DONALDSON, DANGEROUSNESS, AND THE RIGHT TO TREATMENT

*By George M. Grant**

I. Perspective on the Right to Treatment

In August, 1956, Kenneth Donaldson, a forty-eight-year-old divorced Philadelphia carpenter, traveled to Florida to visit his eighty-year-old parents who then resided in Pinellas County. The visit was pleasant but uneventful until late November when Donaldson began to complain of drowsiness and suggested to his father the possibility that a neighbor might be putting something in his food. When asked why he suspected such an unlikely occurrence, Donaldson explained that several years earlier, while regularly eating at a diner in Los Angeles, he had experienced similar drowsiness and on the advice of his landlady had a urine sample analyzed by a physician. The sample showed significant amounts of codeine, a sedative. Donaldson, a Christian Scientist, had been taking no medication which could have accounted for the presence of the drug and on the suspicion that something had been put in his food at the diner, stopped eating there and immediately began to feel better.

On December 10, 1956, Donaldson's father filed a petition with the Pinellas County Court requesting a sanity hearing for his son. The father claimed that because of a "persecution complex, [and] increasing signs of paranoid delusions, petitioner believes him to be potentially dangerous."[1] On the basis of this petition Donaldson was placed under civil arrest later the same day and taken to jail. Three days later, by recommendation of the county examining committee (two nonpsychiatrist physicians and a deputy sheriff), Donaldson was involuntarily civ-

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1. B. ENNIS, PRISONERS OF PSYCHIATRY 83, 84 (1972) [hereinafter cited as PRISONERS]. This account of the events which led up to Donaldson's involuntary civil commitment, the commitment process, and his repeated attempts to secure freedom through the judicial process is taken from PRISONERS. *See also* Birnbaum, *The Right to Treatment: Some Comments on its Development*, in MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 97 (F. Ayd, Jr. ed. 1974) [hereinafter cited as Birnbaum, *Comments*]. Ennis and Birnbaum were counsel for Donaldson in O'Connor v. Donaldson, 422 U.S. 563 (1975), *vacating* 493 F.2d 507 (5th Cir. 1974), the case which is the subject of this note, and in several lower court cases.

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illy committed. Thus began a period of incarceration which would last for fifteen years.[2]

When Donaldson had already been institutionalized for over three years, Dr. Morton Birnbaum, a physician (not a psychiatrist) and attorney, published an article in the *American Bar Association Journal* entitled *The Right to Treatment*.[3] In this article, Birnbaum proposed that institutionalized mental patients have a constitutionally enforceable right to receive therapeutic treatment. Birnbaum also advocated many institutional reforms previously urged upon the psychiatric profession, such as accreditation of mental hospitals by appropriate agencies, more adequate staffing ratios, detailed recording of patient treatment and progress, and later, Social Security Administration certification of eligibility for medicare and medicaid benefits.[4] The novelty of Birnbaum's position lay in the suggestion that adequate treatment of the mentally ill is more than simple government largess that a sane majority should sympathetically extend to the disadvantaged insane. Rather, he argued, treatment is a right which both morality and the Constitution require as the price for the deprivation of liberty accompanying involuntary commitment.

Since Birnbaum's seminal article, commentators have theorized that the constitutional legitimacy of the right to treatment springs from the limitations imposed by the due process clause of the Fourteenth Amendment on the state's exercise of its *parens patriae* powers over the mentally ill.[5] Specifically, it has been suggested that as a quid pro

2. For a description of the operation of the Florida civil commitment mechanism which existed at that time, see PRISONERS, *supra* note 1, at 84-89. The due process aspects of this commitment process were not at issue in the *Donaldson* case as presented to the Supreme Court, and as the Court noted in 422 U.S. at 566, Florida civil commitment law has been revised substantially since that time.

For details of the physical and emotional conditions that prevailed at the Florida State Hospital in Chattahoochee where Donaldson was confined, see the Fifth Circuit opinion in Donaldson v. O'Connor, 493 F.2d 507, 510-12 (5th Cir. 1974).

3. 46 A.B.A.J. 499 (1960).

4. Birnbaum's original definition of the right to treatment set forth in his seminal article has been updated by more recent articles, such as Birnbaum, *Some Comments on "The Right to Treatment,"* 13 ARCH. GEN. PSYCHIATRY 34 (1965); Birnbaum, *A Rationale for the Right*, 57 GEO. L.J. 752 (1969); and Birnbaum, *Comments, supra* note 1.

5. *See* Bassiouni, *The Right of the Mentally Ill to Cure and Treatment: Medical Due Process*, 15 DE PAUL L. REV. 291 (1966); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 97-104 (1967); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134, 1137-43 (1967). The Fifth Circuit's opinion in *Donaldson*, although specifically vacated by the Supreme Court, also bears reading as perhaps the most succinct expression to date of the constitutional basis of the right to treatment. Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), *vacated*, 422 U.S. 563 (1975).

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quo for the "massive curtailment of liberty"[6] inherent in involuntary civil commitment, each patient must be provided with adequate psychiatric treatment. Continued failure to provide rehabilitative treatment violates due process since the state's basis for institutionalization of the mentally ill disappears absent some police power justification.[7]

The right to treatment has been described in its affirmative aspect as "the right of involuntarily hospitalized mental patients to receive adequate therapy as an exchange for their being deprived of their liberty."[8] It has also been described in a more negative formulation: "[I]f the patient is confined not because he is considered dangerous, but because of a supposed need for treatment, then, failing such treatment, the justification for confinement disappears."[9]

Birnbaum's proposed right to treatment enjoyed a generally favorable reception at the time the article appeared. It was accompanied in the same issue of the *American Bar Association Journal* by a strongly supportive editorial[10] and also prompted an editorial in the *New York Times.* After seeing the *Times* article, Donaldson contacted Birnbaum and enlisted his aid in seeking judicial review of his continuing commitment in the Florida State Hospital at Chattahoochee. During the following eleven years, Donaldson made fourteen separate attempts before various Florida and federal courts,[11] and four before the United States Supreme Court[12] to obtain release on the grounds that he was not dangerous, did not require institutionalization, and was receiving inadequate treatment.[13] All eighteen attempts failed. The lack of ju-

6. Humphrey v. Cady, 405 U.S. 504, 509 (1972).

7. *See* PRISONERS, *supra* note 1; Birnbaum, *Comments, supra* note 1; Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974).

8. Robitscher, *Courts, State Hospitals, and the Right to Treatment,* 129 AM. J. PSYCHIATRY 298 (1972).

9. PRISONERS, *supra* note 1, at 89. This negative formulation of the right to treatment contains subjective assumptions which require further scrutiny as discussed in greater detail below. For example, how distinct are the boundaries of the *parens patrie* power and the police power? Is treatment the *only* justification for segregation of the mentally ill?

10. Editorial, *A New Right,* 46 A.B.A.J. 516 (1960).

11. PRISONERS, *supra* note 1, at 89.

12. Donaldson v. O'Connor, 400 U.S. 869 (1970); Donaldson v. O'Connor, 390 U.S. 971 (1968); Donaldson v. Florida, 371 U.S. 806 (1963); *In re* Donaldson, 364 U.S. 808 (1960).

13. Both Ennis and Birnbaum present vivid, if not entirely unbiased, accounts of the inadequacy of treatment provided for Donaldson and other patients at Chattahoochee. Medical records showed that, except for a few hours during his first two weeks at the facility, Donaldson was never seen by psychiatrists for periods longer than five to ten minutes and during the next five years was seen for a grand total of two or three hours. During one eight and one-half year period Donaldson spoke with his supervising psychiatrist an average of fourteen minutes per year. There were twenty-eight physicians at the hospital to service five thousand patients, but only eight were licensed to

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dicial response to Donaldson's pleas in the sixties led the result-oriented Birnbaum to describe that period as the "nowhere" era in the history of the right to treatment.[14] While it is true that the courts did not generally acknowledge a right to treatment nor order improvement of treatment and upgrading of standards, an immense amount of academic comment was generated which laid the foundation for future developments. In its 1961[15] and 1963[16] hearings on constitutional rights of the mentally ill, the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary heard considerable testimony concerning the existence of a right to treatment, and the desirability of its statutory implementation. Under the direction of the subcommittee chairman, Senator Sam Ervin, a right to treatment provision was included in the Hospitalization of the Mentally Ill Act of 1964,[17] which became the law of the District of Columbia.[18]

It is significant that the right to treatment found its first legislative expression in a jurisdiction with a presiding federal circuit judge who

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practice in Florida. Of eighteen psychiatrists, only four were licensed to practice medicine, and only two were board certified. As opposed to an ideal ratio of one psychiatrist for every 125 patients in Donaldson's supposed condition, Chattahoochee provided about one per 800 patients.

A Christian Scientist, Donaldson refused proffered drug and electroshock treatments. The only other therapy provided was "milieu therapy" which consisted of the exposure of Donaldson to the "therapeutic milieu" of the hospital. Although acknowledged by some to be a valid therapeutic technique with particular mental patients, "milieu therapy" at Chattahoochee was of dubious therapeutic benefit. Donaldson resided in buildings many of which were over 150 years old, was confined in wards where ⅓ of the patients were committed as criminally insane, and under the supervision of orderlies who were oftimes illiterate (Donaldson himself had attended college). In the decisions by the Fifth Circuit and the Supreme Court, Donaldson's care at Chattahoochee was termed "custodial."

