptics to undergo a medical examination prior to being granted a license, and seems to have ample statutory support.[333]

More interesting, perhaps, is the procedure occasionally invoked for enabling persons to drive despite an incompetency adjudication. Though there appears to be no statutory provision directly in point, superior courts have sometimes, when requested, issued orders to clarify that a declaration of incompetency was entered solely because of one's inability to manage his property, but that it was not intended to adjudicate his competency to operate a vehicle and ought not to be interpreted as affecting that right. Such clarifying orders, seemingly honored by the Motor Vehicle Division, can be exceptionally important in Arizona, where, in the absence of adequate public transportation, the inability to drive may in effect result in a deprivation of a panoply of other rights.

The use of "clarifying orders" in the motor vehicle area raises a fundamental problem with incompetency determinations in general. Just

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in an interview with Mr. J. Musser, Supervisor, Tucson office, Driver's License Service, Motor Vehicle Division, Arizona Highway Department.

331. Typically, judicial declarations of incompetency are forwarded by the court clerk to the Motor Vehicle Division of the Highway Department, whereupon the license of the adjudged incompetent is suspended and canceled. But the issue may arise again when the person applies at a later time for a license.

332. *See* Opinion 61-13, 1961 OP. ARIZ. ATT'Y GEN. 25 (concerning incompetency and restoration). *See also* Opinions 65-35L, 1965 *id.* 118, & 66-35L, 1966 *id.* 110, which indicate that convicted felons may hold licenses in Arizona.

333. ARIZ. REV. STAT. ANN. § 28-413(A)(8) (Supp. 1970-71), requires the department to refuse to license a person "when the department has good cause to believe that the operation of a motor vehicle on the highways by the person would be inimical to public safety or welfare."

as it is now recognized that the need for hospitalization should not per se cast doubt on one's legal competency, so too one's mental inability to manage his property—which may lead to an adjudication of incompetency—ought not per se to cast doubt on his ability adequately to exercise various other legal rights and responsibilities—such as voting and driving. Modern behavioral theory, in other words, seemingly calls for the dismantling of the "blanket" adjudication of incompetency concept, and suggests instead that the law formulate a notion of "selective" or "qualified" incompetency. Under such a notion, adjudication of incompetency would be carefully tailored and would function to deprive one only of the right to perform those legal functions which he is in fact legally incapable of performing.[334]

In some ways, Arizona law already conforms to the advanced notion of qualified incompetency. Besides the motor vehicle example just mentioned, it is clear from Arizona case law, for instance, that an individual will not be deemed incompetent to serve as a juror merely because he is under guardianship due to an inability to manage property.[335] Similarly, termination of the parent-child relationship seems to be tailored to the specific instance where "the parent is unable to discharge the parental responsibilities because of mental illness or mental deficiency and there are reasonable grounds to believe that the condition will continue for a prolonged indeterminate period."[336] The provision may be affected, however, by the recent adoption law which, in accordance with "blanket" incompetency theory, provides that "consent [to adoption] is not necessary from a parent who has been declared incompetent."[337]

Revamping Arizona incompetency law and procedure in order to construct and implement the concept of qualified incompetency would surely constitute a major task, involving many thorny theoretical and practical problems.[338] Nonetheless, attention should be focused in that direction. Current concepts of "blanket" incompetency, jaded according to contemporary psychiatric wisdom, violate the spirit of the "less drastic means" rationale[339] and, as fully discussed elsewhere in the analo-

334. *1970 Hearings, supra* note 22, at 220-22, 452. The new California conservatorship law largely conforms to the modern "selective" incompetency theory. CAL. WELF. & INST'NS CODE § 5357 (West Supp. 1971).

335. Anderson v. State, 54 Ariz. 387, 96 P.2d 281 (1939). *Cf.* State v. Brown, 102 Ariz. 87, 425 P.2d 112 (1967); *In re* Sherrill's Estate, 92 Ariz. 39, 43, 373 P.2d 353, 356 (1962) ("That one is under guardianship does not prevent him from performing the acts of which he is in fact capable.").

336. ARIZ. REV. STAT. ANN. § 8-533(3) (Supp. 1970-71).

337. *Id.* § 8-106(A)(1)(a). Despite its shortcomings, the recent statute is an improvement over its predecessor, which dispensed with the necessity for consent by a parent declared "insane or incompetent." *See* ch. 96, § 3, [1952] Ariz. Sess. Laws 203.

338. *See 1970 Hearings, supra* note 22, at 220-22, 452.

339. See "The Constitutional Doctrine of Less Drastic Means," pp. 140-46 *infra.*

gous context of prisoners' rights,[340] may be vulnerable on due process grounds for failing to bear a reasonable relationship to a legitimate legislative purpose.

DANGEROUSNESS AND COMMITTABILITY: THE STANDARD IN ARIZONA

A number of psychiatric, legal and social issues are implied in the statutory qualification that commitment of the mentally ill is dependent upon a finding that the proposed patient is a danger to himself, others or property.[341] In this section, an attempt will be made to weigh the meaningfulness of dangerousness as a test of committability and to delineate the boundaries of the standard, with a look at its application in Arizona's commitment process. As will be discussed, higher substantive standards of dangerousness[342] or higher evidentiary burdens[343] than those currently practiced may reflect a wiser social policy or, perhaps, be constitutionally compelled. Thus, this section will conclude with comments regarding the impact of more stringent substantive and evidentiary standards for commitment and how such standards would fit into the total community mental health scheme.

The Problem of Prediction

The model commitment statute recently proposed by the Center for Study of Responsive Law[344] characterizes the determination of dangerousness as a legal question to be decided by a judge or jury without the aid of "expert" testimony.[345] This characterization appears to stem from a recognition of the failure of the medical expert to demonstrate that his skills in predicting behavior are commensurate with his ability to render an accurate prognosis of physical disease. Recently, Professor Schreiber has documented the assertion that the psychiatrist is not competent to perform such a predictive task.[346] While "it may seem elementary that

340. Note, *Civil Disabilities of Felons*, 53 VA. L. REV. 403 (1967).
341. ARIZ. REV. STAT. ANN. § 36-514(C) (Supp. 1970-71).
342. *See* text accompanying notes 355-59 *infra*. *See also* the recent California legislation discussed pp. 111-17 *infra*.
343. *In re* Winship, 397 U.S. 358 (1970), requires a reasonable doubt test for juvenile delinquency adjudications, and may well be read to hold civil commitment proceedings to the criminal burden of proof. Where a legal hearing may result in the loss of personal liberty and inordinate social stigma, the fact that the hearing is labeled "civil" seems irrelevant. For a discussion of *Winship's* applicability to the California procedures for civil commitment of mentally ill sex offenders, *see* Comment, *The MDSO—Uncivil Civil Commitment*, 11 SANTA CLARA LAW. 169, 173-178 (1970). *But see* Tippett v. Maryland, 436 F.2d 1153 (4th Cir. 1971) (preponderance standard sufficient under Maryland's defective delinquent commitment law).
344. *1970 Hearings*, *supra* note 22, at 391.
345. For a discussion of the terms of the act proposed by the Center, see pp. 115-16 *infra*.
346. Schreiber, *Indeterminate Therapeutic Incarceration of Dangerous Criminals: Perspectives and Problems*, 56 VA. L. REV. 602, 618-621 (1970).

experienced criminologists and psychiatrists should be able to make [a prediction of dangerous future behavior], doubts about predictive accuracy are widespread."[347]

After extensive hearings and research on the civil commitment process, the Subcommittee on Mental Health Services of the California State Legislature concluded that "with regard to potentially dangerous persons, the evidence available indicates that there are no tests that can predict an individual's capacity for dangerous behavior."[348] This conclusion is consistent with the 1968 survey made by Alan M. Dershowitz of all the available literature on prediction of anti-social conduct.[349] Dershowitz reported that the available studies "strongly suggest that psychiatrists are rather inaccurate predictors—inaccurate in an absolute sense—and even less accurate when compared with other professionals, such as psychologists, social workers and correctional officials; and when compared to actuarial devices, such as prediction or experience tables."[350]

For obvious reasons, no institution has yet been persuaded to release randomly some inmates it considers to be dangerous in order to test empirically the validity of its predictive methods. Yet, although a controlled experiment on this subject is socially unlikely, if not impossible, data gathered from Maryland's Patuxent Institution has been analyzed in one meaningful study. The patients of Patuxent are "defective delinquents" who demonstrate emotional deficiency, have a propensity toward crime, and have been adjudged to present a danger to society. They are to be held indefinitely until the institution's professionals find them no longer dangerous, or until they are released judicially over the objections of the institution.

Professor Schreiber presents the following data regarding release from Patuxent in support of his assertion that expert prediction of dangerousness is often inaccurate.

> Experience at the Patuxent Institution confirms the difficulty of predicting dangerous behavior. Approximately 45 percent of those paroled by Patuxent have violated the terms of their parole, 26 percent by committing new crimes. On the other hand, of the 432 inmates released by the courts contrary to the recommendations of Patuxent, all 432 of whom the staff believed were a danger to society at the time of their release, only 137, or 32 percent, committed new offenses. These inaccurate predictions of dangerousness could have resulted in the need-

347. *Id.* at 618-19. Schreiber refers to Professor Halleck's remark that actual scientific research on this topic is "practically non-existent."

348. SUBCOMMITTEE ON MENTAL HEALTH SERVICES, CALIFORNIA LEGISLATIVE ASSEMBLY INTERIM COMMITTEE ON WAYS AND MEANS, THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA 143 (1965).

349. Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways*, 2 PSYCHOLOGY TODAY 43 (Feb. 1969).

350. *Id.* at 47. Of course, the ability of the clinician vis-á-vis objective devices remains a disputed topic among those in the behavioral sciences. *See* Meehl, *Psychology and the Criminal Law*, 5 U. RICH. L. REV. 1, (1970).

> less incarceration of 295 individuals—68 percent of those released by court order over the staff's objections.[351] (footnotes omitted).

In the uncertain case, the doctor faces a dilemma. Aware of his own inability to make accurate predictions, he may either be solicitous of individual freedom and refuse to categorize the patient as dangerous, or he may be concerned more with the protection of society and recommend commitment. For a number of reasons, including the medical rule of thumb that it is better to be safe than sorry, the doctor seems generally to take the latter course. Thus, in the commitment setting, there is generally overprediction of dangerousness in the reported psychiatric evaluations.[352]

It is the commitment statute, of course, that places the physician in the role of behavioral forecaster. In fairness to the medical profession it should be noted therefore that not all doctors have willingly submitted to the lawyer's insistence that psychiatrists provide behavior analysis in accordance with legal categorization.[353] Nevertheless, in Arizona the common practice continues, as doctors testify that in their expert opinion the patient is mentally ill and dangerous and should be committed to an institution.

The foregoing reveals the difficulties involved in predicting dan-

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351. Schreiber, *supra* note 346, at 619.

352. Dershowitz has reported that, "Even more significant for legal purposes, it seems that psychiatrists are particularly prone to one type of error—overprediction. They tend to predict antisocial conduct in many instances where it would not, in fact, occur. Indeed, our research suggests that for every correct psychiatric prediction of violence, there are numerous erroneous predictions." Dershowitz, *supra* note 349, at 47. *See also* T. SCHEFF, BEING MENTALLY ILL 105-27 (1966). Psychiatric overprediction in Arizona was brought home to the project by an interview with a psychiatrist who testifies regularly at Maricopa County commitment hearings. In that county, there are two "teams" of testifying psychiatrists—one team for the Tuesday hearings and another for the Thursday hearings. The interviewed doctor claimed that the other member of his team worked part time at the state hospital and, as such, was sensitive to the problem of wrongful commitments of borderline patients. Their team, accordingly, was supposedly more reluctant than the other team to recommend commitment of borderline patients. The interviewed doctor claimed that his team recommended commitment of 5 percent fewer patients than did the "conservative" team. Yet, it is quite clear that even the "liberal" team follows a pattern of overprediction. The same psychiatrist, for instance, told the project that if his examining team cannot readily determine whether a proposed patient is dangerous, it seeks to have the hearing continued (thus prolonging the patient's detention) to allow more time for evaluation and observation. *See also* text and note 208, p. 65; note 312, p. 90; text and notes 88-91, pp. 19-23; text and notes 251-258, pp. 77-78 *supra*.

353. Harold Kaufman, a lawyer-physician and adjunct professor of law and psychiatry at the Georgetown Law Center in Washington, D.C., has condemned the role often played in the judicial process by his fellow members of the American Psychiatric Association.

> Fundamentally, of course, I am also questioning the legitimacy of the use of all diagnostic labeling for judicial or other social purposes. . . . When we try to answer the court's questions we implicitly assent to their validity. We thereby reinforce the confusion of the judge, jury and public, while perpetuating an absurd dilemma for the legal system and forensic psychiatrists. *1970 Hearings, supra* note 22, at 401.

gerousness. That inaccurate predictions may be made is tragic when it is remembered that the consequence of mistake is the wrongful deprivation of individual liberty. Professors Livermore, Malmquist and Meehl present what has become the classic statistical paradigm revealing the risk involved in commitment by prediction of dangerousness.

> Assume that one person out of a thousand will kill. Assume also that an exceptionally accurate test is created which differentiates with ninety-five percent effectiveness those who will kill from those who will not. If 100,000 people were tested, out of the 100 who would kill, 95 would be isolated. Unfortunately, out of the 99,900 who would not kill, 4,995 people would also be isolated as potential killers. In these circumstances, it is clear that we could not justify incarcerating all 5,090 people. If, in the criminal law, it is better that ten guilty men go free than that one innocent man suffer, how can we say in the civil commitment area that it is better that fifty-four harmless people be incarcerated lest one dangerous man be free?[354]

Finally, it should be noted that there may be constitutional limitations on the breadth of the dangerousness concept used to justify commitment. Bruce J. Ennis, a civil liberties advocate, cites *Minnesota* ex rel. *Pearson v. Probate Court*[355] for the proposition that the term "dangerous" as a commitment standard may be subject to constitutional attack unless its definition calls for a showing of actual dangerous behavior in the recent past.[356] In *Pearson*, the Supreme Court approved the Minnesota sexual psychopath statute as it had been construed by the highest court of that state. Noting that the definitional gloss supplied to the sexual psychopath act by the Minnesota court[357] saved the statute from attack on vagueness grounds, the Court remarked: "These underlying conditions, *calling for evidence of past conduct pointing to probable consequences* are as susceptible of proof as many of the criteria constantly applied in prosecutions for crime."[358] The Court stressed that it was not deciding the validity of the more general statutory wording, but rather that it was dealing only with the statute as interpreted by the Supreme

354. Livermore, Malmquist and Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 84 (1968). For the unintiated this example may appear to be double talk, *i.e.*, how can a test be "95 percent effective" when it falsely identifies 4,995 citizens out of 100,000 as being dangerous when they are not? The point is that the error cuts both ways so that while five of the one hundred (5 percent) who will kill are not identified, 5 percent (4,995) of the remaining 99,900 individuals who will *not* kill will be erroneously identified as predictable killers.

355. 309 U.S. 270 (1940).

356. *1970 Hearings, supra* note 22, at 277.

357. Despite the definitional problems regarding the classification of psychopath in psychiatric circles, the Minnesota court had devised a fairly stringent definition of the term "sexual psychopath" as it is used in its legal context. The patient must demonstrate an "habitual course of misconduct in sexual matters," a total lack of control over sexual impulses, and a likelihood, based on evidence of past acts, to engage in assaultive behavior. 309 U.S. at 274.

