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A COMMENTARY:  
WHY CIVIL COMMITMENT LAWS DON'T  
WORK THE WAY THEY'RE SUPPOSED TO

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*It is often presumed that the legal rights of those who are mentally ill or alleged to be mentally ill are adequately protected by the changes in civil commitment statutes that most states instituted during the 1970s. The author who participated in the writing of these reform statutes recently observed 63 civil commitment hearings. The gap between the stated requirements of the statute and the actual conduct of the commitment hearings was substantial. This paper attempts to explain why the reality has failed to meet the promise.*

In the late 1960s and throughout the decade of the 1970s, substantial changes in the civil commitment laws in the United States were enacted. Prior to these changes a person could be committed to a mental hospital simply upon the certification of a physician that a person was mentally ill, and without benefit of any meaningful judicial review or oversight. The new statutes established a new and tougher standard of committability—a person had to be both mentally ill and as a result of that mental illness physically dangerous to themselves or others—and that determination had to be made by a judge or jury only after a judicial hearing that contained adequate due process procedures and safeguards. Physical dangerousness is conceived of as either direct physical injury to the person or others or as physical injury resulting from an inability to attend to basic physical needs such as food, clothing, and shelter.

Recently there has been some retrogression in a small number of states where a lesser standard of “mentally ill and in need of

treatment" has been added to the standard of mentally ill and dangerous, but the stringent model developed during the 1960s and 1970s stands as the legal format in the vast majority of states.

Thus civil commitment in most parts of the United States requires that it be shown by clear and convincing evidence that a person is both mentally ill and dangerous as a result, and that determination is to be made at a judicial hearing in which the person has the right to be present, to be represented by counsel, to have at least one mental health professional who is recommending commitment personally testify, to secure an independent psychiatric examination, and the right to present and rebut evidence. Further, before a temporary or emergency commitment can be accomplished (to be followed by a court hearing in a stated number of days), a person must be certified as meeting the commitment standard by either a physician or a mental health professional as well as by a psychiatrist.

Considering these statutory requirements, one might be led to believe that commitment hearings constitute fairly vigorous judicial proceedings. The reality is quite different. The average commitment hearing lasts only about 15 to 20 minutes and results in about 95 percent of the respondents being committed for treatment either as an inpatient, outpatient, or some combination of the two.

The author, who in the 1970s, participated in the writing of the commitment laws in two large states—Michigan and Illinois—recently researched the pertinent literature and subsequently observed some 63 commitment hearings held in a variety of jurisdictions within Michigan. Thus, while the following observations apply most directly to Michigan, all the available evidence indicates that the process is more or less the same throughout the United States. In fact, Michigan probably ranks above the majority of states in attempting to safeguard the legal rights of those who are mentally ill or alleged to be mentally ill.

Unfortunately, the only precise way to determine what percentage of people who go through commitment hearings in Michigan actually are committed for in-patient or out-patient treatment in any year would be to pull all of the appropriate court files in each of Michigan's 83 counties. The task of going through several thousand court records was beyond the scope of my investigation, and to my knowledge has not been done in any other state. I

consider the estimate of a 95 percent commitment rate to be a reasonable perhaps even a conservative one. Of the 63 commitment hearings I attended in three different jurisdictions representing some ten counties, there were only two outright releases—a 97 percent commitment rate. In addition, an examination of the court records for another and smaller county indicated that of the 18 commitment hearings held there in 1997, there were no releases. Further, numerous conversations with presiding judges, participating prosecutors and defense attorneys, and court administrative personnel supported this estimate—in fact some thought that the figure was probably even higher. Finally, while the literature from other states on commitment rates is eminently sparse, I have found nothing that would indicate that the Michigan experience is unusual.

Why is it that with most state commitment statutes fairly rigorously drawn, the commitment process itself is so truncated and the commitment rate so exceedingly high? Many different forces and factors seem to be at work and are here set forth:

#### STATUTORY EROSION

First, as previously noted there has, in fact, been some erosion in state statutes. For example, in 1995, the Michigan legislature amended the Michigan Mental Health Code so that the person who files the petition for commitment is not required to testify at the hearing and consequently can avoid being questioned by the respondent's (the patient's) attorney (1995 Mich. Acts 290). In general, one can observe that there is a whole constellation of interest groups (professional and self-described advocacy) who seek to ease or dilute the requirements for commitment and who represent influential or substantial constituencies. Against this stand an ever-diminishing band of civil rights lawyers who have either been financially declawed or whose attentions have been refocused on newer and "hotter" areas of social concern plus some few academics who have viewed the mental health system and who consider constitutional rights of some importance.

#### PRESUMPTION OF MENTAL ILLNESS

Since before a commitment hearing can be held the patient must have been certified as meeting the standard of commitment

by a physician or mental health professional (variously defined) and a psychiatrist (variously defined), there is almost a palpable presumption in the courtroom that the respondent must in fact be mentally ill and dangerous and which presumption appears to infect the entire proceeding. Whatever merit there may be to that presumption, the essential thrust of the reform movement in civil commitments—contrary to previous law—was that such a determination was to be made by a judge (or jury) and not by physicians or mental health professionals who could offer testimony (expert or otherwise), but no more.

