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A Proposal for Changing Florida's Civil Commitment System

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Abstract

For purposes of this analysis, "civil commitment" is a form of noncriminal confinement for those who are legally found to be mentally ill.1 With the minor exception of rare confinement for some communicable diseases, there is no analogue of involuntary commitment for physical illness.

KEYWORDS: changing, florida, civil

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For purposes of this analysis, "civil commitment" is a form of non-criminal confinement for those who are legally found to be mentally ill.[1] With the minor exception of rare confinement for some communicable diseases, there is no analogue of involuntary commitment for physical illness.

Florida's civil commitment system, the "Baker Act,"[2] is in need of change because it has not kept pace with legal developments of recent years. To the extent developments in the law occur conservatively, and to the extent these developments could not have occurred without a consensus of professional and social opinion, it is also fair to say the Baker Act has not kept pace with developments in the mental health disciplines.

The changes in the Baker Act proposed here (see Appendix) are the product of comparison with a nationally circulated model act, the

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1. *See* BLACK'S LAW DICTIONARY 222-23 (5th ed. 1979). *See also* T. SZASZ, LAW, LIBERTY AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES 39 (1963): "Commitment is compulsory or involuntary detention of a person in an institution designated as a mental hospital."

The civil liberties subfield of mental health policy analysis has certain areas of unexpected inattention: "for example, the problems posed by trying to 'treat' or 'help' people through the rehabilitative model (including problems of mental commitment, psychosurgery, and chemotherapy) appear not to have become grist for the scholarly mill (but see *The Civil Liberties Review*)." CIVIL LIBERTIES POLICY AND POLICY MAKING ix-x (S. Wasby ed. 1977).

2. FLA. STAT. §§ 394.451-.481 (1981).

Suggested Statute on Civil Commitment,[3] and consideration of such recommendations as the Report of the President's Commission on Mental Health.[4] The author's original intent was to draft a new mental health act as a substitute for the Baker Act, using the Suggested Statute on Civil Commitment. Upon analysis, however, the Suggested Statute is quite verbose and difficult to follow. In addition, the Baker Act already has several features of the Suggested Statute. Thus, the proposed changes to the Baker Act constitute improvements from the Suggested Statute added to the existing Florida civil commitment structure and language, without changing either the basic structure or words.

The comparison Suggested Statutes on Civil Commitment is part of a project suggested by the Mental Health Association involving the National Institute of Mental Health (NIMH) and the Mental Health Law project (the leading multidisciplinary, mental disability law, public interest firm in the country) to prepare analyses and suggested model statutes on such state mental health care issues as civil commitment.[5] During drafting, the Suggested Statute on Civil Commitment was reviewed and critiqued by a broadly representative, sixteen person, national interdisciplinary advisory panel, and by more than seventy other national mental health professionals, professional and consumer groups, lawyers, judges, and law professors.[6]

During the 1979 legislative session in Florida, the Suggested Statute on Civil Commitment was endorsed by such organizations as the Florida Mental Health Association, the National Association of Social Workers, the Florida Center for Children and Youth, and the District Two Human Rights Advocacy Committee for Florida State Hospital.[7]

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3. *See American Bar Association Commission on the Mentally Disabled,* 2 MENTAL DISABILITY L. REP. 57, 129-59 (1977). [hereinafter cited as MENTAL DISABILITY L. REP.].

4. REPORT OF THE TASK PANEL ON LEGAL AND ETHICAL ISSUES TO PRESIDENT'S COMMISSION ON MENTAL HEALTH, REPORT TO THE PRESIDENT, Vol. IV, App. (1978).

5. The other issues covered are: mental health advocacy service; mental health standards and human rights; zoning for community residences; therapeutic confidentiality (including electronic data processing); guardianship; mental health treatment for minors; right to education; state imposed disabilities; discrimination; incompetence to stand trial on criminal charges; insanity defense; and, mental health treatment for prisoners.

6. 2 MENTAL DISABILITY L. REP. at 61.

7. FLA. STAT. § 20.19(7) (1981), a third-party mechanism for protecting consti-

Despite widespread opinion that the Baker Act had not kept pace with national developments expressed in judicial decisions, legislative changes, and mental health care, the Florida legislature has not addressed the Suggested Statute on Civil Commitment, primarily because it is difficult to identify the differences between the Baker Act and the lengthy Suggested Statute. The Suggested Statute on Civil Commitment is twenty-eight pages long, including annotations; the introductory analysis is forty-nine pages long. In contrast, the Baker Act fills only eleven pages in the statute book, and includes issues addressed separately in the Suggested Statutes on Mental Health Standards and Human Rights (ten pages),[8] Procedures for Voluntary Treatment (four pages),[9] and Mental Health Treatment for Minors (ten pages).[10]

In late March 1981, changes to the Baker Act proposed here (Appendix A) were unanimously endorsed by both the Board of Governors for the Florida Bar and, in principle, by the Mental Health Association Board of Directors for the Florida Mental Health Association. These proposed changes to the Baker Act represent a distillation of an item by item comparison to the Suggested Statutes. The changes are not exhaustive; they cover those areas most needing amendment. The changes also attempt to be politically realistic. For example, the following proposals, however desirable, were omitted: jury trial;[11] protection from being a witness against oneself;[12] "beyond a reasonable doubt" or

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tutional and human rights of clients.

8. 2 MENTAL DISABILITY L. REP. at 291.

9. *Id.* at 329.

10. *Id.* at 459.

11. *See, e.g.,* Note, *Confinement of Mabel Jones: Is There a Right to Jury Trial in Civil Commitment Proceedings?,* 6 FLA. ST. U.L. REV. 103 (1978). Seventeen jurisdictions (Alaska, Arkansas, California, Colorado, District of Columbia, Illinois, Kansas, Kentucky, Michigan, Montana, New Mexico, Oklahoma, Tennessee, Texas, Washington, Wisconsin, and Wyoming) have a right to a jury trial in civil commitment as of November, 1978. 3 MENTAL DISABILITY L. REP. 205, 206-14 (1979).

12. *See, e.g.,* Aronson, *Should the Privilege Against Self-Incrimination Apply to Compelled Psychiatric Examinations?,* 26 STAN. L. REV. 55 (1973); Fielding, *Compulsory Psychiatric Examination in Civil Commitment and the Privilege Against Self-Incrimination,* 9 GONZ. L. REV. 117 (1973); Wesson, *The Privilege Against Self-Incrimination in Civil Commitment Proceedings,* WIS. L. REV. 697, (1980); Comment, *Defective Delinquent Commitment Proceedings and the Constitution: The Privilege Against Self-Incrimination and the Right to Counsel at the Examination Stage,* 22 AM. U.L. REV. 619 (1973).

"clear, unequivocal and convincing evidence" as a standard of proof.[13]

Cf. Estelle v. Smith, 447 U.S. 934 (1981). (Prosecution's use of psychiatric testimony at the sentencing phase of a capital murder trial to establish future dangerousness violated respondent's constitutional rights to fifth amendment protection against self-incrimination and sixth amendment right to counsel, where respondent was not apprised of his rights and did not knowingly decide to waive them when faced while in custody with a court-ordered psychiatric inquiry, and where respondent was not given prior opportunity to consult with counsel to decide whether to submit to psychiatric examination).

13. Fifteen jurisdictions (California, District of Columbia, Hawaii, Idaho, Kansas, Kentucky, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, Oklahoma, Oregon, Utah, and Wisconsin) require proof "beyond a reasonable doubt" in civil commitment proceedings; two states (Oklahoma and Tennessee) require "clear, unequivocal, and convincing" evidence; and three states (North Carolina, Washington, and West Virginia) require "clear, cogent, and convincing" evidence. The other states, including Florida, merely require "clear and convincing" evidence for an individual to be involuntarily committed to a mental institution.

The standard of proof needed to involuntarily commit an individual to a state mental hospital for an indefinite period has been established by the United States Supreme Court to be at least "clear and convincing" evidence. Addington v. Texas, 441 U.S. 418 (1979). Whatever standard of proof is required under state law, if the standard does not "inform the factfinder that the proof must be greater than the preponderance of the evidence standard applicable to other categories of civil cases," due process demands are not met. *Id.* at 433. If the required standard of proof is "beyond a reasonable doubt," or an equivalent, such as "clear, unequivocal, and convincing" evidence, their is serious question that the state should be able to prove anyone to be both mentally ill and dangerous. *See* Greenberg, *Involuntary Psychiatric Commitments to Prevent Suicide,* 49 N.Y.U.L. Rev. 227, 266-67 (1974); Note, *Civil Commitment of the Mentally Ill: Theories and Procedures,* 79 HARV. L. REV. 1288, 1291 (1968); Note, *Due Process and the Development of "Criminal" Safeguards in Civil Commitment Adjudications,* 42 FORDHAM L. REV. 611, 624 (1974).

Chief Justice Burger's lack of consistency in mental disability law decisions emerges in *Addington* and has not gone unnoticed. *See* Shuman, *Warren Burger and the Civil Commitment Tetralogy,* 3 INT'L J.L. & PSYCHIATRY 155 (1980). In *Addington,* the Chief Justice introduced the idea that an individual's interest in liberty includes not only physical liberty, but also mental freedom: a "free to be free" consideration for involuntary commitment. 441 U.S. at 429 (citing Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill,* 133 AM. J. PSYCHIATRY 496, 498 (1976); Schwartz, Myers & Astrachan, *Psychiatric Labeling and the Rehabilitation of the Mental Patient,* 31 ARCH. GEN. PSYCHIATRY 329, 335 (1974)). He used these references, provided by Joel Klein, counsel for the American Psychiatric Association, as *amicus curiae,* to reach the value judgment that unlike the criminal justice system, "[i]t cannot be said, therefore, that it is much better for a mentally ill person to 'go

This article reviews the proposed changes in the Baker Act issue by issue. The justification for each proposed change will be presented with respect to legal developments and, where appropriate, developments in mental health disciplines.

Definition of "Mentally Ill"

In Florida, the current definition of "mentally ill" is "having a mental, emotional, or behavioral disorder which substantially impairs the person's mental health."[14] Circular and tautological, this definition identifies mental illness as an absence of mental health, without defin-

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free' than for a mentally normal person to be committed." 441 U.S. at 429. *See* Brief for the American Psychiatric Association as *Amicus Curiae,* in P. FRIEDMAN, LEGAL RIGHTS OF MENTALLY DISABLED PERSONS 297, 303 (1979). Ironically, Klein, former clerk to Justice Powell and former attorney with the Mental Health Law Project (the Project provided counsel for appellant Addington), is reported to have been involved with Justice Stewart's clerks in formulating the following response to Chief Justice Burger's statement in O'Connor v. Donaldson, 422 U.S. 563 (1965), ("There can be little doubt that in the exercise of its police power a state may confine individuals solely to protect society from the dangers of significant antisocial acts or communicable disease." *Id.* at 582-83):

> May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community?. . .[T]he mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarcertation is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends. See *Shelton v. Tucker,* 364 U.S. 479, 488-490.
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> May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.

Id. at 575. *See* B. WOODWARD & S. ARMSTRONG, THE BRETHREN: INSIDE THE SUPREME COURT 370, 373-74, 376-77 (1979).

For a review of what, in civil commitment, must be proved by at least "clear and convincing" evidence, see A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 1980 SUPPLEMENT 127-28 (1980).

14. FLA. STAT. § 394.455(3) (1981). This definition was amended during the 1982 legislative session, while this article was in publication. *See infra* note 16.

ing mental health.

"Mentally ill" is a legal definition; it is one of the criteria for civil commitment. As a legal definition, it should give notice of those circumstances under which a person can be deprived of his freedom. The current definition of "mentally ill" has so far withstood constitutional challenge for vagueness because statutorily[15] it must be read in conjunction with the other criteria for commitment (e.g., likely to injure others, or likely to injure self).[16] Some courts, such as Pennsylvania's,[17] have found even better definitions of mental illness[18] to be unconstitu-

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15. FLA. STAT. § 394.463(2)(a) (1981).

16. *See In re* Beverly, 342 So. 2d 481 (Fla. 1977). The definition enacted in 1982 is:

> an impairment of the emotional processes, of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology, except that, for the purposes of this act, the term does not include retardation or developmental disability as defined in chapter 393, simple intoxication, or conditions manifested only by antisocial behavior or drug addiction.

FLA. STAT. § 394.455(3)(effective July 1, 1982). While this definition is substantially similar to the one here proposed, the 1982 changes in the Baker Act fell far short of those needed.

17. Finken v. Roop, 233 Pa. Super. 762, 339 A.2d 764 (1975), *cert. denied*, 424 U.S. 960 (1976). *See* Gross v. Pomerleau, 465 F. Supp. 1167 (D. Md. 1979) (medical concept of mental illness insufficient, legal definition should be relied upon in taking personal liberty); Bell v. Wayne County Gen'l Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974).

Compare, e.g., MICH. COMP. LAWS ANN. § 330.1400a (1980): " 'mental illness' means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life"; WIS. STAT. ANN. § 51.01(13)(b) (1981): "Mental illness, for purposes of involuntary commitment, means a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not incldue alcoholism." These are examples of new legal definitions for mental illness accepted by state legislatures in response to successful litigation against older definitions. They are similar to the definition of mental illness for Florida proposed here.

18. The unconstitutionally vague Pennsylvania definition specified mental illness that "so lessens the capacity of a person to use his customary self-control; judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care." 339 A.2d at 775 n.14 (quoting section 201 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 codified in 50

tionally vague for failure to give fair warning of legally proscribed conduct, or to set a standard for restricting governmental discretion. The current Florida definition may be subject to more successful constitutional challenge in the future.

The proposed definition now substantially enacted, is as follows:

> "Mentally ill" means a substantial impairment of emotional processes, ability to exercise conscious control of one's actions or ability to perceive reality or to reason or understand, which impairment is manifested by instances of grossly disturbed behavior; it does not include retardation or developmental disability as defined in Chapter 393, brief periods of intoxication caused by substances such as alcohol or drugs, or dependence upon or addiction to any substance such as alcohol or drugs.

