

ONE

Civil Commitment and Paternalism

Legal and Psychiatric Dynamics

OVERVIEW. *The legal and psychiatric communities are largely responsible for fashioning social (and public) policy in relation to the mentally ill. The question, of course, is to what extent do these systems work in concert to affect meaningful outcomes that include the sensibilities of persons with diagnosed psychiatric disabilities. This chapter examines a full range of forensic issues that impact civil commitment determinations. How are involuntary hospitalization decisions made? In what way are treatment needs balanced against liberty rights? What are the aims of civil confinement? To what extent is justice for the mentally ill assured through institutionalization? What role, if any, does paternalism, punishment, or both play in the decision-making process? These and other similar questions are explored in the pages that follow.*

INTRODUCTION

The history of civil commitment and confinement law in general reflect long-standing attitudinal divisions among the psychiatric and legal communities, patients' rights advocates, governmental agencies, legislative bodies, and other invested constituencies (Deutsch, 1949; Grob, 1973, pp. 4–12; Scull, 1989, pp. 4, 10). At the center of this controversy are two well-established and, at times, competing social values that attempt to fashion appropriate mental health policy. On the one hand, involuntary hospitalization for mentally ill persons diagnosed as dangerous or otherwise disabled is encouraged. On the other hand, the slightest abridgment of personal autonomy and individual liberty for these citizens is discouraged. While the medical profession asserts its responsibility to treat dangerous (Chodoff, 1976, p. 496) and obviously ill persons (Treffert, 1985, p. 259) so that they are effectively controlled (Zusman, 1982, pp. 110–113), civil libertarians seek to challenge psychiatric judgments altogether. These advocates maintain that

mental illness is manufactured (Szasz, 1970, pp. 1–15), that civilly confined persons are in fact prisoners (Ennis, 1972, p. 2) and that the “preciousness of liberty” doctrine demands that the practice of involuntary hospitalization be abolished (Morse, 1982a, pp. 54, 106).

The results of this and prior debates have produced large-scale reforms with disappointing consumer-oriented outcomes. From the introduction of the asylum and public intervention in the form of moral treatment (Morrissey & Goldman, 1984, p. 786); to the emergence of the psychopathic hospital and the mental hygiene movement (Grob, 1983, p. 144), to the more recent spawning of community mental health and its emphasis on deinstitutionalization (Bachrach, 1978, pp. 573, 574; Musto, 1975, p. 53; Talbott, 1979, pp. 621, 622), one reality has endured: “While cyclical patterns of institutional reform” have been the hallmark of America’s response to the mentally ill (Morrissey & Goldman, 1984, p. 790; Morrissey & Goldman, 1986, pp. 12, 13), the politics of abandonment has been and continues to be its legacy (Rhoden, 1982, p. 375; Isaac & Armat, 1990, p. 250).

This statement is not so much an indictment of those forces that largely shape civil commitment laws or develop intervention strategies for effective treatment. It is, however, a recognition that although we have journeyed beyond the institutional “snakepits” of the past (Deutsch, 1948, pp. 3–21), the “right to rot” is not an acceptable path (Appelbaum & Gutheil, 1980, pp. 720–723). Our contemporary social landscape, especially over the last 25 years, poignantly reflects this theme of abandonment. Psychiatric facilities, viewed in the past as nightmarish warehouses servicing chronically mentally ill persons have been replaced by ill-conceived and poorly managed new “asylums” in the community (Goldman & Morrissey, 1985, p. 722; Lamb, 1979, p. 129). And while treatment regimens for persons committed against their will continue to evolve through psychopharmacological and other therapy-based discoveries, the best available evidence shows that these interventions are only minimally better than doing nothing at all (Brooks, 1987, pp. 339, 341; Durham & LaFond, 1988, p. 305).

Coupled with these disturbing realities are the commitment laws themselves (Perlin, 2000). No where else are the entrenched tensions that beset the psychiatric and legal communities more evident. Challenges to the scientific meaning of mental illness (Morse, 1978, pp. 527, 528; Scheff, 1984, pp. 1–3; Laing, 1969, pp. 7–10), pitfalls in predicting dangerousness (Morse, 1982b, p. 95; Shah, 1977, pp. 91, 98), debate over the promise and peril of involuntary outpatient commitment (Mulvey, Geller, & Roth, 1987, p. 571; Miller, 1985, pp. 265, 267; Hinds, 1990, pp. 346, 349), division over the patient’s right to refuse treatment (Roth, 1986, p. 139, 142; Brooks, 1987, p. 339), disagreement about the efficacy of the least restrictive alternative doctrine (Arrigo, 1992b, pp. 1–31; Schmidt, 1985, p. 13; Hiday & Goodman,

1982, pp. 81–83), and other such matters demonstrate a woeful lack of consensus on how best to deliver much needed services to psychiatrically disordered citizens, while respecting the intrinsic dignity and right to self-determination these consumers possess. It is not surprising that in the wake of such acrimony over appropriate mental health policy, deinstitutionalization remains a dream deferred for the chronically disordered (Dorwart, 1988, pp. 287, 290), involuntary treatment for the homeless mentally ill continues to escalate (Belcher, 1988, p. 1203; Lamb, 1984, pp. 899–903), and an alarming number of mental health systems users find themselves displaced throughout the criminal justice system (Brakel, et al., 1985, pp. 1–15; Lamb, 1982, p. 17; Slovenko, 1977, pp. 817–818).

The purpose of this chapter is to examine critically the role that both law and psychiatry have played in casting mentally ill persons as deviants; citizen/outsideers caught in a crossfire of illness politics (Szasz, 1987; Grob, 1994). This examination will focus on those values protected and privileged by the medical and legal professions as reflected in confinement law and policy primarily during the last quarter of the twentieth century. The social, economic and political power these disciplines exercise in the lives of psychiatric citizens raises significant questions concerning the future of involuntary civil commitment both from a clinical and justice policy perspective. As such, these matters will be addressed as well. No attempt will be made here to detail the historical dimensions of abandonment in the care and treatment of the mentally ill. Similarly, assessing other environmental influences contributing to this phenomenon (e.g., urbanization, immigration, industrialization, transinstitutionalization) is beyond the scope of this chapter. While these factors are significant components in the development of civil commitment laws, they are decidedly more global in nature.

