NEW DEVELOPMENTS IN DEFENDING COMMITMENT OF THE ELDERLY

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I

INTRODUCTION

The state may authorize the commitment of a person to a mental institution through the exercise of either its police power to protect society from dangerous persons or its parens patriae power to protect dangerous persons from themselves. Society often assumes that those seeking to commit an elderly person are seeking to protect that person's welfare. On the contrary, the moving party may desire the commitment merely because she is inconvenienced by the presence, needs, and querulous or eccentric behavior of the elderly person.[1] Mental institutions have recently contained three times as many inmates as prisons,[2] and the elderly, committed for the convenience of others rather than for the severity of their mental impairment, constitute a large percentage of these inmates.[3]

Individuals suffer the ultimate indignity when, in their final years, they are stigmatized as mentally incompetent. The United States Supreme Court has repeatedly recognized that civil commitment constitutes a "massive curtailment" of one of the most basic human rights, liberty of movement.[4] The Court remarked that commitment "can engender adverse social consequences to the individual. Whether we label this phenomenon 'stigma' or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual."[5]

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1. Note, *Legal Needs of the Elderly,* 30 BAY. L. REV. 807, 809 (1978), *citing* GOVERNOR'S COMMITTEE ON AGING, STATE OF TEXAS, ARE THESE UNWANTED? (1962).

2. Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill,* 44 TEX. L. REV. 424, 433 (1966).

3. *Id.* at 434; Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae,* 40 MO. L. REV. 215, 266, 273 (1975); S. BRAKEL AND R. ROCK, THE MENTALLY DISABLED AND THE LAW 39 (1971).

4. Vitek v. Jones, 445 U.S. 480, 491 (1980) (quoting Humphrey v. Cady, 405 U.S. 504, 509 (1972)); Addington v. Texas, 441 U.S. 418, 425 (1979); *see also* Humphrey v. Cady, 405 U.S. 504, 509 (1972) (dictum); *cf.* Specht v. Patterson, 386 U.S. 605, 608 (1967) (due process and equal protection applicable in psychiatric commitment of sex offenders).

5. *Addington,* 441 U.S. at 425-26; *see also Vitek,* 445 U.S. at 492.

Furthermore, experience has demonstrated that institutionalization usually does not benefit the elderly. One study found that in nearly every case studied the condition of the aged inmate had deteriorated after commitment, and in almost no case did an individual benefit in a way which could not have been achieved without institutionalization.[6] Analysts have concluded that mental hospitals are actually antitherapeutic. Survival of elderly persons is negatively related to placement: 50% to 60% of older persons admitted to mental hospitals die during the first year.[7] An attitude of "therapeutic nihilism" surrounds institutionalized elderly persons so that they probably will receive only custodial care rather than treatment, and their placement probably will be permanent.[8] In short, commitment is often no more than warehousing pending an accelerated death.

The moving party may seek a guardianship of the person on grounds similar to those for commitment. The guardian of the person ordinarily has the power to place an elderly ward in a nursing home or a private custodial home or hospital or, in some jurisdictions, to commit her to a mental institution.[9] The past decade has seen an assault on unwarranted commitments at the same time that an increase in funding sources has made possible a large growth in the number of nursing homes. These homes vary widely in quality; many are seriously inadequate and offer an environment even more adverse to an elderly person than a mental hospital. They have become dumping places for persons who, at one time, would have been committed.[10] To some extent the imposition of a guardianship may be as devastating as a mental commitment.

The possibility that these drastic detrimental effects will be visited on the elderly person means that she is entitled to counsel.[11] The attorney for the elderly person carries a heavy obligation to resist unnecessary confinement or guardianship which could lead to confinement. This is the only

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6. G. ALEXANDER AND T. LEWIN, THE AGED AND THE NEED FOR SURROGATE MANAGEMENT 136 (1972) [hereinafter cited as ALEXANDER & LEWIN].

7. *Id.* at 63; *see also* Lessard v. Schmidt, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972), *vacated on other grounds,* 414 U.S. 473, *modified,* 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds,* 421 U.S. 957 (1975).

8. The term "therapeutic nihilism" is used in both the mental health and legal disciplines to describe the paucity of treatment offered to institutionalized elderly persons. *See* E. MILLER, ABNORMAL AGEING 121 (1977); Horstman, *supra* note 3, at 234, (quoting Lawton, *The Philadelphia Story,* in UNIV. OF SOUTHERN CALIFORNIA ETHEL PERCY ANDRUS GERONTOLOGY CENTER, RESEARCH IN MENTAL HEALTH: UTILIZATION FOR THE AGED, SUMMARY OF PROCEEDINGS Apr. 27-28, 1970).

9. Horstman, *supra* note 3, at 231; *see* Dahl v. Akin, 630 F.2d 277, 280 (5th Cir. 1980).

10. SENATE SUBCOMM. ON LONG-TERM CARE, SPECIAL COMM. ON AGING, INTRODUCTORY REPORT, S. REP. No. 1420, 93rd Cong., 2d Sess. 5-11 (1974); HABENSTEIN AND KULTGEN, POWER, SELF AND PATIENTS 5 (1981) (eight percent of all residents in nursing homes were former residents of mental hospitals).

11. *Cf.* Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968) (right to counsel in commitment hearings of mentally retarded); Lynch v. Baxley, 386 F. Supp. 378, 389 (M.D. Ala. 1974) (same); *Lessard,* 349 F. Supp. at 1097 (same).

assurance the elderly client has that she will receive due process and not suffer unwarranted loss of liberty.

Unfortunately, attorneys representing those for whom commitment or guardianship is proposed seldom prepare adequately and do not effectively participate in the hearing. This perfunctory performance occurs in part because attorneys incorrectly assume that experts have determined that commitment is necessary for psychiatric reasons, and in part because they wish to avoid informal sanctions from their peers and the judiciary for disrupting a system which depends upon mass processing of cases in the shortest time possible.[12] The Supreme Court has noted "[t]he expanding concern of society with problems of mental disorders" reflected in efforts in recent years to "protect the rights of the mentally ill."[13] The practicing lawyer should know how to effectively represent elderly clients faced with commitment proceedings.

This article will present a brief survey of procedural and substantive constitutional requirements applied to mental health-related commitment proceedings. Primary degenerative dementia, the mental disorder most likely to be diagnosed in elderly subjects, will be discussed and related to substantive constitutional requirements.

II

PROCEDURAL PROTECTION

The United States Supreme Court has often recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.[14] However, the Court itself has decided only two procedural issues: the right to counsel and the burden of proof in commitment proceedings. Lower courts have confronted only a few additional procedural due process issues in commitment settings. Nevertheless, these decisions suggest that courts are willing to set aside commitments resulting from hearings in which these rights were not respected. Because many attorneys lack experience in representing elderly clients, particularly in commitment proceedings, they often inadvertently deprive those clients of the full panoply of rights. An extended consideration of the right to counsel

12. Cohen, *supra* note 2, at 448. Indications are that effective representation is rarely provided even under modern reform legislation. *See* Taney, 8 BULL. AM. ACAD. OF PSYCHIATRY AND THE LAW 8 (1980); Munetz, Kaufman, and Rich, *Modernization of a Mental Health Act: Commitment Patterns,* 8 BULL. AM. ACAD. OF PSYCHIATRY AND THE LAW 83 (1980); *see also,* Parham v. J.R., 442 U.S. 584, 609 n.17 (1978).

13. Addington v. Texas, 441 U.S. at 426.

14. *Id.* at 425 (civil commitment requires due process); Jackson v. Indiana, 406 U.S. 715, 738 (1972) (individual entitled to due process hearing on reasons for commitment before state may commit); Humphrey v. Cady, 405 U.S. at 509 (civil commitment under Wisconsin sex offenders statute is a massive curtailment of liberty); *In re* Gault, 387 U.S. 1, 27-28 (1967) (delinquency commitment is great deprivation of liberty which entitles juvenile to due process); Specht v. Patterson, 386 U.S. at 610 (New charge of dangerously mentally ill under Sex Offenders Act requires due process hearing).

and a brief look at other procedural rights should alert attorneys to the strategies they can employ to protect their elderly clients.

A. Right to Effective Counsel and Pre-hearing Preparation

The Supreme Court in *Humphrey v. Cady*[15] and numerous lower federal courts have held that there is a due process right to counsel at the commitment hearing.[16] But because we do not have a tradition of active participation by appointed attorneys on behalf of clients for whom commitment is proposed, attorneys have difficulty visualizing what effective role they might play.[17]

Preparation is an essential element in the successful advocacy of the client's cause. The cases which have defined the right to counsel in commitment hearings have held that the right entails notice of the hearing and appointment of counsel sufficiently in advance of the hearing to ensure an opportunity for effective preparation.[18] Consequently, the attorney should object to being appointed within minutes, hours, or even a day or two of the hearing.

It is particularly important to give elderly clients a role in the representation process. During the initial interview the attorney should explain to the client that she can represent the client but that the client is entitled to either represent herself or to select a different attorney.[19] This assures the client that the attorney is separate from the commitment system and reinforces the client's own independence. Once the attorney establishes that she is the client's chosen representative, she should explain that the outcome of the case will largely depend both on the client's cooperation during the preparation period and on the client's performance at the hearing itself.

In preparing to defend a client, the attorney should thoroughly explore the facts and seek alternative means to resolve the problem. The main inquiry in a commitment proceeding will be whether the client is dangerous to herself or to others. The attorney should direct her preliminary investigation to this issue. The attorney should find out whether the client is self-sufficient or able to use support services, and whether the help of her neighbors and friends may eliminate the need for professional help. The

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15. 405 U.S. 504, 512-13 (1972); *cf.* Vitek v. Jones, 445 U.S. 480 (1980).

16. Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968); Doremus v. Farrell, 407 F. Supp. 509, 516 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378, 389 (M.D. Ala. 1974); *Lessard,* 349 F. Supp. at 1097; *accord In re* Beverly, 342 So.2d 481, 489 (Fla. 1977) (individual is entitled to counsel at all significant stages of commitment proceeding).

17. Cohen, *supra* note 2, at 446; Note, *Civil Commitment of The Mentally Ill,* 87 HARV. L. REV. 1190, 1288 (1974).

18. Lynch v. Baxley, 386 F. Supp. at 389.

19. Mutnick and Lazar, *A Practical Guide to Involuntary Commitment Proceedings,* 11 WILLAMETTE L.J. 315, 320 (1975). Many of these suggestions for pre-hearing preparation which follow were made by Mutnick and Lazar or by Cohen, *supra* note 2.

lawyer should discuss with professionals whether the client is able to function without harming herself or others.

The attorney should obtain all records filed in the court, hospitals, doctors' offices, and social agencies. The medical report upon which the petition is based is the primary document against which to check all the other information obtained. The attorney should interview any doctors or social workers who treated, examined or dealt with the client, as well as any staff members at institutions or hospitals where the client has recently resided. The attorney should learn what medications and treatments the client has had. If the attorney understands the client's treatment and confers with the professionals with whom the client has had contact, she may be able to develop alternatives to commitment and encourage the professionals to consider these alternatives.

The attorney should also interview any relatives and friends who may have been instrumental in filing the petition or who may testify at the hearing either for or against the client. It is often helpful to visit the client's neighborhood and ask neighbors for their impressions of the client's condition. Through these contacts, the attorney should try to learn about the client's daily life.

After these inquiries, the attorney should be able to assess the probability that the petition will be granted and will be ready to advise her client. If the client is able to communicate, the attorney should familiarize the client with the proceeding that will be conducted. They should discuss the setting, the questions that will be asked, and the probable consequences of commitment. The attorney should advise the client if voluntary care or treatment is the only alternative to involuntary commitment. If the attorney believes that the client is able to make judgments concerning alternative treatment plans or whether to contest a hearing, the attorney should determine the client's wishes.[20]

If the case goes to a hearing, counsel must present the best possible case on behalf of her client. At a minimum, this means the attorney must present all the evidence which tends to show that the client is not mentally ill, suggest alternative plans, assure that only proper evidence is admitted at the hearing, question the expert witnesses to reveal the bases for their opinions, and object to commitment if any statutory or constitutional prerequisites are absent.

