North Dakota Law Review

Volume 86 | Number 2 Article 1

1-1-2010

The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process

William M. Brooks

THE TAIL STILL WAGS THE DOG: THE PERVASIVE AND INAPPROPRIATE INFLUENCE BY THE PSYCHIATRIC PROFESSION ON THE CIVIL COMMITMENT PROCESS

WILLIAM M. BROOKS*

ABSTRACT

The imposition of substantive and procedural protections in the civil commitment process thirty years ago created the expectation that courts would scrutinize commitment decisions by psychiatrists more closely and serve as a check on psychiatric decision-making. This has not happened.

Today, psychiatrists continue to play an overly influential role in the civil commitment process. Psychiatrists make initial commitment decisions that often lack accuracy because they rely on clinical judgment only. Furthermore, many psychiatrists do not want legal standards interfering with treatment decisions, and the nebulous nature of the concept of dangerousness enables doctors to make pretextual assessments of danger. At civil commitment hearings, lawyers for patients often fail to vigorously represent their clients. Judges continue to defer, almost blindly, to expert testimony. The result, no doubt, has been the confinement of nondangerous mentally ill individuals.

Numerous steps can be taken to help lessen the inappropriate influence of psychiatrists. First, psychiatrists can engage in structured risk assessment evaluations. Next, courts can, as a matter of right, provide expert assistance to patients in a way that will not significantly delay civil commitment proceedings. Furthermore, courts should prohibit expert opinion testimony on dangerousness based on clinical judgment alone. Finally, patients' lawyers can systematically appeal civil commitment decisions to facilitate the development of a body of law that can serve to clarify what mental states and conduct constitute a sufficient level of dangerousness as to warrant involuntary hospitalization.

I. INTRODUCTION

In the United States, psychiatric hospitals involuntarily confine more than one million individuals per year,[1] a process the Supreme Court has characterized as "a massive curtailment of liberty[.]"[2] Until the late 1960s and early 1970s, hospitals committed individuals on the basis that such people required care and treatment.[3] Indeed, prior to 1972, courts paid little attention to the standards and procedures governing civil commitment.[4] The civil commitment process was characterized by cursory psychiatric evaluations that resulted in commitment of most individuals against whom proceedings were commenced; individuals were powerless and the commitment process forced them into psychiatric hospitals, often for indeterminate periods.[5]

However, in 1972, a three-judge court, in *Lessard v. Schmidt*,[6] invalidated Wisconsin's civil commitment laws on both substantive and procedural grounds.[7] The court found the state's commitment standards violated substantive due process because the standards authorized the confinement of nondangerous individuals.[8] Because civil commitment deprived an individual of liberty, the state could justify its means only by invoking a compelling government interest.[9] Only the interest in protecting against harm to oneself or others justified depriving someone of liberty through the

---

*Professor of Law and Director of the Civil Rights Litigation Law Clinic, Touro College, Jacob D. Fuchsberg Law Center, Central Islip, New York. The author would like to thank Rodger Citron for his helpful comments on the article. The author would also like to thank Laurel Spahn, Tony Rothert, and Susan Stefan for gathering or facilitating the gathering of data about the civil commitment process in areas outside of New York.

1. John K. Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks,* 4 PSYCHOL. PUB. POL'Y & L. 377, 378 n.6 (1998).

2. Vitek v. Jones, 445 U.S. 480, 491 (1980) (quoting Humphrey v. Cady, 405 U.S. 504, 509 (1972)).

3. Bruce Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing,* 10 J. CONTEMP. LEGAL ISSUES 37, 39 (1999).

4. In 1972, the Supreme Court noted the absence of litigation challenging the states' authority to confine mentally ill individuals. *See* Jackson v. Indiana, 406 U.S. 715, 737 n.22 (1972).

5. Virginia A. Hiday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom,* 11 LAW & SOC'Y REV. 651, 651 (1977).

6. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds sub nom.* Schmidt v. Lessard, 414 U.S. 473 (1974), *reinstated and enforced sub nom.* Lessard v. Schmidt, 379 F. Supp. 1376 (D. Wis. 1974), *vacated on other grounds sub nom.* Schmidt v. Lessard, 421 U.S. 957 (1975), *reinstated sub nom.* Lessard v. Schmidt, 413 F. Supp. 1318 (E.D. Wis. 1976).

7. *Id.* at 1090-1103.

8. *Lessard*, 349 F. Supp. at 1093.

9. *Id.* at 1084.

state's civil commitment process.[10] Three years later, the Supreme Court reached a similar conclusion in the context of a damages action filed by an individual confined many years at a state psychiatric hospital in Florida. The court held, in *O'Connor v. Donaldson*,[11] the state could not confine a nondangerous individual who was capable of living safely outside an institutional setting with the help of family or friends.[12]

Following the decisions in *Lessard* and *O'Connor*, numerous lower courts examined the constitutionality of civil commitment laws that authorized the confinement of nondangerous individuals. These statutes authorized confinement of individuals deemed to be in need of care and treatment regardless of whether the patient was dangerous.[13] This type of commitment standard places great discretion in the hands of physicians: whether a person requires care and treatment for mental illness requires a clinician to simply exercise clinical judgment as a way to determine whether a patient satisfies the legal criteria for civil commitment.

The courts that examined the constitutionality of the states' commitment standards unanimously held states could not confine involuntarily nondangerous mentally ill individuals.[14] A state's interest in providing the care and treatment deemed necessary simply could not justify the significant deprivation of liberty that civil commitment entailed.[15] As a result, physicians could not confine mentally ill individuals unless the patients posed a danger to themselves or others.[16] In theory, the imposition of a dangerousness requirement in lieu of a care and treatment standard limited the amount of clinical discretion psychiatrists exercised because it provided more objective criteria to govern civil commitment.[17] Moreover, the imposition of procedural protections—designed to provide a meaningful

10. *Id.* at 1084-86.

11. 422 U.S. 563 (1975).

12. *O'Connor*, 422 U.S. at 575.

13. *See, e.g.*, Project Release v. Prevost, 722 F.2d 960, 965-66 (2d Cir. 1983); *Lessard*, 349 F. Supp. at 1093.

14. *See Project Release*, 722 F.2d at 973; Suzuki v. Yuen, 617 F.2d 173, 178 (9th Cir. 1980); Colyar v. Third Judicial Dist. Court for Salt Lake Cnty., 469 F. Supp. 424, 432 (D. Utah 1979); Stamus v. Leonhardt, 414 F. Supp. 439, 449-51 (D. Iowa 1976); Doremus v. Farrell, 407 F. Supp. 509, 514-15 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378, 389-92 (M.D. Ala. 1974); Bell v. Wayne Cnty. Gen. Hosp. at Eloise, 384 F. Supp. 1085, 1095-98 (E.D. Mich. 1974); State *ex rel.* Hawks v. Lazaro, 202 S.E.2d 109, 123 (W. Va. 1974).

15. *See, e.g.*, *Lessard*, 349 F. Supp. at 1093; *State* ex rel. *Hawks*, 202 S.E.2d at 123; *In re* Harry M., 468 N.Y.S.2d 359, 364 (N.Y. App. Div. 1983).

16. *See supra* notes 14-15 and accompanying text.

17. *See* R. Michael Bagby, *The Effects of Legislative Reform on Admission Rates to Psychiatric Units of General Hospitals,* 10 INT'L J.L. & PSYCHIATRY 383, 384 (1987) (discussing how dangerousness criterion is allegedly more objective and capable of being addressed in a sounder evidentiary manner than care and treatment statutes that were couched in medical language).

opportunity to challenge one's hospitalization—further theoretically curtailed the ability of psychiatrists to effectuate involuntary hospitalization of those individuals deemed to be in need of inpatient care because courts become the decision-makers as to whether patients have satisfied the civil commitment criteria.[18]

The imposition of substantive and procedural protections on the civil commitment process theoretically made the civil commitment process more legalistic than medical in nature. However, approximately thirty years after the imposition of legal protections designed to provide objective legal criteria to govern the deprivation of liberty resulting from involuntary hospitalization, psychiatrists still exercise not only an inordinate amount of influence on the civil commitment process, but an *inappropriately* inordinate amount of influence on the process. Indeed, the narrowing of commitment statutes failed to result in a decrease in the instances of commitment, which suggests tighter standards and procedures have not been applied in practice.[19]

The pervasive influence of psychiatrists first begins at the initial admission stage. Most states authorize involuntary confinement of allegedly mentally ill individuals upon the certification of physicians that a civil committee poses a danger to the committee's self or others.[20] Once hospitalized, when civil committees challenge their confinement in court, psychiatrists testifying on behalf of the confining hospitals render opinions about an individual's mental illness and dangerousness. However, civil committees often do not have the opportunity to offer their own expert.[21] As a result, patients are significantly disadvantaged because judges will invariably defer to expert testimony when deciding whether to authorize the confinement of the civil committee.[22] The upshot is psychiatric hospitals

18. The Supreme Court has held due process required the use of a clear and convincing evidentiary standard at commitment hearings. Addington v. Texas, 441 U.S. 418, 432 (1979). Lower courts have held that due process requires the provision of such procedural protections as the right to counsel, the right to confront and cross-examine adverse witnesses, and notice of rights. *See, e.g.*, Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968) (right to counsel); *Stamus*, 414 F. Supp. at 447-48 (right to counsel); *Doremus*, 407 F. Supp. at 515-16 (right to counsel, to notice of hearing, and to confront and cross-examine witnesses); *Lynch*, 386 F. Supp. at 388-89 (right to counsel, to notice of hearing, and to confront and cross-examine witnesses); *Lessard*, 349 F. Supp. at 1092, 1097 (right to counsel and notice of hearing).

19. GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS § 10.05, at 348 (3d ed. 2007).

20. Bagby, *supra* note 17, at 383 (noting forty-eight states had adopted dangerousness criterion by 1980); SAMUEL JAN BRAKEL ET AL., THE MENTALLY DISABLED AND THE LAW 101-05 (3d ed. 1985) (detailing the authorization of involuntary hospitalization by medical certifycations in the majority of states).

21. *See infra* note 171 and accompanying text.

22. *See infra* notes 138-41 and accompanying text.

retain control over the confinement of those individuals deemed to require inpatient confinement.[23]

Many reasons exist to question the influence psychiatrists exercise over the commitment process. First, psychiatrists possess a well-recognized bias toward treatment.[24] Second, evidence indicates that while psychiatrists are not as inept at evaluating an individual's dangerousness as originally thought, psychiatrists are not particularly good at assessing risk either.[25] As a result of these considerations, it may well be that only the threat of civil liability serves as a check upon psychiatrists' desire to provide treatment that is deemed clinically appropriate by certifying a patient as dangerous.[26] Finally, and perhaps most significantly, few legal concepts are more ambiguous than the concept of danger. The concept of dangerousness has engendered its share of confusion among courts, legislatures, and scholars. This confusion has no doubt resulted in part from the failure of the courts that originally required a finding of dangerousness to define what they meant by "dangerousness."[27]

Moreover, it remains unclear whether dangerousness is a concept that focuses only on the likelihood of causing physical harm to oneself and others, or also includes harm to property. Does it include the likelihood of committing emotional harm to others or financial ruin to oneself that results from a spending spree in a manic state? While the commission of harm need not be a certainty, must the likelihood of potential harm reach a certain probability level before commitment can be authorized? Must a court or psychiatrist take into account the imminence of potential harm? What about the magnitude of potential harm? The longer these questions remain

23. *See, e.g.*, *infra* notes 142-48 and accompanying text.

24. *See infra* notes 76-77 and accompanying text.

25. *See infra* notes 58-65, 310-11 and accompanying text.

26. However, because of the difficulty in prevailing in a damages action against a physician, even the threat of a damages action may very well prove more illusory than real. A civil rights plaintiff faces a number of hurdles to overcome in order to prevail in an action pursuant to 42 U.S.C. § 1983. If the plaintiff unsuccessfully sought release in state court, collateral estoppel will bar an attempt to litigate the legality of the confinement. *See, e.g.*, Kulak v. City of New York, 88 F.3d 63, 71-73 (2d Cir. 1996). Furthermore, immunity attaches to physicians' actions if any objectively reasonable basis existed for physicians to conclude patients posed a danger to themselves or others. *See, e.g.*, Glass v. Mayas, 984 F.2d 55, 57 (2d Cir. 1993). Courts have shown a willingness to equate the symptoms of mental illness with evidence of dangerousness without any direct evidence tying the symptomatology with an increased risk of harm. *See, e.g.*, Mawhirt v. Ahmed, 86 F. Supp. 2d 81, 89-90 (E.D.N.Y. 2000) (equating dangerousness with paranoid and delusional behavior without any testimony connecting the symptoms with an enhanced risk of harm); Katzman v. Khan, 67 F. Supp. 2d 103, 110 (E.D.N.Y. 1999) (determining it was objectively reasonable to find a plaintiff dangerous as he was delusional and behaving bizarrely).

27. *See, e.g.*, Project Release v. Prevost, 722 F.2d 960, 973 (2d Cir. 1983); Stamus v. Leonhardt, 414 F. Supp. 439, 450-51 (D. Iowa 1976); Bell v. Wayne Cnty. Gen. Hosp. at Eloise, 384 F. Supp. 1085, 1095-98 (E.D. Mich. 1974); Lessard v. Schmidt, 349 F. Supp. 1087, 1093 (E.D. Wis. 1972).

unanswered, the greater the power for psychiatrists to confine individuals and to seek influence over judicial assessments of danger.[28]

A significant difference exists between understanding what a dangerousness evaluation actually entails and properly applying the legal and clinical criteria an assessment of danger encompasses. Most state statutes and court decisions simply have not incorporated all of the components of a dangerousness determination: probability, imminence, and magnitude of harm to person.[29] The absence of these clarifying concepts, which would limit the discretion of the civil commitment evaluators, provides an opportunity for psychiatrists to label individuals as dangerous when the doctors wish to confine people deemed to be in need of treatment. Significantly, when psychiatrists learn the legal system imposes few constraints on their clinical decision-making, they tend to disregard the law and permit their clinical judgment to dictate how they will act.[30]

This article will first explain what it means to be dangerous: posing a sufficiently high probability of causing harm as to warrant clinical intervention in the form of involuntary hospitalization. It will then detail that, to the extent the ability of psychiatrists to make assessments in the civil commitment context is known, the ability is not very good. Numerous reasons exist to explain why psychiatrists lack the ability to accurately assess risk. First, they generally rely excessively on clinical judgment alone, which results in a failure to apply criteria that have been empirically linked to an increased risk of harm-causing behavior. Non-clinical factors also adversely impact the clinical assessment process. These factors include a bias toward treatment and a fear of liability or other adverse consequences if a doctor wrongfully assesses a person as nondangerous.

Next, this article will describe not only do psychiatrists lack an ability to accurately assess danger, but many assessments of risk are pretextual in nature. Doctors want to treat people deemed to require care and treatment, and if they must certify a patient as dangerous in order to facilitate treatment, doctors will do so. The article will then focus on the ability of civil commitment hearings to remedy errors at the certification stage of the commitment process. Judges routinely defer to psychiatric assessments of danger, and lawyers that represent patients all too often fail to engage in the

28. *See infra* notes 183-214 and accompanying text.

29. *See* People v. Stevens, 761 P.2d 768, 772-73 nn.4-7 (Colo. 1988) (surveying commitment standards throughout the country).

30. *Cf.* Paul Appelbaum & Robert Hamm, *Decision to Seek Commitment: Psychiatric Decision Making in a Legal Context,* 39 ARCHIVES GEN. PSYCHIATRY 447, 447 (1982) (presenting an empirical study that found a substantial percentage of patients for whom psychiatrists applied for commitment did not meet the criteria for commitment); *see also infra* notes 104-30 and accompanying text.

kind of vigorous advocacy needed to serve as a check on unfettered clinical discretion. Also, this article will explain why the inherently vague meaning of danger further serves to permit clinicians to exercise unfettered discretion in the commitment process. Indeed, without narrowing concepts, the meaning of "dangerous" is sufficiently ambiguous as to contravene notions of due process.

This article then offers a number of suggestions to lessen the influence of unchecked psychiatric assessments of danger. First, doctors should engage in more structured risk evaluations by necessarily focusing on empirically based criteria when conducting assessments of danger. Next, when a patient challenges his or her hospitalization, due process requires courts to promptly appoint expert assistance at the commitment hearing. In addition, psychiatrists' lack of ability to assess risk means courts should not permit psychiatrists to render opinions about an individual's dangerousness, at least when these experts base their opinions on clinical judgment alone. Furthermore, lawyers for patients in the commitment process should systematically appeal adverse decisions for the simple reason that only appellate case law can narrow and clarify the ambiguous concept of danger.

Finally, a word of candor. The views expressed in this article have been shaped by my work experience: first as an attorney for the New York Mental Hygiene Legal Service, representing patients in the civil commitment process; and then as the supervising attorney of a law school clinical program that is funded pursuant to the Protection and Advocacy for Individuals with Mental Illness Act.[31] In the latter role, I am the attorney for the plaintiff class in *Monaco v. Hogan*[32] and was the attorney for the plaintiff class in *Goetz v. Crosson*,[33] two cases discussed in this article. However, I have tried to insure that any position I have taken is supported by both the law and professional literature and is not simply a reflection of observations. If anyone disagrees, by all means, respond.

In addition, I attempted to gather empirical data on the civil commitment process. Over a ten-year period, information was gathered from Suffolk, Queens, and Kings Counties in New York; Dade County in Florida; and Cook, Kane, Madison, and Union Counties in Illinois. These counties were chosen simply as a function of finding an individual who was

31. *See generally* Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. ch. 114 (1986). The PAIMI Act authorizes the provision of legal actions on behalf of individuals suffering, or having been diagnosed as suffering, from mental illness. *See* 42 U.S.C. § 10805(a)(1). The clinic has provided representation to individuals seeking damages who believe that they have been wrongly involuntarily hospitalized, and the clinic has served as counsel in a number of class actions challenging the civil commitment process.

32. 576 F. Supp. 2d 335 (E.D.N.Y. 2008).

33. 967 F.2d 29 (2d Cir. 1992).

in a position to observe the commitment process and willing to tabulate what he or she observed. When pertinent, this article will detail the extent to which the empirical findings support or refute contentions set forth in the literature.

II. UNDERSTANDING WHAT A DETERMINATION OF DANGEROUSNESS ENTAILS

More than a little confusion exists over what it means to be dangerous.[34] The dictionary defines dangerous as able or likely to inflict injury and involving the chance of loss or injury.[35] Accordingly, a determination of dangerousness is a statement of probability.[36] Hence, it makes little sense to speak of a "prediction of dangerousness." When one predicts, one states whether an event will occur.[37] A bookmaker assesses the odds of an underdog beating the favorite; a gambler predicts who will win when placing a bet.

The confusion about the meaning of dangerous has arisen from many sources. The Supreme Court contributed to this confusion when it noted the impracticality of the beyond a reasonable doubt standard in the civil commitment context because of the difficulty in proving "that an individual is both mentally ill and *likely to be* dangerous."[38] This text certainly suggests the Court equated the concept of danger as the causing of harm. This is so because it should not be particularly difficult for a committing hospital to prove beyond a reasonable doubt a person is *likely* to cause harm. Other courts also have contributed to this confusion, concluding the Fourth Amendment requires a probability or substantial chance of dangerousness,

---

34. *See, e.g.*, Randy K. Otto, *On the Ability of Mental Health Professionals to "Predict Dangerousness": A Commentary on Interpretations of the "Dangerousness" Literature*, 18 LAW & PSYCHOL. REV. 43, 43 n.1 (1994).

35. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 573 (1993).

36. *See, e.g.*, John Monahan & David Wexler, *A Definite Maybe: Proof and Probability in Civil Commitment* 2 LAW & HUM. BEHAV. 37, 38 (1978); *see also* Gary Gleb, Comment, *Washington's Sexually Violent Predator Law: The Need to Bar Unreliable Psychiatric Predictions of Dangerousness from Civil Commitment Proceedings*, 39 UCLA L. REV. 213, 226 (1991) (distinguishing between assessment of probability and prediction of harm).

37. *See* Henry J. Steadman, *From Dangerousness to Risk Assessment of Community Violence: Taking Stock at the Turn of the Century,* 28 J. AM. ACAD. PSYCHIATRY L. 265, 266-67 (2000) (recognizing that assessment of danger has moved from a prediction of a future event to a probability assessment).

38. Addington v. Texas, 441 U.S 418, 429 (1979) (emphasis added). If one recognizes the concept of danger is an assessment of risk, then the Supreme Court clearly erred. It is certainly possible to prove beyond a reasonable doubt that an individual poses a significant risk of causing harm. *See In re* Commitment of Kientz, 597 N.W.2d 712, 718 (Wis. 1999) (holding the state proved beyond a reasonable doubt it was much more likely than not the committee would engage in future acts of violence).

as opposed to harm-causing, behavior.[39] Courts that have questioned the ability of psychiatrists to "predict danger" have also contributed to the confusion.[40]

Empirical scholarship that has attempted to assess the ability of psychiatrists to accurately assess dangerousness has also contributed to the confusion. Empirical studies have attempted to assess the ability of mental health professionals to accurately assess danger by tracking mentally ill individuals previously assessed as dangerous to determine whether these people have caused harm.[41] The studies have simply applied elementary statistical principles. When one has determined a high probability of an event occurring exists, the failure of the event to take place does not mean the prognosticator made an incorrect assessment of risk. On the other hand, an examination of a statistically significant number of events—specifically, determinations that a person is at a significant risk of causing harm—will provide information about the ability of mental health professionals to accurately assess the likelihood of harm-causing behavior.[42] Because these studies have focused on a statistically significant number of individuals, it is not particularly inappropriate for the authors of these studies to ask whether mental health professionals possess the ability to "predict behavior" of a statistically significant number of individuals. However, these studies and the use of the word "prediction" may well have created the impression an individualized assessment of danger requires a determination of whether someone will cause harm; it does not.