358. *Id.* (emphasis added).

Court of Minnesota.[359] Thus, the validity of a more general definition—or the use of that term without any objective definition at all—has not actually been decided. But the Court's efforts in avoiding the issue are proof enough of its troubling nature. At the least, then, *Pearson* suggests that specific evidence of past misconduct is a constitutionally preferable test of future dangerousness, and may well be the only constitutionally adequate standard.

The Definition of Dangerousness in Arizona Rural Counties

The measure of dangerousness applied in Arizona's 12 less populous counties appears to be related to factors other than a determination of the legal criteria. That is to say, the elastic definition of dangerousness may vary according to the local doctors' admitted lack of expertise in predicting dangerous behavior, according to the community's attitudes towards deviance, or according to the practical placement problems found in rural counties without therapeutic resources.

After interviewing judges and physicians involved in the commitment process in the 12 less populous Arizona counties, project members reported the presence of a disfavorable attitude towards use of commitment as a problem solving device. The interviews, however, revealed wide variance in the application of the dangerousness criteria once the commitment process was invoked.

In the rural counties, an initial and admitted problem in the prediction of dangerousness relates to the lack of physicians trained in psychiatry. In at least two counties, the doctors do not even go through the motions of undertaking a prediction task; their recommendation is instead candidly based on their opinion of the patient's need for psychiatric evaluation. If such a need is found, the recommendation will be to commit the patient.[360] In one county, this practice occurs in a court where the veteran judge freely expressed his own lack of knowledge regarding mental illness to the end that he has exclusively followed the doctors' recommendations for the past 20 years. In another county, little concern was expressed about the statutory commitment standards, for the attitude prevailed that the state hospital was capable of correcting errors which might be made by the committing court.

The statutory language is applied as a "symbolic" test by psychiatrists involved in the commitment process in one Arizona county. The literal meaning of dangerousness is admittedly ignored in favor of the best interest of the patient, *i.e.*, whether he will benefit from treatment. Although

359. *Id.* at 273.

360. Yet, the commitment is seemingly ordered under the ordinary indefinite civil commitment section, ARIZ. REV. STAT. ANN. § 36-514 (Supp. 1970-71), rather than under the statutory section authorizing a 30-day observational commitment, *id.* § 36-515.

it is recognized by these doctors that such a determination is probably illegal, they feel it is more humanitarian to require treatment than to be thwarted statutorily in their attempt to prescribe it.

An interview with an examining physician in another county revealed a shocking emphasis on the protection of the quality of the community. To that individual, a determination of dangerousness was not as important as was purging the community of undesirables. In his view, misfits should be placed outside the community, and civil commitment is one acceptable means of accomplishing that goal.

During the course of the field interviews, an interesting phenomenon was revealed that is indicative of the *parens patriae* attitude of the committing courts. In at least two counties, it is a common practice to allow the proposed patient to remain at home prior to the hearing. Although this does not preclude altogether an assumption of dangerousness, it at least raises the question of the respondent's potential for actual or imminent dangerous behavior—it is somewhat anomalous to commit a patient as dangerous to himself or others when no great risk is perceived in leaving him at liberty prior to the hearing.

One attorney, often appointed to represent patients in one county's commitment proceedings, maintained that if he is not convinced of the patient's actual danger, he will proceed in an adversary manner. The more common attitude expressed by attorneys, judges and physicians, however, was that literal interpretation of the dangerousness requirement should be avoided. That approach is buttressed by the lack of community resources to provide the aid needed in particular cases. In one county, for example, the judge was critical of the state hospital's definition of dangerousness for release purposes as being more literal than the situation required. Specifically, the judge noted that he would commit alcoholics under a general definition of dangerousness but for the fact that the state hospital has in the past released them almost immediately as not dangerous.[361] The judge noted that, since in his community there were no facilities to help such people, commitment seemed a logical alternative. The obervations and analysis in the following discussion will demonstrate, however, that the systematic stretching of the definition of dangerousness to attain therapeutic goals is not a practice reserved to the rural judge.

Maricopa County: A Systematic Study of the Dangerousness Criteria

Under the standard involuntary commitment statute, a person cannot technically be committed unless he is both mentally ill and dangerous to himself, others or property. In Maricopa County, where 51 commitment

361. Although no formalized attempt has yet been made to improve communications between the state hospital and officials in rural counties, such an attempt has recently begun between the state hospital and Maricopa County with respect to

ILLUSTRATION 1. Observers' Rating Form

Patient's Name _____

Court _____

(1) Clearly committable
(2) Borderline
(3) Clearly not committable

	Preponderance of Evidence	Beyond Reasonable Doubt
Patient is dangerous to others:		
A. as he has committed recent overt acts of physical aggression upon the person of another and has stated that he intends to engage in similar behavior if allowed to remain free.		
B. as he has committed recent overt acts of physical aggression upon the person of another and doctors predict that he will continue (in all probability) to commit similar acts if allowed to remain free.		
C. as he has committed recent overt acts of physical aggression upon the person of another.		
D. as he has verbally threatened to commit an overt act of physical aggression, and doctors predict that in all probability he will do so if allowed to remain free in society (although he has committed no such assault in the recent past.)		
E. as his behavioral disorder, as diagnosed by physicians, indicates that in all probability he will commit acts of physical aggression against another even though he has not committed such an act in the past.		
F. as he demonstrates inappropriate and socially offensive behavior (but not physically aggressive) resulting in an assault upon the peace of mind and sensibilities of those with whom he comes in contact.		

Patient is dangerous to self:		
I. as his behavior reflects a very substantial risk of physical harm to his own person as manifested by recent *attempt* or *attempts* of suicide or serious bodily harm.		
II. as his behavior reflects a very substantial risk of physical harm to his own person as manifested by recent *threats* of suicide or serious bodily harm.		
III. as his personality is disorganized to the point that, left free in open society, there exists the substantial probability that the patient would fall victim to serious physical harm (caused by the patient's patent inability to avoid the normal hazards of daily life).		
IV. as the patient's personality is so defective that he cannot care for himself in a normal manner, giving rise to future possibility of eventual physical deterioration.		
V. as he demonstrates inappropriate behavior, troublesome to himself or others so that remaining in open society represents a threat to the patient's social acceptability or such freedom would give rise to the possibility of involvement with authorities for the commission of minor infractions.		
Patient is dangerous to property:		
1. as he has committed acts destructive of the property of others and doctors predict that he will do so in the future.		
2. as he has committed acts destructive of the property of others.		
3. as doctors predicted that he will in the future commit acts of destruction of the property of others although he has not done so in the past.		
4. as he has committed acts in violation of others' property rights (i.e., conversion, bad checks, etc.) in the past and doctors predict that he will commit such acts in the future if left free in society.		

hearings were actually observed, the project attempted to determine the proposed patients committability under various tests of dangerousness as measured by different evidentiary standards. This data was thought to be helpful not only as an aid in presenting the total picture of civil commitment in Arizona, but also in predicting the possible impact of a more rigorous substantive standard of committability. To these ends, the following study was conducted by the project.

Two project members observed civil commitment hearings in Maricopa and Pima Counties for a period of 5 weeks.[362] At the conclusion of each hearing day the observers, having taken extensive notes during the hearings, rated each patient's "dangerousness" on a form supplied by the project. The observers were instructed to consider only the evidence introduced at the hearings[363] and to classify the patient as either clearly committable, borderline or clearly not committable under each definition of dangerousness printed on the form.[364]

As can be seen by reference to the forms, reconstructed in Illustration 1, the definitions were categorized under the tripartite statutory definition of dangerousness to self, others and to property. The definitions themselves were ordered in what was believed by the project to be a decreasing scale of actual danger.[365]

Thus, to be committable under the most rigorous test of danger to

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definitions of committability. The Admissions Unit of the state hospital has instituted a procedure of writing the county hospital staff when the former receives from Maricopa County a patient it deems not in need of state hospitalization.

362. In Pima County, the hearings normally took place on Thursdays, but on occasion the hearing date would be changed for administrative reasons. The project was not notified on such occasions, so that some hearings during this period were not attended by project members. Maricopa County Hearings were held on Mondays and Thursdays. Observers attended all the Thursday hearings during the observation period.

363. In Maricopa County, little testimony regarding the patient's behavior is elicited at the hearing. Instead, the witnesses are asked to indicate whether they have read the petition and whether the allegations in the petition are true. See pp. 38-42 *supra*, for a full description of the Maricopa County hearing procedure. In order for the observers' ratings to be made on the basis of the evidence known to the judge, team members would read all the relevant petitions at the outset of each hearing day.

364. The observer method has been used in at least two previous studies—both sociological in nature—involving civil commitment. *See* T. SCHEFF, *supra* note 352, at 144; Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. HEALTH & SOC. BEH. 66 (1969). In the Wenger and Fletcher study, the authors conceded that the use of the observer methodology presents problems, but they knew of no other method useful for assessing committability. It should be pointed out that the project's observers were second and third year law students. As such, they would presumably have some familiarity with discerning whether the evidence was sufficient to establish specified legal criteria. The law students were simply asked to play the role of judge—a task not unlike the Socratic agonies they experience in their daily law school diet.

365. In order to preserve objectivity, the observers were not informed of the existence of this hierarchy. Those who guessed it were told that there was no particular structure to the standards, but they were to be separately applied. The resulting evaluations demonstrate, we believe, the validity of the hierarchy.

others (item *A*), the evidence must have indicated that the patient had recently committed acts of physical aggression upon the person of another and had given verbal indication that he would do so again. At the other end of the scale (item *E*), the patient would have been rated as committable if he was shown to be dangerous to others because he offended the peace of mind and sensibilities of others.

The assessments of committability were made by both the civil evidentiary standard of preponderance of the evidence and the criminal standard of proof beyond a reasonable doubt. The observation team was therefore called upon to make several judgments for each patient: the evidence was assessed under 15 definitions of dangerousness, under two evidentiary standards, and by three levels of certainty of committability.[366]

Because so few commitment hearings were held in Pima County[367] during the 5 week period, the data obtained from those hearings will not be presented fully. Reference will be made, however, to the degree of dangerousness normally demonstrated at the Pima hearings which were observed. In Maricopa County, however, of the 51 cases observed, 32 led to commitment, so that the observation teams' ratings in that county are more meaningful.

The tabulations presented in Tables I through IV present the observation team's judgment of the highest rating of committability, according to the above variables, for each *committed* patient.[368] These tables deal only with the patients' possible danger to self or to others. The data dealing with the proposed patients' danger to property will not be presented. Although the statute provides for commitment on a showing that the proposed patient is dangerous to property, the commitment judge rarely

366. Measuring committability by two evidentiary standards and by varying levels of certainty of committability was thought to be useful as it reflected in two respects (evidentiary and substantive) the judicial decision-making process. First, it is apparent that the judicial decision-maker may conclude that the *evidence* establishes committability to a varying degree of certainty depending upon the standard of proof. For example, he may feel that a proposed patient is clearly committable under a preponderance standard, but could only rate the patient as borderline if the evidentiary standard were raised to a reasonable-doubt test. In another case, however, the proposed patient could be clearly committable under both standards of proof.

The use of three degrees of certainty of committability may also reflect the judicial decision-makers' confidence regarding whether the facts—even if undisputed—fall within or without a given *substantive* definition of dangerousness. An observer might, for example, classify as a "borderline" threat to do injury to another the undisputed remark of a mentally ill individual that, "If it were not assize-time . . . ." Tuberville v. Savage, 1 Mod. 3, 86 Eng. Rep. 684 (K.B. 1669).

367. See the section on the community mental health model, pp. 135-36 *infra*, regarding the recent marked reduction in the number of Pima County patients who reach the hearing stage.

368. In the usual observed situation very little testimony is presented at the hearing about a patient who is not committed. Generally the doctors report that the patient is doing well and dismissal of the petition is recommended. Thus the presentation of observer ratings of dangerousness of those patients would not be meaningful, nor necessary in this study which focuses upon the dangerousness of those patients actually committed as "dangerous" to the state hospital.

makes a determination of this issue and in no observed case did a doctor's report allege that the patient was dangerous to property.[369]

The numerical representations in Table I indicate the number of committed patients whose highest ratings of committability were those of "clearly committable" or "borderline" under the various tests of dangerousness by the preponderance-of-the-evidence standard. The same is true of Table II, except that each total includes only those patients rated as "clearly committable". Tables III and IV indicate the same observations as Tables I and II when the observers made their determinations by the evidentiary standard of proof beyond a reasonable doubt.

The letters along the horizontal axis of each table refer to the definition of dangerousness on the "danger-to-others" observers' rating form portrayed in Illustration 1. Roman numerals corresponding to the "danger-to-self" definitions used in the rating forms are listed along the vertical axis. Row *VI* and Column *G* of each table therefore represent those categories where, in the observer's opinion, no evidence was produced to

TABLE I: The Highest Ratings of Committability for Those Committed Patients Rated as Borderline or Clearly Committable by the Preponderance of the Evidence

Standard		*Danger to Others*							*Total Patients*
		A	*B*	*C*	*D*	*E*	*F*	*G* (Not Dangerous)	
Danger to Self	I					3		1	(4)
	II	1			2				(3)
	III	2			2	2	5	2	(13)
	IV		1			1		2	(4)
	V	2	1		2			2	(7)
	VI (Not Dangerous)							1	(1)
Total Patients		(5)	(2)	(0)	(6)	(6)	(5)	(8)	(n=32)

369. In Maricopa County, the vast majority of committed patients were rated "clearly not committable" as dangerous to property under all definitions, using both standards of proof.

TABLE II: The Highest Ratings of Committability for Those Committed Patients Rated as Clearly Committable by the Preponderance of the Evidence

Standard		Danger to Others							Total Patients
		A	B	C	D	E	F	G (Not Dangerous)	
Danger to Self	I					1	1	1	(3)
	II			1			1		(2)
	III		1				2	2	(5)
	IV				1	2	1	2	(6)
	V	1	4		2	2	2		(11)
	VI (Not Dangerous)							5	(5)
Total Patients		(1)	(5)	(1)	(3)	(5)	(7)	(10)	(n=32)

TABLE III: The Highest Ratings of Committability for Those Committed Patients Rated as Clearly Committable or Borderline by Proof Beyond a Reasonable Doubt

Standard		Danger to Others							Total Patients
		A	B	C	D	E	F	G (Not Dangerous)	
Danger to Self	I					1	1	1	(3)
	II		1					1	(2)
	III		1				1	2	(4)
	IV	1				3	2	2	(8)
	V		3		2	2	2		(9)
	VI (Not Dangerous)							6	(6)
Total Patients		(1)	(5)	(0)	(2)	(6)	(6)	(12)	(n=32)

TABLE IV: The Highest Ratings of Committability for Those Committed Patients Rated as Clearly Committable by Proof Beyond a Reasonable Doubt

Standard		Danger to Others							Total Patients
		A	B	C	D	E	F	G (Not Dangerous)	
Danger to Self	I							2	(2)
	II								(0)
	III							1	(1)
	IV						1	4	(5)
	V	1	2	1	1		2	2	(9)
	VI (Not Dangerous)			2		2	3	8	(15)
Total Patients		(1)	(2)	(3)	(1)	(2)	(6)	(17)	(n=32)

demonstrate sufficiently that the patient was committable as dangerous under any of the listed definitions.

