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The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness

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THE DANGER ZONE:
HOW THE DANGEROUSNESS
STANDARD IN CIVIL COMMITMENT
PROCEEDINGS HARMS PEOPLE WITH
SERIOUS MENTAL ILLNESS

Sara Gordon[†]

“It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe.”¹

“Civil libertarians say no—that it is our right to commit crimes that land us in prison, that it is our choice to be so ill that we prefer to forage through garbage and live on the streets, that it is our prerogative to let voices in our heads torment us into sleepless nights. But something tells me that the people locked up in San

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1. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 609–10 (1999) (Kennedy, J., concurring). In *Olmstead*, the Court held that under the ADA,

States are required to provide community-based treatment for persons with mental disabilities when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

Id. at 607 (majority opinion). Justice Kennedy’s concurrence, however, warned that this holding should be applied with “caution and circumspection” so as not to pressure states with “some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision.” *Id.* at 610 (Kennedy, J., concurring). Since *Olmstead*, “[twelve] states and the District of Columbia have completely eliminated large state-run [psychiatric facilities].” Liz Robbins, *For Special-Care Residents, State Policy Means Leaving Home*, N.Y. TIMES (Jan. 29, 2015), <http://www.nytimes.com/2015/02/01/nyregion/as-new-york-moves-people-with-developmental-disabilities-to-group-homes-some-families-struggle.html> [<http://perma.cc/KJF4-FF42>].

Quentin with a mental illness, and the people roving the back alleys of skid row, are not singing "God Bless America."²

ABSTRACT

Almost every American state allows civil commitment upon a finding that a person, as a result of mental illness, is gravely disabled and unable to meet their basic needs for food and shelter. Yet in spite of these statutes, most psychiatrists and courts will not commit an individual until they are found to pose a danger to themselves or others. All people have certain rights to be free from unwanted medical treatment, but for people with serious mental illness, those civil liberties are an abstraction, safeguarded for them by a system that is not otherwise ensuring access to shelter and basic medical care.

States' continued and primary use of dangerousness standard in civil commitment proceedings does not meet our obligations to people with serious mental illness. Continued perceptions of the link between mental illness and violence, coupled with the strict interpretation of commitment statutes based on states' *parens patriae* authority, have resulted in commitment standards that effectively commit people only when they are dangerous, which is often far past the point that they are in need of help. Courts and psychiatrists should recognize states' obligations to provide health care to people with mental illness by interpreting gravely disabled statutes to allow for commitment when an individual is unable to provide for her basic needs but does not pose a danger to herself.

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2. Jim Randall, *Helping Those Who Don't Know They Want It*, L.A. TIMES (Mar. 12, 2006), <http://articles.latimes.com/2006/mar/12/opinion/oe-randall12> [<http://perma.cc/7F9U-S42F>].

INTRODUCTION

Serious mental illness affects approximately 9.6 million people in the United States, or about 4.1% of the population.³ In addition to the many debilitating symptoms of serious mental illness, many people also lack insight into the extent and effects of their symptoms; lack of insight is neurologically based and is often a hallmark of serious mental illness.⁴ This lack of insight coupled with the complexities of serious mental

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3. U.S. Dep't OF HEALTH & HUM. SERVS., *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings* (Dec. 2013), http://www.samhsa.gov/data/sites/default/files/2k12MH_Findings/2k12MH_Findings/NSDUHmhfr2012.htm [<http://perma.cc/6HQ2-V3SN>] (“SAMHSA defined SMI as persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. . . . In 2012, there were an estimated 9.6 million adults aged 18 or older in the United States with SMI in the past year. This represented 4.1 percent of all adults in this country in 2012 The percentage of adults with past year SMI in 2012 was similar to that in 2008 (3.7 percent).”).
 4. Between 57 and 98% of people with schizophrenia have some lack of insight into their illness and over 84% of bipolar patients experience lack of insight during pure manic phases. Frederick Cassidy, *Insight in Bipolar Disorder: Relationship to Episode Subtypes and Symptom Dimensions*, 6 NEUROPSYCHIATRIC DISEASE AND TREATMENT 627, 629 (2010); see also E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 116 (2012). “The term anosognosia . . . refers to a neurologically based denial of illness and unawareness of disability.” Douglas S. Lehrer & Jennifer Lorenz, *Anosognosia in Schizophrenia: Hidden in Plain Sight*, 11 INNOVATIONS IN CLINICAL NEUROSCIENCE 10, 13 (2014). The authors break down the origin of the term anosognosia further, “[A]=without, noso=disease, gnosia=knowledge.” *Id.* at 12–13. Although the exact anatomical basis is still unclear, it appears that the frontal and parietal lobes are most affected in people with anosognosia. TORREY, *supra*, at 116 (“The anatomical basis of anosognosia, however, should not be oversimplified. Most brain functions utilize circuits involving multiple brain areas, and this is certainly true for anosognosia. Thus there is no single ‘anosognosia center’; rather, self-awareness is a product of a complex circuit prominently involving areas in the frontal and parietal lobes, the connections between them, and other brain areas.”). Although this lack of insight has been noted in people with serious mental illness throughout history, the term was first used to describe people suffering from paralysis after a stroke who denied that they were paralyzed. Supreme Court Justice William Douglas suffered from anosognosia following a stroke; when he became paralyzed on his left side “he initially dismissed the paralysis as a myth, and weeks later he was still inviting reporters to go on hiking expeditions with him.” James Shreeve, *The Brain That Misplaced Its Body*, DISCOVER MAG. (1995) available at <http://discovermagazine.com/1995/may/thebrainthatmisp502> [<http://perma.cc/35K2-GXR8>].

illness means that people with chronic and long-term illnesses like schizophrenia and bipolar disorder often need some assistance in order to obtain mental health treatment and services.⁵ Without assistance, whether from family members, communities, or the state, many are otherwise largely unable to care for themselves or access appropriate mental health care. This lack of access to treatment and resources has led to the marginalization of many people with mental illness—to the streets, to prisons, and to a variety of situations where they are at higher risk of becoming victims of crimes.⁶

Before the 1950s, many people with serious mental illness in the United States lived for most or all of their lives in state-run institutions.⁷ But as states began to “deinstitutionalize” inpatient psychiatric patients and heighten civil commitment standards, more patients who would have previously been treated in a long-term inpatient facility were left to find treatment on their own in the community. Well-intentioned civil rights and community mental health advocates believed that most people suffering from serious mental illness would be better served in their own communities.⁸ Of course, along with this belief was a corresponding expectation that those individuals would voluntarily seek that treatment and that treatment would be available to them in those communities.

For some patients with chronic and serious mental illness, however, especially those without the resources to obtain care in the community, neither of these things happened. Instead, many of these people have become “revolving-door patients”; they have a serious mental disorder, do not voluntarily comply with treatment, and are unable to live successfully in the community without treatment. They often cycle in and out of hospital emergency rooms, where they receive the minimum amount of care necessary to stabilize them, and are discharged. Long-term treatment in the community is often unavailable, and without that care, many people with serious mental illness live on the streets,

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5. People without such insight into the nature of their illnesses are often unaware they have an illness, have difficulty recognizing the symptoms and deficits of the illness, and do not understand the need for treatment of the illness. Lehr & Lorenz, *supra* note 4, at 11. Impaired insight in patients with serious mental illness is associated with lower treatment adherence, impaired social skills and work performance, higher rates of relapse, and increased violence and suicidal behavior. Peter F. Buckley et al., *Lack of Insight in Schizophrenia: Impact on Treatment Adherence*, 21 CNS DRUGS 129, 130 (2007).
 6. Virginia Aldigé Hiday, *Criminal Victimization of Persons with Severe Mental Illness*, 50 PSYCHIATRIC SERVS. 62, 66 (1999) (“The rate of violent criminal victimization in the sample was more than two and a half times the rate in the general population.”).
 7. Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY 30, 32 (2010).
 8. TORREY, *supra* note 4, at 3–5.

commit crimes for which they are sent to prison, or become victims of crime themselves.

Access to appropriate mental health care is a problem with tremendous scope in this country and there is no easy solution. Issues ranging from funding, to delivery, to quality of care have led many to conclude that the “mental health care system is ‘in shambles.’”⁹ For some people with serious mental illness, however, it is not just a question of the delivery or quality of the care they receive; it is that they receive almost no mental health services at all. Civil commitment is one way to ensure that people who are otherwise not receiving treatment for mental illness receive those services. Although most states have statutes that ostensibly allow for commitment when a person is not dangerous to herself or others but is nevertheless unable meet her basic needs for food and shelter, these standards are often interpreted strictly to require dangerousness. In these cases, the individual’s lack of ability to meet her basic needs must be so grave that death is likely to result. For this reason, some people with untreated serious mental illness do eventually harm themselves or another person, further increasing public perceptions of a link between mental illness and violence, and stigmatizing those with mental illness. Meanwhile, people with serious mental illness who are not dangerous often do not have access to appropriate mental health care, or the resources to obtain available care.

This Article proposes that courts and psychiatrists go beyond a finding of dangerousness as a predicate for civil commitment, and instead interpret gravely disabled statutes to allow for commitment when an individual is unable to provide for her basic needs but does not pose a danger to herself. An expansion of civil commitment is far from an ideal solution, but it is one that could potentially provide access to mental health care and treatment to individuals who will not otherwise receive it.

Part I of this Article traces the history of civil commitment in the United States, as well as shifts in attitudes about the role of the state in providing mental health care to people with serious mental illness. Part II reviews current state statutes and trends relating to civil commitment, including dangerousness and gravely disabled grounds. Part III examines the role of psychiatrists and courts in civil commitment proceedings and the tendency of both to read a dangerousness requirement into gravely disabled grounds for commitment. Part IV considers the public perception of the link between mental illness and violence and argues that this perception has been perpetuated by civil commitment statutes that incorporate connections between mental illness and dangerousness. This Part also examines the current research on the lack of a direct connection between mental illness and violence. Part V exam-

9. RICHARD G. FRANK & SHERRY A. GLIED, *BETTER BUT NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950* 2 (2006).

ines the effect of deinstitutionalization and heightened commitment standards on access to mental health treatment for people with serious mental illness. Part VI concludes and recommends that courts and psychiatrists recognize states' obligations to provide health care to people with serious mental illness by interpreting gravely disabled statutes to allow for commitment when an individual is unable to provide for her basic needs but does not pose a danger to herself.

I. THE HISTORY OF CIVIL COMMITMENT IN THE UNITED STATES

The United States has undergone enormous shifts in its treatment of people with mental illness, which has taken various forms from a more paternalistic model—one that sought to commit people whenever they might benefit from intervention—to a more libertarian model, or one that seeks to limit any form of commitment to people who might harm themselves or other members of society.¹⁰ In this way, mental health differs markedly from physical health; patients must give informed consent to medical treatment for any physical disorder and any person “of adult years and sound mind has a right to determine what shall be done with his own body.”¹¹ When an illness is mental rather than physical, however, the state is empowered by civil commitment statutes to impose its decision-making and requirements on that treatment. The scope of that power, however, has long been a subject of controversy.

State intervention in the mental health treatment of citizens in the form of civil commitment statutes is a fairly recent development in this country. In Colonial America, family members were the source of most care for the mentally ill, and those without familial support often formed groups of itinerant “drifters” who moved from town to town.¹² If a mentally ill person became violent or otherwise posed a threat to the community, he was imprisoned.¹³ Because the family was responsible for supporting its members, early examples of community action appear limited to attempts to help impoverished families care for their mentally

10. Testa & West, *supra* note 7, at 32–33.

11. *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914). As the Supreme Court noted when citing *Schloendorff*, the informed consent doctrine “has become firmly entrenched in American tort law.” *Cruzan v. Dir., Missouri Dep’t of Health*, 497 U.S. 261, 269 (1990). Furthermore, the Court has found this right to be a constitutionally protected liberty. *Riggins v. Nevada*, 504 U.S. 127, 133–34 (1992).

