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CIVIL COMMITMENT: RIGHTS OF THE MENTALLY DISABLED, RECENT DEVELOPMENTS AND TRENDS

Edward B. Beis*

The 1967 Mental Health Code was considered an enlightened legislative approach to the area of the civil commitment of mentally disabled. The area has become confused both in terms of legal practice and medical treatment. Mr. Beis presents a lucid account of what the law has been and should be based on his experience in Cook County and on the statutory and case-law development. He sets forth a very instructive article outlining the specific procedure for committing individuals and analyzes the attorney's role in the attorney-client relationship. Mr. Beis sees civil commitment as a matter of the protection of the individual's rights as well as a means of helping a client medically.

The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest.¹

In 1967 the Illinois Legislature enacted a Mental Health Code² which provides substantial protections for persons admitted, voluntarily or involuntarily, to mental hospitals. The purpose of this article is to give attorneys unfamiliar with mental health law a basic understanding of how the process works in Cook County. Also to be discussed will be the recent developments which affect the rights of the mentally disabled and whether, in view of these developments, the Code as implemented adequately protects persons falling within its purview.

HOSPITALIZATION PROCEDURE

There are several procedures available for the hospitalization of a person who is believed to be in need of mental health care. A

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* Director, Patient Legal Services, Cook County Legal Assistance Foundation, Inc., Chicago, Illinois.
1. J. S. MILL, ON LIBERTY 18 (Gateway ed. 1962) [emphasis added].
2. ILL. REV. STAT. ch. 91½, §§ 1-1 et seq. (1971) [hereinafter referred to as the "Code"].
person who desires treatment may go to the intake unit of a facility and request either an "informal" or a "voluntary" admission—the latter is by far more common than the former. A person who is diagnosed as afflicted with a mental disorder and who does not desire treatment may be involuntarily hospitalized if that person, as a result of such mental disorder, is reasonably expected at the time the determination is being made or within a reasonable time thereafter to intentionally or unintentionally physically injure either himself or other persons, or is unable to care for himself so as to guard himself from physical injury or to provide for his own physical needs.

Should it be decided that involuntary admission is necessary, three methods are available: emergency admission, which is the most widely used; admission on the certificate of a physician; and a petition for examination and hearing upon a court order.

The situation where a person must be involuntarily committed poses a problem. An effort should be made to persuade that person to voluntarily seek assistance. If this fails, trickery should not be used:

What do you tell the patient? Whatever you do, don't lie. Don't tell him he is going for a ride in the country to get the fresh air or that he is going to a nursing home or some other transparent fiction. Tell him that he is disturbed, or a bit high, or too depressed, or upset—or whatever is the truth—and that he is going to be hospitalized until he gets over this. You can say frankly that if he will go along without fuss, there will be no police, no goggle-eyed neighbors. And if you can't persuade him to go quietly, it is better to use force than fraud.

Before the situation reaches a crisis stage, the family may have

3. Only .006% of the admissions to state hospitals in Illinois in 1972 were "informal", while over 70% were "voluntary". ILL. DEPT. OF MENTAL HEALTH, Net Additions to Inpatient Mental Health and Mental Retardation Facilities and Direct Admissions According to Mental Health Code Legal Status on Admissions, table 2 in MENTAL HEALTH STATISTICS FOR ILLINOIS, FISCAL YEAR 1972 [hereinafter cited as STATISTICS]. In Cook County, "informal" admissions constituted only .4% and "voluntary" 63.9% of all admissions. Id.


5. STATISTICS, supra note 3. In Cook County, the emergency admission is routine. In 1972, there were 3,013 emergency admissions as opposed to only 342 on a physician's certificate in Cook County. Statewide in 1972, there were 4,776 admissions under emergency petitions and 1,947 on the certificate of a physician. Id. For a discussion of the use of the emergency procedure outside of Cook County, see Brakel and South, Diversion from the Criminal Process in the Rural Community, 7 AM. CRIM. L.Q. 122, 170 (1969).

6. See note 58 infra.

7. Davidson, Commitment in a Hurry, 3 EMERGENCY MEDICINE 90, 95 (1971).
sought help from one of the social agencies in Cook County.\(^8\) Generally, the family will simply take the person to the hospital against his will. The concerned party—usually a family member or relative—can also go to the State’s Attorney and request, by means of a petition for hospitalization, that the person be involuntarily taken to the hospital by the police. Anyone who is eighteen years or older may file this petition. The State’s Attorney will then interview the petitioner as to the reasons why the person is felt to be in need of hospitalization. In Cook County, the State’s Attorney requires that the petitioner sign a statement\(^9\) under oath to support the petition. This statement declares that the person in need of mental treatment has not been examined by a physician and sets forth the reasons why. Commonly, the person in need of mental treatment has refused to be examined by a physician. The statement must also present facts which led the petitioner to believe that the person is in need of mental treatment, for example, “subject is threatening to kill his family and exhibiting suicidal tendencies.”\(^10\) The petitioner must also state that he is not involved in any legal controversy, either civil or criminal in nature, with the person alleged to be in need of mental treatment. This sworn statement supports the “Petition for Hospitalization” which is signed by the petitioner.\(^11\) The State’s Attorney arranges for the preparation of the “Order for Detention and Examination”\(^12\) and the “Writ for Detention, Examination and Appearance Before a Court.”\(^13\) The Petition, with the statement, is presented to the court and, if the judge grants the motion for

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8. The Chicago Board of Health, for example, operates 18 community health centers where help may be sought. Chicago Sun-Times, Oct. 7, 1973 at 12, col. 1.

9. “Statement in Support of Petition for Emergency Detention and Examination of a Person in Need of Mental Treatment.” This affidavit is an unofficial form which contains general conclusions and is usually retained by the State’s Attorney.

10. This summary sentence was on a statement in a recent case handled by the author. The case is not cited in order to protect the identity of the respondent.


12. MHC form 10 (1968).

detention and examination, he signs the order and the writ. In Cook County, the writ usually directs the police to apprehend and transport the person alleged to be in need of mental treatment to a hospital for an admission under the emergency procedure. This writ procedure is not a major means by which persons are admitted to the hospital. The State's Attorney refuses to request a writ in about fifty percent of the cases in which his office is asked to proceed.

Another way for a person to end up at the hospital is through the criminal law process. The police are often called when someone is creating a disturbance in a public place, such as on a street, or in a restaurant or a theatre. If such a person appears to have a mental problem or is known to have a history of hospitalization for mental problems, the police will usually take him directly to the hospital. On the other hand, the police may take such a person to the police station, place charges against him, usually disorderly conduct, and then decide the person has a mental problem and take him to the hospital. The police may also take the person to the emergency room of a medical hospital where a physician will sign a certificate. Then the police will take the person to the mental hospital. Thus, a person incarcerated in the county jail may be sent to the hospital because the jail physician concludes that he has a mental problem.

When a person appears in court on a misdemeanor charge, either the defense attorney or the State's Attorney may ask the court to order an examination if either feels the person to have a mental problem. If the court so orders, the person is sent to the Psychiatric Institute of Cook County for an examination. If, in the opinion of the examining psychiatrist, the person is in need of mental treatment, a Petition and a Physician's Certificate will be filed by the psychiatrist and the person will be sent to the hospital.

14. A police officer has no authority to involuntarily take a person to the hospital without either a Petition or an Application for Hospitalization and a "Certificate of Need for Hospitalization". ILL. REV. STAT. ch. 91½, § 3-4 (1971). However, the solution is not to force a situation wherein the police charge the individual with disorderly conduct before he is hospitalized.

15. Two authors note that in Chicago in 1970 the courts referred over 6100 misdemeanor cases to the Psychiatric Institute and that, in about a third of these cases, the defendant was transferred to the mental hospital. Gilboy & Schmidt,
A person charged with a felony may be sent to the Psychiatric Institute for an examination in order to determine whether he is fit to stand trial, that is, whether he is able to "understand the nature and purpose of the proceedings against him" and is able to cooperate with his counsel in the preparation of his defense. If the psychiatrist determines that the person is unfit to stand trial, a hearing is held. If the court also finds that the person is unfit to stand trial, it will place him in the custody of the Department of Mental Health and he will be sent to a mental hospital.

Admission to a Hospital

A person arriving at the hospital will be taken immediately to the intake unit. A social worker interviews the person and completes an intake summary which includes personal information, the circumstances surrounding and the reasons for the person’s presence at the hospital, and a diagnostic impression. This information may be obtained from persons who accompany the patient to the hospital—family members, police officers or jail officials. The patient is also asked to fill out an intake questionnaire which contains such general information as the patient’s address, social security number, age, income, place of employment, whether the patient has been previously hospitalized, whether the patient is a veteran and the names and addresses of the nearest relatives.

The patient is then examined by a physician who makes a diagnosis. One author has described what the physician should look for in his examination:

You note the patient’s general appearance, tidiness, and whether he is bedridden, chairbound, or ambulatory. Is he aware of his surroundings and well oriented? Is he restless, overactive, silly, mute, overtalkative, coherent, or talking under pressure? What is his mood? How deep is the mood, how stable, and how appropriate to the situation? How well does he remember recent and remote events? Does he have any grandiose delusions, ideas of personal unworthiness, or sense of being persecuted?

"Voluntary" Hospitalization of the Mentally Ill, 66 Nw. U.L. REV. 429, 444 (1971) [hereinafter referred to as “Gilboy & Schmidt”].


17. This brief examination hardly exhausts all the means by which a person may arrive at the hospital, e.g., a patient in a medical hospital which has no psychiatric ward will be sent to a mental hospital because of an attempted suicide or some other manifestation of a mental problem.
Does he have visual or auditory hallucinations? Does he consider himself mentally ill?18

If the physician believes that the person is in need of assistance with a mental problem and the person, in fact, wishes to be admitted to the hospital, he usually will allow the person to sign in as a "voluntary" patient. However, the physician could allow the person to be admitted on an "informal" basis, but this rarely occurs in Cook County.19

If the person is at the hospital involuntarily and the opinion of the physician is that he has a mental problem, the physician usually will encourage him to become a "voluntary" patient. Thus, some persons who are brought to the hospital involuntarily stay on a "voluntary" basis. If the person refuses, the physician then must determine, whether in his opinion, the person is in need of mental treatment as defined by the Code.20 If the physician so finds, he must prepare a "Certificate of Need for Hospitalization" certifying that the person is in need of mental treatment, before the person can be involuntarily admitted.21 The physician should be as specific as possible:

If he [the patient] has an idea that he is being persecuted, for instance, it is not enough to write that. Illustrate by quoting what he actually says to that effect.

If the patient tells you, "They look at me in a very suspicious way," write it down just like that, in quotation marks. Don't write: "Patient thinks they look at him in a funny way."

. . . .

Perhaps another physician has just heavily sedated the patient with tranquilizers, barbiturates, or other medications. If he is then confused, unresponsive, or mute, it is unfair to note that on a commitment paper without specifying that he was also oversedated—and, if you know, with what.22

Information might be obtained by asking relatives or other persons whether the patient had made any recent overt threats of violence

18. Davidson, supra note 7, at 95.

19. For the difference between an "informal" admission and a "voluntary" admission, see text accompanying notes 40-56, infra.

20. ILL. REV. STAT. ch. 91 1/2, § 1-11 (Supp. 1972). This is the statutory definition of in need of mental treatment.

21. For a discussion of the involuntary procedure, see text accompanying notes 57-85, infra. The Certificate of Need for Hospitalization, MHC form 4 (July, 1973) is hereinafter referred to as the "Physician's Certificate."