39. *See* Monday v. Oullette, 118 F.3d 1099, 1102 (6th Cir. 1997); Waananen v. Barry, 343 F. Supp. 2d 161, 171 (D. Conn. 2004); Hoffman v. Cnty. of Del., 41 F. Supp. 2d 195, 209 (N.D.N.Y. 1999). A few legislatures and courts have authorized civil commitment when an individual is likely to be dangerous. These holdings amount to a directive to determine whether the civil commitment subject is likely to likely cause harm.

40. *See, e.g.*, *In re* Cochran, 487 N.E.2d 389, 390-92 (Ill. App. Ct. 1985) (commenting on the inexact nature of "predicting future dangerousness"); Conservatorship of Roulet, 590 P.2d 1, 7 (Cal. 1979).

41. *See, e.g.*, Charles W. Lidz et al., *The Accuracy of Predictions of Violence to Others*, 269 JAMA 1007, 1008 (1993); Dale McNeil & Renee Binder, *Clinical Assessment of the Risk of Violence Among Psychiatric Inpatients*, 148 AM. J. PSYCHIATRY 1317, 1318 (1991).

42. *See* Alexander Scherr, *Daubert & Danger: The "Fit" of Expert Predictions in Civil Commitments,* 55 HASTINGS L.J. 1, 23 (2003).

III. THE ABILITY OF PSYCHIATRISTS TO ASSESS RISK: WHAT WE DO AND DO NOT KNOW

A. THE DEGREE OF PROFICIENCY IN ASSESSING RISK OF HARM

Two generations of researchers have examined dangerousness assessments conducted by mental health professionals.[43] Authorities in legal and medical journals have detailed, with much empirical support, that psychiatrists lack the ability to assess danger proficiently.[44] This lack of skill has resulted in mental health professionals overpredicting instances of harmful behavior.[45] Accordingly, while the leading scholar on risk assessment, John Monahan, has concluded analysis of current risk assessment literature "suggests that clinicians are able to distinguish violent from nonviolent patients with a modest, better-than-chance level of accuracy,"[46] he has also concluded little has transpired to inspire confidence in mental

43. *See* Daniel A. Krauss et al., *Beyond Prediction to Explanation in Risk Assessment Research,* 23 INT'L J.L. & PSYCHIATRY 91, 110 (2000).

44. *See, e.g.*, Bruce A. Arrigo, *Paternalism, Civil Commitment and Illness Politics: Assessing the Current Debate and Outlining a Future Direction,* 7 J.L. & HEALTH 131, 144 (1992-93) (discussing how studies demonstrate a "low rate of accurate predictions of dangerousness" and "harmless persons are routinely diagnosed as dangerous"); Herbert A. Eastman, *Metaphor and Madness, Law and Liberty,* 40 DEPAUL L. REV. 281, 341 (1991) (stating "journals are replete with studies confirming the unreliability of psychiatrists' predictions as to dangerousness"); Lidz et al., *supra* note 41, at 1009-10 (noting that while an empirical study indicated clinicians can predict dangerousness at better-than-chance level, the relatively low numbers of accurate assessments of harm demonstrate clinicians are relatively inaccurate predictors of violence); Judith S. Thompson & Joel W. Ager, *An Experimental Analysis of the Civil Commitment Recommendations of Psychologists and Psychiatrists,* 6 BEHAV. SCI. & L. 119, 120 (1988) ("Although some experts disagree . . ., the common interpretation of this literature is that mental health professionals are no better able to predict dangerousness than laymen.").

45. *See* David B. Wexler, *The Structure of Civil Commitment: Patterns, Pressures, and Interactions in Mental Health Legislation,* 7 LAW & HUM. BEHAV. 1, 3 (1983); *see also* Deidre Klassen & William A. O'Connor, *A Prospective Study of Predictors of Violence in Adult Male Mental Health Admissions,* 12 LAW & HUM. BEHAV. 143, 144 (1988) (discussing a number of studies on clinical assessments of danger found false positive rates ranging from sixty-five to eighty-six percent). When mental health professionals err, the most common error consists of a false positive, a conclusion that a person is dangerous when he or she is not. *See* Randy K. Otto, *Prediction of Dangerous Behavior: A Review and Analysis of "Second-Generation" Research*, 5 FORENSIC REP. 103, 128 (1992).

46. John Monahan, *Violence Risk Assessment: Scientific Validity and Evidentiary Admissibility,* 57 WASH. & LEE L. REV. 901, 915 (2000); *see also* Randy Borum, *Improving the Clinical Practice of Violence Risk Assessment: Technology, Guidelines, and Training*, 51 AM. PSYCHOLOGIST 945, 946 (1996) (stating a number of authorities believe mental health professionals have at least a modest ability to predict violence; predictions of violence are significantly more accurate than chance); Michael A. Norko, *Commentary: Dangerousness—A Failed Paradigm for Clinical Practice and Service Delivery*, 28 J. AM. ACAD. PSYCHIATRY & L. 282, 286 (2000) (providing the accuracy of assessments of danger by psychiatrists is only modestly better-than-chance).

health professionals using "unstructured clinical judgment to accurately assess violence risk."[47]

One must further recognize that studies that have helped establish empirical data relating to harm causing behavior, which help to improve the accuracy of assessments of danger made by those professionals who carefully apply the data, have often focused on groups of individuals who previously engaged in criminal conduct.[48] The risk factors inherent in this population do not necessarily exist in the class of civil committees deemed to pose a danger to others as a result of mental illness.[49] Hence, clinicians who wish to rely on empirical data when assessing civil committees for the risk of violence may have less to guide the assessment process than do clinicians who assess insanity acquittees or other population of individuals who have committed criminal acts.

Similarly, research indicates psychiatrists lack the ability to accurately assess the risk posed by possible suicidal behavior,[50] primarily because clinicians fail to take into account the low base rate of suicide.[51] As one authority has noted, mental health professionals "do not possess any item of information or any combination of items that permit us to identify to a useful degree the particular persons who will commit suicide, in spite of the fact that we do have scores of items available, each of which is significantly related to suicide."[52] Furthermore, a substantial percentage, if not a majority, of cases in which psychiatrists label a patient as dangerous in the civil commitment context involve instances in which a psychiatrist opines a patient is dangerous because of an inability to meet his or her basic needs.[53]

---

47. John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 406-07 (2006). One can argue that while most studies involving the ability of mental health professionals to assess violence risk involve long-term risk of harm, while a decision to civilly commit a mentally ill individual amounts to a qualitatively different decision because it involves an assessment of short-term risk. *See* John Monahan, *Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration*, 135 AM. J. PSYCHIATRY 198, 200 (1978). While some research indicates mental health professionals can assess violence on a short-term basis better than originally thought, *see* Otto, *supra* note 45, at 129, a review of the studies details only one-in-two predictions of short-term behavior are correct. *See id.* at 130.

48. *See* R. Karl Hanson, *What Do We Know About Sex Offender Risk Assessment?*, 4 PSYCHOL. PUB. POL'Y & L. 50, 50 (1998).

49. *Id.* (citing factors including history or criminal behavior and antisocial personality).

50. MELTON ET AL., *supra* note 19, at 326.

51. *Id.*

52. *Id.* (quoting Alex D. Pokorny, *Prediction of Suicide in Psychiatric Patients: Report of a Prospective Study*, 40 ARCHIVES GEN. PSYCHIATRY 249, 257 (1983)).

53. *See* Eric Turkheimer & Charles D.H. Parry, *Why the Gap? Practice and Policy in Civil Commitment Hearings*, 47 AM. PSYCHOLOGIST 646, 648 (1992) (stating in an empirical study, seventy-eight percent of initial commitments and ninety-four percent of recommitments are based on a grave disability standard, the equivalent of an inability to meet needs standard); Virginia Aldigé Hiday & Lynn Newhart Smith, *Effects of the Dangerousness Standard in Civil Commit-*

A survey of literature relating to risk assessment details a complete absence of empirical literature validating psychiatrists' ability to accurately assess harm based on an inability to meet basic needs.[54]

As a result, no one knows whether psychiatrists possess any proficiency in determining whether patients pose a risk to themselves because of an inability to meet their basic needs. The absence of literature relating to an inability to meet basic needs will no doubt result in far less discussion about this type of risk assessment. It will also result in the continuation of psychiatric evaluations in an unchecked manner because, in the absence of any literature on this topic, an unstated assumption exists that psychiatrists can accurately assess whether a person lacks the ability to meet his or her needs. However, the well-documented problems with the exercise of clinical judgment and the other non-clinical factors that adversely impact clinical judgment[55] indicate any such assumption more than likely will prove false.[56]

B. WHY PSYCHIATRISTS ERR WHEN ASSESSING RISK

1. *The Indiscriminate Use of Clinical Judgment*

While psychiatrists routinely rely on their clinical judgments to reach conclusions about dangerousness,[57] statistical studies have demonstrated that assessments of risk based on empirical data are more accurate than the clinical method.[58] In other words, in all cases of comparison, statistical

---

ment, 15 J. PSYCHIATRY & L. 433, 441-42 (1988) (noting when civil committees failed to engage in harm-causing behavior, psychiatrists opined the committees lacked the ability to meet their basic needs).

54. *See, e.g.*, MICHAEL PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL 104-21 (2d ed. 1998 & Supp. 2008); *see also* Turkheimer & Parry, *supra* note 53, at 648, 651 (discussing danger based on an inability to meet needs "has attracted little theoretical or scientific attention;" studies of assessments of inability to meet needs have not been undertaken).

55. *See infra* notes 57-90 and accompanying text.

56. This is particularly true because, while ample literature exists informing clinicians of what factors empirically related to harm-causing behavior a clinician should evaluate, this author is not aware of any literature providing clinicians with empirically-based information relating to individuals placing themselves at significant risk because of thinking so disorganized they cannot meet their basic needs. If, even with the existence of professional literature, medical schools and hospitals have lacked the ability to train psychiatrists to adequately assess individuals' risk of violence, what basis exists to believe psychiatrists have been adequately trained to assess an inability to meet basic needs?

57. *See* Eric S. Janus & Robert A. Prentky, *Forensic Use of Actuarial Risk Assessment With Sex Offenders: Accuracy, Admissibility and Accountability*, 40 AM. CRIM. L. REV. 1443, 1444, 1454, 1497 (2003).

58. *See* William M. Grove & Paul E. Meehl, *Comparative Efficiency of Informal (Subjective, Impressionistic) and Formal (Mechanical, Algorithmic) Prediction Procedures: The Clinical-Statistical Controversy*, 2 PSYCHOL. PUB. POL'Y & L. 293, 293, 298 (1996); Monahan, *supra* note 47, at 407-08; *see* Janus & Prentky, *supra* note 57, at 1444, 1454 (noting in only eight cases of 128 did the clinical method out-perform the actuarial assessments). The clinical method involves

predictions were superior to clinical predictions, and statistical predictions yielded relatively lower false positive rates.[59]

When assessing risk based on clinical judgment alone, psychiatrists often fail to act in a properly systematic manner when gathering information necessary to accurately assess risk.[60] Instead, the exercise of clinical judgment related to an assessment of risk may well depend on murky and ambiguous clinical hunches.[61] Accordingly, one must recognize the exercise of clinical judgment alone produces uneducated and uninformed decisions.[62] Notwithstanding the failures and antiquated nature of the unstructured clinical judgment process, only a minority, and maybe a small minority, of mental health professionals employ structured risk assessment techniques.[63]

Perhaps the use of clinical judgment alone produces the errors it does because, despite advances in knowledge about the risk of violence by people with mental illness, there have been virtually no systematic efforts to incorporate the information into a useful, empirically-based framework for clinical assessment. Legal constraints may require clinicians to use empirical data to guide the evaluation process because due process requires clinicians to conduct civil commitment evaluations pursuant to standards that promote some degree of accuracy.[64] Accordingly, mental health professsionals must integrate the almost separate worlds of research on the assessment of violence risk with clinical practices on a day-to-day basis to

---

an evaluator utilizing his or her own intuitive judgment after considering any information deemed appropriate. *See* Grove & Meehl, *supra*, at 293.

59. Klassen & O'Connor, *supra* note 45, at 144; *see also* Hanson, *supra* note 48, at 54, 61-63 (describing the accuracy of clinical assessments of danger as "unimpressive," while approaches that direct clinicians to consider empirically-based factors provide greater accuracy); Grant T. Harris & Marnie E. Rice, *Risk Appraisal and Management of Violent Behavior*, 48 PSYCHIATRIC SERVICES 1168, 1169 (1997) (stating actuarial methods constantly outperform professional judgment in assessment of danger); Thomas Litwack, *Actuarial Versus Clinical Assessments of Dangerousness*, 7 PSYCHOL. PUB. POL'Y & L. 409, 409 (2001) (noting numerous authorities recognize actuarial assessments of risk have been proven superior to unstructured clinical assessments).

Admittedly, much of the literature challenging the efficacy of clinical judgment addressed the ability of clinicians to "predict" harm as opposed to assessing risk. *See, e.g.*, Grove & Meehl, *supra* note 58, at 299. However, any prediction of harm-causing behavior is based on an assessment of risk. Hence, if actuarial methodology produces greater accuracy in the predictive process than clinical judgment, then actuarial methods provide a more accurate picture of the level of risk posed in comparison to clinical judgment.

60. *See In re* R.S., 773 A.2d 72, 80-81 (N.J. Super. Ct. App. Div. 2001).

61. *See* Douglas Mossman, *Commentary: Assessing the Risk of Violence—Are "Accurate" Predictions Useful?*, 28 J. AM. ACAD. PSYCHIATRY L. 272, 277 (2000).

62. Litwack, *supra* note 59, at 413.

63. John Monahan, Tarasoff *at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497, 513-14 (2006).

64. *See* Rodriguez v. City of New York, 72 F.3d 1051, 1062 (2d Cir. 1995) (holding due process requires clinicians to make commitment decisions that promise some degree of accuracy).

enhance the accuracy of civil commitment evaluations.[65] The need for judicial scrutiny of the evaluation process might be alleviated to one degree or another by the careful dissemination of risk assessment information within hospitals. If hospital administration provided better education to clinical staff on this issue, clinicians would engage in more accurate examinations of patients.[66]

However, as noted, posing a risk of harm to others is but one way a mentally ill individual can satisfy a dangerousness requirement. Indeed, in all likelihood, posing a danger to others is not the contention relied upon by psychiatrists to justify civil commitment in a majority of instances.[67] Rather, people can put themselves in serious danger of harm by showing: an inability to meet their basic needs of food, clothing and shelter;[68] an inability to meet their medical needs;[69] behavior that can provoke others to retaliate and use force against the civil commitment subjects;[70] or a lack of judgment to such a degree the civil commitment subjects may well place themselves in a harm-producing situation.[71] Unlike assessments of risk to others, which are aided by two generations of empirical study,[72] judges and mental health professionals must wait for the first set of data relating to how clinicians can more accurately assess whether mentally ill individuals pose a threat of harm to themselves because of an inability to meet their basic needs.

65. Borum, *supra* note 46, at 947.

66. For example, in *Monaco v. Stone*, the New York City Health and Hospitals Corporation (HHC) settled a lawsuit that alleged psychiatrists in all facilities in New York state, operated by state and local authorities, confined nondangerous patients because psychiatrists wanted to treat nondangerous patients whose clinical condition nevertheless warranted inpatient care. Stipulation and Order of Settlement, Monaco v. Carpinello, No. CV-98-3386, 2006 U.S. Dist. LEXIS 85689, at docket entry 326, attachment 1 (E.D.N.Y. Nov. 27, 2006). This settlement can be viewed at http://www.nyed.uscourts.gov through the PACER system, which requires the purchase of a PACER number. In this settlement, HHC agreed to provide education and training to all psychiatrists who conducted civil commitment evaluations and directed the initial examining physician to evaluate as many as forty-three risk factors relating to violence, suicide, and an inability to meet needs, as well as factors that mitigate the risk of harm. *Id.*

67. *See supra* note 53 and accompanying text.

68. D.J. v. State, 59 S.W.3d 352, 355 (Tex. App. 2001); Boggs v. New York City Health & Hosps. Corp., 523 N.Y.S.2d 71, 85 (N.Y. App. Div. 1987).

69. *See, e.g.*, Armstrong v. State, 190 S.W.3d 246, 249 (Tex. App. 2006).

70. *See, e.g.*, *In re* Maxwell, 703 P.2d 574, 576 (Ariz. Ct. App. 1985).

71. *See, e.g.*, *Boggs*, 523 N.Y.S.2d at 85 (addressing a civil commitment subject running into traffic); County Attorney v. Kaplan, 605 P.2d 912, 914 (Ariz. Ct. App. 1980) (discussing driving the wrong way on a freeway).

72. *See* Krauss, *supra* note 43, at 110.

2. *Non-Clinical Reasons Why Clinicians Render Inaccurate and Unreliable Assessments of Dangerousness*

Numerous reasons exist for a lack of significant proficiency in the area of risk assessment that do not relate directly to the evaluation process. First, the medical imperative is to presume sickness, and this occurs when doctors examine patients for civil commitment purposes.[73] When a psychiatrist evaluates an individual in a psychiatric emergency room, the nebulous criteria for various mental illnesses within the Diagnostic and Statistical Manual–IV often makes it difficult for the subject of the evaluation to rebut the presumption of illness that exists when one is brought to the emergency room,[74] which enables the psychiatrist to find an illness when it does not exist.[75]

Psychiatrists' biases toward treatment constitute another reason why doctors inaccurately assess the likelihood of harmful behavior:

> Treatment bias refers to the professional attitude that incorrect failure to treat is a greater error than treating unnecessarily. Mental health professionals are well-meaning clinicians whose whole training orients them to find problems and remedy them. Thus, they tend to overdiagnose and overpredict. This is perhaps especially true in the mental health field where there are fewer objective criteria of illness and less prognostic knowledge than in physical medicine.[76]

---

73. Arrigo, *supra* note 44, at 144. Hence, it is not surprising one study found when individuals attempted to facilitate involuntary hospitalization of another person, they often exaggerated the dangerousness of the subject of commitment. When this occurred, psychiatrists assumed the behavior set forth in the petition even when the commitment subject denied it and the court later found no evidence of such conduct. Hiday, *supra* note 5, at 658.

74. *See In re* Goodwin, 366 N.W.2d 809, 813 (N.D. 1985). The Diagnostic and Statistical Manual-IV is a text published by the American Psychiatric Association (APA) that sets forth the criteria the APA has established for various forms of mental illness. To illustrate the difficulty in interpreting behavior as symptomatic of mental illness, one needs to look at some of the criteria for mania. These include the following: an inflated self-esteem or grandiosity; becoming more talkative than usual; an increase in goal-directed activity; and excessive involvement in pleasurable activities. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 362 (Am. Psych. Ass'n ed., 4th ed. text rev. 2000). Very often, it is nearly impossible for a psychiatrist examining a patient in a psychiatric emergency room to accurately determine whether these criteria exist. At what point does an explanation of a person's life become grandiose? How does a clinician demarcate the point at which an increase in pleasurable activities becomes symptomatic of mental illness?

75. Bruce A. Arrigo & Christopher Williams, *Chaos Theory and the Social Control Thesis: A Post Foucauldian Analysis of Mental Illness and Involuntary Civil Confinement*, 26 SOC. JUST. 177, 187 (1999).

76. Stephen J. Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 SO. CAL. L. REV. 527, 599 (1978); *see also* Robert L. Goldstein, *Hiring the Hired Gun: Lawyers and Their Psychiatric Experts*, 11 LEGAL STU. FORUM 41, 41 (1987) (recognizing how value systems and ideological leanings can bias what purportedly constitutes an impartial

Accordingly, a number of studies have found incorrect assessments of harm-causing behavior are a function of doctors labeling an individual dangerous as a means of ensuring treatment.[77]

Next, a concern for liability can impact a clinician's decision-making in the commitment context because it can create a conflict with the goal of committing only those individuals who, after a careful assessment and application of clinically appropriate criteria, meet the commitment standard.[78] When this occurs, clinicians err on the side of protection from liability.[79]

Beyond a direct fear of liability, psychiatrists are inclined to err on the side of safety and caution when assessing dangerousness.[80] Physicians are trained to act cautiously and to operate under a theory of when in doubt, provide treatment.[81] The psychiatrist who fails to accurately assess a dangerous patient and authorizes the release or suggests a court release a mentally ill individual who subsequently engages in harm-causing behavior will be subject to severe criticism. On the other hand, if the psychiatrist incorrectly assesses a nondangerous individual as dangerous, he will suffer no consequences. The psychiatrist's assessment of likely harm-causing behavior cannot be challenged because no one knows whether harm would have occurred if the doctor did not authorize coercive clinical intervention.[82] Thus, both the public and the committing psychiatrist will rarely, if ever,

---

psychiatric assessment); David B. Wexler & Stanley E. Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 100-01 (1973) (stating doctors recognize that, while it is probably illegal, they disregard a strict application of the dangerousness standard in favor of a "best interests of the patient standard" because they believe it is more humanitarian to provide treatment than to be statutorily thwarted in the provision of treatment).

77. *See* Edward P. Mulvey & Charles W. Lidz, *Back to Basics: A Critical Analysis of Dangerousness Research in a New Environment*, 9 LAW & HUM. BEHAV. 209, 214 (1985) (citing Appelbaum & Hamm, *supra* note 30; John Monahan & Leslie Cummings, *The Prediction of Dangerousness as a Function of its Perceived Consequences*, 2 J. CRIM. JUST. 239 (1975)). Another study found decisions to commit were influenced primarily by the degree of psychiatric impairment manifested and not the level of risk posed by the civil committee. *See* Lois Pokorny et al., *Dangerousness and Disability as Predictors of Psychiatric Patients' Legal Status*, 17 BEHAV. SCI. L. 253, 264 (1999). In a different legal setting, one study found a recognition that an individual should receive needed treatment impacted assessments of a defendant's competence to stand trial. *See* Grant Morris et al., *Competency to Stand Trial*, 4 HOUS. J. HEALTH L. & POL'Y 193, 222 (2004).

