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Comment: Mental Health Law - Temporary Detention of Voluntary Patients by Hospital Authorities: Due Process Issues

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NOTES AND COMMENTS

COMMENT: MENTAL HEALTH LAW—Temporary Detention of “Voluntary” Patients by Hospital Authorities: Due Process Issues

I. INTRODUCTION

Compulsory hospitalization of the mentally ill has been justified for decades on the basis of the sovereign's responsibility to care for the disabled and power to protect the safety and welfare of the community. In recent years, medical and legal authorities have questioned the efficacy of compulsory hospitalization and have supported legislation which is designed to increase voluntary admissions. In many states, however, voluntary admission statutes allow hospital authorities to detain voluntary patients after they have requested release. This Comment will discuss the constitutionality as well as the wisdom of transforming voluntary patients into involuntary detainees at the option of hospital authorities. It will also consider the constitutional sufficiency of the process by which the decision to detain a patient is made.

II. VOLUNTARY ADMISSION PROCEDURES GENERALLY

Legislative schemes generally divide institutional¹ treatment of the mentally disabled into two categories: “voluntary” and “involuntary.”² Standards and procedures for admission, rights of the patient while hospitalized, and procedures for discharge, are closely regulated by statute in all states, and will differ according to whether the patient is characterized as “voluntary” or “involuntary.”³ Typically, a voluntary admission requires an affirmative act or at least acquiescence⁴ on the part of the individual who recognizes his need for mental health treatment in a residential facility.⁵

1. In this Comment, the term “institution” is used interchangeably with “hospital” and “residential facility” to mean an in-patient facility for the treatment of persons with mental disorders.

2. Compare N.M. Stat. Ann. §§ 43-1-11, -12 (1978) (involuntary commitment) with § 43-1-14 (1978).

3. American Bar Foundation, *The Mentally Disabled and the Law* 17 (S. Brakel & R. Rock eds., rev. ed. 1971) [hereinafter cited as American Bar Foundation].

4. In most states a person may be “voluntarily” admitted by another person on his behalf. See, e.g., Ga. Code Ann. § 88-503.1 (1978); Ill. Ann. Stat. ch. 91½, § 3-401 (Smith-Hurd 1979).

5. There is evidence that a large percentage of patients admitted under voluntary procedures are actually under coercion from family or police when they are presented for admission and agree to hospitalization under threat of involuntary procedure. Gilboy & Schmidt, “*Voluntary*” Hospitalization of the Mentally Ill, 66 Nw. U.L. Rev. 429 (1971) [hereinafter cited as Gilboy & Schmidt]. Categorization of these patients as “voluntary” is clearly inappropriate and may be no more than an attempt to avoid the more complicated and demanding procedures for involuntary commitment. This Comment assumes that there is a large number of persons for whom voluntary admission is appropriate and possible. The interests of this latter group and the advantages of voluntary treatment warrant legislative and public concern that truly voluntary hospitalization be made available.

The availability of voluntary admission to mental health facilities is important for both medical⁶ and societal⁷ reasons. A person presumably⁸ seeks hospitalization because he recognizes that he needs psychiatric treatment. He is consequently more likely to participate actively in his treatment and cooperate with his physician, elements which are extremely important for effective treatment.⁹ Additionally, the availability of voluntary hospitalization will increase the likelihood that an individual will seek treatment at an early stage, when there is a greater likelihood of recovery.¹⁰ The positive aspects of voluntary hospitalization promote societal interests as well. In the commentary to the 1952 Draft Act Governing Hospitalization of the Mentally Ill,¹¹ the National Institute of Mental Health emphasized the costs to the community resulting from an exclusively involuntary hospitalization system:

Making hospitalization . . . readily available to the mentally ill . . . should reduce the financial and human cost of mental illness which is greatest when the patient's condition has been aggravated by delay in treatment or by the experience of forcible hospitalization, and when, recovery having become impossible, life-long custody is the only prospect.¹²

From the medical point of view, the recovery prospects are better and the length of hospitalization is often shorter when the patient voluntarily seeks early treatment. The expenditure of funds¹³ and manpower required by extended hospitalization justify the attempts to construct a truly voluntary system of mental health care.

6. From the strictly medical point of view, there is little doubt as to the desirability of voluntary admissions to a treatment program as opposed to involuntary commitment. . . . Motivation to seek help is implicit in voluntary admission. The patient recognizes he has a problem. He wants to be treated. He is receptive to therapy.

Hearings before the Senate Subcomm. on Constitutional Rights, 91st Cong., 1st & 2nd Sess., 35 (1970) (Statement of Dr. John Donnelly, Psychiatrist in Chief, Institute of Living, Hartford, Conn.) [hereinafter cited as 1970 *Hearings*]. The therapeutic advantages of voluntary submission to treatment will only apply when the patient is truly a volunteer. See *supra* note 5.

7. See National Institute of Mental Health, Federal Security Agency, A Draft Act Governing Hospitalization of the Mentally Ill, Commentary at 19 (Public Health Service Pub. no. 51, 1952) (Reprinted in *The Mentally Disabled and The Law* 454 (S. Brakel & R. Rock eds., rev. ed. 1971)), [hereinafter cited as *Draft Act*].

8. See *supra* note 5.

9. See *Draft Act*, *supra* note 7, Commentary at 19.

10. See *Draft Act*, *supra* note 7, Commentary at 19.

11. See *supra* note 7.

12. *Draft Act*, *supra* note 7, Commentary at 19.

13. A 1974 study by The Joint Information Service of the American Psychiatric Association and the National Association for Mental Health revealed that maintenance expenditures per patient-day averaged \$30.86 in the United States in that year and that expenditures of state and county mental health hospitals totaled nearly \$2.5 billion. These figures represented a 107 percent increase from a previous study in 1970. 16 Indices 14-15 (Joint Information Service 1976 ed.).

The harmful effects of compulsory hospitalization make the need for voluntary procedures for admission even more clear. Some authorities in the mental health field insist that forced hospitalization makes effective treatment impossible.¹⁴ There is evidence that the trauma caused by forced hospitalization actually can result in deterioration of the patient's physical and psychological condition.¹⁵ The advantages of voluntary treatment compared to the harmful effects of compulsory hospitalization make readily available voluntary admission an important legislative goal.¹⁶

Voluntary hospitalization in a mental health facility cannot always, however, be considered entirely voluntary. Many mental health codes give the institution the option of detaining a voluntary patient after he has requested release.¹⁷ The period which may elapse before the hospital must release a patient or institute involuntary proceedings is usually specified and ranges from twenty-four hours¹⁸ to thirty-five days.¹⁹ Under most statutes, hospital authorities may institute involuntary commitment proceedings during detention.²⁰ The filing of a commitment petition may result in further extended detention, pending civil commitment proceedings.²¹

It is clear that, at the point the patient requests release, he is no longer affirmatively seeking residential treatment or even acquiescing passively in its provision. He can no longer be considered voluntary. Although he may continue to be categorized as "voluntary," the denial of immediate release necessarily changes the circumstances of hospitalization to that of compulsion.

Statutory provisions which allow the hospital to detain a voluntary patient after he has requested release may deter a mentally disabled individual who would otherwise become a voluntary patient from admitting himself. One court pointed out that the advantages of voluntary admission

are less likely to be realized and persons who recognize their need for hospitalization are less likely to seek it if, after . . . voluntary

14. Constitutional Rights of the Mentally Ill: Hearings before the Subcomm. on Constitutional Rights of the Sen. Comm. on the Judiciary, 87th Cong., 1st Sess. 75 (1961) (Statement of the American Psychiatric Association) [hereinafter cited as 1961 *Hearings*].

15. Prock, *Effects of Institutionalization: A Comparison of Community, Waiting List, and Institutionalized Aged Persons*, 59 Am. J. Pub. Health 1837 (1969).

16. Mental Health Law Project, *Legal Issues in State Mental Health Care: Proposals for Change*, 2 Mental Disability L. Rep. 57, 94 (1977) [hereinafter cited as Mental Health Law Project]; American Bar Foundation, *supra* note 3, at 18; *Draft Act*, *supra* note 7, Commentary at 19.

17. See, e.g., Alaska Stat. § 47.30.050 (1979); Ariz. Rev. Stat. Ann. § 36-519(C) (Supp. 1980); Ga. Code Ann. § 88-503.2 (1978); N.M. Stat. Ann. § 43-1-14(C) (1978).

18. Ariz. Rev. Stat. Ann. § 36-519(B) (Supp. 1980).

19. Alaska Stat. § 47.30.050 (1979) (request for release may not be made until patient has been hospitalized thirty days; discharge may be postponed for an additional five days).

20. E.g., N.M. Stat. Ann. § 43-1-14(C) (1978).

21. E.g., Ill. Ann. Stat. ch. 91½, § 3-403 (Smith-Hurd Supp. 1979) (five days initially, plus five days pending proceedings).

admission . . . they then can be subjected to involuntary commitment without a significant change in their condition, the perception of their condition, or their willingness to be hospitalized.²²

Such a deterrent effect may undermine legislative efforts to encourage voluntary submission to treatment.

The detrimental effects which necessarily accompany forced hospitalization are immediate. According to testimony presented to the Senate Subcommittee on Constitutional Rights:

[E]xperience has indicated that any kind of forceable detention of a person in an alien environment may seriously affect him in the first few days of detention, leading to all sorts of acute traumatic and iatrogenic symptoms and troubles. By "iatrogenic" I mean things that are caused by the very act of hospitalization which is supposed to be therapeutic; in other words, the hospitalization process itself causes the disturbance rather than the disturbance requiring hospitalization.²³

III. COMPETING INTERESTS

The deterrent and detrimental effects of a hospital's option to detain a previously voluntary patient may discourage voluntary admissions and will often negate the therapeutic advantages of voluntary admission.²⁴ Such provisions will undermine legislative efforts to encourage voluntary admission. The reason for this apparent inconsistency is that encouraging voluntary admission over involuntary commitment is not the only purpose underlying mental health legislation. Statutory regulation of mental health facilities attempts to accommodate several different and often conflicting interests and viewpoints. Analysis of a provision which allows a hospital to detain a patient who has entered voluntarily requires consideration and balancing of the interests of the individual patient, the treatment providers,

22. *Appeal of Niccoli*, 372 A.2d 749, 754 (Pa. Super. 1977):

The hospital should not, . . . at any time abrogate that voluntary agreement of the patient. It has two effects.