12. SAMUEL J. BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 12 (1985).

13. *Id.* at 12–13.

ill members. In this way, the treatment of the very poor and the mentally ill seem quite similar, and were often seen as examples of charity to the family, rather than any attempt to help the mentally ill person. For example, in 1655, Providence, Rhode Island, gave a man 15 shillings “for helpe in this his sad condition of his wife’s distraction.”¹⁴

In 1771, the first mental hospital was established in Pennsylvania and communities began to take a more active role in treating the mentally ill; soon state legislatures began passing laws that allowed for the involuntary commitment of citizens to state institutions.¹⁵ These early statutes primarily allowed for the mentally ill to be confined when they were violent and posed a danger to themselves or their community, and when they did not have relatives who could properly care for them.¹⁶ One of the first cases of commitment of a nonviolent mentally ill person was in 1845 in Massachusetts.¹⁷ A man named Josiah Oakes was detained not because he was violent, but because his family believed that following the death of his wife, his hallucinations caused him to become engaged to a much younger woman of “bad character.”¹⁸ The court found that his detention was appropriate, both because his illness might cause him to take actions harmful to himself, but also because the restraint itself might “be conducive” to his restoration.¹⁹

For much of the next two hundred years, civil commitment statutes and the ability of the state to confine the mentally ill continued to expand. Many scholars attribute this expansion to two primary causes. First, as local governments expanded, the view that the family was solely obligated to care for its members changed and communities began to take a larger role in assuming responsibility for this care. Second, as the psychiatric field gained greater prominence, techniques were developed to help “treat” the mentally ill, and detention began to be seen as part of the therapeutic process.²⁰ As treatment for mental illness—and

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14. ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA* 49 (1937).
 15. CHRISTOPHER SLOBOGIN ET AL., *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 804 (5th ed. 2013).
 16. BRAKEL ET AL., *supra* note 12, at 14 (citing a 1788 New York statute that noted that “there are sometimes persons, who by lunacy or otherwise are furiously madd, or are so far disordered in their senses that they may be dangerous to be permitted to go abroad”).
 17. *In re Oakes*, 8 Law Rep. 122 (Mass. 1845).
 18. *Id.* at 127 (“The fact of an old man, a widower, wishing to marry a young wife, is not of itself evidence of insanity. But the circumstances, and the conduct of Mr. Oakes, attending the proposed marriage, are evidence that lie was laboring under a hallucination of mind.”).
 19. *Id.* at 129.
 20. SLOBOGIN ET AL., *supra* note 15 at 805–06. As Slobogin notes, one well-known exception to this general expansion of commitment authority was a woman named Mrs. Packard, who was committed to the Illinois State Hospital in

optimism about that treatment—continued to develop, mental hospitals opened throughout the country.²¹ Meanwhile, the standard for civil commitment continued to loosen and, by 1970, thirty-one states had statutes that allowed commitment upon a finding by a physician that the person was mentally ill and was in need of treatment.²²

As state commitment standards evolved, courts began to articulate two primary legal principles that give states an interest in the civil commitment of people with mental illness. The first is the *parens patriae* authority, which gives the state the power—and the responsibility—to intervene on behalf of citizens who cannot act in their own best interests.²³ The *parens patriae* authority obligates the state to care for people whose mental illness renders them unable to make appropriate medical decisions for themselves.²⁴ The second principle is the police power, which obligates states to protect the interest of citizens.²⁵ The state, therefore, owes a duty to people other than the mentally ill individual. Statutes that allow for civil commitment when a person is believed to be dangerous to others are one example of the state’s exercise of this police power to implement laws that may benefit society at large, though at the cost of the individual liberties of the mentally ill patient.²⁶

1860 under a statute that allowed for “[m]arried women and infants, who in the judgment of the medical superintendent are evidently insane or distracted, may be received and detained in the hospital at the request of the husband . . . without the evidence of insanity or distraction required in other cases.” Her commitment was based primarily on the testimony of two doctors, one of whom said she was rational, but was a “religious bigot,” and the other who said she had “novel” ideas. Mrs. Packer was released three years later and vigorously campaigned against laws that allowed people to be committed based solely on their opinions. The Illinois legislature subsequently enacted a statute that required a jury trial before a person can be committed to a mental institution. *See also* BRAKEL ET AL., *supra* note 12, at 15.

21. SLOBOGIN ET AL., *supra* note 15, at 806.
22. *Id.*
23. For a general overview of the state’s *parens patriae* authority as a basis for civil commitment, see BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 66–68 (2005).
24. *See* Addington v. Texas, 441 U.S. 418, 426 (1978) (holding that “[t]he state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves”).
25. *Jacobson v. Massachusetts*, 197 U.S. 11, 27 (1905). For a general overview of the state’s police power as a basis for civil commitment, see WINICK, *supra* note 23, at 59–66.
26. Eric S. Janus, *Toward a Conceptual Framework for Assessing Police Power Commitment Legislation: A Critique of Schopp’s and Winick’s Explications of Legal Mental Illness*, 76 NEB. L. REV. 1, 2–4 (1997).

Notwithstanding the development of controlling legal standards, it was fairly simple to hospitalize a person against her will throughout the first half of the twentieth century: one simply had to establish the presence of mental illness and provide a physician's recommendation that treatment at a psychiatric hospital was necessary.²⁷ Inpatient treatment was considered beneficial and there were few procedural barriers to admission.²⁸ Because commitment statutes were overwhelmingly based on the states *parens patriae* authority, and because the government was ostensibly meeting its obligation to provide patients with necessary treatment during commitment, few were concerned with the coercive nature of requiring patients to comply with the prescribed treatment.²⁹

Beginning in the 1950s, however, the country began experiencing another shift in its treatment of the mentally ill, this time away from the more paternalistic *parens patriae* approach and towards a libertarian approach—one where the state began to intervene less, commitment requirements became stricter, and mental hospitals began to rapidly diminish. This period of deinstitutionalization can be traced to a number of factors, including a series of exposés about the treatment of the mentally ill in state-run institutions,³⁰ and the concurrent efforts of civil rights lawyers and mental health professionals who pushed for mental health care reform.³¹ At the same time, advances in modern psychiatric treatment and pharmacology contributed to the change. Chlorpromazine, or Thorazine, first became available in 1954 and was the first antipsychotic medication that controlled the symptoms of schizophrenia for some patients, thus allowing them to live outside the constraints of a psychiatric facility.³² Mental health professionals began to

27. WINICK, *supra* note 23, at 4.

28. Testa & West, *supra* note 7, at 32.

29. *Id.*

30. See, e.g., Mike Gorman, *Misery Rules in State Shadowland*, THE DAILY OKLAHOMAN 3 (1946), available at <http://profiles.nlm.nih.gov/ps/access/TGBBGW.pdf> [<http://perma.cc/ZNK9-7YCY>] (describing “the frightful squalor these unfortunates live in—beds jammed against one another, holes in the floor, gaping cracks in the wall, long rows of hard, unpainted benches, dirty toilets, dining halls where the food is slopped out by unkempt patient attendants and, above all, the terrifying atmosphere of hopelessness in institutions where thousands of patients are penned in day after day and night after night endlessly staring at blank walls”); ALBERT DEUTSCH, THE SHAME OF THE STATES 42 (1948) (describing mental hospitals as “buildings swarming with naked humans herded like cattle and treated with less concern, pervaded by a fetid odor so heavy, so nauseating, that the stench seemed to have almost a physical existence of its own”).

31. TORREY, *supra* note 4, at 3–5.

32. E. FULLER TORREY ET AL., THE SHORTAGE OF PUBLIC HOSPITAL BEDS FOR MENTALLY ILL PERSONS: A REPORT OF THE TREATMENT ADVOCACY CENTER 3 (2008); Testa & West, *supra* note 7, at 33.

see psychotic patients as more manageable, and also more able to manage their own lives outside of institutions.³³

At the same time, deinstitutionalization became judicially sanctioned when federal and state courts began changing standards for commitments.³⁴ Civil commitment laws were rewritten to provide greater protections to the mentally ill, and included provisions meant to protect the right to liberty of patients. Among these protections were the patient's right to a trial with an attorney present and increased oversight by courts throughout the duration of confinement.³⁵ Patients were also given rights to litigate before and after admission and to refuse treatment. The process effectively shifted from one overseen and administered by physicians to a more adversarial process subject to judicial review.

States also began to adopt stricter civil commitment standards, shifting away from the traditional need for treatment model to narrower "dangerousness to self or others" standards. Unlike traditional commitment standards, which relied on states' *parens patriae* authority, this heightened standard was an exercise further justified by the state's police power. Because the state has an interest in protecting citizens from the dangerous acts of people with mental illness, many states amended civil commitment statutes to allow for commitment only when the mentally ill person was found to pose a danger to themselves or others.³⁶ This standard continues to invoke the state's *parens patriae* authority to protect an individual who is dangerous to herself, but also uses the police power to protect communities from individuals who are dangerous to others.

Another related and significant explanation for the shift towards the closing of psychiatric facilities and the movement of the mentally ill into communities is the creation in the 1960s of federal programs and federal funding of the treatment of the mentally ill. For instance, in

33. Lisa Davis et al., *Deinstitutionalization? Where Have All the People Gone?*, 14 CURRENT PSYCHIATRY REP. 259, 260 (2012).

34. Gerald N. Grob, *The Paradox of Deinstitutionalization*, SOC'Y 51, 53 (July/August 1995). As Grob notes,

[t]he traditional preoccupation with professional needs was supplemented by a new concern with patient rights. Courts defined a right to treatment in a least-restrictive environment, shorted the duration of all forms of commitment and placed restraints on its application, undermined the sole right of psychiatrists to make purely medical judgments about the necessity of commitment, accepted the right of patients to litigate both before and after admission to a mental institution, and even defined a right of a patient to refuse treatment under certain circumstances.

Id.

35. Testa & West, *supra* note 7, at 32.

36. WINICK, *supra* note 23, at 58–59.

1963 Congress passed the Community Mental Health Act,³⁷ providing funding for the creation of community-based outpatient treatment centers. The Act was meant to move treatment of individuals out of isolated hospitals and into the community, where they would have access to support groups and employment opportunities.³⁸ In 1965, Medicare and Medicaid were introduced, which provided federal funds to states for the treatment of mentally ill individuals, but only if those individuals lived in the community.³⁹

These federal programs, therefore, created an incentive for states, which had traditionally financed mental hospitals with state funds, to discharge patients into the community and defer the cost of treatment to the federal government.⁴⁰ Outpatient treatment was expanded and states began moving mentally ill patients out of state hospitals and into federally subsidized facilities like nursing homes and group homes.⁴¹ Other social welfare programs were also becoming more common during this time, including Social Security Income (SSI) and Social Security Disability Income (SSDI), which allowed people with mental illness who were living in the community to receive benefits from the federal government for housing and food stamps.⁴²

While states may have originally been financially incentivized to shift the care of people with mental illness into communities, federal funding of community-based mental health services was significantly curtailed with the passage of the Omnibus Budget Reconciliation Act of 1981.⁴³ This act consolidated federal funding and shifted treatment costs for the mentally ill back to individual states, and provided a single block grant that allowed each state to administer its funds to mentally ill individuals.⁴⁴ Appropriations for the block grant were significantly

37. Pub. L. No. 88-164, 77 Stat. 282.

38. SLOBOGIN ET AL., *supra* note 15, at 810.

39. Davis et al., *supra* note 33, at 260.

40. TORREY ET AL., *supra* note 32, at 3 (2008); *see also* Robert A. Brooks, *Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey*, 35 J. AM. ACAD. PSYCHIATRY L. 219, 219 (2007) (noting that, following California's lead from the 1960s, states increasingly "tighten[ed] criteria for civil commitment"); AM. PSYCHIATRIC ASS'N, MANDATORY OUTPATIENT TREATMENT RESOURCE 2 (1999). For an excellent description of the development of the role of Medicaid, Medicare and SSI in the coverage of mental health care, *see* FRANK & GLIED, *supra* note 9, at 93-96.

41. Davis et al., *supra* note 33, at 260.

42. *Id.*

43. *Id.*

44. *Id.* *See also* Nat'l Inst. of Mental Health, *Important Events in Mental Health History*, <http://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh> [<https://perma.cc/YV7E-DPGS>]

lower than previous federal expenditures on community-based mental health programs, and the mental health system also had to compete with other governmental programs to receive its share of the funds.⁴⁵ As a result, state mental health spending has declined; Medicaid is now the largest funder of mental health services in the United States and contributes more money to mental health than any other public or private provider.⁴⁶ But this decentralization of services and entitlements is largely uncoordinated; “[t]he resources flow from a dizzying range of federal, state, and private organizations.”⁴⁷

These shifts in state approaches to treatment of the mentally ill have benefited many people with mental illness. Institutions in the middle of the twentieth century were often used to warehouse the mentally ill; many people lived in hospitals for most or all of their lives without receiving care. But, as discussed in the next Part, for people with serious mental illness who are not dangerous to either themselves or other people, but who are nevertheless unable to provide for their basic needs in the community, heightened standards for civil commitment have meant that not all individuals with serious mental illness living in their communities are receiving appropriate mental health care and services.

II. CURRENT TRENDS IN CIVIL COMMITMENT

A. Danger to Self or Others

Civil commitment laws in the United States are primarily the responsibility of individual states.⁴⁸ And while commitment statutes vary tremendously among states, every state first requires a finding that the person subject to commitment is mentally ill, and that as a result of that mental illness, the person meets one or more of the additional grounds for commitment.⁴⁹ Historically, the additional ground needed

(last updated Feb. 19, 2016) (depicting critical events in mental health treatment history).