78. Paul Appelbaum, *Civil Commitment from a Systems Perspective,* 16 LAW & HUM. BEHAV. 61, 65 (1992).

79. *Id.* at 65-66.

80. Arrigo & Williams, *supra* note 75, at 184-90 (stating the "'better safe than sorry' climate of the medical community is responsible for ceaseless numbers of perfectly harmless individuals routinely being diagnosed as 'dangerous' and consequently subjected to involuntary confinement"); Arrigo, *supra* note 44, at 144.

81. *See* Janus & Prentky, *supra* note 57, at 1458 n.85.

82. *See* Bernard Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439, 447 (1974); *see also* MELTON ET AL., *supra* note 19, at 348 (noting the decision to release a patient can produce disastrous consequences for a clinician who releases a patient who causes harm).

learn about an incorrect assessment of dangerousness, but they will always learn about an incorrect assessment of nondangerousness.[83]

For these reasons, it is not uncommon for psychiatrists to determine civil commitment is warranted for further evaluation of a patient.[84] When psychiatrists believe it is appropriate to involuntarily hospitalize someone when a question exists as to whether a patient meets the civil commitment criteria, little incentive exists for the clinician to gather all necessary information in the emergency room, which is needed to make a careful assessment. Rather, doctors can, and will, develop an attitude of commit first, and gather all pertinent information later.[85] The busier the emergency room, the easier it becomes for doctors to develop this attitude.

The lack of risk assessment training in medical school further adversely impacts a doctor's ability to assess the likelihood of risk-causing behavior.[86] One study found only forty percent of graduate programs offered any formal training in the study of suicide.[87] Because diagnosing mental illness focuses on symptoms and behaviors that differ from many risk assessment criteria, the diagnostic skills a clinician learns in medical school are of limited utility when assessing dangerousness.[88] Finally, the lack of fluency in English of foreign-born doctors and the concomitant inability to fully understand statements and to otherwise communicate effectively with the individuals they assess contribute to inaccurate assessments of danger.[89] The physician who is unable to grasp the meaning of statements made by

---

83. Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 712 n.57 (1974).

84. Discovery in *Monaco v. Hogan*, a lawsuit that challenged the adequacy and pretextual nature of psychiatric evaluations, illustrates the nature of this problem. In a review of twenty of these involuntarily hospitalized individuals, seven were committed when psychiatrists concluded further evaluation was necessary. Certificate of P.C. dated September 30, 2006; Certificate of R.C. dated June 7, 2007; Certificate of M.C. dated June 27, 2008; Certificate of B.C. dated February 10, 2006; Certificate of C.O. dated November 9, 2007; Certificate of M.M. dated May 11, 2007; Certificate of K.S. dated June 6, 2007. Certifications on file with the author.

85. In *Monaco*, the following exchange occurred between counsel and a committing physician in a deposition in which the physician conceded the prevailing philosophy at his hospital was commit first and ask questions later: "Q. 'Fair to say you, the prevailing philosophy is certif[y] first and then attempt to get the information, one about the patient, and two, alternative forms of care and treatment?' A. 'Yeah, that's [the] philosophy, yeah.'" Declaration of William Brooks, Exhibit N at 122-23, Docket Entry 418.

86. Borum, *supra* note 46, at 953-54 (noting it is questionable whether the mental health profession is adequately training clinicians to properly evaluate an individual's potential for violence).

87. *Id.*

88. Christopher Slobogin, *Dangerousness and Expertise*, 133 U. PA. L. REV. 97, 129 (1984).

89. *See* Bradley McGraw et al., *Civil Commitment in New York City: An Analysis of Practice,* 5 PACE L. REV. 259, 277 (1985); Richard Van Duizend & Joel Zimmerman, *The Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, 33 DEPAUL L. REV. 225, 247 (1984).

the patient is likely to misinterpret a patient's statements and, hence, reach a diagnosis that lacks accuracy.[90]

C. BEYOND A LACK OF COMPETENCE IN THE ASSESSMENT PROCESS —THE PRETEXTUAL NATURE OF PSYCHIATRIC EVALUATIONS

As former District of Columbia Circuit Judge David Bazelon found, the personal biases of psychiatrists can drive their decision-making.[91] The excessively vague nature of the concept of danger[92] has created an opportunity for psychiatrists to ignore, to a very significant degree, the constraints the law has attempted to place on their discretion.[93] Decisions such as *O'Connor v. Donaldson* and those that imposed more stringent substantive commitment standards and provided broader procedural safeguards, generated significant hostility from the psychiatric profession; the profession viewed judicial decisions that limited their clinical discretion as an encroachment on their professional prerogative.[94] One psychiatrist asserted mentally ill individuals were "[r]otting with their rights on," a phrase that reflected frustration by psychiatrists with being forced to withhold treatment they deemed necessary.[95] Many psychiatrists believe they know best and any limitations placed upon their ability to impose clinically indicated treatment, whether imposed by the courts or the legislatures, constitute bad policy that causes more harm than good.[96] As one group of physicians noted:

---

90. *See* McGraw et al., *supra* note 89, at 277; Van Duizend & Zimmerman, *supra* note 89, at 247.

91. *See* David L. Bazelon, *The Dilemma of Criminal Responsibility*, 72 KY. L.J. 263, 274 (1983-84).

92. *See infra* notes 183-214 and accompanying text.

93. It is fair to ask what difference exists between a decision to commit that is influenced by a treatment bias, see *supra* notes 76-77 and accompanying text, and a pretextual decision that a patient is dangerous. A pretextual decision is more result-oriented; the psychiatrist knows the result he or she wants and documents clinical findings that support the result sought when the overarching goal of the evaluation is to determine whether the patient's clinical condition warrants inpatient treatment. A commitment decision unduly influenced by treatment bias is less dishonest. Physicians may not realize biases they have are impacting the decisions they must make.

94. *See* MICHAEL PERLIN, THE HIDDEN PREJUDICE 85 (Bruce D. Sales et al. eds., 2000).

95. Eastman, *supra* note 44, at 315; *see also* MELTON ET AL., *supra* note 19, at 816 n.271 ("[M]ental health professionals perceive legalistic laws as an unnecessary constraint in the treatment of mentally ill persons.").

96. As one psychiatrist noted, "The need to demonstrate dangerousness . . . promotes a galling kind of hypocrisy when, in order to effect a necessary commitment, dangerousness must be invented or exaggerated." Paul Chodoff, *Involuntary Hospitalization of the Mentally Ill as a Moral Issue,* 141 AM. J. PSYCHIATRY 384, 386 (1984); *see also* Rael Jean Isaac, *Protect the Mentally Ill From Their Advocates*, WALL ST. J., May 7, 1991, at A22; H. Richard Lamb, *Involuntary Treatment of the Homeless Mentally Ill*, 4 NOTRE DAME J.L. ETHICS & PUB. POL'Y 269, 277 (1989); Norko, *supra* note 46, at 288 (stating the dangerousness requirement should be changed to a criterion that better supports clinical reality in which doctors act like doctors); Darold Treffert, *The Obviously Ill Patient in Need of Treatment: A Fourth Standard for Civil Commi-*

> Emergency involuntary hospitalization procedures have become adversary in form and function, with lawyers who have no training in psychiatry whatsoever forcing their views on doctors who have an entirely different perspective in their approach to the mentally ill . . . . They should leave the practice of psychiatry to those who have had experience in the field—not on or around the bench.[97]

Comments like this reflect a view of some psychiatrists that attempts by lawyers to strengthen individual rights in the civil commitment process amount to a "legal onslaught" or "holy legal war" against the system of public psychiatry.[98]

Psychiatrists are authoritarian in nature and more comfortable with compulsory treatment than nonmedical mental health professionals;[99] they support broader grounds for commitment than other mental health professionals.[100] The authoritarian nature of many psychiatrists has produced a value system that de-emphasizes individual liberty and autonomy. The authoritarian nature of many psychiatrists has produced a hostility and disrespect for those laws that have broadened the rights of civil committees.[101] When stricter commitment laws conflict with deeply held values of psychiatrists, the doctors give preference to their values at the expense of compliance with the law.[102] Indeed, one set of authorities gathering extensive literature has concluded, "The often flagrant failure to apply the legal standards for civil commitment has been documented in numerous jurisdictions."[103]

The nebulous nature of the dangerousness requirement has enabled psychiatrists to disregard the law while creating an appearance of adherence. A finding of danger, unlike most other legal determinations, does not require a conclusion that a particular act took place. Rather, a psychiatrist need only conclude threat of harm is substantial enough to warrant confinement.[104] The psychiatrist who wishes to pay lip service to the law, if for no other reason than to satisfy his or her conscience, can

---

tment, 36 HOSP. & COMMUNITY PSYCHIATRY 259, 264 (1985) ("Changes in mental health law have produced a pendulum swing . . . too harsh, too restrictive, and too unyielding.").

97. Glenn C. Affleck, Michael A. Peszke & Ronald M. Wintrob, *Psychiatrists' Familiarity with Legal Statutes Governing Emergency Involuntary Hospitalization*, 135 AM. J. PSYCHIATRY 205, 209 (1978).

98. Arrigo, *supra* note 44, at 147.

99. *See* Eastman, *supra* note 44, at 344.

100. Robert Brooks, *Psychiatrists' Beliefs and Wants About Involuntary Civil Commitment Grounds*, 29 INT'L J.L. & PSYCHIATRY 13, 14 (2006).

101. *See supra* notes 93-98 and accompanying text.

102. *See* Appelbaum, *supra* note 78, at 65.

103. MELTON ET AL., *supra* note 19, at 815 n.270.

104. *See supra* note 35 and accompanying text.

always assert enough symptoms of mental illness or factors relating to harm-causing behavior exist to justify confinement.[105] The psychiatrist who lacks respect for the law can simply act with impunity, knowing the court system will rarely second guess his or her determination. Moreover, relatively few individuals who suffer from mental illness have the wherewithal or fortuity to find counsel who will file a damages lawsuit when the facility, or in rare instances a court, releases a patient.[106] In sum, psychiatrists can engage in what can be fairly characterized as systematic civil disobedience—continuing to hospitalize those individuals whose clinical conditions they believe warrant in-patient treatment.

Numerous studies strongly suggest psychiatrists have flaunted the laws that supposedly govern their clinical discretion by making assessments of danger that are pretextual in nature. After commitment laws narrowed in one jurisdiction, a physician reportedly stated, "Doctors will continue to certify those whom they really believe should be certified; they will merely learn a new language."[107] Studies of psychiatric admissions in many jurisdictions that promulgated stricter commitment standards substantiate this contention.

Studies on the impact of commitment statutes suggest the statutes have not had an impact on the number of admissions.[108] An immediate decline in involuntary admissions followed the passage of tighter commitment statutes in Arkansas, Hawaii, Kansas, Nebraska, North Carolina, and Ontario, Canada.[109] However, these jurisdictions reported an increase in involuntary commitments in the second and subsequent years.[110] Similar reversals occurred in Florida, Pennsylvania, New Mexico, North Dakota, Texas, and Washington.[111]

Minnesota and California experienced an initial increase, and only Massachusetts and Michigan sustained decreases in involuntary hospitalizations.[112] Studies further indicated these reversals could not be attributed to more frequent readmissions of patients who may have been released as a

105. *See* Grant Morris, *Defining Dangerousness: Risking a Dangerous Definition*, 10 J. CONTEMP. LEGAL ISSUES 61, 88 (1999) (noting how clinicians "apply their own, unchallenged notions of committability to confine those who are deemed to need treatment").

106. *See supra* note 26 and accompanying text.

107. William O. McCormick, *Involuntary Commitment in Ontario: Some Barriers to the Provision of Proper Care*, 124 CAN. MED. ASS'N J. 715, 717 (1981).

108. MELTON ET AL., *supra* note 19, at 349.

109. R. Michael Bagby et al., *Decision Making in Psychiatric Commitment: An Experimental Analysis,* 148 AM. J. PSYCHIATRY 28, 28 (1991).

110. *Id.* at 29.

111. *Id.*

112. *Id.*

result of the implementation of tighter commitment standards.[113] Hence, as one authority found after studying admissions subsequent to amended commitment statutes, as many as half the committed individuals failed to satisfy the criteria for commitment.[114]

Scrutiny of the details of the commitment process helps to clarify how and why stricter commitment statutes do not produce fewer admissions. Many authorities have found a desire to provide treatment, and not an intention to adhere to and apply the governing legal criteria, motivates decisions by physicians who decide to hospitalize mentally ill individuals.[115] It is not difficult to reach this conclusion because studies detail a patient's clinical status, rather than an honest application of legal criteria, which drives commitment decision-making.[116] When this occurs, physicians will use an assessment of dangerousness as a post-hoc justification for treatment.[117] If the ticket to involuntary hospitalization is an assessment of danger, "many

113. *See* Bagby, *supra* note 17, at 391.

114. Joseph Frueh, Note, *The Anders Brief in Appeals from Civil Commitment*, 118 YALE L.J. 272, 303 (2008).

115. *See* Bagby et al., *supra* note 109, at 29, 32 (discussing a study that found highly treatable individuals are more likely to be committed than individuals characterized as not very treatable); Renee L. Binder & Dale E. McNiel, *Some Issues in Psychiatry, Psychology, and the Law,* 59 HASTINGS L.J. 1191, 1192 (2008) (noting hospitalization can be viewed as an opportunity to provide needed treatment). One study found psychiatrists are more likely to recommend involuntary hospitalization when a patient suffers from schizophrenia or bipolar disorder than substance abuse. Brooks, *supra* note 100, at 14. Any study that finds that the diagnosis of a patient serves as a basis for the decision to commit, as opposed to the level of risk posed by the patient, suggests an interest in treating individuals with a particular diagnosis influences the commitment decision-making process. *See* Appelbaum, *supra* note 78, at 65 (stating a desire to help those perceived to be in need provides an explanation for what authorities have demonstrated: mental health professional prioritize personal values over legal standards when conflict between the two exists); Stewart Page, *New Civil Commitment Legislation: The Relevance of Commitment "Criteria"*, 25 CAN. J. PSYCHIATRY 646, 646 (1980) (considering a study that found approximately seventy percent of commitments did not meet statutory criteria).

116. *See* Appelbaum, *supra* note 78, at 65; Bagby, *supra* note 17, at 385 (stating studies in one jurisdiction found physicians failed to determine civil committees met the legal requirements under the commitment provisions between eighty and ninety percent of the time in which the physicians certified patients for involuntary hospitalization); Bagby et al., *supra* note 109, at 32 (noting twenty percent of patients that physicians recommended for commitment did not meet legal criteria for involuntary hospitalization); Judith S. Thompson & Joel W. Ager, *An Experimental Analysis of the Civil Commitment Recommendations of Psychologists and Psychiatrists*, 6 BEHAV. SCI. & L. 119, 120 (1988) (discussing that empirical studies of physician's familiarity with relevant statutes, or lack thereof, and adequacy of physician certification forms support the contention that an application of commitment standards does not necessarily govern psychiatrists' decisions to seek commitment); *see also* Michael J. Leiber et al., *A Comparison of Pre-Reform and Post-Reform Civil Commitment Decisionmaking in Dane County Wisconsin*, 20 NEW ENG. J. CRIM. & CIV. CONFINEMENT, 1, 22-23 (1993) (finding continued adherence to clinical concerns in part to paternalistic considerations underlying commitment decisions that the court in *Lessard v. Schmidt* sought to eliminate).

117. Mulvey & Lidz, *supra* note 77, at 217.

psychiatrists . . . are willing to punch it."[118] In summary, when a psychiatrist evaluates a patient in the civil commitment context, a presumption of illness exists,[119] and if the patient fails to rebut this presumption, it may well be that the clinician then applies a near irrefutable presumption of dangerousness.

The conclusory nature and concomitant lack of detailed objective criteria with much of the psychiatric diagnostic process enables psychiatrists to support assessments of danger when the patient's mental status would not justify this conclusion.[120] To illustrate, the presence of paranoia is a risk factor for danger.[121] The psychiatric profession defines paranoia as a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent.[122] A civil committee may say his doctor is "against" him or her because the patient wants to be released but the doctor has decided otherwise. The doctor knows he or she is trying to help the patient because he or she recognizes mental illness that requires treatment. Accordingly, the doctor may conclude the patient manifests a false belief system of a persecutory nature. When an honest application of legal criteria no longer serves as the sole criteria for application of civil commitment laws, not only does a desire to help and the patient's clinical condition influence dangerousness assessments, but so do other factors unrelated to the assessment process. These include the availability of bed space and insurance.[123]

How many psychiatrists assess numerous symptoms of mental illness, such as delusions and hallucinations, illustrates how psychiatrists can manipulate the diagnostic process to find danger where none exists. Professional literature has made clear no necessary correlation exists between the presence of delusions or hallucinations and a heightened risk of harm.[124] On the other hand, particular delusions and command hallucinations heighten the risk of harm posed by a person with mental illness.[125] Psychiatrists

118. JOHN MONAHAN, NAT'L INST. OF MENTAL HEALTH, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 51 (1981).

119. *See* Arrigo & Williams, *supra* note 75, at 187.

120. *See* Douglas Mossman, *"Hired Guns," "Whores," and "Prostitutes": Case Law References to Clinicians of Ill Repute*, 27 J. AM. ACAD. PSYCHIATRY & L. 414 (1999) (recognizing psychiatrists can mold testimony to further the litigation objectives of the party on whose behalf the expert is testifying).

121. CHRISTOPHER WEBSTER ET AL., HCR-20: ASSESSING RISK FOR VIOLENCE 54 (1997).

122. AMERICAN PSYCHIATRIC GLOSSARY 100 (7th ed. 1994).

123. Nancy B. Engleman et al., *Clinicians' Decision Making About Involuntary Commitment*, 49 PSYCHIATRIC SERVICES 941, 943-44 (1998); Herbert Sacks, *Who's on First, What's on Second, I Don't Know's on Third (For Profit Psychiatric Hospital Chains and the Games They Play)*, PSYCHIATRIC NEWS, Sept. 5, 1997, at 3.

124. *See, e.g.*, Harris & Rice, *supra* note 59, at 1169.

125. *Id.*

can, and will, justify a finding of danger on the basis that a patient manifests delusions or hallucinations, without specifying whether the delusions or hallucinations are risk-enhancing.[126]

Tellingly, studies have documented a "remarkable degree of ignorance" of commitment criteria.[127] Significantly, those psychiatrists who certified the largest number of patients for involuntary hospitalization were among the least knowledgeable about the law.[128] If psychiatrists who commit individuals are ignorant of the law, then considerations other than the legal criteria that should govern their decisions guide their assessment process. The handful of damages cases the author has worked on illustrates

126. Evidence presented in *Monaco v. Hogan* is instructive on this issue. *See generally* Monaco v. Hogan, 576 F. Supp. 2d 335 (E.D.N.Y. 2008). In *Monaco*, the plaintiffs argued psychiatrists confined individuals—regardless of whether the individuals were actually dangerous—for the purpose of providing needed treatment, in violation of the Fourteenth Amendment. *Id.* at 351. In other words, some certifications of dangerousness are pretextual.

Discovery in *Monaco* revealed clinicians acknowledged that an intent to act on delusions or a history of acting on delusions heightened the risk of harm even though delusions in and of themselves did not. *See* Declaration of William Brooks, Exhibit L at 126, 156, 198, Exhibit O at 42-43, Exhibit P at 36, 70, Exhibit S at 69-71, *Monaco*, 576 F. Supp. 2d 335 (No. CV-98-3386), *available at* http://www.nyed.uscourts.gov (search for "CV-98-3386"; then follow "Docket Entry 418"). Notwithstanding what should have constituted a need to differentiate between risk enhancing delusions and hallucinations and delusions and hallucinations that were not, when the plaintiffs came forth with voluminous instances of the failure of clinicians to make these distinctions, *see* Declaration of William Brooks, Exhibit V, Exhibit W, *Monaco*, 576 F. Supp. 2d 335 (No. CV-98-3386), *available at* http://www.nyed.uscourts.gov (search for "CV-98-3386"; then follow "Docket Entry 418"), the Office of Mental Health failed to come forth with one instance in which a doctor who conducted a civil commitment evaluation justified a finding of dangerousness based on a particular risk enhancing delusion or hallucination, as opposed to finding dangerousness based on delusions or hallucinations in general. *See* Declaration of Michael Peeples, *Monaco*, 576 F. Supp. 2d 335 (No. CV-98-3386), *available at* http://www.nyed.uscourts.gov (search for "CV-98-3386"; then follow "Docket Entry 418"). Despite this evidence, the court held because hospital physicians gave legitimate reasons for making commitment decisions, the plaintiffs failed to prove their claim of pretextual confinement. *Monaco*, 576 F. Supp. 2d at 353-54. The court further held the decisions of the physicians to commit did not violate the substantive component of the Due Process Clause because the commitments did not shock the conscience. *Id.* at 349-51. The court adopted the shocks the conscience standard to ensure physicians can operate effectively when examining patients. *Id.* at 351. To the extent the court found any commitment of a nondangerous person is lawful as long it does not shock the conscience, the court clearly erred. *See* Bolmer v. Oliveira, 594 F.3d 134, 144-45 (2d Cir. 2010) (rejecting the shocks the conscience standard in general and the *Monaco* court's decision as establishing the proper substantive due process framework for civil commitment). By justifying the adoption of the shocks the conscience standard on the need to permit physicians to operate effectively, the court conflated the governing substantive due process standard, which prohibits the confinement of a nondangerous mentally ill individual and considerations underlying the qualified immunity defense. *See* Will v. Hallock, 546 U.S. 345, 352 (2006).