On Donaldson's treatment at Chattahoochee, see PRISONERS, *supra* note 1, 92-98; Birnbaum, *Comments, supra* note 1, 97-98, 116-18. On milieu therapy, see Abroms, *Defining Milieu Therapy*, 21 ARCH. GEN. PSYCHIATRY 553 (1969); Cameron, *Nonmedical Judgment of Medical Matters*, 57 GEO. L.J. 716, 731-33 (1969); Note, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 YALE L.J. 87, 107 (1967).

14. Birnbaum, *Comments, supra* note 1, at 114.

15. *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 87th Cong., 1st Sess. (1961) [hereinafter cited as *1961 Hearings*].

16. *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 88th Cong., 1st Sess. (1963).

17. D.C. CODE ANN. § 21-501 to -591 (1966). The right to treatment provision is embodied in § 21-562 which reads: "A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment."

18. For further discussion of prior and subsequent statutory developments concerning the right to treatment, see notes 21 and 26 and accompanying text *infra*.

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is keenly sensitive to the problems of the involuntarily committed mentally ill. In 1966, under the direction of Chief Judge Bazelon, the United States Court of Appeals for the District of Columbia rendered what has properly been termed a landmark decision concerning the right to treatment in the case of *Rouse v. Cameron.*[19] Following acquittal on misdemeanor charges, plaintiff Rouse was confined for three years without treatment in the maximum security unit at St. Elizabeth's Hospital. Pursuant to the District of Columbia statutory provision previously mentioned, Rouse brought an action against the director of the hospital, Dr. Dale Cameron, seeking a writ of habeas corpus. The *Rouse* decision, written by Judge Bazelon, was significant in two respects. First, by suggesting the possibility of conditional or unconditional release in cases where "the opportunity for treatment has been exhausted or treatment is otherwise inappropriate,"[20] the decision put teeth into otherwise uncertain statutory language.[21] Second, and most importantly, the court recognized the possibility that continued involun-

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19. 373 F.2d 451 (D.C. Cir. 1966).

20. *Id.* at 459.

21. Birnbaum termed the District of Columbia right to treatment statutory language a "precatory phrase" and was surprised when the *Rouse* court interpreted it as it did. Birnbaum, *Comments, supra* note 1, at 121-22. The ten state right to treatment statutes cited by the *Rouse* court as evidence of recognition of the right among the states (373 F.2d at 455 n.21) could even more aptly be termed "precatory phrases." Most were patterned after the National Institute of Mental Health Model Draft Act promulgated in 1952. In pertinent part the act provided: "§ 19. *Right to humane care and treatment.* Every patient shall be entitled to humane care and treatment and, to the extent that facilities, equipment, and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice." NATIONAL INSTITUTE OF MENTAL HEALTH, FEDERAL SECURITY AGENCY, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL 14-15 (Public Health Service Pub. No. 51, 1951) [hereinafter cited as *NIMH Model Draft Act*], reprinted as Appendix A in both editions of THE MENTALLY DISABLED AND THE LAW (F. Lindman & D. McIntyre eds. 1961) and (S. Brakel & R. Rock eds. 1971). Viewed in the overall historical context of treatment of the mentally ill in America, the model act represented a laudable statement of purpose. But from the viewpoint of public mental hospital administrators, chronically plagued with severe budgetary constraints, the language contained an enormous loophole in that facilities, equipment, and personnel need only be provided to the extent available. Significantly, such limiting language was omitted from the District of Columbia law passed by Congress (see note 17 *supra*) and has generally been absent from statutory right to treatment provisions enacted by the states since the *Rouse* decision. The statutes of 26% of the states still contain provisions based on the NIMH Model Draft Act. Alaska Stat. § 47.30.130(a) (1962); Hawaii Rev. Stat. § 19-334-35 (1968); Kan. Stat. Ann. § 59-2927 (Cum. Supp. 1975); Ky. Rev. Stat. Ann. § 202.267 (1972); Me. Rev. Stat. Ann. tit. 34, § 2252 (1965); Mo. Rev. Stat. § 202.840 (1972); N.J. Stat. Ann. § 30:4-24.1 (Cum. Supp. 1975); N.M. Stat. Ann. § 34-2-13 (Supp. 1975); Ohio Rev. Code Ann. § 5122.27 (1970); Okla. Stat. tit. 43A, § 91 (1954); Tenn. Code Ann. § 33-306(b) (Cum. Supp. 1974); Vt. Stat. Ann. tit. 18, § 7703 (1968); Wyo. Stat. Ann. § 25-70 (1967).

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tary institutionalization without adequate treatment[22] portended serious constitutional consequences. Thus, although Rouse's petition was disposed of on statutory grounds, the *Rouse* court was the first to suggest the constitutional underpinnings of the proposed right to treatment.[23]

Following *Rouse*, other courts began to speak of the rights of the involuntarily committed (including not only the mentally ill but also juveniles and the mentally retarded) in constitutional terms.[24] A significant but often overlooked aspect of this judicial and academic ferment in the late sixties is the effect it had on state right to treatment legislation. In a 1969 article concerning then pending Pennsylvania right to treatment legislation,[25] the authors made the following observation:

> The direction of the preceding [line of right to treatment cases] should be a signal to state legislatures that sooner or later the right of every public mental institution inmate to adequate treatment may be expressly placed within the 14th amendment due process and equal protection requirements by the highest courts of the state or even the U.S. Supreme Court.[26]

In the years between the *Rouse* decision and the Supreme Court's *Donaldson* decision, 1966 to 1975, fifty percent of the states passed right to treatment legislation.[27] Unlike earlier statutes patterned after

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22. Few concepts in the area of the right to treatment are more elusive of definition than "adequate treatment." Like the concept of mental illness itself, the idea varies with the individual or group to which it is applied. Myriad commentaries on the right to treatment have attempted to deal with this issue. *See, e.g.*, Schwitzgebel, *Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria*, 8 HARV. CIV. RIGHTS-CIV. LIB. L. REV. 513, 519-29 (1973); Cameron, *Nonmedical Judgment of Medical Matters*, 57 GEO. L.J. 716 (1969); American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIATRY 1458 (1967).

23. 373 F.2d at 455.

24. *See, e.g.*, Stachulak v. Coughlin, 364 F. Supp. 686 (N.D. Ill. 1973); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972). Several later District of Columbia cases repeated the constitutional language of *Rouse*. *See, e.g.*, *In re* Curry, 452 F.2d 1360, 1362-63 (D.C. Cir. 1971); Covington v. Harris, 419 F.2d 617, 625 (D.C. Cir. 1969). Another District of Columbia case which actually preceded *Rouse*, Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966), applied the equal protection "least restrictive alternative" concept to the right of treatment, in essence holding that treatment provided for the involuntarily committed mentally ill should be that which causes the least interference with the liberties of the patient.

25. Furman & Conners, *The Pennsylvania Experiment in Due Process*, 8 DUQUESNE L. REV. 32 (1969-70).

26. *Id.* at 43.

27. ARIZ. REV. STAT. ANN. § 36-511 (1974); CAL. WELF. & INST'NS CODE §§ 5001 (e), 5152 (West 1972); COLO. REV. STAT. ANN. § 27-10-116 (1973); CONN. GEN. STAT. ANN. § 17-206c (1958); DEL. CODE ANN. tit. 16, § 5161(a)(1) (Cum. Supp. 1975); FLA. STAT. ANN. §§ 394.459(2), 394.459(3)(a) (1973); GA. CODE ANN. §§ 88-502.2, 88-502.3 (Cum. Supp. 1970); IDAHO CODE § 66-344 (Cum. Supp. 1975); ILL. ANN. STAT.

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the National Institute of Mental Health Model Draft Act, the right to treatment embodied in these statutes is not subject to the availability of adequate facilities, equipment, and personnel. The New Hampshire statute[28] is typical of the unqualified right these statutes guarantee:

> Every mentally ill patient has a right to adequate and humane treatment including such psychological, medical, vocational, social, educational or rehabilitative services as his condition requires to bring about an improvement in condition within the limits of modern knowledge.[29]

Thus, New Hampshire and states with similar statutes have provided the means by which involuntarily committed mental patients can enforce certain minimum treatment standards. No statute, however carefully worded, can be any more effective in the protection of personal liberties than the courts which interpret it. Still, these newer statutes, lacking the ambivalence of the older laws, may provide a firmer standard by which courts can assess the justifications for deprivation of liberty in involuntary commitment.

Two decisions from the Fifth Circuit, the only federal circuit court which has specifically addressed the constitutional aspect of the right

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ch. 91½, § 12-1 (Cum. Supp. 1976-1977); IND. STAT. ANN. § 16-14-1.5-2 (1973); MD. ANN. CODE art. 59, § 2 (1957); MASS. GEN. LAWS ANN. ch. 123, § 55(e) (Cum. Supp. 1976-1977); MICH. COMP. LAWS ANN. § 330.1708 (1975); MINN. STAT. ANN. § 253A. 17(9) (Cum. Supp. 1976); MONT. REV. CODES ANN. §§ 38-1324, 38-1304 (Cum. Supp. 1975); NEV. REV. STAT. § 433.721 (1957); N.H. REV. STAT. ANN. § 135-B:43 (Supp. 1973); N.Y. MENTAL HYGIENE LAW § 15.03 (McKinney Cum. Supp. 1975-1976); ORE. REV. STAT. § 426.385 (1953); R.I. GEN. LAWS ANN. § 40.1-5-9 (Supp. 1974); S.D. COMP. LAWS ANN. § 27-7-50 (Supp. 1975); UTAH CODE ANN. § 64-7-46 (Supp. 1975); VA. CODE ANN. § 37.1-84.1 (Cum. Supp. 1975); WASH. REV. CODE ANN. § 71.05.360(2) (1975); W. VA. CODE ANN. § 27-5-9(b) (Cum. Supp. 1975).