The attorney should prepare the client to take part in the hearing by reviewing with the client how the proceeding will be conducted and how the client should respond to questions. Since one of the first questions asked at a hearing is typically "What are you doing here today?", the attorney needs to be certain that the client understands the reason for the hearing, the facts which led to it, and its consequences.[21] Since such a question may confuse

20. *See* MODEL RULES OF PROFESSIONAL CONDUCT, Rules 1.2, 1.14 and Notes (Proposed Final Draft 1981).

21. Mutnick and Lazar, *supra* note 19, at 323.

the client and elicit an extended response, the attorney might instruct the client to respond by saying that she is present to determine whether she is mentally ill. The attorney should instruct her client to be truthful in the hearing, to be concise, to answer questions as directly as possible, not to volunteer information, and if she does not understand a question, to ask that it be repeated or that she be allowed to consult with counsel.[22] If the client has had institutional treatment or custodial care, the attorney should review the medical records with the client so that the client will remember what occurred in those institutions and respond accurately to questions about them. If the client believes that there are discrepancies in a record, the attorney should find out whether this is true prior to the proceeding.

Finally, but very importantly, the attorney must find out whether her client's medication has been changed just before trial. Commentators point out that "it is distressingly common for doctors to begin, discontinue, or change the patient's medication shortly before a hearing so that the patient will appear before the judge at his worst."[23] Therefore, if the medication benefits the client, the attorney should tell the doctor not to change it. If the doctor changes it anyway, then the attorney can question the doctor about the change and how it affects the client. If the attorney believes the medication adversely affects the client, she should request it be ceased prior to the hearing.

B. Burden of Proof

In recent years, the question of which side bears the burden of proof has divided the courts more than any other due process issue.[24] Although a few states and some courts had required a "beyond reasonable doubt" standard,[25] the United States Supreme Court in *Addington v. Texas*[26] in 1979 settled the controversy by clearly holding that fourteenth amendment due process requires, at a minimum, proof by clear and convincing evidence. The Court refused to apply a beyond a reasonable doubt standard, but emphasized that more than a mere preponderance of evidence is necessary to minimize sufficiently the risk of erroneous decisions and to reflect "the value society places on individual liberty."[27]

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22. *Id.* at 324.

23. B. ENNIS & R. EMORY, THE RIGHTS OF MENTAL PATIENTS 193 (1978).

24. *See, e.g., In re* Beverly, 342 So.2d 481, 488 (Fla. 1977) (requiring clear and convincing evidence); State v. Turner, 556 S.W.2d 563, 566 (Tex. 1977), *cert. denied,* 435 U.S. 929 (1978) (same); Sabon v. People, 142 Colo. 323, 325, 350 P.2d 576, 577 (1960) (requiring preponderance of evidence); *Lessard,* 349 F. Supp. at 1095 (requiring proof beyond a reasonable doubt); *see generally* Annot., 97 A.L.R. 3rd 780 (1980).

25. Hawaii Rev. Stat. § 334-60(b)(4)(I) (Supp. 1981); *In re* Ballay, 482 F.2d 648, 669 (D.C. Cir. 1973); *Lessard,* 349 F. Supp. at 1095; Proctor v. Butler, 380 A.2d 673 (N.H. 1977).

26. 441 U.S. 418 (1979).

27. *Id.* at 425 (quoting Tippett v. Maryland, 436 F.2d 1153, 1166 (4th Cir. 1971), *cert. denied,* 407 U.S. 355 (1972)).

The Court acknowledged the state's legitimate interest in confining dangerous individuals, but emphasized that "civil commitment for any purpose constitutes a significant deprivation of liberty" that "can engender adverse social consequences to the individual"[28] even after release. The Court was concerned that a factfinder might decide to commit an individual on the basis of the few isolated instances of unusual conduct which every person at one time or another exhibits.[29] The increased burden of proof, the Court said, "is one way to impress the factfinder with the importance of the decision and thereby perhaps to reduce the chances that inappropriate commitments will be ordered."[30] Elderly persons are often considered eccentric simply because their behavior reflects the values of an earlier generation. They suffer from loneliness, poor health, poverty, and sensory deprivation more than others, and for these reasons often act in ways which younger persons might consider abnormal.[31]

In her opening statement, the attorney should impress on the factfinder the importance of and the reasons for the higher standard of proof, and should urge the trier of fact to judge the evidence on each element necessary for commitment by the clear and convincing standard. In the closing argument, the attorney in reviewing the evidence should again stress the higher degree of proof required and the reasons for it.

C. Other Procedural Rights

Courts have seldom litigated the individual's right to be present at the commitment hearing, but this right is at the heart of due process.[32] In *Specht v. Patterson,*[33] and *Illinois v. Allen,*[34] the United States Supreme Court held that a criminal defendant had a right to be present in the courtroom as part of her sixth amendment right to be confronted with the witnesses against her. If the subject of a commitment hearing is not present, this is often because of perfunctory performance by the attorney, rather than lack of any basis for a right to be present.[35] Any client who appears able to provide for herself and who is not dangerous should attend the hearing. Not only should the client be present, but she has the constitutional right to be free of medications that adversely affect her ability to take part in

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28. *Id.* at 425-26.
29. *Id.* at 427.
30. *Id.*
31. Brotman, *Who Are the Aged?,* in THE ELDERLY CONSUMER 14 (1976).
32. Doremus v. Farrell, 407 F. Supp. 509, 515 (D. Neb. 1975); Kendall v. True, 391 F. Supp. 413, 419 (W.D. Ky. 1975); Bell v. Wayne County Hosp., 384 F. Supp. 1085, 1094 (E.D. Mich. 1974).
33. 386 U.S. 605, 610 (1967).
34. 397 U.S. 337, 338 (1969).
35. *See* NATIONAL SENIOR CITIZENS CENTER, EMPIRICAL STUDY OF GUARDIANSHIP AND CONSERVATORSHIP FILINGS IN LOS ANGELES COUNTY (1977) (reported as available from the author in Alexander, *Premature Probate: A Different Perspective on Guardianship for the Elderly,* 31 STAN. L. REV. 1003, 1010 (1979)).

the proceedings.[36] If doctors refuse to cease medication prior to the hearing, the attorney should request postponement of the hearing until the medication has ceased and the client has recovered from its effects. The attorney can request this on the ground that the right to be present and participate so requires.[37] If the state argues that an institutionalized client is too dangerous or ill to be transported to the court, counsel can request that the hearing be held at the mental facility.[38]

Well before the hearing, the attorney must decide, preferably with the client's cooperation, whether to request a formal open court proceeding and whether to request a jury trial. Unless the client has characteristics which would render an open court proceeding or a jury trial inadvisable, both will increase the likelihood of preventing her commitment. The formality of an open court room should increase the adversarial nature of the proceedings. The United States Supreme Court has recognized that a jury trial introduces the element of lay judgment, so that values generally held in the community are used to evaluate whether the kinds of potential harm that justify the confinement of a person are present in the subject.[39] A jury is less likely to commit than a judge who is accustomed to relying solely on psychiatric testimony and to ordering commitments more or less automatically.[40] However, not all states have statutes that provide for jury trial and it has not yet been held that a jury trial is constitutionally required in commitment proceedings.[41]

Although the United States Supreme Court has held that the fifth amendment privilege against self incrimination is applicable in juvenile proceedings,[42] there has been little litigation on its applicability in civil commitment proceedings. A federal district court in *Lessard v. Schmidt* held that a statement of an allegedly mentally ill person to a psychiatrist could not be used to commit that person without a showing that she knew she was under no obligation to speak.[43] Consequently, an attorney might offer an objection to the admission of a medical record or to testimony by a doctor where the record or the testimony contains statements made by a client who was not informed of a right to remain silent.[44] However, more recent authority suggests that the privilege against self incrimination does not

36. *Doremus,* 407 F. Supp. at 515.

37. *Id.*

38. *Bell,* 384 F. Supp. at 1094.

39. Humphrey v. Cady, 405 U.S. at 509.

40. *See* Cohen, *supra* note 2, at 447.

41. *See Doremus,* 407 F. Supp. at 516 (no constitutional right to jury in civil commitment proceedings); Lynch v. Baxley, 386 F. Supp. at 394-95 (although highly desirable, jury in civil commitment proceedings is not a constitutional right); R. BROWN, ACLU HANDBOOK ON THE RIGHTS OF OLDER PERSONS, 312 (1979).

42. *In re* Gault, 387 U.S. at 55.

43. 349 F. Supp. at 1101, 1102. However, the court upheld the required examination without presence of counsel. *Id.* at 1101.

44. *Cf.* Estelle v. Smith, 101 S. Ct. 1866 (1981) (*Miranda* warning required at pre-criminal-trial psychiatric hearing later used in determining death sentence.)

apply so long as the statement is not used for criminal prosecution, because civil commitment is for treatment and is not a criminal proceeding.[45] Nor will the constitutional right against self incrimination require *Miranda* warnings prior to questioning or observing the person subject to commitment.

The petitioner may attempt to offer into evidence medical records from the confining institution or from a physician who has examined or treated the client prior to the hearing. These records may already be in the court file when counsel is appointed. Where the records appear helpful, as when they illustrate a client's willingness to obtain treatment voluntarily or when they indicate exculpating behavior, the attorney may wish to allow such records to be introduced as evidence. However, if the records reduce a client's chances of avoiding commitment, the attorney should attempt to keep them from the trier of fact.[46] The attorney should try to cross examine the source of any statements that may lead to commitment.

Some courts have held that the civil rules of evidence should apply with particular stringency in commitment proceedings.[47] Therefore, the attorney may successfully object to the admission into evidence of written statements, affidavits, and records on hearsay grounds.[48] The use of the hearsay objection alone has a practical drawback, however. Commitment cases tend to be processed on an assembly-line basis, and it has become customary for courts to allow the use of written records to expedite the hearing. Most written memoranda will probably be admitted over a hearsay objection.

A more promising approach would be to combine the hearsay objection with a claim that the use of written documents, especially to establish the mental illness requisite to commitment, violates the client's sixth amendment right to confront witnesses. This right was first applied to the states through the fourteenth amendment in *Pointer v. Texas*.[49] The full extent of the right is still unclear, but the Supreme Court has concluded that it is more exclusionary than the hearsay rule, in part because the clause's policy reflects a preference for face to face confrontation and cross examination of the witness.[50] Some courts have interpreted the sixth amendment to guar-

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45. For example, courts have held that a psychiatrist can testify about statements made by the subject during examination, French v. Blackburn, 428 F. Supp. 1351, 1359 (M.D.N.C. 1977); and that the subject cannot invoke the fifth amendment and refuse to testify in court, People v. Taylor, ____ Colo. ____, 618 P.2d 1127, 1140 (1980). The Ninth Circuit Court of Appeals upheld a statutory requirement of a five day commitment for medical evaluation, the results of which could be used to extend commitment. However, in that case there was other external evidence sufficient to find that the subject was mentally ill and dangerous, Suzuki v. Yuen, 617 F.2d 173, 177-78 (9th Cir. 1980).

46. *See* Kirkpatrick, *Oregon's New Mental Commitment Statute: The Expanded Responsibilities of Courts and Counsel*, 53 ORE. L. REV. 245, 263 (1974).

47. *Lessard*, 349 F. Supp. at 1103; *In re* Beverly, 342 So.2d 481, 489 (Fla. 1977).

48. *See* MCCORMICK, EVIDENCE 579-608 (1972). The classic hearsay objection is that an out of court statement is inadmissable to prove the truth of its contents unless it comes within a specific exception.

49. 380 U.S. 400 (1965).

50. Ohio v. Roberts, 448 U.S. 56, 63 (1980).

antee the patient's right to be present in mental commitment hearings.[51] In *Doremus v. Farrell* the court held that "[t]he right to be present at the hearing necessarily includes the constitutional right of confrontation and cross-examination."[52] The attorney for the elderly client must have the opportunity to cross examine expert witnesses in order to expose any shortcomings in their diagnosis or treatment. Therefore, the attorney should strenuously object on both evidentiary and constitutional grounds to the use of written records at the hearing without the presence and availability of the author for cross-examination.

