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THE LEGAL SIGNIFICANCE OF THE "MENTAL ILLNESS" CRITERION IN THE CIVIL COMMITMENT PROCESS

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Since the 1954 *Durham* decision,[1] the concept "mental illness" has acquired increased significance in our legal system. In place of the old "M'Naghten" test[2] and the "irresistible impulse" test,[3] the definition of insanity in criminal proceedings now depends, in many jurisdictions, on the following criterion: "[A]n accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect."[4]

Concurrently, the term "mental illness" is now widely employed in a number of legal contexts related to the incarceration ('hospitalization') or restriction of persons who have engaged in, or are "likely" to engage in, some form of anti-social behavior. Thus, a precedent finding of "mental illness" is required as a criterion in the involuntary civil commitment process; in the legal decision to retain or release persons involuntarily

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[1] Durham v. United States, 214 F.2d 862 (D.C. Cir. 1954).

[2] "To establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong." M'Naghten's Case, 10 Cl. & F. 200, 210, 8 Aug. Rep. 718, 722 (H.L. 1843).

[3] An expanded version of the "M'Naghten" test allowed in some jurisdictions. Whereas in "M'Naghten" jurisdictions abnormal mental condition is conceived as a defect of the mind arising from a "defect of reason," the "irresistable impulse" test suggests that a "defect of the will" also suffices, to explain abnormal mental behavior.

[4] 214 F.2d 862, 875 (D.C. Cir. 1954). The MODEL PENAL CODE has also adopted a test which places greater emphasis on the "mental disease" criterion than does "M'Naghten."

MODEL PENAL CODE (Proposed Final Draft No. 1, 1961):

Section 4.01—Mental Disease or Defect Excluding Responsibility

(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminal wrongfulness of his conduct or to conform his conduct to the requirements of law.

(2) The terms "mental disease" or "defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial behavior.

committed to mental institutions; and, in proceedings which impose involuntary guardianship upon those adjudged incompetent to engage in certain legal transactions. All of the foregoing instances are, by present legal classification, adjudications of a "civil" nature.[5]

But whether the context be criminal or civil, the underlying assumptions upon which commitment to mental institutions is predicated are the same: namely, that such persons are dangerous; and, that the special kind of rehabilitative help available in mental hospitals will be of substantial benefit to the committed individual as well as a guarantee of security to society when the "cure" is completed and the patient released.

The problem which this article will consider is whether the criterion "mental illness" is a useful or viable element in determinations which commit persons to mental institutions prior to actual criminal conduct. That is, do the assumptions underlying society's determination to commit such individuals to mental hospitals require a finding of "mental illness," or should it be sufficient to prove merely that an individual is "likely" to be dangerous to himself and/or others?[6] Consideration will be limited to the context of the civil commitment process because the issues raised clearly have general applicability to the entire range of legal problems in which the "mental illness" criterion is employed. In addition, the civil commitment process requires very special scrutiny because it entails a drastic deprivation of personal liberty based in large measure upon the accuracy of predictions utilizing "mental illness" as a factor contributing to the likelihood of some future anti-social conduct.

The theoretical goals of the civil commitment process are threefold: protection of others (i.e. prevention of future anti-social behavior directed at others); protection of the individual, diagnosed as "ill," from himself and others;[7] and the provision of treatment furthering "recovery" of the committed individual. Of these goals, only "prevention" of conduct harmful to self or others is consistent with the purposes of criminal incarceration. Civil detention cannot be justified on the basis of any of

[5] "Mental illness" is also used as a legal criterion in the *criminal* context in determinations of competency to stand trial, in decisions related to the release of persons originally committed to mental hospitals upon findings of "not guilty by reason of insanity," and where prisoners are found to be ill and committed while serving a prison sentence.

[6] This is a common statutory formulation. See *e.g.*, D.C. CODE, chapter 21, sects. 501-541 (1966).

[7] The state here assumes the role of *parens patriae*. *Cf.* Matter of Oakes, 8 Mass. 122 (1845); Matter of Heukelekian, 24 N.J. Sup. 407 (1953).

the other classic rationales for criminal detention—deterrence, retribution, and rehabilitation through "punishment."