127. *See* Appelbaum, *supra* note 78, at 65. In one study where doctors' knowledge of commitment laws was explored, some thought patients must present an immediate, clear, or imminent danger to self or others, while other doctors thought patients are committable if they present a probable, possible, or potential danger; still other physicians thought only homicidal or suicidal patients could be certified for emergency hospitalization, and self-destructive tendencies could be a basis for commitment. *See* Affleck, Peszke & Wintrob, *supra* note 97, at 208.

128. *See* Affleck, Peszke & Wintrob, *supra* note 97, at 208.

the problematic nature of the psychiatric evaluation process. Invariably, questions have arisen about the seriousness of purpose in which one or more clinicians have attempted to gather information from the plaintiff[129] or the adequacy of the evaluation as a result of the amount of time one or more committing physicians has spent evaluating the plaintiff.[130]

Psychiatrists who examine individuals to determine whether they meet a state's civil commitment criteria have been designated by society to temporarily replace the role of judges and become impartial factfinders who must determine whether enough facts exists to deprive someone of a fundamental liberty interest.[131] When psychiatrists lack knowledge of the law they must apply, no question exists that when committing individuals, the psychiatrists think less about the legal constraints that must govern their decision-making and more about other considerations they deem more important than legal criteria.[132] The attempts by the psychiatric profession

---

129. *See, e.g.*, Declaration at ¶¶ 7-9, Jacob v. Bon Secours Charity Health System, Inc., No. 02 Civ. 1398 (BSJ) (RLE), 2008 WL 2216275 (S.D.N.Y. May 28, 2008) (detailing a lack of interest in gathering information from the plaintiff after one physician discussed the case with the plaintiff's husband) (on file with author).

130. *See* Joint Appendix at 395, Marion v. LaFargue, 05-3797-cv, 186 Fed. Apps. 96 (2d Cir. 2006) (including a concession by the initial committing physician he may have spent as little as five minutes evaluating the plaintiff) (on file with author); Kulak v. City of New York, 88 F.3d 63, 67 (2d Cir. 1996) (stating the initial committing physician conducted a five minute interview); Rodriguez v. City of New York, 72 F.3d 1051, 1056 (2d Cir. 1995) (committing physician met with the plaintiff for ten minutes); Bolmer v. Oliveira, 570 F. Supp. 2d 301, 309 (D. Conn. 2008) (stating plaintiff alleged the certifying physician met with him for a few minutes and the admitting physician for five minutes); Tewksbury v. Dowling, 169 F. Supp. 2d 103, 107 (E.D.N.Y. 2001) (stating plaintiff asserted certifying physician never evaluated her; physician asserted he did so for five minutes); Lubera v. Jewish Ass'n for Servs. for the Aged, No. 95 CIV. 7845 (DLC), 1996 WL 426375, at *3 (S.D.N.Y. July 30, 1996) (indicating plaintiff was admitted to the hospital, as evidenced by being thrown into shower, prior to any evaluation by a physician).

Demarco v. Sadiker, 897 F. Supp. 693 (E.D.N.Y. 1995), is particularly illuminating. In *Demarco*, the plaintiff opposed a summary judgment motion on the ground that one of the physicians never evaluated him and submitted an affidavit making this assertion. *Id.* at 703. The defendant, citing, inter alia, a detailed admission note, and failing to recognize the contents of such could have been produced by copying other documents, argued the plaintiff's assertion was simply too incredible for the court to believe. *Id.* at 703. Nevertheless, the court denied the physician qualified immunity and directed the parties to conduct limited discovery. *Id.* at 703-04. During the deposition of the admitting physician, he acknowledged he first met the plaintiff at 12:45 p.m. *See* Declaration of Patricia Hingerton, Exhibit A, *Demarco*, 897 F. Supp. 693 (No. 93-CV-5938 (ARR)). A review of the commitment certificate signed by the physician detailed that the physician committed the plaintiff at 12:45 p.m., the time the physician first observed the plaintiff. *Id*., Exhibit 4. When questioned about the certification of the plaintiff at the moment the physician first observed him, the physician responded the plaintiff was angry, agitated, and paranoid, and that the plaintiff threatened to sue on the ground of false imprisonment. *Id.* at 76. If the handful of cases the author has litigated invariably contain evidence of significant deficiencies with the evaluation process, and if one extrapolates to the approximate one million involuntary hospitalizations that occur annually, see *supra* note 1 and accompanying text, one can imagine the number of problematic evaluations that occur each year.

131. *See* Foucha v. Louisiana, 504 U.S. 71, 86 (1992).

132. *See* Appelbaum, *supra* note 78, at 65.

to involuntarily hospitalize nondangerous individuals have been described as a "blatant attempt to aggregate power, to subvert the law, and to privilege expertise over all competing social values."[133] In the 1950s, when school administrators attempted to flout the integration requirements imposed by the Supreme Court, their civil disobedience made news headlines, and many within the country, including courts and the news media, eventually denounced what amounted to an attempt to elevate what school officials believed constituted the proper set of values over the rule of law.[134] Many psychiatrists have done the same with little outcry. Leaving aside the culpability of the psychiatrists who have subverted the law, fault also lies with lawyers for civilly committed individuals and with the judges who have abdicated their judicial decision-making role to the purported experts who appear before them.

IV. THE INABILITY OF CIVIL COMMITMENT HEARINGS TO SERVE AS A CHECK ON FAULTY PSYCHIATRIC DECISION-MAKING

A. THE DEFERENCE TO PSYCHIATRISTS BY JUDGES

The role a psychiatrist plays in the civil commitment process is truly *sui generis*. When psychiatrists enter a courtroom, they are often defending their decisions to involuntarily hospitalize a mentally ill individual. When this occurs, the psychiatrists, for all intents and purposes, is the real party in interest.[135] In instances when the psychiatric expert testifies in connection with a patient whom another psychiatrist has decided to hospitalize, the expert testifies on behalf of a fellow doctor, an individual with whom the testifying expert no doubt has significant professional, if not also personal, contact. In either case, a substantial potential for bias exists.[136] However, the testifying psychiatrist also assumes the role of an "expert," a witness with specialized knowledge, upon whom the court must rely for an informed decision.[137] As detailed below, this anomaly results in courts inappropriately deferring to psychiatric "expertise."

Notwithstanding the tightening of psychiatric standards, judges typically defer to psychiatric judgments that a committed person meets the

133. PERLIN, *supra* note 94, at 90.

134. *See, e.g.*, Cooper v. Aaron, 358 U.S. 1, 14-17 (1958).

135. *See* Robert S. Berger, *The Psychiatric Expert as a Due Process Decisionmaker*, 33 BUFF. L. REV. 681, 702 (1985).

136. *See* Binder & McNeil, *supra* note 115, at 1197 (noting advocacy associated with a treating role renders it difficult for clinicians to act impartially and objectively).

137. *See* 1 MCCORMICK ON EVIDENCE 69-70 (6th ed. 2006).

criteria for civil commitment.[138] Clinicians' opinions about mental illness and danger are dispositive in commitment hearings regardless of the particular commitment standard used; studies indicate the concordance rate, *i.e.*, the rate of correlation between clinicians' opinions and factfinders' opinions, range between ninety and one hundred percent.[139] Approximately thirty years ago, one authority described civil commitment proceedings as ceremonial in nature, in which courts "rubber stamp" expert conclusions.[140] However, the perfunctory nature of civil commitment proceedings remains today, more than twenty-five years after the Supreme Court decided *O'Connor v. Donaldson*, and three-judge courts imposed supposedly stringent procedural safeguards.[141] When judges defer to psychiatrists at a rate between ninety and one hundred percent of the time the psychiatrist experts actually become the decision-makers in the civil commitment process.

Numerous reasons exist for this excessive deference by judges. First, most jurisdictions give judges little or no training in mental health law or the finer points of psychiatric diagnosis and treatment.[142] Accordingly,

138. *See* Grant H. Morris, *"Let's Do the Time Warp Again": Assessing the Competence of Counsel in Mental Health Conservatorship Proceedings*, 46 SAN DIEGO L. REV. 283, 314-15 (2009); Bagby, *supra* note 17, at 385 ("[Li]ngering deference to psychiatric recommendation, commitment without evidence of facts of dangerousness.") (internal quotations omitted); *see also* David L. Bazelon, *The Dilemma of Criminal Responsibility*, 72 KY. L.J. 263, 267 (1983-84) (asserting judges prefer to delegate difficult decision-making to psychiatric experts).

139. MELTON ET AL., *supra* note 19, at 349. In reaching this conclusion, the authors relied in part on a study in Iowa that found civil commitment hearings served as little more than a rubber stamp of physicians' opinions. *Id*. at 319; *see also* Harold J. Bursztajn, Robert M. Hamm & Thomsas G. Gutheil, *Beyond the Black Letter of the Law: An Empirical Study of an Individual Judge's Decision Process for Civil Commitment Hearings*, 25 J. AM. ACAD. PSYCHIATRY L. 7982, 7982-83 (1997) (noting in Massachusetts, a court ordered committed every patient who psychiatrists petitioned for commitment; a second study in Colorado found judges committed twenty-four of twenty-seven patients whom psychiatrists petitioned for commitment); Morris, *supra* note 138, at 329-30, 332 (2009) (stating courts granted applications for conservatorships, proceedings tantamount to civil commitment in California, in 97.9% of cases; in each case, counsel introduced psychiatric testimony); William Hoffman Pincus, Note, *Civil Commitment and the "Great Confinement" Revisited: Straightjacketing Individual Rights, Stifling Culture*, 36 WM. & MARY L. REV. 1769, 1806-08 (1995) (discussing an empirical evaluation that found an almost ninety percent correlation rate between psychiatric testimony and judicial dispositions); Winick, *supra* note 3, at 41-42 (stating the concordance rate most frequently exceeds ninety-five percent). The rate of correlation detailed by the authors in the 1990s hardly differed for the rate of correlation found in the 1960s and 1970s. *See* Virginia A. Hiday, *Application of the Dangerousness Standard in Civil Commitment*, 5 LAW & HUM. BEHAV. 275, 277 (1981) (noting numerous studies detail how courts deferred to psychiatrists for judgments of dangerousness and, hence, abrogate their decision-making responsibility); Norman G. Poythress, Jr., *Mental Health Expert Testimony: Current Problems*, 5 J. PSYCHIATRY & L., 201, 213 (1977) (stating in six studies of civil commitment hearings between 1964 and 1972, the correlation between expert testimony and judges' decisions ranged from ninety-six to one hundred percent). In the hearings from which the author gathered information, the concordance rate from all localities was 86.3%. This ranged from 66.6% in Queens County, New York, to 100 % in Dade County, Florida.

140. Poythress, *supra* note 139, at 211.

141. *See* Eastman, *supra* note 44, at 322.

142. Appelbaum, *supra* note 78, at 66.

judges defer to psychiatric opinion because they feel they lack the requisite expertise to independently assess whether patients meet the statutory criteria for commitment.[143] Furthermore, judges do not want to stand in the way of clinicians providing treatment to those deemed in need of care.[144] Hence, judges lack interest in scrutinizing the substance of expert testimony when scrutiny compels a finding that a patient does not meet the civil commitment standards.[145] In this way, a desire to not interfere with needed care often results in a lack of interest in applying governing legal standards.[146]

Finally, a paternalistic, non-adversarial approach to the civil commitment process constitutes the safest course of action for judges. Just as the release of a patient who causes harm can produce horrible consequences for the doctor who released the patient, a judge who releases a patient who harms another person after release will likely suffer the same fate.[147] However, the acceptance of psychiatric testimony at face value at the expense of an honest application commitment standards amounts to judges acting as enforcers of a societal morality that believes it is better to both err on the side of caution and provide treatment to those who are deemed to need it than it is to carefully apply governing law that impacts on fundamental rights.[148] For these judges, reliance upon expert testimony provides a basis for a decision that can often withstand appellate scrutiny. The affirmance of a trial court's decision relying on unsubstantiated expert testimony is most likely to occur when little factual basis exists to disprove the unsubstantiated opinion. When commitment hearings lack vigorous advocacy on behalf of the patient, chances increase that an appellate court will not have a detailed factual record that will either substantiate or disprove an

143. Hiday, *supra* note 5, at 665.

144. MELTON ET AL., *supra* note 19, at 348-49 (stating when attorneys acted in adversarial fashion, judges made clear such advocacy did not impact their decision-making process if the goals of legal advocacy conflicted with the opinions of the medical experts); *see also* Hiday, *supra* note 139, at 288 (arguing courts exhibit an impulse to move beyond rigid, formal legal process and consider the whole person); Hiday, *supra* note 5, at 651.

145. *See* Richard Rogers, *The Uncritical Acceptance of Risk Assessment in Forensic Practice*, 24 LAW & HUM. BEHAV. 595, 602 (2000) (discussing a number of authorities have convincingly demonstrated triers of fact do not accurately utilize probabilistic estimates, even when the estimates are carefully explained).

146. MELTON ET AL., *supra* note 19, at 348; *see also* Michael J. Saks, *Expert Witnesses, Nonexpert Witnesses, and Nonwitness Experts*, 14 LAW & HUM. BEHAV. 291, 293 (1990) (detailing the acknowledgement of a judge to law students that he authorized the commitment of individuals who did not meet commitment criteria because of a desire to facilitate needed treatment).

147. MELTON ET AL., *supra* note 19, at 349.

148. *See* Arrigo & Williams, *supra* note 75, at 184-87.

opinion rendered by a psychiatric expert. As detailed below, vigorous efforts at representation often do not exist.

B. OTHER FAILURES OF THE SUPPOSED ADVERSARY SYSTEM

While many federal and state courts imposed numerous, supposedly stringent, substantive and procedural protections in the 1970s and 80s,[149] the failure of a narrowing of commitment statutes to result in a decrease in the number of commitments suggests tighter standards and procedures have not been applied in practice.[150] Court hearings were supposed to serve as a check on psychiatric decision-making; all too often they have not.[151] Responsibility for this failure lies, to a significant degree, with attorneys who represent patients in commitment proceedings but who have shirked their responsibility to act as effective advocates for their clients.[152] Instead of rigorous advocacy by attorneys, norms of cooperation and accommodation typically govern the civil commitment process.[153] Notwithstanding the tightening of psychiatric standards, attorneys who represent civil committees often act in a passive, nonadversarial, or perfunctory manner.[154] Some attorneys come unprepared to represent their client,[155] accept at face value the conclusions of psychiatric experts without even the slightest degree of skepticism,[156] and otherwise fail to effectively participate in the hearing.[157]

The lack of an adversarial role of civil committees' attorneys and the concomitant informal nature of commitment proceedings can be evinced in a comparison between how attorneys present and challenge evidence of

149. *See supra* notes 13-17 and accompanying text.

150. MELTON ET AL., *supra* note 19, at 348.

151. *See, e.g.*, Morris, *supra* note 138, at 329-41; Turkheimer & Parry, *supra* note 53, at 646-48.

152. *See* Michael L. Perlin, *"I Might Need a Good Lawyer, Could Be Your Funeral, My Trial": Global Clinical Legal Education and the Right to Counsel in Civil Commitment Cases*, 28 WASH. U. J.L. & POL'Y 241, 241 (2008) ("If there has been any constant in modern mental disability law in its thirty-five year history, it is the near universal reality that counsel assigned to represent individuals at involuntary civil commitment cases is likely to be ineffective."); Winick, *supra* note 3, at 41 (recognizing the failure of attorneys to fulfill their adversarial role has turned commitment hearings "into a farce and a mockery in which . . . judges appear to 'rubber stamp' the recommendations of clinical expert witnesses"); *see generally* Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 LAW & HUM. BEHAV. 39, 39 (1992).

153. Arrigo, *supra* note 44, at 144.

154. Appelbaum, *supra* note 78, at 66; Bagby, *supra* note 17, at 385 (internal quotations omitted).

155. *See* McGraw et al., *supra* note 89, at 285; *see also* Poythress, *supra* note 139, at 210-11.

156. *See* Hiday, *supra* note 139, at 287 (noting in one study, seldom did the patient's counsel challenge the psychiatrist's assertions of dangerousness set forth in doctors' affidavits, even though in ten percent of cases, the affidavits did not contain the legally required facts detailing imminent danger).

157. *See* Morris, *supra* note 138, at 330-32.

dangerousness in commitment proceedings involving sexual offenders and commitment proceedings of individuals who suffer from mental illness. Extensive case law exists that has arisen out of attempts to offer actuarial or other empirically-based evidence of danger in sexual offender proceedings.[158] The testimony results in clinicians offering opinion on the specific probability of a committee engaging in future acts of sexual violence.[159] It may well be that attorneys representing the state rely on actuarial evidence because mental health professionals recognize that clinical judgment alone results in assessments of danger with questionable validity while the clinically adjusted actuarial method has been considered the most accurate method of assessing risk.[160] The adversarial nature of the proceedings require attorneys to put forth evidence that has the best chance of withstanding vigorous cross-examination.

In the civil commitment context, instances of vigorous cross-examination often generate hostility from both judges and psychiatric witnesses.[161] Judges often discourage zealous advocacy and make clear vigorous representation does not impact the decision-making process when the position put forth by counsel controverts the opinions put forth by psychiatric experts.[162] As a result, attorneys will limit their advocacy efforts to what they believe judges will tolerate.[163] That psychiatrists do not generally complain about intensive cross-examination in other legal contexts[164] may well mean the general lack of adversarialness in the civil commitment context has created an expectation that patients' lawyers should play only a perfunctory role in the commitment process. Perhaps that is why patients' attorneys rarely call more than two witnesses and frequently call none.[165] When attorneys fail to present a fully competent case, those judges who

158. *See, e.g.*, *In re* Holtz, 653 N.W.2d 613, 616 (Iowa Ct. App. 2002); People v. Taylor, 782 N.E.2d 920, 923-24 (Ill. App. Ct. 2002); *In re* Commitment of R.S., 773 A.2d 72, 77-80 (N.J. Super. Ct. App. Div. 2001); *In re* Dean, No. 17320-8-III, 2000 WL 690142, at *2 (Wash. App. May 30, 2000).

159. *See, e.g.*, *Dean*, No. 17320-8-III, 2000 WL 690142, at *2.

160. *See supra* note 58 and accompanying text.

161. Perlin, *Fatal Assumption*, *supra* note 152, at 52.

162. *See* Appelbaum, *supra* note 78, at 66; MELTON ET AL., *supra* note 19, at 349; *see also* Winick, *supra* note 3, at 42; Perlin, *supra* note 152, at 44 n.33 (stating judges, often in anger, rebuff vigorous cross-examinations).

163. Frueh, *supra* note 114, at 306-07.

164. Perlin, *Fatal Assumption*, *supra* note 152, at 52.

165. MELTON ET AL., *supra* note 19, at 348; *see also* Morris, *supra* note 138, at 330-31 (in forty-three of forty-seven hearings, the commitment subject served as the only witness for his side; in only one case did the attorney for the commitment subject present a witness other than the commitment subject). In the seventy-six hearings about which the author gathered data, the patient's lawyer failed to call any witnesses fourteen times, called one witness forty-seven times, two witnesses twelve times, and three witnesses three times. Of the forty-seven times in which a lawyer called one witness only, the patient was the only witness called forty-one times.

carefully attempt to apply legal criteria lack the ability to adequately assess the merits of the hospital's position seeking confinement.[166] Judges tend to lack knowledge of the weak basis for psychiatric testimony.[167] Hence, the failure of lawyers to vigorously represent their clients in civil commitment proceedings results in even well-intentioned judges failing to learn about the weaknesses of psychiatric testimony.[168] Moreover, while judges give great deference to psychiatric opinions,[169] and psychiatrists appearing in court invariably testify on behalf of the committing hospital,[170] attorneys infrequently seek independent psychiatric testimony.[171]

In addition, many commitment hearings have evolved into proceedings that are not accusatorial in nature, but rather inquisitorial.[172] The committing hospital will occasionally call the patient as a witness in hopes that the patient will "hang himself." This is done when a hospital fails to present a strong case in support of hospitalization.[173]

The failure of the hospital to put on a persuasive case can occur when the patient's treating physician is a foreign-born doctor who lacks fluency in English. Some facilities have found a solution to this problem through the use of a professional witness, *i.e.*, a physician who testifies regularly for the hospital while not necessarily serving as a certified or treating doctor for any particular patient. This type of witness usually makes a much better witness than the typical doctor. This witness is more familiar with civil commitment law and knows how to present psychiatric testimony in a manner that is useful for the court.[174] This witness quickly learns what evidence

166. *See* Appelbaum, *supra* note 78, at 67.

167. Hiday, *supra* note 5, at 655.

168. *Id.* Vigorous advocacy should result in attempts to educate the court about weaknesses in psychiatric assessments of dangerousness through cross-examination. However, when psychiatrists are so lacking in professional expertise they are ignorant of the well-documented weaknesses in expert testimony, then the lawyer loses the ability to effectively educate the court through cross-examination. When this occurs, the lawyer must rely on a court-appointed expert to elicit testimony about the weaknesses in expert testimony.

169. *See supra* notes 138-39 and accompanying text.

170. *See* McGraw et al., *supra* note 89, at 289.

171. MELTON ET AL., *supra* note 19, at 349 (citing Serena D. Stier & Kurt J. Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 IOWA L. REV. 1284 (1979) (discussing how one study in Iowa found that patients' attorneys failed to request the appointment of an independent expert in more than ninety-nine percent of cases)); *see also* Morris, *supra* note 138, at 330-31 (noting that in none of forty-seven contested cases did the attorney for the commitment subject seek an appointment of a psychiatrist). Two reasons exist for this failure. First, lawyers fear the court-appointed expert will render the same opinions as the expert testifying for the hospital. McGraw et al., *supra* note 89, at 278. Second, any appointment of an independent psychiatrist will delay the proceeding, which serves as a major disincentive to seek the appointment of an expert. Van Duizend & Zimmerman, *supra* note 89, at 246.