III

THE SUBSTANTIVE BASES FOR COMMITMENT

A. The "Big Five" Requirements

Recent trends in constitutional law and legislative reform suggest that five basic findings, all of which must be supported by evidence, must be made in order to justify an involuntary commitment. Those requirements are:

1. the individual is mentally ill;
2. the individual is dangerous to others or herself;
3. the individual is in need of care or treatment;
4. the proposed commitment is the least restrictive alternative available to meet the needs of the public or the individual; and
5. if the proposed commitment is for the protection of the individual alone, she lacks the capacity to determine for herself whether or not commitment is desirable.

These five conditions will be referred to in this article as the "Big Five" to highlight the fact that the petitioner's failure to establish any one of them should constitute a barrier to commitment. Unfortunately for the individual resisting an attempted commitment, court decisions or statutory authority to buttress the assertion that all five must be established is not readily available. Particular statutes, especially if enacted or amended recently, are likely to specify at least the first three of the basic requirements and may include the last two as well.[53] The attorney should urge the court to interpret the statutory language as requiring by implication any of the five not specified.

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51. *See* cases cited *supra* note 32.

52. 407 F. Supp. at 515. *See also* State v. Fields, 77 N.J. 282, 304-06, 390 A.2d 574, 585-86 (1978) (discussion of need for psychiatric testimony rather than records in reevaluations of persons committed after being found not guilty by reason of insanity).

53. *See, e.g.*, MO. REV. STAT. § 632.105 (1980); MONT. CODE ANN. §§ 53-21-101-126 (1981).

The constitutional foundations for the Big Five in United States Supreme Court decisions are largely a matter of implication rather than clear holding. Since 1972 the Court has indicated a number of times its recognition that mental commitment is an extreme curtailment of constitutionally protected liberty.[54] The most significant holdings in this area are *O'Connor v. Donaldson*[55] and *Addington v. Texas.*[56] Although neither case specifically endorses all of the Big Five, the reasoning and language provide a sound basis for the lower courts to do so.

O'Connor involved a mental patient who was committed under a state statute upon a judicial finding that he was suffering from "paranoid schizophrenia."[57] Although the patient, Donaldson, was not dangerous to himself or others and in spite of the fact that friends and community organizations would be available for help when he was released, the director of the institution rejected his pleas for freedom and refused his release for fifteen years.[58] During those fifteen years Donaldson received no treatment and was kept with other mental patients. Objecting to this "regime of enforced custodial care,"[59] district and circuit courts found that Donaldson had a constitutional right to treatment.[60] The Supreme Court refused to affirm the lower court's holding on that ground, but nevertheless found that Donaldson's confinement violated his constitutional right to liberty. Pointing out that "[t]he fact that state law may have authorized confinement of the harmless mentally ill [person] does not itself establish a constitutionally adequate purpose for the confinement,"[61] the Court declared: "A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement . . . [T]here is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."[62]

Furthermore, the opinion continued, the state cannot confine a person merely to insure her an adequate standard of living, since a person might prefer her home to the "comforts of an institution,"[63] and because institutionalization "rarely, if ever" is necessary to raise the patient's standard of living.[64] Finally, the Court declared that the State could not constitutionally "fence in the harmless mentally ill solely to save its citizens from

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54. Addington v. Texas, 441 U.S. at 425; O'Connor v. Donaldson, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring); Jackson v. Indiana, 406 U.S. 715 (1972); Humphrey v. Cady, 405 U.S. at 509; *In re* Gault, 387 U.S. at 30; Specht v. Patterson, 386 U.S. at 610.

55. 422 U.S. 563 (1975).

56. 441 U.S. 418 (1979).

57. *O'Connor,* 422 U.S. at 565.

58. *Id.* at 567-69.

59. *Id.* at 569.

60. Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), *aff'd,* 422 U.S. 563 (1975).

61. *Id.* at 574.

62. *Id.* at 575.

63. *Id.*

64. *Id.*

exposure to those whose ways are different," since that would allow the state to incarcerate anyone who is "physically unattractive or socially eccentric."[65] The Court concluded in *O'Connor:* "In short, a state cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[66]

In *Addington* the Supreme Court dealt with the standard of proof applicable in a civil commitment hearing.[67] The Court imposed the clear and convincing standard of proof in order to reduce the chances of inappropriate commitment. The Court declared that loss of liberty "calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior."[68] Although the Court affirmed the state's countervailing interest, it circumscribed that interest carefully, saying:

> The State has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the State also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill . . . . However, the State has no interest in confining individuals involuntarily if they are not mentally ill or if they do not pose some danger to themselves or others.[69]

These two decisions contain the most comprehensive Supreme Court language concerning substantive justifications for involuntary mental commitment. That language forms the basis for requiring all of the Big Five. Without question, mental illness must be found. It is also clear that danger to the public or self could justify commitment. The Court's reference to a non-dangerous individual who can live safely by herself with help implies the necessity for establishing both that the individual must need the care or treatment provided by the confinement to control or cure the dangerousness, and that less restrictive alternatives are not sufficient. The Court's concern with the individual's liberty interest, its recognition of the adverse consequences of institutionalization, and its tolerance of bizarre or idiosyncratic behavior suggest that, if squarely presented with the commitment of a person who is dangerous only to herself, the Court would also require that the individual be incapable of rationally deciding for herself whether to forego the treatment.

The Supreme Court has not ruled comprehensively on any mental commitment case, and close analysis of *O'Connor* and *Addington* reveals

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65. *Id.*
66. *Id.* at 576.
67. For discussion, *see supra* text accompanying notes 26-30.
68. *Addington,* 441 U.S. at 427.
69. *Id.* at 426.

their limitations. They do not hold that an individual must be dangerous to warrant commitment, but only that dangerousness would suffice.[70] They do not hold that need of care or treatment, institutionalization as the least restrictive alternative, or incapacity to make a rational choice about institutionalization must be proved by the petitioner. The Court's holdings only imply that substantive due process requires these last three of the Big Five findings. Likewise, although lower courts have held that one or more of the Big Five findings must be reached, they only imply that each of them is required in order to justify commitment.[71] These will be discussed in connection with suggestions for implementing each of the Big Five in a proceeding involving a elderly client.

B. Implementing the Big Five

Whether or not a statute or the Constitution requires each of the Big Five, the attorney for the elderly client should remember that each of the five is ultimately a legal and factual issue that must be resolved by the judge and jury rather than by an expert witness.[72] Of course, experts may present psychiatric or psychological evidence relevant to the question of mental illness or to any of the other criteria. Various writers suggest that many attorneys fail to properly represent commitment clients because they are afraid to challenge a psychiatrist in a field about which they know little.[73] A related phenomenon is the great extent to which judges rely upon psychiatric opinion in ordering commitment. Whether they lack psychiatric expertise or simply unconsciously shift the decision making role, attorneys and judges too often happily avoid the awesome responsibility for the commitment decision by leaving it to the psychiatrist.[74] However, the protection of a client's liberty should not rest by default with an unquestioned psychiatric expert. The attorney should not only insist that the Big Five be found, but she must attack the evidence, including psychiatric testimony, presented by the petitioner to establish each requirement.

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70. One major issue which the Court has carefully avoided addressing is whether confinement of a person not dangerous even to himself could be justified solely for purposes of treating him. The statement in *O'Connor,* 422 U.S. at 575, that improving the subject's standard of living would not suffice suggests that treatment alone would not justify confinement.

71. Among the most comprehensive opinions are Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974), *rev'd* 651 F.2d 387 (5th Cir. 1981); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds,* 414 U.S. 473, *modified,* 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds,* 421 U.S. 957 (1975); State *ex rel* Hawks v. Lazaro, 157 W. Va. 417, 202 S.E.2d 109 (1974).

72. *See* Hardisty, *Mental Illness: A Legal Fiction,* 48 WASH. L. REV. 735 (1973); J.B. AKER, A. WALSH, & J. BEAM, MENTAL CAPACITY: MEDICAL AND LEGAL ASPECTS OF THE AGING 38 (1977) [hereinafter cited as AKER & WALSH].

73. Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom,* 62 CALIF. L. REV. 693, 745 (1974); Cohen, *supra* note 2, at 450.

74. Kirkpatrick, *Oregon's New Mental Commitment Statute: The Expanded Responsibilities of Courts and Counsel,* 53 ORE. L. REV. 245, 257 (1974).

1. Mental Illness

a. Psychiatric opinion not definitive

When courts or statutes use the terms "mental disorder," "mental illness" or "mental disease" as a requisite for involuntary commitment, it is often assumed that the medical profession, particularly psychiatry, has defined these terms precisely and that only medical experts understand them fully. Consequently, attorneys and judges may too easily shift the burden of defining these legal terms to the psychiatric expert. Retaining the legal determination of mental illness for the judge or jury should be easier when practitioners recognize that neither assumption is justified.

Psychiatry is extremely imprecise. No generally acceptable definition exists within the profession of the term "mental illness."[75] Some psychiatrists say no more than that the words connote individual behavior which society believes should be the concern of psychiatrists.[76]

Psychiatry deals with persons exhibiting abnormal, unwanted or antisocial behavior. Because psychiatry is primarily interested in behavioral characteristics for which the physiological causes need not be known, many have questioned whether the medical model of illness is appropriate for making legal determinations of mental fitness.[77] One authority suggests that when a psychiatrist qualifies as an expert because she is a medical doctor, the opposing lawyer should try on cross-examination to lead her to admit that her professional experience is limited to behavioral factors. The lawyer may then move to strike her entire testimony because she is not qualified as an expert in psychology.[78] Psychiatrists do not work with physical phenomena, but base their diagnoses on observed behavioral characteristics. They have not formulated a behavioral description for the term "mental illness." Consequently psychiatry is much less precise than either the other medical disciplines or the physical sciences.[79]

The American Psychiatric Association has attempted to organize the discipline's theories in the Diagnostic and Statistical Manual. The Manual lists groups of behavioral characteristics to which it assigns a name. A

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75. See AMERICAN PSYCHIATRIC ASSOCIATION, THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 5 (3d ed. 1980) [hereinafter cited as DSM III] which states: "Although this manual provides a classification of mental disorders, there is no satisfactory definition that specifies precise boundaries for the concept 'mental disorder'. . . ." No definition is attempted. The manual does not use the term "mental illness."

76. *E.g.*, R. ALLEN, E. FERSTER & H. WEIHOFEN, MENTAL IMPAIRMENT AND LEGAL INCOMPETENCY 6, 42 (1968).

77. J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 330-347 (3d ed. 1981). This publication provides the most comprehensive coverage available of the issues, problems, and practical considerations connected with the use of psychiatric testimony in legal proceedings. *See also*, Hardisty, *supra* note 72, at 736-40; Ennis & Litwack, *supra* note 73, at 745.

78. J. ZISKIN, *supra* note 77, at 343.

79. Pollack, *Principles of Forensic Psychiatry for Psychiatric-Legal Opinion-Making*, LEGAL MEDICINE ANNUAL (1971) (cited in J. ZISKIN, *supra* note 77, at 42-43).

psychiatrist would probably claim that a person exhibiting a particular group of characteristics has a mental disorder with that name.

These categories lack a scientifically verifiable basis; the Manual was adopted and is revised periodically by committee drafts and a final vote of the membership of APA.[80] The chairman of the American Psychiatric Association Task Force on Nomenclature and Statistics, the group that produces the DSM, co-authored an article which acknowledges that ample data exists to substantiate "the well-known, generally low degree of reliability of current psychiatric diagnostic practice."[81] The article refers to the differences of opinion within the profession as to criteria to be used in diagnosis. In discussing glossaries of mental disorders, including the DSM, they state:

> Some of the lack of clarity in the definitions provided by the standard glossaries has been deliberate because the glossaries were designed for general use. To gain acceptance by groups with widely divergent views, clear rules that reflect a particular point of view were avoided because they would have been unacceptable to some groups.[82]

Some categories of characteristics labeled as mental disorders are so broad as to allow the diagnostician "to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason . . ."[83]

In pejorative but accurate terms, psychiatric diagnosis is both unreliable and invalid. The lack of scientific basis for the diagnostic categories results in an extremely low degree of reliability and validity of diagnosis. In other words, the percentage of diagnoses upon which different psychiatrists will agree and the percentage of diagnoses which reflect the patient's actual condition is low.[84] Reliability studies show that the rate of agreement on a second diagnosis varies from a low of eighteen percent to a high of sixty percent.[85] A dramatic example of this unreliability occurred in a study in

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80. A notorious episode which exposed the lack of scientific principles underlying diagnoses and the wide divergence of opinion among psychiatrists was the controversial vote on whether to continue to list homosexuality as a mental disease or disorder. J. ZISKIN, *supra* note 77, at 134. The third edition lists a "mental disorder" which may draw even more skepticism than the homosexuality listing: Tobacco Organic Mental Disorder. DMS III, *supra* note 75, at 159. This "mental disorder" is described in terms familiar to any normal person who has experienced the agony of withdrawal from cigarette smoking.