Note, then, that while a particular patient may be rated as not dangerous under item *G* of the danger-to-others scale, he could still be considered extremely dangerous to himself if he is also placed in Row *I* or *II* of the danger-to-self scale. Similarly, a patient whose rating falls at the intersection of Row *VI* and Column *A* would not represent a danger to himself but would be considered to be an extreme danger to others.

These tables therefore indicate under each of the two evidentiary standards and three degrees of certainty, the most rigorous definition of dangerousness under which each of the 32 patients could have been committed.

Before proceeding to a discussion of the project's findings, a caveat is in order. As these observers' ratings are based on the evidence presented at the hearing, they are not necessarily reflective of the patients' actual "dangerousness." In reality, a patient's behavior could have indicated a higher level of dangerousness although evidence of such was not presented at the ritualistic Maricopa County hearing. Furthermore, if the testimony indicated that that patient was obviously dangerous in one sense, there

might be no need to examine how that patient could also be classified as dangerous in another sense. For example, if the evidence indicated that the patient was acutely suicidal, no purpose would be served by inquiring into how the patient might be considered to be a danger to others, at least if his dangerousness to others was not exceptionally high. Thus, the observation team's ratings might indicate that a given patient is not dangerous to others when, in fact, he may be. Nevertheless, our distinct impression is that, on both scales, obvious danger is probably always elicited when it in fact exists.

An initial examination of the data presented in Tables I through IV reveals an obvious pattern. As the standard of proof and certainty of committability become more rigorous, the ratings of committability cluster in those categories representing the broadest, least rigorous definitions of dangerousness to either self or others. For example, under the highest standards of proof and certainty of committability (Table IV) only eight patients were rated as either suicidal[370] (rows *I* and *II* of the danger to self scale) or virtually helpless[371] (rows *III* and *IV* of the danger to self scale). By the lesser commitment standards of Table I, however, 24 patients were assigned their highest rating of committability under these defintions.

A similar pattern is presented when danger to others is considered. Under columns *D* and *E*, a patient could be committed if he had either threatened to commit an assaultive act or if the doctors predicted he would commit such an act in the future.[372] Under the lesser standards of Table I, the observers reported that 12 patients, at most, could be committed under these definitions of dangerousness. But where, in Table IV, the standard of proof and certainty of commitment were raised, only three patients fell within those definitional categories. This pattern indicates that under the higher standards of evidence and of certainty, it is doubtful that the majority of these patients could have been committed as potentially assaultive. Note, however, that the pattern does not hold true

370. The most obvious situation where the patient is considered to be dangerous to himself is in the case of a recent suicide attempt. In Pima County, several commitments during the observation period followed unsuccessful suicide attempts by prisoners incarcerated in the county jail. A patient rated as a substantial risk to himself was observed in a Maricopa County hearing where the evidence indicated that the patient, though he had not made a recent attempt at suicide, was in a state of severe depression and in the past, while so depressed, the individual had "nearly cut his arms off" attempting to take his own life. *See* pp. 74-75 *supra.*

371. See text accompanying note 384 *infra,* regarding the committability of the "gravely disabled."

372. Among the patients rated as committable under these definitions were a 27-year-old epileptic female demonstrating psychosis who heard voices directing her to harm her children; an unemployed laborer who threw knives at a wall, broke dishes and made general threats to kill the whole world, and a housewife who was hearing voices, breaking household objects and turning on gas jets without lighting them.

where the evidence indicated that the patient had actually engaged in assaultive acts in the past. Seven patients were rated committable or borderline under the definitions calling for a showing of actual aggressive behavior (columns *A*, *B* and *C*)[373] under the preponderance-of-the-evidence standard of proof (Tables I and II), and only one patient was lost from this group when the evidentiary standard was raised to proof beyond a reasonable doubt (Tables III and IV).

Before discussing the specific impact of more rigorous substantive definitions of dangerousness, it is worth mentioning here the number of actually committed patients who, from the evidence produced, seem not dangerous or dangerous in only the most questionable sense, and who would have been committed, if at all, by the observers only under a very general definition of danger to self or others. These patients are represented at the intersections of columns *F* and *G* with rows *V* and *VI* of Tables I through IV. According to these definitions of dangerousness, the committed patients were, at worst, a danger to others because their behavior was simply inappropriate and socially offensive, and a danger to themselves because their behavior would detract from their social acceptability or might lead to some contact with authorities for commission of a minor offense. The number of the 32 committed patients who, at most, met those standards is presented in Table V.

TABLE V: PATIENTS COMMITTABLE ONLY UNDER BROADEST DEFINITION OF DANGEROUSNESS OR NOT DANGEROUS

Standard of Evidence	*Certainty of Committability*	*Number of Actually Committed Patients Committable Only Under Broadest Definition of Dangerousness* or Not Dangerous***
Preponderance of Evidence	Clearly committable and borderline	3
Preponderance of Evidence	Clearly committable	7
Beyond Reasonable Doubt	Clearly committable and borderline	8
Beyond Reasonable Doubt	Clearly committable	15
	Patients Actually Committed: 32	

* Column *F* by Row *V*, Tables I through IV.
** Column *G* by Row *VI*, Tables I through IV.

Under the lowest standards of proof and certainty of committability, three committed patients were rated as not committable or at best commit-

373. The observation team rated one patient as committable where the evidence indicated that he had engaged in recent altercations with others and the doctor

table only under this broad definition. As the evidentiary and certainty standards rise, however, the committability of many more patients becomes contingent upon a definition of dangerousness which amounts to "troublesome, bothersome or merely inappropriate." Where the burdens are the highest, fully 15 of the 32 patients actually committed were rated as either not dangerous at all or dangerous only under the broadest possible definition.

This finding demonstrates what people in the system have often verbalized to project interviewers: that many individuals are committed who are really not dangerous by any commonsense definition of the term.[374] The project found that the decision to commit is commonly viewed as an undesirable—yet available—solution to human behavior problems. Rejection of this approach in favor of a statutory scheme which recognizes the impact of expanded community services will be discussed in later parts of this project,[375] but it should be obvious at this point that a logical concomitant of increased community mental health services would be more rigorous standards of state hospital committability. The impact of the application of such higher standards is discussed immediately below.

The Impact of a More Rigorous Definition of Dangerousness for Commitment Purposes

The data regarding the committability of the observed patients takes on special significance when analyzed in terms of predicting the fate of committed patients had the court been operating under a more rigorous test of dangerousness. At this point therefore, the hearing disposition for the 32 committed Maricopa County patients will be presented as if their commitment had been dependent upon such a test.[376] Once again, it must be borne in mind that the results are based on evidence elicited at the actual hearings, and it may be that if committing courts were required to operate under higher substantive or evidentiary standards, and if their determinations were carefully scrutinized, more evidence of dangerouness might be elicited in court.

This discussion will focus primarily on the possible impact on Ari-

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testified that the patient suffered from paranoid schizophrenia which required treatment to avoid further deterioration. Another patient was rated as clearly committable by the observation team under item *B* of the danger-to-others scale where the appointed counsel asked to be sworn during the hearing and testified that the patient had, during the ward interview, hit him "real good."

374. For example, one experienced social worker assigned to a ward at the Arizona State Hospital estimated that 80 percent of the patients on her ward were not dangerous in the sense of potentially harming others or committing suicide. The superintendent of the state hospital, in an interview with the project, expressed his view that certainly more than 50 percent—and perhaps as many as 80 percent—of his patients were not dangerous under the ordinary meaning of that term.

375. See pp. 116-17, 140-46 *infra.*

376. Of course, the plain language of any such standard could be rendered

zona commitments that might be wrought by the adoption in this state of more stringent statutory standards, such as those embodied in California's *Lanterman-Petris-Short Act*[377] and in the statute recently proposed for Washington, D.C., by the Center for Study of Responsive Law.[378]

It has been shown that many committed patients could, at best, be classified as dangerous only under the broadest definition of that requirement. If the Arizona dangerousness standard were applied more literally, or if the substantive standards were explicitly raised, the hearing outcome would obviously have been different for several of the patients observed during the study period. For analysis purposes, consider the impact of the following hypothetical interpretation of the term "danger to self and others."

> A patient is committable as a danger to himself if it is demonstrated that he has recently attempted or threatened suicide.
>
> A patient is committable as a danger to others if it is demonstrated that he has recently committed, attempted or threatened acts of physical aggression upon the person of another.

Under this hypothetical definition, only those patients whose highest rating of committability fell in rows *I* or *II* or columns *A*, *B*, *C* or *D* of Tables I through IV would be committable. The drastic reduction in the number of committable patients is represented in Table VI.

TABLE VI: PATIENTS COMMITTABLE UNDER HYPOTHETICAL DEFINITION OF COMMITMENT STANDARDS

[When contrasted with the 32 patients actually committed, all hypothetical commitment figures in this table are statistically significant beyond the .001 level of significance.]

Standard of Evidence	*Certainty of Committability*	*Number of Patients Committable Only Under Hypothetical Definition of Dangerousness**
Preponderance of Evidence	Clearly committable and borderline	17
Preponderance of Evidence	Clearly committable	14
Beyond Reasonable Doubt	Clearly committable and borderline	12
Beyond Reasonable Doubt	Clearly committable	9

Patients Actually Committed: 32

* Columns *A*, *B*, *C* and *D* and Rows *I* and *II* of Tables I through IV.

meaningless if ignored by the committing court. It is assumed, however, that statutory definitions of dangerousness are amenable to reasonable interpretation and that they can be honestly applied by a hearing judge.

377. CAL. WELF. & INST'NS CODE §§ 5000 *et seq.* (West Supp. 1971).

378. *See 1970 Hearings, supra* note 22, at 391 *et seq.*

The California legislature has provided for an assortment of dangerousness definitions that vary with the length of confinement. For example, a California patient may be detained for a 72-hour evaluation and treatment if he is either dangerous to himself or others or "gravely disabled," and by reviewable medical certification, a gravely disabled person can be held an additional 14 days while the feasibility of conservatorship proceedings are explored, and a suicidal person can be held for two 14-day periods.[379] But, for the patient to be hospitalized for the most extensive time—a 90-day period—he must have recently either threatened, attempted or successfully inflicted physical harm upon another individual.[380] Table VII presents the projected outcome of the observed hearings had the Arizona commitment court been limited by this more specific definition of dangerousness.[381]

TABLE VII: PATIENTS COMMITTABLE UNDER THE CALIFORNIA 90-DAY STANDARD

[When contrasted with the 32 patients actually committed, all hypothetical commitment figures in this table are statistically significant beyond the .001 level of significance.]

Standard of Evidence	*Certainty of Committability*	*Patients Whose Highest Rating of Dangerousness Would Render Them Committable Under the California 90-day Standard**
Preponderance of Evidence	Clearly committable and borderline	13
Preponderance of Evidence	Clearly committable	10
Beyond Reasonable Doubt	Clearly committable and borderline	8
Beyond Reasonable Doubt	Clearly committable	7
	Patients Actually Committed: 32	

* Columns *A*, *B*, *C* and *D* of Tables I through IV.

Under the California scheme, a suicidal patient may be detained as a danger to himself for 14 days, and may be confined for an additional

379. CAL. WELF. & INST'NS CODE §§ 5150-5278 (West Supp. 1971).
380. *Id.* § 5300.
381. Under the California statute, a mentally ill patient can be committed for 90 days if (1) he was taken into custody for attempting or inflicting harm upon the person of another, or if (2) he attempted, inflicted or threatened such harm while being detained for either 72-hour evaluation and treatment or 14-day intensive treatment.

For purposes of Table VII, we will assume that our definitions *A*, *B*, *C* and *D* of the danger-to-others scale meet these additional requirements. Note, however, that insofar as persons who simply *threatened* harm *prior* to being taken into

14 days if he either threatens or attempts suicide during the first period or "continues to present an imminent threat of taking his own life."[382] Table VIII presents the number of committed Arizona patients who could have been detained as suicidal but who could not have been committed under the more drastic 90-day provision as dangerous to others.[383]

TABLE VIII: PATIENTS DETAINABLE UNDER CALIFORNIA'S MAXIMUM 28-DAY DETENTION FOR SUICIDAL PATIENTS

[For notes on a statistical comparison with the 32 patients actually committed, see note 385 *infra*.]

Standard of Evidence	*Certainty of Committability*	*Patients Whose Highest Rating of Dangerousness Would Render Them Detainable as Suicidal**
Preponderance of Evidence	Clearly committable and borderline	4
Preponderance of Evidence	Clearly committable	4
Beyond Reasonable Doubt	Clearly committable and borderline	4
Beyond Reasonable Doubt	Clearly committable	1

* Including Rows *I* and *II* of Tables I through IV, and excluding Columns *A*, *B*, *C*, and *D* of Tables I through IV.

Finally, the California scheme provides for 72-hour detention and 14-day intensive treatment for those determined to be "gravely disabled." That term is defined by the statute to mean "a condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing or shelter."[384] While so confined, the patient is afforded treatment, outpatient alternatives are explored, and the feasibility of instituting conservatorship proceedings are investigated. The number of nonaggressive and nonsuicidal patients thought to be committable for the least drastic 14-day period, or who may be proper subjects for conservatorship are presented in Table IX[385] under the definitions

custody are included in definition *D*, Table VII overrepresents the number of Arizona patients who might have found themselves confined for 90 days if the California scheme were operative.

382. CAL. WELF. & INST'NS CODE § 5260 (West Supp. 1971).

383. Since it is virtually impossible to determine whether a patient "continues to present an imminent threat of taking his own life," *id.*, we have simply assumed, once again by over-inclusion, that patients falling within definition I or II of the dangerousness-to-self scale meet the California criteria.

384. *Id.* § 5008(h).

385. A statistical comparison of patients who would have been, at worst, detained as suicidal or gravely disabled under the California commitment scheme with the 32 patients actually committed during the study period would be misleading. While California's long-term commitment requirements and the proposal of the

(definitions *III* & *IV* of the dangerousness-to-self scale) most closely approximating the grave disability concept.[386]

TABLE IX: PATIENTS DETAINABLE AS GRAVELY DISABLED

[For notes on a statistical comparison with the 32 patients actually committed, see note 385 *infra*.]

Standard of Evidence	*Certainty of Committability*	*Number of Patients Detainable for 14 Days as Gravely Disabled* but Not Physically Aggressive** nor Suicidal****
Preponderance of Evidence	Clearly committable and borderline	12
Preponderance of Evidence	Clearly committable	9
Beyond Reasonable Doubt	Clearly committable and borderline	10
Beyond Reasonable Doubt	Clearly committable	6

* Rows *III* and *IV* of Tables I through IV.
** Excluding Columns *A*, *B*, *C*, and *D* of Tables I through IV.
*** Excluding Rows *I* and *II* of Tables I through IV.

