Civil Commitment of the Mentally Ill in California: 1969 Style

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COMMENTS

CIVIL COMMITMENT OF THE MENTALLY ILL IN CALIFORNIA: 1969 STYLE

In the State of California, the Lanterman-Petris-Short Bill\(^1\) went into effect on July 1, 1969, providing new procedures for commitment of the mentally ill person.\(^2\) Almost immediately the provisions of the bill were challenged in a suit contesting its constitutionality.\(^3\)

Supporters of the new enactments are convinced that patients in psychiatric facilities will be treated more humanely, returned to their homes and communities faster, and receive more enlightened psychiatric treatment than was true under previous commitment procedures. Some opponents of the new provisions believe that patients dangerous to themselves and others will be released too soon. Other opponents attack the new laws on the basis that there is insufficient safeguarding of the patient's constitutional rights. The latter claim that he is denied due process in the application of the provisions governing involuntary commitment of a person deemed to be a danger to himself or a danger to others.

The dilemma presented in considering the benefit to be derived from the new legislation is twofold.

First, how shall the state protect the suicidal patient from injuring himself and the dangerous patient from injuring others, without abridging his fourteenth amendment right of "due process"?

Second, how effective is involuntary commitment in a psychiatric hospital in accomplishing either the desired "medical" goal of improving that individual's mental well-being or the legal goal of protecting society and the person from his person-endangering acts?

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1 **CAL. WELF. & INST'NS CODE** §§ 5000-401 (West Supp. 1970) [hereinafter cited as LPS].

2 The Lanterman-Petris-Short Bill was passed by the California Legislature in 1967 and then modified subsequently in the 1968 and 1969 sessions. As modified, it went into effect July 1, 1969.

3 The act was challenged in a suit filed in San Diego County on July 3, 1969. Judge Hugo Fisher declared the act unconstitutional. The suit is now pending before the California Supreme Court: San Diego v. Superior Court *ex rel.* Callahan, Civil No. 1276 (Superior Court, San Diego County, July 3, 1969). Arguments are presently scheduled to be heard in January, 1970, before the California Supreme Court, No. LA 29669.
HISTORY OF INVOLUNTARY COMMITMENT PROCEDURES

For many years California has followed the policy of hospitalization of individuals deemed mentally ill. If such hospitalization was not accepted voluntarily by the patient, the courts, authorized by specific statutes, ordered involuntary commitment to a state hospital regardless of whether such commitment and involuntary hospitalization resulted in benefit to the individual. For many years when state hospitals were overcrowded and the number of psychiatrists and psychiatric staff were grossly inadequate, no real argument could be made that such involuntary commitment was for the benefit of the patient.

Patients arrived at a state hospital because the individuals of their local community or local milieu could not tolerate them any further. State hospitals became the dumping ground of the unwanted and the tolerated from the local community. The justifi-

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4 For an excellent review of the history of hospitalization of mentally ill patients, see Projects, Civil Commitment of the Mentally Ill, 14 U.C.L.A. L. Rev. 822 (1967) [hereinafter cited as Projects].

5 "Perhaps the most alarming statistics on the ineffectiveness of current facilities were presented in a California State Department of Mental Hygiene Bulletin: 'If all doctors in California's State Mental Hospital spent all their working time with patients, each patient would get only five minutes of attention a day.' The state hospitals are without adequate staff, equipment, or space. With all these barriers the goal of effective treatment is frequently not achieved through hospitalization. Furthermore, hospitalization may not be beneficial to a majority of those for whom that alternative is chosen." Projects, supra note 4, at 860-1.

See also Mendel, On the Abolition of the Psychiatric Hospital, Comprehensive Mental Health: The Challenge of Evaluation 237 (L. Roberts ed. 1968); and Subcommittee on Mental Health Services, California Legislative Assembly Interim Committee on Ways and Means, 1963-65 Sessions, The Dilemma of Mental Commitments in California: A Background Document (Subcomm. Print 1965) [hereinafter cited as DILEMMA].

6 Interview with Norman R. Rogers, M.D., Medical Program Director, Division V, Agnews State Hospital, at Agnews State Hospital, Sept. 30, 1969.

7 Case 1. A sixty-eight-year-old woman who had been married to her present husband for twenty-two years showed increased confusion and absent-mindedness in the care of her house. She would leave the fire on in the kitchen stove throughout the day. She would forget to get meals ready. Her memory of recent events was confused and poor. She would talk to children of her previous marriage who had since died. And she would often put several dresses on, one over the other.

A medical evaluation was requested, and she was found to have chronic brain syndrome in which arteriosclerotic changes had resulted in gradual diminution of her cerebral abilities.

Her husband had no relatives or friends to assist him in caring for her during the day while he was at work. At first, she was placed in a convalescent home. This had a cheerful, homelike, living in arrangement in which the patient had her own room, her own closet, dresser and belongings. However, after several months, this institution had to suggest some other placement because she wandered away from the grounds. There was not sufficient staff to keep constant watch on her. In addition, she went into other bedrooms and put on clothes that belonged to other patients. At one time,
cation for such treatment derived from the concept of the state functioning in the role of parens patriae for the mentally ill person.\(^8\) In many instances, the individual had committed no crime. It was rationalized, however, that "treatment" in a state hospital via involuntary commitment was necessary to protect the public and the person from his potentially "dangerous" acts.\(^9\)

However, changes in psychiatric management of disturbed patients,\(^10\) the economic vicissitudes of California state hospital

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she accused another patient of taking things from her room when in the opinion of the staff this had not occurred.

Placement in another nursing home of somewhat similar arrangements resulted in a repetition of the same type of events.

The patient was taken to the Psychiatric Ward of the county hospital. There she was adjudged mentally ill and was committed to the state hospital for an indefinite time period. (Personal case of the author.)

\(^8\) "Advocates of this extension of state authority trace its origin specifically to the ancient doctrine of parens patriae. However, parens patriae was a product of feudal society and as such focused on the administration of land, probably to preserve it and the revenue it produced from the rash acts of the deranged vassal. The proceeds from the administration were used to support the incompetent seizor. This sovereign benevolence is the only link between parens patriae and current commitment laws. The ancient doctrine never contemplated hospitalization or rehabilitation." Projects, supra note 4, at 828.

\(^9\) Dilemma, supra note 5, at 15.

\(^10\) Modes of Treatment. Prior to the advent of the major tranquilizers (the phenothiazine group), there was actually no effective treatment except "time" to reduce the ranks of such individuals in the state hospital system. In the early 1930's, the use of metrosol and insulin to give convulsive or coma treatments was put into effect. A small percentage of patients were benefited by these treatments, but overall, the results were disappointing.

The advent of electric shock treatment in the 1940's was then given widespread use. Many patients in the throes of deep and unyielding depression were benefited with this treatment, but major medical complications such as spinal fractures and loss of mental acuity made electric shock procedures a mixed blessing. At about the same time, prefrontal lobotomy as a psychosurgical technique was utilized. Again, some patients derived benefit in that their manic phases were abated or ameliorated, but the individual, though calm and placid, often lost much of his imaginative mental abilities. Prefrontal lobotomy was a highly controversial procedure and is not used now to any extent.