81. Spitzer, Endecott, & Robins, *Clinical Criteria for Psychiatric Diagnosis and DSM-III*, 132 AM. J. PSYCH. 1187, 1188 (1975), *quoted in* J. ZISKIN, *supra* note 77, at 133. *But see* notes 89 and 90, *infra*.

82. *Id.* at 1188, *quoted in* J. ZISKIN, *supra* note 77, at 133.

83. Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 80 (1968). *See also* J. ZISKIN, *supra* note 77, at 133.

84. "The uncertainty of diagnosis in this field and the tentativeness of professional judgment" has been acknowledged by Chief Justice Burger. *See O'Connor*, 442 U.S. at 584 (Burger, C.J., concurring).

85. *See* J. ZISKIN, *supra* note 77, at 253; Ennis & Litwack, *supra* note 73, at 701-711; Kirkpatrick, *supra* note 74, at 258.

which eight normal persons gained admission to twelve different mental hospitals for stays varying from seven to fifty-two days, and acted "normally" after they initially reported hearing voices. All were diagnosed as schizophrenic or manic depressive and were never found out; they were released as "in remission."[86] In another study which involved nearly 1,000 persons, at least ninety-four percent of the predictions of dangerousness were invalid.[87] A number of appellate court opinions in recent years have recognized the uncertainty of psychiatric diagnosis.[88]

The American Psychiatric Association is justifiably concerned with the notorious unreliability of psychiatric prediction. It tried to increase the reliability of diagnosis based on DSM III criteria by testing with a series of field trials using early drafts of DSM III.[89] Although the DSM III authors believe the studies show some improvement in the reliability of diagnoses, the studies do not establish reliability sufficient for legal purposes.[90]

b. Primary Degenerative Dementia

(1) Diagnostic criteria

An elderly person for whom commitment is considered may be described by the psychiatrist as having "cerebral arteriosclerosis" or "athero-

86. Rosenhan, *On Being Sane in Insane Places*, 13 SANTA CLARA LAWYER 379 (1973).

87. Ennis & Litwack, *supra* note 73, at 712. *See infra* text accompanying notes 192-194.

88. *E.g.*, Smith v. Schlesinger, 513 F.2d 462, 477 (D.C. Cir. 1975); *In re* Ballay, 482 F.2d 648, 665 (D.C. Cir. 1973); People v. Burnick, 14 Cal. 3d 306. 325-27, 535 P.2d 352, 365-66, 121 Cal. Rptr. 488, 501-02 (1975).

89. DSM III, *supra* note 75, at 467 *et seq.* The results using kappa coefficients are summarized in DSM III.

90. The authors of DSM III state that a "high kappa indicates good agreement," *id.* at 468, but the manual does not explain what it means by the term "good." Although these studies might indicate a higher degree of reliability in diagnosis than that previously obtained, moving from abysmal to poor does not convert unreliability to reliability, nor does it constitute agreement that is sufficient for legal purposes. The kappa statistics given do not reflect the percentage of agreement among diagnoses but rather the amount of agreement in excess of chance. For example, a high kappa coefficient of .80 does not mean that two clinicians using DSM III would agree on their diagnosis 80% of the time, but rather that the probability of their agreement over chance has been increased 80%. The amount of disagreement in many of the categories may be especially significant in view of how the field trials were conducted. Because the participant clinicians were volunteers there is an unknown volunteer bias. The various participants diagnosed differing numbers of subjects so that an unknown distortion in results could have occurred if better or more experienced diagnosticians evaluated large numbers of subjects. There is no indication in the Manual as to how the subjects were selected for evaluation. If they had already been hospitalized, the degree of consensus in diagnosis should be higher than that expected with subjects evaluated because a relative or neighbor had been seeking to institutionalize them.

That DSM III is not an adequate basis for legal judgments is strongly suggested by its own statements. DSM III states: "The use of this manual for nonclinical purposes, such as determination of the legal responsibility, competency or insanity, or justification for third-party payment must be critically examined in each instance within the appropriate institutional context." *Id.* at 12. Later, DSM III warns that its own diagnostic criteria are no more than useful guides, stating that the "criteria are based on clinical judgment, and have not yet been fully validated; with further experience and study, the criteria will, in many cases, undoubtedly be revised." *Id.* at 31.

sclerosis," "primary degenerative dementia," "organic brain syndrome," or "senile dementia."[91] These terms all refer to a condition evidenced by a cluster of symptons which worsen progressively. The two primary symptons are loss of memory and disorientation. The memory impairment first affects immediate recall and causes shortened retention span and loss of recent memories.[92] Disorientation usually begins with difficulty in finding one's way, first in unfamiliar, then in familiar surroundings.[93] Ultimately, loss of intellectual abilities—including judgment and abstract thought and changes in personality can occur.[94]

DSM III labels this "mental disorder" which most often afflicts elderly persons as primary degenerative dementia.[95] In the absence of extraordinary laboratory techniques or death and autopsy, its presumed pathology is degeneration or atrophy of the brain.[96]

The DSM III text sets out three "diagnostic criteria" for primary degenerative dementia:

> A. Dementia.
>
> B. Insidious onset with uniformly progressive deteriorating course.
>
> C. Exclusion of all other specific causes of Dementia by the history, physical examination, and laboratory tests.[97]

(2) Criterion A: Dementia Brain Syndrome

The first criterion necessary for the diagnosis of the "mental disorder" called primary degenerative dementia is the syndrome "dementia." It is one of ten different organic brain syndromes which are described in the preceding pages of DSM III.[98] Establishing the organic brain syndrome, dementia, is the key element in the diagnosis of the mental disorder, primary degenerative dementia.

The use of the term "dementia" at both the mental disorder and the brain syndrome levels is confusing. When a psychiatrist uses the term or describes the criteria necessary for a finding of "dementia," the attorney should insist that the psychiatrist specify whether she is discussing the mental disorder itself or its first criterion, the organic brain syndrome. Throughout this discussion the precise terminology of DSM III will be

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91. *See* AKER & WALSH, *supra* note 72, at vii.

92. Kral, 17 CANADIAN PSYCHIATRIC ASSOC. J. 25 (1972), *quoted in* AKER & WALSH, *supra* note 72, at 137.

93. SCHETTLER & BOYD, ATHEROSCLEROSIS 683 (1969), *quoted in* AKER & WALSH, *supra* note 72, at 121.

94. DSM III, *supra* note 75, at 107.

95. *Id.* at 125. At this point DSM III uses "Dementia arising in the Senium" to mean onset after age 65 and "Arising in the Presenium" to mean onset prior to age 65. The full description can be found in Section One, which deals with Organic Mental Disorders.

96. *Id.*

97. *Id.* at 126.

98. *Id.* at 104.

quoted and applied so that the attorney may become familiar with the psychiatric jargon.

The comment in DSM III describes the essential feature of the dementia syndrome as a loss of intellectual abilities with memory impairment being the most prominent symptom.[99] The precise wording of DSM III's statement of diagnostic criteria for the dementia syndrome should be studied closely:

Diagnostic Criteria for Dementia:

A. A loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

B. Memory impairment.

C. At least one of the following:

1. impairment of abstract thinking, as manifested by concrete interpretation of proverbs, inability to find similarities and differences in related words, difficulty in defining words and concepts, and other similar tasks;

2. impaired judgment;

3. other disturbances of higher cortical function, such as aphasia (disorder of language due to brain dysfunction), apraxia (inability to carry out motor activities despite intact comprehension and motor function), agnosia (failure to recognize or identify objects despite intact sensory function), "constructional difficulty" (e.g., inability to copy three-dimensional figures, assemble blocks, or arrange blocks in specific designs);

4. personality change (i.e., alteration or accentuation of premorbid traits).

D. State of consciousness not clouded (i.e., does not meet the criteria for Delirium or Intoxication, although these may be superimposed).

E. Either (1) or (2):

1. evidence from the history, physical examination, or laboratory tests of a specific organic factor that is judged to be etiologically related to the disturbance;

2. in the absence of such evidence, an organic factor necessary for the development of the syndrome can be presumed if conditions other than organic mental disorders have been reasonably excluded and if the behavioral change represents cognitive impairment in a variety of areas.[100]

99. *Id.* at 107-08.
100. *Id.* at 111-12.

The first criterion, "loss of intellectual abilities" in paragraph A, is not a criterion at all. It is actually a general description of the syndrome. It is stated in terms of severity sufficient to "interfere with social or occupational functioning," thus calling for the psychiatrist to make a value judgment about external behavior which he or she is no more competent than others to make. Nothing in the definition suggests how the deterioration in intellectual abilities is to be determined or confirmed other than by the observation of interference with social or occupational functions.

DSM III states a caution in diagnosis which is relevant here but which is confusingly located under the heading "Differential Diagnosis" in the materials describing the primary degenerative dementia mental disorder. The text acknowledges that the "nature and significance" of the changes in intellectual functioning associated with the normal process of aging are controversial. It cautions the psychiatrist to limit the primary degenerative dementia diagnosis to cases where there is "clear evidence of progressive and significant deterioration of intellectual and social or occupational functioning."[101] Therefore, the psychiatrist should be cross-examined thoroughly in regard to the basis of her conclusion that the first criterion of the dementia syndrome has been met. Without "clear" evidence demonstrating "significant" interference with social or occupational functioning the psychiatrist has not made a valid diagnosis. In the event that evidence tending to establish significant interference with functioning is described, the psychiatrist should then be questioned as to how this condition differs from that due to the normal process of aging. If the difference cannot be clearly stated, the requisite "mental illness" has not been established.

Memory impairment, the second diagnostic criterion, and one of the four components listed under the third criterion are the only impairments necessary to make the dementia syndrome diagnosis. The comments describing the memory impairment criterion state that short term memory impairment may be tested by asking an individual "to memorize the names of several unrelated objects, or a brief sentence, and then to repeat them after a few minutes of distraction."[102] Whether the memory impairment is sufficient to interfere with social and occupational functioning (as required by the first criterion) is determined without a standard system for quantification; there are no agreed guidelines concerning the extent of the impairment that should be found in order to make the diagnosis. Shocking possibilities for abuse exist because of the lack of professional standards. For example, one text suggests that:

Goldfarb's simple ten-point scale be used to estimate impairment. The questions to be asked are:

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101. *Id.* at 110. This caution is warranted by studies which show preservation of social functioning despite memory disturbances and disorientation, E. MILLER, ABNORMAL AGING 39 (1977); *see also* C. WELLS, DEMENTIA 248 (1977).

102. DSM III, *supra* note 75, at 108.

1. Where are we now? (place orientation)

2. Where is this place located? (place orientation)

3. What month is it? (time orientation)

4. What day of the month is it? (time)

5. What year is it? (time)

6. How old are you? (memory)

7. When is your birthday? (memory)

8. Where were you born? (memory)

9. Who is the President of the United States? (general information and memory)

10. Who was President before him? (general information and memory)[103]

The scale rates none to two errors as no, or mild, impairment, three to eight errors as moderately advanced impairment, nine to ten errors as severe brain dysfunction. The author then cautions that this scale is "obviously not useful when subtle judgments are needed . . ."[104] Obviously, the expert should be questioned concerning the indicia of memory impairment and, particularly, her standard to measure severity and how that standard relates to the ability to function in one's own home.