Under the strict standard proposed by the Center for Study of Responsive Law, a patient would be committable only if it could be proven that he has recently "without reasonable provocation overtly attempted or inflicted serious physical harm upon the person of another."[387] As represented in Table X, the application of this high standard—calling for

Center for Study of Responsive Law, pp. 115-17 *infra*, are comparable in nature to Arizona's commitment standards, California's specialized short-term detention procedures for the suicidal and gravely disabled are not. It is appropriate, however, to examine in statistical terms how the 32 committed patients would have fared under the total California compulsory mental health system. This can be done by combining Tables VII, VIII and IX and comparing the totals with the figure of 32. Thus, under the preponderance-of-evidence standard, we would arrive at a total figure of 29 when we look at cases which are clearly committable and borderline, and the total falls to 23 when we confine ourselves to clearly committable cases. Similarly, the figures for the reasonable doubt standard are 22 and 14 under the respective certainty of committability tests. When compared with the 32 patients committed in Arizona, the figure of 29 narrowly misses statistical significance (though a figure of 28 would have been significant beyond the .05 level); the figure of 23 is significant at the .01 level; and the two remaining figures are significant beyond the .001 level.

386. An example of a patient rated committable under this concept is a previously hospitalized 29-year-old epileptic who was diagnosed as a psychotic. As his personality had become increasingly disorganized, he had failed to take medication that would control his seizures. He became further withdrawn and seizures increased in frequency until he was taken to the county hospital in a coma. A most common type also to be found in this category is the senile patient who is not able to fend for himself and whose diet is irregular. In Maricopa County, one elderly lady was said to spend her modest income not on her own meals, but would instead feed her 51 cats.

387. *1970 Hearings, supra* note 22, at 393.

an actual assault or attempted assault—would drastically limit the committability of the patients observed in the study period. Note that while the number of committable patients is seriously reduced under this high standard of dangerousness, the number of individuals perceived to be potentially very dangerous seems to remain constant even though the standard of proof and certainty of committability are raised.

TABLE X: PATIENTS COMMITTABLE UNDER THE STANDARD PROPOSED BY THE CENTER FOR THE STUDY OF RESPONSIVE LAW

[When contrasted with the 32 patients actually committed, all hypothetical commitment figures in this table are statistically significant beyond the .001 level of significance.]

Standard of Evidence	*Certainty of Committability*	*Number of Patients Committable Under Center's 90-day Standard**
Preponderance of Evidence	Clearly committable and borderline	7
Preponderance of Evidence	Clearly committable	7
Beyond Reasonable Doubt	Clearly committable and borderline	6
Beyond Reasonable Doubt	Clearly committable	6
	Patients Actually Committed: 32	

* Columns *A, B* and *C* of Tables I through IV.

Both the Center proposal and the California legislation, it will be noted, insist that involuntary commitment be predicated on specific past activity. Both, in other words, reflect discontent with the pure "preventive detention" possibilities inherent in most commitment schemes, as well as with the predictive capabilities of the medical profession, and both are in keeping with the *Pearson*[388] caveat that substantive commitment criteria not based on past activity may be constitutionally suspect.

Unlike the Center proposal, however, which is philosophically opposed to the *parens patriae* doctrine, the total California scheme does take cognizance of danger to self, though not in the context of an extreme 90-day involuntary commitment. A suicidal patient can, as we have seen, be held for a certain relatively short period of time—the outside limit of which approximates one month—but can be held no longer than a month unless he again threatens or attempts suicide during the period of his confinement. And "gravely disabled" persons—those unable, because of

388. Minnesota *ex rel.* Pearson v. Probate Court, 309 U.S. 270 (1940). See notes 356-59 and accompanying text *supra.*

mental illness, to provide for food, clothing or shelter[389]—are ordinarily not to be institutionalized for more than 14 days under the California statutory scheme, but are instead assisted in their daily existence by a far-reaching "less drastic" program of conservatorship of the person and of the estate.

In Arizona, adoption of the philosophically pure Center model would probably seem impractical at least until voluntary and community mental health programs are more fully developed. The benevolently motivated judicial avoidance of a literal definition of dangerousness bears witness to the fact that the legal system will go to great lengths to see that the mentally infirm will be looked after.[390]

The California sliding scale approach, then, seems at the moment the more feasible one for Arizona to model: a relatively short term determinate commitment based on specific past activity of danger to others, an even shorter determinate detention based on suicidal threats or attempts, and a community-oriented perspective—coupled with an expanded notion of guardianship of the person and the estate—as a "less drastic alternative" to state hospitalization for the non-dangerous gravely disabled. Ideally, of course, the focus on community mental health and short-term crisis intervention ought to be built into the statutory scheme. But even in the absence of a statute, a resourceful lawyer well-versed in community facilities, programs and services can often act skillfully and swiftly in an informal context to avert the commitment of his client.

389. *1970 Hearings, supra* note 22, at 706.

390. One Pima County judge admitted to a project interviewer that as a human being he could not turn his back on an elderly and senile female indigent who was in need of help. If the statute required him to find her to be "dangerous" to send her to the state hospital, the judge indicated he would do so.

COMMUNITY MENTAL HEALTH: SOCIAL IMPACT AND LEGAL IMPLICATIONS

COMMUNITY MENTAL HEALTH AND CRISIS INTERVENTION

The convergence of many forces is responsible for the community mental health movement. For one thing, the adverse effects of hospitalization for more than a brief period of time have been amply demonstrated.[391] Even if the hospital eschews the notion of custodial care and undertakes to develop a true treatment perspective, it is difficult for patients to readjust to society after they are discharged. They suffer from the effects of societal isolation, from high functional disability, from a dependency syndrome, and are very likely to be readmitted to the hospital.[392] Even a series of brief admissions prior to a "cure" has been found preferable to continuous hospitalization in terms of total time spent in the hospital.[393]

Furthermore, displacement of a patient from his normal environment puts him into a setting where he is expected to play the "sick role."[394] Acting as a sick person should in a place where sick people belong reinforces a patient's self-concept as a mentally ill person. A related problem of hospitalization is that it sidesteps the nucleus of the problem. By removing the individual from his normal environment, the interpersonal issues which may have precipitated the crisis episode are obscured.[395]

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391. Gruenberg, *The Social Breakdown Syndrome—Some Origins*, 123 AM. J. PSYCHIATRY 1481 (1967); Hunt, *Ingredients of a Rehabilitation Program*, in APPROACH TO THE PREVENTION OF DISABILITY FROM CHRONIC PSYCHOSES (F. Bourdeau & E. Gruenberg eds. 1958); Mendel, *Effect of Length of Hospitalization on Rate and Quality of Remission from Acute Psychotic Episodes*, 143 J. NERV. & MENT. DISORDERS 228 (1966); *cf.* Engle & Sabin, *Partial Hospitalization*, in THE PRACTICE OF COMMUNITY MENTAL HEALTH, ch. 15 (H. Grunebaum ed. 1970). The debilitating effects of state hospitalization are further explored in the "General Conclusion," pp. 237 *et seq. infra.*

392. Goldberg, *Hospital Work and Family: A Four Year Study of Young Mental Hospital Patients*, 112 BRIT. J. PSYCHIATRY 177 (1966); Lehrman, *Follow-Up of Brief and Prolonged Psychiatric Hospitalization*, 2 COMP. PSYCHIATRY 227 (1961); Ruesch, *Hospitalization and Social Disability*, 142 J. NERV. & MENT. DISORDERS 203 (1966).

393. D. LANGSLEY & D. KAPLAN, THE TREATMENT OF FAMILIES IN CRISIS 32 (1968).

394. *Id.* at xvii.

395. A. Querido, *Early Diagnosis and Treatment Services*, in MILBANK MEMORIAL FUND, ELEMENTS OF A COMMUNITY MENTAL HEALTH PROGRAM (1956).

The discovery of the psychoactive drugs offered an opportunity in many cases to avoid hospitalization and its resultant dangers.[396] Such drugs can relieve the anxiety and lessen the tension which often precede and accompany overt manifestations of mental illness. Relief from those stress factors enables the individual to direct more energy toward coping with the instant situation,[397] and also makes it easier for him to blend with the rest of society instead of being hospitalized and isolated.

Another force which focused public attention on the need for change in mental health policy was a study of social class and mental illness.[398] That analysis revealed that the poor, as contrasted with other social classes, were tremendously overrepresented in the mental health system, that they suffered from the most severe forms of emotional disturbance, and that they received the least preferable forms of treatment, often no more than custodial care in a state hospital.

Perhaps the most immediate cause of the community mental health trend came when the development of the psychoactive drugs as a therapeutic technique and the concomitant trend toward outpatient treatment were recognized by the Joint Commission on Mental Illness and Health in its final report in 1961.[399] As a result, President Kennedy submitted to Congress in 1963 a proposal for a national mental health plan.[400] The ensuing legislation[401] has lent great impetus to the development of community mental health programs and facilities.[402]

The mental health programs envisioned by the federal legislation are

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396. *See, e.g.*, CENTRAL NEURO-PSYCHIATRIC RESEARCH LABORATORY, VETERANS HOSPITAL, PERRY PT., MARYLAND, DRUG TREATMENT IN PSYCHIATRY (1970); Wolpert, *Psychopharmacology: An Overview*, 42 PSYCHIATRIC Q. 444 (1968); *see* Jarvik, *The Psychopharmacological Revolution*, in READINGS IN CLINICAL PSYCHOLOGY TODAY 93 (1970). Arizona Health Planning Authority, Mental Health in Arizona (Jan. 1970), gives an account of the impact of psychoactive drugs on Arizona State Hospital patients:

> These drugs changed their disturbance, violence, destructiveness and excitement to more quietness, better adjustment and more amenability to other treatment activities . . . 40 percent of the approximately 1,000 treated with these drugs improved greatly so that their length of hospitalization was reduced . . . results were secured within a few days . . . when patients were improved, they were counseled and a program of occupational therapy outlined which would start them toward recovery. During this time about 80 percent of the patients admitted to the hospital for the first time were discharged. On June 30, 1956 there were 907 patients out of the total of 1,639 who had been in the hospital for more than 5 years. *Id.* at 9, *quoting* Arizona State Hospital, 75 Years of Progress. (deletions in original).

397. D. LONGSLEY & D. KAPLAN, *supra* note 393, at 159.

398. A. HOLLINGSHEAD & F. REDLICH, SOCIAL CLASS AND MENTAL ILLNESS: A COMMUNITY STUDY (1958).

399. JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH 28-29 (1961).

400. For a text of the speech, see 109 CONG. REC. 1744 (1963).

401. 42 U.S.C. §§ 2681-87 (1963).

402. G. CAPLAN, THE THEORY AND PRACTICE OF MENTAL HEALTH CONSULTATION 4 (1970), refers to estimates by the Director of the National Institute of Mental Health predicting that by 1970 about 500 centers will have been funded, with the total rising to 2,000 by 1980.

for the most part not yet fully developed, and the shape each plan will take will depend to a very large extent upon the community in which it will operate.[403] The general objectives of all programs will be the same, however, and have been succinctly stated in an official position paper of the American Psychological Association:

> The core of the plan is this: to move the care and treatment of the mentally ill back into the community so as to avoid the needless disruption of normal patterns of living, and the estrangement from these patterns, that often come from distant and prolonged hospitalization; to make the full range of help that the community has to offer readily available to the person in trouble; to increase the likelihood that trouble can be spotted and help provided early when it can do the most good; and to strengthen the resources of the community for the prevention of mental disorder.[404]

This approach to mental illness has evolved as an alternative to the traditional medical model.[405] Under that model, the illness was viewed as similar to physical illness, inhering in the person. As a result, the treatment focused on the individual and was normally administered by a doctor or psychiatrist.[406] Under current theory, however, the individual's behavior is looked upon as a result of situational and environmental determinants as well as of personality malfunction.[407] Thus, treatment focuses on

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403. Newton, *The Comprehensive Mental Health Center: Unchartered Horizons for Inpatient Services*, 123 AM. J. PSYCHIATRY 1210 (1967); Yolles, *The Community Mental Health Center in National Perspective*, in THE PRACTICE OF COMMUNITY MENTAL HEALTH 787, 800-02 (H. Grunebaum ed. 1970).

404. Smith & Hobbs, *The Community and the Community Health Center*, 21 AM. PSYCHOLOGIST 499 (1966). That article sets forth guidelines for the development and operation of a community mental health center, and was adopted on March 12, 1966 by the Council of Representatives as an official position paper of the American Psychological Association.

405. Blackman & Goldstein, *Some Aspects of a Theory of Community Mental Health*, 4 COMM. MENT. HEALTH J. 85 (1968).

406. Traditional psychotherapies have been of an "insight" variety, seeking through a lengthy process of communicative interaction to impart to the patient an insight into his problem. Because of the nature of these procedures, their success depends largely on patients who are articulate and who are willing to undergo lengthy process. *See* E. HILGARD, R. ATKINSON, & R. ATKINSON, INTRODUCTION TO PSYCHOLOGY 493 (5th ed. 1971) (discussing psychoanalysis). Not surprisingly, then, in-depth psychotherapy seems unsuitable for lower class patients, many of whom are inarticulate and unwilling to defer gratification.

407. O'Connell, *Institutionalization and Cognitive Functioning of Schizophrenics*, 25 PSYCHOLOGICAL REP. 621 (1969); Overall, Hollister, Kimbell & Shelton, *Extrinsic Factors Influencing Responses to Psychotherapeutic Drugs*, 21 ARCH. GEN. PSYCHIATRY 89 (1969); SCHROAB, WARHEIT & MCGINNIS, ABSENT PERSPECTIVES IN SOCIAL PSYCHOSOMATICS 18 (1970). "Behaviorism" is another current psychological approach growing in clinical acceptance and application. Behaviorism has been defined as:

> A systematic approach or school of psychology which regards objective, observable manifestations such as motor and glandular responses as the key to an understanding of human behavior. Consciousness, feeling, and other 'subjective' phenomena are disregarded as unnecessary or regarded as mediating processes between stimulus and response. J.C. COLEMAN, ABNORMAL PSYCHOLOGY AND MODERN LIFE 657 (3rd ed. 1964).

This theory focuses on behavior as a learned response to given stimuli, and much of what is generally called mental illness is considered to be learned responses sub-

a large configuration of community interrelationships, and many different types of personnel, some of them paraprofessional,[408] are utilized in the resolution of the problem.

The federal legislation contemplated development of mental health programs pursuant to guidelines established by the Secretary of Health, Education and Welfare in consultation with the Federal Hospital Council and the National Advisory Mental Health Council.[409] Under those regulations, the areas served by mental health centers are not defined on the basis of geographical or political lines, but rather on the size of the population served. These "catchment areas" must have a lower population limit of 75,000 and a ceiling of 200,000.[410]

In order to qualify for federal support, a community mental health center must provide five essential services: inpatient service, outpatient service, partial hospitalization,[411] emergency services available at all times, and consultation and educational services to community agencies and professional personnel.[412] These five essentials are the minimum and centers are encouraged to develop comprehensive programs, which also include diagnostic services, rehabilitative services, precare and aftercare services in the community, training, and research and evaluation programs.[413]

One result of the community mental health movement is the popularity of the concept of outpatient emergency treatment. This concept is variously referred to as "crisis therapy," "brief psychotherapy," and "emergency psychotherapy," but for the purposes of this project it shall be re-

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ject to the same methods of modification as is "normal" behavior. *See* Eysenck, *New Ways in Psychotherapy*, in READINGS IN CLINICAL PSYCHOLOGY TODAY 65 (1970). One of its most obvious advantages in public mental health is that, unlike insight psychotherapy, it knows no social class restrictions and can be applied to patients who lack communicative and intellectual capabilities.