My aim is to provide a current account of how law and psychiatry, despite their respective calls to safeguard individual rights and to treat the sick, have fashioned an ineffective system of care. I begin with a brief history emphasizing the social, scientific, and legal developments that set the stage for present-day civil commitment policy. I then outline in what context law and psychiatry speak for the mentally ill, evaluate some controversial and significant areas where treatment, liberty, or both are sacrificed, and describe the inherent social values law and psychiatry promote through confinement practices. By carefully considering the manner in which involuntarily committed persons are simultaneously subjected to and repeatedly forced to choose among principles of freedom in the abstract and clinical interventions in the extreme, my intent is to identify the parameters of a debate that embody the ongoing climate of uncertainty in civil commitment matters. Along these lines, I conclude this chapter with several tentative recommendations for ameliorating the crisis in civil confinement practice and policy.

HISTORICAL BACKGROUND

The first half of the 20th century was marked by minimal activity regarding civil commitment laws or policy making (Appelbaum & Gutheil, 1991, p. 46). While state statutes reflected regional or even local interests in appropriate service delivery to the mentally ill, many states provided only modest procedural protections to these citizens (Deutsch, 1948, p. 215). In addition, some states recognized a practice of indeterminate commitment on the basis of what can only be described as vague statutory construction (i.e., the person was a “social menace” or “a fit and proper” candidate for institutionalization) (Myers, 1983–1984, pp. 367, 381).

Coupled with these lenient commitment standards was a belief on the part of many psychiatrists that institutional confinement was far more humane than the ravages of poverty or incarceration (Cohen, 1979, pp. 339, 340–351; Deutsch, 1948, p. 73). Through reliance on a “need-for-treatment” approach (Deutsch, 1949, p. 171), physicians were afforded a great deal of latitude in civil confinement matters. This latitude was indicative of a period marked by discretion rather than procedure in the care and treatment of the mentally ill (Mulvey, 1987, p. 575). In fact, the majority of the states adopted this standard for civil commitment from the 1930s through the 1960s (Myers, 1983–1984, p. 381). The net effect of these scientific and sociolegal practices was the swelling number of persons that found themselves involuntarily hospitalized. In 1955, for example, the average daily census of persons committed in state and county mental hospitals was a staggering 560,000 (Goldman, Adams, & Taube, 1983, p. 129).

The excesses of this period in civil confinement matters were substantially the result of the state’s unbridled authority to impose involuntary commitment (Morse, 1978, p. 529). This authority is derived from two sources: the police power and the *parens patriae* power (LaFond, 1981, pp. 499, 502; Kittrie, 1972, p. 59). The police power accords the states “a plenary power to make laws and regulations for the protection of the public health, safety, welfare and morals” (Comment, 1974, pp. 1191, 1222). Moreover, this authority bestows on states the responsibility to commit involuntarily mentally disordered persons whose behaviors demonstrate that they are a danger to self or others. The other prong of authority vested in the states is the *parens patriae* power. Under this doctrine, states are entrusted with civilly confining persons against their will when they are unable to care for themselves. This is generally understood to include an inability to provide for one’s basic needs (e.g., food, clothing, safety, and shelter).

What is most significant about the concept of *parens patriae*, is the historical value attributed to this practice of paternalism. It is deeply embedded in Western culture and thought. Indeed, the disturbing dimensions of *parens patriae*

can be traced from Roman law to English law to colonial American jurisprudence (Grob, 1994; Holdsworth, 1966; Kittrie, 1972, pp. 12–40). Designed to protect “idiots and lunatics” while managing their estates (Blackstone, 1783, p. 426), these duties were abused by avaricious and profit-minded persons, leaving the mentally disabled all too frequently to their own devices (Meyers, 1983–1984, p. 403). Based in large measure on the law of property, the Crown protected the heirs of wealthy “idiots and lunatics” from disinheritance by invoking the right of *parens patriae* (*Hawks v. Lazaro*, 1974, p. 109). And, as for the impecunious, English law required that the Crown assume societal responsibility to care for those individuals unable to care for themselves (Comment, 1974, p. 1239).

With the independence of the American colonies, *parens patriae* was understood to be vested in the state legislatures (*Hawaii v. Standard Oil Co.*, 1972, pp. 251, 257). Later, this authority was generally (but explicitly) reaffirmed by the Supreme Court to be vested in the “[s]tate as [the] sovereign” (*Fontain v. Ravenel*, 1855, pp. 369, 394). Early appellate cases like *In re Barker* (Johns. Ch., 1816, p. 232) and *In re Oakes* (Law Rep., 1845, p. 122), firmly established the court’s jurisdictional claim in matters pertaining to the protection of the psychiatrically disordered. All available evidence indicates that *parens patriae* was relied on as much for the protection of the mentally disordered as for matters of property and wealth (Myers, 1983–1984, p. 384). In 1890, for example, the U.S. Supreme Court described the state’s parental power in the following manner: “[I]t is a most beneficent function, and often necessary to be exercised in the interests of humanity, and for the prevention of injury to those who cannot protect themselves” (*Mormon Church v. United States*, 1890, p. 57).

With the dawn of the 20th century, this *parens patriae* theme was renewed when a federal district court stated that “[a] state would indeed be derelict of its duty if it failed to make adequate provision for the care and treatment of the insane. The state is the *parens patriae* of the insane” (*Hammon v. Hill*, 1915, pp. 999, 1000). Soon thereafter, the Oklahoma Supreme Court reasserted the notion of *parens patriae* as a viable state mechanism for protecting the incapacitated and for overseeing matters of property and wealth (*McIntosh v. Dill*, 1922, pp. 917, 925). As the Court maintained, “[t]he doctrine . . . may be defined as the inherent power and authority of a Legislature of a state to provide protection of the person and property of persons *non sui juris*” (*McIntosh v. Dill*, 1922, pp. 917, 925).

In the late 1970s, Utah expressly upheld the *parens patriae* justification for civil commitment by declaring it to be a legitimate source of state power when hospitalizing mentally ill persons against their will (*Colyar v. Third Judicial Dist. Court*, 1979, p. 429). And finally, a New York appellate court relatively recently enunciated the state’s *parens patriae* authority by declaring that a respondent’s homelessness was the result of “serious mental illness” and not a

“lack of housing for the poor” (*Boggs v. N.Y. City Health and Hosp. Corp.*, 1987, pp. 340, 365; see also, Williams & Arrigo, 2001).