This definition limits legal involvement to situations of major mental impairment. The definition covers the three aspects of mental functioning (emotion, volition and cognition) in words understandable to lay persons, judges and attorneys, and mental health professionals.[19] It prevents mental health professionals from usurping judicial responsibility for determining the circumstances under which persons can be deprived of liberty. The definition excludes mental retardation, developmental disability, intoxication, and dependence or addiction to such substances as alcohol or drugs. These conditions are addressed by other statutes and programs in Florida.[20]

The definition is comparatively conservative. There is substantial psychiatric literature[21] supporting the position that mental illness is a

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PA. CONS. STAT. § 4102 (1966)).

19. 2 MENTAL DISABILITY L. REP. at 89. *See* Keiter, *A Constitutional Analysis of Involuntary Civil Commitment in Wyoming,* 15 LAND & WATER L. REV. 141, 158 & 160 (1980) (statutory definitions of mental illness are frequently circular or ambiguous and fail to give the term any context; behavioral definition should be used); Note, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation,* 64 IOWA L. REV. 1284, 1373, 1428 (1979) (Suggested Statute on Civil Commitment definition of mental illness is specifically recommended).

20. FLA. STAT. §§ 393.061-.20 (1981) deals with developmental disabilities; FLA. STAT. §§ 396.012-.171 (1981), alcoholism; FLA. STAT. §§ 397.011-.20 (1981) drug dependency.

21. *See, e.g.,* D. COOPER, PSYCHIATRY AND ANTI-PSYCHIATRY (1967); R. GEERTSMA, CLINICAL ASSESSMENT IN COUNSELING AND PSYCHOTHERAPY 238 (1972);

theory for identifying behavior or thought processes which we do not

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S. HALLECK, PSYCHIATRY AND THE DILEMMA OF CRIME 36, 219 (1967); L. HOHMAN, CURRENT APPROACHES TO PSYCHOANALYSIS (1960); K. MENNINGER, THE CRIME OF PUNISHMENT 117-18, 130 (1968); P. ROCHE, THE CRIMINAL MIND (1958); T. ROTHMAN, THE FUTURE OF PSYCHIATRY 247 (1962); T. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY (1966); THE MEDICAL MODEL OF MENTAL ILLNESS (S.L. Sharma ed. 1970); T. SZASZ, *supra* note 1; T. SZASZ, THE MYTH OF MENTAL ILLNESS: FOUNDATION OF A THEORY OF NORMAL CONDUCT (1961); Agnew & Bannister, *Psychiatric Diagnosis as a Pseudo-Specialist Language,* 46 BRIT. J. MED. PSYCH. 69 (1973); Albee, *Models, Myths, and Manpower,* 52 MENTAL HYGIENE 168 (Apr. 1968); Ausebel, *Relationships Between Psychology and Psychiatry: The Hidden Issues,* in CLINICAL PSYCHOLOGY IN TRANSITION (J. Braur ed. 1966); Baur, *Legal Responsibility and Mental Illness,* 57 NW. L. REV. 12, 14 (1962); Cavanagh, *A Psychiatrist Looks at the Durham Decision,* 5 CATH. U. L. REV. 25 (1955); Coles, *The Limits of Psychiatry,* 31 THE PROGRESSIVE 32 (May 1967); Davidson, *The Semantics of Psychotherapy, 115* AM. J. PSYCHIATRY 410 (1958); Davidson, *Point of View,* 52 MENTAL HYGIENE 5 (1967); Eysenek, *The Outcome Problem in Psychotherapy,* THE INVESTIGATION OF PSYCHOTHERAPY (A. Goldstein ed. 1966); Furrow, *Defective Mental Treatment: A Proposal for the Application of Strict Liability to Psychiatric Services,* 58 B.U.L. REV. 391 (1978); Goldstein, *The Fitness Factory Part I: The Psychiatrist's Role in Determining Competency,* 130 AM. J. PSYCHIATRY 1144, 1147 (1973); Guiora & Harrison, *What is Psychiatry? A New Model of Service and Education,* 130 AM. J. PSYCHIATRY 1275, 1275 (1973); Halleck, *The Psychiatrist and the Legal Process,* 2 PSYCHIATRY TODAY 24 (1969); Jackson, 20 STAN. MED. BULL. 202 (1962); Kaschak, *Therapist and Client: Two Views of the Process and Outcome of Psychotherapy,* PROF. PSYCHOLOGY 271 (May 1978); Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment,* 117 U. PA. L. REV. 75 (1968); Mariner, *A Critical Look at Professional Education in the Mental Health Field,* 22 AM. PSYCHOLOGIST 271 (1967); McReynolds, *DSM-III and the Future of Applied Social Science,* PROF. PSYCHOLOGY 123, 125 (Feb. 1979); Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law,* 51 S. CAL. L. REV. 527 (1978); Pugh, *The Insanity Defense in Operation: A Practicing Psychiatrist Views Durham and Brawner,* 1973 WASH. U.L.Q. 87, 104; Robitscher, *The New Face of Legal Psychiatry,* 129 AM. J. PSYCHIATRY 91 (1972); Roche, *Symposium on Criminal Responsibility and Mental Disease: Medical Aspects,* 25 TENN. L. REV. 221 (1959); Salzman, *Changing Styles in Psychiatric Syndromes: Historical Overview,* 130 AM. J. PSYCHIATRY 147 (1973); Sarbin & Mancuso, *Failure of a Moral Enterprise: Attitude of the Public Toward Mental Illness,* 35 J. CONSULTING & CLINICAL PSYCHOLOGY 159 (1970); Sarbin & Mancuso, *Paradigms and Moral Judgments: Improper Conduct is not Disease,* 39 J. CONSULTING & CLINICAL PSYCHOLOGY 6, 7 (1972); Shah, *Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior,* 53 MENTAL HYGIENE 21 (1969); Shepherd, *A Critical Appraisal of Contemporary Psychiatry,* 12 COMPREHENSIVE PSYCHIATRY 302, 304, 312 (1971); Strupp & Hadley, *A Tripartite Model of*

understand, rather than a disease susceptible to diagnosis and treatment in the same manner as physical illness. Indeed, the problems of defining and classifying these conditions remain an ongoing issue. The new Diagnostic and Statistical Manual of Mental Disorders (DSM-III)[22] favors the use of the general term "mental disorder" over "mental illness" or "mental disease." More specific classification of the disorder may vary with the individual making the classification. The results of field studies conducted to determine the reliability and correlation of classifications done by different individual raters under the new "multiaxial system" are given in the manual;[23] they show good

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Mental Health and Therapeutic Outcomes with Special Reference to Negative Effects in Psychotherapy, 32 AM. PSYCHOLOGIST 187 (1977); Tarrier, *The Future of the Medical Model, a Reply to Guze, An Editorial,* 167 J. NERVOUS & MENTAL DISEASE 71 (1979); Taylor & Heiser, *Phenomenology: An Alternative Approach to Diagnosis of Mental Disease,* 12 COMPREHENSIVE PSYCHIATRY 480 (1972); Tuma, May, Yale & Forsythe, *Therapist's Experience, General Clinical Ability and Treatment Outcome in Schizophrenia,* 46 J. CONSULTING & CLINICAL PSYCHOLOGY 1120 (1978); Van Praag, *The Position of Biological Psychiatry Among the Psychiatric Disciplines,* 12 COMPREHENSIVE PSYCHIATRY 1 (1961); Wooten, *Academic Lecture: The Place of Psychiatry and Medical Concepts in the Treatment of Offenders,* 17 CAN. PYSCHIATRIC A.J. 365 (1972) "[I]t is time to admit that the sick and the wicked are not scientifically distinguishable. . . ." *Id.* at 371.

But see, e.g., M. SIEGLER & H. OSMOND, MODELS OF MADNESS, MODELS OF MEDICINE (1976); Ausubel, *Personality Disorder is Disease,* 16 AM. PSYCHOLOGIST 69 (1971); Guze, *The Future of Psychiatry: Medicine or Social Science? An Editorial,* 165 J. NERVOUS & MENTAL DISEASE, 225 (1977); Paris, *Diagnosis Before Treatment,* 20 CAN. PSYCHIATRIC J. 305 (1975); Reiss, *A Critique of Thomas S. Szasz' 'Myth of Mental Illness,'* 128 AM. J. PSYCHIATRY 1081 (1972); Shagrass, *Editorial Book Review,* 164 J. NERVOUS & MENTAL DISEASE 380 (1977).

See generally A. FLEW, CRIME OR DISEASE? (1974); Boorse, *On the Distinction Between Disease and Illness,* 5 PHILOS. & PUB. AFFAIRS 49 (1975); Coryell & Wetell, *Attitudes Towards Issues in Psychiatry Among Third Year Residents: A Brief Survey,* 135 AM. J. PSYCHIATRY 732 (1978); Houlgate, *Rights, Health and Mental Disease,* 22 WAYNE L. REV. 87 (1975); Kety, *From Rationalization to Reason,* 131 AM. J. PSYCHIATRY 957 (1974); Macklin, *Mental Health and Mental Illness: Some Problems of Definition and Concept Formation,* in BIOMEDICAL ETHICS AND THE LAW (J. Humber & R. Almeder eds. 1976); Moore, *Some Myths About "Mental Illness",* 32 ARCH. GEN. PSYCHIATRY 1483 (1975); Shuman, *The Right to be Unhealthy,* 22 WAYNE L. REV. 61 (1975).

22. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980).

23. *Id.* at Appendix F.

reliability. However, the extent to which this favorable reliability is dependent upon a statistic called the "kappa coefficient" renders the proffered reliability questionable.[24] Other criticisms cite additional substantive deficiencies in the manual.[25] This is only to suggest that DSM-III is no panacea to the problems of definition of the term "mentally

24. *See, e.g.,* J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 138-41 (3d ed. 1981), (citing Cohen, *Weighted Kappa: Nominal Scale Agreement with Provision for Scaled Disagreement or Partial Credit,* 70 PSYCHOLOGICAL BULL. 213 (1968)); Fleiss, Spitzer, Endicott & Cohen, *Quantification of Agreement and Multiple Psychiatric Diagnosis,* 26 ARCHIVES OF GEN. PSYCHIATRY 168 (1972); Helzer, Robins, Taibleson, Woodruff, Reich & Wish, *Reliability of Psychiatric Diagnosis,* 34 ARCHIVES OF GEN. PSYCHIATRY 129 (1977); Janes, *Agreement Measurement and the Judgment Process,* 167 J. NERVOUS & MENTAL DISEASE 343 (1979); Spitzer, Cohen, Fleiss & Endicott, *Quantification of Agreement in Psychiatric Diagnosis,* 17 ARCHIVES OF GEN. PSYCHIATRY 83 (1967); Spitzer & Fleiss, *A Re-analysis of the Reliability of Psychiatric Diagnosis,* 125 BRIT. J. PSYCHIATRY 341 (1974).

25. *E.g.,* McLemore & Benjamin, *Whatever Happened to Interpersonal Diagnosis? A Psycho-social Alternative to DSM-III,* 34 AM. PSYCHOLOGIST 17 (1979); McReynolds, *supra* note 21; Schacht & Nathan, *But Is It Good for the Psychologist? Appraisal and Status of DSM-III,* 32 AM. PSYCHOLOGIST 1017 (1977); Zubin, *But Is It Good for Science?,* 31 CLINICAL PSYCHOLOGIST 1 (1977-1978).

Newmark noted that preliminary drafts of DSM-III were beseiged by criticism concerning lack of specificity in the definition of terms defining schizophrenia. Newmark, Konanc, Simpson, Boren & Prillaman, *Predictive Validity of the Rorschach Prognostic Rating Scale with Schizophrenic Patients,* 167 J. NERVOUS & MENTAL DISEASE 135 (1979). The ultimate value of DSM-III awaits use and tests for reliability in the various categories, but recent studies continued to note the difficulty of defining schizophrenia or determining appropriate diagnostic criteria. *See, e.g.,* Newark, et al., *MMPI Criteria for Diagnosing Schizophrenia,* 42 J. PERSONALITY ASSESSMENT 366 (1978); Newmark, et al., *The Discriminative Value of the Whitaker Index of Schizophrenic Thinking,* 42 J. PERSONALITY ASSESSMENT 636 (1978); Reade & Wertheimer, *A Bias in the Diagnosis of Schizophrenia,* 44 J. CONSULTING & CLINICAL PSYCHOLOGY 878 (1976). Similarly, critical recent studies of depression have been available. *See, e.g.,* Endicott & Spitzer, *Use of the Research Diagnostic Criteria and the Schedule for Affective Disorders and Schizophreia to Study Affective Disorders,* 136 AM. J. PSYCHIATRY 52 (1979); Hirschfield & Klerman, *Personality Attributes and Affective Disorders,* 136 AM. J. PSYCHIATRY 67 (1979); Klerman, Endicott, Spitzer, & Hirschfield, *Neurotic Depressions: A Systematic Analysis of Multiple Criteria and Meanings,* 136 AM. J. PSYCHIATRY 57 (1979); Owens & Maxmon, *Mood and Affect: A Semantic Confusion,* 136 AM. J. PSYCHIATRY 97 (1979); Winokur, Behar, Vanvalkenburg & Lowry, *Is a Familial Definition of Depression Both Feasible and Valid?,* 166 J. NERVOUS & MENTAL DISEASE 764 (1978).

ill."

The proposed definition should reduce inappropriate use of the mental health system by emphasizing substantial mental impairments, while excluding civil commitment for conditions such a retardation, developmental disability, intoxication, substance dependence, and addiction. The civil commitment process will be more efficient once mental illness is more narrowly and appropriately defined.

Definition of "Likely to Injure Himself"

Currently, there is no statutory definition in Florida for "likely to injure himself." The Florida Supreme Court stated in *In re Beverly:* "In order to conclude that the person is likely to injure himself. . ., the judge must conclude that there is such a threat of harm as to comprehend the positive infliction of injury. . . ."[26]

The proposed definition is as follows:

> "Likely to injure himself" means that it is more likely than not that in the near future the person will attempt to commit suicide or inflict serious bodily harm upon himself by violent or other actively self-destructive means, as evidenced by behavior causing or attempting the infliction of serious bodily harm upon himself within twenty days prior to the initiation of the proceeding.