The Texas statute enacted in 1957 (TEX. REV. CIV. STAT. art. 5547-70) and the Iowa statute enacted in 1939 (IOWA CODE § 225.15, 1949) also might be interpreted as right to treatment statutes.

The most ambitious attempt at right to treatment legislation occurred in Pennsylvania with the proposed "Right to Treatment Law of 1968." Drafted with the aid of Dr. Morton Birnbaum, author of the original right to treatment concept, the measure would have established boards and committees to assure adequate treatment on an institutional and individual basis, more stringent licensing procedures for all mental hospital personnel, and detailed records of patient treatment. The Pennsylvania General Assembly to date has failed to enact the statute, which was introduced in 1968 and successive years. For discussions of the Pennsylvania proposal, see Furman & Conners, *The Pennsylvania Experiment in Due Process*, 8 DUQUESNE L. REV. 32 (1969-1970); Robitscher, *The Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient*, 18 VILL. L. REV. 11, 23-24 (1972); Birnbaum, *Comments*, *supra* note 1, at 121-22. For full text of the measure (Right to Treatment Law, S.B. 1274, Pa. Gen. Assembly, 1968 Sess.) see Helpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782, 811 (1969).

28. N.H. REV. STAT. ANN. § 135-B:43 (Supp. 1975).

29. *Id.*

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to treatment, provide contrasting approaches to the implementation of the right. The first case[30] involved the same Kenneth Donaldson who in 1971 had been certified competent and released from the mental hospital in Chattahoochee, Florida. Donaldson brought a damage action against several doctors at Chattahoochee[31] under 42 U.S.C. § 1983[32] alleging that his confinement constituted an unconstitutional deprivation of liberty because he was nondangerous and because he had been provided no therapeutic treatment. At the trial, the jury unanimously found for Donaldson, awarding $28,500 in compensatory, and $10,000 in punitive damages. In its 1974 opinion upholding the trial court verdict, the Fifth Circuit strongly supported a constitutional right to treatment. The court held that "a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition."[33] The case was significant in two respects. First, a federal appellate court for the first time expressly and unequivocally recognized the right to treatment as constitutionally required. Second, the court approved the award of damages as a remedy for the violation of this right.[34]

Later in 1974, the Fifth Circuit in *Wyatt v. Aderholt*[35] relied on its *Donaldson* reasoning to sustain an application of a constitutional right to treatment to the entire Alabama state mental hospital system. Although the court of appeals in *Wyatt* modified the manner in which the

30. Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974).

31. Both defendants, Dr. O'Connor and Dr. Gumanis, were attending physicians to Donaldson during his stay at Chattahoochee. O'Connor was superintendent of the facility from 1963 until 1971. The suit was initiated as a class action on behalf of all patients at the Florida State Hospital while Donaldson was still confined. Upon his release from the hospital, Donaldson was forced to abandon the class action aspect of the suit.

32. "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other persons within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

33. Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974).

34. Birnbaum notes several important weaknesses of this money damages remedy. First, with public mental hospital facilities already seriously understaffed, "the potential of this decision to drive state hospital doctors out of these facilities is obvious." Birnbaum, *Comments, supra* note 1, at 127. Second, in order for such an action for injuries to be brought successfully, realistically one must be out of the hospital. *Id.* at 126.

35. 503 F.2d 1305 (5th Cir. 1974), *aff'g in part* Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972), 344 F. Supp. 373 (M.D. Ala. 1972), *enforcing* 325 F. Supp. 781 (M.D. Ala. 1971).

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district court had chosen to implement the right,[36] its support for the constitutional basis of the right to treatment was unqualified, and its application of the principle to an entire hospital system unprecedented.

II. The Supreme Court's Decision in O'Connor v. Donaldson[37]

A. Unanswered Questions

The Supreme Court's grant of certiorari in *Donaldson* was highly significant. With the exception of two rather minor cases from the last century and the beginning of this century dealing largely with property issues,[38] this was the first case in which the Court agreed to deal with the civil rights of an involuntarily committed mental patient who had committed no crime. Unrestrained by precedent, the Court could have confronted the challenge created by the lower court's assertion of a constitutional right to treatment.[39] Instead, adhering to the "judicial prac-

36. In Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), the federal district court judge granted injunctive relief by imposing on the Alabama state mental hospital system various objective standards ranging from staff-patient ratios to the frequency of linen changes. Affirmed as to this relief (see note 35 *supra*), the decision was remanded in part by the court of appeals on the issue of the propriety of court ordered sale of state lands and budget realignments mandated by the district court. *See* Drake, *Enforcing the Right to Treatment: Wyatt v. Stickney*, 10 AM. CRIM. L.Q. 587 (1972); Note, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282 (1973). The "macro" approach to enforcement of the right to treatment in *Wyatt* is more in line with the approach favored by Dr. Birnbaum than the individual approach followed in *Donaldson, Rouse*, and most of the other right to treatment decisions. Birnbaum fears that by emphasizing the right vis-a-vis the individual, "most of the time of staff physicians, nurses and other needed personnel may well be spent in testifying and preparing to testify in courtroom proceedings, rather than in attending to the needs of the hospital's patients." Birnbaum, *Comments, supra* note 1, at 121.

37. 422 U.S. 563 (1975).

38. Simon v. Craft, 182 U.S. 427 (1901); Dexter v. Hall, 82 U.S. (15 Wall.) 9 (1872).

39. Many who had watched and participated in the judicial and academic debates surrounding the right to treatment during the fifteen years prior to the *Donaldson* decision saw favorable hints in prior Supreme Court decisions. Widely quoted was the "massive curtailment of liberty" language from Humphrey v. Cady, 405 U.S. 504, 509 (1972), a case involving the indefinite commitment of an individual under the Wisconsin Sex Crimes Act. More specific language was found in Jackson v. Indiana, 406 U.S. 715, 738 (1972) regarding the relationship which must exist between the "nature and duration of commitment" and the "purpose" of such commitment. *In re* Gault, 387 U.S. 1 (1967), was sometimes relied on with reference to the quid pro quo which must be extended due to relaxed procedural safeguards in the civil commitment process.

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tice of dealing with the largest questions in the most narrow way,"[40] Justice Stewart, speaking for a unanimous Court, concluded that "the difficult issues of constitutional law dealt with by the Court of Appeals are not presented by this case in its present posture."[41] Accepting the jury findings that Donaldson was not dangerous and that Dr. O'Connor confined Donaldson knowing that he was nondangerous, the Court concluded that O'Connor violated Donaldson's constitutional right to freedom.[42] En route to this conclusion, the Court declared: "A State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[43] Ultimately, however, the Court vacated the Fifth Circuit decision and remanded the case for reconsideration in light of a recent decision concerning the qualified immunity of state officials under 42 U.S.C. § 1983.[44]

The Supreme Court in *Donaldson* nonetheless has expressed a rule of far-reaching practical impact by holding that nondangerous mentally ill persons capable of functioning successfully outside the mental hospital are entitled to liberty. Donaldson's counsel, Bruce Ennis, may not have been exaggerating when he claimed that as a result of the decision "many thousands" of harmless mental hospital inmates would be entitled to freedom.[45]

40. Youngstown Sheet & Tube Co. v. Sawyer, 343 U.S. 579, 635 (1952) (Jackson, J., concurring).

41. 422 U.S. at 573. Counsel for Donaldson, Bruce Ennis, strongly urged such a narrow position in his argument before the Court: "Mr. Justice White: 'Some conditions are not curable.' Ennis: 'But here, the patient was not dangerous. If treatment could not improve his condition, he should be released. This is a very narrow case.' Mr. Justice Blackmun: 'You believe that this case should be narrowly decided.' Ennis: 'Yes, what the petitioner is asking for is an advisory opinion.' . . . The Chief Justice: 'In some states, persons who are acquitted of criminal charges by reason of insanity have to undergo civil commitment proceedings before they can be confined in a mental institution. In that case, he would be within your constitutional theory.' Ennis: 'But we are not concerned with these "criminal cases." This is a much narrower case.'" 43 U.S.L.W. 3397, 3398 (Jan. 21, 1975). As a matter of tactics, Ennis sought to avoid the risk involved in asking the Court for broad approval of a constitutional right to treatment at the cost of the substantial gains which might result from affirmance on more restricted grounds. Given the concurring opinion by the Chief Justice and comments in the oral argument by other members of the Court, this decision seems to have been prudent. *See, e.g.*, 422 U.S. at 578 (Burger, C.J., concurring).

42. 422 U.S. at 576.

43. *Id.*

44. *Id.* at 577. As Justice Stewart noted, the vacating of the court of appeals opinion by the Supreme Court removed all precedential value from the Fifth Circuit holding strongly affirming a constitutional right to treatment.

