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Where Involuntary Commitment, Civil Liberties, and the Right to Mental Health Care Collide: An Overview of California's Mental Illness System

by
MEREDITH KARASCH*

Introduction

Buford George is a fifty-three-year-old diagnosed schizophrenic with violent and criminal tendencies who can often be found on the sidewalk along Mission Street in San Francisco.¹ Over the past twenty years, George has been in and out of jail, mental institutions, and homelessness.² In 1980, he was arrested for assaulting a woman and released when the case resulted in a deadlocked jury.³ He was placed under conservatorship between 1984 and 1986, arrested again in 1998, and released after fifteen months of treatment because he was found competent to stand trial.⁴ In between episodes such as these, he can usually be found near Fourth and Mission Streets with a “constantly evolving collection of old luggage and clothing” and speaking mostly in unintelligible mumbles.⁵ Douglas R. Korpi, a San Francisco court psychologist, commented, “I just can’t even begin to tell you how common this is.”⁶

Since 1969, California has been operating under the Lanterman-Petris-Short Act (“LPS Act”), which allows the state to release patients from mental hospitals and limits the state’s right to detain people who are mentally ill.⁷ Whereas people like George once

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1. Patrick Hoge, *Squalor in the Streets*, S.F. CHRON., Nov. 4, 2001, at A20.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

would have been indefinitely committed to a hospital for treatment, now the mentally ill are left to fend for themselves, cycling between homelessness, seventy-two hour detentions for treatment and evaluation, and prison.

Although the LPS Act and most civil commitment statutes include provisions for both people who are classified as either dangerous to themselves or others, and those who are gravely disabled, the focus of this Note will be on the mentally ill who are gravely disabled. Gravely disabled people often fall into an amorphous category that engenders minimal interest in the community at large.⁸ Although society is concerned about the mentally ill who are dangerous, there is more apathy for the non-violent mentally ill.⁹ A lack of funding and services for the mental health system reflects this apathy.¹⁰

The current situation has enormous consequences for the mentally ill; it is an entrenched system that often produces homelessness, violence, and death.¹¹ This Note argues that the LPS Act does not adequately provide for the mentally ill because it entails a cumbersome process that strikes a balance too far toward preserving due process rights. Part I provides an overview of California's mental health system. Part II will argue that the LPS Act makes confinement and treatment too difficult and does not include an affirmative right to treatment, thereby forcing the mentally ill to face miserable consequences. Part III points out that the LPS Act has the ironic result of unfairly depriving the mentally ill of liberty since many are imprisoned for minor crimes. This Note concludes by arguing that solutions to this problem should include changes in funding and services so that the mental health system provides adequate treatment for the gravely disabled. The LPS Act needs to be transformed to emphasize the right to quality treatment and to provide alternatives to confinement in institutions.

It is important to distinguish what this Note does not argue. It does not advocate involuntarily confining anyone who merely exhibits the symptoms of mental illness. More importantly, it does not advocate indefinite confinement of the mentally ill. This Note simply points out inconsistencies and illogical processes in the LPS Act that result in inadequate treatment for the mentally ill—people who face difficulty fending for themselves.

8. See E. FULLER TORREY, M.D., *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* 1-3 (1997).

9. *Id.*

10. *Id.*

11. *Id.* at 13-24.

I. Overview of the Mental Illness System

A. History of Mental Illness Law and the Civil Rights Movement

Many of the problems the mentally ill face in receiving treatment can be traced to a procedure known as deinstitutionalization, which is the process of releasing the mentally ill from treatment in hospitals and then closing these hospitals.¹² Beginning in 1955, there was a nationwide policy of deinstitutionalization that corresponded with the widespread introduction of chlorpromazine, more commonly known as Thorazine, “the first effective antipsychotic medication.”¹³ Thorazine made it easier to control a patient and mask his symptoms, as long as he continued to take the medication.¹⁴ Thus, the state decreased spending on care and treatment of the mentally ill and instead relied on the “wonder drug.”¹⁵

The process of deinstitutionalization has had a profound effect on treatment of the mentally ill in this country. According to psychiatrist Dr. Torrey, without deinstitutionalization, 92% of the people who would have been hospitalized in 1955 were not by 1994.¹⁶ Even accounting for people who would have been treated in general hospitals or community mental health centers, 763,391 mentally ill people who would have been hospitalized forty years ago are part of the general population in the United States, a number commensurate in size to the population of San Francisco.¹⁷

The situation also changed politically for the mentally ill in the mid-1960s. Civil rights attorneys, rather than mental health professionals, turned their attention to involuntary hospitalization and pointed to the fact that the use of community mental health programs and the extensive use of psychotropic drugs made

12. *Id.* at 8–11. Dr. Torrey terms this process a “Psychiatric Titanic” due to its tendency to play a major part in the mental illness crisis. *Id.*

13. *Id.* at 8.

14. *Id.*

15. *Id.* Although one would hope that this process would be restricted to borderline cases of mental illness, in fact this is not the case. Unfortunately, many people who were deinstitutionalized were among the severely mentally ill. *Id.* at 10. This emphasis on medicating the mentally ill instead of “fostering services to let them lead productive lives” has hampered actual treatment of these people. *Report Says Mental Health System Not Meeting Needs*, S.F. CHRON., Sept. 17, 2002, at A4.

16. TORREY, *supra* note 8, at 9.

17. *Id.* Ironically, many people were discharged from hospitals without receiving follow-up treatment. *Id.* at 10. Thus, instead of helping the situation, deinstitutionalization exacerbates the problem because these individuals were unable to successfully transition to living in the community when there were no longer beds available for them in the hospital. *Id.*

involuntary hospitalization "less advised and less necessary."¹⁸ This climate produced California's LPS Act in 1967 and court decisions such as *Lessard v. Schmidt*, which restricted Wisconsin's power to commit people involuntarily.¹⁹ Subsequent decisions added new procedural due process protections to the commitment process.²⁰

The United States Supreme Court joined the debate in 1975 with *O'Connor v. Donaldson*.²¹ The plaintiff in this case had been committed in a Florida state mental hospital for fifteen years even though he was not dangerous to himself or others and was not involved in a treatment program.²² The Court held that a finding of "mental illness," without more, could not justify keeping someone in indefinite custodial confinement.²³ However, the Court stopped short of declaring a right to treatment or even articulating acceptable criteria for confinement. Four years later the Court decided *Addington v. Texas*, a case in which the appellant sued the state when his mother committed him indefinitely.²⁴ The appellant contested commitment asserting that he was not gravely disabled, although he admitted having a mental illness.²⁵ A jury committed him for an indefinite period on the state's evidence that he suffered from serious delusions, threatened to injure his parents, assaulted people while hospitalized, and caused property damage at his parents' home.²⁶ He appealed, alleging that the standards for commitment violated his substantive due process rights.²⁷ The Supreme Court held that due process requires a higher standard than a regular civil proceeding if it

18. Stephan J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 55 (1982); see also Grant H. Morris, *The Supreme Court Examines Civil Commitment Issues: A Retrospective and Prospective Assessment*, 60 TUL. L. REV. 927 (1986). However, as this note will argue later, deinstitutionalization has not resulted in community mental health treatment. See *infra* notes 69-155 and accompanying text.

19. 349 F. Supp. 1078 (E.D. Wis. 1972). In *Lessard*, the district court found that Wisconsin's civil commitment process did not provide adequate protection of due process rights. *Id.* The court required of the institution adequate notice, right to counsel, a probable cause hearing within forty-eight hours of detention, burden of proof beyond a reasonable doubt, availability of privilege against self-incrimination, and a speedy hearing. *Id.* There were further proceedings, with the Supreme Court remanding the case twice. See *Schmidt v. Lessard*, 414 U.S. 473 (1974); *Lessard v. Schmidt*, 421 U.S. 957 (1975). However, these further proceedings have not challenged the underlying holding. See *Lessard v. Schmidt*, 413 F. Supp. 1318 (E.D. Wis. 1976).

20. See, e.g., *Conservatorship of Roulet*, 590 P.2d 1, 4 (Cal. 1979) (establishing a reasonable doubt standard and requiring a unanimous jury to appoint a conservator).

21. 422 U.S. 563 (1975).

22. *Id.* at 567-69.

23. *Id.* at 575.

24. 441 U.S. 418 (1979).

25. *Id.* at 421.

26. *Id.* at 420-21.