This definition, another part of the criteria for involuntary commitment, incorporates provisions requiring a showing of recent, overt, self-injurious behavior.

With "likely to injure himself" now statutorily undefined in the Baker Act, mental health professionals are left with the uncomfortable and inappropriate discretion to do something they *cannot* do: accurately and consistently predict dangerousness to self. Mental health professionals predict dangerousness to self much more frequently than self-injury actually occurs. One study indicated that psychiatric predictions of suicide would produce five erroneous commitments for every person who might actually commit suicide.[27] Another researcher con-

26. *In re* Beverly, 342 So. 2d at 487.

27. Greenland, *Evaluation of Violence and Dangerous Behavior Associated with Mental Illness,* 3 SEMINARS IN PSYCHIATRY 345, 354 (1971). *See generally* Under-

cluded that highly accurate predictive tools are not even available for such supposedly high risk populations as suicide attempters.[28]

The base rate for suicide is extremely low. Despite what one might think from the media's portrayal, only about one percent of people attempting suicide actually succeed in killing themselves within one year of the attempt.[29] Identifying and helping the truly suicidal present many problems. It has been proposed that a mental health professional who could correctly identify four out of five potential suicides would possibly erroneously hopitalize five individuals for every person who might actually kill himself.[30]

The inability to predict suicide, and especially the broader behavior of self-injuriousness, is further complicated by the following considerations. Suicide is not necessarily a mentally disordered act. Suicide may be an appropriate response to such circumstances as terminal illness, the loss of a loved one or extreme degradation. Thus, suicide can be the product of conscious, rational decision-making, and may even correlate with "mental health."[31] "Mental health professionals usually cannot judge the rationality of a suicide attempt on any medical or objective scale. They must rely, instead on their own subjective deter-

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wood, *Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment,* 88 YALE L.J. 1408 (1979).

28. Murphy, *Clinical Identification of Suicidal Risk,* 27 ARCHIVES GENERAL PSYCHIATRY 356, 357 (1972).

29. Greenberg, *Involuntary Psychiatric Commitments to Prevent Suicide,* 49 N.Y.U.L. REV. 227, 239 (1974) and literature reviewed in *Id.* at 237-40.

30. *Id.* at 259-62 where Greenberg developed the following example. In a hypothetical medium sized city where 1,000 people survive a suicide attempt, ten will kill themselves within the following year. If mental health profesionals were 80% efficient in predicting suicide (80% correctly identified as suicides and nonsuicides, 20% misidentified), eight of the ten suicides will have been accurately identified, and only two of the 794 [80% of (1000 minus eight)] predicted non-suicides will suicide. However, only eight of the 206 (1000 minus 794) predicted suicides will suicide (4% accuracy). This means that for every one person (4%) who will suicide committed as dangerous to self, 24 people will be erroneously committed; for every ten truly suicidal persons correctly committed, 240 persons who would not suicide will be committed. In order for all surviving suicide attempters to be appropriately at liberty, the prediction decisions of mental health professionals should be 99% efficient because only one percent of suicide attempters actually kill themselves within a year of the attempt.

31. *Id.* at 234-36 n.46; Note, *Developments in the Law: Civil Commitment of the Mentally Ill,* 87 HARV. L. REV. 1190, 1227 n.141 (1974).

mination of normal and abnormal responses to events, a function for which they are not specially qualified by training or experience."[32] Except for obvious cases like slashed wrists, distinguishing suicidal behavior from other potentially self-destructive behavior is difficult. Smoking cigarettes, racing cars or climbing mountains does not result in involuntary commitment, yet such behavior may be quite hazardous to self. Supreme Court Justice Robert Jackson was told in 1954 that a return to the Court following a heart attack would kill him. When he died five days after returning to the bench, his choice was praised.[33]

Unless Florida is prepared to engage in preventive detention for alleged suicides, which would further exacerbate at enormous cost Florida's already high per capita rate of confinement, the statutory definition for "likely to injure himself" should require recent, overt, self-injurious behavior. The reported suicide rate for the United States in 1974 was one out of every 8500 persons.[34] On the other hand, of those who attempt suicide, the death rate reported has varied from one in seventy to one in fifty.[35] The recent overt behavior requirement will at least reduce the extent to which the current civil commitment system inefficiently and unsuccessfully engages in pure speculation.

An argument can be made that the recent overt behavior requirement should not apply for continued involuntary commitments because of the alleged "masking" effect.[36] "Masking" is the artificial suppression of violence accomplished by a controlled institutional environment. A short time period, e.g., twenty days within which overt behavior must have occurred, enhances the validity of a dangerousness prediction; the shorter the time period, the more accurate the prediction, and the greater the reduction of erroneous and inappropriate commitments. This benefit should be weighed against the nominal impact of any so-called "masking effect." In the California experience, by permitting no

32. B. ENNIS & R. EMERY, THE RIGHTS OF MENTAL PATIENTS 51 (1978).

33. In Memoriam Mr. Justice Jackson, 349 U.S. XXVII, XXVIII-XXIX (1951).

34. 2 MENTAL DISABILITY L. REP. at 87.

35. Tuckman & Youngman, *Identifying Suicide Risk Groups Among Attempted Suicides*, 78 PUB. HEALTH REPS. 763 (1963).

36. *See* People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978)(en banc); Scopes v. Shah, 59 A.D.2d 203, 398 N.Y.S.2d 911 (App. Div. 1977). These cases are critiqued in a letter from Robert Pass to Winsor Schmidt (Sept. 25, 1980).

more than two 14-day periods of involuntary commitment for suicidals, fewer than one percent over a two-year period required the second 14-day period, with none of them suiciding. This compares with a suicide rate of three percent within six months for those committed for longer periods under the previous statute.[37] If commitment of suicidals "masks" anything, it may mask the possible harm of commitment to suicidals.

The requirement of recent, overt, self-injurious behavior in the definition for "likely to injure himself" will effect statutorily what is already constitutionally required by many courts[38] and widely endorsed by commentators.[39] The proposed definition will also reduce inappropriate and potentially harmful commitments and should enhance the

37. *See* ENKI, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-71) 152 (1972). Indeed, long periods of commitment may increase the rate of suicide rather than decrease it. *See* Greenberg, *supra* note 29, at 236, 250, 256-59; Light, *Treating Suicide: The Illusions of a Professional Movement,* 25 INT'L SOC. SCI. J. 475, 482-84 (1973); Pokorny, *Myths About Suicide,* SUICIDAL BEHAVIOR: DIAGNOSIS AND MANAGEMENT (H. Resnick ed. 1968).

38. *See* Gross v. Pomerleau, 465 F. Supp. 1167, 1173 (D. Md. 1979); Bension v. Meredith, 455 F. Supp. 662, 673 (D.D.C. 1978); Suzuki v. Alba, 438 F. Supp. 1106, 1110 (D. Hawaii 1977); Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976); Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974); Bell v. Wayne County Gen. Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated,* 414 U.S. 473 (1974), *on remand,* 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated,* 421 U.S. 957 (1975), *on remand,* 413 F. Supp. 1318 (E.D. Wis. 1976); Finken v. Roop, 233 Pa. Super. 762, 339 A.2d 764 (1975), *cert. denied,* 424 U.S. 960 (1976).

But see United States *ex rel.* Matthew v. Nelson, 461 F. Supp. 707 (N.D. Ill. 1978); People v. Sansone, 18 Ill. App. 3d 515, 309 N.E. 733 (1974).

39. *See, e.g.,* Elkins, *Legal Representation of the Mentally Ill,* 82 W. VA. L. REV. 157, 205 (1979)(even an overt act is not enough without further explanation and circumstances); Elliott, *Procedures for Involuntary Commitment on the Basis of Alleged Mental Illness,* 42 U. COLO. L. REV. 231 (1970); Griffith & Griffith, *Duty to Third Parties, Dangerousness, and the Right to Refuse Treatment: Problematic Concepts for Psychiatrist and Lawyer,* 14 CAL. W.L. REV. 241 (1978); Keiter, *supra* note 19, at 161-62; Note, *supra* note 19, at 1376, 1384, 1431 (because of inaccuracy in predicting dangerousness, the entire dangerousness standard from the Suggested Statute on Civil Commitment is recommended, including the requirement of a recent overt act within the past 20 days); Note, *Standards for Involuntary Civil Commitment in Pennsylvania,* 38 U. PITT. L. REV. 535 (1977). *But see, e.g.,* Tanay, *Law and the Mentally Ill,* 22 WAYNE L. REV. 781 (1976).

treatment of persons who are likely to injure themselves.

Definition of "Likely to Injure Others"

Florida's present statute does not define the term "likely to injure others." The Florida Supreme Court attempted to fill the gap in *In re Beverly:* "In order to conclude that the person is likely to injure . . . others, the judge must conclude that there is such a threat of harm as to comprehend the positive infliction of injury. . . ."[40]

The proposed definition is as follows:

> "Likely to injure others" means that it is more likely than not that in the near future the person will inflict serious, unjustified bodily harm on another person, as evidenced by behavior causing, attempting or threatening such harm, including at least one incidence thereof within twenty days prior to the initiation of the proceeding.

This definition for the police power criterion in civil commitment incorporates provisions requiring a showing of recent, overt, dangerous behavior to others.

Just as mental health professionals are unable to accurately and consistently predict suicidal behavior, so too, are they unable to predict behavior that injures others. Psychiatrists overpredict violence; "for every correct psychiatric prediction of violence, there are numerous erroneous predictions."[41] Pressure from the legal system is perceived as too great for mental health professionals to do other than the "safe" thing, i.e., predict dangerousness.[42]

A dramatic illustration of the invalidity of predictions of violence occurred in the aftermath of the United States Surpeme Court decision

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40. *In re* Beverly, 342 So. 2d at 487. The Florida Supreme Court elaborates: "Ordinarily, this would refer to physical injury, but the judge may very well conclude that the person is likely to inflict emotional injury to another. The statute contemplates the latter as well as the former." *Id.*

41. Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways,* 2 PHYCHIATRY TODAY 43 (Feb. 1969)(reviews existing prediction studies).

42. Diamond, *The Psychiatric Prediction of Dangerousness,* 123 U. PA. L. REV. 439, 447 (1974).

in *Baxstrom v. Herold*,[43] regarding New York's maximum security forensic hospitals. The 969 allegedly "dangerous" mentally ill (criminally insane) persons, detained in forensic facilities after expiration of their prison terms, were ordered released or committed to civil facilities because the holdover detention was a constitutional violation. Despite the original psychiatric determinations that inmates were mentally ill and too dangerous to be released or even transferred to a civil hospital, one year after the Supreme Court's order, 702 were in civil hospitals posing no problems to the staff, 147 had been discharged into the community, and only seven had to be returned to the forensic facility.[44] Several years later, 27% were living in the community, two were convicted of felonies, seven of misdemeanors, and three percent were in maximum security institutions.[45]

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43. 383 U.S. 107 (1966).

44. Hunt & Wiley, *Operation Baxstrom After One Year*, 124 AM. J. PSYCHIATRY 974, 976 (1968). The balance consisted of deaths (24), transfers (10), convalescents (62), and miscellaneous (24).

45. Steadman & Keveles, *The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-1970*, 129 AM. J. PSYCHIATRY 304, 309 (1972).

A very similar experience ocurred in Pennsylvnia. *See* Dixon v. Attorney Gen., 325 F. Supp. 966 (M.D. Pa. 1971); T. THORNBERRY & J. JACOBY, THE CRIMINALLY INSANE: A COMMUNITY FOLLOW-UP OF MENTALLY ILL OFFENDERS (1977) (only fourteen percent of 438 released "mentally disordered offenders" engaged in injurious behaviors within four years of release). *See also* Cocozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976); Cocozza & Steadman, *Some Refinements in the Measurement and Prediction of Dangerous Behavior*, 131 AM. J. PSYCHIATRY 1012, 1013-14 (1976); Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972); Steadman, *A New Look at Recidivism among Patuxent Inmates*, 5 BULL. AM. ACAD. PSYCHIATRY & L. 200 (1977).

In reassessing their Baxstrom reasearch, Cocozza and Steadman suggested the generalizability of their results to contemporary patient populations could be limited because of the high average age (47) and mean length of continuous institutionalization (almost 15 years) of the *Baxtrom* group, and because their retention in institutions for the criminally insane could have been the result of administrative inertia or discretion rather than dangerousness. Cocozza & Steadman, *supra* at 1093-94. However, Cocozza and Steadman concluded elsewhere that incorporating age variables yielded a false positive ratio of two to one and "if we were to attempt to use this information for statistically predicting dangerous behavior our best strategy would still be to predict that none of the patients would be dangerous." Cocozza & Steadman, *supra* at 1013-14.

In short, the psychiatrists "lacked the ability properly to diagnose dangerous mental illness and to determine the necessity for maximum security confinement."[46] Mr. Chief Justice Burger concluded: "There can be little responsible debate regarding 'the uncertainty of diagnosis in this field and the tentativeness of professional judgment.' "[47] Reliance upon mental health professional's predictions of dangerousness results in commitment of several nondangerous persons for every truly harmful person,[48] a minimum overcommitment of several hundred percent.

Courts now hold that a better approach to the police power criterion for civil commitment is to require findings of specific violent behavior rather than to rely solely on a medical assessment of dangerousness.[49] Many state civil commitment statutes also require additional

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Monahan weathered the bureaucratic inertia suggestion by concluding: "It is not an acceptable retort to the research for psychiatrists and psychologists to say, after the fact, that they did not really believe the patients to be violent. If bureaucratic pressure influences prediction, then that pressure is part of the social reality that should be empirically studied." J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 51 (1981). Following his extensive review of the dangerousness prediction literature, Monahan concluded: "It may be that short-term 'emergency' predictions in a person's normal environment generate more accurate estimates of violent behavior." *Id.* at 60. However, a "judicious assessment of the research to date is that *we know very little about how accurately violent behavior may be predicted under many circumstances.*" *Id.* at 15 (emphasis in original).