45. FRANK & GLIED, *supra* note 9, at 60–61.
46. Cynthia Shirk, *Medicaid and Mental Health Services*, 66 NAT’L HEALTH POL’Y F. 3 (2008) (“In 2003, Medicaid spent over \$26 billion on mental health services—about 26 percent of total national mental health expenditures.”).
47. FRANK & GLIED, *supra* note 9, at 5.
48. Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43 ISR. J. PSYCHIATRY & RELATED SCI. 209, 211 (2006).
49. *See, e.g.*, ALA. CODE § 22-52-10.4 (2016) (“(a) A respondent may be committed to inpatient treatment if the probate court finds, based upon clear and convincing evidence that: (i) the respondent is mentally ill; (ii) as a result of the mental illness the respondent poses a real and present threat of substantial harm to self and/or others; (iii) the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and (iv) the respondent is unable to make

for commitment was a simple finding of “need for treatment.”⁵⁰ The need for treatment model was justified by the states’ *parens patriae* authority and allowed the government to substitute its decision-making for that of an incompetent individual.⁵¹ But beginning in the 1950s, states began to modify civil commitment standards, shifting away from the traditional need for treatment models to narrower “dangerousness to self or others” standards. The state’s interest in protecting citizens from the dangerous acts of others is a fundamental part of its police power, and forms the basis for civil commitments based upon a finding of dangerousness to others.⁵² In 1964, the District of Columbia adopted the first civil commitment statute with dangerousness as the only allowable grounds for commitment,⁵³ and in 1967 California adopted the Lanterman-Petris-Short Act, allowing for civil commitment only when a person was an imminent danger to themselves or others, or was so “gravely disabled” that he would be unable to meet his basic needs for survival.⁵⁴ Other states began adopting stricter dangerousness standards and rejecting previous “need for treatment” standards as vague and unconstitutional.⁵⁵

Every state now allows that an individual may be committed upon a finding that she poses a danger to herself or others.⁵⁶ There are significant differences among states, however, as to the definition of danger

a rational and informed decision as to whether or not treatment for mental illness would be desirable.”). Most states also require that a decision in civil commitment adjudications represent the “least restrictive alternative.” JOHN PARRY, *CIVIL MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY* 475 (2010) (“Often, this requirement affects if, where, and under what conditions commitment will take place, and not whether a person meets the commitment standards.”).

50. See *supra* text accompanying notes 18–20.
51. WINICK, *supra* note 23, at 66.
52. *Id.* at 59.
53. Anfang & Appelbaum, *supra* note 48, at 211.
54. Carol A.B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California’s Lanterman-Petris-Short Act*, 11 L. & SOC’Y REV. 629, 630 (1977).
55. Anfang & Appelbaum, *supra* note 48, at 211.
56. Testa & West, *supra* note 7, at 33. Although Testa and West note that a minority of states, including Delaware and Iowa, did not allow for a commitment upon a finding of danger to self or others, both states have since updated their laws. *Id.* Delaware amended its statute in 2014 to allow for commitment when, “[b]ased upon manifest indications, the individual is: a. dangerous to self; or b. dangerous to others.” DEL. CODE ANN. tit. 16, § 5011(a) (2014). Similarly, in 2013, Iowa amended its statute to allow for a commitment of a “person who presents a danger to self or others and lacks judgmental capacity due to . . . serious mental impairment.” IOWA CODE ANN. § 229.6(2) (West 2016). A person with a “serious mental impairment” is one who “[i]s likely to

to self or others. Dangerousness is usually interpreted to mean physical harm to self, including attempted suicide, or to others, including overt acts and threats of violence.⁵⁷ At one time, most states required evidence of recent and overt threats or actions to establish that the individual posed a danger to others,⁵⁸ but many states now allow predictions of future dangerousness to be established based on recent behavior.⁵⁹ Some states require that the danger be imminent, or likely to occur immediately or in the near future,⁶⁰ while others have eliminated the imminence requirement, as long as the danger is substantial.⁶¹ Other

physically injure the person's self or others if allowed to remain at liberty without treatment." IOWA CODE ANN. § 229.1(20) (West 2016). Neither statute allows for commitment upon a finding of grave disability.

57. PARRY, *supra* note 49, at 476.
58. *Id.* See, e.g., Nev. Rev. Stat. § 433A.115(3) (2013) ("A person presents a clear and present danger of harm to others if, within the immediately preceding 30 days, the person has, as a result of a mental illness, inflicted or attempted to inflict serious bodily harm on any other person, or made threats to inflict harm and committed acts in furtherance of those threats, and if there exists a reasonable probability that he or she will do so again unless the person is admitted to a mental health facility . . . and adequate treatment is provided to him or her.").
59. See, e.g., S.D. CODIFIED LAWS § 27A-1-1(6) (2013) ("'Danger to others,' a reasonable expectation that the person will inflict serious physical injury upon another person in the near future, due to a severe mental illness, as evidenced by the person's treatment history and the person's recent acts or omissions which constitute a danger of serious physical injury for another individual.").
60. See, e.g., GA. CODE ANN. § 37-3-1(9.1)(A)(i) (2012) ("'Inpatient' means a person who is mentally ill and . . . [w]ho presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons.").
61. See, e.g., UTAH CODE ANN. § 62A-15-631(10)(b) (LexisNexis 2015) ("[B]ecause of the proposed patient's mental illness the proposed patient poses a substantial danger . . ."). See also Robert I. Simon, *The Myth of "Imminent" Violence in Psychiatry and the Law*, 75 U. CIN. L. REV. 631, 632 (2006) (discussing the somewhat arbitrary timeframes clinicians use to determine "imminence"). In assessing imminent dangerousness to others, Simon notes that clinicians have used standards ranging from "[seven] days following assessment," to "the near future (i.e., days or a week or so)." *Id.* at 633. And while he observes that "[t]hese time limits seemed to be pulled out of thin air," he concedes that "in prediction research it is appropriate to use the term 'imminent,' so long as the time frame is specified . . ." *Id.* at 634. In assessing imminent dangerousness to others, Simon notes that "[c]linicians ascribe arbitrary time limits for 'imminent' suicide, although most time frames are vague, usually given as a range such as 12-24 hours, 24-48 hours, 1-3 weeks, 1 month or 1 year." *Id.* at 632.

statutes do not define dangerousness or include a timeframe, but simply require that the person pose a threat of harm to herself or others.⁶²

In *O'Connor v. Donaldson*,⁶³ the only Supreme Court case to speak directly to civil commitment criteria, the Court held that Kenneth Donaldson—a Florida man who had been held for fifteen years in a state hospital with no treatment—could not be held “without more” if he were not dangerous and “capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”⁶⁴ The Court’s use of the term “without more” has caused some to question whether the absence of treatment or the dangerousness criterion was more critical to the Court’s analysis.⁶⁵ In other words, the opinion could be read to mean “if treatment is provided *or* if the patient is dangerous, commitment can continue.”⁶⁶ Nevertheless, most courts have interpreted the case to endorse the dangerousness standard in civil commitment cases.⁶⁷

62. See, e.g., ALA. CODE § 22-52-10.4(a)(ii) (2016) (“[A]s a result of the mental illness the respondent poses a real and present threat of substantial harm to self and/or others . . .”).

63. 422 U.S. 563 (1975).

64. *Id.* at 576.

65. As Anfang and Appelbaum note, “the Court’s comments . . . were so ambiguous that they could be interpreted to support either position.” Anfang & Appelbaum, *supra* note 48, at 211.

66. *Id.* Interestingly, in a later case finding that patients must be mentally competent to sign consent forms for a voluntary inpatient commitment, the Court cited a different portion of the *O'Connor* decision, which seems to endorse the dangerousness standard *Zinerman v. Burch*, 494 U.S. 113, 134 (1989) (citing *O'Connor*, 422 U.S. at 575) (“[T]here is no constitutional basis for confining mentally ill persons involuntarily ‘if they are dangerous to no one and can live safely in freedom’”). The Court did not cite the portion of the prior opinion that referred to “without more.” Compare *O'Connor*, 422 U.S. at 575, with *Zinerman*, 494 U.S. at 134.

67. The Court also defined the burden of proof for a civil commitment in *Addington v. Texas*, where it rejected the beyond-a-reasonable-doubt standard and established the clear-and-convincing standard as providing the minimum procedural threshold for issuing an involuntary commitment order. *Addington v. Texas*, 441 U.S. 418, 432–33 (1979) (“We have concluded that the reasonable-doubt standard is inappropriate in civil commitment proceedings because, given the uncertainties of psychiatric diagnosis, it may impose a burden the state cannot meet and thereby erect an unreasonable barrier to needed medical treatment. . . . To meet due process demands, the standard has to inform the factfinder that the proof must be greater than the preponderance-of-the-evidence standard applicable to other categories of civil cases.”); see also Alexander Tsesis, *Due Process in Civil Commitments*, 68 WASH. & LEE L. REV. 253 (2011) (arguing that the clear-and-convincing standard did not adequately protect patients’ due process rights); PARRY, *supra* note 49, at 483 (“Forty-seven jurisdictions have statutory language that requires clear and convincing evidence or something that includes that

As states began adopting statutes that required a finding of dangerousness as grounds for commitment, this necessitated a means of assessing future dangerousness. As one author put it, the need for a reliable method of predicting future dangerousness

did not arise as a result of clinical experience or wisdom, or of empirical evidence, or even of the quest for testable hypotheses about human behavior and its antecedents. It arose out of pragmatic needs for criteria to make distinctions between patients appropriate for inpatient or outpatient treatment, or for voluntary or involuntary treatment, when those became real choices in the 1960s and 1970s.⁶⁸

Predicting the likelihood of future dangerousness required by civil commitment statutes, however, is a difficult task and has long posed unique challenges to clinicians. Early studies examining the accuracy of future risk assessment found that “clinicians had little expertise in predicting violent outcomes.”⁶⁹ These critiques of clinical predictions of violence based on informal impressions and individual judgment led to the development of standardized psychological tests—actuarial risk assessment instruments—that help clinicians evaluate the likelihood that an individual will become violent.⁷⁰ And while these instruments have improved clinicians’ ability to forecast future violence, they are not foolproof and many consider the field of risk assessment to continue to be largely unreliable.⁷¹

standard plus something a little more, such as ‘clear, cogent, and convincing’ in North Carolina, Washington, and West Virginia.”).

68. Michael A. Norko & Madelon V. Baranoski, *The Prediction of Violence: Detection of Dangerousness*, 8 BRIEF TREATMENT & CRISIS INTERVENTION 73, 73 (2008).
69. See Mairead Dolan & Michael Doyle, *Violence Risk Prediction*, 177 BRIT. J. OF PSYCHIATRY 303, 303 (2000) (citing various studies); see also Stephen D. Hart et al., *Precision of Actuarial Risk Assessment Instruments*, 190 BRIT. J. OF PSYCHIATRY (SUPP. 49) S60, S60 (2007) (“Research indicates that predictions of violence made using unaided (i.e., informal, impressionistic or intuitive) judgement are seriously limited with respect to both inter-clinician agreement and accuracy.”).
70. Jennifer L. Skeem & John Monahan, *Current Directions in Violence Risk Assessment*, 20 CURRENT DIRECTIONS IN PSYCHOL. SCI. 38, 38 (2011); see also Hart et al., *supra* note 69, at S60 (discussing the development and use of actuarial risk assessment instruments (ARAI)). Some states even require that specific risk assessment tools be used when assessing likelihood of future risk. Skeem & Monahan, *supra*, at 38 (noting that “Virginia’s Sexually Violent Predator statute not only mandates the use of a specific instrument but also specifies the cutoff score on that instrument that must be achieved to proceed further in the commitment process”).
71. See, e.g., Norko & Baranoski, *supra* note 68, at 79–80 (noting that “[d]espite clear progress in the empirical understanding of the correlates of violence,

Furthermore, even with improved assessment techniques, dangerousness is a concept that is difficult to define and subject to individual interpretation. One study found that some psychiatrists interpreted a dangerousness standard to require that a patient pose an immediate, clear, or imminent danger to self or others, while others thought the statute required that the patient's condition present a probable, possible, or potential danger.⁷² Others thought emergency hospitalization was permitted only for homicidal or suicidal patients, while some believed commitment was permissible when a patient exhibited self-destructive impulses.⁷³ Because many state statutes do not define "danger," the statutes themselves put the burden on clinicians to substitute their own judgment for what a finding of dangerousness should encompass.⁷⁴ Finally, a determination of dangerousness is distinct from most factual determinations because it requires clinicians to predict the likelihood of an event occurring in the future, as opposed to determining whether a particular event has already occurred.⁷⁵ Without clear statutory guidance on the definition of danger, many psychiatrists are necessarily forced to use "discretion to rule in a manner consistent with his or her value system, as opposed to applying fact and law in a neutral manner."⁷⁶

B. Grave Disability

A finding of danger to self or others has therefore become the primary grounds for civil commitment since deinstitutionalization, and one

there are substantial limitations of the science, especially in application to individual patients or evaluatees"); Dolan & Doyle, *supra* note 69, at 303 ("Violence risk prediction is an inexact science and as such will continue to provoke debate.").