First of all, on the particular patient, and secondly, it has the effect that word of this spreads to all other patients, and the fear instilled in them, both those in the hospital and those who might come into the hospital, would lead to a great diminution rather than an increase in voluntary admissions.

See, 1970 *Hearings*, *supra* note 6, at 39 (Statement of Dr. John Donnelly).

23. 1970 *Hearings*, *supra* note 6, at 210 (Statement of Arthur Cohen, National Capitol Area Civil Liberties Union).

24. Some patients who are detained temporarily after they have requested release may be persuaded to accept treatment. It is difficult to determine, however, whether a patient has voluntarily and understandingly accepted treatment or has relented under coercion from hospital staff and the environment of the hospital itself. See *infra* note 122 and accompanying text.

and the public.²⁵ This analysis reveals the dilemmas inherent in designing a mental health system which will serve these interests effectively.

A. *Private Interests: The Interests of the Mentally Disabled*

The interests of the individual mental health patient may themselves be conflicting. The legal advocate of the patient would protect the constitutional rights of the individual from unnecessary deprivation of his liberty and intrusion into his privacy. From the viewpoint of the medical profession, the interest of the patient in treatment and recovery is paramount. The personal interests of the patient who has requested release potentially encompass elements of both sets of professional interests. The voluntary patient's request for release reflects his desire to avoid the highly restrictive and intrusive environment of the hospital. The request does not, however, necessarily indicate the patient's failure to recognize his need for continued treatment. Many patients may have a dual interest in avoiding institutionalization and in seeking treatment in a less restrictive environment.

1. *Liberty Interest of the Patient*

The United States Supreme Court has recognized that, to the individual, institutionalization means a "massive curtailment of liberty"²⁶ and personal autonomy. The restraint on physical liberty in most residential mental health facilities is no less than that imposed by penal incarceration.²⁷ In many instances, mental health institutionalization will entail even more restriction on liberty than the simple confinement typical of penal incarceration.²⁸ In a residential facility, the mental patient's every activity is regulated by hospital administrative and medical staff.²⁹ Hospital conditions,³⁰ staff efforts to make their jobs more manageable, and medical therapeutic controls closely regulate the patient's every move.

25. In *Mathews v. Eldridge*, 424 U.S. 319 (1976), the United States Supreme Court outlined the balancing test for measuring constitutional sufficiency of a statute under procedural due process analysis. See *infra* notes 87-156 and accompanying text.

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

27. Mental Health Law Project, *supra* note 16, at 80 and 57.

28. Freedom of movement may be even more important to the mentally disabled individual than to the mentally healthy criminal defendant. There is evidence that involuntary hospitalization will exacerbate the symptoms of mental illness. 1970 *Hearings*, *supra* note 6, at 214-15, 319, 409.

29. Mental Health Law Project, *supra* note 16, at 8; 1970 *Hearings*, *supra* note 6, at 424.

30. State mental hospitals are often over-crowded and under-staffed. Although many mental health codes now require that facilities maintain "a humane psychological and physical environment," e.g., N.M. Stat. Ann. §43-1-6(D) (1978), limited resources and administrative burdens often make accomplishment of this goal impossible. In many institutions, the mental patient is subject to overcrowding, unsanitary conditions, and often abusive, or at least intrusive, behavior of other patients. See Mental Health Law Project, *supra* note 16, at 80. The 5th Circuit Court of Appeals, studying conditions in Alabama institutions, found that:

In the area of criminal procedure, the United States Supreme Court has repeatedly recognized the high value placed on freedom of movement by American society.³¹ The courts have distinguished the mental health patient from the criminal defendant, stressing that detention of the mentally ill is not penal, but paternal in nature.³² The courts have also recognized, however, the importance to the individual of not being restrained in a mental health institution unnecessarily,³³ no matter how good the intentions of the custodian.³⁴

There is an additional private liberty interest in avoiding the social stigma³⁵ of having been confined to a mental institution. The United States Supreme Court characterized the damage to reputation which may result from involuntary commitment as deprivation of "liberty," which is distinguished from physical restraint.³⁶ Countervailing considerations make

There were severe health and safety problems: patients with open wounds and inadequately treated skin diseases were in imminent danger of infection because of the unsanitary conditions existing in the wards, such as permitting urine and feces to remain on the floor; there was evidence of insect infestation in the kitchen and dining areas. Malnutrition was a problem. . . .

Wyatt v. Aderholt, 503 F.2d 1305, 1310 (5th Cir. 1974). Professor Rosenhan found that, even where conditions are adequate, even plush, institutionalization is dehumanizing. Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara Lawyer 379 (1973).

31. See, e.g., *Argersinger v. Hamlin*, 407 U.S. 25 (1972) (heightened procedural safeguards required where criminal defendant faces jail sentence).

32. *Logan v. Arafeh*, 346 F. Supp. 1265, 1269 (D. Conn. 1972), *aff'd sub nom. Briggs v. Arafeh*, 411 U.S. 911 (1973) (many due process safeguards guaranteed in criminal procedure do not attach in the civil commitment process); *but see Lessard v. Schmidt*, 349 F. Supp. 1078, 1088-90 (E.D. Wis. 1972), *remanded*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (1974), *remanded*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (1976): "Even a brief examination of the effects of civil commitment upon those adjudged mentally ill shows the importance of strict adherence to stringent procedural requirements and the necessity for narrow, precise standards." *Id.* at 1088.

33. *Parham v. J. R.*, 442 U.S. 584, 600 (1979); *Addington v. Texas*, 441 U.S. 418, 425 (1979); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *Specht v. Patterson*, 386 U.S. 605 (1965).

34. *Cf., In re Gault*, 387 U.S. 1 (1967) (Constitution requires procedural protection of the juvenile's liberty interest in delinquency proceedings). One court stated that, "[i]t is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process." *Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968).

35. In addition to the social stigma which results from hospitalization in a mental institution, Erving Goffman describes a self-stigmatization which "mirrors" the degrading hospital experience. E. Goffman, *Asylums* 148-152 (1961).

In the mental hospital, the setting and the house rules press home to the patient that he is, after all, a mental case who has suffered some kind of social collapse on the outside, having failed in some over-all way, and that here he is of little social weight, being hardly capable of acting like a full-fledged person at all.

Id. at 151-152.

36. *Vitek v. Jones*, 445 U.S. 480, 492 (1980): "The loss of liberty produced by an involuntary commitment is more than a loss of freedom from confinement. It is indisputable that commitment to a mental hospital 'can engender adverse social consequences to the individual' . . . *Addington v. Texas* [441 U.S. 418 (1979)] at 425-26." Comparing the effects of the criminal sentence, one lower

it difficult, however, to assess the weight of the voluntary patient's interest in avoiding the stigma of institutionalization.

In two recent cases, considering the constitutionality of procedural aspects of civil commitment, the United States Supreme Court expressed the view that the stigma of institutionalization may be less than the stigma of the "symptomatology of a mental or emotional illness" in the community.³⁷ The Court assumed that the bizarre behavior of a severely disabled person may cause more serious social, financial and legal difficulties than would hospitalization which may remit the symptoms of the disorder. In both cases, the Court was reviewing procedures for initiation of hospitalization. The Court considered the stigmatization of bizarre behavior in the community as an alternative to the stigma produced by hospitalization. The voluntary patient, however, is already hospitalized. The decision to deny his request for release provides the additional source of stigma resulting from involuntary hospitalization.

The voluntary patient may also be viewed as suffering only *de minimus* additional stigma as a result of being detained beyond the time he has been institutionalized voluntarily. Any stigma which attaches to the fact of hospitalization has attached as a consequence of the patient's voluntary act. It may be that the individual's interest in protecting his reputation will be considered minimal by courts and legislatures, because he entered the hospital voluntarily and because hospital authorities may only detain him temporarily before establishing the need for continued hospitalization.

The decision to detain a patient is, however, stigmatizing in a way that voluntary admission to the hospital is not. Involuntary institutionalization has a detrimental effect on an individual's liberty interest which may be particularly damaging to the mental health patient. The decision to deny a voluntary patient's request for release reflects a determination that the patient is incapable of making his own decisions about how he should live and deal with his problems. The patient's awareness of this determination results in self-deprecation and loss of self-confidence.³⁸ Indeed, the decision to detain a patient may eventually prove to be erroneous. Further investigation by hospital authorities or civil commitment proceedings may result in release. The injury to the patient's liberty interest in the form of loss of self-worth, however, may be substantial and irreparable.

federal court pointed out that the social stigma which attaches to imprisonment may be less than that of the ex-mental patient. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1088-89 (E.D. Wis. 1972), *remanded*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (1974), *remanded*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (1976); *See also*, 1970 *Hearings*, *supra* note 6, at 284 (Testimony of Bruce J. Ennis, American Civil Liberties Union, New York City).

37. *Parham v. J. R.*, 442 U.S. 584, 601 (1979); *Addington v. Texas*, 441 U.S. 418, 429 (1979).

38. Mental Health Law Project, *supra* note 16, at 81.

Similarly, the disruption of family, social, and economic ties may be attributed to the patient's own voluntary act of admission for treatment. This "discounting" of the individual's interest in maintaining involvement with the community ignores the important factor of the duration of institutionalization. One expert testified before the Senate Subcommittee on Constitutional Rights that the longer a person is hospitalized, the more difficult it becomes for him to re-integrate into community life.³⁹ The increasing difficulty is in part due to the dissolution of community ties and the impossibility of carrying on normal social and economic activity while the patient is hospitalized. The duration of institutionalization which will irreparably damage community relationships and endeavors will vary with the individual. The effect of the disruption on mental health is more certain: "Through our accumulated research findings and clinical experience, we know that most mental illness can be treated more effectively when detected and diagnosed early and properly, and when the positive relationships between the individual and his family, his job, and his community are not severed."⁴⁰ Although the individual may have initially cut himself off from the community voluntarily, he may request release because he is aware of an increasing or unforeseen effect which segregation will have on his return to the community.