408. Paraprofessionals in the mental health field are also commonly referred to as subprofessionals, nonprofessionals, and indigenous mental health workers. Such workers are sometimes indispensable in working with ethnic minorities, particularly those who are not English-speaking. *Cf.* Ennis, *Mental Illness*, 1969-70 ANN. SURV. AM. L. 29, 42 n.68 (discussing communication problems between black patients and foreign born institutional psychiatrists). Riessman & Hallowitz, *The Neighborhood Service Center: An Innovation in Preventive Psychiatry*, 123 AM. J. PSYCHIATRY 1408, 1412 (1967), express the view that

> [i]t is evident that nonprofessionals can intervene in critical situations, engage comparatively pathological people in meaningful relationships, stimulate them to take action in their own behalf, mobilize community resources, and serve as a bridge between the client-in-need and the professional service.

409. 42 U.S.C. § 2683 (1964), *as amended, id.* (Supp. V, 1970).

410. 42 C.F.R. § 54.203 (1971). These rules are subject to exceptions, however, and by mid-1968 about 10 percent of the funded centers were excepted from the general limitations. R. GLASSCOTE, J. SUSSEX, E. CUMMING & L. SMITH, THE COMMUNITY MENTAL HEALTH CENTER: AN INTERIM APPRAISAL 16 (1969). Also, a given center may serve patients from outside its catchment so long as it is providing the essential services to the people living with the catchment. *Id.* at 17.

411. *See* R. GLASSCOTE, A. KRAFT, S. GLASSMAN & W. JEPSON, PARTIAL HOSPITALIZATION FOR THE MENTALLY ILL (1969).

412. 42 C.F.R. § 54.212(a) (1971).

413. *Id.* § 54.203(a).

ferred to as "crisis intervention."[414] Crisis intervention, which is epitomized by suicide prevention programs,[415] is based largely upon the concept of stress as the factor precipitating "psychosis." Under that model,[416] life is viewed as an endless series of situations with which an individual must cope. To the extent that these confrontations are minor ones, or major ones for which an appropriate solution has previously been developed, the individual can master them and retain his state of balance or "equilibrium." When an acute stress is not readily masterable, however, a "crisis" develops.[417] In the ensuing struggle, the person will ordinarily develop an appropriate response and psychological balance will result, but if his response is inappropriate or insufficient, aberrant behavior will result. If the resulting behaviorial aberrations are quite severe, the person will probably be labeled "psychotic," even though that term ordinarily implies deeprooted sickness and is thus, in the crisis context, something of a misnomer. The goal of crisis intervention is to render appropriate aid immediately to relieve the acute stress situation and restore proper psychological balance.

Although there are different views of the crisis intervention process, there are eight principles that are almost universal.[418] The first of these is to build upon the patient's expectations of receiving help by maintaining a positive relationship. The therapist must assume an interested and sin-

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414. Parad, *Brief Ego-Oriented Casework with Families in Crisis*, in EGO-ORIENTED CASEWORK: PROBLEMS AND PERSPECTIVES (H. Parad & G. Miller eds. 1963) [hereinafter cited as H. PARAD & G. MILLER] suggests:

> A crisis consists of hazardous circumstance or stress that constitutes a threat for individuals and families whose psychological organization makes the stressful event meaningful in terms of two broad criteria: (1) the stress threatens important life goals such as health, security, or affectional ties, and (2) the threat posed by the stress appears impossible of immediate solution and overtaxes the immediate resources available to the ego. *Id.* at 145.

415. Farberow, *Training in Suicide Prevention for Professional and Community Agents*, 125 AM. J. PSYCHIATRY 1702 (1969). The major characteristics of a crisis situation are "its demand for immediate attention, heightened effect, starkly dichotomized choices between life and death, attendant chaos and disorganization, and potentiality of final, irreversible resolution." *Id.* at 1703. *See also* Farberow, *Suicide Prevention: A View from the Bridge*, 4 COMM. MENT. HEALTH J. 469 (1968).

416. *See* D. LANGSLEY & D. KAPLAN, *supra* note 393, ch. 1.

417. Rapoport, *The State of Crisis: Some Theoretical Considerations*, in H. PARAD & G. MILLER, *supra* note 414, at 22, 26, relates the phases of the process as formulated by Gerald Caplan in seminars at the Harvard School of Public Health, 1959-60:

> [H]abitual problem solving mechanisms are called forth. If the first effort fails, there will be an increase in the level of tension with an increase in feeling upset and ineffective. This state may then call forth 'emergency problem-solving mechanisms.' Three things are likely to happen: (1) the problem may actually be solved; (2) there may be a redefinition of the problem in order to achieve need-satisfaction; (3) the problem may be avoided through need-resignation and the relinquishment of goals. If the problem cannot be solved in any of these ways, a state of major disorganization may ensue.

418. D. LANGSLEY & D. KAPLAN, *supra* note 393, at 18-23. *See also* a similar analysis consisting of six elements in Parad, *Introduction to Part III*, in H. PARAD & G. MILLER, *supra* note 414.

cere posture as well as project an image of being actually able to help the person. Second, the focus is on the present illness and the events which precipitated the present crisis. The past may be explored, but only to discover its possible influence on the present crisis.[419] The third principle is that the therapist must take an active role rather than the passive one typical of many other types of therapy.[420] The fourth notion is possibly the most important to this theory. Since the focus is on a specific set of circumstances, the approach to crisis alleviation cannot be the same for all cases. The key notions are eclecticism and pragmatism and encouraging the therapist to tap various sources for a method that will work for the given situation.[421] The fifth concept is to try to enhance the patient's self-esteem, which will normally have been diminished to some extent. In simple terms, this is accomplished by appropriate praise and the reinforcement of healthy behavior. The next technique is to manipulate the environment of the patient so as to alleviate the possible precipitating stresses. This may entail little more than a telephone call to a landlord or government agency, or obtaining emergency food supplies for a starving family. Seventh, psychoactive drugs may be used in appropriate cases to alleviate symptoms of the crisis, especially tension and anxiety. Finally, the therapeutic relationship must be terminated in such a way as to leave the door open for help in the event of future crisis.[422]

In contrast to crisis intervention, traditional psychotherapy generally involves a one-to-one doctor-patient relationship. Thus, the number of persons requiring help make it costly and impractical in most cases,[423] particularly in the area of public mental health and the commitment context.[424] Crisis intervention, on the other hand, offers a therapeutic model

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419. Kritzer & Langsley, *Training for Emergency Psychiatric Services*, 42 J. MED. EDUC. 1111, 1114 (1967):

> The initial evaluation should focus on the present crisis. The patient must be encouraged to examine the events leading to the current disturbance and to provide information about environmental and interpersonal difficulty which may have an important bearing. Skillful interviewing by the psychiatrist can often expose these factors and their related effects.

420. L. HANKOFF, EMERGENCY PSYCHIATRIC TREATMENT: A HANDBOOK OF SECONDARY PREVENTION 41 (1969):

> The providing of specific direct services to the patient serves three functions: (1) it enhances the relationship, (2) it diminishes the impact of the crisis on the individual, and (3) it demonstrates to the individual the use of coping mechanisms in relation to the challenges of the crisis.

421. *Id.* at 58: "The professional should offer generic emergency care to patients and not be preoccupied with a specific treatment modality, *e.g.*, psychotherapy or pharmacotherapy. All modalities of treatment should be immediately available at the initial contact."

422. Not all theoretical approaches to crisis intervention accept this last tenet. Some hold that termination should be gradual, with diminishing amounts of treatment, while others maintain that the impression should be conveyed that the door will not be open in the future, so the patient will have more incentive to succeed on his own.

423. W. BARTON, INTRODUCTION TO THE COMMUNITY HEALTH CENTER: AN ANALYSIS OF EXISTING MODELS (1964).

424. Traditional psychotherapy may also be inappropriate in this context. See notes 406-07 *supra*.

that is appropriate for application to the commitment process—or rather for avoiding the commitment process. It is relatively short-termed and probably less expensive than traditional approaches;[425] it offers immediate aid when the crisis is occurring and, if its assumptions are true, it remedies the behavioral aberrations which are the subject of commitment hearings.[426]

Critics of the community mental health movement have complained that the effectiveness of the program has not been sufficiently proven.[427] While that objection is not completely unfounded, there are studies that lend strong support to the concept that hospitalization should be held to a minimum.[428] Also, some systematic studies of the community mental health technique have already been conducted.

The first of these was undertaken in Louisville, Kentucky in 1961 to test the efficacy of treating schizophrenics in their homes.[429] The 152 subjects were drawn from the population of patients entering the Central State Hospital. Preliminary screening was done by a psychiatrist at the hospital who determined whether the patient was schizophrenic and in need of hospitalization, yet not so psychotic as to present a suicidal or homicidal danger. If those requirements were met, the psychiatrist would inform the Institute Treatment Center (ITC)[430] by telephone.[431]

The social worker at the Center would then begin making arrangements to interview the family. During the interview, the social worker would determine whether the family was willing to accept the patient for home care, and would later inform the project director. At approximately the time of the family interview, the psychiatrist connected with the ITC would examine the patient to confirm the earlier diagnosis and to make sure the patient was not dangerous in a suicidal or homicidal sense. Upon notification by the psychiatrist that the patient was acceptable, the project director would draw the next randomized card from his file to determine which treatment modality would be utilized.

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425. D. LANGSLEY & D. KAPLAN, *supra* note 393, at 169-70.

426. B. PASAMANICK, F. SCARPITTI & S. DINITZ, SCHIZOPHRENICS IN THE COMMUNITY: AN EXPERIMENTAL STUDY IN THE PREVENTION OF HOSPITALIZATION 15 (1967) [hereinafter cited as B. PASAMANICK, ET AL.], suggest, as do many others, that a real distinction should be drawn between true mental illness and the merely frustrating problems of life.

427. Newton, *supra* note 403; Editorial Comment, *Mental Hygiene Law—1967*, 41 PSYCHIATRIC Q. 766 (1967).

428. *See* D. LANGSLEY & D. KAPLAN, *supra* note 393, at 5-6; Mendel, *Brief Hospitalization Techniques*, 6 CURRENT PSYCHIATRIC THERAPIES 31 (1969). In the last-mentioned study, the ability to function socially upon release was shown to be negatively correlated to the number of days in the hospital (the shorter the period of hospitalization, the higher the level of functioning in the course of posthospital adjustment). Also, the length of hospitalization was found to be directly correlated to the length of subsequent rehospitalization.

429. B. PASAMANICK, ET AL., *supra* note 426; *see also* G. FAIRWEATHER, COMMUNITY LIFE FOR THE MENTALLY ILL (1969).

430. The name was made as innocuous as possible in order to avoid any stigmatizing effect on the patients.

431. For a complete description of the methodology involved in the study, see B. PASAMANICK, ET AL., *supra* note 426, at 33-52.

Of the 152 patients studied, 57 received home treatment with drugs, 41 were treated at home with placebos, and 54 were hospitalized as a control group.[432] The hospitalized group participated in the normal routine of the psychiatric hospital. The two home care groups differed from one another only in the types of medication they received, with only the director knowing which patients were on placebos.

Aside from medication, the treatment of the home care groups consisted mainly of visits by public health nurses. These nurses had been chosen from the Louisville area and were given training in handling psychiatric patients. The nurse assigned to a particular patient began her series of visits the day after the patient was accepted into the program. The weekly visits were gradually reduced to a once-a-month basis after 6 months. The nurses offered commonsense advice and assurance to the patients, but at no time did a nurse attempt any method of formal therapy.

Originally, each patient was to be seen by the ITC psychiatrist every 3 months, technically for reevaluation. But the nurses often had qualms about the condition of patients, and families and the patients themselves often demanded that the psychiatrist see the patient. As a result, the psychiatrist saw many of the patients more often than every 3 months.

The results of the study are impressive. Over 77 percent of the drug home care patients and 34 percent of the placebo home care patients remained in the community for their entire participation in the project. When compared with the hospital group, these figures are even more significant, for after an initial hospitalization averaging 83 days, the controls experienced greater failure rates when they returned home, with nearly half of that group having to be rehospitalized. The end result was that the hospital control group spent only 75 percent of its time at home, while the placebo home care group spent 80 percent, and the drug home care group 90 percent of the time in the program at home.[433]

The implications of the foregoing study for the community mental health movement are particularly important when it is noted that schizophrenia is generally considered a very severe illness, and that schizophrenics occupy almost half of all mental hospital beds.[434] If a community treatment program can be successful with such patients, it should be very appropriate for treatment of patients with less severe mental illnesses and with mere problems in living.

The second study,[435] conducted at the Comprehensive Community Mental Health Center of Denver General Hospital, investigated the effectiveness of family crisis treatment, a form of crisis intervention. The object of that type of treatment is to give immediate aid to the identified patient,

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432. *Id.* at 81.
433. *Id.* Chapter 6 contains an analysis of all the findings of the study.
434. B. WOLMAN, HANDBOOK OF CLINICAL PSYCHOLOGY 978 (1965).
435. D. LANGSLEY & D. KAPLAN, *supra* note 393.

but the real focus is on the family. The crisis is identified as a family problem and the family is enlisted to aid in its resolution.

The population from which a random sample was drawn consisted of all those voluntarily seeking psychiatric help who lived in a family in the Denver Metropolitan area and who were deemed by the resident psychiatrist to be in immediate need of admission to the hospital. In order to obtain a random sample from that population, the psychiatrist would call the Family Treatment Unit (FTU) after he determined the patient to be in need of immediate admission but before he told the family of his decision. Upon receiving the call, a member of the FTU opened a sealed envelope which contained the words "yes" or "no". If the envelope contained a "no," the patient was admitted to the hospital. If the answer was "yes," the FTU assumed responsibility for the patient, and family crisis treatment was utilized instead of hospitalization.[436]

The initial step of trying to alleviate the symptoms of the identified patient was followed by a meeting with the whole family. The latter procedure was followed to gain a clearer picture of the immediate situation, on the premise that distortions or misinterpretations by one member may be corrected by another member of the family. Within 24 or 36 hours of the first contact with the family, a visit in the family home was scheduled for a member of the FTU. Such visits provide an opportunity for firsthand observation of interaction within the family and for discovering the strengths and weaknesses of family functioning. They also demonstrate to the family that the FTU is sincere in its efforts and intends to help in any way possible.

After these initial contacts, various attempts may be made to relieve stresses upon individuals within the family and to eliminate stress-producing conditions. The family may be given tasks to perform which are related to the current crisis. For example, if an identified patient is an adolescent whose problems stem from approaching adult independence or adult sexual behavior, the family may be given the task of formulating rules for the patient which are appropriate for the circumstances and consistent with the rules governing the family members. This often serves not only to get the family involved in seeking a resolution of the crisis, but also to alleviate a principal stress factor causing the crisis situation.

Through the course of treatment, the FTU participates in an average of five office visits, a home visit, two or three phone calls and, if applicable, a collateral contact or two with the referring agencies or with other social agencies which have been involved with the family prior to the crisis. Once the crisis is resolved, after an average treatment period of 2½ weeks,[437] referrals may be made if appropriate, and the relationship is terminated with an open door for future assistance.

436. *Id.* at 22-23.
437. *Id.* at 27.