The third criterion for diagnosis of the dementia syndrome requires a finding of only *one* of four characteristics: impairment in abstract thinking, impairment in judgment, "other disturbances of higher cortical function," or personality change. The comments indicate that each of these phenomena may take many forms.[105] In fact, so many are suggested that a psychiatrist could quite easily find *one* of them in numerous persons otherwise considered normal but a bit eccentric. For example, the text states that an individual with dementia interprets proverbs concretely and has difficulty finding similarities and differences. Therefore it suggests, as tests for impairment in abstract thinking, asking the individual to interpret proverbs or to find similarities and differences between related words.[106] Impaired judgment and impulse control, according to the text, could be established by coarse language, inappropriate jokes, and a "general disregard for the conventional rules of social conduct."[107] Among the variety of disturbances of higher cortical function suggeted by the text are "vague, stereotyped, and

103. E. BUSSE & E. PFEIFFER, MENTAL ILLNESS IN LATER LIFE 91-92 (1973), *quoted in* AKER & WALSH, *supra* note 72, at 116.

104. *Id.*

105. DSM III, *supra* note 75, at 108.

106. *Id.*

107. *Id.*

imprecise" language and disturbance in "constructional ability, *i.e.*, difficulty in copying three dimensional figures or arranging sticks in specific designs."[108] Personality change may be evidenced by narrowed social involvement or indifference to appearances or any other departure from formerly evidenced personality traits. The text indicates such change is "almost invariably" present in dementia.[109]

DSM III provides no guideline or standard by which to measure any of these four characteristics to determine what level of severity indicates mental disorder. The third diagnostic criterion, more than any other, allows the examiner's own social values to influence his diagnosis. This criterion could be met without any judgment concerning the individual's ability to carry out her daily living tasks. The psychiatrist should be asked what impairments she found and how she established them. She should be asked if she has observed the client exhibiting these alleged impairments in daily living tasks. Additionally, a diagnosis based on only one of the four characteristics should be strongly questioned.[110]

The fourth diagnostic criterion requires that the patient not meet the "clouded consciousness" criteria of the delirium syndrome, "although these may be superimposed." This language implies that "clouded consciousness" is not a symptom of dementia but of delirium, though dementia and delirium may exist simultaneously. Furthermore, the first paragraph of the comment on dementia states that the dementia diagnosis "is not made if these features [the loss of intellectual abilities] are due to clouding of consciousness, as in delirium."[111] In other words, if the psychiatrist believes the dementia symptoms are actually caused by delirium, the diagnosis should *not* be dementia.[112]

In the description of delirium, clouding of consciousness is described as ". . . a reduction in the clarity of awareness of the environment. . . manifested by difficulty in sustaining attention to both external and internal stimuli . . . easily distracted . . .," and "sensory misperception . . . misinterpretations, illusions and hallucinations," and "disordered stream of thought . . . thinking . . . appears fragmented and disjointed . . . reflected in speech that . . . is limited . . . incoherent, with unpredictable switching from subject to subject."[113]

The APA is extremely cautious about the possibility of confusing the two syndromes and states:

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108. *Id.* at 109.
109. *Id.*
110. Miller casts doubt on diagnoses made on the strength of word and drawing tests, and states that measurement of personality change is difficult. E. MILLER, *supra* note 101, at 69, 116.
111. DSM III, *supra* note 75, at 107.
112. *Id.*
113. *Id.* at 104.

> One cannot diagnose Dementia in the presence of significant Delirium, because the symptoms of Delirium interfere with the proper assessment of Dementia. Only a definite history of pre-existing Dementia allows one to decide that an individual with Delirium also has Dementia. When there is uncertainty . . ., it is best to make a provisional diagnosis of Delirium. This should lead to a more active therapeutic approach . . . .[114]

The attorney should ask the expert who insists on a dementia diagnosis detailed questions about what she did to exclude delirium. If excluded, the attorney should ask the expert to acknowledge that the client's consciousness of real life around her is not clouded. A trier of fact is less likely to find mental illness in one who clearly relates to her environment.

The last diagnostic criterion for the dementia syndrome is evidence of an organic causal factor. Alternatively, an organic factor necessary for the development of the syndrome can be presumed from behavioral change which represents cognitive impairment, provided conditions other than organic mental disorders are excluded. It is generally assumed that an organic cause exists and that it is associated with brain deterioration; dementia or chronic brain syndrome is thereby distinguished from the purely functional disorders.[115] The insubstantial nature of this characteristic as a diagnostic criterion lies in the fact that it is ordinarily presumed from the existence of the other stated criteria, the behavioral characteristics. This is because it is often not practical to detect atrophy of brain cells during life[116] and there remains uncertainty about the precise organic causes of the dementia syndrome.[117] The apparent inconsistency stems from the fact that psychiatrists believe an organic cause exists when they cannot demonstrate it and DSM III states it as a diagnostic criterion even when it must be presumed from behavioral characteristics. The attorney should not allow such obfuscation to mislead either herself or the trier of fact.

This criterion adds nothing to the behavioral characteristics used for diagnosis. Instead, it requires the diagnostician to double check those characteristics against similar ones that would indicate the existence of a nonorganic mental condition. Schizophrenia, for example, is a condition which

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114. *Id.* at 107.

115. AKER & WALSH, *supra* note 72, at 134-35; Horstman, *supra* note 3, at 227.

116. Although DSM III states that brain atrophy with widened cortical sulci and enlarged cerebral ventricles may be demonstrated in life by computer-assisted tomography or pneumoencephalography, these devices are not likely to be readily available and the testing is expensive and complex. Electroencephalography is not sufficiently helpful for diagnosis. *See* K. BICK, R. KATYMAN & R. TERRY, ALZHEIMER'S DISEASE: SENILE DEMENTIA AND RELATED DISORDERS, 227-71 (1978) [hereinafter cited as BICK & KATYMAN], discussing diagnostic methodology. At p. 269 a Dr. Roth is quoted as stating, "What is lacking at present is a reliable diagnosis of the pathological process during life . . . . all we have is a clinical profile described in psychiatric terms." *See also* E. MILLER, *supra* note 101, at 76-79, and C. WELLS, *supra* note 101, at 248.

117. *See infra* text accompanying notes 129-43.

could be confused with dementia since it sometimes produces intellectual disorientation.[118] The presumption of an organic condition, if too quickly made, can be detrimental to the patient. If the possibility of a non-organic condition is erroneously eliminated possible treatment for the elderly patient will be foregone.

If causes other than organic brain deterioration have been eliminated, the psychiatrist is likely to consider the dementia an untreatable condition. This explains the attitude of "therapeutic nihilism" surrounding the institutionalized elderly who tend to be placed permanently with no more than custodial care.[119] Consequently, to diagnose the dementia syndrome when the individual is actually suffering from another, more treatable condition would be disastrous. The failure to identify treatable cases has been recognized as a major danger in diagnosis of dementia.[120]

The condition exhibiting characteristics most like dementia is depression.[121] Depression is often dramatically treatable with drugs or other therapy because it is a disturbance of mood not generated by permanent physiological changes in the brain. Unfortunately, the symptoms of depression in elderly persons are easily confused with those of dementia.[122] DSM III recognizes this diagnostic difficulty at the brain syndrome level, stating that disorientation, apathy, difficulty in thinking and concentration, and memory loss may indicate "pseudo-dementia,"[123] depression exhibiting symptoms like those of dementia. Two combinations of criteria, either of which alone could indicate dementia, could also indicate depression: memory impairment with difficulty in thinking *or* memory impairment with apathy or personality change. DSM III recommends that if the symptoms which suggest a major depressive episode are at least as prominent as those suggesting dementia, it is best to diagnose and treat as depression in order to see whether the cognitive impairment will diminish as the mood improves.[124] Obviously, the attorney should question the psychiatrist to determine whether depression had been properly considered before the dementia diagnosis was entered.

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118. DSM III, *supra* note 75, at 110.

119. E. MILLER, *supra* note 101, at 121; C. WELLS, *supra* note 101, at 248.

120. AKER & WALSH, *supra* note 72, at 82, 119, 137, 303, Pocket Supp. 53-58. Cole, 2 MCCLEAN HOSP. J. 210-11 (Fall 1977) *quoted in* AKER & WALSH, *supra* note 72 at Pocket Supp. 57, states: "The most dramatic results in the treatment of apparent senile dementia are achieved by diagnosing and treating some other condition which is masquerading as senile dementia."

121. DSM III, *supra* note 75, at 111.

122. AKER & WALSH, *supra* note 72, at 110; E. MILLER, *supra* note 101, at 105; Libow, 21 J. OF AM. GERIATRICS SOC. 118 (Mar. 1973); Cole, 2 MCCLEAN HOSP. J. 211 (Fall 1977), *quoted in* AKER & WALSH, *supra* note 72, at Pocket Supp. 58. See *In re* Ballay, 482 F.2d 648, 659, n.41 (D.C. Cir. 1973), where the court describes the testimony of Dr. Cameron before a Senate committee that an individual diagnosed as "senile dementia" was not always so, but rather could be depressed and, therefore, treatable.

123. DSM III, *supra* note 75, at 111 and 112.

124. *Id.*

This analysis of the stated criteria for establishing the dementia syndrome makes frighteningly clear why old age is often equated with mental disease.[125] Since the fourth and fifth criteria are exclusionary and the first is merely a general description, only the second criterion of memory impairment and any one of the four characteristics in the third criterion suffice for a medical diagnosis of dementia. There is no requirement that the person's judgment be impaired. Furthermore, dementia syndrome is the more likely cause if the person's awareness of her environment is not reduced, because unawareness would indicate delirium, not dementia. Finally, there is no standard for determining how severe the memory and other impairments must be to constitute dementia other than the opinion of the particular psychiatrist that those impairments interfere with the person's social or occupational functioning. Therefore, these diagnostic criteria would support a formal diagnosis of primary degenerative dementia for a person who is aware of her environment and who is capable of rational judgment about her personal and business affairs, but who, in the opinion of the examiner, cannot sufficiently remember lists of objects, interpret proverbs, and restrain herself from telling coarse and inappropriate jokes.

Close cross-examination of the psychiatrist about the elderly person's inability to live at home or in her neighborhood without serious personal danger may reveal a picture quite different from that suggested by the psychiatrist's dementia diagnosis under DSM III. In addition, the psychiatrist's acknowledgment of the ambiguity of these minimal requirements for finding the dementia syndrome may significantly weaken her conclusions in the eyes of the legal factfinder.

(3) Criterion B: Insidious onset

The second criterion for diagnosing the mental disorder primary degenerative dementia is that the condition be insidious or gradual in onset and follow a uniformly progressive, deteriorating course.[126] By contrast, a rapidly appearing dementia syndrome exhibiting abrupt and fluctuating changes is classified as a different mental disorder and is thought to be caused by multiple infarcts in the brain tissue.[127] This disorder is labeled multi-infarct dementia in DSM III.[128] It will not be analyzed further in this discussion.

In the early stages of development of primary degenerative dementia, according to DSM III, memory impairment may be the only apparent

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125. *See* DSM III, *supra* note 75, at 109 ("Dementia is found predominately in the elderly . . ."); Smith v. Schlesinger, 513 F.2d 474 (D.C. Cir. 1975) (civil discovery of an investigatory file permitted because the information in it might be helpful to distinguish "between a medical judgment of mental illness and a social judgment about the desirability of an individual's lifestyle and associations").

126. DSM III, *supra* note 75, at 125.

127. *Id.* at 127-28.

128. *Id.* at 127.

cognitive deficit, though there may also be personality changes and quiet withdrawl from social interactions.[129] The text describes the middle stage as having various cognitive deficits and more obvious personality and behavior changes.[130] The text describes the individual in the late stage as being totally incapable of caring for herself.[131] Since this incapacity is listed only at the late stage of primary degenerative dementia, the attorney should request the psychiatrist to state in what stage of primary degenerative dementia she considers the client to be. A response of early or middle stage would imply that capacity to care for self remains.

(4) Criterion C: Exclusion of other specific causes

DSM III suggests that evaluations be done on a "multiaxial" basis, and sets out axes or classes of information to be considered.[132] The first two are the classifications of mental disorders and a third is physical disorders.[133] According to DSM III each diagnosis should assess the individual on each of the first three axes. This means the evaluator should consider not only the criteria for each category of mental disorder but also should have asessed the possibility that the behavior is caused by physical disorders before arriving at a diagnosis of mental disorder. An evaluation on these three axes completes the official diagnostic assessment.