Drug Therapy. The modern era of psychopharmacology began in 1951 with the synthesis of chlorpromazine. It was used first in Europe and from 1954 on in the United States. It changed the mode of hospital psychiatric treatment drastically. Upon being introduced into the state hospital systems throughout the United States, it was found to be of major benefit for grossly disturbed patients. Many patients improved faster and left the hospital sooner as a result of phenothiazine therapy.

For an expanded discussion of modes of treatment, see Tourney, Therapeutic Fashions in Psychiatry, 124 Am. J. Psychiat. 784, 790 (1968).

Decline in State Hospital Census. In 1967 because of these trends, and in recognition of certain political commitments, the Department of Mental Hygiene in California reduced funds for the state hospital system. The reduction was justified, according to proponents, by a decrease in the state hospital census. Opponents of the reduction of funds pointed out that the state hospitals never had had adequate personnel. Their contention was that this perpetuated inadequate staffing and inadequate treatment.

Nevertheless, the trend in reduction of state hospital census continued, and in
financing, and the genuine concerned desires of public-minded individuals to improve the care and end results of treatment for mentally ill patients led to studies and hearings for improved legislation.

After lengthy hearings by both Assembly and Senate interim committees the present legislation was enacted. Its intent was to

September, 1969, one state hospital, Agnews, had dropped to a census of 1,200 patients where two years before it had been approximately 2,500.

Part of this decline took place as a result of transferring senile patients out of the state hospital back to convalescent or nursing homes in the patient's home community. Another factor in the lowered census was the use of such alternative disposition of patients prior to the transfer to the state hospital.

See Epstein and Simon, Alternatives to State Hospitalization for the Geriatric Mentally Ill, 124 AM. J. PSYCHIAT. 955 (1968).

For discussion of the approach of the San Francisco courts to disposition of the mentally ill even before LPS went into effect, see Note, The Need for Reform in the California Civil Commitment Procedure, 19 STAN. L. REV. 992 (1967).

The state hospital then did not harbor the patient even temporarily. Earlier, such a patient would have been sent to the state facility almost automatically.

Since July, 1969, the shorter treatment stay and the treatment of mentally ill patients in a community facility under provisions of the Short-Doyle Act have meant fewer admissions to the state hospitals. The concepts and financial support of the Short-Doyle provisions have stimulated development of psychiatric facilities in the local community or county. The “community” concept developed along with the treatment approach of the “therapeutic milieu.”

Therapeutic Milieu. All of these changes in mode of treatment are concurrent with changes in psychiatric thought which have occurred since World War II. During World War II, the concept of the “therapeutic community” was elaborated in England and has been popularized, extended, modified and in various guises used as a treatment vehicle. The belief is that many aspects of emotional disturbance are aggravated and intensified by lack of acceptance of the individual and his actions by those around him. It argues that his recovery can be speeded by the influence of a supporting, accepting social climate with interpretation and counsel by trained professional “therapists” taking part in the “therapeutic community.”

There have been and still are many conflicting theories as to the origin and mechanisms of syndromes of mental illness labeled schizophrenia, paranoia, depression, and anxiety reactions. Yet there is general agreement that separating the individual from his community and from his home milieu deprives him of whatever acceptance he might still have as a functioning individual. It is contended that thrusting him into an impersonal, institutionalized type of ward (usually locked) does not promote recovery, but in many cases, perhaps makes his condition worse. For further discussion re worsening of condition of hospitalized patients see Mendel and DILEMMA, supra note 5.

11 Ronald Reagan became Governor of the State of California on January 1, 1967. Reductions of financial support for the mental health program in state hospitals coincided with his administration's budget cuts at that time.

12 DILEMMA, supra note 5.

13 LPS, supra note 1 [hereinafter cited in this footnote by section number only].

The LPS provides changes in the treatment of the mentally ill in three main categories. It provides new time limits and new procedures for the involuntary commitment of the mentally ill person, a so-called “bill of rights” for the patient committed to a state or other governmentally operated psychiatric facility, and allows a judicially designated conservatorship for a person termed “gravely disabled because of chronic alcoholism or mental disorder.”

The person considered to be a danger to himself or to others may be taken by a peace officer to a county designated facility for psychiatric evaluation. Section 5150.
improve patients' treatment, to shorten hospital stay, to encourage patient treatment and reintegration in his own community, and still to protect society from the "dangerous" person and a suicidal person from endangering himself.

The peace officer or professional person designated by the facility may place that person in the county designated facility for a seventy-two hour observation detention period. Section 5151. There is reference in the act to "[M]ember of the attending staff, as defined by regulation, of an evaluation facility designated by the county . . ." as also being empowered to place a person in custody in the psychiatric facility for the seventy-two hour observation period. Section 5150. The act does not define whether "attending staff" refers to physicians, members of the medical staff, or to other nonmedical personnel. The patient may be released before or at the end of the seventy-two hour period if "in the opinion of the professional person in charge of the facility or his designee, the person no longer requires evaluation or treatment. . . ." Section 5152.

A person so detained for observation may elect to continue hospitalization and treatment on a voluntary basis. In such case, the duration of treatment depends on the agreement between psychiatric recommendation for further treatment and the patient's decision to continue to accept such treatment. If, however, at the end of the seventy-two hour period or during voluntary treatment, the patient refuses further hospitalization, the professional person in charge of the county designated psychiatric facility, believing further treatment and involuntary commitment is necessary, may "certify" the person for further involuntary commitment. The first such certification is for a fourteen day period of intensive treatment. Section 5250. A second fourteen day period may be certified for the suicidal patient. Section 5260. The notice of certification "[M]ust be signed by the professional person in charge of the agency or facility providing evaluation services and a physician, if possible a board-certified psychiatrist, who participated in the evaluation." Section 5251.

If the person involuntarily committed requests release, any member of the treatment staff of the psychiatric facility must allow the person committed to fill out a request for release. This must be transmitted to the professional person in charge of the facility, and "As soon as possible, the person notified shall inform the superior court for the county in which the facility is located of the request for release. "Any person who intentionally violates this section is guilty of a misdemeanor." Section 5275. The Act provides for appointment of the public defender as counsel if the patient detained cannot afford private counsel and specifies that "The court shall grant a writ of habeas corpus or order an evidentiary hearing within two judicial days after the petition is filed." Section 5276. The Act does not provide for a jury trial at this stage of detention and treatment.

Where an individual has threatened, attempted or inflicted physical harm upon the person of another after being taken into custody, or was taken into custody as a result of attempting or inflicting injury on another and "[W]ho presents, as a result of mental disorder, an imminent threat of substantial physical harm to others," the professional person in charge of the psychiatric facility may petition the court to require a further ninety day period of treatment following the fourteen day certification period. Section 5300. The patient is entitled to have court-appointed counsel to represent him. Section 5302. The proceedings on the petition for the postcertification ninety day involuntary commitment must be held within four judicial days of filing of the petition. Section 5303. The person subject to the ninety day commitment period may request a jury trial at the time of the judicial hearing. Section 5303. In such jury trial the decision of the jury must be unanimous to support the further ninety day commitment. Section 5303. The Act further provides for a further involuntary commitment period for the person potentially dangerous to others if the professional person in
ADVANTAGES AND DISADVANTAGES UNDER LPS

The provisions of the Lanterman-Petris-Short Act and its enabling legislation, the Short-Doyle modifications, recognize improved trends in the management of patients with emotional charge of the psychiatric facility “[F]iles a new petition for postcertification treatment on the grounds that he has threatened, attempted, or actually inflicted physical harm to another during his period of postcertification treatment, and he is a person who, by reason of mental disorder, presents an imminent threat of substantial physical harm to others.” Section 5304. The Act does not specify the length of the second post-certification period.