22. Davidson, supra note 7 at 95.
or had actually harmed himself or others. One might also ask

[does he drink excessively or use marijuana, “speed,” L.S.D., opiates, barbiturates, or other mood-influencing drugs? Can these people describe any manifestations of destructive or suicidal behavior? Does the patient have a history of spells or seizures? Is he literate in English? Is he mentally retarded? Has he worked regularly?]

After the interviews and examination, the physician and the social worker each make out reports on the patient. The physician will also have given the patient a physical examination, generally writing out a prescription for him, and ordering that routine lab work, such as urinalysis, blood tests, x-rays, and tests for venereal disease, be conducted.

Once the examinations are completed, a security guard will take the patient's clothing and money. Any amount of money in excess of five dollars, which the patient may keep with him, is placed in a trust fund. With regards to security generally, if the patient is charged with a misdemeanor other than disorderly conduct under the city ordinance, he is sent to the mittimus unit which has greater security than the other wards. If the person is charged with a felony he is sent to a special unit at the Illinois State Psychiatric Institute. A security guard or aide will take the patient to the assigned ward. If the patient is violent, he may be placed in restraints.

Treatment

Upon arrival at the ward, the patient is introduced to a member of the nursing staff. The nurse tries to make the patient feel at ease and will inquire about any physical problems. The nurse begins a chart on the patient with the documents sent from the intake unit. The progress of the patient can be ascertained by a careful

23. Id.
25. Patients who are placed in this unit cannot be released upon discharge, but must be held for the sheriff because they have criminal charges pending and normally have not made bond. There are no ground passes available as in the other wards.
26. Restraints usually consist of broad leather straps placed around one of the patient's forearms and one of his legs, which then are attached to a bed. See text accompanying note 221, infra.
27. These include the intake summary, the intake questionnaire, the reports of the physician and social worker, legal papers (e.g., voluntary application, Physi-
review of this chart.\textsuperscript{28}

Most patients are assigned to therapy groups the following day. Medication, however, normally begins immediately unless it is for an involuntary patient who objects to the medication and is awaiting a hearing, which in Cook County is held from two to four days after admission.\textsuperscript{29} A person may be forced to take medication if he is acting in such a manner as to be a danger to himself or others.\textsuperscript{30} A patient has a right to make phone calls (there is usually a pay phone in the ward), write letters and receive visitors, although visitors who may have a detrimental effect on the mental health of the patient may be denied this privilege. The patient may also be given a grounds pass which allows him access to the hospital grounds, the work shop and other areas. A patient also may be given a "buddy" pass which allows him off the ward with another patient.

The Code provides that all patients are "entitled to adequate and humane care and treatment."\textsuperscript{31} The right of an involuntary patient to treatment is now in the process of being litigated in many states.\textsuperscript{32} Consent of the patient or his guardian or conservator must be obtained for some treatment, for example, electro-shock treatment or psycho-surgery.\textsuperscript{33}
The hospitals in Cook County provide short term treatment. If the patient shows no improvement within sixty days, the hospital may transfer him to a downstate hospital for long term treatment. If the patient is violent and either threatens or actually harms himself or others, the ward staff may request that the patient be transferred to the maximum security hospital at Chester. The patient is entitled to an administrative hearing on this issue. Until the hearing, the patient will be housed in the mittimus unit.

Involuntary commitments are indefinite in length since the patient is to remain in the hospital until he is no longer in need of mental treatment. If the patient wishes to leave he may file a "Petition for Discharge." This must be accompanied by a certificate of a physician or psychologist stating that the patient is no longer in need of mental treatment. The patient may file a petition for a writ of habeas corpus to have his confinement reviewed. There are also periodic reviews of the patient's mental condition as required by the Code.

If the patient is admitted on a "voluntary" basis, he may sign a request for release and the hospital must either discharge him within five working days or file a Petition for Hospitalization and Physician's Certificate to initiate proceedings for an involuntary commitment. If the patient has been admitted on an "informal" basis, he may leave at any time during the day hours of operation.

ADMISSIONS

Voluntary Admission

In Illinois, there are two procedures for the voluntary admission of persons to a mental hospital for treatment—the "informal" admission and the "voluntary" admission. A person admitted under

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34. See text accompanying notes 238-42, infra.
35. MHC form 21 (1968).
37. See text accompanying notes 228-30, infra.
39. ILL. REV. STAT. ch. 91 1/2, § 4-1 (1971).
the "informal" procedure\textsuperscript{40} is free to leave at any time during specified day hours and must be informed of this right "in writing and orally, in a language he understands, at the time of admission."\textsuperscript{41}  

A person admitted under the "voluntary" procedure\textsuperscript{42} may leave the hospital within five working days after giving "written notice of his desire to leave"\textsuperscript{43} to any professional staff person, unless, prior to leaving, either the patient withdraws such request by a written retraction,\textsuperscript{44} or someone initiates proceedings for his involuntary commitment.\textsuperscript{45}

Mental health professionals consider the voluntary admission to a mental hospital far more beneficial to a person than an involuntary admission:

There is no question but that the prognosis for a motivated patient who takes the first hard step of acknowledging his need for help and seeking such help on his own initiative is very much better than for patients forced to enter treatment against their will. In addition, voluntary patients for the

\textsuperscript{40} Id. A request is made by signing a "Request for Informal Admission," MHC form 1 (1968).

\textsuperscript{41} Ill. Rev. Stat. ch. 91\textfrac{1}{2}, § 4-1 (1971). A copy of the "Application for Voluntary Admission," MHC form 2 (1968) (hereinafter referred to as the "Application"), which contains a statement of the patient's right to leave, must be given to the patient and that right must be explained in language that the patient understands. A copy of the Application must also be given to any person who accompanies the patient to the hospital. Ill. Rev. Stat. ch. 91\textfrac{1}{2}, § 5-2 (1971). While a voluntary patient under the age of eighteen may not sign the Application, he may, if he is thirteen years or older, request his own release. In the past the Department of Mental Health failed to inform persons under the age of eighteen of their right to leave and to give them a copy of the Application. The department also refused to allow them to sign a "Request for Release of Patient on Informal or Voluntary Admission," MHC form 26 (1968). However, in 1972, a court held that "[s]uch a procedure is not consistent with the language of the statute and is a practice which does deny" persons under eighteen of their fourteenth amendment rights to due process and equal protection. In re Lee, Nos. 68 J(D) 1362, 66 J(D) 6383 (Cir. Ct. of Cook Cty., Ill., order of February 29, 1972) (unpublished).

\textsuperscript{42} Ill. Rev. Stat. ch. 91\textfrac{1}{2}, §§ 5-1 to 5-3 (1971). A person who is eighteen years old may himself sign the Application or a relative or attorney may sign, with the person's consent, on his behalf. If a person is under eighteen, "a parent, guardian, person in loco parentis, the Department of Corrections or Department of Children and Family Services" must sign the Application. Id. at § 5-2 (1971).

\textsuperscript{43} MHC form 26 (1968).

\textsuperscript{44} Some wards type up a retraction while others utilize an unnumbered form entitled "Retraction of Request to Leave" which is authorized by Ill. Rev. Stat. ch. 91\textfrac{1}{2}, § 5-3 (1971). Hospital personnel often times try to convince a patient to retract his request to leave based on the argument that he is still in need of treatment.

\textsuperscript{45} Ill. Rev. Stat. ch. 91\textfrac{1}{2}, § 5-3 (1971).
most part seek assistance at an earlier stage of their illness, at a time when the therapeutic intervention can be maximally effective.\textsuperscript{46}

Illinois' "informal" procedure is considered the ideal form of admission:

The ideal would be a hospital structure in which any individual having an emotional or mental condition requiring hospital treatment could feel free to gain admission without going through such procedures as voluntary commitment. This is in the same sense that one does not commit himself for the treatment of his acute appendicitis or for his fractured leg. Optimally a person should be able to go into a hospital and to leave a hospital upon due notice, regardless of the medical condition.\textsuperscript{47}

Unfortunately the "informal" procedure is seldom used in Illinois—only .006 percent of admissions to state mental health centers were "informal" in fiscal year 1972.\textsuperscript{48} The reasons for the infrequent use of this procedure is that hospital personnel believe that it does not give them sufficient control over the patient since, under this procedure, he may leave against their advice if he so desires.\textsuperscript{49} It has also been characterized as an "inconvenience" for the hospital personnel and "an unnecessary allowance" to patients.\textsuperscript{50}

The "voluntary" admission procedure in Illinois is something less than purely voluntary. In an "informal" admission situation, the patient agrees to admit himself for treatment and the hospital agrees to allow him to leave during day time hours if he so desires. In a "voluntary" admission situation, the patient agrees to admit himself for treatment and the hospital agrees either to allow him to leave

\textsuperscript{46} Hearings on Constitutional Rights of the Mentally Ill Before the Senate Subcommittee on Constitutional Rights of the Committee on the Judiciary, 91st Cong., 1st & 2d Sess. 322 (1970) [hereinafter cited as Hearings] (testimony of Dr. Sherman Kieffer, Director, National Center for Mental Health Services, Training and Research of St. Elizabeth's Hospital, Washington, D.C.). See Hearings, id. at 27 (testimony of Zigmond M. Lebensohn, M.D., Clinical Professor of Psychiatry, Georgetown University School of Medicine and Chief of the Department of Psychiatry, Sibley Memorial Hospital, representing the American Psychiatric Association); Note, District of Columbia Hospitalization of the Mentally Ill Act, 65 COLUM. L. REV. 1062 (1965).

\textsuperscript{47} Hearings, supra note 46, at 116 (testimony of Dr. Leon Yochelson, Chairman of the Committee on Mental Health of the District of Columbia Medical Society). Another witness noted: "I do think that the experience of New York and Illinois does make it clear to us that informal admission is even better than so-called voluntary admission, because it is precisely the same kind of admission which occurs when a patient walks into a hospital for medical observation and treatment." Hearings, id. at 27 (testimony of Zigmond Lebensohn, M.D.).

\textsuperscript{48} Statistics, supra note 3.

\textsuperscript{49} Gilboy & Schmidt, supra note 15, at 432.

\textsuperscript{50} Id.
within five working days from the time of his request to leave or if it is felt that he is still in need of treatment, subsequent to the request, to seek a court order to involuntarily commit him. The "voluntary" procedure was utilized in over seventy percent of the admissions to Illinois state mental hospitals in fiscal year 1972.51

Several problems arise, however, in the context of the "voluntary" admission. "Voluntary" patients do not always understand that, should they express a desire to leave, the hospital staff may initiate involuntary commitment proceedings. This lack of understanding may be caused by an inadequate explanation of the procedure by the intake personnel. Another explanation may be that the patient is too ill to understand the procedure, in which case the appropriateness of such an admission is rendered questionable.52 Regardless of the reason, an incomplete understanding of the agreement by the patient will neutralize the therapeutic benefits associated with a "voluntary" admission.

Another problem centers around the pressure exerted by the hospital staff on a person to become or remain a "voluntary" patient. It is not improper to encourage a person to become or continue as a voluntary patient if the hospital personnel are convinced that such a person is in need of mental treatment. To bombard the patient, however, with the advice that he ought to become or remain "voluntary" and to induce the fear of an involuntary commitment court hearing as a means of obtaining this end is undue coercion. Coercion by the hospital staff can range from the overt—making it difficult to sign a request to leave, to the more subtle—the therapist feigning to take the request to leave personally and being "hurt" by such a request. This problem is compounded when hospital personnel wish the patient to remain in the hospital as a "voluntary" patient because, from their medical viewpoint, he is in need of mental treatment even though the patient should legally be discharged as not "in need of mental treatment" according to the statute.