46. Morris, *Criminality and the Right to Treatment,* 36 U. CHI. L. REV. 784, 796 (1969).

47. O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (citing Greenwood v. United States, 350 U.S. at 375 and Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom,* 62 CAL. L. REV. 693, 697-719 (1974)). *See* Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness,* 18 CRIME AND DELINQUENCY 371, 390-91 (1972); Wenck, Robison & Smith, *Can Violence be Predicted?,* 18 CRIME & DELINQ. 393, 395-96 (1972).

48. A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 27-33 (1975); Diamond, *supra* note 42; Laves, *The Prediction of Dangerousness as a Criterion for Involuntary Civil Commitment: Constitutional Considerations,* 3 J. PSYCHIATRY & L. 291 (1975); AMERICAN PSYCIATRIC ASSOCIATION, TASK FORCE REPORT 8: CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 23-28 (1975).

49. *See* Gross v. Pomerleau, 465 F. Supp. at 1173; Bension v. Meredith, 455 F. Supp. at 672; Stamus v. Leonhardt, 414 F. Supp. at 453; Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378; Finken v. Roop, 233 Pa. Super. 762, 339 A.2d 764. (1975), *cert denied,* 424 U.S. 960 (1976).

factual information to reduce the unfairness and speculation in involuntary commitment for dangerousness.[50] The accuracy and imminence of predicted dangerousness is enhanced by requiring, as suggested in the proposed definition, evidence of recent behavior that causes, attempts, or threatens infliction of "serious, unjustified bodily harm on another person." As noted above,[51] the recent overt act requirement mirrors current legal trends.[52]

Definition of "Lacks Sufficient Capacity to Make a Reasonable Application On His Own Behalf"

Before the Baker Act was amended in 1979, the criteria for involuntary hospitalization included mental illness and either 1) likelihood of injuring self or others, or 2) need for care or treatment and lack of sufficient capacity to make a responsible application for treatment.[53] The "need for care and treatment and lacking capacity" provision, challenged as unconstitutionally vague, was upheld by the Florida Supreme Court in *In re Beverly* by incorporating the following judicial criteria:

> If the person is non-dangerous, the judge must conclude that he is in need of care and treatment and lacks sufficient capacity to make a responsible application on his own behalf. A mere conclusion that the person is "in need of care and treatment" is insufficient. The judge must further conclude that such person "lacks sufficient capacity to act for himself."
>
> If the judge concludes that the mental illness manifests itself in neglect or refusal to care for himself, that such neglect or refusal poses a real and present threat of substantial harm to his well-being, *and that he is incompetent to determine for himself whether treatment for his mental illness would be desirable,* then the criteria of the statute have been met.
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> However, even though the other criteria are met, *a nondangerous individual who is capable of surviving safely in free-*

50. *See* 3 MENTAL DISABILITY L. REP. 206-14 (1978).

51. *Supra* note 38 and text accompanying notes 36-37.

52. *E.g.,* Doremus v. Farrell, 407 F. Supp. at 517; Lynch v. Baxley, 386 F. Supp. at 391; Finken v. Roop, 233 Pa. Super. 762, 339 A.2d 764.

53. FLA. STAT. §§ 394.467(1)(a)-(b) (1977).

> *dom by himself or with the help of willing and responsible family members or friends should never be hospitalized involuntarily.*[54]

Most of the third paragraph is verbatim from the decision of the United States Supreme Court in *O'Connor* v. *Donaldson.*[55]

The 1979 amendments to the Baker Act removed the "lacks sufficient capacity" language from the statutory criteria, and replaced it with *some* of the language from *Beverly*: "In need of care and treatment *which, if not provided, may result in neglect or refusal to care for himself, and such neglect or refusal poses a real and present threat of substantial harm to his well being.*"[56]

The problem with the 1979 revision is its failure to incorporate all of the criteria required by the Florida Supreme Court. There was no provision, for example, that the person be "incompetent to determine for himself whether treatment for his mental illness would be desirable."[57] The changes proposed here restore the "lacks sufficient capacity to make a reasonable application on his own behalf" language required by the Florida Supreme Court, and provide a statutory definition for this *parens patriae* commitment criterion. The suggested definition is as follows:

> "Lacks sufficient capacity to make a reasonable application on his own behalf" means the person's inability, by reason of mental condition, to achieve a rudimentary understanding, after conscientious efforts at explanation, of the purpose, nature or possible significant benefits of treatment; provided that a person shall be deemed incapable of understanding the purpose of treatment if, due to impaired mental ability to perceive reality, he cannot realize that he has recently engaged in behavior likely to injure himself or others; and provided further that a person shall be deemed to lack sufficient capacity if his reason for refusing treatment is expressly

54. *In re* Beverly, 342 So. 2d at 487 (emphasis added).

55. O'Connor v. Donaldson, 422 U.S. at 576: "In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

56. *See* FLA. STAT. § 394.463(2)(a)(2) and § 394.467(1)(b)(2) (1979) (emphasis added).

57. 342 So. 2d at 487.

based on either the belief that he is unworthy of treatment or the desire to destroy, harm or punish himself.

This definition specifies objective standards relating to an individual's mental functioning.[58] It appropriately focuses on the individual's ability to understand the purpose, nature and benefits of treatment.[59] The definition provides for a finding of incapacity when an individual believes himself unworthy of treatment, or expressly desires to be self-destructive.

As suggested by *Beverly*, a finding of incapacity should be a constitutional pre-condition for acceptable *parens patriae* commitments,[60] i.e., commitments based on the authority to protect individuals who cannot act for themselves.[61] Because civil commitment results in loss of individual liberty, "due process requires that the nature . . . of commitment bear some reasonable relation to the purpose for which the individual is committed."[62] The compelling state interest for *parens patriae* commitment is to provide mental health care for individuals who cannot address their own mental health needs. Because many mentally ill persons are as capable of making their own hospitalization decisions as physically ill persons,[63] due process requires a finding of individual incapacity or incompetence before a mentally ill person can be hospitalized involuntarily.

The individual's interest in freedom from inappropriate *parens patriae* commitment is bolstered by the constitutional right to privacy and

58. For a more specific explanation, *see* 2 MENTAL DISABILITY L. REP. AT 91-93.

59. Halleck, *Legal and Ethical Aspects of Behavior Control*, 131 AM. J. PSYCHIATRY 381 (1974).

60. *See* 2 MENTAL DISABILITY L. REP. at 90.

61. Hawaii v. Standard Oil Co., 405 U.S. 251, 257 (1972). *See generally* Coleman & Solomon, *Parens Patriae "Treatment": Legal Punishment in Disguise*, 3 HASTINGS CONST. L.Q. 345 (1976); Curtis, *The Checkered Career of Parens Patriae: The State as Parent or Tyrant?*, 25 DEPAUL L. REV. 895 (1976); Custer, *The Origins of the Doctrine of "Parens Patriae,"* 27 EMORY L.J. 195 (1978) (*parens patriae* jurisdiction, which came to be vested in courts of equity, is based on "a logical but incorrect restatement of a misprinted precedent"); Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 MO. L. REV. 215 (1975).

62. Jackson v. Indiana, 406 U.S. 715, 738 (1972).

63. *See, e.g.*, Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 88-89 (1968).

autonomy.[64] The Florida Constitution states: "Right of Privacy—every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein. . . ."[65]

A number of courts have already recognized that the mentally ill person, like the physically ill person, must be allowed to decide whether to seek hospitalization, unless the state can show his inability to make such a decision because of the illness.[66] Other courts have relied on the reasoning and language of *O'Connor* v. *Donaldson*[67] to find unconstitutional state laws based only on the *parens patriae* authority.[68] Several courts have either eliminated *parens patriae* as a rationale for involuntary commitment or found the *parens patriae* standard so vague and unreviewable as to violate due process.[69]

The proposed definition for "lacks sufficient capacity" salvages the constitutionality of the *parens patriae* criterion for involuntary commitment and provides more objective standards for assessing such competency.[70]

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64. *See, e.g.,* Roe v. Wade, 410 U.S. 113, 153 (1973) (right to terminate pregnancy); Griswold v. Connecticut, 381 U.S. 479 (1965) (right to contraception in the privacy of the home); *In re* Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976) (right to decline medical treatment under certain circumstances).

65. FLA. CONST. art. 1, § 23.

66. *In re* Ballay, 482 F.2d 648 (D.C. Cir. 1973); Winters v. Miller, 446 F.2d 65, 68 (2d Cir. 1971), *cert. denied,* 404 U.S. 985 (1971); Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424 (D. Utah 1979); Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974); Lessard v. Schmidt, 349 F. Supp. 1978 (E.D. Wis. 1972).

67. 422 U.S. at 575-76.

68. *E.g.,* Goldy v. Beal, 429 F. Supp. 640 (M.D. Pa. 1976); Stamus v. Leonard, 414 F. Supp. 439 (S.D. Iowa 1976); Finken v. Roop, 233 Pa. Super. 762, 339 A.2d 764 (1975).

69. *E.g.,* Kendall v. True, 391 F. Supp. 413 (W.D. Ky. 1975); Bell v. Wayne County Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974); Hawks v. Lazaro, 157 W. Va. 417, 202 S.E.2d 109 (1974); *In re* Levias, 83 Wash. 2d 253, 517 P.2d 588 (1973); *In re* Quesnell, 83 Wash. 2d 224, 517 P.2d 568 (1973).

70. *See* Note, *supra* note 19, at 1429 (specifically recommending the adoption of this suggested incapacity standard).

Payment for Care of Involuntary Patients

Florida currently allows the Department of Health and Rehabilitative Services to require involuntary patients, their spouses, parents of involuntarily committed children, and third party payors to participate in the cost of services or to pay fees for services, even if the services are unwanted.[71] This creates a financial incentive for public mental institutions to admit involuntary patients and to retain them longer than might otherwise be necessary. Requiring maintenance fees for involuntary patients places public mental institutions in a conflict of interests between expeditious treatment and discharge on one hand, and economic reward for holding involuntary patients on the other. The practice is a financial disincentive to high quality and low cost mental health care. Furthermore, facilities are thus discouraged from competing with each other.

The suggested amendment to section 394.457(7) is as follows:

> (7) PAYMENT FOR CARE OF PATIENTS.—Fees and fee collections for patients in treatment facilities shall be according to s. 402.33, except that no person evaluated, detained, committed or treated involuntarily pursuant to the provisions of this part, or parents or spouse of the person, or third party payor, shall be required to participate in the costs or to pay fees incurred for their evaluation, treatment, care, maintenance or custody pursuant to this part; provided that if, upon the patient's request the patient is placed in any private facility, the patient shall bear the expense of the patient's care, maintenance and treatment at such facility.

This amendment codifies the right of involuntarily committed patients not to pay the costs of unwanted services through their families or third party payors. There is already some legal support for the proposition that involuntary patients should not be required to pay for unwanted services.[72] While, the state might argue that treatment of invol-

71. FLA. STAT. § 394.457(7) & § 402.33 (1979).

72. *See, e.g.,* McAuliffe v. Carlson, 377 F. Supp. 896 (D. Conn. 1974), 386 F. Supp. 1245 (D. Conn. 1974), *rev'd on other grounds,* 520 F.2d 1305 (2d Cir. 1975); Department of Mental Hygiene v. Kirchner, 60 Cal. 2d 716, 388 P.2d 720, 36 Cal. Rptr. 488 (1964); Department of Mental Hygiene v. Holey, 59 Cal. 2d 247, 379 P.2d 22, 28 Cal. Rptr. 718 (1963); Department of Mental Hygiene v. Bank of America, 3

untary patients results in an implied contract with unjust enrichment of the involuntary patient; this theory is unlikely to succeed.[73] The double-taxation aspects of requiring involuntary patients to pay for state mandated treatment is a more viable argument against such payments.[74]

Policy objections to requiring involuntary patients to pay for care they do not request, include: maintenance fees extracted from involuntary patients are not always expended for purposes of their mental health; enforcement frequently requires those with very little to support those with even less (rather than a rich relative supporting a poor one); enforcement creates breaches and rifts in family relationships; and enforcement can deplete and exhaust resources that could finance discharge followed by a less restrictive alternative placement, thus perpetuating dependence and prolonged involuntary hospitalization.[75]

Right to Treatment Plan

While a constitutional right to treatment has not been recognized by the United States Supreme Court,[76] Florida does provide a "statu-

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Cal. App. 3d 949, 83 Cal. Rptr. 559 (1969); Miller v. State Dep't of Treasury (Revenue Div.), 385 Mich. 296, 188 N.W.2d 795 (1971); Boldt v. State, 98 Wis. 2d 445, 297 N.W.2d 29 (Wis. App. 1980) (state has no claim for support from social security benefits of a person held incompetent to stand trial in mental institution pursuant only to pending criminal charge); Comment, *Compulsory Contribution to Support of State Mental Patients Held Deprivation of Equal Protection,* 39 N.Y.U.L. REV. 858 (1964); Annot., 20 A.L.R.3d 363 (1968) (discusses attack theories of class legislation, double taxation, impairments of the obligations of contracts, taking of property without just compensation, undue delegation of legislative power to administrators, and defective title).

But cf. Fayle v. Stapley, 607 F.2d 858 (9th Cir. 1979) (not unreasonable to require contribution from criminally insane person); Ivory v. Wainwright, 393 So. 2d 542 (Fla. 1980) (upholding prisoner pay law); *In re* Nelson, 98 Wis. 2d 261, 296 N.W.2d 736 (1980) (payment for care upheld for acquittee by reason of mental disease); Op. Atty. Gen., 074-271 (Fla., Sept. 6, 1974) (patient may be involuntarily committed to private facility if the cost is born by the patient or guardian).

73. *See* B. ENNIS & R. EMERY, *supra* note 32, at 156-58.