2. *Privacy Interest of the Patient*

In addition to the patient's liberty interest, detention in a mental institution threatens constitutionally protected privacy interests. Conditions in a typical state mental institution often make individual privacy impossible.⁴¹ State hospitals typically house large numbers of patients in wards where there is insufficient space to provide any individual patient with privacy.⁴² Also, in order to maintain control over the behavior of a large number of patients, hospital staff keep "watch" on the wards twenty-four hours a day.⁴³ One commentator has likened mental hospital living to a "goldfish-bowl existence."⁴⁴

39. 1970 *Hearings*, *supra* note 6, at 409 (Statement of Dr. Sherman Kieffer, Director, National Center for Mental Health Services, Training and Research, of St. Elizabeth's Hospital, Washington, D.C.).

40. 1970 *Hearings*, *supra* note 6, at 319 (Statement of Dr. Sherman Kieffer).

41. *See supra* note 30. A federal court, reviewing conditions in Alabama hospitals found that "[p]atients in the hospitals were afforded virtually no privacy: the wards were overcrowded; there was no furniture where patients could keep clothing; there were no partitions between commodes in the bathrooms." *Wyatt v. Aderholt*, 503 F.2d 1305, 1310 (5th Cir. 1974).

42. 503 F.2d at 1310.

43. Several state legislatures have provided for some measure of privacy by requiring that the patient be provided "reasonable storage space for his personal possessions" and that he "be afforded reasonable privacy in his sleeping and personal hygiene practices." N.M. Stat. Ann. § 43-1-6(D) (1978). As with most legislative attempts to improve hospital conditions, however, "reasonable" privacy measures are limited by inadequate staffing and budgets.

44. Mental Health Law Project, *supra* note 16, at 81.

The mental patient is deprived of an even more important privacy interest when he loses the right of control over medical and psychological treatments.⁴⁵ Psychiatric examination, by its nature, is particularly intrusive in that it probes into the innermost thoughts and feelings of the patient.⁴⁶ Courts considering the mental patient's right to refuse treatment have stated that the individual who voluntarily admits himself to the hospital, in effect, consents to the treatment choices of the physician.⁴⁷ If the voluntary patient has no right to select or refuse treatment modalities chosen by the physician while hospitalized, his only means of control is to seek release. As a practical matter, the hospital's denial of release is a denial of the patient's only semblance of control over treatment decisions.

The individual privacy interest protected by the Constitution is not, however, absolute.⁴⁸ It is necessarily limited by overriding public interests and the interests of other individuals.⁴⁹ It may not be feasible to administer a mental hospital in such a way as to provide full privacy to patients.⁵⁰ The special difficulties of treating the mentally disabled may also justify intrusive treatment absent the patient consent which is required in ordinary medical treatment.⁵¹ As a consequence, the patient's protected privacy

45. See *Rennie v. Klein*, 462 F. Supp. 1131, 1144-45 (D.N.J. 1978) (privacy includes the right to protect one's mental processes from interference); *In re K.K.B.*, 609 P.2d 747, 750 (Okla. 1980) (when "forcibly medicated, a patient's emerging constitutional right of privacy may be violated."); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977) (privacy "encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity" where countervailing interests of the state do not outweigh the individual interest); *Cf.*, *Ingraham v. Wright*, 430 U.S. 651, 673 (1977) ("Among the historic liberties [protected by the Due Process Clause] was the right to be free from . . . unjustified intrusions on personal security."); *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957) ("right of an individual that his person be held inviolable").

46. *Cf.*, *Caesar v. Mountanos*, 542 F.2d 1064, 1071-72 (9th Cir. 1976) (Hufstедler, Cir. J., concurring and dissenting), considering the confidential nature of psychiatrist-patient communications: "Psychotherapy probes the core of the patient's personality. The patient's most intimate thoughts and emotions are exposed during the course of treatment."

47. *Rogers v. Okin*, 634 F.2d 650, 661 (1st Cir. 1980), *cert. granted*, 49 U.S.L.W. 3788 (April 21, 1981), *argued, sub nom.* *Mills v. Rogers*, 50 U.S.L.W. 3569 (Jan. 13, 1982).

48. *Roe v. Wade*, 410 U.S. 113, 153-54 (1973); *Doe v. Bolton*, 410 U.S. 179 (1973).

49. See *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (protection of innocent third persons and prevention of suicide discussed as countervailing state interests which can outweigh individual interest in being free from nonconsensual invasion of bodily integrity). *Cf.*, *Roe v. Wade*, 410 U.S. 113, 163-64 (1973) (state's interest in protecting fetal life overrides the mother's privacy interest at the point of viability).

50. See *supra* note 43.

51. The conflicting viewpoints concerning the voluntary patient's right to refuse treatment are beyond the scope of this Comment. It should be noted, however, that the courts have recognized that, in some circumstances, the interests of the state will justify treatment without the consent of the patient. See, e.g., *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980) *cert. granted*, 49 U.S.L.W. 3788 (April 21, 1981), *argued, sub nom.* *Mills v. Rogers*, 50 U.S.L.W. 3569 (Jan. 13, 1982) (forced medication permissible to prevent violence).

interests are necessarily threatened whenever the hospital authorities have the option of detaining him.

3. Another Viewpoint

Proponents of treatment in mental institutions point to positive aspects of the effects on the individual of compulsory hospitalization. One legal commentator, discussing policy considerations underlying civil commitment, summarized the arguments which could be made in support of compulsory hospitalization:

Temporary regulation of daily routine and the provision of necessities may free an individual to focus his attention and efforts upon his mental and behavioral difficulties. Forced medicatio [sic] and other forms of treatment may relieve symptoms that would otherwise prevent the individual from functioning effectively and may so demonstrate their value to him that he is soon willing to accept them voluntarily.

[T]emporary removal from the community during a psychotic episode may protect the individual from more serious personal problems than result from commitment.⁵²

These potentially positive aspects of residential treatment may, in some cases, outweigh the negative consequences to the individual of compulsory hospitalization. The only patients who will benefit from these positive aspects, however, are the patients who indeed require compulsory hospitalization and for whom confinement can be justified. They cannot, in any case, justify the deprivation suffered by the patient who is restrained unnecessarily.

B. Interests of the Physician/Hospital⁵³

Mental health clinicians and administrators protest that their interest in detaining patients is not different from those of the patient and society. From the medical viewpoint, the more important right and need of the patient is that of effective treatment, though the patient's illness may prevent him from recognizing his need for professional help.⁵⁴ Clinicians

52. Mental Health Law Project, *supra* note 16, at 81.

53. The interests of the physician and hospital and those of the state are theoretically the same. The option of the hospital to detain a patient is a delegation of the state's power and is justified only in that the action promotes state interests. *See infra* notes 68-81 and accompanying text. There are interests of the physician/hospital, however, which are distinct from those of the state and will have a special effect on the decision to deny a voluntary patient's request for release.

54. American Psychiatric Association, *Comments on Civil Commitment*, 2 Mental Disability L. Rep. 519 (1978) [hereinafter cited as American Psychiatric Association].

By training and inclination, . . . [the physician would prefer] to treat people who in their assessment need treatment even though their illness may lead some of those people to make the choice of not being treated. The physician, in other

and administrators point to the potential harm to effective mental health care if they are cast as adversaries to the interests of the patient.⁵⁵ Inevitably, however, when the voluntary patient's desire to leave the hospital is resisted by physicians or hospital personnel, physician and patient become adversaries.

The conflict which arises between the physician and the patient will not necessarily be between the desire to treat and the desire to avoid treatment. The interest of the patient which is adverse to the interest of the physician is that of protecting his liberty and privacy. A request for release from the restrictive environment of the hospital does not always indicate a denial of the need for treatment. In many cases, the patient may only wish to seek less restrictive alternative modes of treatment. In these cases, the physician/hospital's interest in providing treatment will not necessarily conflict with that of the patient. The interest of the physician in ameliorating the symptoms of mental disorder is often better served by treatment in a less restrictive environment than that of the residential facility.⁵⁶ Compulsory hospitalization may, in fact, only retard the patient's progress and thus will fail to serve the interest of the clinician in effective treatment.⁵⁷

It is more appropriate to focus on the physician/hospital's interests underlying the desire to retain the authority to decide whether a voluntary patient should be released.⁵⁸ Though related, these interests will be secondary to the principal function of the profession, that of providing necessary care. The medical profession has an interest in preserving the right to make decisions as to appropriate treatment modalities, unencumbered by legal limitations and procedures.⁵⁹ Any emphasis placed on the liberty

words, would prefer to err in the direction of giving treatment that may not be necessary while the [lawyer] would err in the direction of not giving treatment even though it may be desirable or necessary.

55. See, e.g., American Psychiatric Association, *supra* note 54, at 519; Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Calif. L. Rev. 840, 843 (1974).

56. Some authorities suggest that the benefits of less restrictive treatment available through community mental health centers mandate a preference for community treatment over in-patient care in all cases. See Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 Mich. L. Rev. 1107 (1972).

57. See *supra* notes 12-13, 32 and accompanying text.

58. Not all mental health professionals want the responsibility of making that decision:

I would say that the vast majority of psychiatrists feel that if a patient admits himself voluntarily to a hospital, then he should retain the right to leave the hospital. If it is necessary that confinement be instituted, then there should be some other procedure other than the hospital taking that step.

1970 Hearings, *supra* note 6, at 38 (Statement of Dr. John Donnelly). The medical profession's response to legislation which limits the physician's prerogatives, however, indicates that Dr. Donnelly's "vast majority" is exaggerated. See, e.g., L. Kahle & B. Sales, "Due Process of Law and the Attitudes of Professionals Toward Involuntary Civil Commitment," *New Directions in Psychological Research* 265-292 (P. Lipsitt & B. Sales, eds., 1980); American Psychiatric Association, *supra* note 54.