27. *Id.* at 421.

might result in indefinite commitment, finally settling on the clear and convincing standard.²⁸ In *Mills v. Rogers*, the Court agreed that the state could recognize a constitutionally protected right of mentally ill patients to refuse drug therapy.²⁹ The Court explained that because states can recognize greater liberty interests than the federal government, the district court was justified in finding that involuntary commitment provides no basis to infer the person is incompetent without a further judicial finding.³⁰

In response to these legal decisions and concern for the rights of the mentally ill, commentators noted that “[t]he balance between . . . liberty and autonomy on the one hand, and the state’s paternalistic right to confine . . . persons involuntarily on the other, has clearly shifted to a preference for liberty.”³¹ However, many mental health professionals argue that this shift towards liberty (deinstitutionalization) has only led to devastating consequences for the mentally ill.³² Instead of enjoying their liberty, the mentally ill are left afraid and alone.³³ These commentators have sardonically noted that the result of civil rights lawyers meddling in the mental illness field is that the mentally ill are “[dying] with their rights on.”³⁴

B. The LPS Act

California’s “preference for liberty” began with the LPS Act.³⁵ Enacted in 1969, this Act repealed indefinite detention and emphasized voluntary treatment with periods of involuntary intervention for people who are unable to care for themselves.³⁶ It authorizes a seventy-two hour detention of any person who is either a danger to himself or others or who is gravely disabled, in order to provide for observation and crisis treatment.³⁷ At the end of this

28. *Id.* at 432–33.

29. 457 U.S. 291, 299 (1982).

30. *Id.* at 298–302.

31. Morse, *supra* note 18, at 55.

32. Darold A. Treffert, *The Practical Limits of Patients’ Rights*, in *PSYCHIATRISTS AND THE LEGAL PROCESS: DIAGNOSIS AND DEBATE* 227 (Richard J. Bonnie ed., 1977). Even further, some commentators have used the term “rotting with their rights on” to describe the condition where doctors abandon their patients, preferring instead to use drugs to treat them. Paul S. Appelbaum & Thomas Gutheil, *The Boston State Hospital Case: “Involuntary Mind Control,” the Constitution and the “Right to Rot,”* 137 *AM. J. PSYCHIATRY* 720, 723 (1980).

33. See Treffert, *supra* note 32, at 227.

34. *Id.*

35. CAL. WELF. & INST. CODE §§ 5000–5579 (West 1998) (effective July 1, 1969).

36. *Id.*

37. “Gravely disabled” is defined as “[a] condition in which a person, as a result of a mental disorder, is unable to provide for his . . . personal needs for food, clothing, or shelter.” *Id.* § 5008(h)(1)(A).

term, the state may certify the patient for an additional fourteen days under certain conditions.³⁸ There is an automatic certification review hearing, conducted by a judge, for persons certified for this intensive treatment.³⁹ The patient may be confined for an additional period of up to 180 days if the judge determines he is dangerous to others in this hearing.⁴⁰ The program must make progress reports every ninety days and give a final report at the end of 180 days.⁴¹ The statute also authorizes a judge to appoint a conservator for any person found gravely disabled as a result of a mental disorder, and the judge may specify the conservator's powers.⁴² These powers may include any power that could be granted to a conservator under the Probate Code, such as payment of debts, management of property and the estate, and defense of the conservatee's estate.⁴³ The patient may also be given medication involuntarily if he or she is found incapable of refusing treatment in a separate hearing.⁴⁴ The state or the conservator may renew these powers every year.⁴⁵

The first judicial test of the LPS Act was *Thorn v. Superior Court*, where a hospital challenged the law after a non-profit legal service sought to apprise the patients of their rights.⁴⁶ The California Supreme Court upheld the LPS Act holding that it contained suitable safeguards to protect patients.⁴⁷ The LPS Act protects due process rights by repealing indefinite commitment and upholding the rights to counsel and *habeas corpus*.⁴⁸ Although amended after *Doe v. Gallinot*, which held that due process requires a mandatory hearing in connection with certification for a fourteen-day intensive treatment,⁴⁹ the LPS Act has otherwise remained intact to this day. Under *Conservatorship of Roulet*, the court expanded protections for the

38. *Id.* § 5250. These conditions include: the professional staff providing evaluation has analyzed the person's condition and has found him gravely disabled, the facility is designated to provide intensive treatment and agrees to admit the person, and the person is unwilling to accept treatment voluntarily. *Id.* Furthermore a person is not "gravely disabled" if he can survive safely with the help of responsible family and friends who are willing and able to provide for that person. *Id.*

39. *Id.*

40. *Id.* § 5300.

41. *Id.* § 5305.

42. *Id.* § 5350. This same provision does not exist for people confined as a result of being a danger to themselves or others.

43. CAL. PROB. CODE § 1852 (West 1991); CAL. WELF. & INST. CODE § 5357.

44. *See, e.g.,* *Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199 (Ct. App. 1987).

45. CAL. WELF. & INST. CODE § 5350.

46. 464 P.2d 56 (Cal. 1970).

47. *Id.* at 62.

48. *Id.*

49. 657 F.2d 1017, 1025 (9th Cir. 1981). Previously a patient had to request a writ of *habeas corpus* for this hearing; the Ninth Circuit felt this left too much burden on patients for effective protection. *Id.* at 1022-23.

mentally ill, requiring a unanimous jury to find a person gravely disabled beyond a reasonable doubt before appointing a conservator.⁵⁰

C. Current State of Mental Health Care

The procedure for determining mental incapacity has remained virtually unchanged since the LPS Act was adopted in 1969. A person may be detained for seventy-two hours if a peace officer or certain professionals find probable cause that the person is gravely disabled.⁵¹ In order to be certified for limited treatment, the person must be found gravely disabled by a preponderance of the evidence.⁵² Determination of incapacity, required for involuntary treatment, must be made by clear and convincing evidence at an evidentiary hearing.⁵³ Furthermore, the state (or a conservator) must show that a patient is presently disabled—not that he may relapse in the future.⁵⁴ Absent a judicial determination of incompetence, there must be informed consent before giving drug treatment.⁵⁵ One of the cardinal principles of the LPS Act is that the court will not presume that mental patients are incompetent because of their need for hospitalization.⁵⁶

In practice, under the LPS Act, if a police officer or health official suspects a person is gravely disabled as a result of a mental disorder, he or she can detain that person under a probable cause standard for seventy-two hours.⁵⁷ The evidence required to authorize detention does not have to be gathered under a search warrant, and it is not subject to the exclusionary rule.⁵⁸ A doctor can certify a person for an intensive fourteen-day treatment with a certification review hearing under a preponderance of the evidence standard.⁵⁹ In these early intervention steps, the LPS Act does not require much evidence, and these cases usually hinge on the word of the official involved.⁶⁰ Furthermore, the usual constitutional safeguards do not apply since the emphasis is on treating a person in a crisis. On the other hand, if the state wishes to appoint a conservator it must prove its case in an

50. 590 P.2d 1 (Cal. 1979).

51. CAL. WELF. & INST. CODE § 5150 (West 1998). See also *In re Azzarella*, 254 Cal. Rptr. 922, 924 (Ct. App. 1989).

52. *Azzarella*, 254 Cal. Rptr. at 926.

53. *Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 204 (Ct. App. 1987).

54. *Conservatorship of Neal*, 235 Cal. Rptr. 577, 580 (Ct. App. 1987).

55. *Riese*, 271 Cal. Rptr. at 212.

56. *Id.*

57. CAL. WELF. & INST. CODE § 5150 (West 1998).

58. *Conservatorship of Susan T.*, 884 P.2d 988, 997 (Cal. 1994).

59. *In re Azzarella*, 254 Cal. Rptr. 922, 926 (Ct. App. 1989).

60. See *Conservatorship of Johnson*, 1 Cal. Rptr. 2d 46, 47 (Ct. App. 1991).

evidentiary hearing beyond a reasonable doubt.⁶¹ Furthermore, if the state (or a conservator, if appointed) then wants to treat that confined mentally ill person who is refusing treatment, it must prove in a later hearing that the person is incompetent by clear and convincing evidence.⁶²

Thus, it is relatively easy to provide confinement and crisis treatment to someone who is unable to provide for his own basic personal needs. However, outside of a crisis situation it is much more difficult to provide treatment that will make a difference. Although California recognizes the need to exercise its *parens patriae* power and will lower safeguards to treat the mentally ill in crises, it is far more difficult to protect and treat people who suffer from chronic mental illness.

In this way the LPS Act scrupulously protects patients' rights at the expense of protecting the patient. Although the Act states that its purpose is to provide treatment,⁶³ in reality it prevents the state from providing care for many mentally ill people and never proposes a right to treatment. As previously discussed, all too often the unfortunate effect of the LPS Act is that people who are gravely disabled and unable to receive treatment become homeless. Furthermore, this so-called "liberty" is often illusory since the fate of most mentally ill homeless is arrest for petty crimes, ending in involuntary and stigmatizing confinement on worse terms than hospitalization.

However, by broadening the right to involuntarily commit someone, California would offer the Scylla of the state-run mental institution to the Charybdis of homelessness and the criminal justice system. In *Wyatt v. Aderholt*, the Fifth Circuit affirmed a right to treatment after noting that the inadequate environment of the state-run mental hospital was "a far cry from the humane psychological and physical environment the district court envisioned as *sine qua non* of rehabilitative treatment."⁶⁴ The court graphically described the inhumane treatment of patients. The hospital afforded no privacy and had numerous health and safety problems.⁶⁵ The state spent little funding on comfort for the patients and the food "[came] closer to 'punishment' by starvation than nutrition."⁶⁶

In addition to the unpleasant conditions, the institution also lacked any real therapeutic value due to severe understaffing. There was one medical doctor with psychiatric training for 5,000 patients,

61. Conservatorship of Roulet, 590 P.2d 1, 4, 11 (Cal. 1979).

62. *Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 211 (Ct. App. 1987).