172. MELTON ET AL., *supra* note 19, at 349.

173. Van Duizend & Zimmerman, *supra* note 89, at 261.

174. *Id.* at 258.

judges find persuasive;[175] he can turn the psychiatric evaluation into a quasi-interrogation, enabling him to gather evidence that buttresses the hospital's position that the patient is mentally ill and dangerous. The non-treating psychiatrist can help eliminate problems that might plague the hospital's case, due to lack of preparation, by asking the patient information contained in the hospital record or provided by individuals familiar with the patient. Particularly because patients cannot refuse to answer questions,[176] the non-treating psychiatrist can use statements made by the patient as admissions.

In sum, one author of an empirical study concluded data on the civil commitment process in California confirms what the Montana Supreme Court held: the civil commitment process "is an 'obvious systematic failure' 'that routinely accepts—and even requires—an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation.'"[177] The combination of the abdication of one's adversary role by attorneys, the substantial deference paid by courts to psychiatrists, and the use of hearsay in lieu of testimony subject to cross-examination creates the potential for the deprivation of liberty based on hearings that last very brief periods of time.[178]

---

175. *See* Hiday & Smith, *supra* note 53, at 441-42 (examining dangerous behavior).

176. Prior to the Supreme Court's decision in *Allen v. Illinois*, 478 U.S. 364 (1986), courts were split as to whether civil committees could assert the privilege against self-incrimination to refuse to answer questions posed to them by psychiatrists. *Compare* Suzuki v. Quisenberry, 411 F. Supp. 1113, 1130-32 (D. Haw. 1976) (holding the privilege against self-incrimination attaches in civil commitment proceedings); Lynch v. Baxley, 386 F. Supp. 378, 394 (D. Ala. 1974); Lessard v. Schmidt, 349 F. Supp. 1078, 1101 (D. Wis. 1972); *with* French v. Blackburn, 428 F. Supp. 1351, 1358-59 (D.N.C. 1977), *aff'd*, 443 U.S. 901 (1977) (holding the privilege against self-incrimination does not attach in civil commitment proceedings); State *ex rel.* Hawks v. Lazaro, 202 S.E.2d 109, 126 (W. Va. 1974). In *Allen*, the Supreme Court held a committee subject to confinement pursuant to a sexual delinquency proceeding deemed civil in nature could not assert the privilege. *Allen*, 478 U.S. at 375. Since *Allen*, there have been very few cases in which a civil committee asserted the privilege against self-incrimination; in the few cases that have addressed the issue, courts have held the privilege does not attach to civil commitment proceedings. *See* Goetz v. Crosson, 728 F. Supp. 995, 1002 (S.D.N.Y. 1990); Ughetto v. Acrish, 518 N.Y.S.2d 398, 403 (N.Y. App. Div. 1987). Ironically, in *Ughetto*, the court held the privilege against self-incrimination did not attach to examinations conducted by a non-treating psychiatrist on the ground that the purpose of a civil commitment was not the marshalling of evidence but a determination of the clinical needs of the patient. *Ughetto*, 518 N.Y.S.2d at 403. This rationale was clearly wrong because when a non-treating psychiatrist examines a patient, he or she does so for the express purpose of gathering evidence to support the hospital's position.

177. Morris, *supra* note 138, at 340-41 (quoting *In re* Mental Health of K.G.F., 29 P.3d 485, 494, 492 (Mont. 2001)).

178. Eastman, *supra* note 44, at 325; Morris, *supra* note 138, at 330 (noting hearings average approximately twenty-three minutes); Michael Perlin, *"Their Promises of Paradise": Will* Olmstead v. L.C. *Resuscitate the Constitutional "Least Restrictive Alternative" Principle in Mental Disability Law*, 37 HOUS. L. REV. 999, 1021 (2000). The average time of the seventy-eight hearings about which the author gathered data was forty-one minutes. However, if one excludes eight hearings conducted in Cook and Kane counties in Illinois, the average time was

Accordingly, while physicians will certify patients who do not meet the civil commitment criteria,[179] the failings of the commitment system have resulted in hospitals continuing to confine individuals who fail to satisfy the commitment standard.[180] Like nearly blind deference to psychiatric testimony by judges, informal, non-adversarial commitment proceedings also serve to further an unstated goal of providing treatment to those who require treatment regardless of whether they pose a danger to themselves or others.[181] The failure of the civil commitment hearing to fulfill its *raison d' etre*, namely limiting commitments to those who satisfy the commitment criteria, emboldens clinicians who wish to confine individuals—whom they deem require treatment but who fail to satisfy the commitment criteria—to seek the commitment of such individuals.[182] Coupled with the excessive deference judges give to psychiatric testimony, the failures many authorities have found inherent in the civil commitment system have meant stricter commitment standards have not resulted in a concomitant protection of liberties for subjects of civil commitment.

V. COMPOUNDING THE PROBLEM—THE ARBITRARY AND EXCESSIVELY VAGUE CONCEPT OF DANGER

What has also contributed to the ability of psychiatrists to unduly influence the legal process is the exceedingly ambiguous concept of danger.[183] By definition, any standard imposed by the Supreme Court to satisfy due process cannot violate the Constitution. However, as the school desegregation cases have taught, broad constitutional standards, such as "all deliberate speed,"[184] require further interpretation and clarification if the class of individuals who have been subject to unconstitutional actions are going to benefit from a seminal Supreme Court decision that changes the legal landscape. In the civil commitment context, the seminal Supreme Court case was *O'Connor v. Donaldson*, which held a state cannot confine a mentally ill person who is capable of surviving safely in the commu-

thirty-four minutes. In Cook and Kane counties, the eight hearings observed averaged one hour and forty-nine minutes in length.

179. *See supra* notes 57-134 and accompanying text.

180. *See, e.g.*, Appelbaum, *supra* note 78, at 67.

181. *In re R.O.* serves as an example of a court subverting basic due process principles to the goal of providing treatment deemed necessary. *See generally In re R.O.*, 2002 ND 154, 652 N.W.2d 327. In that case, the court required a mentally ill individual to proceed with his commitment hearing—when the court-appointed counsel only one day earlier—on the ground that a continuance was not in the committee's best clinical interests. *Id.* at 327.

182. *See* Appelbaum, *supra* note 78, at 67.

183. *See, e.g.*, Arrigo & Williams, *supra* note 75, at 187 (detailing descriptions of the dangerousness requirement as "woefully lacking" and "malleable and clouded by incoherence").

184. Brown v. Board of Educ., 349 U.S. 294, 301 (1955).

nity.[185] This is particularly true when, as in both the school desegregation and civil commitment contexts, those charged with enforcing or applying the new protective standard oppose the new standard and utilize what amounts to unforeseen vagueness to frustrate its implementation.[186]

Well-settled Supreme Court doctrine requires individuals who enforce government law may not act on an ad hoc or subjective basis.[187] Hence, due process requires the existence of "reasonably explicit standards for those who are to enforce the rules and regulations."[188] Similarly, the Supreme Court has strongly suggested due process is violated when a law provides state officials "absolute discretion" to determine what conduct falls within the statute.[189]

Challenges to the use of undue discretion in the enforcement of a government law have generally been based on void for vagueness grounds.[190] The lack of a generally accepted legal or psychiatric meaning of "dangerousness" in many jurisdictions, and the failure of psychiatrists to receive training to evaluate dangerousness, have resulted in mental health experts providing their own personal and subjective definition of the term.[191] As detailed below, without clarifying or otherwise narrowing the concept of dangerousness, the commitment of mentally ill individuals, because physicians have deemed them "dangerous," can result in the type of arbitrary enforcement the void for vagueness doctrine prohibits. Under this doctrine, a legal standard is impermissibly vague and, hence, violates due process, when it results in "those who are responsible for its administration . . . 'differ[ing] as to its application.'"[192]

First, it is not entirely clear what the concept of "dangerousness" encompasses. At the very least, any contention that a person is dangerous encompasses numerous assertions. A psychiatrist who certifies an individual as dangerous concludes the person has certain characteristics that are associated with a certain probability of harmful behavior. The probability of harmful behavior is sufficiently great as to justify preventive intervention.[193] In addition to assessing the likelihood of harm, the factfinder may

185. *See supra* notes 11-12 and accompanying text.

186. *See, e.g.*, Morris, *supra* note 105, at 66 (stating the absence of a requirement to specify gravity of harm has resulted in an arbitrary application of commitment laws).

187. Grayned v. City of Rockford, 408 U.S. 104, 108-09 (1972).

188. Bass Plating Co. v. Town of Windsor, 639 F. Supp. 873, 880 (D. Conn. 1986).

189. *See* City of Chicago v. Morales, 527 U.S. 41, 61 (1999).

190. *See, e.g.*, *id.* at 46-52.

191. Steadman, *supra* note 37, at 267.

192. *In re* Commitment of N.N., 679 A.2d 1174, 1181 (N.J. 1996) (quoting Coates v. Cincinnati, 402 U.S. 611, 614 (1971)).

193. Monahan & Wexler, *supra* note 36, at 38.

also examine the magnitude and imminence of any harm that may occur.[194] Finally, in the absence of qualifying language, an evaluator must determine the nature of harm that is at risk of occurring. Is it physical harm to oneself or another person?[195] Does the concept of harm also include emotional harm, as one court concluded?[196] Is someone subject to commitment if he or she poses a threat of harm to property but not another person?[197]

While a few courts have addressed the issue of whether a finding of dangerousness encompasses the likelihood of imminent harm and the magnitude of harm that may occur,[198] courts in most jurisdictions have not addressed these considerations and, hence, have failed to establish a framework for physicians to apply.[199] Moreover, in the absence of statutory language or a judicial opinion clarifying the meaning of "danger," a clinician can interpret any threat to cause harm as creating a danger, regardless of the remoteness of the threat.[200] Likewise, when the perceived

194. *See* Joel A. Dvoskin & Kirk Heilbrun, *Risk Assessment and Release Decision-Making: Toward Resolving the Great Debate,* 29 J. AM. ACAD. PSYCHIATRY & L. 6, 9 (2001) (detailing how a clinician or factfinder can assess magnitude, probability, and imminence); McNeil & Binder, *supra* note 41, at 1321 (stating even commitment statutes with specific probability estimates are often vague about the time frame of risk and setting in which harm may occur).

195. *See* Stamus v. Leonhardt, 414 F. Supp. 439, 451 (D. Iowa 1976); Doremus v. Farrell, 407 F. Supp. 509, 514-15 (D. Neb. 1975); *In re* Harry M., 468 N.Y.S.2d 359, 364 (N.Y. App. Div. 1983).

196. *See* Lynch v. Baxley, 386 F. Supp. 378, 392 (D. Ala. 1974).

197. *See* Suzuki v. Yuen, 617 F.2d 173, 176 (9th Cir. 1980) (examining the constitutionality of a commitment statute that authorized confinement based on a threat of harm to property); State v. Krol, 344 A.2d 289, 301 (N.J. 1975) (holding "danger" includes a risk of substantial destruction of property).

198. *See* Cross v. Harris, 418 F.2d 1095, 1100 (D.C. Cir. 1969); *In re* Torksi C., 918 N.E.2d 1218, 1230 (Ill. App. Ct. 2009); Hatcher v. Wachtel, 269 S.E.2d 849, 852 (W. Va. 1980); *Krol*, 344 A.2d at 302.

199. *See* PERLIN, *supra* note 54, § 2A-4.1. A concept of danger that requires a factfinder to take into account the probability, magnitude, and imminence of any harm helps to reconcile these competing interests of the state in protecting against harm and individual interest in liberty. It also creates a less arbitrary concept of danger by structuring an assessment process where the greater the magnitude, the less certainty of harm should be needed. *See* Commonwealth v. Nasasr, 406 N.E.2d 1286, 1291 (Mass. 1980). For example, a vast difference exists between someone who has access to guns and manifests homicidal ideation toward a specific potential victim and someone who lacks impulse control but has no history of violent behavior and does not manifest homicidal ideation. Certainly with the former commitment subject, a factfinder should not have to reach the same conclusion about the level of certainty and imminence as would the factfinder assessing the latter commitment subject.

200. Sherry Colb, *Insane Fear: The Discriminatory Category of "Mentally Ill and Dangerous"*, 25 NEW ENG. J. CRIM. & CIV. CONFINEMENT 341, 348 (1999). Two states have recently removed an imminence requirement from their commitment statutes. Monahan, *supra* note 47, at 401. An absence of an imminence requirement is particularly significant because in the civil commitment context, psychiatrists base most commitments on an assessment that a patient is dangerous because of an inability to meet his or her basic needs. *See supra* note 53 and accompanying text. Even if patients have been meeting their basic needs, if a psychiatrist opines a patient's symptoms render the patient at risk of suffering harm in the future, the absence of empirical data on the issue of one's inability to meet needs makes cross examination difficult.

danger amounts to a threat of harm to property, one must ask whether the potential harmful acts consist of property destruction that also places individuals at risk of harm or that simply place one at risk of losing money.[201] Hence, little question exists that the dangerousness criteria is sufficiently flexible or vague to allow considerable discretion in determining whether an individual satisfies the criteria.[202]

A determination of an individual's dangerousness differs from most fact-finding determinations. It is a forward-looking determination where a physician, at the very least, evaluates the likelihood of an allegedly mentally ill person causing harm to either self or others.[203] This differs from the traditional fact-finding in which the trier of fact must evaluate whether a set of facts occurred previously and apply this set of facts to a particular legal standard. Put another way, in criminal and in most civil contexts, the ultimate issue involves an application of past fact to law; in the civil commitment context, the trier of fact must apply facts to assess the likelihood of an event occurring in the future.[204]

Because one purpose of a civil commitment hearing is to assess the likelihood of a particular event occurring, rather than determining whether specific conduct has occurred, in the absence of definitive guidelines that incorporate all facets of a dangerousness determination, the trier of fact has

---

Coupled with the deference given to psychiatric opinions, see *supra* notes 138-48 and accompanying text, the absence of an imminence requirement makes it much easier for clinicians to justify an assessment of self-danger that may have little basis in fact. *See, e.g.*, Robert Simon, *The Myth of "Imminent" Violence In Psychiatry and the Law*, 75 U. CINN. L. REV. 631, 636 (2006) (recognizing a requirement of likely harm in the foreseeable future can range from ten minutes to ten years).

In *In re Commitment in Dennis H.*, 647 N.W.2d 851 (Wis. 2002), the court found a commitment statute was not unconstitutionally vague when it required, inter alia, a substantial probability that, if left untreated, the individual would suffer severe mental, emotional, or physical harm that would result in loss of ability to function independently in the community. However, the court never addressed whether the clause "function independently in the community" resulted in undue discretion in its application. For example, does the ability to sustain oneself by living in a homeless shelter constitute an ability to function independently in the community?

201. *See In re* H.G., 632 N.W.2d 458, 462-63 (N.D. 2001) (holding an insignificant financial injury resulting from poor business judgment was insufficient to satisfy the danger requirement).

202. Bagby et al., *supra* note 109, at 32; *see also* Steven Datlof, *The Law of Civil Commitment in Pennsylvania: Toward a Consistent Interpretation of the Mental Health Procedures Act*, 38 DUQ. L. REV. 1, 3, 18 (1999); Christyne Ferris, Note, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 VAND. L. REV. 959, 973 (2008) (stating without limiting criteria, the broad scope of the dangerousness standard renders it meaningless); Janus & Prentky, *supra* note 57, at 1449. For a comprehensive survey of the language of civil commitment statutes detailing the disparity in specificity in commitment statutes, see Steven Erickson et al., *Beyond Overt Violence: Wisconsin's Progressive Civil Commitment Statute as a Marker of a New Era in Mental Health Law*, 89 MARQ. L. REV. 359, 388 (2005).

203. *See supra* notes 35-36 and accompanying text.

204. *See* David Simpson, Jr., Note, *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241, 255 (1984).

far greater discretion to rule in a manner consistent with his or her value system, as opposed to applying fact and law in a neutral manner.[205] As one New York Judge candidly recognized when pleading with the appellate courts or legislature to clarify the meaning of posing a substantial "threat of harm," decisions to commit or release "were inevitably based upon my personal values and standards."[206]

Jurek v. Texas[207] does not compel a different result. In *Jurek*, the Supreme Court rejected a vagueness challenge to a death penalty statute that required a determination there was a probability the defendant would commit criminal acts of violence that would constitute a continuing threat to society.[208] However, no reasonable juror could believe the issue of imminence was a consideration in this determination: having concluded a defendant committed murder, the statute required a determination that the defendant would engage in violent, criminal conduct at any future time.[209] Likewise, because the statute required an assessment of a probability of violent, criminal conduct, no issue of magnitude existed for the jury.

A review of the few vagueness challenges to dangerousness requirements in state civil commitment statutes reveals that whether an application of the dangerousness requirement violates due process may depend on whether, to what degree, and how a state legislature has defined danger.[210] An Illinois appellate court held the definition of "dangerous conduct" in the state's commitment law is impermissibly vague and violates due process, even though the statute defined "dangerous conduct" as "threatening behavior or conduct that places another individual in reasonable expectation of being harmed, or a person's inability to provide, without the assistance of family or outside help, for his or her basic physical needs so as to guard himself or herself from serious harm."[211] On the other hand, another court

205. *Cf.* William J. Brennan, Jr., *Reason, Passion and "The Progress of Law,"* 10 CARDOZO L. REV. 3, 4-5 (1988); Paul Carrington, *Of Law and the River*, 34 J. LEGAL EDUC. 222, 226-27 (1984).

206. *Judge Sees Lack of Guidelines For Committing Mental Patients*, N.Y. L.J., November 27, 1987, at 1. Indeed, there is little question that any assessment of dangerousness contains a normative component through which a clinician reaches a conclusion that the level of risk posed is sufficiently great as to warrant the deprivation of liberty that civil commitment entails. *See* Nicholas Scurich & Richard John, *The Normative Threshold for Psychiatric Civil Commitment*, 50 JURIMETRICS J. 425, 427 (2010).

207. 428 U.S. 262 (1976).

208. *Jurek*, 428 U.S. at 267-68, 275-76.

209. *See id.* at 269.

210. *See* Simon v. Cook, 261 Fed. Appx. 873, 883 (6th Cir. 2008) (determining a statute that authorized police to detain a dangerous individual was not impermissibly vague because the statute defined dangerous as a "substantial physical harm or threat of substantial physical harm upon self, family or others").

211. *In re* Torksi C., 918 N.E.2d 1218, 1230 (Ill. App. Ct. 2009). The court reasoned the statute was impermissibly vague because it arguably authorized confinement in circumstances

has strongly suggested a statute authorizing confinement when an individual poses a "substantial risk of physical harm" satisfies due process, while a statute authorizing confinement when an individual "constitutes a danger" does not.[212] Likewise, "danger of physical harm" does not provide sufficient guidance to satisfy due process.[213] To summarize, whether individuals transported to a hospital's psychiatric emergency room for evaluation suffer a deprivation of liberty often depends on the comparative weight the particular examining physician gives to the competing interests of liberty and the need for treatment.[214] Until appellate courts impose limiting criteria

---

where the state does not have a legitimate interest in confining someone, such as when a person places another at risk of suffering emotional harm as a result of being subject to racial slurs. *Id*. at 1231.

212. *See* Recovery Northwest v. Thorslund, 851 P.2d 1259, 1260 (Wash. Ct. App. 1993).

213. *See* Mays v. State of Washington, 68 P.3d 1114, 1121 (Wash. Ct. App. 2003).

214. Admittedly, a number of other courts have rejected void for vagueness challenges to state civil commitment statutes. *See generally In re* LaBelle, 728 P.2d 138 (Wash. 1986); *In re* Maricopa County, 840 P.2d 1042 (Ariz. Ct. App. 1992). However, in neither case did the courts examine the risk of arbitrary enforcement created by a standard that permits, but does not require, utilization of the concepts of imminence and magnitude and gives physicians the opportunity to weigh the probability of harm against the need for treatment. Indeed, the court in *LaBelle* recognized utilization of the civil commitment process presented a danger of impermissibly imposing majoritarian values on a person's chosen lifestyle. *LaBelle*, 728 P.2d at 144. However, the *LaBelle* court held this danger was remedied by the requirement of recent, tangible evidence of a person's inability to meet one's basic needs that presented "a high probability of serious physical harm within the near future." *Id*. Not only are judges generally more informed about any narrowing of legal criteria than are physicians, but, notwithstanding the performance of many lawyers in the civil commitment process, see *supra* notes 152-57 and accompanying text, one would expect lawyers to educate those judges who are ignorant of the governing legal criteria. In the absence of good legal training and some sort of directive that physicians not only apply the commitment statute on its face but adhere to narrowing constructions by courts, physicians are left with a broad range of discretion when examining individuals in the psychiatric emergency room. Indeed, the court in *Maricopa County* upheld the commitment standard because "[t]he difficulty in expressing concepts [that would narrow and/or clarify governing substantive criteria] is particularly evident in mental health statutes." *Maricopa County*, 840 P.2d at 1050. The difficulty in articulating relevant mental health concepts does not justify permitting continued application of the statute. Rather, administrative directives must direct physicians to apply the standard in a uniform manner. Finally, the court in *In re Commitment of Curiel*, upheld a statute that authorized commitment if the court found it was "substantially probable" the committee would commit sexual violence. *See generally In re* Commitment of Curiel, 597 N.W.2d 697 (Wis. 1999). The *Curiel* court found its interpretation of the term "substantially probable" to mean "much more likely than not" meant individuals of common intelligence would not differ as to its applicability. *Id.* at 708-09.