Under the last criteria for finding the dementia syndrome the psychiatrist may presume an organic cause of the behavioral symptoms if she can exclude non-organic mental disorders. Assuming the presumption of organic etiology obtains and the dementia syndrome is found, the last criterion for diagnosing the mental disorder primary degenerative dementia becomes significant. It requires "[e]xclusion of all other specific causes of dementia by the history, physical examination, and laboratory test."[134] The phrase "all other specific causes" is ambiguous because the antecedent of "other" is not clarified, discussed or defined. It is only obvious that the examiner is now required to rule out certain possible organic causes of the dementia syndrome before she makes the final diagnosis of the mental disorder primary degenerative dementia.

DSM III can be interpreted as permitting the primary degenerative dementia mental disorder diagnosis only when the psychiatrist has eliminated all causes other than those associated with the traditional dementias known as Alzheimer's or Pick's disease. Alzheimer's and Pick's diseases are those etiologically related to gradually progressing physical deterioration in

129. *Id.* at 125.
130. *Id.*
131. *Id.*
132. *Id.* at 23.
133. *Id.* Axis IV is Severity of Psychosocial Stressors, meaning the severity of psychological stresses placed on the individual by her environment. Axis V is Highest Level of Adaptive Functioning in the Past Year. Axes IV and V are most useful in planning treatment and predicting its outcome. *Id.*
134. *Id.* at 126.

the brain.[135] At least to the extent that actual atrophy has occurred, the condition has been considered incurable.[136] The sequence of statements in the discussion of the organic mental disorders labeled primary degenerative dementia suggests that a psychiatrist fails to follow the DSM III diagnostic steps if she gives her diagnosis as primary degenerative dementia without having completed extensive testing to eliminate physical causes other than irreversible brain atrophy. The attorney should cross-examine the psychiatrist to see whether that was done.

DSM III includes both Alzheimer's and Pick's dementias within the single classification of primary degenerative dementia.[137] Multi-infarct dementia is excluded from that class because of Criteria B.[138] When dementia is due "to some other known disease" such as a brain tumor or vitamin B-12 deficiency "the *specific disease* should be noted on Axis III and the *presence* of a Dementia on Axis I . . . ."[139] Axis III is the physical disorder classification, as explained above. On the following page, under the heading "Differential diagnosis," DSM III states: "subdural hemotoma, normal-pressure hydrocephalus, cerebral neoplasm, Parkinson's disease, vitamin B-12 deficiency, hypothyroidism, substance intoxication, and *other specific and possibly treatable physical disorders* that may cause Dementia *need to be ruled out* by the history, physical examination, and appropriate laboratory test."[140] The phrase, "need to be ruled out," carries the same connotation as "Exclusion of all other specific causes" in Criterion C.[141] Therefore, the presumption of organic cause in paragraph E, the fifth criterion of the dementia syndrome, is not sufficient for a diagnosis of primary degenerative dementia. The psychiatrist must actually test to discover the particular physical cause. If a specific physical cause is indicated it must be noted on Axis III. Only when treatable causes have been ruled out may the psychiatrist finalize the diagnosis of primary degenerative dementia. The attorney who understands the reason for the somewhat complicated diagnostic requirements of DSM III may be able to secure genuine treatment, rather than "warehousing" and neglect, for the elderly client.

It is generally agreed that the symptoms of dementia arise from physical changes in the brain. These changes are thought to be caused by insufficiency in blood supply or inefficiency in the brain's utilization of the oxygen in the blood, but there is no agreement on the exact mechanisms which cause these problems.[142] For example, a psychiatrist may testify that a person

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135. *Id.* at 125; *see* E. MILLER, *supra* note 101, at 12; BICK & KATYMAN, *supra* note 116, at 509; C. WELLS, *supra* note 101, at 248.
136. *Id.*
137. DSM III, *supra* note 75, at 124.
138. *See supra* text accompanying note 127.
139. DSM III, *supra* note 75, at 124.
140. *Id.* at 126 (emphasis added).
141. *See supra* text accompanying note 97.
142. AKER & WALSH, *supra* note 72, at 74-76.

manifests the symptoms of "chronic brain syndrome with arteriosclerosis with reaction"[143] or "psychosis with cerebral arteriosclerosis."[144] These statements attribute the behavior to a lack of oxygen in the brain caused by arteriosclerosis, or "hardening" of the arteries.[145] The etiological theory is that the thickened arterial wall impedes the transfer of oxygen from the blood.[146] However, the mechanism by which brain impairment occurs is not known; a major study on the effect of aging on the brain concluded that neuron changes could not be attributed to arteriosclerosis.[147] This apparently explains why DSM III no longer classifies dementia associated with vascular disease as a psychosis with cerebral arteriosclerosis, but instead, created the multi-infarct dementia class.[148]

Some psychiatrists may attribute dementia to atherosclerosis which is narrowing of the arteries.[149] They theorize that either the diminished blood flow itself results in brain cell death,[150] or that the thickened arterial wall impedes oxygen transfer.[151] Textbooks often say that atherosclerosis is a cause of dementia, but some experts assert that there is no evidence to demonstrate a causal relation.[152]

DSM III attributes primary degenerative dementia to gradual atrophy of the brain. Three physiological changes are generally apparent from postmortem microscopic examination of brain tissues: senile plaque, neurofibrillary tangles, and granulovacular degeneration of neurons.[153] These are the classic neurological effects of Alzheimer's disease. DSM III does not indicate any known cause. One of the most recent theories is that the disease is caused by a virus.[154]

In contrast, within the past fifteen to twenty years, scientists have discovered that numerous specific physical disorders, many of which can be treated, cause dementia symptoms.[155] For example, dementia symptoms could be triggered by barbiturates[156] or insulin.[157] Likewise, a vitamin deficiency, particularly of vitamin B-12, may cause an apparently chronic dementia, although a vitamin regime can bring about marked improvement.[158] Varying degrees of improvement in dementia symptoms have also

143. Lake v. Cameron, 364 F.2d 657, 658 (D.C. Cir. 1966).
144. DSM III, *supra* note 75, at 124.
145. AKER & WALSH, *supra* note 72, at 61.
146. *Id.* at 81.
147. *Id.* at 26.
148. DSM III, *supra* note 75, at 124.
149. AKER & WALSH, *supra* note 72, at 61.
150. *Id.*
151. *Id.* at 81.
152. *Id.* at 63-64.
153. BICK & KATYMAN, *supra* note 116, at 1-4; C. WELLS, *supra* note 101, at 120-23.
154. DSM III, *supra* note 71, at 125. *See also*, C. WELLS, *supra* note 101, at ch. 5.
155. *See* AKER & WALSH, *supra* note 72, at 57-112.
156. *Id.* at 108-09.
157. *Id.* at 87-89.
158. *Id.* at 108, 293.

resulted from treatment with anticoagulants and vasodilators[159] and by the withdrawal of blood pressure drugs and psychotropic medicines.[160] Surgery and oxygen administration are sometimes successful.[161] Because of the success of some of these treatments, the past practice of classifying the condition in those cases as an untreatable organic brain disorder[162] was erroneous.

Certainly, such treatments do not require commitment in a mental institution. An erroneous diagnosis of untreatable primary degenerative dementia could needlessly consign an elderly person to commitment for the remainder of her life. The tendency to classify dementia as untreatable must give way to a concerted effort to identify those 35 to 40% of dementia patients who can be cured or improved by treatment.[163] For this reason the elderly person's attorney must question the psychiatrist to see whether tests were done to exclude specific treatable physical causes[164] and discover the least restrictive mode of treatment feasible for the physical conditions.

c. Statutory exclusions of dementia as a basis for commitment

Even if the attorney cannot discredit the dementia diagnosis, recent changes in some commitment statutes may prevent the commitment. These changes can be interpreted to exclude from the mentally ill category, the only constitutionally permissible basis for involuntary commitment, persons diagnosed as having chronic brain syndrome or dementia. For example, the Illinois statute excludes from the "mental disorder" category "a person whose mental processes have merely been weakened or impaired by reason of advanced years."[165] In a Missouri statute "mental illness," which is the basis for extended involuntary commitment, specifically excludes "disorders such as senility . . . not of an actively psychotic nature."[166] In both examples it is difficult to determine the meaning of the terms, especially "weakened . . . by reason of advanced years," and "senility." However, the

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159. *Id.* at 260-88.

160. *See id.* at 299.

161. E. MILLER, *supra* note 101, at 122-23; BICK & KATYMAN, *supra* note 116, at 115-25.

162. BICK & KATYMAN, *supra* note 116, at 1-9; C. WELLS, *supra* note 101, at 248. Wells suggests that this practice was due to "therapeutic pessimism" resulting from the paucity of known successful treatments. *Id.*

163. Wells estimates that 15% of dementia cases are correctible and an additional 20 to 25% can be improved with treatment, C. WELLS, *supra* note 101, at 248, 250.

164. For an excellent exposition of the possibly treatable conditions for which a psychiatrist should test and for suggested diagnostic methodology, *see* C. WELLS, *supra* note 101, at ch. 12.

165. ILL. REV. STAT. Ch. 91 1/2 § 1-11 (Supp. 1975), *repealed by* Ill. P.A. 80-1414 § 6-106, effective Jan. 1, 1979.

166. MO. REV. STAT. § 630.005.1(20), as amended by H.B. 1724, 2d Sess., 80th Gen. Ass. (1980). Other Sections permit extended commitments only after a finding of mental illness, *e.g.*, MO. REV. STAT. § 632.355 (1980). To remove all doubt, another section provides that persons who are senile are not to be judicially detained unless they are also mentally ill, MO. REV. STAT. § 632.380 (1980).

attorney who must defend an elderly person against a commitment attempt has superb statutory tools in such language. In general, the legislative intent of such statutes is that the elderly should not be locked up in mental institutions, but that they be cared for elsewhere. Because "advanced years" and "senility" are so often linked with dementia and since psychiatrists do not agree upon a particular cause, a psychiatrist's testimony that aging is the cause may block the commitment. Also, in the absence of evidence of specific cause, the opposing expert's admission that dementia occurs most among the elderly may facilitate a finding that it is caused by advanced years.[167]

2. Dangerousness

The requirement that an individual must present an imminent danger of significant harm to others or to herself before she can be committed is the linchpin between her mental illness and the order for commitment. Although the Supreme Court has not clearly held that dangerousness must be present in order to justify involuntary commitment, numerous other decisions have so held.[168] Earliest and most relevant is *Lessard v. Schmidt,* in which a relatively harmless old lady, diagnosed as suffering from paranoid schizophrenia, was held for more than twenty-six days without a full hearing.[169] She was then ordered committed for an additional thirty days on the basis of evidence that she had made certain telephone calls and a doctor's conclusion that she needed hospitalization.[170] Summarizing the history and negative effects of institutionalization for mental illness, the court suggested that all Big Five requirements must be met. In particular, the court held that "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."[171]

In *Colyar v. Third Judicial District Court of Salt Lake County,* the court analyzed the liberty interests involved, and declared that the state must demonstrate a compelling state interest to use its police power or parens

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167. The Missouri statute, however, may be more easily used to prevent commitment than the Illinois statute because the former does not require a causal relation between the impairment and advanced years for exclusion, but only evidence that "senility" refers to dementia.

168. Suzuki v. Yuen, 617 F.2d 173, 176 (9th Cir. 1980); *In re* Ballay, 482 F.2d 648, 658 (D.C. Cir. 1973); De Angelas v. Plaut, 503 F. Supp. 775, 780 (D. Conn. 1980); Johnson v. Solomon, 484 F. Supp. 278, 286-88 (D. Md. 1979); Doremus v. Farrell, 407 F. Supp. 509, 514-15 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378, 389 (M.D. Ala. 1974).

169. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds,* 414 U.S. 473, *modified,* 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds,* 421 U.S. 957 (1975).

170. *Id.* at 1096, n.27.