63. CAL. WELF. & INST. CODE § 5001 (West 1998).

64. 503 F.2d 1305, 1310 (5th Cir. 1974).

65. *Id.*

66. *Id.*

one psychologist for every 1,670 patients, and one or two non-professional aides for as many as 200 patients.⁶⁷ Since there is no right to treatment, the Associate Commissioner for Mental Retardation for the Alabama Department of Mental Health testified, “the physical environment was inadequate for treating inmates [because] ‘we don’t have the staff, we don’t have the facilities, nor do we have the financial resources.’”⁶⁸ It is understandable that California might want to spare the mentally ill from similar, appalling conditions by narrowing the criteria for commitment. However, those with mental illnesses who are not committed to avoid subjecting them to such horrible conditions are, nonetheless, unprotected and highly vulnerable.

D. Mental Health Alternatives

In an attempt to turn the mental illness battle into a fight for mental health, President Carter established a Commission on Mental Health.⁶⁹ In broad terms the Commission recommended that the federal government build a network of comprehensive services so that communities could provide for mentally ill patients and limit commitment in large institutions.⁷⁰ It advocated a move toward community-based programs so that care could be provided in halfway houses, family and group homes, private hospitals and offices, foster-care settings, and community mental health centers in order to integrate social services with formal mental health care.⁷¹ The Commission recognized that many groups of mentally ill people are underserved, if not unserved, and the needs of people with chronic mental illness must be prioritized.⁷²

To meet the special needs of people with long-term and severe mental disorders, the Commission fashioned a plan that would assure high quality institutional care when required. The need for institutional care would be minimized with follow-up services and community-based alternatives combined with job placement assistance and higher Supplemental Security Income payments.⁷³ The Commission stated that procedural protections should include a clear and convincing evidentiary burden, initial screening by mental health agencies, and a comprehensive evaluation of functional abilities.⁷⁴ In

67. *Id.* at 1311.

68. *Id.* at 1310.

69. See 1 PRESIDENT’S COMMISSION ON MENTAL HEALTH, REPORT TO THE PRESIDENT (1978).

70. *Id.* at 35.

71. *Id.* at 5.

72. *Id.* at 17, 22.

73. *Id.* at 22–26.

74. *Id.* at 70–71.

addition, courts should tailor guardianship to cover only those activities with which the patient needs help.⁷⁵ Central to the Commission's idea of providing protection was the need to include a statutory right to humane and therapeutic treatment that could not be denied due to a lack of funding.⁷⁶ To implement its plan, the Commission recommended a federal grant and an appropriation of at least \$75 million for the first year and \$100 million for the next two years. Unfortunately, the Commission's findings and resulting legislation never passed through Congress; if it had, the shape of mental illness law would look startlingly different. Nevertheless, the mental health utopia they envisioned could provide guidance to states.

Sounding a similar theme, the United States Supreme Court in *Olmstead v. L.C.* also advocated a community-based alternative for treatment of the mentally ill.⁷⁷ In *Olmstead*, mentally ill and mentally disabled patients sued under the Americans with Disabilities Act ("ADA"), arguing that their confinement in a mental institution violated its anti-discrimination provisions.⁷⁸ The Court noted that Congress described the segregation and isolation of the mentally ill as a serious and pervasive form of discrimination that the ADA was designed to eliminate.⁷⁹ Under the ADA, people with disabilities may not be denied participation in public services.⁸⁰ One regulation requires public entities to administer treatment programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities.⁸¹ The Supreme Court held that states must place persons with mental disabilities in community settings rather than institutions when treatment professionals determine that community placement is appropriate.⁸²

The trial court in *Olmstead* held that unnecessary segregation in an institution was discrimination *per se*, which could not be justified by lack of funding. The Supreme Court went further, qualifying this right. The Court held that the state may consider whether it has the resources available and whether the placement is a reasonable accommodation.⁸³ As shown, quality alternatives to institutionalization exist. However, as will be discussed, the focus of

75. *Id.* at 43.

76. *Id.* at 71.

77. 527 U.S. 581 (1999).

78. *Id.* at 587.

79. *Id.* at 588.

80. *Id.* at 589-90.

81. *Id.* at 591-92.

82. *Id.* at 587.

83. *Id.*

the LPS Act is on limiting confinement with little thought to treatment.

II. The Arguments in Favor of Limiting Involuntary Commitment Leave the Gravely Disabled Mentally Ill to “Die with Their Rights On”

A substantial number of mentally ill people will go untreated unless there is involuntary commitment. Many mentally ill people have impaired decision-making capacity and therefore do not have the insight into their disease required to recognize the need for treatment.⁸⁴ With its strong emphasis on due process rights, the LPS Act is “protecting their civil liberties much more adequately than [it is] protecting their minds and their lives.”⁸⁵ The LPS Act exacerbates the problems of mental illness by making it difficult to provide involuntary commitment and by not articulating a right to quality treatment.

A. The LPS Act and Capacity

The LPS Act embodies a fundamental misapprehension of what constitutes mental illness. States have defined mental illness as an impairment of thought processes. For example, the Indiana Code defines mental illness as a “psychiatric disorder which substantially disturbs a person’s thinking, feeling, or behavior and impairs the person’s ability to function.”⁸⁶ If mental illness is defined by a condition where people cannot think with sufficient precision to care for themselves, it seems reasonable that the state, acting in concert with a knowledgeable mental health professional, should be able to substitute its judgment when it finds, through an evidentiary hearing, that the patient is incompetent. Substitution of judgment is not a novel concept. Parents make decisions for children because “[m]ost children . . . simply are not able to make sound judgments.”⁸⁷ The state even has control over parental discretion when the child’s health—mental or physical—is in jeopardy.⁸⁸

Commentators who disagree with involuntary commitment laws note that there are many homeless who are not mentally ill but who would also benefit from state provided care and treatment.⁸⁹ This argument points out that the state does not, and cannot, confine

84. See TORREY, *supra* note 8, at 156–63.

85. *Id.* at 141

86. IND. CODE § 16-14-9.1-9(g) (2000).

87. Parham v. J.R., 442 U.S. 584, 603 (1979).

88. *Id.*

89. Morse, *supra* note 18, at 95–96.

homeless people against their will.⁹⁰ The state allows people who prefer homelessness to choose this lifestyle. These commentators see great hypocrisy in only providing care and treatment for the mentally ill.⁹¹ Other commentators analogize mental illness to physical illness using a similar argument. As Professor Winick points out, “a patient with cancer or heart disease is not involuntarily treated, but a patient with schizophrenia or depression may be.”⁹² This argument illustrates how commentators mischaracterize mental illness. The state lets people choose homelessness because they are *capable* of making this choice. Arguments in favor of permitting the gravely disabled to make treatment decisions fail to account for the fact that many are not competent to do so. There is simply no meaningful analogy between a person with cancer who is otherwise able to take care of himself and a person so disabled by schizophrenia that he cannot. To allow gravely disabled mentally ill people the full panoply of decisionmaking rights afforded to competent adults misconceives the nature of mental illness.

B. The MacArthur Study

The capacity of the mentally ill to make decisions about their treatment is one of the most controversial aspects of mental illness law. In an effort to provide information about the ability of the mentally ill to make treatment decisions, Paul S. Appelbaum and Thomas Grisso developed an elaborate research project called the MacArthur Study.⁹³ They rated the ability of people suffering from schizophrenia, depression, and ischemic heart disease to understand relevant information regarding their disease, appreciate the nature of their situation and its likely consequences, manipulate information rationally, and communicate a choice.⁹⁴ When they compared subjects of all three groups, the schizophrenic group differed in treatment decisionmaking from the other two groups and the depression group differed from the medically ill group.⁹⁵ However,

90. *Id.*

91. *Id.*

92. Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL., PUB. POL'Y & L. 137, 139 (1996).

93. Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*, 19 L. & HUM. BEHAV. 105 (1995) [hereinafter MacArthur I]; Thomas Grisso et al., *The MacArthur Treatment Competence Study II: Measures of Abilities Related to Competence to Consent to Treatment*, 19 L. & HUM. BEHAV. 127 (1995) [hereinafter MacArthur II]; Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 L. & HUM. BEHAV. 149 (1995) [hereinafter MacArthur III].