59. American Psychiatric Association, *supra* note 48, at 520.

and privacy interests of the individual necessarily results in limitation and regulation of the physician's decision-making authority.

The mental health profession has defended the right to make treatment decisions most vigorously. The individual patient's resistance to a form of treatment is often viewed as a symptom of disorder. Some patients are actually unable, by reason of their disorders, to make their own treatment decisions.⁶⁰ Additionally, some mental health professionals insist that psychiatric training is so specialized that laypersons are never qualified to make treatment decisions.⁶¹

Another of the physician/hospital interests is similar to governmental interests in confining the mentally ill: protecting the individual and third persons from the dangerous acts of the prematurely released patient.⁶² The sources of the physician/hospital's concern, however, may be different from those of the state.

The medical profession has a general ethical responsibility to preserve life and relieve suffering.⁶³ The general view is that, in order to fulfill this responsibility, the psychiatric professional must be permitted to control behavior of patients who are potentially dangerous to themselves or others.⁶⁴

Furthermore, in some jurisdictions, the party responsible for negligently releasing a patient can be held liable for the eventual suicide of the patient⁶⁵ or harm caused⁶⁶ by the patient. Appropriate legislation would prevent this concern. The physician or hospital cannot be held liable for failure to act when they are forbidden by law to act. Legislation which

60. Critics of the mental health profession express doubt, however, as to whether the nature of mental disorder justifies the power psychiatrists have traditionally held over their patients. See, e.g., J. Robitscher, *The Powers of Psychiatry* (1980); *Drugs in Institutions: Hearings Before the Subcomm. to Investigate Juvenile Delinquency, Sen. Comm. on the Judiciary, Cong., Sess. 13-17, 4* (1975) (Statement of Janet Gotkin, ex-mental patient) [hereinafter referred to as *1975 Hearings*]; B. Ennis, *Prisoners of Psychiatry* (1972).

61. See American Psychiatric Association, *supra* note 54, at 520. For a discussion of the allocation of decision-making authority between the medical expert and the layman which considers the opposite viewpoint as well as that of the physician, see Gold, *Wiser Than the Laws?: The Legal Accountability of the Medical Profession*, 7 *Am. J. of L. and Med.* 145 (1981). One noted commentator has characterized the medical profession's effectiveness as illusory and trust in the special expertise of physicians as the "new epidemic". I. Illich, *Medical Nemesis* (1976). Illich warns that "[a] crisis of confidence in modern medicine is upon us." *Id.* at 4. He states that, "[a]s soon as medical effectiveness is assessed in ordinary language, it immediately appears that the most effective diagnosis and treatment do not go beyond the understanding that any layman can develop." *Id.* at 172.

62. See *infra* notes 68-74 and accompanying text.

63. American Psychiatric Association, *supra* note 54, at 519.

64. *Id.* at 519-20.

65. *Meier v. Ross Gen. Hosp.*, 69 Cal.2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968); *Vistica v. Presbyterian Hosp.*, 67 Cal. 2d 465, 432 P.2d 193, 62 Cal. Rptr. 577 (1967); see generally, W. Prosser, *Law of Torts* 172, n. 39 (4th ed. 1971).

66. See generally, Annot., *Liability of One Releasing Institutionalized Mental Patient for Harm He Causes*, 38 A.L.R.3d 699 (1971); *Underwood v. United States*, 356 F.2d 92 (5th Cir. 1966).

expressly denies the hospital's authority to detain a voluntary patient or statutory exemption from liability for premature release,⁶⁷ should effectively end such concern.

C. State Interests

The state's power to detain any person deemed to be "mentally ill," is founded on two doctrinal bases: the "police power" of the state to protect the community and the parental or *parens patriae* responsibility to care for disabled members of the community.⁶⁸ Statutory authority in the hospital to detain a voluntary patient after his request for release is a delegation of the state's power. Thus, the hospital's authority can be justified only on the basis of the state's police or *parens patriae* power.

1. Police Power

Each state has the authority, derived from its police power, to protect the members of the community from the anti-social acts of the mentally disabled.⁶⁹ This inherent power in the states provides the basis for involuntary commitment of individuals who present a threat of harm to the person or property of others.⁷⁰ All states have statutes which permit involuntary commitment to a mental hospital where there has been a finding that, as a result of mental disorder, the person presents a threat of serious harm to others.⁷¹

67. Some states already provide similar exemption. See, e.g., Ga. Code Ann. § 88-502.23 (1978); Wash. Rev. Code Ann. § 71.05.120 (Supp. 1982). A recent survey of the tort case law on the responsibility of mentally disabled persons indicates that "[t]he general rule is that mentally disabled adults are to be held responsible for the torts they commit." Ellis, *Tort Responsibility of Mentally Disabled Persons*, 1981 Am. B. Found. Research J. 1079, 1081 (citing *McGuire v. Almy*, 297 Mass. 323, 8 N.E.2d 760 (1937); *Johnson v. Lambotte*, 147 Colo. 203, 363 P.2d 165 (1961)). Professor Ellis also observed, however, that "[m]entally disabled persons as a class tend to be judgment proof." *Id.* at 1080. The individual who has been institutionalized will often lack resources sufficient to compensate a victim of his tortious conduct. The physician or hospital will frequently be a better source of compensation. If the physician and hospital are not liable for premature release of the patient, the victim may, in many cases, have no recourse. The victim of a tortfeasor who has been released from a mental institution is in no different position, however, than is the victim of any other "judgment-proof" tortfeasor.

68. Kittrie, *Compulsory Mental Treatment and the Requirements of "Due Process,"* 21 Ohio St. L. J. 28 (1960). Professor Kittrie includes in his discussion the authority of the state to care for the "pauper" community. The state's interest in protecting the poor falls under the *parens patriae* power, the general power of the state to protect the helpless.

69. *O'Connor v. Donaldson*, 422 U.S. 563, 582-83 (1975) (Burger, C.J., concurring).

70. Mental Health Law Project, *supra* note 16, at 83.

71. *Id.*; See, e.g., N.M. Stat. Ann. § 43-1-10 (1978) (Emergency Detention), § 43-1-11 (1978) (Involuntary Commitment for a Thirty-Day Period).

Commitment under the criterion of dangerousness has been severely criticized in light of evidence that psychiatric predictions of violence are extremely inaccurate. See, Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Calif. L. Rev. 693, 711-716 (1974); Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 Crime

2. *Parens Patriae*

The states are also vested with the *parens patriae* power and moral obligation to protect persons who, by reasons of disability, are unable to act for themselves, including "infants, idiots, and lunatics."⁷² Under this power and obligation, the state may commit a mentally disabled person to prevent suicide or self-inflicted bodily harm⁷³ or physical harm resulting from inability of the person to care for himself.⁷⁴

The state's power to detain a mentally disabled individual is traditionally recognized by the courts.⁷⁵ On the other side, the individual's right

& Delinq. 371 (1972); Wenk, Robison & Smith, *Can Violence be Predicted?* 18 *Crime & Delinq.* 393 (1972); Hunt & Wiley, *Operation Baxstrom After One Year*, 124 *Am. J. Psychiatry* 974 (1968). Despite the evidence, psychiatric indicators of potential dangerousness continue to be considered constitutionally adequate to commit an individual involuntarily. *Cf.*, *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) ("potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty.").

72. *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972) (quoting 3 W. Blackstone, *Commentaries* *47).

73. *See, e.g.*, N.M. Stat. Ann. § 43-1-13(E) (1978) (involuntary commitment of disabled adults to residential care on finding that client's disability "creates . . . imminent likelihood of serious harm to himself.").

As with the criterion of dangerousness, *supra* note 71, there is doubt as to whether psychiatrists can predict suicide. Arthur Cohen of the American Civil Liberties Union has suggested that the option to detain a voluntary patient is aimed at persons who, in the view of the hospital, are suicidal. Mr. Cohen reports that the incidence of suicides among those persons is rare and concludes that preventive detention of a voluntary patient is inappropriate to prevent suicide. 1970 *Hearings, supra* note 16, at 212-228. *See also* Greenberg, *Involuntary Psychiatric Commitments to Prevent Suicide*, 49 *N.Y.U. L. Rev.* 227 (1974).

74. "Harm to self" may include harm which falls short of suicide or self-inflicted bodily harm. While recognizing the state's power to confine a person whose way of life may harm him, the United States Supreme Court appears to limit the state's power when there is no showing of potential harm:

May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom

O'Connor v. Donaldson, 422 U.S. 563, 575 (1975).

A third criterion for commitment under the State's *parens patriae* power is the mental or emotional deterioration of the individual who may be benefitted by hospitalization and treatment. Several courts have held, however, that need for treatment is insufficient as a sole justification for compulsory hospitalization. *Doremus v. Farrell*, 407 F. Supp. 509, 514 (D. Neb. 1975) ("In the mental health field, where diagnosis and treatment are uncertain, a need for treatment . . . is not a compelling justification."); *Kendall v. True*, 391 F. Supp. 413 (W.D. Ky. 1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Bell v. Wayne County Gen. Hosp.*, 384 F. Supp. 1085 (E.D. Mich. 1974); *Cf.*, *O'Connor v. Donaldson*, 422 U.S. 563 (1975): "Assuming that [the term mental illness] can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom." *Id.* at 575.

75. *See O'Connor v. Donaldson*, 422 U.S. 563, 582-83 (1975) (Burger, C.J., concurring) (discussion of sources of state's power to confine); *Parham v. J.R.*, 442 U.S. 584 (1979).

to liberty is expressly protected by the fourteenth amendment.⁷⁶ The Court has recognized the individual's right to privacy as "fundamental."⁷⁷ Both interests are protected against unnecessary deprivation by state action. There is "no constitutional basis for confining . . . persons involuntarily if they are dangerous to no one and can live safely in freedom."⁷⁸

When the state authorizes hospital authorities to detain an individual, the constitutional limitations on the state's power must also limit the power of the hospital. In order to justify detaining a voluntary patient for any amount of time after his request for release, the decision-maker must be held to constitutionally permissible criteria. The voluntary patient whose detention would not serve the state's permissible interests cannot be detained. Statutes which allow a physician or hospital administrator to detain, for any amount of time, patients who are neither dangerous to themselves nor to others, are constitutionally invalid.