Hospital personnel sometimes have an ulterior motive for keeping the patient "voluntary"; they are not required to perform the inten-

51. Statistics, supra note 3.
52. If a patient is too ill to understand the agreement or incompetent, then he is incapable of agreeing to a "voluntary" admission. There are, however, no guidelines for intake personnel to follow in order to ascertain whether a patient is capable of signing an application.
sive examination necessary to prepare the Physician’s Certificate for an involuntary commitment proceeding. The staff time saved by not developing and presenting a formal case in court can be devoted to the treatment of patients. Some hospital staffs also fear going to court and being questioned about their clinical judgment. These considerations sometimes lead hospital personnel to go beyond permissible bounds in persuading a person to remain as a “voluntary” patient.

In a 1971 study, it was found that

in a majority of the cases in which voluntary admission procedures were used, the individuals were already under some form of official custody and were faced with the threat of involuntary commitment proceedings as the principal alternative to voluntary admission. Neither at the mental hospital admissions office when persons were brought to that office by the police, nor in court when persons came before the judge at involuntary commitment hearings, was a serious effort made to adequately inform the individuals about the choice they were making.53

The person who chooses a “voluntary” admission in order to avoid going through the process of involuntary admission gives up all of the constitutional safeguards required in the later process.54 If a person does not wish to become a patient but becomes one out of the fear of being committed through the involuntary process, the therapeutic benefits of the “voluntary” admission may well be lost to that person while he has been coerced into giving up his constitutional safeguards. It has been suggested that if the patient is fully informed, he is thus giving up the right to the safeguards of the involuntary process for “the less restrictive and pejorative status” of a voluntary patient, a situation which may be roughly analogous to the plea bargaining process in criminal law.55 However, where the decision to become a voluntary patient is based on the fear of a court hearing and the official record of the testimony induced by hospital officials, family, friends or police, then the situation becomes more like that of a coerced confession.56

54. See text accompanying notes 57-85, infra for a discussion of these safeguards.
55. Gilboy & Schmidt, supra note 15, at 450. As authority for this assertion, the authors cite to Brady v. United States, 397 U.S. 742, 753 (1970).
admission is shown to be coerced, then the person may be entitled to be released. If the hospital personnel wish to detain the patient, they should be required to do so by using the statutory structure set up for "involuntary" admissions with all of its procedural safeguards.

**Involuntary Admissions**

There are three procedures established in the Code for the purpose of involuntarily committing persons who are asserted to be in need of mental treatment: Emergency Admission; Admission on Certificate of a Physician; and Petition for Examination and Hearing Upon Court Order. In Cook County, the emergency admission procedure is the one ordinarily used. In the fiscal year 1972, there were 3,013 cases filed under the emergency procedure and only 342 under the admission on certificate of a physician procedure.

**Emergency Admission**

If a person "is or is asserted to be mentally retarded or in need of mental treatment and in such a condition that immediate hospitalization is necessary for the protection from physical harm of such person or others," a Petition for Hospitalization may be presented to the superintendent stating the reasons for such a conclusion. This Petition must be accompanied by a Physician's Certificate which is based on an examination by a physician within 72 hours prior to admission. The certificate affirms that the person should be immediately hospitalized as a person in need of mental treatment or as a mentally retarded person and states the reasons for this affirmation. If a physician (or a psychologist if the person is as-
serted to be mentally retarded) is not immediately available, then the person may be admitted based upon the Petition alone for a period not to exceed 24 hours.\textsuperscript{65} Within 12 hours after the patient’s admission, he must be given a copy of the Petition and a “written statement in simple, clear and concise terms stating that the patient will be examined relative to the allegations of the Petition and will appear before a court for a hearing within 5 working days” after the court receives notice of the patient’s hospitalization.\textsuperscript{66} Within 24 hours, the patient must be examined by a psychiatrist. If the psychiatrist does not certify the patient to be either in need of mental treatment or mentally retarded, the patient must be released.\textsuperscript{67}

\textit{Admission on Certificate of a Physician}

This procedure differs from the emergency procedure in that an application\textsuperscript{68} instead of a Petition is filed with the Physician’s Certificate. The Application for Hospitalization states the facts supporting the applicant’s belief that the person is in need of mental treatment. Since no emergency exists, the Application for Hospitalization contains no allegation that immediate hospitalization is necessary. Within five working days after the Application for Hospitalization and the Certificate have been filed with the court, a judge of the Circuit Court must meet with the patient, explain his rights and determine “whether there is reasonable doubt as to whether the

(2) state his conclusion as to whether the person is in need of hospitalization on an emergency basis because he is likely to physically harm himself or others unless immediately hospitalized; (3) describe the specific acts upon which he bases his conclusion; (4) give the place and date of each of these acts; (5) list the witnesses to each of these acts and their addresses; and (6) list the names and addresses of his sources of information as to each act. If the information was obtained from a report or other written document, a copy must be attached. MHC form 4 (July, 1973).

65. \textsc{Ill. Rev. Stat.} ch. 91\textfrac{1}{2}, §§ 7-2, 7-3 (1971).

66. \textsc{Ill. Rev. Stat.} ch. 91\textfrac{1}{2}, § 7-4 (1971). The patient’s attorney and nearest relative must receive a copy of the Petition and written statement [MHC form 5 (1968)] within 24 hours either in person or by mail. The patient may designate that these documents be sent to two other persons and the patient may also make at least two phone calls of his choice upon admission.

67. \textsc{Ill. Rev. Stat.} ch. 91\textfrac{1}{2}, § 7-5 (1971).

68. “Application for Hospitalization on Certificate of a Physician,” MHC form 3 (1968) [hereinafter referred to as the “Application for Hospitalization”]. The Application for Hospitalization, unlike the Petition must be executed within 10 days prior to admission. \textsc{Ill. Rev. Stat.} ch. 91\textfrac{1}{2}, § 6-1 (1971).
patient should be detained as in need of mental treatment." If the judge so determines or if the patient indicates in any manner that he desires a hearing, the court shall order a hearing to be held within five working days. The judge may find that there is not probable cause to continue the hospitalization and may discharge the patient. If the patient does not indicate that he desires a hearing and the judge determines that there is no reasonable doubt as to the need for detention, the patient will remain hospitalized. At any time within the next sixty days, the patient may request a hearing. Under this procedure, a hearing also must be held on the written request of "any relative, friend or other interested person." If no hearing is requested during the sixty day period and the superintendent determines that the patient is in need of continued hospitalization, he must apply to the court for an order authorizing continued hospitalization. The patient, his attorney, his nearest relative, and, at the patient's option, at least two other persons designated by the patient, must be given written notice of the Application for Hospitalization which clearly states that the patient will receive a hearing if a request is made by the patient or someone on the patient's behalf. If a request is made, the court must set a date for a hearing within five working days.

Petition for Examination and Hearing Upon Court Order

Under this procedure, a Petition for Hospitalization is filed with the court. The court then makes such orders as are necessary to provide for an examination or a hearing. If the Petition is accompanied by a Physician's Certificate, the matter is immediately set for a hearing. If there is no Physician's Certificate, the court may order an examination. "[T]he person to be examined must

69. ILL. REV. STAT. ch. 91½, § 6-4 (1971). The infrequent use of this procedure in Cook County may be due to the lack of judges available to provide probable cause hearings at the hospitals.
70. Id.
71. Id.
73. Id. at § 6-6.
74. Id.
77. At least 36 hours prior to examination, a copy of the petition and order
be permitted to remain in his home or other place of domicile pending any examination, and be permitted to be accompanied by one or more of his relatives or friends to the place of examination" unless the court finds it necessary to order the person admitted to the hospital pending such examination.\textsuperscript{78} In the later situation, the court could order a sheriff, police officer or other person to transport the person to a hospital.\textsuperscript{79} The person cannot be held longer than 24 hours for purposes of examination and "shall" be released earlier if the examination is complete.\textsuperscript{80}

If the examining physician executes a Physician's Certificate, however, stating that the person is in need of mental treatment or mentally retarded, a hospital may admit the person and the matter is set for a hearing. When the court orders a hearing, notice of the time and place must be given to the patient, his attorney and the patient's two nearest relatives at least 48 hours prior to the hearing.\textsuperscript{81} The person "must be permitted to remain in his home or other place of domicile pending any hearing" unless the courts find hospitalization necessary."\textsuperscript{82} The hearing must be scheduled within five working days after receipt of the Petition and Certificate.\textsuperscript{83}

The Mental Health Code provides that once a hearing for involuntary commitment is scheduled, the patient may request, at any time prior to the court's finding that he is in need of mental treatment, to be admitted as an "informal" or "voluntary" patient, at which time the court will dismiss the pending petition.\textsuperscript{84} Since the hospital staff and administrators do not favor "informal" admissions and the Department of Mental Health acquiesces in this practice, the effectiveness of this option is greatly diminished. If the proceedings have been instituted by a petition for emergency admission or a petition for examination and hearing upon a court order, "the court may

\textsuperscript{78} \textit{Id.} at § 8-5.  
\textsuperscript{79} "Writ for Detention, Examination and Appearance Before a Court," MHC form 11 (1968).  
\textsuperscript{80} \textit{I.LL. REV. STAT.} ch. 91\%\%, § 8-5 (1971).  
\textsuperscript{81} \textit{Id.} at § 8-7.  
\textsuperscript{82} \textit{Id.}  
\textsuperscript{83} \textit{I.LL. REV. STAT.} ch. 91\%\%, § 8-8 (1971).  
\textsuperscript{84} \textit{Id.} at § 3-5.
require proof that such dismissal is in the best interest of that person and the public."\textsuperscript{85} Generally, the court will want to hear the opinion of the physician concerning the advisability of "voluntary" admission. The physician will normally recommend that the patient be allowed to admit himself on a "voluntary" basis if the person recognizes that he has a problem and wishes to remain in the hospital for treatment. If the physician feels that the person will immediately sign a request to leave or if the person has a history of frequent unauthorized absences, he will probably not recommend that the person be admitted on a "voluntary" basis.

THE HEARING

Role of Counsel

The patient has a right to counsel at the hearing and, if he is indigent, to the appointment of a public defender.\textsuperscript{1} If no public defender is available, the court must appoint counsel who will be paid a statutory fee.\textsuperscript{86} "Counsel shall be allowed time for adequate preparation and shall not be prevented from conferring with the person at reasonable times nor from making such reasonable investigation of the matters in issue and presenting such relevant evidence at such hearing as he believes is necessary to a proper disposition of the proceedings."\textsuperscript{87} The attorney for the patient should prepare for the hearing by interviewing the patient and examining his hospital records. He should also interview the patient's therapist, physician, relatives, family and any other witnesses to any of the incidents which are relevant to the hearing.\textsuperscript{88} Examination of the chart of the patient is essential, however, the patient's consent should be obtained in writing and presented to the ward staff when requesting

\textsuperscript{85} Id.

\textsuperscript{86} ILL. REV. STAT. ch. 91 1/2, § 9-4 (1971). The patient has a constitutional right to counsel. Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968). In Cook County, "the majority of the people subjected to commitment proceedings are the poor." Schneider, \textit{Civil Commitment of the Mentally Ill}, 58 A.B.A.J. 1059, 1061 (1972).

\textsuperscript{87} ILL. REV. STAT. ch. 91 1/2, § 9-4 (1971).