The LPS Act provides for the appointment of a conservator of the person, of the estate or of the person and the estate for any person who is gravely disabled as a result of mental disorder or impairment by chronic alcoholism. Section 5350. The person for whom conservatorship is being sought has the right to demand a jury trial on the issue of whether he is gravely disabled. Section 5350. A temporary conservator appointed by the court may detain a patient in a psychiatric facility pending the appointment of a permanent conservator. Section 5353. The permanent conservator has the right to place his conservatee in a medical, psychiatric, nursing or other state licensed facility so specified in the court order. Section 5358. Conservatorships are made for a period of one year and may be renewed on petition to the court. Section 5361.

The Act provides that “No person, nor agency, shall be designated as conservator whose interests, activities, obligations or responsibilities are such as to compromise his or their ability to represent and safeguard the interests of the conservatee. Nothing in this section shall be construed to prevent the Department of Mental Hygiene from serving as guardian pursuant to Section 7284.” Section 5355. A conservatee may petition the court for a rehearing on his status but not more often than once each six months. Section 5364. An attorney shall be provided for the conservatee or the proposed conservatee. Section 5365.

The patient does not lose his civil rights because of commitment in the psychiatric facility. Section 5005. The act specifies certain rights retained by the patient while in the hospital including the right to wear his own clothes, keep his own possessions, to keep and be allowed to spend reasonable sums of his own money, to have his own personal storage space, to see visitors each day, and to have reasonable access to telephones to make and receive calls. Section 5325. He has the right of access to letter writing materials and to mail and receive unopened correspondence. He has the right to refuse electric shock treatments and to refuse lobotomy. Section 5325. However, there may be limitations to these rights since the Act provides, “A person's rights under Section 5325 may be denied for good cause only by the professional person in charge of the facility or his designee.” Section 5326.

The LPS Act specifically excludes epileptics from commitment under its provisions. It does not apply to mentally disordered sex offenders, narcotic addicts, habit-forming drug addicts, mentally abnormal sex offenders, juvenile court wards, or mentally disordered criminal offenders. Section 5002. Judicial commitment of mentally disordered persons and persons impaired by chronic alcoholism is prohibited by Section 5002. However, there is provision for a judicially ordered evaluation for mentally disordered persons. Sections 5200-08. After such evaluation, the person may be detained for a seventy-two hour period and be subject to other provisions of the LPS Act if he is considered to be a danger to himself or others or a gravely disabled person due to chronic alcoholism or mental disorder.

A criminal defendant who appears to be gravely disabled as a result of chronic alcoholism may have a psychiatric evaluation ordered judicially. Section 5225. After such evaluation, he may be released to the sheriff if the criminal charge has not been dismissed or be subject to involuntary detention for psychiatric treatment under other provisions of the LPS Act. Section 5230.

disturbance. The Act shortens hospital stay and with the Short-
Doyle enabling legislation encourages treatment close to the home
community. It "restores" patient rights while in the hospital and
proscribes loss of certain civil rights which, under previous legisla-
tion, were forfeited by the patient adjudged mentally incompetent.
Provisions of the Act exempt the chronic alcoholic from commitment
at the whim of family or "friends" and remove the harmless senile
from society's dustbin of involuntary hospitalization. All of these
changes are for the better and reflect improved treatment for psychi-
atric patients.

There are, however, real disadvantages in the procedures for
involuntary commitment under the LPS Act. The sticky question
still remains whether the state is justified in depriving a person of
his liberty without counsel and judicial hearing prior to commitment.
The conclusion that patients benefit from involuntary hospitalization
for mental illness is implied by the bill's provisions, and then such
rationalization is used as justification for depriving a patient of his
liberty through involuntary commitment.

There is a subtle, unexpressed, but powerful conclusional theme
running through the LPS bill and many other states' commitment
procedures for the "mentally ill" person, which is as follows:

The patient is sick.
He needs treatment.
He doesn't want to be treated.
He has to be treated for his own good. (Society's good)

15 Under the Short-Doyle Act modifications, supra note 14, enacted concurrently
with the LPS Act, supra note 1, counties designate their own psychiatric facilities for
treatment purposes and are allowed reimbursement from state funds for those ex-
enses. As of July 1, 1969, the Short-Doyle Act modifications provided that such
 counties would receive ninety percent of their costs from state funds. Earlier it had
been on a fifty-fifty basis. Certain counties are continuing to use a state hospital as a
contracting agency to handle the disposition and treatment under the LPS Act. Other
 counties more remote from the state hospitals have developed their own facilities and
handle the treatment of such patients at home.

17 Id. § 5002.
18 "Our libertarian views usually lead us to assert that treatment cannot be forced
on anyone unless the alternative is very great social harm. Thus while we will require
smallpox vaccinations and the segregation of contagious tuberculars, we will not
ordinarily require bed rest for the common cold, or a coronary, or even require a
pregnant woman to eat in accordance with a medically approved diet. Requiring treat-
ment whenever it seemed medically sound to do so would have utilitarian virtues.
Presumably, if death or serious incapacitation could thereby be avoided society would
have less worry about unsupported families, motherless children, or individuals no
longer able to support themselves." Livermore, Malmquist & Meehl, On the Justifica-
Society will enforce treatment since the patient is not competent to make the (right) decision to have treatment. These predetermined conclusions are then expressed as:

First, society will furnish treatment through involuntary commitment to a psychiatric hospital for the patient's and society's benefit.

Second, the benefits to the patient (and society) of such treatment justify loss of his liberty despite denial of due process.

It is desirable to consider both the constitutional issues involved in denial of due process and the effectiveness of such involuntary treatment in an evaluation of the involuntary commitment provisions of the LPS Act.

**Deprivation of Liberty Without Due Process of Law**

*The LPS Act*

Under the LPS Act a person may be detained for seventy-two hours on the written statement of a police officer or professional person designated by the county. Weekends and holidays are excluded from that seventy-two hour period so that the initial observation period may be five or six days. During this time, the patient has no legal right to counsel under the provisions of the bill. The psychiatric staff may then certify the person for further observation for fourteen days without any prior judicial review. If he is termed a suicidal person, he may be certified for an additional fourteen day period following the first fourteen day certification.

Although the patient may request a hearing after being certified, he must request such hearing through a habeas corpus, which is not automatic. A suicidal person can be detained involuntarily for as long as thirty-three days without judicial review if he does not seek a writ of habeas corpus.

The Act provides for a judicial hearing for the establishment

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19 "Mental illness' is the triggering conclusionary phrase which allows the state to legally remove an individual involuntarily to an institution for treatment despite the fact that he has not violated a criminal statute." Kaplan, Civil Commitment "As You Like It," 49 B.U. L. Rev. 14, 16 (1968).