72. Glenn G. Affleck et al., *Psychiatrists' Familiarity with Legal Statutes Governing Emergency Involuntary Hospitalization*, 135 AM. J. PSYCHIATRY 205, 208 (1978).

73. *Id.*

74. William M. Brooks, *The Tail Still Wags The Dog: The Pervasive And Inappropriate Influence By The Psychiatric Profession On The Civil Commitment Process*, 86 N.D. L. REV. 259, 293 (2010) [hereinafter Brooks]. See, e.g., HAW. REV. STAT. ANN. § 334-1 (West 2008) ("Dangerous to others" means likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat . . . 'Dangerous to self' means the person recently has: (1) Threatened or attempted suicide or serious bodily harm; or (2) Behaved in such a manner as to indicate that the person is unable, without supervision and the assistance of others, to satisfy the need for nourishment, essential medical care, shelter or self-protection, so that it is probable that death, substantial bodily injury, or serious physical debilitation or disease will result unless adequate treatment is afforded.").

75. Brooks, *supra* note 74, at 294.

76. *Id.* at 295.

that is justified under the state's police power and its *parens patriae* authority. More recently, however, many states have begun to recognize the value of commitment for individuals who are seriously mentally ill but not dangerous to themselves or others.⁷⁷ These additional grounds for commitment, including grave disability, are premised solely on states' *parens patriae* authority, in that the state is substituting its judgment for that of the mentally ill person and providing treatment that the individual might have chosen for herself had she been competent.⁷⁸ For the state to commit an individual using its *parens patriae* authority, hospitalization must be more than beneficial to the person; it must also be necessary because the person's ability to make decisions for herself is so impaired that she is unable to understand that treatment is in her own best interest.⁷⁹

In the 1970s, states began including grounds for commitment based on "grave disability." Although grave disability can implicate states' police power when based upon a finding that the individual is dangerous to herself, it can also implicate the *parens patriae* authority when based upon a finding that the individual is unable to provide for her basic needs as a result of mental illness.⁸⁰ Although almost every state has a

77. Anfang & Appelbaum, *supra* note 48, at 212.

78. WINICK, *supra* note 23, at 66. Some states have allowed for even greater expansion of the *parens patriae* authority in civil commitments by again including explicit "need for treatment" standards in commitment statutes. *See, e.g.*, HAW. REV. STAT. ANN. § 334-60.2 ("A person may be committed to a psychiatric facility for involuntary hospitalization, if the court finds: (1) That the person is mentally ill or suffering from substance abuse; (2) That the person is imminently dangerous to self or others; and (3) That the person is in need of care or treatment, or both, and there is no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization.").

79. WINICK, *supra* note 23, at 42-43.

80. PARRY, *supra* note 49, at 478. At least forty-two states now incorporate a gravely disabled standard into civil commitment statutes. These include Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. *See* TREATMENT ADVOCACY CENTER, STATE STANDARDS FOR ASSISTED TREATMENT: CIVIL COMMITMENT CRITERIA FOR INPATIENT OR OUTPATIENT PSYCHIATRIC TREATMENT (2014). A few states do not follow this trend. For example, Delaware allows for civil commitment when the person is unable to make reasonable decisions about hospitalization. DEL. CODE ANN. tit. 16, § 5005(a) (Supp. 2014). Other states expand standards for gravely disabled. Iowa, for example, allows for commitment if the person has a mental illness and "[i]s likely to inflict serious emotional injury on members of the person's family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental

ground for commitment based on an individual's inability to provide for her own basic needs, many state statutes do not clearly distinguish between grave disability based on dangerousness to self, and grave disability based on an inability to provide for basic needs like food, clothing, shelter, and medical care.⁸¹ When grave disability is based on an inability to provide for one's basic needs, most states require that the resultant harm be "serious."⁸² Other states simply require that as a result of mental illness, the person is unable to provide for basic needs.⁸³

illness is allowed to remain at liberty without treatment." IOWA CODE § 229.1(17)(b) (West 2016).

81. Parry, *supra* note 49, at 478 ("The requirement that proposed patients be unable to provide for their basic needs is found both as an independent criterion and also as part of the grave disability provisions. Like grave disability, the most common formulation is one in which the inability to care for oneself causes substantial personal harm."). Some states also include the inability to make rational decisions within gravely disabled grounds for commitment. *See, e.g.*, COLO. REV. STAT. § 27-65-102(9) (2015) ("Gravely disabled' means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for his or her essential needs without significant supervision and assistance from other people."); CONN. GEN. STAT. § 17a-495 (2016) ("[G]ravely disabled' means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital treatment is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his psychiatric disabilities.").
82. *See, e.g.*, WASH. REV. CODE § 71.05.020 ("Gravely disabled' means a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety."). COLO. REV. STAT. § 27-65-102(9) (2015) ("Gravely disabled' means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for his or her essential needs without significant supervision and assistance from other people. As a result of being incapable of making these informed decisions, a person who is gravely disabled is at risk of substantial bodily harm, dangerous worsening of any concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of his or her essential needs that could result in substantial bodily harm.").
83. *See, e.g.*, OR. REV. STAT. § 426.005(1)(f) (2015) ("Person with a mental illness' means a person who, because of a mental disorder, is . . . [u]nable to provide for basic personal needs that are necessary to avoid serious physical harm in the near future, and is not receiving such care as is necessary to avoid such harm."); CAL. WELF. & INST. CODE § 5008(h)(1)(A) (West Supp. 2016) ("[G]ravely disabled' means . . . [a] condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.").

A minority of states explicitly tie a finding of grave disability to imminent danger.⁸⁴

Many states have civil commitment statutes that allow for commitment on grounds of both danger to self and grave disability. Arizona's statute, for example provides the following:

“Danger to self” (a) means behavior that, as a result of a mental disorder: (i) Constitutes a danger of inflicting serious physical harm on oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out (ii) Without hospitalization will result in serious physical harm or serious illness to the person (b) Does not include behavior that establishes only the condition of persons with grave disabilities.

“Persons with grave disabilities” means a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because the person is unable to provide for the person's own basic physical needs.⁸⁵

Some states have tried to make their *parens patriae* authority more explicit in gravely disabled commitment grounds by adding “deterioration” language to their civil commitment statutes, which allow for commitment when a person is not in imminent harm due grave disability, but is likely to become so in the near future without further treatment.⁸⁶ These broadened commitment standards are intended to provide treatment to people with serious mental illness, and also reduce the numbers of people with serious mental illness who become homeless or are incarcerated.⁸⁷ For example, Idaho defines gravely disabled to include an individual who, without treatment is substantially likely to “physically,

84. GA. CODE ANN. § 37-3-1(9.1) (2012) (allowing for inpatient commitment of a person “[w]ho is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis”).

85. ARIZ. REV. STAT. § 36-501.

86. John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCHOL., PUB. POL'Y, & L. 377, 385 (1998). *See also* MISS. CODE ANN. § 41-21-61(e) (2016) (defining “person with mental illness” as “a person who, based on treatment history and other applicable psychiatric indicia, is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness to himself or others when his current mental illness limits or negates his ability to make an informed decision to seek or comply with recommended treatment”).

87. Cornwell, *supra* note 86, at 385–86.

emotionally or mentally deteriorate to the point that the person will, in the reasonably near future, be in danger of serious physical harm due to the person's inability to provide for any of his own basic personal needs such as nourishment, essential clothing, medical care, shelter or safety."⁸⁸ Under these standards, the *parens patriae* authority explicitly allows for commitment before an individual is dangerous to herself.

Notwithstanding available *parens patriae* grounds for civil commitment, including grave disability, many courts and psychiatrists continue to read a dangerousness requirement into *parens patriae* grounds for commitment.⁸⁹ After the predicate finding of mental illness, "dangerous to self or others" is the most commonly used grounds for civil commitment orders.⁹⁰ And as discussed in the next Part, in civil commitment proceedings, "dangerousness determinations predominate whichever standard is used."⁹¹

III. THE ROLE OF PSYCHIATRISTS AND COURTS IN CIVIL COMMITMENT PROCEEDINGS

In the United States, mental health professionals typically testify in civil commitment hearings, and courts rely heavily on that testimony when deciding if an individual meets the state's standards for civil commitment.⁹² Psychiatrists are "perceived as holding the most power in the commitment process—in fact, some observers see courts as 'rubber stamps' of psychiatrists' testimony."⁹³ Studies suggest that there is a high correlation between psychiatrist's recommendations and judges'

88. IDAHO CODE ANN. § 66-317(13) (West 2016).

89. See *infra* text accompanying notes 158–170.

90. PARRY, *supra* note 49, at 476.

91. *Id.* at 474.

92. Brooks, *supra* note 40, at 219 ("Psychiatrists make decisions on admissions and discharges, and also frequently provide expert testimony in civil commitment cases."). See also WINICK, *supra* note 23, at 63 (noting that "[c]ivil commitment courts typically rely upon the testimony of clinical expert witnesses who have evaluated the individual and who present their clinical conclusions concerning the degree of risk he or she is thought to present"); Grant H. Morris, "Let's Do the Time Warp Again": *Assessing the Competence of Counsel in Mental Health Conservatorship Proceedings*, 46 SAN DIEGO L. REV. 283, 314–15 (2009) ("[D]espite the fallibility of psychiatric testimony, judges and juries, serving as fact finders in civil commitment and conservatorship proceedings, typically defer to psychiatric judgments that the person has a mental disorder and that the mental disorder meets the statutory standard for commitment or a conservatorship.").

93. Brooks, *supra* note 74, at 285 ("When judges defer to psychiatrists at a rate between 90 and 100 percent of the time the psychiatrist experts actually become the decision-makers in the civil commitment process.").

decisions in civil commitment proceedings, often as high as 90%.⁹⁴ Most judges have little training in mental health law or psychiatric diagnosis, so this deference to psychiatric forensic testimony in civil commitment proceedings is not surprising.⁹⁵ Furthermore, civil commitment proceedings may not be given priority by judges with busy caseloads, who may therefore lack an incentive to carefully scrutinize psychiatrists' recommendations.⁹⁶ Civil commitment proceedings tend to be short and perfunctory; as one author put it, "It seems safe to conclude that civil commitment is a disfavored stepchild in the large family of concerns that must be addressed by the justice system."⁹⁷

Like judges, lawyers are also deferential to psychiatrists in commitment adjudications. One study of North Carolina lawyers found that lawyers felt conflicted by their dual roles in commitment proceedings.⁹⁸ They viewed mental illness and treatment as medical problems, and tended to defer to psychiatrists' opinions and recommendations regarding civil commitment.⁹⁹ At the same time, they felt obligated to advocate for their clients and prevent the client's loss of freedom that would result from commitment.¹⁰⁰ Many lawyers in the study noted that "if they fought commitment under these circumstances, they could obtain release for anyone, even for the dangerously mentally ill; but release of the dangerous would be a Pyrrhic victory that would endanger the respondent or society and eliminate the chance for help."¹⁰¹ Perhaps as a result of these conflicting goals, most lawyers prepared much less for civil commitment cases than for other cases, many did not speak to clients before the hearing, and "rarely took an adversary role to obtain release of their clients whom psychiatrists had recommended for commitment."¹⁰²

94. *Id.*

95. Paul S. Applebaum, *Civil Commitment from a Systems Perspective*, 16 L. & HUM. BEHAV. 61, 66 (1992); see also Brooks, *supra* note 74, at 286 ("[J]udges defer to psychiatric opinion because they feel they lack the requisite expertise to independently assess whether patients meet the statutory criteria for commitment.").

96. Applebaum, *supra* note 95, at 66–67.

97. *Id.* at 66.

98. Virginia Aldigé Hiday, *Are Lawyers Enemies of Psychiatrists? A Survey of Civil Commitment Counsel and Judges*, 140 AM. J. PSYCHIATRY 323, 326 (1983).

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.* (noting that "they almost never challenged the medical affidavit or argued that the respondent was not mentally ill" and that "[o]nly infrequently did they argue that the dangerousness criterion was not met").

Civil commitment proceedings necessarily involve the interaction of two distinct systems: the mental health system and the justice system.¹⁰³ When testifying in civil commitment proceedings, psychiatrists therefore rely on both state commitment statutes and on the criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Typically, the DSM is used to diagnose the requisite mental condition, and it refers to its use in civil commitment proceedings by noting

[w]hen used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination.¹⁰⁴

In the context of civil commitment statutes, however, the DSM-5 is not determinative with respect to the outcome of a civil commitment proceeding. The finding of a “mental illness” is a predicate to other legal determinations, such as whether a person is dangerous or gravely disabled. Psychiatrists in commitment proceedings are therefore asked to make both clinical and legal determinations, and those legal determinations require knowledge of the relevant statutes and case law. For instance, how a psychiatrist believes the law requires her to interpret “gravely disabled” can have a large impact on whether a person is found to satisfy commitment statutes.