What the foregoing discussion reveals is how deeply interwoven the *parens patriae* concept is in the fabric of American jurisprudence. In recent years, some commentators have staunchly criticized the medical profession’s widespread reliance on it when involuntarily hospitalizing the mentally ill (Durham & LaFond, 1985, pp. 395, 397; LaFond, 1981, pp. 526–535; Morse, 1978, pp. 628–640; Perlin, 1999). Despite concerns for abuses in and sacrifices of personal liberties, other commentators find the doctrine’s underlying theme of social responsibility for dangerous and gravely disabled persons to be sound (Appelbaum, 1984, pp. 133, 134). As I shall demonstrate shortly, however, it is precisely this valued notion of paternalism (in its police power and *parens patriae* form) that continues to underscore both the psychiatric and legal approach in matters of civil commitment; an approach that has resulted in casting the mentally ill as deviants, contributing to a legacy of abandonment. In other words, the historical value of paternalism, as currently expressed in the law, is responsible for the present climate of uncertainty that plagues the mental health system.

By the mid-20th century, it was evident that social reform in the care and treatment of the mentally ill was essential. Large state hospitals functioned as primary care-takers for the growing number of patients committed against their will (Grob, 1983, p. 189). Conditions in these institutions were abominable (Deutsch, 1949, pp. 448–449). Not only was understaffing rampant (*Wyatt v. Stickney*, 1972, p. 375), but the qualifications and skill level of many hospital employees providing basic services to mental health consumers was dangerously suspect (*Halderman v. Pennhurst State School & Hospital*, 1977, p. 1295). Soft shackle restraints and seclusion rooms were found in most psychiatric facilities (Scull, 1981, pp. 1–18). Long-term chronic patients deteriorated to a state of helpless institutional dependency (Goffman, 1961, p. 47; Rhoden, 1980, p. 403; Vail, 1966, pp. 22–23). Brutish attacks by residents and staff, at times resulting in death, were not uncommon (*Wyatt v. Aderholt*, 1974, pp. 1305, 1311). And the vision of social reform anticipated by the mental hygiene movement and the psychopathic hospital was reduced to obscurity, not unlike those involuntarily hospitalized persons whose promise of treatment translated into the perils of life-time confinement (Scull, 1981, p. 171; Scull, 1989, p. 143).

These abuses signaled a need to alter significantly services delivered to mental health consumers. In 1946, the National Institute of Mental Health was founded, and funding for community mental health care was made available (Schoonover & Bassuk, 1983, p. 135). In 1952, the introduction of chlorpromazine, an antipsychotic medication, was hailed as a curative chemical agent for treating the symptoms of psychotic patients (Pepper & Ryglewicz, 1982, p. 389; Scull, 1984, p. 189). At the same time, a nascent humanitarian belief that long-

term confinement of the profoundly ill produced warehousing, dehumanizing, and, therefore, harmful effects was popularized (Goffman, 1961, pp. 4–10; Pepper & Ryglewicz, 1982, p. 388; Scull, 1984, p. 189). Court cases decided during the late 1960s and early 1970s extended this awareness. Specifically, a number of landmark decrees, recognizing the fundamental liberty interests of the mentally ill were upheld, including community-situated treatment (*Lake v. Cameron*, 1966, p. 657); due process procedural protections (*Lessard v. Schmidt*, 1972, p. 1078); the right to treatment (*Rouse v. Cameron*, 1966, p. 451); medical and Constitutional minimal standards in treatment (*Wyatt v. Stickney*, 1972, p. 373); and the right to refuse treatment. In addition, state hospital administrators, alarmed by conditions of population overcrowding (Bardach, 1972, p. 52; Jones, 1972, p. 83) and structural decay (Bardach, 1972, p. 52), considered their hospitals “bankrupt beyond remedy” (Robitscher, 1975, p. 146). And finally, legislators, responding to the public clamor for institutional reform, adopted a series of statutory remedies. In 1963, the Community Mental Health Centers Construction Act (CMHC) was passed by Congress, making community-based mental health a crucial service available throughout the country (Myers, 1983–1984, p. 418). In 1965, the Medicare and Medicaid programs were enacted, providing relief for mental health consumers receiving community-based services and care (Lamb & Mills, 1988, p. 475). And, in 1969, California passed the Lanterman-Petris-Short Act; legislation that set a nationwide standard for civil commitment based on the criterion of dangerousness (Lamb & Mills, 1988, p. 475). Now, not only was the need-for-treatment approach essential to involuntary civil commitment decision making, but so too was the patient’s demonstrated danger to self or others (Wexler, 1981; Perlin, 1999).

These events triggered the massive deinstitutionalization movement that occurred during the late 1960s (Grob, 1983, p. 121; Scull, 1984, p. 33). So sweeping were these measure that the per day number of residents in state and county mental hospitals reached a low of 138,000 in 1981 (Goldman, Adams, & Taube, 1983, pp. 129, 132). Deinstitutionalization brought with it an expanding array of neighborhood services for mental health consumers. Outreach, residential care, day programming, crisis intervention, and other maintenance-based strategies reduced general reliance on psychiatric facilities for many chronically mentally ill citizens (Goldman, 1983, pp. 129–134).

Notwithstanding these advances—measures promulgated by the social, scientific, and legal developments outlined above—deinstitutionalization possessed severe limitations. For example, community support was not immediately forthcoming (Rhoden, 1982, p. 431; Talbott, 1980, p. 47). Indeed, to this day, many mentally disordered persons find themselves unwelcomed residents or guests of board-and-care homes, single room occupancies, welfare hotels, and flophouses (Arrigo, 1994a; Hoch & Slayton, 1989, p. 189). Others filter through the criminal justice system, somehow surviving in local lock-up and detention

centers or security prisons (Treffert, 1982, pp. 123–125). And still other psychiatrically disabled persons marginally exist on the streets where they sometimes die homeless (Lamb, 1984, p. 903; Lamb, 1989, p. 269; Arrigo, 2001b). These disturbing realities are exacerbated by bouts of involuntary rehospitalization or multiple hospitalization for the chronically mentally ill (Bachrach, 1983, pp. 73–91). Even when community placements are secured, the results are not always rewarding (Scull, 1984, pp. 99–101). The clinical, controlled, and predictable delivery of psychiatric services in these environments often echoes the familiar regimen of asylum practices (Torrey, 1997).

Many mentally ill lives have been punctuated by intrusive institutional confinement. This confinement has been replaced by a neglectful community care system, featuring ongoing cycles of short-term civil commitment, incarceration, or homelessness (Costello & Preis, 1987, p. 1538). Perhaps most troublesome is the woeful lack of effective community mental health services for mentally ill young adults (between the age of 18 and 35). Possessing limited social skills, complicated by persistent, and at times, severe psychiatric impairments, these individuals wander through life confronted by its stress and their own psychosis (Pepper & Ryglewicz, 1982, p. 389).