94. MacArthur I, *supra* note 93.

95. MacArthur III, *supra* note 93, at 167.

although the mentally ill patients scored significantly lower on measures of understanding, appreciation, and reasoning, there was considerable heterogeneity within each group.⁹⁶ The majority of schizophrenic patients did not manifest deficits in decision-making ability, and the researchers attributed the lower overall score to a minority within that group.⁹⁷ The researchers warn that the results may have underestimated the deficits of the mentally ill since they did not enroll patients who were most acutely disturbed in the study.⁹⁸

Based on these results, it is evident that the MacArthur Study provides information that is useful in the context of competency hearings. The fact that mentally ill patients show a great deal of heterogeneity in thinking patterns should lead to recognition that individualized hearings are necessary.⁹⁹ In order to obtain true informed consent, doctors must explain the disease and treatment carefully, and there must be an inquiry into a patient's reason for refusing treatment.¹⁰⁰ Although some commentators believe that the MacArthur Study refutes the assumption that mentally ill patients differ in their decision-making capacity,¹⁰¹ the results of the study are of limited value for two reasons. First, it is difficult to develop a research tool to measure capacity and second, it excluded the group most affected by this study, the gravely disabled.

Some commentators have pointed out that the MacArthur Study does not, and could not, provide a reliable "capacimeter" or tool to accurately measure capacity.¹⁰² Professors Kapp and Mossman liken the search for a reliable and accurate way to assess mental decision-making capacity to a search for the "Holy Grail."¹⁰³ Although the MacArthur Study provides important contributions in evaluating and characterizing different types of decision-making impairments, it does not provide determinations of legal incompetence to consent to treatment.¹⁰⁴ A single test and score can never account for the variety of medical, legal, ethical, and other factors that inform a competency decision.¹⁰⁵ Both evaluators and patients produce unreliable results; "[s]ubjectivity, idiosyncrasy, and lack of sufficient reliability among capacity evaluators all combine to limit the accuracy and fairness of

96. *Id.* at 168.

97. *Id.*

98. *Id.*

99. Winick, *supra* note 92, at 137.

100. *Id.* at 149-50.

101. Bruce J. Winick, *Foreword: A Summary of the MacArthur Treatment Competence Study and an Introduction to the Special Theme*, 2 PSYCHOL. PUB. POL'Y & L. 3, 4 (1996).

102. Marshall B. Kapp & Douglas Mossman, *Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter,"* 2 PSYCHOL. PUB. POL'Y & L. 73 (1996).

103. *Id.* at 73.

104. *Id.* at 75.

105. *Id.* at 87-88.

capacity assessments, both in the process of conducting them and in gauging their results."¹⁰⁶ Furthermore, the subjects of the study differ markedly in education, language, cultural background, and ethnicity.¹⁰⁷

Performance on standardized tests of capacity may be affected by such factors in a way that reveals little or nothing about an individual's cognitive and emotional abilities to engage in a rational decision-making process once information is explained and choices are presented in a manner that is understandable and relevant to that person.¹⁰⁸

The MacArthur Study should be recognized for its value, albeit limited. The study does tend to show that people who are mentally ill and impaired in some mental functioning may still be capable of making rational treatment decisions. Mental illness does not necessarily mean incompetence. In fact, there should be no presumption of incompetence at all; the state should have the burden of proving incompetence. Nevertheless, for people who are gravely disabled, there should be an inquiry into the patient's competence and nothing in the MacArthur study refutes the need for a searching inquiry of this type. Since the MacArthur Study excluded those with grave mental illnesses, the study does not show that people who are gravely disabled are competent decision makers, or even that they usually make competent decisions. The MacArthur Study excluded this group and only looked at schizophrenia and depression. However, the study found that the more severe the disorder, the more likely the subject would be unable to make a competent treatment decision.¹⁰⁹ The study attributes the poor performance of the mentally ill groups to a minority comprised of the most mentally ill subjects.¹¹⁰ The study never establishes that mentally ill people are, across the board, able to make treatment decisions. If anything, this study supports the argument that some mentally ill people have impaired decision-making ability. Furthermore, some commentators believe the MacArthur Study provides grounds to set the bar higher for involuntary confinement.¹¹¹

106. *Id.* at 78–79.

107. *Id.* at 84.

108. *Id.*

109. See MacArthur III, *supra* note 93, at 169.

110. *Id.* at 173.

111. See, e.g., Trudi Kirk & Donald N. Bersoff, *How Many Procedural Safeguards Does It Take to Get a Psychiatrist to Leave the Lightbulb Unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study*, 2 PSYCHOL. PUB. POL'Y & L. 45 (1996).

III. The LPS Act Does Not Sufficiently Provide for Treating the Gravely Disabled Mentally Ill

While limiting confinement is a problem, once a person is committed, the LPS Act guards personal liberty by sacrificing the right to receive treatment for mental illness. Under *Roulet*, the state may only establish a conservatorship if it can prove mental illness beyond a reasonable doubt.¹¹² The court reasoned that any commitment constitutes incarceration, even if it is for the benefit of medical treatment.¹¹³ The court explained that since civil commitment is such a significant deprivation of liberty, equivalent to confinement in the criminal context, it should require the same stringent burden of proof so as not to confine an innocent (mentally competent) person.¹¹⁴

This reasoning was expanded in *Conservatorship of Rodney M.*,¹¹⁵ making it even more difficult to establish a conservatorship. Here, the court found that, while only a unanimous jury can establish a conservatorship, three-fourths of the jury can find that the person is not gravely disabled.¹¹⁶ This analysis grew out of *Roulet's* concerns that the consequences of erroneous commitment are so grave that “[i]t would be small solace to a person wrongly judged mentally incompetent that his road to commitment was paved with good intentions.”¹¹⁷ This court found that the double standard was in line with *Roulet's* objective of protecting people from an unjustified conservatorship.¹¹⁸ Thus, because of California's concern that people will erroneously be found gravely disabled, the courts have created a situation where it is infinitely easier to find someone not disabled than to provide help.

The court's analysis also overlooks an important difference between civil and criminal commitment. To equate criminal confinement with civil commitment misconstrues the purpose of the commitment: to treat mental illness. Though treatment, without more, should not validate confinement, the court does not account for the fact that the treatment process provides potential for review. Contrary to the view the court gives, a confined mentally ill person is not alone in his illness.¹¹⁹ Rather, there are daily opportunities for doctors and nurses, as well as visiting family and friends, to review the

112. *Conservatorship of Roulet*, 590 P.2d 1 (Cal. 1979).

113. *Id.* at 7–10.

114. *Id.*

115. 58 Cal. Rptr. 2d 513, 517 (Ct. App. 1996).

116. *Id.*

117. *Id.* at 516 (citing *Roulet*, 590 P.2d 1).

118. *Id.*

119. *Addington v. Texas*, 441 U.S. 418, 428–29 (1979).

person's progress.¹²⁰ Furthermore, as underfunded as mental institutions are, there is no incentive to confine someone who does not need treatment.¹²¹

Using these arguments, the Supreme Court upheld Georgia's procedures to commit a mentally ill child without a hearing. The Court noted that in the mental health system, a single physician does not have "unbridled discretion."¹²² A finding that mental institutions exercise unlimited powers would require an assumption that the many doctors and nurses involved in treatment, and who review each other are either indifferent to the patient's welfare or incompetent.¹²³ The Court was unwilling to make this determination.¹²⁴ There is, therefore, ample evidence to believe that the chance of committing someone who is not mentally ill on a long-term basis is minimal.

The *Roulet* court also reasoned that the "beyond a reasonable doubt" standard is necessary to safeguard against the stigma of having a conservator.¹²⁵ While this is a valid point, the court fails to take account of the fact that acting "crazy" in a society that is, at best, apathetic to mental illness, is stigmatizing.

The Supreme Court noted that a significant source of social stigma comes from the illness itself, not from the state, which labels a person by providing medical treatment.¹²⁶ In reaching its conclusion, the Court agreed with psychiatric research showing that the stigma following hospitalization is not a major problem, but that "[d]ischarge [from a mental hospital] before disturbed behavior is well controlled may advance the patient into an inhospitable world that can incubate the chronicity that was to be avoided in the first place."¹²⁷ In *Parham*, the court found that:

120. *Id.*

121. Morse and other commentators point out the lack of funding as one reason not to confine. See *supra* notes 72-79 and accompanying text. It seems unreasonable, if the figures are as dire as they say, to turn around and argue that doctors would allow an overflow of patients. If institutions are underfunded, doctors would be hard pressed to hospitalize a person who they felt did not require treatment.

122. *Parham v. J.R.*, 442 U.S. 584, 615 (1979). *Parham* actually took this argument from *Addington*. In *Addington*, the Court found that "even though an erroneous confinement should be avoided in the first instance, the layers of professional review and observation of the patient's condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected." 441 U.S. at 428-29.

123. *Parham*, 442 U.S. at 615.

124. *Id.* at 615-16.

125. *Conservatorship of Roulet*, 590 P.2d 1, 6-7 (Cal. 1979).

126. *Parham*, 442 U.S. at 600-01.

127. *Id.* at 601 n.13 (1979) (citing Schwartz, Myers & Astrachan, *Psychiatric Labeling and the Rehabilitation of the Mental Patient*, in 31 ARCHIVES OF GENERAL PSYCHIATRY 334 (1974)).