Several studies of psychiatrists and other clinicians “have documented a remarkable degree of ignorance of commitment criteria.”¹⁰⁵ Specifically, some psychiatrists are not aware of available grounds for civil commitment apart from grounds based upon a finding of danger to self or others. For instance, one study surveyed 1,500 members of the American Psychiatric Association (APA), including 1,000 APA general members and 250 members from each of two APA membership sections (Emergency Psychiatry and Suicide/Self-Injury) whose members were thought to have had more experience with civil commitment.¹⁰⁶ The study found many psychiatrists were not accurate when asked about grounds for civil commitment in their state. Only 70.7% of respondents correctly believed that grave disability was a ground for commitment

103. Applebaum, *supra* note 95, at 64–66.

104. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL ON MENTAL DISORDERS 25 (5th ed. 2013).

105. Applebaum, *supra* note 95, at 65.

106. Brooks, *supra* note 40, at 220.

in their state when it was a ground.¹⁰⁷ In contrast, 61.5% of respondents thought grave disability was a ground when it was not.¹⁰⁸

Furthermore, some scholars have suggested that mental illness and dangerousness are so intertwined that psychiatrists and judges are in fact unable to separate them.¹⁰⁹ This conflation is reflected in the Supreme Court's decision in *O'Connor v. Donaldson*¹¹⁰ and in states' responses to that decision, namely that the majority of states now have a dangerousness criterion in their civil commitment statutes.¹¹¹ Several studies have found that changes in civil commitment standards do not affect court practices or rates of commitment.¹¹² This discrepancy between civil commitment laws and their application has led some authors to "conclude that the actors' socially embedded agency—their perspectives, motivations and interests, as influenced by broader social representations—is the most determinant factor in civil commitment decisions."¹¹³

107. *Id.* at 223.

108. *Id.*

109. *E.g.*, Bernadette Dallaire et al., *Civil Commitment Due To Mental Illness And Dangerousness: The Union Of Law And Psychiatry Within A Treatment-Control System*, 22 SOC'Y OF HEALTH & ILLNESS 679, 691 (2000) (noting that "the widely shared tendency to equate mental illness with dangerousness is manifested in the rationale for, and operationalisation of, civil commitment laws").

110. 422 U.S. 563 (1975).

111. PARRY, *supra* note 49, at 476 (noting that "'dangerous to self or others,' or similar criteria based on harm to self or others, is the most commonly used statutory element for extended involuntary inpatient commitment; it is incorporated in some manner into the statutes of 36 jurisdictions and is an absolute requirement in most of them").

112. *See, e.g.*, Jonathan J. Marz & Richard M. Levinson, *Statutory Change And 'Street-Level' Implementation Of Psychiatric Commitment*, 27 SOC'Y SCI. & MED. 1247, 1253–54 (1988) ("Thus, rather than being passive objects of statutory changes, participants in the mental health system may actively adapt to the changes and look for ways to cope within the framework to obtain desired outcomes . . . the ambiguity of statutory criteria combined with the interests of participants dilute the impact of changes in the law."); Paul S. Appelbaum, *Almost A Revolution: An International Perspective On The Law Of Involuntary Commitment*, 25 J. AM. ACAD. OF PSYCHIATRY & L. 135, 142 (1997) (discussing the "relative lack of impact of commitment law changes in the United States").

113. Dallaire et al., *supra* note 109, at 690; *see also id.* at 689 ("[W]e observed that the pertinent legal provisions appeared less as rules uniformly applied than as rhetorical instruments where the actual citation of the entire article of the law served as sole argument for the law to be applied."). Of course, it is also possible that judges and psychiatrists do not apply standards with which they disagree. As one author put it, "laws are enforced by people; they do not enforce themselves. Unless a law is generally accepted as being worthy

While many states therefore include grave disability as an additional ground for commitment, courts and psychiatrists often conflate the two provisions, perhaps because some state statutes require that the grave disability due to an inability to provide for basic needs put the individual in danger of serious harm. Yet even in states that require serious harm, this requirement of harm should not be interpreted to rise to the level of danger or imminent danger to self as required by other dangerousness grounds for commitment. A common canon of statutory construction provides that if a statute includes a specific provision targeting a particular issue, that provision should apply instead of provisions more generally covering the issue.¹¹⁴ Gravely disabled provisions premised on an inability to provide for one's basic needs are included in almost every state civil commitment statute. This ground for commitment is included as an additional ground to provisions that allow for commitment when a person poses a danger to herself. For that reason, gravely disabled grounds that require a person's inability to meet her basic needs to require serious harm should not also be read to require a heightened finding of danger to self.

Moreover, the legislative intent of the gravely disabled standard seems to have been to broaden commitment statutes to allow for commitment before an individual was found to be dangerous. The Alaska Supreme Court, for example, in reviewing the legislative history of Alaska's addition of gravely disabled to its statutes in 1984, noted that the law before the amendment only allowed the state "to hold people with violent tendencies and the addition of the 'gravely disabled' language would allow [the state psychiatric facility] 'to hold people that need to [be held], but haven't shown a violent tendency.'"¹¹⁵ The intent of the gravely disabled grounds for commitment was to allow "a person [to] be committed before it's too late."¹¹⁶ Similarly, proponents of a bill to include a separate ground of "gravely disabled" in Hawaii statutes governing emergency commitment noted that

the courts have been reluctant to enforce Hawaii's civil commitment laws absent a finding that the individual is imminently dangerous, thereby forcing the individual to live on the streets or left in the care of family and friends who must watch the individuals

of respect, it will be widely ignored." PAUL S. APPLEBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 41 (1994).

114. *E.g.*, *Green v. Bock Laundry Mach. Co.*, 490 U.S. 504, 524 (1989) (stating that "[a] general statutory rule usually does not govern unless there is no more specific rule").

115. *Wetherhorn v. Alaska Psychiatric Inst.*, 156 P.3d 371, 377 (Alaska 2007).

116. *Id.*

decompensate to the point of becoming dangerous to themselves or others before obtaining treatment.¹¹⁷

Yet despite the availability of a finding of grave disability due to a person's inability to meet her basic needs, dangerousness determinations predominate commitment adjudications and many courts interpret "gravely disabled" to mean that a person is unable to care for her own basic needs and therefore poses an imminent danger to herself.¹¹⁸ For example, in *In re M.M.*,¹¹⁹ a Louisiana court found that an individual was not gravely disabled because the hospital

did not prove clearly and convincingly that she is unable to provide for her own basic physical needs as a result of her illness *and* that she is unable to survive safely in freedom or protect herself from serious harm, the statutory requirements for a finding that she was gravely disabled. There is no evidence in the record indicating that she was dangerous to herself or dangerous to others.¹²⁰

The Louisiana statute defines "grave disability" as "the condition of a person who is unable to provide for his own basic physical needs, such as essential food, clothing, medical care, and shelter, as a result of serious mental illness or substance abuse and is unable to survive safely in freedom or protect himself from serious harm."¹²¹ Louisiana's code has a separate provision that defines "[d]angerous to self" as "the condition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person."¹²² Louisiana's definition of grave disability does not require a finding of "danger to self," only that the person cannot survive safely in freedom. Moreover, the inclusion of a separate definition of "danger to self," which does encompass situations where an individual is likely to inflict physical harm on herself, suggests that the legislature intended to create a gravely disabled grounds for commitment that was broader than the strict "danger to self" grounds, namely one that allowed for the commitment of an individual when she cannot "survive safely in freedom" but does not necessarily pose a danger to herself. Notwithstanding this additional ground for commitment, the Louisiana court seems to have inter-

117. S. 16-2650, Reg. Sess., at 1180 (Haw. 1992).

118. PARRY, *supra* note 49, at 474.

119. 552 So. 2d 528 (La. Ct. App. 1989).

120. *Id.* at 530.

121. LA. REV. STAT. ANN. § 28:2(10) (2015).

122. *Id.* at § 28:2(4).

preted the gravely disabled requirement of serious harm to mean imminent danger to self, thus conflating the two separate commitment grounds.

Similarly, in *In re C.K.*,¹²³ a Washington court found that C.K. was gravely disabled because he refused to take medication and if he were not ordered to take his medication, there would be a “very high probability that his behavior will once again become dangerous to himself and others.”¹²⁴ Yet the Washington statute governing civil commitment defines “gravely disabled” as “a condition in which a person, as a result of a mental disorder is . . . in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety.”¹²⁵ Like Louisiana, the Washington statute distinguishes between harm to others and harm to self, and provides that a person presents a “likelihood of serious harm” to herself when there is a substantial risk that “[p]hysical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself.”¹²⁶ While the court in this case did find that the person satisfied the commitment standard, the language of the decision again reflects a misunderstanding of the separate grounds for commitment, as well as the likely legislative intent behind the inclusion of two separate grounds.

While some state legislatures have therefore recognized that many people with serious mental illness might benefit from civil commitment before they have deteriorated to the point that they might pose a danger to themselves or others, the research suggests that some psychiatrists and courts have not fully embraced standards other than a dangerousness standard in civil commitment proceedings. And while a heightened standard of civil commitment is appropriate and protective of the civil liberties of people with mental illness, it has also had unintended effects. Many people with serious mental illness are unable to perceive a need for treatment, and many of those people also lack the financial resources or support systems to help them obtain treatment. For these individuals, a heightened commitment standard coupled with a lack of available community-based resources has led to a near-complete absence of

123. *In re C.K.*, 29 P.3d 69.

124. *Id.* at 75 (finding that “the court below properly considered C.K.’s past patterns of behavior, taking into consideration C.K.’s prior decompensation when not under treatment and discontinuing his medication, his dangerous behavior as a result of his serious mental disorder while not medicated, his lack of appreciation for the necessity of taking his medication, his stated intent to discontinue medication unless ordered by the court, and the very high probability that his behavior will once again become dangerous to himself and others if not under court order to take his medication”).

125. WASH. REV. CODE ANN. § 71.05.020(17) (West 2016).

126. *Id.* § 71.05.020(27(a)).

mental health care. As explained in the next Part, moreover, the interpretation of commitment standards to require a finding of dangerousness may be further perpetuating perceptions about the link between mental illness and violence, and the associated stigma experienced by people with untreated mental illness.

IV. PUBLIC PERCEPTIONS ABOUT MENTAL ILLNESS & DANGEROUSNESS

When civil commitment standards began changing from a need-for-treatment standard to a dangerousness standard, so too did public perceptions of the dangerousness of people with mental illness. In one study, researchers compared perceptions of the link between mental illness and dangerousness in 1950 and in 1996. For both time periods, respondents were asked: “When you hear someone say that a person is ‘mentally-ill,’ what does that mean to you?”¹²⁷ During both time periods, people who described mental illness as including psychosis were more likely to mention violence in their description of mental illness.¹²⁸ But the number of people who described mental illness as including psychosis and violence more than doubled between 1950 and 1996, from 12.7% in 1950 to 31% in 1996.¹²⁹ In other words, people in 1996 were more than twice as likely to think of people with mental illness as both psychotic and violent than they were in 1950.

Another recent study examined these attitudes slightly differently. Respondents were given descriptions of a man named “John” and asked how likely they thought it was that John would be violent towards other people.¹³⁰ In the first scenario, John was described as someone who was “troubled,” but otherwise not suffering from any mental illness.¹³¹ In this scenario, John was sometimes a little worried or a little sad, but otherwise “getting along pretty well.”¹³² In response to this

127. Jo Phelan et al., *Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to be Feared?*, 41 J. HEALTH & SOC. BEHAV. 188, 191 (2000).

128. “[T]his association between descriptions of psychosis and mentions of dangerousness increased substantially over the period under study. Among respondents who did not mention psychosis in their description of a mentally ill person, the percentage who mentioned violence decreased from 3 percent in 1950 to 2 percent in 1996.” *Id.* at 197.

129. *Id.*

130. Bernice A. Pescosolido, *The Public’s View of the Competence, Dangerousness, and Need for Legal Coercion of Persons With Mental Health Problems*, 89 AM. J. PUB. HEALTH 1339, 1340 (1999).

131. *Id.*

132. The full scenario is as follows:

description, 16.8% of respondents said that John was likely or very likely to do something violent to another person.¹³³ In the second scenario, John was given characteristics of a person suffering from major depression.¹³⁴ He was described as “feeling really down. . . . Even when good things happen, they don’t seem to make John happy. He pushes on through his days, but it is really hard.”¹³⁵ In response to this description, 33.3% of respondents felt that John was likely or very likely to do something violent to another person.¹³⁶ In the last scenario, John was described as a person with characteristics of schizophrenia.¹³⁷ John was

John is a [ETHNICITY] man with an [EDUCATION LEVEL] education. Up until a year ago, life was pretty okay for John. While nothing much was going wrong in John’s life he sometimes feels worried, a little sad, or has trouble sleeping at night. John feels that at times things bother him more than they bother other people and that when things go wrong, he sometimes gets nervous or annoyed. Otherwise John is getting along pretty well. He enjoys being with other people and although John sometimes argues with his family, John has been getting along pretty well with his family.

The full description of the vignettes is taken from Bruce G. Link et al., *Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance*, 89 Am. J. Pub. Health 1328, 1329 (1999).