21 Id. § 5151.

22 Id. § 5250.

23 Id. § 5260.

24 Id. § 5275.
of a conservatorship for the "gravely disabled person." This procedure is being used to detain the person who is thought to be "potentially dangerous" but who has not actually threatened or performed an assaultive act during the initial fourteen day certification period. For this person, twenty-one to twenty-three days could elapse before a judicial hearing is held.

Under the provisions of the present legislation, involuntary commitment of the mentally ill person is effected prior to his committing antisocial acts. This situation is at marked variance with those provisions of criminal law which provide that a concurrence of mens rea and actus reus must coincide in the commission of a crime. Even in those instances where mens rea is implied because of the antisocial character of the action, the legal process requires not only the implied mens rea but also the actual commission of the actus reus before an individual is held guilty of that crime. In the civil commitment of an individual on the basis of being a danger to himself or others, or because he is gravely disabled due to chronic alcoholism or mental disorder, this concurrence is not present. In fact the person is deprived of his freedoms on the basis of a state of mind rather than because of actions which he has perpetrated.

The Constitution

As early as 1901 the California Supreme Court ruled unconstitutional certain legislative acts providing for involuntary commitment of a mentally ill person. In Matter of Lambert, the petitioner had been committed to the state hospital under provisions of the Insanity Law enacted in 1897. He claimed he had been deprived

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25 Id. § 5350.
26 Cal. Pen. Code § 20 (West 1955). "In every crime or public offense there must exist a union, or joint operation of act and intent . . . ."
27 Id. § 21. "The intent or intention is manifested by the circumstances connected with the offense, and the sound mind and discretion of the accused."
28 "It seems paradoxical that a state whose criminal laws are predicated upon act and intent, as opposed to mens rea alone, should deprive a person of liberty for a condition deemed preparatory to future acts. Such an apparent inconsistency can only be explained with reference to the underlying philosophies of both criminal and commitment laws. The criminal law is reflective of western society's adherence to the idea of free will, the power of choice. As such it is particularly solicitous to afford the individual every opportunity to exercise that power, i.e., to act in a manner otherwise than that suggested by all available indicia. Conversely, commitment law postulates an absence of any meaningful power of choice. Thus, commitment is viewed not as a deprivation of freedom, but rather as a means to prevent inevitable conduct. To allow an individual to remain in society once it is established that he suffers from a mental illness likely to make him a danger to himself or to his neighbors would be, it is assumed, both unwarranted and unconscionable." Projects, supra note 4, at 827.
29 134 Cal. 626, 66 P. 851 (1901).
of his liberty without due process of law and argued the legislative act was unconstitutional. The court declared the commitment provisions of the Insanity Law unconstitutional in that there was neither provision for notice to the alleged insane person of the proceedings against him nor provision requiring the person to be brought before a judge for an opportunity to be heard prior to imposition of the commitment order.\footnote{31}

Arguments for the necessity of due process and preservation of constitutional liberties in the process of involuntary commitment are elaborated in numerous law review articles\footnote{32} and recent cases. \textit{In re Gault}\footnote{33} emphasized that the judicial process for juveniles must "measure up to the essentials of due process and fair treatment."\footnote{34} \textit{Gault} affords to juveniles the right to counsel, constitutional privilege against self-incrimination, right to judicial hearing, and right to cross-examine witnesses.\footnote{35}

The individual being considered for involuntary commitment because of mental illness should have the same basic liberties protected as the juvenile, and the person to be involuntarily confined must have protection of rights at every step of the commitment process.\footnote{36}

\footnotesize{\textsuperscript{31} Matter of Lambert, 134 Cal. 626, 633, 66 P. 851, 854 (1901).


\textsuperscript{33} 387 U.S. 1 (1967).

\textsuperscript{34} \textit{Id.} at 30.

\textsuperscript{35} "For many years the constitutional safeguards afforded criminals were denied juveniles . . . by the state as \textit{pares patriae}. The primary purpose was to benefit the child; rehabilitation, not punishment was the goal. The Supreme Court in \textit{In re Gault}, felt that this distinction could no longer be sustained. The first consideration was that a juvenile proceeding could possibly involve a loss of personal liberty. Secondly the Court recognized the fact that the promise of treatment was often illusory because of the scarcity of adequate rehabilitative facilities." Notes, \textit{supra} note 32, at 203.

\textsuperscript{36} "In 1940, the United States Supreme Court held in \textit{Minnesota v. Probate Court of Ramsey County}, 309 U.S. 270, 276-77, that due process is required in judicial proceedings that involve persons alleged to be mentally ill.

In May, 1966, the New York Court of Appeals ruled that due process and equal protection of the laws require that an involuntarily held mental patient be afforded the assistance of court-appointed counsel in a proceeding brought to determine whether he should continue to be so incarcerated." Harris, \textit{supra} note 32, at 65.

"A jury trial to determine the need for confinement should be mandatory whenever the patient or his agent requests one. An indigent patient should be provided by the court with the assistance of a psychiatrist as well as legal counsel. A person, once commits, is entitled to periodic re-examination by a court, with the assistance of an attorney, with a view to his release when his condition so permits. The burden of proving the necessity for continued detention then rests with the hospital," Harris, \textit{supra} note 32, at 66.
In *Hereyford v. Parker*, discussing the involuntary commitment of a mentally deficient boy to a state training school, the Tenth Circuit Court of Appeals states:

But like Gault, and of utmost importance, we have a situation in which the liberty of an individual is at stake, and we think the reasoning in Gault emphatically applies. It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It 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 mentally incompetent—which commands observance of the constitutional safeguards of due process. Where, as in both proceedings for juveniles and mentally deficient persons, the state undertakes to act in parens patriae, it has the inescapable duty to vouchsafe due process, and this necessarily includes the duty to see that a subject of an involuntary commitment proceedings is afforded the opportunity to the guiding hand of legal counsel at every step of the proceedings, unless effectively waived by one authorized to act in his behalf.

*San Diego v. Superior Court* points out certain inequities within the Act itself which provide due process of law for some individuals and not others who are subject to its provisions. A criminal defendant who appears to be a danger to others or himself, or who is gravely disabled as a result of chronic alcoholism is entitled to a judicial hearing prior to commitment. But for the noncriminal mentally ill, the postcertification procedures provide for a writ of habeas corpus after certification for treatment. A judicial hearing is required before establishment of a conservatorship. Moreover, the conservatee has a right to a jury trial should he disagree with the decision of that judicial hearing that he is "gravely disabled." The LPS Act itself affords more protection of basic rights to the alleged criminal mentally ill person than it does to one alleged mentally ill but not accused of having committed a crime.

The use of the "conservatorship" procedure for the "gravely disabled person due to mental disorder" in order that involuntary commitment of a potentially dangerous person can be effected for more than ninety days may be a subversion of the intent of the act. The "conservatee" may petition for a judicial hearing only once every six months. However, the involuntary commitment of the potentially dangerous person is subject to judicial review at the end of ninety days, and the act does not specify the length of detention.

37 396 F.2d 393 (10th Cir. 1968).
38 Id. at 396.
39 See note 3 supra.
41 Id. § 5275.
42 Id. § 5350.
which the court may order after a second judicial hearing for a person "dangerous to others."