### ROLE OF COUNSEL

It is axiomatic that no statute is self-executing. In commitment hearings the role of the respondent's counsel is crucial. Unless counsel mounts a vigorous defense in accordance with the expressed wishes of his or her client, the client will be overwhelmed. The reasons why counsel seldom does so are intricate and are related to the manner in which counsel is selected, the fees received, what I regard as an often misplaced benevolence, and, perhaps most importantly, an astonishing naivete' about the nature of mental illness and psychiatric expertise.

In Michigan, counsel is selected from a rotating court roster, on which any attorney can have his or her name placed, and for which he or she is paid about \$50 per commitment hearing. When I speak of their astonishing naivete' concerning mental illness, I am making reference (among other things) to the fact that almost all of the lawyers I spoke to who were participating in commitment hearings believed that a psychiatrist could establish a diagnosis of schizophrenia, bipolar disorder (manic depression), or clinical depression by means of some biological test such as urine, blood, or spinal fluid analysis, or through genetic testing or brain imaging. The scientific fact, of course, is that such diagnoses are only subjective evaluations based on the patient's reported history and the examiner's personal interpretation of what he sees and hears.

### DANGEROUSNESS

It is perhaps ironic that because the older laws only required a finding of mental illness and the newer laws require a finding of

both mental illness and dangerousness, that the issue of whether someone is actually mentally ill will now usually receive less attention than whether they are dangerous. In the 63 hearings that I recently attended, not once did I hear a respondent's attorney challenge the diagnosis of the state's testifying clinician. In fact, not once was the clinician forced to justify his diagnosis by reference to some benchmarked criteria. Since the respondent's counsel was either unable or unwilling to deal with psychiatric matters, his or her inquiry tended to focus on facts, allegations, and issues related to whether the respondent should or should not be considered dangerous to himself or others—and subsequently to treatment dispositions—inpatient, outpatient, or a combination.

#### INDEPENDENT PSYCHIATRIC EXAMINATION

If one has witnessed a criminal trial in which the defendant's sanity is a matter of issue, you are apt to observe that the psychiatric and psychological testimony offered by the state and the defense can be at considerable variance both as to diagnosis and prognosis. Consonant with that reality, contemporary commitment statutes will often provide that a respondent has a right to secure an independent psychiatric examination—and at state expense if indigent.

The Michigan statute has such a provision, and yet in all the hearings I observed, an independent examiner testified but once. Subsequent inquiries to court administrative personnel indicated that independent psychiatric examinations are utilized in only about two percent of the hearings—which is more or less consistent with the experience in other states (Van Duizend & Zimmerman, 1984).

As to why the percentage is so low, a specific answer is elusive. Probable factors include: counsel's or the patient's lack of knowledge that such a provision exists, the low fee paid by the state to an independent examiner, the probability that the examiner will be chosen from the same facility that employs the state's testifying clinician (and thus the possibility of a less than independent opinion), subtle discouragement from the court to avoid incurring the cost and lengthening the proceeding, the patient's disinclination

to delay or postpone the hearing which might thereby result (particularly if he or she is already hospitalized), and finally counsel's belief that an independent examination would simply confirm the state's diagnosis.

With the exception of the last explanation, the absence of an independent examination leads to an almost untenable situation. The state produces a clinician who testifies that the respondent is mentally ill. The respondent produces no opposing clinical testimony, and the respondent's counsel—as previously noted—almost never challenges the diagnosis of the state's clinician. Ergo.

### CLEAR AND CONVINCING EVIDENCE

In order for someone to be civilly committed in the United States, it must be proved by at least "clear and convincing evidence" that the person meets the criteria for commitment. This standard of proof was enunciated by the U.S. Supreme Court in 1979 (*Addington v. Texas*), and had been the standard utilized in the 1974 Michigan Mental Health Code. In the older commitment statutes, it was not unusual for people to be committed based on "a preponderance of the evidence," which is the common standard utilized in civil proceedings. The criminal standard, of course, is "beyond a reasonable doubt."

Of the three standards of proof, clear and convincing appears to be the most subjective in application. It has been suggested that a preponderance of the evidence should mean a 51 percent level of proof, clear and convincing a 75 percent level of proof, and beyond a reasonable doubt a 95 percent level of proof. It appears, however, that it is intellectually and emotionally easier to intuit a 51 percent level or a 95 percent level than it is a 75 percent level. In fact, since clear and convincing is a relatively recent legal construction, there is relatively little in case law or otherwise to illuminate at what point the balance is tipped, and none that I know of in Michigan.

Thus in observing commitment hearings it seemed clear that the participants were applying different levels of proof-certainty under the rubric of clear and convincing evidence and further that levels seemed to vary from court to court.