74. *See, e.g., id.* at 158; Annot., *supra* note 72, at 378.

75. *See* A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 935 (1974).

76. *See O'Connor,* 422 U.S. at 573 ("there is not reason now to decide whether mentally ill persons dangerous to themselves or to others have a right to treatment

tory right to receive individual treatment."[77] The scope of the required treatment is not clear, however. The current statute merely provides that no one shall have mental health treatment denied or delayed, that the least restrictive available treatment shall be utilized, and that a physical examination must be given within twenty-four hours of admission.[78]

The suggested amendment to section 394.459(2) is as follows:

> (d) Not more than 5 days after the beginning of treatment, each patient shall have and receive an individualized treatment plan in writing that the patient has maximum opportunity to assist in preparing. Each plan shall contain at least:
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> 1. A statement of the specific problems and specific needs of the patient;
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> 2. A statement of intermediate and long-range objectives, with a projected timetable for their attainment;
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> 3. A statement and rationale for the plan of treatment for achieving these objectives;
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> 4. A statement of the least restrictive treatment conditions necessary to achieve the purposes of placement;
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> 5. A specification of treatment staff responsibility and a

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upon compulsory confinement by the State"). *Id.* at 577-78 n.12 (Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), finding a constitutional right to treatment, vacated; "deprives that court's opinion of precedential effect, leaving this Court's opinion and judgment as the sole law of the case"); Pennhurst State School v. Halderman, 451 U.S. 1, 16 n.12 (1981) ("this Court has never found that the involuntarily committed have a constitutional 'right to treatment'. . ."); Morales v. Turman, 562 F.2d 933 (5th Cir. 1977).

But cf. Burnham v. Department of Mental Health, 349 F. Supp. 1335 (N.D. Ga. 1972) (no constitutional right to treatment), *rev'd*, 503 F.2d 1319 (5th Cir. 1974) (citing Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) and *Donaldson*, 493 F.2d 507). *See also* Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980), *vacated*, 50 U.S.L.W. 4681 (June 18, 1982) (persons involuntarily committed to state institutions for the mentally retarded have due process rights to: conditions of reasonable care and safety, freedom from unreasonable bodily restraint, and "such training as an appropriate professional would consider reasonable to ensure [the patient's] safety and to facilitate [the patient's] ability to function free from bodily restraints." *Id.* at 4683).

77. *O'Connor*, 422 U.S. at 566-67 n.2; FLA. STAT. § 394.459(2) (1981).

78. *See* Wyatt v. Stickney, 325 F. Supp. 781, *enforced* 334 F. Supp. 1341, 1343-44 (1971), *supplemented* Wyatt v. Stickney, 344 F. Supp. 373, 384 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

description of proposed staff involvement with the patient in order to attain the objectives;

6. Criteria for release to less restrictive treatment conditions;

7. The additional disclosure information required in s. 394.459 (3)(a).

The requirement for individualized treatment plans and their elements are taken from federal court decisions in Alabama and the fifth circuit. Individualized treatment plans are one of the three fundamental conditions (along with a humane psychological and physical environment, and sufficient numbers of qualified staff) for minimally adequate treatment in public mental institutions. This does not involve legislative prescription of treatment, but rather identifies and specifies a condition without which treatment cannot possibly occur.

This amendment would not appear to be unnecessary since these elements are already prescribed by judicial decision. However, some institution staff do not know the elements of a treatment plan, or its significance; thus this amendment would facilitate *implementation* of each patient's statutory right to treatment for mental illness.[79]

Definition of "Safety Justifying Emergency Treatment"

Regarding the right to express and informed consent, Florida's statute until recently provided that treatment "may" be rendered a patient, who refuses treatment and is not discharged, "on an emergency basis, upon the written order of a mental health professional when such mental health professional determines treatment is necessary for the safety of the patient or others."[80] Treatment without consent was only authorized when an emergency jeopardized the safety of the patient or others. This section was recently held to be unconstitutional.[81]

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79. *See also* W. SCHMIDT, THE RIGHT TO TREATMENT IN MENTAL HEALTH LAW (Nat'l A. of Att'y Gen. 1976); Spece, *Justifying Invigorated Scrutiny and the Least Restrictive Alternative As a Superior Form of Intermediate Review: Civil Commitment and the Right to Treatment as a Case Study,* 21 ARIZ. L. REV. 1049 (1979); Spece, *Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories,* 20 ARIZ. L. REV. 1 (1978).

80. FLA. STAT. § 394.459(3)(a) (1981).

81. FLA. STAT. § 394.459(3)(a) and § 394.467(4)(h) have been declared uncon-

The suggested amendment would add the following language:

"Safety is jeopardized only by a situation threatening death or serious bodily harm."

It is elementary tort law, according to Prosser quoting Mr. Justice Holmes, that " '[t]he absence of lawful consent is part of the definition of an assault.' "[82] Consent can be implied "in an emergency which threatens death or serious bodily harm, [but] the mere desirability of treatment cannot justify. . .going ahead without the consent of the patient, or at least that of a near relative."[83] Furthermore, "[i]f the plaintiff is known to be incapable of giving consent because of. . .mental incompetence, his failure to object, or even his active manifestation of consent will not protect the defendant."[84]

The Department of Health and Rehabilitative Services nevertheless changed the presumably clear legislative intent regarding the right to consent by defining "safety" as "the physical and emotional well being of an individual separate and apart from threat or violence, either physical or verbal."[85] There is little direct authority to justify "emotional well being" as a definition for "safety." The most recent substantial definition of that word consists of a remand by the United

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stitutional because they allowed hearing examiners to make the judicial decision regarding competence to consent to treatment during recommitment hearings in violation of FLA. CONST. art. 5, § 20(c)(3). Bentley v. State *ex rel.* Rogers, 398 So. 2d 992 (Fla. 4th Dist. Ct. App. 1981). Section 20(c)(3) gives the circuit courts jurisdiction over proceedings relating to "guardianship, involuntary hospitalization, the determination of incompetency." (By similar reasoning, the provisions allowing hearing examiner jurisdiction over continued involuntary hospitalization should also be unconstitutional).

The 1982 legislature addressed the problem identified by *Bentley* through passage of CS/HB 665 which changed "hearing examiner" to "court" in section 394. 459(3)(a), and provided that the hearing examiner may issue a recommended order to the court regarding incompetence to consent to treatment in section 394. 467(4)(h).

The decision in *Bentley* and the legislative activity occurred while this article was being written. The proposal here regarding the definition of "safety justifying emergency treatment" is otherwise viable.

82. W. PROSSER, LAW OF TORTS 102 (3d ed. 1964).

83. *Id.* at 104.

84. *Id.* at 103-04. *See also* Furrow, *Defective Mental Treatment: A Proposal for the Application of Strict Liability to Psychiatric Services,* 58 B.U.L. REV. 391 (1978).

85. FLA. ADMIN. CODE ch. 10E-5.09(10) (1977).

States Court of Appeals for the First Circuit "for consideration of alternative means for making incompetency determinations in [*parens patriae*] situations where any delay [in administration of antipsychotic drugs] could result in significant deterioration of the patient's mental health."[86] Even this decision held, for the police power situation, that first there must be procedures for ensuring that patient interests, such as side effects in refusing antipsychotics, are taken into consideration by a qualified physician; second, that forcible administration of antipsychotics does not occur absent findings that patient interests are outweighed by a need to prevent violence; and third, that less restrictive alternatives are unavailable.[87]

Other courts have defined "emergency" as a situation in which a physician certifies there has been "a sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital,"[88] or "where a patient presents a danger to himself or other members of society" (or is judicially declared incompetent).[89] An administrative bulletin of the New Jersey Division of Mental Health and Hospitals allowed emergency administration of medication "if a physician certifies that it is essential to administer psychotropic medication in order to prevent death or serious consequences to a patient."[90] The prior Florida law that was tracked in drafting 394.459(3)(a) provided for emergency surgical treatment only where it is deemed lifesaving, or following a mandatory adversarial hearing to determine the appropriateness of surgery.[91]

Notwithstanding some questions regarding procedures for implementing the right to consent,[92] the mental patient's constitutional right

86. Rogers v. Okin, 634 F.2d 650, 660 (1st Cir. 1980), *vacated,* 50 U.S.L.W. 4676 (U.S. June 18, 1982) (for consideration in light of *In re* Roe, 421 N.E.2d 40 (Mass. 1981). *But see* note 40 *supra.*

87. *Rogers,* 634 F.2d at 657.

88. Rennie v. Klein, 476 F. Supp. 1294, 1313 (D.N.J. 1979).

89. *In re* K.K.B., 609 P.2d 747, 750 (Okla. 1980).

90. *See* Rennie v. Klein, 462 F. Supp. 1131, 1149 (D.N.J. 1978).

91. FLA. STAT. § 394.459(3)(b) and (c) (1979).

92. *See* Bentley v. State *ex rel.* Rogers, 398 So. 2d 992 (Fla. 4th Dist. Ct. App. 1981). (FLA. STAT. § 394.459(3)(a) and § 394.467(4)(h) violate article 5, section 20(c)(3) of the Florida Constitution regarding circuit court jurisdiction over guardianship, involuntary hospitalization, the determination of incompetency.) By similar reasoning, the provisions allowing hearing examiner jurisdiction over continued involun-

to refuse intrusive treatment, such as the administration of psychotropic (antipsychotic) medication, is becoming recognized in Florida.[93] There are many legal bases for the right to consent to, and refuse, treatment: privacy and personal autonomy (including the ninth amendment);[94] first amendment protection of thought processes or religious beliefs; eighth amendment cruel and unusual punishment protection prohibiting use of drugs for control or aversive conditioning; procedural and substantive due process; equal protection; and using the least restrictive alternative.[95]

As noted by the Oklahoma Supreme Court: "There is no support in common law for the proposition that treatment, medical or psychiatric, constitutes a legally nonreversible medical decision. . . . In a society ruled by laws [rather than by individuals], social actions that infringe or control individual freedoms must be judged by legal

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tary hospitalization should also be unconstitutional.

93. *In re* Rewis, Case No. 80-2011B (Division of Administrative Hearings, Feb. 20, 1981) (citing Scott v. Plante, 532 F.2d 939, 946 (3rd Cir. 1976)); Davis v. Hubbard, 506 F. Supp. 915 (W.D. Ohio 1980); Rogers v. Okin, 478 F. Supp. 1342, 1360 (D. Mass. 1979), *rev'd in part on other grounds,* 634 F.2d 650 (1st Cir. 1980), *cert. granted,* 451 U.S. 906 (1981); Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978), *enforced,* 476 F. Supp. 1294 (D.N.J. 1979), *refusing stay,* 481 F. Supp. 552 (D.N.J. 1979) (appeal pending in the Third Circuit); *In re* K.K.B., 609 P.2d 747 (Okla. 1980); Geodecke v. Department of Insts., 198 Colo. 407, 603 P.2d 123 (1979) (en banc) (decided on basis of state law); Souder v. McGuire, 423 F. Supp. 830 (M.D. Pa. 1976); Price v. Sheppard, 307 Minn. 250, 239 N.W.2d 905 (1976); Kaimowitz v. Department of Mental Health, 1 MENTAL DISABILITY L. REP. 147, Case No. 73-18434-AW (Mich. Wayne Co. Cir. Ct. filed July 10, 1973).

94. *See, e.g.,* FLA. CONST. art. 1, § 23: "Right of Privacy—every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein."

95. *See generally* Dubose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?,* 60 MINN. L. REV. 1149 (1976); Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment,* 72 NW. L. REV. 461 (1977); Schwarz, *In the Name of Treatment: Autonomy, Civil Commitment, and the Right to Refuse Treatment,* 50 NOTRE DAME LAW. 808 (1975); Comment, *Madness and Medicine: The Forcible Administration of Psychotropic Drugs,* 1980 WIS. L. REV. 497; Comment, *Advances in Mental Health: A Case for the Right to Refuse Treatment,* 48 TEMP. L.Q. 354 (1975). *See also* Comment, *Brave New World Revisited: Fifteen Years of Chemical Sacraments,* 1980 WIS. L. REV. 879 (1980).

standards."[96] The American Pyschiatric Association has thus recognized the individual's right to refuse treatment:

> Except in emergencies, if a patient who is competent to participate in treatment decisions declines to accept treatment recommended by staff, we accept the patient's right to refuse. If the physician believes the patient is not competent to participate in treatment decisions, he should ask a court to rule on the patient's competency. If the patient is found not competent, an impartial third party, designated by the court, should be given the authority of consent.[97]

Many psychiatrists consider forced treatment to be unethical.[98]

The rule[99] promulgated by the Florida Department of Health and Rehabilitative Services flies in the face of this consensus, and the clear legislative intent.[100] The rule, if honored, makes the statutorily mandated right to express and informed consent meaningless. The rule requires treatment to occur with the label of "emergency treatment order" whenever there is refusal to consent by a patient, or refusal by the guardian or guardian advocate of an incompetent patient, or failure to discharge the refusing patient. The rule does not allow the refusal of treatment to be honored under any circumstances.

The suggested definition of "emergency" would further clarify legislative intent, and conform Florida's law to recent legal developments.

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96. *In re* K.K.B., 609 P.2d at 751.

97. *Id.* (citing AMERICAN PSYCHIATRIC ASSOCIATION, TASK FORCE ON THE RIGHT TO TREATMENT, THE RIGHT TO ADEQUATE CARE AND TREATMENT FOR THE MENTALLY ILL AND MENTALLY RETARDED 12 (Final Draft, May 8, 1975)). *But see In re* Roe, 421 N.E.2d 40 (Mass. Supp. Jud. Ct. 1981) (a court, not a third party, must determine what an incompetent patient living in the community would have preferred when competent before allowing the state to administer antipsychotic drugs; also, only the least restrictive of either involuntary confinement, or compulsory medication, may be used—not both).

98. Address by Lewis H. Gaughan, The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution, *Univ. of Richmond Law School* (March 6, 1978). *See* Gaughan & LaRue, *The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution,* 4 L. & PSYCHOLOGY REV. 43 (1978).