In re Vanderblomen, while resolving a vagueness challenge to the constitutionality of a commitment statute, does not provide authority on this issue. *See generally In re* Vanderblomen, 956 P.2d 1320 (Kan. 1998). The patient in *Vanderblomen* asserted the statutory definition of mental illness violated the void for vagueness doctrine because mental illness required reference to the DSM-IV, a diagnostic guide published by the APA that modified the categories of mental disorders defined as mental illnesses. *Id.* at 1323. The challenge to the statute in question did not involve an assertion that the absence of any reference to the concepts of magnitude and imminence in connection to an assessment of dangerousness rendered the statute vague. *But see* Glatz v. Kort, 807 F.2d 1514, 1521 (10th Cir. 1986) (upholding the constitutionality of a law authorizing the release of an insanity acquitee only when the individual has no mental condition that would likely cause harm to be a danger to self or others); United States v. Schell*,* 692 F.2d 672, 675

on this standard, certifying physicians retain the ability to fit their legal findings to their desired clinical objectives.

VI. CORRECTING THE PROBLEMS: STEPS TO LIMIT THE INAPPROPRIATE INFLUENCE OF PSYCHIATRISTS

A. UTILIZE STRUCTURED CLINICAL EVALUATIONS TO LIMIT THE EXERCISE OF UNSTRUCTURED CLINICAL DISCRETION AT THE CERTIFICATION STAGE

To rectify the problems related to the exercise of unstructured clinical judgment when assessing risk, psychiatrists should base their opinions on empirically-based data.[215] For instance, they can rely on the use of the clinically adjusted actuarial method, which has been considered the most accurate method of assessing risk.[216] Literature suggests a number of ways to improve dangerousness assessments of patients facing civil commitment.[217] The clinically adjusted actuarial method involves the use of a statistically based formula with the clinician making adjustments based on the particular clinical aspects of the case.[218] Alternatively, the guided clinical approach requires a clinician to identify and incorporate into the evaluation process specific risk factors, but permits the clinician to weigh the factors in any manner he or she deems appropriate.[219] It may well be the clinically adjusted actuarial method and guided clinical approach improve the accuracy of the assessment process because they limit clinical

(10th Cir. 1982) (upholding a federal law requiring the imposition of increased punishment for dangerous special offenders). However, at least *Schell* appears to be distinguishable. In *Schell*, the court was making a determination of future harm only after a conviction. *Schell*, 692 F.2d at 675. A diminished liberty interest in this instance may well provide the government with greater latitude in taking steps to further its police power. *See* Gagnon v. Scarpelli, 411 U.S. 778, 789 n.12 (1973) (holding a person who possesses an absolute liberty interest and faces a loss of liberty is differently situated from an already-convicted defendant and entitled to a higher degree of protection).

215. *See, e.g.*, Borum, *supra* note 46, at 953 (stating structured and standardized risk assessment processes will improve accuracy); Dvoskin & Heilbrun, *supra* note 194, at 9; Caroline Mee & Harold Hall, *Risky Business: Assessing Dangerousness in Hawaii,* 24 U. HAW. L. REV. 63, 90-112 (2001) (detailing various empirically-based methods of assessing danger); Steadman, *supra* note 37, at 269 (detailing the usefulness of two tools in assessing risk of harm: the HCR-20 and the Violence Risk Assessment Guide).

216. *In re* Commitment of R.S., 773 A.2d 72, 80 (N.J. Super. Ct. App. Div. 2001). The clinically-adjusted actuarial method involves the use of a statistically-based formula with the clinician making adjustments based on the particular clinical aspects of the case. *See id.*

217. Admittedly, much of the literature addressing ways to improve the process of assessing danger does not involve the assessment of the civil commitment population. However, because all relevant literature involves the assessment of people with mental illness, one can expect that what empirical research involving the mentally ill population as a whole has found will prove instructive in the context of civil commitment.

218. *See id.*

219. *See* Scherr, *supra* note 42, at 21.

discretion while enabling clinicians to take into account significant particular aspects of any case.[220]

Two risk assessment scholars, Dale McNeil and Renee Binder, have aided clinicians who recognize the need to structure clinical judgment by developing a concise actuarial screening tool to aid in assessment of a patient's potential for violence.[221] The tool has correctly classified sixty-five percent of individuals assessed and demonstrates the potential for developing simple, easy-to-use actuarial type methods that enhance the accuracy of risk assessments.[222] Other, perhaps less simplistic, actuarial assessment tools that have been shown to enhance the accuracy of the assessment process consist of the HCR-20[223] and a classification tree that directs psychiatrists to analyze specific empirically-based factors when assessing risk.[224]

The use of some sort of checklist can help to eliminate a common problem in dangerousness assessments, which can be considered one-way evaluations of dangerousness: the examination of risk factors only. A risk factor is a measurable characterization of each subject in a specified population that precedes the outcome of interest and that can be used to divide the population into two groups: a high risk group, and a low risk group.[225] An evaluation of risk factors, but not protective factors, *i.e.*, factors that lower the risk of harm-causing behavior, is inherently inaccurate and constitutes an implicitly biased evaluation.[226]

---

220. *See* Binder & McNeil, *supra* note 115, at 1192 (stating assessment tools enhance evaluations by grounding assessments in variables associated with probability of harm); Litwack, *supra* note 59, at 414 (noting the use of actuarial or structured assessment tools ensures clinicians will consider certain relevant factors).

221. Dale McNiel & Renee Binder, *Screening for Risk of Inpatient Violence*, 18 LAW & HUM. BEHAV. 579, 584-85 (1994). This consists of a screening checklist that contains five items: physical attacks during the two-week period prior to admission; absence of suicidal behavior (attempts, gestures, or threats) in the two-week period prior to admission; diagnosis of schizophrenia or mania; male gender; and the status of currently married or living together. *See also* Ole Thienhaus & Melissa Piasecki, *Assessment of Psychiatric Patients' Risk of Violence Toward Others*, 49 PSYCHIATRIC SERVICES 1129, 1129-30 (1998) (recommending clinicians gather concrete sets of information when assessing risk of violence).

222. McNeil & Binder, *supra* note 221, at 584.

223. *See* Litwack, *supra* note 59, at 431. The HCR-20 is a risk assessment guide that requires a clinician to evaluate ten historical criteria, five clinical criteria, and five risk management criteria. *Id.* at 430.

224. *See* John Monahan et al., *Developing a Clinically Useful Actuarial Tool for Assessing Violence Risk*, 176 BRIT. J. PSYCHIATRY 312, 318 (2000).

225. Helena Kraemer et al., *Coming to Terms with the Terms of Risk*, 54 ARCHIVES GEN. PSYCHIATRY 337, 338 (1997).

226. *See* Rogers, *supra* note 145, at 598; *see also* Hanson, *supra* note 48, at 52-53 (discussing three plausible approaches to assessment of harm to others—guided clinical, pure actuarial, and adjusted actuarial—all of which require reference to specifically delineated factors).

No reason exists why similar clinicians cannot utilize similar checklists when their initial clinical impressions suggest a patient may pose a danger to himself by suicide or as a result of an inability to meet one's basic needs. Known risk factors related to suicide exist,[227] which should facilitate the utilization of a checklist related to suicide. In the absence of literature, mental health professionals, hospital administrators, and patients' lawyers should attempt to collaborate on a checklist that will guide the evaluation process when a clinician believes a patient may lack the ability to meet his or her needs. The use of structured clinical decision-making can help eliminate pretextual assessments of danger. Structured risk assessments require clinicians to apply an individual's history, symptoms, and behavior to a predetermined empirically-based set of criteria. Accordingly, clinicians will no longer be able to justify an assessment of danger on symptoms, behaviors, or history presented by a patient that best justify a determination sought to be reached prior to the beginning of the examination.[228]

Today, it is not uncommon to see hospital records containing forms with clearly delineated criteria that guide a clinical assessment of risk. However, psychiatrists complete these forms after a patient has been certified for commitment. The failure to require psychiatrists to use these forms at the certification stage facilitates the continued use of unstructured clinical judgment. It also sends a message to physicians that a careful, structured assessment of risk at the certification stage is not important; a careful assessment of risk is important only after certification of the patient has been completed. In other words, a careful assessment of risk is important for risk management consideration but not because the consequences of the assessment can significantly impact individual rights.

B. FOLLOWING CERTIFICATION, PROMPTLY PROVIDE COURT-APPOINTED EXPERT ASSISTANCE

When civil committees challenge their hospitalization, the committing hospital will offer, as evidence, expert testimony of a psychiatrist.[229] The

227. *See, e.g.*, MELTON ET AL., *supra* note 19, at 355-57.

228. *Cf.* Monahan, *supra* note 63, at 503.

229. *See, e.g.*, McGraw et al., *supra* note 89, at 289; Morris, *supra* note 138, at 331; Van Duizend & Zimmerman, *supra* note 89, at 258. In all of the forty-six hearings in New York about which the authored gathered data, the committing hospital presented expert psychiatric testimony. Likewise, in fifteen of the sixteen hearings in Dade County, the hospital presented medical testimony; the lone exception occurred when the hospital presented the patient's guardian as its lone witness. The pattern varied somewhat in Illinois. In Cook County, the committing hospital proffered the testimony of a psychologist in four out of four cases. In Kane County, the hospital presented a psychiatric expert in all four cases observed. In the four cases observed in Madison County, the hospital presented a psychiatrist once, a psychologist once, and a social worker twice. In the two cases that went to trial in Union County, the hospital presented a psychologist twice.

ability of psychiatrists to conclude a patient is dangerous when they want to provide treatment as a result of the amorphous nature of the concept of danger, and the significant reliance on this expert testimony by judges, places civil committees at a distinct disadvantage. Only the ability of committees to offer expert testimony of their own enables them to overcome this disadvantage; the failure to provide an opportunity to offer this evidence violates due process.

The Supreme Court has recognized, for all intents and purposes, civil commitment proceedings revolve around psychiatric and other expert testimony:

> There may be factual issues to resolve in a commitment proceeding, but the factual aspects represent only the beginning of the inquiry. Whether the individual is mentally ill and dangerous to either himself or others and is in need of confined therapy turns on the *meaning* of the facts which must be interpreted by expert psychiatrists and psychologists.[230]

That a committing hospital always employs psychiatrists in its attempt to prove its case indicates the use of psychiatric experts is a "necessit[y], not [a] luxur[y]."[231] Indeed, one Supreme Court Justice has recognized because commitment for compulsory psychiatric treatment involves medical issues, "a person possessing . . . [psychiatric or other mental health] . . . qualifycations normally would be preferred" to the assistance of an attorney.[232]

Lower state courts that have examined the issue have also recognized expert assistance may well be more important than the assistance of a lawyer:

> No matter how brilliant the lawyer may be, he is in no position to effectively contest the commitment proceedings because he has no way to rebut the testimony of the psychiatrist from the institution who has already certified to the patient's insanity . . . .

230. Addington v. Texas, 441 U.S. 418, 429 (1979).

231. Gideon v. Wainwright, 372 U.S. 335, 344 (1963).

232. Vitek v. Jones, 445 U.S. 480, 500 (Powell, J., concurring); *see also* United States v. Johnson, 238 F.2d 565, 572 (1956) (Frank, J., dissenting) ("The best lawyer in the world cannot competently defend an accused person if the lawyer cannot obtain existing evidence crucial to the defense [such as an expert] . . . . In such circumstances, if the government does not supply the funds, justice is denied the poor—and represents but an upper bracket privilege[.]"); Proctor v. Harris, 413 F.2d 383, 389 (D.C. Cir. 1969) ("[I]f an indigent patient needs and is entitled to a lawyer, far more may he also need the assistance of a psychiatrist in the preparation of his case.); David Medine, *The Constitutional Right to Expert Assistance for Indigents in Civil Cases,* 41 HASTINGS L.J. 281, 329 (1990) (recognizing in a number of settings, an expert is more valuable to a litigant than an attorney).

> This court has had enough experience to know that psychiatrists differ very definitely in their evaluations and diagnoses of mental illness. In a commitment proceeding where the court is in effect bound by the expertise of the psychiatrist, the right to counsel is of little value without a concurrent right to an independent psychiatric examination.[233]
>
> Another court noted:
>
> "[T]he rights to counsel and to be heard in a civil commitment proceeding will often fail to adequately protect the respondent unless he is able to secure the advice or testimony of his own examiner. Otherwise, the respondent and his lawyer will have difficulty in rebutting or exposing errors and other deficiencies in the testimony of the expert state witnesses."
>
> . . . Where the respondent's liberty is at stake, the assistance of an independent expert is essential to a fair trial and impartial hearing.[234]

In *Ake v. Oklahoma,*[235] the Supreme Court held a criminal defendant who raised the insanity defense was entitled to a psychiatric expert to assist in the preparation and presentation of the case.[236] An application of *Ake* to the civil commitment context warrants the conclusion that involuntarily hospitalized individuals who challenge their confinement are also entitled to this assistance. A court must afford a litigant an "opportunity to participate meaningfully in a judicial proceeding in which his liberty is at stake."[237] This right to meaningful participation applies to civil proceedings that are "quasi-criminal" in nature.[238] While the Supreme Court has never defined "quasi-criminal," the state involvement in commitment proceedings and the constitutionally protected interests, such as liberty, that are at stake in a commitment proceeding suggest that commitment hearings are "quasi-criminal" in nature.[239]

---

233. *In re* Gannon, 301 A.2d 493, 494 (N.J. Super. Ct. App. Div. 1973).

234. *In re* Williams, 478 N.E.2d 867, 869 (Ill. App. Ct. 1985) (quoting GOVERNOR'S COMM'N FOR REVISION OF THE MENTAL HEALTH CODE OF ILL., REPORT 60 (1976)) (citation omitted); *see also* Commonwealth v. Curnette, 871 A.2d 839, 843 (Pa. Super. Ct. 2005) (holding an indigent individual facing civil commitment is entitled to expert assistance in a sexually violent predator civil commitment proceeding).

235. 470 U.S. 68 (1985).

236. *Ake*, 470 U.S. at 83.

237. *Id.* at 76.

238. *Id.*

239. *See* Little v. Streater, 452 U.S. 1, 9-10 (1981) (holding a paternity suit was quasi-criminal because state involvement "undeniably pervaded" the proceeding); *In re* Ruffalo, 390 U.S. 544, 551 (1968) (determining disbarment proceedings, which require due process protection, "are adversary proceedings of a quasi-criminal nature"). Civil commitment proceedings are far

However, the concept of meaningful participation is only a starting point when determining whether due process requires the provision of expert assistance. Rather, in determining whether due process requires the provision of expert assistance, a court must examine the private interest affected by the action of the state, the governmental interest affected if a court provides the procedural right in question, the probable value of the safeguard sought, and the risk of an erroneous deprivation of the appropriate interest if the safeguard is not provided.[240]

As noted, civil commitment "produces a massive curtailment of liberty;"[241] an "almost uniquely compelling" interest,[242] which the Supreme Court has characterized as a fundamental right.[243] While the Supreme Court has held the Due Process Clause requires the provision of an expert psychiatrist to an indigent criminal defendant who places his sanity in issue, the civil committee possesses a far more significant liberty interest than does the criminal defendant. The criminal defendant who successfully utilizes expert assistance to win a verdict of not guilty or not responsible by reason of insanity will nevertheless suffer a deprivation of liberty in a psychiatric hospital instead of prison.[244] On the other hand, a civil committee who prevails at his commitment hearing obtains outright release. Indeed, the Supreme Court has concluded liberty differs qualitatively from other constitutionally protected interests, requiring greater procedural protections than other constitutional interests.[245] An involuntarily hospitalized patient also suffers the stigma of the court system labeling him or her as mentally ill and dangerous, which "can have a very significant impact" on the committee.[246] Finally, involuntary hospitalization can subject the civil committee to liability for care and treatment charges.[247]

---

more quasi-criminal than these proceedings because the state will invoke its police or *parens patriae* powers to confine those deemed to pose a threat to society or themselves. *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1222 (1972).

240. *Ake*, 470 U.S. at 77.

241. Vitek v. Jones, 445 U.S. 480, 491 (1980) (quoting Humphrey v. Cady, 405 U.S. 504, 509 (1972)).

242. *Ake*, 470 U.S. at 77.

243. *See* Foucha v. Louisiana, 504 U.S. 71, 86 (1992).

244. *See, e.g.*, N.Y. CRIM. PROC. LAW § 330.20(2) (McKinney 1996); Jones v. United States, 463 U.S. 354, 364 (1983).

245. *See, e.g.*, Lassiter v. Dep't of Soc. Servs., 452 U.S. 18, 26-27 (1981) (holding the right to counsel presumptively attaches only when an indigent litigant could face a loss of physical liberty).

246. Addington v. Texas, 441 U.S. 418, 428 (1979).

247. *See, e.g.*, N.Y. MENTAL HYG. LAW § 43.01 (McKinney 1989) (authorizing the New York State Office of Mental Health to assess care and treatment charges); Rodriguez v. City of N.Y., 861 F. Supp. 1173, 1188-89 (S.D.N.Y. 1994), *rev'd on other grounds*, 72 F.3d 1051 (2d Cir. 1995); Chill v. Miss. Hosp. Reimbursement Comm'n, 429 So.2d 574, 580-81 (Miss. 1983); Musselman v. Dept' of Soc. & Health Servs., 134 P.3d 248, 251 (Wash. Ct. App. 2006).

The government interest in not providing expert assistance is ambiguous at best. This is particularly true because of the different governmental entities whose interests are implicated by the appointment of a psychiatric expert. One can assume payment for a psychiatric expert comes from the budget of a state's office of court administration. While this governmental agency has a financial interest in not spending money for experts, this interest is "not substantial."[248] On the other hand, the provision of expert assistance furthers the interests of the state agency that operates a state's psychiatric hospitals and the municipalities that operate psychiatric wards or entire facilities. Because the provision of psychiatric assistance enhances the accuracy of civil commitment proceedings,[249] psychiatric assistance furthers the governmental interest "in confining its costly mental health facilities to cases of genuine need"[250] and achieving just and accurate adjudications within the judicial process.[251]

The appointment of a psychiatric expert is of great value to a civil committee; the risk of an erroneous deprivation of liberty without the expert is significant. What the Supreme Court described in *Ake* in the context of a mentally ill defendant asserting the insanity defense applies with equal, if not greater, force in the civil commitment context: "[P]sychiatrists gather facts, through professional examination, interviews, and elsewhere, that they will share with the judge or jury; they analyze the information gathered and from it draw plausible conclusions."[252] Similarly, the Supreme Court held for the putative insanity acquittee, expert testimony was a necessity, and the defendant may be at an unfair advantage "if he is unable because of poverty to parry by his own witnesses the thrusts of those against him."[253] It is inconceivable that a different conclusion can be reached for a person civilly committed. First, while doctors invariably testify that a patient is dangerous, the lack of accuracy in dangerousness assessments warrants the

248. Ake v. Oklahoma, 470 U.S. 68, 79 (1985); *see also* Tennessee v. Lane, 541 U.S. 509, 533 (2004) ("[O]rdinary considerations of cost and convenience alone cannot justify a State's failure to provide individuals with a meaningful right of access to the courts."); Little v. Streater, 452 U.S. 1, 16 (1981) (noting a state's monetary interest in not providing blood grouping "is hardly significant" compared to the interests of both the individual participants and the state in obtaining an accurate determination).

249. *See infra* notes 256-58 and accompanying text.

250. *See* Parham v. J.R., 442 U.S. 585, 604-05 (1979). To illustrate, one study in New York found more accurate psychiatric assessments can result in diverting to patients living in the community approximately $40,000 per patient wrongfully determined to require inpatient hospitalization. Alan Lipton & Franklin Simon, *Psychiatric Diagnosis in a State Hospital: Manhattan State Revisited*, 36 HOSP. & COMMUNITY PSYCHIATRY 368, 372 (1985).

251. *See* Medine, *supra* note 232, at 329.

252. *Ake*, 470 U.S. at 80.

253. *Id.* at 82 n.8 (internal quotations omitted).

need for a second opinion.[254] If judges carefully scrutinized expert testimony, the absence of a court-appointed expert might not create a particularly significant risk of erroneous deprivations of liberty. However, it is clear judges do not carefully scrutinize psychiatric testimony.[255]

It is fair to ask, if psychiatrists frequently lack accuracy in their assessments of danger, why a court-appointed expert could reach a more accurate assessment about a person's dangerousness than a psychiatrist who testifies on behalf of the committing hospital. First, the doctor-patient relationship does not exist between the court-appointed expert and the civil committee; this relationship may result in an assessment of danger as a function of a desire to treat.[256] More significantly, even if the conclusions of the court-appointed expert are no more inherently accurate than the hospital physician, when two doctors reach the same conclusion about an individual's dangerousness, then one can feel more confident in the assessment of the hospital physician than if no other doctor reached the same conclusion. If the court-appointed expert reaches a different conclusion about a committee's dangerousness than the hospital physician, the differing opinions will force a judge to scrutinize the opinions of both experts to determine which opinion should carry more weight.

Finally, the need to combat potentially biased testimony is another consideration when assessing whether the Constitution requires the provision of expert assistance.[257] Indeed, perhaps more than any other witness in any other litigation, the psychiatrist has the ability to color testimony to reach the conclusion he or she wishes—that the patient is dangerous. A lay witness must testify to observations. Experts must support testimony through detailed methodology and, in the field of science, empirical support. However, because of both the lack of empirical data related to short-

254. *See supra* notes 44-56 and accompanying text; *see also Ake*, 470 U.S. at 81 (noting psychiatrists frequently disagree on an individual's dangerousness); Addington v. Texas, 441 U.S. 418, 429 (1979) (discussing the "[l]ack of certainty and the fallibility of psychiatric diagnosis"); Lipton & Simon, *supra* note 250, at 370 (stating hospital psychiatrists at one state hospital incorrectly diagnosed seventy-three out of eighty-nine patients as schizophrenic, a diagnosis that may carry an incorrect prognosis for long-term hospitalization).