My own impression, and it is definitionally a personal one, is that judges were deciding cases much closer to a standard

of preponderance of evidence than to a standard of clear and convincing evidence. In fact, my own conclusion was that in less than one-third of the cases was it made clear and convincing to me that the respondent met the standard of commitment. This observation is made not to point a finger but to suggest that the standard of clear and convincing permits too wide an area of discretion and in application tends to pivot to a lesser standard of proof rather than to a more rigorous one—or at least so it seems in commitment hearings. What is obviously needed, as difficult as it may be to construct, is some legislative or judicial articulation that provides more specific guidance as to the weight and fulcrum of evidence that applies.

### DEFINITION OF MENTAL ILLNESS

As noted, the commitment standard requires a finding of both mental illness and dangerousness as a result of that illness. How is the fact of mental illness legally established? Again, as noted, the state's testifying clinician, most often stipulated as an expert witness, will offer his or her diagnosis usually in a conclusive fashion (the patient is suffering from a bipolar disorder); the respondent's attorney will neither challenge the diagnosis nor require the clinician to specify the signs that led to that diagnosis. The prosecutor will then ask the clinician whether in his or her opinion the respondent's illness falls within the definition of mental illness as set forth in the statute. The answer is invariably "yes."

Obviously defining mental illness in a generic sense is no simple task. The American Psychiatric Association's official definition (mental disorder) consists of 148 words that first appeared in its 1990 Diagnostic and Statistical Manual III and has been repeated in DSM III R and DSM IV. This definition presumably applies to the 300 or so syndromes listed in DSM IV.

The author examined the statutory definition of mental illness or mental disorder as contained in each of the 50 state civil commitment statutes. Aside from California which has no statutory definition (nor did Michigan until one was added to the 1974 Mental Health Code by a subsequent amendment), the definitions consist of one or two sentences.



About one-quarter of the states define the term either tautologically (A mentally ill person is someone who suffers from a psychiatric disorder) or by combining the two prongs of the commitment standard (A mentally ill person is someone who is mentally ill and dangerous to themselves or others). Another quarter define mental illness in functional terms (Mental illness is a mental disorder that results in adverse effects on a person's ability to function).

Approximately 50 percent of the states employ a definition that replicates or appears to be derived from a definition promulgated by the Massachusetts Department of Mental Health in 1970, when that state's civil commitment statute was rewritten. The wording then and now is: "Mental illness 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."

The derivative Michigan definition contained in its commitment statute is "'Mental illness' means a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life."

Two points deserve comment concerning the Michigan definition—and by extension the other 25 states employing a similar definition.

First, not once in any of the hearings that I attended was the issue raised by either the respondent's counsel or the court as to whether the alleged mental illness was indeed "substantial" or one that resulted in a "significant" impairment. Nor was the issue specifically addressed by the state other than by asking, *pro forma*, the state's clinician as to whether the respondent's illness met the statutory definition of mental illness.

Second, if the modifiers substantial and significant are implicitly or explicitly removed from the definition, what remains is a statement so inclusive as to imperil us all. Thus literally read, the definition would define me as mentally ill if I had a disorder of mood that impaired my judgment or behavior. I must say this happens to me at least once a month.

It was stated previously that the original draft of the Michigan Mental Health Code (and the Illinois Code) chose not to define the

term mental illness. It was felt by its authors that in the absence of a definition, the parties in a commitment hearing would be forced to examine more concretely and critically the substance of such an allegation. To my knowledge, California is the only state that does not have such a definition, but I have been unable to uncover any material that has examined that singular approach and its consequences. But surely the definitions of mental illness by which people are committed in the United States should give us all some pause.

### JUDICIAL CAUTION

Most judges who preside over commitment hearings have to stand for reelection from time to time. Thus, it should not be surprising if judges would seek to avoid situations where someone they had decided should not be committed then proceeded to inflict serious physical harm on themselves or even more dramatically on others. This would seem to lead to a bias (although some would deny it) for commitment, for however short a period of time, and a transfer of the release decision to a mental health professional who is not as publicly visible and who does not have to run for elective office. This bias or tendency seems to be actively reinforced by a general public perception, strongly advanced by some mental health professional and advocacy groups, that mental illness is biologically based (whatever that means) or a biologically caused illness, although the evidence to support a biological etiology (except in clear organic situations) is far from persuasive (Valenstein, 1998). But judges are first human beings with careers and other obligations to consider, and it should not be surprising if they tended to play it safe rather than to adhere to the strict letter of the law, particularly in an area so loaded with uncertainties.

### CONCLUSION

It was more than two hundred years ago that Sir William Blackstone, a prime molder of Anglo-American jurisprudence, offered the criminal law maxim that "It is better that ten guilty persons escape than that one innocent suffer" (Commentaries, 1769). When it comes to civil commitment, which the U.S. Supreme

Court in 1972 defined as a "massive curtailment of liberty" (*Humphrey v. Cady*), and which the Court has consistently reiterated, most recently in *Kansas v. Hendricks* (1997), we seem to prefer a much less rigorous standard.

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