133. Pescosolido, *supra* note 130, at 1341 (noting that the other respondents answered as follows: Very likely: 4.3%; Somewhat likely: 12.5%; Not very likely: 45.9%; Not likely at all: 37.4%).

134. The full scenario is as follows:

John is a [ETHNICITY] man with an [EDUCATION LEVEL] education. For the past two weeks John has been feeling really down. He wakes up in the morning with a flat heavy feeling that sticks with him all day long. He isn’t enjoying things the way he normally would. In fact nothing gives him pleasure. Even when good things happen, they don’t seem to make John happy. He pushes on through his days, but it is really hard. The smallest tasks are difficult to accomplish. He finds it hard to concentrate on anything. He feels out of energy and out of steam. And even though John feels tired, when night comes he can’t go to sleep. John feels pretty worthless and very discouraged. John’s family has noticed that he hasn’t been himself for about the last month and that he has pulled away from them. John just doesn’t feel like talking.

Link et al., *supra* note 132, at 1329.

135. *Id.*

136. Pescosolido, *supra* note 130, at 1341 (noting that the other respondents answered as follows: very likely: 9.2%; somewhat likely: 24.1%; not very likely: 49.3%; not likely at all: 17.4%).

137. *Id.* at 1340. The full scenario is as follows:

John is a [ETHNICITY] man with an [EDUCATION LEVEL] education. Up until a year ago, life was pretty okay for John. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. John

“hearing voices even though no one else was around. These voices told him what to do and what to think.”¹³⁸ When given this description, 60.9% of respondents thought that John was likely or very likely to do something violent to another person.¹³⁹ As the authors concluded, respondents had “increased expectations of violence if they labeled the vignette person as having a mental illness.”¹⁴⁰

There are many reasons for this increase in the public perception that people with mental illness are more likely to be violent or dangerous to others. One possible explanation is that many people acquire much of their knowledge of mental illness from television and the news; one study found that 74% of Americans cited newspapers as their source of information about psychiatric disorders.¹⁴¹ Television and movies about mental illness often feature “plots and characters that connect mental illness with violence or depict people with mental illness primarily as caricatures or stereotypes-subjects of humor or derision.”¹⁴² In newspapers, stories involving homicide committed by a person with mental illness are more likely to receive front-page coverage, and more likely to receive a follow-up story.¹⁴³ When stories are told about people with mental illness, moreover, they are most likely to involve a violent act,¹⁴⁴

was convinced that people were spying on him and that they could hear what he was thinking. John lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. John was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

Link et al., *supra* note 132, at 1329.

138. Link et al., *supra* note 132, at 1329.

139. Pescosolido, *supra* note 130, at 1341 (noting that the other respondents answered as follows: Very likely: 12.8%; Somewhat likely: 48.1%; Not very likely: 30.8%; Not likely at all: 8.3%).

140. *Id.* at 1343.

141. Otto Wahl, *News Media Portrayal of Mental Illness: Implications for Public Policy*, 46 AM. BEHAV. SCIENTIST 1594, 1594 (2003).

142. NAMI, *Wonderland Premiere Brings Call on White House to Fight Stigma in Entertainment Industry*, (March 20, 2000), <https://www.nami.org/Press-Media/Press-Releases/2000/Wonderland-Premiere-Brings-Call-on-White-House-to> [http://perma.cc/PL4P-FZ8F]. *See also, e.g.*, PSYCHO (Paramount Pictures 1960); AMERICAN PSYCHO (Lions Gate Films 2000); FRIDAY THE 13TH (Paramount Pictures 1980); THE SHINING (Warner Bros. 1980).

143. Otto Wahl et al., *Newspaper Coverage of Mental Illness: Is It Changing?*, 6 PSYCHIATRIC REHABILITATION SKILLS 9, 10–12 (2002) (reviewing various studies).

144. GREG PHILO ET AL., *MEDIA AND MENTAL DISTRESS* 50 (1996) (concluding that “this is a media world populated by ‘psychopaths,’ ‘maniacs,’ and ‘frenzied knife men’”). This trend is not unique to the United States. *See, e.g.*, Raymond Nairn et al., *From Source Material To News Story In New*

and the most common theme of stories about mental illness is the dangerousness of the mentally ill person.¹⁴⁵

Furthermore, when a person with a mental illness does commit a violent act, state legislatures often react by passing laws like New York's Secure Ammunition and Firearms Enforcement Act.¹⁴⁶ New York's law created a database of New Yorkers who are considered "too mentally unstable to carry firearms," and contains approximately 34,500 names.¹⁴⁷ While defending the law, which was enacted in response to the Newtown Connecticut shooting in 2012, Mayor Cuomo noted, "God bless you, be a sportsman, be a hunter. We're not against guns. But not guns for criminals and for the mentally ill."¹⁴⁸ It is difficult to miss the implicit link between criminality and mental illness in this statement, and many have criticized the law as further stigmatizing people with mental illness and reinforcing perceptions that people with mental illness are invariably violent. As one commentator noted, "[t]hat

Zealand Print Media: A Prospective Study Of The Stigmatizing Processes In Depicting Mental Illness, 35 AUSTL. & N.Z. J. PSYCHIATRY 654, 658 (2001) ("Throughout the corpus of material, the themes and production practices we have described mutually reinforced and nuanced each other, consistently linking mental illness with violence and unpredictability.").

145. Wahl, *supra* note 143, at 14. Wahl selected 300 articles discussing mental illness from six U.S. newspapers, including the *New York Times*, the *Washington Post*, the *Los Angeles Times*, the *St. Louis Post-Dispatch*, the *Boston Globe*, and the *St. Petersburg Times*. He found that in 77 of the 300 articles (or 23%) that discussed mental illness, the most common theme was that "people who have mental illness may be dangerous." *But see* Phelan et al., *supra* note 127, at 203 (noting that "mentions of dangerousness were not significantly related to the frequency of reading the newspaper or of watching television").
146. *See* NY MENTAL HYG. 9.46 Reporting Requirements for Mental Health Professionals (2013) ("Amendments to the Mental Hygiene Law will help ensure that persons who are mentally ill and dangerous cannot retain or obtain a firearm. First, mental health records that are currently sent to NIDCS for a federal background check will also be housed in a New York State database. A new Section 9.46 of the Mental Hygiene Law will require mental health professionals, in the exercise of reasonable professional judgment, to report if an individual they are treating is likely to engage in conduct that will cause serious harm to him- or herself or others.") NY A02388 MEMO, http://assembly.state.ny.us/leg/?default_fld=&bn=A02388&term=2013&Summary=Y&Memo=Y [<https://perma.cc/7VCZ-8KF5>].
147. Anemona Hartocollis, *Mental Health Issues Put 34,500 on New York's No-Guns List*, N.Y. TIMES (Oct. 19, 2014), http://assembly.state.ny.us/leg/?default_fld=&bn=A02388&term=2013&Summary=Y&Memo=Y [<https://perma.cc/7VCZ-8KF5>].
148. Anemona Hartocollis & Thomas Kaplan, *Cuomo Defends Law Denying Guns to Mentally Ill People*, N.Y. TIMES (Oct. 19, 2014), <http://www.nytimes.com/2014/10/20/nyregion/cuomo-defends-law-denying-guns-to-mentally-ill-people.html> [<https://perma.cc/Z2PT-M9JU>].

[number] seems extraordinarily high to me. Assumed dangerousness is a far cry from actual dangerousness.”¹⁴⁹

Finally, some authors have theorized that the change in the language of commitment standards themselves and the widespread inclusion of language referring to dangerousness has actually increased stigma and the perception that mentally ill people are violent.¹⁵⁰ One study found that when respondents were asked in 1950 to describe a person with mental illness, 24 out of 335 people (or 7.2%) mentioned violence, but only one of those people used the term “dangerous to self or others.”¹⁵¹ When asked the same question in 1996, 75 out of 622 people (or 12.1%) mentioned violence, but 33 people used the term “dangerousness to self or others.”¹⁵² In other words, people who used the phrase “dangerous to self or others” to describe mental illness increased “from 4.2% of respondents in 1950 to 44% of respondents in 1996.”¹⁵³ The authors concluded that these results suggest “widespread public knowledge of the dangerousness criterion for involuntary commitment might indeed have fueled the stereotype that people with mental illnesses are dangerous.”¹⁵⁴ The dangerousness standard itself may therefore reinforce the idea of a link between mental illness and dangerousness and “reproduce stereotypes depicting as threats to public safety persons who experience severe psychological distress or disturbances.”¹⁵⁵

There is some disagreement in the psychiatric community about the actual link between violence and mental illness, although most mental health professionals and the APA generally caution against a direct

149. Hartocollis, *supra* note 147.

150. J.C. Phelan & B.G. Link, *The Growing Belief that People with Mental Illnesses are Violent: The Role of the Dangerousness Criterion for Civil Commitment*, 33 SOC. PSYCHIATRY PSYCHIATR. EPIDEMIOL. S7, S8 (1998).

151. *Id.* at S9.

152. *Id.*

153. *Id.* at S7.

154. *Id.* at S10. The authors note however, that “we cannot draw such a conclusion without reservation. In particular, it is possible that more people would have mentioned violence in 1996 than in 1950 for other reasons, and that they simply used ‘dangerous to self or others’ as a familiar phrase with which to express their beliefs.” *Id.*

155. Dallaire et al., *supra* note 109, at 693; *see also id.* at 692–93 (“Because the widely shared tendency to equate mental illness with dangerousness is manifested in the rationale for, and operationalization of, civil commitment laws, however they are written, a civil commitment system which couples mental illness with dangerousness has little or no effect on restraining commitments that would otherwise be made on the basis of need for treatment. The net result of a dangerousness criterion, then, may be to manifest, reinforce, and reproduce stereotypes depicting as threats to public safety persons who experience severe psychological distress or disturbances.”).

link between mental illness and violence or dangerousness.¹⁵⁶ But some researchers have concluded that there is a link, and that major mental disorders, like schizophrenia and bipolar disorders are “associated with significantly higher risks for physical violence against others.”¹⁵⁷ Other authors have argued that this correlation is so strong that “[t]he mental health community has to start by accepting that violent and antisocial behaviours are among the potential complications of having a schizophrenic syndrome” and should respond accordingly by creating structured programs to manage “the active symptoms of the disorder [and] prevent the progress to violence.”¹⁵⁸

Other researchers have reached different results and present persuasive evidence that there is no causal link between mental illness and

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156. J. Arboleda-Florez, et al., *Understanding Causal Paths Between Mental Illness and Violence*, 33 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY S38, S38 (1998); see also AM. PSYCHOL. ASS’N (Apr. 21, 2014), <http://www.apa.org/news/press/releases/2014/04/mental-illness-crime.aspx> [<http://perma.cc/BT98-NFC8>] (citing Jillian K. Peterson et al., *How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders With Mental Illness?*, 38 L. & HUM. BEHAV. 439 (2014)). As Peterson et al. note, however,

the study sample was relatively small . . . and excluded offenders with a violent index offense (like the mental health court pool from which it was drawn). Therefore the results may not generalize to ‘violent offenders.’ This concern is only partly mitigated by the fact that nearly one fifth (17%) of the crimes analyzed in this study were violent or potentially violent because participants reported crimes other than their index offense. It is possible that the rate of direct crimes would differ in a sample with more violent offenses.

Jillian K. Peterson et al., *How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders With Mental Illness?*, 38 L. & HUM. BEHAV. 439, 446 (2014).

157. Christian C. Joyal et al., *Mental Disorders and Violence: A Critical Update*, 3 CURRENT PSYCHIATRY REVS. 33, 34 (2007) (noting that “[o]nce gender, age, socio-demographic and socio-economic status are taken into account, the overall risk for physical assault is generally estimated to be 3 to 5 times higher than that of the general population”).
158. Paul Mullen, *Schizophrenia and Violence: From Correlations to Preventive Strategies*, 12 ADVANCES IN PSYCHIATRIC TREATMENT 239, 239, 243 (2006).

There is a correlation between having a schizophrenic syndrome and increased rates of antisocial behavior in general and violence in particular. The evidence that such associations are not just statistically but clinically and socially significant is now overwhelming. Why, if the connection is so clear, has it not been widely recognized by clinicians and service planners?

Id. at 239 (citations omitted). The author feels so strongly about this connection that the opening line of the abstract notes that “[p]eople with schizophrenia make a significant contribution to violence in our communities and, in so doing, often lay waste to their own lives.” *Id.*

violence in the general population.¹⁵⁹ Violence is not predicted by mental illness alone, and “[t]he predicted probability of violence for severe mental illness alone is approximately the same as for subjects with no severe mental illness.”¹⁶⁰ Instead, people with mental illness who also had some other risk factor, especially substance abuse or a history of violence were at higher risk of violence. People with a severe mental illness and both substance abuse and a history of violence “showed nearly 10 times higher risk of violence compared with subjects with severe mental illness only.”¹⁶¹ But as the authors concluded, “If a person has severe mental illness without substance abuse and history of violence, he or she has the same chances of being violent during the next 3 years as any other person in the general population.”¹⁶²

Furthermore, multiple studies have shown that people with serious mental illness are most likely to be violent during an initial psychotic episode before they have been diagnosed or treated,¹⁶³ or when they

159. See, e.g., Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions*, 66 ARCHIVES GEN. PSYCHIATRY 152 (2009).

160. *Id.* at 155.