[a]ppellees overlook a significant source of the public reaction to the mentally ill, for what is truly 'stigmatizing' is the symptomology of a medical or emotional illness. The pattern of untreated, abnormal behavior—even if nondangerous—arouses at least as much negative reaction as treatment that becomes public knowledge. A person needing, but not receiving, appropriate medical care may well face even greater social ostracism resulting from the observable symptoms of an untreated disorder.¹²⁸

The Fourth District Court of Appeal used *Parham's* analysis to find that the appropriate standard of proof to justify certification was preponderance of the evidence, specifically rejecting the reasonable doubt standard.¹²⁹ The recognition of the stigma that comes from acting "crazy" should have been considered in *Roulet*.¹³⁰ Although well intentioned, a reasonable doubt standard for involuntary treatment is unnecessary. Several states have adopted the clear and convincing standard because it protects against misuse and allows for treatment when needed.¹³¹ Furthermore, the rationale of protecting against stigma is illogical because stigma also attaches perhaps to a greater degree to those who act abnormally and to those who enter the criminal justice system.

Following these decisions, it seems that *Roulet's* analysis is neither the most sensible nor the only solution for involuntary treatment of the mentally ill. Many other states do not use the strict beyond a reasonable doubt standard, preferring instead the standard the Supreme Court articulated in *Addington*.¹³² At issue in *Addington*

128. *Parham*, 442 U.S. at 601.

129. *In re Azzarella*, 254 Cal. Rptr. 2d 922, 927–28 (Ct. App. 1989).

130. Although neither the LPS Act nor the Probate Code specify a standard of proof to appoint a conservator, the standard necessary to appoint a conservator under the Probate Code is only the clear and convincing standard, as opposed to the reasonable doubt standard required for LPS Act cases. *Conservatorship of Sanderson*, 165 Cal. Rptr. 217, 222 (1st Dist. 1980). This lowered standard does not pose due process problems because a conservator for probate purposes does not attach as much stigma and does not include the power to commit, though many rights and privileges are nonetheless stripped from the conservatee. *Id.* This situation is counter-intuitive for a number of reasons. First, if there is stigma surrounding conservatorship and allowing someone else complete power over your life then it seems equal in both situations. The only difference is the label "crazy" which is stigmatizing in its own right and not from the conservatorship. Furthermore, the power to commit is the power to treat, so it seems that a conservator's job under the LPS Act is more important than that under the Probate Code.

131. *See infra* note 132.

132. *See A. E. v. Mitchell*, 724 F.2d 864, 867 (10th Cir. 1983) (noting that under Utah law, a court may order hospitalization if it finds by clear and convincing evidence that the person is gravely disabled); *In re Hoylman*, 865 P.2d 918, 920 (Colo. 1993) (citing a statute that provides that a court or jury shall determine if a person is in need of care if the court or jury finds, by clear and convincing evidence, that the person is gravely disabled as a result of mental illness); *In re Commitment of G.M.*, 743 N.E.2d 1148, 1150–53 (Ind. App. 2001) (finding that conclusion of "gravely disabled" was supported by clear and convincing

was the question of what minimum standard of proof was needed to adequately protect due process rights in the involuntarily commitment process.¹³³ The Supreme Court began by pointing out that a given standard of proof instructs a factfinder about the degree of confidence society thinks it should have in the correctness of its conclusion; increasing this burden can impress the factfinder with the importance of the decision.¹³⁴ The Court concluded that, because commitment requires a deprivation of liberty, a higher standard than mere preponderance of the evidence is required.¹³⁵ The Court also relied on the fact that mental health professionals do not require a higher standard and, given the lack of certainty in the diagnostic process, it is questionable whether the state could ever prove mental illness beyond a reasonable doubt.¹³⁶ A higher level of proof would require a stricter standard than the medical community itself requires, thereby denying treatment to a significant number of mentally ill people; “[s]uch ‘freedom’ for a mentally ill person would be purchased at a high price.”¹³⁷

Furthermore, in contrast to the criminal justice system, where it is better to let a guilty person go free than to convict an innocent person, someone who is suffering from a debilitating mental illness that requires treatment is not “wholly at liberty nor free of stigma. It cannot be said, therefore, that it is much better for a mentally ill person to ‘go free’ than for a mentally normal person to be committed.”¹³⁸ This is further supported, according to the Court, by the fact that, while erroneous commitments should be avoided, unlike criminal detention, commitment provides an ongoing opportunity for review by friends, family, and doctors.¹³⁹ It is far more practical and helpful to lower the standard to the point where most people who need help will receive it, especially in light of the fact that those who are erroneously caught in this net will be able to escape. Thus, the Court found that the clear and convincing evidence standard accurately reflected the balance of interests between an individual’s freedom and society’s *parens patriae* interest.¹⁴⁰

evidence when there was testimony that patient was often covered in his own vomit and excrement and had suicidal and homicidal ideations); *In re J.C.*, 790 So. 2d 656, 657 (La. Ct. App. 2001) (finding that commitment under the Mental Health Law requires a showing by clear and convincing evidence that the person is gravely disabled as a result of mental illness).

133. *Addington v. Texas*, 441 U.S. 418, 419–420 (1979).

134. *Id.* at 424–27.

135. *Id.* at 427.

136. *Id.* at 429–30.

137. *Id.*

138. *Id.* at 429. (citation omitted).

139. *Id.* at 428–29.

140. *Id.* at 426–27.

Some commentators have argued that the miserable conditions found in the institutions themselves are another reason to limit confinement of the mentally ill.¹⁴¹ Professor Morse argues that because of inadequate funding and conditions, which have been a hallmark of state-run facilities, “to maintain that involuntary commitment is ultimately beneficial . . . is to propagate a cruel myth.”¹⁴² This argument sidesteps the point. The argument that many state mental hospitals are underfunded and inadequate is not a sufficient reason to withhold confinement and treatment. If true, the solution should be to fix the system, not to deny healthcare. Furthermore, inpatient programs at mental institutions are not the only alternative. State funding of community treatment programs is less expensive and more effective.¹⁴³ These programs are less restrictive and, therefore, fit in well with state and federal law.

Though it would be wrong to take away an individual’s liberty in the guise of treating mental illness and simply confine him with no hope of therapy, it does not follow that such a terrible possibility should be used as an excuse for not treating the mentally ill. Taken to its logical conclusion, this argument would preclude children from attending public schools because the educational system is underfunded and often unsuccessful. The Fifth Circuit adopted a far more reasonable solution in *Aderholt*, declaring that the state owes a duty to provide adequate care to people confined through involuntary commitment.¹⁴⁴ The court stated that people confined in this way have a constitutional right to treatment.¹⁴⁵ “The failure to provide suitable and adequate treatment to the mentally ill cannot be justified by lack of staff or facilities.”¹⁴⁶ This analysis has a far more therapeutic effect than Morse’s approach of liberating the mentally ill because the state does not provide adequate treatment.

Although it may offend our sense of liberty,¹⁴⁷ the best approach to treatment for those people who cannot provide for their basic

141. Morse, *supra* note 18, at 79–84. Morse actually spends only one paragraph describing the situation. He argues that many doctors are unqualified, staffing is inadequate, and “satisfactory treatment is a myth.” *Id.*

142. *Id.*

143. TORREY, *supra* note 8, at 116–118.

144. *Wyatt v. Aderholt*, 503 F.2d 1305, 1312–13 (5th Cir. 1974).

145. *Id.*

146. *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971) (citing *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966)).

147. The journalist Charles Krauthammer also noted this dilemma:

In fact the homeless mentally ill are abandoned, not free. Nor is their degraded condition at all inevitable. It is the result not of mysterious determining forces, but of the failed, though well-intended social policy. And social policy can be changed. In this case, it will not be easy. There will be a lot of thundering from civil libertarians. But it certainly can be done.

needs due to mental illness is involuntary treatment.¹⁴⁸ Involuntary processes should be available for continuous treatment and not solely for crises. Many states have revised their statutes to broaden criteria for involuntary commitment.¹⁴⁹ Hawaii's statute allows commitment for people that are "obviously ill," defined as a "condition in which a person's current behavior and previous history of mental illness, if known, indicate a disabling mental illness, and the person is incapable of understanding that there are serious and highly probable risks to health and safety involved in refusing treatment."¹⁵⁰ The American Psychiatric Association proposed a model law, eventually defeated by mental health lawyers, which would have allowed involuntary commitment for people who need treatment due to behavior indicating "significant deterioration."¹⁵¹

California should be thus guided and change the LPS Act to allow for commitment based on the need for treatment. One only has to look to the nearest park bench, bridge, or abandoned building to see that the voluntary outreach services that try to persuade the mentally ill to seek treatment have failed. As a direct result of impaired decision-making, many mentally ill people do not believe that anything is wrong with them and see no reason to accept hospitalization.