99. FLA. ADMIN. CODE ch. 10E-5.11(3)(b) (1977).

100. *Compare* FLA. STAT. § 394.459(3)(a) (declared unconstitutional, *see* note 81 *supra*).

Treating without consent an individual whose "emotional well being" is jeopardized is neither constitutionally nor therapeutically appropriate. "[I]t is universally recognized as fundamental to effective therapy that the patient acknowledge his illness and cooperate with those attempting to give treatment."[101] Forcibly drugging patients without consent is unacceptable in a society ruled by law.

Clinical Record: Confidentiality

The proposed amendment for Florida Statutes section 394.459(9) is underlined below:

> (9) CLINICAL RECORD: CONFIDENTIALITY. -
> A clinical record for each patient shall be maintained. The record shall include data pertaining to admission and such other information as may be required under rules of the department. Unless waived by express and informed consent by the patient or his guardian or attorney, the privileged and confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency. Notwithstanding s. 90.503(4)(b), no communication made by a patient to a mental health professional, including but not limited to a psychotherapist, may be used for any purpose other than a proceeding under this chapter. The clinical record shall not be a public record and no part of it shall be released, except:. . . .

Section 90.503(4)(b) is one of the exceptions to the psychotherapist-patient privilege. The exception provides that there is no psychotherapist-patient privilege for communications made during a court-ordered examination of a patient's mental condition.

The proposed amendment preserves the confidentiality and fifth amendment right of a person examined for his mental condition, including a court-ordered examination, not to be compelled to give evidence against himself in a criminal prosecution. With this amendment, disclosures to a mental health professional could only be used in proceedings under chapter 394.

A strong case can be made for generally affording the right to

101. *O'Connor*, 422 U.S. at 584.

remain silent to individuals in the civil commitment process.[102] An exception to the right can be made when refusal precludes the presentation of evidence regarding treatability and capacity to make informed decisions concerning treatment. Some courts disagree,[103] but other courts apply the privilege against self-incrimination to involuntary civil commitment proceedings.[104]

The Florida Supreme Court decided that the psychotherapist-patient privilege provision[105] of the old evidence code did *not* apply to testimony of the examining physician where the patient was previously warned that communications would *not* be privileged.[106] Florida's new

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102. 2 MENTAL DISABILITY L. REP. at 101-04 (applicability of the fifth amendment to civil commitment proceedings and the right to remain silent as a due process requirement); sources in note 12 *supra.*

A person in the custody of the police is warned that he or she has a right to remain silent because of the probability of indirect or subtle coercion to make a statement. Hospital custody in civil commitment is at least as coercive as police custody because: (1) involuntary mental patients are deprived of liberty and segregated from friends and family; (2) the person is in an unfamiliar hospital environment at a time of greatest depression or agitation; (3) patients do *not* have a right to bail and are dependent upon hospital staff discretion for discharge; (4) patients do *not* get an attorney within a matter of hours; (5) patients may *not* be as mentally capable of protecting their interests as persons accused of crime; (6) patients receive treatments that can lessen their ability to remain silent or resist coercive confinement measures; (7) mental health professionals act as both therapist and agent of the state, whereas police have a clear adversarial role to persons in custody; and (8) mental health professionals are probably more experienced and adept at eliciting information than police officers. B. ENNIS & R. EMERY, *supra* note 32, at 75. *Cf.* Estelle v. Smith, 450 U.S. 929 (1981) (prosecution use, during sentencing phase of capital murder trial, of unwarned statements, without assistance of counsel, to psychiatrist violates fifth amendment privilege against self-incrimination and sixth amendment right to counsel).

103. *See* Suzuki v. Yuen, 617 F.2d 173, 177-78 (9th Cir. 1980); French v. Blackburn, 428 F. Supp. 1351, 1359 (M.D.N.C. 1977), *aff'd*, 443 U.S. 901 (1979); People *ex rel.* Keith v. Keith, 38 Ill. 2d 405, 231 N.E.2d 387 (1967); McGuffin v. State, 571 S.W.2d 56 (Tex. Civ. App. 1978); Ramsay v. Santa Rose Medical Center, 498 S.W.2d 741 (Tex. Civ. App. 1973).

104. *See* Lessard v. Schmidt, 349 F. Supp. at 1102; Finken v. Roop, 339 A.2d 764 (Pa. Super. Ct. 1975); State *ex rel.* Memmel v. Mundy, Case No. 441-417 (Cir. Ct. Milw. Wis. filed Aug. 18, 1976), *on appeal* 249 N.W.2d 573 (Wis. 1977).

105. FLA. STAT. § 90.242(3)(a) (1973).

106. *In re* Beverly, 342 So. 2d at 489. In addition to the appropriateness of a warning, the best practice would be to have an attorney present during any psychiatric interview for civil commitment. *See* Finken v. Roop, 339 A.2d at 764. *See also* Lee v.

evidence code[107] fails to require such a warning, thus increasing the importance of one commentator's suggestion that the extent of any self-incrimination protection should be clearly set out in the Florida commitment statutes.[108]

The amendment proposed here is a compromise position. The position was recognized in a recent California Supreme Court decision holding the privilege against self-incrimination only protects mentally disabled individuals from giving evidence that would tend to implicate them in criminal activity or subject them to potential criminal prosecution.[109] The amendment would clarify the extent of self-incrimination protection enjoyed by persons subject to civil commitment in Florida.

Rights of Mental Health Professionals

The suggested amendments to Florida Statutes section 394.460 relating to the rights of mental health professionals are as follows:

> (2) Mental health professionals testifying at hearings conducted pursuant to this part may, if appropriately qualified, give expert testimony:
> (a) Describing the present mental functioning of a person whom the witness has personally examined;
> (b) Stating an opinion as to what the prospects are that proposed and available treatment will improve the person's mental condition;
> (c) Stating an opinion whether the person has a mental illness, as defined in s. 394.455(3); provided that any witness so testifying shall provide a detailed explanation as to how any such descriptions and opinions were reached and a specification of all behaviors and other factual information on which such descriptions and opinions are based.

County Court, 27 N.Y.2d 432, 267 N.E.2d 452, 318 N.Y.S.2d 705 (1971), *cert. denied*, 404 U.S. 823 (1971) (defendant in criminal proceeding has a right to counsel at pretrial mental examination).

107. FLA. STAT. § 90.242(3)(a) (1976).

108. Note, *Involuntary Hospitalization of the Mentally Ill Under Florida's Baker Act: Procedural Due Process and the Role of the Attorney*, 26 U. FLA. L. REV. 508 (1974).

109. Cramer v. Tyars, 23 Cal. 3d 131, 588 P.2d 783, 151 Cal. Rptr. 653 (1979).

(3) Mental health professionals testifying at such hearings shall not be permitted to give opinion testimony:

(a) Stating the diagnostic category applicable to a person, unless the person raises the issue through cross-examination or the presentation of evidence, or

(b) Notwithstanding s. 90.703, stating a conclusion that a person is likely to injure himself or others, or that a person's neglect or refusal to care for himself poses a real and present threat of substantial harm to his well being.

Much has been written about the rights of mental patients, but comparatively little is said about the rights of the mental health professionals charged with the care, treatment and honoring of the rights of mental patients. Mental health professionals complain about spending an inordinate amount of time in court, in a role they are neither trained nor qualified to exercise and in an inappropriate adversarial relationship to their patient.[110] The suggested amendments delineate the testimony that mental health professionals may offer, limiting it to that which they are qualified to give.

The amendments excuse mental health professionals from invoking inconsistent, unreliable and invalid diagnostic labels often established by vote (e.g., homosexuality voted in and out as a disease) rather than by scientific verification. Diagnostic labels in the courtroom frequently communicate impressions of disturbed or incapacitated conditions without providing information useful to the commitment process.[111]

> Also specific psychiatric diagnoses are extremely unreliable and often contradictory.
>
> Civil commitment proceedings call for detailed information about the individual's mental and emotional functioning. Descriptive information can be supplied by psychiatric and psychological witnesses without any reference to diagnostic conclusions which are often of questionable utility to professionals and meaningless or

110. *See generally* LAW AND THE MENTAL HEALTH PROFESSIONS: FRICTION AT THE INTERFACE (W. Barton & C. Sanborn eds. 1978); Galie, *An Essay on the Civil Commitment Lawyer: Or How I Learned to Hate the Adversary System,* 6 J. PSYCHIATRY & L. 71 (1978); Slovenko, *Criminal Justice Procedures in Civil Commitment,* 24 WAYNE L. REV. 1 (1977).

111. Ennis & Litwack, *supra* note 47, at 741.

misleading to laymen.[112]

The amendments also relieve mental health professionals of the uncomfortable responsibility of deciding the legal criteria for commitment. The responsibility of determining whether an individual meets the legal criteria for commitment lies with the judge or hearing examiner, based on the evidence presented, not with a psychiartrist. A neutral judge is particularly important in view of the considerable evidence that psychiatric diagnosis is strongly influenced by the socio-economic histories of both patient and clinician, with a lower patient socio-economic history biasing the diagnosis toward greater illness and poorer prognosis than is actually presented by the clinical picture.[113] This ef-

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112. 2 MENTAL DISABILITY L. REP. at 105 (citing V. NORRIS, MENTAL ILLNESS IN LONDON 42-53 (Maudsley monograph No. 6, 1959)) (60% are of agreement on diagnosis of 6,253 patients when second diagnostician knew the original diagnosis). A 1962 research project illustrates this point: Beck, Ward, Mock, & Erbaugh, *Reliability of Psychiatric Diagnoses: 2. A Study of Consistency of Clinical Judgments and Ratings,* 119 AM. J. PSYCHIATRY 351, 356 (1962) (average rate of agreement for specific diagnoses under controlled conditions was only 54%). *See generally* J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 123-45 (1970); Ash, *The Reliability of Psychiatric Diagnoses,* 44 J. ABN. & SOC. PSYCH. 272 (1949) (three psychiatrists all agreed on specific diagnoses in only 20% of the cases and all three disagreed 31% of the time). Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitments,* 117 U. PA. L. REV. 75, 80 (1968) ("The diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes. . . ."); Schmidt & Fonda, *The Reliability of Psychiatric Diagnosis: A New Look,* 52 J. ABN. & SOC. PSYCHOLOGY 262 (1956) (47% agreement as to classification of non-organic psychoses).

See supra notes 22-25. DSM-III probably constitutes an improvement over DSM-II, but whether reliability and validity are sufficiently high for legal use remain to be thoroughly reseached. J. ZISKIN, *supra* note 24 and numerous sources cited therein.

In addition to endorsement by the Florida Bar, the suggested provisions regarding rights of mental health professionals have been specifically and unanimously endorsed by the Board of Directors for the Florida Mental Health Association. FLORIDA MENTAL HEALTH ASSOCIATION, BAKER ACT REVIEW TASK FORCE FINAL REPORT (Oct. 1981).

113. *See* Lee & Temerlin, *Social Class, Diagnosis, and Prognosis for Psychotherapy,* 7 PSYCHOTHERAPY: THEORY, RESEARCH & PRAC. 181 (1970) and sources cited in Ennis & Litwack, *supra* note 47, at 724 n.108.

See also Roth & Lerner, *Sex-Based Discrimination in the Mental Institutionalization of Women,* 62 CAL. L. REV. 789 (1974) (Psychiatric bias based on sex makes it easier for a woman to be committed than a man under the same circumstances, results

fect combines with the extremely deficient predictions of assaultive and suicidal behavior discussed earlier. A review of the literature and research[114] necessarily leads to the conclusion that psychiatric predictions of dangerousness to self and others, and predictions of the need for care and treatment, are invalid; that psychiatric judgments are not sufficiently reliable or valid to justify their admissibility under traditional rules of evidence; and that psychiatric judgments do not convey meaningful or otherwise unavailable information about the issues relevant in a civil commitment proceeding.

Whether the suggested amendment to the statutory section titled "Rights of mental health professionals" actually increases or abridges the rights of mental health professionals probably depends upon the perception of the individual professional. Some would say the suggested amendments abridge their right to speak freely, the right to use specialized terminology and expertise to provide greater justice and humanity for their patients. Others would say the suggested amendments promote efficiency in their court appearances, lessen their adversarial approach to their patients and free them of judgmental roles.

Admission for Court-Ordered Evaluation, Involuntary Placement, and Continued Involuntary Placement

The suggested amendments in the last sections of the proposed bill (Appendix) do the following things:

(1) provide that the "need of care or treatment" criterion for court-ordered evaluation and involuntary placement be manifest rather than predicted;

(2) restore the "lacks sufficient capacity to make a reasonable ap-

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in different treatment for women—such as more use of electro-convulsive therapy and psycho-surgery—and makes it more difficult for women to be released. Women are often hospitalized for exhibiting traits which would not lead to hospitalization for a man, such as aggressiveness, running away, or sexual promiscuity.)

114. Ennis & Litwack, *supra* note 47. The uncertainty, tentativeness, fallibility, and subjectivity of psychiatric diagnosis and judgment have been recognized by the United States Supreme Court. *Addington*, 441 U.S. 418 (1979); *O'Connor*, 422 U.S. at 584.

See generally Albers, Pasewark & Meyer, *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 CAP. U.L. REV. 11 (1976).

plication in his own behalf" criterion to court-ordered evaluation and involuntary placement, as required by the Florida Supreme Court to maintain constitutionality;

(3) change the maximum period of initial involuntary placement from six months to three months if likely to injure others, or in need of care or treatment, and from six months to two weeks if likely to injure self;

(4) allow one continued involuntary placement;

(5) require substantial probability that treatment will significantly improve the patient's mental condition before continued involuntary placement can occur.

Many of the justifications for these suggestions have been discussed above. Requiring manifest evidence of need for care or treatment, rather than prediction of need, is consistent with the legal trend toward requiring recent overt acts; this minimizes the extent to which commitment becomes preventive detention, and recongizes the inability of any witness to accurately predict another's future behavior.