Underlying the goals of the civil commitment process are certain assumptions. First, it is assumed that society will in fact be protected by preventive detention of mentally ill, dangerous persons. That is, we assume the prediction is sufficiently accurate because it is founded on correct premises and derived in rigorous fashion. Presumably enough truly dangerous people will be detected and committed to justify inevitable overpredictions and the even more serious problem of depriving persons of their liberty *prior* to overt criminal behavior.

Second, and equally important, we assume that treatment will be provided so that individuals may return to society and function normally without danger to their own welfare or the safety of others. Thus, incarceration is indefinite because in no sense punitive.[8] Implicit is the idea of treatment followed by release when and if there is satisfactory "recovery" from illness.

The civil commitment—as it presently stands—has its advocates and critics. Some proponents even favor expansion of the scope of civil commitment statutes to include those persons who might benefit from care but lack the capacity to seek help. They would have such persons committed regardless of "dangerousness to self or others."[9] What this position entails is the notion that the state, as *parens patriae*, owes a custodial duty to those incapable of looking after themselves. Unfortunately, this contention offers little, and for that reason is mentioned only in passing, in relation to issues of central importance: whether the assumptions underlying the goals of the civil commitment are in fact realized; whether the concept "mental illness" effectively contributes to the predictive process; and if not, whether the whole procedure should be abolished, or altered, to better reflect those goals.

Two positions which generally attack the underlying assumptions of civil commitment are worthy of consideration. Professor Alan Dershowitz is highly critical of the criterion "mental illness" as presently utilized in every legal context. With specific reference to civil commitment, his position is that the "mental illness" concept has little utility

[8] See Overholser v. O'Bierne, 302 F.2d 852 (D.C. Cir. 1962).

[9] See, *e.g.*, Statement of Sam Ervin, Senate Hearings on Constitutional Rights of the Mentally Ill (*Hearings Before the Subcommittee on Constitutional Rights of the Committee on the Judiciary*, U.S. Senate, 87th Congress, 1st Session; 88th Congress; 1st Session 1961 and 1962); Statement of Professor Henry Weihofer, Director, Mental Competency Study, George Washington University.

because it tends to obscure the true purpose of the prediction effort, which is primarily to weed out persons likely to commit harmful or anti-social acts in the future. Professor Dershowitz asserts that, given the need for deterrence, the goals of the civil commitment would be better served if the law would focus with greater particularity on the specific nature of the "harm" which is likely to occur in the future, and prescribe more precisely "how likely" it is that this harm will occur. Thus, he states:

> If the function of involuntary hospitalization is the preventive detection of dangerous people, then why should it matter whether such people are or are not 'mentally ill'? If a 'mentally healthy' person is sufficiently dangerous, why should he not be confined? If a 'mentally ill' person is not sufficiently dangerous, why should he be confined?
>
> The law should not authorize the detention of allegedly dangerous persons . . . who are mentally ill unless we would also be willing to incarcerate especially dangerous persons who are not . . . mentally ill.[10]

Thus, Professor Dershowitz believes the criterion "mental illness" obscures not only the predictive process because the term has become, as a product of *Durham*, a "label" which in itself can provide little relevant information; but it also obscures the basic reason for confinement, which is simply to prevent "dangerous" conduct rather than to detain persons who are allegedly "mentally ill." Therefore, the argument concludes, if society continues to authorize preventive detention, authorization should depend only on the formulation in precise terms of words such as "harm" and "likely," instead of the present emphasis upon "mental illness" as the basic test. Psychiatric testimony is relevant only insofar as it provides reliable information upon which to base predictions about the likelihood of future anti-social behavior.

Dr. Thomas Szasz also has little regard for the criterion "mental illness" as presently employed in the civil commitment process. But, contrary to Professor Dershowitz, he suggests that there is little value in the retention of the entire institution of the civil commitment because of these doubts.