255. *See supra* notes 134-46 and accompanying text; *see also* MELTON ET AL., *supra* note 19, at 350 (suggesting the use of a second physician in court may reduce the probability of an erroneous commitment as a result of uncritical acceptance of a lone doctor's testimony); Morris et al., *supra* note 77, at 200 (discussing a study finding judges agreed with clinicians' assessments of danger in 327 out of 328 cases).

256. *See supra* notes 76-77 and accompanying text. Admittedly, the patient's treating doctor may not testify in court. *See supra* notes 174-76 and accompanying text. However, in these situations, the court-appointed expert may not face the same institutional loyalties or pressures that might compromise an assessment of danger, such as testifying against the clinical positions taken by a colleague.

257. *See* Little v. Streater, 452 U.S 1, 14 (1981) (recognizing the utility of expert testimony in combating the strong self-interest of litigants that could color testimony in paternity litigation).

term risk, particularly whether a patient can meet his basic needs, and the vague and value-laden nature of the dangerousness standard,[258] when psychiatrists wish to reach a conclusion a person is dangerous, there is little to deter the expert from reaching this conclusion.

An application of the *Ake* standard should have resulted in any court looking at this issue and concluding the Due Process Clause requires the provision of expert assistance to a civil committee.[259] The one federal court that addressed this issue ruled otherwise. In *Goetz v. Crosson*, the court held due process requires the appointment of a psychiatric expert to assist a civil committee only in those specific instances when a committee's attorney can detail reasons why an expert is needed to educate him or her in particular aspects of a case.[260] The court further held due process requires the appointment of an "independent" psychiatrist, an expert who will serve the court and be available to testify for either side in the commitment hearing, when the committee is indigent and the trier of fact determines he or she cannot accurately assess whether a patient meets the civil commitment criteria in the absence of an expert to provide information to the court.[261]

The court first noted the results of a civil commitment hearing impact more than a committee's interest in liberty, stigma, and paying for hospitalization; a civil committee possesses an interest in receiving treatment for one's mental illness.[262] The committee also has an interest in avoiding situations that both place the committee at risk of harm or subject the committee to incarceration or acts of reprisal by third-parties.[263] The court also intimated the provision of expert assistance will result in some mentally ill individuals not receiving treatment.[264] The court concluded the provision of experts will result in fewer commitments, though a decrease in commitments differs from an increase in erroneous adjudications, and the court-appointed expert will not always be correct when testifying for the patient.[265]

The court further differentiated civil commitment proceedings from a criminal trial, concluding that in the commitment setting, the interests of the parties are not entirely adverse, which lessens the imperative that court-

258. *See supra* notes 54, 206 and accompanying text.

259. One could view the right to expert assistance as part of the right to effective assistance of counsel that necessarily includes the right to reasonably necessary ancillary services. *See* Waltz v. Zumwalt, 213 Cal. Rptr. 529, 531 (Cal. Ct. App. 1985).

260. Goetz v. Crosson (*Goetz I*), 967 F.2d 29, 35 (2d Cir. 1992).

261. *Id.* at 36.

262. *Id.* at 33.

263. *Id.* at 33.

264. *Id.* at 34.

265. *Id.*

appointed experts arrive at the most accurate assessment possible.[266] Moreover, the court-appointed neutral expert fulfills the most important function of the *Ake*-type expert—providing testimony favorable to the committee if the doctor's conclusions warrant this testimony.[267] Finally, the court expressed confidence that lawyers for civil committees could develop a sufficient level of expertise in the field of psychiatry to render unnecessary the services of an expert to assist in the preparation and presentation of the committee's case.[268]

The rationale adopted by the Second Circuit to avoid applying *Ake* in a straightforward manner cannot withstand scrutiny. Without citing any authority, the court assumed state court judges lack the ability to parse conflicting psychiatric testimony. While ample literature exists detailing what some—including this author—believe constitutes poor performance by many state court judges who conduct civil commitment hearings,[269] one would expect the addition of contrasting expert testimony would facilitate a discontinuation of the abdication of the decision-making function by the courts, if for no other reason than a court must determine which expert provided more persuasive testimony. As the Second Circuit itself recognized, the underlying premise of the adversary system is if counsel for each party vigorously represents their clients to the best of their ability, this action should result generally in an accurate resolution of the case.[270] The Second Circuit cited no reason to believe otherwise in the civil commitment context.

Furthermore, the need for lawyers to develop expertise does not justify the appointment of an expert for the court in lieu of one for the civil committee.[271] If the appointment of an expert to assist the court, as opposed to

266. *Id.*

267. *Id.* at 35.

268. *Id.*

269. *See supra* notes 138-48 and accompanying text.

270. *See Goetz I*, 967 F.2d at 34 (noting competing psychiatric testimony enables the fact-finder "to make its most accurate determination of the truth on the issue") (internal quotations omitted). However, the court concluded because civil commitment proceedings were not completely adversarial in nature, the logic underlying the "battle of the experts" did not hold in the civil commitment process. *Id.* This statement is disingenuous. The logic underlying how a battle of the experts enhances the truth finding process applies regardless of the degree of adversity between the parties. To what degree a court should attempt to enhance the truth finding process is another question.

271. It may be that regardless of the development of expertise, counsel cannot provide the same level of cross-examination as he or she would with the assistance of an expert. *See* John West, Note, *Expert Services and the Indigent Criminal Defendant: The Constitutional Mandate of* Ake v. Oklahoma, 84 MICH. L. REV. 1326, 1353-54 (1986). As one authority has asserted, in order for attorneys to provide effective cross-examination, they must develop expertise through, inter alia, consultation with their own experts. *Id.* at 1355 (citing 2 F. LANE, GOLDSTEIN TRIAL TECHNIQUE § 14.23 (3d ed. 1985)). Even if the Due Process Clause does not require an optimal

the civil committee, furthered any significant governmental interest, then advantages resulting from the appointment of an expert to assist the committee might not be warranted. However, the interest in saving money, which is the only legitimate government interest implicated by the appointment of an expert, is essentially the same regardless of what type of expert a court appoints.[272]

Finally, the Second Circuit's willingness to treat commitment proceedings as less than fully adversarial is also questionable. In reaching this conclusion, the court relied in substantial part on the recognition that "[i]t cannot be said . . . that it is much better for a mentally ill person to 'go free' than for a mentally normal person to be committed."[273] However, this consideration is pertinent when determining the proper burden of proof in a commitment hearing because the burden of proof serves, inter alia, to allocate the risk of error in any judicial proceeding.[274] It has no relevance when examining the constitutional status of a procedural protection aimed at enhancing the accuracy of the judicial determination at issue. Regardless of how the risk of error should be allocated, "an erroneous confinement should be avoided in the first instance."[275]

It is not entirely clear why the Second Circuit believed a hospital's desire to provide treatment justified a less than completely adversarial trial process. Did the court believe even if commitment proceedings resulted in the confinement of mentally ill individuals who were erroneously deemed dangerous, the treatment provided to the individuals rendered wrongful hospitalization more tolerable than a wrongful conviction? The premise assumes all individuals subject to the civil commitment process suffer from mental illness and will benefit from treatment; a premise that is certainly questionable.[276] Accordingly, any decision to justify reduced procedural

level of cross-examination, the relative equality of access to assistance at the trial level between a committing hospital and a patient should constitute a factor in the overall due process analysis, particularly when little countervailing interests exist in providing a neutral expert as opposed to a witness for the civil committee.

272. The role of a consultant expert would require approximately the same amount of time as would the role of an independent expert. The time spent examining the civil committee, reviewing records, and perhaps talking to others is the same in both roles. The amount of travel time and appearance time is approximately the same. The only difference consists of the ability of an independent expert to leave the courthouse following his testimony while a consultant expert would remain to assist throughout the entire hearing. Admittedly, the role of a consultant would require the expert to engage in case discussion and preparation with the civil committee's attorney. However, this constitutes a small percentage of the time spent by the expert. Hence, any difference in the cost of a consultant expert as compared to the cost of an independent expert is de minimus.

273. *Goetz I*, 967 F.2d at 35 (quoting Addington v. Texas, 441 U.S. 418, 429 (1979)).

274. *Addington*, 441 U.S. at 423.

275. *Id.* at 428.

276. *See* MELTON ET AL., *supra* note 19, at 351 (suggesting the stigma and institutional dependency resulting from hospitalization may outweigh the benefits of treatment).

safeguards because the government acts in the best interest of the committee must be "candidly appraised" and is particularly troubling in "light of the wide divergence of medical opinion regarding the diagnosis of and proper therapy for mental abnormalities."[277]

Because of the often questionable consequences of institutional treatment, it is reasonable to conclude a wrongful involuntary hospitalization will be, at times, more pernicious than a wrongful conviction. This is so for no other reason than psychiatric hospitals subject civil committees to "intrusive inquiries into . . . [their] . . . innermost thoughts"[278] through the use of mind-altering medication that produces many debilitating side effects.[279]

Finally, by limiting the provision of an expert to serve the court to only those cases in which the court deems the appointment necessary for a reliable assessment of the committee, the Second Circuit placed the committees in a particularly tenuous position. Primarily because judges overvalue psychiatric testimony,[280] which also necessarily means courts undervalue lay evidence, civil committees may require expert testimony just to explain why a reliable assessment of his psychiatric condition requires independent expert testimony. The plaintiffs in *Goetz* raised a second issue of importance in developing a mechanism to provide expert testimony to assist individuals in the commitment process: the permissible period of delay resulting from the appointment of an expert. The *Goetz* plaintiffs litigated this issue following the remand of the case by the Second Circuit, as the appointment of the court expert resulted in delays of four to six weeks.[281] A review of pertinent law demonstrates that a failure to provide a timely commitment hearing when a court appoints an expert violates the Constitution.[282]

277. O'Connor v. Donaldson, 422 U.S. 563, 586-87 (1975) (Burger, C.J., concurring).

278. Heller v. Doe, 509 U.S. 312, 324 (1993).

279. Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982).

280. *See supra* notes 138-39 and accompanying text.

281. Goetz v. Crosson (*Goetz II*), 41 F.3d 800, 803 (2d Cir. 1994).

282. It is difficult to set forth a bright-line rule regarding the point at which a delay will violate due process because courts are reluctant to measure due process requirements in a fixed term of days. *See* Project Release v. Prevost, 722 F.2d 960, 975 (2d Cir. 1983). However, due process is "flexible and calls for such procedural protections as the particular situation demands[.]" *Id.* (internal quotations omitted). Thus, due process requires courts to take steps to develop a list of experts—similar to a list of lawyers—who are available for appointment to satisfy the constraints of *Gideon v. Wainwright*, 372 U.S. 335 (1963). In so doing, due process requires courts to spend enough money to induce experts to serve on the panel and remain available to promptly examine patients and testify. *See, e.g.*, Nicholson v. Williams, 203 F. Supp. 2d 153, 257 (E.D.N.Y. 2002); N.Y. Cnty. Lawyers' Ass'n v. State, 196 Misc.2d 761, 790 (N.Y. Sup. Ct. 2003) (holding the judicial system violates due process when it fails to effectively provide constitutionally required procedural protections because of the amount of money it pays professionals to provide services).

The government may not condition the exercise of a right or privilege upon the forfeiture of another right or privilege.[283] State law conferred upon the plaintiff class in *Goetz* a right to a hearing within five days.[284] Furthermore, many courts have recognized the Constitution requires the right to a hearing within a period shorter than six weeks.[285] Hence, requiring civil committees to wait up to six weeks for a hearing with the opportunity to present favorable expert testimony can be construed as conditioning the exercise of the right to expert assistance upon the forfeiture of the right to a prompt hearing and/or a violation of basic due process tenets that require a prompt hearing in order to challenge one's hospitalization.[286]

Significant delays that result from the appointment of an expert violate another constitutional doctrine: the government may not institute a practice that chills the assertion of a constitutional right.[287] An impermissible chill exists when requiring patients to choose between a hearing within five days and requesting the appointment of an independent psychiatrist "impairs to an appreciable extent any of the policies behind the rights involved."[288]

283. Dolan v. City of Tigard, 512 U.S. 374, 385 (1994); *see also* Thomas v. Review Bd. of Ind. Emp't Sec. Div., 450 U.S. 707, 716-17 (1981).

284. *See* N.Y. MENTAL HYG. LAW § 9.31 (McKinney 2006).

285. *See, e.g.*, Lessard v. Schmidt, 349 F. Supp. 1078, 1091-92 (D. Wis. 1972), *vacated and remanded on other grounds*, 414 U.S. 473 (1974), *reinstated*, 379 F. Supp. 1376 (D. Wis. 1974), *vacated and remanded on other grounds,* 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (D. Wis. 1976) (requiring a judicial hearing within fourteen days); Kendall v. True, 391 F. Supp. 413, 419 (D. Ky. 1975) (requiring a court hearing within twenty-one days of confinement; requiring a probable cause hearing initially); Lynch v. Baxley, 386 F. Supp. 378, 388 (D. Ala. 1974) (requiring a full judicial hearing within thirty days, but a probable cause hearing within seven days).

286. As two officials of the National Center for State Courts recognized, a litigant whose liberty is at stake should not forfeit statutory or constitutionally imposed standards governing speedy trial provisions simply because the litigant requires the use of a psychiatric expert. *See* Pamela Casey & Ingo Keilitz, *An Examination of Mental Health Expert Assistance Provided to Indigent Criminal Defendants: Organization, Administration and Fiscal Management*, 34 N.Y. L. SCH. L. REV. 19, 106-07 (1989).

287. *See, e.g.*, United States v. Jackson, 390 U.S. 570, 581-82 (1968); United States v. Glover, 588 F.2d 876, 878 (2d Cir. 1978) (examining whether a statute that permits a court to impose the costs of prosecution chills a defendants' assertion of the right to stand trial). Although the impermissible chill argument is similar to the argument that the excessive delays resulting from the appointment of an expert impermissibly conditions the right to expert testimony on the waiver of the right to a prompt hearing, these arguments are distinct. The latter argument is based upon a line of cases that prohibit the state from requiring an individual to choose between one of two rights or privileges, both of which an individual is entitled to exercise. The "chill" argument is based upon a line of cases that hold the government may not unduly discourage the exercise of one's constitutional right by imposing an unwarranted penalty that significantly deters an individual from exercising such right. *See, e.g.*, *Jackson*, 390 U.S. at 581-82; *Glover*, 588 F.2d at 878.

288. Chaffin v. Stynchcombe, 412 U.S. 17, 32 (1973). The right to a prompt hearing furthers the individual interest in avoiding unnecessary confinement and the possible liability for hospital charges. *See supra* notes 241, 247 and accompanying text. It also furthers the governmental interest in limiting inpatient mental health services to cases of genuine need. *See supra* note 250 and accompanying text.

However, in *Goetz v. Crosson* (*Goetz II*),[289] the Second Circuit failed to address these issues.[290] Rather, the court concluded because of the lack of available experts, and the failure of the plaintiffs to provide a meaningful remedy to correct the problem, the district court did not err in finding four to six week delays did not violate the rights of civil committees.[291] However, in so ruling, the court ignored the firmly established distinction between a constitutional violation and the remedy needed to correct it.[292]

Until state courts implement a plan that guarantees civil committees with such assistance, the committees will remain severely disadvantaged when they challenge initial dangerousness determinations by psychiatrists. Any such plan must require psychiatrists to commit to examine patients and appear on the first scheduled date of the proceeding, while understanding the appointment requires them to assist the civil committee and his counsel. If and/or when civil committees in other jurisdictions raise challenges similar to those in *Goetz I* and *Goetz II*, the courts should reject those cases as persuasive authority.

C. PROHIBIT EXPERTS FROM RENDERING OPINIONS ABOUT AN INDIVIDUAL'S DANGEROUSNESS BASED ON UNSTRUCTURED CLINICAL JUDGMENT

Whether a psychiatrist, in testifying, "predicts" that a civil committee will likely cause harm or "assesses" the level of risk posed by the committee as sufficiently great to render him or her dangerous, the expert renders expert testimony on the ultimate issue of danger. Numerous authorities have asserted psychiatrists should not render opinion testimony about an individual's dangerousness.[293] More significantly, there exists support in

---

Delaying the commitment hearing many weeks clearly lessens the remedial impact of a hearing that should correct errors in the initial decision by one or more physicians to confine an individual. If requiring indigent defendants to reimburse the government for the cost of court-appointed counsel impermissibly chills the right to court-appointed counsel, *see* Olson v. James, 603 F.2d 150, 155 (10th Cir. 1979); Fitch v. Belshaw, 581 F. Supp. 273, 276 (D. Or. 1984), any plan that significantly penalizes a mentally ill individual for seeking favorable expert testimony poses significant concerns. Likewise, if undue delays in the appellate criminal process violate due process, *see* Cody v. Henderson, 936 F.2d 715, 719 (2d Cir. 1991), or other proceedings in which a constitutional interest is at stake, *see* Kraebel v. Dep't of Hous. Pres. & Dev., 959 F.2d 395, 405 (2d Cir. 1992), the same result should apply when one must wait an excessive amount of time in a psychiatric hospital before challenging one's confinement.

289. 41 F.3d 800 (2d Cir. 1994).

290. *Goetz II*, 41 F.3d at 803-05.

291. *Id.* at 804-05.

292. Swann v. Charlotte-Mecklenburg Bd. of Educ., 402 U.S. 1, 15-16 (1971).

293. *See, e.g.*, MELTON ET AL., *supra* note 19, at 350; Robert Schopp et al., *Expert Testimony and Sexual Predator Statutes After Hendricks,* 6 EXPERT EVIDENCE 1, 15 (1998); Robert Schopp & Michael Quattrocchi, *Predicting The Present: Expert Testimony and Civil Commitment*, 13 BEHAV. SCI. & L. 159, 160 (1993).

the law for prohibiting experts from rendering opinions about an individual's dangerousness.

The Supreme Court's opinions in *Daubert v. Merrell Dow Pharmaceuticals*[294] and *Kumho Tire Co. v. Carmichael*[295] established the standards governing expert testimony in federal court.[296] Numerous states have adopted the *Daubert* criteria.[297] The standard adopted in *Frye v. United States*[298] continues to serve as the law governing expert testimony in other jurisdictions.[299] An application of either standard requires courts to rule psychiatrists should not testify a patient is or is not "dangerous" when these clinicians base their opinion on clinical judgment alone. This is the case whether the expert seeks to testify the patient poses a danger to others, poses a danger to self because of an inability to meet his or her basic needs, or is dangerous because of a threat of suicide.

Daubert requires a trial judge to consider the following criteria to determine the admissibility of expert opinions: whether the scientific theory or technique can be, and has been, tested;[300] whether the theory or technique has been subject to peer review and publication; the known rate of error for any particular technique; and the general rate of acceptance within the relevant scientific community.[301] A court can also consider whether existing standards control the technique's operation.[302] As for assessments of danger based on a determination that a patient lacks the ability to meet his or her needs, there has been no testing whatsoever to determine what factors correlate to a heightened risk of self-harm.[303]

294. 509 U.S. 579 (1993).

295. 526 U.S. 137 (1999).

296. *Daubert* addressed the issue of the admissibility of scientific testimony. *See Daubert*, 509 U.S. at 593. *Kumho Tire* applied *Daubert* to all expert testimony. *See Kumho Tire*, 526 U.S. at 147-48. Hence, *Kumho Tire* eliminates the need to address the rather thorny question of whether psychiatry is a science, although one court has characterized it as an art rather than a science. *See* People v. Stoll, 49 Cal.3d 1136, 1159 (Cal. Ct. App. 1989).

297. *Post Daubert Standards for Admissibility of Scientific and Other Expert Evidence in State Courts*, 90 A.L.R.5th 453 §§ 12-13 (2001) [hereinafter *Post Daubert Standards*].

298. 293 F. 1013 (D.C. Cir. 1923).

299. *Post Daubert Standards*, *supra* note 297, §§ 12-13.

300. *Kumho Tire* makes clear that a trial judge can also consider whether any theory or technique underlying specialized, but non-scientific, knowledge can be, and has been, tested. *See Kumho Tire*, 526 U.S. at 149.

301. *Daubert*, 509 U.S. at 594.

302. *Kumho Tire*, 526 U.S. at 149.

303. *See supra* note 54 and accompanying text. A risk factor is a variable that correlates with a projected outcome and the variable precedes the outcome, although a causal relationship does not necessarily exist between the variable and the outcome. *See* Monahan, *supra* note 46, at 905-06 n.27. Viewed another way, "[a] correlation is the statistical degree of relationship between two variables." Erica Beecher-Monas & Edgar Garcia-Rill, *Danger at the Edge of Chaos: Predicting Violent Behavior in a Post-Daubert World*, 24 CARDOZO L. REV. 1845, 1860-61 n.91 (2003).

Although not applying *Daubert*, one court concluded expert testimony lacked competence when the expert relied on risk factors derived from clinical judgment not based on any scientific research or principles accepted in the psychological community.[304]

Likewise, there have been virtually no publications relating to the assessment process pertaining to one's inability to meet one's needs.[305] Moreover, while there is no known rate of error, literature suggests psychiatrists lack the ability to determine who can manage in the community in the absence of inpatient treatment.[306] Furthermore, empirical data relating to the assessment of violence risk establishes clinical evaluations alone are far less accurate than both actuarial assessments and assessments where an actuarial assessment guides the clinical process.[307] There is general acceptance of clinical assessments in the sense that the psychiatric profession continues to engage in them, notwithstanding the general criticism of the process. Finally, no standards exist to control the manner in which psychiatrists assess one's ability to meet one's needs.