In addition, section 5355 implies that the guardian of a "conservatee" shall represent and safeguard the interests of the "conservatee." Yet the next sentence of the same section allows the Department of Mental Hygiene to serve as such guardian. Conceivably, this might create a conflict of interest for personnel within the Department of Mental Hygiene which would not allow the conservatee to have his interests properly safeguarded. There is vagueness and confusion in the equal application of "due process" of law under the LPS Act.

Furthermore, under the LPS Act as well as the previous legislation, weekends and holidays are excluded from the seventy-two hour hold. A juristic system which provides counsel for the indigent accused, extensive and expensive trial procedures to protect his rights, and, in some instances, provides trial transcripts for the conduct of an appeal from an adverse verdict, surely can extend its legal protections to the alleged emotionally disturbed individual seven days a week.

It is obvious that individual rights are not fully protected under LPS. Even under the previous legislation, such rights often were in jeopardy.43 There is a real question whether under the present LPS legislation or the previous legislation providing for involuntary commitment, a patient is or was afforded the protection of due process, indicated as necessary in Hereyford. An individual subjected to the status of involuntary commitment must have the same basic rights.

43 Case 2. A thirty-six-year-old woman was taken into custody by a deputy sheriff under a judicial commitment order from the superior court judge of that county. She was apprehended at her home after supper and brought to the state hospital. When she arrived there, she was extremely distraught and angry. She was so angry that she was incoherent. However, her anger increased her awareness of what was happening and modified the effects of the alcohol she had ingested that evening.

She claimed that her husband wanted her out of the house because he was having an affair with the children’s governess. She admitted that she had a history of drinking but denied being unable to handle her affairs. She was given the opportunity to contact her lawyer. This was a Friday night, and at the time that she arrived at the state hospital, it was approximately 9:30 p.m. She was unable to contact her lawyer that evening. There was a real question in the medical examiner’s mind on duty that night that this patient should be committed, but pursuant to the judicial commitment order, she was admitted to the hospital, which at that time meant being kept within a locked ward. This was prior to the passage of the LPS Act, and judicial hearings at that hospital were held on a Tuesday. Having come in on a Friday night, the seventy-two hours of observation and treatment did not go into effect until the following Monday and that meant that she missed the next Tuesday hearing. As a result, her case was not heard until the following Tuesday at which time she was released. She had been kept behind locked doors for approximately ten days. (Personal case of the author).
as the juvenile in *Gault*. His rights must be guarded jealously at every stage of the commitment process.\textsuperscript{44}

**TREATMENT OF PATIENTS INVOLUNTARILY COMMITTED**

*Need*

The need for treatment of the mentally ill patient to protect him from himself or to protect others in society from his acts is said to override the constitutional issues involved in abridging an individual's liberty through involuntary hospitalization. Such justification assumes that the persons needing treatment can be accurately identified, that the "disease" process can be properly labeled, that treatment facilities are adequate, and that the results of treatment are satisfactory. These assumptions are based on a belief that psychiatry and recommendations of psychiatrists represent an exact science with definite correlation of predictability and results. There is both legal opinion and much psychiatric evidence to the contrary.\textsuperscript{45} The argument that we must give credence to the findings of psychiatry becomes invalid if, in fact, such findings are not consistent or strongly reliable.\textsuperscript{46}

The embarrassing questions require consideration. How consistent is diagnostic labeling of mental illness? How accurately can a person dangerous to himself or others be identified by diagnostic label or pattern of behavior? When involuntary commitment is imposed, how adequate are facilities and staff to provide effective treatment? Finally, what is the score on the outcome of such treatment in preventing future danger to self or others?

\textsuperscript{44} "The rights of the involuntarily held mental patient can never be fully protected unless he is represented by a lawyer who carefully tests each element of the case presented against his allegedly mentally ill client." Harris, *supra* note 32, at 66.

"These statistics indicate that there is a clear danger of prolonged commitment of non-mentally ill patients. They show that the patient who did not have legal assistance, either because of financial inability or because he was a juvenile and lacked sufficient experience to enable him to retain an attorney, was denied equivalent access to the channels of discharge. Such a denial, in the case of patients who could medically and legally qualify for release if given an opportunity, is a most serious invasion of a patient's constitutional rights for by reason of invidious economic discrimination, it deprives him of his most precious freedom—liberty of his person." Lewin, *Disposition of the Irresponsible: Protection following Commitment*, 66 Mich. L. Rev. 721, 729-30 (1968).

\textsuperscript{45} See notes 47, 49, 51, 52 & 53, infra.

\textsuperscript{46} "If ever it be proven that psychiatry is not reliable, there will be created a doctrinal abyss into which will sink the whole structure of commitment law, not just those portions that deal with the harmlessly insane. However, scientific observation of mental patients over many generations has established the accuracy of psychiatric theory and the psychiatrist's understanding of the functions of the mind." Projects, *supra* note 4, at 829 n.35.
Treatment for mental illness based on either voluntary or involuntary hospital commitment presupposes a defineable, categorical mental illness which requires such treatment. One cannot deny that conditions of extreme mental disturbance of a person require extraordinary care and concern of those around that individual. Nevertheless, a survey of both the legal and psychiatric literature reveals differences in definition of mental illness.\textsuperscript{47} Such differences in labeling make assessment of effectiveness of treatment very difficult indeed. There is much evidence to indicate that preciseness of definition and general agreement as to nomenclature are lacking in both the legal and psychiatric approaches to the problem of involuntary commitment. As recently as 1968, the American Psychiatric Association adopted a new arrangement of the terminology of conditions classified under illness.\textsuperscript{48} Much heated debate has focused on this nosological arrangement of diagnoses and some psychiatrists argue that the functioning of the individual is more important than the diagnostic label.

There is a valuable contribution made by psychiatry. For a disturbed individual and those around that individual it provides both medical and psychological techniques for soothing, ameliorating and aborting the crisis confronting that individual. Techniques which include acceptance and support for the disturbed individual and, over a period of time, encouragement of gradual acquisition of awareness and insight, do help the person to function more effectively in his milieu.

The fact that competent psychiatrists disagree as to diagnostic labels does not deny the value of psychiatric procedures. It does raise questions as to the accuracy of predictability and assessment of results based in part on those labels.\textsuperscript{49}

\textsuperscript{47} "Obviously, the definition of mental illness is left largely to the user and is dependent upon the norms of adjustment that he employs. Usually the use of the phrase 'mental illness' effectively masks the actual norms being applied. And, because of the unavoidable ambiguous generalities in which the American Psychiatric Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there." Livermore, Malmquist & Meehl, \textit{supra} note 18, at 80.

\textsuperscript{48} COMMITTEE ON NOMENCLATURE AND STATISTICS, AM. PSYCHIAT. ASS'N, \textit{DIAGNOSTIC AND STATISTICAL MANUAL, MENTAL DISORDERS (DSM-II)} (2) (1968).