To be sure, the magnitude of society's failure to provide adequately for the needs of the mentally ill during the last 25 years is immense (Grob, 1994; Perlin, 2000). The devastating effects "in terms of human suffering is incalculable" (Pepper & Ryglewicz, 1982, p. 389). Driven by paternalistic intentions, current state civil commitment laws and policies bear out these unpleasant circumstances. Chronic patients are forced to choose between two dichotomous and altogether dissatisfying alternatives: total freedom from involuntary hospitalization or total confinement in the restrictive setting of a psychiatric facility (or its functional equivalent in the community) (Myers, 1983–1984, p. 381). Advocates from our legal and scientific professions have bequeathed to the mentally ill an uncertain future in civil commitment matters; a future where psychiatric persons remain citizen/outside (Arrigo, 1996b). This legacy of abandonment is directly linked to the specific areas in which both disciplines speak for the psychiatric consumer. Because these issues begin to disclose the values that law and psychiatry privilege, an examination of these topic areas is in order.

WHEN THE COURTS AND PSYCHIATRY SPEAK FOR THE CITIZEN/OUTSIDER

On the Meaning of Mental Illness

Scheff (1969, pp. 6–30; see also, Scheff, 2000) maintains that in the face of uncertainty both the legal and psychiatric communities strongly favor a pre-

sumption of illness when rendering decisions in the care and treatment of the mentally disordered. Nowhere else is this more evident than in their consideration of the meaning of mental illness. In most jurisdictions, the process leading to involuntary civil commitment initially requires a showing of the substantive standard of mental illness or a showing that the individual is suffering from a mental disorder (Reisner & Slobogin, 1990, p. 453). The inability on the part of most state legislatures to operationalize this construct has given the courts the role of “fashion[ing] a definition for the words “mentally ill . . . thereby fill[ing] the void in the statutory hospital law” (*Dodd v. Hughes*, 1965, pp. 540–542). This responsibility is complicated when considering the due process liberty interests of the psychiatric citizen protected under the 14th Amendment. Any law that impinges on these rights (e.g., rights pertaining to freedom of movement and freedom from bodily restraint), requires “reasonably clear guidelines” as to their reach (*Smith v. Goguen*, 1974, pp. 573; *Youngberg v. Romeo*, 1982, p. 307).

Confronted with the task of determining whether or not a person is mentally sane, courts typically rely on the expert testimony of physicians and mental health professionals (Reisner & Slobogin, 1990, p. 455; Warren, 1982, pp. 106–122). This diagnostic judgment by experts subjects the commitment proceeding and its outcome to the available medical evidence. Some important strides have been made to assess mental illness as more than deviation from the psychiatric norm in both Great Britain (Laing, 1967, pp. 1–50; Laing, 1969, pp. 33–69), and the United States (Szasz, 1963, pp. 1–15; Szasz, 1974, pp. 1–35). Additionally, other necessary efforts to construct commitment laws satisfying patients, doctors, and lawyers (Appelbaum, 1984, pp. 133–134; Roth, 1979, p. 1121; Stromberg & Stone, 1983, p. 275) have been attempted. Nonetheless, the greatest difficulty with psychiatric testimony is its unreliability in the courtroom (Ennis & Litwack, 1974, p. 712), especially when vague labels are relied on to describe mental illness (Haddad, 1974–1975, p. 439; Shell, 1979–1980, p. 6).

Despite the numerous studies and research protocols documenting the differences in diagnoses among psychiatrists and other mental health clinicians (Shell, 1979–1980, p. 6), courts encourage and depend on this testimony in civil commitment matters. The deferential posturing of most courts allows the meaning of mental illness to be shaped by the attending physician and treatment team. Charged with diagnosing and treating particular maladies (Scheff, 1984, p. 17), the psychiatrist defines mental illness as disease (Szasz, 1987, pp. 45–103). Given that the medical imperative is to presume sickness, this same logic is applied when rendering decisions for purposes of civil commitment, regardless of uncertainty (Kutner, 1962–1963, p. 383). In sum, then, the norms of cooperation and accommodation govern the commitment proceedings (Scull, 1989, pp. 130–189); a process in which both legal and psychiatric role playing have evolved into what one critic has coined a consensual and “commonsense model” of madness (Warren, 1982, p. 38).

Pitfalls in Predicting Dangerousness

A second substantive element required by most states in the wording of the civil commitment laws is the finding that some specified adverse consequence will follow if the person is not involuntarily hospitalized (Reisner & Slobogin, 1990, p. 460). This is generally understood to mean that the person is a danger to self, others, or both. While mental illness as the sole basis for commitment was first rejected by the U.S. Supreme Court in *O'Conner v. Donaldson* (*O'Conner v. Donaldson*, 1975, p. 563), this did not eliminate the inherent difficulties subsequent courts found in applying such a standard; specifically, there is an assessment of probability of dangerousness in every instance of civil commitment (Diamond, 1974, pp. 439–444; Wexler, 1981, p. 11). Despite both legal and psychiatric efforts to understand adequately and to apply consistently this standard, the practical results have not been promising. In short, this requirement is disturbing because of its propensity for over- and underinclusivity (Diamond, 1974, p. 111; Monahan, 1996).

A representative body of literature indicates that psychiatrists are inclined to prefer safety and caution in their predictions of dangerousness (Chambers, 1972, pp. 1107, 1153; Monahan, 1996), and that overinclusivity tends to be more common than its counterpart (Monahan, 1981, p. 112). More disturbing than these findings are studies that report the low rate of accurate predictions of dangerousness or studies that demonstrate how harmless persons are routinely diagnosed as dangerous (Ennis & Litwack, 1974, p. 693).

While the psychiatric profession's inaccurate predictions of dangerousness have fashioned a system of wrongful preventive detention (Morse, 1982a, p. 85), "both federal and state courts continue to sustain police power authority in involuntary civil commitment proceedings" (Haddad, 1974–1975, p. 225). The complicity of the legal community regarding the dangerousness criterion endorses the consensual values of cooperation and accommodation previously referenced. Despite empirical arguments advanced by legal and social science commentators documenting why psychiatric evidence should be significantly circumscribed (Ennis & Litwack, 1974, p. 733) or altogether eliminated (McCormick, 1972, p. 29), it appears that in matters of civil commitment it is "better to be safe than sorry." Expert testimony is admitted into evidence because it is believed that it "will aid the trier in his search for truth" (Cleary, 1972, p. 30). The underlying presupposition is that experts can draw inferences from a set of circumstances that lay persons cannot. Whether or not psychiatric predictions of future dangerousness meet this general test of admissibility, given the unreliability of psychiatric judgments, does not appear to be particularly relevant from the standpoint of the courts.