They *know* the CIA implanted electrodes in their brain that are producing the voices. They *know* they own the White House. They *know* they are loved by a famous movie star. They *know* they are being followed and watched 24 hours a day. And no amount of education or persuasion is going to change their minds.¹⁵²

Research suggests that twice as many people would be eligible for treatment if it was based on need-for-treatment criteria, rather than the existing standards.¹⁵³ This means that a significant number of people who need help will not receive it under the LPS Act's procedures. Furthermore, as noted before, involuntary treatment does not necessarily require inpatient settings. Outpatient commitment, which is a court order requiring the mentally ill person to take medication and comply with the treatment plan, is less restrictive and can be very successful.

TORREY, *supra* note 8, at 162–63.

148. *Id.* at 156.

149. *Id.* at 158.

150. *Id.*

151. *Id.*

152. *Id.* at 156–57 (emphasis in original).

153. *Id.* at 157.

California's effort to help the mentally ill should center on community-based treatment combined with increased funding.¹⁵⁴ Research on outpatient commitment showed that people in outpatient programs were more likely to take their medication and follow their treatment plan. Furthermore, such patients were less likely to require re-hospitalization, and their violent behavior was substantially reduced.¹⁵⁵ In order to provide care for California's mentally ill, some form of involuntary treatment may be necessary.

A. There Is No Right to Treatment Under the LPS Act

In addition to limiting availability of treatment, the LPS Act does not establish the right to treatment. California case law provides that a mentally ill person may be confined if that person, as a result of mental illness, is found gravely disabled beyond a reasonable doubt.¹⁵⁶ However, a person found gravely disabled by hearing or granted a conservator has the right to refuse treatment unless adjudged incompetent in a separate hearing by clear and convincing evidence.¹⁵⁷ Thus, it is possible to deprive someone of freedom, and not provide treatment. This result seems far more unjust than also requiring treatment. It seems that the only justification for depriving someone of liberty in this way should be for treatment.

Under California law, a court must reach a judicial determination of incompetence, in a hearing that is separate from the commitment or conservatorship proceedings, before doctors can administer

154. On September 28, 2002, Governor Gray Davis signed Laura's Law, a law that would allow a court to order outpatient treatment for those defined in Health and Safety Code section 5600.3. A.B. 1421 (Cal 2002). The bill creates an assertive community treatment program, albeit temporarily (until January 1, 2008), which involves community-based care from multidisciplinary teams with high staff to patient ratios. *Id.* In justifying the new legislation, the bill cited findings from a Rand Corporation Report that shows people with "psychotic disorders and those at risk for poor outcomes benefit from intensive mental health services provided in concert with a sustained outpatient commitment order." *Id.* The program also includes periodic doctor reports (at least every sixty days) and medication will not be forced absent a separate order. *Id.* However, participation in this program is voluntary and counties must pay for it themselves. *Id.* See also FOLLOW UP EDITORIAL, <http://www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2002/10/02/ED28585.DTL> (last visited Oct. 25, 2002). In enacting this legislation, California has become one of the last states to create outpatient treatment; only nine other states have yet to create this type of program. See HEALTH POLICY TRACKING SERVICE, FACT SHEET: OUTPATIENT CIVIL COMMITMENT, <http://www.ncsl.organization/programs/health/hpts/commit.htm> (last visited Oct. 25, 2002).

155. TORREY, *supra* note 8, at 160. Furthermore, a recently released report by the National Council on Disability indicates that this lack of community-based services results in the unnecessary institutionalization that California is trying to avoid. *Report Says Mental Health System Not Meeting Needs*, S.F. CHRON., Sept. 17, 2002, at A4.

156. Conservatorship of Roulet, 590 P.2d 1, 4 (Cal. 1979).

157. *Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 211 (Ct. App. 1987).

treatment, since incompetence is not presumed from a finding of grave disability.¹⁵⁸ While the MacArthur Study points out that incompetence cannot be presumed from mental illness itself, it never establishes that a gravely disabled person will make competent decisions. The LPS Act begs the question, how can a person be so disabled from a mental disorder that he is unable to provide for his own needs and still be legally competent? It cannot be that one justification serves as a basis for depriving liberty, but this same justification does not serve as a basis for treatment.

Idaho disagrees with California's standard, opting for a single standard to prove incompetence and grave disability.¹⁵⁹ This standard is lower than the reasonable doubt standard California uses, though the Idaho Supreme Court found it is stringent enough to protect liberty interests.¹⁶⁰ As the court pointed out:

[c]onsidering the general intent of the legislature in adopting the Act,¹⁶¹ there is no valid reason to require clear and convincing evidence to commit a patient, and then impose a different standard for a determination of capacity to make decisions regarding treatment. Given the significant interests involved, and to ensure uniform evidentiary standards are applied to commitment cases, we hold that a finding of lack of capacity to make an informed decision about treatment must also be supported by clear and convincing evidence.¹⁶²

This standard recognizes the connection between a determination to commit and a determination of incompetence. Though these hearings may represent different aspects of the problem, they require similar evidence and expert testimony. There is simply no reason to have a different burden for a finding of incompetence. The requirement of multiple hearings, with effectively the same burdens of proof, illustrates how the LPS Act has been pieced together with little thought to the population it serves. The Idaho system is more rational and protective of the interest in treating the mentally ill than the California standard. However, the Idaho system also needlessly requires two separate hearings, which is a waste of judicial resources and of time, resulting in delayed treatment.

Even more effective is Utah's scheme. The statutory definition of mental illness states that the person must lack the ability to provide the "necessities of life" and to engage in a rational decision-making

158. *Id.* at 1315.

159. *See Bradshaw v. Idaho*, 816 P.2d 986, 990 (Idaho 1991).

160. *Id.* at 989.

161. The intent of the legislature in enacting this act is the same as the LPS Act. *See IDAHO CODE* §66-329 (Michie 1991).

162. *Bradshaw*, 816 P.2d at 990.

process regarding medical treatment.¹⁶³ The Tenth Circuit faced a constitutional challenge to this statute in *A.E. v. Mitchell*.¹⁶⁴ In this case, mental patients claimed that it was unconstitutional to be forcibly medicated without a prior judicial determination of incompetence.¹⁶⁵ In applying the Utah code, the appellate court agreed with the district court that “[o]nly those who are incompetent to consent to treatment can be committed under the statute.”¹⁶⁶ Thus, the Utah statute is both protective of the individual’s liberty interest yet provides an efficient process whereby those with severe mental illness are treated. The focus is on treatment; those involved are not diverted by multiple and repetitive hearings.

This procedure of making confinement and conservatorship available (which the California Supreme Court argues is stigmatizing)¹⁶⁷ without allowing administration of therapy is a result of the LPS Act’s omission of an explicit right to treatment. While one purpose of the LPS Act is to help the mentally ill, it is difficult to imagine how this will be accomplished if there is no right to treatment, or as Torrey terms it, no “right to get well.”¹⁶⁸

Many courts have found that committing people involuntarily without providing treatment raises troubling constitutional questions.¹⁶⁹ The Fifth Circuit first battled this issue in a series of cases in Alabama.¹⁷⁰ In 1971, the guardians of a group of confined patients brought a class action suit to establish that the program at the hospital was scientifically and medically inadequate and, thus, deprived the patients of their constitutional rights.¹⁷¹ The district court agreed, finding that there is no legal or moral justification for holding involuntarily committed patients in custodial care without adequate treatment.¹⁷² Patients involuntarily confined have a constitutional right to treatment that will give them a reasonable opportunity to be cured.¹⁷³ Failure to provide adequate treatment, according to the court, “violates the very fundamentals of due

163. UTAH CODE ANN. § 64-7-36(10) (2000).

164. 724 F.2d 864 (10th Cir. 1983).

165. *Id.* at 865.

166. *Id.* at 867.

167. Conservatorship of Roulet, 590 P.2d 1, 6-7 (Cal. 1979).

168. TORREY, *supra* note 8, at 141-66.

169. *See, e.g.*, Rouse v. Cameron, 373 F.2d 451, 453 (D.C. Cir. 1966); Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971); Welsch v. Likins, 373 F. Supp. 487, 492 (D. Minn. 1974); Nason v. Bridgewater State Hosp., 233 N.E.2d 908, 913 (Mass. 1968).

170. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971); Wyatt v. Stickney, 334 F. Supp. 1341 (M.D. Ala. 1971); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), *aff’d sub nom* Wyatt v. Aderholt, 503 F.2d 1305, 1312 (5th Cir. 1974).

171. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971).

172. *Id.* at 785.

173. *Id.* at 784-85.

process.”¹⁷⁴ In 1972, the district court declared that these patients have a constitutional right to “such individual rehabilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society.”¹⁷⁵ The Fifth Circuit affirmed and held that “where the justification for commitment was treatment, it offend[s] the fundamentals of due process if treatment were not in fact provided.”¹⁷⁶

Other district courts have agreed with this analysis. Before the Fifth Circuit affirmed the *Wyatt* line; one district judge ruled that due process requires that people committed for mental disability receive minimally adequate treatment for a reasonable opportunity to be cured.¹⁷⁷ Both *Wyatt* and *Welsch* were grounded in constitutional law, and not solely on the state’s statutory scheme. Thus, it is possible for a state to find a constitutional right to treatment, and California would protect this right by following suit.