When the voluntary patient is denied release, the deprivation of his private interests is no different than that under involuntary commitment.⁷⁹ Under the equal protection clause of the fourteenth amendment, the state cannot deprive voluntary patients of liberty and privacy under standards more lax than those applied to persons who are involuntarily hospitalized in commitment proceedings.⁸⁰ The United States Supreme Court has held that a person may be involuntarily committed only upon "clear and convincing" proof that the patient meets the criteria for commitment.⁸¹ This standard would appear to be constitutionally required in the decision to detain a voluntary patient who has requested release.⁸²

The voluntary patient who does meet constitutionally permissible criteria for involuntary hospitalization presents an entirely different question than the patient who does not. The latter cannot be deprived of his liberty for any amount of time because his confinement would serve no overriding state interest. The judicially recognized interests of the state in confining and treating the individual who presents a danger to himself or others, however, is sufficient to justify depriving the former individual of his liberty and privacy. This individual's interests are not lessened by the fact that he may be dangerous. Nor is the state's interest in encouraging

76. "[N]or shall any State deprive any person of . . . liberty . . . without due process of law" U.S. Const. amend. XIV, § 1.

77. *Roe v. Wade*, 410 U.S. 113, 152 (1973) (citing to cases in which the constitutional notions of a guarantee of privacy have developed).

78. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

79. See *supra* notes 14-23 and accompanying text.

80. *Jackson v. Indiana*, 406 U.S. 715 (1972).

81. *Addington v. Texas*, 441 U.S. 418 (1979).

82. The United States Supreme Court has not considered what standard should be applied in determining whether a voluntary patient can be detained after he has requested release. It follows, however, from the Court's decisions in *Jackson* and *Addington* that the determination must be made under the same standard as that applied in other procedures to involuntary commit.

voluntary treatment assured by procedures which allow unnecessary involuntary hospitalization. In order to protect the interests of the individual and the state, the legislature should provide procedures which assure that voluntary patients are not detained unnecessarily.

IV. PROCEDURE FOR DECISION TO DETAIN A VOLUNTARY PATIENT: *MATHEWS v. ELDRIDGE*

None of the statutes studied provides an interim procedure for deciding whether a voluntary patient should be allowed to leave the hospital at his request prior to civil commitment proceedings. Most statutes specify only the decision-maker, usually the hospital superintendent,⁸³ and the criteria for detention.⁸⁴ Few statutes prescribe any standard for decision-making, although Connecticut does give the patient the right to a probable cause hearing.⁸⁵ In most hospitals, there appears to be no formal procedure for deciding whether to detain a patient.⁸⁶

The test applied to non-judicial decision-making in *Mathews v. Eldridge*⁸⁷ serves as the framework for analyzing the constitutional sufficiency of procedures required before an individual may be deprived of liberty or property. Eldridge's social security disability benefits were terminated after an administrative determination that he was no longer disabled.⁸⁸ He challenged the constitutional validity of the administrative procedures provided.⁸⁹ Eldridge relied on the Court's decision in *Goldberg v. Kelly*⁹⁰ and subsequent cases⁹¹ which established a right to a hearing prior to

83. See, e.g., N.Y. Mental Hyg. Law § 9.13(b) (McKinney 1978). The Washington statute provides that "the professional staff of any public or private agency or hospital" may detain a patient. Wash. Rev. Code Ann. § 71.05.050 (Supp. 1982).

84. Alaska Stat. § 47.30.050(a)(3) (1979) (discharge "would be unsafe to the patient or others"); Ga. Code Ann. § 88-503.2 (1979) (same); N.M. Stat. Ann. § 43-1-14(C) (1978) (client requires continued confinement and meets the criteria for involuntary residential treatment). The Idaho Code allows detention when the patient is dangerous to the property of others. Idaho Code § 66-319 (Supp. 1979).

85. Conn. Gen. Stat. Ann. § 17-187(d) (West Supp. 1981).

86. R. Rock, M. Jacobson & J. Janopaul, *Hospitalization and Discharge of the Mentally Ill* 230-32 (1968) [hereinafter cited as *Hospitalization and Discharge*]. This author could locate no more recent studies which would indicate that hospitals provide more formal procedure for determining whether a voluntary patient's request for release should be denied. Although legislatures have recently focused on the rights of voluntary patients, see, e.g., Alaska Stat. § 47.30.050 (1979); Ariz. Rev. Stat. Ann. § 36-519 (Supp. 1981), there has been virtually no change in legislatively prescribed procedures for the interim determinations. This Comment considers the constitutional sufficiency of the procedure for the hospital's decision to detain a patient pending commitment proceedings, when, in fact, the method for decision-making is often hardly recognizable as "procedure" at all.

87. 424 U.S. 319 (1976).

88. *Id.* at 324.

89. *Id.* at 325.

90. 397 U.S. 254 (1970): "[W]hen welfare is discontinued, only a pre-termination evidentiary hearing provides the recipient with procedural due process." *Id.* at 264.

91. *Fuentes v. Shevin*, 407 U.S. 67 (1972) (interest in real property); *Bell v. Burson*, 402 U.S. 535 (1971) (revocation of driver's license).

termination of property interests.⁹² The *Eldridge* Court distinguished *Goldberg*, based on the differences between the claimants and the nature of the inquiries relevant to the challenged procedures.⁹³ The *Eldridge* Court analyzed *Goldberg* and other prior decisions and found that:

[I]dentification of the specific dictates of due process generally requires consideration of three distinct factors: First, the private interests that will be affected by the official action; second, the risk of an erroneous deprivation of such interests through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interests, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail. See, e.g., *Goldberg v. Kelly*, [397 U.S.] at 263-271⁹⁴

The Court also considered under what circumstances a claimant would be entitled to a hearing before he was deprived of an important interest.

Eldridge challenged a procedure which deprived him of a property interest. The Court expressly held, however, that the test should be applied to governmental decision which deprives an individual of "liberty" as well.⁹⁵ Subsequently, courts have applied the *Eldridge* test to involuntary commitment decision-making.⁹⁶ The hospital decision to detain a voluntary patient who has requested release is a deprivation of constitutional rights which warrants scrutiny under the *Eldridge* factors for analysis.

A. Pre-Deprivation Hearing

The first issue addressed by the *Eldridge* Court was whether an individual threatened with governmental action is entitled to a predeprivation hearing.⁹⁷ The Court stated that "[a] claim to a predeprivation hearing as a matter of constitutional right rests on the proposition that full relief cannot be obtained at a postdeprivation hearing."⁹⁸ The reason the courts have provided heightened procedural safeguards when governmental ac-

92. 424 U.S. at 325-6.

93. 424 U.S. at 340-46. The Court pointed out that "the disabled worker's need is likely to be less than that of the welfare recipient," 424 U.S. at 342. The Court characterized welfare recipients as "persons on the very margin of subsistence" 424 U.S. at 340. In the case of the disabled worker, "a medical assessment of the worker's physical or mental condition is required. This is a more sharply focused and easily documented decision than the typical determination of welfare entitlement." 424 U.S. at 343. For a thorough discussion of *Eldridge*, see Mashaw, *The Supreme Court's Due Process Calculus for Administrative Adjudication in Mathews v. Eldridge: Three Factors in Search of a Theory of Value*, 44 U. Chi. L. Rev. 28 (1976).

94. 424 U.S. at 335.

95. 424 U.S. at 332.

96. See, *Parham v. J.R.*, 442 U.S. 584, 599-600 (1979).

97. 424 U.S. at 331.

98. *Id.*

tion threatens to deprive an individual of liberty⁹⁹ is that the harm caused by restraint is irreparable.

Fundamentally, the guarantee of due process protection is a guarantee of the right to be heard at a meaningful time in a meaningful manner.¹⁰⁰ Unnecessary denial of liberty for any amount of time cannot be compensated.¹⁰¹ Consequently, it appears at first glance that the patient's right to liberty can be adequately protected only if he is given an opportunity to be heard before the hospital authorities may detain him, even temporarily, pending the decision on whether to institute civil commitment proceedings. This may be accomplished by a probable cause hearing soon after the patient's request for release.¹⁰²

A preliminary hearing held soon after a request for release may, however, deny the patient the opportunity to be heard in a meaningful manner. The *Eldridge* Court placed emphasis on the opportunity for *effective* communication provided the recipient of social security benefits prior to the termination of benefits.¹⁰³ The opportunity to communicate with the decision-maker must include a meaningful opportunity to present arguments and evidence and access to the evidence supporting the decision.¹⁰⁴

The patient who is denied immediate release should be afforded legal counsel to assist him in gathering evidence and to present his arguments at the hearing. The patient should also have access to examination and advice from a medical expert who is independent from the hospital staff. The opportunity to communicate effectively with the decision-maker should also include access to the evidence which will be used to support a decision to detain him.¹⁰⁵ If a hearing to determine whether there is probable cause

99. See *supra* note 31 and accompanying text.

100. *Armstrong v. Manzo*, 380 U.S. 545 (1965).

101. Kenneth Donaldson claimed and was awarded damages under 42 U.S.C. § 1983, against members of the staff of a hospital in which he was confined against his will for 15 years. *O'Connor v. Donaldson*, 422 U.S. 563 (1975). Unlike harm to economic interests, however, the harm caused by deprivation of an individual's liberty and privacy interests cannot be truly compensated. The claimant cannot be "made whole" and damages serve only as a substitute for his loss.

102. A federal court, considering emergency commitment of mentally ill persons, held that "the maximum period which a person may be detained without a preliminary hearing is 48 hours." *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *remanded*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (1974), *remanded*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (1976). The Wisconsin legislature responded to the *Lessard* decision by requiring that a patient involuntarily confined be given a probable cause hearing within 72 hours of the emergency patient's arrival at the facility. Wis. Stat. Ann. § 51.20(7) (West Supp. 1981).