The long-term results of the program are not yet ascertainable, but a look at some of the initial figures is revealing.[438] The interim appraisal is based on a total sample of 150 families, half treated by the FTU and half a hospital control group.[439] None of the 75 FTU cases were hospitalized in the initial treatment phase and only 14 were admitted to the hospital during the following 6 months. The entire control group was, of course, admitted initially and 16 of these patients were rehospitalized. Though the differences between 14 and 16 hospitalizations would not seem significant, it is highly important to recognize that the FTU program enabled 61 of its 75 patients to forego hospitalization altogether. Furthermore, upon closer analysis, even the 14 hospitalized FTU's proved to be far better off than their 16 rehospitalized counterparts: the length of stay of the two groups shows a great difference. In the 6 months following the acute treatment period, the 14 FTU patients spent a total of 423 days in the hospital, while the controls who were readmitted stayed for 1,091 days. These figures lend support to Mendel's conclusion that the least possible hospitalization is the optimum amount.[440]

From these studies, it would appear that community mental health programs and crisis therapy are surely not any less effective than hospitalization, and are probably more effective. Moreover, they are devices protective of liberty. Therefore, lawyers as well as mental health professionals must become aware of various community programs and their potential for averting commitment. With this in mind, it is appropriate to examine community mental health in Arizona.

COMMUNITY MENTAL HEALTH IN ARIZONA

Dichotomous State Scheme

Unlike virtually all of her sister states, Arizona does not have a unified mental health authority.[441] One of the most often mentioned failings of the present scheme is its dichotomous nature.[442] Under the split struc-

438. *Id.* at 161-64.

439. The control group was chosen from those whose envelopes said "no" and was chosen to correspond as closely as possible to the FTU group. There is great similarity between the two groups as evidenced by the fact that they showed no appreciable differences in the 15 variables on which they were compared.

440. *See* note 428 *supra.* Another important aspect of the Denver study is the success of individual crisis treatment in the Emergency Psychiatric Service. This unit was formerly used merely as an evaluation center to determine whether a person should be admitted to the psychiatric hospital or sent home. The initiation of crisis treatment reduced the proportion of those interviewed who were admitted from 52 percent to 26 percent. D. LANGSLEY & D. KAPLAN, *supra* note 393 at 176.

441. Arizona State Hospital, 1969-70 Annual Report 7 (Aug. 14, 1970).

442. *E.g.*, Interview with Dr. Allen Beigel, Director, Southern Arizona Mental Health Center and Pima County Combined Program Oct. 1970; Interview with Mr. Gilbert Sanchez, Executive Director and Dr. Heinman, Head Psychiatrist, Tucson-Southern Counties Mental Health Center Jan. 1971; Interview with Mr. James Matters, Director, Bureau of Mental Health Services, Maricopa County Department of Health Dec. 1970.

ture, the State Department of Health, through its Division of Mental Health, is in charge of all facets of mental health not delegated to the state hospital, which is autonomous. This lack of a comprehensive planning authority has resulted in a system in which "planning is a somewhat sporadic and disjointed affair, with various agencies free to go their own way and coordination mainly a voluntary matter."[443]

In 1965, the Governor's Advisory Committee on Mental Health recommended the establishment of a State Department of Mental Health and Mental Retardation.[444] The legislative history of measures directed to this end, however, has been anything but encouraging. Between 1965 and 1970, five different bills directed at a unified mental health authority were introduced in the state legislature and four of them died in committees.[445]

The sixth legislative endeavor, House Bill 9,[446] passed the preliminary hurdle and worked its way out of committee, passed the House, but met its demise in the Senate.[447] As introduced, House Bill 9 would have combined the state hospital and the Mental Health Division of the State Department of Health into the State Department of Mental Health.[448] Administrative supervision of the new department would have been provided by a director required to be a certified psychiatrist of 5 years experience in the administration of mental health programs. The department would have served as the primary mental health authority for the state for all purposes except those explicitly delegated to other agencies. It would have been charged with the responsibility of operating all state mental health services, including the state hospital, as well as coordinating state mental health programs and activities with those conducted by local mental health organizations. Other duties would have entailed assisting the development of community mental health facilities and conducting basic operational research in the area of mental health.[449] Though the proposal was actively supported by mental health professionals, its supporters were not able to muster sufficient legislative support this past session. Hopefully, they will be more fortunate during the forthcoming legislative session.

Maricopa County Facilities

1. COUNTY HEALTH DEPARTMENT. A suite of offices at the Maricopa

443. State Department of Health, Arizona State Plan for Construction of Mental Health Centers 43 (Ann. Rev. 1970) [hereinafter cited as 1970 State Plan].
444. Arizona Health Planning Authority, Mental Health in Arizona 26, 29 (Jan. 1970) [hereinafter cited as Mental Health in Arizona].
445. *Id.* at 53-55.
446. H.B. 9, 30th Ariz. Legis., 1st Sess. (1971) [hereinafter cited as H.B. 9].
447. See "General Conclusion," pp. 237 *et seq. infra* for a discussion of the fervent controversy over H.B. 9 bred by persons fearful that it was backed by a "communist conspiracy."
448. A perpetually competing proposal is to merge the state hospital into the Division of Mental Health, thereby having the entire mental health apparatus under the jurisdiction of the State Department of Health.
449. H.B. 9, *supra* note 446.

County Health Department is devoted to the Bureau of Mental Health Services (BMHS).[450] The staff consists of the head of the service, four social workers with masters degrees, one psychiatric social worker, and a social worker with a bachelors degree.[451] There are two part-time psychiatric consultants, and psychological services are provided by private psychologists on a contractual basis.[452] The BMHS has combined with other mental health agencies in the county to provide a 24-hour suicide prevention service. It also offers crisis intervention and outpatient care, as well as short-term therapy. Approximately 2,500 patients were seen in 1969, and the present patient load is 200 to 250 at any given time.[453]

The BMHS is the sole facility in Maricopa County for receiving commitment petitions. Evidently, it does not, however, assume a screening role as active as that of the Southern Arizona Mental Health Center (SAMHC). In most cases, the staff does not see the patient prior to accepting a petition and while alternatives to commitment will be discussed with the petitioner the staff does not actively discourage the filing of the petition if the petitioner is insistent.[454] After the petition is filed, the duties of the staff are mainly procedural, *e.g.*, notifying the petitioner and the patient's family of hearing dates.

More staff is needed, particularly to be able to take an active role in the commitment process and petition prevention. Other needs are expanded outpatient and inpatient facilities, greater availability of services to the public, and full-time medical coverage to facilitate immediate prescription of psychoactive drugs.[455]

2. OTHER MARICOPA COUNTY FACILITIES. For purposes of the federal program,[456] Maricopa County has been divided into eight catchment areas. Although some of these areas have more facilities and services available than others, the county as a whole has a reasonable number of mental health facilities, including numerous hospitals, the state hospital, several mental health centers, and many mental health professionals in private practice.[457] Due to the great number of facilities, the project's investi-

450. For a description of the BMHS role in the civil commitment screening proces, see pp. 16-18 *supra.*

451. Interview with Mr. James Matters, Director, Bureau of Mental Health Services, Maricopa County Department of Health, in Phoenix, Arizona, Dec. 1970.

452. *Id.* At present the psychiatric consultants are available only 2 days per week.

453. *Id.*

454. Mr. Matters provided this rationale for the policy:

> Q. Do you ever attempt to discourage the filing of the petition?
> A. No, because the law provides that everyone does have the right to file if they insist on it. We never try to second guess the judge or anything like that. *Id.*

455. *Id.*

456. See text accompanying notes 400-413, pp. 119-21 *supra.*

457. *See generally* 1970 State Plan, *supra* note 443; Mental Health in Arizona, *supra* note 444. *See also* "Table XII: Distribution of Mental Health Resources in Arizona," p. 138 *infra.*

gation was necessarily superficial. Therefore, the present analysis will focus on the three comprehensive mental health centers in the area.

a. *The Camelback Hospital Complex.*[458] Camelback Hospital is a private organization controlled by a board of trustees. It contains 89 beds and has an open staff policy, allowing the patient's private psychiatrist to continue to treat the patient while he is in the hospital. Various services, including group therapy, individual therapy, and occupational and recreational therapy, are available from the hospital staff if prescribed by the private practitioner. Camelback is basically an acute treatment facility, with an average patient stay constituting 20 days.

Affiliated with the hospital, but located about 5 miles away, is the Arizona Foundation for Neurology and Psychiatry. The first functioning comprehensive mental health center in Arizona,[459] the Foundation provides inpatient treatment, outpatient care, partial hospitalization, 24-hour emergency service, and consultation and education services to the community. It has a 21-member staff consisting of five psychiatrists (1 full-time, 2 half-time and two less than half-time), four social workers with masters degrees, two registered nurses utilized as social workers, six psychiatric nurses, two clinical psychologists, and two occupational and recreational therapists. It is financed by federal and state funds, as well as by some patient fees. Fees are based on the patient's ability to pay, however, and most pay nothing.

There is some involvement of the Camelback Complex in the commitment process. A petitioning family may designate on the petition that the respondent should be detained at Camelback Hospital until the commitment hearing, and this occasionally happens. Patients confined at Camelback may be treated by their private psychiatrists, who may recommend their release to the court at any time. Other individuals may enter the commitment process through the mental health center. If the staff believes that one who is being treated at the Center is in need of hospitalization and he refuses to accept it voluntarily, a call may be made to his family to encourage a family member to initiate legal proceedings. In the rare cases where hospitalization is thought to be required and the family is not receptive to the idea, the staff may take the initiative and cause a petition to be filed.

The present facilities are felt to be sufficient for the present demand. New programs are constantly being instituted, however, with the current emphasis on improving the social work program so that the families can be involved in the treatment process.

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458. Except as otherwise indicated, the following information was obtained from a telephone interview with Mr. Bill Luzader, Assistant Administrator of Camelback Hospital, April 22, 1971.

459. 1970 State Plan, *supra* note 443, at 66.

b. *St. Luke's Hospital Medical Center.*[460] St. Luke's is a comprehensive mental health center which provides the five essential services[461] and also has a research unit. It is an acute treatment facility, and if the clinic's program is responsive to the needs of the patient only three to four therapy sessions are generally required. The center is presently operating at its peak capacity, handling over 375 patient visits per week.[462]

St. Luke's is not involved in the commitment process very often—generally only once or twice a month—except for patients who are committed to that hospital. The more common occurrence is for the center to make its services available in order to avoid a possible petition.

Presently contemplated is a plan to utilize St. Luke's to take some of the load off of the overburdened county hospital, which was built for 36 patients but usually has a census of 45 to 48. Such a plan would hopefully operate to allow the county hospital to concentrate on the patients confined there, and should also eliminate some of the present commitments of persons requiring only short-term hospitalization.

Due to a reduction of federal funding, the center is looking to the state and county for funds for future expansion which it is hoped will take the form of two branch locations that will make it possible for more people to be reached. An expanded crisis intervention group is also contemplated so that therapeutic services can be delivered immediately to people in acute stress situations.

c. *St. Joseph's Mental Health Center.*[463] St. Joseph's is a private hospital which offers mental health services consisting of inpatient and outpatient treatment, as well as individual, group, and family therapy. The staff of therapists includes four full-time and one part-time psychiatrist, three doctors of psychology, six counseling psychologists with masters degrees, and two social workers with masters degrees. About 1,400 outpatients are presently being served, and in 1970 over 26,000 were treated. Patients are charged on a sliding fee scale, based on their ability to pay.

Most potential respondents are treated in the hospital, so there is little contact with the commitment process. About one hundred patients a year are referred to Maricopa County General Hospital or to the state hospital, either because the referred patients are considered candidates

460. Except as otherwise indicated the following information was obtained from a telephone interview with Dr. James A. Haycox, Chief of Psychiatric Services at St. Luke's Hospital Medical Center, April 26, 1971.

461. These services are described at pp. 121-22 *supra.*

462. Letter from Dr. Haycox to the *Arizona Law Review,* April 26, 1971. During the week of March 15 to 21, 1971, 46 new patients were admitted to the system: seven inpatients; eight psychiatric outpatients; 15 alcoholism and drug service patients; two day-hospital patients; nine emergency visits; and five referred by outreach workers. Not counting visits to inpatient or day-hospital patients, the staff saw 140 patients in follow-up visits for a total of 376 patients visits. It is estimated that future figures will be at least this high.

463. Telephone interview with Sister Francesca Fischer, Administrative Coordinator of the Mental Health Center of St. Joseph's Hospital, April 26, 1971.

for long-term hospitalization, or because private treatment would be a severe financial drain. Some formerly committed patients receive aftercare therapy at the hospital for which the state hospital pays a minimum fee per therapy session.

Pima County Facilities

1. PIMA COUNTY COMBINED PROGRAM. In 1961 the Attorney General of Arizona issued an important opinion relating to mental health.[464] It stated that mental illness comes within the pertinent statutory definition of "sickness", and that accordingly the County Boards of Supervisors must provide for the care of the indigent mentally ill as well as of physically ill indigents.[465] The duty seemingly exists even if the mentally ill patient would not qualify for admission to the state hospital under the statutory commitment standards.[466]

As a result of several factors, including a threatened lawsuit to enforce the duty and a report filed by a special mental health task force,[467] Pima County in 1970 initiated a system to provide the requisite services. Arizona State Hospital and Pima County General Hospital entered into an agreement[468] to coordinate their efforts to provide improved mental health services to the people of Pima County. The agreement also involved the Department of Psychiatry of the College of Medicine of the University of Arizona in a psychiatric teaching program.

The involvement of the state hospital in this program is primarily exercised through the Southern Arizona Mental Health Center (SAMHC) located in Tucson. SAMHC, technically a branch of the state hospital, was established 8 years ago to provide continuing aftercare for patients discharged from the state hospital. At present, SAMHC is involved in the Combined Program through two of its facilities: the Walk-in Clinic and the Day-Care Program.

A person's initial contact with the mental health center is likely to be through the Walk-in Clinic. It is headed by a doctor of clinical psychology, and his staff consists of three part-time psychiatrists, two social workers, a nurse, and a number of graduate psychology students.[469] The clinic operates five days a week from 8 a.m. to 4 p.m., and serves approximately 130 to 150 new patients per month.[470] After 4 p.m., one member of the

464. Opinion 61-22, 1961 OP. ARIZ. ATT'Y GEN. 38. Most of the opinion is reprinted *infra* at pp. 239-41.
465. *See* ARIZ. REV. STAT. ANN. § 11-291 (1956).
466. Opinion 61-22, *supra* note 464.
467. Pima County Report, *supra* note 171. The report, which urged county care, also mentioned the threatened suit.
468. The Combined Mental Health Care and Psychiatric Teaching Program Agreement. [Copy on file at *Arizona Law Review*.]
469. Interviews with Dr. Allen Beigel, Director, Southern Arizona Mental Health Center and Pima County Combined Program in Tucson, Arizona, Oct.-Jan. 1970-71.
470. *Id.*

staff moves to the emergency room of Pima County General Hospital until 11:30 each night. Various staff members are on call for the remaining hours of the day and on weekends.[471]

The initial mission of the clinic is screening and evaluating potential patients. The patient relates his story in an interview with the staff member assigned to "primary intake" for the given day. This session is conducted on an informal basis, with the interviewer trying to create an atmosphere that will facilitate the intercourse. The problem may be of an ordinary nature, such as simply needing someone to talk to or even needing help with a problem not directly related to a behavior disorder.[472] In such cases, the relationship may be terminated at the end of the interview and a referral made to another agency, such as a welfare agency or the Veterans' Administration for vocational counseling.