171. *Id.* at 1093.

patrie power to commit an individual to a mental hospital.[172] The court concluded that a statute which did not require danger to the person or others and subjected the individual to involuntary commitment was unconstitutional.[173] To find dangerousness the trier of fact must predict future conduct. Studies have shown that dangerousness "is the single most important determinant of judicial decisions to commit . . . ."[174] A prediction of dangerous future conduct in effect results in preventive detention through commitment. In view of our justice system's hostility toward preventive detention, a court should accept such predictions with extreme caution. When a case involves a history of repeated violence to others or life-threatening failure to care for oneself there is little difficulty in predicting sufficient future dangerousness. However, when the subject has little or no history of dangerous acts, the petitioner's evidence may be only a psychiatrist's opinion. The elderly person's attorney should argue that psychiatric testmony is of little value in predicting her client's future conduct.

a. Dangerousness is a legal concept

The switch from a statutory standard of merely "in need of treatment" to "dangerous to self or others" signals a change from a decision which requires medical expertise to one that does not rest exclusively upon the expertise of the court appointed examiners. The *Lessard* opinion traces the history of institutionalization from its heyday when courts readily assumed that the medical profession could adequately treat the mentally ill, through the period of disillusionment when courts recognized that institutionalization severely abridges liberty without effectively treating or benefiting the confined individual.[175] The courts shifted to the dangerousness standard to protect against unwarranted denial of liberty. Therefore, "the commitment decision under the new standard ultimately must be a legal judgment by a court rather than a medical diagnosis by examining experts."[176]

In arriving at a legal judgment the judge or jury, not medical experts, should weigh the probability and seriousness of the expected harm because it is their function to determine the kind and amount of risk which society will tolerate.[177] The issue of dangerousness is not beyond the expertise of the jury; indeed, its lay value judgment may be essential to a fair determination. The United States Supreme Court, construing a Wisconsin statute that required a jury decision to commit, stated:

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172. 469 F. Supp. 424 (D. Utah 1979).

173. *Id.* at 431.

174. Ennis & Litwack, *supra* note 73, at 711.

175. 349 F. Supp. at 1084-1090.

176. Kirkpatrick, *supra* note 74, at 257. *See also* Hammond, *Predictions of Dangerousness in Texas: Psychotherapists' Conflicting Duties, Their Potential Liability and Possible Solutions,* 12 ST. MARY'S L.J. 141, 143 (1980); Tanay, *Reflections on a Debate,* 8 BULL. AM. ACAD. OF PSYCHOLOGY AND THE LAW VII (1980).

177. Kirkpatrick, *supra* note 74, at 260.

> Like most . . . States . . ., Wisconsin conditions such confinement not solely on the medical judgment that the defendant is mentally ill and treatable, but also on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty. In making this determination, the jury serves the critical function of introducing into the process a lay judgment, reflecting values generally held in the community, concerning the kinds of potential harm that justify the State in confining a person for compulsory treatment.[178]

Because a person's potential dangerousness is a legal issue to be decided by the trier of fact, the psychiatrist's testimony is not conclusive on that issue and the jury should be instructed that it is not bound by the expert's conclusory opinion.[179]

To reduce the possibility of erroneously committing a harmless person, a number of courts have stated the dangerousness requirement in strict terms. In *Addington v. Texas,*[180] the Supreme Court indicated that requiring clear and convincing evidence to carry the burden of proof was one way to impress the factfinder with the importance of the decision and reduce the chance that the courts will order inappropriate commitments.[181]

Several federal courts have required that the impending harm be immediate or imminent.[182] In addition, it has been held that *O'Connor*[183] requires that the immediate danger to self must be severe enough to threaten basic survival.[184]

A number of decisions require evidence of an overt act or threat of violence to support a dangerousness finding.[185] However, two other courts have declined to impose the requirement as a constitutional requisite for the validity of commitment statutes, even where evidence suggests that prediction is unreliable. In *Colyar v. Third Judicial District,* the court did not believe that adding the requirement would decrease the chance of error in predicting dangerousness.[186] In *United States* ex rel. *Mathew v. Nelson,* the court refused to declare the commitment statute unconstitutional because it was not convinced that psychiatric prediction was so unreliable as to always

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178. Humphrey v. Cady, 405 U.S. 504, 509 (1972).

179. *See* J. ZISKIN, *supra* note 77, at 11; Bazelon, *A Jurist's View of Psychiatry,* 1975 J. PSYCHOLOGY & LAW 175 *et seq.* (Spring).

180. 441 U.S. 418 (1979).

181. *Id.* at 427.

182. Suzuki v. Yuen, 617 F.2d 173, 178 (9th Cir. 1980); *Lessard,* 349 F. Supp. 1078, 1093.

183. O'Connor v. Donaldson, 422 U.S. 563 (1975).

184. Colyar v. Third Judicial Dist. Court of Salt Lake County, 469 F. Supp. 424, 431 (D. Utah 1979).

185. Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976); Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974).

186. 469 F. Supp. at 435.

require an overt act.[187] The court refused to deprive the state of the power "to protect the mentally ill person and society" in the absence of an overt act.[188]

Although the *Mathew* court declined to declare the statute unconstitutional, it recognized the importance of placing the burden of proof of dangerousness on the party urging commitment. The court stated:

> It may well be that in most cases the psychiatric determination necessary to support the finding of reasonable expectation that the statute requires could not be made in the absence of an overt act, just as it could not be made in the absence of other facts found in the patient's history or discovered in examining him. In those cases, the evidence will not justify a determination of dangerousness.[189]

As for persons alleged to be unable to care for themselves, the *Mathew* opinion stated, "[W]e should think that in most, if not all, cases in which commitment is sought on this ground, evidence of some prior act or omission which demonstrates the alleged inability [to care for oneself] will be necessary . . . ."[190] Since most elderly are subjected to commitment proceedings because they are allegedly unable to care for themselves, the court's dicta suggests that past overt action demonstrating that inability must be demonstrated before commitment can be required.

b. Psychiatrists cannot reliably and validly predict dangerousness

Studies suggest that psychiatric testimony about the future dangerousness of clients has minimal probative value.[191] The most dramatic of studies in the early 1970's documented the results of Operation Baxstrom.[192] The Supreme Court ordered the release of 969 patients detained in maximum security hospitals after psychiatric findings that they were mentally ill and too dangerous to be transferred to civil hospitals. One year later, 147 had been discharged and 702 were in civil hospitals, presenting no special problems. Only seven required recommitment to a Department of

187. United States *ex rel* Mathew v. Nelson, 461 F. Supp. 707, 711 (N.D. Ill. 1978). There was no mention of the APA brief in *Tarasoff, see infra* text accompanying note 201, and an expert testified that no studies indicate what effect evidence of a particular overt act would have on predictability.

188. 461 F. Supp. at 711.

189. *Id.*

190. *Id.* at 712.

191. *See, e.g.*, studies cited in J. ZISKIN, *supra* note 77; Ennis & Litwack, *supra* note 73, at 711; Kirkpatrick, *supra* note 74; Dershowitz, *Psychiatry in the Legal Process: "A Knife that Cuts Both Ways,"* 51 JUDICATURE 370, 377 (1968); Troland, *Involuntary Commitment of the Mentally Ill,* 38 MONT. L. REV. 307, 313 (1977). *See also* J. ROBITSCHER, THE POWERS OF PSYCHIATRY ch. 12 (1980). Other studies and law review articles are cited in *Mathew,* 461 F. Supp. at 710 n.7.

192. Operation Baxstrom is described in J. ZISKIN, *supra* note 77 at chapter eight and Ennis & Litwack, *supra* note 73, at 712.

Corrections hospital. It is easy to conclude "that psychiatric predictions are incredibly inaccurate . . . [B]ut for a Supreme Court decision, nearly 1,000 human beings would have lived much of their lives behind bars . . ."[193] These studies convincingly demonstrate that "[n]o one can predict dangerous behavior in an individual with no history of dangerous acting out."[194] "[Psychiatrists] cannot predict even with reasonable certainty that an individual will be dangerous to himself or others."[195] There are "*no* reports in the scientific literature which are supported by valid clinical experience and statistical evidence that describe psychological or physical signs or symptoms which can be reliably used to discriminate between the potentially dangerous and the harmless individual."[196]

Because there is no reliable method of determining dangerousness, psychiatric predictions of dangerousness often turn out wrong. Practical experience provides little or no feedback to psychiatrists about the inaccuracy of their predictions because there is no way to prove that an incarcerated person would remain harmless if left at liberty. Psychiatrists also overpredict anti-social conduct.[197] This results in more "false positives" than accurate predictions.

"False positives" are the harmless persons falsely predicted to be dangerous. Even with carefully controlled and lengthy tests, the number of false positives in a group of studies analyzed by one scholar varied from 60% to 95%.[198] For example, in a study predicting suicides among 12,000 mental patients, forty patients did commit suicide, and of those, thirty had been correctly identified. However, to achieve those thirty correct predictions 3,020 persons were predicted suicidal. Although 75% of the actual suicides were predicted, 2,990 persons were incorrectly predicted to be suicidal. The overall erroneous prediction rate was 99%.[199] If all persons predicted suicidal had been committed to institutions to protect them, 2,990 harmless people would have been locked up.[200]

No study better documents the psychiatric community's lack of confidence in its ability to predict dangerous behavior in mental patients than does a brief filed in the California case, *Tarasoff v. Regents of the Univer-*

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193. Ennis & Litwack, *supra* note 73, at 713 (quoting Ennis, *The Rights of Mental Patients,* in THE RIGHTS OF AMERICANS 487 (Dorsen ed. 1970)).

194. Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness,* 18 CRIME & DELINQUENCY 371, 384 (1972).

195. Usdin, *Broader Aspects of Dangerousness* in THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL 43 (J.R. Rappeport, M.D. ed. 1967).

196. Diamond, *The Psychiatric Prediction of Dangerousness,* 123 U. PA. L. REV. 439, 444 (1974) (emphasis added).

197. Dershowitz, *supra* note 191, at 377.

198. Ennis & Litwack, *supra* note 73, at 714-15.

199. Kirkpatrick, *supra* note 74, at 260-61 n.82.

200. *See generally* J. ZISKIN, *supra* note 77 and Ennis & Litwack, *supra* note 73.

sity of California.[201] *Tarasoff* was a tort action against a psychologist and his psychiatrist supervisor for wrongful death. The plaintiff argued that the defendants had failed to warn the decedent that their patient had indicated his intention to kill the decedent. The California Supreme Court held that a psychotherapist who can reasonably determine, according to the standards of his profession, that his patient presents a serious threat of violence to another must use reasonable care to protect the intended victim. In an *amicus curiae* brief, the American Psychiatric Association (APA) opposed the imposition of any duty to possible victims. The brief states that psychiatrists have not demonstrated an ability to predict future violence or dangerousness and that no special psychiatric "expertise" in the area had been established.[202] The APA said a duty to warn imposes an "impossible burden upon the practice of psychotherapy," requiring the psychotherapist to perform a function he is "ill-equipped to undertake."

Expert witnesses ordinarily provide their opinions upon matters that jurors presumably cannot determine from their common knowledge. The APA warns that psychotherapists may not be able to provide such opinions on the issue of dangerousness. It is incorrect, the APA announces, to assume that psychotherapists are "in some way more qualified than the general public to predict future violent behavior of their patients."[203] Most poignant is the APA's declaration concerning research results:

> What these studies and numerous similar ones show is that absent a prior history of violence, no therapist can accurately predict whether his patient is in fact dangerous or not . . . no special professional ability or expertise has yet been demonstrated in the prognoses of dangerousness. Instead the few studies which have been done 'strongly suggest that psychiatrists are rather inaccurate predictors.'[204]

One author, who is both a lawyer and a psychologist, argues that psychiatrists should not be recognized as expert witnesses on any matter. As to the particular issue of dangerousness he concludes:

> . . . it would be unconscionable for a psychiatrist to give testimony on the issue or regarding the issue of dangerousness in civil commitment proceedings . . . no court should allow the psychiatrist to testify in regard to this issue. The [APA] brief states flatly, baldly, and unequivocally that psychiatrists do not possess such expertise.[205]

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201. 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976). The case is discussed at length in J. ZISKIN, *supra* note 77, at 15-20.

202. J. ZISKIN, *supra* note 77, at 18.

203. *Id.* at 16.

204. *Id.* at 18.

205. *Id.* at 20.