45. N.Y. Times, June 27, 1975, at 36, col. 3.

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Nevertheless, by declining to examine the proposed constitutional origin of the right to treatment, the Court has left major questions unanswered. The following statement highlights one dilemma: "If one is not getting at least minimally adequate treatment according to certain objective standards, then the patient should be able to leave the hospital at will. *Why else has he been hospitalized?*"[46] Aside from the state's exercise of its police powers in cases of alleged dangerousness, is treatment the only constitutionally valid justification for involuntary institutionalization? Right to treatment advocates, citing the due process quid pro quo analysis, answer with a resounding "yes." But, in *Wyatt v. Aderholt*,[47] the state of Alabama suggested that "the 'need to care' for the mentally ill—and to relieve their families, friends, or guardians of the burdens of doing so—can supply a constitutional justification for civil commitment."[48] The court of appeals rejected this strictly "rational" state interest as a justification for civil commitment, citing the fundamental interest in personal liberty at stake.[49] In his concurring opinion in *Donaldson*, however, Chief Justice Burger, after a brief review of the history of the treatment of the mentally ill in America, recalled the "dual functions of institutionalization" and suggested that "custodial confinement" of the dependent insane may continue to be a valid exercise of the *parens patriae* power.[50] "In short, the idea that States may not confine the mentally ill except for the purpose of providing them with treatment is of very recent origin, and there is no historical basis for imposing such a limitation on state power."[51] Justice Stewart, writing for the Court, chose to analyze the possible justifications for involuntary institutionalization of the mentally ill from a negative perspective.

> A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.[52]

Thus, the Court neither confirmed nor denied that treatment is a possible justification for involuntary institutionalization.[53]

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46. Birnbaum, *Comments, supra* note 1, at 101 (emphasis added).
47. 503 F.2d 1305 (5th Cir. 1974).
48. *Id.* at 1313.
49. *Id.*
50. 422 U.S. 563, 582 (1975) (Burger, C.J., concurring).
51. *Id.*
52. *Id.* at 575.
53. Justice Stewart's opinion seems ambivalent on the issue of whether detention is justifiable where therapeutic treatment is provided. Only two cryptic words in the

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By declining to decide whether a constitutional right to treatment exists, the Court also left unanswered the question of whether the dangerously mentally ill, unaffected by the possibility of liberty which *Donaldson* extends to the nondangerous, might have such a right. In answering this question the Court would be faced with difficulties no matter which position it took. If the dangerously mentally ill have no constitutional right to receive treatment and if they may be confined as long as they remain dangerous then there would appear to be no practical or legal remedy for the deprivation of their liberty. Absent an enforceable right to treatment, the numerous situations in which understaffing in mental hospitals results in little or no treatment, as was the case with Donaldson, would more closely approximate detention under a punishment rationale than under the therapeutic rationale now asserted. When detention is justified for reasons of punishment, the detention is generally accompanied, as due process requires that it must be, by limitations now absent in the case of the mentally ill, such as the requirement that confinement result from the commission of specific proscribed overt acts,[54] and that it be for prescribed period of time.[55]

If the Court ruled in favor of a constitutional right to treatment the difficulties would be less theoretical than practical. Arguably, the number of institutionalized mentally ill has so outstripped the number of competent professional personnel in state hospitals that a genuine right to treatment would be impossible to implement. Bearing this in mind, the Court might reject as an unacceptable administrative burden the task of drawing up adequate minimum standards and supervising their implementation as the district court did in *Wyatt v. Stickney*.[56] Additionally, the Court might well balk at the prospect of supporting a concept so nebulous as "adequate treatment."[57]

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holding hint that Justice Stewart might allow treatment as a justification for continued involuntary confinement of the mentally ill: "[A] State cannot constitutionally confine *without more* a nondangerous individual . . . ." 422 U.S. at 576 (emphasis added). In his concurring opinion, the Chief Justice left no doubt of his opposition to treatment as a justification for involuntary confinement. "Nor can I accept the theory that a State may lawfully confine an individual thought to need treatment and justify that deprivation of liberty solely by providing some treatment. Our concepts of due process would not tolerate such a 'tradeoff'." *Id.* at 589. On providing treatment as a justification for involuntary confinement of the mentally ill, see Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 93 n.53 (1968) [hereinafter cited as Livermore].

54. J. HALL, GENERAL PRINCIPLES OF CRIMINAL LAW 171-211 (2d ed. 1960).

55. *Id.* at 55-58.

56. 325 F. Supp. 781 (M.D. Ala. 1971).

57. See note 22 *supra*. "Given the present state of medical knowledge regarding abnormal human behavior and its treatment, few things would be more fraught with peril than to irrevocably condition a State's power to protect the mentally ill upon the provid-

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B. The Rationale: New Equal Protection?

Although the Supreme Court's opinion in *Donaldson* was based upon an individual deprivation of liberty, the result is consistent with one that might have been reached under modern equal protection analysis[58] and invites conjecture that the Court implicitly applied a more rigorous standard of review. A statute that interferes with the exercise of a fundamental right or infringes upon the rights of a suspect class under new equal protection analysis generally triggers the strict scrutiny test.[59] In marked contrast to the great deference paid to legislative choices under the minimum rationality standard of review, strict scrutiny demands that the classification be necessary to the accomplishment of a compelling state interest that is protectable by no less onerous alternative. If the Court in *Donaldson* had explicitly applied new equal protection analysis it might have required proof of a compelling state interest because either a fundamental right or the rights of a suspect class were involved.

Applying fundamental rights analysis, the Court might have reasoned that since liberty is a fundamental right, deprivation of liberty must be justified by a compelling governmental interest. Where the mentally ill patient is dangerous, the state has a compelling interest in preventing possible harm to society generally or to the mentally ill individual himself and may do so by exercising its police power. Further, if the mentally ill individual is not dangerous to himself or others but is incapable of functioning successfully beyond the confines of the hospital even with the help of family or friends the state in exercise of its *parens patriae* responsibility has a compelling interest in preventing abandonment that might occur if such an individual were left to fend for himself. If, however, the mentally ill individual is nondangerous and is capable of functioning outside of the institution, the state has no compelling interest in keeping him confined.

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ing of 'such treatment as will give [them] a realistic opportunity to be cured.'" O'Connor v. Donaldson, 422 U.S. 563, 588-89 (1975) (Burger, C.J., concurring).

58. For a general discussion of this analysis, see Gunther, *Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1 (1972).

59. In San Antonio Ind. School Dist. v. Rodriguez, 411 U.S. 1 (1973), Justice Powell, writing for the majority, provided one of the Court's most explicit statements of the new equal protection theory. Fundamental rights, he wrote, are those "explicitly or implicitly guaranteed by the Constitution" (*id.* at 33-34), and "traditional indicia of suspectness" are found where "the class is . . . saddled with such disabilities, or subjected to such a history of purposeful unequal treatment, or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process." *Id.* at 28.

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Although the Court has been reluctant to add to the classifications already recognized as suspect,[60] an argument can be made that the mentally ill constitute a discrete class that is characterized by certain traditional indicia of suspectness and that therefore the compelling state interest test should be applied to any statute that infringes the rights of the class.[61] The criteria set forth by Justice Powell in *San Antonio Independent School District v. Rodriguez*[62] to define a suspect class[63] seem to apply to the mentally ill. First, the class is saddled with obvious disabilities. Involuntary commitment statutes are generally enacted on the premise that the mentally ill are too irrational to be aware that they require treatment. Second, historically, the mentally ill undeniably have been subject to purposeful unequal treatment.[64] Third, the mentally ill are without any meaningful political power. To a much greater degree than members of other acknowledged or proposed suspect classes the mentally ill depend for the defense of their rights on the intercession of the majority.[65] If the mentally ill are a suspect class,

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60. Classifications that have been deemed suspect are race (Korematsu v. United States, 323 U.S. 214 (1944)), nationality (Hernandez v. Texas, 347 U.S. 475 (1954)), and alienage (*In re* Griffiths, 413 U.S. 717 (1973)). Despite repeated urgings and opportunities to do so, a majority of the Court has refused to find sex a suspect classification. Frontiero v. Richardson, 411 U.S. 677 (1973). The Court has similarly declined to designate illegitimacy (Jimenez v. Weinberger, 417 U.S. 628 (1974)) and poverty (James v. Valtierra, 402 U.S. 137 (1971)) as supect classes. For a thorough discussion of suspect classes and equal protection generally, see *Forum: Equal Protection and the Burger Court*, 2 HASTINGS CONST. L.Q. 645 (1975).

61. An excellent, detailed analysis which suggests that the mentally ill do in fact comprise a suspect class is found in Note, *Mental Illness: A Suspect Classification?*, 83 YALE L.J. 1237 (1974). The author considers the effect that designation of the mentally ill as a suspect class would have on existing laws regarding the mentally ill. *Id.* at 1258-70.

62. 411 U.S. 1 (1973).

63. See note 59 *supra*.

64. *See, e.g.*, A. DEUTSCH, THE MENTALLY ILL IN AMERICA (2d ed. 1949); N. DAIN, CONCEPTS OF INSANITY IN THE UNITED STATES, 1789-1865 (1964). Dr. Birnbaum analogizes the historical and contemporary attitude in this country towards the mentally ill to racism—calling unequal treatment of the mentally ill "sanism." Quoting Justice Thurgood Marshall on racism, Birnbaum suggests that "it is of no consequence to the oppressed mentally ill whether the sanism of our society is deliberate or unintentional." Birnbaum, *Comments*, *supra* note 1, at 105-14. "As primary evidence of the sanism that pervades our entire society, the severely mentally ill need only point to the too often grossly inadequate conditions that frequently exist in our state mental hospitals. These inadequate conditions, which are due primarily to insufficient funding by our state legislatures, are well known and routinely accepted." *Id.* at 107.