\textsuperscript{88} Since the proceeding is conducted in accordance with the Civil Practice Act, ILL. REV. STAT. ch. 91 1/2, § 13-1 (1971), the attorney for the patient has discovery methods available to him. However, since a hearing will be conducted in two to four days, he will have to choose between a continuance in order to utilize discovery procedures and a speedy hearing.
Particularly helpful is the comprehensive treatment plan which should be found at the beginning of the program notes. This plan should give the attorney an overall view of the patient’s situation. The intake reports will state the circumstances under which the patient was admitted to the hospital. The daily progress notes will indicate how the patient has been doing since his admission. The results of the physical examination should be reviewed and the doctor should be asked if any physical problem could be responsible for the patient’s mental condition. If the patient is drowsy or complains about the medication, the prescription and the amount of medication administered should be checked. Medication sometimes may cause such physical symptoms as restlessness and nervousness. The Petition, Physician’s Certificate, intake reports and criminal complaints will contain the names of potential witnesses. It is also important for counsel to determine, where criminal charges are pending, whether the patient has posted bond, since a discharge at the hearing will, in the absence of bond or some substitute, mean he will be sent to the County Jail.

The attorney should also explore the possibility of treatment short of hospitalization. There is always the possibility of negotiating a compromise for the patient. The physician may agree on outpatient treatment as a viable alternative if he could be convinced that the patient would take his medication. If it can be demonstrated to the physician that the patient has made realistic post-discharge plans and that he is not returning to the situation which caused the hospitalization, he may recommend the discharge of the patient. The physician and therapist will be concerned about such factors as whether the patient has a place to stay, if he has sufficient funds, whether he is going to school or if he has a good opportunity to obtain a job. The attorney may wish to advise the patient on these matters.

Counsel should explain to the patient his rights and discuss the

89. Consent is required because the patient’s records and reports are confidential. Ill. Dep’t of Mental Health, Rule 5.01 (1970) [hereinafter cited as “DMH”]. The Code has been amended to allow the patient as well as the attorney to examine these records. Ill. Rev. Stat. ch. 91½, § 12-3 (Supp. 1973).
90. See note 28, supra.
91. See text accompanying notes 18-26, Admission to a Hospital, supra.
possibility of a "voluntary" admission as well as the consequences of involuntary commitment. It is also important for the patient to understand the reasons that the psychiatrist and therapist may have for favoring involuntary commitment. If, after a full discussion, the patient wishes to remain outside the hospital, the attorney should advocate that position to the fullest extent. Counsel may offer his opinion and suggest alternatives, but once the patient decides to oppose hospitalization, counsel has the responsibility to fully represent his client's interests as the patient perceives them, not as the attorney judges them to be.92 As the Supreme Court said in regard to a defense attorney's responsibilities on a criminal appeal, "The constitutional requirement of substantial equality and fair process can only be attained where counsel acts in the role of an active advocate in behalf of his client, as opposed to that of an amicus curiae."93

There are other views on the role the attorney should play in an involuntary commitment hearing.94 One author has stated:

It is not adequate to have a public attorney or a public defender appear merely at the court hearings. From our observations, this type of legal representation proves ineffectual in practice. I feel that the patient needs a much different type of representation. He needs someone to "listen to his case"; someone who can give him advice about the legal consequences of hospitalization. The task of the lawyer would not be to "get the patient off" wherever possible. Instead, he would objectively weigh the medical, social and legal aspects of the proposed commitment, and then advise and assist the patient accordingly. Lawyers are accustomed to performing this type of counseling service, and they can be very effective at it. I am sure that, in most cases, the attorney would advise the patient that hospitalization will be the best thing for him.95

92. An attorney who defends patients, when asked whether the role of counsel should be more like that of guardian ad litem than that of a defense counsel, stated: Basically I resolve it in my own mind on a case-by-case basis. I try to be a "counsel" but also I try to arrive at an understanding of my patients' problems. If it appears he needs help, I try to persuade him into staying. However, when the patient absolutely insists on seeking release, I feel that I have to assist him all the way to that end.

Hearings, supra note 46, at 187 (testimony of David Addlestone, Staff Attorney, District of Columbia Legal Aid Agency).


The Right to a Jury, to be Present at the Hearing, and the Statutory Standard

The Code provides that the hearing "shall be conducted in accordance with the 'Civil Practice Act'." A person who is claimed to be either in need of mental treatment or mentally retarded has a right to a jury trial. Generally, a jury trial is not a good strategy as any instability or peculiarity could be easily elicited from a patient who could not withstand a tough cross-examination by a competent State's Attorney. The more peculiar the conduct of the patient, the more likely it is that the jury will feel that he should be in the hospital, even though the patient may not be dangerous to himself or others and is able to care for himself. The court will generally give cautionary instructions as to the jurors' role in the administration of justice in such a proceeding. Then the jurors will receive basic instructions on their obligation to consider all of the evidence, their right to consider the evidence in light of personal observation and experience, and their duty, as "the sole judges of the credibility of the witnesses," to determine the truthfulness of the testimony. Finally, the court will instruct the jury as to the burden of proof "in terms of what is more probably true than not true" and specifically as to the burden of proof on the factual issue:

The State has the burden of proving each of the following propositions:

First, that the Respondent is afflicted with a mental disorder;

Second, that the Respondent, as a result of such a mental disorder, is reasonably expected now or within a reasonable time hereafter to (a) intentionally or unintentionally physically injure himself, (b) intentionally or unintentionally physically injure other persons or (c) is unable to

97. A jury of six is to be chosen in the same manner as in other civil proceedings. Ill. Rev. Stat. ch. 91 1/2, § 9-2 (1971). This right should be discussed at the interview with the patient so that an intelligent decision can be made prior to the hearing.
98. Illinois Pattern Jury Instructions 2d, § 1.01 (1971) [hereinafter cited as IPI 2d].
99. IPI 2d, supra note 98 at § 1.02.
100. IPI 2d, supra note 98 at § 1.04.
101. IPI 2d, supra note 98 at § 2.01.
102. IPI 2d, supra note 98 at § 21.01.
care for himself so as to guard himself from physical injury or to provide for his own physical needs.\textsuperscript{103}

The defense attorney may wish to draft other instructions to fit his particular factual situation—that the medication is influencing the appearance of the patient or that a physical problem may be causing or affecting his mental condition. The patient must be present at the hearing “unless the attorney for the patient waives the patient’s presence and the court is satisfied by a clear and positive showing that the attendance of the patient would cause a serious risk of physical or emotional injury to him, in which circumstance the judge, or the jury, if there is a jury, shall personally observe and confer with the patient.”\textsuperscript{104}

The definition of “in need of mental treatment” requires that the person be afflicted with a mental disorder. However, textbooks on psychiatry discuss a great number of mental states referred to as disorders.\textsuperscript{105} The statutory definition specifically excludes persons whose mental processes have “merely been weakened or impaired by reason of advanced years.”\textsuperscript{106} It does not require that there be evidence of recent overt acts of physical violence or threats directed by the patient towards himself or others. It requires only a reasonable expectation “at the time of the determination or within a reasonable time thereafter that the respondent will intentionally

\textsuperscript{103} This is adapted from the statutory definition of a person in need of mental treatment. ILL. REV. STAT. ch. 91 1/2, § 1-11 (Supp. 1972). \textit{See} text accompanying note 4, \textit{supra}.

\textsuperscript{104} ILL. REV. STAT. ch. 91 1/2, § 9-4 (1971). Sometimes a relative or friend wishes to exclude the patient from the courtroom so as not to jeopardize his relationship with the patient. While a relationship may be jeopardized, if the testimony does not threaten any injury to the patient, the exclusion should not be allowed because the patient is often the only person who can refute or explain facts testified to by the witness. In Lessard v. Schmidt, 349 F. Supp. 1078, 1091 (E.D. Wis. 1972), the court said that attendance at the hearing by the detained party could not be waived.

\textsuperscript{105} \textit{See} \textit{American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders} (1969).

\textsuperscript{106} ILL. REV. STAT. ch. 91 1/2, § 1-11 (Supp. 1972).

When a person of advanced years is presented for admission, the hospital must ensure that a comprehensive physical and mental examination is performed along with a study of his family and community situation. This data will be used “to determine whether some program other than hospitalization will meet the needs of such person with preference being given to care or treatment in his home community.”

ILL. REV. STAT. ch. 91 1/2, § 3-7 (1971).
or unintentionally injure himself or others or be unable to care for himself."\(^{107}\)

**The Witness**

The first witness called by the state in commitment-related proceedings in the Circuit Court of Cook County is usually the certifying physician\(^ {108} \) who is an employee of the Department of Mental Health. The majority of such physicians are practicing under a State Hospital Permit or Temporary Certificate of Registration due to their inability to pass the examination enabling a physician to practice medicine in all its branches as required by Illinois and other states. The permits and certificates are issued pursuant to the Medical Practice Act.\(^ {109} \) Section 14(a) of this Act was amended in 1972 to provide that all such permits were to expire on July 1, 1973. As a condition to renewal, "the permit holder shall be required to show proof of having passed an examination given by the Department of Registration and Education or to have passed an examination deemed by the Department to have been at least equal in all substantial respects to the Department's examination."\(^ {110} \) This amendment was challenged by a group of physicians employed by the Department of Mental Health as unconstitutional because it would deprive the physicians of their licenses to practice medicine, and thus their jobs, without due process.\(^ {111} \) In denying the defendant's motion to dismiss in *In re Rios*, the court said:

It is clear that the State of Illinois has extended tenure to the plaintiffs to practice medicine within the standards of their limited licenses. The State cannot now add arbitrary requirements to their licenses. Nor does this threaten the patients, as Amicus suggests. If, at any time, the State finds a doctor unqualified to practice under a limited license, the Civil Service laws provide for the doctor's removal in accordance with due process guarantees. While Amicus argues correctly that the mentally ill patients of this State are entitled to qualified doctors, it is also the law that doctors

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\(^{107}\) *ILL. REV. STAT.* ch. 91½, § 1-11 (Supp. 1972).

\(^{108}\) "Physician" means any person licensed by the State of Illinois to practice medicine in all its branches, and includes any person holding a State Hospital Permit or Temporary Certificate of Registration, as provided in the Medical Practice Act." *ILL. REV. STAT.* ch. 91½, § 1-14 (1971).

\(^{109}\) *ILL. REV. STAT.* ch. 91, §§ 1 to 18 (1971).

\(^{110}\) *Id.* at § 14(a) (Supp. 1972).

\(^{111}\) *In re Rios*, No. 72 CH 6076 (Cir. Ct. of Cook Cty., Ill., filed Oct. 24, 1972).
who have qualified to serve these patients are entitled to due process protections of their employment.\textsuperscript{112}

The Court has yet to reach the question of whether the statute was unconstitutional.

Normally, the physician will also be a psychiatrist—defined under the Code as one who has devoted "a substantial portion of his time to the practice of psychiatry and has practiced psychiatry for one year immediately preceding the Certification of any patient."\textsuperscript{113} The testimony of the physician or psychiatrist is crucial.\textsuperscript{114} This witness will describe the mental disorder of the patient in medical terms—\textsuperscript{115}—that the patient is paranoid or schizophrenic—and may explain that the patient has delusions, hallucinates, is not oriented as to time and space, or lacks sufficient insight or capacity to make a responsible decision. Generally, the physician will testify as to what the patient told him in the interview about the circumstances surrounding his admission to the hospital.\textsuperscript{116} This may involve an incident which prompted the family or friends to bring the person to the hospital—beating a family member, attempting suicide, refusing to eat or work or destroying property—or an incident with the police that resulted in the admission such as, wandering in the middle of the street shouting or in a daze, or acting out in a public place. The physician will then give his or her opinion as to whether the patient is suffering from a mental disorder and if so, whether the patient, as a result of this disorder, will be dangerous or unable to care for himself at that time or a reasonable time thereafter.