His argument is twofold. First, he argues that the term "mental illness" is overly vague, and that the state of the art is not sufficiently ad-

[10] Dershowitz, *The Role of Law in the Prediction and Prevention of Harmful Conduct*; paper delivered at the 43rd meeting of the American Orthopsychiatric Association (1966), reprinted in GOLDSTEIN, KATZ, AND DERSHOWITZ, PSYCHOANALYSIS, PSYCHIATRY, AND THE LAW 588 (1966).

vanced to diagnose for other than psychiatric circles the presence of "mental illness." Thus he states:

> I have very serious doubts about the usefulness of the term 'mental illness.' Even if we grant the argument, first, that there is ['mental illness'], and that this is a metaphysical expression denoting, usually, some sort of socially deviant or inappropriate behavior . . . and second, that such illness can be 'diagnosed' and 'treated,' we are still left with the question: does a person have the right to be 'mentally ill'? And further: Does he have the right to be 'mentally ill' and deliberately not seek treatment?
>
> Should it be desirable to consider mental illness a major public health hazard—a position that seems to me factually incorrect but logically quite tenable—this would require establishing objective, and by objective I mean publicly verifiable, criteria for diagnosing the presence or absence of this alleged disorder. In other words, this could no longer be diagnosed simply by professional opinion. Do satisfactory criteria for this exist at present . . . So long as the descriptive and prescriptive (or promotive) aspects of psychiatric diagnosis remain combined and confused, as they are today, we need especially enlightened legislative vigilance to protect people from what I consider the police powers of psychiatrists.[11]

Dr. Szasz's second argument is even more revolutionary when considered in light of widely held assumptions about the nature of mental illness. For he asserts that there is no reason to assume that so-called "mentally ill" persons are any more dangerous than so-called "healthy" persons. Therefore, he asks, why should society separate out and discriminate against the former through procedures like the civil commitment?

> It is my personal opinion that insofar as we divide human beings or populations into 2 large groups, one who never have been and never will be mentally ill, and another who have been or are now or will be—there is no evidence that the ones who are mentally ill are any more dangerous than the ones who are mentally healthy. Nor do I think that any evidence will be found, or ever could be found, to show that mentally ill people are more dangerous than others, unless mental illness were defined objectively and in advance of the behavior to which it is to be applied. If mental illness is defined à posteriori—for

[11] Statement of Dr. Thomas Szasz, Senate Hearings on Constitutional Rights of the Mentally Ill; (see note 9, *supra*) and see generally, SZASZ, THE MYTH OF MENTAL ILLNESS (1961).

example, by asserting that every drunken driver is mentally ill—then of course the answer will be yes, mentally ill persons are dangerous. If we define every employer who behaves unreasonably and makes other people under him suffer, then yes, they are dangerous.

But if we define mental illness *empirically*, that is, in terms of actual observation, then the question is quite open. By empirical definitions of mental illness, I mean such things as for example defining those inside of mental hospitals as mentally ill, and those outside as not; of those who go to psychiatrists for help as mentally ill, and those who do not as not ill. These may not be good definitions, but if we insist on talking about mental illness we have got to have some measures for defining it. Now, if we define mental illness in some such ways as these, then I say there is not a shred of evidence that the mentally ill are any more dangerous than the mentally healthy. . . .[12]

Thus, Szasz not only vehemently agrees with the Dershowitz statement that "mental illness" makes little sense as a criterion for civil commitment; indeed, he significantly departs from that stance by further asserting that the entire involuntary civil commitment process is an unfortunate social institution which ought to be abandoned. Until substantial evidence is produced that the class of persons labeled "mentally ill" are more dangerous than others, Szasz concludes, society must recognize that such persons should have a legal "right to be ill."[13]

Taking first things first, the major problem with the Dershowitz position is that it fails to realize that the criterion "mental illness"—vague as it may be *must* be preserved in order to justify retention of civil commitment. For, essentially it is the underlying rationale of the right to treatment in a hospital-like setting which distinguishes civil commitment from simple "pre-attempt" criminal incarceration.[14]

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[12] *Id.*

[13] Dr. Szasz continuously refers to this right. As a concomitant, he ascribes the raison d'être of the civil commitment to the unjust favoritism which society exhibits toward family units at the expense of individual members who frequently behave in idiosyncratic ways. See discussion of Dr. Szasz, Senate Hearings See note 9, *supra.*