\textsuperscript{49} "Mental illness in short is, as I have earlier suggested, a conclusionary term. Along with Justice Stewart those of us who are trained, \textit{i.e.}, psychiatrists, psychologists, medical men and even perceptive laymen, 'know it when they see it.' In this sense mental illness is a dynamic label affixed by societal institutions and correlated with certain individual states deemed pathological by a consensus of those who for any reason are concerned with the individual in question. This is not to deny that certain individual psychic states exist which are not in the range of the experimental spectrum of the majority. These 'medical' states may be subject to a certain amount of classification for treatment purposes by appropriate therapists. Even by the use of
Reliability of Identification

The difficulty of identifying predictive patterns of behavior, mood or mental content that would foretell violent assaultive acts against another person is compounded by the lack of unanimity in the definitions of psychiatric nomenclature. There are shadings of differences in definition of the four major behavioral areas: organic brain disease, maladaptive personality structure, psychoneurosis and psychosis. Greater areas of disagreement among psychiatric professionals exist in the diagnosis and classification of the subgroups within each main diagnostic group. This is particularly true of the terms paranoia, schizophrenia and paranoid schizophrenia, labels which are used broadly in diagnosing psychotic individuals. Often the affixing of the label causes subsequent actions of the individual to be interpreted in that connotation and helps confirm the diagnosis. It has been shown that psychiatric diagnoses are "sensed" by the trained observer and he then looks for symptoms and diagnostic clues to substantiate his clinical impression. Although he may thereby arrive at a different diagnosis, the majority of psychiatric labels decided upon for a particular patient by the psychiatrist are pinned on that patient as a result of a total "Gestalt" which the psychiatrist discerns in the patient.

It should be noted that the majority of involuntary commitments for psychiatric illness are made in periods of crisis and tension for the physician as well as the patient. This has some effect upon the perspective and reasoned judgment of the psychiatrist who, in the exercise of his best judgment, deprives another person of his freedom for a period of time. A study of decision making and diagnostic judgment in the emergency room shows marked differences in labels affixed to the patient by the emergency room admit-

labels, however, nosological categories are arbitrary, overlapping and descriptive." Kaplan, supra note 19, at 29.

"Were we to ignore the fact that no definition of dangerous acts has been agreed upon, our standards of prediction have still been horribly imprecise. On the armchair assumption that paranoids are dangerous, we have tended to play safe and incarcerate them all. Assume that the incidence of killing among paranoids is five times as great as among the normal population. If we use paranoia as a basis for incarceration we would commit 199 non-killers in order to protect ourselves from one killer." Livermore, Malmquist & Meehl, supra note 18, at 85.


ting psychiatrist and the ward psychiatrist later.65 These studies indicate, at the least, much variability in affixing diagnostic labels and reveal the great possibility of error in classifying certain groups of patients or patterns of behavior as most likely to be associated with assaultive acts in the future.

Here too, one must question the results of studies which assess results in terms of diagnostic categories, where there is variability and some inconsistency in the diagnosis used at the time of imposing involuntary commitment.

Adequacy of Facilities and Staff

Prior to the passage of the LPS Act, extensive evidence existed that state hospitals were overcrowded and understaffed.66 Stagnation of professional competence and sagging morale was evident in the state hospital personnel.67 The morale of professional staff was lowered further with the cutback in state hospital funding which took effect July 1, 1967.68

Any consideration of the effectiveness of treatment through involuntary hospital commitment must consider whether staffing, physical facilities and hospital fundings are sufficient to provide the means of effective treatment. Obviously, stuffing a patient into an already overcrowded, understaffed and morale-poor ward does not argue for the value of "treatment" just because he has been involuntarily detained there under either a psychiatric certification or a court order. In fact, a study of 3,000 schizophrenic patients treated in a state hospital indicated such hospitalization prolonged mental illness rather than shortened it!69

Often outpatient care or short hospital stay for crisis intervention is of more benefit to the patient than a long term stay in a hospital setting.60

Two cases in the District of Columbia indicate that treatment

65 Id. at 1545; Mendel & Rapport, Determinants of the Decision for Psychiatric Hospitalization, 20 ARCH. GEN. PSYCHIAT. 321 (1969).
66 DILEMMA, supra note 5, at 66-69.
67 Id. at 64.
68 Id. & personal observation of the author.
69 Mendel, supra note 5, at 242.
70 "We treat a sample of patients who ordinarily would be hospitalized immediately at the Colorado Psychopathic Hospital and we have been able to keep 95% of these patients out of the hospital during the acute phase and 85% in follow-up which has gone on for up to two years." Donald G. Langsley M.D., then Director of Inpatient Service, Colorado Psychopathic Hospital and now Professor of Psychiatry and Chairman of the Department of Psychiatry, University of California Medical School, Davis, California, quoted in DILEMMA, supra note 5, at 77.
which involves inadequate staffing, overcrowding or imprecise therapeutic approach may be equivalent to no treatment at all and be grounds for release of the patient held under involuntary commitment.

In Lake v. Cameron, an elderly woman was confined in St. Elizabeth's Hospital as an insane person by reason of chronic brain syndrome. This was associated with aging and demonstrable lack of memory and ability to make sound judgments. The majority of the D.C. Circuit Court of Appeals ruled that the lower court was under a duty to explore alternatives to involuntary confinement of this patient as a mentally ill person. Such alternatives included nursing home and private care. The dissent stated that the opinion of the majority raised issues which had not been presented by the patient herself. The dissenting judges felt that the issue was only whether this patient should be released completely or confined for her own protection. Since, in the trial court's opinion, she was not able to care for herself, the dissenting opinion of the circuit court was that she should therefore remain committed.

The same court in Rouse v. Cameron discussed the question of adequacy of treatment. There, a fifteen-year-old boy was taken into custody for possession of firearms and then committed to St. Elizabeth's Hospital as insane. The proceeding in Rouse was an appeal from a denial of a writ of habeas corpus. The court in reversing the denial and remanding for further proceedings said:

Continuing failure to provide suitable and adequate treatment cannot be justified by lack of staff or facilities. . . .

We think law and justice 'require' that we remand for a hearing and findings on whether appellant is receiving adequate treatment.

The opinion in Rouse implies that in actuality there was no treatment. This situation has had its duplicate in past instances in California. Individuals have been held in the state hospital for periods of six to nine months having almost no contact with a psychiatrist, except for the dispensing of psychotropic medication such as phenothiaazines through the intermediary of the nurse. The argument that this constituted adequate treatment by those pro-

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61 364 F.2d 657 (D.C. Cir. 1966).
62 Id. at 660.
63 Id. at 663. Justice Burger, now Chief Justice of the United States Supreme Court, concurred with the minority dissent.
64 373 F.2d 451 (D.C. Cir. 1966).
65 Id. at 457.
66 Id. at 459.
67 Personal experience of patients of the author.
ponents of the state hospital system usually boiled down to the statement, "this is all the treatment that could be given under the existing conditions of overcrowding of patients and understaffing of personnel." Undoubtedly, the ubiquity of this type of situation led to the changes of the law now effective under the Lanterman-Petris-Short Act.

There may be occasion for this same question of adequacy of treatment to occur under the new enactment. Just because treatment is now focused in a county facility rather than in a state facility does not change or limit the possibilities of abuse of the legal provisions. Overcrowding, understaffing and poor morale amongst staff can occur in small institutions as well as large. Lake and Rouse indicate that inadequacies to the degree that the patient is only in custody and not really receiving psychiatric treatment, can be bases for release of the patient from involuntary commitment.8

Outcome

Assuming accurate diagnostic labeling and reliable prediction of future behavior is possible, then the effectiveness of involuntary commitment in protecting society or the individual from himself is important to assess. Put baldly, the questions are:

First, does involuntary commitment reduce the incidence of suicide among potentially suicidal patients?