If the patient is alleged to be mentally retarded, the witness will testify as to the psychological evaluation of the person which includes his social age, IQ and whether the person is educable, trainable and either severely or profoundly mentally retarded.\textsuperscript{117} The

\textsuperscript{112} Id. Memorandum Opinion and Ruling on Motion to Dismiss at 10 (Sept. 27, 1973).

\textsuperscript{113} ILL. REV. STAT. ch. 91½, § 1-15 (1971).

\textsuperscript{114} "No person may be found to be in need of mental treatment unless at least one psychiatrist or physician [or psychologist in case of mental retardation] who has personally examined the respondent so testifies in person at the hearing. . . ." Id. at § 9-4.

\textsuperscript{115} Id.

\textsuperscript{116} See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (1969).

\textsuperscript{117} The Code defines mental retardation as "subaverage general intellectual functioning generally originating during the developmental period and is associated
testimony will also include an assessment of his potential development and a recommendation as to an appropriate placement, such as discharge, hospitalization, out-patient treatment, or release into the custody of a family. He may also give a prognosis as to how long the patient may have to be treated.

On cross examination,118 the defense attorney should ask whether the physician had warned the patient that the information obtained in the interview might be repeated in an in-court involuntary commitment proceeding.119 The physician should be asked to translate his diagnosis into lay terms and describe the symptoms which support his diagnosis. He should also be asked to explain how the mental disorder would cause the patient to be a danger to himself or others or render him unable to care for himself, since neither of these conditions necessarily follow from the fact that a person is suffering from delusions or hallucinations.120 It is difficult to

with impairment in adaptive behavior. Impaired adaptive behavior may be reflected in delayed maturation or reduced learning ability or inadequate social adjustment.” ILL. REV. STAT. ch. 91 1/2, § 1-12 (1971).

The majority of mentally retarded persons fall into the “educable” group. Their I.Q. score is approximately 55 to 69. “If allowed to learn at their own pace, with teachers who understand their limitations, they can be taught social and vocational skills, and can earn their living in simple jobs. They may marry; and they may have normal children.” F. Ogg, SECURING THE LEGAL RIGHTS OF RETARDED CHILDREN (Public Affairs Pamphlet No. 492) at 3 (1973). A person falling into this category should not be involuntarily admitted to a mental hospital.

Almost six percent fall into the “trainable” or moderate category where I.Q.s range from 40 to 54. “While they cannot go much beyond second grade in academic subjects, they can be trained in manual skills. They can hold jobs too but they need living arrangements that give them some supervision. . . . Only 5 percent are either ‘severely’ retarded, with I.Q.s from 25 to 39, or ‘profoundly’ retarded, with I.Q.s below 25. They require constant care.” Id.


119. See text accompanying notes 184-88, infra. “There is no privilege . . . for any relevant communications . . . if the judge finds that the patient, after having been informed that the communications would not be privileged, has made communications to a psychiatrist in the course of a psychiatric examination ordered by the court, provided that such communications shall be admissible only with respect to issues involving the patient’s mental condition. . . .” ILL. REV. STAT. ch. 51, § 5.2 (1971). Whether the lack of warning should be raised in an objection to the foundation laid for the testimony or on a motion to strike is not clear. It has been raised in both ways. If raised on an objection to the foundation, the court will not hear the testimony if the State’s Attorney does not bring out the warning on direct examination. However, defense counsel may indirectly bring out on cross examination that no such warning was ever given and then move to strike.

120. Texts and publication of authorities on mental disorders may be used to
assert that the patient may be a danger to himself in the future when there is no evidence that he ever inflicted or attempted or threatened to inflict harm either on himself or another person.

Judge Joseph Schneider has commented on this difficulty:

First, let us examine the “dangerous to others” category. Since many of the persons who fall into this category may not have inflicted harm on anyone, we are predicting that they are likely to cause harm in the future... If society is to allow the involuntary hospitalization of the mentally ill on the prediction of certain harmful conduct in the future, then we must strive for more precise criteria. At this point we must define the category or kinds of harm that justify society’s intervention. Should we expect the harm to be serious bodily injury, such as murder, rape or aggravated battery? What if the bodily injury is of a more minor nature, such as a punch or a slap? Should that be enough to commit?

Some people have proposed that psychological harm or anticipated psychological harm to others should justify commitment. They speak of the damage from exhibitionism or of neglect of children by a mentally ill parent. What if the anticipated harm is only against property, such as breaking windows or shoplifting?

What degree of certainty is the prediction of harm? Some studies show that psychiatrists err in the over prediction of dangerousness. The solution is not to abandon the contribution that psychiatry can make to the court process but [to understand] that law and psychiatry must learn to ask and answers the kinds of questions posed earlier. Perhaps we [were] asking too much of psychiatry when we asked for predictions of this kind.121

When one considers that a large number of the psychiatrists who testify hold temporary licenses to practice medicine, have been unable to pass their medical boards, have no formal training in psychiatry, and often disagree on the definition of fundamental terms, the possibility of their predicting “dangerousness” with any accuracy is decreased substantially.122

The physician should be asked how the physical condition of the patient may affect his mental behavior123 and whether the med-
ication may account for any of his symptoms. If the physician should also be asked whether alternative means of treatment, such as releasing the patient into the custody of a family member or outpatient care, are viable possibilities. If the physician insists that hospitalization is the only alternative, then the attorney may wish to explore the physician's expectations of the type of treatment the patient will receive at the hospital.

The therapist or social worker assigned to the patient by the hospital usually testifies as to the patient's record of past hospitalizations, statements made by the patient in conversations which may include the patient's explanation of how his admission came about, and finally, as to the patient's behavior as observed on the ward. This may involve a description of the patient as withdrawn or aggressive towards other patients. The testimony may also include the attempts at or threats of suicide. The therapist is not permitted, however, to give an opinion unless he or she is qualified by holding a degree in psychiatric social work.

It may be appropriate here to mention a problem which arises from this interaction between the legal and medical communities at the hearing. When it is the hospital personnel who initiate the involuntary proceedings, for example, in order to keep a "voluntary" patient who wishes to be discharged, a great deal of damage may be

124. The attorney also should examine the patient's chart to determine the type and amount of medication administered. See note 28, supra.

125. ILL. REV. STAT. ch. 91½, § 9-6 (1971). "If any person is finally found to be in need of mental treatment or mentally retarded, the court, as part of the hearing shall consider the alternative forms of care or treatment which are desirable for and available to the patient, including but not limited to hospitalization." Id. The least restrictive alternative doctrine was applied in Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966). For a general discussion, see Wormuth & Mirkin, The Doctrine of the Reasonable Alternative, 9 UTAH L. REV. 254 (1964); Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 MICH. L. REV. 1107 (1972) (a discussion not only of the legal obligations of the physician or psychiatrist to search for alternatives but also an outline of the practicalities of such a search).

126. The psychiatrist as a witness in a civil commitment case is necessary, but he is not the only witness who has an important contribution to make. Objective testing by a skilled psychologist can give insights and depth to the understanding of the person. The same is true of the competent social worker, who can give the court a fuller picture of the life experiences of the person, his strengths as well as weaknesses. These disciplines can assist the court when their contribution can withstand denigration in a contested situation.

Schneider, supra note 86 at 1060.
done to the relationship between the patient and the psychiatrist or therapist. This occurs because the psychiatrist and therapist must testify in court that the defendant is either dangerous or unable to care for himself in rather particular terms. In order to avoid this confrontation, hospital personnel often encourage the family, relatives or friends of the patient to take the responsibility for initiating the procedure by signing the petition for hospitalization. However, even in this situation, the psychiatrist and therapist generally testify at the hearing.\textsuperscript{127} This raises the question of whether a patient's right to treatment is compromised when he is involuntarily committed by the persons responsible for his treatment in light of the disrupted relationship which the courtroom confrontation often causes.\textsuperscript{128}

Other witnesses may include the patient's family, relatives, or friends who would be able to testify as to incidents leading up to the patient's admission to the hospital. Such witnesses may have called the police because of physical violence by the patient or may testify that the patient cannot safely go outside because he wanders in traffic or fails to eat or take care of his other physical needs.\textsuperscript{129}

The state may call the patient as a witness under section 60 of the Civil Practice Act.\textsuperscript{130} However, the patient may refuse to answer questions that would tend to incriminate him.\textsuperscript{131} At the end of the

\textsuperscript{127} It may be argued that since the basic forms of treatment are group therapy and chemotherapy, it is unlikely that the therapeutic relationship is endangered by an involuntary commitment.

\textsuperscript{128} For a discussion of an involuntary patient's right to treatment see text accompanying notes 196-209, infra.

\textsuperscript{129} Predictability of future conduct can be more accurate when the court has available testimony of witnesses as to the pattern of conduct exhibited by the person prior to the initiation of the commitment proceeding. Testimony of family members, neighbors, friends, employees and others who have personal knowledge of the person can give substance to the decision making on the part of the judge. What was the motivation behind the initiating of the commitment procedure? Was the fear of danger by the person or to the person realistic? Was the threshold of tolerance of the community of the behavior of the respondent so low that the allegations are overpredictions of danger? What social, cultural and emotional factors led to the use of the court in an attempt to solve this problem? The court is constantly struggling to answer this question and it needs help. Much research is necessary to help understand and to develop more reliable means of predicting dangerous behavior.

Schneider, supra note 86 at 1060-61.


\textsuperscript{131} U.S. Const. amend. V. Cf. Mathis v. United States, 391 U.S. 1, 4 (1967)
state’s case, the defense attorney should always move for a directed verdict.

The defense will generally have the patient testify in order to overcome the main thrust of the state’s case. If the state has maintained that the patient is unable to care for himself, the patient may testify that he can care for himself and explain how he will go about it. The patient may wish to explain his future plans for employment and living arrangements. If there is evidence of an overt threat or act of violence, the respondent may wish to refute that evidence by delving into relevant mitigating circumstances.

The defense may also call a psychiatrist as a defense witness to counter the testimony of the state as to the patient’s mental disorder. If the patient is indigent, he has the right to the services of an expert witness.132

Constitutional Safeguards

Since, in an involuntary commitment proceeding, the state seeks to deprive the patient of his liberty, said proceeding must comply with the requirements of the fourteenth amendment to the United States Constitution133 and the comparable section of the Illinois Constitution.134 In a recent decision, Lessard v. Schmidt,135 a three judge federal court invalidated the Wisconsin mental health code and required stringent safeguards for persons faced with involuntary commitment.

The court rejected the argument that due process requirements should be relaxed due to the fact that involuntary incarceration carries with it a constitutional right to treatment for basically the same reasons that the United States Supreme Court in Kent v. United States136 refused to relax due process standards in juvenile proceedings. That argument, the Lessard court said, “ignores the fact that

( extending Miranda to a tax investigation “where no criminal proceeding might even be brought...”).