Though never declaring a right to treatment, the Supreme Court in *Youngberg v. Romeo* found that the due process clause creates a constitutionally protected interest in providing a reasonable level of minimally adequate training for a profoundly mentally disabled adult who was involuntarily committed.¹⁷⁸ The Court noted that an involuntarily committed person is completely dependent on the state, which owes a duty to provide certain care.¹⁷⁹ By balancing the patient’s liberty interests with those of the state, the Court concluded that minimally adequate training would protect the patient’s interest in “safety and freedom from unreasonable restraints.”¹⁸⁰ Although the Supreme Court is unlikely to expand *Youngberg* to establish a constitutional right to treatment for the mentally ill, California may establish this right through statute. California could use *Youngberg* as a guide in establishing such a right.

Looking at cases that do grant a right to treatment, it logically follows that this right should include administration of psychotropic drugs. Patients who receive psychotropic drug therapy are more likely to be able to lead normal lives and respond to behavioral therapy.¹⁸¹ It also follows that if patients are unable to make treatment decisions competently, then the right to treatment extends to forced administration. Although *Youngberg* required leaving a

174. *Id.* at 785.

175. *Stickney*, 344 F. Supp. at 390.

176. *Wyatt v. Aderholt*, 503 F.2d 1305, 1312 (5th Cir. 1974).

177. *Welsch v. Likins*, 373 F. Supp. 487, 499 (D. Minn. 1974).

178. 457 U.S. 307, 324 (1982).

179. *Id.* at 317.

180. *Id.* at 322.

181. *See* TORREY, *supra* note 8, at 6, 50–51. *See also infra* notes 184–187 and accompanying text.

patient free from undue restraints, this requirement would not be violated by a statute that forced care on someone who does not have the capacity to make the decision himself.

Furthermore, there are consequences for patients who do not receive treatment through psychotropic drugs. "A tragic consequence of the efforts of mental health lawyers to make it difficult to hospitalize and treat the mentally ill is that the person's symptoms may irreversibly worsen."¹⁸² Frequently, failure to take medication results in increased violence.¹⁸³ According to one study, institutionalized patients not treated with psychotropic drugs were more likely to be subjected to physical forms of restraint.¹⁸⁴ In the year after the *Rogers* decision, which made it easier for patients to refuse treatment, seclusion and restraint of patients who refused treatment increased from 244 patients and 5,868 hours to 392 patients with a total of 11,855 hours.¹⁸⁵ Treatment was also more likely to be interrupted when these patients were moved to different wards.¹⁸⁶ In another Massachusetts study, the data revealed that courts overturned refusals for twenty out of twenty-two patients, but their treatment was delayed an average of four and a half months while waiting for a court hearing.¹⁸⁷ Perhaps ironically, forcing a person to undergo drug therapy, where that person's capacity to make decisions is impaired by mental illness, might actually result in more freedom.

One alternative that guarantees freedom would simply be to refuse to confine the mentally ill. Those who agree with Morse's view would embrace this proposal, yet it seems like a drastic shift and would fail to care for a significant segment of our society. It seems far more humane to find that the state has a compelling interest in providing care that outweighs the mentally ill person's interest in freedom from treatment.¹⁸⁸

Analogies to other types of mental disability help explain why the LPS Act process may not be preferable. The California Supreme

182. TORREY, *supra* note 8, at 152. However, while medication is an important part of treatment, it is not the entire solution to treating mental illness. See *supra* note 15 and accompanying text. The National Council on Disability has advised that treatment should focus on "serving the whole person, and not merely the most obvious symptoms." TORREY, *supra* note 8, at 152.

183. TORREY, *supra* note 8, at 50-51.

184. ROBERT D. MILLER, M.D., PH.D., INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL IN THE POST-REFORM ERA 150 (1987).

185. *Id.*

186. *Id.*

187. *Id.* at 151.

188. A National Institute of Mental Health panel met in 1989 to create a plan to improve services for the mentally ill and noted that "[o]ne could argue that in the name of individual liberty we have moved to a system that is a much greater danger to life and the pursuit of happiness than the one it replaced." TORREY, *supra* note 8.

Court held that it is constitutional to have a physician as the sole evaluator to find an elderly person incompetent in order to provide involuntary medical treatment.¹⁸⁹ In *Rains*, the court upheld a challenge to Health and Safety Code section 1418.8, which allows medical treatment for nursing home patients after a physician determines the patient's incapacity to consent to treatment.¹⁹⁰ The court performed a detailed balancing of interests needed to answer the "difficult and perplexing problem" of how to provide nonemergency treatment to people who lack the ability to consent because of incompetence while protecting the due process rights of the individual.¹⁹¹ *Rains* concluded that the individual's due process interest in this situation was outweighed by the state's compelling interest in protecting the needs of the incompetent.¹⁹² Although patients in nursing homes have a protected privacy right, it is questionable whether an incompetent patient, whose care is already extensively regulated by the state and inevitably subject to a physician's decisions, has a reasonable expectation of privacy.¹⁹³ The court declined to hold that this invasion would be more serious if decided by a physician rather than a conservator.¹⁹⁴ Judicial intervention is not more sensitive to privacy rights since it necessarily includes involvement of more people.¹⁹⁵ Moreover, the court found that due process does not require postponement of medical intervention until lack of capacity can be established in an adversarial hearing.¹⁹⁶ Thus, the California Supreme Court found that the statutory scheme under section 1418.8, which allows a streamlined system for establishing incompetence (and involuntary medical treatment) by using the judgment of a medical professional and not an evidentiary hearing, adequately protects both the privacy interests and due process rights of elderly people in nursing homes.

Similarly, the United States Supreme Court has found it appropriate to rely on the advice of medical professionals. In fact, it has repeatedly concluded that medical decisions are not within the province of the courts. In *Washington v. Harper*, the Supreme Court upheld a law permitting administration of medication to mentally ill prisoners.¹⁹⁷ It also found that allowing a doctor to determine treatment for mentally ill inmates adequately, and perhaps better,

189. *Rains v. Belshe*, 38 Cal. Rptr. 2d 185, 192 (Ct. App. 1995).

190. *Id.* at 186.

191. *Id.* at 189.

192. *Id.* at 201.

193. *Id.* at 192-94.

194. *Id.*

195. *Id.* at 177.

196. *Id.* at 198.

197. 494 U.S. 210, 231 (1990).

protected their interests than if that decision were made by a judge.¹⁹⁸ In *Youngberg*, the Court opined that “there is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions” and explained that courts should show deference to judgments exercised by qualified professionals.¹⁹⁹ Similarly, in *Parham* the Court stated that the question of whether a child is mentally ill and can benefit from treatment is “essentially medical in character.”²⁰⁰ Furthermore, the Supreme Court has refused to find that this discretion will lead to an abuse of power or prescriptions for reasons other than medical need and has always upheld the view that the medical profession is dignified enough to prevent these problems; “indeed the ethics of the medical profession are to the contrary.”²⁰¹

The court in *Rains* did not reach the LPS Act, noting that the LPS Act is immune from its analysis since there is a statutory requirement to find incompetence through judicial review.²⁰² However, the situation facing the incompetent elderly seems strikingly similar to that of the mentally ill. In fact, the court in *Rains* based its decision in part on the situation in *Washington* that allowed administration of medication to prisoners pursuant to the medical judgment of a physician, “which is in some ways analogous to section 1418.8.”²⁰³

Absent a statutory requirement for a hearing, which this Note argues should not exist, treatment for the mentally ill could easily fit into the *Rains* scheme. As was convincingly stated in *Rains*, these are medical decisions and it is unnecessary and wasteful, at best, and harms treatment, at worst, to send the case through the judicial system. “We consider that a practice of applying to a court to confirm such decisions [to give or withhold medical treatment to a comatose patient] would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession’s field of competence, but because it would be *impossibly cumbersome*.”²⁰⁴ Assuming the MacArthur Study is correct in its conclusion that many mentally ill people are competent to make treatment decisions, this does not explain the need for such a cumbersome system to determine incompetence. Following the *Rains*

198. *Id.*

199. 457 U.S. 307, 322–23 (1982). Because doctors are more expert in such areas than are judges, a decision made by a medical professional is “presumptively valid.” *Id.* at 323.

200. 442 U.S. 584, 609 (1979).

201. *Washington v. Harper*, 494 U.S. 210, 222–23 n.8 (1990).

202. *Rains v. Belsh*, 38 Cal. Rptr. 2d 185, 190–91 (Ct. App. 1995).

203. *Id.* at 191.

204. *Id.* at 198.

analysis would be far more sensible, would streamline treatment, and would still protect patients' rights.