The Gravely Disabled Criterion

A number of states allow for the civil commitment of nondangerous mentally ill persons by protecting those who cannot provide for their own physical needs

(Comment, 1974, p. 1223). The American Psychiatric Association's Guidelines for State Legislation on civil commitment of the mentally ill, has, in pertinent part, defined this criterion as follows:

[The person] . . . is substantially unable to provide for some of his basic needs, such as food, clothing, shelter, health, or safety or [the person] will, if not treated, suffer or continue to suffer severe mental and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own. (Schmidt, 1985, p. 29)

With such a criterion in mind, some commentators assert that the American Psychiatric Association is attempting to expand the scope of the state's *parens patriae* power (Schmidt, 1985, p. 29; Arrigo, 1993c). This "distress and deterioration" provision is targeted at the large numbers of second-generation mental health consumers; chronically ill patients living in the community, cycling in and out of hospitals, somehow surviving in abandoned buildings and alleyways (Stromberg & Stone, 1983, p. 278).

Coupled with these APA guidelines are efforts by some state legislative bodies to extend civil commitment to persons deemed obviously ill (Treffert, 1985, p. 260), or to generally broaden the statutory criteria for civil commitment (Washington Revue Code Ann., 1985). These measures are, in part, acknowledged as a response to libertarian critics of involuntary hospitalization. As one commentator opposed to restrictive commitment standards put it, "How real is the promise of individual autonomy for a confused person set adrift in a hostile world" (Bazelon, 1975, p. 907).

Patients' rights attorneys and other critics of this more recent trend in civil commitment matters are concerned with the justice policy implications for increasing the state's authority to involuntarily hospitalize people (Durham & LaFond, 1988, pp. 317, 330). While the psychiatric community and supporters of the psychiatric ideology favor commitment standards based on medical criteria (Treffert & Krajeck, 1976, pp. 283–294), albeit with constructive legal safeguards (Chodoff, 1976, pp. 499–501; Roth, 1979, pp. 1123–1127), civil libertarians believe such guidelines will only foster more unwarranted (Durham & Pierce, 1982, p. 216) and improper (Morse, 1982a, p. 54) commitments. In addition, these critics maintain that the practical assessment of the "distress and deterioration" criterion will subject mental health consumers to the increased and relative treatment discretion of psychiatrists (Rubenstein, 1983, p. 559; Ley & Rubenstein, 1996).

Perhaps most troubling for advocates is the potential loss of liberty interests secured during a flurry of mental health litigation during the late 1960s and early 1970s. For example, one of these cases (*Rouse v. Cameron*, 1966, p. 451), addressed why mentally disordered persons needed to be singled out as a special class deserving treatment, especially when the treatment typically resulted in institutional

confinement (Ennis, 1972, p. 33; Comment, 1974, p. 1264). These objections are predicated upon what civil libertarians view as the psychiatric community's continued use of questionable and imprecise criteria regarding definitions of mental illness and crazy behavior (Morse, 1978, pp. 527–654). Although acknowledging the “scandalous conditions” in which many psychiatrically disabled persons live (Schmidt, 1985, pp. 11–15), these critics do not accept the suggestion that civil commitment criteria should therefore be expanded. As one analyst exploring this relationship has argued, too much discretion has already been given individual psychiatrists in commitment matters, thus arrogating what “is fundamentally a moral, social, and legal question—not a scientific one” (Morse, 1982a, p. 60).

The foregoing discussion demonstrates that both the legal and scientific communities contribute greatly to the policy formulation of substantive standards in civil commitment. While some psychiatrists perceive the intervention on the part of mental health lawyers as a “holy legal war” against state hospital psychiatry (Halleck, 1975, pp. 2–7) or as a “legal onslaught” (McGarry, 1976, p. 320), other psychiatrists regard the judicial involvement as a welcomed move toward shared decision making (Hoffman, 1977, pp. 84–87). Notwithstanding these opinions, some level of legal and mental health systems interaction is evident in civil commitment matters (Shah, 1981, pp. 219–259); specifically, in defining mental illness, assessing dangerousness and interpreting gravely disabled criteria. While some accommodation is operative in commitment hearings (i.e., the court's reliance on psychiatric diagnoses and predictions of dangerousness), this value does not appear to be as forthcoming in issues relating to increasing the state's *parens patriae* authority.

In both instances, however, it is clear that the courts and psychiatry speak for the mentally disabled citizen (Perlin, 2000). In this context, both disciplines exercise a level of paternalism, despite their apparent intentions to represent the best interests of the mental health consumer. It is precisely this value which places mentally disordered persons outside the normative social order, subjecting them to a neglectful system of care. This dilemma is magnified when strong adversarial and antagonistic situations develop. What follows are some selected areas of intense controversy.

CAUGHT IN THE CROSSFIRE: PSYCHIATRIC TREATMENT AND A PREFERENCE FOR LIBERTY

The Right to Refuse Antipsychotic Medications

Of particular importance during the deinstitutionalization movement, was hospital reliance on psychotropic drugs which facilitated massive patient discharge

from public mental institutions (Scull, 1984, p. 171; Brooks, 1987, p. 345). These new medications were praised by psychiatrists and mental health policy makers because of their primary capacity to relieve psychotic symptoms; specifically, delusions, hallucinations, and agitation. Thus, persons previously unable to live in the community were now able to do so, sometimes with only minimal support or supervision. While the initial impact of antipsychotic drugs significantly helped to reduce patient assaultiveness and disruptiveness, a dark side to these medications surfaced in the 1960s and 1970s (Brooks, 1980, pp. 180–181; Brooks, 1987, pp. 342–345; Rhoden, 1987, p. 401). An alarming number of mental health consumers experienced physical, emotional, and mental side effects that diminished the person's quality of life (Conley, 1986, p. 64). While some hospital experts believed that the harms caused by these chemical agents were more damaging to the patient than the psychosis itself (Brooks, 1987), other psychiatric physicians minimized their unavoidable impact, insisting that the side effects could be controlled (Klein & Davis, 1969, p. 42).