161. *Id.* Other risk factors associated with a higher risk of violence included reporting parental physical abuse, witnessing parents physically fighting, parental criminal history, juvenile detention, perceiving threats, being unemployed in the past year, being recently divorced, and being recently victimized. *Id.* at 154–155; see also Seena Fazel et al., *Schizophrenia, Substance Abuse, and Violent Crime*, 301 J. AM. MED. ASSOC. 2016, 2021 (2009) (finding that “the association between schizophrenia and violent crime is minimal unless the patient is also diagnosed as having substance abuse comorbidity”). The authors found that, among patients without such comorbidity, the risk of increased violence, as compared to the general population or siblings without mental illness, was 1.2 to 1.3. *Id.*

162. Elbogen & Johnson, *supra* note 159, at 157.

163. Matthew M. Large & Olav Nielssen, *Violence in First-Episode Psychosis: A Systematic Review and Meta-Analysis*, 125 SCHIZOPHRENIA RES. 209, 214 (2011) (“The finding of high rates of violence among first-episode psychosis patients is consistent with the finding of a disproportionate number of homicides, violent suicide attempts and serious harms such as cases of major self mutilation in first-episode psychosis compared to later in the course of the illness.”) (citations omitted); see also Olav Nielssen & Matthew Large, *Rates of Homicide During the First Episode of Psychosis and After Treatment: A Systematic Review and Meta-analysis*, 36 SCHIZOPHRENIA BULL. 702, 708 (2010) (“The main findings of this study can be summarized as (i) approximately 4 in 10 of the homicides committed by people with a psychotic illness occur before treatment, (ii) approximately 1 in 700 people with psychosis commit a homicide before treatment, (iii) approximately 1 in 10,000 patients with psychosis who have received treatment will commit a homicide each year, and (iv) the rate of homicide in psychosis before treatment is approximately 15 times higher than the annual rate after treatment.”).

have discontinued treatment.¹⁶⁴ But because many people with serious mental illness are unable to recognize the severity of their illness or their need for treatment—and because the state typically does not intervene until people are dangerous—a small number of these people go without treatment until, paradoxically, they become violent. These violent acts and the defendant’s mental illness are then heavily publicized, further reinforcing the perception between mental illness and violence.¹⁶⁵ The pervasiveness of perceptions about the connection between mental illness and violence or dangerousness, coupled with the interpretation of gravely disabled grounds for commitment to require dangerousness may be further perpetuating this connection.

V. THE AFTERMATH: EFFECTS OF DEINSTITUTIONALIZATION
AND THE DANGEROUSNESS STANDARD

As commitment laws became stricter, more patients who would have previously been treated in a long-term inpatient facility were returned to their communities. Civil rights and community mental health advocates believed that most people suffering from serious mental illness would be better served in their own communities.¹⁶⁶ At the same time, well-meaning lawyers and mental health professions expected that people with mental illness would voluntarily seek that treatment and that treatment would be available to them in their communities.

Deinstitutionalization and heightened commitment standards have made improvements in the lives of many people with mental illness.¹⁶⁷

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164. E. Fuller Torrey, *Stigma and Violence: Isn't It Time to Connect the Dots?*, 37 SCHIZOPHRENIA BULL. 892, 893 (2011) (citing various studies).
165. *E.g.*, Hipolito Corella, *Tucson Shooting: No Mental Health Treatment for Loughner Before Giffords Rampage*, ARIZONA DAILY STAR (Mar. 27, 2013), http://tucson.com/news/local/crime/tucson-shooting-no-mental-health-treatment-for-loughner-before-giffords/article_70b5b03c-96f4-11e2-b7dc-0019bb2963f4.html [<http://perma.cc/H6B5-HQU6>]; *James Holmes Saw Three Mental Health Professionals Before Shooting*, CBS NEWS (Sept. 19, 2012), <http://www.cbsnews.com/news/james-holmes-saw-three-mental-health-professionals-before-shooting/> [<http://perma.cc/7JGD-DS59>].
166. *See, e.g.*, David L. Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1109 (1972) (“[E]ven if we concede that governments may hospitalize an ill person to protect him from himself, or to protect others from him, or simply to treat or care for him, these goals can generally be better served by keeping him in the community than by removing him.”).
167. Davis et al., *supra* note 33, at 263; *see also* FRANK & GLIED, *supra* note 9, at 1 (“Almost all severely ill patients receive some treatment. That treatment, although not always entirely effective, is unlikely to be dangerous or inhumane. The living conditions of people with severe illnesses have generally improved at least as much as have conditions for the rest of society over the past five decades.”).

Access to mental health care has continued to improve and the quality of care is better than it was when deinstitutionalization began, especially in regards to medications available to treat chronic mental illness.¹⁶⁸ Social welfare programs like Medicaid and Medicare, and SSI and SSDI have helped people with mental illness to obtain better housing and improved income status.¹⁶⁹ Many of these improvements, however, are largely seen in people who are in the middle class, and in those who have less serious disorders.¹⁷⁰

For people with serious mental illness who are dependent on the state to provide mental health care and treatment, improvements in access to care and the quality of that care since deinstitutionalization have been more modest. Most communities have not developed appropriate structures to provide appropriate care to people with chronic and serious mental illness and psychiatric beds that were once available in state hospitals have not been recreated in the community. In order to live in communities, these individuals need community-based resources in place that assist them in obtaining appropriate mental health treatment. Because these systems have not been sufficiently developed, people suffering from serious mental illness continue to be overrepresented among the homeless, among the incarcerated, and among victims of violent crime.¹⁷¹ Furthermore, when people with serious mental illness or their families attempt to obtain care within communities, they often encounter “a fragmented array of public programs that are run out of a large number of distinct federal, state, and local government bureaucracies.”¹⁷²

Instead of receiving appropriate long-term care in their communities, many of these people have become “revolving-door patients,” those who have a serious mental disorder, do not voluntarily comply with treatment, and are unable to live successfully without treatment in the community.¹⁷³ They often live on the fringes of their communities, where they deteriorate to the point that they meet emergency commitment standards and are hospitalized, often in hospital emergency rooms.¹⁷⁴ Long-term treatment is often not available, so patients are

168. Davis et al., *supra* note 33, at 263.

169. *Id.*

170. FRANK & GLIED, *supra* note 9, at 1.

171. *Id.* at 143.

172. *Id.* at 144.

173. Mark R. Munetz et al., *The Ethics of Mandatory Community Treatment*, 31 J. AM. ACAD. PSYCHIATRY & L. 173, 173 (2003).

174. One can find examples of this phenomenon in most major cities around the country. See, e.g., Brian M. Rosenthal, ‘Boarding’ Mentally Ill Becoming Epidemic In State, SEATTLE TIMES (Oct. 5, 2013), http://seattletimes.com/html/localnews/2021968893_psychiatricboardingxml.html [<http://perma.cc/>

held just long enough to stabilize on medication and regain competency, where they are again released into the community. Once there, they discontinue treatment, decompensate, and the cycle begins again.¹⁷⁵

One reason for unavailability of long-term psychiatric treatment following deinstitutionalization is the rapid decrease of psychiatric inpatient hospital beds in the United States; beds that were not recreated in communities after state facilities were closed.¹⁷⁶ Residents in state hospitals numbered almost 559,000 people in 1955; by 2003 that number had fallen to 47,000.¹⁷⁷ And while we know that most people with serious mental illness no longer live in state institutions, it is harder to say where they are living now. Many live with family members, who have once again been tasked with the primary responsibilities of caring for loved ones with mental illness when those individuals are too ill to care for themselves, but do not meet a civil determination of dangerousness. One study interviewed mothers of adult children with serious mental illness, and described the difficulty family members face waiting “for the inevitable point at which their children would meet criteria to be

53U9-DQ52]; Yesenia Amaro, *Inundated By The Mentally Ill, Valley Emergency Rooms Close To Ambulances*, LAS VEGAS REVIEW-JOURNAL (Feb. 26, 2014), <http://www.reviewjournal.com/news/inundated-mentally-ill-valley-emergency-rooms-close-ambulances> [<http://perma.cc/CCP4-AX62>].

175. See Munetz et al., *supra* note 173, at 174 (noting that this particularly affects patients “who do not believe they are ill or need treatment”).

176. This Article does not address in detail, but does not mean to ignore, the profound impact that a lack of available beds might have on psychiatrists’ decisions to recommend civil commitment. Faced with a shortage of inpatient psychiatric beds:

[A] clinician might rightly engage in a sort of a triage. The patients who are thought to be most in need of hospitalization are committed, while patients who constitute somewhat less urgent cases, although still meeting commitment standards, are turned away. This low-visibility decision depends not on judges’ enforcing the state’s commitment laws, but on emergency room and admitting office clinicians’ attempting to protect their institutions from being overwhelmed.

APPLEBAUM, *supra* note 113, at 52.

177. Testa & West, *supra* note 7, at 33; see also Davis et al., *supra* note 33, at 259; *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005-2010*, TREATMENT ADVOCACY CTR. (July 19, 2012) (noting that in 2010, the number of state psychiatric beds per capita in the United States was nearly the same as the number of state psychiatric beds per capita in 1850 (14 beds per 100,000 individuals)); TORREY ET AL., *supra* note 32, at 5 (finding that the state with the most available public psychiatric beds per 100,000 population in 2005 was Mississippi (49.7), while the states with the fewest beds were Nevada (5.1) and Arizona (5.9)).

hospitalized involuntarily.”¹⁷⁸ As one woman described it, “It’s like you wait till something horrible happens before something can be done.”¹⁷⁹

For those without family to help, the situation is worse. While the numbers of people with mental illness receiving SSI has risen, those people are still about 60% more likely than people without mental illness to report incomes below \$20,000 a year.¹⁸⁰ “For this group, living circumstances depend critically on access to publicly funded benefits, but benefits are meager and leave most people with severe illnesses in poverty.”¹⁸¹ Moreover, as the price of housing has increased, available subsidized housing has not increased enough to keep housing affordable for people with mental illness who rely on public benefits.¹⁸²

Another commonly referenced result of deinstitutionalization and heightened commitment standards is increased rates of homelessness among people with serious mental illness. Recent estimates suggest that more than 25% of the homeless population in the United States has a serious mental illness,¹⁸³ while only 4.1% of the general population suffers from serious mental illness.¹⁸⁴ One study in Ohio found that 36% of study participants were homeless six months after discharge from a

178. Darcy Ann Copeland & MarySue V. Heilemann, *Getting “to the Point”*: *The Experience of Mothers Getting Assistance for Their Adult Children Who Are Violent and Mentally Ill*, 57 NURSING RES. 136, 139 (2008).

179. *Id.* The sampled mothers noted a desire for their children to have earlier access to mental health treatment:

The mothers felt that their desire for early intervention was in their children’s best interests. Also, they did not want to be victimized violently. These mothers repeatedly voiced their frustration at having to wait until violence occurred before being able to access mental health treatment for their children. This situation resulted in worse outcomes for both mothers and their children.

Id. at 142.

180. Sherry A. Glied & Richard G. Frank, *Better but Not Best: Recent Trends in the Well-Being of The Mentally Ill*, 28 HEALTH AFF. 637, 645 (2009).

181. *Id.*

182. *Id.* (“Improvements in living conditions that might have been generated by increases in receipt of public benefits were offset by the increase in housing prices in many areas.”).

183. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., CURRENT STATISTICS ON THE PREVALENCE AND CHARACTERISTICS OF PEOPLE EXPERIENCING HOMELESSNESS IN THE UNITED STATES (2011); see also Laurence Roy et al., *Criminal Behavior and Victimization Among Homeless Individuals with Severe Mental Illness: A Systematic Review*, 65 PSYCHIATRIC SERVS. 739, 739 (2014) (noting that “between 20% and 50% of homeless adults also have a severe mental illness”).

184. NAT’L INST. OF MENTAL HEALTH, SERIOUS MENTAL ILLNESS AMONG ADULTS (2012), http://www.nimh.nih.gov/statistics/SMI_AASR.shtml [<http://perma.cc/U66H-BNL4>].

psychiatric facility.¹⁸⁵ Another study in Massachusetts found among 187 patients with serious mental illness, 17% were “predominantly homeless” and 10% were “occasionally homeless” in the six months after discharge from a state psychiatric hospital.¹⁸⁶

The effects of deinstitutionalization and heightened commitment standards can also be seen in the increase in rates of mentally ill people in jails and prisons.¹⁸⁷ Among state prison inmates, approximately 24% have a recent history of a mental health problem.¹⁸⁸ Another recent study reviewed the prevalence of serious mental illness in jail inmates in New York and Maryland.¹⁸⁹ The researchers found that rates of serious mental illness in women were 31%, while comparable rates among men were 14.5%.¹⁹⁰ If we generalize these findings to the 13 million

185. John R. Belcher, *Rights Versus Needs of Homeless Mentally Ill Persons*, 33 SOC. WORK 398, 399–400 (2001) (“[N]arrow interpretation of commitment criteria by service providers and other mental health professionals contributed to mental deterioration and homelessness for some respondents.”).