133. “No State shall... deprive any person of life, liberty, or property without due process of law...” U.S. Const. amend. XIV.
134. “No person shall be deprived of life, liberty or property without due process of law...” ILL. Const. art. I, § 2.
135. 349 F. Supp. 1078 (E.D. Wis. 1972) [hereinafter cited as Lessard].
unless constitutionally prescribed procedural due process requirements for involuntary commitment are met, no person should be subjected to 'treatment' against his will."137 The argument also ignores the fact that many mental illnesses are untreatable, as well as the fact that there is "substantial evidence that any lengthy hospitalization, particularly where it is involuntary, may greatly increase the symptoms of mental illness and make adjustments to society more difficult."138

The argument that the proceeding is civil and not criminal and therefore that the due process requirements should be relaxed was also rejected, having been laid to rest, the court said, by the Supreme Court's decision in In re Gault.139 "Even a brief examination of the effects of civil commitment upon those adjudged mentally ill shows the importance of strict adherence to stringent procedural requirements and the necessity for narrow, precise standards."140 Among these effects are the deprivation of civil rights, "the difficulties that the committed individual will face in attempting to adjust to life outside the institution following release" and perhaps the most serious, "the statistics which indicate that an individual committed to a mental institution has a much greater chance of dying than if he were left at large."141

The court held that due process requires that a person may not be detained longer than forty-eight hours without a preliminary hearing and that a full hearing must be held within ten to fourteen days of that hearing.142 Notice of the scheduled hearing must be given far enough in advance to afford a "reasonable opportunity to prepare" for the hearing and such notice "must set forth the basis for detention with particularity."143 A person detained on grounds of mental illness has a right to counsel and, if indigent, to appointed counsel.144 A person also has the right not to speak to a psychiatrist and must be given notice of the fact that his statements may be

137. 349 F. Supp. at 1087.
138. Id.
139. 387 U.S. 1 (1967).
140. 349 F. Supp. at 1088.
141. Id. at 1089.
142. Id. at 1091-92.
143. Id. at 1092.
144. Id. at 1097.
used to incriminate him in the eyes of the psychiatrist and the trier of fact in a civil commitment proceeding. Before commitment, it must be shown that the patient was so notified. Also, hearsay evidence is not admissible in a civil commitment proceeding.

It is important to note that the court in Lessard stated that due process requires that the standard of proof be beyond a reasonable doubt and that “there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others.” This conclusion of dangerousness must be “based upon a finding of a recent overt act, attempt or threat to do substantial harm to oneself or another.” Even upon a finding that the person is in need of mental treatment, full-time involuntary hospitalization should be ordered only as a last resort.

Due Process Issues in Illinois

Currently there are many due process issues in Illinois similar to those raised in Lessard.

Notice Requirements

Under the procedure for admission on a certificate of a physician, the Application for Hospitalization and the Certificate “must state in reasonable detail the basis for the belief of the persons executing them that the person whose hospitalization is desired is in need of mental treatment.” Under the emergency admission procedure, the Petition must state reasons for the conclusion that a person is “in such a condition that immediate hospitalization is necessary for the protection from physical harm of such person or others. . . .” In addition, the Petition must state “the names of the witnesses by which the facts asserted may be proved.”

145. Id. at 1101.
146. Id. at 1102-03.
147. Id. at 1093.
148. Id.
149. Id. at 1095.
150. ILL. REV. STAT. ch. 91½, § 6-1 (1971); MHC form 5 (1968).
151. ILL. REV. STAT. ch. 91½, § 7-1 (1971).
152. Id.
in Cook County do not meet the notice requirements of the Code.\textsuperscript{153}

In \textit{Lessard} the court held that due process required reasonable notice of the hearing in order to afford a reasonable opportunity for preparation by the patient:

\begin{quote}
Notice of date, time and place is not satisfactory. The patient should be informed of the basis for his detention, his right to jury trial, the standard upon which he may be detained, the names of examining physicians and all other persons who may testify in favor of his continued detention, and the substance of their proposed testimony.\textsuperscript{154}
\end{quote}

The only notice which the patient receives prior to the hearing is a copy of the Petition along with a written statement that he "will be examined relative to the allegations of the petition and will appear before a court for a hearing within 5 days. . . ."\textsuperscript{155} In the recently litigated Illinois case, \textit{United States ex rel. Matthew v. Glass},\textsuperscript{156} the issue of adequate notice was raised and then dismissed by agreement because "[t]he Department of Mental Health has agreed to adopt regulations and forms requiring the petition for involuntary hospitalization to set forth act or acts of the respondent which lead the petitioner to believe the respondent to be in need of mental treatment."\textsuperscript{157}

\textit{Detention Without a Timely Hearing}

Under the involuntary procedures in Illinois a person may not get a hearing for five to seven days after admission.\textsuperscript{158} In \textit{Lessard}, the court stated that "no significant deprivation of liberty can be justified without a prior hearing on the necessity of the detention."\textsuperscript{159} While the state may wish to detain persons on an emergency basis because they are a danger to themselves or others, such a detention

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\textsuperscript{153}. \textit{See Report to the Board Managers of the Chicago Bar Association from the Mental Health Committee} 1 (June, 1973) (where the Mental Health Committee recommended "[t]hat petitions filed pursuant to the Mental Health Code must be supported by a statement of facts, and not be merely conclusions, such as 'He is dangerous'").
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\textsuperscript{154}. 349 F. Supp. at 1092.
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\textsuperscript{155}. \textit{ILL. REV. STAT.} ch. 911/2, § 7-4 (1971); MHC form 5 (1968).
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\textsuperscript{156}. Nos. 72 C 2104, 72 C 1979 (D.C. N.D. Ill., filed Aug. 23, 1972).
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\textsuperscript{157}. \textit{Id.}, Motion to Dismiss Certain Issues and to File Amended Complaint (granted Oct. 25, 1972). The revised Physician's Certificate requires much more information. \textit{See note 64, supra.}
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\textsuperscript{158}. \textit{ILL. REV. STAT.} ch. 911/2, §§ 6-4, 7-6 (1971).
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\textsuperscript{159}. 349 F. Supp. at 1091.
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can be justified only for the time necessary to arrange a hearing before a non-partisan judge. "[T]he maximum period which a person may be detained without a preliminary hearing is 48 hours. It must be remembered that at this time the necessity for commitment of an individual has not yet been established." In *United States ex rel. Matthew v. Glass*, the plaintiffs argued that a probable cause hearing must be held within forty-eight hours as required by *Lessard*. The issue was settled by a stipulation and all persons detained as in need of mental treatment will be given a hearing within two to four days after admission.

**Standard of Proof: Preponderance of the Evidence as Violative of Due Process**

Article XIII of the Code provides that the hearing is civil in nature. That provision propounds the relevant standard of proof: preponderance of the evidence. In *Lessard* the court said that "[c]ivil commitment cannot . . . be justified upon a mere preponderance

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160. *Id.* In *Logan v. Aradeh*, 346 F. Supp. 1265 (D.C. Conn. 1972), the emergency procedure in Connecticut allowing 45 days of hospitalization without a hearing was held not to violate due process. The court reasoned:

There is a compensating advantage to the committed person because in many cases during this period the medical staff at the hospital can adequately alleviate his mental illness or by use of non-emergency diagnostic procedures determine that he is not a 'danger to himself or others.' In such cases, the stigma of court record is avoided and the length of confinement is shortened. It must be remembered that commitment has not been undertaken for the sake of penal detention. The patient is committed for treatment and care, and some knowledge of his mental condition can be gained by visual observation and diagnostic tests. This takes time . . . where a full blown court trial must be had . . . additional time to undertake more elaborate testing of the patient's mental condition, and a more detailed probe into his relevant history, by both the hospital authorities and the expert witnesses who will testify in behalf of the patient is needed.

*Id.* at 1269.

This opinion failed to take into consideration the patient who would have been released upon a hearing to establish probable cause and is contrary to the holding in *Lessard*. The *Logan* court notes that the remedy of a writ of habeus corpus is available. However, there are many obstacles to the use of this remedy by persons held in a mental hospital. Also, the availability of this remedy does not save a constitutionally defective statute, see *Fhagen v. Miller*, 306 F. Supp. 634, 638 (S.D. N.Y. 1969).


of the evidence,"\textsuperscript{163} citing \textit{Woodby v. Immigration & Naturalization Service}\textsuperscript{164} where the United States Supreme Court said that, in a deportation case, a person could not be "banished from this country upon no higher degree of proof than applies in a negligence case."\textsuperscript{165} The court in \textit{Lessard} concluded that a civil commitment involved a greater loss of freedom than that in deportation and required that the standard of "beyond a reasonable doubt" be applied, citing \textit{In re Winship}.\textsuperscript{166} There, in the words of the court in \textit{Lessard}, the Supreme Court held that

proof beyond a reasonable doubt was required to prove every fact necessary in juvenile delinquency proceedings, noting that "extreme caution in fact finding" . . . is necessary because of 'the possibility that [the individual] may lose his liberty upon conviction and because of the certainty that he would be stigmatized by the conviction."\textsuperscript{167}

The court also cited \textit{In re Gault} for the proposition that "civil labels and good intentions do not themselves obviate the need for criminal due process safeguards,"\textsuperscript{168} reasoning that the higher standard was even more compelling in a civil commitment because the individual is deprived of basic civil rights and would certainly be "stigmatized by the lack of confidentiality of the adjudication."\textsuperscript{169}

The Court of Appeals for the District of Columbia has held, in \textit{In re Balley},\textsuperscript{170} that due process requires a standard of beyond a reasonable doubt. In examining the reasons behind the varying standards, the court in \textit{Balley} stated:

The process accorded in any adversary proceeding reflects the interests at stake. In the present case the paramount interest is liberty, since the individual who is civilly committed faces restrictions which may exceed in length those imposed in most circumstances on the criminal or juvenile delinquent. Our deliberation therefore focuses on competing interests in an attempt to determine whether any may offset the immense individual interests involved. Focusing precisely on the state interest is a difficult task, however, because the statutes which address the enormous problem of mental illness broadly reflect dual motives, each of which may permit or require distinct procedures if considered separately. The first and dom-

\textsuperscript{163} 349 F. Supp. at 1094.
\textsuperscript{164} 385 U.S. 276 (1966).
\textsuperscript{165} Id. at 284.
\textsuperscript{166} 397 U.S. 358 (1970).
\textsuperscript{167} 349 F. Supp. at 1095.
\textsuperscript{168} 397 U.S. at 365-66.
\textsuperscript{169} 349 F. Supp. at 1095.
\textsuperscript{170} 482 F.2d 648 (D.C. Cir. 1973).
inanst objective involves society's concern with antisocial conduct. This
leads inexorably to analogy with the criminal system, not only because
there are certain similarities in objective but primarily because the result-
ing restriction of liberty has assumed a significant and visible role in the
creation of inhibitions to the state's overzealous or mistaken application
of that power. On virtually every plane of comparison the civil model
presents an equally compelling plea for a stringent burden of proof.

Inextricably intertwined in both the statute and its legislative history is a
second state interest involving its role as parens patriae. While viscerally
a more persuasive rationale in terms of offsetting the individual's loss of
liberty, the argument largely dissolves upon closer inspection. No dis-
tinction is made between the statutory standards permitting institutiona-
lization where dangerous to society and where dangerous to self in terms of
the individual or in terms of the differing process which distinct interests
may require. Moreover, the latter standard itself sweeps in varied and
complex classes who represent different interests and it also presents equally
perplexing definitional problems. Recognizing again the immense individ-
ual interests involved, it is questionable whether a rather significant mar-
gin of error should be tolerated regardless of the rationale, particularly
since a more demanding burden of proof is by its nature largely neutral
in its affect on relevant state policies. It is more appropriately charac-
terized as a particularly suitable means of reducing the risk of factual er-
rors which may be engendered by the statute or by the difficulties inherent
in the disciplines associated with mental illness. Finally, we cannot help
but recognize the stigma which unfortunately still accompanies a finding
of mental illness.

'Stone walls do not a prison make, nor iron bars a cage.' We align our-
selves with those courts that have held that proof of mental illness and
dangerousness in involuntarily civil commitment proceedings must be be-
yond a reasonable doubt. 171

In United States ex rel. Matthew v. Glass,172 the issue of standard
of proof was raised but dismissed by stipulation because, all of the
proceedings where held before a judge and thus it was not clear
which standard had been applied.