Amid this climate of psychiatric uncertainty, civil libertarian attorneys, patients' rights advocates, and other concerned citizens began exploring the extent to which the administration of psychotropic medication was both unnecessary and avoidable (Klein, 1986, pp. 80–86; Tanay, 1980, p. 1; Winick, 1986, pp. 7–31). In some instances, courts found that medication reliance was administered strictly for staff convenience not patient treatment (*Davis v. Hubbard*, 1980, p. 926). In addition, inaccurate diagnoses subjected many mental health consumers to a forced regimen of harmful neuroleptics (Lipton & Simon, 1985, p. 369; Pope & Lipinski, 1978, pp. 825–826). Compounding these problems was the countertherapeutic use of antipsychotic drugs for purposes of punishment and control (Brooks, 1987, p. 352; Szasz, 1977, p. 12; Szasz, 1984, p. 86). All of these factors led a district court judge to conclude that the administration of antipsychotic medications by public hospital staff occurred in a "grossly irresponsible" fashion (*Rennie v. Klein*, 1979, p. 1301).

Despite increasing evidence detailing the harmful effects and inappropriate administration of drug treatment for psychiatrically ill citizens, most state mental hospitals continue to rely on this intervention believing it to be the most effective mode of treatment (LaFond & Durham, 1992; Levy & Rubenstein, 1996). In the wake of this controversy, the constitutional right of involuntarily committed mental patients to refuse antipsychotic medications was born (*Rennie v. Klein*, 1981, p. 836; *Rogers v. Okin*, 1980, p. 650; *Mill v. Rogers*, 1982, p. 291; *Winters v. Miller*, 1971, p. 65). The establishment of this liberty interest was based on a right to privacy which emphasized autonomy and self-determination (*Roe v. Wade*, 1973, p. 113; *Griswold v. Connecticut*, 1965, p. 479). This right does not pertain to persons either dangerous to self or others, in an emergency situation, or to those individuals unable to make a rational treatment decision (Doudera & Swazey, 1982; Roth, 1986, p. 139). The purpose of this right was

originally drafted so as to place final refusal in the hands of the consumer not the clinician (Brooks, 1987, p. 358). The practical effect, however, has been to grant patients a right of objection and to insist that the hospital staff review the person's medication regimen (Roth & Appelbaum, 1982, p. 179). Final authority regarding treatment decisions continues to be vested with the psychiatrist and attending treatment team (*Youngberg v. Romeo*, 1982), provided their judgments correspond with the agreed on practices of the medical profession (Gutheil, 1980; Gutheil, 1985).

Although the right-to-refuse treatment doctrine was designed to curb psychiatric abuses in the care and treatment of the mentally ill, procedural safeguards ensuring this right have significantly hampered its effectiveness (Brooks, 1987, p. 341; Winick, 1997a). While the right to a due process hearing presided over by an independent psychiatrist not affiliated with the state mental health system ensures that the case is decided on the merits of the refusal, this private physician must consider issues of patient competence or dangerousness, must assess the side effects of the medication, and must evaluate the availability of a less intrusive treatment for the patient (*Mills v. Rogers*, 1982).

This process was made formidable with the decision in *Rogers v. Okin* (1984) (Isaac & Armat, 1990, p. 250). Here, the court ruled that a judicial hearing was required on the issue of competence and that the appointment of a guardian *ad litem* was necessary for refusing patients diagnosed as incompetent. As a result of the competency question, many mental health consumers declining medication returned to their previous chronically ill state (Gormley, 1984, p. 366; Hughes, 1984, p. 483; *In re Guardianship of Roe*, 1981, p. 40). Additionally, this latter guardianship protection raised important ethical questions involving the substitution of one's judgment for the diagnosed incompetent mental health consumer (Treffert, 1982, pp. 123–125), and the role that informed consent played in a patient's right-to-refuse decision making (Appelbaum & Gutheil, 1981, pp. 129–202). Psychiatrists criticized the legal system for abuses in competency hearing delays, and have drawn attention to what they regard as the real issue; namely, quality of care (Appelbaum & Gutheil, 1981, p. 720) not the "right to rot" (*Project Release v. Prevost*, 1983, p. 971).

Subsequent courts addressing the issue of a nondangerous mentally ill person's rights to refuse treatment have continued this focus on the matter of competence (*Mills v. Rogers*, 1982, p. 306). And, as I will subsequently explain in my discussion of the least intrusive means or least restrictive alternative doctrine, the shifting tensions in the psycholegal debate appear to be moving in the direction of the medical profession's preference for treatment. While the U.S. Supreme Court has declined to assess whether or not an involuntary committed mental patient has a federal constitutional right to refuse antipsychotic drugs (*Stensvad v. Reivitz*, 1985, p. 131), other federal district courts are addressing related matters (*Stensvad v. Reivitz*, 1985, p. 131). Their judgments reflect an ever-increasing ero-

sion of the right-to-refuse treatment phenomenon established by earlier decisions. As one court concluded, “an involuntary commitment is a finding of incompetency with respect to treatment decisions. Nonconsensual treatment is what involuntary commitment is all about” (cited in Durham & LaFond, 1985, p. 434).

Notwithstanding these legal trends, it is clear that civilly committed persons exercising their right to refuse antipsychotic medications conjures up strong adversarial sentiment among psychiatric and legal commentators (Winick, 1997). Governed by values of providing treatment and safeguarding liberty respectfully, the results of their antagonism has alternatively fashioned a system of ineffective treatment (Isaac & Armat, 1990, p. 263; Levy & Rubenstein, 1996) and noncare for the mentally ill (*Lake v. Cameron*, 1966, p. 660; *O’Conner v. Donaldson*, 1975, p. 576). This dilemma is exacerbated by the controversial meaning and application of the least restrictive alternative phenomenon; a doctrine that not only challenges the quality of treatment but also the locus of care.

The Least Restrictive Alternative Doctrine

The central question posed by the least restrictive alternative doctrine in cases of civil commitment is whether or not the method of treatment is least intrusive (*Jackson v. Indiana*, 1972, p. 729; *Youngberg v. Romeo*, 1982, p. 317; *Thomas S. v. Morrow*, 1986, p. 375), and the locus of care least confining (Hermann, 1990, pp. 382–384). These matters challenge clinical judgments regarding what constitutes the most effective psychiatric intervention (Costello & Preis, 1987, p. 1551), and medical and legal decisions about where that intervention can best be administered (Keilitz, Conn, & Giampetro, 1985, pp. 703–710). The obvious and persistent tensions created by such considerations are designed to satisfy the patient’s interest in being free from unnecessary and harmful treatment (Brooks, 1987, p. 351; Gutheil et al., 1983, pp. 7, 10; Zlotkin, 1981, pp. 375, 412).