Other legal scholars have urged that psychiatrists should not qualify as experts on dangerousness unless they can establish their qualifications with objective data.[206]

3. In Need of Care or Treatment

Basic to substantive due process is the concept that curtailment of personal liberty by the state must be at least reasonably related to the furtherance of a valid state interest.[207] The state has clear authority under its police power to hold the mentally ill person who is dangerous to others.[208] Furthermore, the state may use its *parens patriae* power to commit elderly people suffering from dementia who have been found dangerous only to themselves.[209] Thus, the state may hold the elderly individual dangerous to herself if she is in need of treatment[210] or, presumably, if she is only in need of custodial care. The Supreme Court has noted, "[T]he state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves. . ."[211] However, "due process requires that the nature and duration of commitment bear some reasonable relation to the purposes for which the individual is committed."[212] Thus, the individual is entitled to know whether she is being committed for care or for treatment, so that she can determine whether her confinement furthers the appropriate goal.[213] This knowledge is particularly important for elderly persons diagnosed as suffering from dementia because of the long existing attitude of "therapeutic nihilism" toward these patients.[214] The attorney, therefore, should insist that constitutional due process guarantees mirror the DSM III requirement of delineating "other specific causes"[215] which may be treatable. First,

206. Diamond, *supra* note 196, at 452; Dershowitz, *supra* note 191, at 370; Ennis & Litwack, *supra* note 73.

207. Jackson v. Indiana, 406 U.S. 715 (1972). *See also* Addington v. Texas, 441 U.S. 418 (1979); Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), *aff'd*, 422 U.S. 563 (1975).

208. *See O'Connor*, 422 U.S. at 582-83.

209. Hawaii v. Standard Oil Co., 405 U.S. 251, 257 (1972); *Addington*, 441 U.S. at 426; Parham v. J.R., 442 U.S. 584, 605 (1978); *O'Connor*, 422 U.S. at 583 (Burger, J., concurring); Horstman, *supra* note 3, at 225.

210. Overholser v. Lynch, 288 F.2d 388, 394 (D.C. Cir. 1961), *rev'd on other grounds*, 369 U.S. 705 (1962); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1961).

211. *Addington*, 441 U.S. at 426 (dictum). *See also* Romeo v. Youngberg, 644 F.2d 147, 149, 158 (3rd Cir. 1980), *aff'd*, 50 U.S.L.W. 4681 (U.S. June 18, 1982); *O'Connor*, 422 U.S. at 580 (Burger, C.J., concurring); *Colyar*, 469 F. Supp. at 431 n.5.

212. Jackson v. Indiana, 406 U.S. 715, 738 (1972); *O'Connor*, 493 F.2d at 521; *Romeo*, 644 F.2d at 168.

213. In his extensive concurring opinion in O'Connor v. Donaldson, 422 U.S. at 578 *et seq.*, Chief Justice Burger sought to negate any implication that committed individuals invariably had a right to treatment, but he acknowledged that the reasons for committing a person must be established and that "confinement must cease when those reasons no longer exist." *Id.* at 580.

214. *See supra* note 8; *In re* Ballay, 482 F.2d 648, 659 n.41 (D.C. Cir. 1973).

215. *See supra* text accompanying note 134.

the lawyer should attack any assumption that the client is untreatable. Second, she should argue that if her client is to be committed for treatment, the state must give that treatment.[216] Otherwise, confinement would prevent the client from obtaining treatment elsewhere and would not further the state's goal of protecting the client's interests. If the confinement does not further treatment, the state has no basis for curtailing the client's liberties.[217] Using this constitutional argument, the attorney should demand that the state formulate a treatment plan before or shortly after commitment, including a schedule for periodic reevaluation.[218]

Whether the confinement is for treatment or merely custodial care, the attorney should also encourage the trier of fact to consider whether institutional care would improve the client's condition. If institutionalization would make the client worse off than she would be in freedom, then deprivation of liberty is not justified. The Supreme Court stated that the nature of confinement must relate to its purpose,[219] and that one may not be confined unnecessarily for medical treatment.[220] Justice Burger has suggested that any scheme for the protection of the mentally ill must rest on a determination that it is compatible with the "best interests of the affected class."[221] These statements buttress the conclusion that, at a minimum, confinement must itself improve the welfare of the patient.

The elderly client's attorney should use the extensive evidence available which shows that involuntary confinement is detrimental to the welfare of aged persons[222] and argue that involuntary commitment could not be in the client's best interests.[223] The attorney should try to convince the trier of fact that her client does not need the care or treatment which commitment would provide because confinement would not improve her condition.

4. Least Restrictive Alternative

In 1960, the Supreme Court held that even a substantial and legitimate governmental purpose may not be pursued "by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved."[224] The court which decided *Lake v. Cameron* read this concept into a state commitment statute[225] in order to avoid constitutional invalida-

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216. *O'Connor,* 493 F.2d at 521.

217. *Id.,* 422 U.S. at 574; *Overholser,* 288 F.2d at 394; Rouse v. Cameron, 373 F.2d 451, 453 (D.C. Cir. 1967); *Romeo,* 644 F.2d at 168; Horstman, *supra* note 3, at 274-75.

218. Horstman, *supra* note 3, at 275.

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

220. Parham v. J.R., 442 U.S. 584, 600 (1978).

221. *O'Connor,* 422 U.S. at 583 (Burger, C.J., concurring).

222. *See supra* text accompanying notes 5-7. See also Horstman, *supra* note 3, at 275; *In re* Ballay, 482 F.2d 648, 659 n.41 (D.C. Cir. 1973); State *ex rel* Hawks v. Lazaro, 157 W. Va. 417, 433, 202 S.E.2d 109, 121 (1974).

223. Horstman, *supra* note 3, at 275.

224. Shelton v. Tucker, 364 U.S. 479, 488 (1960).

225. D.C. Code §§ 21-501 to 21-591 (Supp. V, 1966).

tion of the statute.[226] During the past decade many of the lower federal courts held that the least restrictive alternative concept requires the moving party, which is usually the state, to investigate and prove that the proposed institutionalization is the least restrictive means of treating or caring for the patient.[227] The petitioner must demonstrate the ineffectiveness of a number of possible treatment alternatives, including voluntary or court-ordered outpatient treatment, day care or night treatment in the hospital, placement in a private hospital or nursing home rather than a state mental institution, placement with a willing friend or relative, referral to a community health clinic, home health aid services and prescribed medication.[228]

It has been noted that in recent times 30% of the inmates in mental hospitals were elderly even though they constitute only 10% of the general population.[229] This is because in as many as half of the cases, people simply commit the elderly for physical care rather than use alternatives to commitment.[230] During the past decade, people have developed a growing number of such alternatives and have helped the elderly to be more self-sufficient, so that a suitable alternative should exist in all but the most severe cases.[231] The attorney for the elderly person should have explored alternatives and determined which is suitable for her client prior to the hearing. One judge has recommended that counsel in the commitment proceeding should offer the court a detailed and concrete program for alternative care and treatment of the prospective patient. The alternative program should be available as a backup even if the counsel firmly believes that the client should be discharged.[232] If a nursing home, community mental health clinic, visiting

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226. Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) (hailed as the "magna charta for the aged," by Horstman, *supra* note 3, at 265).

227. Eubanks v. Clarke, 434 F. Supp. 1022, 1027 (E.D. Pa. 1977); Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976); Lynch v. Baxley, 386 F. Supp. 378, 391 (M.D. Ala. 1974); Wyatt v. Stickney, 344 F. Supp. 373, 384 (M.D. Ala. 1972), *enforcing* 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd in relevant part, rem. in part, dec. reserved in part, sub nom* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); *In re* Ballay, 482 F.2d at 658; *Lessard,* 349 F. Supp. at 1095; Welsch v. Likins, 373 F. Supp. 487, 501 (D. Minn. 1974). *See also* Halderman v. Pennhurst State Sch. & Hosp., 612 F.2d 84 (3d Cir. 1979), *rev'd on other grounds,* 451 U.S. 1 (1981); Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980), 50 U.S.L.W. 4681 (U.S. June 18, 1982).

228. *Lynch,* 386 F. Supp. at 392. Discussion of various alternatives can be found in: Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives,* 70 MICH. L. REV. 1107 (1972); Chambers, *The Principle of the Least Restrictive Alternatives: The Constitutional Issue* in THE MENTALLY RETARDED CITIZEN AND THE LAW 486-99 (1976); Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill,* 14 SAN DIEGO L. REV. 1100 (1977); Zlotnick, *First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment,* 83 W. VA. L. REV. 375 (1980).

229. Horstman, *supra* note 3, at 273.

230. Lake v. Cameron, 364 F.2d at 660 n.9 (quoting *Hearings Before the Subcommittee on St. Elizabeth's Hospital of the House Committee on Education and Labor,* 88th Cong., 1st Sess. 23-24 (1963) (Testimony of Dr. Cameron)).

231. *See supra* text accompanying notes 148-68.

232. McClennan, *quoted in* Kirkpatrick, *supra* note 74, at 245 n.96.

nurse program, or friend or neighbor is the alternative, a representative of the organization or the friend should testify.

5. Subject Lacks Capacity for Rational Choice

The last requirement, that the subject lack capacity for rational choice, recognizes that "a finding of mental illness does not necessarily mean that an individual is deprived of all of his capacity to make rational decisions."[233] In view of the possible adverse consequences, particularly the stigma of commitment, "it is not difficult to see that the rational choice in many instances would be to forego treatment . . . ."[234] However, the test for commitment is not whether the trier of fact would consider the individual's decision irrational; it is whether the individual is "incapable of making a rational choice regarding the acceptance of care or treatment."[235] The individual must "lack the capacity to weigh for himself the risks of freedom and the benefits of hospitalization."[236] The fact that a person declines treatment cannot be equated with incapacity to decide; she could rationally choose to refuse treatment.[237] One court also differentiated between a "rational" and a "responsible" decision and held unconstitutional a statute which permitted commitment of one who lacks insight to "make a responsible decision" as to care and treatment, saying that the term was too vague and too subjective.[238] The court held that the test should not concentrate on the content of the subject's decision but rather on the method or decision-making ability of the subject.[239] Since persons diagnosed as having dementia or organic brain syndrome may retain their powers of judgment, this last requirement allows them to retain their freedom if they wish to endure its risks.

If the psychiatrist expert's responses to questions reveal that the lawyer's client lacks the clouded consciousness associated with delirium, the lawyer should be able to establish a foundation from which to argue that her client has the clarity of mind needed to make rational decisions about the desirability of her commitment. The lawyer may wish to put her client on the stand to persuade the trier of fact that the client reasons logically from premises to conclusions and uses correct information in doing so. In the closing argument the lawyer should emphasize that mere value judgments which differ from those of the community are the client's prerogative and are not a basis for committing her.

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233. Colyar v. Third Judicial Dist. Court for Salt Lake County, 469 F. Supp. 424, 431 (D. Utah 1979).

234. *Lessard,* 349 F. Supp. at 1094, *quoted in Colyar,* 469 F. Supp. at 431.

235. *Colyar,* 469 F. Supp. at 431.

236. *Lynch,* 386 F. Supp. at 391.

237. *Colyar,* 469 F. Supp. at 431. For analysis see generally N. KITTRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY (1971).

238. *Colyar,* 469 F. Supp. at 432.

239. *Id.* at 433.

IV

CONCLUSION

Involuntary commitment or involuntary placement of an elderly person in an institution or other restrictive environment is likely to be detrimental to the individual's welfare. The adverse consequences of mental commitments have been recognized for many years, but attorneys traditionally have demonstrated little skill or desire to prevent it. Recent interest in the attorney's role has sharpened awareness that attorneys can assure that only those persons for whom no other alternative exists are institutionalized. Three recent developments should aid attorneys in their task of preventing unjust involuntary confinement. First is recognition of numerous procedural and substantive constitutional and statutory rights that must be honored in the commitment proceeding. Second is the 1980 revision of the American Psychiatric Association's Diagnostic and Statistical Manual which formulates a new and detailed statement of the criteria necessary to diagnose an individual as suffering from the mental disorder dementia. Third are discoveries of various treatable causes of dementia symptoms. An attorney chosen or appointed to represent an elderly person in a commmitment proceeding should be able to utilize these three new developments. Central to the defense is an ability to understand the psychiatric diagnosis. The attorney who can convey to the trier of fact the import of the psychiatric diagnosis in relation to treatment alternatives and to the constitutional and statutory requirements for commitment can be an effective advocate for the client. The effective advocate can insure that the only persons who will be involuntarily committed are those who have untreatable primary degenerative dementia which would be life-threatening in the absence of institutionalization.