Restoring the "lacks sufficient capacity to make a reasonable application on his own behalf" criterion to court-ordered evaluation and involuntary placement assures the constitutionality of the commitment criteria as required by the Florida Supreme Court in *Beverly*.[115] A finding of incompetence seems to be a constitutional pre-condition to commitment against one's wishes.

The suggested amendments also shorten the maximum period of initial involuntary placement and allow one continued involuntary placement. Prolonged hospitalization is antitherapeutic and harmful to patients. One review of earlier studies concluded: "The major thrust of the evidence is that living in an institution has harmful physical and psychological effects . . . regardless of the particular characteristics of the population or the unique qualities of the total institution."[116] The

115. *In re* Beverly, 342 So. 2d at 487.

116. Prock, *Effects of Institutionalization: A Comparison of Community, Waiting List and Institutionalized Aged Persons*, 59 AM. J. PUB. HEALTH 1837 (1969). *See* BARTON, INSTITUTIONAL NEUROSIS (1966); WING & BROWN, INSTITUTIONALIZATION AND SCHIZOPHRENIA (1970); Gruenberg, *From Practice to Theory: Community Mental Health Service and the Practice of Neurosis*, 1969 THE LANCET 721; Myerson, *Can Institutionalization Be Prevented?*, MASS. J. MENTAL HEALTH 17 (Summer 1972).

negative effects of prolonged institutionalization so outweigh any benefits of continued confinement that staff ultimately expend more energy treating the negative secondary effects than they do treating the original condition.[117] The issue then becomes the appropriate maximum period of involuntary commitment. The broadest proposal for amending civil commitment standards presented by the President's Commission on Mental Health limits the original commitment to six weeks, with one possible six week extension.[118] The initial commitment period in Michgan has been sixty days,[119] ninety days in California[120] and Washington,[121] and four months in Maine.[122] There is statistical support for an involuntary commitment period of no more than ninety days.[123] The American Psychological Association, the American Orthopsychiatric Association and leading commentators agree with the amendments proposed here: no one should be involuntarily committed to a mental institution for more than a total of six months.[124]

California has had different commitment periods for persons presenting different problems. For example, when a patient demonstrates at least an imminent threat of substantial physical harm to others (likely to injure others), the commitment period is limited to ninety days. Persons presenting at least an imminent threat of taking

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See also Kiesler, *Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients,* 37 AM. PSYCHOLOGIST 349 (1982) (reviewed ten studies randomly assigning treatment modes of seriously ill psychiatric patients and found no case where hospitalization was more beneficial than alternative treatment).

117. LEGAL RIGHTS OF THE MENTALLY HANDICAPPED, 437-50, 514-20, 749-55 (B. Ennis & P. Friedman eds. 1973). *See also O'Connor,* 422 U.S. at 574-75.

118. TASK PANEL ON LEGAL AND ETHICAL ISSUES, THE PRESIDENT'S COMMISSION ON MENTAL HEALTH, MENTAL HEALTH AND HUMAN RIGHTS: REPORT OF THE TASK PANEL ON LEGAL AND ETHICAL ISSUES, *reprinted in* 20 ARIZ. L. REV. 49, 117-22 (1978). [hereinafter cited as TASK PANEL ON LEGAL AND ETHICAL ISSUES].

119. MICH. COMP. LAWS § 330.1472 (1980).

120. CAL. WELF. & INST. CODE §§ 5300-5304 (Deering 1979)(the Code provides for 14 days of intensive treatment plus further treatment not to exceed 90 days.

121. WASH. REV. CODE § 71.05.320 (1975).

122. ME. REV. STAT. ANN. tit. 34, § 2334 (Supp. 1978).

123. *See* Shah, *Some Interactions of Law and Mental Health in the Handling of Social Deviance,* 23 CATH. U.L. REV. 674 (1974).

124. *See* B. ENNIS & R. EMERY, *supra* note 32, at 130; B. Ennis & P. Friedman, *supra* note 117, at 437.

their own life (likely to injure self) are subject to two fourteen-day commitment periods.[125] This different policy for suicidals is consistent with the *lack* of substantial evidence that mental health services successfully prevent suicides.[126] In fact, there is some evidence that involuntary treatment may increase the rate of suicide.[127] The President's Commission on Mental Health suggests a forty-eight hour commitment for suicide attempters.[128] Greenberg recommends physical and medical interference for twenty-four hours maximum.[129]

One evaluation of California's overall experience with limited term commitments came to the following conclusions:

> —"patient discharge was affected by time periods at which staff decisions were forced by non-therapeutic requirements;"
> —"the 14-day certification time period for involuntary patients conforms closely to the optimum time periods utilized by professional staff without any legally imposed limitations;"
> —"having the patient committed until medically ready for discharge did not result in any better prognosis than when the patient was mandatorily released;"
> —"results indicate little correlation between prognosis and keeping individuals hospitalized until medically ready for discharge;"
> —prior to the statutory limitations, "involuntary patients were hospitalized longer than voluntary," while as a result of the limitations, "the trend reversed;"
> —the study "supports the contention by some professionals that there is little correlation between treatment duration and later outcomes;"
> —the results "negate the prediction that mandatory discharge at a specified time would result in a significant detriment to treat-

125. CAL. WELF. & INST. CODE §§ 5150-5152, 5200-5213, 5250-5268 (Deering Supp. 1979). There is also a provision for a 72-hour evaluation.

126. *See* Greenberg, *supra* note 29, at 256 (the few controlled studies on the effectiveness of treatment for suicidals are inconsistent or negative); Light, *Treating Suicide: The Illusions of a Professional Movement,* 25 INT'L SOC. SCI. J. 475, 482-84 (1973).

127. Greenberg, *supra* note 29, at 236, 250, 256-59.

128. TASK PANEL ON LEGAL AND ETHICAL ISSUES, *supra* note 118.

129. Greenberg, *supra* note 29, at 243.

ment and functional level of the discharged patient."[130]

Several United States Supreme Court decisions support limited periods for involuntary commitment. The Court held in *Jackson v. Indiana* that persons incompetent to stand trial can be confined only for a limited period of time: "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."[131] In *McNeil v. Director,* the Court held that "just as the [*Jackson*] principle limits the permissible length of a commitment on account of incompetence to stand trial, so it also limits the permissible length of a commitment 'for ob-

130. A. Urmer, A Study of California's New Mental Health Law (1969-1970), ENKI Research Institute, 1242-51.

131. 406 U.S. at 738. In *Jackson,* a mentally defective deaf mute was found incompetent to stand trial in cases involving two separate robberies of four and five dollars respectively, and was committed indefinitely for treatment until competence could be restored. At the time of the appeal, the petitioner had been confined for three and one-half years; the record indicated it was unlikely he would ever be able to fully participate in his trial. The Court indicated there must be progress toward that degree of competence, the goal of his confinement. If it was not likely that goal would be achieved, then the State must either release him or initiate the customary civil commitment proceeding. The Court set no specific time limits, but noted his three and one-half year confinement to date and cited New York legislation providing that a misdemeanor defendant could be committed for no more than ninety days nor a felony defendant committed for more than two-thirds of the maximum sentence permissible if convicted. N.Y. CODE CRIM. PROC. §§ 730.50(1), (3) (1971).

Jackson is an incompetence-to-stand-trial commitment case, rather than a civil commitment case, but it illustrates the duration of commitment must relate to the purpose of confinement.

Cf. Flicker v. Florida, 352 So. 2d 165 (Fla. 1st Dist. Ct. App. 1977) (concern expressed about six months detention in jail after discharge from hospital as competent to stand trial); Williams & Miller, *The Processing and Disposition of Incompetent Mentally Ill Offenders,* 5 LAW & HUMAN BEHAV. 245 (1981) (Florida mentally ill offenders spend unnecesarily long periods of time in jail and hospital awaiting court processing).

See generally, e.g., Comment, *Substantive Due Process Limits on the Duration of Civil Commitment for the Treatment of Mental Illness,* 16 HARV. C.R.-C.L. L. REV. 205 (1981) (proposed a quantitative declining-marginal-benefit criterion for civil commitment based upon a net benefit principle legally grounded in *Jackson v. Indiana*). The declining-marginal-benefit criterion appears more technical than may be legislatively or judicially feasible at this time.

servation.' "[132] In *O'Connor v. Donaldson,* the Court cited these two cases for the proposition that involuntary commitment cannot "constitutionally continue" after the basis for commitment ceases.[133]

Extended involuntary commitments in Florida are an inappropriate use of limited resources. Commitment periods seem to correspond to the length of time that government reimbursement is available rather than to patient needs. Involuntary commitment periods should be limited to a maximum of two three-month periods for those who are likely to injure others or are in need of care or treatment. A maximum of two two-week periods should be given to those likely to injure themselves. Persons who are so dangerous that they commit crimes should be prosecuted in the criminal justice system. Persons with chronic disabilities should be processed pursuant to guardianship law.

Finally, the amendments provide that the additional involuntary commitment period can occur only if there is substantial probability that treatment during the additional period will significantly improve the patient's mental condition. The two concepts encompassed by this treatability criterion are:

> First, the individual's condition should be susceptible to improvement or cure through techniques that may properly be administered involuntarily. A second and equally important aspect of treatability is that the resources needed to achieve improvement or cure are available and will be applied.[134]

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132. McNeil v. Director, 407 U.S. 245, 248-50 (1972). In *McNeil,* a person convicted of two assaults in 1966 and sentenced to five years imprisonment was referred to Patuxent Institution for examination to determine the appropriateness of indefinite commitment to Patuxent under Maryland's Defective Delinquency Law, MD. CODE ANN. art. 31B (1971). The prisoner allegedly refused to cooperate with the examination. No determination was made, the sentence expired, and confinement in Patuxent continued. Citing *Jackson,* the Court in *McNeil* held it was a denial of due process to hold someone for observation indefinitely, without sufficiently safeguarding his rights, where there is no reason to anticipate the person will be easier to examine in the future.

McNeil involved commitment of a convicted person for observation and evaluation, rather than civil commitment; but it illustrates when the purpose of confinement no longer exists, confinement for that purpose must cease. Thus, confinement of the mentally ill cannot constitutionally continue if the basis for commitment (e.g., treatment for dangerousness to others, treatment for dangerousness to self) no longer exists.

133. *O'Connor,* 422 U.S. at 575.

134. 2 MENTAL DISABILITY L. REP. at 93.

The treatability criterion is a corollary and rough equivalent of Judge Johnson's ruling in *Wyatt v. Stickney* that persons who are involuntarily committed to a mental institution have a "right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition."[135] Unless an involuntarily committed person is treatable, "the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense."[136] In short, "[t]o deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate resources violates the very fundamentals of due process."[137]

Deliberations about limiting the duration of commitments and requiring treatability should address the consequences of such changes. The anticipated results include reduced commitment of the many people predicted to be dangerous who do not actually inflict harm; "criminalization" of some frightening or annoying behavior; increased diversion of persons from the criminal justice system to mental health treatment program participation agreements; effective intervention in suicide attempts similar to the successful British program "Samaritans"; increased voluntary mental health services; increased utilization of guardianship; increased demand for and provision of non-mental hopsital custodial care for the elderly poor; less harm to people in public mental hospitals; and more appropriate use of limited resources.[138]

Conclusion

The Florida Mental Health Act (Baker Act) does *not* reflect recent developments in mental disability law. Despite its intended design,

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135. *Wyatt*, 325 F. Supp. at 784. For a recent exhaustive and sophisticated rehabilitation of the right to treatment, relying upon the constitutional principle of the least restrictive alternative, *see* Spece, *supra* note 79.

136. *Wyatt*, 325 F. Supp. at 784 (citing Ragsdale v. Overholser, 281 F.2d 943, 950 (1960)).

137. *Wyatt*, 325 F. Supp. at 785.

138. *See* 2 MENTAL DISABILITY L. REP. at 94-96.

Cf. MD. CODE ANN. art. 31B (1977) (abolishing indeterminate sentence; making program participation optional with eligible offenders; establishing mandatory twenty-five year sentence for third-time violent offenders, without parole except through Patuxent).

to encourage voluntary admissions for mental health care, an excessively high proportion of admissions are involuntary. Commitment hearings in much of Florida are embarrassingly short, especially considering that the consequences (lifelong stigma, prolonged institutionalization) can be worse than conviction for a crime. There are hundreds of persons in Florida's unaccredited public mental institutions who have received institutional care for dozens of years, even though institutionalization is neither the most appropriate nor least restrictive placement. The result is that their primary problem is the institutionalization syndrome itself. Many have the anomolous and illegal classification of being "voluntary," though incompetent, and without a guardian.

Many of these problems result from a lack of less restrictive alternatives. However, they are also the product of any bureaucracy's tendency to follow the path of least resistance. It is still comparatively easy to have a person involuntarily committed, and recommitted, in Florida.

The suggested amendments to Florida's Baker Act reviewed here, reflect recent legal developments. They are consistent with the recommendations of the President's Commission on Mental Health, the national Suggested Statute on Civil Commitment, and the experiences in other states and countries. Based on the following conclusions of a recent survey of psychiatrists, it is also fair and accurate to say: "Most psychiatrists *are* generally in favor of extending civil rights to their patients"[139] and "phychiatrists would be better characterized as supporting the increased concern over [legal] rights than as opposing it."[140]

> —Psychiatrists do not favor involuntary civil commitment for individuals who are mentally ill but not dangerous.
> —Psychiatrists favor a restrictive definition of *dangerous to others* which is based on recent behavioral evidence and the imminent likelihood of a future ocurrence.
> —Psychiatrists hold that "commitment hearings should be mandatory."

139. 2 MENTAL DISABILITY L. REP. at 677 (1978).

140. Kahle & Sales, *Due Process of Law and the Attitudes of Professionals Toward Involuntary Civil Commitment;* LISPETT & SALES, NEW DIRECTIONS IN PSYCHOLOGICAL RESEARCH (1978).