If the person is in a mild crisis situation which has not yet erupted, he will probably be scheduled to see a member of the staff for therapy on a regular basis until the problem is resolved. If there are stress factors which can be alleviated, the interviewer will take the appropriate action. This may amount to no more than a phone call to a parent, spouse, or high school principal, or the prescription of drugs for the patient. In other cases hospitalization may be prescribed, as when an alcoholic wishes to "dry out."[473]

The situation changes when the patient is in the middle of a crisis that has erupted. Therapy will immediately be initiated, including psychoactive drugs if appropriate. In cases of severe agitation, arrangements may be made for voluntary entry into Pima County General Hospital, but if the patient refuses, it may be necessary for a petition to be filed.[474]

If the patient does not require hospitalization but needs more attention than a daily therapy session, he may be placed in the Day-Care Program. As the name implies, the patients spend most of the day in the program and then return to their homes at night. This section is headed by a registered nurse who has a masters degree in psychiatric nursing. The staff consists of another registered nurse, two part-time psychiatrists, one full-time volunteer, and four women, described as "mental health specialists," who have bachelors degrees in psychology and "some experience."[475] The services available include occupational and recreational therapy, group therapy, and individual consultation.

The inpatient facility for the Combined Program is Pima County General Hospital, which has a 20-bed psychiatric unit. Prior to implementa-

471. Interview with Harold Russell, Ph.D., Director, Screening and Evaluation Unit, Southern Arizona Mental Health Center, Tucson, Arizona, Nov. 1970.
472. Observation by a project member of patient interviews conducted by Dr. Russell.
473. *Id.*
474. Interview with Dr. Russell, *supra* note 471.
475. Interview with Dr. Beigel, *supra* note 469.

tion of the new program, only involuntary patients were eligible for this facility. Under the present procedures, however, where patients are encouraged to seek voluntary community help and avoid commitment, voluntary patients are allowed, and some patients are bussed daily to SAMHC to take part in the Day-Care Program.[476]

One important factor in the Combined Program is the close liaison that is maintained between SAMHC and the state hospital.[477] A member of the Aftercare Clinic goes to the state hospital every week to meet with the hospital staff to discuss the patients who are almost ready for discharge and to formulate discharge plans. Also, the SAMHC calls the Pima Unit at the state hospital every time a patient is sent there, in order to inform the hospital of the history of the case and to relate any special circumstances involved.[478]

SAMHC, like many other mental health agencies in Arizona, could use more personnel and improved facilities. The director of SAMHC's screening and Evaluation Unit told the project that the program should at least be expanded to 24 hours a day, 7 days a week, and, ideally, there should be another full-time clinic at a different location so that more people could avail themselves of the services.[479]

2. TUCSON-SOUTHERN COUNTIES MENTAL HEALTH CENTER. The Tucson-Southern Counties Mental Health Center offers services similar to SAMHC and cooperates with it on an informal basis. Organized in 1966, this corporation underwent certain internal changes in 1970 in order to qualify for federal funding. It is an amalgamation of services offered by St. Mary's Hospital, the University of Arizona Vocational Rehabilitation Center, and the Arizona Children's Home. The board of directors has been expanded to permit a maximum of 25 directors, a majority of whom must be members of the community and not affiliated with any of the organizations providing services. Under the federal program the Center serves a catchment area of 214,000 people which includes southern Pima County and the five southern counties of Arizona.

The outpatient clinic and general headquarters serve as the walk-in clinic and daytime crisis center, operating from 8 a.m. to 5 p.m., 5 days a week. For the remainder of the day and on weekends, crisis therapy is available from the staff of the emergency room at St. Mary's Hospital. The director of the clinic has a masters degree in social work. His staff consists of two psychiatrists, a social worker, a vocational rehabilitation counselor with a masters degree, and an "outreach worker." The latter is a person whose main qualifications are that he is from the community, in-

476. *Id.*
477. The impact of the community health movement on commitments is discussed *infra* pp. 135-36.
478. Interview with Dr. Beigel, *supra* note 469.
479. Interview with Dr. Russell, *supra* note 471.

terested, and trainable. There are positions which are not yet filled for a master of social work and a doctor of psychology.

The inpatient facilities at St. Mary's Hospital presently consist of only three beds staffed by two registered nurses, one of whom is a psychiatric nurse, and two psychiatric technicians. A new wing is being developed, however, which will have a staff of 45, 34 psychiatric beds, and facilities for 50 to 75 day-care patients. The Vocational Rehabilitation Center at the University of Arizona provides the services of an occupational therapist, a job evaluator, a psychometrist, and the previously mentioned vocational rehabilitation counselor.

Another service of the mental health center is its drug treatment program, which provides a much-needed service to the community although it is not a part of the required federal program. The drug treatment program is staffed by two part-time psychiatrists, a research psychologist, a social worker, three nurses, two supervisory counselors, twelve counselors, and a project administrator.

At the time of the project interview, the center had 351 patients on its roles, with an average of 10 new patients per week. The center handles a wide range of problems in a manner similar to SAMHC, but has very little to do with the commitment process. Petitioners and potential respondents are referred to the Walk-in Clinic at SAMHC or to Pima County General Hospital.

3. IMPACT OF COMMUNITY MENTAL HEALTH ON COMMITMENTS FROM PIMA COUNTY.[480] The availability of dynamic community programs in Pima County, bent on slashing involuntary commitments and on encouraging utilization of local resources, has already indelibly left its mark on the legal process. SAMHC in particular has, through its Walk-in Clinic, undertaken an important informal screening function. So far as is possible, prospective petitioners and respondents are funneled through the clinic, where the staff seeks to recommend appropriate alternatives to commitment—such as voluntary hospitalization, out-patient treatment, etc. And even if a commitment petition is filed and a detention order issued, intensive screening efforts continue at this stage by an examining psychiatrist and other mental health personnel. If a voluntary, non-commitment alternative can be arranged, the case will be "dismissed by letter"[481] prior to hearing.

480. See "Pre-petition Screening," pp. 16-18 *supra.*

481. Dismissal by letter is discussed under "The Role of the Physician," pp. 60-66 *supra.* Other significant developments in Pima County mental health include plans by SAMHC to open a "halfway house" or "night hospital" (basically to serve persons returning to Tucson after discharge from the state hospital and persons without resources or with stressful home environments who might be able to avoid state hospitalization by accepting night hospitalization) and plans by the county to buy a wing of a nursing home to house elderly persons with mental problems. Tucson Daily Citizen, May 14, 1971, at 10.

Commitment hearings are now held at the Pima County Hospital only if the above described screening efforts fail.[482] The director of the Combined Program began his screening efforts in August 1970 and the Combined Program officially made its debut on September 14, 1970.[483] Table XI,[484] indicating the number of commitment hearings held at the Pima County Hospital each month during 1969 and 1970, dramatically illustrates the Combined Program's remarkable impact on the local legal system.

TABLE XI: NUMBER OF COMMITMENT HEARINGS HELD IN PIMA COUNTY DURING 1969 & 1970

	1969	1970	
Month	*Hearings*	*Hearings*	
January	79	57	
February	58	74	
March	56	73	
April	79	82	
May	52	85	
June	54	52	
July	60	74	
August	71	37	Initial Screening
September	70	14	Combined Program
October	94	10	
November	67	9	
December	76	8	
Total Hearings	816	575	

Coconino County[485]

The Northern Arizona Comprehensive Guidance Center is headquartered in Flagstaff and has the responsibility of planning services for the five northern counties. An element of this overall plan is the Coconino Community Guidance Clinic which, in conjunction with the Flagstaff Community Hospital, has qualified for federal funding. It offers a full array of outpatient services, including day-care, group therapy, and family therapy. The staff consists of one psychiatric social worker, two psycholo-

482. This is not to say that state hospitalization is inevitably called for in all cases reaching the hearing stage. As aggressive as the SAMHC and County Hospital staffs are in screening, their busy schedules must obviously result in their leaving some stones unturned, perhaps unwittingly.

483. In August, the director instituted the practice of dismissing cases "by letter," which accounts for the reduction in hearings that month. But use of the Walk-in Clinic, Day-Care Program, etc., began with the official launching of the Combined Program in September 1970.

484. The chart is a combination of parts of two tables appearing in Pima County Superior Court, 1969 Annual Report 40; Pima County Superior Court 1970 Annual Report 40.

485. Except as otherwise indicated, the following discussion is gleaned from interviews conducted by project members in Coconino County.

gists with masters degrees, three community aides, one minister knowledgeable in psychology, one psychiatric nurse, and one doctor of internal medicine with 4 years' experience at the Arizona State Hospital.

A prime function of the clinic is to consolidate various community agencies into a collective effort to abate crisis situations. The effectiveness of the approach is particularly apparent from its impact on the commitment process. Petitions are obtainable from the clerk of the superior court, but the clerk or the judge's secretary automatically refers the petitioner to the Guidance Center for consultation. The practical result of such a procedure is that some commitment alternative (*e.g.* the clinic, welfare agencies, vocational rehabilitation) is agreed upon, obviating the need for filing the petition. Since the inception of this program in October 1970, only one person has ultimately reached the state hospital, and his admission was the result of a voluntary certification.[486]

Despite the lack of a central state agency coordinating state hospital and community facilities[487] the Arizona State Hospital has tried on its own to further the community mental health movement by seeking to underwrite part of the cost of community treatment for patients from Coconino County who formerly would have been committed to the state hospital.

> The Arizona State Hospital proposes to embark upon a pilot project which would, with the cooperation of county authorities, make payments to local mental health agencies to provide treatment to patients who otherwise are likely to require hospitalization in the Arizona State Hospital. Thus in many cases admission to the State Hospital would be avoided and patients could instead be treated near their homes and in their communities.[488]

The Guidance Clinic has taken this proposal and the community mental health concept to heart and has provided effective and less drastic alternatives to civil commitment.

The Remaining Counties

The 11 other Arizona counties have limited mental health facilities and do not merit separate discussions. Two recent mental health planning documents[489] made available by state agencies, and reports prepared by project members after visiting every county in the state, reveal that these counties lack both adequate personnel and facilities. Thus, alternatives less drastic than commitment are not readily available. Guidance clinics are present in many counties and provide services to individuals, families,

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486. During the prior 2-year period, the county had an average of three commitments per month. *Id.*

487. See "Dichotomous State Scheme," pp. 127-28 *supra.*

488. Arizona State Hospital Proposal to Contract with Local Mental Health Agencies for Care of Certain Patients at 1 (private contract) [copy on file with the *Arizona Law Review*].

489. 1970 State Plan, *supra* note 443; Mental Health in Arizona, *supra* note 444.

schools and the communities in general. It is the lack of full scale community mental health centers, however, that prevents effective local care in the crisis situation, so that commitment often follows as a matter of course. It should be noted that some of the counties are sufficiently close to metropolitan centers to avail themselves of some of the programs existing outside the county limits.

Table XII reveals the concentration of mental health resources in metropolitan counties, which is significant in terms of the impact inadequate local resources must have on the commitment system.

TABLE XII: DISTRIBUTION OF MENTAL HEALTH RESOURCES IN ARIZONA[490]

Jurisdiction	*Psychiatrists*	*Psychologists*	*Graduate Social Workers*	*School Psychologists*	*General Hospital Psychiatric Beds*	*Private Hospital Psychiatric Beds*
Maricopa County	58	86	216	34	133	89
Pima County	19	52	110	8	23	34
Coconino County	2	11	8	1	4	0
Other Counties	3 (9)	9 (7)	32 (2)	7 (4)	1 (10)	0 (11)
Total Resources	82	158	366	50	161	123

Conclusion

A community mental health model would discourage long-term confinement but circumstances may require statutory means by which an individual could be confined for evaluation purposes. In California the distinction between the therapeutic and legal necessities of long- and short-term confinement has been recognized. In that state there are provisions for forced detention of a mentally ill person who is dangerous or gravely disabled.[491] They may be invoked, however, only after thorough screening of the petition,[492] attempts by mental health authorities to obtain the voluntary cooperation of the patient, and a court order compelling the appearance of the patient for an outpatient evaluation.[493] If the patient refuses to comply with the court order he may then be picked up by a peace officer and detained for a 72-hour evaluation.[494] Peace officers and

490. Compiled from data in Arizona Health Planning Authority, Mental Health in Arizona 56-57 (Jan. 1970) [copy on file with the *Arizona Law Review*]. The figures in parentheses indicate the number of counties without any of the given resource.

491. CAL. WELF. & INST'NS CODE § 5206 (West Supp. 1971). See the discussion of these standards, pp. 111-17 *supra*.

492. *Id.* § 5202.

493. *Id.* § 5206.

494. *Id.*

designated mental health officials are given power outside the petitioning process so that they may procure an individual's short-term confinement for evaluation purposes.[495]

These principles are consistent with modern mental health theory in that duration of the confinement is limited, petitions are carefully screened, the cooperation of the patient is solicited and there is some provision for dealing with the emergency situation. In addition, long-term commitment, which is now thought to be debilitating[496]—and often unwarranted—is reserved for "Imminently Dangerous Persons," is limited to a 90-day period, and can only result from a due process hearing, with a jury trial available upon the patient's request.[497] It is worthy of special note that the most drastic commitment in California is for a maximum of 90 days whereas in Arizona commitment is for an indeterminate period.

It is important to note that, in Pima County at least, present statutes have not prevented the creation of an active and effective community mental health system. On the other hand, possible statutory revision may be in order to encourage—or compel—similar developments throughout the state. The basic thrust of such revision should center on procedures and requirements for both short- and long-term confinement.

It should be apparent to the reader of this project that long-term commitment is, at the very least, constitutionally and therapeutically justifiable only when it results from a full due process hearing which elicits positive evidence that the patient constitutes a real danger to himself or others. This is not to say that short-term detention need be conditioned upon such complicated procedure or substantive standards. The present standards for issuance of a detention order in Arizona, however, are no doubt much lower than circumstances necessitate.

The due process implications of short-term detention have been discussed, but it is important to note that the Supreme Court of California has upheld that state's 14-day certification procedure where the detained patient is fully informed of his habeas corpus rights and counsel is made available to him.[498] While the non-judicial detention by peace officers or mental health officials obtainable under the California statute may well be a needed procedure in an emergency situation, its application should be so limited and further protection could be afforded the patient. For example, the statute could require that the individual responsible for the detention file a document with the court.[499] This certification would set out with particularity the basis upon which the detention is justified, and the judge could be required to approve or reject the certificate within 24 hours. If

495. *Id.* § 5150.
496. See "After Commitment: The Arizona State Hospital," pp. 189-23 *infra.*
497. CAL. WELF. & INST'NS CODE § 5302 (West Supp. 1971).
498. Thorn v. Superior Court, 1 Cal. 3d 666, 464 P.2d 56, 83 Cal. Rptr. 600 (1970).
499. *Cf.* MASS. GEN. LAWS ch. 123, § 12 (Supp. 1970).

he were not satisfied that the statutory requirements had been met, the judge could either convene a hearing, or simply order the release of the patient.

These comments are not intended to suggest model legislation.[500] They are, however, intended to indicate the direction possible statutory revision should take. Experience with community mental health models in other jurisdictions should be examined before such legislative steps are made.

In any event, the Pima County experience makes it clear that an active, community-oriented team can have substantial impact upon the commitment system and that current statutes do not stand as a bar to the development of such programs in every county of the state.