Empirical literature detailing risk factors for suicide exists.[308] To the extent literature has assessed the accuracy of clinical assessments of danger, the low base rate of suicide behavior results in inaccurate assessments of danger.[309] As in the case of assessing one's ability to meet needs, the psychiatric profession engages in the practice, but the profession has imposed no controls over the manner in which psychiatrists conduct the assessments.

The application of the *Daubert* criteria to assessments of the risk of harm to others does not warrant a different result in connection with an unstructured assessment of danger. First, a slightly better-than-chance level of success[310] should not satisfy the requirement of evidentiary reliability as to warrant admissibility. When one compares the slightly better-than-chance success rate with the significant concordance rate between opinion

304. *See In re* Coffel, 117 S.W.3d 116, 129 (Mo. Ct. App. 2003).

305. One set of authorities has detailed a number of considerations for clinicians to examine when assessing one's ability to meet his needs. *See* MELTON ET AL., *supra* note 19, at 358. These criteria appear to consist of practical, common sense factors that enable clinicians to draw logical inferences about a person's ability to meet his or her needs. However, they were not based on empirical studies. Two authorities contend testifying clinicians should limit any assertion that a civil committee is dangerous to those situations where the civil committee presents similar characteristics to subjects in studies that serve as the predictive model for the testifying expert. *See* Thomas Grisso & Paul S. Appelbaum, *Is it Unethical to Offer Predictions of Future Violence*, 16 LAW & HUM. BEHAV. 621, 624 n.4 (1992). As noted, no such models exist today.

306. *See* Morse, *supra* note 76, at 596. Although Professor Morse detailed this lack of skill over thirty years ago, the author is not aware of any more recent research to the contrary.

307. *See supra* notes 58-59 and accompanying text.

308. *See, e.g.*, MELTON ET AL., *supra* note 19, at 355-57.

309. *See, e.g.*, *id.* at 357.

310. *See supra* note 46 and accompanying text.

testimony and judicial dispositions,[311] the prejudicial effect of the expert testimony outweighs its probative value.[312] Accordingly, while the two generations of this type of empirical research have been subject to publication and peer review, the general unreliability of unstructured clinical assessments and the absence of any limitations on clinical judgment should render these opinions inadmissible.[313]

Finally, the amorphous meaning of danger means any assessment of danger results in an expert incorporating his or her own values about liberty, a factor that has no relation to any professional expertise.[314] Until empirically-generated data enables clinicians to offer specific opinions about the level of risk posed in terms of particular numerical probabilities that are based on a reasonable degree of professional certainty, any assessment of risk contains a value judgment that warrants a finding of inadmissibility.[315] Nor should courts that apply the *Frye* standard admit into evidence opinions about a civil committee's dangerousness. *Frye* authorizes admission when the principle or procedure in question has gained

311. *See supra* note 139 and accompanying text.

312. *See* Daubert v. Merrell Dow Pharm., 509 U.S. 579, 595 (1993). To illustrate, there has been only one study over the last twenty years that examined the accuracy of violence assessments made in psychiatric emergency rooms. Monahan, *supra* note 47, at 407. This study contained a false positive rate of almost forty-seven percent. *See* Lidz et al., *supra* note 41, at 1010. If one assumes a ninety percent concordance rate between judicial dispositions and expert conclusions, *see supra* note 139 and accompanying text, this means a court will erroneously confine approximately four out of every ten patients assessed. This turns on its head the contention by Judge Newman of the Second Circuit that the ratio of erroneous releases to erroneous confinements should be approximately three or five to one. *See* Goetz v. Crosson, 967 F.2d 29, 39 (2d Cir. 1992) (Newman, J., concurring).

313. *See* Harris & Rice, *supra* note 59, at 1169 (stating no evidence exists that clinicians' unaided assessments of violence risk are better than those of laypersons). One authority has concluded from the time of the initial studies detailing an inability of clinicians to assess violence risk, "[l]ittle has transpired . . . to increase confidence in the ability of psychologists or psychiatrists, using their unstructured clinical judgment, to accurately assess violence risk." Monahan, *supra* note 47, at 406-07; Simon, *supra* note 200, at 642 (noting an assessment of imminent harm is unlikely to satisfy the *Daubert* requirements). *But see* Nenno v. State, 970 S.W.2d 549, 562 (Tex. Crim. App. 1998) (holding expert testimony about a defendant's dangerousness admissible notwithstanding the absence of any particular methodology that one could subject to scrutiny because of empirical research relating to sexual offenders).

314. *See* Binder & McNeil, *supra* note 115, at 1192; Schopp & Quattrocchi, *supra* note 293, at 166. Perhaps one day appellate decisions will generate enough specificity as to what constitutes dangerousness to eliminate the potential for an expert's intrinsic values about liberty impacting any assessment about an individual's dangerousness. This might well require case law clarifying: (1) the likelihood of harm required in terms of a particular percentage; (2) how, if in any way, the potential magnitude impacts any assessment of danger; and (3) the impact of considerations of the imminence of any potential harm.

315. *Cf.* Paul Slovic et al., *Violence Risk Assessment and Risk Communication: The Effects of Using Actual Cases Providing Instruction, and Employing Probability Versus Frequency Formats*, 24 LAW & HUM. BEHAV. 271, 272 (2000).

general acceptance in its specified field.[316] However, when one evaluates the general acceptance of psychiatric assessments of danger, a little perspective is in order. Prior to *O'Connor v. Donaldson* and its progeny, both the law and clinical practice required psychiatrists to assess only mental illness and a need for treatment. This required only an assessment of symptoms and behaviors, a practice for which members of the psychiatric profession were trained. When the law required a completely different determination of dangerousness, psychiatrists continued to make the required assessments without regard to their ability to do so. While a few authorities have questioned the appropriateness of a dangerousness standard,[317] the psychiatric profession as a whole has continued to make these assessments willingly, if for no other reason than it has helped perpetuate its control over the civil commitment process.[318]

Hence, assessments of danger differ from all other novel scientific evidence that *Frye* governs. When examining the admissibility of a particular scientific technique, the scientific community of which the testifying expert is part has little interest in the particular judicial proceeding at hand, or judicial proceedings in general that the question requiring expert analysis has been raised. The profession's only interest is its professional integrity. However, the psychiatric profession possesses an institutional interest in: (1) accepting its clinical assessment as reliable; and (2) having assessments of danger gain general acceptance in the community to further the professional prerogative of facilitating the commitments of individuals doctors want to treat. Accordingly, an assumption exists that when novel scientific evidence gains acceptance in the relevant scientific community, sufficient evidentiary reliability exists to warrant admissibility. This is not the case with assessments of danger.

As a general rule, opinion testimony is admissible when an expert possesses sufficient skill, knowledge, or experience so the opinion will aid the trier of fact.[319] It is clear as to the issues of the risk posed by one's inability to meet one's needs and one's suicidality, no particular expertise exists. While empirical research provides a font of knowledge for psychiatrists to apply on the issue of violence, the unchecked use of clinical

316. *See, e.g.*, People v. Wesley, 633 N.E.2d 451, 454 (N.Y. 1994); *In re* Detention of Strauss, 20 P.3d 1022, 1025 (Wash. Ct. App. 2001).

317. *See, e.g.*, Norko, *supra* note 46, at 282.

318. This can be evidenced in no small part by the brief of the APA before the Supreme Court where the APA argued psychiatrists lacked the ability to assess long-term danger, but emphasized the existence of the professional prerogative to assess short-term danger in the civil commitment process. Brief of Amicus Curiae for the American Psychiatric Association at 10 n.7, Barefoot v. Estelle, 463 U.S. 880 (1983) (No. 82-6080).

319. 1 MCCORMICK ON EVIDENCE, *supra* note 137, at 69-70.

discretion renders too many assessments of risk unreliable. When an expert relies on clinical judgment alone, no mechanism exists to determine whether the expert has applied the empirical data in a valid way to warrant the conclusion the testimony will aid the trier of fact.[320] That the question of an individual's dangerousness is an ultimate issue in a commitment hearing further militates toward a determination that opinions of dangerousness are inadmissible.[321] Opinion testimony on an ultimate issue is admissible only when it addresses subject matter beyond the realm of the factfinder, the facts cannot be described to the factfinder in a way that will enable him or her to form an accurate judgment, and no better evidence than opinion testimony is available.[322]

Better evidence is available and it enables clinicians to provide appropriate testimony in civil commitment proceedings. Clinicians can testify about what factors relate to any heightened risk of harm and how the symptoms of mental illness and the civil committee's behavior relate to known risk factors for harm.[323] Such a rule strikes a proper balance between the court's interests in obtaining information from experts who can educate the court while eliminating highly prejudicial testimony that is both value-laden and evidentiarily unreliable.[324]

Approximately thirty years ago, one critic equated psychiatrists who render testimony with used car salesman and carnival barkers—individuals

320. *See* Monahan, *supra* note 63, at 513 (discussing the longstanding recognition that assessments produced by clinical judgment alone lack reliability and validity).

321. The ultimate issue is a question that must be answered to resolve a proceeding. *See* BLACK'S LAW DICTIONARY 908 (9th ed. 2009).

322. People v. Keindl, 502 N.E.2d 577, 582-83 (N.Y. 1986); People v. Cronin, 458 N.E.2d 351, 352 (N.Y. 1983).

323. *See* MELTON ET AL., *supra* note 19, at 350; Schopp et al., *supra* note 293, at 15. Use of expert testimony in this manner answers the court in *People v. Ward*, where the court admitted expert testimony about an individual's dangerousness on the ground, inter alia, that in civil commitment cases, an expert's prediction about danger may be the only evidence available. People v. Ward, 83 Cal. Rptr. 2d 828, 832 (Cal. Ct. App. 1999). In addition to excluding testimony about subject matter that far exceeds any clinician's expertise, prohibiting experts from rendering opinions about a subject's dangerousness helps to eliminate the problem of judges relying on expert testimony without any scrutiny. *See* Paul Appelbaum et al., *Expert Approaches to Communicating Violence Risk*, 24 LAW & HUM. BEHAV. 137, 145 (2000).

324. Two courts, relying on *Barefoot v. Estelle,* 463 U.S. 880 (1983), have authorized the use of clinical assessment of an individual's dangerousness. *See In re* Commitment of R.S., 773 A.2d 72, 90 (N.J. Super. Ct. App. Div. 2001); Lyle G. v. Harlem Valley Psychiatric Ctr., 521 N.Y.S.2d 94, 95 (N.Y. App. Div. 1987). Reliance on *Barefoot* to exclude testimony under state evidentiary principles was wrong because the court in *Barefoot* held only that the Constitution did not prohibit expert testimony about danger. *See Barefoot*, 483 U.S. at 896, 905 n.9. Ironically, the Court in *Barefoot* distinguished *People v. Murtishaw*, 631 P.2d 446 (Cal. 1981), where the California Supreme Court held the trial court committed error in admitting a testimony concerning dangerousness. The Court in *Barefoot* distinguished *Murtishaw* on the ground, inter alia, that the California Supreme Court did not base its decision on constitutional grounds. *See Barefoot*, 463 U.S. at 901-02 n.8.

who engage in polished double talk to hide a lack of competence about which they speak.[325] While such criticism no longer applies to clinicians who assess risk based upon empirically grounded criteria, it holds true today with those psychiatrists who assert patients cannot meet their needs when no empirical research exists to support such testimony. Prohibiting psychiatrists from rendering expert opinions sends a message: if you believe someone poses enough of a risk to warrant commitment, first back up your conclusions with empirical data, and then show the court your assessment has eliminated any value judgments inherent in any assessment of danger.

D. ATTORNEYS FOR PATIENTS MUST SYSTEMATICALLY APPEAL ADVERSE COMMITMENT DECISIONS AND APPELLATE COURTS MUST HOLD THESE APPEALS FALL WITHIN A MOOTNESS EXCEPTION

The amorphous and value laden nature of the concept of dangerousness means that in the absence of appellate decisions interpreting the concept of danger, physicians and trial courts will remain relatively free to interpret danger in any way they choose.[326] Only systematic appeals that result in appellate courts interpreting the dangerousness criteria will eliminate the problem.

Systematic appellate review enables courts to set forth criteria for lower courts to apply when assessing whether a patient's clinical condition warrants a finding of danger.[327] Appellate review further results in clarification as to what conduct and symptoms of mental illness are sufficiently probative of the level or risk of harm that satisfies the legal criteria of danger.[328]

---

325. *See* Poythress, *supra* note 139, at 205-06.

326. *See, e.g.*, Datlof, *supra* note 202, at 3, 18 (noting the elastic concept of dangerousness has resulted in courts within the same jurisdiction interpreting the criteria inconsistently).

327. *See In re* David B., 97 N.Y.2d 267, 277-78 (N.Y. 2002) (suggesting courts consider a patient's history of violent relapses when released into the community, history of substance abuse, the need for medication to control possible violence, and likely noncompliance with prescriptions); *In re* George L., 85 N.Y.2d 295, 308 (N.Y. 1995); *In re* Burton, 464 N.E.2d 530, 534 (Ohio 1984) (directing lower courts to examine, inter alia, a patient's insight into his or her clinical condition as to warrant compliance with a medication regimen and likelihood of compliance if not confined).

328. To illustrate, case law out of Oregon limits clinical discretion by making clear that a direct link must exist between prior actions, symptoms of mental illness, and a sufficiently high risk of harm as to warrant commitment. *See, e.g.*, State v. M.C., 206 P.3d 1096, 1098 (Or. Ct. App. 2009) (destroying an identification card in a fit of rage, spending disability income on drugs, and choosing to live on the streets in the dead of winter does not constitute clear and convincing evidence the civil committee posed enough risk of harm to self to warrant commitment); State v. Hambleton, 123 P.3d 370, 375 (Or. Ct. App. 2005) (swimming once in forty degree weather did not render a patient dangerous because there was no showing the patient would again engage in

Appellate courts can also interpret ambiguous terms inherent in the concept of danger, which will further lessen the potential for the personal values of experts to inappropriately influence their testimony.[329] Finally, appellate review can also result in other rules that will lessen the influence of psychiatric assessments of danger, such as requiring proof of a factual basis supporting expert opinions.[330] However, the short-term nature of civil commitment orders results in the expiration of an appealed commitment order prior to the resolution of most appeals. Appellate courts have struggled with the issue of whether the short-term nature of commitment orders warrants finding an exception to the mootness doctrine to such a degree that the same court has issued seemingly contradictory rulings.[331]

If for no other reason, the collateral consequences of a commitment order warrant the resolution of any appeal rendered moot by the expiration of the commitment order.[332] Moreover, the cyclical nature of mental illness means it is likely a civil committee will again be subject to another commitment proceeding.[333] Because one's clinical and behavioral history impacts

---

the conduct or that the patient had or would suffer hypothermia); State v. Hayes, 121 P.3d 17, 21 (Or. Ct. App. 2005) (holding auditory hallucinations that told the civil committee to act out sexual assault on a puppy was insufficient proof the committee would suffer harm as a result of the hallucinations); State v. North, 76 P.3d 685, 688-89 (Or. Ct. App. 2003) (determining a likely eviction, a desire not to take medication, and suffering one assault, without more, did not mean the patient would lack an ability to meet needs in the near future or suffer another assault if not confined); State v. Nguyen, 43 P.3d 1218, 1220 (Or. Ct. App. 2002) (failure to treat diabetes did not mean the disease was life-threatening; general mental or physical deterioration did not necessarily mean the patient was dangerous).

329. *See* Cooley v. Superior Court, 57 P.3d 654, 670 (Cal. 2002) (defining "likely to reoffend" as a "serious and well-founded risk" that the committee will commit sexually violent crimes); *In re* Commitment of Curiel, 597 N.W.2d 697, 704 (Wis. 1999) (defining "substantially probable" as much more likely than not).

330. *See, e.g.*, Johnstone v. State, 961 S.W.2d 385, 388 (Tex. App. 1997); *In re* Cochran, 487 N.E.2d 389, 390-92 (Ill. App. Ct. 1985).

331. *Compare* Boggs v. N.Y.C. Health & Hosp. Corp., 70 N.Y.2d 972, 974 (1988) (dismissing appeal as moot), *and In re* Alfred H.H., 910 N.E.2d 74, 77-85 (Ill. 2009) (holding none of the exceptions to mootness doctrine warranted a determination of appeal), *with George L.*, 85 N.Y.2d at 302 n.2 (determining an expiration of a commitment order does not render an appeal moot because of the impact an appeal would have in the future), *and In re* Barbara H., 702 N.E.2d 555, 559 (Ill. 1998) (stating the exception to mootness doctrine exists because of the short-term nature of a commitment order and the reasonable expectation a civil committee would again be subjected to the same action).

332. *See e.g., In re* Nancy A., 801 N.E.2d 565, 574-75 (Ill. App. Ct. 2003) (determining commitment impacts adversely on the reputation of even someone previously hospitalized numerous times, thus requiring appellate review); *In re* Commitment of R.B., 386 A.2d 893, 894 (N.J. Super. Ct. App. 1978) (noting a lien resulting from imposition of care and treatment charges warranted deciding the commitment appeal); J.M. v. State, 178 S.W.3d 185, 189 (Tex. Ct. App. 2005) (stating the stigma resulting from hospitalization constitutes a collateral consequence of a moot commitment order); State v. Condrick, 477 A.2d 632, 633 (Vt. 1984) (holding the imposition of legal disabilities and the resulting stigma from commitment warranted resolution of an otherwise moot appeal).

333. *See Barbara H.*, 702 N.E.2d at 559-60.

any assessment of danger,[334] there can be little question any judicial determination of mental illness and danger creates collateral consequences for the civil committee by creating a very real risk a history of hospitalization will have an adverse impact on a future assessment of danger. However, more than any collateral consequences resulting from commitment, appellate courts must recognize only they, through the promulgation of case law, can provide the necessary guidance as to what constitutes a sufficient level of risk of harm to warrant commitment. The need to clarify governing standards relating to the systematic deprivation of liberty of a vulnerable segment of society satisfies the public interest exception to the mootness doctrine that warrants resolution of appealed commitment orders that have expired.[335]

Furthermore, while a court may initially believe the adoption of the public interest exception to the mootness doctrine simply to clarify the law through precedent is unwarranted,[336] the need to clarify law that is in disarray warrants invoking the public interest exception.[337] A legal standard that enables those who wish to apply it in a significantly unfettered manner amounts to law that is in disarray. Attorneys for civil committees should continue to attempt to clarify the meaning of danger through appeals of commitment orders until the highest court of their state concludes the need to clarify what constitutes "dangerousness" does not warrant invoking an exception to the mootness doctrine. If this were to occur, then it might well mean the failure of a state's court system to clarify a constitutional standard that is inherently ambiguous amounts to a due process violation that warrants relief in the federal courts.[338]

334. *See, e.g.*, WEBSTER ET AL., *supra* note 121, at 28, 38.

335. Numerous jurisdictions have adopted a public interest exception to the mootness doctrine. *See, e.g.*, *In re* Ballay, 482 F.2d 648, 651 (D.C. Cir. 1973) (holding a resolution to an appeal of a moot commitment order was warranted because a number of people would be impacted by such an appeal); Campbell v. State, 846 S.W.2d 639, 640 (Ark. 1993) (stating the court will decide moot cases of great public interest); Hashimi v. Kalil, 446 N.E.2d 1387, 1389 (Mass. 1983) (holding a public interest exception to mootness doctrine was invoked because of the great public importance in interpreting a commitment statute); *In re* N.B., 620 P.2d 1228, 1231 (Mont. 1980) (deciding an appeal of an expired commitment order because of broad public concern in the resolution of the appeal); Proctor v. Butler, 380 A.2d 673, 675 (N.H. 1977) (invoking a public interest exception to mootness doctrine to decide important questions of law); *In re* Brunnell, 668 P.2d 1119, 1121 (N.M. Ct. App. 1983) (deciding a moot commitment appeal of great public importance).

336. *See Alfred H.H.*, 910 N.E.2d at 81.

337. *Id.*

338. *See supra* notes 183-214 and accompanying text.

VII. CONCLUSION

After the Supreme Court decision in *O'Connor v. Donaldson*, and federal district court cases such as *Lessard v. Schmidt*, imposed substantial substantive and procedural protections on states' civil commitment processes, much promise existed that psychiatrists would be prohibited from imposing their values as to what is best for someone at the expense of civil liberties. It did not happen. Like the defeated confederacy after the Civil War, much of institutional psychiatry made clear its disdain for the new legal order and challenged those in a position to enforce the newly established legal norms to force change. With a few exceptions, little has happened. Again, with exceptions, lawyers for civilly committed patients have ceded their adversary role and tiptoed gingerly in the courtroom. To a significant degree, courts have abandoned their role of neutral arbiters. In addition, the amorphous concept of danger, a constitutional standard that was supposed to significantly limit commitments, has significantly contributed to psychiatrists continuing to impose their values in an unchecked manner. It is time for lawyers and courts to step up.

Courts must afford committed patients an opportunity to present prompt expert testimony and prohibit psychiatrists testifying on behalf of either party in the commitment process from rendering testimony on the ultimate issue of danger. Lawyers for patients must vigorously represent their clients in the commitment process in a way they would want others to represent their closest family members. This includes systematically appealing adverse commitment decisions in a way that generates case law that clarifies the meaning of danger as to limit the discretion of psychiatrists in the future.

Finally, psychiatrists must respect the law and take their obligation to conduct careful assessments of risk far more seriously than they presently do. They must recognize regardless of whether they agree with legal standards that limit their clinical discretion, the law has entrusted them to apply these standards. Psychiatrists can start with recognizing use of clinical judgment alone is likely to result in too many erroneous assessments of danger, and structure risk assessments around empirically-based clinical criteria. When all this occurs, the protections set in place over thirty years ago will no longer be more apparent than real.