The Statutory Standard

According to the court in Lessard, the statutory standard to be
met in determining if a person is in need of mental treatment is
not satisfied if it is predicted that the person is dangerous to himself
or others or unable to care for himself. There must be evidence

171. Id. at 649-50.
172. Nos. 72 C 2104, 72 C 1979 (D.C. N.D. Ill. filed Aug. 23, 1972), Motion
to Dismiss Certain Issues and to File Amended Complaint.
of a recent overt act or threat.\textsuperscript{173} The court in \textit{Lessard} held that "[a]lthough attempts to predict future conduct are always difficult, and confinement based upon such a prediction must always be viewed with suspicion, we believe civil confinement can be justified in some cases if the proper burden of proof is satisfied and dangerousness is based upon finding of a recent overt act, attempt or threat to do substantial harm to oneself or another."\textsuperscript{174} The court relied on \textit{Humphrey v. Cady},\textsuperscript{175} where the Supreme Court held, in the words of the court in \textit{Lessard}, that "the [Wisconsin] statute itself requires a finding of 'dangerousness' to self or others in order to deprive an individual of his or her freedom."\textsuperscript{176} While the Supreme Court had not considered the degree of dangerousness that is constitutionally required before a person may be committed, the \textit{Lessard} decision stated that the Supreme Court's approval of a requirement that the potential for doing harm be 'great enough to justify such a massive curtailment of liberty' implies a balancing test in which the state must bear the burden of proving that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others.\textsuperscript{177}

To support this proposition, the Court in \textit{Lessard} cited a discussion of mental illness:

Obviously, the definition of mental illness is left largely to the user and is dependent upon the norms of adjustment that he employs. Usually the use of the phrase 'mental illness' effectively masks the actual norms being applied. And, because of the unavoidably ambiguous generalities in which the American Psychiatric Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason. . . \textsuperscript{178}

The rationale behind requiring a finding of dangerousness to be supported by a "recent overt act, attempt or threat to do substantial harm to oneself or another" is due to the inability of psychiatrists to predict behavior with any accuracy. This statement is amply supported by testimony before the Senate Subcommittee on Constitutional Rights:

\textsuperscript{173} \textit{See} text accompanying note 4, \textit{supra}.
\textsuperscript{174} 349 F. Supp. at 1093.
\textsuperscript{175} 405 U.S. 504 (1972).
\textsuperscript{176} 349 F. Supp. at 1093.
\textsuperscript{177} \textit{Id.} (emphasis added).
The criteria by which we psychiatrists reach our conclusions about dangerousness, diagnosis, need for treatment, mental illnesses and the like are so vague and subjective and illusive that well-trained psychiatrists . . . can manipulate any set of facts to sustain almost any conclusion about people that they examine. The decision-making process is invisible and it is untestable. The patient is therefore helpless before the psychiatrist . . . to rebut these conclusions because the psychiatrist is recognized by law and custom as the expert.  

Another witness felt that

The state of prediction in our field is abysmally poor, and even experts cannot tell you with any sureness to what extent a person is likely to do something.

If board certified psychiatrists have difficulty in making accurate predictions of future conduct, most predictions by "psychiatrists" in the employment of the Department of Mental Health would appear even more suspect. In Illinois more judicial guidance in this area may soon be forthcoming since the issue of whether the due process clause of the fourteenth amendment requires evidence of a recent overt threat or act as held in Lessard is pending in both the federal court and the Illinois Appellate Court.

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179. Hearings, supra note 46, at 305 (testimony of Dr. Harold Kaufman, Adjunct Professor of Law and Psychiatry, Georgetown University).

180. Hearings, supra note 46, at 83 (testimony of Dr. David J. Vail, Psychiatrist and Medical Director, Department of Public Welfare, State of Minnesota). Other observers have also noted this problem. Professor Dershowitz has noted that psychiatrists are rather inaccurate predictors [of danger]—inaccurate in an absolute sense—and even less accurate when compared with other professional officials; and when compared to actuarial devices such as prediction of experience tables. Even more significant for legal purposes, it seems that psychiatrists are particularly prone to one type of error—over-prediction.


Professor Norvel Morris of the University of Chicago Law School has stated:

To take power over the lives of others on predictions of their future criminality, in particular of the likelihood of future physical injury they may inflict on others, is no light assumption of competence. Those who cautiously and modestly assess their abilities would, it might seem, hesitate in the face of such awesome authority; but neither lawyers nor psychiatrists seem to have been unduly disturbed by such reflections. The distressing moral problem inherent in this situation can be stated as: Whom shall we trust? Our reply, for the time being, is: Nobody.


181. See text accompanying notes 110-12, supra.


Right to Remain Silent

In Lessard it was held that a patient "should be told by counsel and the psychiatrist that he is going to be examined with regard to his mental condition, that the statements he may make may be the basis for commitment, and that he does not have to speak to the psychiatrist."184 This right rests on the Supreme Court's decision in In re Gault185 and the concurring opinion of Justice Douglas in McNeil v. Director, Patuxent Institutions:

Whatever the Patuxent procedures may be called—whether civil or criminal—the result under the Self-Incrimination clause of the Fifth Amendment is the same. As we said in In re Gault, . . . there is harm and self-incrimination whenever there is a deprivation of liberty; and there is such a deprivation whatever the name of the institution, if a person is held against his will.186

The court in Lessard added that medical evidence indicates "that patients respond more favorably to treatment when they feel they are being treated fairly and are treated as intelligent, aware, human beings."187 In United States ex rel. Matthew v. Glass, the issue of notice of the right to remain silent was raised and dismissed because "[t]he Department of Mental Health has agreed to inform orally and in writing those asserted to be in need of mental treatment that they do not have to talk to the doctors and social worker and that everything they say might later be repeated at the hearing."188 It is interesting to note that the author raised this issue in a recent case citing the above authority and the judge said that he was not bound by any lower federal court decisions and that he did not believe that any such constitutional right exists.

Other Due Process Issues

In United States ex rel. Matthew v. Glass, the plaintiffs raised the question of whether a patient waiting for an involuntary hearing could be forced to take medication. The issue was dismissed because "[t]he Illinois Department of Mental Health has agreed not
to drug those asserted to be in need of mental treatment prior to their hearing against their will, unless the person is acting out in a manner which would be dangerous to himself or others.\(^{189}\)

The plaintiffs also alleged that as indigents they had not been informed of either their right to appointed counsel on appeal or of their right to petition for discharge. This issue was also dismissed because the Circuit Court of Cook County promised to establish a practice of orally informing those asserted to be in need of mental treatment of their right to appeal and, if indigent, of their right to free transcripts and appointed counsel. The Illinois Department of Mental Health has also “agreed to provide to those found to be in need of mental treatment a copy of a statement of their rights to appeal and of their rights to petition for discharge, together with the forms necessary to make these requests.”\(^{190}\)

**EFFECTS OF INVOLUNTARY COMMITMENT**

**Duration**

An order for treatment in a hospital\(^{191}\) is, at the present time, for an indeterminate period although the Code provides for periodic review of the patient’s status.\(^{192}\) It has been predicted that the Code will be amended to require commitments for fixed terms because “[i]t is well established now that after two years, maybe less, the greatest obstacle to mental health and discharge is institutionalization itself.”\(^{193}\)

**Civil Rights**

A patient is not automatically adjudged incompetent nor does he lose his civil rights.\(^{194}\) In order for a patient to be found incompe-
tent, there must be a specific finding at the hearing.\textsuperscript{195} Incompetency should not be confused with fitness to stand trial. A person is declared incompetent because he is unable to manage his affairs and a conservator is appointed in order to perform this function for the person. Generally, this finding is made by the probate court since property or other assets are involved. At times the state has asked the probate court to appoint a physician of the Department of Mental Health to be the conservator of a patient in order to obtain approval for an operation. The better practice would be to have a family member or relative, if available, appointed conservator.

*Treatment*

The justification for depriving the patient of his liberty is the expectation that the patient will be given treatment. The Code provides that "[e]very patient is entitled to adequate and humane care and treatment,"\textsuperscript{196} and defines "treatment" as including "hospitalization, examination, diagnosis, care, detention, training, pharmaceuticals and other services provided for patients in mental health programs."\textsuperscript{197} In *Rouse v. Cameron*,\textsuperscript{198} the court interpreted a District of Columbia statute on treatment which provided that a person shall, "during his hospitalization, be entitled to medical and psychiatric treatment . . ."\textsuperscript{199} to mean that there exists a recognized enforceable right to treatment. Since the court based its decision on this statute, it did not reach the question of whether a constitutional right to treatment exists.\textsuperscript{200}

In *Wyatt v. Stickney*,\textsuperscript{201} it was held that persons who are involuntarily committed as either in need of mental treatment or mentally retarded have a constitutional right to adequate treatment because, absent treatment, the hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense . . . ." The

\textsuperscript{195} Id.; "Order for Treatment or Discharge," MHC form 13 (1968).


\textsuperscript{197} Id. at § 1-8.

\textsuperscript{198} 373 F.2d 451 (D.C. Cir. 1966).


\textsuperscript{200} The *Rouse* court did, however, discuss the constitutional aspects. 373 F.2d at 453-55.

purpose of involuntary hospitalization for treatment purposes is *treatment*
and not mere custodial care or punishment. This is the only justification,
from a constitutional standpoint, that allows civil commitments...202

In effecting these principles, the court set minimum standards for
hospital staff and physical facilities.

*Burnham v. Dept. of Public Health*203 held that no constitutional
right to treatment exists and the court there even questioned the
justiciability of the issue due to the uncertainty of the meaning of
treatment.204 In *New York State Ass'n for Retarded Children v.
Rockefeller*,205 it was also held that there was no constitutionally
based right to treatment.206

It has been suggested by Dr. Morton Birnbaum that the right
to treatment should include a requirement for a "minimum number
of consultations and physical examinations within a certain period
of time" as well as

the availability of halfway houses and other full-time post-hospitalization
facilities. For it has been repeatedly shown that the lack of these facilities
hinders not only the planning for the care of the patient while he is in
the hospital, but also hinders his discharge.207

This same psychiatrist-lawyer takes the position that, while the law
should require some basic minimum standards of care and treat-
ment, it should not set out any requirement concerning such subjec-
tive treatment as chemotherapy, shock treatment, and psycho-ther-
apy, since these have traditionally been solely medical questions.208
Contrary to that position, others have argued that standards of treat-
ment can be measured by the effectiveness of the treatment.209

On the reverse side of this question, no surgery, including experi-
mental procedures,210 may be performed without the patient's con-

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202. *Id.* at 784 (court’s emphasis).
203. 349 F. Supp. 1335 (N.D. Ga. 1972), appeal docketed, No. 72-3110 (5th
 Cir. Oct. 4, 1972) (*Wyatt, supra* note 200, and *Burnham* have been consolidated on
 appeal).
204. *Id.* at 1340-42.
206. *Id.* at 758-65.
207. *Hearings, supra* note 46, at 44 (testimony of Dr. Morton Birnbaum,
Member of the New York City Bar).
208. *Id.* at 62.
209. See, e.g., Schwitzgebel, *Right to Treatment for the Mentally Disabled: The
Need for Realistic Standards and Objective Criteria*, 8 HARV. CIV. RIGHTS-CIV. LIB.
210. There is some fear of psychosurgery.
sent except when an emergency exists and the life of the patient is endangered. In that case, "consent need not be obtained, provided substantiation of the emergency is documented."\textsuperscript{211} The decision to accept or refuse surgery is a civil right of the patient which he may exercise as long as he has not been declared incompetent. The Department of Mental Health has set out the elements of informed consent which must be obtained before the patient participates in any "behavioral and medical science investigations where a procedure may induce in the subject an altered state or condition potentially harmful to his personal welfare."\textsuperscript{212} These elements are:

1. A full and fair explanation of the procedures to be followed, including an identification of those which are experimental;
2. A description of the attendant discomforts and risks;
3. A description of the benefits to be expected;
4. A disclosure of appropriate alternative procedures that would be advantageous for the subject;
5. An offer to answer any inquiries concerning the procedures;
6. An instruction that the subject is free to withdraw his consent and to discontinue participation in the project or activity at any time.