In the involuntary hospitalization of the mentally ill, the least intrusive means analysis is an important consideration in right to refuse treatment cases (Brooks, 1987, p. 361; Gutheil et al., 1983, p. 10; Zlotkin, 1981, pp. 423–428). At issue is the careful balancing of the mental health consumer’s interests to be advanced by the administration of antipsychotic drugs (*Rennie v. Klein*, 1981, pp. 845–847). Some commentators, suspicious of this approach, claim that rather than securing efficacious treatment, “legal advocates have imposed a system of noncare in the most restrictive alternative” (Isaac & Armat, 1990, p. 333). Others point to the swelling number of chronically ill persons who, for lack of treatment, find themselves either homeless (Lamb, 1984a, p. 902; Rhoden, 1982, p. 408), or filtered through the criminal justice system (Treffert, 1982, p. 132; Myers, 1983–1984, p. 403).

More recently, because of the fallout of the least restrictive alternative principal, courts are deferring to the medical community's agreed upon assessment of what treatment is least intrusive (*R. A. J. v. Miller*, 1984, p. 1322; *Rivers v. Katz*, 1986, p. 345). While some jurisdictions continue to recognize this doctrine on the basis of state statutes and common law (*Rodgers v. Commissioner of the Department of Mental Health*, 1983), this liberty interest is giving way to what the U.S. Supreme Court has called "the demands of an organized society" (*Youngberg v. Romeo*, 1982, p. 320). In short, state mental hospitals are deciding what is in the best interest of the psychiatric citizen; judgments that carry with them a presumption of validity.

The problem with this approach in civil commitment matters is the unlikely probability that professional psychiatric consensus will opt to forego drug therapy or hospital confinement when treating mental health consumers (Arrigo, 1992b, p. 26). Essentially, the medical establishment would need to admit that a treatment regimen of antipsychotic medication and involuntary hospitalization possessed only limited effectiveness (Durham & LaFond, 1988, pp. 346–351) and, therefore, was not consistent with reasonable professional standards in treating mentally ill persons (*Clark v. Cohen*, 1986, p. 79). Moreover, community-situated treatment would have to be consistent with reasonable professional standards, satisfying the "minimally adequate" treatment needs of the psychiatric consumer (Costello & Preis, 1987, pp. 1548–1549). This kind of deliberate departure from the medical model approach does not appear to be forthcoming (Levy & Rubenstein, 1996).

Aside from the problems of forced treatment and institutional care, are the disturbing consequences of the court's more recent wholesale support for psychiatric decision making in confinement matters. The deference afforded the medical profession's mode of psychiatric intervention presupposes that mental health consumers are persons lacking control and judgment, needing to be confined for their own good (Morse, 1982a, pp. 58–67). Some critics denounce psychiatric assessments citing what they believe to be the medical community's manufacturing of madness (Szasz, 1970, pp. 83–110). Other commentators resist judicial support for total psychiatric decision making in civil commitment and treatment matters, maintaining that "psychiatric opinions are essentially political judgments" (Pfohl, 1978, p. 229).

Whether opposed to heightened psychiatric authority in issues of patient treatment, or a firm believer that "the worst home is better than the best mental hospital" (Cumming & Cumming, 1957, p. 34), the results of the clinicolegal debate on the least restrictive alternative doctrine have only further stigmatized the mental health consumer (Scull, 1989, p. 218). The meaning of liberty for the involuntarily committed person is "social marginality, deprivation, and despair" (Warren, 1982, p. 203). Both the courts and psychiatry have fashioned a system which one observer woefully concludes, "harms and kills the

sick” (Warren, 1982, p. 203). These outcomes are a product of the imposition of legal and medical values that unfortunately cast the psychiatric citizen as a social outcast (Arrigo, 1996b). One attempt to minimize stigmatization that provides for treatment while respecting legal safeguards, has been the suggestion of involuntary outpatient commitment. Amid a climate of flux and uncertainty in matters of civil commitment, this strategy ostensibly offers hope for a necessary balance between individual and state interests.

Involuntary Outpatient Civil Commitment

A logical extension of the right to refuse treatment and least restrictive alternative controversies is the issue of involuntary outpatient commitment (Hinds, 1990, p. 847; Keilitz et al., 1985, p. 693; Winick, 1997a). The mental health literature reflects that there is no standard definition, shared perception, or agreed on practice among states invoking this doctrine on what exactly it entails (Miller, 1982, p. 265). Quasi-experimental studies offer only limited information regarding outpatient commitment procedures (Hiday & Goodman, 1982, pp. 791–793) and patient types admitted with expanding commitment laws (Miller & Fiddleman, 1984, p. 149). This notwithstanding, legal commentators have relied on it to construct arguments outlining when state intervention in the lives of psychiatric citizens is beneficial or problematic. Some reviewers argue that compulsory community treatment is essential so that the state does not discriminate against the poor; consumers disproportionately committed to psychiatric facilities (Bleicher, 1967, p. 93). Others propose a more selective reliance on the practice of involuntary outpatient commitment, restricting its use to individuals committed under the *parens patriae* justification (Myers, 1983–1984, p. 412), or pursuant to conditional release or outpatient commitment statutes (Hinds, 1990, p. 381).

Despite differing views on its meaning and its use from both the medical and legal professions, compelling treatment in the community is increasingly recommended for chronically mentally ill individuals (Hinds, 1990, p. 381). The hope is that those persons with a history of failing to follow through on their treatment plans (voluntarily taking prescribed antipsychotic medications and consistently maintaining scheduled therapy appointments), can be prevented from future inpatient hospitalization by involuntary outpatient civil commitment (Bursten, 1986, p. 1256; Hiday & Scheid-Cook, 1987, p. 229).

A number of arguments have been put forth which address the advantages and disadvantages of compelling involuntary treatment in the community (Mulvey, Geller, & Roth, 1987, p. 571). Proponents argue that a population of some mentally ill persons cannot experience the full benefits of living freely and autonomously in our society without the imposition of some structure (Lamb,

1984a, p. 903). Involuntary outpatient civil commitment ensures this structure, protects mental health consumers from becoming disenfranchised and abandoned, and safeguards their liberty to the fullest extent that their disability will allow. Supporters also point to the possibility for greater comprehensive service delivery when treating patients in the community; avoiding the reactive, crisis-oriented approach that governs most state mental hospital systems (Caton & Gralnick, 1987, p. 860). Finally, advocates of this position maintain that psychological treatment in the community “introduces the patient to the experience of living . . . in a nonpsychotic state” (Mulvey, Geller, & Roth, 1987, p. 578). Therefore, involuntary outpatient commitment facilitates an ongoing process of stable rehabilitation in a community setting.