> —Psychiatrists favor extending a number of rights to the subject of a commitment petition during the process of involuntary civil commitment proceedings.
> —Psychiatrists favor extending a number of rights to individuals who have been involuntarily committed.
> —There is little in the way of major "differences between the philosophy of psychiatrists and the philosophy of lawyers" which should influence the wording of involuntary civil commitment laws. . . . [T]he philosophical rivalry appears to be between the American Psychiatric Association leadership and membership. While the leadership prefers to ignore past psychiatric abuses and to defend the "right" to be "unencumbered by complicated legal procedures," the membership prefers to protect against future abuses through legislation.[141]

Rather than reflect a so-called "criminalization" of civil commitment, the suggested amendments change the present situation whereby persons accused of crime are accorded more rights and protections than persons committed to a mental institution against their will. Legal protections are particularly important for persons subject to involuntary commitment, who are least able to protect themselves, or get someone else to protect them.

The suggested amendments orient Florida's Baker Act toward a health care model,[142] and away from a preventive detention social control model. The amendments will reduce cost by minimizing inappropriate use of expensive mental health facilities and resources.

The manner in which a society deals with its less fortunate and disadvantaged is often said to be the measure of a civilization. More immediately the question should be asked: what protections would I want for myself, my family, or a friend, if we were subject to involuntary civil commitment in Florida?

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141. 2 MENTAL DISABILITY L. REP. at 677-78.

142. *See* Cumming & Gover, *Therapeutic Consequences of the Involuntary Commitment Process,* 2 AM. J. FORENSIC PSYCHIATRY 37 (1979) (commitment process has therapeutic value for patients; adversary process presents role model for rational approach to problem solving).

Appendix
A bill to be entitled

An act relating to mental health; amending s. 394.455(3), Florida Statutes, and adding subsection (23), (24), (25) to said section; providing definitions; amending s. 394.457(7), Florida Statutes; providing an exception to payment for care; amending s. 394.459(3)(a), (9), Florida Statutes, and adding subsection (2)(d) to said section; specifying when safety is jeopardized; providing for confidentiality; providing for individualized treatment plan; amending s. 394.460, Florida Statutes, adding subsections (2), (3) to said section; prescribing testimony of mental health professionals; amending s. 394.463(2)(a), Florida Statutes; providing additional criterion; amending s. 394.467 (1)(b), (2)(d), (3)(a), (4)(f), Florida Statutes; providing additional criteria; establishing time limitations.

Be It Enacted By the Legislature of the State of Florida

Section 1. Subsection (3) of section 394.455, Florida Statutes, is amended and subsections (23), (24), and (25) are added to said section to read:

394.455 Definitions. - As used in this part, unless the context clearly requires otherwise.

(3) "Mentally ill" means a substantial impairment of emotional processes, ability to perceive reality or to reason or understand, which impairment is manifested by instances of grossly disturbed behavior; it does not include retardation or developmental disability as defined in Chapter 393, brief periods of intoxication caused by substances such as alcohol or drugs, or dependence upon or addiction to any substances such as alcohol or drugs.

(23) "Likely to injure himself" means that it is more likely than not that in the near future the person will attempt to commit suicide or inflict serious bodily harm upon himself by violent or other actively self-destructive means, as evidenced by behavior causing or attempting the infliction of serious bodily harm upon himself within twenty days prior to initiation of the proceeding.

(24) "Likely to injure others" means that it is more likely than not that in the near future the person will inflict serious, unjustified bodily harm on another person, as evidenced by behavior causing, attempting or threatening such harm, including at least one incident thereof within twenty days prior to initiation of the proceeding, which behavior gives rise to reasonable fear of such harm from said person.

(25) "Lacks sufficient capacity to make a reasonable application on his behalf" means the person's inability, by reason of mental condition, to achieve a rudimentary understanding, after conscientious efforts at explanation of the purpose, nature or possible significant benefits of treatment; provided that a person shall be deemed incapable of understanding the purpose of treatment if, due to impaired mental ability to perceive reality, he cannot realize that he has recently engaged in behavior likely to injure himself or others; and provided further than a person shall be deemed to lack sufficient capacity if his reason for refusing treatment is expressly based on either the belief that he is unworthy of treatment or the desire to destroy, harm or punish himself.

Section 2. Subsection (7) of section 394.457, Florida Statutes, is amended to read:

394.457 Operation and administration.-

(7) PAYMENT FOR CARE OF PATIENTS. - Fees and fee collections for patients in treatment facilities shall be according to s. 402.33, except that no person evaluated, detained, committed or treated involuntarily pursuant to the provisions of this part, or parents or spouse of the person, or third party payor, shall be required to participate in the costs of pay fees incurred for their evaluation, treatment, care, maintenance or custody pursuant to this part; provided that if, upon the patient's request the patient is placed in any private facility, the patient shall bear the expense of the patient's care, maintenance and treatment at such facility.

Section 3. Subsections (3)(a) and (9) of section 394.459, Florida Statutes, are amended and subsection (2)(d) is added to said section to read:

394.459 Rights of patients. -

(2) RIGHT TO TREATMENT. -

(d) Not more than 5 days after the beginning of treatment, each patient shall have and receive an individualized treatment plan in writ-

ing that the patient has maximum opportunity to assist in preparing. Each plan shall contain at least:

1. A statement of the specific problems and specific needs of the patient;

2. A statement of intermediate and long-range objectives, with a projected timetable for their attainment;

3. A statement and rationale for the plan of treatment for achieving these objectives;

4. A statement of the least restrictive treatment conditions necesary to achieve the purposes of placement.

5. A specification of treatment staff responsibility and a description of proposed staff involvment with the patient in order to attain the objectives;

6. Criteria for release to less restrictive treatment conditions;

7. The additional disclosure information required in s.394.459(3)(a).

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT. -

(a) All persons entering a facility shall be asked to give express and informed consent for treatment after disclosure to the patient if he is competent, or his guardian if he is a minor or is incompetent, of the purpose of the treatment to be provided, the common side effects thereof, alternative treatment modalities, the approximate length of care, and that consent given by a patient may be revoked orally or in writing prior to or during the treatment period by the patient or his guardian. If a voluntary patient refuses to consent to or revokes consent for treatment, such patient shall be discharged within 3 days or in the event the patient meets the criteria for involuntary placement, such proceedings shall be instituted within 3 days. If any patient refuses treatment and is not discharged as a result, treatment may be rendered such patient in the least restrictive manner on an emergency basis, upon the written order of a mental health professional when such mental health professional determines treatment is necessary for the safety of the patient or others. Safety is jeopardized only by a situation threatening death or serious bodily harm. If any patient refuses consented to treatment or revokes consent previously provided, and if, in the opinion of the patient's mental health professional, the treatment not consented to is essential to appropriate care for such patient hereunder, then the administrator shall immediately petition the hearing

examiner for a hearing to determine the competency of the patient to consent to treatment. If the hearing examiner finds that the patient is incompetent to consent to treatment, he shall appoint a guardian advocate, who shall act on the patient's behalf relating to provisions of express and informed consent to treatment. A guardian advocate appointed pursuant to the provisions of this act shall meet the qualifications of a guardian contained in part IV of chapter 744, except that no mental health professional, department employee, or facility administrator shall be appointed.

(9) CLINICAL RECORD: CONFIDENTIALITY. -

A clinical record for each patient shall be maintained. The record shall include data pertaining to admission and such other information as may be required under rules of the department. Unless waived by express and informed consent by the patient or his guardian or attorney, the privileged and confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency. Notwithstanding s. 90.503(4)(b), no communication made by an individual to a mental health professional, including but not limited to a psychotherapist, may be used for any purpose other than a proceeding under this act. The clinical record shall not be a public record and no part of it shall be released, except: . . .

Section 4. Section 394.460, Florida Statutes, is amended and subsection (2) and (3) are added to said section to read:

394.460 Rights of mental health professionals. -

(1) No mental health professional shall be required to accept patients for treatment of mental, emotional, or behavioral disorders. Such participation shall be voluntary.

(2) Mental health professionals testifying at hearings conducted pursuant to this part may, if appropriately qualified, give expert testimony:

(a) Describing the present mental functioning of a person whom the witness has personally examined;

(b) Stating an opinion as to what the prospects are that proposed and available treatment will improve the person's mental condition;

(c) Stating an opinion whether the person has a mental illness, as defined in s. 394.455(3); provided that any witness so testifying shall provide a detailed explanation as to how any such descriptions and

opinions are reached and a specification of all behaviors and other factual information on which such descriptions and opinions were based.

(3) Mental health professionals testifying at such hearings shall not be permitted to give opinion testimony:

(a) Stating the diagnostic category applicable to a person, unless the person raises the issue through cross-examination or the presentation of evidence, or

(b) Notwithstanding s. 90.703, stating a conclusion that a person is likely to injure himself or others, or that a person's neglect or refusal to care for himself poses a real and present threat of substantial harm to his well being.

Subsection 5. Subsection (2)(a) of section 394.463, Florida Statutes, is amended to read:

304.463 Admission for emergency or evaluation. -

(2) COURT-ORDERED EVALUATION. -

(a) Criteria. - A person may be admitted to, or retained in, a receiving facility for evaluation if there is reason to believe that he is mentally ill and because of his illness is:

1. Likely to injure himself or others if allowed to remain at liberty; or

2. In need of care or treatment that manifests itself in neglect or refusal to care for himself, that such neglect or refusal poses a real and present threat of substantial harm to his well being, and that he lacks sufficient capacity to make a reasonable application on his own behalf.

Section 6. Subsections (1)(b), (2)(d), (3)(a), and (4)(f) of section 394.467, Florida Statutes, are amended to read:

394.467 Involuntary placement. -

(1) CRITERIA. -

(b) Any other person may be involuntarily placed if he is mentally ill and, because of his illnes, is:

1. Likely to injure himself or others if allowed to remain at liberty; or

2. In need of care or treatment that manifests itself in neglect or refusal to care for himself, that such nelgect or refusal poses a real and present threat of substantial harm to his well being, and that he lacks sufficient capacity to make a reasonable application on his own behalf.

(2) ADMISSION TO A TREATMENT FACILITY. -

(d) A written notice that the patient or his guardian or representa-

tive may apply immediately to the court to have an attorney appointed if the patient cannot afford one.

The petition may be filed in the county in which the patient is involuntarily placed at any time within 6 months of the date of the certificate. The hearing shall be held in the same county, and one of the patient's physicians at the facility shall appear as a witness at the hearing. If the hearing is waived, the court shall order the patient to be transferred to the least restrictive type of treatment facility based on the individual needs of the patient, or, if he is at a treatment facility, that he be retained there. However, the patient can be immediately transferred to the treatment facility by waiving his hearing without awaiting the court order. The involuntary placement certificate shall serve as authorization for the patient to be transferred to a treatment facility and as authorization for the treatment facility to admit the patient. The treatment facility may retain a patient for a period not to exceed 6 months from the date of admission if the patient is likely to injure others or is in need of care or treatment and lacks sufficient capacity to make a reasonable application on his own behalf, or for a period not to exceed 2 weeks from the date of admission if the patient is likely to injure himself. If continued involuntary placement is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing not more than one continued involuntary placement.

(3) PROCEDURE FOR HEARING ON INVOLUNTARY PLACEMENT. -

(a) If the patient does not waive a hearing or if the patient, his guardian, or a representative, files a petition for a hearing after having waived it, the judge shall serve notice on the administrator of the facility in which the patient is placed and on the patient. The notice of hearing must specify the date, time, and place of hearing; the basis for detention; and the names of examining mental health professionals and other persons testifying in support of continued detention and the substance of their proposed testimony. The judge may serve notice on the state attorney of the judicial circuit of the county in which the patient is placed, who shall represent the state. The court shall hold the hearing within 5 days unless a continuance is granted. The patient, his guardian or representative, or the administrator may apply for a change of venue for the convenience of parties or witnesses or because of the condition of the patient. Venue may be ordered changed within

the discretion of the court. The patient and his guardian or representative shall be informed of the right to counsel by the court. If the patient cannot afford an attorney, the court shall appoint one. The patient's counsel shall have access to facility records and to facility personnel in defending the patient. One of the mental health professionals who executed the involuntary placement certificates shall be a witness. The patient and his guardian or representative shall be informed by the judge of the right to an independent expert examination by a mental health professional. If the patient cannot afford a mental health professional, the judge shall appoint one. If the court concludes that the patient meets the criteria for involuntary placement, the judge shall order that the patient be transferred to a treatment facility or, if the patient is at a treatment facility, that he be retained there or that he be treated at any other appropriate facility or service on an involuntary basis. The judge shall consider testimony and evidence regarding the patient's competence to consent to treatment. If the judge finds that the patient is incompetent to consent to treatment, he shall appoint a guardian advocate who shall act on the patient's behalf relating to the provision of express and informed consent to treatment. The order shall adequately document the nature and extent of a patient's mental illness. The judge may adjudicate a person incompetent pursuant to the provisions of this act at the hearing on involuntary placement. The treatment facility may accept and retain a patient admitted involuntarily for a period not to exceed 3 months if the patient is likely to injure others or is in need of care or treatment and lacks sufficient capacity to make a reasonable application on his own behalf, or for a period not to exceed 2 weeks if the patient is likely to injure himself, whenever the patient is accompanied by a court order and adequate documentation of the patient's mental illness. Such documentation shall include a psychiatric evaluation and any psychological and social work evaluations of the patient. If further involuntary placement is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing not more than one continued involuntary placement.

(4) PROCEDURE FOR CONTINUED INVOLUNTARY PLACEMENT. -

(f) If the patient by express and informed consent waives his hearing or if at a hearing it is shown that the patient continues to meet the criteria for involuntary placement, and that there is a substantial probability that treatment will significantly improve the patient's

mental condition, the hearing officer shall sign the order for continued involuntary placement. The treatment facility shall be authorized to retain the patient for a period not to exceed 3 months if the patient is likely to injure others or is in need of care or treatment and lacks sufficient capacity to make a reasonable application on his own behalf, or for a period not to exceed 2 weeks if the patient is likely to injure himself. There shall be no more than one continued involuntary placement period.