Second, does involuntary commitment reduce the incidence of assaultive, tortious acts of a person termed "dangerous to others"?

Suicide

Suicide is a problem of great magnitude in the United States. In 1955 suicide was listed as tenth in order of the leading causes of death.9 More than 20,000 people in the United States commit suicide each year. It is estimated that the actual incidence, including victims who conceal suicidal death in an "accidental" death, ap-

8 "[T]he warning of the Rouse court should be remembered: failure to provide adequate treatment might render a commitment statute constitutionally suspect. Treatment failures, then might threaten the foundation of the entire scheme." Lewin, supra note 44, at 725.

"The most dramatic abuse noted in the Ionia study was the retention in confinement, for substantial periods, of patients who were apparently eligible for discharge. Significantly, the incidence of such prolonged unnecessary confinement was greater where the patient was without counsel; in those cases in which a private attorney was retained, the abuse was minimized." Id. at 728.

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approaches 50,000 per year.\textsuperscript{70} Suicide has as many modes and syndromes of intent as another escape entity, chronic alcoholism. A list of five areas of characteristic suicidal behavior includes the patient's considering: ideas of death, sustained ideas or recurrent wishes of death, frustrated feelings and impulsive behavior leading to suicidal activities, suicide as the course of last resort, or that suicide represents a logical end result to life itself.\textsuperscript{71} The LAD syndrome in which "L" stands for loss of a loved one, "A" stands for aggression (expressed outwardly as homicide or expressed inwardly as suicide), and "D" stands for acute depression, is present for most suicidal patients.\textsuperscript{72}

One group of patients who commit suicide successfully are those who do not give any prior warning to those around them. That \textit{fait accompli} obviously is not deterred by involuntary commitment imposed by someone else. He or she conveys his intent with the completed self-destructive act itself before any intervention is possible.\textsuperscript{73} These patients have been termed "non-communicators" of

\textsuperscript{70} \textit{Id.} at 171.
\textsuperscript{71} \textit{Id.} at 173.
\textsuperscript{72} Hirsh, \textit{Dynamics of Suicide}, 44 \textit{Mental Hygiene} 274, 278-79 (1950).
\textsuperscript{73} Case 3. A thirty-five-year-old single white woman was seen at the emergency room of a local hospital having been brought to that hospital by ambulance. The story given was that she had been traveling on Highway 99 between Bakersfield and Los Angeles on a very hot summer day. Her car had overheated, boiled over and she was forced to pull to the side of the road. She herself became weak and dizzy from heat prostration, and eventually was brought to the hospital, some thirty miles from the scene of her physiologic collapse. The patient was hospitalized and given supportive treatment, including intravenous fluids. She remained in the hospital for the next thirty-six hours, at which time she was much improved, cheerful and stated that she felt fine.

She was seen in the doctor's office the following day and there was some discussion of her interpersonal relationships. She was single, having been married and divorced some years previously. There were no children from that marriage.

She was working as a radio dispatcher for the Sheriff's Department in a community remote from the county seat. She had a boyfriend with whom she had been going for several years. There was no indication noted by the physician of depression or suicidal intent. She seemed an attractive and personable woman enjoying her work and not unhappy about her single status.

Five days later, a newspaper carried an account of this same young woman who was found dead in her apartment. Information gleaned later indicated that she had taken an overdosage of sleeping pills prescribed by a Los Angeles physician some two weeks prior to the time she was seen in the emergency room. Her associates at her work knew of some differences of opinion between the deceased and her boyfriend, but had no indication that she planned to take her life.

It is entirely speculative whether the prostration which was associated with excessive heat and dehydration seen when she went into the emergency room was aggravated by emotional factors which the physician did not detect. Certainly at the hospital and at the follow-up visit in the office, there was no indication of a profound grief, disturbed emotional content or depression which would have given the examiner a hint that this woman was planning suicide at that time. Again, it is quite speculative whether the sleeping pills which she had obtained earlier, were obtained with the
suicide intent. Studies indicate 70.2 percent of successful suicides in military service were non-communicators. In a Veteran's Administration hospital population, only 25 percent were non-communicators. Other statistics show equally wide variation in warning of suicidal intent.

For those patients who do give prior warning there is the argument that hospitalization prevents the very depressed patient from completing his suicidal intent. In the VA study cited above, "of thirty-seven of these patients who had left the hospital, twenty had committed suicide within thirty days. Five such patients were still resident in the hospital at the time of the successful suicide." The questions posed for the psychiatric staff study are how long such hospitalization should be continued, and how predictable is the possibility of the patient still committing suicide after leaving the psychiatric hospital. The legal question is whether involuntary hospitalization prevents eventual suicide.

One report on suicides following discharge from a Western Australian psychiatric hospital indicates that "of 494 men and 135 women who committed suicide between 1955 and 1961 in Western Australia, 10.3 percent of the men and 17.8 percent of the women had, at some time previously, been admitted to a particular acute psychiatric hospital." It has been pointed out that there are a variety of factors which influence a patient's further conduct after he leaves a psychiatric hospital, including those affecting him even before he arrives there. Moreover, environmental factors play a great role in the patient's response to the possibility of suicide. The study further points out that the use of tranquilizers did not appear to affect the end result as far as percentages of successful suicide were concerned.

possibility of suicide in mind, or that the over-dosage was an impulse act performed without prior planning before the time of ingestion of the sleeping pills. (Personal case of the author.)


Pokorny, supra note 75, at 322.

James & Levin, Suicide Following Discharge from Psychiatric Hospital, 10 Arch. Gen. Psychiat. 43, 46 (1964).

Recent articles discussing treatment for the suicide prone patient are of significance in that they do not stress the use of hospitalization, voluntary or involuntary. Rather, emphasis is laid on person-to-person contact and continued sympathetic support for the individual.\footnote{Naftulin, supra note 69, at 172.}

The very profound introjection of the bystander and his feelings into the role of the person who takes his own life prevents the bystander's impersonal analysis of the situation. The fact that common law prohibited suicide and that a person who took his own life was planted at the crossroads of the highways with a stake impaled through his chest still permeates the thinking of our modern day approach, prohibiting an individual from taking the responsibility for ending his own life. Yet our society approves audacious behavior in which the risk of death is so great as to excite admiration or awe. Sky diving, motorcycle riding, mountain climbing and car driving at excessive speeds with or without the influence of alcohol, are all ways in which chances of death or maiming are taken sometimes in fool-hardy proportions. These "fringes" are still within acceptable norms of society. Only when the individual makes some gesture in solitude, such as turning on the gas jets or ingesting an excessive number of sleeping pills, is the public sense of decency outraged to the extent that society must take some action to protect the individual from himself.

Authorities do not know whether involuntary commitment does decrease the rate of self-destruction. Such hospitalization rarely results in any increase of self-responsibility on the part of the patient. He does not thereby gain any additional insight into the problems and conflicts which have led him to a suicide-prone posture. Under the LPS Act there may be slavish obeisance to the involuntary commitment principle even though this may not be in the best interests of the patient.