Critics of this intervention strategy are primarily concerned with what they believe to be another effort at coerced treatment under threat of state action for noncompliance (Hinds, 1990, p. 388). Concerns about the limited efficacy of available treatment, especially when forced, suggests that individual liberty interests will be sacrificed at the expense of mere social monitoring functions (Morse, 1982a, p. 74). This raises additional questions about the extent of governmental intrusion in the lives of mental health consumers. Intervention in the form of compulsory community treatment may lead to unwarranted intrusions elsewhere for an expanded group of mental health clients. Specifically, because the dangerous standard for involuntary outpatient civil commitment would necessarily be lower than the inpatient standard, the need-for-treatment criterion would gain greater prominence. This could subject many mentally disordered persons to the same discretionary abuses psychiatry practiced prior to the inclusion of the dangerous criterion. In addition, the right-to-refuse treatment doctrine would not extend to cases involving compulsory community care. “By definition, a person cannot refuse treatment while being involuntarily committed on an outpatient basis” (Mulvey, Geller, & Roth, 1987, pp. 516–517). Another objection to the practice of involuntary outpatient civil commitment is the potential for abuse and the difficulty with ensuring quality control. The outpatient relationship occurs in a noncontrolled environment, between a patient and professional. Transactions are private and monitoring of actual service delivery, both in method and manner, are not easily verifiable. A final concern voiced by opponents of involuntary outpatient commitment is the harm caused to the therapeutic relationship. Reliance on coercion significantly jeopardizes the likelihood that consumers will positively and willingly accept treatment, no matter how efficacious the intervention may be. A system predicated on negative sanctions can only further stigmatize persons already suffering from acute alienation (Mulvey, Geller, & Roth, 1987, p. 577).

What the preceding analysis on involuntary outpatient civil commitment discloses, is how uncertain both the psychiatric and legal communities are when addressing issues of effective treatment that do not infringe on an

individual's fundamental liberty interests. Once again, both camps assume to know what is best for the psychiatric citizen. Whether asserting a need for treatment or a right to liberty, these professions exercise a degree of paternalism that significantly distances the mentally ill from the rest of society. Although some courts have recognized the right of *competent* mental health consumers to refuse medication absent an emergency (*Rogers v. Okin*, 1980, p. 656; *In re Guardianship of Roe*, 1981, p. 55), and although arguments have been advanced that assert the right of a competent outpatient to refuse medication in a nonemergency situation (Hinds, 1990, p. 392), one thing is unequivocally clear: courts decide on the issue of competency (Weiner, 1985, p. 341), and clinicians treat consumers as patients that are sick (Scheff, 1984, pp. 8–12) and incompetent (Roth et al., 1977, p. 280). The point is not that the legal and psychiatric communities have no role to play in the lives of mental health clients. Moreover, the point is not that the mentally disordered need no care. *The real issue is understanding the implicit values that underpin clinicolegal decision making and then evaluating what consumer needs are being met by such an approach.* This undertaking will significantly help to contextualize the kind and quality of services provided to the mentally disabled. In addition, by comprehending just what values are protected by civil commitment and confinement laws, it may be possible to initiate a system that moves beyond the present climate of uncertainty and abandonment.

THE POLITICS OF ABANDONMENT

I have argued that existing psychiatric and legal decision-making practices in civil commitment matters foster a disturbing system of care for mental health consumers. Moreover, this system effectively treats these citizens as the outcasts neither profession necessarily intends them to be. One possible explanation for the failed service delivery system involves the social values that underpin psychiatric and judicial intercession. While reference to the historical dimensions of paternalism has been cited as a contributory factor, scant attention has been given to the various forms in which paternalism currently manifests itself in relation to the mentally ill. As a point of departure, I recognize that there is, ostensibly, a fundamental clash of interests operating in civil commitment matters (Hermann, 1990, p. 361); namely, the rights of an individual to engage in independent choice-making versus state interference justified on the basis of benevolently securing the happiness, welfare, and needs of the coerced party (Dworkin, 1979, pp. 78–90). Notwithstanding this tension, the intrusion into the lives of many mentally disturbed persons is significant and profound. In part, this is the product of law and psychiatry's commitment to paternalism, a social value that is recognizable by its three distinct forms.

THE THREE FORMS OF PATERNALISM

Social Control

The social control argument essentially posits that involuntary hospitalization is a necessary and acceptable response to a disabled person's lack of behavioral control (Zusman, 1982, pp. 118–125). This position further assumes that the individual mental health consumer, contrary to the ordinary citizen, lacks choice-making capacity and therefore cannot knowingly be deterred from engaging in violent or dangerous conduct (Treffert, 1985, p. 259).

The contribution of the legal system in deferring to and then regulating what psychiatry labels incapacity through dangerousness, grave disability, or both demonstrates how this profession esteems social control interests (Perlin, 2000). While many courts attempt to ensure that full disclosure of the risks and benefits inherent in a particular course of psychiatric treatment are made available to a consumer with sufficient faculties to reasonably understand what is being proposed (*Von Luce v. Rankin*, 1979, p. 448; *Truman v. Thomas*, 1980, p. 905), questions involving the voluntariness of the consent (*Aden v. Younger*, 1976, p. 662; *Price v. Sheppard*, 1976, p. 908) and concerns about the patient's ability to comprehend the impact of treatment, are part of the court's decision-making role (Gormley, 1984, p. 361). As previously mentioned, courts are increasingly relying on psychiatric expert testimony to ascertain whether or not individual mentally disturbed persons possess choice-making capacity to assume responsibility for their physical welfare (Reiser & Slobogin, 1990, p. 397). When an incompetency determination is made, the court may appoint a guardian to represent the interests of the consumer (*In re Guardianship of Roe*, 1981; *In re Colyar*, 1983, p. 738). When the psychiatric citizen is found incapable of rendering informed consent in matters of treatment or confinement, a substituted judgment must be made for the patient by the court (Gromley, 1984, p. 365).

There is a striking parallel that I wish to draw between the court's interest in protecting the welfare of mentally ill citizens and wards of the state; specifically minors. In fact, recent statutory language addressing guardianship law states the following: "[A] guardian of an incapacitated person is responsible for care, custody, and control of the ward. . . . [Such] guardian has the same duties, powers and responsibilities as a guardian for a minor" (Uniform Probate Code, 1990) (emphasis added). Moreover, massive support for the enactment of Adult Protective Service statutes (APS) has occurred during the past 15 years. This is evidenced by the majority of the states having adopted some sort of APS provision (Myers, 1983–1984, p. 416). These statutes, designed to provide necessary treatment for the mentally ill, are modeled after comparable statutes representing the needs of children and youths (Myers, 1983–1984, p. 416). Finally, while the U.S. Supreme Court has recognized that juveniles possess a panoply of pro-