65. "The mentally disabled do not have minority pride, like blacks. They do not organize like grape pickers, or agitate like students, or rebel like prisoners. They passively wait for action to be taken on their behalf." Robitscher, *Implementing the Rights of the Mentally Disabled: Judicial, Legislative and Psychiatric Action*, MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 142 (F. Ayd ed. 1974).

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infringement of their rights can be justified only by some compelling state interest. According to the *Donaldson* Court, in the absence of dangerousness or the inability to exist successfully outside the mental hospital the state has no compelling interest in the confinement of the mentally ill.

Again it is conceded that nowhere in its opinion does the *Donaldson* Court acknowledge use of the new equal protection analysis or application of the strict scrutiny test. Justice Stewart characterized the central issue of the case as the "relatively simple, but nonetheless important question concerning every man's constitutional right to liberty."[66] Yet as a result of the decision numerous state civil commitment statutes that allowed a group, characterized by all the indicia of a suspect class, to be deprived of a fundamental right are no longer applicable to a large percentage of that class. This interpretation of the result in *Donaldson* is only inferential since the issue of equal protection was not submitted to the Court in the briefs or urged in the oral argument. As a tool in future cases involving the rights of the mentally ill, however, *Donaldson* has fascinating equal protection potential.[67]

Notwithstanding the many issues left open by the *Donaldson* decision viewed in the historical context of treatment of the mentally ill, the recognition that the nondangerous mentally ill have a fundamental right to liberty is highly significant. In spite of its uncertain application to the dangerously mentally ill, the decision seems to validate the negative implications of the right to treatment alluded to previously.[68] In the absence of a legitimate justification for confinement (be it dangerousness or treatment), the mentally ill, like the sane, have a right to liberty.

Justice Stewart's narrow holding in *Donaldson* raises, however, an often neglected problem inherent in most civil commitment statutes.[69] The concept of dangerousness is a major criterion for civil commitment although it is generally left undefined, as it was in *Donaldson*. The

66. 422 U.S. at 573.

67. Because St. Elizabeth's Hospital in Washington, D.C. and the District of Columbia right to treatment statute (D.C. CODE ANN. § 21-562 (1966)) are fertile sources of right to treatment litigation, it should be noted that the new equal protection considerations discussed with respect to *Donaldson* would appear to apply with equal force in the federal context. See Justice Brennan's opinion in Weinberger v. Wiesenfeld, 420 U.S. 636 (1975), where he declares: "This Court's approach to Fifth Amendment equal protection claims has always been precisely the same as to equal protection claims under the Fourteenth Amendment." *Id.* at 638 n.2.

68. See note 9 and accompanying text *supra*.

69. "In short, a State cannot constitutionally confine without more a *nondangerous* individual who is capable of surviving safely in freedom . . . ." 422 U.S. at 576 (emphasis added).

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holding in *Donaldson* promises an even more prominent role for dangerousness, the new dividing line between those involuntarily committed mentally ill individuals who may go free if they wish, and those who must remain institutionalized. The remainder of this note presents a critical and analytical examination of the concept of dangerousness.

III. Dangerousness as a Viable Criterion in Civil Commitment and Continued Confinement of the Mentally Ill

A. The Undefined Standard

Dangerousness has long been a favored standard by which legislatures and courts have sought to determine the propriety of institutionalizing mentally ill individuals.[70] It continues to be used, and this usage is underscored by *Donaldson*, by mental hospital officials as a determinant for release of patients. Given the importance of the standard, it is remarkable that the concept of dangerousness has survived so long without substantive definition. The reason for this lack of definition is easily understood by analogy to a somewhat dated statement concerning mental illness: "There is no great occasion to be solicitous about the definition of a disease which everybody knows."[71] So too dangerousness. Our everyday experiences and interactions with people and things supply each of us with a definition of dangerousness sufficient to meet our casual needs. But when this community standard of dangerousness becomes the legal dividing line between one group that continues to enjoy liberty and another that is involuntarily separated from society, we must question whether such a general definition is sufficient.

Under our system of jurisprudence courts would be loathe to apply such a general standard in an area such as the criminal law.[72] Yet this standard is tolerated as applied to the mentally ill, perhaps because they are deemed irrational and therefore incapable of recognizing their predicament, or because they are the objects of beneficent designs of the sane majority. One is reminded, however, of the admonition of Justice Brandeis:

70. *See, e.g.*, CAL. WELF. & INST'NS CODE § 5150 (West Supp. 1976). *See generally* THE MENTALLY DISABLED AND THE LAW 72-76 (Table 3.2) (S. Brakel & R. Rock eds. 1971); Kumasaka, Stokes & Gupta, *Criteria for Involuntary Hospitalization*, 26 ARCH. GEN. PSYCHIATRY 399 (1972).

71. W. BUCHAN, DOMESTIC MEDICINE; OR, THE FAMILY PHYSICIAN 303 (1772) *quoted in* N. DAIN, CONCEPTS OF INSANITY IN THE UNITED STATES, 1789-1865, at 6 (1964).

72. *See, e.g.*, Dershowitz, *Psychiatry in the Legal Process: "A Knife that Cuts Both Ways,"* 51 JUDICATURE 370 (1968) [hereiniafter cited as Dershowitz].

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> Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.[73]

A review of the relatively few state commitment statutes that attempt a definition of dangerousness supports the contention that legislators have generally ignored or been unsuccessful in their efforts to adequately define the concept.[74] Typical of one group of statutes that attempt to define dangerousness are those that define the concept in terms of itself. For example, the South Dakota statute[75] reads: "(3) 'Danger to himself,' behavior which constitutes a *danger* of intentionally inflicting substantial bodily harm upon oneself; (4) 'Danger to others,' behavior which constitutes a *danger* of inflicting substantial bodily harm upon another person."[76] Although such a statute admirably attempts to define the nature of the harm feared, in this instance substantial bodily harm, it fails to shed light on the term "danger" itself. Such a circular definition is of doubtful utility to the courts.

A second and potentially more confusing category of statutes is that group which defines dangerousness in terms of mental illness, thus equating the two concepts. The Kansas statutory definition[77] of a "mentally ill person," for example, includes one "who is or will probably become dangerous to himself, or the person or property of others if not given 'care and treatment.' "[78] As legislative translations of community values and standards regarding mental illness, such statutes undoubtedly reflect in some measure the generally unfounded yet widely accepted stereotype concerning the supposed dangerous propensities of the mentally ill.[79] While mental illness is as illusive of precise definition as dangerousness, to define one in terms of the other is to blur two very distinct and independent concepts. Indeed, were dangerousness and mental illness equivalent, involuntary institutionalization of the mentally ill would hinge not on any independent showing of dan-

73. Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).

74. "The variety of definitions used . . . is so great that no generalization can be made. The statutes are replete with vague, ambiguous and circuitous terms." Judge J. Schneider, *The Court's Role in the Hospitalization and Discharge of the Mentally Ill*, reprinted in *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st and 2d Sess., at 678 (1969-1970) [hereinafter cited as *1969 Hearings*].

75. S.D. COMP. LAWS ANN. § 27-1-1.1 (Supp. 1975).

76. *Id.* (emphasis added).

77. KAN. STAT. ANN. § 59-2902(1) (Cum. Supp. 1975).

78. *Id.*

79. While there is an inclination to equate mental illness and dangerousness, "the fact is that the great majority of hospitalized mental patients are too passive, too silent, too fearful, too withdrawn" to be dangerous. *1961 Hearings*, *supra* note 15, at 43 (statement of Albert Deutsch). *See also* Livermore, *supra* note 53, at 82 n.22.

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gerousness, as *Donaldson* implies it must, but rather on the status of mental illness. If this were the case, the criterion of dangerousness would be meaningless because confinement would necessarily follow the status of mental illness. Such confinement based upon status would raise grave due process questions regarding punishment of status offenses.[80]

B. Toward a Definition

A meaningful appraisal of dangerousness begins with the understanding that the concept is not self-apparent, unchanging, or capable of absolute abstract exposition. Definitions of dangerousness borrowed from other areas of the law are of little value in the search for its meaning in the context of mental illness, where it is essentially a socially defined concept. Like mental illness, dangerousness represents deviation from the standard of conduct labeled "normal" by society.[81] In reality labels such as "dangerous" and "nondangerous" as applied to human behavior are merely a manner of distinguishing those harms resulting from deviant behavior that society will accept without sanction from those that cross some threshold of tolerance and require a societal response. Focusing on the *harms* involved in the various types of deviant behavior displayed by the mentally ill may produce a more realistic and workable definition of dangerousness than that currently used in the majority of the jurisdictions. Indeed, many commentators have noted the contrast between the great detail contained in penal codes, which enumerate specific harms for which criminal sanctions are imposed, and the general lack of any such specificity in civil commitment statutes.[82] Whether some analogous form of behavioral code covering the actions of the mentally ill is the best solution to the current lack of definition of dangerousness is subject to dispute. Unlike criminal codes, which detail proscribed conduct, a behavioral code for the mentally ill would not serve the purpose of warning them in advance

80. Robinson v. California, 370 U.S. 660 (1962).

81. "[*S*]*ocial groups create deviance* [dangerousness] *by making the rules whose infraction constitutes deviance* [dangerousness], and by applying those rules to particular people and labeling them as outsiders [dangerous]. From this point of view, deviance [dangerousness] is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant [dangerous individual] is one to whom that label has successfully been applied; deviant [dangerous] behavior is behavior that people so label." H. BECKER, OUTSIDERS: STUDIES IN THE SOCIOLOGY OF DEVIANCE 9 (1963). *See also* Shah, *Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior*, 53 MENTAL HYGIENE 21, 31 (1969) [hereinafter cited as Shah]; Kittrie, *The Flowering and Decline of the Therapeutic State?*, MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 81 (F. Ayd ed. 1974) [hereinafter cited as Kittrie].