The Connecticut statute which authorizes the hospital to detain a voluntary patient provides for a probable cause hearing on request within 72 hours of the request for release. Conn. Gen. Stat. Ann. § 17-187(d) (West Supp. 1981).

103. 424 U.S. at 337-39, 345-46.

104. *Id.* at 345-46.

105. Patients often encounter difficulties in obtaining their own records. See *Gotkin v. Miller*, 514 F.2d 125 (2d Cir. 1975). Testifying before a United States Senate Subcommittee, investigating drugs in institutions, Mrs. Gotkin described the difficulties a mental patient encounters when he attempts to obtain his hospital records:

to detain a patient is held too soon after his request for release, the patient may not have time to prepare an adequate defense.

The patient's opportunity to defend at a preliminary hearing is especially important in light of the effect an adverse finding may have on subsequent commitment proceedings. A finding of probable cause to believe that the patient meets the criteria for civil commitment would serve its purpose only if based upon thorough examination of the evidence. Such a finding may prejudice the patient in a later commitment proceeding.

It may better serve the patient's interests to dispense with the notion of a preliminary hearing and provide for civil commitment proceedings without delay. In such a case, hospital authorities should be authorized to detain only patients against whom they intend to petition for commitment.¹⁰⁶ This requirement will help to assure that hospital authorities detain only patients they are reasonably certain meet the criteria for commitment. Also, by means of the petition for commitment, the patient will be notified of the bases of the hospital's tentative decision.¹⁰⁷ Where commitment proceedings will be the first opportunity the patient will have to be heard, they should be delayed no longer than is necessary to prepare evidence, to enable the patient to consult with an attorney and with an independent medical expert, and to allow the patient to review the evidence against him.¹⁰⁸

At a civil commitment proceeding, the patient will be afforded the same procedural protections provided all persons facing involuntary confinement.¹⁰⁹ Pending commitment proceedings, however, the patient who

[I]n practice, an ex-mental patient cannot have access to their records, unless they go through the procedure of requesting a doctor, and the doctor is supposed to screen out what would be harmful, because the assumption behind it, whether it is real or pretended is that we have been mentally ill, or we will be mentally ill, and therefore, are not stable enough to see what has been written about us.

My own interpretation is a much more political one . . . I think the hospitals are very intent and very serious upon maintaining a certain power, a certain secrecy, and that they are able to function the way they have functioned, . . . because the institutions are closed and they are not open to scrutiny.

1975 *Hearings*, *supra* note 60, at 7. The Connecticut statute provides for full access to records. Conn. Gen. Stat. Ann. § 17-178 (West Supp. 1981). This provision is, however, unusual. Most statutes include a provision for keeping a patient from reviewing those portions of his records which, in the discretion of the physician, would be harmful to the patient. *See, e.g.*, N.M. Stat. Ann. § 43-1-19(D) (1978).

106. *See, e.g.*, N.M. Stat. Ann. § 43-1-19(D) (1978).

107. The New Mexico statute governing involuntary commitment specifies that the petition "include a description of the specific behaviors or symptoms of the client which evidence a likelihood of serious harm to the client or others" and "shall also list the prospective witnesses for commitment and a summary to the matters to which they will testify." N.M. Stat. Ann. § 43-1-11(A) (1978).

108. Preparation for a commitment hearing should take no more than 5 days, as provided in N.M. Stat. Ann. § 43-1-14(C) (1978).

109. *See, e.g.*, Conn. Gen. Stat. Ann. § 17-178 (West Supp. 1981); N.M. Stat. Ann. § 43-1-11(B) (1978).

continues to be confined may require special protection because of disadvantages peculiar to hospitalization. Confinement may limit the patient's ability to communicate with counsel or prepare evidence in his defense. The patient under medication may be unable to present organized and coherent evidence in his defense. While detained, the patient is subject to the coercive atmosphere of the institution, without any of the protections afforded criminal arrestees in the similarly coercive atmosphere of the police station.¹¹⁰ He may be interrogated during this time by the very persons who will testify to his need for continued hospitalization.¹¹¹ Temporary detention pending commitment proceedings may thus hamper the patient's ability to protect himself against more extended loss of liberty resulting from commitment proceedings. Special protections may be required to avoid disadvantage to the hospitalized patient facing civil commitment.

1. Private Interests

The first factor for consideration under the *Eldridge* test is the private interest threatened by governmental action. The degree of threatened deprivation is a factor in the analysis.¹¹² The deprivation which results from detention of a voluntary patient is sufficient to require special safeguards.¹¹³

110. See *Miranda v. Arizona*, 384 U.S. 436 (1966).

111. This communication may be inadmissible as evidence under law which provides a patient-psychiatrist confidentiality privilege, absent a waiver or disclosure that the information will not be privileged. See *C.V. v. Texas*, 616 SW.2d 441 (Tex. Civ. App. 1981); Tex. Rev. Civ. Stat. Ann. art. 5561(h) (Vernon Supp. 1981). In jurisdictions which provide such protection, the patient must at least be warned that his statements will be used against him.

In New Mexico, there is a general rule that "[a] patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purposes of diagnosis or treatment of his mental or emotional condition. . . ." N.M. R. Evid. 504(b). The statute makes a specific exception to the rule in proceedings for hospitalization: "There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization." N.M. R. Evid. 504(d)(1).

112. 424 U.S. at 342.

113. See discussion accompanying notes 26-50, *supra*. The state's authority to detain a patient may be considered by some to be contractual. The voluntary submission to institutionalization may be considered a voluntary diminution of the patient's interests. Justice Stewart, in his concurring opinion in *Parham v. J.R.*, 442 U.S. 584 (1979), distinguished the circumstance of voluntary patients: "Clearly, if the appellees in this case were adults who had voluntarily chosen to commit themselves to a state mental hospital, they could not claim that the State had thereby deprived them of liberty in violation of the Fourteenth Amendment." *Id.* at 622 (Stewart, J., concurring opinion). In *Parham*, the Court considered whether the state should be required to have an adjudicative or adversarial hearing for juveniles prior to "voluntary" commitment by their parents. The Court's decision that such hearings were not required was based, in large part, on the duty and authority of parents to care for the needs of their children. *Id.* at 602. The children had been committed "voluntarily" by their parents and continued to be hospitalized at the will of their parents. *Id.* The Court had no opportunity in that case to consider the loss of liberty of the adult patient, whose true status had changed from voluntary to involuntary.

The voluntary patient conceivably will be deemed to have waived his interests when he subjected himself to treatment. The United States Supreme Court has accepted an individual's waiver of constitutional rights, however, only where certain requirements are met. In order to be sufficient, waiver of constitutional rights must be both "intelligently and understandingly" made¹¹⁴ and waiver must be "voluntary and uncoerced."¹¹⁵

Waiver must be "intelligently and understandingly" made.¹¹⁶ Voluntary admission statutes sometimes specifically provide that a patient be advised of the hospital's option to detain him should he request release.¹¹⁷ Some statutes require that the terms of the patient's agreement appear in the admission consent form and that they be posted in the hospital wards.¹¹⁸

Several lower courts have held void any agreement to waive the right to liberty. In *Ex parte Romero*, 51 N.M. 201, 181 P.2d 811 (1947), a New Mexico court rejected the argument that a voluntary patient had, in effect, contracted to remain in a mental institution for the statutory period. The court based its findings that the "agreement" was invalid on an assumption that any patient who needs treatment is *per se* incompetent. The court noted: "Obviously, it does not require citation of authority that one may not enforce such a contract made with a person he knows to be so disordered in mind as to require treatment in an institution for the treatment of mental diseases." *Id.* at 203, 181 P.2d at 813. More recently, a New York court invalidated a voluntary patient's agreement to deprive himself of rights accorded to "involuntary" patients based on similar rationale. *People ex rel. Kaminstein v. Brooklyn State Hosp.*, 49 Misc. 2d 57, 266 N.Y.S. 2d 916, 922-23 (Sup. Ct. 1966).

The conclusion in *Romero* that detaining a voluntary patient after request for release is a violation of due process is appropriate. The rationale of the case is, however, dangerous. The decision reflects the old rule that "mental patient status *per se* establishes legal incompetence—a rule which the law has been dismantling rather successfully for some time." Wexler, *Mental Health Law and the Movement Toward Voluntary Treatment*, 62 Calif. L. Rev. 671, 678 (1974). Commentators, writing for the American Bar Foundation, point out that such a rule of law would be inappropriate to present concepts of mental health treatment. "[T]he contention that any patient who needs treatment is *per se* incompetent to consent to admission unquestionably runs counter not only to the policy underlying voluntary admission statutes of forty-nine states but to the weight of contemporary medical and legal opinion." American Bar Foundation, *supra* note 3, at 22; see also *Buttonow v. O'Neill*, 23 N.Y.2d 385, —, 244 N.E.2d 677, 682 (1968).

A better argument is that no person may contract away his liberty and that it would be unconstitutional to enforce such an agreement. In *Ex parte Lloyd*, 13 F. Supp. 1005 (E.D. Ky. 1936), the court considered the contract of a drug addict to submit to confinement until such time as he ceased to be an addict under a federal statute. The court stated that to enforce the terms and conditions of such a contract would be in violation of the due process clause of the fifth amendment and the thirteenth amendment prohibition against involuntary servitude. *Id.* at 1007, quoting *Ex parte McClusky*, 40 F. 71 (D. Ark. 1889):

No man or no power has the right to take away another's liberty, even though with consent, except by due process of law. . . . Liberty . . . is an inalienable prerogative, of which no man by mere agreement can divest himself. Any divestiture not occurring by due process of law is null.

Id. at 74.

114. *Boykin v. Alabama*, 395 U.S. 238, 242 (1969).

115. *Miranda v. Arizona*, 384 U.S. 436, 476 (1966).

116. *Boykin v. Alabama*, 395 U.S. 238, 242 (1969); *Johnson v. Zerbst*, 304 U.S. 458 (1937).