IV. Failing to Confine for Treatment Does Not Ensure Liberty: Many Mentally Ill People Are Imprisoned for Minor Crimes

Unfortunately, failure to commit those with grave mental disorders in treatment facilities paradoxically results in involuntary confinement of a different sort. A consequence of this failure is that they are frequently incarcerated for minor crimes. In fact, in the first year following the enactment of the LPS Act, the number of mentally ill people in the prisons rose dramatically.²⁰⁵ Most of these arrests were for misdemeanors and were highly correlated with the offender's mental illness and corresponding behavior.²⁰⁶ Police often use catch-all charges to sweep mentally ill people off the street.²⁰⁷ These charges may include petty theft, assault, trespassing, and disorderly conduct.²⁰⁸ "Mercy-bookings" by policemen are also common as a way to protect people the police feel are easily victimized.²⁰⁹

The consequences of this situation are drastic. One article in the Los Angeles Times described the prison system as "the world's largest mental institution."²¹⁰ This speculation has been corroborated with statistics. Depending on the study, researchers investigating the records of prison inmates have found that between six to eight percent suffer from a serious psychiatric illness.²¹¹ Research based on inmate interviews shows that the number of prisoners with a

205. TORREY, *supra* note 8, at 36.

206. *Id.* at 37-38.

207. *Id.* at 38-39. Often it is local businessmen who prompt this type of police action. Police in tourist towns routinely arrest the mentally ill. *Id.* at 39. New Orleans has a well-known reputation for "cleaning the streets" by arresting homeless people. *Id.* at 39.

208. *Id.* at 38-39.

209. *Id.* at 39-40. This is especially true for mentally ill women who are vulnerable to assault and rape. *Id.* Responding to the fact that the local psychiatric hospital discharges many mentally ill people, one jail official stated, "[i]f the mental institutions will not hold them, I will." *Id.* at 39.

210. *Helping People off the Streets*, L.A. TIMES, Nov. 20, 2001, at B12. Baca, the newly elected Sheriff of Los Angeles, and his staff tried to start a program to break the "jail-to-streets cycle" that threatens the mentally ill homeless. *Id.* The article also points out that the sheriffs' department spends \$10 million a year on psychiatric medicine and California spends \$1.8 billion a year arresting, trying, and imprisoning the mentally ill. *Id.* While some people are critical of his plan, Baca has shown leadership in attacking the problem. As he puts it, "[j]ail cells should be used to lock up serious criminals, not to house trespassers with mental illness. And letting people live and die on the sidewalks ought to be a crime." *Id.* See also *supra* note 15. The National Council on Disability report also commented on how prisons have become the largest source of treatment for people with mental illness. See *supra* note 15.

211. TORREY, *supra* note 8, at 28-31.

psychiatric disorder jumps to ten to fifteen percent.²¹² Furthermore, much research indicates that there is a large overlap between the mentally ill who are homeless and those in jail. One study of people living in shelters who had previously been hospitalized for mental illness found that 76% of them had also been arrested.²¹³ By limiting the numbers to include only schizophrenia, manic-depression, and severe depression, about ten percent of the prison population in the U.S. qualifies, which is approximately 159,000 people.²¹⁴

This incarceration is particularly unfortunate because people who are gravely disabled are not necessarily dangerous to others.²¹⁵ Moreover, the incarceration of people who are gravely disabled by mental illness can lead to tragic results. Prison is designed for criminals and operates by rigid rules that the mentally ill might find difficult to follow. The bizarre behavior that mentally ill people display is often met with a lack of understanding and violence by guards and inmates.²¹⁶ Suicide is also common for mentally ill inmates, and about half of prison suicides are committed by people who were previously hospitalized for mental illness.²¹⁷ Furthermore, incarcerating a mentally ill person is likely to exacerbate their symptoms, often resulting in solitary confinement sometimes without any medical treatment.²¹⁸ In 1995, a federal judge wrote an opinion severely criticizing the deplorable conditions facing the mentally ill in the California jails, citing "a rampant pattern of improper or inadequate care that nearly defies belief."²¹⁹

Furthermore, once the mentally ill person is part of the criminal justice system, he suffers from the label of "criminal." Surely, the stigma of being a criminal is at least as damaging as that of mental illness. Consequently, if commentators such as Morse were truly concerned about a "preference for liberty," they would be more concerned about therapeutic treatment of the mentally ill. As psychiatrist Darold Treffert explains, "[t]he liberty to be naked in a padded cell in a county jail, hallucinating and tormented, without

212. *Id.* at 30.

213. *Id.* at 30-31.

214. *Id.* at 31.

215. CAL. WELF. & INST. CODE, § 5008(h) (West 1998). The LPS Act provides for commitment of either people who are dangerous *or* people who are gravely disabled. *Id.* Therefore, although the categories may overlap, someone who is committed because he is gravely disabled is not necessarily dangerous.

216. TORREY, *supra* note 8, at 31.

217. *Id.* at 33.

218. *Id.* at 34.

219. *Id.* at 35.

treatment that ought to be given is not liberty; it is another form of imprisonment—imprisonment for the crime of being ill.”²²⁰

Conclusion

Society’s misunderstanding of and lack of sympathy for mental illness is startling.²²¹ The LPS Act embodies this sentiment and, while it confers power to hospitalize for acute situations, it does not go far enough in its intervention to actually treat and care for the mentally ill. By making it easier to confine than to treat, and by failing to provide a right to adequate treatment, it appears that the LPS Act is actually more focused on protecting the sane from the insane than achieving its goal of helping the mentally ill.

The answers to this dilemma are far from clear. Certainly the solution at the turn of the Nineteenth Century, which involved indefinite confinement, was too severe and did not benefit the mentally ill. Yet, the pendulum counter-swing of too little treatment does not benefit this community either. Now California faces the situation where it is difficult to confine and even more difficult to treat someone who is gravely mentally disabled. When confined, the mentally ill are warehoused in inadequate institutions. The middle ground, where the solution must lie, is murky. Any solution must find some way to strike a balance between the Constitutional right to be free of constraints and the human right to live with dignity.

The first step should be to prioritize treatment. The fact that the LPS Act does not include a right to treatment means that the state mental health system can continue to run underfunded hospitals that provide inadequate care. The solution to helping the mentally ill, especially those who are homeless, is not to announce their liberty, complain that the mental health system does not work, and then leave them alone. This method has not worked in the past and will not provide effective assistance in the future. California must reprioritize the LPS Act to make treatment and care a priority. If this is indeed California’s goal, involuntary confinement and treatment must be a

220. Darold A. Treffert, *The Obviously Ill Patient in Need of Treatment: A Fourth Standard for Civil Commitment*, in 36 HOSP. AND COMMUNITY PSYCHIATRY 259–64 (1985); TORREY *supra* note 8, at 142.

221. A perfect example of society’s apathy for the mentally ill is exhibited by the Andrea Yates trial. Andrea Yates was convicted of murdering her five children after the jury deliberated for about thirty minutes. Paul Duggan, *Texas Mother Convicted of Murder: Verdict Is Swift in Bathtub Drownings*, WASH. POST, Mar. 13, 2002, at A1. As her lawyer said in his closing argument, her actions were no different than if she had a stroke while driving and killed someone. *Id.* Yet, the jury there was unsympathetic to this argument and found her guilty of murder after the short deliberation, even though all jurors believed she was mentally ill. *Dateline Profile: The Jury Speaks; Jury Members Discuss Andrea Yates’ Trial* (NBC television broadcast, Mar. 17, 2002).

possibility. Only by giving up the falsehood of exchanging liberty for confinement and treatment will California be able to provide care for a significant segment of its population that will only grow larger under existing policies.

It is important to remember that this discussion is not only an academic debate of constitutional law. This state of affairs has actual and devastating consequences for a significant number of people on a daily basis. Failing to treat people who are mentally ill and cannot afford treatment more often than not *actually* results in homelessness, imprisonment, and crime directed at them. Deinstitutionalization and the resulting limitations on the ability to treat the mentally ill has been a disaster. As Dr. Torrey eloquently writes about the people affected by this “psychiatric *Titanic*,”

[t]heir lives are virtually devoid of “dignity” or “integrity of body, mind, and spirit.” “Self-determination” often means merely that the person has a choice of soup kitchens. The “least restrictive setting” frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies. Even one [victim] is too many; hundreds of thousands are a disgrace.²²²

The civil rights movement is not wrong. With advanced medicine mentally ill people can live normal lives in greater numbers than before. This should lead to states being more careful in exercising their *parens patriae* power. However, the pendulum has swung too far in the backlash of the old “19th century” notions of mental illness, as Professor Winick terms it.²²³ Instead of leaving mentally ill people who are gravely disabled free to irrationally “choose” a life of homelessness or worse, California should be more careful in applying the LPS Act. There are more options than the either/or of freedom and institutionalization. The LPS Act is fraught with inconsistencies and pitfalls that leave the mentally ill with little help. The mentally ill citizens of this state deserve a more critical inquiry into the process of dealing with their problems. The policy California chooses to deal with this problem has too profound an effect on too many people not to choose carefully.

222. TORREY, *supra* note 8, at 11.

223. Winick, *supra* note 92, at 140, 161.