[14] Many courts have employed the distinction between "treatment" and "punishment" to either justify "unlimited" preventive detention or denial of other rights normally accruing to those accused of crimes. See Overholser v. O'Bierne, 302 F.2d 852 (D.C. Cir. Ct., 1962), where the court states:

> The dissenting opinion does not meet the central issue in the case but rather asserts in essence that 3½ years in St. Elizabeths Hospital constitutes too much confinement for a one year offense. This approach strikes at the very heart of the effort to rehabilitate the maladjusted offender . . .
>
> It is fundamentally wrong, we think, to measure the treatment needs of a sick person by the length of the penal sentence he would have received had

Two inescapable problems result from the suggestion to preserve civil commitment but eliminate "mental illness" as a criterion. First, the Bill of Rights would require amendment, an unlikely prospect. Should a legislature significantly expand the scope of criminal liability for "attempts,"[15] serious Fourth and Fifth Amendment questions would be raised which do not here merit further elaboration.[16]

Second, and more centrally, the suggestion to eliminate "mental illness" as a criterion in civil commitment would also eliminate the rationale of "treatment." Logically, those committed could be preventively detained in prison prior to overt criminal conduct as incurably dangerous for an indefinite period without prospect of release. No longer would there be a point at which such persons might regain their health and thus qualify for release. A series of recent decisions has repeatedly emphasized the importance of the "right to treatment" as a basic justification for the whole procedure. The main thrust of these cases is to assert that the only substantial moral, social, and indeed, legal basis for preventive detention in such circumstances is adequate treatment which in turn holds out some prospect for release.[17]

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he not been excused from punishment, for in the eyes of the law such a person has committed no *crime*. Statutes tell us how long a sentence should be but neither statutes nor medical books can tell us how much hospitalization is needed to effect rehabilitation . . . (at 859).

See also: Overholser v. Leach, 257 F.2d 667 (D.C. Cir. Ct. 1957), *cert. denied*, 359 U.S. 1013 (1959).

Both cases cited above were decided in the context of the criminal insanity plea. The question raised but avoided in the O'Bierne decision is whether a constitutional "right to treatment" exists. See note 17, *infra*.

[15] Dr. Szasz suggests that the only way to justify the civil commitment process and thereby curtail its arbitrary discrimination against the so-called "mentally ill" is to incorporate the procedure into the regular law of attempts. He states, for example:

> . . . as far as homicide is concerned, there I think we are dealing similarly with a variant of a criminal problem and it seems to me there the problem is one of preventive jailing. How long do you wait until someone commits a crime? This is a problem for criminalists and is no different for the mentally ill or the healthy. I don't think one should wait too much.

Statement of Dr. Thomas Szasz, see note 9, *supra*.

[16] Apparently the *Treatment of Inchoate Crimes: Attempt, Solicitation, and Conspriacy* in the MODEL PENAL CODE of the American Law Institute does not really grapple with this problem although its approach is somewhat similar. *See* discussion in Wechsler, Jones, and Korn, *The Treatment of Inchoate Crimes in the Model Penal Code of the American Law Institute: Attempt, Solicitation, and Conspiracy*, 61 COLUMBIA LAW REVIEW 571 (1963).

[17] The leading case is Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. Ct., 1966), a recent District of Columbia case holding that society cannot confine a man on the assumption that he needs treatment and then forget him. Charles Rouse was committed to St. Elizabeths Hospital under a D.C. statute providing

It is evident the remaining and key issue which must be confronted is whether the criterion "mental illness" can be used *accurately* to predict future anti-social conduct and therefore realize another of the basic goals of the civil commitment process previously outlined. If "mental illness" is as irrelevant to the predictive process as Dr. Szasz suggests, then it follows civil commitment itself ought to be abandoned lest we fall into the previous dilemma of commitment without prospect of treatment and recovery.

There is no excuse for abandoning civil commitment on this pretext, however, for several reasons. Of course Dr. Szasz is correct in asserting that the "mental illness" criterion suffers the "vice of vagueness." But it is generally accepted as factual, Dr. Szasz to the contrary notwithstanding, that certain gross forms of deviant behavior *can* be prevented by early detection. Further, such behavior is often caused, the vast majority of experts would agree, by "mental illness," disputes over "labels"—as psychosis versus psychopathy—also to the contrary notwithstanding.