117. See, e.g., N.Y. Mental Hyg. Law § 9.07 (McKinney 1978).

118. See, e.g., N.Y. Mental Hyg. Law § 9.07(b) (McKinney 1978).

Even where an attempt is made to comply with these provisions,¹¹⁹ however, there is currently no procedural method for testing whether the patient knew in fact that his agreement to be admitted was contingent on waiver of his liberty interest. Even in the case of the truly voluntary patient, there is a question as to whether the patient who suffers from the stress of mental disorder and seeks the drastic measure of institutionalized treatment has agreed "understandingly" to relinquish his liberty sometime in the future.¹²⁰

Waiver of a constitutional right must also be "voluntary and uncoerced."¹²¹ The atmosphere of a mental institution may be as coercive as that of a police station. The Court has recognized the possible effect of the jail environment on voluntary waiver of the right to remain silent, and has placed protective restrictions on police interrogation of a criminal arrestee.¹²² No such protection has been afforded the voluntary patient who may be coerced into agreeing to the terms of admission.¹²³

The circumstances of voluntary admission to a mental hospital and the nature of residential mental health care certainly make any claim of waiver of the patient's constitutional right to liberty questionable. However, it is difficult to conceive of a statutory scheme which would absolutely assure that every mental patient understands his rights and is free from coercion. There should be a specific statutory requirement that the patient be kept informed of his rights with regard to release and a prohibition against using any form of coercion to persuade the patient to stay in the hospital. The patient will be more able to make informed decisions if he is allowed to seek independent medical advice. He will be better equipped to resist coercion with the assistance of legal counsel. Such provisions should not, however, be considered sufficient as bases for waiver of the patient's constitutional rights.

The voluntary patient's interest in preserving his liberty and privacy cannot be presumed to be different from that of any other individual. One federal court, while providing for extensive procedural protection to an

119. One study indicated that the conditions of voluntary admission are sometimes presented to the patient only cursorily for a variety of administrative reasons. Gilboy & Schmidt, *supra* note 5, at 442-43. See also Owens, *When is a Voluntary Commitment Really Voluntary?* 47 Am. J. Orthopsychiatry 104 (1977); Beis, *Civil Commitment: Rights of the Mentally Disabled, Recent Developments and Trends*, 23 De Paul L. Rev. 42, 52-53 (1973) [hereinafter cited as Beis].

120. To stay that the stressful conditions of admission to a mental hospital make the "understanding" waiver of a constitutional right questionable is not to say that a patient of a mental hospital is *per se* incompetent as a matter of law. See discussion at note 113, *supra*.

121. *Miranda v. Arizona*, 384 U.S. 436, 476 (1966).

122. *Id.* A Michigan court determined that legally adequate consent to experimental psychosurgery could not be given by adults involuntarily confined in a mental institution. *Kaimowitz v. Dep't. of Mental Health*, 2 Prison L. Rep. 433 (Cir. Ct. Mich. 1973).

123. See *supra* note 5.

emergency patient, recognized that "the state may sometimes have a compelling interest in emergency detention of persons who threaten violence to themselves or others for the purpose of protecting society and the individual."¹²⁴ In such emergency situations, the state has the power to authorize hospital authorities to detain a voluntary patient after he has requested release, based upon a reasonable determination that the patient is dangerous. Under such circumstances, the patient should be afforded a proceeding in which such determination will be fairly tested as soon as possible after his request for release has been denied.

2. Risk of Error/Fairness of the Proceeding

The second consideration under the *Eldridge* test is the risk that the procedure available will result in error. The *Eldridge* Court analyzed the risk of error in the procedure by considering the nature of the relevant inquiry.¹²⁵ In *Eldridge*, the relevant inquiry was whether the recipient of Social Security disability benefits continued to be disabled. In the case of a patient of a mental hospital, the inquiry will be whether the patient's mental state is such that the state may deprive him of his liberty and privacy. In jurisdictions where there are no specified criteria for the decision to detain a voluntary patient¹²⁶ the "relevant inquiry" will not be clear. The omission of specified criteria in a statute would appear to authorize hospital authorities to detain a patient based on an individual physician's opinion of the need for continued hospitalization, and would certainly result in arbitrariness. The findings required in order to civilly commit an individual¹²⁷ would be more appropriate to a decision which effectively results in an involuntary commitment. Where the hospital is authorized to detain only patients against whom a petition for commitment will be filed, there would be greater assurance that the detained patient in fact meets the criteria for commitment.

No matter what criteria the decision-maker is required to meet, the evidence on which the decision is based should be a valid assessment of the individual patient's mental condition. This assessment may not be as

124. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1091 (E.D. Wis. 1972), *remanded*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (1974), *remanded*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (1976).

125. 424 U.S. at 343.

126. See *supra* note 84 and accompanying text.

127. N.M. Stat. Ann. § 43-1-11(C) (1978) provides for a thirty-day commitment:

[I]f the court finds by clear and convincing evidence that: (1) as a result of a mental disorder, the client presents a likelihood of serious harm to himself or others; (2) the client needs and is likely to benefit from the proposed treatment; and (3) the proposed commitment is consistent with the treatment needs of the client and with the least drastic means principle.

"sharply focused"¹²⁸ or as credible as the assessment of physical condition approved in *Eldridge*.¹²⁹ In many state mental hospitals the psychiatrist-patient ratio is so inadequate as to limit severely the frequency and duration of examinations.¹³⁰ The authority making the decision whether to detain a patient will often depend primarily on notes made in the patient's record by non-medical staff.¹³¹ A decision based on examination while a patient is hospitalized may also be influenced by the institutional environment. Otherwise normal behavior is often diagnosed as abnormal, simply because it occurred within the confines of a mental institution.¹³²

The decision to detain or release a patient may also be based upon, or at least affected by, non-medical factors which bear no relation to the patient as an individual.¹³³ The patient may effectively be denied immediate release by failure to respond to the request or by attempts to dissuade the patient on the part of hospital staff.¹³⁴ This staff response may result from such non-medical factors as the administrative difficulty in processing the request,¹³⁵ or even out of simple annoyance.¹³⁶

Where the criterion for detention is dangerousness,¹³⁷ institution au-

128. The *Eldridge* Court found submission of written medical reports sufficient to guarantee the fairness and reliability of the Social Security Disability termination decision: "[T]he decision whether to discontinue disability benefits will turn, in most cases, upon 'routine, standard, and unbiased medical reports by physician specialists,' *Richardson v. Perales*, 402 U.S. [389], 404 [(1971)], concerning a subject whom they have personally examined. [Footnote omitted]" 424 U.S. at 344 (emphasis added). In the mental health context, the hospital's decision to detain a voluntary patient after he has requested release may not be so "sharply focused" as in the case of a medical determination of physical disability. See *infra* notes 129-140 and accompanying text.

129. 424 U.S. at 344 (citing *Richardson v. Perales*, 402 U.S. 389, 404 (1971)).

130. See Mental Health Law Project, *supra* note 16, at 92.

131. See *Hospitalization and Discharge*, *supra* note 86, at 230-32. Non-medical staff notes may often provide descriptions of behavior which will indicate dangerous tendencies. Such descriptions will often be helpful in determining whether a patient must be detained, especially where the hospital's medical staff is inadequate to provide thorough examination. Non-medical staff notations should, however, be given appropriate weight in the decision-making process and should not substitute for medical assessment.

132. Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara Lawyer 379 (1973). Professor Rosenhan's interesting study revealed that a patient's admission diagnosis "profoundly colors others' perceptions of him and his behavior." *Id.* at 386-388. Both normal and aberrant behavior was perceived as symptomatic. In the study, pseudopatients were placed in separate mental hospitals. Nurses observed the pseudopatients making notes of their observations. The staff records indicated that the writing was perceived as pathological behavior. *Id.* at 388. See also S. Sorenson, *The Clinical Interaction* (1954).

133. See *Hospitalization and Discharge*, *supra* note 86, at 215-18. Rock's study, which covers voluntary and involuntary patients, indicates that "[t]he decision to discharge a patient depends on a variety of factors both medical and non-medical." *Id.* at 215.

134. See Beis, *supra* note 119, at 52-53.

135. *Id.*

136. The *Goldberg* Court, agreeing with the conclusions of the lower court, held that a pre-termination evidentiary hearing was required before terminating welfare benefits. The decision was in part due to "the possibility for honest error or irritable misjudgment." 397 U.S. 254, 266 (1970) (quoting *Kelly v. Wyman*, 294 F. Supp. 893, 904-905 (1968)) (Emphasis added).

137. See *supra* note 84.

thorities may have a tendency to overpredict dangerousness if they will face liability for the acts of a prematurely released patient.¹³⁸ A patient who has recovered to the extent that he no longer requires hospitalization may be detained because he has no family or home to return to in the community.¹³⁹ Hospital authorities may be especially reluctant to release a patient who has been institutionalized for an extended period of time and may be considered no longer able to adapt to community life.¹⁴⁰

The risk of a decision based on non-medical factors suggests that the decision to detain a patient may not be based upon a "sharply focused" and entirely credible medical assessment. The weight given to such non-medical factors will increase the risk of error in the decision-making process, especially where there are no specific criteria or standards of proof to which the decision-maker can be held.

The Court has not defined the "error" against which the procedure for deciding whether an individual should be involuntarily committed must be measured. The most obvious error would be to detain a mentally healthy individual who does not require hospitalization or treatment at all. In light of the harm which would be caused by unnecessary deprivation of liberty, detaining any individual who is mentally ill but who does not meet the minimum criteria for involuntary commitment should also be considered error.

The Court has also failed to make clear how it will measure error resulting from an existing procedure and what percentage of erroneous deprivation will be tolerated under constitutional analysis. The *Eldridge* Court stated vaguely that the risk of error will be measured with regard to the results of the procedure "as applied to the generality of cases, not the rare exceptions."¹⁴¹

Where the criteria for detention are clear, error may be measured by the number of patients who are detained but do not in fact meet the specified criteria. If the criteria for detention are the same as those required

138. See *supra* notes 65-67 and accompanying text.

139. [I]n application the common discharge standard depends on specific social circumstances over which the patient has little control. The same circumstances can influence his treatment program. The patient with strong social supports attracts treatment and early release, whereas the patient lacking these supports receives less treatment and his release is often delayed, or even withheld.