82. *See, e.g.*, Dershowitz, *supra* note 72, at 374.

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of the consequences of their conduct since by definition the dangerously mentally ill would be unable to choose rationally between the proscribed act and some more acceptable form of behavior. It would, however, allow judges and juries to make commitment decisions on a more objective basis, circumventing many of the subjective pitfalls discussed below.

In the process of drawing up such an enumeration of dangerous acts, however, society would have to confront the core problem of precisely where the line between nuisance behavior and truly harmful conduct must be drawn. The *Donaldson* decision leaves no doubt that civil commitment sanctions may not attach to mere nuisance behavior.

> May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.[83]

While this statement is a guide, it does not attempt to tell us where eccentricity and nuisance behavior end and truly harmful behavior begins. Many civil commitment statutes which discuss the harmful conduct of the mentally ill do so only to the extent of distinguishing between the possible objects of such harm, with occasional emphasis on degree. Thus statutes may differentiate the harm which a mentally ill individual may cause to himself from the harm which he may cause to others. Additionally, adjectives such as "serious" or "substantial" may establish the degree of such harm while "bodily" or "to the property of" may further specify the objects of the harm.[84] Confinement to prevent harm to oneself requires a different theoretical justification from confinement to prevent harm to others. Yet the justifications are often not distinguished by the courts.

State intervention to prevent possible harm to others is justified under a police power rationale as in the criminal model. Intervention to prevent harm to oneself, in contrast, is justified under the *parens patriae* theory.[85] Arguably, the Court's holding in *Donaldson* has seriously limited the state's exercise of this paternalistic power.

> [T]he mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for

83. 422 U.S. at 575.

84. Recall the South Dakota statute; see text accompanying note 75 *supra*.

85. *Parens patriae* is derived from the English concept of the king's role as the father of the country. "In this role, society allegedly seeks not to punish but to change or to socialize the nonconformist through treatment and therapy." Kittrie, *supra* note 81, at 89.

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> raising the living standards of those capable of surviving safely in freedom . . . .[86]

Thus, the Court suggests that the possibility of harming oneself may still provide a basis for civil commitment under the *parens patriae* power. But this is no more than a throwback to questions concerning the degree and nature of the harm.[87]

Few courts, juries, or experts would have difficulty finding dangerousness in acts involving violent, physical injury to oneself or another. More problematic is the vast gray area of bizarre, nuisance type behavior. Should dangerousness defined by harms include physical harms only? If so, which ones? Is some nuisance behavior sufficiently deviant as to merit sanction or be proscribed due to emotional harm it might cause?[88] If freedom from emotional harm is an interest that deserves protection, where is the line to be drawn? While public acts of exhibitionism wound the sensibilities of many, does the emotional harm that may result from this deviant behavior outweigh the individual's right to liberty?[89] An underinclusive definition of dangerousness framed in terms of physical harms only may subject society to intolerable levels of emotional distress. Defined overinclusively, dan-

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86. 422 U.S. at 575.

87. One classic illustration of the double standard which is applied to self-destructive conduct exhibited by sane and insane people is found in a memorial to Justice Jackson. After suffering a severe heart attack in the spring of 1954, he was told by his doctors that he could retire from the Court and live a life of inactivity or continue his work on the Court with the prospect of dying at any time. "With characteristic fortitude he chose the second alternative." Justice Jackson died of a heart attack in October of the same year. *In Memory of Mr. Justice Jackson*, 349 U.S. xxvii, xxviii-xxix (1955).

88. Freedom from emotional distress is receiving increasing protection in the courts through civil tort actions based on the intentional infliction of emotional distress. Since these tort actions do not extend to conduct of the mentally ill, which arguably lacks rational intention, preventing emotional harm caused by the mentally ill becomes largely a matter of controlling nuisance behavior.

89. "*Case 3*: A man who compulsively engages in acts of indecent exposure has been diagnosed as having a sociopathic personality disturbance. The probability is eighty percent that he will again expose himself. Even if this condition is untreatable, we would be disinclined to commit. In our view, this conduct is not sufficiently serious to warrant extended confinement. For that reason, we would allow confinement only if 'cure' were relatively quick and certain." Livermore, *supra* note 53, at 90. *But see* Millard v. Harris, 406 F.2d 964, 976 (D.C. Cir. 1968): "Concerning the likely effect of the appellant's exhibitionism on others, psychiatrists agreed that the effect would vary with the viewer. . . . There was no evidence presented of any actual harm to adult women from the appellant's past exhibitionism. Dr. Weickhardt did testify, however, that one viewer had suffered 'serious psychological harm'—the appellant's son . . . who was six years old at the time of appellant's commitment. . . ."

"*Case 4*: A person afflicted witb schizophrenia walks about town making wild gestures and talking incessantly. Those who view him are uncomfortable but not endangered. We doubt that commitment is appropriate even though it would promote the psychic ease of many people." Livermore, *supra* note 53, at 90.

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gerousness becomes synonymous with mental illness and offers little guidance to courts and mental hospital administrators.

Dangerousness must be defined by state legislatures, and the difficult questions posed above must be answered. If, as *Donaldson* suggests, the concept of dangerousness is to divide those mentally ill who will remain institutionalized from those who may go or remain free, then, to avoid constitutional invalidity for vagueness, more workable and precise statutory definitions must be formulated.[90]

C. The Likelihood of Harm

The determination that the concept of dangerousness is best approached in terms of harm does not complete the groundwork for a workable definition. Since harmful conduct, however it is defined, will not occur unless the mentally ill individual exhibits the proscribed behavior, the next inquiry must be how *likely* it is that a specific individual will engage in specific harmful conduct. The inquiry regarding the likelihood of harmful behavior subsumes three component questions. First, how can or should a propensity to engage in harmful behavior be shown? Second, who should determine that a likelihood of harmful behavior exists? Third, where commitment hinges on predictability of future harmful behavior, what degree of predictability should be demanded by the courts or delineated in the statutes? Similar questions are implicitly answered in all civil commitment and habeas corpus actions involving the mentally ill, although this process is seldom articulated.

While civil commitment statutes are generally not helpful, the courts have adopted several means for assessing the likelihood that an individual will engage in harmful behavior. As the word "likelihood" itself indicates, the primary concern is the *prediction* of future harmful behavior. Dispute in this area hinges on the appropriate basis for prediction. Historically, bare prediction based on expert psychiatric testimony or lay testimony in or out of court has often been a sufficient basis.[91] While the commission of some overt harmful act by the men-

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90. The vagueness challenge rests ultimately on the procedural due process requirement of notice. As suggested above, due to mentally ill persons' supposed lack of rational ability to choose between proscribed and permissible conduct, the lack of notice rationale cannot be applied. However, as one commentator has argued, the doctrine is "most frequently employed as an implement for curbing legislative invasion of constitutional rights other than that of fair notice . . . ." Note, *The Void-for-Vagueness Doctrine in the Supreme Court,* 109 U. PA. L. REV. 67, 87-88 (1960).

91. "Mr. Justice Rehnquist: 'If [Donaldson] was not dangerous to himself or to others, and he was competent, but there was no cure for his illness, what's the reason for confinement?' Gearey [Asst. Atty. Gen. for Florida]: " 'Well, when he was committed, there was evidence that he was dangerous both to himself and others.' " 43 U.S.L.W. 3398 (Jan. 21, 1975).

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tally ill individual might influence the determination, such behavior has not been considered indispensable to the prediction of future harmful conduct with resultant institutionalization. In this respect civil commitment of the mentally ill is in striking contrast with the criminal model.

> Criminal law traditionally has required an overt act on the part of the offender before state intervention was justified. Thoughts alone and propensity to action, regardless of how vile, were not punishable. The introduction of the therapeutic model, viewing the deviant as a man suffering from a dangerous malady, allowed state intervention as soon as the dangerous status or condition was diagnosed. No longer did the state have to await and react to a harmful act. A prediction of future dangerousness was sufficient to call into effect preventive measures. The therapeutic approach thus permitted prophylactic interventions not possible under the penal process.[92]

The most common explanation given for this difference in prerequisites for confinement is that unlike criminals, the mentally ill are considered to be incapable of making the rational choice of whether to indulge in or abstain from such harmful behavior.[93]

Sensing the inconsistency of such a disparity of treatment between criminal incarceration based on the commission of a specific proscribed act and civil commitment predicated on the illusive "mental illness" label, legal scholars, the courts, and an occasional statute have de-

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"[After Donaldson's arrest] . . . the county judge ordered the sheriff of Pinellas County to summon an 'examining committee.' Two of the committee members . . . were physicians, but not psychiatrists. The third . . . was the Pinellas County deputy sheriff. Later that day, each of the three committee members signed a printed form stating that the committee had made 'a thorough examination' of Donaldson's 'mental and physical condition.' Most of the form was left blank. The committee added only Donaldson's age and, at the bottom of the printed form, that he suffered from 'paranoid schizophrenia,' that his particular hallucinations were 'auditory' and 'visual,' and that his propensities were 'delusions.'