In addition, the agreement, written or oral, which the subject enters into, should include no exculpatory language through which the subject is made to waive, or to appear to waive, any of his/her legal rights, or to release the facility or its agents from liability for negligence.\textsuperscript{213}

The requirements of informed consent apply with equal force to electro-shock treatment.\textsuperscript{214}

In \textit{Kaimowitz v. Michigan Department of Mental Health}\textsuperscript{215} it was held that a patient "who is involuntarily detained in a state institu-

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\textsuperscript{211} ILL. REV. STAT. ch. 91\frac{1}{2}, § 1-8 (1971); DMH Rule 12.03 (1969).
\textsuperscript{212} ILL. DEP'T OF MENTAL HEALTH, GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS 3 (Oct. 1973).
\textsuperscript{213} Id. at 2.
\textsuperscript{214} DMH Rule 12.03 (1969).
tion is legally incapable of consenting to undergo experimental surgical procedures that are designed to change his behavior by irreversibly destroying his abnormal brain tissue.”

The court stated that “[t]o be legally adequate, a subject’s informed consent must be competent, knowing and voluntary.”

To be competent, the patient must rationally understand the nature of the procedure, its risks and other relevant information. First, “[e]ven if an involuntarily detained patient can intellectually comprehend his circumstances, the very nature of his incarceration diminishes his capacity to consent to psychosurgery.”

Second, “knowledgeable consent to psychosurgery is literally impossible” since so little is really known about its effects.

Finally, it is difficult for the consent to be voluntary:

The most important thing to an involuntarily detained mental patient is freedom. When freedom is dependent upon a patient’s cooperation with the authorities, it is impossible for the patient to be free of ulterior forms of restraint or coercion when giving his consent to experimental surgery. The institutional environment is inherently coercive. Patients who are involuntarily confined cannot reason as equals with the doctors and administrators. This inherent inequality in their position makes them incapable of voluntarily giving an informed consent to undergo psychosurgery.

The patient may not be kept in restraints without a physician’s prescription and then only for limited periods of time.

Restraints may only be used on a patient “to prevent physical injury to himself or others. In no event shall restraints be utilized solely to punish or discipline a patient, nor are restraints to be used as a convenience for the staff.”

In Wheeler v. Glass, the Seventh Circuit Court of Appeals held a complaint which alleged that two mentally retarded youths in a state hospital had been bound to their beds in spread-eagle fashion in a public area of the hospital for 77½ hours after an alleged consensual homosexual act and had been

216. Id. at 2064.
217. Id.
218. Id.
219. Id.
220. Id. The court also held that, even with the patient’s formal consent, much psychosurgery would violate the patient’s first amendment right to generate ideas, as well as his constitutionally protected right to privacy.
221. DMH Rule 12.02 (1973).
222. Id. There are also limits on the seclusion of a patient, DMH Rule 12.03 (1969).
223. 473 F.2d 983 (7th Cir. 1973).
CIVIL COMMITMENT

forced to scrub walls for over ten consecutive hours to be sufficient to state a cause of action for deprivation of their civil rights. The plaintiffs also alleged that they were subjected to cruel and unusual punishment under the eighth amendment.

APPEALS, TRANSFER AND DISCHARGES

While a patient may appeal the “Order for Treatment or Discharge” as in other civil cases, it takes far too long for it to be an adequate remedy for obtaining the patient’s discharge. A more effective remedy is a “Petition for Discharge,” accompanied by a certificate of a physician, which states that the patient is either no longer in need of hospitalization for mental treatment, or in need of care and custody, or mentally retarded, and which sets forth the facts upon which such a statement is based. If the petitioner is indigent, the court will appoint a physician or psychologist to examine the patient and execute a certificate of a physician. The patient will then be given a hearing identical to a commitment hearing.

The Department of Mental Health “shall, as frequently as practicable but not less than every 6 months, review the need for continued hospitalization of the patient, and make the results of such examination a part of the patient’s record.” At least once during the first year of hospitalization and once during every two year period thereafter, the Department of Mental Health must file a written report “setting forth the reasons supporting the need for further hospitalization of the patient.” At the time of the written report the hospital must give notice to the patient, his attorney,

224. MHC form 21 (1968); ILL. REV. STAT. ch. 91½, § 7-3 (1971).
225. MHC form 23 (1968). This petition must contain the patient’s name, the underlying circumstances, the date of the prior court order which had either hospitalized the patient or had him placed in the care and custody of another person, a request for discharge and the reasons for that request. ILL. REV. STAT. ch. 91½, § 10-1 (1971).
226. MHC form 23 (1968).
228. Id. at § 10-3.
229. Id. at § 10-2. The results can be found in the patient’s chart on the ward.
230. Id.; MHC form 27 (1968).
232. MHC form 29 (1968).
his nearest relative and two other persons designated by the patient, and to the court.\textsuperscript{233} The patient is then entitled to a hearing on the need for continued hospitalization if he sends a request for one to the superintendent, to the hospital or to the court within ten days after receipt of the notice.\textsuperscript{234} This hearing is procedurally identical to the commitment hearing.

In \textit{Davis v. Levitt},\textsuperscript{235} the Department of Mental Health decided to discharge a patient who wished to remain in the hospital for treatment. The plaintiff argued that he could not be discharged without a hearing since treatment is a valuable right to which he is entitled by statute. To deprive him of treatment without a hearing, plaintiff argued, is a violation of due process.\textsuperscript{236}

If a patient leaves the hospital on unauthorized leave, that is, without being discharged and "such patient is considered by the superintendent to be in such condition as to require immediate detention for the protection of such patient or other persons" the superintendent may request the police to apprehend and return the patient.\textsuperscript{237} If the patient is not deemed to be dangerous to himself or others it will be on his records as "discharged against medical advice."\textsuperscript{238}

\textbf{Transfers}

The Code provides that "[t]he Department may transfer any patient from one state hospital to another whenever such transfer is deemed advisable."\textsuperscript{239} However, it has been held that when the

\begin{itemize}
\item \textsuperscript{233} \textit{ILL. REV. STAT.} ch. 91\textsuperscript{1/2}, § 10-2 (1971); MHC form 28 (1968).
\item \textsuperscript{234} \textit{ILL. REV. STAT.} ch. 91\textsuperscript{1/2}, § 10-2 (1971).
\item \textsuperscript{235} No. 73 Co 895 (Ill. Cir. Ct. Cook Cty., filed July 5, 1973).
\item \textsuperscript{236} The suit relies heavily on \textit{Burchett v. Bower}, 355 F. Supp. 1278 (D. Ariz. 1973) where the court held that a prisoner could not be transferred from a mental hospital back to prison without a hearing because treatment was a right protected by the fourteenth amendment.
\item \textsuperscript{237} \textit{ILL. REV. STAT.} ch. 91\textsuperscript{1/2}, § 12-6 (1971).
\item \textsuperscript{238} It is . . . Department policy that a patient on unauthorized absence, whether voluntary or committed, should be discharged after a reasonable period of time and no attempt shall be made to expend the energies of the Department in notifying law enforcement authorities for the purpose of apprehending said patient unless the patient is deemed to be dangerous to himself or the community. DMH Rule 5.01(4) (1970). However, relatives, conservators or guardians must be notified immediately of the unauthorized absence of the patient. DMH Rule 5.02 (1969).
\item \textsuperscript{239} \textit{ILL. REV. STAT.} ch. 91\textsuperscript{1/2}, § 12-4 (1971).
\end{itemize}
Department wishes to transfer a patient to the maximum security hospital at Chester, the patient is entitled to an administrative hearing before a committee.\textsuperscript{240} The requirements set forth in the holding have been promulgated as a regulation of the Department.\textsuperscript{241} The committee must consist of at least three experienced mental health professionals, one of whom must be a board certified psychiatrist. The patient has a right to counsel, and a written transcript. Before the committee approves a transfer, all available alternatives must be considered, including transfer to other programs within the facility or to another facility with a suitable program.\textsuperscript{242} Upon approval of transfer, the committee records the reasons for its finding and formulates:

a treatment plan describing what the . . . committee expects the treatment program can accomplish and an estimate of the length of time, in their judgment, that the patient is expected to reside at the Illinois Security Hospital or a facility's maximum security unit.\textsuperscript{243}

The hearings in Cook County are informal. The physician and therapist must explain why they wish to transfer the patient to a maximum security hospital and before questions can be asked of these witnesses, the committee often asks the patient to comment. This makes it difficult for the attorney to structure his case. Hear-say testimony is generally not admitted into evidence. Thus, the physicians often cannot testify as to facts not of their own knowledge. Often none of the parties desiring the transfer have first hand facts either. The chairman of the committee generally refuses to allow more than one attorney to represent the patient or even attend the hearing.

All of the hospitals in Cook County are "short term" hospitals where patients are admitted for sixty days. The general policy of the Department is that if the patient does not show improvement within sixty days, he is to be transferred to a long term hospital for extended treatment. This policy has been challenged on the ground that a patient has an interest in his treatment and drastic

\begin{thebibliography}{99}
\addcontentsline{toc}{section}{References}
\bibitem{240} In the Interest of —, 72 Co. NMT 2635 (Ill. Cir. Ct. of Cook Cty. 1973) (opinion and order) in Flashner, \textit{supra} note 193, at 31. (Judge Schneider, who included the case in the volume, withheld the names of the parties for their protection.)
\bibitem{241} DMH Rule 14.01 (1973).
\bibitem{242} \textit{Id.}
\bibitem{243} \textit{Id.}
\end{thebibliography}
changes cannot be made solely because he is a long term patient. In *Levitzke v. Levitt*, it was argued that if the patient being transferred opposes transfer, he is entitled to a hearing at which the Department must justify its action.

**CONSTITUTIONAL PROVISIONS**

A provision of the new Illinois constitution protects the mentally handicapped. Section 19 provides:

All persons with a physical or mental handicap shall be free from discrimination in the sale or rental of property and shall be free from discrimination unrelated to ability in the hiring and promotion practices of any employer.

The state legislature implemented this constitutional provision by passing the Equal Opportunities for the Handicapped Act on August 23, 1971. The Act provides criminal penalties for its violation.

**CONCLUSION**

At the present time, the emphasis in mental health law is focusing more and more upon the task of ensuring that no individual will be involuntarily committed without being provided full due process rights; that a person who is deprived of his liberty on the basis that he is in need of treatment will, in fact, be provided with adequate treatment; and that patients will be released when they are no longer in need of treatment. This trend in mental health law is quite similar to the early stages of the criminal law revolution of the 1960's which gave tremendous scope to constitutional protections afforded defendants in criminal proceedings.

While the Mental Health Code of 1967 went a long way towards protecting the rights of persons involved in the commitment process, many more changes are needed to fully protect their rights. Many of the issues examined in this article have been debated and discussed for some time. The time for implementation and active reform is at hand.

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244. No. 73 Co 887 (Ill. Cir. Ct. of Cook Cty., filed July 6, 1973).