186. Robert E. Drake et al., *Housing Instability and Homelessness Among Aftercare Patients of an Urban State Hospital*, 40 PSYCHIATRIC SERVS. 46, 49 (1989). See also Roy et al., *supra* note 183, at 743 (noting that homeless people with mental illness are also significantly more likely to be arrested for crimes).

187. TORREY, *supra* note 4, at 128–29.

188. DEP’T OF JUST., MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES (2006). The study used the following methodology:

A recent history of mental health problems was measured by several questions in the BJS’ inmate surveys. Offenders were asked about whether in the past 12 months they had been told by a mental health professional that they had a mental disorder or because of a mental health problem had stayed overnight in a hospital, used prescribed medication, or received professional mental health therapy.

Id. Jail inmates had slightly lower rates of recent mental health problems (21%) and federal prisoners had the lowest rate (14%). When asked about mental health problems that were not recent, that is those that had not required treatment in the past twelve months, the numbers jumped to 56% for state prisoners, 64% for jail inmates, and 45% for federal prisoners. *Id.* See also Christine M. Sarteschi, *Mentally Ill Offenders Involved with the U.S. Criminal Justice System: A Synthesis*, SAGE OPEN 1, 8 (2013) (“The most common types of psychological disorders found among inmates, according to government and congressional surveys and data collected from studies in the literature, include anxiety, affective, thought, and substance abuse disorders.”).

189. Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 761 (2009) (including schizophrenia, schizophrenia spectrum disorder, schizoaffective disorder, bipolar disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified).

190. *Id.* at 764.

annual jail admissions in the United States, there were about two million annual bookings of people with serious mental illness in 2007.¹⁹¹ People with serious mental illness are also more likely than people without mental illness to be arrested. For instance, one study in Massachusetts found that among people with serious mental illness, 28% of them had been arrested in the past ten years.¹⁹²

Although several studies have shown that people with mental illness are overrepresented in the prison population, these studies should not be read to suggest a link between mental illness and criminal behavior.¹⁹³ Instead, some authors have suggested that the large numbers of people with mental illness who are incarcerated might reflect a lack of access to appropriate mental health care: because people with mental illness regularly encounter obstacles to treatment and inadequate treatment, this “results in patients being arrested for both violent and non-violent crimes. Often such charges are based on behaviors that are direct manifestations of the patients’ then untreated symptoms, such as paranoia leading to trespassing or grandiosity resulting in breaking and entering.”¹⁹⁴

Furthermore, while heightened commitment standards were meant to reduce coercion of people with mental illness, many people with mental illness are already experiencing some type of state involvement in their receipt of the mental health services they do receive, and often these services involve conditions. People with mental illness regularly come into contact with various state agencies, including mental health agencies, social service agencies, and the criminal justice system, all of

191. *Id.*

192. William H. Fisher et al., *Patterns and Prevalence of Arrest in a Statewide Cohort of Mental Health Care Consumers*, 57 PSYCHIATRIC SERVS. 1623, 1625 (2005). Of the total arrests, 13.6% were for crimes including violence against other people; the remaining arrests were for crimes against public order, property crimes, motor vehicle offenses, less serious crimes against persons, drug offenses, public decency offenses, assault and battery on a police officer, firearm violations, and miscellaneous offenses. *Id.* Men were more likely to be arrested than women (36.1% of men with serious mental illness had experienced an arrest, while only 17.5% of women had been arrested in the previous ten years), and non-whites were more likely to be arrested than whites (26.5% of white individuals with serious mental illness had been arrested in the past ten years, while 33.3% of non-whites with serious mental illness had been arrested). *Id.* at 1326.

193. See Hiday, *supra* note 6, at 62 (finding that people with serious mental illness are about two-and-a-half times more likely to be the victim of a violent crime).

194. Marie E. Rueve, *Violence and Mental Illness*, 5 PSYCHIATRY 34, 36 (2008).

which apply some leverage to the individual in an attempt to improve treatment compliance.¹⁹⁵

One recent study found that between 12 and 20% of people who are receiving treatment for mental illness have received either outpatient or inpatient commitment orders at some point during their lives, and nearly three-quarters “reported experiencing other kinds of leverage applied through the legal or social welfare system to improve their treatment adherence.”¹⁹⁶ People who had a history of civil commitment were also more likely to have been ordered to seek treatment as a result of a criminal offense, or ordered to participate in treatment as a condition of receiving social security benefits.¹⁹⁷ They were more likely to have lived in some type of subsidized housing where treatment was mandated as a condition of occupancy.¹⁹⁸ Furthermore, people with some history of civil commitment often reported pressure from medical personnel and family members to comply with prescribed medication and treatment recommendations.¹⁹⁹

Most people with serious mental illness therefore do not just experience coercion if they are civilly committed—instead they experience coercion at all levels of their involvement with the mental health system, in their receipt of social benefits, and through their involvement with the criminal justice system.²⁰⁰ The small numbers of mentally ill people whose only experience with mandated mental health treatment is civil commitment or a related civil court treatment order report low

195. Marvin S. Swartz et al., *Use of Outpatient Commitment or Related Civil Court Treatment Orders in Five U.S. Communities*, 57 PSYCHIATRIC SERVS. 343, 349 (2006).

196. *Id.* at 346–47.

197. *Id.* at 346. This study sampled:

A total of 1,011 adult outpatients recruited from sites that provide public psychiatric services in five cities across the United States, including Chicago; Durham, North Carolina; San Francisco; Tampa; and Worcester, Massachusetts. . . . Recruitment criteria specified that participants had to be aged 18 to 65 years, English or Spanish speaking, and in treatment during the past six months for a mental disorder, excluding those with only a substance use disorder.

Id. at 344.

198. *Id.* at 346.

199. *See id.* (“[A] history of outpatient commitment or similar civil court-ordered treatment was not significantly associated with satisfaction with mental health treatment or perceived sense of autonomy in everyday affairs.”).

200. The groups of people with mental illness most likely to be subject to a civil commitment order are those who have poor social support, a history of violence, and a history of involvement with the police. The orders are also more common for people who live in group facilities and have co-occurring substance abuse problems. Swartz et al., *supra* note 195, at 347.

perceived coercion and high treatment satisfaction, “perhaps because their singular experiences with civil court treatment orders alone, without other types of leverage, identifies a group with a more benign course and a successful return to treatment adherence.”²⁰¹ In contrast, people who have felt coerced by several different forms of leverage in their receipt of mental health services “likely had a more tumultuous course in which multiple agencies and actors attempted to ensure treatment adherence.”²⁰²

VI. RECOMMENDATIONS: THE NEED FOR A BROADER
INTERPRETATION OF GRAVELY DISABLED
COMMITMENT STANDARDS

While deinstitutionalization and heightened commitment standards have therefore helped many individuals, some authors have noted that for others, it has been “one of the great social disasters of recent American history.”²⁰³ For many people with serious mental illness, especially the poor and people with chronic illnesses, the complexities of access to psychiatric care and the decentralization of services have created new and sometimes insurmountable obstacles to receiving care and services.²⁰⁴ Furthermore, while heightened commitment standards were intended to reduce coercion, protect patient’s civil liberties and ensure they receive the best possible treatment in the least restrictive setting, the requirement that the patient pose a danger to herself or others often means the person’s health must deteriorate significantly before she will meet the commitment standard.²⁰⁵ In many cases, this heightened standard has resulted in the marginalization of people with serious mental illness into poverty and homelessness, into prisons, and into a variety of situations where they are at higher risk of becoming victims of crimes.²⁰⁶

This is not a simple problem, nor one with an elegant solution. Improving access to mental health care will require reforms at all levels of government. Improving access to mental health care for individuals

201. *Id.* at 348.

202. *Id.*

203. TORREY, *supra* note 4, at 1 (noting that “[t]here are two major origins of the disaster—deinstitutionalization and the legal profession.”)

204. Davis et al., *supra* note 33, at 263. These complexities are further exacerbated by the rise of health maintenance organizations (HMOs), private psychiatric hospitals, and Managed Behavioral Health Organizations (MBHOs), all of which have impacted access to treatment for people with severe mental illness. *Id.* at 260; *see also* Glied & Frank, *supra* note 180, at 637 (“[N]ot all people with mental health problems have shared in these improvements.”).

205. Testa & West, *supra* note 7, at 34.

206. Hiday, *supra* note 6, at 62.

with serious mental illness is made more difficult by the complexities of serious mental illness and by the fact that many individuals are so ill they do not recognize a need for treatment. Creating systems that meaningfully improve access to mental health care, however, takes time. This Article does not propose that we abandon those efforts, but that in the meantime, courts and psychiatrists use systems that are already in place to provide care to individuals with serious mental illness who are otherwise living in deplorable conditions, on the streets, in poverty, or in the criminal justice system. One existing system is civil commitment and gravely disabled grounds for commitment. While all people have certain rights to be free from unwanted medical treatment, for people with serious mental illness who are homeless or in prison, those civil liberties are an abstraction, safeguarded for them by a system that is not otherwise allowing them access to shelter and basic medical care. As one psychiatrist famously noted, these patients are “dying with their rights on.”²⁰⁷

States have an obligation to provide citizens with appropriate mental health care and a more robust civil commitment standard, one that more fully embraces the state’s *parens patriae* authority and allows for commitment on gravely disabled grounds absent a finding of dangerousness could help provide that care. Although the police power has become the primary justification for civil commitment in the United States since deinstitutionalization, a requirement that a person be found dangerous to themselves or others before the state takes responsibility for providing mental health care is harming people with serious mental illness. Moreover, because many of these individuals lack insight into their need for treatment, they often do not voluntarily seek treatment, which can cause their illnesses to manifest “disturbed and disturbing behavior that can result in incarceration from stable housing arrangements, limited access to housing, and increased vulnerability to crime and abuse.”²⁰⁸

207. Darold A. Treffert, *Dying With Their Rights On*, 130 AM. J. PSYCHIATRY 1041 (1937). Treffert described Wisconsin’s dangerousness standard for civil commitment:

Under this law, a 49-year-old anorexic woman starved herself to death; a 70-year-old man died a self-perpetuating, metabolic, toxic death; and a 19-year-old student, while unable to qualify for commitment under the new guidelines, was able to hang herself. Each of these patients needed commitment; none qualified. Each outcome was entirely predictable. Each of these patients went to his or her grave with his rights entirely intact.

Id.

208. *See supra* text accompanying notes 4–5.

Civil commitment and the dangerousness standard have become almost synonymous in the minds of the public, the mental health community, and the legal system. But the primary use of a dangerousness standard grounded in states' police powers is still failing a small but vulnerable population—individuals with untreated serious and chronic mental illness. Until we can create a better system—one that effectively provides community-based resources and treatment to individuals suffering from serious mental illness—courts and psychiatrists should more readily base commitment adjudications on states' *parens patriae* authority, including gravely disabled standards that allow for commitment when an individual is unable to meet her basic needs but is not dangerous to herself. This ground for commitment is already available in most state statutes, but the connection between mental illness, civil commitment, and dangerousness is so strong that many psychiatrists and courts are not interpreting these available standards to provide people with mental illness the care and treatment they need. The result is that many with serious mental illness are not receiving treatment at all.

CONCLUSION

States are empowered—and obligated—to provide appropriate mental health care to citizens under the *parens patriae* authority. Many states legislatures recognize this obligation and have amended civil commitment statutes to allow for the commitment and treatment of people with serious mental illness before they reach the point of dangerousness. Statutes that allow for commitment upon a finding of grave disability when a person is unable to meet her basic needs for survival are an appropriate exercise of states' *parens patriae* authority. However, continued perceptions of the link between mental illness and violence, coupled with a lack of awareness and underuse of those statutes have resulted in commitment standards that effectively commit people only when they are dangerous, which is often far past the point that they are in need of help, homeless, or imprisoned. In turn, many people who need treatment, but are not dangerous to themselves or others, receive little or no mental health care.

While all people have certain rights to be free from unwanted medical treatment, those civil liberties are perhaps less imperative than more immediate needs like shelter and basic medical and mental health care. States' continued and primary use of a dangerousness standard in civil commitment proceedings does not meet our obligations to people with serious mental illness. Courts and psychiatrists should recognize states' obligations to provide health care to citizens with serious mental illness by interpreting gravely disabled statutes to allow for commitment when an individual is unable to provide for her basic needs but does not pose a danger to herself.