"These five words, inserted in a form, would serve as the basis for Donaldson's commitment. More troubling than the sketchiness of the report was Donaldson's claim that he was not actually seen by the committee members until several days after they had signed the form." PRISONERS, *supra* note 1, at 84-85.

92. Kittrie, *supra* note 81, at 91. *See also 1969 Hearings, supra* note 74, at 262, 263 (statement of Bruce Ennis), 303 (statement of Stephen B. Rosenberg); Morris, *Legal Problems Involved in Implementing the Right to Treatment*, 1 BULL. AM. ACAD. PSYCHIATRY AND LAW 1 (1972); Livermore, *supra* note 53, at 84.

93. Ennis, in his statement before the Senate Subcommittee on Constitutional Rights of the Mentally Ill, made the point that various segments of society present a much greater propensity toward dangerousness than the mentally ill. Ex-felons, ghetto residents, and teenage males have a much higher degree of predictability in terms of likelihood of future harmful behavior than the mentally ill. Yet our system of justice would not tolerate preventive detention of any such segment of the population. "We demonstrate our belief in individual responsibility by refusing to incarcerate save for failure to make a responsible decision." Livermore, *supra* note 49, at 86. However, as Ennis points out, "If a sane man is dangerous, then, by definition, his 'rationality' and aware-

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manded that institutionalization of the mentally ill justified by alleged harmful propensities be based on the more palpable foundation of the recent commission of some overt act. Typical is the recent holding in *Lynch v. Baxley*:[94]

> To confine a citizen against his will because he is likely to be dangerous in the future, it must be shown that he has actually been dangerous in the recent past and that such danger was manifested by an overt act, attempt or threat to do substantial harm to himself or to another.[95]

Similarly, a recent addition to the Arizona statutes on mental health defines "danger to others" as follows:

> "Danger to others" means behavior which constitutes a danger of inflicting substantial bodily harm upon another person based upon a history of having inflicted or having attempted to inflict substantial bodily harm upon another person within twelve months preceding the hearing on court ordered treatment.[96]

Thus the Arizona statute specifies the type of harm proscribed (bodily or physical harm), the degree of harm (substantial), and the time period within which the harm must have occurred (twelve months).[97]

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ness of the consequences of apprehension do not deter his dangerous acts." *1969 Hearings, supra* note 68, at 263.

94. 386 F. Supp. 378 (M.D. Ala. 1974).

95. *Id.* at 391. *See also 1969 Hearings, supra* note 74, at 83, 265.

96. ARIZ. REV. STAT. ANN. § 36-501.3 (Supp. 1974-1975). The statute goes on to provide for an extension of the twelve month period if the patient has been physically or pharmacologically restrained, or confined during this preceding period, or the attempted harm was "grievous or horrendous." (Note the common "danger means behavior which constitutes a danger" language discussed at text accompanying note 75 *supra.*) Section 36-501.4 defines danger to self as "behavior which constitutes a danger of inflicting substantial bodily harm upon oneself, including attempted suicide." The section further excludes inability to provide for personal food, clothing, or shelter needs or the effects of degenerative brain disease and old age from the category of "danger to self." This enumeration of included and excluded harms, though by no means exhaustive, is valuable in providing much needed guidance to the courts that must apply otherwise vague and usually undistinguished concepts of dangerousness to self and others.

See also California's Lanterman-Petris-Short Act provisions with respect to civil commitment of the dangerously mentally ill. CAL. WELF. & INST'NS CODE §§ 5260, 5264, 5300 (West 1972). The law authorizes involuntary confinement of a person who is suicidal, but for no more than thirty-one days. At the end of that time he must be released unless he is dangerous to others or is so "gravely disabled" that a conservator can be appointed. A person who presents an "imminent threat of substantial physical harm to others" can be confined for ninety days, but only if he threatened, attempted, or inflicted physical harm upon another in the immediate past. Thereafter, he can be held for an additional ninety days, but only if he still "presents an imminent threat of substantial physical harm to others," and only if he "threatened, attempted, or inflicted physical harm" to another during his initial period of confinement.

97. The authors of what is undoubtedly the most thorough examination of prediction of dangerousness reached the following conclusion regarding the relationship between prediction of dangerousness and the presence or absence of some overt act: "We

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Such attempts by courts and legislatures to isolate and to define objectively the basis for a finding of dangerousness are to be applauded.

Whether the prediction of harmful behavior is based on an overt act or some other measure of predictability, a primary concern is who should make the determination. Traditionally, judges and juries have shown great deference to the medical expert, generally the psychiatrist, in civil commitment and habeas corpus proceedings. On questions of dangerousness and prediction of harmful behavior laymen evince a reverence for physicians generally by tending to defer to the psychiatric profession, although psychiatrists themselves disagree as to symptoms and treatment of mental illness.[98] As a result, judges and juries often act as surrogates for medical experts when making determinations in commitment proceedings.

Several criticisms may be leveled against such reliance. First, just as dangerousness has remained largely undefined by the law, so also has it eluded medical definition. Indeed, "[p]reoccupation with labels or definitions is operationally irrelevant to the dynamically-oriented psychiatrist."[99] We should not be surprised, then, to find that when asked as an expert medical witness to discuss the dangerousness of a certain individual, the psychiatrist applies many of the same subjective standards to the determination that a layman might.

> There are different vectors of considerations that culminate in a psychiatrist's resultant conclusion as to "dangerousness," yea or nay. Some aspects are primarily determined by his expertise, and others by his value preferences in matters involving community values . . . .[100]

To the degree that the psychiatrist bases his decision concerning dangerousness on "community values and standards" he ceases to be an expert witness and enters an area in which the judge or jury has been given the responsibility of deciding. One solution to such difficulties is to require that the expert medical witness inform the court as much as possible of the subjective, "community value" aspects of his conclusion.

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submit that to properly assess indications of *possible* dangerousness in the absence of an actual instance of dangerous acting out requires the highest degree of psychiatric expertise and may well exceed the present limits of our knowledge. . . . *No one can predict dangerous behavior in an individual with no history of dangerous acting out.*" Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371, 384 (1972) (final emphasis added).

98. Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 694-95 (1974) [hereinafter cited as *Coins*]. *See also* Dershowitz, *supra* note 72; Shah, *supra* note 81, at 31.

99. *1969 Hearings, supra* note 74, at 679 (statement of J. Schneider).

100. United States v. Ashe, 478 F.2d 661, 668 (D.C. Cir. 1973). *See also* Lynch v. Baxley, 386 F. Supp. 378, 391 n.8 (M.D. Ala. 1974); Dershowitz, *supra* note 72.

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> [T]he jury hearing a psychiatrist's testimony of dangerousness, should be informed of its various components . . . . The expert must be prepared to state the bases for his conclusion and be aware that the attorney, seeking to expose the predicate of the expert's conclusion is not necessarily challenging his expertise within its proper realm, but may properly be seeking to ask the jury to come to a different ultimate conclusion on the basis of the community-value factor involved.[101]

It should be noted that attorneys often invite such unarticulated, community value laden conclusions by the vagueness and generality of their questioning of medical experts. Rather than asking whether or not the psychiatrist believes that X is a danger to himself and others, attorneys could more profitably ask what types of harmful behavior X might engage in if left at liberty, and what the probability is that X will, in fact, so behave.[102]

Considering these subjective inputs to the psychiatrist's determination of dangerousness as well as continued discord within the medical profession as to treatment and diagnosis of various mental ailments, we again should not be surprised that, like laymen, medical experts often err in their prediction that a given individual is or will be dangerous. What is surprising is the assertion that psychiatrists are less accurate in their predictions of future dangerous behavior than various nonexperts. After extensive research, one commentator, reporting on various studies following up psychiatric predictions of anti-social behavior, stated:

> [T]hese few studies strongly suggest that psychiatrists are rather inaccurate predictors; inaccurate in an absolute sense, and even less accurate when compared with other professionals, such as psychologists, social workers and correctional officials; and when compared to actuarial devices, such as prediction or experience

101. United States v. Ashe, 478 F.2d 661, 668-69 (D.C. Cir. 1973). *See also* Goldstein & Katz, *Dangerousness and Mental Illness: Some Observations of the Decision to Release Persons Acquitted by Reason of Insanity*, 70 YALE L.J. 225 (1960) [hereinafter cited as Goldstein & Katz]. "[I]n deciding whether *behavior "X"* (*e.g.*, homosexual acts) is sufficiently 'dangerous' to preclude release, the psychiatrist, as any other member of the community, may attempt to influence legislative and court decisions by expressing his value preferences. Making such a distinction among the roles psychiatrists may play at different points in the decision-making process should alert them, as well as all participants, to the extent to which value preferences permeate expert judgments. This, in turn, should prompt careful scrutiny of conclusionary statements qualified by such phrases as 'on the basis of my professional opinion . . . ,' expose those views which primarily reflect the psychiatrist's value preferences, and thus facilitate identification of decision points at which the psychiatrist should minimize his value orientation and at which the community has the right to establish policy. This is not to suggest that experts are to avoid, or can avoid, value judgments, *but rather that they openly articulate them as such.*" *Id.* at 231 (final emphasis added).