Recognizing, however, the valid concerns expressed by critics like Dr. Szasz over the vagueness of the term "mental illness" as presently employed in the law, the civil commitment process (with its heavy dependence on this concept) continues to be justified only if the predictive use to which the concept is put is substantially improved.

First and foremost, it behooves both the legal and psychiatric communities to "clean up" the morass of psychiatric testimony related to proof of illness and dangerousness presented at commitment hearings. Judge Bazelon's formulation in *Durham v. U. S.* that, ". . . the fact-finder should be free to consider all information advanced by relevant

that persons found not guilty of crimes by reason of insanity be committed to a mental hospital. Rouse had been confined there three years before seeking release on a petition for habeas corpus alleging inadequate treatment. The court recognized his claim as legally sufficient and remanded for a hearing on the adequacy of treatment. See also: Millard v. Cameron, 373 F.2d 468 (D.C. Cir. Ct., 1966) (companion case with Rouse, also remanded for findings on treatment under the District's sexual psychopath statute); Dobson v. Cameron, #20, 563 (D.C. Cir., Sept. 1, 1967) (*en banc*), (*per curiam*); Stult v. Cameron, #20, 576 (D.C. Cir. Ct., Sept. 1, 1967) (*en banc*) (*per curiam*). These cases all concerned civil commitment, and were likewise remanded habeas corpus petitions alleging inadequate treatment. Additionally, see Note, *Civil Restraint, Mental Illness, and the Right to Treatment,* 77 YALE L.J. 87 (1967); Comment, *Due Process for All: Constitutional Standards for Involuntary Civil Commitment and Release,* 34 VA. U. L. REV. 633 (1967); Note, *The Nascent Right to Treatment,* 53 VIRGINIA L. REV. 1134 (1967); 80 HARV. L. REV. 898 (1967); 45 TEXAS L. REV. 777 (1967).

scientific disciplines . . ."[18] is of course entirely à propos the civil commitment problem. But the task of psychiatric testimony is not to present the rhetoric of abstractions and labels. Rather, such testimony should address itself specifically to the lack of criminal "responsibility" or, in the civil commitment context, specific psychiatric reasons which point to the potential for and the likelihood of dangerous behavior.

It has been suggested that too often psychiatric examinations are shallow and summary. Rules of evidence should become an integral part of civil commitment requirements in order to promote the relevance and specificity of psychiatric testimony. Perhaps a minimum period of examination should also be required to further protect individuals from hasty, superficial examinations.[19]

Finally, some commentators have suggested that greater over-all procedural safeguards are essential to the protection of the rights of those subject to civil commitment. This idea entails the requirement of a mandatory adversary proceeding because of the seriousness of the potential deprivation of liberty.[20] Others, however, have expressed concern with this proposal in light of the trauma of public exposure forced upon the individual and his family.[21] These individuals advocate a more informal inquiry which is equally capable of exposing relevant information to the court.

Summarizing, this article has attempted to show that "mental illness" is a necessary criterion, for better or for worse, in the civil commitment determination. Whether the entire civil commitment process itself is justified warrants separate evaluation, and depends, it is submitted, on whether society (*i.e.* the legislature) is willing to seriously confront the assumptions which underlie the goals of civil commitment by considering the foregoing and related suggestions for improvement.

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[18] 214 F.2d 862, 874 (D.C. Cir. 1954). See also Dodd v. Hughes, 398 F.2d 540 (1965).

[19] For instance it has been suggested that all individuals who are committed must be examined by at least two psychiatrists and for a total of at least 10 examination hours, that the psychiatrists submit their findings in writing, etc.

[20] *See e.g.*, Statement of Elyce H. Zenhoff, ACLU, in *Senate Hearings* (note 9; and *see*, Denton v Commonwealth, 383 S.W.2d 681 (Ky., 1964).

[21] *See e.g.*, Statement of Dr. Jack Ewalt, Pres., Am. Psychiatric Association, *Senate Hearings*. See note 9 *supra*.