Hospitalization and Discharge, *supra* note 86, at 218.

140. With the passing of each year discharge becomes a more remote possibility for long-term patients. They become totally dependent on institutional care. Their ties with the community gradually dissolve until they have no desire to be released. Their families tend to drift away, their employable skills, if ever there were any, tarnish and become obsolete, and they come to require the supervised life in order to live at all.

Hospitalization and Discharge, *supra* note 86, at 228.

141. 424 U.S. at 344.

for involuntary commitment,¹⁴² the percentage of patients who are committed after a civil proceeding may indicate the percentage of error in the initial decision to detain with regard to those individuals. The findings of the civil commitment court will either confirm or reverse the hospital's finding that the patient was an appropriate candidate for involuntary hospitalization. It is not clear, however, that the Court would use this percentage as a measure of the risk of error in procedures under which hospital authorities decide to detain a patient who has voluntarily admitted himself.

The *Eldridge* Court expressly rejected use of *appealed* reversals as the sole measure of error in the social security termination procedure, and stated that, "in order fully to assess the reliability and fairness of the system of procedure, one must . . . consider the overall rate of error for all denials. . . ."¹⁴³ In the case of social security benefit termination, the percentage of all decisions to terminate which were eventually reversed, at various levels of review, was substantially lower than the percentage of terminations which were appealed and ultimately reversed. Consequently, the percentage of erroneous initial determinations appeared much lower when the overall rate of reversal was considered.¹⁴⁴

Consideration of the number of patients who were denied immediate release, whether or not involuntary commitment proceedings are later instituted against them, would probably lead to an opposite result. The decision on the part of hospital authorities to forego civil commitment proceedings against a patient who has been detained for that purpose would indicate a decision that the initial assessment of the need for continued hospitalization was erroneous. Consequently, factoring in the overall number of patients who are detained but are never involuntarily committed by a court would indicate a higher percentage of error than would consideration of only commitment petitions which result in involuntary commitment.

There is another group of voluntary patients who are denied release upon request but for whom the reliability of the procedure cannot be tested. Frequently, patients request release and later withdraw their requests. The decision to withdraw a request may reflect only that the patient has vacillated in his desire for institutionalized treatment. There is evidence, however, that patients sometimes withdraw requests in response to threats of involuntary commitment from hospital personnel.¹⁴⁵ The initial decision to detain such patients, withdrawn when the request for

142. See, e.g., N.M. Stat. Ann. § 43-1-14(C) (1978).

143. 424 U.S. at 346, n. 29.

144. *Id.*

145. Unpublished study by Gilboy & Schmidt, American Bar Foundation (1973).

release is withdrawn, will not be tested for error or factored into the measure of the reliability of the procedure.

The identity of the decision-maker is another factor affecting the fairness and sufficiency of the procedure. The courts vary widely on the issue of whether medical decision-making is appropriate in the context of institutionalization of the mentally ill.¹⁴⁶ Some courts,¹⁴⁷ and a few mental health professionals, point to the highly speculative nature of psychiatric diagnosis.¹⁴⁸

The appropriateness of the decision-maker will depend, to some extent, on the criteria for determination. The medical expert may be the better judge of psychiatric indicators.¹⁴⁹ The court is well practiced, however, in hearing and applying medical testimony from experts in a particular field. Judicial decision-making is also more appropriate where legal standards are being applied.¹⁵⁰ Furthermore, the judicial process is better equipped to protect the liberty interest at stake, applying established due process requirements. It would be appropriate to authorize a judgment on the part of hospital authorities only as to whether a patient meets the criteria for commitment, subject to immediate judicial review.

146. Due process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. [Footnotes omitted.] Surely, this is the case as to medical decisions, for "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments." *In re Roger S.*, 19 Cal.3d 921, 942, 141 Cal. Rptr. 298, 311, 569 P.2d 1286, 1299 (1977) (Clark, J., dissenting).

Parham v. J.R., 442 U.S. 584, 607 (1979). *But see*, *O'Connor v. Donaldson*, 422 U.S. 563 (1975), on the question of whether treatment provided to a patient justified confinement:

[Petitioner, hospital superintendent,] argues that, . . . the Court must assume that [the patient] was receiving treatment sufficient to justify his confinement, because the adequacy of treatment is a "nonjusticiable" question that must be left to the discretion of the psychiatric profession. That argument is unpersuasive. Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present. See *Jackson v. Indiana*, 406 U.S. 715.

Id. at 574, n. 10.

147. The question . . . , "turns on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists." *Addington v. Texas*, 441 U.S., at 429, . . . The medical nature of the inquiry, however, does not justify dispensing with due process requirements. It is precisely "the subtleties and nuances of psychiatric diagnoses" that justify the requirement of adversary hearings. *Addington v. Texas*, 441 U.S., at 430, . . .

Vitek v. Jones, 445 U.S. 480, at 496 (1980).

148. See, e.g., F. Hickman & R. Abrams, *Preparation and Trial of a Civil Commitment Case*, (A.B.A. Commission on the Mentally Disabled, 1979), reprinted in 5 Mental Disability L. Rep. 358 (1981) [hereinafter cited as Hickman & Abrams].

149. *But see supra* note 147 and accompanying text.

150. Hickman & Abrams, *supra* note 148, 5 Mental Disability L. Rep. at 369; American Bar Foundation, *supra* note 3, at 56.

3. Governmental Interest in Avoiding Additional Procedure

The final factor for consideration under the *Eldridge* test is the governmental interest, including administrative and economic costs, in avoiding additional or substituted procedure.¹⁵¹ Hospital authorities have an interest in avoiding additional administrative burdens. Many residential mental health facilities are already operating with inadequate financial and manpower resources.¹⁵² Additional procedure, designed to safeguard the patient's right not to be restrained unnecessarily, requires specific criteria and standards against which the decision to detain a patient can be measured. In order to justify detaining a patient under such standards, hospital personnel will necessarily become more involved with gathering and considering evidence of the need for continued hospitalization. These additional requirements will divert limited resources away from mental health treatment activities.¹⁵³ Also, where legislative safeguards for the voluntary patient prove more burdensome to the hospital than do the requirements of civil commitment, hospitals may refuse to accept voluntary admissions, consequently defeating the legislative goal of making voluntary hospitalization available.

The decision to detain a voluntary patient, absent legal guidelines, protective procedures, and standards, will not, however, best serve the interests of the state. Traditionally, the state has an interest in protecting its citizens from the harmful acts of prematurely released dangerous patients.¹⁵⁴ The state also has a traditionally recognized obligation to detain citizens who pose a danger to themselves.¹⁵⁵ The validity of both of these interests is unclear in light of evidence that "dangerousness" is not predictable with the use of present psychiatric tools.¹⁵⁶ They remain, nonetheless, recognized state interests.¹⁵⁷ Evidence of the advantages of voluntary hospitalization¹⁵⁸ indicates an additional and equally important state interest in encouraging voluntary submission to mental health treatment. In order to better serve state interests, legislative regulation should assure that the decision is indeed based on reliable medical indicators, fairly evaluated by an appropriate decision-maker.

151. 424 U.S. at 347-48.

152. *Hospitalization and Discharge*, *supra* note 86, at 69-70.

153. "One factor that must be considered is the utilization of the time of psychiatrists, psychologists, and other behavioral specialists in preparing for and participating in hearings rather than performing the task for which their special training has fitted them." *Parham v. J.R.*, 442 U.S. 584, 605-606 (1979).

154. *See supra* notes 69-71 and accompanying text.

155. *See supra* notes 72-78 and accompanying text.

156. *See supra* notes 71 and 73.

157. *See supra* notes 68-78 and accompanying text.

158. *See supra* notes 6-16 and accompanying text.

CONCLUSION

Courts have held that the state may retain the mentally disabled person in order to prevent harm to the individual or to others. The individual's interest in avoiding unnecessary detention is so great that the state may not deprive the individual of his liberty and privacy without providing appropriate procedures which will assure a correct determination that he should be detained. The legislature must provide procedures which assure a just determination without delay, based on valid indicia that the patient meets specified criteria under clear standards.

Ideally, under principles of due process, such a determination should be made before the voluntary patient is detained against his will for any period of time. A determination made immediately subsequent to the patient's request for release may, however, deny the patient a meaningful opportunity to defend against a decision to detain him. The decision to detain a patient, based upon a preliminary hearing which purports to meet the requirements of due process, may give rise to a presumption that the patient meets the criteria for civil commitment. Even where a preliminary hearing determines only that there is probable cause to believe that the patient meets the criteria for civil commitment, such a determination may unfairly disadvantage the patient in the civil commitment proceeding.

The problem remains, however, that the decision by hospital authorities to detain a patient deprives him of important liberty and privacy interests. Detention of voluntary patients may also have a detrimental effect on the advantages of voluntary treatment and the state's interest in encouraging voluntary admissions. Unless the decision to detain a voluntary patient after he has requested release is based upon a valid medical assessment of the patient's mental condition and measured against criteria which justify involuntary hospitalization, there is a risk that many patients will be deprived of important interests unnecessarily. If the state determines that hospital authorities should have the power to detain patients who present a danger to themselves or others, due process requires some safeguards against erroneous deprivation.

No patient should be confined longer than necessary to provide a meaningful opportunity to defend the patient's decision to leave the hospital. Civil commitment proceedings, which provide the procedural protections afforded other persons facing involuntary hospitalization, should be held without delay. If the hospital administrators are authorized to detain only those patients against whom they intend to petition for commitment, there is some assurance that the decision to detain will be based upon a reasonable belief that the patient meets the criteria for involuntary hospitalization. In order to assure that the patient is able to develop an adequate

defense while confined pending proceedings, the patient should be afforded full opportunity to consult with counsel and seek independent medical advice.

It is unfortunate that any individual should be deprived of his liberty and privacy by being held in a mental hospital against his will. Such deprivation is unjustifiable when the patient's confinement serves no legitimate state purpose.

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