Finally, involuntary hospitalization for the suicide gesture patient may often be a punitive approach without any medical or psychological benefit to patient, family, or society.\footnote{Case 4. A twenty-three-year-old housewife who had been having difficulties with her husband in her second marriage, took ten valium tablets asserting that she wanted to do away with herself. She was brought to the emergency room of a private hospital where measures were taken to evacuate her stomach. Although distraught and tearful, and further distraught as a result of the vomiting induced by the stomach-clearing process, she was conscious, aware of reality, and did not indicate any further suicidal wishes. In keeping with policy at that hospital, psychiatric treatment was suggested including remaining in the psychiatric ward (an open ward) of the private hospital. The patient agreed to this. Shortly after this a deputy sheriff who had been called to the house by the wife's husband came to the private hospital}
occurs the situation where the enforced hospitalization becomes a “payoff” in game playing between husband and wife. As such, the state enforced involuntary commitment becomes a manipulative tool wielded either by the suicide-gesturer or the spouse whom the gesture is meant to impress.

Assaultive Behavior, Danger to Others, Homicide

Each time there is a newspaper article relating a particularly violent and senseless murder of family, friends, or innocent victims, the public reacts with the almost universal comment: “why didn’t someone do something to put such a person in an asylum so that he couldn’t have performed this tragic act?” The problem lies with identification of the aggressor with sufficient accuracy so that non-assaultive or non-homicidal persons will not be unnecessarily deprived of their freedom. The accuracy of predicting which persons will erupt with violent assaultive behavior toward others is very low. Numerous studies have attempted to identify such persons with little success.\textsuperscript{82} Although the label of paranoid schizophrenic is thought to be the magic word which identifies those potentially homicidal and assaultive persons, this is not always the case. Various studies show there is little correlation between certain patterns of disturbed behavior and later occurrence of antisocial assaultive acts.\textsuperscript{88} One study of women who kill indicates the presence of a variety of personality patterns including the masochistic, the overtly hostile violent, the covertly hostile violent, the inadequate, the psychotic and the amoral.\textsuperscript{84}

Another retrospective analysis of male criminals shows labels of sociopathy, alcoholism and drug dependence to be the primary psychiatric conditions associated with criminal actions, that is, injuries to persons and injuries to property.\textsuperscript{85} In this same study, female criminals showed hysteria, sociopathy, alcoholism and drug dependence as the primary psychiatric conditions present in women committing criminal actions. Schizophrenic process, manic-depressive disease or organic brain disease were not found to be any greater in the criminal population than in the general population.\textsuperscript{86}

and attempted to take the patient to the county psychiatric ward, which had a locked ward facility. It was only with great difficulty and after considerable argument that the deputy sheriff was dissuaded from this intention. She remained in the open psychiatric ward voluntarily. The patient returned to her husband and family two days later. (Personal case of the author.)

\textsuperscript{82} See notes 84, 85 & 87 infra.
\textsuperscript{83} See notes 87 & 89 infra.
\textsuperscript{85} Guze, Goodwin & Crane, Criminality and Psychiatric Disorders, 20 ARCH. GEN. PSYCHIAT. 583, 589 (1969).
\textsuperscript{86} Id.
There are conflicting reports as to the presence of warnings given by the perpetrator of homicide. In a study of "the sudden murder" in comparison with the habitual criminal offender and the sexual deviate, the authors state:

Surprisingly when such a person seemed to be getting along quite well, when society apparently expected him to be even more conforming and mature, and when he had no one to blame, he would become more and more tense and angry. At such a time, even a light provocation would set off the violent surge of rage which would result in murder.87

Still another study indicated that certain syndromes of personality patterns can be identified retrospectively in persons having committed apparently senseless murders; but no estimate is made of the presence of these personality traits in individuals who do not commit murder.88

Of 100 patients who were hospitalized for threats-to-kill, three patients actually carried out threats in the next five year period.89 This may be an argument for the value of such psychiatric hospitalization in that 97 percent did not later carry out their threats, or may indicate that out of 100 such patients a large majority could not be identified accurately as potentially homicidal persons.

The same author concludes:

Involuntary commitment often provides only brief protection for society. It may further undermine the patient's self-respect as well as cause resentment toward the relatives who participated in the court commitment and toward the psychiatrist who was unwilling to treat him in a local hospital or clinic. Because fear of recommitment to the state hospital may discourage the patient from seeking psychiatric help when the next crisis occurs, the risk of homicide may be increased.90

COMMENTS

The factors of reliability, predictability and effectiveness should be evaluated when society, through its legal machinery, deprives an individual of his rights and liberties, even for a short period of time. The recent volume of law journal articles throughout the nation indicates we in California are not alone troubled by this dilemma.91

To put the question in its most extreme, although embarrassing form: If we as physicians and psychiatrists cannot predict reason-

88 Id. at 677.
90 Id. at 481.
91 See notes 18, 19, 32 & 44 supra.
ably well which patients need hospital treatment; if we cannot predict the results of that hospital treatment with any better than coin-tossing accuracy; and if we cannot always agree on the same label to be applied to constellations of behavior, how can we expect legislators to furnish exact guidelines for the involuntary commitment of an individual for his protection or the protection of society?

But if there are no such exact and critical guidelines for deprivation of liberties, and there is serious question of the value to be attained by such involuntary commitments, can one persuasively argue that society's need to protect the public justifies the abridgment of the individual's liberty without due process? Can one reasonably contend that involuntary hospitalization should be justified on any reason except the needs and best interests of the person to be hospitalized. Arguably, even those interests are not best served by "involuntary" treatment.

Conclusion

Medicine and law are concerned that every individual should have emergency medical aid in time of crisis, regardless of economic status or social background. The person in the throes of a severe toxic state, whether from drugs, alcohol or acute emotional disturbance, has a right to emergency care and necessary hospitalization. Society has an obligation to make available such emergency treatment. Such hospitalization and emergency care may be offered and even imposed while his delirium renders him unable to make a rational choice or assume self-responsibility. But if such offer of hospitalization is rejected by the patient, yet imposed for his life protection, he should have availability of counsel and access to due process from the onset of that involuntary detention. In a society which affords its members emergency fire, police, and medical service twenty-four hours a day, seven days a week, there is no valid basis for the fact that personal liberties and their legal redress are suspended on weekends and holidays.

The intent of the Lanterman-Petris-Short Bill in shortening hospital stays and increasing patient's rights during such hospitalization is commendable. It represents significant advances over previous commitment procedures. Nevertheless, there is still denial of "due process" in the arbitrary action of involuntary commitment for a seventy-two hour period without right to counsel or appeal for judicial hearing. The post-commitment judicial hearing provided after certification for intensive treatment is not due process.

Emergency care and voluntary hospitalization for the toxic phase of acute delirium, whether induced by drugs or from emotional
disturbance, is the right of every person. Access to counsel and availability of "due process" is also a basic right of every person for whom involuntary commitment is sought. Such right to counsel and accompanying legal safeguards should be available to the patient from the onset of his involuntary commitment and not deferred five or more days. The legislative enactments governing involuntary commitment need revision in order that "due process" be made available from the beginning of any "involuntary commitment" procedure.

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