102. For examples of the generalized questioning that too often takes place in civil commitment and habeas corpus proceedings, see *1969 Hearings, supra* note 74, at 410-12.

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> tables. Even more significant for legal purposes, it seems that psychiatrists are particularly prone to one type of error—overprediction. In other words, they tend to predict anti-social conduct in many instances where it would not, in fact, occur.[103]

One cogent explanation of this phenomenon of overprediction of dangerousness is found in an article by Jerome J. Shestack.[104] Shestack suggests that in evaluating the possible behavior of a mentally ill individual the psychiatrist is subjected to what may essentially be a conflict of interest. The author illustrates this conflict by quoting Judge Bazelon:

> At the Napa State Hospital in California a few years ago, the superintendent told me in a public meeting that the staff had "Sacramento looking over its shoulder" on all internal decisions. I learned that psychiatric opinions are influenced by the public outcry for "Law and Order" and by personal fears for safety. . . . I have even been told that psychiatrists believe they are justified in fudging their testimony on "dangerousness" if they are convinced that an individual is too sick to know that he needs help.[105]

Alternative explanations of the apparent unreliability of psychiatric predictions have been summarized by Ennis and Litwack as follows: (1) *orientation and training*—the mental health professional has a "set" to perceive mental illness; (2) *context*—dress of the patient and the mental hospital environment of the interview simply add to the impression of the interviewer that the patient must not be "normal"; (3) *timing*—short interviews allow only a very restricted view of a patient;[106] (4) *class and culture*—individual socio-economic backgrounds; (5) *personal biases*—individual personality, value systems and preferences; (6) *inadequacies of the diagnostic system and ambiguity of psychiatric data*; (7) *lack of training and experience in predicting dangerousness*.[107] If, as it seems, the yardstick by which psy-

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103. Dershowitz, *supra* note 72, at 377. "Perhaps the psychiatrist is an expert at predicting which of the persons so diagnosed are dangerous. Sane people, too, are dangerous, and it may legitimately be inquired whether there is anything in the education, training or experience of psychiatrists which renders them particularly adept at predicting dangerous behavior. Predictions of dangerous behavior, no matter who makes them, are incredibly inaccurate, and there is a growing consensus that psychiatrists are not uniquely qualified to predict dangerous behavior and are, in fact, less accurate in their predictions than other professionals." *1969 Hearings, supra* note 74, at 277-78 (statement of Bruce Ennis), *quoted in* Murel v. Baltimore City Criminal Court, 407 U.S. 355, 364-65 n.2 (1972) (Douglas, J., dissenting). *See also 1969 Hearings, supra* note 74, at 83 (statement of Dr. David J. Vail).

104. Shestack, *Psychiatry and the Dilemmas of Dual Loyalties*, MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 7 (F. Ayd ed. 1974).

105. *Id.* at 11 n.3.

106. Even though a patient's behavior may be consistent over time, short interviews may accentuate the effects of otherwise normal mood changes.

107. *Coins, supra* note 98, at 719-34. Such brief descriptions of the explanations for unreliability of psychiatric predictions are unfair abbreviations of the authors' in-

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chiatric experts have measured dangerousness is one that the court and jury are equally if not better able to apply, then basic rules of evidence limit expert testimony on the likelihood of dangerousness.[108] While expert medical opinion will still be essential to illuminate various facts, symptoms, and characteristics of a given illness or patient, the judge and jury should be free as the ultimate decision makers to evaluate potential dangerousness and to do so in the light of reasonably clear statutory definitions.[109]

The third and final inquiry in the consideration of the likelihood of harm involves the degree of predictability of harmful behavior which should be required by the courts or set forth in statutes. Rephrased, the issue is: what is the standard of proof necessary in prediction of harmful behavior to require institutionalization of the individual? Essentially, three possibilities exist. Civil commitment may be based on prediction of harmful behavior beyond a reasonable doubt (criminal model), by a preponderance of evidence (civil model), or by clear and convincing evidence.[110]

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depth analysis. The Ennis-Litwack article is by far the most ambitious and thorough compilation and analysis yet attempted regarding various studies on aspects of psychiatric prediction. Additionally, this article contains a thorough discussion of the legal consequences of the inexpertness of an expert psychiatric witness. The authors briefly summarize their conclusions as follows: "(a) there is no evidence warranting the assumption that psychiatrists can accurately determine who is 'dangerous'; (b) there is little or no evidence that psychiatrists are more 'expert' in making the predictions relevant to civil commitment than laymen; (c) 'expert' judgments made by psychiatrists are not sufficiently reliable and valid to justify nonjudicial hospitalization based on such judgments; (d) the constitutional rights of individuals are seriously prejudiced by the admissibility of psychiatric terminology, diagnoses, and predictions, especially those of 'dangerous' behavior; and therefore (e) courts should limit testimony by psychiatrists to descriptive statements and should exclude psychiatric diagnoses, judgments, and predictions." *Id.* at 696.

108. *See* CAL. EVID. CODE § 801 (West 1965). "If a witness is testifying as an expert, his testimony in the form of an opinion is limited to such an opinion as is: (a) related to a subject that is sufficiently beyond common experience that the opinion of an expert would assist the trier of fact." *Id.* (emphasis added). Given the rather poor record of psychiatric predictions of dangerous behavior by the mentally ill, it appears that dangerousness, if assessed in accordance with statutory guidelines, would not be beyond the common experience of the trier of fact. *See generally* WIGMORE, EVIDENCE §§ 555-56, 1918 (3d ed. 1940); MCCORMICK, EVIDENCE § 13 (2d ed. 1972).

109. *See generally In re* Ballay, 482 F.2d 648, 665 (D.C. Cir. 1973); United States v. Ashe, 478 F.2d 661, 668-69 (D.C. Cir. 1973); Goldstein & Katz, *supra* note 101, at 230; Shah, *supra* note 81, at 31.

110. Most state civil commitment statutes are silent as to the standard of proof by which an individual must be shown to require institutionalization. The few which do approach the issue are often vague. Thus, the Wisconsin statute provides that a court may order a patient involuntarily committed if it is "*satisfied* that he is mentally ill or infirm or deficient and that he is a proper subject for custody and treatment . . . ." WIS. STAT. ANN. § 51.02(5)(c) (1957) (emphasis added). The South Dakota statute, which

Labels such as civil and criminal are not helpful in supplying the proper standard. Although the confinement of the mentally ill is termed civil commitment, the deprivation of liberty to which such a proceeding may lead is anomalous in the noncriminal common law. While an occasional case has held the civil "preponderance of evidence" standard to be sufficient in civil commitment,[111] the better view requires a higher level of proof when the liberty of an individual is at stake.

A split of authority exists as to the remaining two standards. While some courts have applied the less rigorous "clear and convincing" standard,[112] other courts, quoting broadly supportive language in recent Supreme Court decisions, have adopted the "beyond a reasonable doubt" standard.[113] Although the difference between the standards is perhaps only semantic, given the aforementioned uncertainty surrounding predictions of dangerousness and given the transcendent value of liberty, the Constitution would seem to require the higher standard.

Conclusion

Donaldson represents the high water mark of a movement that has been developing over the last sixteen years. The intense academic and judicial ferment surrounding the existence of and constitutional basis for a right to treatment has had a marked effect on the civil commitment statutes of over half the states. Although extensive in its potential practical effect, *Donaldson* has left critical questions unanswered. Do those dangerous mentally ill who remain institutionalized after *Donaldson* have a right to treatment? Has the Court implicitly applied new equal protection analysis to involuntary commitment of the mentally ill, either on the basis of the fundamental right involved or on a tacit designation of the mentally ill as a suspect class? In either case, does willingness to provide therapeutic treatment constitute a compelling state

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provides that the standard for commitment of the mentally ill shall be "clear and convincing evidence," is exceptional. S.D. COMP. LAWS ANN. § 27-7-13.1 (Supp. 1975).

111. *E.g., In re* Alexander, 372 F.2d 925, 927 (D.C. Cir. 1967).

112. Lynch v. Baxley, 386 F. Supp. 378, 391 (M.D. Ala. 1974); Dixon v. Attorney General, 325 F. Supp. 966, 974 (M.D. Pa. 1971); People v. Sansone, 18 Ill. App. 3d 315, 326, 309 N.E.2d 733, 741 (1974).

113. *In re* Ballay, 482 F.2d 648, 669 (D.C. Cir. 1973); Lessard v. Schmidt, 349 F. Supp. 1078, 1095 (E.D. Wis. 1972), *vacated on other grounds sub nom.* Schmidt v. Lessard, 414 U.S. 473 (1974). *See also* Murel v. Baltimore City Criminal Court, 407 U.S. 355, 364-65 (1972) *cert. dismissed as improvidently granted* (Douglas, J., dissenting). "Where one party has at stake an interest of transcending value—as a criminal defendant his liberty—this margin of error is reduced as to him by the process of placing on the other party the burden of . . . persuading the factfinder at the conclusion of the trial of his guilt beyond a reasonable doubt." *In re* Winship, 397 U.S. 358, 364 (1970).

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interest which could justify involuntary institutionalization? In citing nondangerousness as a governing criterion by which the right to liberty of the mentally ill is to be determined, the Court points to an eminently uncertain standard. If *Donaldson* is to have the effect intended by the Court, of freeing or allowing to remain at liberty those who are able to function outside the environment of the mental hospital and who present no risk of harm to the community, legislatures and courts must adopt and implement realistic guidelines defining dangerousness.

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