Moreover, those other areas in Arizona which have implemented community mental health programs as alternatives to civil commitment have found that community treatment is a viable solution. Unfortunately, some areas do not yet have the facilities and personnel necessary to implement such programs. But a skillful lawyer ought not to be limited by county lines in searching for alternatives to commitment.

While there has been vast improvement in many areas of the state, the foregoing discussion reveals that further expansion of the community approach to mental health problems is highly desirable. Indeed, as is discussed in the following section, such expanded services may well be constitutionally compelled.

THE CONSTITUTIONAL DOCTRINE OF LESS DRASTIC MEANS

The right to be free from restraints upon our liberty is ingrained in the framework of our legal system.[501] The antithesis of this right is the call for restraints necessary for an ordered society.[502] These two desired objectives inevitably collide in society's attempt to deal with the mentally disturbed individual. In competition with "the right of the citizen to be free from . . . physical restraint of his person"[503] is the alleged harm a disturbed individual may wreak upon himself and society. In an effort to solve this enduring conflict, all states have adopted statutes providing for the confinement of certain mentally ill persons to institutions.

Regrettably, far too many states have viewed the solution to this conflict as having only two alternative answers—commitment or release. The ramifications of this outlook are unfortunate; some lose their liberty in search of treatment, while others gain liberty at the cost of needed psy-

500. For a more thorough discussion of the need for statutory revision in light of the success of the community mental health movement, see Bleicher, *Compulsory Community Care for the Mentally Ill*, 16 CLEV.-MAR. L. REV. 93 (1967).

501. U.S. CONST. amends. V, XIV. *See, e.g.*, Allgeyer v. Louisiana, 165 U.S. 578, 589 (1897).

502. *See, e.g.*, Cantwell v. Connecticut, 310 U.S. 296, 303 (1940).

503. Allgeyer v. Louisiana, 165 U.S. 578, 589 (1897).

chiatric help.[504] Enlightened state legislatures have realized that there are less restrictive alternatives which will more adequately treat disordered individuals and still protect society from possible harm.[505] The reason for seeking such alternatives is clear: "If government should restrict human activity only to implement a socially useful purpose, government should restrict human activity no more than necessary to implement that purpose."[506] Examples of statutes embodying this concept may be found in Appendix A.

Due Process and Less Drastic Means

Courts "do not sit as . . . super-legislative bod[ies]."[507] In most instances, a court need only find a rational basis for legislation to uphold its constitutionality.[508] To this rule of judicial deference, important exceptions have evolved—the principle of "less drastic means" is one:

> In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of *less drastic means* for achieving the same basic purpose.[509] (emphasis added).

The mechanics of the principle's application are as follows: Given a particular governmental objective, if the means chosen to accomplish the objective restrict certain protected interests, and if a less restrictive alternative means of attaining the objective exists, government may not use the more restrictive method.

This principle of less drastic means as applied through the due process clause has, to date, been invoked by the Supreme Court only in situations involving first amendment freedoms.[510] Although this restrictive first amendment approach may itself require an application of less drastic means to civil commitment of the mentally ill,[511] the loss of liberty inherent in civil

504. Bleicher, *Compulsory Community Care for the Mentally Ill*, 16 CLEV.-MAR. L. REV. 93 (1967).
505. See Appendix *A, infra.*
506. Ratner, *The Function of the Due Process Clause*, 116 U. PA. L. REV. 1048, 1082 (1968).
507. Snaidach v. Family Finance Corp., 395 U.S. 337, 339 (1969).
508. *See, e.g.*, Katzenbach v. McClung, 379 U.S. 294 (1964); Wickard v. Filburn, 317 U.S. 111 (1942).
509. Shelton v. Tucker, 364 U.S. 479, 488 (1960).
510. A similar doctrine has arisen from cases involving the equal protection clause. That doctrine is that statutory classifications based upon suspect criteria or affecting fundamental rights must be justified by a compelling governmental interest. *See, e.g.*, Williams v. Illinois, 399 U.S. 235, 259 (1970) (Harlan, J., concurring).
511. *See* Brief for Appellant, State v. Sanchez, 80 N.M. 438, 457 P.2d 370 (1969) (discussing first amendment freedom of association implications of enforced hospitalization).

commitments would surely seem to compel its application in the involuntary hospitalization context.

In *Williams v. Illinois*,[512] the Supreme Court was faced with a situation involving the incarceration of a criminal defendant in excess of the authorized statutory maximum period. The excessive sentence resulted from the defendant's inability to pay a court-imposed fine, and from the judge's subsequent invocation of the $5 per day work-off rate. Although specific references were made to possible less drastic means,[513] the Court overturned the excessive sentence under the guise of equal protection theory. But Justice Harlan, in a concurring opinion, reached the same result employing the due process approach alluded to by the majority. Justice Harlan reasoned that:

> [T]he deference owed to legislative judgment is not the same in all cases. Thus legislation that regulates conduct but incidentally affects freedom of expression may, although it is a rational choice to effectuate a legitimate legislative purpose, be invalid because it imposes a burden on that right, or *because other means, entailing less imposition, may exist.* See NAACP v. Alabama, 357 U.S. 449 (1958); Lovell v. City of Griffin, 303 U.S. 444 (1938); Garner v. Louisiana, 368 U.S. 157, 185 (1961) (concurring in the judgment); United States v. O'Brien, 391 U.S. 367, 388 (1968) (concurring opinion).
>
> These decisions, by no means dispositive of the case before us, unquestionably show that *this Court will squint hard at any legislation that deprives an individual of his liberty—his right to remain free.* Cf. my dissenting opinion in Poe v. Ullman, [367 U.S. 497,522]. While the interest of the State, that of punishing one convicted of crime is no less substantial, cf. concurring opinion of Mr. Justice Brennan in Illinois v. Allen, 397 U.S. 337, 347 (1970), the '*balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between that liberty and the demands of organized society,*' Poe v. Ullman, *supra*, at 542, 'having regard to what history teaches' is not such that the State's interest here outweighs that of the individual so as to bring into full play the application of the usual salutary presumption of rationality.[514] (emphasis added).

Reasoning that the state's penological interest in the payment of the fine could be achieved by means—such as installment payments—less drastic than institutionalization, Justice Harlan would have ruled the incarceration improper on the basis of less drastic means due process theory.

Civil commitment of the mentally ill is, of course, an attempt "to effectuate a legitimate legislative purpose."[515] In theory, it should at once provide treatment to those committed and protect society from danger-

512. 399 U.S. 235 (1970).
513. *Id.* at 244-45.
514. *Id.* at 263.
515. *Id.*

ous persons. But involuntary hospitalization also "deprives an individual of his liberty—his right to remain free."[516] If, therefore, other means entailing less imposition upon liberty exist, state action imposing greater restrictions upon liberty than are necessary to achieve the state's legitimate goals would seem to be invalid.

Harlan's opinion on the application of less drastic means is particularly impressive not only because it is recent, but also because it was advanced by a member of the Court known ordinarily for his "traditional policy of judicial restraint."[517] Actually, Harlan's opinion strives to give constitutional recognition to Bentham's utilitarian philosophy of punishment which, in part, negated the propriety of punishment

> [w]here it is unprofitable, or too expensive: where the mischief it produced would be greater than what it prevented. When it is needless: where the mischief may be prevented, or cease of itself, without it, at a cheaper rate.[518]

The less drastic means principal, as applied to commitment of the mentally ill, has received recognition in the District of Columbia. The pertinent statutory provision reads:

> If the court or jury finds that the person is mentally ill and, because of that illness, is likely to injure himself or other persons if allowed to remain at liberty, the court may order his hospitalization for an indeterminate period, or order any other alternative course of treatment which the court believes will be in the best interests of the person or public.[519]

In *Lake v. Cameron*,[520] the District of Columbia Circuit heard a claim for release from confinement of Mrs. Catherine Lake, a 64-year-old woman suffering from a "senile brain disease."[521] Because of her needs for care and supervision, and her inability to satisfy those needs through family or paid help, Mrs. Lake had been confined to St. Elizabeth's Hospital. Subsequent to considerable unsuccessful litigation challenging the confinement,[522] the case came before the United States Court of Appeals for the District of Columbia Circuit on appeal from a denial of habeas corpus relief. Speaking for the majority, Judge Bazelon construed the relevant statute as requiring, as a prerequisite to commitment, judicial exploration of other less restrictive alternatives.[523]

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516. *Id.* The possibility of a true "loss of liberty" actually occurs only where a state recognizes but two alternatives—commitment or release. Less restrictive measures (out-patient care, day care, half-way houses) mitigate the deprivations of liberty involved in civil commitment.

517. Graham, *Poverty and Substantive Due Process*, 12 ARIZ. L. REV. 1, 3 n.7 (1970).

518. BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION 382.

519. D.C. CODE ANN. § 21-545(b) (1967).

520. 364 F.2d 657 (D.C. Cir. 1966).

521. *Id.* at 658.

522. Lake v. Cameron, 331 F.2d 771 (D.C. Cir. 1964), *cert. denied*, 382 U.S. 863 (1965).

523. 364 F.2d at 660-62.

Perhaps because of *Lake's* statutory—rather than constitutional—basis, the decision has not carried much weight outside the District of Columbia. Although *Lake* was cited favorably by the Supreme Court in *Gault*[524] as recognizing the "possible duty of a trial court to explore alternatives to involuntary commitment in a civil proceeding,"[525] *Lake* was rejected by the Supreme Court of New Mexico[526] as not applicable in the absence of a statute similar to that of the District of Columbia.

A District of Columbia Circuit decision subsequent to *Lake*, however, may shed some light on its intended constitutional impact. Reviewing a habeas corpus petition for transfer from a maximum security ward at St. Elizabeth's Hospital to a less restrictive ward, the Court in *Covington v. Harris*[527] had occasion to refer to *Lake*. Judge Bazelon, again writing for the court, indicated that the requirement of alternative considerations is not merely statutory:

> The new legislation apart, however, the principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment, which entails an extraordinary deprivation of liberty justifiable only when the respondent is 'mentally ill to the extent that he is likely to injure himself or other persons if allowed to remain at liberty.' A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law.[528] (footnote omitted).

Equal Protection

> The laws are like cobwebs; the small flies are caught but the great break through.
>
> —*Sir Francis Bacon*

In *Lake*, the court noted that the petitioner "would not be confined in Saint Elizabeth's if her family were able to care for her or pay for the care she needs."[529] In remanding for exploration of alternatives, the court left

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524. *In re* Gault, 387 U.S. 1 (1967).
525. *Id.* at 28 n.41 (1967).
526. State v. Sanchez, 80 N.M. 438, 457 P.2d 370 (1967), *appeal dismissed*, 396 U.S. 276 (1970).
527. 419 F.2d 617 (D.C. Cir. 1969).
528. *Id.* at 623. Bazelon cited a well-known less drastic means case—Aptheker v. Secretary of State, 378 U.S. 500, 514 (1964)—as support for his constitutional contention. As *Covington* ably demonstrates, the application of less drastic means to confinement of the mentally ill is not limited to the initial commitment:

> The principle of the least restrictive alternative is equally applicable to alternate dispositions *within* a mental hospital. It makes little sense to guard zealously against the possibility of unwarranted deprivation prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. 419 F.2d at 623-24.

Similarly, the decision whether to retain a patient in a hospital or to release him completely or under certain restrictions is subject to the same considerations. *See* ARIZ. REV. STAT. ANN. § 36-524(A) (Supp. 1970-71) (conditional discharge).
529. 364 F.2d at 660.

unresolved the question whether, if no alternative to total hospitalization were found, "so complete a deprivation of appellant's liberty basically because of her poverty could be reconciled with due process of law and equal protection of the laws."[530]

The standards for contemporary application of the equal protection clause emanate from *Griffin v. Illinois*.[531] In *Griffin*, the Supreme Court held that the failure to provide an indigent with a transcript necessary for appeal from a criminal conviction was a denial of equal protection.[532] The thrust of the decision was that "discriminatory dispensation of justice"[533] denying constitutional rights to impecunious defendants violates the equal protection clause of the fourteenth amendment. The circumstances of Mrs. Lake's confinement are even more suspect than the facts of the incarceration in *Griffin*. In *Griffin*, the defendant had a trial on the merits, and his lack of means related to a review of his conviction. The question which pervades *Lake*, on the other hand, is whether her involuntary confinement was brought about solely by lack of means.

In *In re Antazo*,[534] the Supreme Court of California recently dealt with the incarceration of an indigent defendant solely for his inability to pay the fine imposed by the court. The case arose as a result of the invocation of the "30 days or thirty dollars" sanction against a defendant who could not pay a court fine. Invalidating the practice, the court found that "such a defendant has no choice at all and in reality is being imprisoned for his poverty," which constitutes "invidious discrimination on the basis of wealth in violation of the equal protection clause of the Fourteenth Amendment."[535] In response to the state's major contention that the measure was not punishment but a means to insure payment, the court noted that "the state can impress upon indigents their 'responsibility to the county for [their] criminal behavior' through *available alternative procedures*."[536]

Without a great deal of discussion and without citing *Antazo*, the United States Supreme Court recently converted the California approach into federally compelled constitutional doctrine when, in *Tate v. Short*,[537] the Court held that imprisonment solely because of indigency

530. *Id.* at 662 n.19. On remand, Mrs. Lake's meager financial condition in fact precluded finding a suitable alternative, but the lower court did not consider the equal protection implications of her further hospital confinement. 267 F. Supp. 155 (1967).

531. 351 U.S. 12 (1956).

532. *Id.* at 18-19.

533. *Id.* at 17. *See also The Arizona Supreme Court 1969-70*, 12 ARIZ. L. REV. 111, 115 (1970).

534. — Cal. App. 2d —, 473 P.2d 999, 89 Cal. Rptr. 255 (1970).

535. *Id.* at —, 473 P.2d at 1000, 89 Cal. Rptr. at 256.

536. *Id.* at —, 473 P.2d at 1008, 89 Cal. Rptr. at 264 (emphasis added). This language may suggest that in addition to equal protection, California is receptive to a pure "due process less drastic means" argument when loss of liberty is involved.

537. 91 S. Ct. 668 (1971).

constituted unconstitutional discrimination, particularly since the states could easily resort to other alternatives in enforcing the payment of fines.

A sensible reading of the *Tate-Antazo* rulings could readily compel an interpretation of the equal protection clause which precludes the confinement of mental patients solely on the basis of their poverty, particularly if less restrictive treatment alternatives, now available to affluent patients, could be made available to the needy by a restructuring of state financial outlays. In that regard, many current state expenditures are clearly suspect—such as state costs for the hospitalization of patients who are in need of hospitalization only because they are unable to afford some less drastic means of treatment. It would seem far more sensible—in terms of finances as well as justice—for such persons not to be hospitalized, and for the state, now saved the expenses of hospitalization, to provide for less restrictive treatment measures for those persons.[538] Indeed, if it is true, as claimed,[539] that community care is generally more effective than is institutional care in averting future emotional decomposition, the states may in the long run save considerable amounts by following the community care model.[540]

538. See also the "General Conclusion" pp. 237 *et seq. infra,* which discusses the obligation of the *counties* to provide treatment for the indigent mentally ill.

539. *E.g.* B. PASAMANICK, ET AL., *supra* note 426, at 251.

540. For examples of statutes reflecting the concepts discussed in this section, *see* Appendix A, *infra.*